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DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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March 11, 2024

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From: Brandon T. Nichols, Director
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Judge Michael Nash (Ret.), Executive Director
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REPORT BACK TO THE OCTOBER 17, 2023 BOARD MOTION (ITEM NO. 3) REGARDING SUPPORTS FOR YOUTH WITH COMPLEX CARE NEEDS

On October 17, 2023, the Board of Supervisors (Board) adopted a motion authored by Supervisors Barger and Hahn directing the Department of Children and Family Services (DCFS), the Office of Child Protection (OCP), and the Chief Executive Officer (CEO), in collaboration and consultation with several County partners and stakeholders (the "team") to report back on developing supports for youth with complex care needs. Specifically, your Board directed the relevant County departments to report back on the following:

1. Analyze the feasibility of conducting an expedited solicitation to increase the number of beds available on an emergency basis by contracting with a service provider(s) who has proven expertise working with system impacted individuals with complex health, behavioral health, and mental health needs (see page 3);

2. Identify any returned funds to the State and make recommendations to establish a fund dedicated to a continuum of services for complex care youth that is comprised of immediate crisis response (such as a dedicated psychiatric mobile response team), earmarked beds for temporary hospitalization and subacute mental health beds, and external supports to existing congregate care providers

that are designed to help preserve placements, particularly during times of crisis (see page 26);

3. Build upon the DCFS and the Department of Mental Health (DMH) "strike team" model to establish countywide complex care teams comprised of designated staff from each department to develop a written crisis protocol to ensure continuity of care and case management for each individual complex care youth (see page 29);

4. Develop a plan and cost estimate to expand the DCFS Placement Stabilization Team (PST) (see page 30).

EXECUTIVE SUMMARY

DCFS, OCP, and CEO collaborated with County Counsel, DMH, the Probation Department (Probation), the Department of Health Services (DHS), the Department of Public Health-Substance Abuse Prevention and Control (SAPC), and the Department of Youth Development (DYD) to: (1) conduct a landscape analysis of existing placements, programs, and services that are available to youth with complex needs and to identify opportunities to improve systemic responsibility for these youth; (2) assess funding streams that are currently dedicated to youth with complex needs; (3) establish a countywide written crisis response protocol; and (4) develop a plan and cost estimate for expanding the DCFS Placement Stabilization Team (PST).

The landscape analysis revealed that the County has a comprehensive continuum of placements, programs, and services for youth in foster care; however, very few of these resources are dedicated ***exclusively*** to youth in foster care or to youth with complex needs.

In order to better align existing resources and prioritize service delivery to youth with complex needs, this report recommends:

1. A dedicated, unconditional County-operated or County co-staffed placement setting for youth with complex needs, and

2. Improved countywide integration of services through the System of Care (SOC) model established by California Assembly Bill 2083 and focused implementation of the recommendations in the March 7, 2023, "30-DAY REPORT BACK ON PLACEMENTS AND INTERVENTIONS FOR YOUTH IN FOSTER CARE WITH HIGHEST COMPLEX NEEDS.

The fiscal analysis revealed a handful of funding streams that are currently dedicated to youth with complex needs. The need to establish a dedicated fund with which to serve youth with complex needs should be further explored concurrently with the design of the placement setting described above and after County partners leverage and consider redirection of existing staffing, resources, and funding streams – including Medi-Cal, the California Department of Social Services (CDSS) complex care funds described below, capacity building and program grants to address mental health supports through the Children and Youth Behavioral Health Initiative (CYBHI).

The CEO brought all relevant county partners together to draft a written crisis response protocol that leans on DCFS and DMH to provide the core on-site crisis response de-escalation and intervention supports. As the departments work to finalize and implement the new protocol through the SOC, it should be reconciled with existing practice and the already existing response protocols discussed in this report.

Finally, DCFS developed a plan to expand PST capacity to serve an additional 48 youth. This would allow the program to expand into working with youth in Short-Term Residential Therapeutic Programs (STRTPs).

DIRECTIVE 1: ANALYZE THE FEASIBILITY OF CONDUCTING AN EXPEDITED SOLICITATION TO INCREASE THE NUMBER OF BEDS AVAILABLE ON AN EMERGENCY BASIS BY CONTRACTING WITH A SERVICE PROVIDER(S) WHO HAS PROVEN EXPERTISE WORKING WITH SYSTEM IMPACTED INDIVIDUALS WITH COMPLEX HEALTH, BEHAVIORAL HEALTH, AND MENTAL HEALTH NEEDS (DCFS LEAD)

To analyze the need for a potential expedited solicitation, the team sought to understand three key factors:

1. How do we define the universe of youth with complex needs?
2. What does our existing system of care and placements offer for these youth?
3. What are the gaps that could be addressed by an expedited solicitation?

IDENTIFYING THE POPULATION OF COMPLEX CARE YOUTH AND UNDERSTANDING THEIR NEEDS

In order to effectively address your Board's directives, the team started with the foundational question—what is the definition of a youth with complex needs? It is important to reach a mutual understanding on the scope of the population but, even more importantly, the nature of the needs for these children and youth.

The Numbers

The State of California offers the following parameters to identify the universe of youth with complex needs:

- Highest level of acuity and complexity (could be physical health, mental health, and/or substance use)
- Youth residing in unlicensed settings
- Youth with multiple 14-day notices
- Youth with multiple placement changes
- Youth with long lengths of stay in congregate care settings

The team agreed that, by default, any youth who is placed at an STRTP is a youth with complex needs. The youth who are placed in STRTPs often fall under the State's focus on youth with the "highest level of acuity and complexity" and "youth with long lengths of stay in congregate care settings."

Next, the team focused on your Board's emphasis on emergencies, crisis response, and placement stabilization. Within this priority, the team identified youth who are on the DCFS PST caseload, including the PST wait list. Focusing on this group of youth to define "complex care youth" is consistent with the State's focus on "youth with multiple placement changes" and "youth residing in unlicensed settings," as well as our local commitment to prioritize the needs and stability for youth who are housed in our Temporary Shelter Care Facilities (TSCFs) and County-Operated Shelters (COS).

The assessment confirmed that the number of youth who fall into this special population is quite small in comparison to the overall number of children in care. The number of youth on the PST caseloads and the number who cycle in and out of hotels is quite small; however, the needs of these youth are at the highest levels of acuity and complexity. Understanding who they are and what their needs are even though they are small in number is critical because these are the youths whom are of highest risk for becoming homeless and becoming entangled in the adult justice system if we fail them when they are young.

Ideally, this small number makes it easier and more realistic for all system partners to contribute solutions and resources for this compelling population. The following chart depicts the complex youth population, in the last calendar year, in relation to the overall DCFS youth population.

The Needs

To gain a better understanding of the needs of youth with multiple and complex needs, in 2023, OCP analyzed a sample of 30 youth identified by DCFS as experiencing multiple and complex needs. The OCP analysis included Child and Adolescent Needs and Strengths (CANS) Assessment Tool data, placement reports, aggregate service summaries from DHS, DMH, and SAPC, and interviews with a subset of 11 DCFS social workers who provided detailed reflections on these youth.

OCP used this analysis to create a series of youth profiles to help us better understand these youth (see Attachment A). The OCP youth profiles reveal that the true complexity lies in the multi-faceted nature of this population's needs. Interviews with staff about specific youth profiles indicated that the majority of these youth present with a combination of two or more of the following:

- Significant mental health issues that impact their emotional well-being.
- Co-occurring conditions including mental health issues, intellectual/developmental disabilities, Fetal Alcohol Effects, Fetal Alcohol Disorder, and substance use disorders.
- Extensive complex trauma histories.

- A lack of natural supports or connection to a consistent family member, which lead to challenges with engagement and trust, including mistrust of the county systems that are responsible for providing services.
- Challenges with care and coordination and connection to services including medical, mental health, and intellectual/developmental.
- Inconsistent educational settings and enrollment.

The OCP profiles give a real perspective on the history of trauma and unmet needs that often launch our youth into cycles of failed placements, instability, and deepening trauma. The profiles of "C" and "E" are summarized here[1]:

> ***C is 17 years old. Prior to being adopted as a toddler, C suffered a history of severe physical abuse and neglect, cigarette burns/bruises all over their body, and fetal alcohol syndrome. C entered care at 16 years of age when their parents felt they were no longer able to care for and manage C's needs and behaviors. C has had five placements in just over one year and has spent 18 days in temporary hotel placements. C's substance use started after their first placement and has consisted of marijuana, methamphetamine, and opioids. C has overdosed on fentanyl. C is currently placed at a psychiatric hospital in a developmental delay mental health unit and is conserved. C has an IEP but refuses to do school packets and has been denied admission to non-public schools. C remains connected to their parents but is unable to return to their home.***
>
> ***E is 12 years old. E had prior CPS history of physical and sexual abuse. E also witnessed domestic violence between his parents. He has had 25 placements and is currently placed at an STRTP. E's CANS analysis shows a dangerous/disabling level of impulsivity and adjustment to trauma. He has PTSD, ADHD, and Disruptive Mood Dysregulation Disorder. DCFS' evaluation indicated that E has an intellectual disability but Regional Center found E ineligible for services. E is being re-referred to the Regional Center. E has threatened to kill himself and staff. E is engaging with peers and adults, loves to cook, and is described as loyal, protective, and resourceful.***

The County's existing continuum is equipped to address certain needs in isolation. However, gaps exist for youth who present with a complex combination of needs. For example, if the youth's mental health acuity is low to moderate without additional

[1] C and E are not actual youth/children/young adults. The profiles are based on a compilation of data and are intended only to demonstrate the representative needs of youth/children/young adults who experience placement instability.

complicating factors, our system can be responsive. But, if a youth has high acuity mental health needs *and* intellectual or developmental needs, coordination between multiple systems sometimes proves to be a challenge. Additionally, if a youth has *only* substance use needs, we may succeed in identifying appropriate placement and supportive services. But, almost all substance use providers refuse youth with co-occurring disorders.

When a youth has several factors that contribute to their complex profile, such as a history of abuse, history of juvenile justice involvement, childhood commercial sexual exploitation, substance use, mental health needs, developmental delays, and complex trauma, it becomes challenging for system partners to seamlessly address the youth's needs. Perhaps the most difficult scenario is when any of these complex needs manifest themselves with physical conduct—such as aggressive or violent behavior towards others or damaging property. When that combination of complex needs is present, youth are turned away from many supportive systems and placement options. Additionally, if supportive or treatment services are offered, youth often decline to consent to such services, making it difficult to provide the necessary help.

It is when a young person's needs become increasingly complex over time and, present in combination with one another, that children and youth end up with the instability that leaves DCFS with little to no options, other than temporary shelter care and/or hotel placements. This is when situations become unsafe for youth, social workers and the staff supervising youth in these settings.

WHAT PLACEMENTS AND SERVICES ARE OFFERED IN THE COUNTY'S EXISTING CONTINUUM FOR CHILDREN AND YOUTH IN FOSTER CARE

In order to address your Board's first directive – to determine the feasibility of an expedited solicitation – the team put together a landscape of the existing continuum of placements and services that are already available in the County departments and agencies that serve children and youth (See Attachment B). Going through this landscape analysis was a necessary first step to identifying gaps that may be addressed through an expedited solicitation.

The landscape analysis revealed that the County has a comprehensive continuum of services and deep expertise that could provide the cross-disciplinary care that our complex care youth need. Each county department, on its own, has specialized services that range from outpatient/field services to intensive and residential services. The challenge is that, with few exceptions, only DCFS' placements and services are dedicated exclusively to youth in foster care. For the most part, youth in foster care must compete for limited resources with the entire population of clients that are served by Departments such as DMH, DHS, and DPH/SAPC.

The following is a brief summary of each departments' services, with more detail provided for DCFS and DMH. Each department's continuum, in full, is included in Attachment B.

DCFS Continuum of Placements and Services

DCFS' continuum of care is built to meet State law requirements that children and youth are always to be placed in the least restrictive, most permanent settings possible. DCFS' continuum in Attachment B is in priority order with the path to permanency where a parent's home is the most permanent (and ideal) placement option and shelter care is reflected as the least permanent option.

Consistent with State Continuum of Care Reform, DCFS prioritizes placement with kin, non-related extended family members, and foster homes. Congregate care is reserved as an option of last resort and DCFS' goal is always to make such placements as short-term as possible in favor a family-based placement. Even for children and young people who need intensive mental health or medical services, family-based placement is the preferred option.

The most commonly used placement options in the child welfare system have historically been the following: home of parent; home of relative/nonrelative extended family member; foster homes; temporary shelter-based care; and congregate care (e.g., STRTPs). Although reforms over the years have changed the nature and scope of foster care placements, these have been the core types of placements DCFS has focused on over the years.

But, as noted above, the complexity of needs youth are presenting with has given rise to greater focus on the types of supportive services the Department puts into place. In response, DCFS has evolved the types of placements it develops in order to meet the changing needs of the children and youth who are served by the Department. Accordingly, the placement and services continuum DCFS offers has grown as follows[2]:

- Transitional Housing Placements and Transitional Living Settings: residential settings for Transition Age Youth (TAY) and Non-Minor Dependents (NMDs) in which core services include housing, independent living skills, educational and behavioral support, transition planning and life skills. The current inventory of these placements has the capacity to support a total of approximately 250 TAY and NMDs and DCFS consistently explores opportunities to expand the capacity and type of residential settings for TAY and NMDs.

[2] Where indicated, these programs are in early implementation and/or operating as pilots. Permanency will be based on outcomes and funding.

- Intensive Services Foster Care (ISFC)—Foster Family Agency (FFA) model: Home-based settings for children, youth, and NMDs in which core services include coordinated, comprehensive, community-based services and access to trauma-informed mental health treatment. ISFC home-based placements offer one of the best options for children and youth with high needs. DMH also contracts with the FFAs to deliver specialty mental health services and partners with DCFS to ensure youth are matched with a caregiver who best meets their needs. *The need for ISFC beds currently exceeds the availability as the inventory of ISFC FFA beds is at 80 whereas the need for ISFC beds is estimated to be in the range of 300.*

- Small Family Home: unique to Los Angeles County, these settings are for medically fragile children whose medical complexities require a specialized level of care but does not rise to the level of requiring placement in a medical facility. The current inventory of these beds consists of thirty-eight beds in sixteen homes. This model is one that warrants further exploration as an option to serve youth with complex needs.

- Community Treatment Facility (CTF): secure settings for children, youth and NMDs who have chronic and persistent mental, emotional, and behavioral disorders. This setting is a last-resort option reserved for situations in which less restrictive settings have not met the youth's needs (e.g., multiple hospitalizations, STRTP denials, etc.) Youth must either consent to placement in a CTF or be conserved. There are only two CTFs with a total of 68 beds in the state of California. Both are in Los Angeles County but not dedicated exclusively to DCFS youth. DMH also contracts with the CTFs to deliver specialty mental health services.

- Placement Stabilization Team (expansion underway): DCFS has the only PST in the State. PST social workers are assigned as secondary social workers on the case and are specially trained to stabilize placements for youth who have cycled in and out of temporary shelter care placements. PST social workers are strongly motivated to foster great relationships between youth, caregivers, their community, and DCFS. PST partners with the DMH network of providers such as Wraparound, Full Service Partnership (FSP), and Intensive Field Capable Clinical Services (IFCCS) to address the needs of these youth. Youth receive PST services for anywhere from six to forty-eight months and remain part of the program until they are stable and ready to move forward without their PST social worker. Many of these youth have graduated high school, obtained jobs, and gotten their own residences; some have moved out-of-state. According to the

most recent OCP update, pre-PST intervention, over 74 percent (82 of 112) of the youth working with PST were living in congregate-care settings rather than family settings: home of parent, resource family homes, or transitional housing/independent living programs. With PST intervention, that number has dropped to 45 percent (50 of 112), and over 55 percent (62 of 112) of the youth are now in family settings. As of January 19, 2024, PST was serving 107 youth, with an additional 89 youth on the PST waitlist. With the addition of the newest PST social worker in December 2023, the goal is to soon serve up to 120 youth. With full staffing of the current budgeted positions, the program hopes to serve 140 youth. Pursuant to Directive #4, a proposal to further expand the PST to a capacity of 180-190 youth is set forth below.

- Therapeutic Foster Care Shelter Pilot: DCFS is working with Optimist, through the PST, to provide shelter care that is therapeutic and family/home-based. The key to this model is the 24/7 availability and partnership between the Resource Parents and the DCFS PST social worker. Once a young person is placed in the shelter home, the staff from Optimist convene a Child and Family Team (CFT) meeting within three days of arrival and every five days thereafter until a permanent placement is located for the youth. The clinical staff at Optimist is in place via a contract through DMH. During the length of stay, Optimist staff visits the child/youth daily to coordinate services and address any concerns. Staff is present when the youth arrives at the home and also when the youth transitions to their permanent placement.

- Optimist Temporary Living Setting (TLS) Placement (early implementation): This program offers 40 beds to young people, ages 18-20, with a disrupted placement where all efforts for a more permanent placement have been exhausted. The TLS has successfully been used as an alternative to hotel placements, which has resulted in a near-zero rate of NMDs in hotels since the fall of 2023.

- Near Peer Mentorship Pilot: The Near Peer Mentorship pilot is a collaboration between DCFS, Casey Family Programs (CFP), Castillo Consulting Partners, and OCP. The program began as a demonstration project in October 2022 at one TSCF. As stated by CFP, the “primary intention was to offer a transformative, life-altering experience for youth in the shelters by providing them with access to, and fostering relationships with at least one adult with lived experience who could help them navigate the complexities of adolescence in foster care by relating to and connecting with them on a personal level.” Your Board recently passed a motion that will enable the pilot to expand to all six TSCFs by mid-2024.

- Behavioral Aide Contract with Delta-T: This contract provides 1:1 aides to DCFS youth with the goal of preventing youth from having to enter temporary shelters, experience frequent placement disruptions, and decrease entry into congregate care settings. Aide services are approved for up to 60 days at a time and are initiated by the youth's CFT. These aides provide support to caregivers but are not able to be left alone with the youth, cannot physically restrain youth, and do not provide clinical interventions.

- Intensive Services Foster Care – Public Model (early implementation): This model is similar to the ISFC FFA model described above with the following differences: (1) available to resource parents who are not contracted through an FFA; (2) eligibility is based on the youth's Level of Care (LOC) assessment (initial or redetermination); and (3) ongoing support is provided by DCFS assigned secondary social workers. DCFS launched the ISFC Public Model on December 1, 2023, with one unit of social workers supporting the current caregivers. DCFS is in the process of hiring a second unit of social workers. DMH is supporting this program through its DMH-Specialized Foster Care co-located staff.

- Nonviolent Crisis Intervention for Safety in the Field: DCFS implemented a specialized nonviolent crisis intervention training to promote staff safety and to improve staff engagement skills. A two-day training was designed for social workers and human services aides, and a one-day condensed training was designed for supervising children's social workers. Both trainings focus on understanding and learning the impact of stressors/trauma to children and youth and how DCFS can impact, in a positive or negative way, the interaction that children and youth have with DCFS. Time is also spent learning physical skills for effective self-protection when de-escalation is not a viable option.

DMH Continuum of Programs and Services

The DMH Child Welfare Division (CWD) is a crucial partner of DCFS in providing specialty mental health services to children in the child welfare system. CWD offers various programs and services for the child welfare population at different stages of their involvement with DCFS. In addition, the DMH Intensive Care Division (ICD) operates facility-based services that have become increasingly important due to the growing complexity of needs seen in system-involved youth.

- Specialized Foster Care (SFC): SFC is a mental health services program that is aimed at helping children who enter or are about to enter the child welfare system. The program ensures that children receive the necessary mental health

services. The teams consist of program managers, clinical supervisors, psychologists, psychiatric social workers, and case managers located within DCFS offices countywide. The team offers various services such as screening, assessment, crisis intervention, treatment, teaming, consultation, and linkage to ongoing treatment providers.

- Community-Based Supportive Services: DMH contracts with providers who support families and resource parents through outpatient, intensive in-home services, 24/7 crisis response, intensive care coordination, and multi-disciplinary teaming approaches. DMH provides programs, such as Wraparound and Wraparound FSP, Multidisciplinary Assessment Teams, and Intensive Field Based Services that are dedicated exclusively to DCFS involved youth. These DMH-contracted providers partner closely with the DCFS PST to address the needs of youth served by the PST. Other programs, such as the FSP Program are not DCFS dedicated.

- Psychiatric Mobile Response Team or Mobile Crisis Teams (PMRT/MCT): The PMRT/MCT program provides non-law enforcement-based mobile crisis response for individuals experiencing a psychiatric emergency anywhere throughout the County. The teams are available 24/7 and consist of DMH clinicians or provider staff designated to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others, or who are unable to provide food, clothing, or shelter for themselves. The teams provide caring, de-escalating, and trauma-informed approaches to crisis intervention. The team's strategies support individuals and their families through establishing trustful relationships, ultimately contributing to reducing the stigma surrounding mental health and accessing help.

- Therapeutic Behavioral Services (TBS): TBS is an intensive, individualized, one-to-one behavioral mental health services available to children/youth with serious emotional challenges and their families who are under 21 years old and have full scope Medi-Cal. TBS services target specific behavioral related to serious emotional disturbance. They do not provide crisis intervention and they are not able to physically restrain children/youth. TBS services are available to DCFS youth who meet the criteria and consent to the service. TBS services are not dedicated exclusively to DCFS youth.

  The eligibility criteria for TBS services includes:

- Child/youth is placed in a residential facility (e.g., STRTP) or in a locked treatment facility for the treatment of mental health needs; or
- Child/youth is being considered by the county for placement in a facility described above; or
- Child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months; or
- Child/youth has previously received TBS while a member of the certified class; or
- Child/youth is at risk of psychiatric hospitalization.

- Facility-Based Services: DMH also operates and/or contracts for inpatient and residential-based services, which are overseen by DMH Intensive Care Division. None of these facilities are DCFS-dedicated.

  - Psychiatric Health Facilities (PHF): PHFs are licensed by the State Department of Health Care Services (DHCS) and provide non-hospital 24-hour inpatient services designed to provide innovative and more comprehensive acute care service as an alternative to hospital care to clients ages 13 to 17 years (adolescent) and ages 18 and older. All clients are pre-screened by LAC-DMH as clinically appropriate for Acute Psychiatric Inpatient Hospital level of care according to generally accepted standards. In addition to the age criteria, clients referred to the PHF must meet specific admission criteria.
  - Psychiatric Urgent Care Centers (UCCs): UCCs are Medi-Cal certified and Lanterman-Petris-Short (LPS) designated crisis stabilization units that provide 24/7 rapid access to mental health evaluation and assessment, crisis intervention, and medication support, as well as case management for individuals experiencing psychological distress and/or psychiatric crisis. The length of stay in UCCs is limited to 24 hours.
  - Enriched Residential Services (ERS): ERS provide comprehensive mental health and rehabilitative services in a non-institutional residential setting for individuals 18 and older, who would be at risk of hospitalization, re- hospitalization or other institutional placement if they were not in the ERS program. ERS program accommodates persons discharged from a locked subacute, acute psychiatric inpatient units, jails, or intensive residential facilities at risk of needing higher level of care. ERS targets individuals in higher levels of care who require on-site mental health and supportive services that focus on life skills training, linkage and community engagement activities that support individuals in their effort to restore,

maintain and apply interpersonal and independent living skills and to access community support systems, with the goal stabilizing, preparing, and transitioning individuals to a stable independent community living environment.

- Gateways/Kedren: These hospital facilities provide 24-hour psychiatric treatments. Services are provided in an acute psychiatric hospital or a distinct acute psychiatric part of a general acute care hospital that is approved by the DHCS to provide psychiatric services. Both Gateways and Kedren serve youth ages 13 to 17. Kedren also serves the adult 18+ population.
- Crisis Residential Treatment Program (CRTP): CRTP is an intensive short-term (average length of stay is 30 days with a maximum of three months) and structured residential program utilized as an alternative to hospitalization for clients experiencing acute psychiatric crisis or episode who do not have medical complications requiring nursing care. The goal in a CRTP is to stabilize clients 18 and older so they can transition to a lower level of care. *CRTP expansion to children and youth under the age of 18 is part of the Children's Crisis Continuum Pilot Project described below.*
- Institutions for Mental Disease (IMD) Subacute: Subacute facilities provide psychiatric treatment to individuals 18 and older with severe and persistent mental illnesses in a non-hospital-based therapeutic residential setting. Subacute facilities provide long term care for individuals who no longer meet the criteria for acute care but are not clinically ready to live independently. Subacute facilities provide 24/7 psychiatric care, nursing care, and psychosocial rehabilitation services, geared to the needs of individuals with serious mental illness who are placed under LPS conservatorship. DCFS and DMH have a Memorandum of Understanding (MOU) in place for TAY who meet the criteria for IMD Subacute care.

DCFS and DMH Partnership Programs

- Coordinated Services Action Team (CSAT): The primary function of the CSAT is to provide regionally-based, clinically-focused collaboration with the Children's Social Worker (CSW) and CFT, with the goal of coordinating services to address the mental health, emotional well-being, and developmental needs of system-involved youth, and ensuring alignment of the various providers who serve the family. Each regional office has various staffing resources and needs. The composition of the CSAT may vary depending on the nature of the family/children's needs and status of the child's placement. The CSAT may be

comprised of various members, including but not limited to, the Public Health Nurse (PHN), Residential Care Liaison (RCL), LOC social worker, DMH Specialized Foster Care, Education Specialist, Parents in Partnership (PIP), and Community Based Liaison (CBL). Shared responsibilities (and lead position) may also vary depending on the needs of the case and the CFT. The CSAT provides office-based expertise to identify a family's strength/needs and ensure linkage to community-based resources.

- Field Response Operation: A joint response protocol was developed between DCFS and DMH to ensure individualized safety plans for children/NMDs in crisis. This protocol also established a formal process for the timely identification, notification, and response to DCFS children/NMDs experiencing acute mental health episodes. The protocol outlines communication between DCFS and DMH when the team responds face-to-face to a child who does not meet the criteria for a psychiatric hold. The purpose of a joint response between DCFS and DMH is to provide for the coordination of services between both agencies and to share information and expertise regarding children with acute mental health needs served by DCFS. The goal of the joint response is to ensure real-time communication, a joint assessment of the child and family's safety, risk, and service needs, and mutually agreed upon follow-up activities between DCFS and DMH. Following the crisis, DCFS and DMH staff will work with the child, various team members, and each other to evaluate the results of the crisis intervention and, if applicable, to adapt the current case plan to enhance the outcome for the child and family.

- Family Urgent Response System (FURS): On July 1, 2021, nineteen counties in California implemented FURS, a system of support for children and youth in the foster care system, to allow for swift interventions to prevent placement disruption, interactions with law enforcement and hospitalizations. FURS is a 24/7 coordinated, statewide, regional, and county-level system designed to provide collaborative and timely state-level, phone-based response and county-level, in-home, in-person mobile response during situations of placement instability. FURS statewide hotline requirements include: availability 24/7 to respond to calls from a caregiver, current or former foster youth during situations of instability; hotline workers trained in conflict resolution and de-escalation for children and youth impacted by trauma; and the capacity to provide mediation, relationship preservation for the caregiver, child/youth; and a family centered, developmentally appropriate approach. In Los Angeles County, DCFS and DMH collaborate closely on responding to this population in distress. Both departments utilize developmentally appropriate conflict management and resolution skills

to stabilize the living situation, mitigate the distress of the caregiver or child, connect the caregiver and child to the existing array of local services, and promote a health and healing environment for children, youth, NMD, and families. *The Governor's Proposed 2024-25 Budget proposes to eliminate state funding for FURS.*

- Children's Crisis Continuum Pilot Program (CCCPP): Assembly Bill (AB) 153 mandated the creation of the CCCPP to be jointly implemented by the CDSS and the DHCS. The objective of the CCCPP is to fully integrate the system of care for foster youth enabling a seamless transition between service settings and to provide stabilization and treatment to foster youth with high acuity needs within the least restrictive setting possible.

  A Request for Proposals was released and Los Angeles County (LA County) submitted a proposal to CDSS and DHCS to participate in a five-year pilot program. On February 24, 2023, LA County received a tentative award for $10,000,000 to develop and implement a CCCPP. The final proposal Work Plan and Budget was submitted to CDSS on December 6, 2023, and is currently under review. The Grant Agreements are anticipated to be sent to participating counties in February 2024.

  As part of the CCCPP, LA County is planning to collaborate with The Sycamores (Sycamores) who is proposing to operate three components associated with the CCCPP: a four-bed Children's Crisis Residential Program (CCRP), eight bed ISFC Program, and a Community-Based Supportive Services Program (CBSS).

  The CCCPP ISFC services are critical to support the goal of continuum of care, as it provides the highest level of in-home placement services for children and youth with serious emotional and behavioral issues. This placement will allow the child/youth to reside in a home-based setting with CCCPP ISFC trained Resource Parents, overseen by Sycamores' social work case managers, in- home support counselors, and mental health clinician. Each child/youth will have a personalized intensive mental health services treatment plan that meets the needs of the child/youth, whether the placement is a step-down from CCRP or directly into the CCCPP ISFC service component.

  The program will have eight homes with a one-bed minimum per each home. The goal is to increase the number of available beds as the project continues. The County will leverage the existing ISFC contract with Sycamores

for this CCCPP ISFC component. The anticipated start date of the Project is October 2024.

Los Angeles County will utilize the existing Behavioral Aide Services contract to provide one to one (1:1) support for children/youth with severe behaviors and or mental health challenges. Additional 1:1 support will be provided, utilizing Child Specific Complex Care and Flexible Family Support funds.

The CCRP will be licensed as a STRTP that operates under the CCRP subcategory, consisting of one facility with four beds with an anticipated length of stay of ten consecutive days or less. The CCRP will care for youth in mental health crisis to reduce reliance on hospital stays, preserve placement in less restrictive settings, and to reduce further trauma. The CCRP will also provide respite care for instances when youth have transitioned to lower-level of care and experience a crisis episode, needing stabilization. This will be accomplished through funding and securing vacant beds for youth who participate in the CCCPP until permanency is achieved.

Upon receipt of the CCRP referral, Sycamores' licensed mental health professional will affirm that the child meets the admission requirements in accordance to the mental health program interim standards. Sycamores will adopt the "No Reject, No Eject" policy once eligibility criteria has been met.

The CCCPP will also ensure processes are developed to minimize delays and expedite access to services, will ensure that LA County more closely collaborates with current contractors to strengthen the youth's transitions and add requirements to ensure that the CFT that starts with the youth at initial placement in the crisis continuum will stay with the youth until they are ready to transition from the intensive mental health teams to a less intensive team.

- DMH/DCFS Engagement Team (also referred to as a "Strike Team" in the Directive #3 proposal):

  The March 7, 2023 "30-DAY REPORT BACK ON PLACEMENTS AND INTERVENTIONS FOR YOUTH IN FOSTER CARE WITH THE HIGHEST COMPLEX NEEDS" recommended that County partners in the SOC come together to pilot a "joint staffing/resourcing and shared responsibility for youth outcomes across the System of Care." The report went on to recommend that the "multiagency PST would include the DCFS PST social worker, as well as staff, providers, or resources from Probation, DMH, DPH, SAPC, DHS (or

whomever is the youth's primary care provider), Department of Public Social Services (Linkages program), Regional Centers, DYD, education partners, Credible Messenger or peer support program, and/or others, as needed, to provide case-specific teaming to 30 of DCFS's highest-need/hard-to-place youth."

Since that March report, the recommendation has materialized as an "engagement" or "strike" team concept beginning with DMH and DCFS. The engagement team concept is one in which each department assigns staff to provide consistent and meaningful engagement to young people who have not been amenable to services or placements. The engagement team began accepting referrals on November 28, 2023. To date, the team has received four referrals from DCFS. In each case, the DMH clinician actively engaged the youth and their caregivers. As a result, one youth agreed to accept services and was successfully connected to an IFCCS provider. The three remaining youth have been actively involved with the engagement team clinician who continues to provide support and engagement. Placements for all four referred youth have stabilized. DMH and DCFS program leads have communicated regularly to identify youth for the program and refine the referral workflow. The DMH Engagement Team meets weekly to discuss referred youths' progress and address any systemic barriers. The DMH and DCFS teams have also developed a monthly countywide meeting for staff to discuss cases, address challenges, and share resources. DCFS is actively working to identify additional youth for the program, and DMH expects to receive four additional referrals per week. The DCFS staff who are part of the engagement team are available on a 24/7 basis. While the DMH engagement staff are available only during regular business hours, PMRT, or the MCT, is available 24/7.

- Expanding Dialectical Behavioral Therapy: On April 10, 2023, DMH in collaboration with DCFS and Probation applied to the CYBHI for the Evidenced- Based and Community Defined Practiced Grant Program Round Two: Trauma- Informed Program and Practice to train and implement Dialectical Behavioral Therapy (DBT) to address the emotional dysregulation experienced by complex care youth in foster care including those who are dually supervised. On December 21, 2023, DMH received notification from CYBHI of its $750,000 award. This two-year grant is to create an infrastructure that supports an effective Evidence-Based Practice learning network with DMH as the lead in collaboration with DCFS and Probation as sub-recipients to expand the use of DBT across Los Angeles County's child welfare system. DMH will serve as the primary agency lead responsible for training and implementation of DBT in a

phased approach. DMH awaits the final grant implementation approval while completing a series of deliverables delineated by the DHCS and its third-party administrator the California Institute for Behavioral Health Solutions, along with Heluna Health.

Probation Department Continuum of Placements and Services

The Probation Department's continuum of services and placements are anchored in a young person's involvement with the Juvenile Delinquency Court System and referrals from law enforcement. Commonly, youth have cases in both the delinquency and dependency court systems. Probation is responsible for providing a continuum of services ranging from non-court based informal supervision to the most restrictive setting being the Secure Youth Treatment Facilities (SYTF).

The Probation Department is the only County department that has investigative, placement and supervision jurisdictional responsibility over young people who are charged with various criminal code violations. Pursuant to law, the Probation Department is the only County agency that, pursuant to a delinquency court's order, can hold a youth in custody/out-of-home detention, and/or open or closed placement settings.

The Juvenile Delinquency Court has authority, similar to Dependency Court, to make "suitable placement" orders. A "suitable placement" order is made when the court finds out-of-home placement in a foster care setting is the appropriate disposition of the delinquency petition. In making a "suitable placement" order, the Delinquency Court opens up placement possibilities that are similar to those offered in the child welfare system including: home of parent, relative/nonrelative extended family member, foster home, or STRTP.

In addition, the Delinquency Court has the option of ordering a youth placed at Probation Dorothy Kirby Center (DKC), which is a closed and secure placement setting and a part of Probation's Residential Treatment Services Bureau. DKC is a specialized treatment placement for youth with high needs in a Probation-DMH partnership model focused on high-acuity mental health, behavioral health, and educational services. It is not an STRTP and requires the court to make a "closed" suitable placement order. Post- dispositional youth are only placed at DKC as the result of a Delinquency Court order and then only following an assessment process that includes intensive case review to determine when the youth's needs rise to the level of care offered at DKC.

DHS Continuum of Placements and Services

DMH contracts with DHS to provide specialty mental health services through three Psychiatric Emergency Service (PES)/Psychiatric Emergency Rooms. The program

provides on-site, evaluation, diagnosis, medication and crisis intervention services to adults and children who are experiencing a psychiatric emergency. The DHS PES team can refer patients who are seen for additional services and/or facilitate voluntary or involuntary psychiatric hospitalization if necessary. The psychiatric emergency room serves as the entry point for each DHS hospital's inpatient acute psychiatric program. Services are designed to meet the needs of patients who are experiencing a severe psychiatric emergency according to medical necessity criteria as defined by the State of California.

DMH contracts with DHS to provide specialty mental health services through one acute adolescent psychiatry inpatient unit located at LA General Medical Center (LAGMC), licensed for 10 beds serving adolescents ages 13-18. It provides a twenty-four hour short-term inpatient treatment program to acute adolescents experiencing a psychiatric crisis with the intent to ameliorate the symptoms of danger to self and others or the inability to provide for food, clothing, and shelter due to a mental disability as determined by qualified mental health professional staff. Admission is contingent on the physician's evaluation of the youth to meet acute medical necessity criteria for admission and bed availability. If there are no adolescent inpatient beds available at LAGMC, the PES will conduct a bed search within the youth's mental health plan or DMH's network of care to transfer the youth to the most clinically appropriate level of care. There is no physical space for expansion of this clinical resource. Given the high demand for acute psychiatric care for adolescents within the community and a relative shortage of beds available within Los Angeles County, it is not possible to dedicate all or a portion of these beds exclusively for DCFS youth without serious repercussions on DHS' ability to provide timely, appropriate services for non-DCFS youth requiring this most acute level of care.

DHS also provides an array of other medical services for youth, including the Medical Hubs for DCFS-involved children and youth, Juvenile Court Health Services within Probation facilities, the Strong Healthy and Resilient Kids (SHARK) clinic, medication-assisted treatment services, gender-affirming care, and more, as described in Attachment B. The Medical Hubs are a collaborative effort amongst DHS, DCFS, DMH, and DPH where each department provides specialized services and support.

DPH-SAPC Continuum of Placements and Services

SAPC has several services that are available for DCFS youth. First, SAPC has a 24/7 Substance Abuse Services Hotline (SASH) that is available for general inquiries. SASH can connect youth who are seeking specialty Substance Use Disorder (SUD) services with appropriate SUD providers throughout the County.

SAPC also has a team of SUD counselors as part of the Client Engagement Navigation Services (CENS) in each service planning area across the County. CENS counselors

can provide placement assistance to youth, families and youth-serving entities (such as STRTPs, social workers, and other county staff).

Lastly, SAPC indicated that services are available across the following levels of care for youth under 21 years of age; however, none of these services are dedicated specifically for DCFS youth:

- Early Intervention
- Outpatient
- Intensive Outpatient
- Low Intensity Residential
- High Intensity Residential
- Medication for Addiction Treatment (MAT) services and Withdrawal Management Services are available for young adults (18 and older) and on a case-by-case basis for youth under 18 years of age.

DYD Continuum of Placements and Services

According to its recent quarterly dashboard, DYD is seeing a fair number of DCFS-involved youth in its existing programs. For the quarter ending on December 31, 2023, DYD data shows 169 DCFS-involved youth formally referred to DYD Diversion Providers by law enforcement and the District Attorney's office. Of those 169 youth, 155 enrolled in diversion programming and, of those, 112 DCFS-involved youth have substantially completed their diversion programming.

As DYD moves toward becoming the lead agency on programming for justice-involved youth, it is very likely that DYD's engagement with DCFS-involved youth will increase. The high degree of crossover between DCFS and Probation has been well established and thus, it follows that the cross-over between DCFS and DYD will also be significant. The DYD continuum shows that most of the Department's services and programming are in the early stages of implementation and that its placement model – Safe Healing Centers – is expected to begin as a small pilot in 2024.

Nevertheless, there are opportunities for DCFS and DYD to collaborate in the interest of addressing unmet needs for the complex care population. DYD is already working with DCFS-involved youth in its Diversion Program and the two departments have had preliminary conversations about expanding DYD's Credible Messenger program to the complex care population. Additional collaborations should be explored as DYD stands up more of its programming and services.

DOES THE EXISTING CONTINUUM OF PLACEMENTS AND SERVICES REVEAL GAPS THAT MIGHT BE ADDRESSED THROUGH AN EXPEDITED SOLICITATION?

The Gaps

As demonstrated above and in Attachment B, the countywide continuum for youth in foster care is comprehensive and intended to address even the high acuity and complex needs of children and youth. Nevertheless, there are opportunities to improve services that affect, at a minimum, youth whose trauma materializes through physical and emotional outbursts, serious and dangerous drug use, and a lack of stability that makes placing them in a family environment difficult (if not impossible).

Some opportunities to build a more robust system of care were identified in the March 7, 2023, "30-DAY REPORT BACK ON PLACEMENTS AND INTERVENTIONS FOR YOUTH IN FOSTER CARE WITH THE HIGHEST COMPLEX NEEDS" but, they are
worth repeating here. The recommendations from that report should continue to be implemented as a complement to the findings and conclusions set forth here.

1. There is currently no such thing as an "unconditional" foster care placement for youth who present with complex needs. Every foster care provider must take into consideration the safety of their family, their staff, other youth in their care (including their own children), and the youth who needs a higher level of care and services. For youth with complex unmet needs, the very real way in which their trauma surfaces – drug use, property damage, assaultive behavior, and emotional outbursts – are often the same reasons youth are removed from placements. These decisions do not come lightly, and while DCFS works diligently to preserve placements and bring in the appropriate supports and services into homes and other settings, we cannot do this alone, and must leverage other systems and services from partner agencies. Unfortunately, these other systems are not structured to provide the 24/7 support that many of our youth with unmet, complex needs require.

2. Foster youth often have significant trauma that takes consistent and long-term sustained efforts to engage the youth in services to allow them to heal and grow. Individual systems are effective at providing short-term solutions but there are gaps when it comes to stopping the cycle of short-term solutions in favor of long-term, sustained solutions. Specialized settings and services are often limited in time and scope that do not realistically reflect the high needs of youth in the system. For example, in response to an acute episode, a youth may be taken to a hospital for help. It is not uncommon for bed shortages to leave youth and their social workers waiting in emergency rooms, sometimes up to days, for an open bed. If and by the time a bed becomes available, the youth may present as "stable" and therefore be denied admission. Alternatively, if admitted, it is for a few days, at most. Once stabilized, a prior setting may be unwilling or unable to re-admit the youth for various reasons. This type of disjointed system, which is

endemic to the entire foster care system, is disorienting and causes further trauma to youth.

3. Immediate crisis response for foster youth and their caregivers from other systems is often fragmented because those other systems also serve multiple vulnerable populations. Other crisis response systems also do not always understand the unique challenges experienced by foster youth and caregivers. DCFS has experienced excellent outcomes with the FURS Program. DCFS received 262 calls through the FURS hotline in 2023. Of those calls, 93 percent required an in-person response. The majority of those calls came from resource parents, biological parents, and nonrelative extended family members. The FURS teams were able to maintain 87 percent of youth in their placements. Unfortunately, the program is part of the proposed budget cuts announced by the State earlier this year. The proposed cut comes at a time when more youth could benefit from expansion of the program, as this is one of only a few crisis response models that is designed specifically for foster youth. DMH provides 24/7 crisis response, through contracted providers, for youth who are connected to such providers. When providers are unavailable, the PMRT is an alternative option that can provide crisis response or consultation; however, if a youth is violent, destructive, assaultive, or carrying a weapon, PMRT defers to a law enforcement response. Additionally, PMRT is not a DCFS-dedicated resource. A proposal to designate a PMRT to DCFS youth was recently developed by DMH and is under fiscal review by DCFS.
4. There is an overall shortage of beds for high-acuity children and youth. As noted above, DCFS currently has an inventory of about 80 ISFC FFA beds where the need is estimated to be as high as 300 beds. DCFS is in the process of implementing the ISFC-Public Model, which the Department hopes will significantly close the gap in the ISFC inventory. For acute crises, DHS operates ten adolescent acute psychiatric beds but none of them are dedicated exclusively to DCFS. Additional facility-based acute or intensive psychiatric beds operated by private entities are contracted through the Department of Mental Health but none are not dedicated specifically to DCFS youth. DMH currently has approximately 300 psychiatric beds for children and adolescents.

5. Case reviews for youth are spread out amongst a number of groups or meetings. A review of all meetings in which cases are conferenced revealed that more than 10 different meetings occur within DCFS, DMH, a combination of two agencies, and sometimes with other agencies/stakeholders present too. The case review process should be consolidated under the System of Care Interagency

Placement Committee to avoid conflicting approaches or lack of accountability that comes from decision making that is spread too widely.

6. As youth move from placement to placement, they find themselves starting all over with very few (if any) consistent supports. Near Peer mentors are one of the most promising supports available at this time but the program is new and limited by the number of individuals who are trained and ready to fill the role. The DCFS Placement Stabilization Team is built so that those social workers focus on stabilization and, in doing so, they follow a youth from placement to placement and are available on a 24/7 basis. As such, the PST was a natural fit for the newly developed DMH/DCFS engagement team. Consistent engagement and support from trusted individuals must be part of any treatment or service delivery for young people who have the deep level of trauma often seen in youth with complex needs in order to build the level of trust that will lead to the young person remaining in placement and giving consent to necessary treatments and services. Building capacity in programs such as Near Peer mentors must be a countywide priority.

The Solicitation(s)

The solicitation(s) needed at this time are complex because the goal is to create an entire system of care, under one roof and with a singular chain of command, which is dedicated ***exclusively*** to youth in foster care.

Whether it is through one, or more, solicitations, the following components are needed: placement, case management, consistent peer/mentorship supports, caring and person-centered expertise in medicine, mental health, and substance use treatment modalities, de-escalation expertise and immediate crisis response capabilities, intellectual and developmental disabilities expertise (including expertise interacting with the Regional Center), and unconditional commitment to each individual young person.

All of these components must be offered under “one roof” with all necessary county departments represented in the staff and a collective of providers that operates as one cohesive system dedicated exclusively to this high needs population.

- Placement: The placement option may be County-operated or, operated in partnership with a trusted provider. In either scenario, it must be co-staffed by all departments who are part of the SOC so that “ejection” and “rejection” are not options, as they are when the County is wholly dependent upon a provider.
- Community-Based Partnerships: There must be support from community-based providers when it comes to programming, mentorship, and youth development services.

- Partners are also "staff": There needs to be a strong and central role for near peer mentors and, if possible, credible messengers for youth who have youth justice involvement in their background.
- Crisis Response: Finally, there must be a built-in immediate crisis response that is dedicated ***exclusively to DCFS youth***. Crisis response teams could potentially be deployed directly from the County-operated facility, or, DCFS could potentially contract for a crisis response team that is comprised of psychiatric, de-escalation, and youth engagement experts. Such a contracted team would respond immediately to support DCFS staff on the ground.

As far as the co-staffing, the existing model to build off of is the Probation Department's DKC but instead of detention and locks, the "security" of the setting would lie in the carefully selected staff and community-based partners who build relationships with the youth. The careful selection of staff and intentional reliance on community-based partners would also make this setting distinct from settings that have previously been operated by the County. The licensing model is likely that of an STRTP or perhaps, a Small Family Home, but the key is that the placement setting looks beyond "staff" to engage with youth and that the model is distinct from existing co-location models where the focus is often on physically co-existing rather than true, hands-on, and meaningful co-staffing. In essence, this placement option will be co-staffed by County and non- County professionals who bring equal investment in children and youth and integrate their many areas of expertise under one roof.

Beyond implantation of a "one roof" concept, existing partnerships and components of the SOC need to be reinforced. As noted above, most of these are highlighted in the March 7, 2023, "30-DAY REPORT BACK ON PLACEMENTS AND INTERVENTIONS FOR YOUTH IN FOSTER CARE WITH THE HIGHEST COMPLEX NEEDS." It is essential that all partners refocus and recommit to the joint recommendations that were developed for that report. Some possible areas of focus include:

- 1:1 Clinical Interventions: The existing contract for 1:1 behavioral aides is helpful for situations that don't rise to the level of requiring 1:1 clinical intervention. There is a clear need for a deeper health-based supportive service that should be provided by individuals with training and expertise at the level of, or similar to, a psychiatric technician. Such individuals would be called upon to assist with youth who have a history of running away, engaging in physically dangerous behavior, or assaulting other individuals.

- SOC Interagency Placement Committee (SOC-IPC): There are currently almost a dozen meetings that take place within DCFS and/or in partnership between DCFS and DMH and other departments in which case conferences are held. It

would be extremely beneficial to staff, to youth, and to decision-makers for these meetings to be streamlined to the greatest extent possible. The State-mandated SOC Interagency Leadership Team (SOC-ILT) and the SOC-IPC are natural forums for interagency discussion and case conferences to take place so long as the action steps and decisions that come out of the SOC-IPC are truly systemic and do not place the onus entirely on the case-carrying DCFS social worker. OCP has brought on a State expert to provide technical assistance to the SOC, to strengthen our SOC structure and strategies, including the SOC-IPC process.

- Engagement and Partnership with Existing Providers: The Therapeutic Foster Care Shelter Pilot and the Children's Crisis Continuum Pilot Program are just two examples of the good work that can be done in partnership with existing providers. As the SOC-IPC gets revamped and reinstituted, existing providers must be included to ensure their expertise and input are given in real time as County leaders make critical decisions about youth in placement.

DIRECTIVE 2: IDENTIFY ANY RETURNED FUNDS TO THE STATE AND MAKE RECOMMENDATIONS TO ESTABLISH A FUND DEDICATED TO A CONTINUUM OF SERVICES FOR COMPLEX CARE YOUTH THAT IS COMPRISED OF IMMEDIATE CRISIS RESPONSE (SUCH AS A DEDICATED PSYCHIATRIC MOBILE RESPONSE TEAM), EARMARKED BEDS FOR TEMPORARY HOSPITALIZATION AND SUBACUTE MENTAL HEALTH BEDS, AND EXTERNAL SUPPORTS TO EXISTING CONGREGATE CARE PROVIDERS THAT ARE DESIGNED TO HELP PRESERVE PLACEMENTS, PARTICULARLY DURING TIMES OF CRISIS (OCP LEAD)

Assembly Bill (AB) 153 (Chapter 86, Statutes of 2021) provided limited-term and ongoing funds to "support the urgent and exceptional needs of children/NMDs in foster care under the supervision of a county child welfare agency, or probation department, who otherwise may be placed in an out-of-state residential facility[3]." Funding available through AB 153 falls into three different categories:

(1) Child-Specific Complex Care Funds (CSCC): annual allocations for child-specific requests for funding to support immediate needs of a child/NMD;
(2) Complex Care Capacity Building Funds (CCCB): one-time allocation for county capacity building to address gaps within the continuum of care; and
(3) CCCPP Funds: one-time allocation to fund a Children's Crisis Continuum Pilot Program developed by counties and providers to treat youth with high acuity needs.

[3] California Department of Social Services, County Fiscal Letter (CFL) No. 21/22-54, December 17, 2021. Available at: FY 2021-22 Complex Care CFL No. 21/22-54

Children's Crisis Continuum Pilot Program

Page 16 of this report provides an update on LA County's CCCPP tentative grant award, proposed plan, and project status.

Complex Care Capacity Building Funds

LA County was allocated approximately $11.8 million in CCCB funds - $6.5 million for DCFS and $5.3 million for Probation. CCCB funds are intended to assist with establishing a high-quality continuum of care designed to support foster children/NMDs in the least restrictive setting, consistent with the child/NMD's permanency plan. Funding is available for five years and counties can only use CCCB funds to supplement, not supplant, existing funding. DCFS and Probation partnered to submit five CCCB proposals to the State in September 2022; the proposals were approved by the State in March 2023. LA County's approved CCCB projects include: 1) providing specialty mental health services for NMDs onsite at transitional housing programs through paraprofessionals and peer counselors; 2) expanding integrated care and housing supports for transition age youth to prevent homelessness; 3) contracting with highly-specialized, smaller-setting STRTPs designed to serve high-risk youth and NMDs; 4) contracting with highly-specialized STRTPs to serve youth with co-occurring substance use disorders and mental health needs; and 5) contracting with highly- specialized STRTPs to serve youth who identify as LGBTQIA2S+. In developing these proposals, DCFS and Probation incorporated recommendations from the 2021 STRTP Task Force on expanding the continuum of care to meet specialized population needs; and also discussed the proposals with your Board. Since receiving approval, DCFS and Probation have been working on internal implementation processes and will be reaching out soon to providers that have expressed interest in standing up these specialized programs.

Child-Specific Complex Care Funds

CSCC funds may be used for exceptional services that are needed to support a child in the least restrictive setting. The request is based on the recommendation of behavioral assessments, a qualified individual, technical assistance provided by the CDSS, or a clinical recommendation approved by an interagency placement committee that considers the recommendations of a child and family team. County child welfare and probation departments must submit a request for each individual child to CDSS using the Child Specific Funding Request Template. CDSS convened a workgroup of State and county partners to streamline and update this template, and released the updated template in January 2023.

Since fiscal year 2021-22, LA County has received the following annual allocation of CSCC funds:

Fiscal Year	DCFS	Probation
FY 2021-22	$2.8 million	$2.2 million
FY 2022-23	$3.3 million	$200,000*
FY 2023-24	$3.2 million	$870,627**

*In FY 2022-23, LA County Probation was initially allocated approximately $2 million in CSCC funds. However, in June 2023, CDSS, in consultation with the Chief Probation Officers of California, redistributed approximately $2.1 million in unspent FY 2022-23 CSCC funds that were relinquished by select county probation departments. This included $1.8 million relinquished by LA County Probation, which adjusted their FY 2022-23 CSCC allocation to $200,000.

**For the current fiscal year of 2023-24, the CDSS has adopted a new allocation methodology to maximize usage of these funds. County probation departments received an initial planning allocation in July 2023, of which LA County Probation received $870,627. In a County Fiscal Letter[4] released on February 2, 2024, CDSS notified counties that approximately $2.3 million of CSCC funds have been set aside in one statewide probation-only reserve fund; these funds will be released on a first-come, first-serve basis. There is also a statewide child welfare-only reserve fund of $377,704; any child welfare department that has exhausted its allocation will be able to request funding from this reserve fund on a first-come, first-serve basis. Counties may claim expended funds up to 18 months after the end of the fiscal year. So for example, counties were able to claim funding for FY 2021-22 until December 31, 2023.

DCFS and Probation have primarily used their CSCC allocation to support enhanced supervision for youth including 1:1 aides, medical expenses and specialized therapy not covered by Medi-Cal, childcare assistance, respite care, specialized placements such residential substance use treatment programs, and enhanced programming and extracurricular activities to support youth in placements. The departments have also used CSCC funds to provide the county share-of-cost for the Innovative Model of Care rate for STRTPs, FFA, or resource family homes. An IMC must "provide youth and NMDs with complex needs with service alternatives to residential care, enhance the ability of children to remain in the least restrictive, most family-like setting as possible, and promote services that address the needs and strengths of individual children and their families[5]." LA County has utilized IMC for specialized STRTP programs, like STRTP-for-One and Enhanced STRTP with 24/7 staffing to serve youth with treatment modalities customized to address unmet complex care needs; as well as for FFAs that

[4] California Department of Social Services, County Fiscal Letter (CFL) No. 23/24-47, February 2, 2024. Available at: FY 23-24 Complex Care Child Specific Final Allocation, CFL No. 23/24-47
[5] California Department of Social Services, All County Letter (ACL) No. 22-21, March 8, 2022. Available at: ACL 22-21 (ca.gov)

provide additional training and support to resource families so that youth with unmet complex care needs can be placed in smaller (i.e., one child) family-like settings.

Recommendations to Establish a Dedicated Fund

The need for a County-dedicated fund to support a continuum of services for youth with complex care needs depends on ***what*** we need to fund. There are existing staffing, resources, and funding streams – including Medi-Cal, CDSS's complex care funds outlined above, capacity building and program grants to address mental health supports through the Children and Youth Behavioral Health Initiative, and more – that we may be able to redirect and draw down. As DCFS, CEO, OCP, and SOC partners finalize the crisis response protocol, further described below, and develop any needed solicitations to fill service gaps in the continuum, we will report back to your Board on any additional funding needed to support these efforts.

DIRECTIVE 3: BUILD UPON THE DCFS AND DMH "STRIKE TEAM" MODEL TO ESTABLISH COUNTYWIDE COMPLEX CARE TEAMS COMPRISED OF DESIGNATED STAFF FROM EACH DEPARTMENT TO DEVELOP A WRITTEN CRISIS PROTOCOL TO ENSURE CONTINUITY OF CARE AND CASE MANAGEMENT FOR EACH INDIVIDUAL COMPLEX CARE YOUTH (CEO LEAD)

The CEO worked directly with representatives from the OCP, DCFS, DMH, Probation, DYD, DPH, DHS, Department of Public Social Services, and the Los Angeles County Office of Education (LACOE) to establish a Countywide cross-departmental protocol for when a complex care foster youth is experiencing a crisis event in their current placement setting. This draft crisis protocol is almost completed.

The protocol will govern the creation of a Countywide 24/7 Complex Care Mobile Response Team (CCMRT) to deploy on-site crisis de-escalation and intervention services and supports needed from any of the aforementioned departments. The delivery of services and supports is expected to come from existing resources within each department. The protocol will define the specific roles each department will play and their CCMRT responsibilities. DCFS and DMH are expected to provide the core on-site crisis response de-escalation and intervention supports.

The CCMRT on-site work will have key phases:

1) Phase I: De-escalate the crisis for all parties (foster youth and caregiver)

2) Phase II: Develop maintenance and stabilization strategies for all parties

3) Phase III: Develop post-crisis follow-up plans, which supports the overall needs of the complex care foster youth. This phase may also include the activation of CCMRT departments whose services and supports were not necessarily needed to be on-site to address the immediate crisis.

Finally, once the draft protocol is completed, the OCP, through the SOC ILT, will lead the process to finalize the protocol across all affected departments, as well as lead its implementation and ongoing monitoring. The OCP will provide ongoing CCMRT progress reports, including any barriers or challenges faced, through its quarterly SOC ILT updates submitted to the Board.

DIRECTIVE 4: DEVELOP A PLAN AND COST ESTIMATE TO EXPAND THE DCFS PLACEMENT STABILIZATION TEAM (DCFS LEAD)

As set forth above, the PST currently serves 109 youth, with 89 on the waitlist. Recent expansion approved by your Board, once fully staffed, will bring the number of youth served by the PST to approximately 140. An expansion to serve an additional 48 youth would position the PST to expand into working with youth in the STRTPs. Stabilizing placements in the STRTPs would not only reduce the number of youth moving in and out of shelters, it would also facilitate stepping youth down from STRTPs into less restrictive placements.

The expansion of the program will require the addition of one Assistant Regional Administrator, one Supervising Children's Social Worker, six Children's Social Workers, and one Intermediate Typist Clerk. The annual cost associated with these positions is as follows:

Item	Number	Cost
Assistant Regional Administrator	1x	$295,721
SCSW	1x	$198,109
CSW's	6x	$1,087,956
ITC	1x	$108,256
Total		$1,690,042

If the plan is approved and funding identified, DCFS would need to conduct interviews and allow time for staff to be released from their current assignments. Under an expedited process, the time to bring new staff up to a full capacity of eight youth per staff is approximately 60 to 90 days.

Once on board, all new staff would be required to attend the same training that is required of the DCFS FURS team. This training includes: (1) Building A Trauma Responsive and Resilience Strengthened Child Welfare System; (2) Crisis Intervention; (3) De-escalation and Conflict Resolution; (4) Placement Stabilization; and (5) Motivational Interviewing.

It is recommended that OCP, in partnership with the SOC ILT, lead ongoing implementation, monitoring, and reporting on progress of the recommendations set forth in this report.

If you have questions, please contact us at (213) 371-6236, or via email at bnichols@dcfs.lacounty.gov, and via email at mnash@ocp.lacounty.gov, or your staff may contact Veronica Pawlowski, via email at pawlov@dcfs.lacounty.gov, or Minsun Meeker, via email at mmeeker@ocp.lacounty.gov.

BTN:JF:VP:MN
MPM:td

Attachments (A), (B)

c: Executive Office
Board of Supervisors
Chief Executive Office
County Counsel
Mental Health
Public Health
Health Services
Probation
Youth Development

COMPLEX NEEDS YOUTH PROFILE

Youth 1

Has had 5 placements and spent 18 days in hotels. Previously at a residential school out of state. Has threatened to kill his parents.

Prior to adoption as a toddler, the youth had a history of severe physical abuse and neglect, cigarette burns/bruises all over his arms; Fetal Alcohol Syndrome.

Substance use started after first placement. Easily peer pressured.

Basic Information

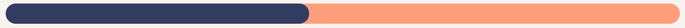
Current Placement	Psychiatric Hospital in a Developmental Delay MH Unit
Conservatorship	Yes
Regional Center	Developmental Learning Disorder Borderline Intellectual Disability
Education/IEP	Youth has an IEP - not enrolled in school, refuses to do packets Non-public schools denied admission
Behaviors	Highly defiant and assaultive
Mental Health	Bi-polar w/psychotic features; Unspecified Mood Affective Disorder
Substance Use	Cannabis, Methamphetamine, and Opioid Use Disorder, OD on Fentanyl,
Strengths	Remains connected to parents able to advocate for himself and identify future goals, is athletic and enjoys outdoor activities

CANS

Behavior/Emotional Domain

78%

Life Functioning Domain



45%

Risk

75%

Behavior/Emotional Domain: Most areas in this domain interfere with the youth's functioning.
Life Functioning Domain: School behavior is at the level of dangerous/disabling; The areas of family functioning, living situation, social functioning, and decision making interfere with functioning.
Risk: The areas of Other Self-Harm (Recklessness) and Intentional Misbehavior interfere with functioning.

COMPLEX NEEDS YOUTH PROFILE

Youth 2

In care due to mothers' substance abuse (meth) and DV between parents.

Was in LG with mother's ex BF but rescinded LG due to youth bxs and safety concerns. Could not handle youth any longer. J is gang involved, considers gang as his family.

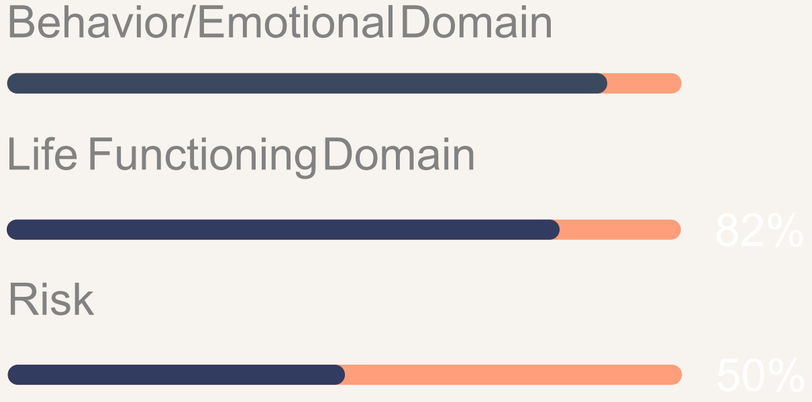
Placement: currently at Dorothy Kirby (Probation Lead.) for assault of STRTP staff and a police officer.

Youth has had 19 placements.

Basic Information

Current Placement	Dorothy Kirby
Conservatorship	No
Regional Center	Yes - Developmental Learning Disorder
Education/IEP	Would not attend school previously Is getting packets while in placement, has an IEP, CASA holds ed rights
Behaviors	Very defiant, anger issues, volatile when told "no", gang involvement
Mental Health	Depression, Anxiety, ADHD, and PTSD Unspecified, (no meds)
Substance Use	Uses marijuana, meth, tried cocaine
Strengths	Insightful, "running his program" goal driven, eager to live on his own, resilient, survivor, resourceful, self-aware

CANS



Behavior/Emotional Domain: The areas of Oppositional, Conduct, Anger Control, and Substance Use are at the level of dangerous/disabling. The areas of Oppositional and Conduct interfere with the youth's functioning.

Life Functioning Domain: The areas of Living situation and Social Functioning are at the level of dangerous/disabling. The areas of Impulsivity, Depression, Anxiety, and Adjustment to Trauma interferes with the youth's functioning.

Risk: Other Self Harm (Recklessness) and Delinquent Behavior are at the level of dangerous/disabling. The areas of Danger to Others and Runaway interfere with the youth's functioning.

COMPLEX NEEDS YOUTH PROFILE

Youth 3

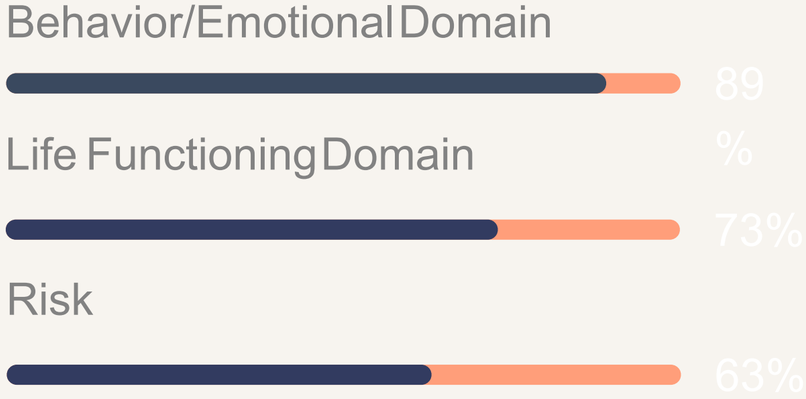
Came to the attention of the department at birth. Youth born premature and there were concerns for mother's lack of bonding. Youth was returned home. ·Youth came back into care due to allegations of general neglect, DV between parents, and youth's significant mental health needs.

Youth spent 84 days in a hotel prior to being placed under Probation supervision for assaults to STRTP & ER staff, and community member and fire setting.

Basic Information

Current Placement	Dorothy Kirby
Conservatorship	No
Regional Center	No
Education/IEP	Recommendation for school based residential placement out of state. Youth has refused.
Behaviors	Increasingly violent, aggressive, and dangerous
Mental Health	PTSD, Bi-polar NOS, Severe Depression Unspecified Mood Affective Disorder,
Substance Use	Methamphetamine, Acid Marijuana, and Alcohol
Strengths	Interested in poetry, art, and music

CANS



Behavior/Emotional Domain: Dangerous/disabling areas in this domain include Depression, Oppositional, Anger Control, and Adjustment to Trauma. Most other areas in this domain interfere with the youth's functioning.

Life Functioning Domain: School behavior, school attendance, and Living situation are at the level of dangerous/disabling; The areas that interfere with functioning include family functioning, social functioning, decision making, school achievement , and sleep.

Risk: The areas of delinquent behavior are at the level of dangerous/disabling. Other Self-Harm (Recklessness), danger to others, and Intentional misbehavior, runaway, and intentional misbehavior interfere with functioning.

COMPLEX NEEDS YOUTH PROFILE

Youth 4

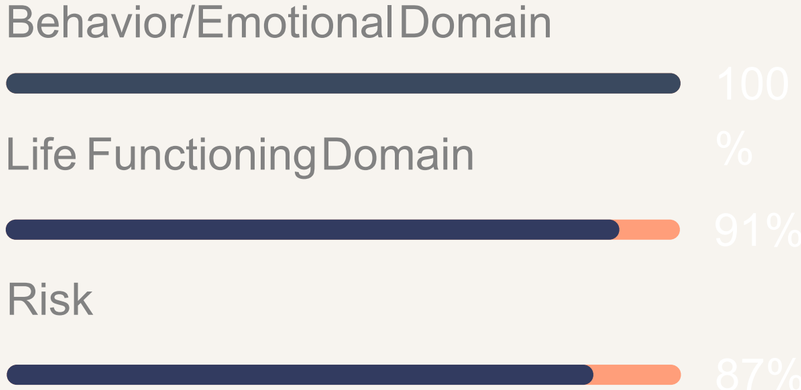
Entered care due to mother's inability to provide for youth's medical and mental health care services.

Youth has spent 48 days in hotels. Youth has had 27 placements. Youth is CSEC. Alleged to have stolen phones to obtain personal bank information, always wants to "party" and has a history of AWOLing.

Basic Information

Current Placement	On an "extended visit" with mother Refuses to go to placement
Conservatorship	No
Regional Center	No
Education/IEP	No IEP; Youth needs 15 credits for her diploma. Recently expelled due to assault on a teacher.
Behaviors	Highly defiant and assaultive, Refuses assessments
Mental Health	Anxiety Disorder, Major Depression Disorder Recurrent, Severe w/Psychotic Symptoms, Depressed Mood Disorder
Substance Use	Marijuana, Acid, Meth, Cocaine, Marijuana, and Alcohol
Strengths	Does makeup well and has earned money with this skill

CANS



Behavior/Emotional Domain: Oppositional and Anger Control areas are at the dangerous/disabling level. All other areas in this domain are at the level of interfering with the youth's functioning.

Life Functioning Domain: All areas in this domain interfere with the youth's functioning.

Risk: All areas in this domain interfere with the youth's functioning except sexual aggression which is at the level of monitoring due to suspected CSEC behavior.

COMPLEX NEEDS YOUTH PROFILE

Youth 5

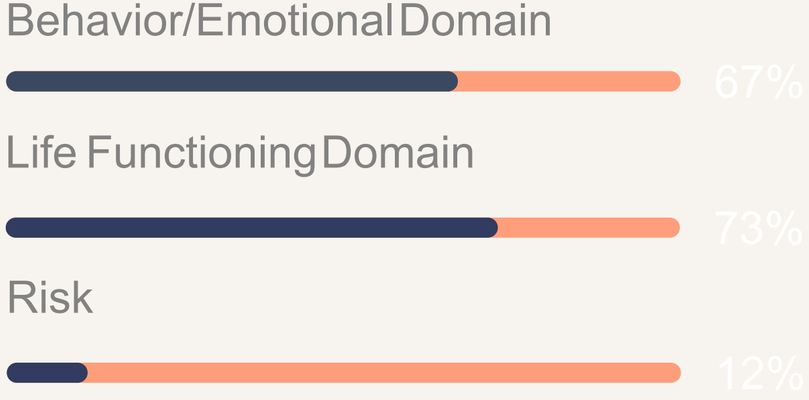
Youth was adopted from a different country. He was previously in an orphanage after being found abandoned and malnourished. No information on bio parents. It was reported that the youth was sexually molested while in the orphanage in his country of birth prior to adoption.

The youth has had one placement and no further contact with adoptive mother.

Basic Information

Current Placement	STRTP - Single Use Placement
Conservatorship	No
Regional Center	Re-referred to RC and had an intake on April 11th
Education/IEP	No IEP; was suspended from school several times for aggression and stealing food
Behaviors	Highly defiant and assaultive
Mental Health	ODD, Unspecified Mood Affective Disorder, Intermittent Explosive Disorder, Autistic
Substance Use	No SUD Hx
Strengths	Does well in school and doing well in current placement

CANS



Behavior/Emotional Domain: The areas of Oppositional and Anger Control are at the level of dangerous/disabling. Impulsivity, Anxiety, Conduct, and Adjustment to Trauma interfere with the youth's functioning. Youth is being monitored for other areas in this domain.
Life Functioning Domain: The areas of family functioning, living situation, decision making, school behavior, school achievement, and school attendance are at the level of dangerous/disabling. Most other areas in this domain interfere with the youth's functioning.
Risk: Danger to others is at the level of dangerous/disabling.

COMPLEX NEEDS YOUTH PROFILE

Youth 6

Court case open at young age due to DV with parents. Child abducted in 2010, taken to Mexico. Returned to custody after 3 years.

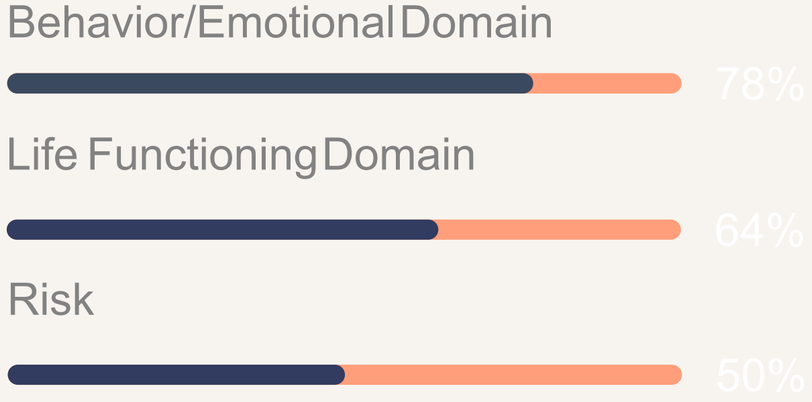
Prior to abduction, allegations of sexual abuse by father. ·Lost sibling to cancer at age 4. Current probation involvement.

Youth spent 44 days in hotels and has had 28 placements. Youth stated, “I don’t know how it is to have parents.”

Basic Information

Current Placement	"Group Home" only placement that would accept the youth
Conservatorship	No
Regional Center	No
Education/IEP	IEP Pending. Hasn’t regularly attended school because of his behaviors & anxiety
Behaviors	Highly defiant destructive, threatening behavior, sexualized behaviors
Mental Health	ODD, ADHD, Major Depressive Disorder NOS
Substance Use	· Methamphetamine, marijuana
Strengths	· Wants a family Responds well to positive engagement

CANS



Behavior/Emotional Domain Impulsivity, Oppositional, Conduct, and Anger Control areas are at the dangerous/disabling level. Depression, Anxiety, and Adjustment to Trauma are at the level of interfering with the youth’s functioning.
Life Functioning Domain: The areas of Developmental/Intellectual, Decision Making, and Sleep interfere with the youth’s functioning.
Risk: Areas in this domain are the level of monitoring.

COMPLEX NEEDS YOUTH PROFILE

Youth 7

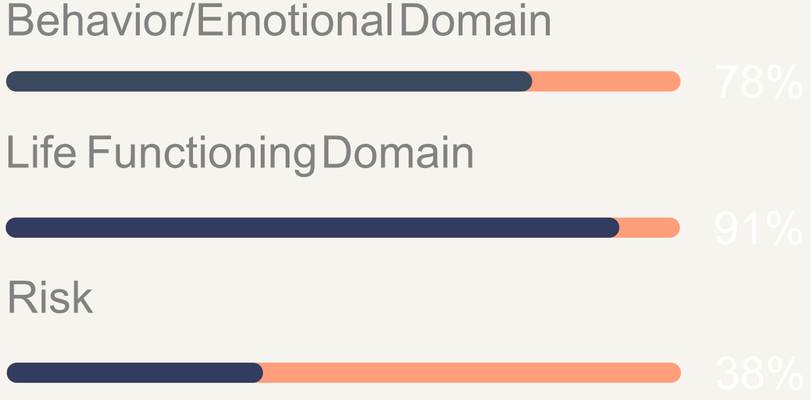
Youth identifies as a transgender female. Youth initially came into care for neglect by mother failing to respond appropriately to youth's MH and Bxs needs which included SI necessary hospitalization resulting in physical altercations between mother and the youth.

Probation involved due to a battery charge. Youth spent 57 days in a hotel placement. Youth has had 8 placements.

Basic Information

Current Placement	RFH: 14-day notice given
Conservatorship	No
Regional Center	No
Education/IEP	No IEP - not assessed to date, planned once enrolled consistently in school, denied enrollment due to low credits
Behaviors	CSEC, impulsive, aggressive, assaultive, minimizes her behavior,
Mental Health	ADHD, Bi-polar, Major Depression Disorder, Mood Bx NOS, Deregulation Disorder, ODD, Adjustment Disorder, Reactive Attachment Disorder, Emotional Disturbance Disorder, ODD
Substance Use	Marijuana
Strengths	Respectful, mindful of her situation, insightful, can follow through with consistency

CANS



Behavior/Emotional Domain: Most of the areas in this domain interfere with the youth's functioning. Youth is being monitored for psychosis/thought disorder and impulsivity.
Life Functioning Domain: The areas of living situation, school achievement, and school attendance are at the level of dangerous/disabling. Most other areas in this domain interfere with the youth's functioning.
Risk: Delinquent behavior is at the level of dangerous/disabling. Runaway and Intentional Misbehavior are at the level of monitoring.

COMPLEX NEEDS YOUTH PROFILE

Youth 8

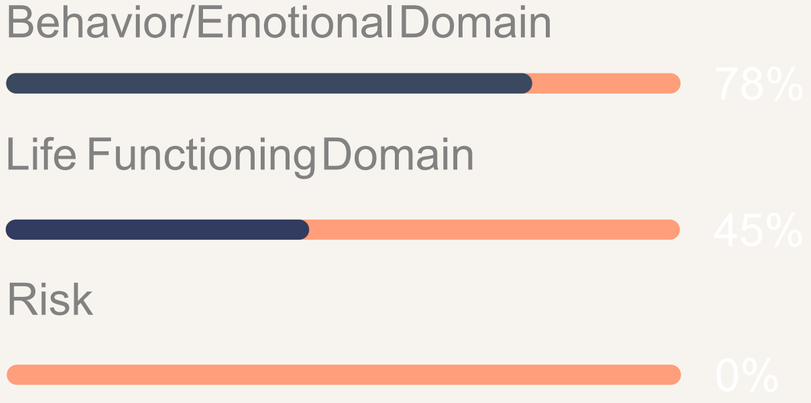
Identifies as a gay male. Came into care due to parent's substance use and general neglect living in a van alone with siblings.

He was placed in LG but LG terminated a few years later. He spent 14 days in a hotel and has had 31 placements. Youth stated, "I've never had a family." Red flagged from several facilities for using or distributing drugs. Abscess medical disorder.

Basic Information

Current Placement	Psychiatric Hospital No steady placement since 2015
Conservatorship	No
Regional Center	No
Education/IEP	Assaultive bxs interfered with education stability but few units from obtaining his HS diploma
Behaviors	Assaultive, steals from staff, uses and/or distributing drugs
Mental Health	Bi-Polar, Depression, Paranoid Schizophrenia
Substance Use	· Marijuana, fentanyl, methamphetamine, and alcohol
Strengths	· Loves music, wants his diploma, wants to work in a gay bar as a long-term goal

CANS



Behavior/Emotional Domain: Most areas in this domain are at the level of interfering with the youth's functioning except depression and anxiety.
Life Functioning Domain: The areas of intellectual functioning, decision making, and sleep interfere with the youth's functioning.
Risk: Youth had minimal risk in this domain and is being monitored.

COMPLEX NEEDS YOUTH PROFILE

Youth 9

Transgendered female came to care with prior CPS history in another state. Youth had been "bounced around with other family and family friends" prior to living with MGGM. Hx of sexual abuse. MGGM tried to place her in a residential facility, but she was kicked out due to bx.

MGGM sent youth to live with mother in Los Angeles. Youth detained due to MH needs not being adequately addressed. Mother not affirming. At risk for CSEC/recruiter engaged her. Has a pending assault charge.

Basic Information

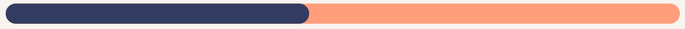
Current Placement	RFH – ·complex care funding rate Challenges with placement due to gender expression
Conservatorship	No
Regional Center	No
Education/IEP	SED, non-public school environment recommended
Behaviors	Highly defiant and assaultive, refuses boundaries
Mental Health	PTSD, impulsive activity disorder, mood disorder nos, Unspecified Psychosis, gender dysphoria, cannabis disorder
Substance Use	marijuana, alcohol
Strengths	Likes to dance, do makeup , and cook

CANS

Behavior/Emotional Domain

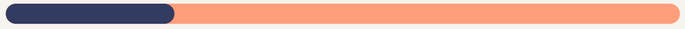
56%

Life Functioning Domain



45%

Risk



25%

Behavior/Emotional Domain: The areas of Psychosis/Thought Disorder, Impulsivity, and Anger Control are at the level of dangerous/disabling. The areas of Oppositional and Conduct interfere with the youth's functioning.
Life Functioning Domain: The areas of Living situation and Social Functioning are at the level of dangerous/disabling. The area of Decision Making interferes with the youth's functioning.
Risk: Suicide Risk and Danger to others are at the level of dangerous/disabling. Intentional Misbehavior interferes with the youth's functioning.

COMPLEX NEEDS YOUTH PROFILE

Youth 10

Youth came into care at a young age, has had 25 placements. Prior CPS history in another state. Prior history of physical abuse and sexual abuse. Youth witnessed DV between parents. Youth has threatened to kill himself and kill staff.

Has been hospitalized in psychiatric hospitals 7 times and currently placed at Five Acres. Youth is triggered by threat of rejection.

Basic Information

Current Placement	STRTP
Conservatorship	No
Regional Center	DCFS evaluation indicated intellectual disability, Being re-referred to regional center. Not yet RC eligible.
Education/IEP	IEP on file and has attended a non-public school. Not currently enrolled.
Behaviors	Highly defiant and assaultive , Enraged, threatening harm to others
Mental Health	PTSD, ADHD, and Disruptive Mood Dysregulation Disorder (r/o Oppositional defiant Disorder
Substance Use	vape - marijuana and tobacco
Strengths	Engaging with peers and adults Loves to cook, very athletic,s loyal, protective, and resourceful

CANS

Behavior/Emotional Domain

89%

Life Functioning Domain

73%

Risk

38%

Behavior/Emotional Domain: The areas of Impulsivity and Adjustment to Trauma are at the level of dangerous/disabling. Other areas in this domain interfere with the youth's functioning.

Life Functioning Domain: Most areas of in this domain interfere with the youth's functioning.

Risk: Non-Suicidal Self Injurious Behavior, Other Self Harm (Recklessness) and Intentional Misbehavior interfere with the youth's functioning.

FY 2023-24 PROBATION SERVICE MATRIX

Type of Programs	Description of Program/Services	Population Served
Community Level Court Dispositions and Services	Probation supervision for youth who are subject to WIC 602 Petitions to include - non-Court Information Probation (654 WIC), Court Ordered Information Probation Supervision pursuant to WIC 654.2; Probation Without Wardship pursuant to WIC 725(A), Deferred Entry of Judgment pursuant to WIC 790, and; Home on Probation and Wardship pursuant to WIC 602. Youth in this section are linked to supportive services based on risk and needs assessments and case plans.	Youth who are subject to a 602 petition request or youth whose is the subject to a 602 petition that has been filed by the District Attorney with juvenile delinquency court and/or have sustained delinquency petitons.
Detention Services Bureau - Juvenile Hall	Juvenile Halls are charged with protecting the community and providing for the physical and social needs of detained youth in a safe and secure environment until disposition of their cases by the courts. A multitude of programs are provided to the youth, programs are designed to help youth reduce undesirable behaviors, address prior trauma and its effect, and increase pro-social behaviors. Detention time is also utilized as an opportunity to assist in redirecting delinquent youth toward a positive, more productive, law□abiding lifestyle. The juvenile halls function as a temporary living facility for youth pending court disposition. The collaborative relationship between the Probation Department and courts is essential to the proper processing of youth within the juvenile justice system	Pre-Adjudication youth who are the subject of a WIC 602 Petition and who have been ordered to be detained in juvenile hall. This may include WIC 241.1 youth.
Suitable Placement (Probation Placement and Child Welfare Services)	Probation Placement and Child Welfare includes supervision and services to youth have been declared wards of the juvenile delinquency court including those who are, per WIC 241.1, are considered dual status or dual supervision and the court has deemed Probation as the lead agency. The majority of youth have been placed in a Short Term Residential Therapeutic Program or with a Resource Parent/Family. PCW also serves Commercially Sexualy Exploited Children, Non-Minor Dependents (as indicated below) and Transitional Aged Youth who are eligible for Independent Living Programs and those in need of housing services. Additional Services include Wraparound services, Functional Family Therapy, and Functional Family Probation.	Adjudicated wards of the juvenile delinquency court and have been ordered into foster care, Non-Minor Dependents, Commercially Sex Trafficked Children, those eligible for Independent Living Programs, and youth who reside in the home of parents, resource parents/families, and those eligible for Independent Living Program Services
Transition Jurisdiction Youth (WIC 450)	Transition Jurisdiction Services provided to youth who have been granted transition jurisdiction (Probation lead) pursuant to WIC 450; youth receive housing services, health/mental health care, educational services and supports, vocational training, workforce readiness.	Non-Minor Dependents
Dorothy Kirby Center	A closed and secure residential treatment program providing services that are centered on mental health care, behavior stabilization, and education.	Adjudicated 602 Wards who have been ordered to a secure residential treatment program.

Camp-Community Placement	The Residential Treatment Services Bureau (RTSB) is charged with providing juvenile probationers with intervention services in a residential treatment setting. The Probation Department, along with its partner agencies, has created an integrated treatment approach in the camps using evidence-based practices to achieve positive behavior change in youth while endeavoring to ensure the safety and security of probationers, the community and staff. Each camp has an on-site school operated by the Los Angeles County Office of Education (LACOE). The Department of Mental Health (DMH) provides mental health counselors seven days per week. Group and individual substance abuse counseling is offered through DMH and various community-based treatment providers. Each camp facility utilizes a cognitive-behavioral intervention, either Dialectical Behavior Therapy (DBT) or Aggression Replacement Training (ART), depending on the camp, to teach youth new skills to replace negative behaviors and decrease behaviors that interfere with treatment. Providing youth with the opportunity to develop the skills needed to control their own behavior and the personal motivation to help them want to achieve positive goals for themselves is what will create lasting change in our youth and communities. Skill-building programs emphasize the importance of the relationship between staff and youth in the learning of new skills. Probation and Mental Health staff frequently co-facilitate skills groups and staff focus on engaging and motivating youth to encourage them to commit to working on their behavior. Positive and healthy relationships between staff and youth are the basic building blocks to motivating and engaging youth to make a commitment to change their behavior and to helping youth maintain this commitment.	Adjudicated 602 Wards who have been ordered to a secure residential treatment program. Services are centered on behavior stabilization.
Secure Youth Track	Senate Bills 92 and 823 (2021) Secure Youth Treatment Facilities (SYTF) established a new dispositional option for eligible youth subject to eligibility, procedural, and review requirements. The standards set forth in the policy, the related procedures, the Welfare and Institutions Code, and other applicable laws, rules, and regulations will be followed by the Probation Department staff while supervising SYTF youth. This dispositional option was the result of the State's reallignment of services, previously adminstered by the California Department of Corrections and Rehabilitation's Division of Juvenile Justice to the counties.	A youth must be at least fourteen (14) years old and have been convicted of an offense specified in Welfare and Institutions Code section 707(b) (Welfare and Institutions Code section 875(a) (1)-(2)) in order to be committed to the SYTF. According to Section 875(a)(3) of the Welfare and Institutions Code, the court must conclude that a less restrictive alternative disposition is inappropriate.”
Secure Youth Treatment Facility (SYTF)/Division of Juvenile Justice (DJJ) Transition Supervision Program	Secure Youth Treatment Facility (SYTF)/Division of Juvenile Justice (DJJ) Transition Supervision Program serves high-risk probationers who transition from SYTF and DJJ to Probation supervision in the community, under Delinquency Court jurisdiction. This community supervision ranges from placement in least restrictive Step Down programs with an array of supportive services to returning home with parents/legal guardians or other supportive adults. The Program focuses on transition services designed to support transition stabilization (includes possible housing, treatment services - e.g. mental health, substance use, etc., job search/placement, continued education/vocational training, etc.) and self-sufficiency in the community.	A youth must be at least fourteen (14) years old and have been convicted of an offense specified in Welfare and Institutions Code section 707(b) (Welfare and Institutions Code section 875(a) (1)-(2)) in order to be committed to the SYTF.

FY 2023-24 PROBATION SERVICE MATRIX - Directly Operated Programs

Type of Programs	Description of Program/Services
Regional Area Offices	Community-based services for youth and families
Detention Services Bureau	Juvenile
Residential Treatment Services Bureau	Probation Camps and Dorothy Kirby Center
Secure Youth Treatment Facilities	TRI-Academy (at Barry J. Nidorf)j; Campus Kilpatrick

Full program and service descriptions can be found on the Probation Services Matrix tab

Los Angeles County DCFS
Placement Continuum for Foster Youth – February 2023

Los Angeles County's placement continuum for foster youth which emphasizes decision making to always include safety and permanency as our goals through the Integrated Core Practice Model with case planning through the Child and Family teaming process.

TYPE	Home of Parent (HOP)	Adoptive Home	Relative NREFM Home	THP & TLS (18-24 year old)	County-Approved Resource Family Home	FFA-Approved Resource Family Home	Intensive Services Foster Care Home (FFA-ISFC)	Small Family Home (SFH)	Short-Term Therapeutic Treatment Program (STRTP)	Community Treatment Facility (CTF)	Shelter Care (ESC/TSCF)
BUREAU	REGIONS	RCAB	RCAB	CSB	RCAB	ASB	BCRS-HMS	BCRS-HMS	ASB	BCRS/HMS	ASB&BSRS
CAPACITY	Varies	Varies	Varies	THP+- 214 Beds POD/Share SPY – 30 beds	Varies	6926 Beds	84 Homes 91 Beds	16 Homes 38 Beds	27 Programs 596 Beds	2 Programs 68 Beds	TSCF – 70 County Op – 12 beds
CAPACITY DEMAND	Varies	Individualized	Individualized	Individualized	Varies	Varies	300 Beds	Varies	600 Beds (Incl. Prob.)	Varies	90 Beds
POP. SERVED		Dependent of the interest of the adoptive family, typically children and youth 0-17, including siblings, children with special health care needs and children with mental health challenges.	Dependent on the relationship. Typically Children and youth 0-17, NMD's, pregnant and parenting, teens, siblings, children with special health care needs and children with mental health challenges	TAY Youth, and NMD youth	• 0-17 • NMDs • Pregnant/parenting teens • Siblings • Children with special health care needs • Children with mental health challenges	• 0-17 • NMDs • Pregnant/parenting teens • Siblings • Children with special health care needs • Children with mental health challenges	Children, Youth and Non-minor Dependents, newly-removed or under ongoing supervision (open case), who require the highest level of intensive therapeutic mental health or medical care available in a homelike setting.	Local (LA County) Decision: Medically-fragile children, newly-removed or under ongoing supervision (open case), whose medical complexities require a level of care that exceeds an F-Rate foster home and falls short of a medical facility.	0-17 NMDs (18-20) Children, Youth and Non Minor Dependents of the Court with chronic, and persistent mental, emotional and behavioral disorders. Placement in the STRTP will be evaluated by the Interagency Placement Committee (IPC) which screens for three qualifying criteria; 1) Medical Necessity for SMHS 2) Serious Emotional Disturbance 3) Behavioral or treatment needs	Children, Youth and NMDs (18-20) of the court with chronic, and persistent mental, emotional and behavioral disorders who given current symptoms and previous treatment experiences (i.e. multiple hospitalizations/ inability to be served in a less restrictive setting or denials of admission from STRTPs) who may benefit from placement in a locked facility. Youth must volunteer and agree to treatment	All Children, Youth and Non-minor dependents. No rejection

<u>Note</u>: Placement grid sets to be in priority order with path to permanency while always ensuring the youth is placed in least restrictive setting as possible yet placed in a setting to ensure they are receiving all the services necessary as communicated through the Child and Family Team.

Los Angeles County DCFS
Placement Continuum for Foster Youth – February 2023

									that can only be met in a STRTP setting	in a locked setting or be conserved. The IPC screens for the three criteria that MUST be present per Title 9; 1)Youth must meet SED criteria 2) Youth may require a period of containment to participate in MH treatment and the CTF program must be reasonably expected to improve the disorder 3) Other less restrictive settings have proved insufficient or the child is in an inpatient psychiatric hospital or an out of state placement.	
CORE SERVICES		N/A	A) Specialty MHS (B) Transition Services (C) Ed., Physical, Behavioral, MH, Extracurricular Supports (D) Transition to Adulthood	Independent living skills, housing, educational and behavioral support, transitioning planning, and life skills.	A) Specialty MHS (B) Transition Services (C) Ed., Physical, Behavioral, MH, Extracurricular Supports (D) Transition to Adulthood	A) Specialty MHS (B) Transition Services (C) Ed., Physical, Behavioral, MH, Extracurricular Supports (D) Transition to Adulthood Services (E) Permanency	• Coordinated, comprehensive, community-based services: ➢ Trauma-informed; ➢ Culturally-relevant; ➢ Age and developmentally-appropriate. • Family reunification support or alternative	•24/7 medical care administered by trained caregivers. •Placement stability/prevention of higher-level replacement. •Family reunification support; •Training of relatives/NREFMs; •Permanency through adoptions.	(A) Specialty MHS (B) Transition Services (C) Ed., Physical, Behavioral, MH, Extracurricular Supports (D) Transition to Adulthood Services (E) Permanency Support Services (F) Indian Child Services G) Therapeutic	• Containment in a locked setting; • Intensive 24/7 supervision; • Individual and group therapy • Day Treatment Intensive program; • Therapeutic Behavioral Services; • Medication assessment and monitoring; • Drug treatment	TSCF Core Services in development

<u>Note</u>: Placement grid sets to be in priority order with path to permanency while always ensuring the youth is placed in least restrictive setting as possible yet placed in a setting to ensure they are receiving all the services necessary as communicated through the Child and Family Team.

Los Angeles County DCFS
Placement Continuum for Foster Youth – February 2023

			Services (E) Permanency Support Services (F) Indian Child Services		Services (E) Permanency Support Services (F) Indian Child Services	Support Services (F) Indian Child Services	permanency through adoptions. • DMH support for: ➢ Access to trauma-informed mental health treatment; ➢ Therapeutic Foster Care service delivery. • FFA support for transition to permanency – mental health education and health services.		Behavioral Services (TBS)	and drug abuse prevention; • Application for conservatorship, as necessary; • Child and Family Team meeting facilitation.	
LENGTH-OF-STAY		Permanent	Dependent on child case plan. May be temporary due to reunification or permanency through adoptions/ KinGap/LG	Dependent of the child case plan and ability to transition to self-sufficiency and independence	Dependent on Child's case plan. May be temporary until reunification occurs or they may provide permanency through adoption or legal guardianship	Varies depending on progress in each child's permanency plan	1 year or less	<u>No Standard</u>	6-months, or longer if necessary in the child's case plan and if supported by the CFT.	Contingent upon a placed child's/youth/non-minor dependent's mental health complexity, demonstrated emotional/behavioral stability and prescribed by CFT recommendations. Treatment progress is evaluated every six months by the DMH Liaison.	FH – 14 Days FFA- 21 Days TSCF – 10 days

<u>Note</u>: Placement grid sets to be in priority order with path to permanency while always ensuring the youth is placed in least restrictive setting as possible yet placed in a setting to ensure they are receiving all the services necessary as communicated through the Child and Family Team.

FY 2023-24 DMH SERVICE MATRIX - Legal Entities		
Type of Programs	**Description of Program/Services**	**Population Served**
Wraparound/Wraparound FSP	Referred children receive a mental health assessment and individualized services that may prescribe the full spectrum of trauma-informed mental health services, which includes therapy; case management services, i.e. Intensive Care Coordination (ICC); rehabilitation, i.e. Intensive Home Based Services (IHBS); and medication support services. Crisis intervention services and supports are also provided as needed during office hours and on-call 24/7. Services are individualized to meet the needs of the children. Given the high needs of this population, the services are intensive, provided in the home of the child, or in other field-based settings, such as school, wherever the service may be warranted. Non traditional mental health support and services are also available to support the children and their caregivers, which may include respite care, subsidies for housing, food, school, and anything else that can be linked to the treatment plan that may not be covered under Medi-cal. Each child and caregiver benefits from a multi-disciplinary team which includes a Child and Family Specialist (assisting with rehabilitation and intensive care coordination), a Parent Partner (supporting the parent/caregiver), a Mental Health Clinician (providing individual and family therapy), a Psychiatrist (assisting with medication support services), and a Facilitator (navigating the coordination of the treatment planning and coordination of the "Child and Family Team (CFT) Meetings"). The Wraparound team meets with the child, caregiver, other supporting staff, i.e. DCFS social worker, etc, and any other members of their natural support system, i.e. friends of the family, school, etc. to plan and coordinate treatement and safety planning on a regular basis using the CFT format, grounded in the "Integrated Core Practice Model", at the heart of all Wraparound program services. The Wraparound team is expected to "follow" each child youth through a placement disruption ensuring cotinuity of care, stabilizing their placement, promoting permanence, safety, well-being, and reducing/preventing hospitalization and/or a higher level of care. Wraparound services are not time-limited and may be provided until treatment goals are met.	Children/youth between the ages 0-21 with an open DCFS case, or Probation Case, or Post Adoptions Services, who are severely emotionaly disturbed and/or exhibiting behavioral problems
Intensive Field Capable Clinical Services (IFCCS)	Field based, trauma-sensitive intensive mental health services delivered countywide with the goal to minimize psychiatric hospitalizations and promote placement stability. An IFCCS provider is comprised of multiple team members (therapist, behavior specialist, facilitator; psychiatrist and parent partner, as needed) and services include, but are not limited to psychological and social support, case management, rehabilitation services and are part of the Child and Family Team to expedite Intensive Care Coordination (ICC) and Intensive Home-Bases Services (IHBS) to children/youth with an open DCFS case. An IFCCS Provider works to "follow" children/youth if placement disruptions occur to ensure continuity of care, and incorporate natural/informal support with the goal of promoting healthy relationships, permanence, safety, and well being. ** Not DCFS dedicated	Children/youth between the ages 0-21
Intensive Services Foster Care (ISFC)	ISFC is an intensive mental health treatment program for youth in resource foster homes. A multi-disciplinary treatment team (therapist, case manager, parent partner, etc.) provides an array of weekly specialty mental health services (individual, family therapy, case management, medication support) tailored to the needs of the youth to increase placement stability and permanency.	Children/youth between the ages 0-21
Child and Youth FSP	FSP is an integrated, intensive, community-based program. A core multi-disciplinary treatment team compromisd of a Mental Clinician, Intensive Care Coordinator and Case Manager, provide an array of service such as ICC and IHBS for community children/youth, Probation and DCFS involved youth. Services are provided according to the Individualized Services and Supports Plan (ISSP) developed for each client and/or family with a committment to do "whatever it takes" to help them progress toward recovery, health and well-being. Services include but are not limited to medication support, 24/7 crisis response, family support, medication support, respite care, individual and family counseling, and case management	Children/youth between the ages 0-21

MAT Assessment and Treatment	A collaborative between DMH, DCFS and mental health providers designed to ensure the immediate and comprehensive assessments of newly detained children, ages 0-18, entering out of home placement (relative or foster care); or for Voluntary Family Maintanence (VFM) cases, ages 0-5, placed in the home of parent. The information gathered by this assessment will be used to determine what interventions and services are most needed by the child(ren) and also with the intention of using this information to ensure the most appropriate placement for the child. Through the MAT Assessment process, the MAT Assessor is imbedded within the Child and Family Team (CFT) and provides a Summary of Findings (SOF) Report to identify Needs and Strengths of the child(ren) and family. This SOF Report provides Recommendations for the existing team and is later submitted to Court to assist in ongoing DCFS Case Planning. The intended goal for MAT is to identify early on need-specific resources and services.	Children/youth between the ages 0-18
Speciality MHS for the Short Term Residential Therapeutic Program (STRTP)	A residential facility that provides an integrated program of 24-hour care and supervision, adjunctive supports, and mental health treatment (Individual, group, family therapy, case management, Mental Health Rehabilitation Services, Medication Support, Crisis Intervention and access to Therapeutic Behavioral Services) to children and youth.	Children/youth between the ages 6-21
Specialized Foster Care Enhanced Mental Health Services	Comprehensive outpatient basic mental health services to those unserved and underserved children/youth involved in the child welfare system. Services are delivered through a strength-based trauma-informed lens and include but are not limited to mental health assessments, individual, family therapy, and group therapy, crisis intervention, medication support, and case management.	Child/youth between the ages of 0 -21
Children's Crisis Residential Programs (CCRPs)	Children's Crisis Residential Programs (CCRPs) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals under 21 years of age, in a safe and therapeutic, home-like setting. CCRPs provide services 24 hours per day, 7 days per week (24/7). CCRPs have a maximum bed capacity of 4 individuals per site. The anticipated length of stay at CCRPs is ten (10) consecutive days or less unless the child meets medical necessity criteria for a longer stay. CCRPs serve as an alternative to hospitalization, and reduce the number of psychiatric inpatient days of individuals. CCRPs are licensed by the California Department of Social Services (CDSS) as a Short Term Residential Therapeutic Program (STRTP), with the mental health program component certified by the California Department of Health Care Services (DHCS) and are Medi-Cal certified.	Child/youth between the ages of 6 -21
Community Treatment Facility (CTF)	Community Treatment Facilities (CTFs) are residential facilities that provide mental health services to children/youth/Non Minor Dependents, identified as seriously emotionally disturbed in sub-acute, secured, and home-like setting for whom other less restrictive mental health interventions have been tried, as documented in the case plan, or who are currently placed in an acute psychiatric hospital or state hospital, or in a facility outside the state for mental health treatment, and who may require periods of containment to participate in and benefit from mental health treatment. Lesser restrictive interventions shall include, but are not limited to, outpatient therapy, family counseling, case management, family preservation efforts, special education classes, or nonpublic schooling. The identification of CTF as an appropriate service shall be in accordance with the recommendation of the Child Family Team (CFT) and authorization by a County Interagency Placement Committee (IPC). CTFs are licensed by California Department of Social Services and have a mental health program certified by the Department of Health Care Services.	Child/youth between the ages of 12 -21

FY 2023-24 DMH SERVICE MATRIX - Directly Operated Programs

Type of Programs	Description of Program/Services	Population Served
Specialized Foster Care and Engagement Teams	Specialized Foster Care (SFC) mental health services program was designed to assist children in the Department of Children and Family Services (DCFS) Child Welfare System. SFC ensures that children receive timely and appropriate mental health services. Services include screening and assessments of DCFS youth, linkage to mental health services in the community, consultation to DCFS Children's Social Workers on mental health issues, assisting with crisis intervention and providing in-service training on mental health topics. ET- Outreach and engagement of youth who are disengaged from MHS, with history of MH, and multiple psychiatric hostpailizations.	Ages range from 0-21
Medical Hubs	The Medical Hubs provide clinical screenings and urgent intervention which supports DCFS in helping to protect the County's children from abuse and neglect. Staff from the Department of Health Services (DHS) Department of Mental Health (DMH) are co-located. Mental Health services include screening, crisis intervention, case management, linkage and referral to mental health services.	Ages range from 0-21

Qualified Individual	The QI determines the setting which provides the child/youth with the most effective and appropriate level of care in the least restrictive environment, consistent with the short and long term goals as specified in the permanency plan. Services include, interviewing members of the Child and Family Team (CFT) including youth, family/informal supports and professionals (social workers, probation officers, therapists, regional center workers, etc) about what is needed to support the youth and what are their strengths and challenges, for purposes of assessing the ideal placement/mental health treatment setting for the youth. Providing Intensive Care Coordination (ICC) by attending (CFT) meetings in the beginning of the assessment period and at the end of the assessment period to present report and recommendations. Reviewing court, mental health, Child and Adolescent Needs and Strengths assessment (CANS), education, developmental reports/assessments. Developing a written assessment for treatment and recommended level of care to best meet the youth's needs. As part of the assessment, the QI develops short- and long-term goals for the youth and offers considerations for aftercare services. When a youth requires an Short-Term Therapeutic Residential Treatment Program (STRTP) and has a placement need, the QI faciliates an Interagency Placement Committee screening (IPC) with DCFS and/or Probation and STRTP providers to determine which program may best fit the youth's needs.	Ages range from 0-21

FY 2023-24 DMH SERVICE MATRIX - Intensive Care Division

Type of Programs	Description of Program/Services	Population Served
PHF	Psychiatric Health Facilities (PHF) provide non-hospital 24-hour inpatient services designed to provide innovative and more competitive acute care service as an alternative to hospital care to clients ages 13 through 17 years (adolescent) and ages 18 and older . All clients are pre-screened by LAC-DMH as clinically appropriate for Acute Psychiatric Inpatient Hospital level of care according to generally accepted standards. In addition to the age criteria, clients referred to the PHF must meet the following criteria: 1) experiencing an acute psychiatric episode or crisis, 2) and require services either on a voluntary or an involuntary basis; 3) or may have a present or past history of substance use disorder, 4) past history of legal charges, convictions, arrests, or justice involvement status; 5)and/or the current presence of suicidal ideation in the absence of actual suicidal behavior or intent in the previous week. Clients must also meet the following medical necessity criteria for admission to a licensed facility for PHF services: 1) have an included diagnosis, 2) cannot be safely or more effectively treated at a lower level of care, except that a client who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and, 3) requires psychiatric inpatient hospital services, due to one of the following: A. Symptoms or behavior due to a mental disorder: 1. Represent a current danger to self or others, or significant property destruction. 2. Prevent the client from providing for, or utilizing, food, clothing, and shelter. 3. Present a severe risk to the client's physical health. 4. Represent a recent, significant deterioration in ability to function. or B. Require admission for one of the following: 1.Further psychiatric evaluation. 2.Medication treatment. 3.Other treatment that can be reasonably provided only if the client is hospitalized.	Ages range from 13-17 and 18 and older

UCC (Adoles and Adult)	Psychiatric Urgent Care Centers (UCCs) are Medi-Cal certified and Lanterman-Petris-Short (LPS) designated crisis stabilization units that provide rapid access to mental health evaluation and assessment, crisis intervention and medication support, 24 hours per day, 7 days per week (24/7), as well as case management for individuals experiencing psychological distress and/or psychiatric crisis. UCC services, include integrated services for co-occurring substance use disorders, are focused on stabilization and linkage to recovery-oriented community based resources. UCCs serve those individuals whose presenting problems can be met with short-term (less than 24 hours), immediate care and linkage to on-going community services and supports, who would otherwise be taken to emergency rooms or incarcerated. Clients served participate in the development of an individualized plan, focused on recovery and wellness principles that will promote successful re-integration into the community. Clients are provided: 1) assessment and Mental Health Services Crisis Intervention, 2) co-Occurring Services Medication Evaluation and Support, 3) case Management and Linkage, 4) transportation Services These services consist of arrangements for transportation to crisis residential facilities or emergency, transitional or permanent housing when appropriate to ensure that successful linkage takes place, 5) housing Services to assist clients to access emergency, transitional, temporary, and permanent housing, 6) physical health care composed of basic physical health assessment, 6) referrals and coordination of care, and 7) benefits establishment and services to the uninsured	Ages range from 13-17 and 18 and older

GATEWAYS/KEDREN	Hospital (twenty-four hour psychiatric treatments) services are provided in an acute psychiatric hospital or a distinct acute psychiatric part of a general acute care hospital that is approved by SDHS to provide psychiatric services. Services shall include, but are not limited to: 1) admission services twenty-four hours a day, seven days a week, 2) safe and clean living environment with adequate lighting, toilet and bathing facilities, hot and cold water, toiletries, and a change of laundered bedding, 3) three balanced and complete meals each day, 4) twenty-four hour supervision of all patients/clients by properly trained personnel (this includes but is not limited to, personal assistance in such matters as eating, personal hygiene, dressing and undressing, and taking of prescribed medications), 5) physical examination and medical history within twenty-four hours of admission, 6) laboratory services when medically indicated, 7) X-Rays, 8) EKGs and EEGs, 9) Convulsive treatment in accordance with WIC Section 5326.7 et seq., 10) medication supervision and/or maintenance program, 11) psychiatric treatment services (including, but not limited to, daily patient review), 12) psychological services, 13) social work services, 14) nursing services, 15) recreational therapy services, 16) occupational therapy services, 17) recommendation for further treatment, conservatorship, or referral to other existing programs, as appropriate (i.e., day care, outpatient, etc.), relative to patient/client needs, 18) prior to discharge of any patient/client, preparation and transmittal of a written aftercare plan.	Gateways Ages range 13 through 17 and 18 and older Kedren Ages range 18 and older

ERS	Enriched Residential Services (ERS) provide comprehensive mental health and rehabilitative services in a non-institutional residential setting for individuals 18 and older, who would be at risk of hospitalization, re-hospitalization or other institutional placement if they were not in the ERS program. ERS program accommodates persons discharged from a locked subacute, acute psychiatric inpatient units, jails, or intensive residential facilities at risk of needing higher level of care. ERS program targets individuals in higher levels of care who require on-site mental health and supportive services that focus on life skills training, linkage and community engagement activities that support individuals in their effort to restore, maintain and apply interpersonal and independent living skills and to access community support systems, with the goal stabilizing, preparing, and transitioning individuals to a stable independent community living environment. ERS program delivers augmented mental health support to individuals residing primarily at a licensed Adult Residential Facilities (ARF) certified by the California Department of Social Services to provide 24 hour a day non-medical care and supervision to individuals 18 of age through to 59 years of age. Other ERS programs in an Adult Residential Treatment (ART) facility are certified as a Social Rehabilitation Program by the Department as either a Transitional Residential Treatment Program or a Long-Term Residential Treatment Program2. ART facility capacity is limited to a maximum of 16 beds. The target population is adults 18 to 59 (age waiver at selected facilities for persons 60 years of age and older): 1) primary DSM-V psychiatric diagnoses of major psychotic disorders or major mood disorders with psychotic features, 2) may have co-occurring substance use disorders, 3) independent and ambulatory without the use of durable medical equipment (DME) Services provided to a client must be medically necessary and clinically appropriate to address the client's presenting condition. For clients 21 and older a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For clients under age 21 a service is "medically necessary" or a "medical necessity" when needed to correct or ameliorate a mental health condition (Note: services do not need to be curative or restorative to ameliorate a mental health condition per CMS). Referrals for ERS can be initiated by any locked subacute, acute psychiatric inpatient units, jails, or intensive residential facilities for clients at risk of needing higher level of care, and the referring facility may call LACDMH Intensive Care Division to initiate a Service Request	Ages range from 18 through 59
CRTP	Crisis Residential Treatment Program (CRTP) is an intensive short-term (average Length of Stay is 30 days, maximum of 3 months) and structured residential program utilized as an alternative to hospitalization for clients experiencing an acute psychiatric crisis or episode who do not have medical complications requiring nursing care. CRTP has a higher staff to client ratio with maximum of 16 beds per facility Services are provided in a non-institutional residential setting with the purpose of restoring a client's independent living skills and access to support systems within the community. On-site services include daily support groups, individual therapy, case management services, and medication support services. Goal is to stabilize client and link them to the next treatment provider such as ERS or FSP.	Age range is 18 and older

IMD SUBACUTE	Subacute facilities provide psychiatric treatment to individuals 18 and older, with severe and persistent mental illnesses, in a nonhospital-based therapeutic residential setting. Subacute facilities provide long term care for individuals who no longer meet criteria for acute care but are not clinically ready to live independently or in a board and care facility. Subacute facilities provide 24/7 psychiatric care, nursing care, and psychosocial rehabilitation services, geared to the needs of individuals with serious mental illness who are placed under LPS conservatorship.	Age range is 18 and older (There is a DMH/DCFS MOU for TAY Youth))

COUNTY OF LOS ANGELES- DEPARTMENT OF HEALTH SERVICES
CHILD AND ADOLESCENT SERVICE MATRIX

Type of Programs	Description of Program/Services	Population Served
Psychiatric Emergency Service (PES)/Psychiatric Emergency Room	The Los Angeles County Department of Mental Health (DMH) contracts with DHS to provide specialty mental health services through three Psychiatric Emergency Service (PES)/Psychiatric Emergency Rooms. The program provides on-site, evaluation, diagnosis, medication and crisis intervention services to adults and children who are experiencing a psychiatric emergency. DHS PES team can refer patients who are seen for additional services and/or facilitate voluntary or involuntary psychiatric hospitalization if necessary. The psychiatric emergency room serves as the entry point for each hospital's inpatient program. Services are designed to meet the needs of patients who are experiencing a severe emergency.	No limit
Acute Adolescent Psychiatric Inpatient Service	The Los Angeles County Department of Mental Health (DMH) contracts with DHS to provide specialty mental health services through one acute adolescent psychiatry inpatient unit, licensed for 10-beds serving adolescents ages 13-18. It provides a twenty-four (24) hour short-term inpatient treatment program to acute adolescents experiencing a psychiatric crisis with the intent to ameliorate the symptoms of danger to self and others or the inability to provide for food, clothing, and shelter due to a mental disability as determined by qualified mental health professional staff.	Ages 13-18

COUNTY OF LOS ANGELES- DEPARTMENT OF HEALTH SERVICES
CHILD AND ADOLESCENT SERVICE MATRIX

Juvenile Court Health Services at Probation	Juvenile Court Health Services (JCHS) staff include Doctors, Nurses, Dentists, Optometrist, Pharmacists, Radiology staff, Laboratory staff, and Health Information Management staff who work together to focus on the overall health and well-being of the youth placed in any of the Probation juvenile justice facilities. Healthcare staff are employees of the Los Angeles County Department of Health Services and work with the Department of Mental Health – Juvenile Justice Mental Health Program (JJMHP) and the Los Angeles County Office of Education as partner agencies with the Department of Probation. The goal is to keep youth healthy while they are in the Probation facilities and to give them the knowledge and skills to stay healthy when they return home. JCHS provides services that include medical examinations and follow-up for identified health issues, dental examinations and treatment, eye examinations with eyeglasses as needed, assessments for any health concerns youth may have, administration of prescribed medications and treatments, immunization updates, and initial response to any health-related emergencies. Additional specialty care is provided by working closely with other County hospitals and clinics. Healthcare staff is available 7 days a week at the juvenile halls and camps. The family may provide medical information to the medical staff at the facility, where the youth is located, which will then be reviewed by the physician and incorporated in the care of the youth. Upon discharge from the juvenile hall or camp, medical information is provided along with any necessary medications/prescriptions, information for further follow-up and educational material for the youth and family. New programs are being developed in collaboration with the JJMHP, Public Health and Probation staff for evaluation, assessment and treatment of youth with substance use disorders. Medications for opioid use disorder are available for those youth who want medical treatment for opioid addiction.	Ages 10-24

COUNTY OF LOS ANGELES- DEPARTMENT OF HEALTH SERVICES
CHILD AND ADOLESCENT SERVICE MATRIX

Gender-Affirming Health Care	The DHS Gender Health Program (GHP) provides access to the full spectrum of gender affirming health care services via direct medical care within the GHP and through coordination and navigation to facilities outside DHS. The Gender Health Program sees patients of all ages, including pediatric patients, young adults, adults, and older adults. Minors who are in Juvenile Hall are seen in the GHP via specialty referral from their primary provider at JCHS. Minors who are DCFS involved are also enter the GHP via specialty referral from the Medical Hubs or via referral from their DCFS assigned CSW. Within the GHP, the intervention recommended for each patient is individual based on multiple factors unique to the patient such as age, identity/personal experience, consent of person(s)/entity who holds legal medical decision-making rights for the minor, etc., specifically for minors (<18 years of age), direct services provided by the DHS GHP include puberty suppression, menses suppression, hormonal therapy and intensive navigation and coordination to outside systems. Navigation and coordination services which are provided, as appropriate, to minor patients include referral to outside systems for gender affirming surgical interventions, legal services (name/gender marker change) and mental health services. DHS does not directly provide gender affirming surgical interventions to minors; however, ensures that any DHS patient still has access to the current standard of care with regards to gender affirming surgical interventions through referral and coordination with outside institutions. These procedures may include chest and facial surgeries as well as hair removal. Gender affirming procedures which are result in sterilization (hysterectomy, orchiectomy, vaginoplasty, phalloplasty) are not typically available to minors, which is consistent with current standards of care and other health systems in California. It is important to note that access to medical or surgical interventions for minors only happen with the consent of the person(s)/entity who holds legal medical decision-making rights for the minor. Minors in the JCHS and DCFS system require consent of the person(s)/entity who holds legal medical decision-making rights. This may be a parent, parents or the Court. The GHP goes through very specific processes to obtain appropriate consent for gender affirming medical interventions for minor patients.	**Prepubertal:** no medical interventions are done however patients in this age group are welcome in our clinic space as we are happy to help with coordination of care, support to ensure a healthy home and school environment, etc. **Puberty and beyond:** medical and surgical interventions can be considered as appropriate for the individual patient. Consent from person(s)/entity who holds legal medical decision-making rights must be obtained for any intervention.

COUNTY OF LOS ANGELES- DEPARTMENT OF HEALTH SERVICES
CHILD AND ADOLESCENT SERVICE MATRIX

Addiction Medicine Medical Providers Who Can Prescribe MAT	Each month DHS cares for hundreds of individuals (some of them are youth) who have various substance use disorders (SUD), including but not limited to those with FDA-approved medications for addiction treatment (e.g. opioid use disorder [MOUD], alcohol use disorder [MAUD], tobacco use disorder [MTUD]). DHS has providers across our system who regularly prescribe medications for addiction treatment (MAT), specifically medications for opioid use disorder (MOUD), for alcohol use disorder (MAUD) and/or tobacco use disorder (MTUD). These providers are in our primary care patient centered medical homes (PCMH), urgent care clinics, emergency departments, street medicine services, correctional health services and inpatient hospital settings. Rescue naloxone is actively prescribed in all of our settings, as well as distributed under standing order by other DHS team members to high-risk individuals for prevention of opioid overdoses. DHS substance use navigators (SUN) are embedded in our PCMHs and work closely with grant-funded SUNs in our acute care settings for the unique care management of our patients of all ages with various SUD, even those not engaging in MAT.	Ages 12-18
SHARK Clinic Medical Hubs	. The Strong, Healthy, and Resilient Kids (SHARK) Program at Rancho Los Amigos is a specialty consultation program designed to address the needs of children and youth who are affected by developmental and behavioral challenges as well as by toxic stress. This program serves as one of several resources offered to LA County's children and youth who screen positive on screens for developmental delay (the Ages and Stages Questionnaire) and for symptoms of toxic stress (the Adverse Childhood Experiences screen). Children are referred from DHS Primary Care Clinics through the eConsult platform for specialty consultation. The SHARK team of pediatric, mental health, nursing, and care coordination staff supports patients and their families through assessment, case management, and referral to community services supporting their medical, social, mental health, and behavioral health needs. The program operates Monday-Friday in the Pediatric Clinic at the DHS Rancho Los Amigos facility. DHS' six Medical Hubs provide medical, mental health, and specialty services to children and youth involved in the child welfare system. All Medical Hub staff are specialized in serving youth in foster care; in addition to DHS clinicians and staff, the Medical Hubs also include co-located DCFS social workers, DMH clinicians, and DPH child welfare public health nurses. The Medical Hubs' core services include: initial medical exam for newly detained children, medical clearances for	Birth-21 years DCFS-involved children, birth-21 years old

COUNTY OF LOS ANGELES- DEPARTMENT OF HEALTH SERVICES
CHILD AND ADOLESCENT SERVICE MATRIX

	children entering shelter care and CSEC survivors, forensic evaluations, mental health screenings and linkages to mental health services, and well-child visits. Some Medical Hubs offer specialty services including care for CSEC survivors, services for LGBTQ+ youth, care for children with Fetal Alcohol Spectrum Disorders, and more. The six Medical Hubs are located at LA General Medical Center (open 24/7), Harbor-UCLA Medical Center, Olive View-UCLA Medical Center, High Desert Regional Health Center, and East San Gabriel Valley.	

DPH Substance Abuse Prevention and Control - Continuum of Services

ADULT SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE

Level Of Care (LOC)	ASAM Level	DHCS ASAM Description	DMC-ODS LOC	ASAM Dimension "D" 1 Acute Intoxication/ Withdrawal	ASAM Dimension "D" 2 Biomedical	ASAM Dimension "D" 3 The "ABCDE"	ASAM Dimension "D" 4 Readiness to Change	ASAM Dimension "D" 5 Relapse/ Continued Use	ASAM Dimension "D" 6 Recovery/ Living Environment	Funding Source
Early Intervention	0.5	Screening, brief intervention, and referral (as needed).	No	No withdrawal risk	None; very stable	No psychiatric conditions; very stable	Willing to explore current use and/ or risky behaviors	Needs an understanding or skills to change current use/ risky behaviors	Social support/ environment increase risk of conflict over use	Health Plans not DMC-ODS
Outpatient	1	Less than 9 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	Not experiencing significant withdrawal; minimal risk; manageable at Level 1-WM	None or very stable; receiving concurrent medical monitoring	None or very stable psychiatric conditions; receiving concurrent mental health monitoring	Ready for recovery but needs motivating strategies	Able to maintain abstinence, control use and pursue recovery	Recovery environment is supportive; client has skills to cope	DMC
Intensive Outpatient	2.1	Nine (9) or more hours of service per week to treat multidimensional instability.	Yes	Minimal risk of severe withdrawal; manageable at Level 2-WM	None; biomedical conditions not distracting from treatment	Mild severity with potential distraction; receiving concurrent mental health treatment	Ambivalent to treatment; lack of insight to substance use disorder or mental health problem; requires structured program many times a week to progress through stages of change	Intensification of symptoms indicate high likelihood of relapse or continued use without close monitoring/ support many times a week	Recovery environment is not supportive but can cope with structure	DMC
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	No	Moderate risk of severe withdrawal	None; biomedical conditions not sufficiently distracting from treatment	Mild to moderate severity with potential distraction	Significant ambivalence to treatment; lack of insight to substance use disorder or mental health problem; requires structured program almost every day to progress through stages of change	Intensification of symptoms indicate high likelihood of relapse or continued use without close monitoring/ support almost every day	Recovery environment is not supportive but can cope with structure and when provided relief from home environment	Per DHCS, not funded under DMC-ODS
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	Yes	None/ minimal/ stable withdrawal risk; concurrently receiving Level 1-WM or Level 2-WM	None/ stable/ receiving concurrent medical monitoring	None/ minimal; not distracting recovery; if stable, a co-occurring capable program is appropriate; if not stable, co-occurring enhanced program is required	Open to recovery but needs structured environment to improve	Understands relapse; needs structure	Dangerous environment but safe with 24-hour structure	DMC
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	Yes	Minimal risk of severe withdrawal; if withdrawal present, manageable at Level 3.2-WM	Mild/ stable/ receiving concurrent medical monitoring	Mild/ moderate severity; needs structure; treatment designed to address cognitive defects; if stable, co-occurring capable program is appropriate; if not stable, co-occurring enhanced program is required	Little awareness; needs interventions available only at this LOC to stay in treatment	Little awareness; needs interventions available only at this LOC to prevent continued use	Dangerous environment; needs 24-hour structure to learn to cope	DMC
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes	Minimal risk of severe withdrawal; if withdrawal present, manageable at Level 3.2-WM	None/ stable/ receiving concurrent medical monitoring	Repeated inability to control impulses; unstable; requires 24-hour setting for stabilization; co-occurring enhanced setting required for those with severe/ chronic mental illness	Marked difficulty/ opposition to treatment with dangerous consequences	No recognition of skills needed to prevent continued use; with imminent dangerous consequences	Dangerous environment; lacks coping skills outside of 24-hour highly structured setting	DMC
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	No	High risk of withdrawal but manageable at Level 3.7-WM	Requires 24-hour medical monitoring but not intensive treatment	Moderate severity; needs 24-hour structured setting; for co-occurring mental disorder, requires concurrent mental health services	Low interest in treatment/ poor impulse control despite negative consequences; needs coping/ motivating strategies safely available only in 24-hour structured setting	No self-control; with imminently dangerous consequences	Dangerous environment; lacks skills to cope outside of a highly structured 24-hour setting	Per DHCS, not funded under DMC-ODS but provided by other healthcare facilities in LA County
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	No	High risk of withdrawal; require Level 4-WM and the full resources of a licensed hospital	Requires 24-hour medical and nursing care with full resources of a licensed hospital	Severe and unstable problems requiring 24-hour psychiatric care with concurrent addiction treatment (co-occurring enhanced)	Problems in these dimensions do not qualify client for this LOC; must have severity in Dimensions 1-3	Problems in these dimensions do not qualify client for this LOC; must have severity in Dimensions 1-3	Problems in these dimensions do not qualify client for this LOC; must have severity in Dimensions 1-3	

Ambulatory Withdrawal Management: Without Extended On-Site Monitoring	1-WM	Yes	Mild withdrawal with daily or less than daily outpatient supervision.	Minimal risk of severe withdrawal that is manageable at this LOC; at least mild withdrawal symptoms or withdrawal is imminent	DMC
Ambulatory Withdrawal Management: With Extended On-Site Monitoring	2-WM	Yes	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	Moderate risk of severe withdrawal outside the program setting; no severe physical and psychiatric complications; safely responds to several hours of monitoring, medication and treatment; signs and symptoms of withdrawal or withdrawal is imminent	DMC
Residential Withdrawal Management: Clinically Managed	3.2-WM	Yes	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	Not at risk of severe withdrawal; moderate withdrawal safely managed at this LOC; signs and symptoms of withdrawal or withdrawal is imminent	DMC
Inpatient Withdrawal Management: Clinically Managed	3.7-WM	No	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	Severe withdrawal syndrome that is manageable at this LOC; signs and symptoms of severe withdrawal or withdrawal is imminent	Per DHCS, not funded under DMC-ODS but provided by other healthcare facilities in LA County
Inpatient Withdrawal Management: Medically Managed & Intensive Services	4-WM	No	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Signs and symptoms of severe withdrawal; severe withdrawal is imminent; requires primary medical and nursing care services, and 24-hour observation, monitoring and treatment	

Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	Yes	Physiological dependence on opioid; requires this LOC to prevent withdrawal	None; can be managed with outpatient medical monitoring	None; can be managed in an outpatient structured setting	Ready to change from opioid use but not for total abstinence from illicit prescription/ non-prescription drug use	High risk of relapse without this LOC and structured therapy	Supportive environment; patient has coping skills	DMC

This is a summary of the description of ASAM dimensions within each level of care. For full details, please consult the American Society of Addiction Medicine's publication,

The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, third edition (2013) by David Mee-Lee, Gerald Shulman, Marc Fishman, David Gasfriend, Michael Miller and Scott Provence.

ADOLESCENT SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE

Level Of Care (LOC)	ASAM Level	DHCS ASAM Description	DMC ODS LOC	ASAM Dimension "D" 1 Acute Intoxication/ Withdrawal	ASAM Dimension "D" 2 Biomedical	ASAM Dimension "D" 3 The "ABCDE"	ASAM Dimension "D" 4 Readiness to Change	ASAM Dimension "D" 5 Relapse/ Continued Use	ASAM Dimension "D" 6 Recovery/ Living Environment	Funding Source
Early Intervention	0.5	Screening, brief intervention, and referral (as needed).	No	No withdrawal risk	None or very stable	None or very stable. Any D3 issues are being addressed through concurrent mental health services and do not interfere with early intervention addiction treatment services.	Willing to explore how current alcohol, tobacco, medications, other drug use and/or high-risk behaviors may affect achievement of personal goals.	Needs an understanding of, or skills to change, current alcohol, tobacco, other drug, or medication use patterns, and/or high-risk behaviors.	Adolescent's risk of initiation of or progression in substance use and/or high-risk behaviors is increased by substance use or values about use. High-risk behaviors of family, peers, or others in the adolescent's social support system.	Health Plans not DMC-ODS
Outpatient	1	Less than 6 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	No withdrawal risk	None; very stable; receives concurrent medical monitoring	Not at risk of harm; minimal interference with addiction/ mental health recovery efforts; minimal to mild social impairment; minimal difficulties with daily living activities but with significant risk of deterioration; minimal imminent risk	Willing to engage in treatment; contemplating change; needs motivating strategies	Can maintain abstinence/ control use/ pursue recovery with minimal support	Supportive family and environment	DMC
Intensive Outpatient	2.1	Six (6) or more hours of service per week to treat multidimensional instability.	Yes	Minimal withdrawal; at risk of withdrawal	None; stable	Low risk of harm; mild interference with addiction/ mental health recovery efforts; mild to moderate social impairment but can perform responsibilities; mild to moderate difficulties with daily living activities and requires frequent monitoring/ interventions; history and current situation predict need for frequent monitoring/ interventions	Requires close monitoring many times a week; no interest in getting help	Significant risk of relapse; problems and deterioration in functioning level; poor prevention skills; needs close monitoring	Environment impedes recovery; requires close monitoring and support	DMC
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	No	Mild withdrawal; at risk of withdrawal	None; stable	Low risk of harm and is safe overnight; moderate interference with addiction/ mental health recovery efforts; moderate social impairment but can perform responsibilities; moderate difficulties with daily living activities and requires near-daily monitoring/ interventions; history and current situation predict need for near-daily monitoring/ interventions	Requires near-daily structured program; no awareness of role of alcohol, tobacco and/or other drugs use in current problems	High risk of relapse; problems and deterioration in functioning level; minimal prevention skills; needs near-daily monitoring	Environment not supportive of recovery without near-daily monitoring or frequent relief from home environment	Per DHCS, not funded under DMC-ODS but provided by other healthcare facilities in LA County
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	Yes	Withdrawal is concurrently managed at another LOC	None; stable; receiving concurrent medical monitoring as necessary	Needs stable living environment; moderate interference with addiction/ mental health recovery efforts needing limited 24-hour supervision to support treatment engagement; moderate social impairment needing limited 24-hour supervision to perform responsibilities; moderate difficulties with daily living activities needing limited 24-hour supervision and frequent prompting; history and current situation predict instability without limited 24-hours supervision	Open to recovery but needs limited 24-hour supervision	Understands consequences of continued use; has emerging recovery skills but needs supervision	Environment poses risk to recovery; requires alternative residence or support	DMC
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	N/A							Non-ASAM Level for Adolescents
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes	Mild to moderate withdrawal; at risk of withdrawal	None; stable; receiving concurrent medical monitoring as necessary	Moderate but stable risk of harm needing medium-intensity 24-hour monitoring; moderate to severe interference with addiction/ mental health recovery efforts needing medium-intensity residential treatment; moderate to severe social impairment; moderate to severe difficulties with daily living activities needing 24-hour supervision and medium-intensity assistance; history and current situation predict destabilization without medium-intensity residential treatment	Needs intensive motivating strategies in 24-hour structured program	Lacks use/ behavior control and avoid impairment without 24-hour structured program; unable to overcome triggers/ cravings; poor treatment response	Dangerous environment; requires residential treatment for recovery/ protection	DMC
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	No	Moderate to severe withdrawal	Requires 24-hour medical monitoring but not intensive treatment	Moderate risk of harm needing high-intensity 24-hour monitoring or secure placement; severe interference with addiction/ mental health recovery efforts needing high-intensity residential treatment; severe social impairment; severe difficulties with daily living activities needing 24-hour supervision and high-intensity assistance; history and current situation predict destabilization without high-intensity residential treatment	Needs motivating strategies in 24-hour medically monitored program; requires secure placement; needs high-intensity case management	Unable to interrupt high-severity or high-frequency pattern of use and/ or behaviors, and avoid dangerous consequences without high-intensity 24-hour interventions	Dangerous environment; requires residential treatment for recovery/ protection	Per DHCS, not funded under DMC-ODS but provided by other healthcare facilities in LA County
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	No	Severe withdrawal; requires intensive active medical management	Requires 24-hour medical and nursing care, and full resources of licensed hospital	Severe risk of harm; very severe interference with addiction/ mental health recovery efforts; very severe, dangerous social impairment needing frequent medical and nursing interventions; very severe difficulties with daily living activities needing frequent medical and nursing interventions; history and current situation predict destabilization without inpatient medical management	Problem in this dimension does not qualify patient for Level 4 services. If patient's only severity is in Dimension 4, 5 and/or 6 without high severity in Dimension 1, 2 and/or 3, then patient does not qualify for Level 4			Per DHCS, not funded under DMC-ODS but provided by other healthcare facilities in LA County
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	N/A							Non-ASAM Level for Adolescents
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	N/A							Non-ASAM Level for Adolescents
Residential Withdrawal Management Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	N/A							Non-ASAM Level for Adolescents
Inpatient Withdrawal Management Clinically Managed	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	N/A							Non-ASAM Level for Adolescents
Inpatient Withdrawal Management Medically Managed	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	N/A							Non-ASAM Level for Adolescents
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	N/A							Non-ASAM Level for Adolescents

This is a summary of the description of ASAM dimensions within each level of care. For full details, please consult the American Society of Addiction Medicine's publication,

The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, third edition (2013) by David Mee-Lee, Gerald Shulman, Marc Fishman, David Gasfriend, Michael Miller and Scott Provence.

SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES FOR YOUTH
FACT SHEET

County of Los Angeles Public Health

CENS For Youth Overview

The Client Engagement and Navigation Services (CENS) for Youth is a youth-focused program designed to facilitate access to early intervention and substance use disorder (SUD) treatment services among youth with complex needs in Los Angeles County. The program will engage youth to provide developmentally appropriate and timely access to substance use screenings for linkages to specialty SUD services, including early intervention, outpatient, intensive outpatient, residential, medication and withdrawal management services (as clinically appropriate).

The CENS for Youth program also serves to strengthen strategic partnerships through collaboration among youth-serving organizations and County partners including the Departments of Mental Health, Children and Family Services, and Probation to integrate services and ensure successful connections for multi-system involved youth into Early Intervention and SUD treatment services.

Staffing

The CENS for Youth counselors are co-located in each Service Planning Area (SPA) throughout the County.

CENS for Youth Services

- Client Outreach & Engagement
- Client Eligibility & Enrollment (e.g. health coverage)
- Client Education / Psychoeducation
- Early Intervention Services
- Screening and Referral to Treatment Services,
- Warm hand-off (appointment scheduling, reminders, and follow-up)
- Service Navigation, Ancillary Referrals and Linkages
- Strengthen partnerships with youth-serving organizations and public service systems
- Documentation and Reporting

Responsibilities of CENS Staff

- Deliver developmentally appropriate, culturally sensitive SUD services to youth, including outreach and engagement, screenings, referrals, and service navigation.

- Provide engagement and care coordination to successfully link and enroll youth with co-occurring needs into a SUD treatment program and ancillary services.

- Conduct eligibility verification for Medi-Cal, Minor Consent programs, or other secondary funding sources; facilitate and assist clients in completing applicable healthcare enrollment, eligibility, and income verification processes for Medi-Cal, Minor Consent, or other eligible programs.

- Serve as a liaison between SUD treatment providers and a network of schools, community-based organizations (CBOs), and other County departments, including Probation, Department of Mental Health and Department of Children and Family Services, to support and strengthen referrals to SUD services.

- Facilitate the development of partnerships to enhance care coordination, integrate services, and expand service delivery among youth with complex needs.

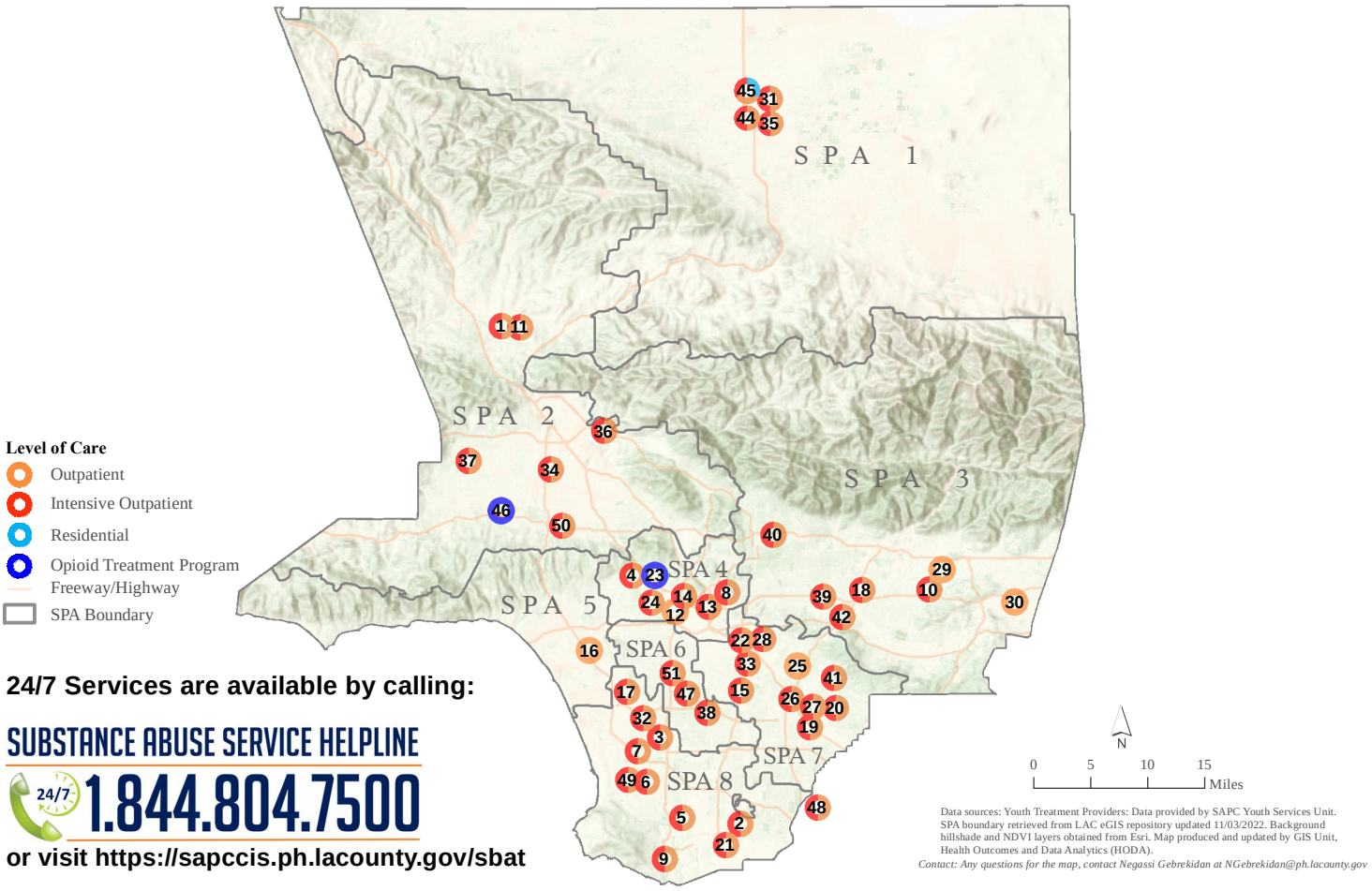
- Conduct outreach at community events to provide presentations on SUD issues and increase awareness of pathways to refer clients to Early Intervention and SUD treatment services.

For More Information

For more information about the program, please contact Duy Tran at dutran@ph.lacounty.gov

V5 11.2023

Substance Abuse Prevention and Control
Youth Treatment Providers and Level of Care
As of 21 June 2023



Data sources: Youth Treatment Providers: Data provided by SAPC Youth Services Unit. SPA boundary retrieved from LAC eGIS repository updated 11/03/2022. Background hillshade and NDVI layers obtained from Esri. Map produced and updated by GIS Unit, Health Outcomes and Data Analytics (HODA).

Contact: Any questions for the map, contact Negassi Gebrekidan at NGebrekidan@ph.lacounty.gov

24/7 Services are available by calling:

SUBSTANCE ABUSE SERVICE HELPLINE

24/7 1.844.804.7500

or visit https://sapccis.ph.lacounty.gov/sbat

1. **Action Family Counseling**
   22722 Soledad Canyon Rd.
   Santa Clarita, 91350
   (800) 367-8336
2. **Asian American Drug Abuse Program**
   1360 East Anaheim St., Suite 205
   Long Beach, CA 90813
   (562) 218-9530
3. **Asian American Drug Abuse Program**
   13931 South Van Ness Avenue
   Gardena, CA 90249
   (310) 768-8018
4. **Behavioral Health Services**
   6838 Sunset Boulevard
   Hollywood, CA 90028
   (323) 461-3161
5. **Behavioral Health Services**
   1318 North Avalon Boulevard, Suite A,
   Wilmington, CA 90744
   (310) 549-2710
6. **Behavioral Health Services**
   1334 Post Avenue,
   Torrance, CA 90501
   (310) 328-1460
7. **Behavioral Health Services**
   15519 Crenshaw Blvd.
   Gardena, CA 90249
   (310) 679-9126
8. **Behavioral Health Services**
   4099 North Mission Road
   Los Angeles, CA 90032
   (323) 221-1746
9. **Behavioral Health Services**
   590 West 8th Street
   San Pedro, CA 90731
   (310) 831-2358
10. **Center For Integrated Family and Health Services**
    540 South Eremland Drive, Suite A,B,C,D
    Covina, CA 91723
    (626) 966-1577
11. **Child & Family Center**
    21545 Centre Pointe Parkway
    Santa Clarita, CA 91350
    (661) 481-2801
12. **Children's Hospital of Los Angeles**
    3250 Wilshire Boulevard, Suite 300
    Los Angeles, CA 90005
    (323) 361-2463
13. **Clinica Monsenor Oscar A. Romero**
    2032 Marengo Street, Suite B
    Los Angeles, CA 90033
    (323) 987-1034
14. **Clinica Monsenor Oscar A. Romero**
    123 South Alvarado Street
    Los Angeles, CA 90057
    (323) 987-1034
15. **Compatior**
    4363 Tweedy Boulevard
    South Gate, CA 90280
    (323) 378-2009
16. **Didi Hirsch Mental Health Services**
    4760 S Sepulveda Blvd
    Culver City, CA 90230
    (310) 895-2300
17. **Divine Healthcare Services**
    405 West Manchester Blvd., Suite A
    Inglewood, CA 90301
    (310) 672-3820
18. **Eggleston Youth Centers**
    13001 Ramona Boulevard, Suites E & J
    Irwindale, CA 91706
    (626) 480-8107
19. **Helpline Youth Counseling**
    12440 Firestone Boulevard Suite 316
    Norwalk, CA 90650
    (562) 864-3722
20. **Helpline Youth Counseling**
    14181 Telegraph Road
    Whittier, CA 90604
    (562) 273-0722
21. **Helpline Youth Counseling**
    920 Atlantic Avenue, 101-102
    Long Beach, CA 90813
    (562) 380-0261
22. **Helpline Youth Counseling**
    5400 East Olympic Blvd., Suite 225
    Commerce, CA 90022
    (213) 226-0969
23. **Hollywood Medical Rehabilitation Care.**
    5232 West Sunset Boulevard
    Los Angeles, CA 90027
    (323) 660 - 0900
24. **Koreatown Youth and Community Center**
    3727 West 6th Street, Suite 411
    Los Angeles, CA 90020
    (213) 365-7400
25. **Los Angeles Centers for Alcohol and Drug Abuse**
    9515 Haney Street
    Pico Rivera, CA 90660
    (562) 348-0083
26. **Los Angeles Centers for Alcohol and Drug Abuse**
    10210 Orr and Day Road
    Santa Fe Springs, CA 90670
    (562) 348-0083
27. **Los Angeles Centers for Alcohol and Drug Abuse**
    11015 Bloomfield Avenue
    Santa Fe Springs, CA 90670
    (562) 906-2676
28. **Mela Counseling Services Center**
    5723 Whittier Boulevard
    Los Angeles, CA 90022
    (323) 721-6855
29. **National Council on Alcoholism and Drug Dependence of East San Gabriel and Pomona Valleys**
    4626 N. Grand Avenue
    Covina, CA 91724
    (626) 331-5316
30. **National Council on Alcoholism and Drug Dependence of East San Gabriel and Pomona Valleys**
    656 N. Park Avenue
    Pomona, CA 91768
    (909) 629-4084
31. **New Directions**
    1331 West. Ave J. #206
    Lancaster, CA 93534
    (661) 802-7167
32. **New Hope Drug & Alcohol Treatment Program**
    1841 & 1841½ W Imperial Highway
    Los Angeles, CA 90047
    (323) 750-2850
33. **Penny Lane Centers**
    5628 East Slauson
    Commerce, CA 90040
    (323) 318-9960
34. **Penny Lane Centers**
    15305 Rayen Street
    North Hills, CA 91343
    (818) 892-3423
35. **Penny Lane Centers**
    43520 Division Street
    Lancaster, CA 93535
    (661) 266-4783
36. **Phoenix Houses of Los Angeles**
    11600 Eldridge Avenue
    Lake View Terrace, CA 91342
    (818) 686-3100
37. **Rancho San Antonio Boys Home**
    21000 Plummer Street
    Chatsworth, CA 91311
    (818) 882-6400
38. **Shields for Families**
    2620 Industry Way, Suite A
    Lynwood, CA 90262
    (323) 328-1645
39. **Social Model Recovery Systems**
    3131 Santa Anita Ave., Ste.112B
    El Monte, CA 91733
    (626) 636-2370
40. **Social Model Recovery Systems**
    1245 East Walnut Street, Suite 117
    Pasadena, CA 91106
    (626) 773-4364
41. **SPIRITT Family Services**
    8000 Painter Avenue
    Whittier, CA 90602
    (562) 903-7000
42. **SPIRITT Family Services**
    2000 South Tyler Avenue
    South El Monte, CA 91733
    (626) 442-1400
43. **Tarzana Treatment Centers**
    18700 Oxnard Street
    Tarzana, CA 91356
    (888) 777-8565
44. **Tarzana Treatment Centers**
    44443 North 10th Street West, Suite A
    Lancaster, CA 93534
    (888) 777-8565
45. **Tarzana Treatment Centers**
    44447 North 10th Street West Building C
    Lancaster, CA 93534
    (888) 777-8565
46. **Tarzana Treatment Centers**
    18646 Oxnard Street
    Tarzana, CA 91356
    (800) 996-1051
47. **Tessie Cleveland**
    8019 Compton Avenue
    Los Angeles, CA 90001
    (323) 586-7333
48. **Twin Town Treatment Center**
    4281 Katella Ave.
    Los Alamitos, CA 90720 (Orange County)
    (562) 596-0050
49. **Twin Town Treatment Center**
    3440 Torrance Blvd., Suite 104
    Torrance, CA 90503
    (310) 787-1335
50. **Twin Town Treatment Center**
    4940 Van Nuys Blvd., Suite 201
    Sherman Oaks, CA 91403
    (818) 985-0560
51. **You Can Health Services**
    600 West Manchester Ave., Suite 5
    Los Angeles, CA 90044
    (323) 750-9247

DEPARTMENT OF YOUTH DEVELOPMENT
CONTINUUM OF SERVICES & SUPPORTS

Note: Any placement/housing-related work is still in the planning phase, though some should launch as pilots later in 2024 (e.g., Safe Healing Center pilot). Additionally, while some work is targeted towards justice-involved (i.e., Probation) youth, some of the work is broader in terms of population served but may still have relevance towards supporting complex care youth.

Type of Service/Support	Description
Youth Development Networks	Youth Development Networks (YDNs) are envisioned to provide free, comprehensive, and culturally responsive youth development programming and services to youth by coordinating low-barrier and high-access networks of care. YDNs will offer a mechanism to increase available services for youth in prevention of and/or responsive reintegration from system involvement. • There will be some targeted reentry investments in YDNs for youth exiting camps and halls (likely to be funded and launched in mid-2024). Set to launch in Spring 2024, YDNs are piloting in each Supervisorial district (East LA, South LA, Antelope Valley, Long Beach and Pacoima). These YDN regions will each begin with 15-20 community-based organizations receiving funding to expand services in the following 3 categories: • Youth Mentorship and Academic Support • Youth Intervention and Wellness Services • Youth Development and Employment Opportunities
24-Hour Youth Centers	Preparing to launch a community engagement process that will inform the design of DYD-funded 24-hour youth centers, with a goal of standing up these centers in each Supervisorial district beginning in 2025.
Youth Diversion	DYD funds CBOs throughout LA County to provide youth diversion services for young people who are referred by law enforcement agencies, probation, and the district attorney, often in lieu of arrest or charges being filed. Services offered by DYD's partner agencies include restorative justice, care coordination, music and arts, employment supports, education supports, mentorship and leadership development. DYD has a Quarterly dashboard with diversion data.

DEPARTMENT OF YOUTH DEVELOPMENT
CONTINUUM OF SERVICES & SUPPORTS

	Additionally, below is document that provides some info on diversion's connection to DCFS youth. An FYI that DCFS-flags are operationalized by either youth stating they are working with DCFS to their case managers or if they were stopped for diversion at a group home, thus may not be capturing all DCFS youth.
Safe Healing Centers	Safe Healing Centers (SHCs) were recommended in the Youth Justice Reimagined report as part of the foundation of a new, care-first youth justice system. Informed by promising practices in youth justice reform and transformation nationally and internationally, the SHC concept is envisioned to fill an important role in the continuum of care needed for justice-involved youth by creating spaces for youth who must be removed from home to receive trauma-responsive support in home-like environments grounded in a youth development framework. A SHC is a small, community-based therapeutic home where youth will be supported to grow, heal and reconnect with their family and community through a safe, open, holistic partnership involving staff from diverse backgrounds, including Credible Messengers. SHCs are envisioned to serve as an alternative to juvenile hall and camp either pre-adjudication or post-disposition, and a healing-based step-down opportunity for youth committed to a SYTF. For the first phase of implementation, DYD will be implementing 1-2 demonstration projects, run by community-based providers and designed for post-disposition (though open to pre-adjudication youth, where appropriate) girls and gender-expansive (GGE) youth who otherwise would be subject to commitment in a locked facility. The proposed demonstration project is informed by the urgent need for increased availability of residential placement options for youth charged with serious offenses and/or justice-involved youth with complex needs, especially for GGE youth. The SHC demonstration project is slated to launch in Fall 2024; additional information can be found here: Board-Memo-Safe-Healing-Center-5-5-23.pdf (lacounty.gov)
Other housing/placement work connected to decarceration of girls and gender expansive youth	DYD will continue to partner with other County and community stakeholders to implement strategies connected to the decarceration of girls and gender expansive youth workplan (Board-Memo-GGE-Decarceration-5-15-23.pdf (lacounty.gov)). Strategies include: • Supporting resource families (e.g., TA to families navigating the RFA application and/or a pilot of families to be funded at a higher rate per month per youth) to help expand the number of families who are

DEPARTMENT OF YOUTH DEVELOPMENT
CONTINUUM OF SERVICES & SUPPORTS

	successfully approved as resource families, therefore increasing the number of available placements for youth. • Supporting and providing TA to CBOs seeking licensing approval as an STRTP. • Judicial engagement around policy and practice approaches to reduce the use of detention for GGE youth • A direct investment in other housing and placement options on the continuum of care as well as resourcing GGE youth and their families during reentry. DYD will utilize a new CFCI grant focused on housing and placements in support of the decarceration of GGE youth to help fund these strategies.

Los Angeles County Department of Youth Development
Diversion Quarterly Dashboard September 30, 2023
Youth with Flagged DCFS Involvement

162

DCFS-involved youth formally referred to DYD Diversion Providers (by LEAs + DA)

148

DCFS-involved youth have enrolled in formal and DA diversion programming

105

DCFS-involved youth have substantially completed formal and DA diversion programming

Table 1. Formal/DA Referrals by Race and Ethnic Identity and DCFS Involvement, September 2023 (n=2398)

Race/Ethnicity	DCFS Flag	NO DCFS Flag	**Total**
API	1.23%	1.43%	**1.42%**
Bi/Multiracial	7.41%	3.13%	**3.42%**
Black or African American	33.95%	25.09%	**25.69%**
Hispanic or LatinX	47.53%	53.98%	**53.54%**
Middle Eastern or South Asian		0.31%	**0.29%**
Native American or Alaska Native	1.85%	0.27%	**0.38%**
Unknown	3.09%	8.41%	**8.05%**
White	4.94%	7.38%	**7.21%**
Total	**100.00%**	**100.00%**	**100.00%**

Figure 1. Formal/DA Referrals Overall Status, DCFS-Involved Youth (n=162)

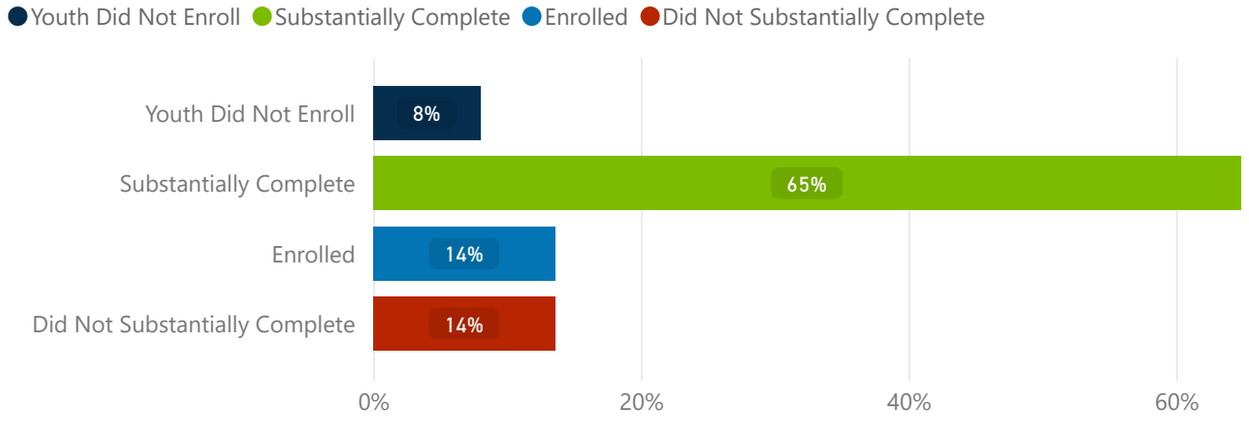


Table 2. Formal/DA Referrals by Age and DCFS Involvement, September 2023 (n=2398)

Age	DCFS Flag	NO DCFS Flag	**Total**
12	2.48%	3.22%	**3.17%**
13	8.07%	9.61%	**9.51%**
14	11.80%	13.57%	**13.45%**
15	22.36%	21.44%	**21.50%**
16	22.36%	21.39%	**21.46%**
17	24.84%	20.70%	**20.99%**
18+	7.45%	9.48%	**9.34%**
Unknown	0.62%	0.60%	**0.60%**
Total	**100.00%**	**100.00%**	**100.00%**

Figure 2. Comparison Table: Formal/DA Referrals Overall Status, Non-DCFS-Involved Youth (n=2236)

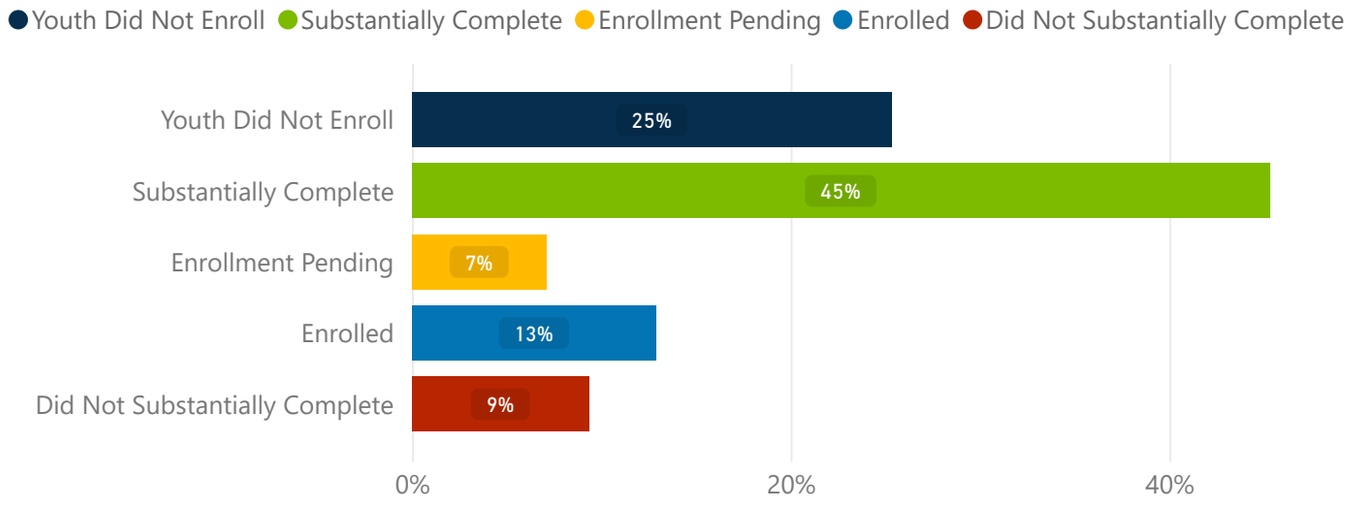


Table 3. Formal/DA Referrals by Gender Identity and DCFS Involvement, September 2023 (n=2398)

Gender Identity	DCFS Flag	NO DCFS Flag	**Total**
Female	37.65%	28.22%	**28.86%**
Gender Non-Conforming		0.36%	**0.33%**
Male	60.49%	68.47%	**67.93%**
Transgender		0.13%	**0.13%**
Transgender Female	0.62%	0.09%	**0.13%**
Transgender Male	0.62%	0.04%	**0.08%**
Unknown	0.62%	2.68%	**2.54%**
Total	**100.00%**	**100.00%**	**100.00%**

Table 4. Formal/DA Referrals by Level Alleged Offense and DCFS Involvement, September 2023 (n=2398)

Alleged Offense Level	DCFS Flag	NO DCFS Flag	**Total**
Alleged Felony	2.21%	28.57%	**30.78%**
Alleged Misdemeanor	4.25%	58.22%	**62.47%**
Alleged Status or Infraction	0.25%	3.84%	**4.09%**
Unknown	0.04%	2.63%	**2.67%**
Total	**6.76%**	**93.24%**	**100.00%**