LOS ANGELES COUNTY MULTIDISCIPLINARY ASSESSMENT TEAM (MAT) PROCESS

Evaluation Report

January 2022
Acknowledgements

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Executive Summary

The California Institute for Behavioral Health Solutions (CIBHS) conducted an independent evaluation of the Multidisciplinary Assessment Team (MAT) process in Los Angeles County. The evaluation focused on four elements of the MAT process:

- Timeliness of MAT and other front-end assessment processes,
- Quality of the MAT Summary of Findings (SOF) document,
- Linkage to treatment, and
- Integration into case planning.

Based on data from cases referred to MAT between July and September 2020, MAT provides a timely, high-quality assessment of children and youth’s strengths and needs after detention. Children who receive a MAT assessment are effectively linked to mental health services when they would benefit from them. MAT can improve by better integrating MAT processes with both court and other front-end assessment processes.

Background

In Los Angeles (LA) County, children newly detained by the Department of Children and Family Services (DCFS) and their families are assessed through the Coordinated Services Action Team (CSAT) process to determine their strengths and needs. During the CSAT process, children and their families have multiple points of contact across LA County human services agencies and receive a clinical mental health assessment, along with other non-clinical screenings and assessments. The members of the CSAT work alongside the DCFS Children’s Social Worker (CSW) to coordinate and identify appropriate services for the child and family and to help inform case planning.

The MAT process is one component of CSAT. MAT was initially piloted in April 2004 with 22 cases in two regional offices with specific goals of:

- Timely, comprehensive, and strength-based assessments of detained children and their families
- Early diagnostic awareness of critical medical conditions leading to early intervention and consistent management of such conditions
- Increased cooperation between families, caregivers, providers of service, and DCFS
- Appropriate team placement decisions for children

In January 2008, MAT became a part of the Katie A. Strategic Plan, which expanded funding to hire staff and initiated planning efforts to implement the program countywide. MAT is a collaborative effort between DCFS and the Department of Mental Health (DMH), designed to ensure a timely and comprehensive assessment and linkage to appropriate services for children and youth newly entering out-of-home placement. While all children and families are served via CSAT, to receive a MAT assessment, a child must be:

- Newly detained (i.e., not a detention on an already open case);
- Medi-Cal eligible;
- Placed in out-of-home care (i.e., relative or foster care); and
- A resident of LA County.
The MAT assesses the child and family’s strengths and needs in the following areas: mental health, education, family/caregiver supports, vocation, medical health, dental health, development, and hearing/language. The information collected in the assessment is used in a MAT Summary of Findings (SOF) meeting by the child, family, and LA County staff to collaboratively develop a mutually agreed upon plan of treatment and recovery that informs case planning and court orders. Since its inception in 2004, MAT processes have evolved based on process improvements identified by county staff, providers, and stakeholders, as well as in response to state-level requirements.

**Evaluation Findings**

CIBHS’ evaluation included data from two samples:

- A **Retrospective Sample** of children and youth involved in the MAT process in early 2019, used to identify commonly used front-end mental health screening and assessment tools for the MAT target population; and
- A **Prospective Sample** of children and youth referred to MAT from July through September 2020, used to evaluate MAT processes and how they contribute to the timeliness and quality of MAT assessments, linkage to services, and integration of the MAT into case planning.

To provide the most up-to-date understanding of the MAT process, this report primarily describes data from the Prospective Sample. Information from the Retrospective Sample was used to create a separate Assessment Tools Crosswalk*.

The Prospective Sample included 599 children and youth from 406 cases referred to MAT between July and September 2020. On average, the MAT process, from referral through finalization of the MAT SOF, took 44.7 days, with 62.2% of cases completed within 45 days and 93.4% within 60 days. The MAT process completed prior to the Disposition Hearing in 78.2% of the 55 cases with data related to both of these milestones.

To evaluate the quality of MAT SOF documents, CIBHS reviewed SOFs for 469 children from 323 cases. MAT SOFs were generally of high quality. As expected for a process facilitated by mental health clinicians, descriptions of the children’s mental health symptoms and behaviors were some of the strongest and most consistent parts of the SOF, and SOFs were more likely to make clear recommendations and referrals related to mental health services than any other assessment domain. 99.1% of SOFs clearly document the types of trauma children have been exposed to (the trauma event¹), though only 34.5% of SOFs document the child’s trauma experience² and 53.7% document the specific effects the trauma has on the child³.

* The Assessment Tools Crosswalk can be found in Appendices D and E of this report.

¹ MAT SOFs that document the trauma event describe the specific trauma to which a child was exposed
² MAT SOFs that document the child’s trauma experience contain a description of how the child felt at the time of the trauma
³ MAT SOFs that document trauma effects document what, if any, adverse effects the child experiences as a result of the trauma

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44.7 days from MAT Referral to SOF Finalization

62.2% within 45 days

93.4% within 60 days
88.1% of children who completed the MAT process without receiving crisis services\(^4\) were linked to mental health services, with at least one-third of those children starting services prior to completion of the MAT process.

The most challenging aspect of the MAT process appears to be integrating the MAT into other processes in the county – most specifically case planning and other required front-end assessments like the Child and Adolescent Needs and Strengths (CANS). Challenges with integration between MAT and case planning are likely due to case workers and judges needing more time to review the MAT SOF report prior to the court hearing to make case planning decisions. Additionally, while the MAT SOF focuses heavily on identifying services and supports for the child, both DCFS and Court Case Plans place a larger emphasis on the needs of the biological parents.

**Recommendations**

Most MAT stakeholders – including attorneys, bench officers, DCFS case workers, and mental health treatment providers – found the process valuable and felt it was useful for their work with the target population, though there are opportunities to provide additional value and improve the efficiency and effectiveness of the MAT process. The MAT process can improve in the following ways:

- Bolstering data collection and information sharing, especially related to MAT milestone dates, completed assessments and reports, and demographic data for MAT participants;
- Reviewing the overlap between the MAT and CANS assessment to streamline the front-end assessment process;
- Structuring the MAT SOF to emphasize case planning recommendations and prompt focus on the effects of trauma, family strengths, and cultural considerations;
- Aligning more consistently with Court timelines, formalizing collaboration between case workers, and enhancing referral tracking to maximize care coordination and integration of the MAT into case planning; and
- Evaluating short- and long-term outcomes for children involved in the MAT process to understand how MAT processes support long-term success for the target population.

Overall, the MAT appears to provide a high quality multi-disciplinary assessment of children and families’ strengths and needs that complies with procedural timelines. By improving the ways downstream users of the MAT SOF can access the SOF, the process can become an even more valuable part of the front-end assessment process for newly detained children and their families.

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\(^4\) Crisis intervention is an unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Children who received crisis services during the MAT process were excluded from analysis of linkage to treatment to facilitate analysis of regularly scheduled service linkages rather than emergency responses. Children who received crisis services during the MAT process and linkage to mental health services were not included in timeliness analyses, as they were provided services immediately when crisis intervention was required.
Introduction

In Los Angeles (LA) County, children newly detained by the Department of Children and Family Services (DCFS) and their families are assessed through the Coordinated Services Action Team (CSAT) process to determine their strengths and needs. The primary function of the CSAT is to provide a regionally-based, clinical management team to assist the DCFS Children’s Social Worker (CSW) in coordinating services for the family and aim to reduce the number of agencies from which the family will receive services. The LA County CSAT process includes multiple tracks that are designed to cater to the specific needs of the child and their family, while also ensuring they are appropriate based on the child’s placement type. In its simplest form, the CSAT process encompasses three unique tracks a youth can follow based on their placement and DCFS case type:

- **Track 1** is for youth who are newly detained and in out-of-home placement;
- **Track 2** is for youth who have a newly opened case and are in the home of their parent; and
- **Track 3** is for those youth with existing open cases and inter-county transfers, re-opened cases, annual check-ins, and re-referrals.

Across all three CSAT tracks, children and their families have multiple points of contact across LA County DCFS, DMH, and the Courts, and receive a clinical mental health assessment along with other, non-clinical screenings and assessments as required by state- and county-level policies and procedures. The members of the CSAT work alongside the CSW to coordinate and identify appropriate services for the child and family and to help inform case planning. While there are many different touchpoints in the overall CSAT process, this evaluation report focuses on one component for children following **Track 1** – the Multidisciplinary Assessment Team (MAT) process – and how it intersects with other elements of CSAT. A more comprehensive depiction of the front-end assessment process including the multiple points of contact between families and county and/or provider agencies, prepared by OCP with input from DCFS, DMH, the Courts, and service providers, can be found in Appendix A.

The LA County MAT process was created in response to a need identified by the Price Waterhouse Cooper Audit of DCFS in 1998. The audit identified a need to quickly assess children to ensure that mental health needs were identified and that children were quickly connected to appropriate mental health services. MAT was initially piloted in April 2004 with 22 cases in two regional offices with specific goals of:

- Timely, comprehensive, and strength-based assessments of detained children and their families
- Early diagnostic awareness of critical medical conditions leading to early intervention and consistent management of such conditions
- Increased cooperation between families, caregivers, providers of service, and DCFS
- Appropriate team placement decisions for children

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5 The terms “assessed” and “assessment” often denote different things when used by DCFS, DMH, OCP, and other entities. For the purposes of this document, assessment refers to any general “judgment” of the child/families’ needs and strengths as determined by DCFS, DMH, service providers, the court, etc. However, assessment can also be a specific term used to denote a comprehensive tool and/or process that results in documentation of a child and family’s strengths and needs, either clinical (i.e., a mental health assessment) or non-clinical (i.e., an assessment of a child’s education). Clinical mental health assessments will be designated as such when discussed in this document.
The Katie A. Corrective Action Plan in 2008 also identified a need for a comprehensive systematic screening, assessment, and provision of individualized mental health services for children in foster care or at imminent risk of entering foster care placement. In January 2008, MAT became a part of the Katie A. Strategic Plan, which expanded funding to hire staff and initiated planning efforts to implement the program countywide. MAT was implemented one DCFS Service Planning Area (SPA) at a time, with full implementation achieved in October 2009. Currently, MAT is present in all 20 DCFS regional offices across eight SPAs.

MAT is a collaborative effort between DCFS and the Department of Mental Health (DMH), designed to ensure a timely and comprehensive assessment and linkage to appropriate services for children and youth newly entering out-of-home placement. While all children and families are assessed via the CSAT process, to receive a MAT assessment, a child must be:

- Newly detained (i.e., not a detention on an already open case);
- Medi-Cal eligible;
- Placed in out-of-home care (i.e., relative or foster care); and
- A resident of LA County.

The MAT assesses the child and family’s strengths and needs in the following areas: mental health, education, family/caregiver supports, vocation, medical health, dental health, development, and hearing/language. The information collected in the assessment is used in a MAT Summary of Findings (SOF) meeting by the child, family, and LA County staff to collaboratively develop a mutually agreed upon plan of treatment and recovery that informs case planning and court orders. The MAT also aims to help a family identify and meet any special needs that could place a child in danger of a lengthy separation and avoid numerous placements for the child.

Since its inception in 2004, MAT processes have evolved based on process improvements identified by county staff, providers, and stakeholders; a pilot (MAT-CFT) that merges the Traditional MAT and Child and Family Team (CFT) processes is currently being implemented in selected regional offices, with the identified goal of implementing countywide. While both processes involve a comprehensive assessment by a qualified mental health clinician, in the MAT-CFT process the MAT Assessor also participates in CFT meetings and the MAT SOF Meeting is conducted as a CFT Meeting. In addition to the MAT-CFT pilot, DCFS and DMH have incorporated parallel assessments and data collection based on state requirements, including the Child and Adolescent Needs and Strengths (CANS) and Level of Care (LOC) assessments. Currently, MAT assessments are performed by approximately 50 contracted community-based providers and are required to be completed within 60 days of detention, though DMH aims to complete MAT assessments within 45 days of detention.

Though the MAT was first implemented in 2004, it has never been formally evaluated by an independent evaluator. Through a competitive procurement process, California Institute for Behavioral Health Solutions (CIBHS) was selected by the Office of Child Protection (OCP) to evaluate the MAT process. This evaluation assesses whether the MAT is meeting process performance indicators to inform DCFS, DMH, and OCP on how MAT and the overall front-end assessment process for DCFS-involved youth can be improved. Specifically, the evaluation addresses whether MAT processes support early identification of critical strengths and needs in DCFS-involved youth, increased coordination and collaboration between people and systems involved in youths’ lives, and appropriate case planning decisions and linkage to services.

The LA County MAT process relies on multiple stakeholders, including DCFS, DMH, community mental health agencies, youth and families, Court bench officers and attorneys, and County Counsel. Throughout the evaluation, CIBHS has collaborated with OCP, DCFS, and DMH to understand the MAT process and relevant policies and procedures in LA County. The plan for this evaluation was informed by a series of focus groups and key informant interviews with DCFS and DMH staff with key knowledge of MAT processes. The evaluation plan was approved through a Research Petition to the Juvenile Court on February 20, 2020, and all data sharing and use was approved by DCFS and DMH Privacy and Security Officers.


7 The sample for this evaluation included data from 19 DCFS regional offices. No cases were included for the Covina office. This may be due to the MAT Automated System reflecting the originating office for cases transferred to other offices during the MAT process.

8 The MAT Assessment is a comprehensive clinical assessment incorporating the child and/or family’s strengths and needs. The MAT Assessment must be administered by a licensed or license-waivered mental health professional.

9 To be completed upon initiation of mental health services or within 60 days of entering the foster care system.

10 To be completed as soon as possible, but no later than 60 days following a triggering event, such as placement in home-based family care.
Methodology

Sampling

This evaluation included data from two samples:

- A Retrospective Sample, used to identify commonly used front-end mental health screening and assessment tools for the MAT target population; and
- A Prospective Sample, used to evaluate MAT processes and how they contribute to the timeliness and quality of MAT assessments, linkage to services, and integration of the MAT into case planning.

To provide the most up-to-date understanding of the MAT process, this report primarily describes data from the Prospective Sample. Information from the Retrospective Sample was used to create an Assessment Tools Crosswalk and added to this report as appropriate.

For both samples, CIBHS collaborated with OCP, the Children’s Law Center of California (CLC), and Los Angeles Dependency Lawyers (LADL) to create and employ a noticing process by which parents of eligible children and youth, as well as eligible youth ages 12 and up, were informed of the evaluation and given the opportunity to opt out of sharing their data. OCP sent parent notices and youth notices in youth-friendly language to all eligible participants for both samples and removed all children and youth from the evaluation sample who opted out or whose notice was returned undeliverable. CIBHS did not receive any information regarding children or youth who opted out of participation in the evaluation.

RETROSPECTIVE SAMPLE

The Retrospective Sample includes MAT SOF documents for up to 400 youth who were newly detained between January 1, 2019 and June 30, 2019. Parents of all children and youth eligible for inclusion in the evaluation were provided advanced notice of the evaluation and given the opportunity to opt out of sharing their data. Youth ages 12 and up were also noticed and allowed to opt out of the evaluation.

PROSPECTIVE SAMPLE

For the Prospective Sample, the approved Research Petition for this evaluation granted CIBHS access to administrative data for up to 600 youth who were newly detained between July 1, 2020 and September 30, 2020 in LA County, as well as MAT SOF documents for up to 500 youth from within that sample. Parents of all children and youth eligible for inclusion in the evaluation were provided advance notice of the evaluation and given the opportunity to opt out of sharing their data. Youth ages 12 and up were also noticed and allowed to opt out of the evaluation.

The 600-child evaluation sample was randomly selected from the full list of cases for which neither parent nor youth opted out of the evaluation. Cases were selected for inclusion in the 500-child subsample (henceforth referred to as the Quality Subsample) based on the following criteria, using administrative data provided by DCFS:

- Children whose MAT was cancelled were not eligible for the subsample (28 children)
- Children whose final SOF report was not submitted to DCFS were not eligible for the subsample (36 children)
- Children without a CANS complete date were not eligible for the subsample (6 children)
- Subsample cases were selected from the remaining eligible case list to ensure representation across as many MAT Agencies, DCFS Offices, and SPAs as possible. CIBHS attempted to match the demographic distribution of cases in the Quality Subsample to that of the overall evaluation sample to the extent possible.
A second, 100-case subsample (henceforth referred to as the Case Planning Subsample) was selected for analysis of DCFS Case Plans, Court Case Plans, and Minute Orders. Case Planning Subsample cases were selected from within the Quality Subsample to represent as many MAT Agencies, DCFS Offices, and SPAs as possible. CIBHS attempted to match the demographic distribution of cases in the Case Planning Subsample to that of the overall evaluation sample to the extent possible.

Data Sources

Data for this evaluation came from the following sources:

- MAT Automated System (maintained by DCFS, henceforth referred to as DCFS administrative data)
- DMH Excel Tracking Logs (maintained by DMH staff)
- MAT Summary of Findings (SOF) documents (provided by MAT Agencies)
- DMH IBHIS Claims System (maintained by DMH)
- DMH Early and Periodic Screening, Diagnosis and Treatment System (EPSDT OMA, maintained by DMH)
- Documents manually provided by DCFS staff
  - DCFS Case Plans
  - Court Case Plans
  - Minute Orders
  - CANS assessments for Case Planning Subsample cases where CANS was completed by DCFS staff
- Qualitative Interviews and Surveys with DCFS and DMH staff, mental health treatment providers, minors’ attorneys, parents’ attorneys, and bench officers
- Review of state- and county-level policies and procedures as well as available evidence-based screening and assessment tools for system-involved youth and families

Data Cleaning

CIBHS made every effort to reconcile data across data sources to identify the best possible data for use in the final evaluation. DCFS administrative data was used as the primary source of data for this evaluation in the event there were discrepancies between data sources that could not be resolved. When selecting the final date for MAT milestones, CIBHS used the date that matched in the most data sources, or the date from the DCFS administrative data when dates mismatched across all systems.
**Data Limitations**

The findings in this evaluation report are primarily based on a review of administrative data and other case documentation. In cases where data recorded in administrative data systems is incomplete or inaccurate, evaluation findings may not fully represent the MAT process as experienced by children, families, and case workers. This is especially true when reviewing the MAT SOF document to evaluate the quality of the assessment, as lack of documentation in the MAT SOF document does not necessarily indicate that information was not gathered and factors were not considered during the assessment process.
**Description of Evaluation Sample**

This evaluation describes findings from a subset of children who were referred for a MAT Assessment between July and September 2020. The evaluation sample includes 599 children from 406 cases. Most cases involved only one child, with an average of 1.5 children per case across the entire sample. Cases in the evaluation sample involved between one and five children each.

Children and youth in the evaluation sample ranged from 0 to 17 years of age at the time they were referred to a MAT assessment, with an average age of 4.9 years at referral. Children’s ages were fairly evenly distributed across three age groups: 0-18 months, 19 months to 6 years, and 6 years or more. Nearly half of MAT cases (48.5%) involved one or more children between 0-18 months of age, and approximately one-third of cases included children in each of the other age groups.\footnote{39.4% of cases (160) included a child over 6 years of age, 32.5% (132) included a child between 19 months and six years of age, and 48.5% (197) included a child 0 – 18 months old.}
Approximately half of the children in the evaluation sample reported male gender identity, and the other half female. The majority of children in the evaluation sample spoke English\textsuperscript{12}, and a significant minority spoke Spanish. The evaluation sample also included a small number of children who speak American Sign Language, Korean, Mandarin, and Russian. 87 children (14.5\%) had more than one language listed. Of Spanish-speaking children, only 35\textsuperscript{13} had Spanish listed as their only language.

Ethnicity data was captured across multiple data systems, often with different information in different systems. CIBHS took an inclusive approach to characterizing clients’ ethnicities for this evaluation, wherein we considered each ethnicity identified in any data system as valid (see Methodology for details). As a result, 36.7\% of children in the evaluation sample (220 children) were classified as having multiple ethnicities. Amongst children with a single ethnicity identified across all datasets, 157 identified as Black, 123 identified as White, 55 identified as Hispanic, 10 identified as Asian/Pacific Islander, and 1 identified as another ethnicity. 33 children did not have any recorded ethnicity information.

When considering children with multiple ethnic identities, 175 children (29.2\% of the total sample) identified as Black\textsuperscript{14} and 260 children (43.4\% of the total sample) identified as Hispanic\textsuperscript{15}. Both Black and White children represented a higher proportion of the evaluation sample than the overall population served by DCFS, while fewer Hispanic children were included in the evaluation sample. While CIBHS is unable to definitively determine whether these differences are influenced by the evaluation sampling/data cleaning methodology or by parents’ and youths’ decisions to opt out of the evaluation, these differences can also be a sign

\textsuperscript{12} 563 of 599 children (94.0\%) spoke English  
\textsuperscript{13} 5.8\% of the total evaluation sample  
\textsuperscript{14} 18 children identified as Black and another ethnicity.  
\textsuperscript{15} 205 children identified as Hispanic and another ethnicity.
of disparity in which children undergo a MAT assessment. Additional investigation is needed to fully understand what, if any, differences there are in the ethnicities of children served by the MAT process.

<table>
<thead>
<tr>
<th>ETHNICITY</th>
<th>DCFS SERVICES (JULY - SEPTEMBER 2020)</th>
<th>MAT EVALUATION SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>23.4%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>57.8%</td>
<td>43.4%</td>
</tr>
<tr>
<td>White</td>
<td>12.0%</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

The evaluation sample includes children served across MAT Agencies, DCFS Offices, and SPAs. Appendix B contains a detailed breakdown of the evaluation sample based on these criteria. Children in the evaluation sample were served via either the Traditional MAT process or the MAT-CFT process. Slightly more children were served through the Traditional MAT process than the MAT-CFT pilot process17.

Notably, children identifying as Black were more likely to be served through the MAT-CFT process18. The reason for this difference is unclear, though it may relate to the demographic makeup of the regions served by DCFS Regional Offices who have already transitioned to the MAT-CFT process. Importantly, this must be considered when evaluating differences in MAT processes based on ethnicity, as differences could be attributable to the processes themselves or to potential differences across ethnicities.

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16 Data and Monthly Fact Sheets | Los Angeles County Department of Children and Family Services (lacounty.gov)
17 252 children (42.1% of children) within 168 cases (41.4% of cases) were served via the MAT-CFT process, while 341 children (56.9% of children) within 233 cases (57.4% of cases) were served by the Traditional MAT process. 6 children (5 cases) did not have data on whether they were served through the MAT-CFT or Traditional MAT process.
18 48.3% of Black children (83 of 172 children) went through the MAT-CFT process, compared to 38.1% of children who did not identify as Black (148 of 388 children). \( \chi^2 (d.f.=1) = 5.028, p=0.025. \)
**MAT Evaluation Sample**

599 children | 406 cases

### Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>10 children</td>
</tr>
<tr>
<td>Black</td>
<td>157 children</td>
</tr>
<tr>
<td>Hispanic</td>
<td>55 children</td>
</tr>
<tr>
<td>White</td>
<td>123 children</td>
</tr>
<tr>
<td>Other*</td>
<td>221 children</td>
</tr>
<tr>
<td>Null</td>
<td>33 children</td>
</tr>
</tbody>
</table>

*Other includes children who identified as having more than one ethnicity or a single ethnicity not listed here.

### Number of Children Per Case

- One child: 287 cases (70.7%)
- Multiple children: 119 cases (29.3%)

### Age of Children

- 0-18 months: 206 children (34.4%)
- 19 mo-6 years: 160 cases (26.7%)
- 6 years or more: 233 cases (38.9%)

### Spanish Language

- Spanish speaking: 115 children (19.2%)
- Non-Spanish speaking: 484 children (80.8%)

### Gender

- Female: 293 children (48.9%)
- Male: 306 children (51.1%)

*Other includes children who identified as having more than one ethnicity or a single ethnicity not listed here.
QUALITY OF DEMOGRAPHIC DATA

Many demographic data elements were included in more than one data source used for this evaluation, and information did not always match across data sources. As such, the demographic data presented herein represent CIBHS’ best understanding of the client and case demographics for the evaluation sample. When there were demographic mismatches across data sources, those mismatches are described in Appendix C. CIBHS used administrative data provided by DCFS as the primary data source for this evaluation, meaning that in cases where it was unclear which data source was correct, we used the data provided in the DCFS administrative data set.

Timeliness of MAT and Other Front-End Assessment Processes

To understand the timeliness of MAT and other front-end assessment processes in LA, CIBHS analyzed the time between key MAT and other process milestones, as well as claims submitted by MAT agencies. This analysis incorporated information from multiple data sources and considered potential variances in timeliness based on demographic and administrative factors that may influence the MAT process.

QUALITY OF DATE DATA

CIBHS considered date data provided in DCFS administrative data, DMH tracking logs, and MAT-SOF documents to identify the final evaluation date for each milestone. The table below defines the data sources containing each data element.

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DCFS ADMINISTRATIVE DATA</th>
<th>DMH TRACKING LOGS</th>
<th>MAT SOF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detention Date</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Date</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Acceptance Date</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SOF Meeting Date</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Final SOF Date</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report to CSW Date</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report to Court Date</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As with demographic data, CIBHS used administrative data provided by DCFS as the primary data source for this evaluation, meaning that in cases where it was unclear which data source was correct, we used the data provided in the DCFS administrative data set. CIBHS compared dates across data systems for each child, then compared the data for each child within a case. The timeliness of completion of MAT process milestones was analyzed per case, rather than per child, to avoid overemphasizing the timeliness of cases with more than one child. The following table summarizes the number of cases with data for each milestone. Details on the comparison of date data across data sources is available in Appendix C.
### TIMELINESS OF MAT PROCESS MILESTONES

#### Referral to MAT

Potential MAT cases are initiated when an Emergency Response (ER) CSW promotes an ER referral to a case in CWS/CMS. Children are referred for a MAT assessment following a court-ordered removal from their homes. Generally, a child’s detention hearing occurs 3 days after they are removed from their home. The cases described in this evaluation were referred to MAT between July and September 2020, at which time COVID-19 cases were extremely high in Los Angeles County and many public services were operating under public health restrictions and emergency orders from the courts. The timing of the detention hearing and referral to MAT may have been influenced by the pandemic.

Following Detention, DCFS reviews detention orders and determines those cases that are eligible for a MAT assessment. To refer a child to MAT, the DCFS MAT Coordinator verifies the child’s Medi-Cal eligibility and assembles the referral packet. The DCFS MAT Coordinator works with DMH and DMH-contracted providers to identify a potential MAT Assessor and refers the case to that provider agency. Children who are not eligible for MAT are referred to other CSAT tracks, like Tracks 2 or 3, based on the specifics of their case. Referral to another CSAT track does not affect the quality of services provided to the child and family, as linkages to appropriate mental health services are coordinated to ensure the child’s proper care.

Eligible children are generally referred for the MAT Assessment within 10 days of detention, though the process may take longer if there are challenges verifying Medi-Cal eligibility. In the Prospective Evaluation Sample, detention precedes referral to MAT in the majority of cases, though a small number of cases had Referral Dates on or before the Detention Hearing Date. Cases were referred to MAT an average of 9.5 days after Detention.

In addition to verifying Medi-Cal eligibility, completing the MAT Referral Packet may be influenced by the availability of Minute Orders and Standalone Documents from the Court. The COVID-19 pandemic may have also affected the timeline for this process, as pandemic-related delays were common during the evaluation period from July to September 2020. The average time from Detention to Referral varied across DCFS Offices and SPAs. There was no difference in the time between Detention and Referral based on whether the case was referred to MAT-CFT or Traditional MAT.

There were no significant differences in the timeliness of the Referral process based on age, language, or the number of children involved in a case. However, cases involving Black children had a longer average time between Detention and Referral than cases involving children of other ethnicities.

---

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>NUMBER OF CASES WITH DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detention Date</td>
<td>406</td>
</tr>
<tr>
<td>Referral Date</td>
<td>406</td>
</tr>
<tr>
<td>Acceptance Date</td>
<td>381</td>
</tr>
<tr>
<td>SOF Meeting Date</td>
<td>381</td>
</tr>
<tr>
<td>Final SOF Date</td>
<td>381</td>
</tr>
<tr>
<td>Report to CSW Date</td>
<td>354</td>
</tr>
<tr>
<td>Report to Court Date</td>
<td>108</td>
</tr>
</tbody>
</table>

19 For all MAT milestones after Referral, dates were only considered for non-cancelled cases.
20 94.8%, 385 of 406 cases
21 3.7% (15 of 406 cases) had Referral and Detention on the same day; 1.5% (6 of 406 cases) had a Referral date prior to the Detention Hearing date
22 N=381 cases
23 Minimum: 3.6 days, Maximum: 26.2 days
24 Minimum: 6.2 days, Maximum: 17.8 days
25 Black/African American: 12.3 days, Not Black/African American: 8.9 days. ANOVA: F (1,383) = 8.801, p=0.003.
The reasons for the observed differences are not clear, but qualitative interviews with DCFS staff during evaluation planning indicated that the primary driver of the timeliness of Referral to MAT is their ability to verify the child’s Medi-Cal eligibility. This can be influenced by the availability of the biological family and their ability to provide key documentation, as well as response time from the State or other agencies when documentation is not readily available.

Completion of the MAT SOF

Once a case is referred to a MAT Agency, that Agency formally accepts the case. Shortly after acceptance, the DCFS MAT Coordinator or Clerk schedules the MAT SOF Meeting or MAT-CFT meeting, depending on the type of process followed (this meeting will be referred to as the MAT SOF Meeting for the remainder of this report). In offices following the Traditional MAT process, the draft MAT SOF document is completed by the MAT Assessor, shared with the DCFS MAT Coordinator, and reviewed during the MAT SOF Meeting. The MAT Assessor makes any necessary changes to the MAT SOF after the MAT SOF meeting and submits the final MAT SOF to the DCFS MAT Coordinator. For MAT-CFT offices, DCFS, the MAT Assessor, and the child and family participate in a Child and Family Team meeting, to which the MAT Assessor brings the draft MAT SOF. The MAT SOF is revised and finalized by the end of the MAT-CFT meeting.

On average, Final SOF Reports are submitted to DCFS 44.7 days after the case is referred to the MAT Agency. The majority of cases are completed within the 45-day benchmark established by DMH and DCFS, nearly all cases are completed within 60 days. Approximately half of cases are accepted by the MAT Agency on the same day as they are referred, with an average of 1.3 days elapsing between Referral and Acceptance Dates\(^26\). The MAT SOF Meeting is held within 45 days of acceptance in over three-quarters of cases\(^27\). The Final SOF Report is submitted to DCFS an average of 1.9 days after the SOF Meeting, with the final MAT SOF report submitted on the same day as the MAT SOF Meeting in approximately half of cases\(^28\).

While the average time from Referral to completing the MAT SOF report varies across MAT Agencies\(^29\), DCFS Offices\(^30\), and SPAs\(^31\), there were no major differences based on demographics. Moreover, there was no difference in the average time to complete the MAT process between Traditional MAT and MAT-CFT cases. Cases with children identifying as Hispanic were more likely to complete the MAT process within 45 days than cases with children who did not identify as Hispanic\(^32\), despite the lack of difference in average time from Referral to completion of the SOF Report.

\(^{26}\) 86.6\% of cases (330 of 381 cases) are accepted within 3 days of referral; 49.1\% (187 of 381 cases) on the same day the case was referred

\(^{27}\) Average time from Acceptance to MAT SOF Meeting = 41.5 days; 79.0\% of MAT SOF Meetings occur within 45 days of Acceptance (301 of 381 cases)

\(^{28}\) 81.6\% of MAT SOF documents (311 of 381 cases) are finalized within 3 days of the MAT SOF Meeting; 52.0\% (198 of 381 cases) on the same day as the MAT SOF Meeting

\(^{29}\) Minimum (of MAT Agencies with at least 5 cases): 34.2 days; Maximum (of MAT Agencies with at least 5 cases): 52.6 days

\(^{30}\) Minimum: 38.7 days, Maximum: 50.2 days

\(^{31}\) Minimum: 41.3 days, Maximum: 48.8 days

\(^{32}\) 70.2\% of cases with Hispanic children completed with 45 days, compared to 55.2\% of cases without Hispanic children. \( \chi^2 \) (d.f.=1) = 8.721, p=0.003
CLAMS FROM MAT AGENCIES

To better understand the amount of time invested in the MAT assessment by MAT provider agencies, CIBHS looked at the Medi-Cal claims submitted by the MAT agency during the MAT assessment period (from Referral through Final SOF Report dates). 549 children had Medi-Cal claims from their MAT Agency during the MAT Assessment, with an average of 812.8 minutes (~13.5 hours) claimed per child. This does not include time spent on activities during the MAT process that are not submitted for reimbursement through Medi-Cal.

The amount of time claimed varied based on MAT Agency, DCFS Office, and SPA. Interestingly, children served by the MAT-CFT process had less time claimed than those served by the Traditional MAT process, though this may not reflect a difference in actual time spent conducting the MAT assessment or participating in other MAT-related processes. Providers frequently inquire about the specific assessment and intensive care coordination activities that are eligible for Medi-Cal reimbursement, and providers may be conservative in billing against Medi-Cal due to past history of denied claims or confusion about recent changes in activities eligible for claiming. These activities may instead be billed against DCFS administrative funds and are not included here. Claiming practices and policies vary between provider agencies. Specific activities that may be billed differently at different provider agencies and depending on the specific details of the case include time the Assessor spends on CFT Staff Engagement activities before they have actually seen the child, time the Assessor spends in CFT meetings when the meeting focuses on non-assessment aspects of the child’s case (such as custody or placement matters), and time spent on MAT-CFT activities after medical necessity has been determined. DMH is currently focusing significant attention on training and retraining providers around Medi-Cal reimbursement eligibility for CFT activities to improve consistency across providers and support providers’ ability to submit comprehensive and reimbursable claims.

Potential Redundancy in Assessment Claims

CIBHS analyzed two elements of claims to evaluate the potential for redundancy in assessment processes during the MAT process. First, there was no significant difference in the amount of time claimed for children who received a CANS assessment through DMH than those who did not. However, 175 children also had assessment claims at another agency between July and December 2020. On average, those children had nearly 5 hours of assessment time claimed at other agencies, which could indicate some degree of redundant assessment.

Indeed, qualitative feedback from mental health treatment providers also suggests that redundant assessments occur when a child is referred for mental health treatment. Only about half of the providers surveyed indicated they received the MAT SOF document in most cases where a child has been referred to them for treatment after undergoing a MAT assessment. Only a third indicated they received the MAT SOF before needing to make treatment decisions in most cases. While most mental health treatment providers found the MAT SOF helpful and said they used it to inform case planning and treatment decisions, some did describe redundancy between the MAT and the DMH initial assessment for children receiving services through DMH-contracted providers.

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33 This analysis was limited to children whose MAT assessment was not cancelled.
34 Minimum (of MAT Agencies with at least 5 cases): 458.7 minutes/7.6 hours; Maximum (of MAT Agencies with at least 5 cases): 1,651.3 minutes/27.5 hours
35 Minimum: 488.1 minutes/8.1 hours; Maximum: 1,189.1 minutes/19.8 hours
36 Minimum: 596.1 minutes/9.9 hours; Maximum: 1,012.8 minutes/16.9 hours
37 MAT-CFT: 746.9 minutes/12.4 hours, Traditional MAT: 850.3 minutes/14.2 hours. ANOVA: F(1,541) = 7.145, p=0.008.
38 289.6 minutes (4.8 hours)
TIMELINESS OF SHARING MAT SOF TO DCFS CASE WORKERS AND COURT OFFICIALS

MAT SOF content is shared with meeting attendees during the MAT SOF meeting, and the document is finalized based on discussion in that meeting. Following finalization of the MAT SOF document, it is shared with DCFS Case-Carrying Children’s Social Workers (CSWs) and Dependency Investigators (DIs), as well as the Courts, to inform case planning decisions. In approximately half of cases, the MAT SOF is shared with the CSW on the day the final report is submitted, with an average of 2.5 days between finalizing the MAT SOF and sharing to CSWs across all cases. Though the reason for the difference is unclear, cases involving Black children had a longer average time between finalizing the MAT SOF and sharing it with the CSW. The timeliness of sharing the MAT SOF with CSWs also varied across DCFS Offices and SPAs, but did not differ based on the MAT Agency or whether the case was a part of the MAT-CFT pilot. The CSWs and DIs surveyed indicated they received the MAT SOF in a timely manner as well, with only one DI stating that they do not receive the MAT SOF with sufficient time to review prior to making case planning decisions. Most DCFS workers surveyed suggested they would like to receive the MAT SOF at least one or two weeks prior to the Disposition Hearing.

The timeliness of providing the MAT SOF to the Courts was more challenging to evaluate, as there was less data available on key Court milestones and how they relate to the MAT process. 108 cases had data on when the MAT SOF was submitted to the Court. On average, the MAT SOF was submitted to the Court 33.7 days following finalization of the SOF report. This timeline varied across DCFS Offices and SPAs, and MAT-CFT cases were submitted to the Courts significantly quicker than Traditional MAT cases. However, this date was not tracked for all DCFS Offices and is heavily dependent on scheduling of the child’s Disposition Hearing. Therefore, this data may not reflect the timeliness with which the report is available to Court officials.

CIBHS also received Minute Orders for a subsample of cases and used that information to determine the Disposition Hearing date. CIBHS was able to identify a Disposition Hearing date for 55 cases. The MAT SOF was completed on or before the Disposition Hearing date for over 80% of those cases.

Only 22 cases had available information for both the Disposition Hearing date and the date the MAT SOF was submitted to the Courts. Of those, the MAT SOF was submitted to the Courts on or prior to the Disposition Hearing date approximately two-thirds of the time. Though this data should be interpreted cautiously due to the small sample size, it aligns with qualitative feedback from bench officers, minors’ attorneys, and parents’ attorneys, who indicated they only receive the MAT SOF in some cases. Most people surveyed suggested receiving the MAT SOF at least a few days prior to the Disposition Hearing was ideal, though they also noted that they carry many cases at a time, so finding time to review the MAT SOF can be challenging.

<table>
<thead>
<tr>
<th>Minimum</th>
<th>Maximum</th>
<th>%</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1 days</td>
<td>8.4 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.0 days</td>
<td>80.8 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.6 days</td>
<td>102.5 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.6 days</td>
<td>46.8 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

39 50.3% (178 of 354 cases)
40 Cases with Black children: 3.8 days, 107 cases; Cases without Black children: 2.0 days, 235 cases. ANOVA: F (1,340) = 5.726, p=0.017.
41 Minimum: 0.0 days, Maximum: 9.0 days; One office had an average time of less than zero days (-0.1 days), indicating that the SOF was provided to the CSW before the final report was submitted in an average MAT case for that office. It is unclear whether that accurately represents the process in that office or if this finding is related to the quality of the data recorded.
42 Minimum: 0.1 days, Maximum: 8.4 days
43 Minimum: 0.0 days, Maximum: 80.8 days
44 Minimum: 0.6 days, Maximum: 102.5 days
45 MAT-CFT: 22.6 days, Traditional MAT: 46.8 days. ANOVA: F (1,104) = 5.960, p=0.016.
46 8 DCFS offices had no data for this measure
47 MAT SOF completed before Disposition Hearing: 43 of 55 cases (78.2%), average 51.7 days before Disposition Hearing. MAT SOF finalized on the day of the Disposition Hearing: 2 of 55 cases (3.6%). MAT SOF completed after Disposition Hearing: 10 of 55 cases (18.2%), average 17.8 days after the Disposition Hearing.
48 MAT SOF submitted to Courts before Disposition Hearing: 9 of 22 cases (40.9%), average 47.8 days before Disposition Hearing. MAT SOF submitted to Courts on the day of the Disposition Hearing: 6 of 22 cases (27.3%). MAT SOF submitted to Courts after Disposition Hearing: 7 of 22 cases (31.8%), average 83.1 days after the Disposition Hearing.
TIMELINESS OF MAT FOR CHILDREN AND FAMILIES

While DCFS and DMH staff rightfully focus on administration of the MAT process within Departmental timeliness standards and the elements of the MAT process under their control (from Referral through completion of the SOF document), children and families involved in the MAT process may find greater relevance in the timeliness of the MAT process based on when they were removed from their homes or legally detained. The average time from these milestones to completion of the MAT process is notably longer – 54.4 days from Detention to completion of the MAT SOF, and 60.6 days from Removal to completion of the MAT SOF. CIBHS did not investigate the timeliness of these milestones in detail, as they are outside of the MAT process, but they are highly likely to influence the perception of the MAT process amongst the people MAT serves.

MAT CANCELLATIONS

MAT assessments were cancelled for 36 children (6.0%) and 23 cases (5.7%) in the evaluation sample. Cancellations were tracked via DCFS administrative data and DMH tracking logs. 28 cancellations were logged in the DCFS administrative data. Of those, 20 were also noted as cancelled in the DMH tracking log. 28 cancellations were also logged in the DMH tracking logs, of which 18 were also marked cancelled in the DCFS administrative data.

On average, MAT assessments were cancelled 23.5 days after the case was referred to a MAT agency. Two cases were cancelled for one or more children, while other children in the case completed the MAT process. The following table documents the reasons for cancellation of the MAT assessment.

<table>
<thead>
<tr>
<th>CANCELLATION REASON</th>
<th>CHILDREN</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child referred to ICC/IHBS program</td>
<td>12 (33.3%)</td>
<td>7 (28.0%)</td>
</tr>
<tr>
<td>Case closed by DCFS</td>
<td>5 (13.9%)</td>
<td>3 (12.0%)</td>
</tr>
<tr>
<td>Child returned to bio parent/home</td>
<td>5 (13.9%)</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Child placed out-of-county (no available providers)</td>
<td>4 (11.1%)</td>
<td>3 (12.0%)</td>
</tr>
<tr>
<td>Existing mental health services</td>
<td>4 (11.1%)</td>
<td>3 (12.0%)</td>
</tr>
<tr>
<td>Child has private insurance</td>
<td>2 (5.6%)</td>
<td>2 (8.0%)</td>
</tr>
<tr>
<td>AWOL</td>
<td>1 (2.8%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>AWOL/Child returned to bio parent/home</td>
<td>1 (2.8%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Court dismissed petition</td>
<td>1 (2.8%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Client hospitalized</td>
<td>1 (2.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>36 children</td>
<td>23 cases</td>
</tr>
</tbody>
</table>

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49 7.8% within 45 days, 64.1% within 60 days  
50 N=23 cases. Range=0-154 days.  
51 ICC/IHBS program: Intensive Care Coordination or Intensive Home Based Services program. Changes at the state level allow ICC/IBHS to be available for any child or youth, regardless of program.  
52 This reason is from the DMH tracking log. No other reason was documented.  
53 The cancel reason for this child was recorded differently in the DCFS administrative data and the DMH tracking log. DCFS administrative data indicated this child was AWOL, while the DMH tracking log indicated they had been returned to their bio parent.  
54 MAT was cancelled for one child on this case, while the MAT process was completed for other children.
TIMELINESS OF OTHER FRONT-END ASSESSMENT PROCESSES

Children undergoing a MAT Assessment could also be engaged in several additional front-end assessment processes. This helps to ensure completion of a variety of screening and assessment tools required by state- and county-level policies and procedures, including a Mental Health Screening Tool (MHST), DMH triage and intake, and DMH co-located staff at Medical Hubs who provide mental health screenings for some children. State-level Continuum of Care Reform (CCR) and updates to California’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) regulations introduced additional tools and requirements in recent years, such as the Level of Care Assessment (LOC), the Child and Adolescent Needs and Strengths (CANS), and the Pediatric Symptom Checklist-35 (PSC-35), all of which are different parts of the CSAT process. These tools and requirements have different policy timelines, as depicted in the figure below. Though these screenings and assessments generally occur within the same timeframe as the MAT assessment, other than the MHST, they are not directly coordinated with the MAT. The existing regulations requiring use of multiple screening and assessment tools can cause the front-end assessment process to feel redundant for children and families as well as service providers. The diagram below highlights the policy timelines for these processes. For a full crosswalk of front-end assessment processes in LA County, see Appendix D.

CIBHS was able to assess the actual timeliness of completing the Mental Health Screening Tool (MHST), Child and Adolescent Needs and Strengths (CANS), and Level of Care (LOC) rate determination, as they relate to the MAT process. This is summarized in the figure and discussed in detail below.

Mental Health Screening Tool (MHST)

Following detention and upon case promotion, the MHST is administered by the DCFS emergency response (ER) social worker to gather information on the child’s mental health acuity and triage needs. All children, regardless of their track in the CSAT process, receive an MHST. Based on eligibility and acuity, the child may be referred to a DMH Contracted Provider for a MAT Assessment or to DMH Co-located Specialized Foster Care (SFC) for triage and linkage to appropriate services. When an MHST result is pre-acute or pre-urgent, the case is shared with DMH SFC for triage. Children with acute or urgent mental health needs will be assessed and treated by DMH Co-located SFC and could be directly referred to intensive mental health services to begin immediate treatment. This activity only occurs if the MAT case has been determined to be “cancelled” and the DMH SFC Clinician is responsible for the clinical needs of the case (i.e., linkage/referral/ongoing clinical coverage until appropriately linked). MHST results are included as part of the child’s referral to additional assessments or mental health services. When a child’s MHST screening indicates pre-routine mental health needs or their acuity is downgraded from pre-acute or pre-urgent to routine upon triage, the child/youth receives a timely and thorough assessment by a DMH Contracted Provider which will lead to linkages to the appropriate services. Efforts are made to assign these cases for a MAT assessment.
584 children in the evaluation sample had data available on the timeliness of MHST administration. The MHST process, including triage and referral to DMH, was completed, on average, 8.4 days after Detention, and on the same day as, or prior to Referral to MAT for over 90% of children. MHSTs were completed within 30 days of Detention for nearly all children in the evaluation sample.

**Child and Adolescent Needs and Strengths (CANS)**

CANS is a mental health assessment tool that evaluates a child’s behavioral and emotional needs, risk behaviors, cultural factors and general life functions. It also assesses the child’s strengths as well as the resources and needs of their caregiver. Training and certification are required to complete the CANS. DHCS requires completion of the CANS-50 for all children upon initiation of services, while CDSS requires the CANS-IP, which contains the 50 elements of the CANS-50 and additional items related to trauma and adverse childhood experiences and events. LA DCFS and DMH have implemented the CANS-IP for all ages, with DCFS capturing the results for children ages 0-5 and the DMH-contracted MAT Providers capturing them for children ages 6 and up. State regulations require that children receive a CANS assessment upon initiation of mental health services (DHCS) or within 60 days of entering the foster care system (CDSS).

Milestone dates associated with CANS are tracked by DCFS and available in the assessment data itself. Data on the timeliness of CANS completion was available for 592 children in the evaluation sample. CIBHS also received complete CANS data for 209 children with CANS assessments recorded by DMH, and another 74 provided by DCFS. CIBHS identified the first date a CANS was completed within the evaluation window and compared that to the timeline of the MAT process. Based on this analysis, it appears that CANS assessments usually coincide with MAT assessments, with 89.0% of CANS occurring after the child was referred to MAT, and 70.3% before the MAT SOF was finalized. On average, CANS assessments were completed 39.7 days after Detention, with 81.3% children receiving a CANS assessment within 60 days of Detention.

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55 531 of 584 children (90.9%)
56 563 of 584 children (96.4%)
57 Info Notice 17-052 POS Functional Assessment Tool (ca.gov)
58 TB-09.pdf (ca.gov)
59 527 of 592 children (89.0%)
60 392 of 592 children (66.3%)
61 481 of 592 children (81.3%)
Notably, there were some potential points of redundancy observed related to CANS assessments. When CANS is completed by the MAT Assessor, the MAT Coordinator forwards a copy of the CANS to a dedicated inbox at DCFS for the Level of Care (LOC) CSW and initial CANS. Nearly a quarter of the 458 children listed as having CANS completed by a child welfare worker, also had a CANS recorded in DMH’s database. This could be a sign of data sharing, or it could represent duplicative assessment across organizations.

There are many similarities between the CANS assessment and the MAT, as both are intended to comprehensively identify a child’s strengths and needs as they begin services. The MAT SOF is informed by information the MAT Assessor gathers from the child, their family, and their professional and informal supports. CANS is designed as a communication tool that encourages the child or family to score themselves or discuss their needs with their clinician. Both assessments must be administered by qualified professionals – MAT is completed by a licensed or license-waivered mental health professional, while CANS administration requires a designated certification.

However, while MAT results in a narrative case summary document, CANS rates the child’s challenges and strengths on a scale of 0-3 across a variety of domains. Both CANS and MAT prompt the assessor to evaluate the child’s mental and physical health, developmental history and current functioning, exposure to and effect of trauma, and educational experience. They also probe the caregiver’s resources and needs. CANS’ structure includes a greater number of specific elements for the assessor to rate than MAT, but the elements all fall within a similar scope. Workflows associated with CANS ensure compliance with state regulations, but there is limited guidance on interpreting the results and incorporating them into case planning and the MAT SOF. It is reasonable to expect that, outside of the administrative burden of completing the assessment forms, a CANS-certified MAT Assessor would not need to collect additional or redundant information from the child or family to complete the CANS assessment. Indeed, CIBHS did not observe a difference in the amount of time claimed by MAT Agencies based on whether they completed a CANS for that child as well (see Claims from MAT Agencies section for details). Completing the CANS may also support improvement to the MAT SOF document, as CANS requires rating the influence of cultural factors and presence of risk factors and safety concerns (see Clinical Best Practices section for details on these items in the MAT SOF). The state-level CANS requirements are relatively new, and implementation of CANS procedures is still in its infancy, so it will be important to continue to track CANS completion as the process matures.

Medical Hub

The Medical Hub clinics include a multidisciplinary team of pediatricians specializing in serving DCFS children, DCFS social workers, DMH mental health clinicians, and LA County Department of Public Health nurses. Co-located DMH staff at the Hubs may work within the CSAT process and provide mental health screenings and triages for some children receiving services at the Medical Hubs. Where possible, Hub DMH staff collaborate with the child’s DCFS MAT Coordinator or DMH co-located staff to avoid potential overlaps in assessment and duplicative referrals to service. In cases where a child has not received a mental health assessment through another part of the CSAT process (by the time they are seen at the Medical Hubs, typically within 30 days of detention), co-located DMH staff at the Medical Hubs will complete a triage/intake process for children receiving IMEs; this includes completing the ICARE or Child/Adolescent initial assessment form, which documents the child’s medical, developmental, and mental health history; family status; and relevant diagnoses. Importantly, DMH can complete this form using information from a referring assessment rather than conducting a duplicate clinical exam. Co-located DMH staff complete the appropriate version of the Hub Mental Health Info Sheet based on the child’s age. Frequently, this process also includes use of the ASQ-3 for children up to 60 months of age. These assessments coincide with referrals through the DCFS CSAT Referral Portal and forms are generally completed and shared with DCFS on the day of assessment at the Hub.

62 111 of 458 children (24.2%)
The extent to which co-located DMH staff at the Medical Hubs completed a triage/intake process for children receiving a MAT is not always clear. Just over half of children in the Prospective Sample had claims from a Medical Hub between July and December 2020. Almost all of those claims were for Medi-Cal Administrative Activities (MAA) or Community Outreach Services (COS), which does not necessarily indicate the child received a mental health screening or assessment. In the Retrospective Sample, a small number of SOFs described ASQ-3 assessment by both the MAT Assessor and the Medical Hub, but the extent of duplication may be significantly greater than documented in the SOFs. There is opportunity for further investigation of the extent to which duplicative mental health occur between the MAT and at the Hubs, as well as the extent to which those duplications can be mitigated through data sharing and care coordination.

**Level of Care (LOC) Rate Determination**

Children placed with Foster Family Agencies (FFAs) also receive an LOC assessment to determine the appropriate funding rate for the case. LOC is required by CDSS to align the Home-Based Family Care (HBFC) rate structure with expectations of Resource Families who care for and supervise a child or youth in out-of-home care. CDSS requires completion of the LOC rate determination within 60 days of HBFC placement. LOC is not a mental health or clinical assessment, nor does it determine appropriate placement or services. It is completed by a DCFS LOC worker, who collects information from the child’s team, including their caregiver, generally within 30 days of detention. LOC does not require contact with the child or their biological parents, though it may incorporate information from the Child and Family Team (CFT). Currently only children placed with FFAs receive a LOC assessment, though this may be expanded to other cases in the future. Depending on placement, children undergoing a MAT assessment may also receive an LOC, which is separate to and distinct from the MAT. LOC completion dates were available for 139 cases in the evaluation sample. The LOC assessment is usually completed around the time the MAT assessment is completed, with just over half of LOC assessments completing before the MAT SOF is finalized, and the rest afterwards.

**Quality of the MAT SOF**

CIBHS reviewed MAT SOF documents for a 469-child subsample of the evaluation sample to evaluate the quality of the MAT SOF document itself. Details of subsample selection are available in the Methodology section of this report. When reviewing the findings in this section, it is important to consider that these findings relate specifically to the quality of the documentation in the MAT SOF itself and may not reflect the full quality of the MAT assessment. The findings herein represent opportunities for improving the quality and consistency of the MAT SOF document itself to facilitate sharing the full breadth and depth of the MAT assessment with families, DCFS workers, Court officers, and mental health treatment providers.

**DESCRIPTION OF THE QUALITY SUBSAMPLE**

The quality subsample was selected with the intent of reflecting the overall evaluation sample to the greatest extent possible. Details on the children included in the quality subsample can be viewed in the following graphic, as well as Appendix B.
**Quality Subsample**

**469 children | 406 cases**

### Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>8 children</td>
</tr>
<tr>
<td>Black</td>
<td>122 children</td>
</tr>
<tr>
<td>Hispanic</td>
<td>53 children</td>
</tr>
<tr>
<td>White</td>
<td>57 children</td>
</tr>
<tr>
<td>Other*</td>
<td>221 children</td>
</tr>
<tr>
<td>Null</td>
<td>8 children</td>
</tr>
</tbody>
</table>

*Other includes children who identified as having more than one ethnicity or a single ethnicity not listed here.

### Number of Children Per Case

- **One child**: 224 cases (69.3%)
- **Multiple children**: 99 cases (30.7%)

### Age of Children

- **0-18 months**: 168 children (35.8%)
- **6 years or more**: 169 children (36.0%)

### Spanish Language

- **Spanish speaking**: 87 children (18.6%)
- **Non-Spanish speaking**: 382 children (81.4%)

### Gender

- **Female**: 232 children (49.5%)
- **Male**: 237 children (50.5%)

*Other includes children who identified as having more than one ethnicity or a single ethnicity not listed here.*
The MAT SOF document is completed by MAT Assessors using a template form. Template forms contain a number of sections and vary slightly based on whether the case goes through the Traditional MAT or MAT-CFT process, as detailed in the table below.

<table>
<thead>
<tr>
<th>SECTION</th>
<th>TRADITIONAL MAT TEMPLATE</th>
<th>MAT-CFT TEMPLATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case and Child Information</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MAT Provider Agency Report Information</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child and Family Team</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Family Story</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child Summary (per child)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Strengths of This Child</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Trauma Exposure</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mental Health History, Current Symptoms and Behaviors</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Current Developmental Functioning</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Observation of Family – Child Interactions</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Physical and Dental Health</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Education/Daycare</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Interests/Hobbies/Career Goals</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child Needs (per child)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>How Can Team Members Help Meet These Needs?</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child Referrals (per child)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Family Referrals</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Current Caregiver/Placement Information (per placement)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MAT SOF Meeting Participants</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

The MAT SOFs reviewed consistently contained the sections defined in the respective templates, and sections were rarely left blank. However, due to the COVID-19 pandemic, only 10.4% of child summaries included documentation of the Assessor’s observation of interactions between the child and their biological parent(s). Many SOFs cited COVID-19 restrictions in this section, though CIBHS did consider documentation of the Assessor’s virtual observation of parent-child interaction (i.e., the parent-child interaction was in person, while the Assessor observed virtually) sufficient.

The SOF clearly documented whether the current placement met the child’s needs for over three-quarters of children. However, only 13.8% of children whose needs were not being met by the current caregiver had documentation of alternate placements identified in the SOF. Notably, recommendations made in the MAT SOF regarding placement are non-binding and often relate to opportunities for improving the match between a child’s language, culture, and food preferences and those of their caregiver. Placement discussions occur best in the child and family team, and DCFS is responsible for the final placement recommendation to the court, not the MAT team. MAT SOFs do often recommend referrals or resources that can support the caregiver to avoid needing to identify an alternate placement.

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69 49 of 469 children (10.4%)
70 362 of 459 children for whom caregiver information was provided (78.9%)
> APPROPRIATENESS TO SOF AUDIENCES

One of the most challenging features of the MAT SOF is its need to cater to a wide variety of audiences. The MAT SOF is completed by mental health clinicians but needs to be written in a manner that supports use by other clinicians, as well as DCFS case workers, bench officers, and minors’ and parents’ attorneys with varying degrees of clinical knowledge. Moreover, the MAT SOF needs to be appropriate for sharing with parents and caregivers, and in some cases older children, even in cases where those individuals have limited education and/or English-language proficiency. Qualitative feedback from non-clinical MAT stakeholders suggests that the MAT generally uses language that is approachable for a non-clinical, but professional audience. CIBHS did observe instances where the MAT SOF contained clinical abbreviations (such as dx or tx) or language (“mother denied child had difficulty with feeding”) that may be misunderstood by non-clinical audiences, though those instances were fairly rare. CIBHS also observed that 4.7% of SOFs (for 22 children) used inconsistent names and/or pronouns when referring to the child. This may occur due to copying standard language or information that applies to multiple children within the same assessment but can decrease the reader’s confidence in the quality and specificity of the information provided.

> CLINICAL BEST PRACTICES

Use of Assessment and Screening Tools During the MAT Process

CIBHS used the Retrospective Sample for this evaluation to understand the extent to which MAT Assessors documented use of specific screening and assessment tools during the MAT process. Though DMH does not require the use of any specific tools during the MAT process, one tool, the ASQ-3, is frequently utilized. Additionally, two other tools must be completed for children at this stage of intake based on state-level regulations: CANS and PSC-35. These three tools and their applications are described in more depth in the subsections below. MAT Assessors also often identify and use other mental health screening and assessment tools based on their clinical judgement of what is appropriate for the child or family. While detailed results and raw data of mental health screening and assessment tools are not usually found in the MAT SOF, the SOF will describe the findings of the tools used.

Ages and Stages Questionnaire (ASQ-3)

The ASQ-3 measures physical, developmental, and communication milestones of children up to 60 months of age. MAT Assessors complete the ASQ-3 as part of the assessment process. Most SOFs for children 60 months of age or younger\(^{71}\) included a description of findings from the ASQ-3. Of the 29 cases that did not describe the ASQ-3, 6 described an alternate developmental assessment tool (the Bayley Scales of Infant Development-III [5 cases] or the ASQ-Social Emotional [ASQ-SE, 1 case]). The results are reviewed by DCFS MAT Coordinators, who assist with service linkages and are particularly interested in the developmental screening results in the SOF report for children who will be referred to Regional Centers. Regional Centers were involved in approximately half of the MAT cases reviewed for children below 60 months of age\(^{72}\). In this situation, detailed ASQ-3 results may be especially helpful to support additional developmental assessment and diagnosis. In the Retrospective Sample, most SOFs described findings and recommendations based on the ASQ-3 but did not include the child’s specific ASQ-3 scores. Approximately one-third of Retrospective Sample SOFs where ASQ-3 was used\(^{73}\) documented the child’s exact ASQ-3 scores at the time of administration.

Child and Adolescent Needs and Strengths (CANS)

As discussed above, CANS is a mental health tool used to facilitate communication with children and families about their behavioral and emotional needs, risk behaviors, cultural factors and general life functions, as well as their strengths and their caregiver’s resources and needs. Use of CANS was not specifically documented in Retrospective Sample SOFs, as CANS was implemented after the Retrospective Sample timeframe. While CANS was used with children and families in the Prospective Sample, its use was not explicitly documented in MAT SOF documents. Moreover, current LA County DMH procedure dictates

\(^{71}\) 180 of 209 children (96.1%)
\(^{72}\) 118 of 209 children (56.5%)
\(^{73}\) 56 of 180 children (31.1%)
that CANS is completed by the MAT Assessor for children 6 years and older who meet Medical Necessity requirements for behavioral health services, while DCFS is responsible for completing CANS for newly-detained children, regardless of whether they meet this requirement. Given the similar scope of the CANS and MAT assessments, this can lead to redundancy of assessment, which may be mitigated by having all CANS assessments completed by the MAT Assessor.

**Pediatric Symptom Checklist-35 (PSC-35)**

The PSC-35 is a psychosocial screening tool that assists with identifying potential cognitive, emotional, and behavioral issues a child may be experiencing to help facilitate the initiation of timely interventions. The PSC-35 is required for children ages 3-18 who receive mental health services through DMH and is to be completed by the parent or caregiver. Since parents/caregivers are completing the tool, training is not required for the PSC-35. PSC-35 must be completed at the beginning of treatment, every six months following the first administration, and at the end of treatment. The PSC-35 is a quality tool that tracks and measures outcomes for children and, much like the MAT, helps to facilitate the coordination of care across the medical and mental health care sectors. As with the CANS, in interviews with CIBHS, both LA DCFS and DMH staff expressed a desire to develop practices and procedures to incorporate data captured by the PSC-35 into the case planning process.

**Other Screening and Assessment Tools**

MAT Assessors may also use a variety of other screening and assessment tools based on their clinical judgement and the specifics of each child and family’s case. MAT SOFs do not frequently list the names or detailed results of other tools used, however, CIBHS has prepared a summary of some commonly used screening and assessment tools that apply to the key domains of the MAT assessment. That summary can be found in Appendix E.

**Providing and Documenting a Trauma-Informed Assessment**

Trauma-informed assessments offer the opportunity for children and their families/caregivers to fully engage in the process, develop trust with the system they are interacting with, and improve long-term health outcomes while minimizing further re-traumatization. There are six key principles of a trauma-informed approach: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and consideration of cultural, historical, and gender issues. While CIBHS was unable to evaluate trustworthiness and transparency, as well as peer support, through reviewing MAT SOF documents, the remaining principles are discussed here.

**Safety.** Approximately one-quarter of SOFs reviewed documented the presence or absence of safety concerns such as suicidal ideation, self-harming behaviors, or risks associated with individuals within the child’s current placement. The presence or absence of safety concerns were more likely to be documented in older children, as well as for cases with multiple children. MAT-CFT cases were more likely to contain clear documentation related to safety concerns than Traditional MAT cases.

---

74 120 of 469 children (25.6%)
75 6 years and older: 40.2%, 0-5 years of age: 17.3%, $\chi^2 (d.f=1) = 29.783, p<0.001.$
76 Multiple children: 33.7%, One child: 16.6%, $\chi^2 (d.f=1) = 18.065, p<0.001.$
77 MAT-CFT: 30.5%, Traditional MAT: 21.9%, $\chi^2 (d.f=1) = 4.422, p=0.035.$
Collaboration and Mutuality. As its name suggests, the MAT process is intended to bring together service team members across disciplines to ensure children and families receive a comprehensive assessment of their strengths and needs. The transition from the Traditional MAT process to the MAT-CFT process aims to build on that concept by increasing engagement of the child and family in the MAT process. To evaluate the extent to which both service professionals and family members are involved in the MAT process, CIBHS investigated their participation in the MAT assessment and their attendance at the MAT SOF meeting.

Individuals were defined as involved in the MAT assessment when the MAT SOF indicated that they were interviewed during the MAT process. The MAT process culminates in a MAT SOF meeting, during which attendees discuss the information in the MAT SOF document. In the MAT-CFT process, this meeting is facilitated as a CFT meeting. The following table summarizes how service professionals participated in the MAT process:

<table>
<thead>
<tr>
<th>PROFESSIONAL</th>
<th>INVOLVED IN MAT ASSESSMENT</th>
<th>ATTENDED MAT SOF MEETING78</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE MAT TEAM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAT Assessor</td>
<td>✓</td>
<td>95.9%, 257 of 268 children</td>
</tr>
<tr>
<td>MAT Supervisor</td>
<td>Not tracked79</td>
<td>4.9%, 13 of 268 children</td>
</tr>
<tr>
<td>DCFS MAT Coordinator</td>
<td>✓</td>
<td>92.2%, 247 of 268 children</td>
</tr>
<tr>
<td>DMH MAT Psychologist</td>
<td>Not tracked</td>
<td>31.0%, 83 of 268 children</td>
</tr>
<tr>
<td><strong>ADDITIONAL DCFS CASE WORKERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSW</td>
<td>94.9%, 445 of 469 children</td>
<td>96.6%, 450 of 466 children</td>
</tr>
<tr>
<td>Dependency Investigator (DI)</td>
<td>56.9%, 267 of 469 children</td>
<td>19.8%, 53 of 268 children</td>
</tr>
<tr>
<td>Emergency Response CSW (ER CSW)</td>
<td>3.4%, 16 of 469 children</td>
<td>Not tracked</td>
</tr>
<tr>
<td>Supervising CSW (SCSW)</td>
<td>2.8%, 13 of 469 children</td>
<td>32.3%, 169 of 466 children</td>
</tr>
<tr>
<td><strong>ADDITIONAL SUPPORTS (WHEN APPLICABLE TO THE CASE)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Services Worker (ISW)</td>
<td>1.5%, 7 of 469 children</td>
<td>Not tracked</td>
</tr>
<tr>
<td>Teacher</td>
<td>4.1%, 19 of 469 children</td>
<td>Not tracked</td>
</tr>
<tr>
<td>Therapist</td>
<td>8.5%, 40 of 469 children</td>
<td>4.1%, 11 of 268 children</td>
</tr>
<tr>
<td>Foster Family Agency (FFA) Worker</td>
<td>4.9%, 23 of 469 children</td>
<td>Not tracked</td>
</tr>
<tr>
<td>Level of Care (LOC) Worker</td>
<td>2.1%, 10 of 469 children</td>
<td>Not tracked</td>
</tr>
<tr>
<td>Medical Provider</td>
<td>3.8%, 18 of 469 children</td>
<td>Not tracked</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>5.8%, 27 of 469 children</td>
<td>Not tracked</td>
</tr>
</tbody>
</table>

Involvement of core MAT team members (the MAT Assessor and Supervisor, the MAT Coordinator(s), and the DMH MAT Psychologist) in the assessment process was not tracked via the SOF document, but their attendance at the MAT SOF meeting was, when the MAT SOF contained an SOF Meeting Attendance List. Unsurprisingly, both the MAT Assessor and DCFS MAT Coordinator attended the MAT SOF meeting for the majority of assessments (95.9% and 92.2%, respectively). A DMH MAT Psychologist attended approximately one-third of MAT SOF meetings and a MAT Supervisor attended approximately 5%.

Similar to the MAT team, the CSW was involved in most assessments and attended most MAT SOF meetings. Dependency Investigators were involved in just over half of assessments and attended approximately one-fifth of MAT SOF meetings, while supervising CSWs were rarely involved in the MAT assessment but attended nearly one-third of MAT SOF meetings. Other professionals, including therapists, public health nurses, foster family agency (FFA) workers, and teachers, attended in 4-10% of

78 See Methodology for a description of the data used to evaluate attendance at the MAT SOF meeting.
79 Items marked “Not tracked” are not reported in the MAT SOF. They may be tracked through other forms of documentation maintained by DCFS and DMH.
cases. DMH MAT Psychologists\textsuperscript{80}, SCSWs\textsuperscript{81}, and DIs\textsuperscript{82} were all more likely to attend the MAT SOF meeting in MAT-CFT cases than Traditional MAT ones.

The table below documents the participation of family members and other support in the MAT process. CIBHS eliminated cases from this analysis where the child’s biological mother or father was not involved in the child’s case in any way, for example when the biological parent was deceased or unknown.

<table>
<thead>
<tr>
<th>FAMILY MEMBER/SUPPORT</th>
<th>INVOLVED IN MAT ASSESSMENT</th>
<th>ATTENDED MAT SOF MEETING\textsuperscript{83}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>73.9%, 311 of 421 children</td>
<td>56.8%, 238 of 419 children</td>
</tr>
<tr>
<td>Father</td>
<td>47.2%, 150 of 318 children</td>
<td>29.7%, 94 of 316 children</td>
</tr>
<tr>
<td>Caregiver</td>
<td>98.3%, 461 of 469 children</td>
<td>49.4%, 230 of 466 children</td>
</tr>
</tbody>
</table>

The children referred to MAT were heavily involved in the MAT process and were seen/interviewed an average of 2.8 times during the assessment process. Almost all caregivers were involved in the MAT assessment, though they only attended the MAT SOF meeting about half of the time. Mothers were more likely to be involved in both the MAT assessment and attend MAT SOF meetings than fathers.

Like professionals, family members and other supports were more likely to attend the MAT SOF meeting in MAT-CFT cases than Traditional MAT ones. Both mothers\textsuperscript{84} and caregivers\textsuperscript{85} attended a higher percentage of MAT SOF meetings in MAT-CFT cases, though fathers’ attendance was unchanged\textsuperscript{86}.

\textsuperscript{80} MAT-CFT: 48.4%, Traditional MAT: 28.7%. \(\chi^2\) (d.f.=1) = 4.974, p=0.026.
\textsuperscript{81} MAT-CFT: 71.1%, Traditional MAT: 10.8%. \(\chi^2\) (d.f.=1) = 178.807, p<0.001.
\textsuperscript{82} MAT-CFT: 38.7%, Traditional MAT: 17.3%. \(\chi^2\) (d.f.=1) = 7.921, p=0.005.
\textsuperscript{83} See Methodology for a description of the data used to evaluate attendance at the MAT SOF meeting.
\textsuperscript{84} MAT-CFT: 65.2%, Traditional MAT: 50.4%. \(\chi^2\) (d.f.=1) = 9.145, p=0.002.
\textsuperscript{85} MAT-CFT: 55.3%, Traditional MAT: 45.0%. \(\chi^2\) (d.f.=1) = 4.872, p=0.027.
\textsuperscript{86} MAT-CFT: 26.4%, Traditional MAT: 32.6%. \(\chi^2\) (d.f.=1) = 1.427, p=0.232.
Empowerment, Voice, and Choice. While there is ample evidence that children are engaged in the MAT process, only 12.2% of assessments\(^{87}\) clearly documented the youth’s choice and preferences related to placement, services, and supports. This does, however, increase for older children\(^{88}\). It is important to note that the lack of documentation of youth choice in the MAT SOF does not mean they were not empowered to share their preferences, nor does documentation of youth choice guarantee access to the placement, services, and supports they prefer. However, clearly documenting youths’ voices within the MAT SOF can help DCFS case workers, the Courts, and mental health treatment providers understand the best ways to serve them after the MAT is completed.

Consideration of Cultural, Historical, and Gender Issues. CIBHS reviewed the extent to which MAT SOFs documented consideration of the child and family’s needs related to culture, gender, and sexual orientation or identity. Only a few assessments\(^{89}\) contained clear documentation of how the child’s needs related to culture, gender, and sexual orientation or identity were incorporated into their recommendations or referrals. Another few assessments\(^{90}\) documented the child’s needs, but not how they were considered in making recommendations and referrals for service. This does not mean that culture, historical, and gender issues were not considered during the MAT process but does indicate there is room for improvement in documenting those considerations in the MAT SOF.

Only 53 MAT SOF documents\(^{91}\) noted a non-English language on the SOF document, although 89 total cases in the quality subsample involved a non-English language based on data from other data sources used for this evaluation\(^{92}\). Approximately one-quarter of assessments listing a non-English language\(^{93}\) documented the child’s language preferences. The current method of capturing language data on the SOF makes it difficult to determine a child’s language preferences if not described in the assessment itself. The SOF only notes the language for the entire case, and the languages listed there may refer to one or more children, or one or more parents, involved in the case.

\(^{87}\) 57 of 469 children (12.2%)
\(^{88}\) 6 years and older: 48 of 169 children (28.4%), 13 years and older: 18 of 41 children (43.9%)
\(^{89}\) 8 of 469 children (1.8%)
\(^{90}\) 11 of 469 children (2.3%)
\(^{91}\) 53 of 469 children (11.3%)
\(^{92}\) See Appendix B for details on how Language data was reviewed across data sources.
\(^{93}\) 12 of 53 children (22.6%)
**Documentation of Impacts of Trauma.** The Substance Abuse and Mental Health Services Administration (SAMHSA) described the concept of trauma and guidance for trauma-informed approaches to care in 2014. Trauma assessments should consider three aspects of how a child is impacted by trauma:

- **The Event:** the specific trauma to which a child was exposed;
  - Traumatic events can include actual physical or psychological harm, threat of harm, or neglect
  - A child may experience a single traumatic event or a series of events over time
- **The Experience:** how the child felt at the time of the trauma; and
  - The same event may be experienced as traumatic by some children but not others
  - Traumatic experiences can be shaped by a child’s cultural beliefs, support system, or developmental stage
- **The Effects:** what, if any, adverse effects the child experiences as a result of the trauma.
  - The effects of trauma can be immediate or delayed
  - Children and family members may not recognize the linkage between a traumatic event and its long-term effects

The extent to which these elements were documented in MAT SOFs varied.

MAT SOFs consistently provide clear documentation of the trauma **events** to which children were exposed. Nearly all assessments documented the child’s exposure to trauma, and especially the traumatic event immediately preceding their detention. Notably, in cases involving multiple children, the trauma event may be repeated multiple times within the SOF, as the same event is documented in each child’s summary. This can cause the SOF to feel repetitive as well as overly emphasize the children’s and family’s negative and traumatizing experiences.

While MAT SOFs robustly document trauma events, they are less likely to describe how a child felt at the time of the trauma (their trauma experience) and the ways in which the trauma results in adverse effects for each child. Only one-third of assessments included documentation of trauma **experience**. Unsurprisingly, this was significantly associated with the age of the child being assessed, with trauma experience documented more frequently in older children. This may also occur due to the additional time needed to develop a sufficient relationship between the clinician and the child wherein the child feels comfortable discussing their traumatic experiences and their effects.

Documentation of trauma experiences varied across MAT Agencies, but did not differ based on DCFS Office, SPA, or the MAT process followed (Traditional MAT or MAT-CFT).

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94 SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach
95 465 of 469 children (99.1%)
96 162 of 469 children (34.5%)
97 6 years or older: 62.1%, 19 months – 6 years: 29.5%, 0-18 months: 10.7%. χ² (d.f.=2) = 100.532, p<0.001.
98 Minimum (of MAT Agencies with at least 5 assessments reviewed): 0.0%; Maximum (of MAT Agencies with at least 5 assessments reviewed): 100.0%
Documentation of trauma effects were often found in either the Trauma Exposure or Mental Health History, Current Symptoms and Behaviors sections of the MAT SOF. Specific trauma effects, meaning the precise ways in which a child was adversely impacted by their traumatic experiences and how those experiences have affected their health and wellbeing, were documented in just over half of assessments, while another 16.2% provided a generic description of how the types of trauma the child experienced may affect them. Similar to trauma experience, specific trauma effects were more likely to be documented in older children. There were also differences in documentation of trauma effects based on language and ethnicity. SOFs for Spanish speakers and those identifying as Hispanic were more likely to contain documentation of specific trauma effects, while SOFs for children identifying as Black were less likely to contain documentation of specific trauma effects. Documentation of specific trauma effects varied across MAT Agencies, DCFS Offices, and SPAs, but did not differ based on MAT process followed (Traditional MAT or MAT-CFT).

Assessment of Mental Health Needs

MAT assessments are conducted by mental health professionals, and their expertise is evident in the MAT SOF documents. Qualitatively, the Mental Health History, Current Symptoms and Behaviors section is the strongest and most consistently thorough section of the MAT SOF document. Most assessments contained clear documentation of the child’s mental health symptoms and needs. This was even more robust for older children and those who were served by the MAT-CFT process, both of which had clear documentation of mental health impacts in over 90% of assessments. There were differences in documentation of mental health symptoms and needs across MAT Agencies, but not DCFS Offices or SPAs.

Strengths-Based Assessment

The MAT process is designed to identify child and family strengths as well as needs, which is especially important for children and families navigating court-ordered detention and reunification. The strengths-based nature of the MAT SOF was noted by Court and DCFS stakeholders in surveys and interviews for this evaluation. They indicated that children and families sometimes open up more to the MAT Assessor than to a CSW, which allows the MAT SOF to provide a more thorough depiction of the family’s circumstances. Concrete and tangible examples of family strengths were documented in less than half of SOFs in the evaluation sample. The DCFS Action Plan asks the team to identify strengths. However, family strengths were most often found in the Family

99 Specific trauma effects documented: 252 of 469 children (53.7%), Generic types of trauma effects documented: 76 of 469 children (16.2%), No documentation of trauma effects: 141 of 469 children (30.1%).
100 6 years or older: 71.6% had specific trauma effects documented, 19 months – 6 years: 52.3%, 0-18 months: 36.9%. \( \chi^2 (d.f.=2) = 40.945, p<0.001. \)
101 Spanish-speaking: 65.5% had specific trauma effects documented, Non-Spanish-speaking: 51.0%. \( \chi^2 (d.f.=1) = 5.968, p=0.015. \)
102 Hispanic: 62.8% had specific trauma effects documented, Not Hispanic: 41.9%. \( \chi^2 (d.f.=1) = 19.988, p<0.001. \)
103 Black: 39.3% had specific trauma effects documented, Not Black: 59.8%. \( \chi^2 (d.f.=1) = 16.515, p<0.001. \)
104 Minimum (of MAT Agencies with at least 5 assessments reviewed): 25.0%; Maximum (of MAT Agencies with at least 5 assessments reviewed): 85.7%.
105 Minimum (of DCFS Offices with at least 5 assessments reviewed): 35.6%; Maximum (of DCFS Offices with at least 5 assessments reviewed): 40.6%.
106 Minimum: 35.8%, Maximum: 70.6%
107 411 of 469 children (87.6%)
108 97.0%, 164 of 169 assessments
109 92.5%, 185 of 200 assessments
110 Minimum (of MAT Agencies with at least 5 assessments reviewed): 44.8%; Maximum (of MAT Agencies with at least 5 assessments reviewed): 100.0%.
Story section of the MAT SOF, which is not included in the SOF template for MAT-CFT cases. Indeed, three-quarters of Traditional MAT assessments (199 of 269 children), which include the Family Story section, documented family strengths. This does not indicate that the MAT-CFT process does not consider family strengths, but likely suggests that for MAT-CFT cases, family strengths are documented outside of the MAT SOF document.

In contrast, nearly all MAT SOFs include a description of the child’s strengths in terms of personal attributes, characteristics, or qualities. 40.3% of SOFs document the child’s strengths in terms of their desires or interests. Desires and aspirations were more likely to be included for older children. In cases where children’s desires or interests were documented, the children almost always had access to their desires and interests.

Only a small percentage of SOFs documented meaningful goals or aspirations held by the child, with almost all of those occurring in SOFs for children 6 years of age or older. Here, it is also important to note a key distinction between the MAT-CFT and Traditional MAT SOF templates that may influence these data. The MAT-CFT template does not include the Interests, Hobbies, and Career Goals section, which is where children’s desires, interests, and aspirations are often documented. However, these items were also found in the Strengths of this Child and Current Developmental Functioning sections of some SOFs and may be found elsewhere in MAT-CFT documentation outside of the SOF.

> CLARITY OF RECOMMENDATIONS

Case workers frequently use the MAT SOF document to make case planning decisions and appreciate the clarity with which the MAT documents recommendations for treatment and service needs. CIBHS evaluated the clarity of recommendations based on the main service types described in the MAT. Nearly all MAT SOFs contained a clear recommendation related to the child’s need (or lack of need) for mental health services. More than half of MAT SOFs also made clear recommendations related to children’s developmental, educational, and physical health service needs. Recommendations related to trauma-specific services were less clear, though many recommendations for trauma-related services could occur under the umbrella of mental health services.

112 199 of 269 children (74.0%)
113 463 of 469 children (98.7%)
114 189 of 469 children (40.3%)
115 6 years or older: 68.6%, 19 months to 6 years: 39.4%, 0-18 months: 12.5%. χ² (d.f.=2) = 110.425, p<0.001.
116 184 of 189 children (97.4%)
117 56 of 469 children (11.9%)
118 46 of 56 children (82.1%)
119 445 of 469 children (94.9%)
120 357 of 469 children (76.1%)
121 294 of 469 children (62.7%)
122 286 of 469 children (61.0%)
123 136 of 469 children (29.0%)
74.2% of MAT SOFs (348 children) documented a referral to mental health services, and referrals to mental health services were documented in the MAT SOF in 95.5% of assessments for which mental health services were recommended (298 of 312 children). Trauma-specific referrals were not tracked, as most trauma-related referrals were characterized as referrals to mental health services.

Documentation of referrals to other types of services were less common. 36.7% of MAT SOFs (172 children) documented a referral to developmental services, with referrals documented in 59.3% of assessments where developmental services were recommended (147 of 248 children). Children’s referrals to educational services were documented in 38.6% of MAT SOFs (181 children) and 55.2% of SOFs where educational services were recommended (101 of 183 children). Referrals to physical health services were documented in 21.3% of MAT SOFs (100 children) and 21.7% of assessments where physical health services were recommended (55 of 253 children). Some SOFs did note that referrals to developmental, educational, or physical health services were being processed by the CSW, so the rate of referral documented in the SOF likely underrepresents the actual rate of referral to these types of services. For instance, DCFS MAT protocol requires the MAT Coordinator to submit a referral to the Regional Center if it is recommended and one has not been submitted by the time of the MAT SOF/CFT meeting. At times, the social worker has already initiated the referral to the Regional Center prior to the MAT SOF/CFT meeting. The extent to which referrals documented in the MAT SOF are integrated into case planning is discussed in detail in the Integration into Case Planning section below.

### Linkage to Treatment

When treatment needs are identified during the MAT assessment, the MAT Coordinator and MAT Assessor work to ensure the child is linked to the appropriate services in a timely manner. While linkage to services is notoriously challenging to track, CIBHS evaluated the extent and timeliness with which children were linked to mental health services.

#### Timeliness of Linkage to MH Treatment

Data on linkage to mental health services is tracked in tracking logs maintained by DMH Service Area staff and can also be assessed using mental health claims data. 88.1% of children for whom mental health services were recommended that completed the MAT process without receiving crisis services were linked to mental health services\(^\text{124}\). CIBHS used the earliest linkage date in either claims or DMH tracking log data to evaluate the timeliness of linkage. Notably, the lack of documented linkage to mental health services in the data available for this evaluation does not necessarily indicate that the child was not linked to services, and the available data for analysis likely underrepresents the number of children linked to services. Submission of mental health treatment claims often occurs months after the services were provided, so some treatment claims may not have been submitted by the time data was extracted for this evaluation. In many cases, children begin receiving services during the MAT process itself. Approximately one-quarter of children who received treatment at the MAT Agency\(^\text{125}\) began receiving treatment services before or during the MAT process for which the MAT was completed.

\(^{124}\) 275 of 312 children (88.1%). 5 of these children were listed as having been linked to services outside of Los Angeles County.

\(^{125}\) 38 of 153 children (24.8%)
process, although this number may be higher due to difficulty distinguishing between MAT claims and treatment claims within the same agency.

Nearly half of children who received treatment at a different agency\(^{126}\) began receiving treatment services before or during the MAT process.

Fewer than half of children\(^ {127}\) received mental health treatment services at the same agency that performed their MAT assessment, while more than half\(^ {128}\) were not treated at the MAT Agency. There is strong evidence that the MAT provider remains engaged in the case following conclusion of the MAT assessment, as Medi-Cal claims were submitted by the MAT provider after the MAT SOF was finalized for more than two-thirds of children who were linked to services\(^ {129}\). Amongst children who began treatment after the MAT process concluded, those who were treated at the MAT agency began receiving services sooner than those treated at another agency\(^ {130}\). However, this data should be interpreted with caution, as it is difficult to determine exactly when treatment began, especially for children served by the MAT agency.

**Integration into Case Planning**

MAT is intended to inform the case planning process, both at DCFS and within the Court system. To evaluate the extent to which MAT is integrated into case planning, CIBHS analyzed the alignment between the referrals recommended in the MAT SOF and the case plans generated by DCFS and the Courts. Analysis of integration into case planning was performed for cases within a 100-case subsample of the evaluation sample. CIBHS received DCFS and Court Case Plans for those 100 children. In most cases, there would be a single DCFS Case Plan for the child and parents, with updated Case Plans as appropriate. In contrast, most cases had a separate Court Case Plan for the mother and father, each of which also contained recommendations for services for the child.

<table>
<thead>
<tr>
<th>Contains Child's Case Information</th>
<th>MAT SOF</th>
<th>DCFS CASE PLAN</th>
<th>MOTHER'S COURT CASE PLAN</th>
<th>FATHER'S COURT CASE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contains Mother's Case Information</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Contains Father's Case Information</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

126 91 of 200 children (45.5%)
127 153 of 353 children (43.3%)
128 200 of 353 children (56.7%)
129 236 of 353 children (66.9%)
130 Treated at MAT Agency: 24.7 days, Not Treated at MAT Agency: 33.2 days. ANOVA: F (1,222) = 6.824, p=0.010.
The majority of DCFS Case Plans contained recommendations (referred to as service objectives) for both the child and their parents. In contrast, where most Court Case Plans ordered referrals to programs for parents, fewer than two-thirds of children were referred to programs in either of their parents’ Court Case Plans. CIBHS noted that Case Plans tended to contain more detailed recommendations for the parents while the MAT SOF was heavily focused on the child. Case Plans also tended to focus more on monitoring and compliance, whereas the MAT SOF recommended more services, resources, and supports. In some respects, this is a necessary feature of case administration by both DCFS and the Courts, but there is an opportunity to continue to build the strengths-focused aspects of the MAT process into case planning.

**REVISITING THE TIMELINESS OF MAT SOF FOR CASE PLANNING**

In order to be incorporated into case planning, MAT SOFs need to be provided to CSWs and the Courts in a timely manner. First, CIBHS reviewed the extent to which MAT SOFs were completed prior to developing Court Case Plans. For most cases, CIBHS received distinct Court Case Plans for both the mother and father. CIBHS was able to identify a Court Case Plan date for 91 mothers and 68 fathers. The MAT SOF was finalized on or prior to the Court Case Plan date for approximately two-thirds of both mothers and fathers. Only 36 mothers and 26 fathers had both the Court Case Plan date and the date the MAT SOF was submitted to the Courts. Of those, the MAT SOF was submitted to the Courts on or prior to the Court Case Plan date for just over half of mothers and fathers.

**ALIGNMENT BETWEEN MAT SOF RECOMMENDATIONS AND CASE PLAN REQUIREMENTS**

For each case within the Case Planning Subsample, CIBHS reviewed the alignment between the recommendations made in the MAT SOF and the action steps and requirements in the associated DCFS and Court Case Plans. Alignment was categorized into three main groups:

- **Fully Aligned:** Case Plan contains service objectives (DCFS Case Plans) or referrals (Court Case Plans) to the same types of programs recommended by the MAT Assessor. Case Plan does not contain additional requirements not recommended in the MAT SOF.
- **Partially Aligned:** Case Plan contains some service objectives or referrals to the same types of programs recommended by the MAT Assessor, but either lacks service objectives or referrals that were recommended in the MAT or contains additional requirements not recommended in the MAT SOF.
- **Not Aligned:** Service objectives or referrals in the Case Plan differ from those recommended in the MAT SOF.

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131 81 of 100 DCFS Case Plans (81.0%) contained child service objectives. 78 of 100 DCFS Case Plans (78.0%) contained service objectives for the child’s mother. 48 of 100 DCFS Case Plans (48.0%) contained service objectives for the child’s father.
132 85 of 93 Mother’s Court Case Plans (91.4%) ordered referrals to programs for parents. 49 of 69 Father’s Court Case Plans (71.0%) ordered referrals to programs for parents.
133 64 of 99 children (64.6%).
134 DCFS Case Plan documents do not contain an effective date, therefore CIBHS was not able to assess timeliness of completing the MAT SOF relative to completing the DCFS Case Plan.
135 MAT SOF completed before Mother’s Court Case Plan: 63 of 91 cases (69.2%), average 45.2 days before Mother’s Court Case Plan. MAT SOF completed after Mother’s Court Case Plan: 28 of 91 cases (30.8%), average 16.1 days after the Mother’s Court Case Plan.
136 MAT SOF completed before Father’s Court Case Plan: 46 of 68 cases (67.6%), average 44.8 days before the Father’s Court Case Plan. MAT SOF completed after Father’s Court Case Plan: 22 of 68 cases (32.4%), average 17.3 days after the Father’s Court Case Plan.
137 MAT SOF submitted to Courts on or before Mother’s Court Case Plan: 20 of 36 cases (55.6%), average 43.5 days before Mother’s Court Case Plan. MAT SOF submitted to Courts after Mother’s Court Case Plan: 16 of 36 cases (44.4%), average 69.4 days after the Mother’s Court Case Plan.
138 MAT SOF submitted to Courts on or before Father’s Court Case Plan: 14 of 26 cases (53.8%), average 45.6 days before Father’s Court Case Plan. MAT SOF submitted to Courts after Father’s Court Case Plan: 12 of 26 cases (46.2%), average 85.3 days after the Father’s Court Case Plan.
Alignment Between MAT SOF and Children’s Case Plans

CIBHS was able to review alignment between the MAT SOF and DCFS and Court Case Plans for 89 children in the Case Planning Subsample. Case Plans were only fully aligned with the MAT SOF for a small number of cases, with approximately one-third of Case Plans either partially or fully aligning with the MAT SOF.

This lack of alignment is, in most part, due to a lack of relevant service objectives or referrals for children in the Case Plan documents. Moreover, only a small number of Case Plans contained service objectives or referrals that were not recommended in the MAT SOF. DCFS case workers and the Courts may be less likely to "require" services for children than for parents, but this could also result in challenges with tracking whether children have been linked to the appropriate resources during the case planning process. Importantly, linkage to services at DCFS and DMH is not dependent on a court order, and case workers connect children to appropriate services when a need is identified regardless of whether those services are explicitly required by a case plan.

Future evaluations may also find greater alignment of service needs and case plans at the 6-month court review, as it is important for the court to monitor that children’s needs are met on an ongoing basis.

Interestingly, CIBHS did not find a relationship between the timeliness of finalizing the MAT SOF or submitting it to the Courts, and the alignment between the MAT SOF and the Court Case Plans. However, further investigation is needed into the timeliness of MAT and how it affects integration of the MAT SOF into case planning, given the limited amount of data available to assess these factors.

139 12 of 89 (13.5%) DCFS Case Plans were fully aligned with the MAT SOF recommendations for children. 12 of 89 (13.5%) of Court Case Plans were fully aligned with the MAT SOF recommendations for children.
140 23 of 89 (25.8%) DCFS Case Plans were partially aligned with the MAT SOF recommendations for children. 17 of 89 (19.1%) of Court Case Plans were partially aligned with the MAT SOF recommendations for children.
141 1 of 89 (1.1%) DCFS Case Plans and 1 of 89 (1.1%) Court Case Plans contain all MAT SOF recommendations for children, as well as additional recommendations that were not included. 4 of 89 (4.5%) DCFS Case Plans and 1 of 89 (1.1%) Court Case Plans contain different recommendations than those in the MAT SOF.
Alignment Between MAT SOF and Parents’ Case Plans

CIBHS was able to review alignment between the MAT SOF and DCFS and Court Case Plans for 27 mothers and 16 fathers in the Case Planning Subsample\(^\text{142}\). Approximately one-third of DCFS and Court Case Plans were fully aligned with the recommendations in the MAT SOF for both the biological mother\(^\text{143}\) and father\(^\text{144}\), with nearly three-quarters of Case Plans either partially or fully aligning with the MAT SOF\(^\text{145}\).

Unlike with children, the lack of alignment between the SOF and parents’ Case Plans often derives from the addition of requirements in the Case Plan that were not recommended in the MAT SOF. This could be due to a lack of relevant recommendations in the SOF document, which focuses more on the child’s strengths and needs, or because of increased attention to monitoring and compliance in the Case Plans.

\[\text{142 MAT SOFs for 68 mothers and 79 fathers in the Case Planning Subsample did not contain referral information for the mother/father.}\]
\[\text{143 8 of 27 (29.6%) DCFS Case Plans were fully aligned with the MAT SOF recommendations for mothers. 9 of 27 (33.3%) of Court Case Plans were fully aligned with the MAT SOF recommendations for mothers.}\]
\[\text{144 5 of 16 (31.3%) DCFS Case Plans were fully aligned with the MAT SOF recommendations for fathers. 5 of 16 (31.3%) of Court Case Plans were fully aligned with the MAT SOF recommendations for fathers.}\]
\[\text{145 11 of 27 (40.7%) DCFS Case Plans were partially aligned with the MAT SOF recommendations for mothers. 11 of 27 (40.7%) of Court Case Plans were partially aligned with the MAT SOF recommendations for mothers. 6 of 16 (37.5%) of DCFS Case Plans were partially aligned with the MAT SOF recommendations for fathers. 7 of 16 (43.8%) of Court Case Plans were partially aligned with the MAT SOF recommendations for fathers.}\]
QUALITATIVE FEEDBACK FROM DCFS CASE WORKERS AND COURT OFFICIALS

In qualitative feedback for this evaluation, CSWs and DIs did indicate that they used the MAT SOF to make case planning decisions when it is available, especially the Child Needs and Child Referrals sections. They felt the SOF was also helpful in understanding the case background and family story, as children and families may open up to the MAT Assessor about things they do not feel comfortable sharing with DCFS case workers. CSWs and DIs also appreciated the opportunity to work alongside the MAT Assessor during the case planning process, but some felt that was happening less frequently for recent cases. This may be related to challenges working collaboratively in a remote context during the COVID-19 pandemic, but is worthwhile to consider in trying to maximize integration of the MAT into case planning processes.

Bench officers also indicated that they used the MAT SOF to make dispositional decisions when it is available, but that the report is often not available on time or included as an attachment to the social worker’s report. Many courtrooms set a “receipt of report” date for the jurisdiction/disposition report, and attaching the MAT SOF report to that report and submitted on the same day could help ensure MAT SOFs are available to court officers in time to review. However, this would likely require adjusting contractual timeframes and expectations for the MAT assessment, as current agreements allow the MAT agencies 45 days to complete the MAT assessment from the day they accept the case. Bench officers felt the recommendations section of the MAT SOF was useful, but that the reports would be more beneficial if they were shorter and more case-specific. As discussed in the Quality of the MAT SOF section, bench officers noted that recommendations in the MAT SOF are less effective when identical recommendations appear for multiple children or language appears non-specific or boilerplate. Minors’ and parents’ attorneys found the MAT SOFs less helpful for themselves and their clients, although they did indicate that the strengths focus, recommendations, and description of parent-child interactions were useful in their roles. Parents’ attorneys recommended increasing the information in the SOF to help the biological parents and focus on reunification, to help tailor case plans and substantiate or refute the allegations against the parents.
CIBHS has prepared a set of recommendations for Los Angeles County for ways to improve the MAT process. However, the MAT process, like most human services systems, functions within resource constraints that can impact the ability to implement these recommendations. To help Los Angeles County identify appropriate next steps and prioritize opportunities for improvements, CIBHS has stratified these recommendations into three categories:

- **Good**: Ways to generate improvement in MAT processes without significant investment of time or financial resources.
- **Better**: Building on the strategies listed under good, these are ways to generate additional improvement or make improvement more efficient or sustainable. They may require more substantial investment of upfront resources and take longer to achieve.
- **Best**: These strategies reflect current best practice for processes like MAT. They may require long-term investment of resources or take a significant amount of time to implement.

### Improvements to Data Collection and Information Sharing

Data for this evaluation was culled from four distinct data systems or tracking logs, as well as four different types of documents. Many elements were tracked in multiple places and did not always align across data sources. This presents challenges to clearly understanding the efficiency and efficacy of the MAT process and creates an unnecessary workload burden for the individuals tasked with administering the process. The following recommendations can result in improvements to the way data is collected and information is shared amongst MAT stakeholders.

#### TRACKING OF DATES ACROSS SYSTEMS

The MAT process would benefit from establishing a single system of record which serves to track progress towards completing MAT process milestones. The ideal system would need to comply with state and federal confidentiality laws, include access controls to maintain confidentiality and ensure that appropriate individuals can view and edit the necessary information. Federal regulations controlling CWS/CMS would also need to be considered in the system design. Use of a single system will encourage use of consistent definitions for each MAT process milestone and potentially facilitate automated date tracking across systems and documents. However, creation of a comprehensive data tracking system would require extensive financial investment, as well as collaboration and shared decision-making across multiple County departments and contracted provider agencies to ensure the system meets everyone’s needs and does not become an additional, redundant system for workers to use and access. If the County did choose to pursue development of a shared data system, it is reasonable to expect development of that system to take multiple years prior to implementation across the County. In the interim or in place of developing a data system, the County should work to collaboratively define the data that should be collected for MAT, as well as where to store that data and who is responsible for maintaining it. More proactive data collection and sharing can minimize significant administrative burden and facilitate more consistent evaluation of MAT processes.
ACCESS TO COMPLETED ASSESSMENTS/REPORTS

The MAT process and other associated front-end processes generate several documents, completed assessments, and reports that can benefit other service providers involved in the child and family’s case. However, service providers do not always know that these documents exist or how to access them, which can result in redundant assessment or requests for information from the child and family or other service providers. As with date tracking, the MAT process would benefit from creation and active management of a system for storing and retrieving all related case documents, and the system would need to comply with all applicable confidentiality laws. A shared IT system would be especially beneficial in circumstances where the same tool is recommended or required for multiple processes or organizations, like the ASQ-3 and CANS. While it is always important for clinicians to review assessment results and exercise clinical judgement to determine whether the results remain applicable to the child they are serving, having quick and easy access to detailed screening and assessment results will decrease the likelihood that a child is assessed using the same tool multiple times. A shared system can also result in decreased requests for information, improved timeliness of information sharing, and increased information security due to fewer information transfers. If linked with a date tracking system, this system could also facilitate automated import of key case information to decrease the administrative burden for service providers. Again, implementation of such a system would take a long time and require significant resources and cross-agency collaboration.

The County can improve staff and providers’ access to information through enhanced use of the data systems already in place, as well as improved documentation of which systems contain which documents and who is responsible for managing them.
Both research and first-person reports continue to document disparities in the quality of care and individual outcomes across human services systems. To continue improving these disparities, it is important to collect standardized and usable data on race, ethnicity, and language, as well as gender and sexual orientation. Lack of standardized data categories can serve as a barrier to collecting and utilizing data in an impactful manner to identify gaps and improve care. Additionally, combining racial and ethnic categories can disguise variations in disparities within each ethnic group. Currently, race, ethnicity, and language data is collected, but the categories used differ across data systems and it is difficult to confidently analyze data to identify disparities. Gender is captured consistently but did not include data on children or youth who may identify as non-binary (i.e., neither male nor female). Establishing consistent data collection strategies can increase the County’s ability to understand and address disparities in the MAT process and improve its overall equity. These efforts are often complicated by state-level data collection requirements, which may differ across regulatory agencies and change on short notice. State requirements also may not fully reflect the diversity of the population in LA County or capture the information needed to use data effectively to promote equity at the local level. To improve the County’s ability to use demographic data, it first needs to establish consistent priorities and data collection standards across departments and provider agencies, and crosswalk those priorities and standards to existing state-level regulations and system requirements. To the extent possible, the priorities should be community-informed, allowing the community to dictate both the language to define their racial, ethnic, and gender identities and how the County reports that to the State.

Additional best practices for capturing demographic data and using it to inform case planning include:

- Ensuring children, youth, and families can decline sharing demographic information if they do not feel comfortable doing so. This can be accomplished by:
  - Allowing the child, youth, and family to self-identify all demographic information. Providers and administrators should not make assumptions or decisions about race, ethnicity, language, gender, or sexual orientation.
  - Include “decline to ask” as an option for cases where providers are unable to ask for demographic information, or where certain demographic information is not appropriate to the individual (such as information on sexual orientation in young children).
  - Though CWS/CMS includes the category “Unable to Determine” for ethnicity data, this phrasing is not ideal. CIBHS encourages the County to use “decline to state,” “decline to ask,” or “unknown” for internal and client-facing data collection purposes to retain focus on client self-identification.
  - Including “decline to state” or “decline to answer” options for all demographic data being collected.
  - Explaining how the County uses demographic data, as well as how confidentiality is protected, when asking people to disclose this information.
- Asking children and youth about their preferences regarding gender, cultural identity, and sexuality in their services.
  - Would they prefer a provider of the same gender, race, or ethnicity?
  - Would they prefer a provider who can provide services in a non-English language?
  - Would they prefer to be served by a trans-affirmative service organization?
- Creating and maintaining a referral and resource guide to help providers match children with stated gender, cultural, or sexual orientation-related service needs to appropriate service providers. This referral and resource guide should include:
  - Information on the service provider’s ability to match children to providers of their gender, race/ethnicity, and language preference.
  - Information on the service provider’s experience working with trans, non-binary, or questioning youth.
  - Information on traditional healing practices or community defined practices used by communities in LA County, as well as service providers who employ these practices.
- Providing training and ongoing supervision to ensure all professionals administering parts of the MAT assessment can do so in a trauma-informed, culturally appropriate manner. Potential training topics include:
  - Cultural humility.
  - Implicit bias.
  - Working with individuals who identify as mixed race.
• Being trans-affirmative and other LGBTQ allyship.
• Overall diversity and inclusion.

Further resources related to capturing and analyzing race, ethnicity, and language data are available in Appendix F.

Current State
- Race and ethnicity are captured in multiple places, often with different information across systems
- Needs related to culture, gender, and sexual orientation are rarely captured in the MAT SOF.

Good
- Convene DCFS and DMH staff to identify race, ethnicity, and gender standards to be used for MAT cases
- Incorporate prompts regarding Culture, Gender, and Sexual Orientation needs in the MAT SOF
- Provide diversity and inclusion training across professionals administering MAT

Better
- Implement standard procedures tracing LA County data to the Federal Office of Management and Budget standards or other State-level standard
- Develop and implement a referral and resource guide with information on providers’ capacity related to culture, gender, and sexual identity

Best
- Conduct a community-driven process to identify standardized race and ethnicity groups that are meaningful to the population served by MAT, crosswalked to federal or state standards
- Regularly maintain the referral and resource guide, including information on traditional healing or community defined practices

Improvements to SOF Form and Content

The MAT SOF documents the findings from a comprehensive assessment of a child and family’s strengths and needs. Creating a single document that effectively communicates the details of complicated cases to a variety of audiences is exceptionally challenging. The following recommendations can result in improvements to the way information is captured within the SOF document that make it more effective in documenting findings and communicating the next steps for a child and family’s case.

STRUCTURE OF SOF FORM

Three key findings stood out related to the structure of the MAT SOF form:
• Documentation of the child and family’s trauma within the MAT SOF was often repetitive and heavily focused on describing the trauma itself;
• The Child Needs section, which was identified by both DCFS case workers and court stakeholders as most useful for case planning, falls toward the end of the report, often after more than 10 pages of assessment details; and
• The MAT SOF could provide additional documentation related to the family structure, informal supports, and the strengths and needs of the biological parents.

Making some structural changes and additions to the SOF form may encourage more consistent documentation related to these factors.
QUALITY OF CLINICAL DOCUMENTATION AND PRACTICES

The overall quality of MAT assessments, as documented in the MAT SOF, is high, but the consistency of assessments can increase through targeted training and engagement efforts. This is especially relevant to documentation and assessment of trauma in younger children, engagement of fathers and Black children and youth, and eliciting information related to children’s and families’ cultural identities, goals, and aspirations.

All professionals involved in administering the MAT could benefit from trainings in trauma- and healing-informed care, as well as trainings that emphasize cultural humility and incorporation of transparency, collaboration, and client choice into the assessment process as much as possible. Both DMH and DCFS staff and contractors already receive mandatory training on providing trauma-responsive services. However, trainings alone are insufficient to fully support use of trauma- and healing-informed approaches throughout the MAT process. The County and provider agencies can also implement field mentoring, wherein a supervisor periodically observes front-line workers’ interactions with children and families and reviews the resulting MAT SOF documents. This allows the supervisor to fully evaluate the quality of the process that produces the assessment, rather than just the MAT SOF itself. Many agencies may already have these kinds of supervisory procedures in place for the MAT assessment and other services they provide.

Selection of the specific tools to be used within the MAT Assessment is delegated to individual providers and clinicians. Creating detailed requirements for mental health screening and assessment tool use is not recommended due to the importance of clinical judgement in case planning and the potential for significant administrative and financial burden. However, reviewing the landscape of validated tools for assessing key functional and clinical domains in the target population, and recommending the most appropriate tools for use in LA could streamline the front-end assessment process by creating consistent expectations across providers and decreasing use of multiple tools to assess similar concepts. This is particularly important as it pertains to assessing trauma, which is currently inconsistent and occasionally perceived as inadequate in the MAT SOF report. Implementation of more consistent trauma screenings and improved language on treatment may be partially accomplished by using a validated tool such as the Pediatric ACEs Screening and Related Life-events Screener (PEARLS).

CANS implementation also provides an opportunity to enhance the quality of the MAT assessment. Since the scope of CANS and MAT are so similar, having CANS completed by all MAT Assessors, regardless of the child’s age and medical necessity of behavioral health services, can both minimize potential redundancy of assessment and specifically prompt the MAT Assessor to evaluate all of the specific elements required by the CANS assessment. Implementation of this policy would, however, require
consideration of the training necessary to administer the CANS, as well as the administrative burden of capturing additional data and sharing that data to DMH and DCFS to meet state requirements. There may also be financial and contractual implications related to Medi-Cal billing and already negotiated agreements with contracted provider agencies. The County is already engaged in significant discussion and decision-making about CANS implementation, which should consider the impact of CANS on the MAT process.

Similarly, the PSC-35 tool is a validated, underutilized tool that was designed to capture cognitive, emotional, and behavioral problems, so that appropriate interventions can be initiated as early as possible. Results from this tool are entered in the appropriate data systems, but do not appear to be used by DMH or DCFS despite the tool’s demonstrated ability to identify substantive behavioral problems. Establishing clear guidelines for MAT Assessors and DCFS/DMH staff to help integrate both CANS and PSC-35 into the MAT SOF and case planning can decrease the instances wherein duplicative assessment processes are used to capture required information, as well as improve the quality of the assessments themselves.

Lastly, as discussed in the previous section, incorporation of a referral and resource guide inclusive of culturally- or community-defined practices can support increased collaboration with the child and family to include their voice and choice into the process of both assessment and referral as much as possible. Increasing collaboration and engagement with the child and family can also be helpful for ongoing assessment, especially since children involved in the MAT process may be at high risk for future service needs, even if those needs do not present at the time of the MAT assessment. As part of the MAT process, the CSW and MAT Assessor should make sure children's caregivers and biological parents know the signs indicating the child may benefit from services. The County could also consider implementing dedicated check-ins after the MAT process is completed for children who were not referred to services or flagging cases with higher risk for ongoing reviews.

Improvements to Care Coordination and Case Planning

Prior to detention and throughout the front-end assessment process, children and families have multiple points of contact with the Courts, DCFS, and DMH. Each of these points of contact play an important role in case planning and administration but can appear duplicative to children and families. At minimum, children and families referred to MAT will be asked to tell all or part of their story three times: first as part of the decision to detain the child, second as part of the DCFS mental health screen, and third as part of the detailed MAT assessment. Youth and families also tell their story to the DI as part of the jurisdiction/disposition of the case, and to their CLC attorney when they meet at the detention hearing. Each of these steps represent a distinct part of the process and accomplish different and progressive levels of understanding of the child and family’s strengths and needs.
Many children and families may have significantly more than three points of contact, depending on their specific circumstances, the timing of their case, and the level of coordination across DCFS, DMH, and DMH-Contracted Providers. Some specific scenarios that may result in additional points of contact are:

- Children whose MHST results in pre-acute or pre-urgent are referred to DMH SFC for triage. For children with acute or urgent mental health needs, this is a critical step in receiving timely mental health services. However, children whose mental health needs are determined to be routine will then be referred to a more comprehensive assessment, such as MAT. This multi-step screening, triage, and assessment may be viewed as duplicative by the child and family.
- In cases where DCFS and/or DMH staff are unable to verify whether a child is or has already been seen by another part of the system of care (i.e., if Hub staff cannot verify that the case has been referred to MAT or intensive mental health services) or whether assessments have already been conducted, the child may be assessed multiple times. For instance, the ASQ-3 may be administered as part of MAT and during the IME, or CANS may be completed by both the MAT Assessor and DCFS staff or a DMH-Contracted Provider.
- Children and youth with identified developmental or educational needs are often referred to the Regional Center or education system for further assessment. While this is critical to ensuring the child or youth receives the appropriate services, it may be viewed as duplicative by the child and family.

Some of these scenarios can be minimized through improvements to data collection and information sharing during the MAT process. However, as with any process involving multiple agencies and individual service providers, MAT requires extensive coordination amongst professionals to be successful. This is especially true for case activities that occur after the MAT is completed, such as linkage to services and case planning through both DCFS and the Courts. The following recommendations can result in improvements to the way service providers engage with one another to ensure the best experience for children and their families.

**SOF MEETING**

The MAT truly is a multi-disciplinary process that engages professionals from multiple agencies to inform the final MAT SOF. As a result, many different professionals may be involved in the MAT assessment and attend the MAT SOF meeting. By design, the MAT heavily weights the mental health aspects of the assessment, but often includes less information on education and other services. Ideally, there should be a balance between engagement of professionals and inadvertently overwhelming the child and family with the presence of numerous County and provider staff, which can reinforce a perceived imbalance of power between the family and DCFS/the Courts. This balance can improve if the MAT Assessor more proactively engages educational supports and those from foster family agencies in the assessment itself, while minimizing the number of professionals present during the MAT SOF meeting.

| Current State | DCFS case workers are highly involved in the MAT assessment and multiple case workers often attend the MAT SOF meeting |
| Good | Actively coordinate with DCFS CSWs and DIs throughout the MAT process |
| Better | Consistently engage a child’s professional supports beyond DCFS (like therapists and teachers) in the MAT process |
| Best | Limit number of professionals in MAT SOF meeting when compared to child and family participants |
| | Ensure child and family know and feel comfortable with the professionals engaged in their case |
ENGAGEMENT WITH CSWS, DIS, AND COURT OFFICERS

While the MAT assessment is very thorough and provides a tremendous amount of information related to the child and family’s case, MAT findings are not always incorporated into case planning due to lack of engagement with CSWs, DIs, and Court Officers. Enhancing engagement while maintaining timeliness can be challenging, but enhanced communication between service providers and case workers often results in greater efficiency for the process and greater coordination of care for the child and family. Ideally, the MAT timeline should align with, and adjust to, the Court timeline for each case, while also adhering to a timeliness standard for completing the assessment in cases where Court timelines are delayed. It is crucial that CSWs, DIs, and Court Officers receive the MAT SOF document prior to the Disposition Hearing and with enough time to review the document and incorporate its recommendations into their case plans. This means the MAT SOF should be submitted to DCFS and the Courts at least 3-5 days prior to the Disposition Hearing, even if that requires completing the assessment in fewer than 45 days.

Implementing this type of requirement can be exceptionally challenging in systems as large as LA’s. To be successful, the County will need to develop procedures for sharing Court timelines across departments and service providers, as well as renegotiate contractual standards with MAT provider agencies. Changes to Court timelines can have disproportionate effects on MAT providers’ ability to manage their case load, which could result in decreased assessment quality or the need to hire additional staff to meet workload demands. However, without making these changes, the County risks investing significant time and resources into the MAT assessment without actually using the MAT to inform case planning decisions.

REFERRAL TRACKING

Tracking referrals is one of the most complicated and essential elements of effective case management. While there are mechanisms in place to track referrals to mental health services resulting from the MAT, tracking of other referrals (such as referrals to Regional Centers or educational services) is less clear. Effective referral tracking involves monitoring the referral to completion in a system that can be accessed by both the referring and referred to organizations. While implementation of a single referral tracking system is likely challenging in a County as expansive as Los Angeles, children and families would benefit from enhanced tracking amongst County and contracted-provider staff. The County is currently working towards developing such a system, which would significantly benefit children and families served by the MAT process.
Opportunities for Additional Research and Evaluation

Some elements of this evaluation, mostly related to linkage to treatment and integration into case planning, would benefit from additional research and evaluation. Those elements include:

- Increased understanding of potential redundancies in mental health and developmental screening and assessment between MAT and the mental health screenings/triage/assessments completed at the Hubs;
- Clarifying actual time spent administering the MAT assessment and whether assessment claims from treatment agencies reflect redundant assessments;
- Investigating the completion of referrals to non-mental health services, such as Regional Center or educational services;
- Improved understanding of when and how Court stakeholders, and especially bench officers, use the MAT and how contractual MAT timelines align with Court timelines; and
- Identifying how involvement of different types of case workers (such as DIs, mental health treatment providers, and teachers) in the MAT process can influence the MAT assessment and case planning.

Moreover, while this evaluation focused on understanding MAT processes and the factors that influence them, many stakeholders CIBHS interviewed during the evaluation planning process expressed greater interest in understanding short- and long-term outcomes for children who receive a MAT assessment. Indeed, investigating placement and service outcomes is crucial to documenting the value of the MAT process, and LA could benefit from internal and independent evaluation of MAT outcomes. CIBHS recommends that LA undertake a similar evaluation planning process with the stakeholders involved in this evaluation, as well as children and families involved in the MAT process, to identify three key items:

- Which outcomes stakeholders find most valuable in evaluating the MAT process;
- What data is available to investigate those outcomes; and
- Which outcomes are best evaluated and tracked by LA County or provider staff, and which would benefit from investigation from an independent evaluator.
Conclusions

Overall, CIBHS’ evaluation of the MAT process in Los Angeles County indicates that the MAT provides a high quality multi-disciplinary assessment of children and families’ strengths and needs. There is strong evidence that MAT complies with procedural timelines, though there is room for improvement in making sure that downstream users of the MAT SOF have access to the SOF with sufficient time to use it for dispositional, case planning, and treatment decisions. While some redundancy is expected due to state and local requirements, as well as clinical best practice, the MAT can improve by bolstering data collection procedures and minimizing redundancies in both administrative and assessment processes. DCFS case workers, Court officials, and mental health treatment providers felt the MAT had value and helped them in different aspects of working with newly detained children, and all parties were invested in optimizing the MAT process to benefit the children and families they serve.
Appendix A.
Map of Front-End Points of Contact
Mental Health Triages, Screenings, & Assessments for Foster Youth – Front-End Process Mapping

Court Process

1. Detention hearing held at Children’s Court within 72 hours of physical detention of child; Judge orders MAT mental health assessment.

2. Jurisdictional hearing is held 15 days after detention hearing for detained youth, or 30 days for youth in home of parent.

3. Dependency Investigator works on Disposition report. May coordinate with MAT providers to integrate mental health assessment findings.

4. Dispositional hearing is held 10 days after jurisdictional hearing for detained youth, or 30 days for youth in home of parent.

5. Refer youth to CSAT team to assess their mental health acuity; see Track 2: newly opened in home of parent (Page 5).

6. 6 month hearing is held.

* Court may order additional mental health assessment at any point.
Mental Health Triages, Screenings, & Assessments for Foster Youth – Front-End Process Mapping

Mental Health at the Medical Hubs

DCFS submits a referral to a Medical Hub for a Forensic or Initial Medical Exam

1

DMH checks in its IBHIS system for whether the youth has an open DMH case and/or has been assessed in the last 30 days

2

Does the child have an open DMH case and/or been assessed in the last 30 days?

Yes

Co-located DMH staff at Hub continues to monitor/follow-up until case is successfully linked

No

Co-located DMH staff at Hub completes a same day mental health screening and/or same day crisis evaluation/stabilization

3

If needed, co-located DMH staff provides same-day referral/linkage to mental health services

4

Co-located DMH staff sends referral/linkage information to the CSW via 56 I(c) in E-mHub

5

End

Co-located DMH staff at Hub continues to monitor/follow-up until case is successfully linked

6

End

30 days

Does the child have an open DMH case and/or been assessed in the last 30 days?

Yes

End

No

Co-located DMH staff coordinates same-day follow-up with mental health provider or CSAT team, if necessary

7

End

Appendix A. continued
1. CSAT team at the regional office reviews the MHST referral for newly detained children/youth in out-of-home care and determines if the youth qualifies for Track 1.

2. What is the acuity of mental health needs based on MHST?

3. Refer youth to PMRT or SFC for triage.

4. Refer youth to MAT provider within 10 days of detention.

5. Pre-Urgent/Pre-Acute, is youth-downgraded or remains at urgent/acute?

6. Further evaluation of clinical need by Specialized Foster Care (SFC) with CSAT and CSW and how to proceed with MAT.

7. Does the youth require PMRT?

8. Follow PMRT protocol, including mental health linkage as needed.

9. SFC completes Assessment and/or linkage to Mental Health Provider for immediate treatment.

10. Is the MAT completed before or after dispositional hearing?

11. DI CSW reviews & incorporates recommendations from Summary of Findings into Case Plan.

12. End
Mental Health Triages, Screenings, & Assessments for Foster Youth – Front-End Process Map
Mental Health at the Regional Offices – Track 2 & 3 (Newly Detained Home of Parent Youth/Children and Youth/Children with Existing Cases)

DCFS CSAT Role

1. Youth either has a newly opened case and is in home of parent (Track 2) OR has an existing case with a new referral (Track 3)

2. What is the acuity of mental health needs based on MHST?

3. DMH SFC

4. Follow PMRT protocol, including mental health linkage as needed

5. Co-located SFC staff at regional office triage the acuity of mental health needs and identifies appropriate level of care (routine, urgent, acute)

6. Co-located SFC staff at regional office triage the acuity of mental health needs and identifies appropriate level of care (routine, urgent, acute)

7. SFC staff completes mental health assessment

8. DMH sends clinical feedback form to the CSW

9. CSW documents information in case notes and sends to court for the dispositional hearing (see page 2, #9) or to walk on to court

10. End

DMH SFC

1. Refer youth to PMRT or SFC for triage

4. Submits MHST and support documentation to SFC

5. Co-located SFC staff at regional office triage the acuity of mental health needs and identifies appropriate level of care (routine, urgent, acute)

6. Co-located SFC staff at regional office triage the acuity of mental health needs and identifies appropriate level of care (routine, urgent, acute)

7. SFC staff completes mental health assessment

8. DMH sends clinical feedback form to the CSW

9. CSW documents information in case notes and sends to court for the dispositional hearing (see page 2, #9) or to walk on to court

10. End

DCFS CSW

1. Youth either has a newly opened case and is in home of parent (Track 2) OR has an existing case with a new referral (Track 3)

2. What is the acuity of mental health needs based on MHST?

3. youth need further evaluation?

4. Follow PMRT protocol, including mental health linkage as needed

5. Co-located SFC staff at regional office triage the acuity of mental health needs and identifies appropriate level of care (routine, urgent, acute)

6. Does youth meet medical necessity

7. SFC staff completes mental health assessment

8. DMH sends clinical feedback form to the CSW

9. CSW documents information in case notes and sends to court for the dispositional hearing (see page 2, #9) or to walk on to court

10. End
## Appendix B.

### Evaluation Sample Details

#### MAT Agency

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<tr>
<th>AGENCY</th>
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<th>IN CASE PLANNING SUBSAMPLE</th>
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## DCFS Office

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<td>Lancaster</td>
<td>65 children, 41 cases</td>
<td>59 children, 37 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td>Metro North</td>
<td>34 children, 24 cases</td>
<td>17 children, 12 cases</td>
<td>3 children, 3 cases</td>
</tr>
<tr>
<td>Palmdale</td>
<td>21 children, 13 cases</td>
<td>20 children, 12 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td>Pasadena</td>
<td>35 children, 24 cases</td>
<td>33 children, 22 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td>Pomona</td>
<td>14 children, 10 cases</td>
<td>13 children, 9 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td>Santa Clarita</td>
<td>21 children, 14 cases</td>
<td>16 children, 13 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td>Santa Fe Springs</td>
<td>35 children, 25 cases</td>
<td>34 children, 24 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td>South County</td>
<td>44 children, 33 cases</td>
<td>42 children, 32 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td>Torrance</td>
<td>36 children, 23 cases</td>
<td>25 children, 14 cases</td>
<td>7 children, 7 cases</td>
</tr>
<tr>
<td>Van Nuys</td>
<td>41 children, 28 cases</td>
<td>30 children, 21 cases</td>
<td>6 children, 6 cases</td>
</tr>
<tr>
<td>Vermont Corridor</td>
<td>47 children, 27 cases</td>
<td>33 children, 20 cases</td>
<td>6 children, 6 cases</td>
</tr>
<tr>
<td>Wateridge</td>
<td>28 children, 18 cases</td>
<td>15 children, 11 cases</td>
<td>4 children, 4 cases</td>
</tr>
<tr>
<td>West LA</td>
<td>20 children, 18 cases</td>
<td>17 children, 15 cases</td>
<td>6 children, 6 cases</td>
</tr>
<tr>
<td>West San Fernando Valley</td>
<td>23 children, 19 cases</td>
<td>17 children, 14 cases</td>
<td>5 children, 5 cases</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>599 children, 406 cases</strong></td>
<td><strong>469 children, 323 cases</strong></td>
<td><strong>100 children, 99 cases</strong></td>
</tr>
</tbody>
</table>
## DCFS SPA

<table>
<thead>
<tr>
<th>SPA</th>
<th>IN TOTAL EVALUATION SAMPLE</th>
<th>IN QUALITY SUBSAMPLE</th>
<th>IN CASE PLANNING SUBSAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>87 children, 54 cases</td>
<td>81 children, 50 cases</td>
<td>10 children, 10 cases</td>
</tr>
<tr>
<td>2</td>
<td>90 children, 65 cases</td>
<td>68 children, 52 cases</td>
<td>17 children, 17 cases</td>
</tr>
<tr>
<td>3</td>
<td>79 children, 51 cases</td>
<td>57 children, 39 cases</td>
<td>17 children, 17 cases</td>
</tr>
<tr>
<td>4</td>
<td>39 children, 28 cases</td>
<td>21 children, 15 cases</td>
<td>4 children, 4 cases</td>
</tr>
<tr>
<td>5</td>
<td>20 children, 18 cases</td>
<td>17 children, 15 cases</td>
<td>6 children, 6 cases</td>
</tr>
<tr>
<td>6</td>
<td>134 children, 84 cases</td>
<td>94 children, 61 cases</td>
<td>23 children, 22 cases</td>
</tr>
<tr>
<td>7</td>
<td>66 children, 47 cases</td>
<td>61 children, 43 cases</td>
<td>11 children, 11 cases</td>
</tr>
<tr>
<td>8</td>
<td>82 children, 57 cases</td>
<td>70 children, 48 cases</td>
<td>12 children, 12 cases</td>
</tr>
<tr>
<td>No Data</td>
<td>2 children, 2 cases</td>
<td>0 children, 0 cases</td>
<td>0 children, 0 cases</td>
</tr>
<tr>
<td>Total</td>
<td>599 children, 406 cases</td>
<td>469 children, 323 cases</td>
<td>100 children, 99 cases</td>
</tr>
</tbody>
</table>

### Appendix B. continued
Appendix C.

Data Quality

Quality of Demographic Data

DATE OF BIRTH

Dates of birth were reviewed across DCFS administrative data, DMH tracking logs, and MAT SOF documents. Dates of birth matched across all data sources for 437 children (73.0%) in the evaluation sample. The final date of birth used for analysis matched the date of birth recorded in the DCFS administrative data for all but one child, for whom the date of birth recorded in the DCFS administrative data was different than the date of birth recorded in both the DMH tracking log and the MAT SOF document for that child. The final date of birth used for analysis matched the date of birth recorded in the DMH tracking logs for 539 children (90.0%). 40.0% of children (24 children) for whom final date of birth data did not match the DMH tracking logs did not have their date of birth entered in the DMH tracking logs. The remaining children (36 children, 60.0%) had a different date of birth recorded in the DMH tracking logs than was used for this evaluation. The final date of birth used for analysis matched the date of birth recorded in the MAT SOF for 352 children (75.1% of the 469 children whose SOFs were reviewed). 80.3% of children (94 children) for whom final date of birth data did not match the MAT SOF either did not have their date of birth recorded on the MAT SOF or the date of birth was redacted in the MAT SOF provided for the evaluation. The remaining children (23 children, 19.7%) had a different date of birth recorded on the MAT SOF than was used for this evaluation.

PREFERRED LANGUAGE

Children’s preferred languages were reviewed across DCFS administrative data, DMH tracking logs, and MAT SOF documents. The DCFS administrative data provided contained two fields for tracking language – Language and CWS_Prim_Language. The Language field was completed more frequently in the DCFS administrative data provided and was therefore used as the primary language source for determining children’s preferred languages. Both DCFS administrative data language fields identified a single language for each child, while the DMH tracking logs and MAT SOF documents included one or more languages. When a child had multiple languages noted across different data fields and data sources, CIBHS considered that child to speak more than one language.

Language data matched across all data fields and sources for only 33 children (5.5%). Data in the primary data source, the DCFS administrative data Language field, matched the final language used for this evaluation for 85.3% of children (511 children). Only 1.1% of mismatches (1 child) resulted from missing data in the DCFS Language field, while 98.9% of mismatched (87 children) were related to one or more additional languages recorded for this child in another data source. In contrast, data in the DCFS CWS Language field matched the final language used for this evaluation for only 54.6% of children (327 children). The majority of these mismatches were due to missing data in the DCFS CWS Language field (224 children, 82.4% of mismatches), while 48 mismatches (17.7%) were related to one or more additional languages recorded for that child in another data source.

Language data entered in the DMH tracking logs matched the final language used for this evaluation for 58 children (9.7%), largely due to this field being blank for 519 children (95.9% of mismatches). For 22 children (4.1% of mismatches), one or more additional languages were recorded for the child in another data source. Of the data sources reviewed, the MAT SOF documents

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146 MAT SOF documents were only reviewed for children in the quality subsample.
147 MAT SOF documents were only reviewed for children in the quality subsample.
had the most comprehensive documentation of children’s preferred languages, with 90.0% (422 of the 469 children for whom MAT SOFs were reviewed) matching the final language used for the evaluation. Only one child did not have language data entered in the MAT SOF, whereas 46 children (97.9% of mismatches) had one or more additional languages recorded in another data source.

ETHNICITY

Ethnicity data was reviewed across DCFS administrative data and MAT SOF documents. The DCFS administrative data provided contained two fields for tracking ethnicity – Ethnicity and Ethnicity Subgroup. Both fields were considered when matching data to the ethnicity recorded in the MAT SOF document. While the ethnicity field in the MAT SOF document could contain any value, the DCFS administrative data fields had a list of options that could be selected, with a consistent relationship between the Ethnicity field and the Ethnicity Subgroups that roll up to each ethnicity. Similar to language, when a child had multiple ethnicities noted across different data fields and data sources, CIBHS considered that child to identify as more than one ethnicity.

Ethnicity data matched across all data fields and sources for 318 children (53.1%). The final ethnicity used for this evaluation matched the DCFS Ethnicity field for 331 children (55.3%). 20.2% of mismatches (54 children) were due to a lack of data in the DCFS Ethnicity field, while 79.9% (214 children) were due to a difference in the data entered across data sources. Data in the DCFS Ethnicity Subgroup field was largely similar to that in the DCFS Ethnicity field. 324 children (54.1%) had data in the DCFS Ethnicity Subgroup field matching the final ethnicity used for this evaluation, with 22.2% of mismatches (61 children) due to missing data and 77.8% (214 children) due to different ethnicity data entered across data sources. Ethnicity data in the MAT SOF document matched the final ethnicity used for this evaluation for 56.3% of children (264 of 469 children for whom MAT SOFs were reviewed). Only 6 children (2.9% of mismatches) had missing ethnicity data on the MAT SOF, while 199 (97.1% of mismatches) had different data on the MAT SOF than in the DCFS administrative data.

148 MAT SOF documents were only reviewed for children in the quality subsample.
## Quality of Date Data

### PER CHILD

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>NUMBER OF CHILDREN WITH DATA</th>
<th>DCFS DATE MATCHES FINAL DATE</th>
<th>DMH DATE MATCHES FINAL DATE</th>
<th>SOF DATE MATCHES FINAL DATE&lt;sup&gt;149&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Date</td>
<td>599</td>
<td>568 (94.8%)</td>
<td>444 (74.1%)</td>
<td>416 (88.7%)</td>
</tr>
<tr>
<td>Data Entry Mismatch</td>
<td></td>
<td>31 (5.2%)</td>
<td>131 (21.9%)</td>
<td>51 (10.9%)</td>
</tr>
<tr>
<td>No Data Entered</td>
<td></td>
<td>0 (0.0%)</td>
<td>24 (4.0%)</td>
<td>2 (0.4%)</td>
</tr>
<tr>
<td>Acceptance Date&lt;sup&gt;150&lt;/sup&gt;</td>
<td>563</td>
<td>501 (89.0%)</td>
<td>440 (78.2%)</td>
<td>423 (90.2%)</td>
</tr>
<tr>
<td>Data Entry Mismatch</td>
<td></td>
<td>31 (5.5%)</td>
<td>109 (19.4%)</td>
<td>39 (8.3%)</td>
</tr>
<tr>
<td>No Data Entered</td>
<td></td>
<td>31 (5.5%)</td>
<td>14 (2.5%)</td>
<td>7 (1.5%)</td>
</tr>
<tr>
<td>SOF Meeting Date</td>
<td>563</td>
<td>504 (89.5%)</td>
<td>463 (82.2%)</td>
<td>448 (95.5%)</td>
</tr>
<tr>
<td>Data Entry Mismatch</td>
<td></td>
<td>19 (3.4%)</td>
<td>58 (10.3%)</td>
<td>16 (3.4%)</td>
</tr>
<tr>
<td>No Data Entered</td>
<td></td>
<td>40 (7.1%)</td>
<td>42 (7.4%)</td>
<td>5 (1.1%)</td>
</tr>
<tr>
<td>Final SOF Date</td>
<td>563</td>
<td>420 (74.6%)</td>
<td>388 (68.9%)</td>
<td>338 (72.1%)</td>
</tr>
<tr>
<td>Data Entry Mismatch</td>
<td></td>
<td>106 (18.8%)</td>
<td>114 (20.2%)</td>
<td>59 (12.6%)</td>
</tr>
<tr>
<td>No Data Entered</td>
<td></td>
<td>37 (6.6%)</td>
<td>61 (10.8%)</td>
<td>72 (15.4%)</td>
</tr>
</tbody>
</table>

### PER CASE

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>NUMBER OF CASES WITH DATA</th>
<th>CASES WHERE ALL CHILDREN MATCHED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detention Date</td>
<td>406</td>
<td>402 (99.0%)</td>
</tr>
<tr>
<td>Referral Date</td>
<td>406</td>
<td>405 (99.8%)</td>
</tr>
<tr>
<td>Acceptance Date&lt;sup&gt;151&lt;/sup&gt;</td>
<td>381</td>
<td>381 (100.0%)</td>
</tr>
<tr>
<td>SOF Meeting Date</td>
<td>381</td>
<td>380 (99.7%)</td>
</tr>
<tr>
<td>Final SOF Date</td>
<td>381</td>
<td>380 (99.7%)</td>
</tr>
<tr>
<td>Report to CSW Date</td>
<td>354</td>
<td>354 (100.0%)</td>
</tr>
<tr>
<td>Report to Court Date</td>
<td>108</td>
<td>108 (100.0%)</td>
</tr>
</tbody>
</table>

---

<sup>149</sup> SOF data was only compared for cases in the Quality Subsample (N=469 children).

<sup>150</sup> For all MAT milestones after Referral, dates were only considered for non-cancelled cases.

<sup>151</sup> For all MAT milestones after Referral, dates were only considered for non-cancelled cases.
<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Category</th>
<th>Notes</th>
<th>Organization</th>
<th>Role</th>
<th>Notes</th>
<th>Used for Ages</th>
<th>Use for Ages</th>
<th>Different Versions Used</th>
<th>LA County Administration Timeframe - Expected</th>
<th>LA County Administration Timeframe - Actual</th>
<th>Notes</th>
<th>Implementation Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ages and Stages Questionnaire- 3rd edition (ASQ-3; Squires and Bricker 1999)</td>
<td>Screening</td>
<td>DMH- Contracted Provider</td>
<td>Mental Health Clinician</td>
<td>MAT Assessors and HUBS often use the ASQ-3</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Within 45 Days of Detention</td>
<td>Different versions are used per age-range validity requirements of tool</td>
<td>Telehealth limits activities/observations by Clinician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Child and Adolescent Needs and Strengths (CANS-50)</td>
<td>Other</td>
<td>Service planning and case management tool</td>
<td>None</td>
<td>None</td>
<td>DMH QA Bulletin 19-02 states that DMH is requiring the use of CANS-JP rather than CANS-50 in the county</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Child and Adolescent Needs and Strengths (CANS-IP; Lyons, 1999)</td>
<td>Other</td>
<td>Service planning and case management tool</td>
<td>Multiple</td>
<td>Multiple</td>
<td>Organization: DMH-Contracted Provider for age 6-18 if youth meets medical necessity, DCFS LOC Worker for age 0-5, 6-18 if youth does not meet medical necessity; Role: Mental Health Clinician (DMH), Social Worker (DCFS). Practitioner must be certified by the PRAED Foundation.</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Multiple</td>
<td>Administered at initial assessment, every 6 months throughout treatment, and at the end of treatment; CANS to be completed prior to development of a case plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Level of Care (LOC) Rate Determination Protocol</td>
<td>Other</td>
<td>Rate determination tool</td>
<td>DOPS</td>
<td>Other County Staff</td>
<td>LOC Worker</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Within 30 Days of Detention</td>
<td>Currently LOC is administered only to youth placed with Foster Family Agencies (FFA). This may be expanded to other cases in the future</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mental Health Screening Tool (MHST; CA Institute for Mental Health)</td>
<td>Screening</td>
<td>DOPS</td>
<td>Social Worker</td>
<td>ER Social Worker</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Within 24 Hours of Promoting to Case</td>
<td>Based on interviews, MHST is completed when the ER Social Worker is promoting the referral to a case. Versions based on age (0-5, 5 and up).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Multidisciplinary Assessment Team (MAT) Process</td>
<td>Non-Clinical Assessment</td>
<td>Comprehensive assessment of youth and family’s strengths and needs non-diagnostic</td>
<td>DMH- Contracted Provider</td>
<td>Mental Health Clinician</td>
<td>Contracted MAT Assessor</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Within 45 Days of Detention</td>
<td>Traditional MAT and MAT/CFT Pilots follow slightly different processes and use slightly different SOF forms. Can be delayed due to Medi-Cal verification; Sometimes there are challenges contacting/gathering information from the biological parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Pediatric Symptom Checklist-30 items (PSC-30; Jellinek, Murphy &amp; Burns, 1986)</td>
<td>Screening</td>
<td>DMH- Contracted Provider</td>
<td>Mental Health Clinician</td>
<td>Contracted or Directly Operated Service Provider</td>
<td>Partial</td>
<td>Yes</td>
<td>No</td>
<td>Multiple</td>
<td>“Age Range: 3-18 years. Expected Administration Timeframe: at beginning of treatment, every six months following administration, and at end of treatment”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>LA DMH Intake Assessment (Infancy, Childhood &amp; Relationship Enrichment Initial Assessment - ICARE, or Child/Adolescent Full Assessment)</td>
<td>Clinical Assessment</td>
<td>Assessment for new LA DMH clients; may decide to use assessment from referring program</td>
<td>DMH- Contracted Provider</td>
<td>Mental Health Clinician</td>
<td>Contracted or Directly Operated Service Provider</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Within 60 Days of Enrollment in Services</td>
<td>ICARE may be used for birth to 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>Name</td>
<td>Organization</td>
<td>Data System</td>
<td>Results Integrated</td>
<td>Notes</td>
<td>Timeframe</td>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Ages and Stages Questionnaire, 3rd edition (ASQ-3; Square and Broker 1999)</td>
<td>Multiple</td>
<td>Other</td>
<td>MAT SOF</td>
<td>&quot;Organization: DMH, Regional Center Data System. Raw data is stored in DMH Contracted Provider’s data system/EMR.&quot;</td>
<td>By CFT/SOF Meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Child and Adolescent Needs and Strengths (CANS-50)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Child and Adolescent Needs and Strengths (CANS-IP; Lyons, 1999)</td>
<td>Multiple</td>
<td>Multiple</td>
<td>Multiple</td>
<td>&quot;Organizations: DCFS, DMH, Probation Data Systems: CWS CMS, CWS CARES, IBHIS, DMH Directly Operated Providers, EPSDT Web Application (DMH Contracted Providers). Results Integrated: MAT SOF and CFT Tools.&quot;</td>
<td>Multiple</td>
<td>Initial results expected to be incorporated into CFT meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Level of Care (LOC) Rate Determination Protocol</td>
<td>DCFS</td>
<td>CWS CMS</td>
<td>No</td>
<td>Results are uploaded in CWS CMS once a LOC tool is scored</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mental Health Screwing Tool (MHST; CA Institute for Mental Health)</td>
<td>DMH</td>
<td>Referral Portal</td>
<td>No</td>
<td>For PreAcute/PreUrgent MHST, DMH completes triage following receipt of MHST results</td>
<td>Within 45 Days of Detention</td>
<td>Based on interviews, timeframe for sharing of MHST results aligns with expectations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Multidisciplinary Assessment Team (MAT) Process</td>
<td>Multiple</td>
<td>Multiple</td>
<td>Multiple</td>
<td>&quot;Organizations: DCFS, DMH, Courts, Others by Request Data Systems: MAT-AS, CWS CMS, Paper Files. Results Integrated: Disposition Report, DCFS Case Plan, Court Case Plan.&quot;</td>
<td>Within 45 Days of Detention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Pediatric Symptom Checklist-35 items (PSC-35; Jellinek, Murphy, &amp; Burns, 1986)</td>
<td>DMH</td>
<td>Multiple</td>
<td>No</td>
<td>Data Systems: IBHIS Directly Operated Providers, EPSDT Web Application (Contracted Providers)</td>
<td>Multiple</td>
<td>Results reported to DHCS EPSDT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>LA DMH Intake Assessment (Infancy, Childhood &amp; Relationship Enrichment Initial Assessment - CARE)</td>
<td>DMH</td>
<td>IBHIS</td>
<td>No</td>
<td>Within 45 Days of Enrollment in Services</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
Applicable Screening and Assessment Tools for MAT Domains

MAT assesses a child and family’s strengths and needs in the following areas: mental health, education, family/caregiver supports, vocation, medical health, dental health, development, and hearing/language. Within the MAT, service providers select assessment tools to assess the described domains of child and adolescent health. The specific tools used are tailored to the youth’s age and may vary based on the details of their case as well as the preferences of the provider agency or clinician(s) assigned to their case. The selection of appropriate tools for assessing each age group and assessment domain below was compiled based on interviews with LA County DCFS and DMH staff, recommendations from the UCLA Pritzker Center, and an inventory of available evidence-based tools. The selected tools are presented by approximate time and cost to administer. Additionally, though tools are organized into groups by primary assessment domain, no two tools are identical.

Mental Health

The MAT Assessment is a comprehensive clinical psychiatric assessment incorporating the child and/or family’s strengths and needs. The MAT Assessment must be administered by a licensed or license-waivered mental health professional. When performing a mental health assessment, there are some key subdomains that should be addressed, including behavior and social-emotional health and trauma. When selecting an assessment tool, the clinician must consider the child’s age, experiences, and circumstances and exercise their clinical judgement to identify aspects of the child’s mental health that warrant deeper assessment.

> BEHAVIOR AND SOCIAL EMOTIONAL HEALTH

The UCLA Pritzker Center recommended use of behavior and social-emotional assessment tools for children and youth of all ages. In LA, this is sometimes done using the ASQ-Social Emotional (ASQ-SE) for young children. Tools for assessing behavior and social-emotional health are listed in Table 1, along with the age groups for which they are appropriate and their relative cost and time to administer.

Table 1. Behavior and Social Emotional Health Assessments

<table>
<thead>
<tr>
<th>TOOL</th>
<th>AGE</th>
<th>TIME TO ADMINISTER</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-3 YEARS</td>
<td>3-6 YEARS</td>
<td>6-18 YEARS</td>
</tr>
<tr>
<td>Infant/Toddler Temperament Questionnaire (IT3)</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Brief Infant Toddler Social Emotional Assessment (BITSEA)</td>
<td>Partial</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Ages and Stages Questionnaire: Social-Emotional (ASQ-SE)</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Behavior Assessment System for Children (BASC-2)</td>
<td>Partial</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Child Behavior Checklist (CBCL) for Ages 1.5-5 and 6-18</td>
<td>Partial</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Bayley-4 Social-Emotional Scale (Bayley-SE)</td>
<td>✓</td>
<td>Partial</td>
<td>✗</td>
</tr>
</tbody>
</table>

152  + = 10 minutes or less; ++ = ~10-30 minutes; +++ = more than 30 minutes

153  Cost ratings are estimates from low ($) to high ($$$) based on publicly available information. Specific costs to LA County or contracted providers may vary and should be negotiated with the tool developers.
The Bayley-SE is a more in-depth assessment subscale of the full Bayley assessment, which is described under development. For youth ages 6-18, The UCLA Pritzker Center recommended adding the CBCL Direct Observation Form (DOF) and the BASC School Report to capture information from multiple reporters.

> TRAUMA

In conversations with LA County DCFS and DMH staff, understanding trauma experienced by newly-detained children and its impacts on their mental health is one of the most challenging aspects of assessing children and linking them to appropriate services. Trauma can be particularly difficult to assess in children 0-3 years old, but two screening tools stand out for trauma assessment in that population: the Pediatric ACES and Related Life-Events Screener (PEARLS) and the Protective Factors Survey (PFS). Both tools are free and intended to be completed by the child’s caregiver. Those tools are also appropriate in older children. In addition, the UCLA Pritzker Center recommended the Trauma Symptom Checklist for Young Children (TSCYC) and Trauma Symptom Checklist for Children (TSCC). Both the TSCYC and TSCC also have a shorter screening form (TSCYC-SF and TSCC-SF, respectively) that can be used to determine if further assessment is needed. The TSCYC and associated screening form are recommended for children ages 3-12, while the TSCC and TSCC-SF are designed for youth ages 8-16/17. Tools for assessing trauma are listed in Table 2.

### Table 2. Trauma Assessments

<table>
<thead>
<tr>
<th>TOOL</th>
<th>AGE</th>
<th>TIME TO ADMINISTER</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protective Factors Survey (PFS)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Young Children Screening Form (TSCYC-SF)</td>
<td>×</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Children Screening Form (TSCC-SF)</td>
<td>×</td>
<td>×</td>
<td>✓</td>
</tr>
<tr>
<td>Pediatric ACES and Related Life-Events Screener (PEARLS)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Young Children (TSCYC)</td>
<td>×</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Children (TSCC)</td>
<td>×</td>
<td>×</td>
<td>✓</td>
</tr>
</tbody>
</table>

Two other commonly referenced tools, the Adverse Childhood Experiences Questionnaire (ACEs) and Positive ACES and Related Life-Events Survey (PACES), can also be used for older children. The recommended age range and time to administer are not documented for ACEs and PACES, but both tools are relatively short and straightforward. Both ask the youth about adverse experiences they have had prior to the age of 18 and are freely available for use. PACES also asks about protective factors in addition to adverse events. Notably, as of 2019, PACES has not yet been validated or standardized, though it is currently being studied.

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154 + = 10 minutes or less; ++ = 10-30 minutes; +++ = more than 30 minutes
155 Cost ratings are estimates from low ($) to high ($$$) based on publicly available information. Specific costs to LA County or contracted providers may vary and should be negotiated with the tool developers.
MANDATED MENTAL HEALTH ASSESSMENT TOOLS

The state of California requires submission of data from two mental health assessment tools for children enrolled in mental health services through DMH: the Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35). Both tools assess a broad range of mental health domains, including behavior, social emotional health, and trauma. These requirements were implemented in 2019, and the tools can often be completed using information gathered as part of the MAT.

Additionally, there is a DMH triage/intake process that includes completing the ICARE or Child/Adolescent initial assessment form, which documents the child’s medical, developmental, and mental health history; family status; and relevant diagnoses. Importantly, DMH can complete this form using information from a referring assessment rather than conducting a duplicate clinical exam.

Development

Based on conversations with LA DCFS and DMH staff, as well as a review of MAT SOFs, the most commonly used tool to assess development in young children is the Ages and Stages Questionnaire (ASQ-3). Some providers also use the Denver Developmental Screening Test. The UCLA Pritzker Center recommended using the Bayley Scales of Infant and Toddler Development (Bayley) for this population. Both ASQ-3 and Denver are short, low cost screening tools, while Bayley should be used for a more comprehensive developmental assessment.

Table 3. Development Assessments

<table>
<thead>
<tr>
<th>TOOL</th>
<th>AGE</th>
<th>TIME TO ADMINISTER</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages and Stages Questionnaire (ASQ-3)</td>
<td>☑️/☑️/☒</td>
<td>++</td>
<td>$</td>
</tr>
<tr>
<td>Denver Developmental Screening Test</td>
<td>☑️/☑️/☒</td>
<td>++</td>
<td>Free</td>
</tr>
<tr>
<td>Bayley Scales of Infant and Toddler Development (Bayley)</td>
<td>☑️/Partial/☒</td>
<td>+++</td>
<td>$$$</td>
</tr>
</tbody>
</table>

Family/Caregiver Supports

Assessment of the strengths and needs of system-involved children’s families and caregivers is a critical component of MAT. Elements of parent-child and caregiver-child interaction are included in some of the assessment tools described for other domains, including CANS, PSC-35, and ASQ-3. For infants, UCLA Pritzker Center recommended using the Nursing Child Assessment Satellite Training (NCAST) Teaching Caregiver/Parent-Child Interaction Scale.

156 " = 10 minutes or less; ++ = ~10-30 minutes; +++ = more than 30 minutes
157 Cost ratings are estimates from low ($) to high ($$$) based on publicly available information. Specific costs to LA County or contracted providers may vary and should be negotiated with the tool developers.
**Education**

MAT includes an educational assessment focused on the child’s schooling and academic achievement. Both CANS and PSC-35 include assessment items related to education. In older children, educational assessments can also include evaluation of the child’s cognitive and executive functioning. The UCLA Pritzker Center recommended the Behavior Rating Inventory of Executive Function-2 (BRIEF-2), for assessment of executive functioning in children ages 5 and up.

**Vocation**

In addition to education, MAT assesses a child’s vocational strengths and needs, including their interests, hobbies, and career goals. In adolescents, this can be assessed with the Strong Interest Inventory, though this tool is only appropriate for youth ages 15 through 21.

**Medical Health**

MAT medical assessments are usually carried out at the Medical Hubs, resulting in completion of the 561(a) form.

**Dental Health**

Dental health assessments are completed by a qualified dental provider and result in completion of the 561(b) form.

**Hearing/Language**

MAT also includes an assessment of hearing and language. Commonly used tools like CANS and ASQ-3 both contain items intended to assess language and communication. In young children, the UCLA Pritzker Center recommended the Autism Diagnostic Observation Schedule (ADOS-2) in cases where a child’s socialization and language skills warrant assessment for autism spectrum disorders.
Appendix F.

Resources for Capturing and Analyzing Race, Ethnicity, and Language Data

- National Center for Education Statistics standards for defining race and ethnicity data: **Standard 1-5 - NCES Statistical Standards (ed.gov)**
- Harvard University Office of Regulatory Affairs and Research Compliance Tip Sheet on inclusive demographic data collection: [ORARC-Tip-Sheet-Inclusive-Demographic-Data-Collection.pdf (harvard.edu)](https://www.harvard.edu)
- Lee, et al., Improving the Collection of Race, Ethnicity, and Language Data to Reduce Healthcare Disparities: A Case Study from an Academic Medical Center. Perspectives in Health Information Management, Fall 2016.

- A-B-C Plan:
  - Adjust the data collection system
    - Replace “Unknown” with Refused/Don’t know
  - Build awareness among professionals and clients
    - Trainings for staff
    - Develop scripts for staff to outline the rationale for data collection
    - Education/1-pager for clients on importance of REAL data collection
  - Collaborate and share lessons learned with other departments/health systems