State of California—Health and Human Services Agency

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

WILL LIGHTBOURNE
DIRECTOR

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ALL COUNTY LETTER (ACL) NO. 16-84
MENTAL HEALTH SUBSTANCE USE DISORDER SERVICES (MHSUDS)
INFORMATION NOTICE NO. 16-049

TO: ALL COUNTY BEHAVIORAL HEALTH PROGRAM DIRECTORS
ALL COUNTY WELFARE DIRECTORS
ALL COUNTY FISCAL OFFICERS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL CHIEF PROBATION OFFICERS
ALL TITLE IV-E AGREEMENT TRIBES
COUNTY WELFARE DIRECTORS ASSOCIATION OF CALIFORNIA
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CHIEF PROBATION OFFICERS OF CALIFORNIA
COUNTY COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES

SUBJECT: REQUIREMENTS AND GUIDELINES FOR CREATING AND PROVIDING A CHILD AND FAMILY TEAM

REFERENCE: ASSEMBLY BILL (AB) 403 and AB 1997 (CHAPTER 773, STATUTES OF 2015 and CHAPTER 612, STATUTES OF 2016)
WELFARE AND INSTITUTIONS CODE 706.6, 832, 16501.1
PATHWAYS TO MENTAL HEALTH SERVICES – CORE PRACTICE MODEL GUIDE

Executive Summary

This ACL and MHSUDS Information Notice provides information and guidance regarding the use of child and family teaming to deliver child welfare services, as required by Assembly Bill (AB) 403, commonly known as the Continuum of Care Reform (CCR). Signed by Governor Jerry Brown in October 2015, the CCR makes sweeping changes to California's child welfare system, with implementation planned to occur in stages between now and 2021. The intent of the CCR is to have children and youth, who must live apart from their biological parents, live in a permanent home with a committed adult(s) who can meet their needs. The CCR changes also include, but are not limited to, providing services and supports to children, youth, and their families that reduce reliance on congregate care, thereby increasing placements in home-based settings.

One of the CCR's most fundamental principles is that child welfare services are most effective when delivered in the context of a child or youth and family-centered, child and family team (CFT) that shares responsibility to assess, plan, intervene, monitor and refine services over time. Welfare and Institutions Code, Section 16501.1 (c) and (d) require that county placing agencies convene a CFT meeting as defined in Section 16501 to identify supports and services that are needed to achieve permanency, enable a child to live in the least restrictive family setting, and promote normal childhood experiences. This requirement applies to all children and youth residing in a group home with an existing case plan or children and youth who come into the child welfare foster care placement after January 1, 2017, including probation youth in foster care and non-minor dependents.

Background

Team-based approaches are not new to California. Beginning in 1997 with Wraparound, team-driven service models such as Functional Family Therapy, Safety Organized Practice, and Team Decision Making have been in use across the state. More recently, the Pathways to Mental Health Services - Core Practice Model Guide provided a comprehensive description of a CFT that reflects what was already occurring in practice; combining the structure of professional interdisciplinary teams with the strengths-based and inclusive principles of family-centered care to make informed decisions. This state approved guide contains valuable guidance about effective CFT processes.

Evidence-based and promising practices in child welfare and probation increasingly rely on youth and family engagement and teaming processes as effective methods to support children, youth, and families and include system partners in the planning, delivery and management of necessary services. As team-based practices have grown in California, so has the recognition of their success in improving outcomes for children, youth, and their families. The CCR builds on this success to provide children and youth who come into contact with California's child welfare and probation systems with this strategy that improves safety, permanency, and well-being.

Child and Family Team Model Overview

A CFT is a group of individuals that includes the child or youth, family members, professionals, natural community supports, and other individuals identified by the family who are invested in the child, youth, and family's success. In addition to mandated participation of involved public agency representatives, the composition of the team is driven by family members' preferences. Successful CFTs include persons with natural supportive relationships with the family, so that the family's support system will continue to exist after formal services are completed. The CFT's role is to include family members in defining and reaching identified goals for the child. The individuals on the team work together to identify each family member's strengths and needs, based on relevant life domains, to develop a child, youth, and family-centered case plan. The plan articulates specific strategies for achieving the child, youth, and/or family's goals based on addressing identified needs, public safety, including following

related court orders, and building on or developing functional strengths. The CFT typically conducts and coordinates its work through a CFT meeting, which is discussed in detail below. It is important to recognize, however, that the CFT and a CFT meeting are not the same. The CFT is a group of people; a CFT meeting is a functional structure and process of engaging the family and their service teams in thoughtful and effective planning.

The CFT process reflects a belief that families have capacity to address their problems and achieve success if given the opportunity and supports to do so. Engagement with families is fundamental to the CFT process. Working with children, youth, and families as partners results in plans that are developed collaboratively and in a shared decision-making process. The family members hold significant power of choice when strategies are defined.

The CFT process reflects the culture and preferences of children, youth, and families, building on their unique values and capacities, and eliciting the participation of everyone on the team. It is important to recognize that at times the child, youth, and family have their own unique cultures. In those cases, care must be taken to integrate their cultures into the plan. Team members should help children, youth, and families recognize their strengths, and encourage them and support them to develop solutions that match their preferences. The team must respect and support the power of learning from mistakes when strategies do not work as intended so that the plan can be revised to improve outcomes.

Composition of Child and Family Teams

For children and youth in the child welfare or probation systems, the placing agency is responsible for engaging members of the CFT. The CFT composition always includes the child or youth, family members, the current caregiver, a representative from the placing agency, and other individuals identified by the family as being important. A CFT shall also include a representative of the child or youth's tribe or Indian custodian, behavioral health staff, foster family agency social worker, or short-term residential therapeutic program (STRTP) representative, when applicable. Other professionals that may be included are: youth or parent partners, public health providers, Court Appointed Special Advocates, school personnel, or others. In addition to formal supports, effective CFT processes support and encourage family members to invite the participation of individuals who are part of their own network of informal support. This may include extended family, friends, neighbors, coaches, clergy, co-workers, or others who the family has identified as a potential source of support.

Family members may be reluctant, for a variety of reasons, to identify and invite friends or neighbors to participate. Family members may be angry or ashamed of being involved with child welfare, behavioral health, or probation; they may subscribe to cultural norms that do not accommodate sharing of personal information with "outsiders." Engagement may also be challenging for families experiencing serious mental illness and/or substance use disorders, or further complicated by the historical or current impact of trauma.

Professionals can work to mitigate family member reluctance by being patient, offering reassurance and encouragement, and demonstrating respect and cultural humility. It is important to explain how the inclusion of others can directly support the family members to achieve their goals in order to exit child welfare or probation services in a timely and effective manner. Individuals with lived experience (e.g. parent partners, youth partners/mentors) can be useful by being mentors and advocates who have personally experienced many of the same challenges and feelings through their own contact with the child welfare, behavioral health, or probation system(s). The parent partner's or youth mentor's unique role often promotes clarity and understanding for the family.

As families move through the CFT process, family members will often come to recognize their own strengths and experience the power of strengths-based support that comes without judgment. Over time and with growing trust, reluctance may fade and inclusion of natural supports will grow. Team membership is intentionally flexible and dynamic, so team participants will continue to change as needs change. Identified natural supports will move into a more significant role, as professionals work towards transitioning out of the team.

Confidentiality

Confidentiality and information sharing practices are key elements throughout the CFT process, and they must be designed to protect children, youth and families' rights to privacy without creating barriers to receiving services. Section 832 of the Welfare and Institutions Code was added to promote sharing of information between CFT members relevant to case planning and providing necessary services and supports to the child, youth and family. To promote more effective communication needed for the development of a plan to address the needs of the child or youth and family, a person designated as a member of a child and family team may receive and disclose relevant information and records, subject to the child or youth and/or their parent or guardian signing a release of information.

When the CFT convenes, members will discuss and address any concerns related to sharing information openly and transparently. Working together as a team to discuss necessary information such as strengths and challenges, will help the family to determine specific goals, and implement a plan to meet those goals. Sharing relevant information allows families and professionals to build trust in each other and in themselves. This strengths-based, collaborative engagement with families is fundamental to the CFT process.

Child and Family Team Meeting

It is important to recognize that a CFT meeting does not represent the entire process, but is simply one part of a larger strategy, which involves children, youth, and families in all aspects of care planning, evaluation, monitoring and adapting, to help them successfully reach their goals.

It is **only a CFT meeting** if decisions about goals and strategies to achieve them are made with involvement of the child, youth, and family members. The child, youth, and family voice, choice, and preferences are an integral part of the CFT process.

For a child or youth in the child welfare or probation system, the placing agency worker is typically responsible for convening the initial CFT meeting, unless the team is already established by the other agency. The placing agency is responsible for coordinating with the family, other child and youth serving system partners, and others identified by the child, youth, and family to convene the team and initiate meetings. If the child, youth, and family already have an established team through another agency such as behavioral health, or program such as Wraparound, the placing agency will support the existing team process to expand and evolve so that the needs and services indicated under the child welfare or probation case are included. **Cross System planning and coordination will ensure that there is only one team process for any single family in care.**

When to Convene a CFT Meeting

For children and youth without an existing CFT, team membership should start to be identified as soon as possible. A CFT meeting shall be convened by the placing agency within the first 60 days of coming into foster care. A CFT meeting will be convened to discuss any placement changes and service needs for the child or youth in out-of-home care, and the team must be consulted to identify the most appropriate placement of the child or youth, while always considering the least restrictive placement option.

Children and youth in child welfare services are screened for potential behavioral health needs by the placing agency (at intake and every year thereafter). When behavioral health issues are identified or are a concern, even if services are not presently being provided, referrals to appropriate treatment professionals should be made so that the child or youth's needs can be assessed. Behavioral health professionals (which may include county staff or county contracted providers for children eligible or enrolled in Medi-Cal) are important CFT resources and their involvement is especially critical when:

- The team is unsure about a child or youth's need for Specialty Mental Health Services (SMHS); or whether the child or youth should continue receiving any SMHS;
- There is a need to provide information to the team or family regarding how the child or youth's behavior or functioning is impacted by their mental health status;
- The team is considering the need for placement for the child or youth in a family relative, non-related extended family member or any other family type setting, a STRTP, Foster Care, or Intensive Treatment Foster Care;
- The team is considering a recommendation for Medi-Cal Therapeutic Foster Care Services; and/or
- A child or youth is prescribed psychotropic medication(s) or psychotropic medication(s) is being considered for the child or youth.

CFT Meeting Frequency, Location, and Logistics

For children or youth in placement who are receiving Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) or Therapeutic Foster Care (TFC), a CFT meeting must occur at least every 90 days. For children and youth who are not receiving SMHS, the placing agency will convene a CFT meeting no less than once every six months. Best practice dictates that meetings should be held as frequently as needed to address emerging issues, provide integrated and coordinated interventions, and refine the plan as needed and, therefore, frequency of meetings and timeframes should be decided by CFT members.

The CFT meetings should be scheduled at times and locations convenient for family member participation. Meetings should be conducted in a way that establishes a safe environment that engenders trust and reflects the child, youth, and family's cultural preferences and norms. If needed, CFT meetings could include an interpreter or translator to ensure effective communication and clear understanding. The meetings should have a clear purpose and follow a structured format. Since services and supports to the family should always be individualized to meet their needs, CFT meeting frequency and duration will look different for each family.

CFT Meeting Preparation and Case Planning

It is important to prepare a child, youth, and family, as well as professionals, to participate in a CFT meeting. Either at the beginning or prior to the start of a meeting, an explanation of the purpose, people involved, or structure of the meeting should occur. This preparatory discussion should include an opportunity for all team members to ask questions and share concerns. Meeting agendas should be developed with the team and reflect the voice of the child, youth, and family.

During the development of a case plan, professionals should consider the family's ideas before making their own suggestions. Children, youth, and their families are the best experts about their own lives and preferences and their natural supports have valuable information and resources to share. Child, youth, and family member preferences should be taken into account in the decision making process, unless these preferences pose a child, youth, or community safety issue or conflict with court orders. Plans must be individualized, culturally responsive and trauma-informed. The team should routinely measure and evaluate child or youth and family member progress and emerging needs. Team meetings can help team members recognize when interventions and treatment plans are working and when they may require revision. The team's role in providing encouragement to continue the work to achieve family goals is a critical component of success.

Who Facilitates a CFT Meeting

Typically, the placing agency facilitates the CFT meeting. The placing agency may choose alternative individuals to facilitate such as another individual from the placement agency, a provider, an informal support, or any other team member as determined by the CFT. The role of the facilitator is one that helps to identify needed contacts, builds consensus within the team around collaborative plans, actively

supports the agenda, and ensures that the family voice and choice is heard throughout the entire teaming process. Facilitation training can be made available through CDSS. The decision of who should facilitate the CFT meetings should be a shared decision that includes the preferences of the child, youth, and family members, although local county practices may dictate who facilitates and may largely be influenced by the purpose of the meeting. Other team members may take on the role of the facilitator; however, coordination of care for the safety, permanency, and well-being of the child and youth will remain the responsibility of the placing agency. The involved public agency providers, along with family and team members, assess immediate safety, stabilization, and crisis support needs, developing an immediate and usable safety plan for the child, youth, and family to follow.

Inquiries

"Frequently Asked Questions" are included as an attachment to this ACL/MHSUDS Information Notice. Further information on confidentiality and documentation of CFTs will be forthcoming.

If you have any inquiries, please direct all CFT questions to the Integrated Services Unit, at (916) 651-6600, or via email at CWScoordination@dss.ca.gov or contact the DHCS, Mental Health Services Division, at (916) 322-7445 or email KatieA@dhcs.ca.gov.

Sincerely,

KAREN BAYLOR, Ph.D., LMFT
Deputy Director
Mental Health and Substance Use
Disorder Services
California Department of Health Care Services

GREGORY E. ROSE, MSW
Deputy Director
Children and Family Services Division
California Department of Social Services

Attachment