INTEGRATED CORE PRACTICE MODEL:

A BLUEPRINT FOR THE CHILD AND FAMILY TEAM

COUNTY CLINICS

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INTRODUCTION

Background:

- 2011 settlement of a class action lawsuit (Katie A. vs. Douglas, previously Bonta) that mandates the provision of intensive in-home and community-based services for children who are in foster care or at imminent risk of removal from their families.

- Requires that the California Department of Social Services (CDSS) and the California Department of Health Care Services (CDHCS) provide comprehensive and integrated services to child welfare children to reduce overdependence on institutional and congregate care services, provide better access to mental health services and improve outcomes for this special needs population of children and youth.

INTRODUCTION (CONT.)

Who is Katie A. ?

- The plaintiff, Katie A., was a 14 year old Caucasian girl in 2002.
- She was removed from her home at age four and had been in foster care for 10 years.
- At age five, assessments of Katie A. indicated that she was a victim of trauma and needed intensive trauma treatment and supportive services for her caregiver.

INTRODUCTION (CONT.)

- She was moved through 37 different placements, including four group homes, 19 different stays at psychiatric hospitals, a two-year stay at Metropolitan State Hospital, and seven different stays at MacLaren Children's Center.
- Despite the recommendations from her previous assessments, she never received trauma treatment or other individualized outpatient mental health services.
- The Katie A. subclass is now referred to as the **Pathways to Well-Being (PWB)** subclass.

THE INTEGRATED CORE PRACTICE MODEL (ICPM)

Definition[1]: "ICPM is an articulation of the shared values, core components, and standards of practice expected from those serving children, youth, and families. It sets out specific expectations for practice behaviors for staff in direct service as well as those who serve in supervisory and leadership roles in child welfare, juvenile probation, and behavioral health as they work together in integrated teams to assure effective service delivery for children, youth, and families. Additionally, the ICPM promotes a set of values, principles, and practices that is meant to be shared by all who seek to support children, youth, and families including tribal partners, education, other health and human services agencies, or community partners."

1. The California Integrated Core Practice Model for Children, Youth, and Families (2018)

THE INTEGRATED CORE PRACTICE MODEL (CONT.)

- It is not a program, it is a "model" that helps guide service providers on how to deliver services to children/youth and their families in a way that is comprehensive, coordinated, and integrated.
- The ICPM is an important shift in the way we view the needs of the child/youth and their families and how to help them achieve their goal toward well-being.
- It helps us move away from a "deficit-based" view of understanding the child or youth to a "strength-based" view.

VALUES AND PRINCIPLES[2]

- *Children are first and foremost protected from abuse and neglect, and maintained safely in their own home.*
- *Services are needs driven, strength-based, and family focused from the first conversation with or about the family.*
- *Services are individualized and tailored to the strengths and needs of each child and family.*
- *Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.*
- *Parent/Family voice, choice, and preference are assured throughout the process.*
- *Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success.*
- *Services are culturally competent and respectful of the culture of children and their families.*
- *When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the team's goals.*
- *Services and supports are provided in the child and family's community.*
- *Children have permanency and stability in their living arrangements.*
- *The team ties the goals and strategies of the plan to observable or measurable indicators of success, monitors progress consistent with those indicators, and revises the CANS and service plan accordingly.*

2. The California Integrated Core Practice Model for Children, Youth, and Families (2018)

TEAMING

Elements of Successful Teaming:

Collaboration towards a common goal

Team membership should include the child/family, social worker and the mental health worker, as well as other invested parties

Who joins the team is guided by the family's input

When and where to meet are based on the needs and preferences of the family

Meeting process is standardized

Everyone contributes to the plan

THE CHILD AND FAMILY TEAM (CFT)

The CFT is central to the Integrated Core Practice Model:

"The CFT is a team of people – it is comprised of the youth and family and all of the ancillary individuals who are working with them toward their mental health goals and their successful transition out of the child welfare system."

Important to differentiate between CFT and CFT Meeting:

- ✓ The CFT is a group of people working together to achieve the child and family's vision for well being.
- ✓ The CFT Meeting is the vehicle by which team members communicate, plan, and coordinate the support services needed to realize the family's vision.

CHILD AND FAMILY TEAM (CONT)

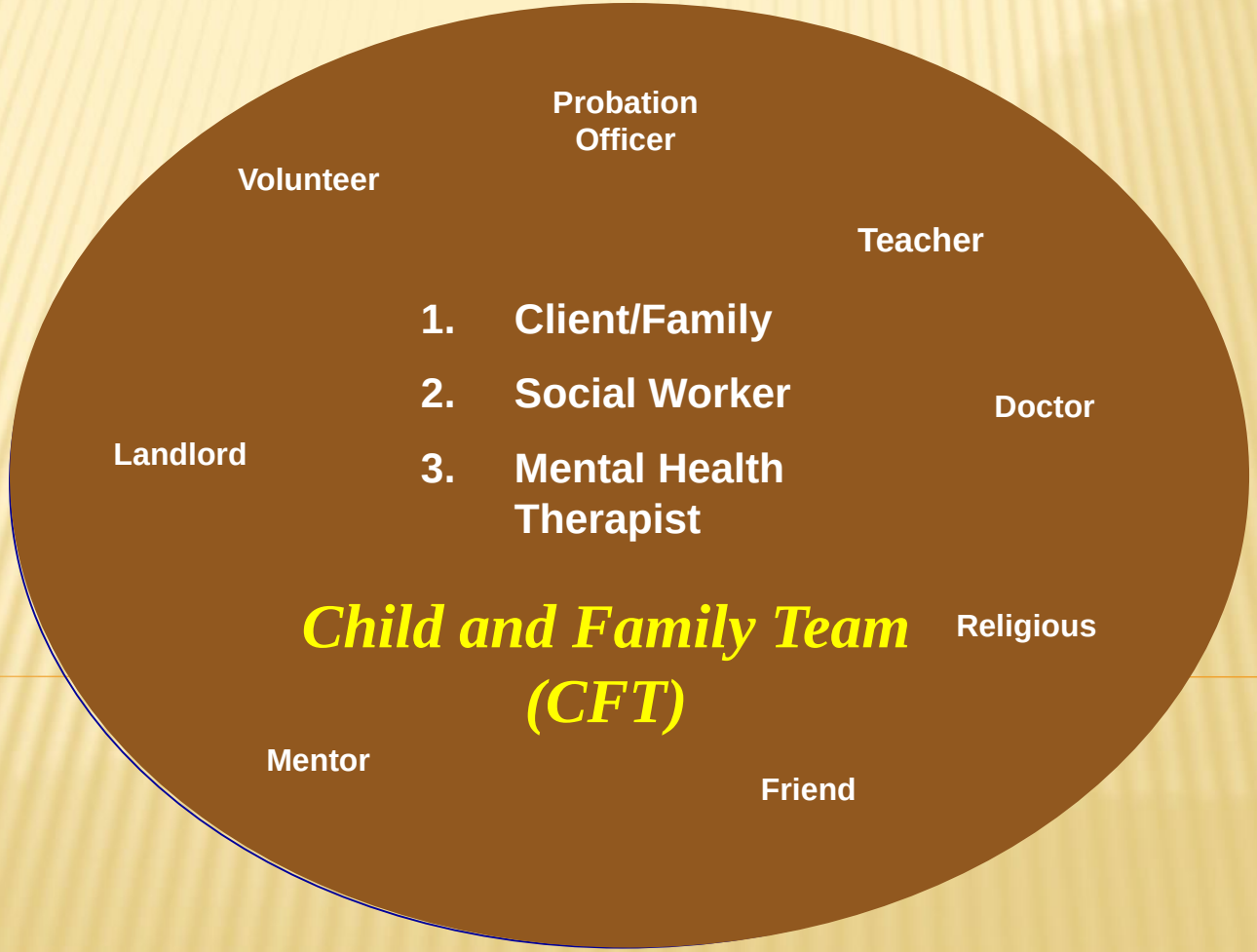
"We already do that."

Yes, historically child welfare and mental health have worked together using various models of collaboration. Team Decision Making (TDMs), WRAP Team, Family Team meetings are some of the common formats for such collaborative efforts. However, the CFT goes beyond just having a meeting or working within a structure. It emphasizes a ***teaming*** process that values:

- Respecting each member's unique contribution to the group
- Clear definition of roles
- A common goal or vision for the child and family
- Accountability
- Child and family voice
- Collaboration at all levels of the Child Welfare and Mental Health systems

Coordinating Multi-Disciplinary Work	Working in a Child and Family Team Environment
Each service provider develops his/her own goals and outcomes with the child and family, ideally making sure that they do not conflict with other service goals	Goals and outcomes are developed and shared by all team members
Each service provider develops his/her own service plan	A single, comprehensive service plan incorporates and drives individual service provider plans
Decision making is done by the service provider with the child and family and communicated to others working with the child and family	Decision making is done by the team
Each service provider informs the other of major changes	Major changes are discussed and agreed to by all team members
Communication is often in summary form	Communication is constant and on-going
Team meetings are generally used for members to inform or report on their work or for a specific limited purpose, such as a placement decision	Meetings are used to plan together, make joint decisions and monitor and evaluate all of the various team member's work
Each service provider is responsible only for the activities related to his or her own discipline	Not only are all team members working toward a common goal, but all team members have the additional responsibility of the group effort
Success is measured independently	Success is measured by how successful the team is in progressing toward their shared goals and outcomes

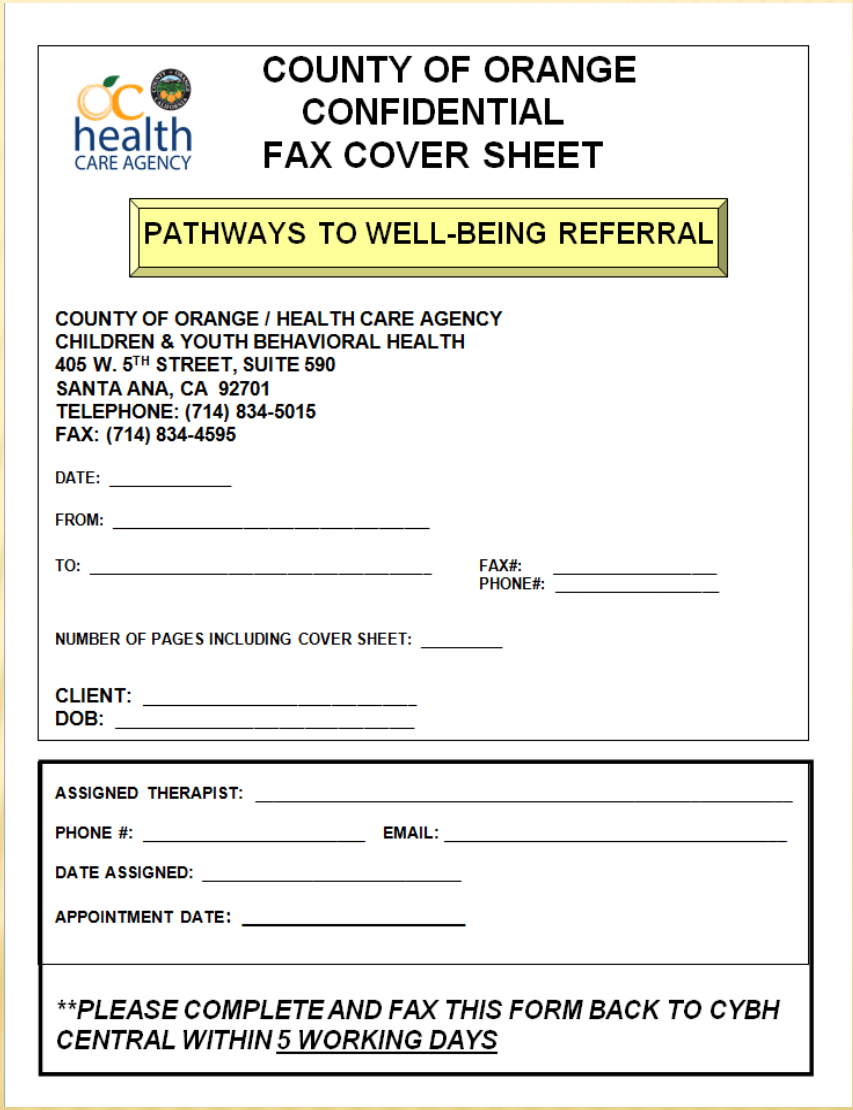
Child and Family Team (CFT)



THE PATHWAYS TO WELL-BEING (FORMERLY KATIE A.) MENTAL HEALTH REFERRAL

- The HCA county clinic will receive a faxed copy of the "Mental Health Referral Packet" from the CYBH Pathways to Well-Being (PWB) Coordinator.
- A special Pathways to Well-Being Referral fax cover sheet will be used for all potential PWB referrals.
- Within 5 working days, the HCA county clinic will fax the PWB Referral cover sheet back to the HCA PWB Coordinator at 714-834-5015 with the assigned clinician's name, phone number, email, and assignment date.

PATHWAYS TO WELL-BEING REFERRAL FAX COVER



COUNTY OF ORANGE
CONFIDENTIAL
FAX COVER SHEET

PATHWAYS TO WELL-BEING REFERRAL

COUNTY OF ORANGE / HEALTH CARE AGENCY
CHILDREN & YOUTH BEHAVIORAL HEALTH
405 W. 5TH STREET, SUITE 590
SANTA ANA, CA 92701
TELEPHONE: (714) 834-5015
FAX: (714) 834-4595

DATE: _____

FROM: _____

TO: _____ FAX#: _____
PHONE#: _____

NUMBER OF PAGES INCLUDING COVER SHEET: _____

CLIENT: _____
DOB: _____

ASSIGNED THERAPIST: _____

PHONE #: _____ EMAIL: _____

DATE ASSIGNED: _____

APPOINTMENT DATE: _____

PLEASE COMPLETE AND FAX THIS FORM BACK TO CYBH CENTRAL WITHIN 5 WORKING DAYS

PROCEDURES FOR INITIATING A CFT MEETING

Step 1: After receiving the Pathways to Well-Being mental health referral packet, HCA Plan Coordinator (therapist) completes the Pathways to Well-Being/Intensive Services (PWB/IS) Eligibility Assessment form.

Step 2: If there is an open child welfare case, within 10 working days [secure] email (do not fax) a copy of the PWB/IS Eligibility Assessment form to the assigned social worker, CFT Inbox, and PHN Inbox **regardless of eligibility**.

Note: For out-of-county Pathways to Well-Being subclass youth, contact the assigned out-of-county social worker to coordinate services. The PWB/IS Eligibility Assessment form does not need to be [secure] emailed to any of the three Orange County SSA email destinations.

PROCEDURES FOR INITIATING A PWB CFT MEETING

Step 3: If the child is Pathways to Well-Being eligible, call the social worker to coordinate the PWB CFT meeting. The Plan Coordinator (therapist) should also provide SSW dates/times for the PWB CFT meeting.

Step 4: SSA social worker and the CFT Scheduler will work together to arrange the initial Pathways to Well-Being (PWB) CFT meeting.

Step 5: The Plan Coordinator (therapist) will assume the role of the Intensive Care Coordinator (ICC) for the PWB CFT.

PROCEDURES FOR INITIATING A CFT MEETING

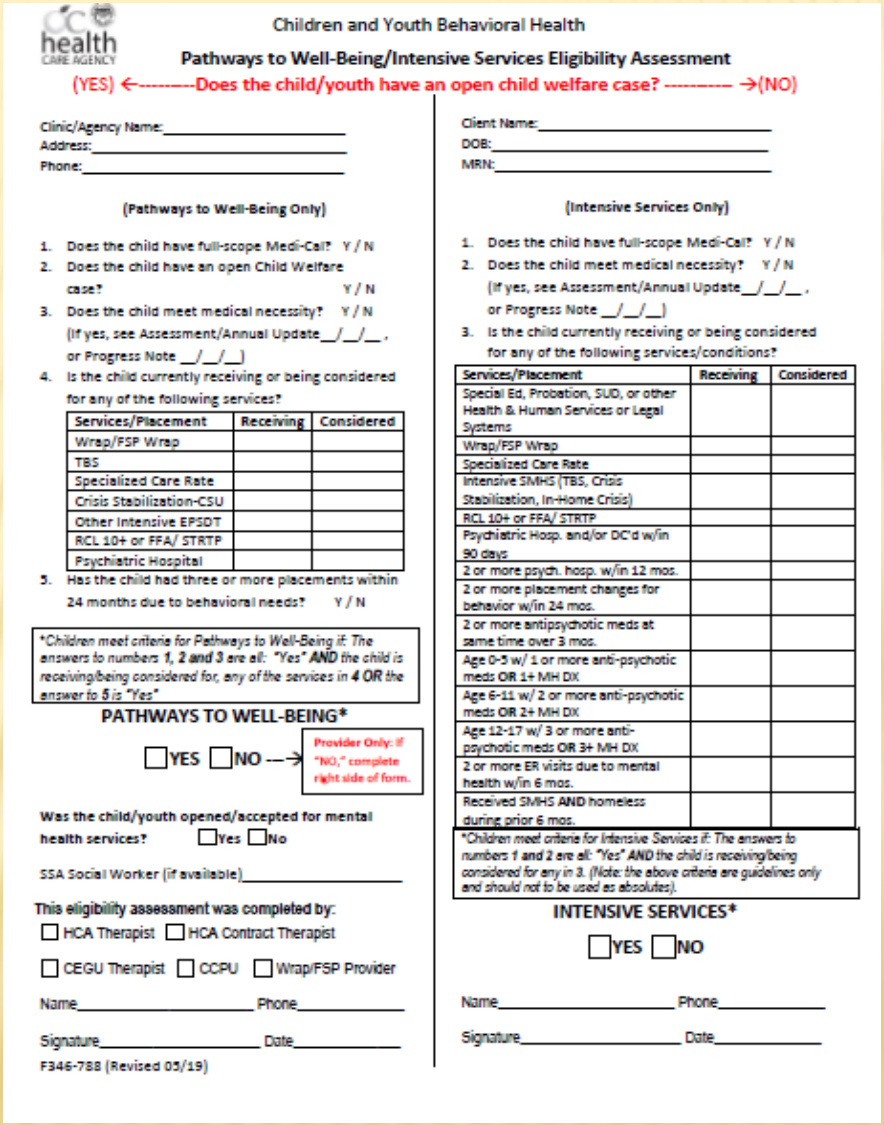
Step 6: The Plan Coordinator (therapist), as the ICC Coordinator, will participate in all PWB CFT meetings with the child/family and the SSA social worker.

Step 7: The Plan Coordinator (therapist), as the ICC Coordinator, will complete the "CFT Plan" at all PWB CFT meetings.

(**CFT Plan** replaces the previous "Individualized Plan of Care" form)

Note: If Wraparound is involved, the Wraparound Care Coordinator, will complete the "CFT Plan."

Pathways to Well-Being/Intensive Services Eligibility Assessment form



Children and Youth Behavioral Health

Pathways to Well-Being/Intensive Services Eligibility Assessment

(YES) ←---------Does the child/youth have an open child welfare case? ---------- →(NO)

Clinic/Agency Name:_____
Address:_____
Phone:_____

(Pathways to Well-Being Only)

1. Does the child have full-scope Medi-Cal? Y / N
2. Does the child have an open Child Welfare case? Y / N
3. Does the child meet medical necessity? Y / N (If yes, see Assessment/Annual Update__/__/__ , or Progress Note __/__/__)
4. Is the child currently receiving or being considered for any of the following services?

Services/Placement	Receiving	Considered
Wrap/FSP Wrap		
TBS		
Specialized Care Rate		
Crisis Stabilization-CSU		
Other Intensive EPSDT		
RCL 10+ or FFA/ STRTP		
Psychiatric Hospital		

5. Has the child had three or more placements within 24 months due to behavioral needs? Y / N

*Children meet criteria for Pathways to Well-Being if: The answers to numbers **1, 2 and 3** are all: "Yes" **AND** the child is receiving/being considered for, any of the services in **4 OR** the answer to **5** is "Yes"*

PATHWAYS TO WELL-BEING*

☐YES ☐NO --→ Provider Only: if "NO," complete right side of form.

Was the child/youth opened/accepted for mental health services? ☐Yes ☐No

SSA Social Worker (if available)_____

This eligibility assessment was completed by:

☐ HCA Therapist ☐ HCA Contract Therapist

☐ CEGU Therapist ☐ CCPU ☐ Wrap/FSP Provider

Name_____ Phone_____

Signature_____ Date_____

F346-788 (Revised 05/19)

Client Name:_____
DOB:_____
MRN:_____

(Intensive Services Only)

1. Does the child have full-scope Medi-Cal? Y / N
2. Does the child meet medical necessity? Y / N (If yes, see Assessment/Annual Update__/__/__ , or Progress Note __/__/__)
3. Is the child currently receiving or being considered for any of the following services/conditions?

Services/Placement	Receiving	Considered
Special Ed, Probation, SUD, or other Health & Human Services or Legal Systems		
Wrap/FSP Wrap		
Specialized Care Rate		
Intensive SMHS (TBS, Crisis Stabilization, In-Home Crisis)		
RCL 10+ or FFA/ STRTP		
Psychiatric Hosp. and/or DC'd w/in 90 days		
2 or more psych. hosp. w/in 12 mos.		
2 or more placement changes for behavior w/in 24 mos.		
2 or more antipsychotic meds at same time over 3 mos.		
Age 0-5 w/ 1 or more anti-psychotic meds **OR** 1+ MH DX		
Age 6-11 w/ 2 or more anti-psychotic meds **OR** 2+ MH DX		
Age 12-17 w/ 3 or more anti-psychotic meds **OR** 3+ MH DX		
2 or more ER visits due to mental health w/in 6 mos.		
Received SMHS **AND** homeless during prior 6 mos.		

*Children meet criteria for Intensive Services if: The answers to numbers **1 and 2** are all: "Yes" **AND** the child is receiving/being considered for any in 3. (Note: the above criteria are guidelines only and should not to be used as absolutes).*

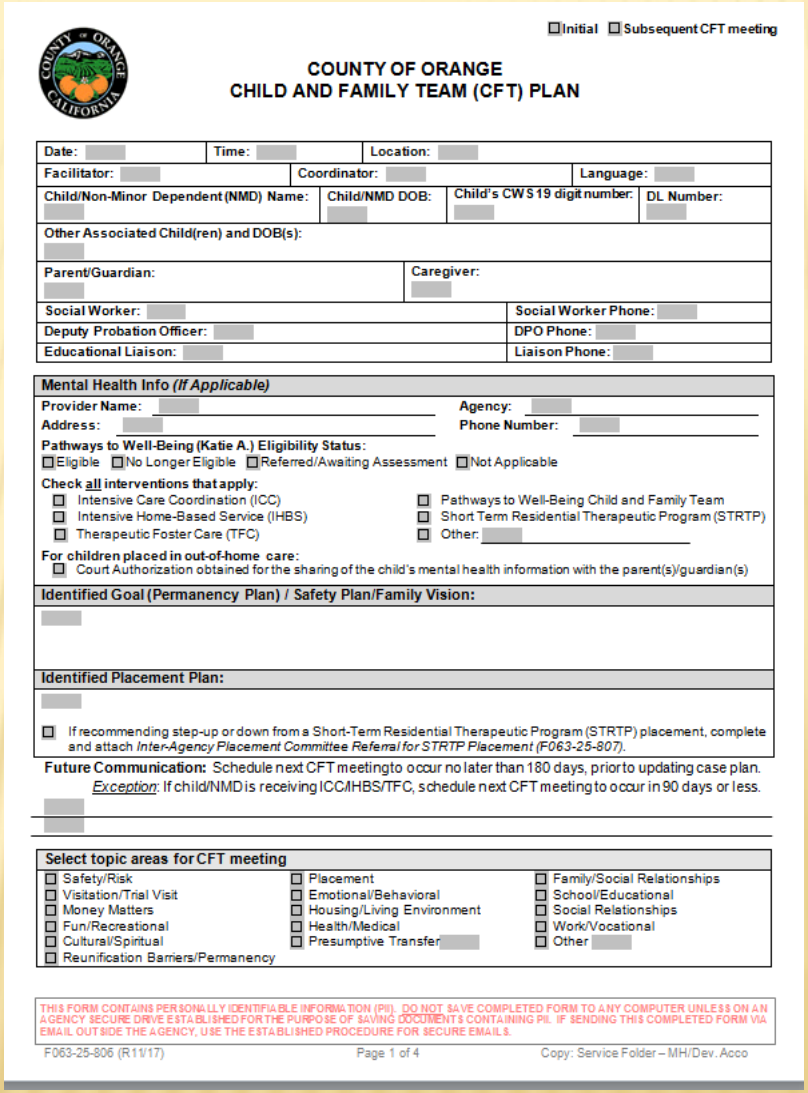
INTENSIVE SERVICES*

☐YES ☐NO

Name_____ Phone_____

Signature_____ Date_____

CFT Plan (4 pages)



☐ Initial ☐ Subsequent CFT meeting

COUNTY OF ORANGE
CHILD AND FAMILY TEAM (CFT) PLAN

Date:	**Time:**	**Location:**	
Facilitator:	**Coordinator:**	**Language:**	
Child/Non-Minor Dependent (NMD) Name:	**Child/NMD DOB:**	**Child's CWS 19 digit number:**	**DL Number:**
Other Associated Child(ren) and DOB(s):			
Parent/Guardian:	**Caregiver:**		
Social Worker:	**Social Worker Phone:**		
Deputy Probation Officer:	**DPO Phone:**		
Educational Liaison:	**Liaison Phone:**		

Mental Health Info *(If Applicable)*

Provider Name: **Agency:**
Address: **Phone Number:**

Pathways to Well-Being (Katie A.) Eligibility Status:
☐ Eligible ☐ No Longer Eligible ☐ Referred/Awaiting Assessment ☐ Not Applicable

Check all interventions that apply:
- ☐ Intensive Care Coordination (ICC)
- ☐ Intensive Home-Based Service (IHBS)
- ☐ Therapeutic Foster Care (TFC)
- ☐ Pathways to Well-Being Child and Family Team
- ☐ Short Term Residential Therapeutic Program (STRTP)
- ☐ Other:

For children placed in out-of-home care:
☐ Court Authorization obtained for the sharing of the child's mental health information with the parent(s)/guardian(s)

Identified Goal (Permanency Plan) / Safety Plan/Family Vision:

Identified Placement Plan:

☐ If recommending step-up or down from a Short-Term Residential Therapeutic Program (STRTP) placement, complete and attach *Inter-Agency Placement Committee Referral for STRTP Placement (F063-25-807).*

Future Communication: Schedule next CFT meeting to occur no later than 180 days, prior to updating case plan.
Exception: If child/NMD is receiving ICC/IHBS/TFC, schedule next CFT meeting to occur in 90 days or less.

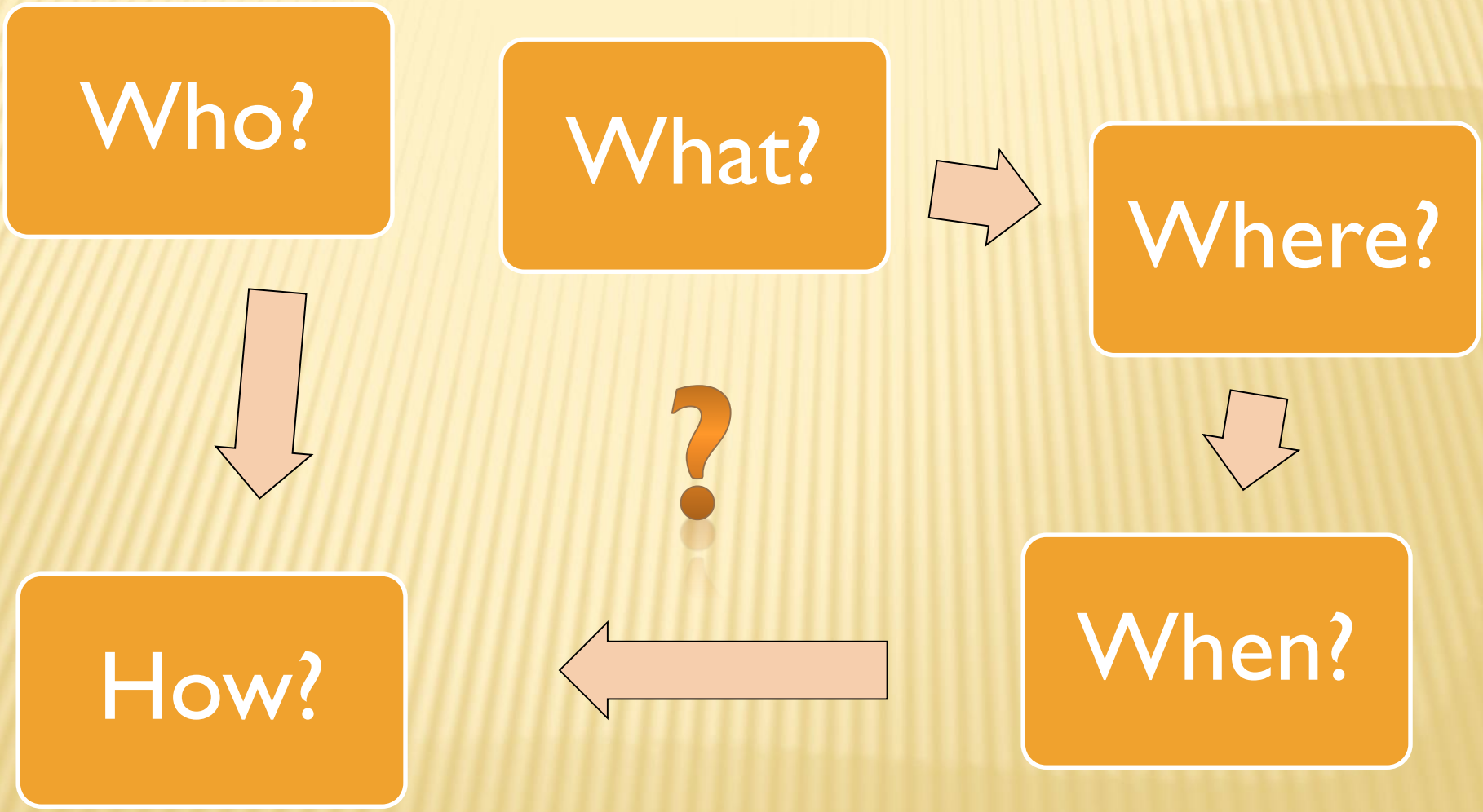
Select topic areas for CFT meeting

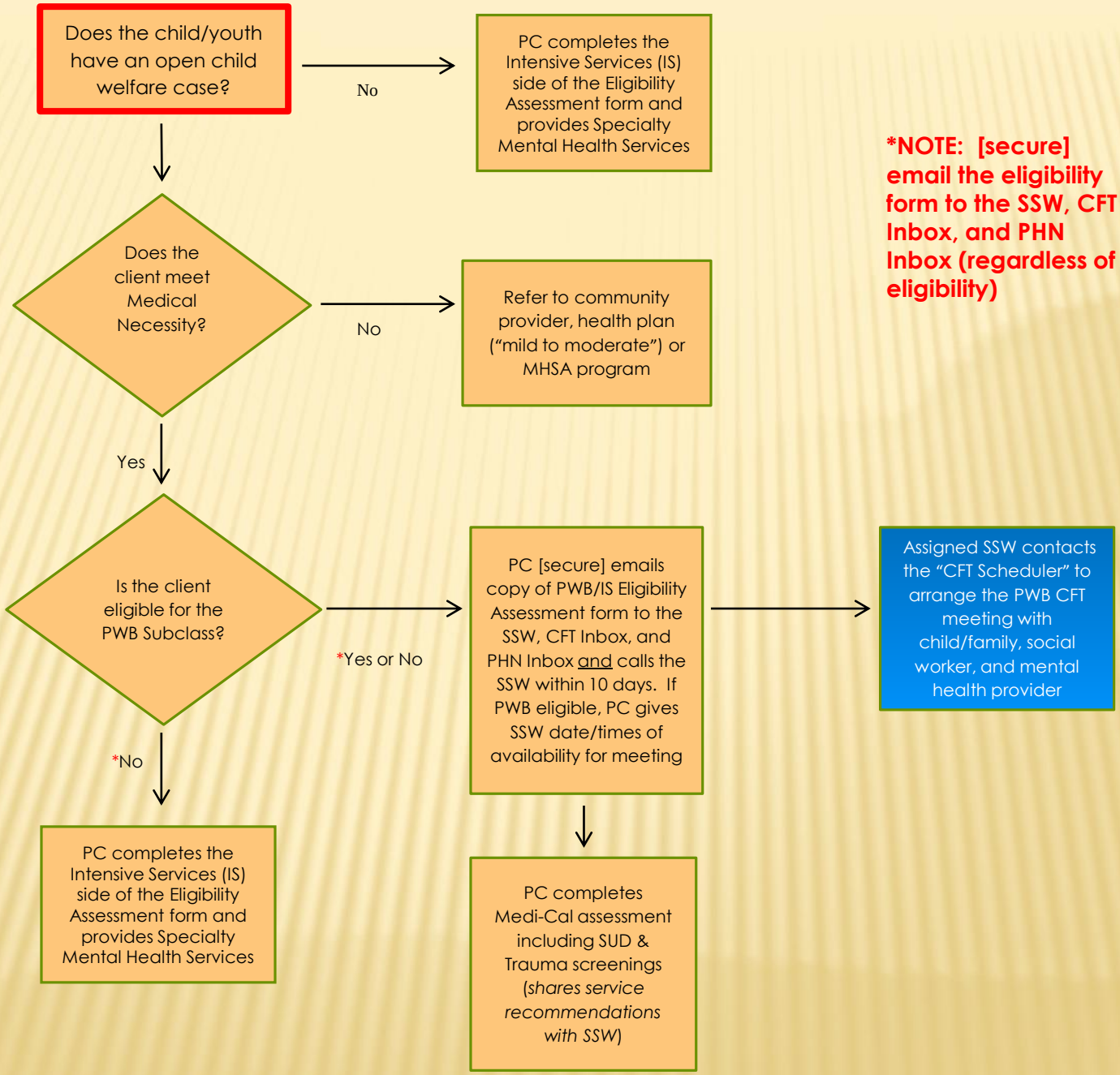
☐ Safety/Risk	☐ Placement	☐ Family/Social Relationships
☐ Visitation/Trial Visit	☐ Emotional/Behavioral	☐ School/Educational
☐ Money Matters	☐ Housing/Living Environment	☐ Social Relationships
☐ Fun/Recreational	☐ Health/Medical	☐ Work/Vocational
☐ Cultural/Spiritual	☐ Presumptive Transfer	☐ Other
☐ Reunification Barriers/Permanency		

THIS FORM CONTAINS PERSONALLY IDENTIFIABLE INFORMATION (PII). DO NOT SAVE COMPLETED FORM TO ANY COMPUTER UNLESS ON AN AGENCY SECURE DRIVE ESTABLISHED FOR THE PURPOSE OF SAVING DOCUMENTS CONTAINING PII. IF SENDING THIS COMPLETED FORM VIA EMAIL OUTSIDE THE AGENCY, USE THE ESTABLISHED PROCEDURE FOR SECURE EMAILS.

F063-25-806 (R11/17) Page 1 of 4 Copy: Service Folder – MH/Dev. Acco

PWB REFERRAL & CFT SCHEDULING FLOW CHART





***NOTE: [secure] email the eligibility form to the SSW, CFT Inbox, and PHN Inbox (regardless of eligibility)**

CONDUCTING THE CHILD AND FAMILY TEAM MEETING

- The child/youth and family, social worker and mental health provider must all be present in order for the meeting to be counted as a "Pathways to Well-Being CFT Meeting."

- The **CFT Facilitator** (SSA representative): This person is responsible for laying out the structure and clarifying the ground rules for the meeting. The facilitator helps the team navigate through the process of establishing goals and objectives for the family. The facilitator ensures that the voice of the child/youth and family is central to the CFT meeting and that their vision for well-being is made clear.

CONDUCTING THE CHILD AND FAMILY TEAM MEETING

- The **ICC Coordinator** (mental health representative): Is responsible for working within the CFT to ensure that plans from any of the system partners are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with services to the child/youth and/or family are coordinated to support and ensure successful and enduring change. The coordinator must be a mental health professional.

CONDUCTING THE CHILD AND FAMILY TEAM MEETING

- The CFT meeting will be standardized to include:

  - A clearly defined purpose, goal and agenda for each meeting

  - An agreed upon decision-making process

  - Identification of family strengths and needs

  - Specific action steps to be carried out by team members according to a timeline

  - A review of the CFT Plan

CONDUCTING THE CHILD AND FAMILY TEAM MEETING

- Everyone must be involved. All members of the CFT must contribute to the decision-making process and the development of goals/objectives. Each member is also responsible for, following through and reporting back on the tasks they have been assigned by the team.
- The mental health provider must contribute by offering his/her expertise in addressing the behavioral, emotional and psychological needs of the child/youth and family.

CONDUCTING THE CHILD AND FAMILY TEAM MEETING

- Reviewing and changing the CFT Plan is an ongoing process and should be done at each Child and Family Team meeting. Reviewing the plan should be done **no less frequent than every 90 days.**
- The child/youth and family must always participate in this review.
- Document any activities related to the review and adjustments to the CFT Plan.

CONDUCTING THE CHILD AND FAMILY TEAM MEETING

- Team members may communicate with one another and with the whole team in various ways,
  - Such as phone calls, conference calls, and/or emails (following confidentiality, HIPPA, PHI and Public Information standards).
  - Plan Coordinator (therapist) will communicate regularly with CFT members and make sure team members have the information needed to make informed decisions.
  - Plan Coordinator (therapist) and social worker will maintain regular/ongoing communication, sharing of information, and face to face discussions.

"Alone we can do so little, together we can do so much." *--Helen Keller*

RESOURCES

- Integrated Core Practice Model Guide: https://www.dhcs.ca.gov/services/MH/Documents/Integrated_Core_Practice_Model_Guide.pdf
- Medi-Cal Manual for ICC, IHBS, and TFC: https://www.dhcs.ca.gov/services/MH/Documents/Medi-Cal_Manual_Third_Edition.pdf
- CDSS Pathways to Well-Being Website:

  https://www.cdss.ca.gov/inforesources/Foster-Care/Pathways-to-Well-Being

CONTACT INFORMATION

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