Child and Family Team Meetings, Shared Family Care Planning & Shared Coaching

A Manual for the San Francisco Human Services Agency & the Department of Public Health Community Behavioral Health Services

June 2015

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Background, Purpose and Overview of the Child and Family Team Meeting

What is Katie A?

Katie A. v. Bonta is a federal class action lawsuit filed on behalf of California foster youth and children at risk of out-of-home placement. Initially filed in July 2002, the lawsuit seeks to improve access to intensive home and community-based mental health services offered through Medi-Cal, California’s Medicaid program. Youth and children who suffer from abuse or neglect “disproportionately suffer from mental health disorders. It is estimated that adolescents living with foster parents or in group homes have about four times the rate of serious mental health needs than those living with their own families.”¹ Unfortunately, children in state custody often do not receive needed mental health treatment.

The Katie A. lawsuit seeks to improve access to effective mental health care and reduce potential trauma from residential settings by ensuring that California’s children and youth at risk of or in the foster care system can receive intensive mental health services in their own homes and communities. An additional intention of the lawsuit is to provide intensive mental health treatment in the home before behaviors escalate beyond the family’s ability to cope so that fewer children will enter foster care.

The Human Services Agency of San Francisco (SFHSA) and San Francisco Community Behavioral Health Services (CBHS) are partnering to achieve the aim of Katie A using a quality improvement approach. This partnership has been developed in the midst of a broader statewide change initiative impacting child welfare known as the California Child Welfare Core Practice Model (CPM).

What is the California Child Welfare Core Practice Model and Teaming Framework?

The California Child Welfare Core Practice Model (CA CPM) is a comprehensive framework intended to guide child welfare practice across California counties. It aims to support consistent

child welfare practice across the state to improve accountability and outcomes for children and families. The CA CPM builds upon proven practice models that are already being implemented across California, such as Safety Organized Practice (SOP), California Partners for Permanency (CAPP), and the Katie A. Core Practice Model. The framework consists of six elements:

- Overarching Theoretical Framework: Overarching theories that provide the foundation for the framework
- Core Values and Practice Principles: Core beliefs of child welfare in their work with children, youth and families
- Casework Components: Basic activities of child welfare practice/casework
- Practice Elements: Broad actions of child welfare workers in order to promote permanency, safety, and well-being for all children and youth
- Practice Behaviors: Expected behaviors of child welfare workers within each practice element

A key practice element of the CA CPM is Teaming. CA CPM dictates that a core activity of child welfare is to work as a team, in partnership with families, communities and all entities that will impact the well-being and safety of the children and youth they serve. Teaming has multiple benefits. It safeguards against individual bias, it ensures varied professional and life perspectives on family experiences, and helps improve planning and decision making. Child and Family Team (CFT) Meetings are part of this broader Teaming framework and are intended to focus on:

a. Engagement of child welfare, foster care mental health, peer parent advocates and the family.

b. Development of strengths-based and family-centered recommendations to support the mental and behavioral health of children/youth that may have been impacted by the traumatic events that brought them to the attention of Child Welfare.

c. Ensuring timely access to needed interventions, supports and services that promote the mental and behavioral health of the child/youth and their family.

What is a Child and Family Team Meeting?

Child and Family Team Meetings (CFT) are held to foster a shared understanding between child welfare staff, mental health staff, and the families of youth at risk of entering, or in the foster care system of the mental and behavioral health needs of the youth that may have resulted from, or been exacerbated by, exposure to traumatic family events. A CFT offers an opportunity for the Family/Youth to discuss the Youth’s mental/behavioral health needs with staff from both
Child Welfare and Behavioral Health agencies, to identify what they would like to see change to improve the Youth’s mental/behavioral health, and to work in collaboration with child welfare staff, foster care mental health staff, and peer parent advocates to design a Shared Family Care Plan that addresses the mental/behavioral health needs of the Youth. The Shared Family Care Plan may involve recommendations related to the parents’ mental and behavioral health needs in order to support the emotional and mental health of the youth as well as their safety.

Who Participates in a Child and Family Team Meeting?

The routine participants in the CFT are the parents and the youth at risk of entering, or in the foster care system, the SFHSA Facilitator, SFHSA case carrying worker, the CBHS Foster Care Mental Health (FCMH) Clinician, and the CBHS or SFHSA Peer Parent Advocate (PP). Each family has an initial CFT when coming in contact with Child Welfare, even if there are multiple children/youth involved. Foster Families attend on a case by case basis.

What Are the Goals and Objectives of a Child and Family Team Meeting?

Goal:
The goal of a Child and Family Team Meeting is to develop a Shared Family Care Plan that enhances the daily safety of the youth and addresses the behavioral health needs of the family and youth involved.

Objectives:
- **Jointly engage** child welfare, foster care mental health, and parent partners with family/youth and establish good working relationships.
- Share Child Welfare safety goals, as well as the results of the Foster Care Mental Health behavioral health assessment with family/youth.
- **Family/youth share their perspective** about the youth’s mental/behavioral health needs, and identify family/community strengths and supports that exist to help them meet their child/youth’s needs as well as the supports and services they believe would help them.
- Create a Shared Family Care Plan where the family/youth, supported by behavioral health, child welfare and peer parent staff, identify the actions they will take, changes they will make, and their responsibilities to meet the child’s mental health need’s and...
achieve their safety goals. The Plan also identifies actions and responsibilities of the agency professionals on behalf of the child.

- **Initiate Shared Family Care Planning Process** where everyone begins to take the steps necessary to implement the Plan. While there is shared accountability to follow through on the mental/behavioral health recommendations in the Plan, the Child Welfare Worker monitors when goals from the Plan are met, as well as when family/youth are not moving forward on action steps in the Shared Family Care Plan. The PSW will request another CFT when the Plan needs to be updated.

**What Are the Roles/Responsibilities of Child and Family Team Participants?**

- **Facilitator:** The Facilitator’s role is to facilitate the meeting and ensure that the family understands not only the purpose of the meeting, but also the different roles of the meeting participants, and that they have an opportunity to speak and share their perspectives. The family’s opinion will be on the Shared Family Care Plan. The Facilitator also documents the Plan on the Shared Family Care Plan form.

- **Child Welfare Worker - Court Dependency Unit (CDU) Worker, Family Services Unit (FSU) Worker, or Non-Court Family Maintenance (NCFM) Worker:** The child welfare worker calls for the CFT meeting and reiterates the family’s safety goals in clear and simple language. The worker provides Foster Care Mental Health (FCMH) the opportunity to share the results of its assessment and offer the family/youth the opportunity to share their perspectives on the youth’s mental/behavioral health needs that have resulted from, or been exacerbated by, the trauma of neglect and abuse. The child welfare worker encourages the family/youth throughout the meeting to share not only their perspectives, but also to identify their strengths and supports. The child welfare worker provides FCMH the opportunity to discuss its recommendations and will collaborate with FCMH and the family/youth to establish a Shared Family Care Plan to address the mental/behavioral health needs. The child welfare worker assesses for a collaborative Shared Family Care Planning process where each CFT participant is actively engaged in shaping the Shared Family Care Plan.

- **Foster Care Mental Health Clinician (FCMH):** The FCMH clinician meets the family/youth prior to the CFT meeting in person, or at minimum by phone. The clinician
reads any accessible behavioral health history on the family or receives a briefing from past behavioral clinicians if possible. It is highly recommended the FCMH clinician completes the CANS prior to the CFT if possible, and explain the behavioral health assessment and recommendations for addressing the youth’s behavioral health needs in clear and simple language. The clinician should collaborate with the family/youth, child welfare worker, and Peer Parent to establish a Shared Family Care Plan to address the mental/behavioral health needs of the youth.

- **CBHS or SFHSA Peer Parent (PP) Advocates:** The PP meets the family/youth prior to the CFT on the phone and schedules an in-person meeting. Due to time constraints, this may occur 15 minutes prior to the CFT. The PP explains the purpose of the CFT in clear and simple language to the family, and answers questions the family may have about the CFT meeting. PPs work closely with family/youth to ensure they are engaged in the Shared Family Care Planning process and that their perspectives help shape the plan. After the meeting, the PP checks in with the parent/caregiver to make sure the parent feels “brought into” the Shared Family Care Plan and schedules a follow up meeting in person or by phone with the parent/caregiver. The PP later meets with other CFT attendees to debrief the meeting.
What are the Core Competencies Needed by Agency Participants to do Shared Family Care Planning within a Child and Family Team Meeting?

<table>
<thead>
<tr>
<th>Foster Care Mental Health</th>
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<tbody>
<tr>
<td><strong>Competency Area</strong></td>
<td><strong>Evidenced By</strong></td>
</tr>
<tr>
<td><strong>A. Values</strong></td>
<td></td>
</tr>
<tr>
<td>1. Demonstrates belief that children/youth should be first and foremost protected from abuse and neglect and maintained safely in their own homes.</td>
<td>☐ Emphasizes the importance of the safety of the child in all discussions that occur in the CFT. &lt;br&gt;☐ Continuously looks for ways the child can be maintained safely in their own home.</td>
</tr>
<tr>
<td>2. Demonstrates belief that the family’s voice, choices, and preferences should be acknowledged throughout the process.</td>
<td>☐ Acknowledges the perspectives of the family during initial discussions, deciding on intervention strategies, and the development of the formal plan. &lt;br&gt;☐ Acknowledges the perspectives of the child during initial discussions, deciding on intervention strategies, and the development of the formal plan.</td>
</tr>
<tr>
<td>3. Demonstrates respect for family’s culture.</td>
<td>☐ Acknowledges differences. &lt;br&gt;☐ Asks questions that draw out the importance and meaning of the family’s culture. &lt;br&gt;☐ Able to explore opinions and judgments related to culture in supervision. &lt;br&gt;☐ Open to feedback.</td>
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### Foster Care Mental Health

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<tr>
<th>Competency Area</th>
<th>Evidenced By</th>
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<tr>
<td>4. Demonstrates belief that services and supports should be provided in the</td>
<td>□ Discussion with family and in supervision reflects this belief.</td>
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<tr>
<td>family’s local community and in the least restrictive and most normative</td>
<td>□ Continuously explores available supports and resources in the community,</td>
</tr>
<tr>
<td>setting possible.</td>
<td>including those of the family.</td>
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### B. Engagement

| Demonstrate ability to effectively build rapport and trust with members of the | □ Projects warmth and interest when speaking with family members.            |
| family.                                                                       | □ Changes their engagement style depending on the nature of the person they |
|                                                                              |   are working with.                                                         |
|                                                                              | □ Tolerant of different levels of family member’s readiness to engage.     |
|                                                                              | □ Family members feel understood rather than interrogated.                 |

| Demonstrates ability to use open ended questions in a non-threatening, yet    | □ Use of open ended questions versus closed ended questions.                |
| exploratory way to invite family members to share their perspectives in their | □ Questions elicit further constructive discussion from family members     |
| own words.                                                                   |   rather closing off discussion.                                            |
|                                                                              | □ Family members’ voices and perspectives are expressed during the meeting. |

<p>| Demonstrates ability to use genuine and congruent affirmations to recognize   | □ Family members exhibit signs of confidence in making a change rather than |
| family member strengths and acknowledge behaviors that lead in the direction  |   feeling hopeless or defeated.                                           |
| of positive change, no matter how big or small.                             |                                                                              |</p>
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<th>Competency Area</th>
<th>Evidenced By</th>
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<tr>
<td>4. Demonstrates ability to pay respectful attention to the content and feelings</td>
<td>☐ Family members acknowledge they have been understood.</td>
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<td></td>
<td>☐ Feelings by family members are expressed that were otherwise unknown.</td>
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<tr>
<td>5. Demonstrates the ability to engage clients in change talk to assist them in</td>
<td>☐ Family members are able to express ambivalence to make changes.</td>
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<td></td>
<td>☐ Family members are able to state their own reasons and desires to make a change.</td>
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<tr>
<td>6. Demonstrates ability to create a safe environment for family members to</td>
<td>☐ Family members are able to make candid statements about themselves and their interactions with others</td>
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<td></td>
<td>without judgment.</td>
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<tr>
<td>7. Demonstrates ability to self-reflect on personal barriers to engagement with</td>
<td>☐ Asks for feedback from supervisor or co-workers during group supervision on how they can more</td>
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<td></td>
<td>effectively engage with specific family members.</td>
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<td>☐ Can discuss a situation from a family member’s point of view in a non-blaming manner.</td>
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### C. Assessment

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<th>Competency Area</th>
<th>Evidenced By</th>
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<td>8. Demonstrates ability to find common ground among family members, child welfare workers, etc.</td>
<td>- Ability to reach compromises in meetings with the family and in discussions with child welfare workers, while also maintaining a sound clinical formulation and plan.</td>
</tr>
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#### C. Assessment

1. Demonstrates ability to identify specific strengths of the family that can be used to not only keep the child safe, but enhance the well-being of the family. This can include talents, skills, environmental resources and supports, as well as desires and aspirations.  
   - Identification of strengths that are specific and detailed enough to be usable to help family achieve a desired goal rather than generic or vague.

2. Demonstrates ability to help the family identify specific needs that if met can help them keep their child safe and enhance the well-being of the family.  
   - Use of a trauma lens to help the family understand the impact that trauma has on child and family development.  
   - Specific family needs are identified by family members.

3. Demonstrates ability to identify meaningful and important goals of the child and the family to keep the child safe and enhance the overall well-being of the family.  
   - Specific meaningful and important goals are identified by family members.  
   - Family members are engaged in discussions about goals.

4. Demonstrates ability to evaluate the effectiveness of previous interventions and strategies that have helped the family keep the child safe in the past.  
   - Motivational interviewing strategies are used to help family identify what has worked.  
   - Positive use of information synthesized from past records.
<table>
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<tr>
<th>Foster Care Mental Health</th>
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<tr>
<td>Competency Area</td>
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<tr>
<td>5. Demonstrates ability to identify environmental and internal triggers that have been precursors to the child not being safe.</td>
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<td>6. Demonstrates ability to go beyond behaviors observed by the child and family to identify possible factors that are underneath those behaviors.</td>
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<tr>
<td>7. Demonstrates ability to assess and write about children’s exposure to multiple traumatic events as well as the potential impact of trauma on observed behaviors and symptoms.</td>
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<tr>
<td>D. Goal Planning</td>
</tr>
<tr>
<td>1. Demonstrates ability to write specific goals using language that is meaningful and understood by the family.</td>
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<tr>
<td>Competency Area</td>
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<td>--------------------------------------------------------------------------------</td>
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<tr>
<td>2. Demonstrates ability to break down goals on the plan into smaller, specific, measurable objectives and action steps.</td>
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<tr>
<td>3. Demonstrates ability to use specific strengths of the family when writing positive objectives and action steps.</td>
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<tr>
<td>ROLE</td>
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<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>CHILD WELFARE: To Be Developed</td>
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<tr>
<td>PEER PARENT ADVOCATE: TBD</td>
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What are the Steps Involved in Preparing for a Child and Family Team Meeting?

- **Schedule the CFT:** Emergency Response (ER) Worker determines if the child will be detained, and refers the child to FCMH for a Child and Adolescent Needs and Strengths (CANS) Screening. Child welfare workers who participate in an Interagency Services Collaborative (IASC) Cohort Team organize the CFT meeting for all assigned families. They inform the SFHSA scheduler that a CFT is needed as soon as a new family is assigned to them. FSU workers who are participating in an IASC cohort as well organize the CFT meeting for all assigned families that have not yet had a CFT while in CDU. They inform the SFHSA Scheduler a CFT is needed as soon as a new family is assigned to them. However, there is a minimum of three days between the CFT being put in the calendar/the email notification being sent to all invited participants and the CFT occurring.

- **When and Where:** CFTs are held anytime that works for the family between 9AM – 7PM. The meeting site is anyplace that is open and works for the family.

- **Meet the Family/Youth before the CFT if possible:** PSW, FCMH, and PP attempt to have in person or over the phone contact with the Family/Youth prior to the CFT. FCMH completes CANS prior to the CFT (this is highly recommended; however CFT can occur and information can be gathered at the CFT for the CANS if necessary). Explain the purpose of the CFT and answer any questions the Family/Youth may have, and allow opportunity for Family/Youth to express needs, hopes, and worries.

- **Talk with your CFT agency team members (Facilitator, CW, FCMH, PP) before the CFT if possible:** Share any pertinent information and insights, especially with Facilitator, so the Family/Youth can be better supported in the meeting and increase likelihood of them authentically engaging in Planning Process.

- **Clarify Roles and Responsibilities, especially if CFT meeting does not go as planned.** Identify answers to questions such as the ones below:
  a. Who will take the lead with a Family/Youth that is difficult to engage? (Some possibilities are the Peer Parent Advocate; the Facilitator; Protective Services Worker; etc.)
b. Who will take the lead if a Family/Youth is not part of the development of services/supports or other recommendations that come up in the meeting?

What are the Phases of a Child and Family Team Meeting CFT Meeting Agenda?

**Phase 1: Engagement (Introductions and Identify the Situation)**

1. The Facilitator establishes purpose of the meeting.
2. The Facilitator summarizes what will occur in the meeting (review plan for the meeting).
3. The Facilitator introduces all participants and their roles.
4. The Family has an opportunity to restate the purpose of the meeting in their language and ask any clarifying questions to ensure shared understanding between the family and the service agency representatives.

**Phase 2: Discussion of Assessments (Assess the Situation)**

1. The Child Welfare (PSW) Worker shares results of child welfare assessment, using Safety Organized Practice (SOP) decision support and assessment tools (Three Houses, Safety Map, etc.).
2. The Foster Care Mental Health Clinician share results of the foster care mental health assessment, using Child and Adolescent Needs and Strengths (CANS) screening and other assessment tools.
3. The Peer Parent Advocate summarizes this information for the Family if necessary to promote understanding.
4. The Family/Youth shares their perspectives of the situation as well as their needs, and the strengths and natural supports they already have in place to help meet those needs.

**Phase 3: Initiate Shared Family Care Planning (Develop Ideas and Reach a Decision)**

1. The Family/Youth describe their safety goals and the parents describe what they will do to make sure their child(ren) are safe while the child(ren) describes what they need to have change to feel safe, etc.
2. The Family and Child describe their behavioral health goals and generate ideas to take
steps toward achieving those goals.

3. The CW Worker identifies child welfare agency safety goals that address the danger statement, timelines related to those goals, and the supports/services the agency can offer to help family meet their goals.

4. The FCMH Clinician describes their recommendations as well as the supports they can offer the Family/Youth in achieving their behavioral health goals.

5. The Facilitator explains to the Family what happens next and who will be doing what.

6. The Facilitator ensures the Family has contact information for all CFT participants.

7. The Parent Partner escorts the Family out of the CFT and ensures they have clear understanding of next steps.

8. During this time, the Facilitator disseminates the CFT Action Plan.

**Phase 4: Recap/Evaluate/Closing (After the Family Leaves)**

1. PP, FCMH, CW, and Facilitator meet for 15 minutes to debrief and discuss observations.

2. During this time, the Child Welfare Worker completes whatever parts of the Shared Family Care Plan they could not complete during the CFT.

3. During this time, the FCMH Clinician completes the PDSA Observation Sheet based on the debrief discussion.
Purpose, Goals, and Process for Shared Family Care Planning

What is the Relationship between a Shared Family Care Plan and a Child and Family Team Meeting?

The CFT Meeting provides the structure and container for engagement and connection between families and professional agency representatives, as well as the promotion of children/youth’s mental and behavioral health. A Shared Family Care Plan is a written form that documents the plan to address the child/youths’ mental and behavioral health needs.

What are the Goals of a Shared Family Care Plan?

The goals of the Shared Family Care Plan are to:

- Identify the mental/behavioral health needs of the child/youth as a result of the trauma suffered by abuse or neglect as well as the mental/behavioral health needs of the family that impact the child’s mental and behavioral health.
- Create a behaviorally-based plan, collaboratively designed by the family/youth, the mental health professional, and the child welfare professional, to address the shared recommendations to improve the mental and behavioral health of the child/youth.

It includes the action steps, commitments and responsibilities of the family as well as the professionals, including child welfare, foster care mental health, and peer parent advocates.

Building the Shared Family Care Plan (SFCP) is a family-centered, strength-based process that is a key strategy to helping families meet the mental health needs of their children. While the process may integrate mental health services and supports to help families meet their children’s emotional and behavioral needs, its purpose is not to identify services.

Instead, the purpose of the Shared Family Care Planning process is to:

- Engage with the family using solution-focused and trauma-informed practices
- Explore with the family their worries and concerns about their child’s mental health
- Increase shared understanding of mental health assessment data that has already been gathered (CANS, other historic clinical documents, etc.) and ongoing data gathering
• Prioritize the child’s mental and behavioral health needs and collaborate with family to define their long term goals and short term objectives to help address those needs
• Identify the child/family’s strengths and barriers in meeting those goals
• Recommend services and supports that, in addition to the family’s natural strengths and supports, may assist them in achieving their goals/objectives
• Collaboratively define (the family, child welfare, and foster care mental health) the intended outcomes of a successful Shared Family Care Plan and a timeframe for those outcomes.
• Monitor, evaluate and adapt the Plan if the intended outcomes are not achieved within the timeframe.

The process incorporates key activities of child welfare practice including: prevention, engagement, assessment, planning, monitoring and adapting. It also incorporates key activities of mental health practice including: assessment, prioritization, goal setting, identification of child/family strengths and barriers to achieving their goals, development of short term objectives and recommendations of services and supports.

What are the Steps of the Shared Family Care Planning Process?

The Shared Family Care Planning Process involves the following key steps:

Preparation and Engagement

Step 1. A child is assigned to a Court Dependency Unit Worker (CDU), a Family Services Unit Worker (FSU) or a Non-Court Family Maintenance Worker (NCFM) who does not have a Shared Family Care Plan.

Step 2. The Protective Services Worker (PSW) reads the family/child case file to obtain the history from Emergency Response Worker or past PSW and determine if a Child and Adolescent Needs and Strengths (CANS) has been completed.

Step 3. The PSW contacts the Scheduler to schedule the Child and Family Team Meeting (CFT).

Step 4. At this time the PSW also refers the child to Foster Care Mental Health (FCMH) for a CANS screening if one has not been completed.
Step 5. Once the **Scheduler** has put a CFT meeting on the calendar, the **FCMH Clinical Coordinator** emails a form to all agency representatives copied on the invitation email with the name of the assigned **FCMH Consultant** and their phone number.

Step 6. Similarly, the **CBHS Peer Parent Advocate Director** as well as the **SFHSA Peer Parent Advocate Director** work together to assign a **Peer Parent Advocate (PP)**. Depending on the family, one of them will inform the **PSW** of the assigned PP.

Step 7. The **PSW** meets with the **family and child**. After engagement with the family, they write a harm and danger statement and transfer this onto the Shared Family Care Plan Form (Current Version: Shared Family Care Plan, Created on April 1, 2015. Updated June 9, 2015. V. 5).

Step 8. The **FCMH Consultant** contacts the **PSW** to obtain necessary contact information and also meets with the family and child in order to complete the CANS.

Step 9. The **PP** contacts the **PSW** to obtain necessary contact information and meets with the family in order to explain the purpose of the CFT and the Shared Family Care Planning Process and answer any questions they may have.

Step 10. The **PSW** and the **FCMH Consultant** meet prior to the CFT. This meeting can be in person or over the phone. It is an opportunity to: exchange information impacting the mental and behavioral health of the child and family that the other professional may not have; identify family strengths and community supports that may help meet the mental health needs of the child (ren); and to ask systems questions or request support from the professional partner during the Shared Family Care Planning process.

Step 11. The **PSW** and/or the **FCMH Consultant** can also seek to promote engagement with the family through meetings with the **CFT Facilitator** or the **PP** prior to the CFT.

**Pre-Meeting**

Step 12. At the scheduled time of the CFT, the **Facilitator**, the **PSW**, the **FCMH Consultant**, and the **PP** all arrive at the arranged site for the meeting. The **PSW** brings the
**Shared Family Care Plan Form.** The **FCMH Consultant** brings the PDSA Observation Work Sheet (Current Version: PDSA Obs. Form, May 4, 2015, V. 3).

**Step 13.** The **PSW** gives the **Facilitator** the Shared Family Care Plan Form with the Harm and Danger Statement and the Safety Goals completed.

**Step 14.** If the **parents** have already arrived, the **PP** will take the parents to a separate meeting area and talk with them about what will occur during the CFT and remind them about the purpose of the Shared Family Care Planning Process and their role in developing the Plan.

**Step 15.** During this time, the **Agency Partners** initiate the **CFT Pre-Meeting.** The Pre-Meeting can last from five to fifteen minutes depending on the complexity of the family. *It is critical to the success of the Shared Family Care Planning Process.* The purpose of the Pre-Meeting is to share pertinent information that will impact the CFT and address any questions or concerns of any of the agency partners. It is led by the Facilitator and includes the following:

- The **Facilitator** leads a discussion between **PSW** and **FCMH** to determine how the current harm and danger impact the mental and behavioral health of the child (ren).
- The **Facilitator** also helps to clarify any worries either worker may have about the Shared Family Care Planning Process and help with problem solving or planning prior to the start of the CFT.
- After this is completed, the **FCMH Consultant** facilitates a discussion to identify the **Facilitator** and the **PSWs** questions and predictions about the CFT and the Shared Family Care Planning Process in order to focus the learning while both are being piloted/tested.

**CFT/Development of the Shared Family Care Plan**

**Step 16.** Once the Pre-Meeting is completed and the **PP** and the **parents** have returned to the meeting room, the CFT begins. The Planning Process is led and facilitated by the **Facilitator.** They will also complete the Shared Family Care Plan Form, documenting the Plan and all agreed upon actions and disseminating this to all attendees at the end of the meeting. Using child welfare practice behaviors such
as Lean In\(^2\), the **Facilitator** will guide the **parents**, the **PSW** and the **FCMH Consultant** through a collaborative planning process that includes:

- Discussing the results of mental health screens and/or assessments, or planning the screens and assessments if they have not occurred;
- Clarifying the mental and behavioral health needs of the child and family;
- Supporting the gathering of more data that will promote better engagement and understanding of the family and child;
- Exploring with the family their worries and concerns about their child’s mental health;
- Getting the perspective of FCMH about the mental and behavioral health needs of the child;
- Asking the family about their goals and short term objectives to support their child’s mental health as well as the strengths and natural supports they have to help them achieve those goals;
- Facilitating discussion about recommended services and supports;
- Finalizing an action plan documented in the Shared Family Care Plan Form that defines all parties’ roles in helping promote the emotional, mental, and behavioral health of the child.

Throughout the Planning Process, the **PP** ensures the **parents** feel supported, empowered, and authentically engaged in the development of the Shared Family Care Plan and answers any questions they may have about the process or roles of different system partners.

**Debrief**

**Step 17.** Once a Plan has been finalized and documented, the **PP** escorts the **parent(s)** out of the building.

**Step 18.** After the family has left, the **PP** joins the **Facilitator, PSW, and FCMH Consultant** for a Debrief Meeting. The Debrief Meeting lasts from five to fifteen minutes depending on the complexity of the CFT. During the Debrief Meeting the agency partners have the opportunity to:

- Ensure common understanding of the next steps
- Assess the CFT/Shared Family Care Plan Process learning by discussing the 3 questions and documenting on the PDSA Observation Form (this is done by FCMH).
Purpose, Goals and Process for Shared Coaching

What is the Definition and Purpose of Coaching?

The practice of coaching has been expanding as a core component of child welfare practice. A definition of coaching that has been adapted from Mink, Owen, & Mink, 1993, is: “Coaching is a process by which the coach creates structured, focused interaction with learners and uses appropriate strategies, tools and techniques to promote desirable and sustainable change for the benefit of the learner, making a positive impact on the organization”. 3

In the past two years, the Executive Leadership at SFHSA has instituted an organizational strategy to promote Coaching throughout their agency to support the development of their workforce and sustain the changes catalyzed by the California Core Practice Model. The key components of their strategy:

- Trained Supervisors and Program Managers in the Art of Coaching so they are familiar with the model and tools.
- Hired external contractors to serve as Coaches for the SFHSA workforce. Contracted Coaches were available to work with staff on any goals they brought to the coaching session. In particular, the Coaches were skilled at using coaching methods to help workers transition to new, family centered and strength-based child welfare practice models, such as Safety Organized Practice.
- More recently, SFHSA opened and filled two internal Coaching positions. These SFHSA Coaches have been trained and their sole role and duties within SFHSA is to Coach Supervisors so they can in turn appropriately Coach their own staff so that throughout SFHSA there is a structured process for learning that uses a common set of known strategies, tools, and techniques.

Coaching is now an ongoing practice that will be instituted within SFHSA and can occur as a parallel process to Shared Coaching.

What is the Purpose of Shared Coaching?

A Shared Coaching Model can support both child welfare and mental health workers to learn how to effectively implement the Shared Family Care Planning Process. PSWs, FCMH Consultants, PPs, and Facilitators are addressing a complex set of issues when attempting to identify and meet the mental and behavioral health needs of children entering or at risk of entering the foster care system. The therapeutic, clinical, and critical decision making skills needed by all professionals involved in working with families to engage in a Shared Family Care Planning Process cannot be taught in a one-time training.

Supporting workers to move from exposure to a skill during a training to effective practice of that skill in daily work, requires use of implementation science and quality improvement tools. A key tool is the Plan, Do, Study, Act (PDSA) cycle. Initially, professionals need training on how to work collaboratively with each other and families to develop a Shared Family Care Plan. However, after this first training, in order to effectively implement the Shared Family Care Planning Process, they will need to spend a period of time treating each CFT/Shared Family Care Planning Process as a “test” where they run a PDSA.

Below is an example of how a CFT can serve as a test, where the goal is to learn how to better implement the Shared Family Care Planning Process:

A. **Plan:** Before attending the CFT, the Professionals from both Child Welfare and Mental Health should Plan their test by identifying the questions they have about the process and their predicted answers as well as their plan for how they will collect data to answer their questions.

B. **Do:** During the CFT, PSWs, FCMH Consultants, PPs, and Facilitators will keep their questions in mind and collect Data through observation.

C. **Study:** Following the CFT, they will discuss what happened and compare this with their predictions, noting unexpected problems, and documenting all of these observations and data. The most critical step in any PDSA, and the most easily overlooked, is the Study. In the busy and often crisis driven environments of human service agencies such as Child Welfare and Mental Health, it is all too easy to forgo the time needed to complete the analysis of the data, do the study, summarize what was learned.

D. **Act:** After the learning is studied it is applied to the next Act, or in other words the next cycle of testing that builds on what has been learned.
The key purpose of the Shared Coaching Model (in the context of implementing and spreading the Shared Family Care Planning Process) is to complete the Study and Act steps of the PDSAs in order to support implementation across the current Cohort Teams and ultimately spread across all of SFHSA and CBHS. It provides an organized process where professionals across agencies with different missions have an opportunity to work on a shared goal in a safe and structured environment that promotes mutual reflection, inquiry, development and growth.

Role of the Coach in Coaching Sessions Shared by Foster Care Mental Health, Child Welfare and Peer Parent Advocates

The Bay Area Academy training on the Art of Coaching states that the role of the Coach is to: “Support learners in meeting a specified goal and to guide their process, reflection, and transformation through the use of powerful questions.” The Bay Area Academy clarifies that coaching is not clinical supervision nor is it administrative supervision. Therefore Coaches in the Shared Coaching Model do not need to have clinical degrees. However, they do need to have the skills necessary to help cross agency learners find alternative perspectives and possibilities, to be able to offer tools that support learners in finding these alternatives, assist in adding clarity to complex situations, encourage action, define measurable outcomes and acknowledge accomplishments.

The practice behaviors of Coaches doing Shared Coaching are the same as those of Coaches working with staff from single agencies. Coaches:

1. Foster an environment for trust and healthy conversations
2. Support learners to identify and achieve next steps
3. Engage in active listening
4. Ask powerful questions/engage in active inquiry
5. Provide thoughtful observations

The key tools are active listening and “powerful questions,” which are open ended questions that support learners to gain clarity and awareness, to see possible solutions, to imagine options for resolution, and to commit to an action plan, timeframe and measures for success.

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4 Bay Area Academy The Art of Coaching Institute: Day 1, April 2015.
5 Bay Area Academy The Art of Coaching Institute: Coaching Skills/Behaviors Rating Scale, v. 2.0, June 2014.
What are the Steps of the Shared Family Care Planning Process?

The Shared Coaching Model involves the following key steps:

**Step 1.** Establish cross agency cohort teams consisting of different units (CDU, FSU, NCFM, Facilitators, and Peer Parent Advocates) and levels of staff (Program Directors, Program Managers, Supervisors, and Workers) from Child Welfare, different levels of staff (Assistant Director, Clinical Coordinator, and Clinicians) and pods from Foster Care Mental Health, and different levels of staff from Legacy Peer Parent Program (Director and Peer Parent Advocates).

**Step 2.** Agree to routine meeting times that last for a minimum of 1.5 hours

**Step 3.** Create a standard agenda with a certain amount of time at each Shared Coaching Session dedicated to discussing specific families and a certain amount of time dedicated to addressing cross agency policy and procedural issues that are identified in the process of implementing the Shared Family Care Planning Process.

**Step 4.** At the start of the Shared Coaching Session, establish shared agreements, contracts the participants establish with each other to create a safe environment where all staff can be open and honest. Address confidentiality limitations. Check in with participants at the start of each Shared Coaching Session to see if any agreements have changed or need to be added.

**Step 5.** Identify which participants would like to present families. Based on the number of families to be presented, establish average amount of time that can be dedicated to each family.

**Step 6.** Families can be presented by any Cohort participant, irrespective of their agency affiliation or level. The learner clarifies their learning goal before presenting the family and describing the Shared Family Care Planning Process.

**Step 7.** The Coach engages in active listening and asks powerful questions. Overtime, the Coach encourages other Cohort participants to also engage in a parallel process where they begin to ask the powerful questions of each other. The Coach is continually clarifying, acknowledging and celebrating successes, promoting the
learner to identify options for addressing their identified challenge or problem they having in implementing the Shared Family Care Planning Process.

**Step 8.** Broad policy, procedural, or systems issues identified while learners are discussing families are documented on a flip chart as “Parking Lot Issues.” These are discussed during the part of the Shared Coaching Session agenda that is dedicated to addressing policy issues. If solutions can get identified during the Shared Coaching Session that do not require approval from higher levels of management in either Child Welfare or Mental Health, they are documented in bi-monthly FAQs that get disseminated to all Shared Coaching Cohorts. If solutions require discussion by upper management they are tabled and raised during monthly Executive Management Team Meetings.

**Step 9.** When each learner finishes developing SMART Goals and their next steps to improve the Shared Family Care Planning Process, the Coach moves onto the next learner until each learner has had the opportunity to present their family or until the time dedicated to that part of the agenda has run out. If all learners did not have the opportunity to present in a Shared Coaching Session, they are the first to present in the next Shared Coaching Session.
Appendix I:

Katie A and IASC Definitions
Katie A. / iASC Definitions

Katie A. – The Katie A. Lawsuit, Katie A. et al. v. Bonta et al., refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011. Katie A. practices utilize the 

Core Practice Model (CPM) which defines the values, principles, teaming model and standards of practice and activities for all child welfare and mental health agencies, service providers and community/tribal partners working with child welfare children, youth and families. California counties began implementing Katie A. in January 2013. (www.cdss.ca.gov, Pathways to Mental Health Services - Core Practice Model)

Class – Includes children and youth who:
- Are in foster care or at imminent risk of placement in foster care,
- Have a mental illness or condition that has been documented, or if assessed would have a diagnosis with a mental illness or condition, and who need individualized mental health services.

Subclass – Includes children who are eligible for full scope Medi-Cal, have an open child welfare case, meet the medical necessity criteria for Specialty Mental Health Services, and meet one of the following criteria:
- Currently in or being considered for wraparound, therapeutic foster care, or other intensive services, therapeutic behavioral services, a specialized care rate due to behavioral health needs, or crisis stabilization intervention; or
- Currently in, or being considered for placement in a level 10 or above group home, a psychiatric hospital or 24 hour mental health treatment facility; or
- Has experienced three or more placements within 24 months due to behavioral health needs. (ACL 13-73)

iASC – San Francisco created the Interagency Services Collaborative (iASC), which sets goals beyond what Katie A. requires, and formally replaces the name ‘Katie A’. iASC expands the collaboration beyond child welfare and mental health, to include juvenile probation, SFUSD and community partners. The goal of iASC is to design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative. The system will support the health, safety, permanency and well-being of children, youth and families that have been involved with or are at risk of involvement with foster care, probation, or special education, and/or are struggling with complications of behavioral health issues.

Pilot Implementation – The iASC pilot implementation program was initiated by San Francisco HSA/FCS and CBHS/FCMH in January 2014. It uses a PDSA quality improvement methodology process (Plan-Do-Study-Act) to guide the system and practice changes. Initially serving a limited
number of Subclass members, the pilot is gradually increasing those being served by iASC in this group. Key objectives of the pilot include developing a model for the Child and Family Team, data collection to determine whether the changes are leading to improvements, developing a Shared Family Care Plan, involving the leadership through the Executive Management Team and Program Managers, and a Shared Coaching model recently introduced to support the change process.

CFT – A Child and Family Team (CFT) includes the family and all of the ancillary individuals who are working with them toward their successful transition out of the child welfare system. In San Francisco the team is comprised of the family/youth, child welfare worker, foster care mental health provider, peer parent (from either FCS or FCMH), facilitator, and other service providers or members as necessary and appropriate. The child welfare worker, mental health staff and service providers collaborate to engage youth and families as partners in the team environment. CFT Meetings provide a strength based, needs driven, and family focused approach for families and their team members to identify and prioritize concerns and challenges, brainstorm solutions, develop action plans, review progress, and adjust the family’s care plan accordingly. FCMB Child and Adolescent Needs and Strengths (CANS) and FCS Safety Organized Practice (SOP) assessments are discussed with the family. The Shared Family Care Plan is the written plan specifying the family’s behavioral health needs, goals and action steps agreed upon by the team. The CFT is also responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan to address the changing needs of the child/youth and family in a timely manner, but not less than every 90 days. (Katie A Medi-Cal Manual)

ICC – Intensive Care Coordination (ICC) is a Medi-Cal-covered service that is responsible for facilitating assessment, care planning and coordination of services, including urgent services for children/youth who meet the Katie A. Subclass criteria. All Subclass members must receive ICC. (Katie A. Medi-Cal Manual)

IHBS – Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child’s functioning. Interventions are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child’s family’s ability to help the youth successfully function in the home and community. (Katie A. Medi-Cal Manual)

ITFC – Intensive Treatment Foster Care (ITFC) provides an alternative to higher level group homes. ITFC does this by placing only one foster child in a specialized foster home. The child has an individualized treatment program and the foster parents are carefully matched to each child with intensive and highly coordinated mental health and support services provided to a foster parent or caregiver to include them as an integral part of the child’s treatment team. (Pathways to Mental Health Services- Core Practice Model)

RBS – San Francisco’s Residentially Based Services Programs (RBS) (also referred to as Family
**Connections Programs** provide comprehensive services and supports for families who have highly disrupted relationships and whose children exhibit a pattern of challenging behaviors that present a significant risk of harm to themselves or others. These programs are designed to promote safety, permanency and well-being through intensive connection-centered services delivered by a care team that work consistently with the youth and family across multiple environments. (SFHSA Handbook 52-24)

**Wrap – Wraparound** is an intensive, individualized care planning and services management process. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans and services that are effective and relevant to the child and family. Wraparound services may include activities which are not reimbursable under Medi-Cal. (Katie A. Medi-Cal Manual)
Appendix II:

SF Core Practice Model
Vision
Design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative to support the health, safety, permanency and well-being of children, youth and families involved in or at risk of involvement in Foster Care, Probation, Special Education and are struggling with the complications of behavioral health issues.

Pilot Implementation
- **HSA / FCS**
  - Child Welfare Worker
  - Child Welfare Case Plan
  - Mental Health Plan of Care
- **CBHS / FCMH**
  - CBHS / FCMH Consultant
  - FCMHP/MH Consultant
  - CANS
  - Shared Coaching
  - PDSAs

**CFT**
- Shared Family Care Plan
- Class — Children and youth with open cases
  - Subclass — Medical eligible with medical necessity and meet Subclass criteria

**CLASS**
- Mental Health Assessment
- Services Tracking and Review

**SUBCLASS**
- ICC
  - Assessment, Care Planning, Coordination of Services, Urgent Services for Subclass
- IHBS
  - MH Rehab Services, Transitional Services

**PROVIDERS**
- SF RBS / WRAP: Edgewood, St. Vincent, Seneca
- SF ITFC County Mental Health Contracts: AFS and Seneca
- Other SF ITFC No Mental Health Contracts: Seneca

See reverse side for Katie A / IASC definitions
Appendix III:

Shared Family Care Plan Form: Draft, June 2015
(Final: Sept. 2015)
CITY AND COUNTY OF SAN FRANCISCO

HUMAN SERVICES AGENCY
Family & Children Services

SHARED FAMILY CARE PLAN
CREATED ON APRIL 1, 2015, V. 5

Date: ___________________ Start Time: _____________ End Time: _____________

Parent(s) Name(s): Child(ren)’s Name(s):

CANS Assessment Status:

_________________________________________________________________

HARM/DANGER STATEMENT (Definition of Harm: The reason the Agency is involved; Definition of Danger Statement: What the Agency is most worried about happening to your child if nothing Changes):

SAFETY GOAL(s) (Definition: What the Agency needs from you with your support system to show that the child will be safe):

SKILL/ BEHAVIORAL GOALS AND INTERVENTION (FCMH):

Updated: June 9, 2015 v. 5 Form Completed by SFHSA Facilitator Page 1 of 2
### Shared Family Care Plan

<table>
<thead>
<tr>
<th>Behavioral/Services: (What behavioral changes will the caregiver/s take to mitigate the danger and achieve sustained safety?)</th>
<th>Action Steps/ Family Responsibilities (Who, what, by when and how will we know?)</th>
<th>Agency Responsibilities: What is HSA/FCMH/PPA going to do to assist the family?</th>
</tr>
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Updated: June 9, 2015 v. 5    Form Completed by SFHSA Facilitator    Page 36 of 2
Appendix IV:

PDSA Observation Form
**PDSA Observation Form**

**May 4, 2015, v. 3**

**Instructions**

- **Before** a CFT, Team identifies key questions they want to get answered in the CFT and FCMH jots down the questions. Examples:
  1. Will I be able to learn about the mental health goals for this family by time the CFT and debriefing are completed?
  2. Will the family engage with mental health, child welfare, and the parent partner?
- **Before** a CFT, Team identifies answers to their questions based on what they think will happen (their predictions) and FCMH jots down answers.
- **After** CFT completed, Team discusses 3 Questions and FCMH jots down answers to each question
- Bring 20 copies to the next IASC Cohort Team Meeting

### 1) CFT PARTICIPANT NAMES

<table>
<thead>
<tr>
<th>Family</th>
<th>Facilitator</th>
<th>PSW</th>
<th>FCMH</th>
<th>PPA</th>
</tr>
</thead>
</table>

### 2) QUESTIONS: What questions are you trying to answer in this CFT? (Write these BEFORE the CFT)

- a. QUESTION 1
- b. QUESTION 2

### 3) PREDICTIONS: What do you think will happen? What are your responses to your questions? (Answer each of your questions BEFORE the CFT)

- a. PREDICTION 1
- b. PREDICTION 2

### 4) 3 Questions:

- a. What went well?
- b. What are our worries?
- c. What are our next steps?
Appendix V:

April 2015 Training for SF Child Welfare, Foster Care Mental Health and Peer Parent Advocates

*Shared Family Care Planning in Child and Family Team Meeting*
Shared Family Care Planning

in

Child and Family Team Meetings

A TRAINING FOR IASC COHORT PARTICIPANTS

APRIL 1, 2015
What is Katie A?
(taken from: http://www.youngmindsadvocacy.org/how-we-work/advocating/litigation/katie-a-v-bonta/)

1. **Katie A. v. Bonta** is a federal class action lawsuit filed on behalf of California foster youth and children at risk of out-of-home placement. Initially filed in July 2002, the lawsuit seeks to improve access to intensive home and community-based mental health services offered through Medi-Cal, California’s Medicaid program.

2. **The Problem:** Children placed outside the home due to abuse or neglect disproportionately suffer mental health disorders. It is estimated that adolescents living with foster parents or in group homes have about four times the rate of serious mental health needs than those living with their own families. Institutional or group care may be necessary for some youth with extremely high level needs, but for others it is unnecessary—even harmful. Indeed, separating children from their homes and families may add to their distress. To make matters worse, children in state custody often do not receive needed mental health treatment.

3. **The Goal:** Katie A. lawsuit seeks to improve access to effective care by enabling California’s most vulnerable children to receive intensive mental health services in their own homes and communities. This will allow children to remain safely with their families or in home-like setting and help prevent additional trauma caused by unnecessary institutionalization. Further, by providing intensive mental health treatment in the home before behaviors escalate beyond the family’s ability to cope, fewer children will enter foster care.
What is the purpose of a Child and Family Team Meeting?

- CFT fosters a shared understanding
- Of the behavioral and mental health needs
- Of the youth and the family
- That may be impacting the safety of the youth
- And to develop a Shared Plan to address those needs

What is Relationship between a CFT Meeting and Shared Family Care Plan?

- A CFT engages Family, Youth, CW, FCMH & PP to Assess for BH Needs and Create a Plan
- Agency Perspectives: Discuss Behavioral Health Assessment & Safety Goals
- Family/Youth Perspective – Discuss Needs, Strengths, and Supports
- Goals & Recommendations Discussed and Shared Family Care Plan “Developed”
- Ongoing Process: Plan Changes as Goals Change
What are the Goals/Objectives of a Child and Family Team Meeting (CFT)?

Goal: Develop a Shared Family Care Plan that enhances the daily SAFETY of the youth and addresses the BEHAVIORAL HEALTH NEEDS of the Family & Youth

Jointly engage child welfare, foster care mental health, and partners with family/youth and establish good working relationships
Share safety goals and the results of the Foster Care Mental Health behavioral health assessment with family/youth
Family/youth share their perspective of the situation, and identify their needs, strengths and supports
Create Shared Care Plan that includes safety goals, and when parent identified, behavioral health goals as well as recommendations for services and supports

Who Participates in CFT?

1. Who are routine participants?

- Family/Youth {One family in each CFT, even if multiple children}
- SFHSA Facilitator
- SFHSA PSW from: Court Dependency Unit, Family Services Unit, or Non-Court Family Maintenance Unit
- CBHS Foster Care Mental Health Clinician
- CBHS or SFHSA Peer Parent Advocate
What are the Roles and Responsibilities of all Participants?

**Facilitator:**
1. Facilitate meeting
2. Ensure family understands purpose of meeting
3. Ensure family understands the different roles of the meeting participants
4. Ensure the family has opportunity to speak, share their perspective and have it inform the Shared Family Care Plan

What are the Roles and Responsibilities of all Participants?

**CDU, FSU, or NCFM Worker**
1. Call for the CFT Meeting
2. Explain their safety assessment in clear and simple language
3. Allow FCMH the opportunity to share the results of their assessment
4. Allow Family/Youth the opportunity to share their perspective on the situation
5. Encourage family/youth participation throughout the CFT Meeting, particularly in:
   - Share any safety goals
   - When there are behavioral health concerns, allow FCMH opportunity to discuss their recommendations, collaborate with family/youth to establish behavioral health goals and develop a plan to achieve those goals
6. Throughout CFT meeting, assess for collaborative Shared Family Care Planning process where each CFT participant is actively engaged in shaping the Shared Family Care Plan
7. During the meeting (or after if not possible during the CFT) complete the Shared Family Care Plan form
What are the Roles and Responsibilities of all Participants?

**FCMH Consultant**

1. Meet the Family/Youth prior to the CFT (on the phone, at minimum)
2. Read any accessible behavioral health history on the family or get briefed by past behavioral health clinicians
3. Complete CANS prior to CFT if possible
4. Explain their behavioral health assessment and recommendations for behavioral health goals in clear and simple language
5. Offer behavioral health information/basic education as questions arise in the CFT
6. Collaborate with Family/Youth to create initial plan to address the behavioral health goals
7. Participate in the development of the Shared Family Care Plan

What are the Roles and Responsibilities of all Participants?

**CBHS or SFHSA Peer Parent Advocates**

1. Meet the Family/Youth prior to the CFT on the phone and schedule an in-person meeting. Due to time constraints, this may be arranging to meet 15 minutes prior to CTF.
2. Explain purpose of CFT in clear and simple language
3. Answer questions the family has about the CFT
4. Collaborate with Family/Youth to ensure they are engaged in the Shared Family Care Planning process and that their perspectives help to shape the Plan
5. Participate in the development of the Shared Family Care Plan
6. Check in with parent/caregiver after meeting to make sure parent feels “bought into” Shared Family Care Plan
7. Schedule follow-up meeting (or phone contact at a minimum) with parent/caregiver.
8. PPA meets with other CFT attendees so all may debrief about CFT.
What is the preparation needed for a CFT?

1. **Schedule the CFT**
   - ER Worker determines if a child will be detained
   - ER Worker refers child to FCMH for a CANS
   - CDU or NCFM Workers that are participating in an IASC Cohort organize CFT meetings for all assigned families. They inform the SFHSA Scheduler a CFT is needed as soon as a new family is assigned to them
   - FSU Workers that are participating in an IASC Cohort also organize CFT meetings for all assigned families that have not yet had a CFT while in CDU. They inform the SFHSA Scheduler a CFT is needed as soon as a new family is assigned to them
   - There is a **minimum of 3 days** between the CFT being put in calendar/the email notification being sent to all invited participants and the CFT occurring

2. **When and Where**
   - CFTs are held anytime that works for the family between 9am -7pm
   - The meeting site is anyplace that is open and works for the family

3. **Meet the Family/Youth before the CFT if possible**
   - PSW, FCMH, and PP attempt to have in person or over the phone contact with the Family/Youth prior to the CFT
   - FCMH completes CANS prior to the CFT (this is highly recommended; however CFT can occur and information can be gathered for the CANS if necessary)
   - Explain the purpose of the CFT and answer any questions the Family/Youth may have
   - Allow opportunity for Family/Youth to express needs, hopes, and worries

4. **Talk with your CFT agency team members (Facilitator, CW, FCMH, PP) before the CFT if possible**
   - Share any pertinent information and insights, especially with Facilitator, so the Family/Youth can be better supported in the meeting and increase likelihood of them authentically engaging in Planning Process
What is the Preparation Needed for a CFT?

5. Clarify Roles and Responsibilities, especially if CFT meeting does not go as planned. Identify answers to questions such as the ones below:

- Who will take the lead with a Family/Youth that is difficult to engage? (Some possibilities are the Peer Parent Advocate; the Facilitator; Protective Services Worker; etc.)

- Who will take the lead if a Family/Youth is not part of the development of services/supports or other recommendations that come up in the meeting?

What are the phases of CFT Meeting Agenda?

San Diego Model:

1. Introductions
2. Identify the Situation
3. Assess the Situation
4. Develop Ideas
5. Reach a Decision
6. Recap/Evaluate/Closing
What are the Phases of a CFT Meeting Agenda?

**Phase 1: Engagement (Introductions and Identify the Situation)**

1. The Facilitator establishes purpose of the meeting.
2. The Facilitator summarizes what will occur in the meeting (review plan for the meeting).
3. The Facilitator introduces all participants and their roles.
4. The Family has an opportunity to restate the purpose of the meeting in their language and ask any clarifying questions to ensure shared understanding between the family and the service agency representatives.

**Phase 2: Discussion of Assessments (Assess the Situation)**

1. The Child Welfare (PSW) Worker shares safety goals or any information from child welfare assessment that will further understanding of the behavioral health needs of the youth, e.g. results of Safety Organized Practice (SOP) decision support and assessment tools- Three Houses, Safety Map, etc.
2. The Foster Care Mental Health Clinician share results of the foster care mental health assessment, using Child and Adolescent Needs and Strengths (CANS) screening and other assessment tools.
3. The Peer Parent Advocate summarizes this information for the Family if necessary to promote understanding.
4. The Family/Youth shares their perspectives of the situation as well as their needs, and the strengths and natural supports they already have in place to help meet those needs.
What are the Phases of a CFT Meeting Agenda?

**Phase 3: Initiate Shared Family Care Planning (Develop Ideas and Reach a Decision)**

1. The Family/Youth describe their safety goals and the parents describe what they will do to make sure their child(ren) are safe while the child(ren) describes what they need to have change to feel safe, etc.
2. The Family and Child describe their behavioral health goals and generate ideas to take steps toward achieving those goals
3. The CW Worker identifies child welfare agency safety goals that address the danger statement, timelines related to those goals, and the supports/services the agency can offer to help family meet their goals
4. The FCMH Clinician describes their recommendations as well as the supports they can offer the Family/Youth in achieving their behavioral health goals.
5. The Facilitator explains to the Family what happens next and who will be doing what.
6. The Facilitator ensures the Family has contact information for all CFT participants
7. The Parent Partner escorts the Family out of the CFT and ensures they have clear understanding of next steps.
8. During this time, the Facilitator disseminates the CFT Action Plan

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What are the phases of CFT Meeting Agenda?

**Phase 4: Recap/Evaluate/Closing (After the Family Leaves)**

1. PP, FCMH, CW, and Facilitator meet for 15 minutes to debrief and discuss observations
2. During this time, the Child Welfare Worker completes whatever parts of the Shared Family Care Plan they could not complete during the CFT
3. During this time, the FCMH Clinician completes the PDSA Observation Sheet based on the debrief discussion
How is a Shared Family Care Plan Developed?

1. FCMH Clinician meets Family/Youth, completes the CANS screen and gathers other assessment information prior to the CFT
2. FCMH Clinician gathers any other behavioral health information they have access to and consents for, i.e. past family clinical records, discussions with other clinical providers, etc.
3. CW Worker meets with Family/Youth and uses SOP interviewing strategies and decision-support tools to assess harm, danger, and safety
4. PP meets with Family to describe explain the CFT to them, identify any immediate needs that may impact the Family’s ability to authentically participate in the CFT, and help develop solutions
5. All of the information is brought to CFT and the Facilitator promotes collaborative teaming among all participants to identify both safety and behavioral health needs of the Family/Youth, goals related to safety and recommendations to address the behavioral health issues of the Family/Youth (see Phases of CFT Agenda)

6. All participants work collaboratively to design concrete action steps:
   - For the Family/Youth
   - For the Agencies

7. If there are no behavioral health issues, the CW Worker only completes their Case Plan. If there are behavioral health issues and recommendations, a Shared Care Planning Process is initiated between the Family/Youth, FCMH and CW. They work together to develop a Shared Family Care Plan that all three entities have shared accountability for implementing.
8. During the CFT or immediately following during the Debrief Session, the CW Worker records all next action steps in the Shared Family Care Plan form.
9. The Shared Family Care Plan is monitored by CW Worker. It is a living document and is updated whenever a goal is achieved or there is a change in the Plan.
How are Facilitators, CW, FCMH, and PPs doing Shared Family Care Planning getting Coached?

1. The purpose of the IASC Cohort Meetings is to get Shared Coaching on running a CFT and doing Shared Family Care Planning

2. In order to best use the Cohort Meetings:
   - Aprille and Jen will be collaborating with for complicated families, the Team that initially worked on the Shared Family Care Plan may want to all attend the same Cohort meeting when that family is presented
   - 3-4 families will be presented per Cohort meeting and staff will get shared coaching
   - Staff that are presenting must bring enough copies of their PDSA Observation Sheet to share with all other Cohort Participants

Questions

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