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|  | Shasta County Health and Human Services Agency Children's Services | |
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1.0 Persons/Programs Affected (Check all that apply)

| | |
|--|--|
| <input type="checkbox"/> All Children's Staff | |
| <input checked="" type="checkbox"/> Adoptions | <input checked="" type="checkbox"/> Foster Care Mental Health |
| <input checked="" type="checkbox"/> CPS/Intake | <input checked="" type="checkbox"/> Children's Mental Health |
| <input checked="" type="checkbox"/> Ongoing | <input checked="" type="checkbox"/> Children's AOD |
| <input checked="" type="checkbox"/> Court Officers/.26 | <input checked="" type="checkbox"/> Children's Psychology Team |
| <input checked="" type="checkbox"/> FTM & HRT Facilitators | <input checked="" type="checkbox"/> Foster Care Nursing |
| <input checked="" type="checkbox"/> Family Preservation | <input checked="" type="checkbox"/> Wraparound |
| <input type="checkbox"/> Foster Care Eligibility | <input type="checkbox"/> Children's Support Staff (Clerical, Analysts, Legal Clerks) |
| <input checked="" type="checkbox"/> Foster Care Licensing | <input type="checkbox"/> Family Workers |
| <input checked="" type="checkbox"/> Options | <input type="checkbox"/> Other (Probation, SCOE, OneSafePlace, CAPC): |

**All employees include all individuals employed by the Children's Services Division full-time, part-time and extra-help.*

2.0 Revision History


| Date | No. | Action: |
|--------|-----|---------------------------|
| 2-7-14 | 1.0 | New Policy Implementation |

3.0 Purpose & Background

On July 18, 2002, a lawsuit entitled *Katie A. et al. v. Diana Bonta et al.* was filed seeking declaratory and injunctive relief on behalf of a class of children in California who: (1) are in foster care or are at imminent risk of foster care placement; (2) have a mental illness or condition that has been documented or, if an assessment had been conducted, would have been documented; and (3) need individualized mental health services, including, but not limited to, professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

In December 2011, the parties reached a Katie A. Settlement Agreement. It is intended that the Katie A. Settlement will improve coordination of resources and services and promote greater uniformity in statewide practices by children services, mental health and other service providers. The objectives of the agreement are to:

- A. Facilitate an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach;
- B. Support the development and delivery of a service structure and a fiscal system that supports the Core Practice Model;

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- C. Support an effective and sustainable solution that will involve standards and methods to achieve quality, based on oversight, along with training and education that support the practice and fiscal models;
- D. Address the more intensive needs of the Katie A. Subclass with medically necessary specialty mental health services in their own home, a family setting or at the most home like setting appropriate to their needs. This is done for the purpose of facilitating reunification, and to meet the child's needs for safety, permanency and well being.

4.0 Policy


All children/youth that become part of an open Child Welfare Services case will be screened for mental health needs during the Intake process. The Mental Health Screening is given to every child/youth over age five by designated staff and for children age 0-5 years the Options Public Health Nurse will complete the Ages and Stages Questionnaire (ASQ). Please see the Ages and Stages Questionnaire Third Edition policy and procedure for further details on the ASQ process.

The Mental Health Screening once completed is given to the Access Clinician who will go through the Access Process (see the Specialty Mental Health Services Access & Urgent Care Policy and Procedure) where based upon the information gathered a child/youth may be referred for a Mental Health Assessment to establish medical necessity. For children that are not opened to mental health services a Mental Health Re-Screening Form is completed by the Ongoing social worker after 90 days from entry into a case and then again annually.

Children's Services staff will use the practices and principles of the Core Practice Model (CPM) approach when working with children and families involved with child welfare and mental health. The CPM approach requires collaboration between child welfare, mental health staff, service providers and community/tribal partners working with the children/youth and families.

For children/youth that are part of the Katie A. Subclass teaming is necessary to serve the needs of the child and family. The Katie A. Subclass is a group of children/youth, who are Medi-Cal eligible, meet medical necessity for Specialty Mental Health Services, have an open child welfare services case, and meet either of the following criteria:

- Child is currently in or being considered for Wraparound, Therapeutic Foster Care or other intensive services, therapeutic behavioral services, specialized care rate due to behavioral health needs or crisis stabilization/intervention; or

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- Child is currently in or being considered for a group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility, or has experienced his/her 3rd or more placement within a 24 month period due to behavioral health needs.

A mental health clinician will evaluate each child who appears to meet Katie A. Subclass eligibility by using the Katie A. Eligibility Evaluation Form. If the child meets Katie A. subclass eligibility a Child and Family Team (CFT) meeting will be scheduled within 30 days of the evaluation. A CFT meeting must include the child and family as well as the social worker and clinician associated with the case. A CFT meeting must take place a minimum of once every 90 days.

If the child does not meet Katie A. subclass criteria the Katie A. Coordinator will recommend, when appropriate, that the Social Worker call for a High Risk Team (HRT) meeting to help address the needs of the child and family. High Risk Team meetings are for current dependents of Shasta County and children who have an open child welfare referral. The content of the HRT is focused on both the child and caregiver(s) needs by addressing behavioral challenges that place the child at risk for multiple placements and providing the caregiver with strategies to address these challenges. Behavior challenges can include but are not limited to mental health, school placement, medical, physical, emotional or developmental delays.

Children's Services Analysts will track the Katie A. Subclass by running a variety of reports in the CWS/CMS system and will evaluate outcomes. Details of the evaluation can be found in the Katie A. Evaluation Plan and Katie A. Logic Model.

5.0 Procedure

5.1 Mental Health Screening

All children/youth that become part of an open Child Welfare Services case will be screened for mental health needs. An initial Mental Health Screening (Attachment A) is completed by designated staff for all children/youth over age 5 with an open child welfare case. For children age 0-5 a Public Health Nurse completes the Ages and Stages Questionnaire (ASQ) screening. When a child screens positive on the ASQ for mental health needs the ASQ-SE (Social Emotional) will be administered and forwarded to the Access Clinician. For additional information on the ASQ screening process please see the Ages and Stages Questionnaire Third Edition (ASQ-3) Policy and Procedure.



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If a child over age 5 does not appear to initially have any mental health needs after completing the mental health screening, the case carrying social worker will follow up at 90 days and annually to complete the Mental Health Re-Screening Form (Attachment B). Social workers will receive a reminder notice the month before the 90 day and annual re-screenings are due. Once the mental health screening has been completed the Social Worker will give the screening to the Access Clinician to begin the triage process.


The Access Clinician reviews the mental health screening, completes the triage process and will interview others (Social Worker, child, foster parent, biological parent, etc.) to determine if the child/youth needs a mental health assessment. If the Access Clinician determines that the child/youth can benefit from receiving a mental health assessment a referral will be made to an Organizational Provider or internal clinician with Shasta County Mental Health to conduct the mental health assessment and determine medical necessity for specialty mental health services. The Access Clinician will send the disposition form to the social worker or the public health nurse (if age 0-5) that informs them of the child/youth's appointment time and where the child has been referred for a mental health assessment. For more detailed information regarding the Access process please see the Specialty Mental Health Access and Urgent Care Policy and Procedure.

The Access Clinician will give a copy of the screening form to the analyst to track in the Mental Health Screening Database to ensure that every child with an open child welfare case is receiving a timely mental health screening.

5.2 **Katie A. Eligibility Evaluation**

The Katie A. Eligibility Evaluation is completed by a mental health clinician to establish eligibility for Katie A. Subclass services. Each child who appears to meet Katie A. Subclass eligibility will be evaluated using the Katie A. Eligibility Evaluation Form (Attachment C). The mental health clinician will gather information about the child from the social worker, care provider, and mental health clinician to verify that the child meets subclass eligibility criteria.

If a case carrying social worker or clinician believes a child on their case load meets Katie A. subclass eligibility they should contact the Katie A. Coordinator to complete an Evaluation. Children can be referred for a Katie A. Subclass evaluation by directly contacting the Katie A. Coordinator or by completing the Mental Health Screening Form that is given to the Access Clinician. Please see the "Process to Refer Open Cases for a Katie A. Subclass Evaluation" (Attachment D) flow chart that describes the various steps necessary to refer for Katie A. Subclass on open child welfare cases. For new temporary

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custody child welfare cases see the “Process to Refer Intake Cases for a Katie A. Subclass Evaluation” (Attachment E) flow chart.

Once the Katie A. Eligibility Evaluation has been completed and the determination is made this information will be sent to the case carrying social worker, clinician, and analyst to track the progress of all evaluations. If the child meets Katie A. Eligibility a notice is also sent to the Electronic Health Record Analyst at Business and Support Services so that the Katie A. Qualifier can be added in the Electronic Health Record for Medi-Cal billing.


5.3 **Child & Family Team (CFT)**

The child and family team (CFT) is a group of people working together to identify the Katie A. subclass child/youth and family’s strengths and underlying needs. Once it has been established that a child/youth meets Katie A. subclass eligibility a CFT meeting should be held within 30 days of the Katie A. Eligibility Evaluation. The CFT meetings should occur as often as the family and/or child deems necessary and no less than once every 90 days in order to re-evaluate subclass eligibility, and child/family needs.

The CFT meeting will focus on integrating a variety of perspectives from individuals committed to working with and supporting the child/youth and family to meet their needs and achieve their goals. Teaming requires a great deal of collaboration where everyone is working toward common goals with a shared understanding of the means to reach those goals. Transparency within the CFT team is important and member of the team need to be clear about their own roles and values and how to communicate these to other team members. The CFT meeting schedule and locations are guided by the family’s needs and preferences.

The key principles of the CFT include:

- Identify important people to participate in CFT.
- Identify the needs and strengths of the child/youth and their family.
- Create goals with the child/youth, family and system partners, so that the efforts of the team plan are in alignment, with a shared goal of child safety, permanency and well-being.
- Develop shared plans to address risks and needs in a way that builds on strengths and natural supports.
- Evaluate and refine the intervention strategies to ensure progress.
- Plan for the transition from formal to informal services.

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The CFT will utilize Safety Organized Practice (SOP) principles and can be facilitated by social workers or clinicians. Participants at a CFT **must** include the case carrying social worker, clinician (Organizational Provider and/or internal Children's Mental Health), family, and child. If the social worker or clinician is not able to attend a scheduled meeting, the supervisor is responsible for representing their staff at the meeting. The CFT meeting will utilize the Shasta County Child & Family Team Meeting Template (Attachment F) which focuses on what is working well, worries and development of a safety plan for the child and family.


The clinician attending the CFT should bill Intensive Care Coordination (ICC) services during the meeting which is a special Medi-Cal billing code for Katie A. subclass children. Social workers must enter the meeting notes into the contacts section of the CWS/CMS system. After the CFT meeting copies of the CFT meeting notes will be made for the social worker and the analyst to track in the Katie A. Subclass Database.

5.3.1 Wraparound & CFT

Children/youth involved in Wraparound are eligible for Katie A. Subclass services. Wraparound is a philosophy and set of practice principles that focuses primarily on working with families rather than a program or a service. Wraparound's greatest strength includes the focus on the whole family's strengths and needs, highly individualized planning, crisis and safety planning and creating a team of formal and informal supports. Wraparound eligibility includes:

- The child must be at risk of going to a level 10 group home or higher, and
- The child has mental health diagnosis and is in danger of losing current placement

Children/youth involved with Wraparound have a team of facilitators, parent partners, clinicians, skill builders, other professionals and community supports which make the Wraparound concept real. The team conducts meetings, supports children in school and assists parents/caregivers in meeting the needs of the child. Initial CFT meetings consist of: developing a Safety Plan, setting ground rules for the meeting and deciding who the family wants present at

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meetings. Additional CFT meetings will identify the family's strengths, what is working well, any concerns or challenges, and creation of a Family Vision.

5.4 High Risk Team (HRT)


When a child is being evaluated for Katie A. subclass and it is determined that the child does not meet subclass criteria, the social worker and/or clinician will seek a high risk team (HRT) to help address the needs of the child and family.

The High Risk Team (HRT) was developed in response to requests from foster and adoptive parents. The HRT works closely with care providers and social workers to access needed services. Shasta County Probation also has the opportunity to utilize this program to improve permanency outcomes for probation wards.

High-risk children, because of severe medical, emotional/behavioral or developmental issues, suffer a far higher rate of placement disruptions, multiple foster care placements, and reentry into foster care. Early identification and intensive case-management is necessary to prevent these disruptions and to increase stability and the likelihood of permanency. Due to the emotional impacts and stresses on foster and adoptive parents when caring for high-risk children, a single point-of-contact provides tools, strategies, support and access to specialized services during the HRT meetings.

The referral process for an HRT includes completing the referral paperwork (located in Shasta Templates under HRT Referral and Attachment G), listing on the referral who should attend and if the HRT needs to occur within 24-48 hours. Once the referral is received the HRT Coordinator will screen and begin the scheduling process within 48 hours of all referrals determined to be appropriate. The HRT Coordinator will review with the social worker that the appropriate releases of information are on file.

Mandatory participants at a HRT meeting include Mental Health, Education, and Public Health who will always be present at the initial and follow up HRT's until determined that it is no longer necessary. In order for a HRT meeting to occur the social worker and the child's care giver **MUST** always be present (parent(s) are also invited unless it would be detrimental to the child or caregiver). Additional participants will be invited to participate in HRT's based on the needs of the child and family and can include: Far Northern Regional Services, Organizational Providers, CASA, private therapists, Foster Family Agency (FFA) social workers, family supports, and medical professionals. Each team member represents their Department and the current concerns and strengths they have regarding the child, as well as possible solutions that their Department can provide.

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The HRT members are responsible for action items assigned during the meeting and participating in creating a safety plan to address any future concerns. The content of the HRT is focused on the child and care provider needs. Meeting notes are taken at all HRT's and a copy is given to the case carrying social worker at the close of the meeting and originals are stored in the child's file. An action plan is generated from the team's list and follow up meetings will be scheduled every two weeks unless the case demands more or less contact.

The HRT Coordinator will enter into CMS/CWS all contact notes and meeting notes regarding the HRT process. Each child who has a HRT meeting will have a file created by the HRT Coordinator that will go to the case carrying Social Worker when the case closes or the HRT process ends. The HRT can remain for the life of the case or until issues have resolved, it has to be a team decision for the HRT process to end.

5.4.1 HRT and CFT Transitions


Sometimes a child/youth who has been involved in the HRT process will meet the criteria for Katie A. subclass eligibility. The HRT Coordinator can stay involved and/or transition the family and child to the CFT meeting coordinator. Both meetings follow a similar format utilizing Safety Organized Practice principles.

The HRT Coordinator is also involved in helping to facilitate CFT meetings for Katie A. subclass children/youth who are seeing Organizational Providers for mental health services. By having the HRT Coordinator facilitate the CFT meetings for Organizational Providers the fidelity of these meeting remains true to the Core Practice Model.

5.5 Transition & Closing CFT

Transition is the process of moving from formal supports and services to informal supports, when intervention by the formal system is no longer needed. Transition plans must reflect the child and family's voices and choices and the team must ensure that the transition plan is documented.

When a child/youth is transitioning out of the Katie A. Subclass every effort should be made to have a closing CFT meeting. When a mental health clinician (Organizational Provider or Children's Mental Health) is considering transitioning a child/youth away from or out of mental health services they must work with their supervisor to staff the case and decide collaboratively when it is appropriate to close a child/youth to mental

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health services. The case carrying social worker must be informed and the CFT must decide that a transition and/or discharge would be in the best interest of the child.

5.6 Social Worker Roles

Social workers play a crucial role in helping to refer a child who may be Katie A. subclass eligible for an evaluation. Intake social workers ensure that the initial mental health screening is completed on all open cases for children age 5 and over. Ongoing social workers ensure that the mental health re-screening takes place at 90 days and annually for those children 5 and over not currently open to mental health services.

Social workers are mandatory members of the CFT and must attend CFT meetings to help assess, monitor and coordinate services for children/youth and families. Social workers may facilitate CFT meetings.

5.7 Mental Health Clinician Roles


Mental health clinicians in Children's Services and with Organizational Providers help to deliver Katie A. mental health services including Intensive Case Coordination (ICC) and Intensive Home Based Services (IHBS). With children that meet Katie A. subclass eligibility, ICC and IHBS services should be delivered and billed in compliance with the "Medi-Cal Manual for ICC, IHBS, and Therapeutic Foster Care (TFC) for Katie A. Subclass Members" handbook.

The clinician is a mandatory member of the CFT and must attend CFT meetings to help assess, monitor and coordinate services for children/youth and families. Children's Service's clinicians may facilitate CFT meetings. Note: if the child/youth is with an Organizational Provider clinician and not receiving medication services the CFT meeting will be facilitated by a Children's Services worker.

5.8 Data Collection & Analyst Roles

In order to help track the Katie A. subclass children/youth there are Children's Services analysts assigned to collect and maintain databases with this information. On a monthly basis reports are run through Business Objects to check for new children/youth:

- Receiving Special Care Rates (SCR) due to behavioral needs,
- In Group Home placement, and
- With 3 or more placement changes.

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Any clients who are new and have not been evaluated or are not currently considered Katie A. clients will be sent to the Katie A. Coordinator to complete a Katie A. Evaluation. All Katie A. subclass clients are tracked in a database showing the date of their initial evaluation, why they meet Katie A. eligibility, who their clinician and social worker are, and when CFT meetings occur.

The analysts track all mental health screenings for those children age 5 and over in a database to ensure that every child with an open case is receiving a screening initially and that they also receive a screening at 90 days and annually if they are not currently open to mental health services. For children age 0-5 the ASQ screening information is entered into the Health and Education passport and can be verified for tracking purposes through Business Objects reporting.

6.0 Implementation Strategy


Upon approval of this policy, Management will select Supervisors and/or staff to help train the persons/programs affected. Supervisors will be expected to complete the training and return the training tracking forms to the Analyst. The Analyst will send out to all Children's Services staff this finalized policy and procedure for review. Copies of this policy will be saved in the shared "Policy and Procedures" folders of the Shasta County and the CWS/CMS computer network.

7.0 Definitions

Child and Family Team (CFT): is established to serve as the primary vehicle for service planning in accord with the Core Practice Model in order to bring significant individual team members together to help the family develop a plan of care that addresses their needs and strengths. The CFT also ensure services are well coordinated and provide a process for transparent communication and problem solving.

Core Practice Model (CPM): was created to focus on the interaction and collaboration among mental health, child welfare, and the children and families involved around meeting the mental health treatment needs of the child. The CPM focuses on being individualized to the child and family needs, values the voice and choice of the child and family, builds on strengths, is family focused, and improves stability while moving towards permanency. The CPM is a guide for standards of practice that can be integrated into current activities with a focus on team building and collaboration.

Intensive Care Coordination (ICC): is a Medi-Cal-covered service for Katie A. subclass members that includes: facilitating mental health assessments, care planning and

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coordination of services in collaboration with the child, youth, and family, and development of the CFT.

Intensive Home Based Services (IHBS): are individualized strength-based mental health treatment interventions that are designed to increase skills and decrease functional impairment resulting from mental health conditions that are Medi-Cal covered for Katie A. subclass members.

Katie A. Class: children in California who:


- (1) Are in foster care or are at imminent risk of foster care placement;
- (2) Have a mental illness or condition that has been documented or, if an assessment had been conducted, would have been documented; and
- (3) Need individualized mental health services, including, but not limited to, professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

Katie A. Subclass: a group of children/youth, who are Medi-Cal eligible, meet medical necessity for Specialty Mental Health Services, have an open child welfare services case, and meet either of the following criteria:

- Child is currently in or being considered for Wraparound, Therapeutic Foster Care or other intensive services, therapeutic behavioral services, specialized care rate (SCR) due to behavioral health needs or crisis stabilization/intervention; or
- Child is currently in or being considered for a group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility, or has experienced his/her 3rd or more placements within 24 months due to behavioral health needs.

Medical Necessity: Title 9, §1830.205 have specified the following medical necessity criteria to determine Medi-Cal reimbursement for Specialty Mental Health Services that are the responsibility of the Mental Health Provider:

- Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders:
 - Pervasive Developmental Disorders (except Autistic Disorders), Disruptive Behavior and Attention Deficit Disorders, Feeding and Eating Disorders of Infancy and Early Childhood, Elimination Disorders, Other Disorders of Infancy, Childhood, or Adolescence, Schizophrenia and other Psychotic


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Disorders, except Psychotic Disorders due to a General Medical Condition, Mood Disorders, except Mood Disorders due to a General Medical Condition, Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition, Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Paraphilias, Gender Identity Disorder, Eating Disorders, Impulse Control Disorder Not Elsewhere Classified, Adjustment Disorders, Personality Disorders, Medication-Induced Movement Disorders related to other included diagnoses

- Have at least one of the following impairments as a result of the mental disorder:
 - Significant impairment in an important area of life functioning.
 - Reasonable probability of significant deterioration in an important area of life functioning.
 - Reasonable probability a child will not progress developmentally as individually appropriate.
- Meet each of the intervention criteria listed below:
 - The focus of the proposed intervention is to address the condition identified above.
 - Expectation that the proposed intervention will: significantly diminish the impairment, or prevent significant deterioration in an important area of life functioning, or allow the child to progress developmentally as individually appropriate.
 - The condition would not be responsive to physical health care based treatment.
- When the requirements of these sections are met, beneficiaries shall receive specialty mental health services for a diagnosis.

Open Child Welfare Case: means any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement, including both court ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made.

Safety Organized Practice (SOP): a holistic approach to collaborative teamwork in child welfare that seeks to build and strengthen partnerships within a family, their informal support network of friends and family, and the agency. SOP utilizes strategies and techniques in line with the belief that a child and his or her family are the central focus and that the partnership exists in an effort to find solutions that ensure safety, permanency and well-being for children.


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8.0 Attachments

- Attachment A: Mental Health Screening Form
- Attachment B: Mental Health Re-Screening Form
- Attachment C: Katie A. Eligibility Evaluation Form
- Attachment D: Process to Refer Open Cases for a Katie A. Subclass Evaluation
- Attachment E: Process to Refer Intake Cases for a Katie A. Subclass Evaluation
- Attachment F: Shasta County Child & Family Team (CFT) Meeting Template
- Attachment G: HRT Referral

9.0 References and Citations

- All County Letter: 13-20
- All County Information Notice: I-72-11, I-26-13,
- Mental Health Information Notice: 13-03, 13-10, 13-13, 13-19
- Core Practice Model Guide
- Medi-Cal Manual for ICC, IHBS & TFC for Katie A. Subclass Members
- Ages and Stages Questionnaire Third Edition (ASQ-3) Policy and Procedure, May 3, 2013
- Specialty Mental Health Services Access & Urgent Care Policy and Procedure, December 6, 2013
- Safety Organized Practice (SOP) - University of California, Davis
<http://humanservices.ucdavis.edu/Academy/SOP/index.aspx?unit=ACADEMY>

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10. **Authorization**

The above policy and procedure has been reviewed and is authorized for immediate implementation:

Maxine Wayda
 Maxine Wayda, Director

2/7/14
 Date

Jane Wilson
 Jane Wilson, Deputy Director

2/7/14
 Date

Doug Shelton
 Doug Shelton, Clinical Division Chief

2-7-14
 Date

Lori Steele
 Lori Steele, Clinical Division Chief

2/7/14
 Date

Nancy Bolen
 Nancy Bolen, Program Manager

2/7/2014
 Date

Wendy Dickens
 Wendy Dickens, Program Manager

2/7/14
 Date

Amber Middleton
 Amber Middleton, Program Manager

2/7/14
 Date

I acknowledge that I have reviewed and understand the Policy and Procedure described herein. I also understand that the above required procedures will be reviewed as a Core Competency in my annual performance evaluation.

 Employee Name/Title

 Date