

SPECIALIZED FOSTER CARE GUIDELINES MANUAL

SECTION 3: DMH PARTICIPATION IN DCFS RMP MEETINGS

I. PURPOSE

This release issues procedural guidelines for use by co-located DMH staff to assist them in participating with DCFS staff in their use of Resources Management Process (RMP) Meetings to provide services, including mental health services, to children in need of, or placed within, RCL 6 through 14 placement facilities.

II. BACKGROUND

In 2002, a class action lawsuit (Katie A.) was filed against the State of California and Los Angeles County, alleging that children in contact with the Los Angeles County's foster care system were not receiving the mental health services to which they were entitled. In July 2003, the County entered into a settlement agreement resolving the County-portion of the lawsuit. Under the terms of the agreement, the County was obligated to make a number of systemic improvements to better serve children with mental health needs. Specifically, the County was ordered to ensure that class members:

- A. Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs,
- B. Receive care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability,
- C. Be afforded stability in their placements, whenever possible, and
- D. Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

DCFS designed the RMP as one means of improving the service delivery system to respond to the lawsuit and help ensure that the objectives listed above are met.

III. DESCRIPTION OF THE DCFS RMP

- A. RMP meetings are a variation of Team Decision Making (TDM) meetings in that they both share the following major characteristics:
1. They both facilitate the planning and decision making process by pulling together at one meeting all of the key participants needed to arrive at a consensus on what needs to be done to best meet the needs of the child. These include family members, extended family members, service providers, parent advocates, other members from the community, as appropriate, and staff from both DCFS and DMH.
 2. They both make use of the DCFS 174, Family Centered Conference Referral Form. This form, formerly known as the Unified Referral Form, was created to simplify the referral process for a CSW. It replaces all forms previously used when requesting a TDM and combines the referral form for TDM and the referral forms for Wraparound, System of Care (SOC), other basic and intensive mental health programs, child care, and mentoring and the above mentioned DMH programs.
 3. They both are intended to produce a Safety/Action Plan, which spells out the intervention steps to be taken to help ensure the ongoing safety of the child.
 4. Both meetings are conducted by a DCFS TDM Facilitator, who has broad knowledge of DCFS policies and procedures, and of available community resources.

Key responsibilities of TDM Facilitators include maintaining neutrality with respect to all meeting participants and working to develop a consensus among the participants on the best course of action to take with regard to the child. They do this by finding common ground amid diverse interests and opinions, focusing on family strengths, utilizing negotiation and active listening skills, and taking the lead in developing the Safety/Action Plan for the child at the conclusion of the meeting.

- B. RMP meetings differ from usual TDM meetings, however, in the following ways:
1. The target client population of RMP meetings is any DCFS youth who:
a) is at risk of entering an RCL 6-14 group home, or b) is at risk of being moved from one RCL 6-14 group home to another, or c) is leaving an RCL 6-14 group home.

Regular TDM meetings, on the other hand, involve a broader group of youth who are not involved in these types of group home placements but who require safety plans regarding removal from the home, foster care placement, or family reunification.

2. In addition to the staff who typically attend TDM meetings, RMP meetings are attended by DCFS Resource Utilization Management (RUM) staff and DMH clinical staff, who participate in the meeting to assist the team in making the best decisions possible regarding the child's need for mental health and other services.
3. Participating DCFS and DMH staff all have the expertise and authority to make firm recommendations regarding the child, with input from the family and those supporting the family, thus streamlining the process by averting the need for additional follow up meetings. The DCFS CSW, however, has the final decision making authority regarding the child.
4. In lieu of the Structured Decision Making (SDM) tool used by the DCFS CSW at TDM meetings, RMP meetings utilize the Child and Adolescent Needs and Strengths – Child Welfare version (CANS-CW) to assess the child's needs and strengths and needs. The form is used to evaluate the child's functioning in terms of school performance, conduct and behavior, social relationships, moods and emotions, substance use, thinking, and aggressive and self-harmful behaviors.

The CANS-CW also assesses the child's caregivers' ability to provide a safe and emotionally nurturing environment, including their ability and willingness to participate in recommended services. The CANS-CW thus helps inform decisions regarding the level of intensity of services and/or the level of placement needed by the child.

DCFS RUM staff and DMH clinical staff are responsible for completing applicable sections of the CANS-CW prior to the RMP meeting and for discussing the results of the CANS-CW at the meeting. DCFS staff will complete Sections A and B and Sections D through I of the form, while DMH staff is responsible for completing Section C, Mental Health Needs.

The CANS-CW is not a formal mental health assessment or diagnostic tool, but rather an informal evaluation of the child's mental health status based upon a review of records and any other information available at the time. Completion of the CANS-CW, therefore, does not require face-to-face contact with the child, or either a signed consent for treatment or an authorization to release information on the part of the parents.

The completion of the CANS-CW would also not generally entail the opening of a case unless there is evidence that a case needs to be opened for other reasons, such as the need to treat a child with a history of suicidal gestures or who appears to be a danger to himself or others.

The portion of the CANS-CW to be completed by DMH staff (Questions 17 through 32) consists of 16 dimensions associated with one's mental health status, as evidenced by various symptoms or behaviors. Ratings are listed from 0 to 3, with 3 being the most serious. In most instances, a rating of 0 indicates that there is no evidence of the symptom or behavior in question.

In a few instances (questions 21, 23, 25, and 26), 0 indicates mild evidence of the behavior. If a review of available information does not indicate that even mild evidence is present in those areas, the DMH rater should print "No available evidence" when answering those four questions.

If, due to time constraints, it is not possible to complete the CANS-CW prior to the RMP meeting, the form will be completed as soon as possible following the meeting. Typical situations include cases referred to DCFS via their Emergency Response Units that require Initial TDM meetings due to safety concerns for the child.

5. Both DCFS and DMH staff are also expected to bring to the meeting a list of potential community resources that may be needed by the child and family, to the extent available. DCFS RUM staff are responsible for bringing a current list of all services and available potential placements located in the youth's community, while DMH staff are responsible for bringing a list of current mental health resources available in that community. Resources include the whereabouts of available slots and the names of service providers that can potentially assist the child and family.

RMP meetings will utilize resources including DMH Intensive In-Home Mental Health Services programs, Multidimensional Treatment Foster Care (MTFC), Multi-systemic Treatment (MST), and the Comprehensive Children's Services Program (CCSP), and DCFS's intensive services, including Wraparound, Intensive Treatment Foster Care (ITFC) and RCL 6 and above residential care.

IV. RMP SCHEDULING IN EMERGENCY SITUATIONS

DCFS will attempt to schedule an RMP within five (5) business days in the following situations:

- A. When the child was moved after hours, or on an emergency basis. In such situations, the CSW will notify the TDM scheduler of the need to schedule an RMP within three business days following the date of placement.
- B. When a 7-day notice has been received from a foster home placement. In such situations, DCFS will attempt to schedule an RMP within three business days following receipt of the notice.

V. DCFS STAFF RESPONSIBILITIES

The roles and responsibilities of DCFS staff with regard to RMP meetings can be found in DCFS Procedural Guide 0070-548.03, Point of Engagement: Team Decision-Making, issued 12/21/05, and in DCFS Procedural Guide 0100-525.40, Team Decision Making: The Resources Management Process (RMP/TDM), issued January 16, 2009.

The above procedures indicate that the DCFS case carrying CSW is the DCFS staff member primarily responsible for making arrangements for the TDM meeting. He/she does this in consultation with the SCSW and in the process interfaces with the family, the DCFS TDM Scheduler, the TDM Facilitator and DCFS RUM staff. He/she also provides access to the case so that DCFS RUM staff and DMH clinical staff can complete the CANS-CW.

DCFS RUM staff, however, are responsible for contacting DMH staff to advise them of the upcoming RMP meeting, and for taking the lead in completing the CANS-CW, in collaboration with the assigned DMH clinician, and prior to the RMP meeting to the extent feasible.

VI. DMH CO-LOCATED STAFF PARTICIPATION IN RMP MEETINGS

Because DMH involvement is integral to the success of the RMP process, DMH Co-Located staff will make every reasonable effort to participate in RMP meetings, depending upon the availability of staff. Factors that will affect DMH staff availability include the location and frequency of meetings, and the amount of lead time provided by DCFS regional office staff when scheduling RMP meetings.

The ideal sites for RMP meetings are DCFS regional offices occupied by Co-Located DMH staff. If meetings are held outside regional offices, DMH staff ability to attend may be decreased due to travel time.

DMH Co-Located staff are responsible for maintaining each business day at each site an on-call staff member who will be available to attend RMP meetings that are scheduled in that office. Since that person can attend only one meeting at a time, the scheduling of more than one meeting in a given time slot at that location will require the participation of additional DMH staff. This, in turn, will necessitate advance planning and scheduling. If given at least two full working days firm advance notice, it is anticipated that DMH staff will be able to attend all RMP meetings. The provision of less than a two day notice will, however, impact DMH ability to arrange for the presence of additional staff. Firm advance notice means that the date, time and location of the meeting are final and will not be changed.

It is recommended that the DMH SFC Supervisor work closely with DCFS RUM staff to coordinate the advance scheduling of RMP meetings. One method that has proved successful at many sites is to set aside certain days of the week for these types of meetings. This allows both DMH and DCFS staff to organize their work schedules and make maximum use of their time.

Since the completion of the Mental Health Needs portion of the CANS-CW is viewed as an integral part of the total RMP process, and is not intended to be completed in isolation from other participating RUM staff, DMH Co-Located staff will be expected to complete the CANS-CW only if they attend the RMP meeting involving the child, whether the meeting is held prior to or following the completion of the form. If an RMP meeting is conducted without DMH staff attendance, DMH staff will not have the involvement and background information needed to complete the CANS-CW.

VII. DMH CO-LOCATED STAFF RESPONSIBILITIES

Below is a description of the responsibilities of the DMH Specialized Foster Care (SFC) Supervisor and the DMH Clinician with regard to participation in RMP meetings:

A. DMH Specialized Foster Care (SFC) Supervisor

1. Receives and reviews the DCFS 174, Family Centered Conference Referral form, submitted by the DCFS RUM staff person, and forwards the referral to the appropriate DMH clinician.
2. Provides consultation to the DMH clinician, as needed, both prior to and following the RMP meeting.

3. When DMH clinical staff were involved in providing follow-up services identified in the Safety/Action Plan, reviews and signs the Clinical Feedback report submitted by the DMH clinician within 60 days following the RMP meeting, indicating the extent to which the Safety/Action Plan was implemented successfully and that the RUM case may be closed.

B. DMH Clinician

1. Receives and reviews the referral assigned by the supervisor.
2. Reviews any information obtained from the DMH IS data base that indicates that the case was previously within the system, and use the information to help formulate a preliminary case plan.
3. Contacts any previous or current mental health (MH) service provider to obtain any case information he/she may have, if available. Advises any such MH service provider of the date and time of the RMP meeting, and requests his/her attendance at the meeting.
4. Contacts the referring CSW to determine if he/she has any other additional case information that might be helpful in understanding the scope of the problem and possible intervention strategies.
5. Asks the referring CSW whether or not the case contains a DCFS 179-MH, Consent for Mental Health and/or Developmental Assessment and Services form, signed by the parent, or a similar form signed by the child, or whether or not such consent has been obtained through the court. If there is a consent form, obtains a copy from the CSW; if not, arranges with the CSW to have the parent or child sign a consent form while attending the RMP meeting. If that does not appear feasible, asks the CSW to submit a consent request to the court as soon as possible.
6. If not already contacted by the DCFS RUM staff person working on the case, contacts that person to make arrangements to complete the CANS-CW, since this should ideally be done together, to facilitate sharing of perceptions and case information.
7. Using information contained in the case record, and any other available information, completes Section C (Questions 17 through 32) of the CANS-CW, to provide an informal evaluation of the child's mental health status. Completion of the CANS-CW does not require a face-to-face contact with the child, or the signing of any consent or authorization forms by the parents.

8. When completing Section C of the CANS-CW, circles 0 (zero) whenever there is no evidence available to indicate that the symptom or behavior in question exists. If such evidence is completely lacking with regard to Questions 21, 23, 25 and 26, prints “No available evidence” when responding to those four questions, since 0 otherwise indicates that there is mild evidence of the symptom or behavior in question.
9. Utilizing all available case information, including information obtained from any involved community-based MH service provider, develops a list of potential mental health resources that can assist the child and family, and contacts the appropriate DMH staff persons administering those programs to determine the programs for which the child is eligible. Based upon those discussions, and to the extent that there is sufficient time, prepares a final list of mental health resources to take to the RMP meeting.
10. Consults the SFC Supervisor to discuss and obtain feedback on the resources identified and makes any necessary adjustments to the list based upon that discussion.
11. Contacts the appropriate DCFS RUM staff involved in the case to discuss the identified resources developed in consultation with the Clinical Supervisor.
12. Along with any involved community-based MH service provider, participates in and provides clinical expertise at the RMP meeting, and assists the TDM Facilitator in developing the Safety/Action Plan.
13. Following the RMP meeting, along with any involved community-based service provider, provides follow up support, as needed and identified in the Safety/Action Plan, to the case carrying CSW by means of ongoing consultation, assistance with problem solving and/or MH case management services. If no such DMH follow-up support was identified, indicates such in DMH case record and closes the case.
14. Within two months following the RMP meeting, if DMH follow-up services were provided, participates in completing the Case Closing Summary Report as follows:
 - a. Completes a Clinical Feedback report to indicate the extent to which the Safety/Action Plan was successfully implemented and that the RUM case may be closed, and submits report to the SFC Supervisor for review and signature.

- b. Following the obtaining of the supervisor signature, forwards Clinical Feedback report to the RUM CSW for incorporation into the RMP Exit/Summary Report.
- c. Signs the RMP Exit/Summary Report when completed by the RUM CSW.