

SPECIALIZED FOSTER CARE GUIDELINES MANUAL

SECTION 4: DMH PARTICIPATION IN THE DCFS CSAT PROCESS

I. PURPOSE

This release issues procedural guidelines for use by co-located DMH staff to assist them in participating in the DCFS Coordinated Services Action Team (CSAT) process.

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. A significant systems enhancement initiated by the County to comply with the intent of the settlement agreement was the creation of the CSAT.

III. DESCRIPTION OF THE CSAT APPROACH

Due to the complex and severe nature of the problems frequently encountered in families involved in the child welfare system, a special resource was needed to enable DCSF and DMH staff to more effectively work together to coordinate their efforts, make more efficient use of their time, and reduce the incidence of inappropriate referrals.

The CSAT was designed to enhance the delivery of services to children and families by serving the following purposes: 1) to provide a regionally-based, clinical management team to assist the Children's Social Worker (CSW) to quickly identify and link children/families in need to the most appropriate services, 2) to assist staff to more effectively navigate a complex array of structures, services and processes that currently exist across the county through a myriad of both public and private agencies, and 3) to expedite: timely referrals and follow-up to medical Hubs, completion of the California Institute for Mental Health (MHST) Screening Tool, establishment of consent, release of information and eligibility for benefits, and linkage for assessment and treatment, as needed.

A secondary function of the CSAT is to manage and enter the necessary data into the Referral Tracking System to produce automated reports that track the provision of services and the utilization of resources. This will provide more accurate data and outcome information related to the services provided and the County's compliance with the terms of the Katie A. Settlement Agreement.

CSATs will be located in each regional office and will be the primary system to assist CSWs to quickly link children and families to needed services. Each CSAT team will also collect, manage and analyze data to provide DCFS and DMH managers with reports that will track trends and utilization patterns. Service Linkage Specialists (SLSs) will act as the CSAT leads and serve as the system navigators and resource coordinators for each regional office. CSATs will also facilitate the arrangement of case conferences, Team Decision Making meetings (TDMs) and training resources as well as assist in supporting the mentoring of line staff.

The overall purpose of the CSAT is to pool resources and coordinate the activities of DCFS and DMH staff in responding to referrals from CSWs and linking children with appropriate community resources. Because of differential staffing patterns within regional offices, and variations among the resources available to staff within each Service Area, each SFC unit will need to utilize the guidelines described below in ways that best fit its unique characteristics.

While staffing patterns will vary among regional offices, SFC staff response to referrals and involvement in the CSAT process will be guided in each locality by the service delivery principles outlined in Section 2 of this Manual, entitled: SFC Vision and Practice Principles. The three overarching principles guiding SFC staff in providing services to children and their families are the following: 1) services are driven by the needs of the child and preferences of the family, and are best addressed through a strengths-based approach, 2) the locus and management of services should occur in a multi-agency collaborative team and be grounded in a strong community base, and 3) the services offered, the agencies participating and the programs generated are responsive to cultural context and characteristics.

The CSAT process is consistent with these principles for several reasons, including the following: 1) the CSAT approach looks at the total needs of the child and family, and emphasizes the importance of directly involving the child and family members in both defining the problems that need to be solved and in devising the solutions that can most effectively solve those problems, 2) the whole purpose of CSAT is to maximize the benefits of utilizing a coherent, coordinated team approach, rather than one that may lend itself to fragmentation and/or duplication of effort, and 3) CSAT recognizes the importance of making use of local community services and resources that are perceived by the child and family as easily accessible and responsive to their needs.

IV. KEY MEMBERS OF THE CSAT

The lead positions in a CSAT are the following: Service Linkage Specialist (SLS), Multidisciplinary Assessment Team (MAT) Coordinators, D-Rate Evaluators, Revenue Enhancement Eligibility Staff, DPSS Linkages GAIN Services Workers, and DMH Co-located Staff. In addition, staff from Resource Utilization Management (RUM), Permanency Partners Program (P-3), Educational Liaisons, Wraparound Liaisons, Public Health Nurses (PHNs), DCFS Sexual Abuse Treatment (SAT), Family-Group Decision Making (FGDM), DMH D-rate Case Manager, DMH Intensive In-Home staff, and DMH Full Service Partnership (FSP) Liaisons may on a case by case basis be called upon to join the team as needed.

V. ROLE OF THE SERVICE LINKAGE SPECIALIST (SLS)

One of the more pivotal members of the CSAT team is the Service Linkage Specialist (SLS). The SLS is a recently created position within DCFS who is intended to serve as the CSAT lead person with regard to new and existing DCFS cases involving non-detained children. The primary focus of the SLS is to ensure that such non-detained children are adequately screened and linked to services, fulfilling a role that parallels that of the MAT Coordinator, who ensures as well that all newly detained children receive a MAT assessment and have a completed MAT Summary of Findings Report completed by a DMH MAT Provider following the completion of the assessment.

The SLS and MAT Coordinators work in close partnership and serve as back-ups to one another. In addition to his/her primary focus, the SLS also serves in a non-supervisory leadership and support role within the CSAT team and is the ultimate point person to the CSAT.

The SLS completes specific tasks and the data entry associated with the completion of the medical Hub exam, Mental Health Screening Tool (MHST), consent, benefits establishment and referral to DMH co-located staff for linkage to assessment and treatment. The SLS also manages the coordination of all CSAT activities and identifies CSAT leads, according to their area of expertise or program design, to carryout activities as needed.

Finally, it is the responsibility of each SLS to enter required data and to produce regular reports for analysis in compliance with Katie A. data tracking requirements.

VI. SUMMARY OF THE CSAT PROCESS

While not all service referrals handled by DMH Co-Located SFC staff are made through CSAT, the CSAT approach was designed to improve the effectiveness of response by DCFS and DMH in the following case situations: 1) when a referral is first received by the child welfare system, whether or not the child has been detained, 2) at the time of the first case plan update on cases that are already in the system but do not have an initial MHST screening, and 3) whenever the CSW on an ongoing case identifies something in the child's behavior that indicates that the child is experiencing some type of developmental or adjustment problem, and an MHST screening either has not yet been done, or one has been completed but the results were negative.

In either situation, the CSW, when making a CSAT referral, will provide a copy of the completed MHST tool and a DCFS 174, Family Centered Conference Referral Form, will have obtained consent for mental health treatment and release of mental health information, will have established benefits eligibility for the child, and will forward the necessary documents to the CSAT in-box, to be handled by the CSAT Screening Clerk.

VII. CONSENT FOR MENTAL HEALTH TREATMENT

A. Parental Consent

The issue of obtaining consent for mental health assessment and treatment arises frequently in the course of providing services to children. The question as to who is authorized to provide consent depends, in part, on the age and maturity of the child, the child's legal status, the nature of the mental health services being sought and/or the availability and willingness of parents to provide such consent.

In general, a child's parents or legal guardians have the legal authority to consent to mental health services, whether the child is placed with the parents/legal guardians or in out-of-home care. Parents, however, cannot provide consent: 1) when adoption proceedings on a child have been initiated but not finalized, in which case the Court must provide consent, 2) when adoption proceedings have been finalized, in which case the adoptive parents provide consent, and 3) when a child is under legal guardianship, in which case the legal guardian usually has the authority to make medical decisions for the child, if indicated in the letters of appointment.

Parents/legal guardians, however, may not consent to psychosurgery or electroconvulsive therapy for any child, or to psychotropic medication or psychiatric hospitalization for any child under the jurisdiction of the Dependency Court. The Court itself, however, may authorize the use of psychotropic medication for children under its jurisdiction.

Finally, foster parents, caretakers, children's attorneys and social workers do not have legal authority to provide consent for mental health assessment and/or treatment except in very limited instances, such as pursuant to a court order or when the parent has provided permission. In those instances, such authority must be verified, such as by reviewing a copy of the court order or the executed Caregiver Authorization Affidavit.

To facilitate the consent process and help ensure that children receive mental health services in a timely manner, DCFS and DMH developed the DCFS 179-MH consent form entitled, "Parental Consent for Child's Mental Health/Developmental Assessment and Participation in Mental Health/Developmental Services" (see attached). This form was designed in close collaboration with the County Counsel's Office of Los Angeles County and is deemed to meet all of the legal requirements of this type of consent form.

By signing the DCFS 179-MH, a parent provides consent for a child's mental health assessment and participation in mental health treatment services. The types of services to which a parent may consent by signing the form include the following: 1) individual or group psychotherapy, 2) individual or group counseling, 3) individual or group rehabilitation, 4) targeted case management, 5) psychological testing, 6) day treatment intensive services, 7) day rehabilitation services, 8) therapeutic behavior services (TBS) and any other appropriate and recognized mental health services appropriate for the child's needs.

B. Child's Consent

When a parent is not available, or declines to provide consent, in most cases consent will be requested from the Court to expedite the provision of mental health services. In some cases, if the child is 12 years of age or older, he/she may consent for his/her own mental health services in lieu of the parent. If the child is providing consent, it is the responsibility of the mental health service provider to ensure that the child is of sufficient maturity and age to give informed consent. If the provider determines that the child does not have the requisite ability, the child's consent will not be sought.

Since the DCFS 179-MH consent form was not designed for use by children, DMH mental health service providers are responsible for obtaining consent from a 12 year old child on applicable forms utilized by those providers.

A youth 12 years of age or older may consent to mental health services or counseling, whether on an outpatient basis or within a residential shelter, if the youth: 1) in the opinion of the attending professional person, is mature enough to participate intelligently in the services, and 2) would either present a danger of serious physical harm to self or other without those services, or is the alleged victim of incest or child abuse.

C. Court Consent

If the parent/legal guardian declined or is not available to sign the DCFS 179-MH form, and the child is under the age of 12, or for other reasons it is more expedient to obtain consent from the Court, the DCFS CSW or other responsible DCFS staff person will attempt to obtain Court consent for mental health services. The usual method is to walk on an Ex-Parte court report requesting an appearance hearing before the court to consent to the youth's mental health assessment and services. The language contained in the Ex-Parte report will be as follows:

"It is respectively recommended that the court authorize a mental health and/or developmental assessment of the child (name of child) and, if indicated, that the child (name of child) be authorized to participate in any services deemed necessary to meet the child's mental health and/or developmental needs, if deemed eligible."

D. Revocation of Parental Consent

A parent may withdraw consent for mental health assessment and services at any time, by signing and submitting to DCFS the "Revocation of Consent" located at the bottom of the DCFS 179-MH. In such instances, the DCFS CSW will contact the DMH service provider to determine the best course of action to follow to facilitate continuity of services, i.e., whether to obtain consent from the child, if 12 years of age or older, or from the Court. The preferred course of action is to obtain consent from the child, if feasible.

E. Youth Refusal to Participate in Services

In some instances, children will refuse to participate in services, even when consent to treatment was provided by the parent or the court. In such situations, the DMH Clinician or service provider will need to inform the CSW in writing that the youth is refusing services so that the CSW, in turn, can inform the court of such refusal.

VIII. DMH CO-LOCATED STAFF ROLES AND RESPONSIBILITIES

Described below are the overall responsibilities of DMH Co-Located staff with regard to their participation in the CSAT process. Due to differences in regional staffing patterns and the specific needs of each case, there will be some variations in the manner in which some CSAT referrals are handled. The responsibilities described below, however, are intended to be compatible with most case situations.

A. Prior to a CSAT Referral

DMH Co-located staff, including Specialized Foster Care (SFC) Supervisors, Psychiatric Social Workers, Mental Health Clinicians, Case Management staff, such as Medical Case Workers, along with DMH MAT Coordinators, MAT Psychologists, D-Rate Coordinators, and Wraparound Coordinators, will be designated to participate as members of the CSAT team and will become involved in providing services to children referred to CSAT, depending upon the services required for which the children are eligible.

The team will serve as the primary DMH resource to provide consultation, and to triage, assess and link children to DMH directly operated service providers or contract providers, including Intensive In-Home Programs, Therapeutic Behavioral Services, AB 3632 Referrals, etc.

The DMH SFC Supervisor is the primary point of contact for cases requiring mental health services within the CSAT team. When communicating with DCFS members of CSAT, the SFC Supervisor will interact primarily with the SLS and the DCFS MAT Coordinator.

Most SFC sites formulate an on-call schedule, to the extent feasible, to have staff available for consultation throughout the normal business day, in the event that the Supervisor is not available.

B. In Response to a CSAT Referral

1. The SFC Supervisor is responsible for:
 - a. Reviewing and screening all CSAT referrals that come to the unit, and assigning cases, within two working days following receipt, either directly to community-based Mental Health (MH) providers or to unit members, as appropriate, depending upon the amount of information available on the case.

The SFC Supervisor identifies the cases with the most urgent need and ensures that they are given priority and handled as expeditiously as possible.

Generally speaking, the more information that is available on the case, the more the case will lend itself to direct linkage to a community-based mental health provider or other community services or resources.

Conversely, the more a case is lacking in such information, the more likely it will need to be assigned to an SFC Clinician, whose primary task will be to gather the information necessary to formulate a plan of treatment. The SFC Clinician, in turn, will then be in a position either to refer the case to a community-based MH provider for treatment, or to a case manager within the unit for follow up case management services, or may provide services him/herself on the case, when the urgency of the situation calls for that type of intervention, and/or whenever an appropriate community-based MH Provider is not readily available.

- b. Depending upon the amount and clarity of case information available, assigns the case to a unit member or to a community-based MH provider, as described above. Advises the SLS of the name of the staff person to whom the case was assigned within two working days following case assignment.
 - c. Consulting with the SLS, as needed, to discuss any aspects of the case that require his/her input.

- d. Providing consultation to staff, as needed, communicating with both DCFS and DMH staff.
 - e. Serving as liaison to the DCFS Regional Administrator (RA) and the Assistant Regional Administrator (ARA), and to DMH contract providers, to resolve any issues that need resolution at that level. Liaison responsibilities with regard to DMH contract providers include responding to any questions about the use of the DCFS 179-MH consent form, and assuring providers that the form is deemed by Los Angeles County to meet all the legal requirements demanded of such forms.
 - f. Serving as liaison, as necessary, between the DCFS SLS and DCFS MAT Coordinator and DMH staff such as the DMH MAT Coordinator, D-Rate Coordinator and Wraparound Coordinator, for purposes of triaging and coordinating the delivery of service on the case.
 - g. Coordinating with the SLS, the CSAT Screening Clerk, Unit Clerk and other appropriate staff, to ensure that cases are accurately and adequately tracked.
 - h. Updating the DCFS/DMH Monthly referral log to reflect the current status of the case, as appropriate.
2. SFC Clinicians are responsible for:
- a. Accepting the referral involving a non-newly detained child from the SFC Supervisor and discussing the case, as necessary.
 - b. Reviewing information obtained from the DMH Integrated System (IS) to identify any current or previous mental health service history on the case. If there is no currently open case, proceeds as indicated below, beginning with step c.

If an open mental health case does exist: 1) forwards the referral to the current mental health service provider, 2) advises the provider to inform the CSW in writing within two working days whenever any significant events or changes occur in the case, 3) notifies the SLS and the CSW that the case was referred to the mental health service provider, and 4) updates the DCFS/DMH Monthly Referral log to reflect the current status of the case.

Examples of significant events or changes that the service provider needs to advise the CSW of include events such as the child refusing treatment, relocating to another area, running away, being hospitalized, exhibiting suicidal gestures, or any major changes made in the treatment plan.

- c. Gathering all available relevant information on the case by contacting the referring CSW and all appropriate collaterals. These include other appropriate family members, relatives and friends, as well as physicians and other professional staff who would have information pertinent to the case.

If such information gathering results in the clinician's being able to determine an appropriate course of treatment for the child, and the clinician does not intend to open the case and provide treatment himself/herself, the clinician may link the child to a community-based mental health provider, or have the case linked to such provider by a unit case manager, such as a Medical Case Worker (MCW).

If such information gathering does not result in the clinician's being able to determine an appropriate course of treatment for the child, the clinician may conduct a face-to-face assessment with the child for the purpose of arriving at a diagnosis and plan of treatment.

- d. Determining whether or not an assessment is needed to evaluate the strengths, needs, risk factors and support system of the referred child, including any relevant cultural considerations, and to arrive at a diagnosis and plan of treatment.

In all likelihood, an assessment would not be necessary in either of the following circumstances: 1) a case is not currently open in the system, but the SFC unit is in possession of an acceptable assessment of the child that was completed within the past 12 months, or 2) there is neither a currently open case nor evidence of a recent assessment, but ample information exists to arrive at a course of treatment, and the available information does not suggest that the child presents a significant risk either to him/herself or others.

On the other hand, an assessment would most likely be appropriate: 1) whenever the available information suggests that the child may represent a significant risk of harm to him/herself or others and/or is confusing, contradictory, or lacking to the extent that an opinion on treatment needs cannot be rendered, or 2) whenever the clinician him/herself intends to open the case and provide treatment.

- e. If an assessment is required, contacting the caregiver and arranging a home call or other face-to-face contact with the child to gather the information needed to complete the assessment. While at the home call, if the child is 12 years of age or older and able to do so, good mental health practice would indicate that the child should be asked to complete the form acknowledging consent to mental health assessment and treatment, unless a copy of a consent form is already contained in the case record.
- f. Contacting and arranging a home call with the parent, if available, to discuss the case from the point of view of the parent and to gather additional case information available to the parent. Other activities that should be completed at this home visit include providing the parent with a copy of the form that advises parents of their rights under the federal Health Insurance Portability and Accountability Act (HIPAA), obtaining the parent's signature confirming receipt of the form, and obtaining the parent's consent for mental health assessment and treatment, utilizing the DMH consent form designed for that purpose.
- g. Consulting with the SFC Supervisor to discuss the dynamics of the case, including strengths, needs and risk factors. Based upon the consultation and the dynamics of the case, determines a mental health diagnosis and treatment plan for the child.
- h. Based upon the strengths, needs, risk factors, diagnosis and care coordination plan, consulting with other Co-Located DMH staff, such as the D-Rate Coordinator and the Wraparound Coordinator, to determine if the child is eligible for those programs.

- i. Preparing for and attending any DCFS TDM or RMP meetings related to the case, and following up on those meetings, as appropriate. This includes providing progress reports and other feedback, and collaborating and coordinating, as appropriate, with the DCFS SCSW, CSW and RUM staff.
- j. If an RMP meeting is scheduled, completes Section C (Questions 17 through 32) of the CANS-CW, to provide an informal evaluation of the child's mental health status, following the procedures contained in Section 3, pages 6 and 7 of this Manual. Those procedures indicate that completion of the CANS-CW does not typically require a face-to-face contact with the child, or the signing of any consent or authorization forms by the parents.
- k. If he/she decides to handle the case, in order to provide follow up services, providing written feedback to the DCFS SLS and CSW in a timely manner, i.e., usually within two working days, whenever significant events or changes occur on the case.

Examples include events such as the child refusing treatment, relocating to another area, running away, being hospitalized, making suicidal gestures, or any major changes made in the treatment plan. Otherwise, forwards the case to a unit case manager, such as a Medical Case Worker, for any necessary follow up case management services, and advises the SLS and CSW of that action.

- l. Updating the DMH clinical chart and DCFS/DMH Monthly Referral Log to reflect the current status of the case.
- m. If the clinician decides not to provide linkage or treatment services him/herself, and the case requires follow-up case management services, forwarding the case to a unit case manager for follow up services, as needed.
- n. Advising the SLS and CSW that the case was referred to a unit case manager for follow-up linkage to a mental health provider.
- o. Documenting and billing service activities, according to DMH and SFC policies and procedures.

3. SFC Unit Case Management Staff are responsible for:
 - a. Receiving the case from the SFC Clinician and discussing the case with the Clinician and/or the SFC Supervisor, as needed.
 - b. Preparing for and attending any DCFS TDM or RMP meetings related to the case, and following up on those meetings, as appropriate. This includes providing progress reports and other feedback, and collaborating and coordinating, as appropriate, with the DCFS SCSW, CSW and RUM staff.
 - c. Providing case management services to the child and family by linking them with the community resources identified through the referral review, information gathering and/or face-to-face assessment process, including appropriate DMH contracted service providers.
 - d. Closing the case when a DMH contracted service provider assumes responsibility for the case.
 - e. Providing written feedback to the Services Linkage Specialist and CSW in a timely manner, i.e., usually within two working days, whenever significant events or changes occur on the case. Examples include events such as the child refusing treatment, relocating to another area, running away, being hospitalized, making suicidal gestures, or any major changes made in the treatment plan.
 - f. Updating the DCFS/DMH Monthly Referral Log to reflect the current status of the case.
 - g. Documenting and billing service activities according to DMH and SFC policies, guidelines and procedures.