Partners for Safe and Healthy Children

A Report to the Board of Supervisors

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Section 1: Background

The Health Department has made advances since 1996 in its ability to improve the health and well being of the county's youngest children at risk of child abuse and neglect. The County Pre-3 Initiative has provided thousands of young children and their families with services to support parenting and improve child health. Pre-3's High-risk Mental Health and Perinatal Addiction Outreach Teams have intervened in the lives of high-risk children and parents by providing an array of assessment and treatment services. Pre-3 outcomes include high rates of well-child care, immunization, breastfeeding and early literacy activities.

Recently the Health Department, in collaboration with Human Services Agency (HSA), has changed and expanded how it provides and oversees treatment and intervention services to children who are at high-risk of abuse and neglect.. The Health Department and HSA began to restructure child abuse and neglect treatment services by centralizing all 0-5 assessment and treatment services in a Health Department team and by issuing a new RFP for community-based organizations to provide services to the 6-18 year-old population. Three considerations have spurred the restructuring:

1. The new State-initiated Child Welfare Redesign and the linked "System Improvement Project," emphasizes earlier and more comprehensive intervention in the lives of children and their families, strengthening community partnerships, enhancing permanent placements, and addressing critical workforce issues.

2. The Pediatric Death Review Team found that several structural problems with the existing assessment and treatment system could be addressed by increasing coordination and accountability across divisions and programs.

3. There is clear focus by all County departments that the protection of the most vulnerable children is a shared responsibility of all County staff.

The Health Department and HSA have created Partners for Safe and Healthy Children (PSHC) and embarked on a planning effort to implement the following vision:

> *A systematic, coordinated, and integrated approach to providing high-risk and vulnerable young children and their families with evidence-based public health and behavioral health assessment, case management and treatment services that are guided by the core value that all children have a right to grow-up and thrive in a safe and healthy environment.*

The long-range goal of PHSC is to develop and implement an assessment, treatment, and case management system of care for all high-risk children with behavioral health and medical needs. The overarching values of the PSHC (appendix 1) will lead to the following actions:

- Ensure better inter-departmental communication and accountability thereby improving a child's safety and well-being;
- Offer a systematic behavioral health and public health treatment approach for all high-risk cases;
- Create a stronger system that is easy to understand, navigate and determine how cases are being managed and who is ultimately responsible for care and services; and
- Create a team oriented decision-making approach between all County stakeholders involved in the safety, well-being and stability of the child.

Implementation will be in phases.

- Phase I is focused on creating a comprehensive and coordinated assessment and treatment team and system for all Child Protective Services (CPS) continuing cases ages 0-5 and Pre-3 cases with high-risk behavioral health problems. This first phase will fulfill an immediate need of establishing a County-staffed and County-operated 0-5 assessment and treatment team for CPS cases.
- Phase II will center on creating a coordinated CPS/Health Differential Response Team to assess the needs of children ages 0-5 who are suspected of being at risk of abuse and neglect.
- Phase III will focus on expanding the work in phase I to those children and families with complex and high-risk medical problems that are not part of the CPS system.

This report discusses Phase I planning and design and outlines the role of the County Health Department and HSA in directly providing and overseeing assessment and treatment services to high-risk cases ages 0-5.[1] This report is the collaborative work of staff in the Health Department and Human Services Agency – from the Alcohol and Other Drug Program (AOD), Children and Family Services (CFS) including Child Protective Services (CPS), Mental Health (MH) and Public Health (PH). The sections of the report are:

1) Background
2) Problem
3) Caseload Size and Population Demographics/Needs
4) Organizational Structure
5) Redesign of the Health Department/Child Protective Services Case Flow
6) Enhancement of Evidence-Based Treatment Practices and
7) Staffing Needs
8) Next steps

Section 2: Problem

[1] While phase 1 does not include a direct role for community based organizations, phases 2 and 3 will draw on community resources and organizations in the development of the system.

Since embarking on this effort, the planning team has identified and addressed structural problems and other barriers to a more effective and integrated system of care. Identified problems include:

- Informal Process for Referring Cases for Behavioral Health Treatment Services. The Health Department and HSA do not have a standardized approach to refer cases for assessment, treatment and intervention services. Without set criteria for making these referral decisions, CPS Social Workers may send cases needing behavioral health treatment to the HSA's Alcohol and Other Drug Case Managers, community based contractors, such as Family Services Agency (FSA), or Health's Pre-3 Mental Health High-risk (MHR) or Perinatal Outreach and Addiction (Planet) Teams.

- No Standardized Approach for Treatment and Intervention Services. The County does not have a comprehensive treatment approach for CPS cases. Such an approach would use evidence-based practices or ensure that appropriate interventions are available to children and caregivers with symptoms of abuse and neglect.

- Unstructured Inter-Agency Process to Coordinate and Manage Cases. The Health Department has not developed a formalized structure to communicate with CPS about cases that are being treated within its system. The structure does not enable Health Department staff overseeing the treatment and coordination of services for these vulnerable children to provide formal input to CPS. For example: two children who were fatally abused in April 2004 were receiving services from Mental Health and Public Health while they were in the CPS system; important information wasn't shared because Health and Human Services did not have a structured forum to share opinions and to develop appropriate interventions.

- Cross Departmental Misunderstandings. The two departments do not understand or know how to navigate each other's system. There is no single point of individual referral for the assessment and treatment services provided by Public Health and Mental Health and consequently HSA does not know which division, or who to contact or hold accountable for issues or concerns. Public Health and Mental Health staff lack understanding of the CPS system and its role and responsibility to require and oversee services in an involuntary service system.

- Capacity Constraints. The Mental Health High-risk Team and Public Health Planet teams both have waiting lists for services. HSA's Alcohol and Other Drug Program has inadequate treatment capacity and has seen a drastic increase in the number of CPS cases being referred or identified with substance abuse issues.

Section 3: Caseload Size and Population Demographics and Needs

Demographics of CPS Cases (n=160)	
Age	
Less than 1 Year	22%
1	19%
2	19%
3	17%
4	15%
5	8%
Gender	
Female	49%
Male	51%
Race/Ethnicity	
Hispanic/Latino	26%
White	37%
Asian	2%
African American	22%
Pacific Islander	12%
Unknown	2%
Primary Language	
English	86%
Spanish	10%
Unknown/Other	4%
Location	
East Palo Alto	15%
Menlo Park	4%
Redwood City	28%
San Mateo	12%
San Bruno	8%
Pacifica	3%
South San Francisco	8%
Daly City	13%
Other Cities	8%
Not From San Mateo County/ Unknown	2%

An average of 160 children ages 0-5 are under the legal jurisdiction of the Child Protective Services (CPS) system at any time (see table below). Fourteen percent of these children are removed from the home and awaiting court placement/decision (Emergency Response); 42 percent are under the jurisdiction of the Court and remain in the parent's home (voluntary and court ordered family services); 41 percent are under the jurisdiction of the Court and removed from the home (family reunification and permanent placement); and 3 percent are awaiting adoptions.

These children have entered the system due to an array of abuse and neglect allegations. Approximately 70 percent of the allegations are related to neglect and incapacity and 30 percent are related to physical, emotional and sexual abuse.

Sixty percent of these children are two and under and sixty percent are of Hispanic (26%), African American (22%), or Pacific Islander (12%) ethnic descent. The gender of the children is very evenly divided.

Almost half of the children are originally from South County and one fifth are from North County. Approximately, ten percent of the children are now being placed in homes that are out of the county. However, the majority of these out-of-county placements are within the greater Bay Area.

In 2003-2004, approximately 315 children ages 0-5 were under the legal jurisdiction of the Child Protective Services (CPS) system. This number of cases has been quite consistent over many years and about half of children ages 0-5 remain in the CPS system for extended periods of time. 32% of them remain the system for six months or less; 23% remain in the system for one year; 31% remain in the system for two years; and 15% remain in the system for more than two years.

Child and Family Services data show that mental health and substance abuse problems are a contributing factor to a large number of CPS cases. Social Workers report that more than 50% of cases have some form of mental health diagnosis (e.g. parent mental health hinders ability to parent, parent has poor impulse control, child's behavior affects parent's ability to cope, lack of parent/child bonding/involvement, and parent does not control anger). Approximately 2/3 of CPS children ages 0-5 come from families with substance abuse problems (e.g., parents of these children are hindered by drug abuse and/or alcohol abuse and/or children were born with drugs in their systems). AOD

Services estimates that it conducts substance abuse assessments on parents of approximately 15 CPS children ages 0-5 each month.

In addition, a large of number of cases requires extensive medical attention. It is estimated that approximately 11 percent of children are developmentally delayed and 10 percent of the children have medical needs that impair functioning.

Under the current referral structure, CPS social workers send cases needing behavioral health treatment to an array of treatment programs. On average, 31 children are being seen by Family Services Agency, 32 are being treated by Planet and 8 by Mental Health High-risk. About 89 CPS children are not receiving comprehensive treatment services and it is projected that approximately 23 of these children would have benefited from expansive medical and behavioral treatment services, if additional capacity were made available.

Section 4: Organizational Structure

One of the goals of the Partners for Safe and Healthy Children (PSHC) is better oversight of treatment and intervention for vulnerable children by improving coordination and communication between the Health Department and external providers, including the Children and Family Services (CFS). This goal has led the Health Department to analyze its internal organizational relationship for high-risk behavioral health and medical services and recommend a revised structure. The restructuring addresses current conditions:

- High-risk cases, both CPS and non-CPS cases, are assigned to Mental Health High-risk Team and Public Health Planet staff that work within different divisions. Consequently, managers and deputy directors within two divisions are accountable for staff overseeing CPS cases.
  - This structure affects the Health Department's accountability to the CPS system and other stakeholders, because there is not a direct chain of command for decision-making and supervision.
  - CPS and community-based organizations may find it difficult and complicated to know which division management to contact regarding issues with high-risk cases.
- As more CPS cases enter the system with complex mental health or alcohol and other drug issues, it will be more difficult to determine whether to place these cases with Planet or MH high-risk teams.
- The prevalence of dual diagnosis cases (mental illness and substance abuse), will require the Health Department to dually train staff on AOD/MH treatment practices. This new skill set will raise questions about supervision and placement (i.e., in the PH Planet or MH high-risk teams) and how the two supervisors can balance caseloads.

The PSHC planning group recommends a phased-in organizational restructuring approach to systematically improve and centralize the assessment, treatment, and case

management of all 0-5 year old high-risk behavioral health and medical cases. This reorganization will balance the immediate need to provide assessment and treatment services to CPS cases with the long-range need to improve coordination and delivery of services to all at-risk and vulnerable children.

In the first phase, an integrated High-Risk Behavioral Health and Medical Team will be created to serve Pre-3 cases with high-risk behavioral health problems and ages 0-5 CPS cases. This will be implemented in the beginning of 2005 and existing Mental Health High-risk and the Public Health Planet teams will be combined into an integrated High-risk Behavioral Health and Medical Team within the Mental Health Division. This new structure will improve coordination and communication, and ensure that vulnerable children receive continuous and coordinated care and oversight. The organizational chart below illustrates the new structure. The Mental Health Division serves as the central point of contact for stakeholders, including CFS, regarding support and assistance related to high-risk children with behavioral health issues.

The Public Health Division and its Family Health Services Program will continue to play an essential role in the delivery of quality assessment and treatment services to at-risk and high-risk children and their families. It will be the central point for treatment, management and service coordination of cases with complex medical problems. It will oversee the Pre-3 Initiative, ensuring that the High-Risk Behavioral Health Team integrates the core concepts of Pre-3 into its structure and services. In this role, it will ensure a clear interface between the behavioral health team and the rest of the Pre-3 partners

Public Health's Family Health Services will also manage Radio Central which will serve as the entry point for these at-risk and high-risk CPS and Pre-3 children ages 0-5. The Case Flow Diagram A (below) demonstrates how Radio Central will preliminarily screen and refer cases.

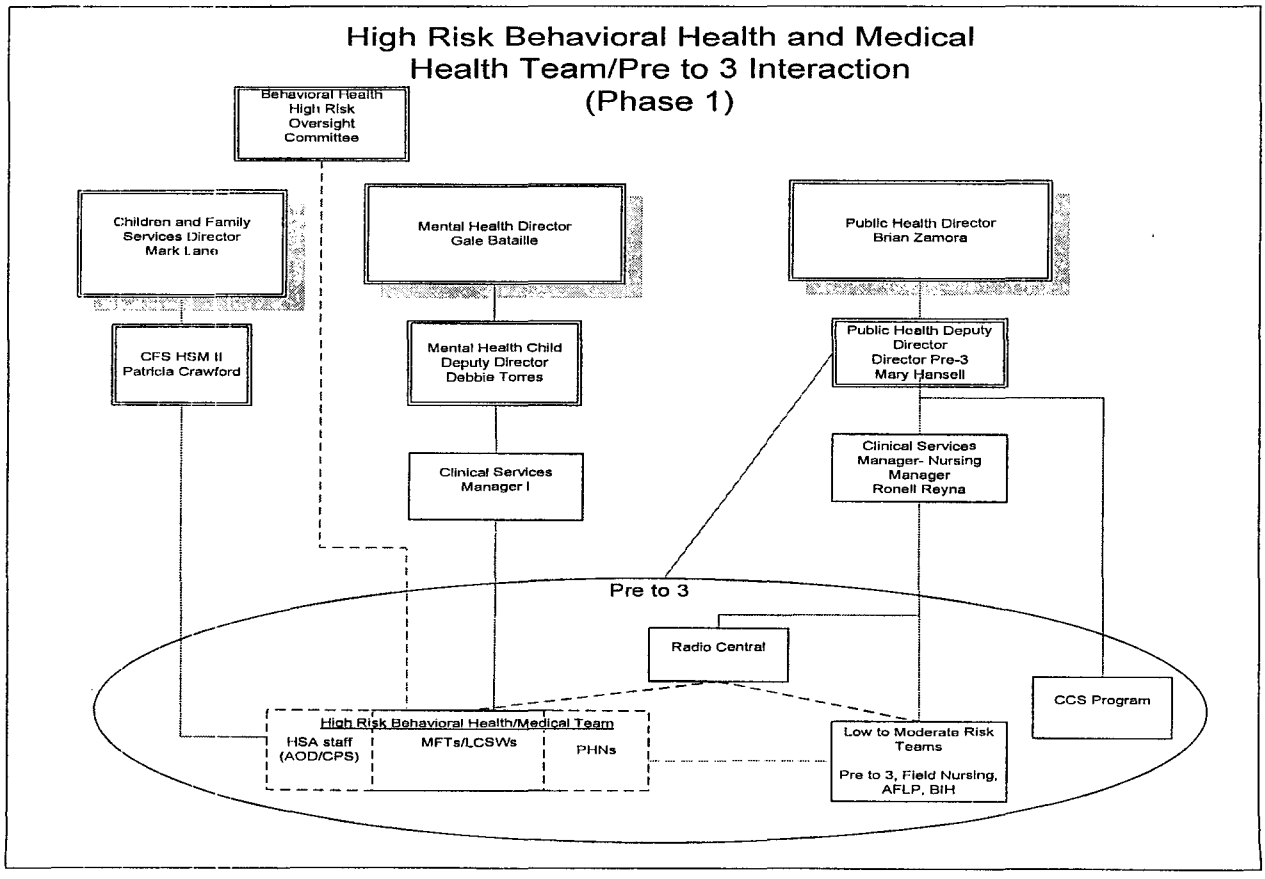
The High-Risk Behavioral Health and Medical Team will oversee 0-5 year old cases that are referred by Radio Central that meet any one of three major criteria: 1) an open case to the CPS system; 2) serious mental health problems; and 3) serious substance abuse problems. A multidisciplinary team will coordinate assessment, case management and treatment of the behavioral health and/or complex medical needs of the children and their caregivers. The team will offer comprehensive, evidence-based behavioral health and medical treatment and assessment services and will be dually trained (mental health/ substance abuse), culturally competent, family focused, strength-based, very experienced and comfortable in working collaboratively with other treatment providers.

The High-Risk Behavioral Health and Medical Team will be composed of Licensed Clinical Social Workers and Marriage and Family Therapists (LCSWs/MFTs), community workers, program specialists, Public Health Nurses (PHNs), AOD staff, and CPS Social Workers. One of the program specialists will provide team members with guidance and expertise on CPS issues and serve as the point person to the CPS system. While the majority of the staff (LCSWs/MFTs) from the team will report directly

to the High-Risk Team supervising clinician, several of the staff (e.g.: PHNs, AOD staff, CPS SWs) will be supervised by other divisions or departments but will work in a team oriented decision making process to provide assessment and treatment services to these high-risk cases. The High-Risk Behavioral Health Team will be managed by a Clinical Services Manager who will be dedicated 60 percent of the time to this team.

Phase III (as noted in the background) will expand to a systematic and centralized approach to assess, treat, and case manage *all* 0-5 year old children with low- and high-risk behavioral health and medical needs. In this phase, the high-risk definition will be expanded to include children ages 0-5 outside the CPS system with complex medical conditions (e.g.: California Children Service (CCS) cases). This phase of reorganization will include expanding the role of Radio Central to assessing and linking 0-5 year old cases to high-risk and low-risk teams and reorganizing staff resources to better case manage and coordinate the care of all high-risk cases, including those within the CCS system (based on the expanded criteria). Planning and implementation of this phase will begin in late 2005.

The High-risk Team during both phases will receive guidance and direction from the Oversight Committee (top level managers representing Public Health, Mental Health, Alcohol and Other Drug, and Children and Family Services). The Oversight Committee will also advise about policies and procedures, program design modifications, and the evaluation of the effectiveness of the PSHC.



Section 5: Redesign of Health Department/Child Protective Services Case Flow

The Phase I plan clearly defines staff roles and responsibilities to ensure the safety, well-being and permanence of children ages 0-5 within Child Protective Services. The flow chart below (Case Flow Diagram A) illustrates these roles and responsibilities and interaction/relationship between CPS and the new High-Risk Behavioral Health and Medical team in providing treatment, intervention and support services to CPS cases.

As shown, Radio Central will receive a call from CPS regarding a CPS continuing case and refer it to the High-Risk Team. The Team Program Specialist will assign a Service Coordinator who will assess the behavioral health and/or public health needs of CPS continuing cases that are dependents of the Court. The Service Coordinator will serve as the point person for the CPS Social Worker providing the CPS Social Worker with on-going advice on the child's behavioral health and medical treatment needs, progress, and recommendations to the Court.

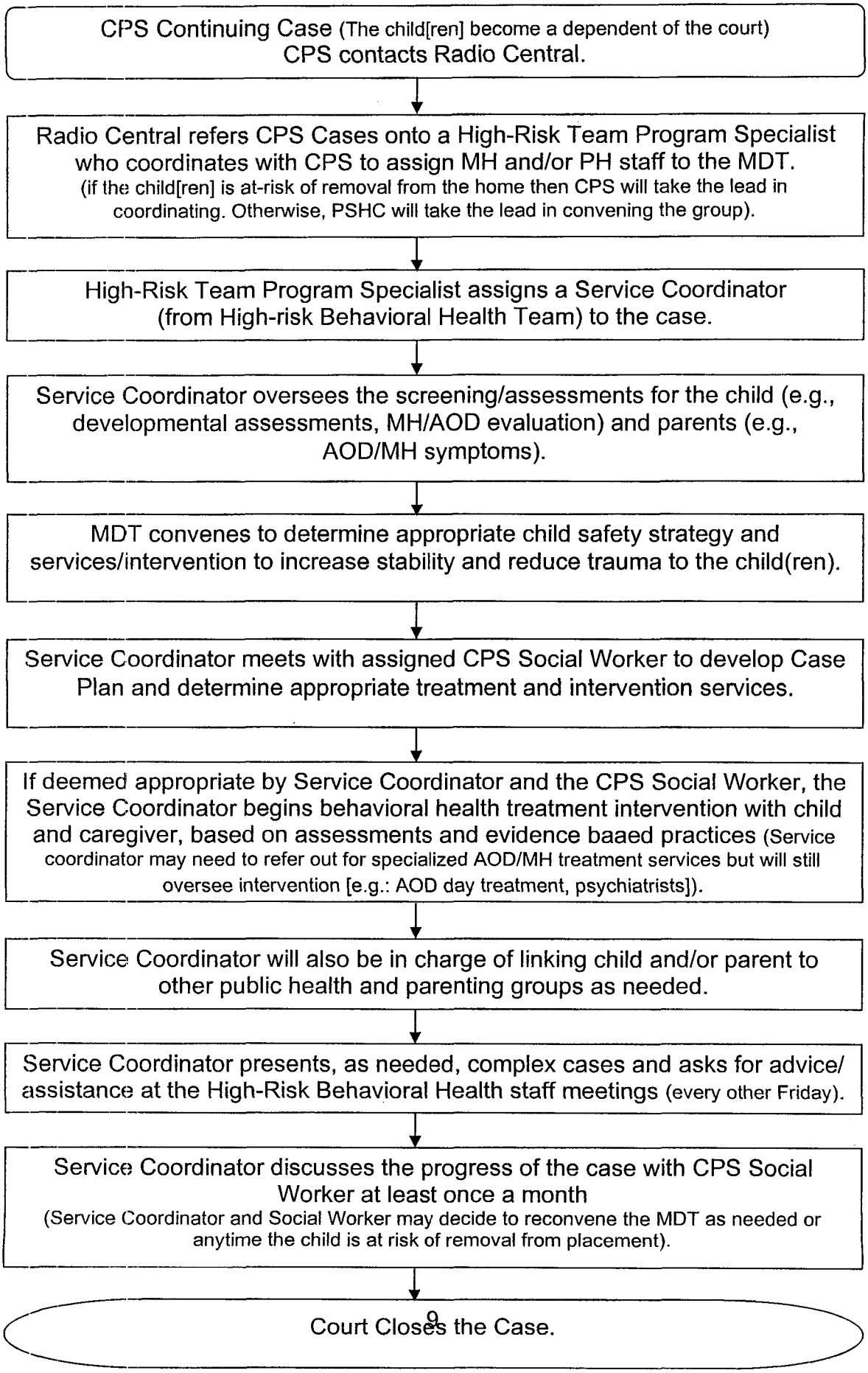
CPS Social Workers will still be ultimately responsible for overall case management services, including the development of the case plan. The CPS Social Worker will oversee child safety, monitor the family's progress with the case plan, and make the ultimate recommendations to the Juvenile Court. The CPS Social Worker will also be responsible for ensuring that the case receives social services, income support, health insurance, child care/pre-school, and domestic violence services.

The new structure will align with the existing CPS juvenile dependency process. When the child becomes a dependent of the Court, regardless of whether removed from the home, the CPS Social Worker and the PSHC service coordinator will convene an in-person Multidisciplinary Team (MDT) meeting--a multidisciplinary group of family members, extended family and community members, and public health, mental health, AOD, and child welfare service providers. The focus of the meeting will be to develop a case plan to improve the child's safety and well being including needed treatment services. The MDT will also reconvene any time there is an imminent removal or change in placement and on a case-by-case basis when the Service Coordinator and Social Worker determine that the group meeting will assist them in determining and implementing appropriate treatment and intervention services.

If the Service Coordinator and the CPS Social Worker (in consultation with the MDT) determine that treatment services are necessary, the service coordinator will also be responsible for case managing the behavioral health and/or public health treatment service needs of these children. The Service Coordinator will be responsible for connecting the child, parent/caregiver to all behavioral treatment needs as well as other public health and social service resources, including medical treatment and parenting classes (see section 6 and Case Flow Diagram B for more information).

Interactions and group management for CPS children will continue until the Court closes the case. These interactions include: Service Coordinator and Social Worker monthly check-ins, PSHC staff meetings to review complex cases, and MDT meetings.

Partners for Safe and Healthy Children (PSHC)
Case Flow Diagram A: Case Management Coordination



Section 6: Behavioral Health and Medical Treatment Evidence-based Practices

The PSHC planning workgroup undertook an analysis of nationally recognized evidence-based practices for child abuse assessment and treatment. Participants undertook an extensive literature review and directly contacted leading national experts. There were several assessment and treatment modalities analyzed and presented, all involving the parent/caregiver due to the age of these children.

Assessment

In the new model, the first step that the PSHC Service Coordinator will take is assessing the behavioral health and medical needs of the child and parents. This behavioral health and medical assessment will be done in coordination with the family needs assessment that the CPS social worker currently undertakes. In addition, the Service Coordinator will review any assessment results reported in the MDT. This coordination with CPS and the MDT will assure non-duplication of child- and family-based assessments.

The analysis of evidence-based practice highlighted the importance of completing a comprehensive needs assessment of the child and parent prior to determining the most appropriate intervention. The most effective intervention models treat the type of difficulties and symptoms that the child exhibits rather than the types of trauma they experience. The assessment components and process are noted in Case Flow Diagram B. The diagram illustrates the process for assessing a child/family referred to the PSHC and treatment options. It is assumed that the staff providing the assessments and /or treatment is dually trained (mental health/ substance abuse), culturally competent, family focused, strength-based and very experienced and comfortable in working collaboratively with other providers.

The new treatment team will use the Children's Crisis Care Center model (Bruce Perry). This model, which is currently being used by Pre-to-Three High-Risk Mental Health Team, offers the most comprehensive, multidisciplinary and multidimensional evaluation (i.e.: historical physical information; life events; family social information; caregiver interview and development assessments of the child). The model is a tool to understand cues for emotional stress and strategies to regulate the child's status and environment.

Staff will also be trained to assess those with dual diagnosis. They will be responsible for assessing children and parents for AOD symptoms. AOD program staff will serve as back-up for assessments in case PHSC staff believe they need further assessments performed for referrals to outside AOD service providers, such as WRA and Women's Enrichment Center.

Mental Health Treatment Evidence-based Practices

After the initial literature review, the group obtained extensive information about a few mental health treatment models proven to be effective in this area. Those models included: 1) Parent-Child Interaction Therapy (S.M.Eyberg), 2) Trauma Focus Cognitive

Behavioral Therapy (TF-CBT--J. Cohen), and 3) Parent/Infant Psychotherapy (A. Lieberman). (See attached explanation and the grid for specific descriptions of these interventions (Appendix 2))

Workgroup participants are in agreement that all these models appear to be extremely effective in addressing specific mental health needs of children (ages 0-5) and their caregivers who have experienced trauma. Yet, the research highlighted that no single specific treatment modality addresses the varying and multifaceted mental health needs of these children and their families.

The workgroup incorporated the majority of the treatment models into a centralized, coordinated treatment approach and selected interventions that will treat symptoms exhibited by the majority of children. The following implementation process was recommended:

1) Enhance and Expand the Use of Parent/Infant Psychotherapy. This model is currently being used effectively by the Pre-3 Mental Health High-Risk Team as a relationship-based treatment approach for infants, toddlers and preschoolers who are experiencing mental health problems or parent / caregiver attachment difficulties. This treatment is recognized as the most effective approach for infants (two years of age and under) and should be expanded with additional staff training and resources and continued to be viewed as the cornerstone for the successful work of the MH High-Risk Team.

2) Incorporate the Use of Trauma Focused Cognitive Behavioral Therapy. The TF-CBT intervention has been proven to be the most effective treatment option in cases of post-traumatic stress disorders. Incorporating this intervention into the team will fulfill an unmet treatment modality for a large number of the 3 to 5 year old population who exhibit trauma-related symptoms, such as nightmares, traumatic play, avoidance of trauma reminders, irritability, and fearfulness. In many cases, the underlying traumatic symptoms must be addressed first before treating the readily apparent behavioral problems. Children and parents receiving the TF-CBT intervention can seamlessly transition and/or receive the core elements of the Parent Child Interactive Therapy or PCIT (see below) as necessary.

3) Contract out for Parent Child Interactive Therapy (PCIT) Services as Needed. PCIT is a costly and rarely-used approach. The team will contract with existing PCIT providers (e.g., Family Services Agency) on a very limited and as-needed basis. After the first year, it will revisit the cost-effectiveness of training team members on the model.

Substance Abuse Treatment

PSHC staff will also be responsible for substance abuse assessment and treatment services for the children and/or parents. A large proportion of CPS cases have

substance abuse issues; PSHC will need to expand its focus on appropriate treatment interventions.

The child-focused interventions will be addressed through the use of the Mental Health evidence-based treatment practices, because the children will require interventions that treat the type of difficulties and symptoms that they exhibit rather than the types of trauma they experience. In addition, these treatment practices will be enhanced by the existing resources and skills of the Pre-3 Planet team.

PSHC staff will need to augment its skills, techniques and approaches to appropriately treat substance abuse needs of the parents. It will rely on the existing dual diagnosis groups as a base for AOD treatment. For more complicated treatment needs, the PSHC will work in tandem with HSA AOD staff to assess and connect clients to available resources such as day treatment programs, residential treatment, etc. The PSHC workgroup will phase-in evidence-based AOD treatment practices over the coming months.

Family Violence Treatment

Data show the need for Family Violence treatment and intervention options. PSHC staff will be responsible for intervention related to the child. Any issues related to the perpetrator will be overseen by the Courts and/or CPS. Since different entities will be responsible for Family Violence services, it is important that PSHC service coordinator and CPS staff remain in close communication to ensure that services are to meet the entire family's needs.

The majority of family-violence-related trauma will be addressed through the Mental Health evidence-based practice interventions that will treat underlying symptoms. If additional treatment services are needed, PSHC will rely on the Healthy Homes Program of the Youth and Family Enrichment Services Agency to provide services to children ages 0-5 who have witnessed or been exposed to family violence.

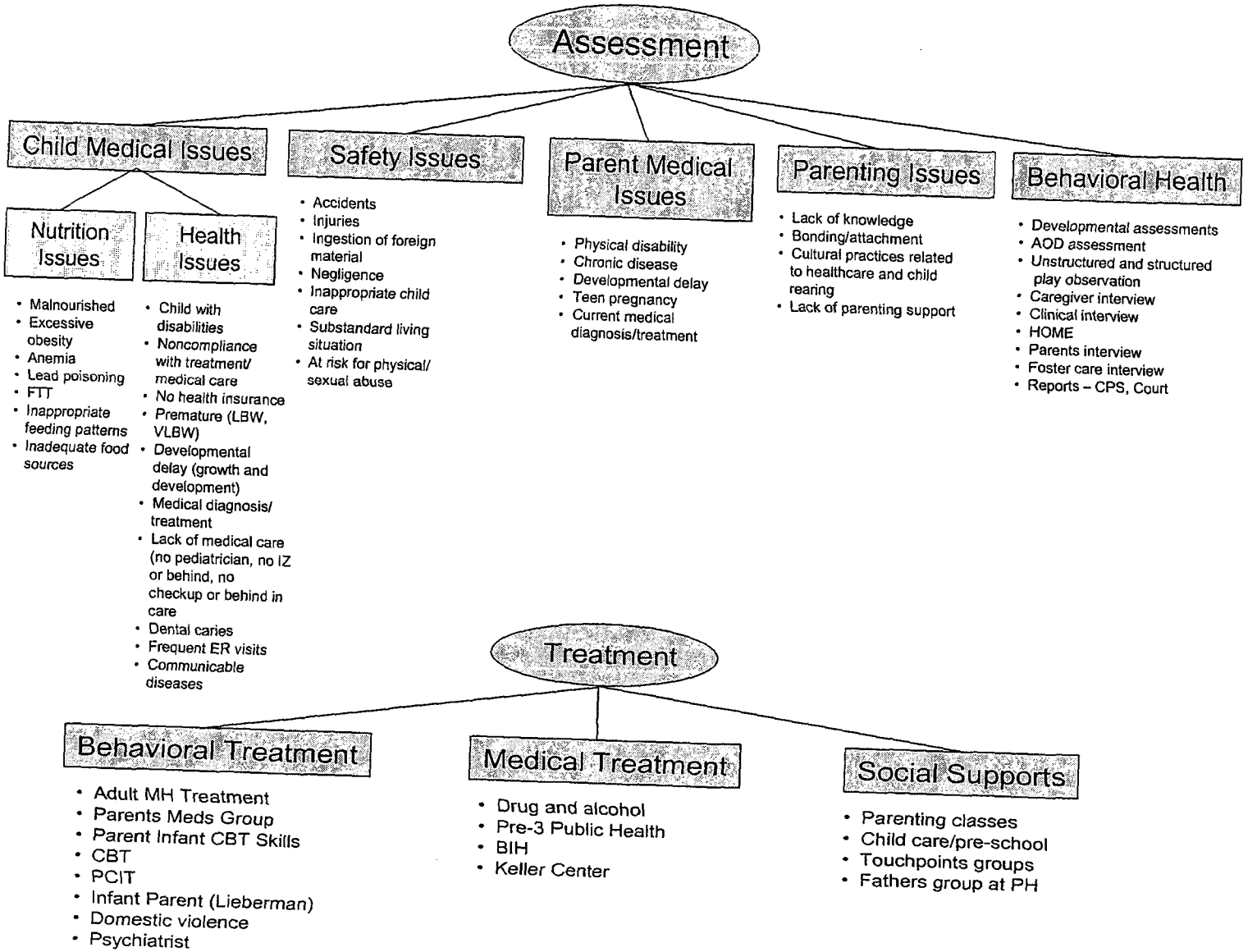
Medical Treatment

The PSHC will case manage the medical needs of children ages 0-5 within CPS. Depending on the presenting symptoms and the decision of the MDT, a PHN may be assigned as the service coordinator. Approximately 20 percent of CPS cases exhibit signs of being developmentally delayed; making it likely that medical treatment will be the primary service need. In these instances, the PHN will coordinate the services that a child in CPS receives to assure they obtain medical assessment and treatment. Case Flow Diagram B outlines the types of services that PHNs will provide.

For all cases, regardless of whether acting as the Service Coordinator, the PHNs will perform a number of the standardized interventions defined for public health nursing. These are: referral and follow-up, health teaching, counseling, collaboration, advocacy, and short-term or long-term consultation. They will focus on child medical issues, safety issues, parent medical issues and parenting issues.

CASE FLOW DIAGRAM B

Behavioral and Medical Assessment, Case Management, and Treatment



Section 7: Staffing Needs for CPS Cases (Phase I)

PSHC High-risk Team Staffing Needs for CPS Cases				
Duty	Position Title	Number of Positions		
		Existing	New	Total
MH/AOD Service Coordinator	MFT/LCSW	2.0	4.0	6.0
PHN Service Coordinator	PHN	2.0		2.0
Child Development Behavioral Specialist	New Classification		1.0	1.0
PSHC Program Specialist	CPS I/II		1.0	1.0
Total		4.0	6.0	10.0

The table above provides a snapshot of staffing needs for the High-Risk team that will be charged with overseeing the medical and behavioral assessment and treatment care of children ages 0-5 within the CPS system (Phase I). The CPS caseload requires I0.0 positions. It will use 2 existing positions from the Mental Health and Planet High-risk Teams and 2 existing positions from HSA; and will require 6 new positions

The PSHC High-Risk Team Service Coordinators should carry an average of 13 CPS cases. The caseload level is based on the complexity of CPS cases and the time intensive nature of the treatment/ interventions that will be provided. The caseload is modeled after the Pre-3 Mental Health High-risk Team's current caseload levels 10 to 14 family cases) and they mirror CPS's experience in managing these cases. The caseloads of Family Maintenance, Family Reunification and Permanence Planning Social Workers, which provide the best comparison to the intensity of services that the PSHC Service Coordinator will offer, hold approximately 25 children per month (approximately 10 to 16 family cases).

Nine staff members will serve as the Service Coordinators for CPS cases.[2] These service coordinators will assess behavioral health and medical treatment needs for all 119 CPS cases ages 0-5 and provide intensive behavioral health and medical treatment services for approximately sixty percent of the children.[3] PSHC currently has 2 positions from the MH and PH Planet teams and 2 PHN positions from HSA to serve this role. It will need an additional 5.0 positions (4.0 LCSW/MFTs and 1.0 Child Development Behavioral Specialist).

[2] 160 children ages 0-5 that are within the CPS system at any point in time are from 119 families. Each family is one case for the PSHC High-risk Team. The Planet and MH High-risk teams already serve approximately 40 children 0-5 that are in the CPS system. PSHC will need additional staff for the other 120 children within the CPS system.

[3] These are the 40 children from the Planet/MH High-risk Team, 31 children from FSA, and an estimated 23 children that are currently not receiving behavioral and medical treatment but are projected to need this intensity of services.

In addition, the team will require psychiatrist time and 1.0 CPS I/II to provide administrative and programmatic support to the team. A detailed description of these positions is outlined below.

The staffing recommendation is based on:

1. PSHC will be taking over the role of the Family Services Agency (FSA), which was providing treatment services to approximately 30 CPS children ages 0-5 on a monthly basis. PSHC will serve in this role without any of the funding shifted from the FSA contract. The $780,000 funding FSA received for assessment and treatment services for the 0-18 population has been redirected, based on the result of an RFP and the direction of Health and HSA leadership. A new community-based non-profit provider will provide a more comprehensive range of assessment and treatment services to the ages 6-18 CPS population.
2. The High-Risk Team will be providing comprehensive behavioral health and medical assessments for all CPS continuing cases (approximately 160 children) which increases the team's assessment caseload from 40 children (pre-3 MH and Planet high-risk teams) to 160.
3. CPS children who are currently in the Pre-3 Planet and MH High-risk system do not receive the appropriate intensity of services because some of the staff carry caseloads of twenty or more.
4. About 23 of the 90 CPS children ages 0-5 who were not receiving services from FSA or Pre-3 will receive intensive and comprehensive evidence-based, behavioral treatment services. These children might not have received services in the past due to waiting lists, out-of-county placements, adoptions, etc.
5. The team members will increase the structural and team-oriented relationship between CPS and the Health Department to ensure communication and accountability to improve a child's safety and well-being and prevent a child from being placed at-risk of further abuse and/or neglect.
6. These additional positions will lead to increased staff time throughout the CPS and behavioral health system of care. For example, as PHSC Service Coordinators will take on the responsibility for assessment and treatment services, thus allowing CPS social workers and administrative staff to increase their focus and attention on monitoring the progress of all cases. In addition, AOD staff will have additional time to focus on assessments and AOD treatment service coordination for non-CPS cases.

Staff Job descriptions are included in Appendix 3.

Fiscal Impact

The total cost of the four LCSW positions and the CPS position in Fiscal Year 2004-05 is $190,224. These costs will be covered by Medi-Cal ($39,224), Supportive Therapeutic Options Program (STOP) ($126,000), and SIP ($25,000). The full year cost in Fiscal Year 2005-06 the cost of these positions and the Child Development Behavioral Specialist will be $600,000. These costs will be covered by Medi-Cal ($209,000), STOP ($126,000), and SIP ($100,000). The remaining $165,000 is

expected to be covered by grants from First 5 San Mateo County and private foundations.

Section 8: Next Steps

Following approval of the core program design, implementation work will be needed. Areas to be addressed include:

- Physical space requirements;
- On-going operational oversight of the new assessment and treatment structure;
- Development of policies and procedures to ensure proper coordination, in-person team decision making meetings, and case management among CPS staff, PSHC multidisciplinary team members, and existing departmental and community based assessment and treatment services;
- Identification of an existing staff member from AOD and CPS that will be assigned to the High-Risk Behavioral Health Team;
- Review of HSA and Health assessment tools and development of a protocol on the appropriate assessment tools to ensure non-duplication;
- Formulation of a position related to enforcement of services for CPS cases (i.e., philosophical shift to mandatory rather than voluntary services);
- A communication strategy about this new program design for internal Health and HSA staff as well as for external child welfare stakeholders;
- Training curriculum for staff in the two Departments, including training components that will facilitate the cultural change necessary to improve shared coordination and responsibility of these cases by all staff;
- Implementation of on-going evaluation and quality improvement plans to assess the PSHC and the need for changes and/or additional resources (e.g., service capacity, transportation and child care needs);
- Create a classification for and add Child Development Behavioral Specialis during the June, 2005 budget hearings.

Preliminary discussions related to implementation the first phase of the project have begun and will be addressed in meetings with Health and Human Services staff and management.

Appendix 1
Values of the new PHSC High-risk Treatment Team

- Serving unsubstantiated and substantiated cases
- Model system of care to ensure safety and permanent well being of children
- Integrated state of the art services for 0-5 who are at risk or have experienced abuse and neglect
- Improving linkage and interaction with CPS, PH, AOD, MH, DV
- Working with Justice system and law enforcement
- Best practice model that is evidence-based and outcome-based and continuously evaluated
- Highly skilled and trained staff
- Continuous Quality Improvement
- Children first
- Strength-based
- Relationship-based
- Caregivers are part of the plan (all types support caregivers)
- Community Collaboration
- Consumer involvement in decision-making
- Parents want to do well by their children

Appendix 2
Evidence-based Models Presented

To obtain more information about **Parent Child Interaction Therapy (PCIT)** we invited Nancy Chang, Clinical Director of Family Services Agency (FSA) to make a presentation to the planning group. PCIT is currently being provided at FSA for children ages 2 to 7 who are referred by Child Welfare. PCIT is an intensive treatment program that is designed to help both parents and children. The PCIT program works with parents and children together to improve the quality of the parent-child relationship and to teach parents the skills necessary to manage their child's severe behavior problems. The intervention involves use of a one-way mirror with the parent and child in the room, (parent having an earpiece) and the therapist outside the room. The therapist gives prompts to the parent regarding the interaction and coaches them on the behavior. The model involves about 11 sessions. PCIT addresses behaviors and it was stated that if the child is experiencing trauma related to the child abuse or domestic violence that it may be recommended that individual or family therapy be provided. The therapy often will precede the PCIT.

The committee had a conference call with Judith Cohen, M.D. Professor of Psychiatry (Medical Director, Center for Traumatic Stress in Children & Adolescents, Allegheny General Hospital, Pittsburgh, PA). She presented the **Trauma Focused Cognitive Behavioral Therapy** model **(TF-CBT).** This model is research-based and the initial research involved children ages 5 and younger who were sexually abused. Dr. Cohen has found this model also very useful with children (ages 3-18) who have experienced other types of trauma in their lives, (e.g.: physical abuse, depression.) The model is short-term consisting of 12 sessions (average treatment has been completed in 8 sessions) with the goal of decreasing the child's symptoms. The model has specific focus/ tasks for each session and a therapist usually sees the child for 30 minutes and then the parent for 30 minutes. The parent and child are then brought together for a joint session to discuss the trauma and then develop of a safety plan.

Mary Newman, LCSW presented the **Child-Parent Psychotherapy** model (Alicia Lieberman). This model is "a relationship-based treatment approach for infants, toddlers and preschoolers who are experiencing mental health problems or whose relationship with the parent is negatively affected as a result of factors such are parental mental illness or family violence, child constitutional characteristics that interfere with the formation of a secure attachment, and/or discordant temperamental styles between the parent and child" (A. Lieberman). This model is currently being utilized in the Pre-to-Three High-risk Mental Health Team. The model is aimed at providing services to children ages 24 months to 59 months and their parent/caregivers. The organization of therapeutic sessions includes joint parent-child sessions and individual sessions with caregiver. Treatment usually lasts about one year. "The goal of child-parent psychotherapy is to return the child to a normal developmental course by restoring a sense of safety, trust and reciprocity in the parent-child relationship" (A. Lieberman). Newman also briefly described the **Children's Crisis Care Center Model: A Pro-**

active, Multidimensional Child and Family Assessment Process (Bruce Perry). This model is a comprehensive evaluation, which is multidisciplinary, and multidimensional (i.e. historical physical information; life events; family social information; caregiver interview and development assessments of the child). The Pre-to-Three High-risk Mental Health Team is also currently utilizing this evaluation model.

Treatment Model	Targeted Population	Age Group	Modalities	Assessment Tools	Outcomes	Staffing required (#, discipline)	Length of treatment	Other
Parent/Infant (Lieberman) Relationship based treatment approach for o-5 yrs old who are experiencing mental health problems or whose relationship with the parent is disturbed.	-Parental Mental Illness -Domestic violence -Victim's of child abuse and trauma -PDE (prenatally drug exposed infants)	0-5 ***SITE*** Home or clinic based	Assessment Phase 4 sessions Treatment Phase – Parent/Child Interaction -Helping parent make sense of child's behavior through teaching and modeling. -Unstructured developmental guidance. -Providing emotional support -Social support (case management etc.)	Caregiver CAPS (PTSD scale) Life Stressor Checklist (Revised) Child Wechsler Preschool Primary Scale of Intelligence Child Behavior Checklist PIR-GAS (Parent Infant Relationship Global Assessment Scale) (Bailey's can be used for Developmental test for younger children. Or Ages and Stages or Denver can be used for screening.)	Cognitive measure showed significant improvement in almost %100 of subjects. PIR-GAS- demonstrated significant improvement in quality of mother/infant relationship. CBC demonstrated significant decrease in children's behavior problems.	-Psychologists -Mental Health Clinicians -Community Workers	Minimum 1 yr.	Intervention consistent with Infant/Mental Health Field. **GOAL:** To promote a positive psychological partnership between child and caregiver. This relationship in turn mediates affect regulation, and development for the child, and improved protective behaviors and appropriate developmental responses of the parent.

Treatment Model	Targeted Population	Age Group	Modalities	Assessment Tools	Outcomes	Staffing required (#, discipline)	Length of treatment	Other
Parent Child Interaction Therapy (Eyberg) Externalizing (behavior) problems are primary issues. Intensive Treatment program that is designed to improve the quality of the parent-child relationship and to teach parents the skills necessary to manage their child's severe behavior problems.	-Victim's of child abuse -children with severe behavioral problems -parents with limited parenting skills. Been used to stabilize placements successfully. Field tested on kids referred by Social Services.	2-7	In-vivo teaching and coaching of dyad Primarily clinic based <u>Two Part Intervention</u> -Relationship Enhancement (PRIDE skills) -Disciplinary Component	Empirically evaluated in over 30 controlled studies. Caregiver -Parental Stress Index -Clinical Interview Child -Child Behavior Checklist -Eyberg Child Behavior Inventory	-decreases child behavior problems -improves parenting skills -enhances quality of relationship between parent and child -reduces risk of recidivism -generalization to untreated siblings -generalizations to home and school -improvements maintained after a 6-yr follow-up.	Mental Health Clinicians	14 to 20 weekly clinic-based sessions depending on complexity. Home-based adjunct services seem to be longer. Additional sessions and/or cycles may be needed.	Does not meet the needs of all issues. (Families may need to be referred for AOD, individual, etc.) Timing needs to be considered. Developmental Delays may prevent client from benefiting. Strong recommendation that skills should be practiced in clinic. Inclusive of siblings.

Treatment Model	Targeted Population	Age Group	Modalities	Assessment Tools	Outcomes	Staffing required (#, discipline)	Length of treatment	Other
Cognitive Behavioral Therapy (J. Cohen) Cognitive Behavioral Therapy for Sexually Abused Preschoolers.	Kids experiencing PTSD, Depression, Anxiety, Aggression, Sexually inappropriate behaviors Children experiencing multiple traumas, sexual abuse, and/or DV Treatment received within 6 months of Social Service Involvement	3-7 Can be used for kids 3-18.	Treatment addresses parent cognitions, coping responses, emotional distress and perceptions in response to trauma. Psycho educational and supportive treatment is incorporated focused on -safety education -assertiveness training -safe touching -feelings -amb. Feelings towards perpetrator	<u>Child measures</u> -Pre-school symptom checklist (PRESS) Parent Measures -Child Sexual Behavior Inventory (CSBI) -Weekly Behavior Record (WBR) -Child Behavior Checklist (CBCL)	CBT demonstrated symptomatic improvement on all measures; All measures demonstrated mean scores fallen to below clinical range	Mental Health Therapists	12 –16 weeks 1.5 hours, time limited. Individual 50 minutes with parent 30 to 40 minutes with child.	-Mental retardation -PDD -Psychosis -Serious Medical Issues -Active AOD of parents

Treatment Model	Targeted Population	Age Group	Modalities	Assessment Tools	Outcomes	Staffing required (#, discipline)	Length of treatment	Other
Children's Crisis Care Center (Bruce Perry) Proactive , timely evaluation that allows aggressive, proactive intervention (data collected facilitates ability to better match placement and target services)	Children in care of Child Welfare Timely reports for CPS is goal. Reports inform case planning.	0-6	Multi-dimensional evaluation (including family) Developmental evaluation Electronic database available for multiple appropriate users Clinicians participate in interdisciplinary teams with CPS Follow-up assessment for outcome evaluation Public/private partnership with distributed leadership and shared responsibility	-Physical (height, weight, blood pressure, pulse, FOC (frontal-occipital circumference), Historical Physical Information Active Problems) -Life Events -Family Social (Interview, Parenting Stress Index, Family Environment Scale) -Development Caregiver Interview (developmental), Denver II, Bayley Infant Neurodevelopment Screener, Batetelle Developmental Inventory - Emotional/Behavioral (Caregiver Interview, CBC 2-3, CBC 4-18)	-Economic (Reduced days in shelter and foster care saved county $25,000 in 1 year) -Children experienced fewer placement disruptions -Average time between initial emergency placement and a longer-term placement was reduced -Children more likely to be placed with relatives -Children returned home at higher rates	Psychometricians, clinicians, administrators, assessment team staff, caseworkers, case aides, supervisors.	Goal: Full assessment completed within 14 days of CPS removal to help inform child welfare plan	Staff involved in systems change must be flexible and willing to work hard, capable of sharing, respectful of other disciplines, and care for the children. Need high degree of buy-in because of collaborative formulation. Assessments not performed by child welfare. Other agencies stressed they were not CPS and gained more cooperation from families

Appendix 3
PSHC staff descriptions

6.0 LCSWs/MFTs. A total of 6.0 LCSWs will serve as the primary service coordinator for cases that exhibit mental health and/or alcohol and other drug symptoms. The majority of cases will present with behavioral health systems as the primary contributing factor. The Health Department will assign two existing staff from Pre-3 MHHR and Public Health Planet to the PSHC team, based on the estimated number of current CPS cases that they currently treat. The Health Department will need to add four additional dually trained LCSWs to serve as the primary service coordinator for the CPS cases with mental health and/or AOD symptoms that will be new to the team. It is projected that two of these four new positions will be identified in HSA. The LCSW Service Coordinators will be supervised by the supervising clinician of the Behavioral Health High-risk Team.

2.0 FTE Public Health Nurses. 2.0 PHNs will act as the service coordinators for CPS cases whose primary diagnoses are medically related. A large percent of children have developmental delays and medical needs. These staff will also provide short-term and long-term consultation to cases. The staffing need is based on the assumption that 100 percent of the cases will need short-term consultation (1 to 3 visits for a month) and 50 percent of the cases will need long-term consultation (1 to 3 visits every month). As with all other Health Department PHNs, the PSHC PHNs will also participate in other public health related activities, such as Bioterrorism, surveillance of emerging problems, disease investigation, delegated direct care tasks, outreach to locate at-risk populations, screening to identify individuals with unrecognized health risk factors, etc. This will take up approximately 15 to 20 percent of their time. The PHNs will be supervised by the Senior PHN in Public Health Family Health Services.

1.0 Child Development Behavioral Specialist: This will be a newly created classification to enable Health to better serve the many CPS children who are experiencing development and behavioral problems which prevent them from successfully participating in pre-school and transitioning into kindergarten. The position will work closely with the other Service Coordinators (MFT/LCSWs and PHNs) but will have a skill set to coordinate programs and procedures involving child development and behavioral services for CPS children ages 0-5.

1.0 Community Program Specialist I/II: This administrative and programmatic support position will be charged with coordinating all the cases on an administrative level (e.g., the MDT meetings, reports, keeping track of which staff are case managing CPS cases and their current caseloads). In the future, the CPS I/II will also be charged with assigning staff to the 10-day response, etc. The CPS I/II will be recruited from within the MH/PH system to support career advancement for entry level staff.

Contracted Psychiatrist. It is projected that 50 percent of the cases that are not currently being seen by the Behavioral Health High-risk Team will also need psychiatrist time. This projection addresses the complexity and acuity of the project caseload. This will work out to the equivalent of a 0.4 FTE psychiatrist.