VENTURA COUNTY
BEHAVIORAL HEALTH

CHILDREN AND FAMILY
SERVICES

Children's Accelerated Access to Treatment and Services (C.A.A.T.S.)

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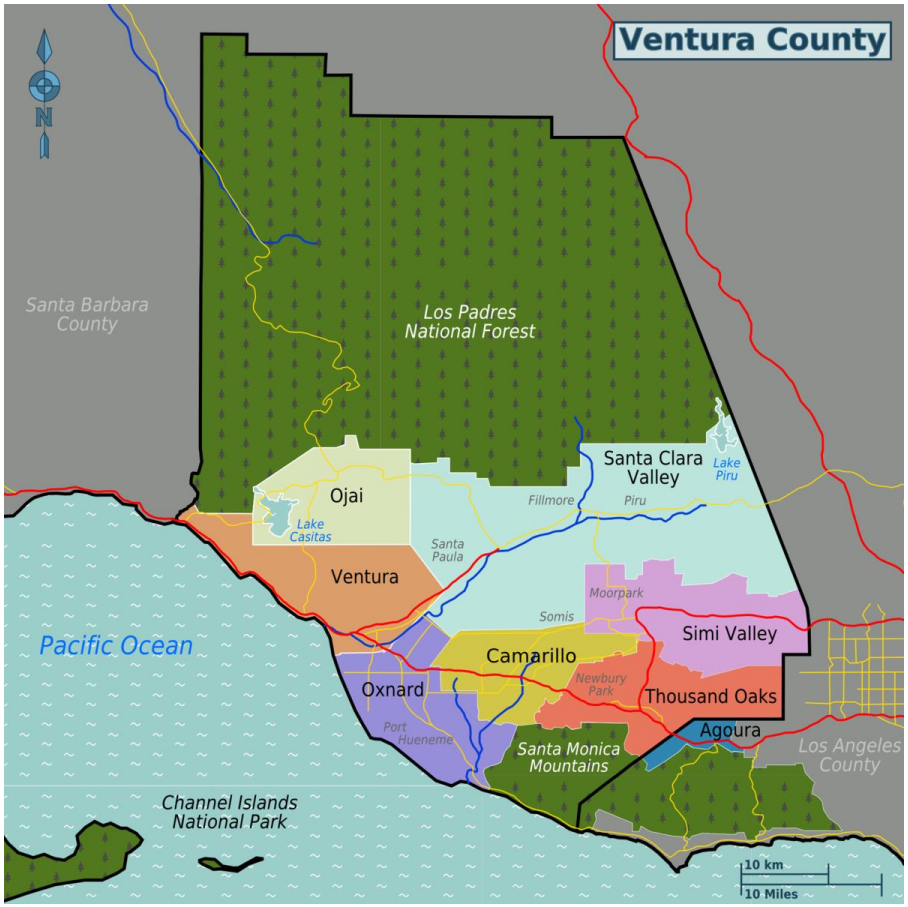
Ventura County



Ventura County

Population - approximately 856,209

- Children (25% of total population): 56% Latino; ~75% of child welfare population
  - Large Mixteco population
- Median household income: ~$78K
  - 7% of families live in poverty – pockets throughout county

Mix of cities and rural

Key industries – agriculture, manufacturing, military, healthcare, tourism, two universities (CLU, CUCI)

Feeling impacts of Thomas Fire (Dec 2017)

Child Welfare & Mental Health Profile

- 5 of the county's 53 zip codes account for 50% of child welfare entries

- Children/Youth in dependency: 1040 (August 2018)
  - Out of Home Care: 740

- CFS children/youth receiving Mental Health Service: 450 (1,006)

	CFS	VCBH/CFS
Latino	73%	50%
0-5 Years	39%	34%
Oxnard Residence	50%	56%

Overview

CAATS (Children's Accelerated Access to Treatment Services):

- Service delivery approach to providing expedited trauma informed clinical support to all children entering child welfare system

Takeaways:

- Truly being trauma informed means treating/healing families, not just screening children
- Creation of continuum of care
- More work to do… to truly provide family centered care

Foundation for CAATS
Strong Interagency Partnership

Child Welfare, Behavioral Health, Probation, Public Health

Collaborative work & Joint governance structures

- Katie A and CCR

Many many many meetings together –

- Understanding each other's roles, mission, responsibilities
- Common understanding of strengths, needs of children and families

Shared vision and responsibility for children and families

- Evolved through our partnership
- From focus on mandates, services, and treatment to teaming, engagement and healing of families
- Specialty MH program serving foster youth (assessments and treatment)

Foundation for CAATS Philosophical Shift

Shifting approach:

From pathology based and stigma driven specialty mental health system to healing the family through relationships

BEFORE:

Child welfare referrals to behavioral health used to be based on externalizing behaviors and functional impairment

NOW:

Recognition that child welfare involvement in and of itself is traumatic even if no symptoms are observed

Foundation for CAATS
Shift in Practice

Agencies have embraced “trauma lens” and are committed to training staff and implementing attachment and neurorelational treatment.

Building resiliency starts in infancy

- Better understanding of impact of trauma on brain development

Development of systems to heal entire family (0-21)

Shift from screening to assessment

Early engagement of families and healing through the Safety Network

Treatment and assessment provided in home or community

Foundation for CAATS

Priority Access to Services and Supports (PASS) - 2016

PASS part of larger effort to expedite access by families to basic needs - wide range services and supports (began with BH)

- Sponsored by CA Child Welfare Council
- Ventura was only pilot county
- Partnership between child welfare, behavioral health (both specialty MH and AOD) and primary mental health

Ensure timely engagement and access, by parents receiving reunification services, into mental health and alcohol and drug services

Referral → Assessment → Treatment (5-5-5 Days)

Demonstrated that systems change can occur

What We Learned From PASS

Significant systems and process change IS possible

- Depends on leadership and multi agency collaboration

Communication and information sharing are critical

Operationalized commitment to serve entire family

- Engagement of family is critical

Most parents referred to AOD or primary mental health services

Results:

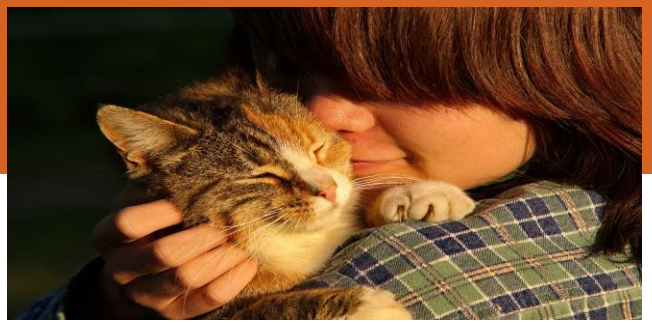
5-5-5 Step	Total
Referral within 5 days	87%
Assessments within 5 days	69%
Treatment initiation within 5 days	85%

Foundation for CAATS Services to Children 0-5

Universal access to specialty MH assessment and short term services for 0-5 CW population - 2016

- 0-5 Training offered to Clinicians, SW, CBOs, Public Health and resource families.
- Recognition of clinical impacts on very young children
- Greater understanding of trauma, brain development, regulation, attachment
- Healing through relationships
- Expansion of contracts with to CBOs - provide short term services

What is CAATS?



Trauma approach:

- Every child entering child welfare receives full MH assessment AND, at a minimum, short term treatment
  - All children meet specialty mental health criteria

Process (5-5-5 Days):

- CW social worker refers all children within 5 business days of entering CFS services
- All children receive an expedited trauma informed mental health assessment that includes the CANS-Trauma Comprehensive within 5 business days.
- All children offered treatment appointment within 5 days of assessment completion

Launched in February 2018

CAATS Process

CAATS – CFS Roles

CFS Emergency Response worker engages parent about CAATS – Consent to treat child completed if possible

- Findings and Orders allow BH to move forward
- Sharing of information has not been an issue
- County counsel at the table

CAATS referral to CFS by court SW within 5 days of detention hearing or case opening

- Dedicated clerical staff responsible for sending and tracking referrals
- Separate CAATS mailbox

CFS invites CAATS clinician to case planning CFT

CAATS – BH Roles

Specialized centralized conducts assessment

- Fully bilingual and bicultural

Continuum county and community providers provide services

- Specialization based on age, treatment modality
- All services are field based
- Continuity of care is critical – shift from access to services to "who do they have relationships with"

Commitment to engage birth parent in assessment and treatment process for children placed in out of home care

Clinicians that are specially trained to speak to the strengths and needs of the entire family

Participation by CAATS clinician in case planning CFT meeting

Tracking

CFS – CWS/CMS

- "MHST" becomes "Referral"
  - CW no longer conducts MH screen upon entry into CFS, since all children referred for assessment by BH
- Document referral as screening on CWS/CMS Screenings tab
- Continue to complete MH referral as screening tool every 6 months for those not in tx

BH: Electronic Health Record

- Track time to service
- Dependency tracking
- Continue to screen and track Katie A Subclass

CANS and CAATS

- BH incorporating CANS in assessment (April 2018)
  - Specialty programs and some CBOs completing CANS
  - Entering CANS in BH EHR
  - In the process of developing various CANS reports
  - Collaborative training and rollout of CANS (Oct 1 cohort)
    - Behavioral Health, Child Welfare, Probation
- Ventura County CANS
  - Includes CANS 50, trauma modules
- Integrated with CFTs

CFT – All About the Network

Increased emphasis on safety and lifetime networks

- Family Engagement "Boot Camp" with Kevin Campbell
- Networks are the center of all planning and practice
- Healing is done through the network
- Transparency
- Empowerment
  - Families and their networks are key in creating action plans, safety plans and care plans
- Network members are being engaged and assigned duties

Role of the CFT - Creating a sense of urgency

Increased frequency of CFT Meetings

- CW: 2 CFTs prior to J&D; every 90 days thereafter for ALL CW cases
- CW and Probation using CFTs to avoid removal of children

Case Planning CFT (prior to J&D)

- Care planning for child
  - Incorporate MH assessment and CANS (CAATS)and PASS
  - Participation by BH generalist clinician
- Case planning for family

Probation – Additional uses for CFT meetings

- Investigations
- Intake
- In-custody

Incorporation of CPM/SOP into CFT Meetings

- Making agreements WITH the family/team, not FOR them
- Use of Danger Statements and Safety Goals
- Use of Circles of Safety and Support
- Parents create their own Harm/Danger Statements
- Using the same CFT facilitator for following CFTs to build relationships
- Having CFT meetings before case closing to develop aftercare plans
- Use of clear, behaviorally specific language

CAATS – How Did We Make it Happen?

Funded through the Mental Health Services Act (MHSA)

- 3 year Innovation project
  - "Research" approach
- Required state approval of proposal
- Expectation that, if successful, it becomes integrated with larger BH system both programmatically and fiscally
- Strong evaluation component

WELLNESS • RECOVERY • RESILIENCE

MHSA Innovation Plan

Program Goal

- To improve access and quality of mental health services through a comprehensive intake process that includes mental health assessments, coordinated interagency services linkages, medication support, and clinical intervention for all youth receiving child welfare services.

Primary Purpose

- To improve quality of services for all children served by child welfare

Approved by Mental Health Services Oversight and Accountability Commission (MHSOAC) in 2017

Structure and Capacity – Behavioral Health

Dedicated assessment unit

- Administrator, bilingual clinicians, mental health associate/LVN
- Increased staffing-5 new positions
- Clinicians role is as “generalist” (serve entire family)
- CFT attendance expected
- Dedicated referral “inbox”

Ongoing Clinical Services

- Dedicated provider continuum to serve CFS children
- Includes both county BH and contracted providers

Structure and Capacity - CFS

Lead administrative specialist to develop policy and procedures

ER SW responsible for obtaining release of information from parents

Court SW obtains MH history for referral

Dedicated clerical staff submits and tracks referral

Unique CFS CAATS email box

No new staff allocated, as CAATS referral replaced MHST process

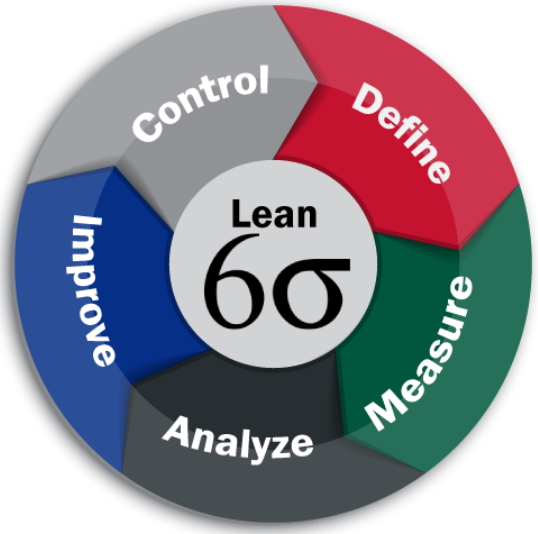
CAATS: The Change Process

Lean 6 Sigma Kaizen Model

- Process improvement model – cosponsored by BH and CW
- Facilitated by human services change management team

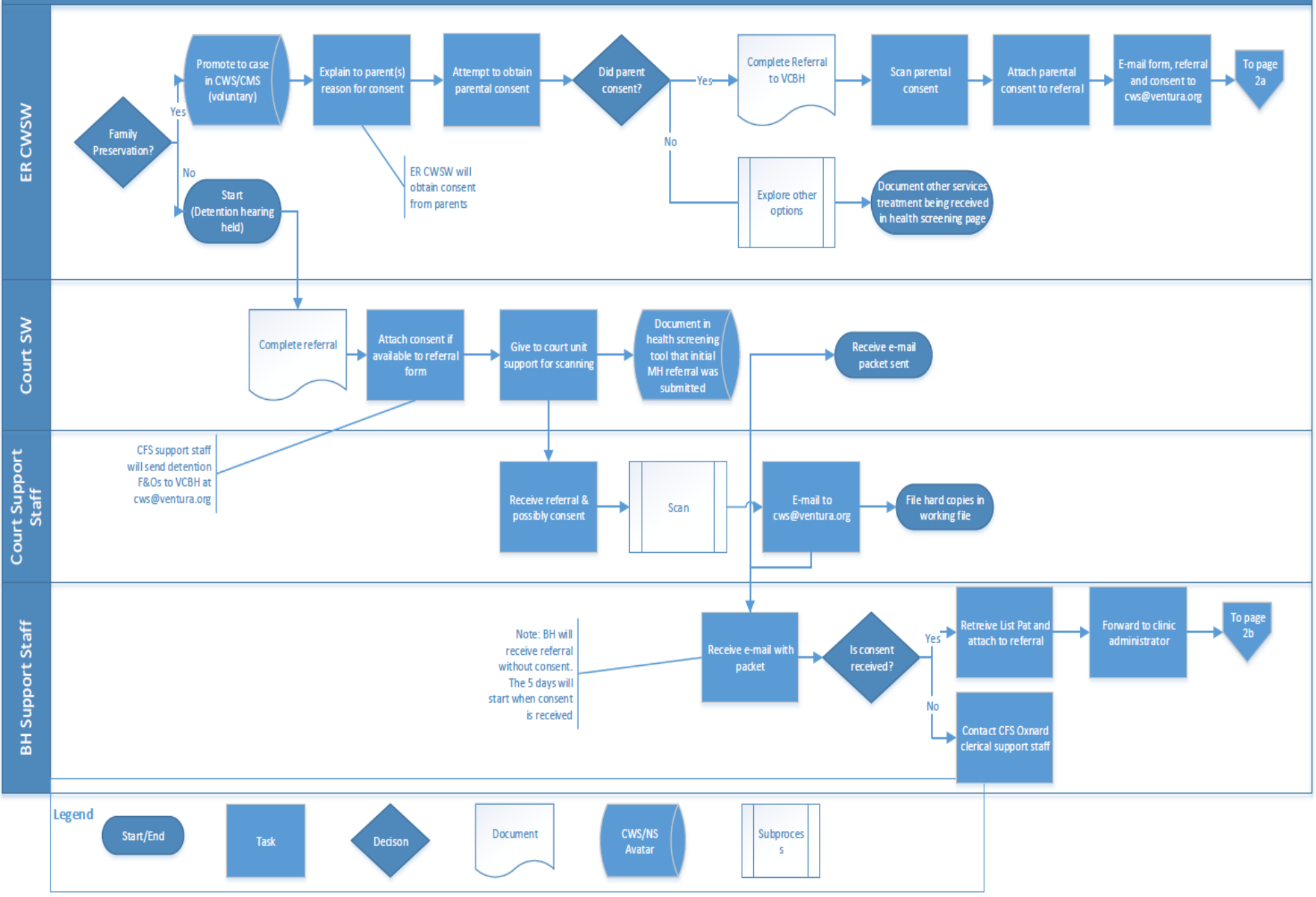
Products

- Process Mapping
- CAATS Implementation Plan
- Tools
  - Referral Form
  - Staff and Caregiver training materials
  - Communication Plan



Children's Accelerated Access to Supports and Services (CAATS)

January 18, 2018



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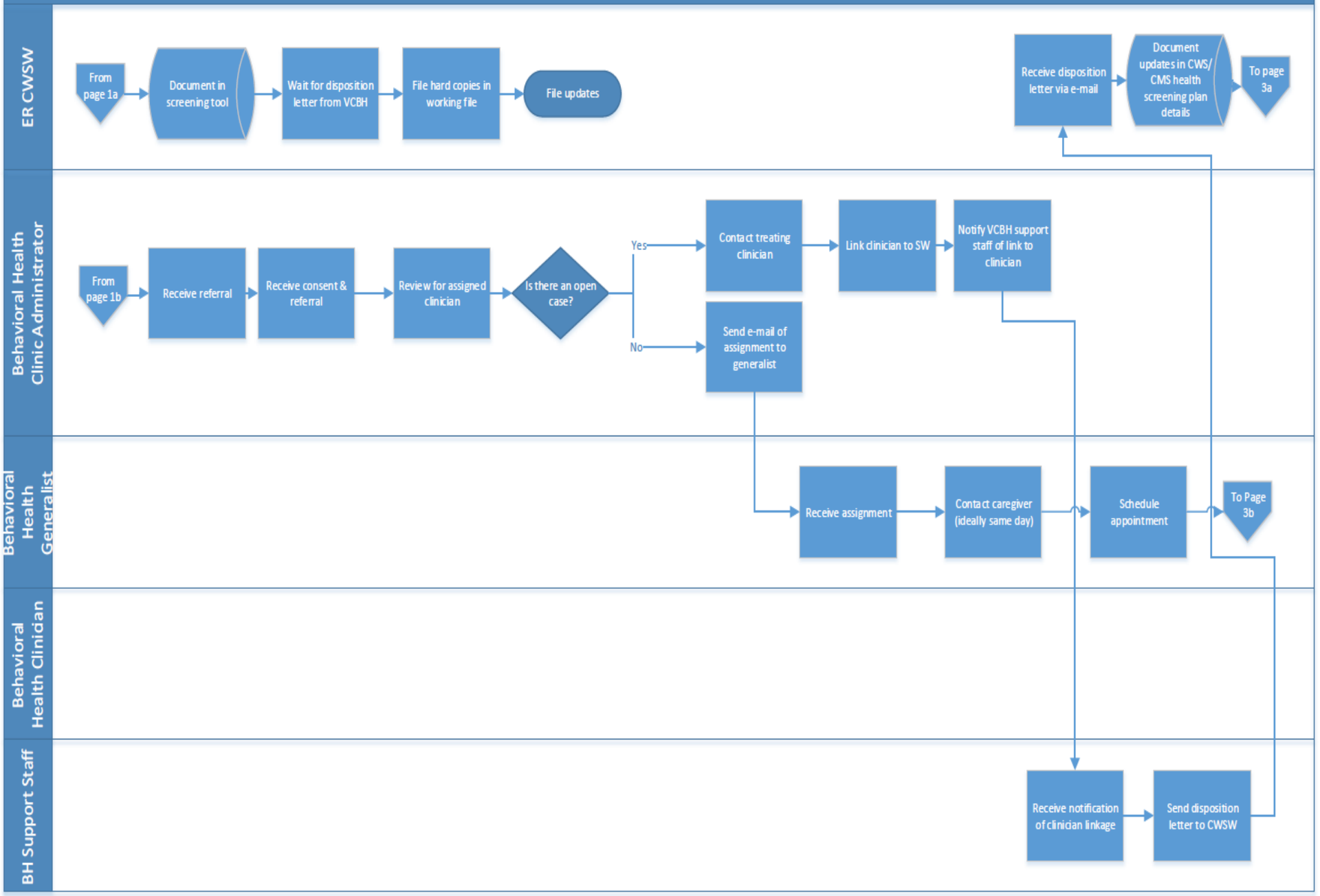

Evaluation: Questions and Measurable Outcomes

Research Question	Indicator	Measures being considered
1. What are the levels of traumatic stress in foster youth?	Clinical Profile	CANS –Trauma and MHSA demographics form
2. Does an expedited process improve outcomes for foster youth and caregiver(s)?	Timely Access	Tracking of service delivery and key events through Avatar
3. Does providing mental health intervention to all foster youth improve mental health outcomes? What is the level of improvement for youth experiencing mild to moderate symptoms?	Mental Health Status and subsection focus for mild to moderate youth	CANS –Trauma and psychosocial assessment. Focus groups with mental health providers and with parents/caregivers
4. Does providing a comprehensive intake assessment and services lead to lower rates of reentry?	Reentry rates within 12 months of reunification	Child Welfare Indicators Project
5. Does providing support, education, and oversight from an LVN lead to better access to and compliance with psychotropic medication?	Psychiatry attendance rates and reported adherence	Surveys given to caregivers and youth. Tracking of psychiatry appointment attendance in Avatar

CAATS – Initial Data

Month	Total Referrals	Initial Referrals	Key Event Referrals	Rescreen Referrals
February	69	36	7	26
March	79	35	7	37
April	67	32	15	20
May	58	25	15	18
June	67	37	16	14
July	88	39	17	32
Aug	93	56	7	28
Sept	93	51	8	34
TOTAL	**614**	281	92	209

- CAATS referrals as of 9/30/18
- Ventura County has approximately 1100 youth in dependency at any given time, and ~750 in out of home care.

CAATS – Initial Data

Manual tracking of the 5-5-5 data

CFS: detention to referral average of 11-12 days. Significant improvement in August and Sept:

- Aug – 32 % of referrals submitted within 5 business days
  68% submitted between 6-16 days from detention
- Sept – 86% of referrals submitted within 5 business days
  14% within 6 days

CAATS – Initial Data

Behavioral Health:

- Assessment and Mental Health Services are field based
- Services are Countywide
- All bilingual staff
- BH for the most part meeting assessment and treatment target dates.
- Feb – Sept 2018
  - Received 281 initial referrals
  - 233 cases assessed within 6 days on average.
  - 48 cases not assessed due to placement changes, moved out of county, already enrolled in services, families not available on date offered or declined services.

Challenges

- Communication to CFS staff – Practice change
  - CAATS applies to all children entering CFS, including non-court FM
- Ensuring clinician invited to CFT
- Delays in implementation – Thomas Fire, CANS implementation
- MHSA Innovation funding is time limited
- Expedited Medi-Cal access for relative caregivers
  - Particularly with infants

Psychotropic Medication Monitoring & Oversight

Looking Forward

- Psychotropic medication Kaizen (co sponsored by CW, BH, PH and Probation)
- Integration of CANS into CFT practice
  - October 1 CANS cohort
  - Exploring shared data options
- Continue to refine CAATS process
  - Tracking, clinician attendance at CFT
  - Measure impact
  - Continue capacity building of trauma informed system
  - Continue shift from treating children to healing families

Come see us in Ventura County…

Questions?

VENTURA COUNTY
BEHAVIORAL HEALTH

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