# A Collaborative Solution: Monterey County's Family Reunification Partnership

Stephanie Montez

## EXECUTIVE SUMMARY

In 2007, Children's Behavioral Health and the Department of Social Services leadership in Monterey County created a solution that broke down silos and strengthened service delivery for children and families engaged in court-ordered Family Reunification Services. The Family Reunification Partnership program in Monterey County exemplifies a highly collaborative approach that recognizes the interconnectedness of mental health treatment plans and child welfare case plans. The Family Reunification Partnership program provides an opportunity for Sonoma County Family, Youth and Children's Services and Behavioral Health to assess their current practices and reimagine a more integrated approach to serving children and families.

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## Introduction and Project Rationale

Children and families served by the child welfare system are involved with multiple professionals and service providers. At times, these professionals operate in silos, resulting in the duplication of efforts and unintentional work in opposition to one another's goals. While all of the professionals involved are well-intentioned, these silos come with a cost and can lead to detrimental outcomes for families. When child welfare and mental health systems create structures that focus on integrating services with team decision-making, such efforts have the potential to significantly improve family outcomes and provide long-lasting benefits for families. The California Child Welfare Core Practice Model and The Pathways to Mental Health Services Core Practice Model Guide outline values and best practices that specifically highlight collaboration and "teaming" as paramount to effectively serving children and families engaged with the child welfare system.

Monterey County Department of Family and Children's Services took a unique approach to solving the issue of service silos by fostering a highly collaborative culture and creating a specialized program, the Family Reunification Partnership (FRP). This case study outlines Monterey's programmatic methods, challenges and growth over time, impact, and subsequent recommendations for Sonoma County to consider.

## Intentional Collaboration

In 2007, leadership within Monterey County Children's Behavioral Health and the Department of Social Services made a deliberate decision to take collaboration between the two departments to the next level. Both entities hoped to better serve the highest-need children and families receiving court-ordered Family Reunification Services by formalizing their partnership in a new way. Under the umbrella of the Mental Health Services Act as a Full Service Partnership, the Family Reunification Partnership (FRP) Unit was established.

By design, the FRP Unit is co-located and co-supervised between the two departments. The team consists of a Children's Behavioral Health clinical supervisor, a Family Reunification supervisor, two seasoned Family Reunification social workers, and four clinicians. The average caseload per social worker is 10–15 children, which is significantly lower than the typical Family Reunification social worker's caseload of about 24. FRP social workers are trained in the Children's Behavioral Health billing system, and a third of their hours are billed to that system for funding purposes, due to the unique clinical nature of the role. Alongside other duties associated with this specialized role is an expectation of intensive and intentional collaboration.

Children who meet medical necessity of having moderate to severe mental health needs and whose biological parent(s) demonstrates a level of engagement in working with the system are considered possible candidates for FRP. The program often works with families who consist of large sibling sets, following the philosophy that these clients will get the most benefit from more intensive services.

An FRP social worker meets their clients on average 2–4 times a month and holds Child and Family Team Meetings (CFT) every 4–6 weeks in

collaboration with the family and all other professionals involved. This schedule exceeds the once monthly state-mandated face-to-face contact and CFT requirements. Each family has a lead clinician who schedules the ongoing CFTs, and each client works with one of the four FRP clinicians. The FRP social workers engage in daily check-ins with the FRP clinicians, once a week three-hour clinical staffings with the FRP Unit, and once monthly best practices unit meetings with the other Family Reunification social workers.

At a Juvenile Detention Hearing, a behavioral health staff member meets with all parents, explains mental health services, and prepares the parents for a phone call regarding an upcoming mental health assessment. During the first in-person meeting, initial release-of-information documents are signed by the parents to enable the collaborative approach to begin. Every child and parent is then assessed by a Children's Behavioral Health clinician and a Family Mental Health Assessment is created. Monterey's justification for this practice is connected to the philosophy that parent mental health is vital to children's mental health and well-being.

FRP has evolved over its existence, providing families with a wide array of services. The team's current supervising clinician describes their work as "therapy plus" with a "whatever it takes approach," where all services combine to benefit the child. Social workers and clinicians currently co-facilitate parent education groups available to all clients receiving court-ordered Family Reunification Services. These groups used to be only for FRP clients but have expanded over time. Discussion topics include skill building, effective communication, trauma, and Adverse Childhood Experiences (ACEs). The FRP Unit also co-facilitates therapeutic groups for youth as needs arise. The team provides placement stabilization through joint visits as needed, engaging with children and parents together when delivering information that may be sensitive in nature, to provide supplemental therapeutic support. Each clinician initially engages with their client in individual therapy, and the intervention progresses towards family therapy work, as appropriate.

FRP work is highly time intensive due to the level of collaboration, and the potential successes delivered reflect this investment. In one case example, a parent and child receiving FRP services were struggling with having successful visits. The parent was engaged in meeting the objectives of their case plan and visits were the biggest hurdle to reunifying. The lead clinician and social worker initiated a staffing with the parent's clinician, child's clinician, and social worker to strategize how to facilitate visitation when, simultaneously, an opposing party to the case was seeking a detriment finding in Court to *stop* visitation. As a team, they came up with a creative plan that involved therapeutic supports for both the parent and child during the visits. This intervention enabled the visits to continue and contributed to the successful reunification of the family. This example illustrates the impact this type of cohesive team approach can have on a family when there is intentional collaboration and trust.

## Funding

Fiscally, there is a cost that comes with staffing a specialized program from both the Behavioral Health and Social Services Departments. Part of the sustainability of the program is maximizing the opportunities for services under the Mental Health Services Act as a Full Service Partnership and leveraging Medi-Cal billing and resources available through social services. As previously mentioned the FRP social workers bill part of their time directly into the Behavioral Health billing system, AVATIR. Additionally, the FPR social workers have a specific code in their Time Study system that reflects the mental health component for funding purposes. The clinicians serve not only the children who meet medical necessity, but also the birth parents through the child's case.

## Information Sharing

The initial Memorandum of Understanding between Department of Social and Employment Services *Family and Children's Services Division* and Health Department Behavioral Health Division *Children's Behavioral Health* as well as their most recent MOU specifically outlines the agreements, duties and responsibilities of each department in regards to the collaborative practices and finances. Additionally, it describes agreements for both departments to have access to one another's database platforms to expedite information sharing necessary with specific guidelines. Co-location is a key factor in the information sharing culture as each department has easy access for in person communication. The clinicians can also send emails to the FRP social workers containing mental health information as well as interoffice mail treatments plans and court reports for ongoing collaboration.

## Programmatic Growth Over Time

As to be expected, FRP has experienced changes and growing pains since 2007, but its core practices, values and culture of intentional collaboration has remained steadfast. Confidentiality was not described as a challenge as one might expect. Early on clients are informed of the program's team approach, appropriate releases are signed upfront and the team is conscientious about sharing only what is needed with one another to progress as a team towards achieving the case plan and mental health treatment goals.

One ongoing challenge described is the inherent difference in mental health treatment timelines and Dependency Court timelines. This is not an uncommon struggle to face in the Child Welfare system in general. Also, within the FRP team some may not always be in agreement with a decision that is made regarding a family they are working with. For example, whether to terminate Family Reunification Services for a family or the readiness of a trial home visit to commence. Through these challenges, they maintain consistent communication and respect for one another with a team-oriented lens. The FRP social workers and clinicians team from the very beginning of a case and this is woven in ongoing in their practice. In trainings, this type of collaborative approach is emphasized and in weekly supervision the FRP supervisor is asking how the team is functioning. Additionally, the FRP social worker supervisor and Behavioral Health supervisor engage in frequent contact and ensure that Program Directives are in alignment. An example is of this a current work on the Child and Adolescent Needs and Strengths (CANS) Program Directive to set new guidelines, trainings and next steps for programmatic roll out. From the client and additional service providers' perspectives, they have described confusion in regards to the role of each person on the FRP team. With so many people already involved in a Family Reunification case it is reasonable to see how this approach could feel overwhelming and confusing. Currently, FRP is facing a staffing shortage of clinicians on the program's team which led to utilizing clinicians who are not accustomed to this highly collaborative model. Staff report it takes more time to educate and work with these outside providers.

While presently working to rebuild their clinical team, FRP is also in a stage of programmatic growth and change. They are looking at ways to expand and formalize services offered to families as well as become more CANS driven in their assessment approach. Previous services provided by FRP that they are planning to reinstate include a 24/7 Parenting Problem Solving Line staffed by FRP clinicians as well as supplemental therapeutic visitation support (formally referred to as Purposeful Visitation) as needed.

## The Collective Benefits

The program's longevity as it enters its thirteenth year in existence is a testament to the value it has brought to the Monterey County clients and employees. The FRP team describes their work as more trauma-informed for families. The social worker and clinicians work closely providing therapeutic

support for clients during highly emotional points in a case. There is also inherent value that comes from developing mental health treatment plans and Family Reunification case plans that complement one another with a goal of helping a family heal regardless of the outcome of the case. Together as a cohesive team they can come up with innovative solutions and approaches to complex family trauma in a way that is efficient and thoughtful. With this team approach, FRP staff report fewer moves for children and youth in foster care and better outcomes for families. When a caregiver, parent, child or youth is in need of additional support they are able to respond with in-home therapeutic support as well as joint visits and utilize the frequent CFTs to problem solve. Even though FRP does not specifically keep data on their placement stability or reunification outcomes, anecdotally they feel both are positively impacted by involvement with the program.

The helping professions are known to have a higher level of staff turnover and secondary trauma due to the nature of the work. FRP staff report they are able to build different and stronger working relationships with their colleagues and state that with this model there is more support for the social workers and clinicians because they lean on one another and feel like they are "in it together". In general, the program has had very low staff turnover and it is a highly desirable program to work in.

## Sonoma County

In Sonoma County there is a desire and need for stronger collaboration and communication between case-carrying social workers and mental health services providers for all dependency cases. FYC and Behavioral Health are progressing in a more collaborative direction by having three Behavioral Health clinicians co-located in the two main FYC locations. However, their scope is focused on the mental health assessments of children and youth. Another contracted agency also provides assessments specifically for children ages 0–5. Based on the outcome of these assessments the children and youth are then referred to a variety of clinicians for ongoing treatment. These may be Behavioral Health clinicians, providers contracted through FYC or through Beacon. The co-located clinicians conducting assessments and ongoing providers are invited to CFTs and attend when possible. In regards to the parents, most are seen by clinicians contracted by FYC, or through Beacon if they have Medi-Cal, and Behavioral Health assesses and serves those with extremely high mental health needs. An integrated approach or program like FRP does not exist. Thus, the flow of communication regarding mental health assessments, treatment planning and coordination of services for children, youth and parents can be disjointed and inconsistent.

## Recommendations

Sonoma County has the opportunity to shift practices and model the FRP framework and create a more integrated approach with case plans and mental health treatment plans. FYC works with both county Behavioral Health and contracted clinicians, therefore the recommended approach starts by first establishing the current baseline of how we work together. The following recommendations can be accomplished within the next six months to a year with a focus on existing practice and identifying opportunities that foster a culture of collaboration and service coordination for all clients. These recommendations require dedicated time by all parties mentioned and can be done within the existing staff structure.

- Consult with County Counsel to review releases of information with a lens that promotes service coordination between mental health providers and social workers.
- Examine funding streams and opportunities for both FYC and county Behavioral Health to maximize services offered to children, youth and parents involved with Child Welfare.
- Establish a team of stakeholders from FYC, Behavioral Health and contracted clinicians to map out the current workflow and collaboration within the professional team who serve children, youth and their parents or guardians

with the objective of establishing clear picture of current practice as well as identifying areas of strength and growth.
- Hold a "Meeting of the Minds" open to FYC staff, Behavioral Health staff and contracted clinicians to engage in a facilitated conversation focused on service coordination/collaboration and concrete suggestions.
- Create formalized collaboration agreements between FYC, Behavioral Health and contracted clinicians utilizing aspects of the FPR model.

These recommendations will move the dial in the direction of breaking down silos and result in operating in a more cohesive and trauma informed manner. It is time to formalize and increase these collaborative partnerships while focusing on strengthening and reimagining how FYC social workers and mental health providers work together on behalf of children and families.

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