

County: Glenn County

Date: April 30, 2014

May 1st Submission (September 1st through February 28th Reporting Period)

October 1st Submission (March 1st through August 31st Reporting Period)

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If your answer below is blank or zero, please provide an explanation.

PART A: Potential Subclass Members Identified During the Reporting Period			
Item #	Information Requested	Column 1 Beneficiary Count	Column 2 Next Steps/Timelines
1	Potential Subclass Members	82	
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.	0	All children who received a mental health assessment met medical necessity criteria for SMHS.
3	Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed.	0	All children who were referred to the MHP for a full mental health assessment received a mental health assessment.
4	Potential subclass members who were unknown to the MHP during the reporting period.	26	These 26 children and youth were placed out-of-county. In order to develop the staff skills and put the Katie A. system in place, we have initially focused on CWS children and youth who were placed in our county. We will expand the number of children served in the next six-month period, including children who are placed out-of-county.

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If your answer below is blank or zero, please provide an explanation.

PART B: Services Provided to Identified Subclass Members at Any Time During the Reporting Period			
Item #	Information Requested	Column 1 Beneficiary Count	Column 2 Timelines
1	Subclass Members	50	
2	Receiving Intensive Care Coordination (ICC).	5	
3	Receiving Intensive Home Based Services (IHBS).	3	
4	Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership Program consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS. <i>Do not include youth already counted in 2 or 3 above.</i>	9	
5	Receiving other intensive SMHS, but not receiving ICC or IHBS. Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC). <i>Do not include youth already counted in 2, 3, or 4</i>	10	
6	Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources).	0	All members of the subclass are receiving mental health services, as reported above.
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).	26	
8	Declined to receive ICC or IHBS.	1	

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If your answer below is blank or zero, please provide an explanation.

PART C: Projected Services			
Item #	Service	Projected number of subclass members to be receiving services by August 31 st	Strategy/Timeline Description
			Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.
1 (a)	ICC	15	We plan to continue identifying, referring, assessing, and enrolling additional children and youth in our Katie A program. We expect this number to be at least 15 children and youth by August 31. These children and youth will all receive ICC services as a component of the program.
1 (b)	IHBS	15	We plan to continue identifying, referring, assessing, and enrolling additional children and youth in our Katie A program. We expect this number to be at least 15 children and youth by August 31. These children and youth will all receive IHBS services as a component of the program.

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	Yes	No
County Contracting Process	Yes	No

Please provide an explanation for any Yes responses above. Are there other barriers not listed above? Explain and add pages, as needed.

We have had a number of staff leave our CWS program in the past few months. As a result, we are recruiting new staff. It is difficult to recruit new staff in this small, rural community.

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Reporting Period: September 1, 2013 – February 28, 2014

Date Completed: April 30, 2014

Please provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principals, and promote implementation of the ICC and IHBS using Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them.

For each section, please indicate if training or technical assistance from the state is needed. When indicated, CDSS and DHCS will contact the county child welfare and mental health departments for further information. Please note that training and technical assistance needs will be addressed in a coordinated manner through each county’s child welfare and mental health contacts.

Use additional pages, if necessary.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
<p>Agency Leadership <i>Leadership’s experience implementing family-centered services in a collaborative setting.</i></p>	<p>Glenn County Human Resource Agency (HRA) and the Health Services Agency (HSA)/Mental Health Services (MHS) continue to collaborate on developing a comprehensive service delivery system to meet the needs of children and youth who meet the criteria for the Katie A. subclass. HRA and HSA share one director which helps promote a strong vision and leadership to support collaboration and coordination across these two agencies.</p> <p>Glenn County has been designated as one of the pilot counties, to work with the state to implement Katie A. early and to serve as mentors for other small counties. We also have been working together over the past two years to improve our coordination and collaboration in linking children in the Child Welfare System (CWS) to receive mental health services quickly and efficiently. We have meetings between the two agencies every two weeks, to identify children and youth, coordinate services, and address areas for improving services.</p> <p>CWS and MH have attended several trainings together, in Redding for the Regional Learning Collaborative as well as holding shared training for staff on implementing the Child and Family Team Model, Core Practice Model, and delivering Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Safety Organized Practice (SOP) is being used to implement the Core Practice Model (CPM). We are also using the same tools for facilitating each Child and Family Team (CFT) meeting. Staff from the mental health program who are involved in</p>	<p>N</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>implementing Katie A. are also being trained to use SOP, so that we can all use the same language. We have also found it valuable to have shared co-facilitation on the CFT – this approach helps to ensure that concerns and strengths for the family and child are represented. This strategy also helps to support family voice and youth voice during these meetings.</p> <p>We have one young adult who was a foster youth who works closely with our Katie A. Team. She helps the team identify opportunities to enhance our system to promote youth voice. While we still have opportunities to improve our youth and family voice, we have made a lot of progress. We continue to identify ways to change our culture to promote youth and parent involvement throughout our systems of care.</p> <p>In the next six months, we will work together to make sure our policies and practices are consistent with family-centered principles of care across both agencies. We are also working on revising our existing Memorandum of Understanding to outline how we will share resources and staff to promote collaboration of services.</p>	
<p>Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i></p>	<p>Glenn County has strong systems and interagency collaboration. We have a Multi-Disciplinary Team (MDT) that meets twice monthly, once in Willows and then in Orland. The MDT membership includes CWS, mental health, schools, law enforcement, and probation staff. The MDT is facilitated by a CWS supervisor and the Children’s Interagency Coordinating Council (CICC) Coordinator. In addition, our CICC includes all child-serving agencies in the county, including education, probation, Child Abuse Treatment (CHAT), network providers, mental health, substance abuse, CWS, law enforcement, tribes and Migrant Education Programs. We also have a Management and Planning Team (MAP) that serves as the county’s Interagency Placement Team. This group includes deputy to mid-level managers from the schools CWS, mental health, probation, and Far Northern Regional Center to coordinate services and approve placements for children at risk of group home placement RCL 10 and above.</p> <p>We have an activity on Friday nights, where all foster families can bring their children. This activity is a team building opportunity for the foster parents, where they can provide support to each other, and the foster children/youth can spend time together and also support each other.</p>	<p>Y</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>We have also developed / revised our shared Release of Information Form. The Health and Human Services Agency has created a new Forms Committee; all policies and procedures are review by this committee, which ensure that there is consistency across agencies.</p> <p>We have also implemented a One-Stop program, where multiple agencies offer services in one location. While this is initially developed to serve SB 109 persons released from the prisons/jails, this is a good illustration of our system collaboration. We have also co-located a mental health clinician at CalWORK's, to provide mental health screening and linkage to services.</p> <p>In the next six months we will continue to utilize these interagency teams to review and implement policies and procedures to support family-centered practices. We will continue to develop strategies to share information across child welfare and mental health information technology systems. It is our goal to have a shared computer system by the end of 2014.</p>	
<p>Systems Capacity <i>The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.</i></p>	<p>One of the CWS Supervisors who has been active in developing and implementing Katie A. services is retiring at the end of April. We have hired a new CWS Supervisor, who has also been active in developing the Katie A. services and will be able to transition easily into this leadership role.</p> <p>We co-located a mental health clinician at CWS to provide early screening for CWS and to deliver counseling and referrals for children who do not have Medi-Cal. We have been working to improve the timeliness of referrals to mental health services for the past two years, and are able to link children and youth to services within a two week window or less.</p> <p>We are working to develop policies to support an effective referral process and linkage to service across multiple systems. We continue to develop strategies for recruiting and hiring staff, including bilingual Spanish and Hmong speakers, our two primary languages. When we updated the Readiness Assessment in October 2013, we had an adequate workforce in place for both CWS and MH Services. However, six months later, we have experienced a shortage in Mental Health Case Managers and are working to identify opportunities to expand our workforce.</p> <p>Historically, CWS has had a consistent rate of turnover in staff every two years.</p>	<p>Y</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>Currently, many of the Child Welfare workers have been in their positions for less than three to four years with several recently hired. There is a need for additional training for staff to learn all aspects of their job, which takes a minimum of two years if they stay in the same position. This situation makes it challenging to implement new programs as the staff must learn their jobs while there are changes in the system.</p>	
<p>Service Array <i>Available services are culturally responsive and include trauma informed care, evidence based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.</i></p>	<p>Glenn County delivers culturally responsive services. Our mental health staff have the capacity to deliver services in English, Spanish, and Hmong. Staff have been trained in evidence-based services including Parent Child Interactive Therapy (PCIT), Cognitive Behavior Therapy (CBT), and trauma-informed CBT. Services are available at home, in the schools, in the clinic, and in other community locations, depending upon the needs of the child, youth, and/or family. Service activities support family-centered principles and promote implementation of ICC and IHBS services and are consistent with the Core Practice Manual (CPM). CWS uses Family to Family and Safety Organized Practice tools and processes that have been found to increase family engagement, promote client voice in decision making, and be culturally sensitive.</p> <p>We attended training by the Chadwick Center on Trauma-Informed Care, as part of the Learning Collaborative in Redding. As a result of this training, we are identifying additional training opportunities for staff to learn more and develop skills in offering services that help reduce trauma for our children, youth, and families. CWS Staff have also attended training in understanding domestic violence and develop skills in reducing the re-occurrence of domestic violence with our families. Staff have also attended training on Parent Child Interactive Therapy (PCIT) and Anger Management.</p> <p>We have discussed the need to share information about trainings across CWS and MH. We are developing a system to notify staff at both agencies when training is offered. This system will help “cross-train” staff and expand the skills of our coordinated service delivery team.</p>	<p>Y</p>
<p>Involvement of Children, Youth & Family <i>How Core Practice Model family-centered principles are reflected in current systems.</i></p>	<p>We have a strong commitment to involve and hire youth and families to work within our children’s service delivery system and to deliver services that are consistent with the Core Practice Model and family-centered principles. We have four part-time Youth Peer Mentor positions with Mental Health, to work at our Transition Age Youth (TAY) Center. These youth provide advocacy and mentoring to other youth</p>	<p>Y</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>receiving mental health services. We plan to expand our capacity to involve youth in the Katie A. services, and participate in ICC and IHBS services, as appropriate.</p> <p>Our TAY Peer Mentors will offer training on promoting youth voice. This training will be available to CWS youth and provide them a way to have a voice and be effective at advocating for their needs. We are also planning on offering training on promoting Youth Voice to CWS and MH staff. We will have a panel of CWS youth to tell about their experience, and invite the TAY Peer Mentors to help support the CWS youth in sharing their experiences. This training will provide an opportunity for staff to talk about what they hear and develop strategies for promoting youth voice.</p> <p>We are collaborating to identify a family member who has had experience with CWS, to participate in our planning meetings and support families as they enter the CWS system. We have identified a youth who has had experience with CWS to participate in our Katie A. planning meetings as well as support youth who are involved with CWS, to provide mentoring and advocacy.</p> <p>CWS has developed a parent satisfaction survey to help obtain feedback about the quality and effectiveness of services. We will review this as a group and implement this in the next six months, as well as administer it at least annually. We will also develop training and written information to help families learn how to become informed decision makers and support them identifying opportunities to make choices to achieve their goals. We have a parent who co-facilitates our Parents Anonymous group with one of our CWS staff. We plan to expand the number of parents who attend this group.</p>	
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i></p>	<p>Glenn County strives to work effectively in cross-cultural settings. Our threshold language is Spanish. We also have a few Hmong/Laos families who receive mental health services. We have an active Cultural Competence Committee, which meets monthly and identifies opportunities to strengthen services and meet the needs of our Hispanic, Native American, and Hmong communities. We have several staff at HRA and HSA who are bicultural and bilingual Spanish. We also have a CWS supervisor who is a tribal member and has 15 years of experience as an Indian Expert Witness. We also have a mental health intern who speaks Hmong. Our written materials are available in Spanish, as well as all brochures and documents.</p> <p>We are also discussing different methods for expanding our outreach to our local</p>	<p>Y</p>

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	<p>Native American community, Grindstone. We have three foster parents located at the tribe. We will develop ways to involve them in services and support them. In addition, we are looking at different ways that we can partner with North Valley Indian Health to promote health a wellness. We will help the tribe to develop a calendar that will help identify opportunities to support them in their activities.</p> <p>We also provide ongoing training to staff to strengthen their skills and develop an understanding how to deliver services to persons from these different cultures and be respectful of the cultural differences in customs and beliefs. We will continue to offer training and partner with culturally-based community groups to ensure programs and services are culturally appropriate to meet the community’s needs.</p>	
<p>Outcomes and Evaluation <i>The strength of current data collection practices, and how outcomes data is used to inform programs and practice.</i></p>	<p>We have a comprehensive evaluation system for measuring outcomes for children, youth, and families. The Mental Health program measures key mental health outcomes, including: length of time in out-of-home placement, stability of living situation, education, and social connections. CWS has well defined outcomes for safety, permanency, and well-being, with about 15 years of data to define trends and patterns common to Glenn County. The county meets quarterly with stakeholders and the state to review the outcomes as quarterly reports are released.</p> <p>We write a five-year System Improvement Plan and an annual report to adjust or add goals as needed. These outcomes are sufficient to use for the Katie A. subclass and have been approved by the California Department of Social Services and the Federal Government. We will work to increase stakeholder involvement in this process, as it has been challenging to implement and sustain. We will learn to merge both mental health and child welfare outcomes to make decisions and determine how to change our systems and practices. We will identify training to support this effort.</p>	<p>Y</p>
<p>Fiscal Resources <i>How fiscal policies, practices, and expertise support family-centered services.</i></p>	<p>Our shared leadership across HRA and HSA builds the foundation for strengthening opportunities to share fiscal resources as we develop our Katie A. family-centered services. In the past six months, we have merged the two separate fiscal units into one. Trainings will be offered on fiscal strategies for staff at HRA and HSA. Our interagency teams will include persons with fiscal expertise, to maximize our ability to share resources and promote healthy outcomes.</p>	<p>Y</p>