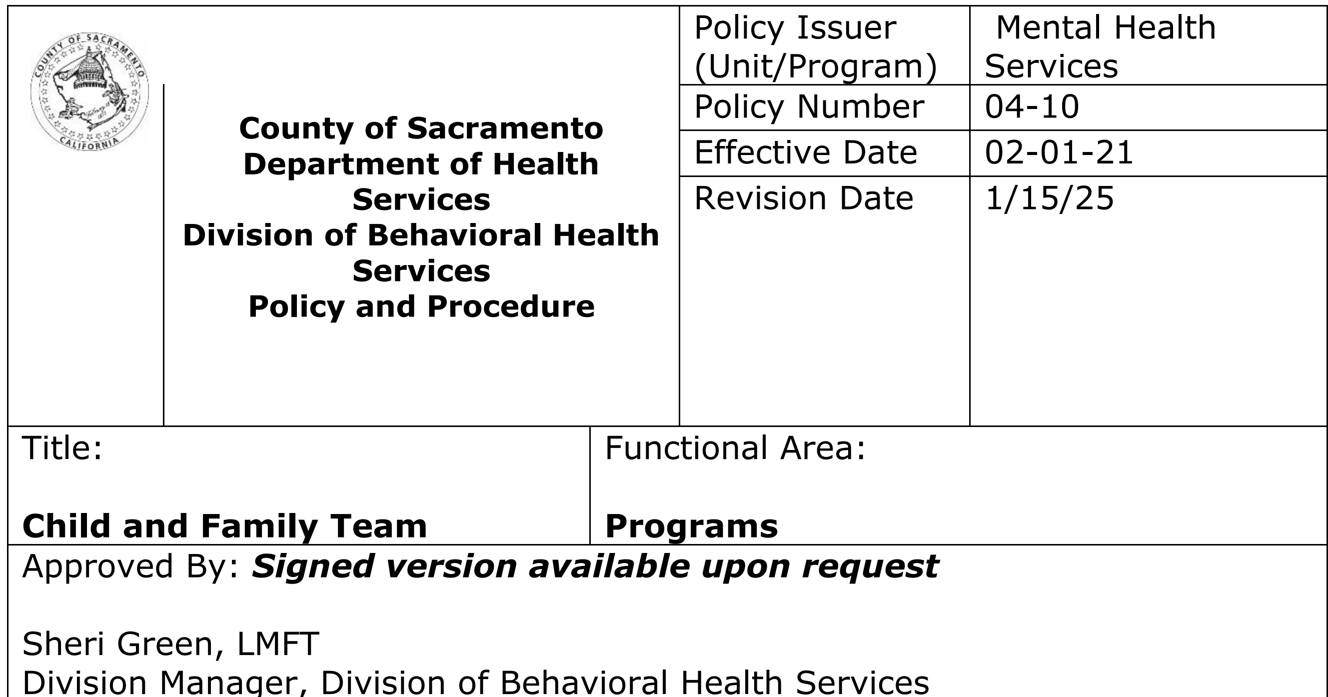

	County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
		Policy Number	04-10
		Effective Date	02-01-21
		Revision Date	1/15/25

Title: **Child and Family Team**	Functional Area: **Programs**
Approved By: ***Signed version available upon request*** Sheri Green, LMFT Division Manager, Division of Behavioral Health Services	

Background/Context:

Assembly Bill (AB) 403, known as the Continuum of Care Reform (CCR), aims to reduce the reliance on congregate care by ensuring that children and youth, who cannot reside with their parents, are placed in a permanent home with committed adult(s) who can meet their needs.

Sacramento County Behavioral Health Plan (BHP) values the Integrated Core Practice Model (ICPM) and strives to integrate ICPM's core principles. ICPM is a set of practices and principles that provide practical guidance and direction to the delivery of timely, effective, and collaborative services to children/youth and their families. The model emphasizes the importance of healing relationships, nurturing family, parents and caregivers, cultural appropriateness, and timely and accessible services for at-risk children and youth. One core component of the ICPM is the establishment of a Child and Family Team (CFT) to guide the services provided to children/youth and their families. The CFT's role is to include the child/youth and family members in defining and reaching identified goals for the child. The individuals on the team work together to identify each family member's strengths and needs, based on relevant life domains, to develop a child, youth, and family-centered treatment plan.

Definitions:

Electronic Health Record (EHR): A cloud-based, web-accessible EHR system that Behavioral Health Providers use to document services, manage billing, and produce reports.

Child and Family Team (CFT): A collaborative group that includes the child or youth, family members, professionals, natural supports, and others identified by the child/youth/family. The CFT works together to achieve the child or youth's safety, permanency, and well-being through coordinated care planning and service delivery.

The CFT meeting is a structured process within this team that engages the family and service providers in thoughtful and effective planning. While the CFT meeting is a key component, it is only one part of an ongoing strategy that ensures children, youth, and families are actively involved in care planning, evaluation, monitoring, and adapting services to meet their evolving needs.

Specialty Mental Health Services (SMHS): Services provided to children and adolescents up to age 21 who are Medi-Cal beneficiaries and meet medical necessity criteria. Service components include but are not limited to outpatient behavioral health services, medication support, targeted case management, therapeutic behavioral services (TBS), crisis intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC).

Behavioral Health Plan (BHP): Provides or arranges for the provision of specialty behavioral health services to Medi-Cal beneficiaries in the county that meet medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals.

Linked child/youth: Children or youth that have been assigned by the Behavioral Health Services Screening and Coordination (BHS SAC) Team and have received at least one from a specialty mental health services provider.

Unlinked child/youth: Children or youth not yet assigned by the BHS SAC Team to receive specialty mental health services and will be encouraged to participate in such services, if eligible.

Integrated Practice - Child and Adolescent Needs and Strengths (IP-CANS): A structured evaluation tool used for identifying youth and family needs and strengths that may form the basis of treatment. The Primary Behavioral Health Provider is required to complete a CANS assessment within 60 days of case opening, but prior to the treatment plan completion date, updated 6 months from the admit date or more often if clinically indicated, or more frequently based on clinical needs or specific circumstances such as STRTP

placements, hospitalizations, significant life changes, and at discharge. The information derived from the CANS must be integrated into the CFT process. For youth that are not yet connected to a provider a CANS assessment can be conducted by the CPS MH team upon CPS SW referral to support CFT care planning processes.

CARES-Live (California Automated Response and Engagement System) is the modernized replacement for CWS/CMS (Child Welfare Services/Case Management System). CARES-Live is being implemented in phases to enhance child welfare case management, service planning, and information sharing, ensuring improved collaboration among child welfare professionals.

Primary Behavioral Health Provider (PBHP): A county operated clinic or a contracted provider with Sacramento County Division of Behavioral Health Services that delivers outpatient specialty behavioral health services to children, youth, and families. The PBHP is responsible for delivering the majority of behavioral health services to the client and will coordinate with adjunctive services such as psychological testing, TBS, and TFC, when indicated.

Intensive Care Coordination (ICC): A targeted case management service that facilitates the assessment, care planning, and service coordination for children and youth with complex needs, ensuring cross-system collaboration.

ICC Coordinator: The ICC coordinator is responsible for coordinating complex care systems that are integrated and addresses the identified goals, objectives and activities of all parties involved with the service to the child/youth and family. The ICC Coordinator is the lead of the CFT and may also facilitate CFT meetings.

Child and Family Team (CFT): The CFT is a formal meeting for those children/youth who are receiving specialty behavioral health services. CFTs are also provided for Family Maintenance (FM) cases, focusing on safety planning to prevent out-of-home placements, and for children and youth receiving various types of services through County providers. The CFT meeting includes, at a minimum, the child/youth and his/her family, CPS social worker, Probation officer, any caregivers or group home staff, ICC coordinator, and any individuals important in the child/youth's life and who are identified by the child/youth and family and invited to participate, including Tribal representatives and other natural supports.

Intensive Home-Based Services (IHBS): Individualized, strength-based interventions designed to improve mental health conditions that interfere with the child's or youth's functioning. Interventions are aimed at helping the child/youth build skills for successful functioning and improving the family's

ability to help the child/youth successfully function in the home and in the community. The services are not office based and are provided in the home and/or community.

Therapeutic Foster Care (TFC): A short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment.

Safety Organized Practice (SOP): A collaborative, trauma-informed and culturally responsive best practice approach to working with children, youth, families, and their networks that is rooted in evidence-based practice and provides practical tools and strategies to support engagement, assessment and critical thinking. SOP actively positions the family as the expert and holds those working with families responsible for honoring the unique culture and perspective of each family by uplifting and building on their strengths to achieve safety, permanency and well-being. SOP provides on-the-ground practice tools intended to support achievement of federal child welfare outcome measures, including improved timely permanency and placement stability and reduced recurrence of maltreatment and re-entry to foster care.

Regional Training Academy (RTA): RTAs provide technical assistance and coaching to CFT and IP-CANS practitioners. The contact information for the RTA can be found on its websites: Northern California Training Academy

Purpose:

This document outlines Sacramento County's Division of Behavioral Health Services (BHS) policies and practices related to CFTs within behavioral health treatment, ensuring alignment with state guidelines.

Details:

A CFT must be in place for children and youth enrolled in BHP services and receiving specialty mental health services.

The CFT process follows the principles, values, and practices of the ICPM, and reflects the culture, developmental levels and preferences of the child, youth, and family by ensuring:

1. Development of specific and measurable safety action plans, consistent with the Safety Organized Practice's (SOP) focus on observable behavioral

changes. The [UC-D SOP Toolkit] is a valuable resource for the development of such plans.

2. Adherence to all components indicated in the most recently published Medi-Cal Manual, Medi-Cal standards, and County's documentation and billing standards.

3. The first CFT meeting, for youth not linked to SBHS, is initiated and scheduled by the case-carrying social worker. Subsequent CFT meetings can be initiated by the youth, family, or another team member (ACL 16-84/MHSUDS IN 16-049).

   The PBHP shall convene and facilitate CFT meetings to create an effective working alliance for change in which the CFT is conducted as a collective process. The PBHP provider must convene CFT meetings within 60 days of program enrollment and subsequent meetings occurring at least every 90 days or more frequently, based on need, including critical incidents. Providers must follow state guidelines regarding meeting frequency and documentation.

   When a critical incident occurs (e.g., hospitalization, placement disruption, safety concerns, juvenile justice involvement, significant emotional deterioration, family crisis), a CFT meeting must be convened immediately to reassess needs, review safety plans, and coordinate services. The meeting should prioritize stabilization, ensure continuity of care, and involve all relevant system partners. All CFT decisions and action steps must be clearly documented.

   Examples of critical incidents requiring a CFT meeting:

   a. **Hospitalization or Psychiatric Crisis:** The child/youth experiences a mental health crisis requiring psychiatric hospitalization, crisis stabilization, or emergency intervention.
   b. **Placement Disruption:** The child/youth is at imminent risk of being removed from their current home, foster placement, or Short-Term Residential Therapeutic Program (STRTP) .
   c. **Safety Concerns:** New allegations of abuse, neglect, exploitation, or trafficking are identified, requiring urgent intervention and safety planning.
   d. **Juvenile Justice Involvement:** The child/youth is arrested, placed in juvenile detention, or subject to new probation conditions affecting their placement and care plan.

e. **Significant Behavioral or Emotional Deterioration:** There is a sudden escalation in behaviors that put the child/youth or others at risk, such as self-harm, aggression, or severe emotional distress.
f. **Major Life Transitions:** A change in guardianship, legal status, or school placement that significantly impacts the child/youth's support system and services.
g. **Family Crisis:** A major event affecting the family's ability to care for the child/youth, such as a caregiver's incarceration, hospitalization, or sudden loss of housing.

The CFT process reflects and documents that families have the capacity to address their problems and achieve success if given equitable opportunity and supports. Engagement with families is fundamental to the CFT process for a shared decision-making process.

4. The CFT Facilitator is aware that the youth, family, and, in the case of a Native American child, the Tribal Representative, have likely not encountered the child welfare system or may have had previous negative experiences. They may experience feelings of fear and uncertainty. A skilled facilitator will help prepare the youth, family, and tribal representative prior to the first CFT meeting and communicate that they want to help achieve common goals, including working towards the youth remaining with the family whenever possible. This trained and skilled facilitator guides the team in generating innovative solutions and building consensus. The facilitator is responsible for ensuring the team addresses risk and safety, the meeting is productive, and all voices are heard, including that of the family and their natural supports. Sacramento County encourages the use of the same facilitator throughout the life of the case, which preserves continuity and minimizes anxiety for the youth and family. Additional strategies for successful facilitation are available in both the CFT Tribal Engagement Guide and CFT Engagement Guide.

5. The CFT process builds on unique values and capacities by eliciting the participation of everyone on the team. Care must be taken to integrate cultural needs and norms into the plan. Team members help children, youth, and families recognize their strengths, and encourage and support them to develop solutions that match their strengths and preferences. The team must support the power of learning from mistakes when strategies

do not work as intended so that the plan can be revised to improve outcomes.

6. The youth should be present for as much of the CFT meeting as possible and meetings be segmented so that the child is present for portions of the meeting that are not overly distressing, triggering or difficult to understand. Youth who have sufficient maturity to understand the CFT process, and in cases of the harm and danger happening in their family system, should be asked how they would like to contribute or participate in the meeting. Youth who can participate in their own safety planning should be involved in the CFT process from the beginning.

7. It is the responsibility of all CFT members to monitor and coordinate the CFT process to verify that team decisions and case planning adhere to this policy and safety recommendations determined by the CFT.

8. The CFT is a safe environment that fosters vulnerability, empowerment and empathy across all members of the CFT, which includes the youth, family, natural supports, clinician, advocates, child welfare, probation, education, Tribal representatives, and other system partners. If needed, CFT meetings must include an interpreter, at no cost to the family, to ensure effective communication and clear understanding when family members have limited English proficiency (see Policies and Procedures CCES 01-02 and QM 01-03).

9. Upon admission into a PBHP program, every family is screened using the ICC/IHBS screening form in the EHR or the PHMP's EHR to determine the focus for a CFT. Family voice and choice will be honored in determining the need for the CFT.

- CFT participants complete the CFT Survey after the meeting to collect qualitative information on the county's FM CFT process. Facilitators may distribute the link to the survey at the end of the meeting for participants to complete when they are able. Counties may access their county's results by emailing CWSCoordination@dss.ca.gov.

10. Confidentiality:

    a. All CFT members must adhere to state and federal confidentiality laws, including Welfare and Institutions Code Section 832. Releases of Information (ROIs) must be signed, reviewed, and updated as needed to ensure transparency and appropriate information sharing within

the CFT. Youth in foster care have the right to consult with an attorney before signing any ROI. (ACL 25-08, pg. 15).

11. IP-CANS:

  a. There must be only one CANS for each child/youth's CFT; if a CANS has been completed by a county placing agency or by county BHP, the existing CANS will be shared as early as possible with all members of the CFT, then update as needed. A CANS completed by a Behavioral Health Provider must be shared with the Child Welfare Social Worker, as early as possible. The assigned CPS worker will ensure the CANS is entered into CARES-Live.

  b. The PBHP shall obtain ROIs to share pertinent information, except information related to drug and alcohol/substance use issues, upon which this information shall be redacted unless the signed ROI indicates drug and alcohol/substance use information may be disclosed. At any point, the client can change their decision to release any pertinent information.

  c. Within the CFT process, the CANS may support engagement with youth and families in their own care by assessing the well-being and identifying a range of social and behavioral needs of the youth and caregivers. Used within the CFT, the CANS shall be used as a structured evaluation tool for identifying youth and family needs and strengths that may form the basis of treatment and a means for monitoring progress and outcomes for the family.

12. Training:

  a. In an effort to provide consistent CFTs to the children, youth, and families served within Sacramento County BHP, Sacramento County BHS has made arrangements with selected providers to deliver a series of CFT trainings to County-operated and contracted providers, or following guidance as directed by the forthcoming DCHS/CDSS ACL related to RTAs. The Primary Behavioral Health Provider (PBHP) must ensure staff participation in CFT Overview training, encompassing skills and teaming practices, as well as facilitation and coaching sessions, as appropriate to their roles.
     i. CFT Overview Training: A half-day training course designed to orient participants to the CFT meeting process. The training is for individuals who participate in CFT meetings or need to know basic information about CFT meetings due to working in or intersecting with behavioral health, child welfare or juvenile probation systems.

ii. CFT Facilitation Training: This full-day training includes the Overview training and will provide participants with basic CFT meeting facilitation knowledge and skills. Trainees will have opportunities for hands-on facilitation practice throughout the training and will be equipped to facilitate CFT meetings. Attendees must be certified to administer the CANS.
iii. Facilitation Coaching Sessions: These monthly drop-in sessions are required for staff who complete the Facilitation training and are designed to enhance skills in this area. Each facilitator must attend at least 3 coaching sessions.
iv. Special Topics: Additional CFT training modules will be offered, which can include the following: specialized modules for crossover youth, Cultural Competency, Wraparound, FIT, and Full Service Partnership (FSP); best practices in virtual CFT meeting facilitation with CFT meetings; managing challenging and unique situations; neuroscience; implementation science; CFT meetings to address safety with child welfare-involved families.

Procedure:

1. Convening a CFT:

   a. The Primary Behavioral Health Provider (PBHP) is responsible for convening and facilitating CFT meetings for children and youth receiving Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), or Therapeutic Foster Care (TFC).
   b. Any member of the treatment team (including child/youth and family) can request a CFT. The CFT will be held at places and times where the child/youth and family are most comfortable.

   c. The PBHP will utilize the ICC screener with all families who will receive a CFT upon admission, and for best practice, when completing a Care Plan update. When the CFT is planned, the family will be assigned to an ICC-Coordinator, who will convene the CFT and determine the frequency for ongoing meetings.

   d. The youth and their parent/guardian/caregiver must be notified upon the scheduling of a CFT meeting by phone, email, text, in person, or another method preferred by the CFT members. The child, youth, or parent must also be notified that they can invite others that are part of their support system to the CFT meeting. In order to allow participants to properly prepare for the CFT, it is best practice to provide this notification no less than 72 hours before the CFT meeting,

unless safety concerns or urgent or emergency needs arise (ACL 25-08, pg13; ACL 22-73)

e. In preparation for CFTs, the PBHP will provide education to the child, youth and family, which includes but not limited to the purpose, who can participate in a CFT meeting, structure of the meeting, and common topics discussed during a CFT meeting. The PBHP can distribute CFT brochures developed by the State.

f. If the child, youth, and family already have an established CFT through CPS or through another provider, the contracted facilitator shall ensure a transition for the CFT, including but not limited to expanding and evolving the existing team process so that any additional team members, including county staff, can be included when appropriate.

g. A CFT meeting should occur as soon as possible and adhere to WIC, Section 16501. The initial CFT meeting should not be delayed to accommodate a pending mental health screening, assessment, or pending referral for services.

h. The CFT can provide input to the placing agency (e.g., CPS or Probation) that identifies the most appropriate placement for the child or youth, while always considering the least restrictive placement option.

i. After a crisis (hospitalization or significant life changes), an emergency CFT meeting will be convened with the child/youth, all appropriate team members, and any additional team members, including county staff when appropriate, to create, review and/or revise safety and treatment plans, as soon as possible. Structured safety planning is a core function and requirement of CFTs, and emergency CFTs are excellent opportunities to develop actionable and measurable safety plans. Safety Organized Practice (SOP)-aligned safety planning tools should be utilized by Facilitators.

2. CFT/Teaming Process:

   a. Team composition shall be guided by the child/youth/family's input and their needs and preferences.

   b. The ICC coordinator will ensure a CFT is comprised of the child or youth, family, and all of the ancillary individuals as determined by the family. A representative of the child or youth's tribe or Indian

custodian, foster family agency social worker, or STRTP shall be included when applicable. The CFT members share responsibility to evaluate, plan, intervene, monitor and refine services over time. Active engagement with Tribal representatives for native American children is essential. Facilitators should refer to the CFT Tribal Engagement Guide and CFT Engagement Guide.

    i. When the CFT will discuss a placement change or a new development and a placement preservation strategy is implemented, the youth's court-appointed educational rights holder must be invited to the CFT meeting, if that person is other than the parent, guardian, or caregiver (ACL 25-08, pg. 15).

c. The PBHP will be responsible for coordinating with the CFT to identify needed contacts, build consensus within the team around collaborative plans, actively support the agenda, and ensure that the family voice and choice is heard throughout the teaming process. Team members' roles will be identified and will be clarified throughout the term of the CFT.

d. The PBHP will be responsible for coordinating with the CFT and identify a Facilitator. The decision of who facilitates the CFT meeting should be a shared decision that includes the preferences of the child/youth and family members. Only staff who have completed the required training and coaching session may function as a Facilitator.

    i. For youth who are receiving ICC/IHBS services, as indicated from the ICC/IHBS screening form, the ICC Coordinator will be responsible for facilitating the CFT meetings.
    ii. For youth and families who want the CFT process but don't need or qualify for ICC/IHBS, the Facilitator may be whomever the team decides, given that individual has appropriate CFT facilitation training.

3. CFT Meetings:

    a. CFT meetings should have a clear purpose and follow a structured format (e.g. CFT Meeting Action Plan).

    b. An agenda will be generated by the Facilitator, with input from the team, for each CFT meeting. The agenda should include all pertinent topics such as: successful treatment of the child or youth's mental health needs, permanency and placement, classroom and

community-based support, medical needs, and achieving goals in other child-serving systems in which the child or youth is involved.

c. The agenda and/or previous meeting minutes will be distributed by the Facilitator one week before the scheduled meeting. This will provide adequate time for the team to review the agenda and address the minutes before the following meeting.

d. Plans must be individualized, culturally responsive and trauma informed. The team should routinely measure and evaluate the team's progress and emerging needs. Team members shall be responsive when plans may require revision.

e. If a team member is unable to attend the CFT meeting in person (due to proximity issues or other conflicts), participation is encouraged by HIPAA compliant video conferencing or phone. This option may be helpful when a child is placed in another county or when schedules do not allow in-person participation. Before the CFT meeting ends, team members should identify how to provide updates to absent team members in a timely manner.

f. When age-appropriate, a child or youth should always participate in a CFT meeting. Participation should be limited if the nature of the meeting's agenda is not suitable for the child or youth. Some examples may include: the focus of the meeting is only about the parent or parents' needs as it relates to the child or youth, or the main topic of discussion is of a sensitive adult nature.

g. It is the responsibility of the placing agency to determine the most appropriate placement in order to achieve public safety, child safety, permanency and well-being.

References:

CFT Parent Brochure (also available in Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Spanish, Vietnamese).

CFT Professional Brochure (also available in Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Spanish, Vietnamese).

ACL 16-84 – Requirements and Guidelines for Creating and Providing a Child and Family Team

ACL 18-09 – Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool Within a Child and Family Team

ACIN I-21-18 – The California Children, Youth, and Families Integrated Core Practice Model and the California Integrated Training Guide

ACL 18-23 – The Child and Family Team (CFT) Process Frequently Asked Questions

ACL 18-85 – Clarification Regarding Sharing of CANS Assessments by County Placing Agencies and Mental Health Programs

ACIN I-71-18 – Using Team Meetings to Increase Cross-system Collaboration Between Local Child Welfare and Education Agencies (LEAs)

ACL (in draft regarding AB 1068)

Related Policies:

CCES 01-02 – Procedure for Access to Interpreter

QM 01-03 – Interpretation Services by Family Members

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