Mental Health Treatment and Services

(Revised 11/18/22)

Forms

The following forms are referenced in this file:

• 04-24A-P	Authorization to Use of Disclose Protected Health Information
• 04-28	CASS Referral (CWS/CMS Template)
• 04-29	Authorization to Use or Disclose Protected Health Information
• 04-83	Therapeutic Behavioral Services (TBS) Prior Authorization Request & Referral Form
• 04-130C	Payment Authorization for Mental Health Services (CWS/CMS Template)
• 04-176A	Therapy Referral Form (CWS/CMS Template)
• 04-176/177c	Initial Treatment Plan/Treatment Plan Update - Child
• 04-176/177p	Initial Treatment Plan/Treatment Plan Update – Parent
• 04-178	Request for TERM-Appointed Evaluator (CWS/CMS Template)
• 04-181	Child Physical Abuse Treatment: Learning Intake Assessment
• 04-181A	Child Physical Abuse Treatment Quarterly Progress Report

Forms (cont.)

- 04-182 DV Victim Intake Assessment
- 04-182A DV Victim Quarterly Progress Report
- 04-183 NPP Intake Assessment
- 04-183A NPP Group Quarterly Progress Report
- 04-445 CFT Meeting Summary and Action Plan

Background

Mental health services and treatment (group, individual, or conjoint) referred and provided through Treatment and Evaluation Resource Management (TERM) that is part of a Child Welfare Services (CWS) Case Plan is different from "standard" psychotherapy. The main differences are:

- Safety issues or risk factors as related to the parents are the focus of the treatment and other intra-personal issues become secondary unless they impact the safety issues
- Confidentiality between parent and provider is limited because information is shared with CWS staff and the court
- Provider is expected to accept the true findings/substantiated allegations in a CWS case even if the parent denies them. Progress in addressing the protective issues is documented on the treatment plan that the Optum TERM providers submit

These distinctions are addressed in the TERM Handbook that provides treatment and reporting guidelines to all paneled providers and is accessible on the Optum TERM website.

CWS uses Optum TERM providers for the following reasons:

- It is a mandated program set forth by the Board of Supervisors concerned with improving the quality of mental health services provided to children, youth, nonminor dependents (herein referred to as youth) and parent(s) served by the Juvenile Court system
- Provides CWS, Juvenile Probation, and Juvenile Court mental health information for case related decisions and ensure the quality and appropriateness of mental health services provided
- Therapists have expertise in working with CWS involved families, giving them a unique lens to provide input on the impact of trauma including what behaviors the parent has demonstrated/not demonstrated over time to address the protective issue(s)
    - Evaluators help CWS understand the unique characteristics of each parent or youth, as well as what mental health services would best serve them
    - This input helps CWS (and the attorneys and the court) make informed, objective, and balanced assessments/decisions

Optum TERM providers understand the:

- nature of forensic therapy/assessment and the goals of dependency hearings,
- Juvenile Dependency Legal process and Optum TERM therapists can help clients understand and navigate this process,

Background (cont.)

- significance of the true finding and Optum TERM therapists maintain the therapeutic focus on the purpose of the therapeutic intervention,
- CWS system and process,
- impact of trauma and its role in child welfare cases, and the expected use of evidence-based treatments,
- purpose of CFT meetings and their role in these meetings,
- the CANS (Child and Adolescent Needs and Strengths assessment completed on youth and their caregivers) and may be CANS certified,
- Optum oversight and quality review of clinical work,
- expected collaboration with SWs, and
- expectation of the potential need to testify.

Policy

The development of objectives and services outlined in the case plan is the outcome of a collaborative discussion with the Child and Family Team (CFT) during the Child and Family Team Meeting (CFTM) CANS conversation, which determines the need(s) and strengths of the child, youth, nonminor dependent (herein referred to as youth) and their parent.

In addition, a discussion with the family should occur regarding the Harm and/or Danger Statement(s) and Safety Goal(s) unique to their circumstance. The Case Plan should articulate the behaviors that the parent(s) will demonstrate (i.e., acts of protection over time) and the service(s) that will support them to create safety for the youth. Therapy, especially individual therapy for a parent, is not to be an automatic element of a Case Plan but rather a specific modality necessary to impact parenting and address the safety and risk factors identified.

Tools available to assist the SW in eliciting the voice of the parents and youth include but are not limited to:

- Interviewing using Solution-Focused Questions
- Three Houses and Safety House
- Genogram and Ecomap to identify support and safety network
- CFTMs

SWs will always consult about Case Plan services at a Multi-Disciplinary Team (MDT) meeting for 300 (e), (f), or (i) cases prior to offering services. There are mental health circumstances for both parents and youth in which a consult with the CWS Staff Psychologist is considered or required when referring to therapy. See Case Consultation policy for additional information.

It is the SW's responsibility to only recommend services to the court that align with this policy. If a judge orders a treatment modality or therapeutic intervention that is contrary to the policy, despite the SW's best effort to only refer to services aligned with policy, it is important to indicate this on the 04-176A.

Should a parent or youth report active suicidal or homicidal ideation to the SW, the SW will immediately take steps to ensure the safety of the parent, youth, and others by consulting with the supervisor regarding which appropriate services (e.g., Mobile Crisis Response Team (MCRT), Access & Crisis Line, or law enforcement) to contact to address the behavioral health crisis. If there is an immediate threat to the safety of the youth, parent, or others, call 911.

Mental Health Screening and Treatment for Youth

The Continuum of Care Reform, also known as Pathways to Well-Being, ensures that all youth in an open child welfare case are screened for potential mental health needs using the CANS.

The Emotional/Behavioral Needs Domain (ages 6-21) or Challenges Domain (ages 0-5) of the CANS will serve as the initial and ongoing mental health screening assessment for treatment and services.

A score of 1, 2, or 3 in any of the questions from these domains identifies a need and an action item to refer the youth for mental health services (or continue services if there is already a provider) will be listed in Form 04-445 completed during the CFTM.

NOTES:

- While a score of 1 in other CANS domains is typically not considered an action item, per All County Letter (ACL) 18-81, a score of 1 in the Emotional/Behavioral Needs or Challenges Domains is considered an action item for the purposes of completing the required mental health screening and services for all youths in open cases.
- Youth with a score of 1 may benefit from a referral to a Behavioral Health Services (BHS) Contracted Providers for Youth.
- Youth with a score of 2 or 3 may meet the conditions listed below for a referral to an Optum TERM provider.

Referring Youth for Individual Therapy

Mental health services for the youth are primarily provided by Optum TERM or Behavioral Health Services (BHS) Contracted Providers for Youth.

In some instances, a Community Based Organization (CBO) may be appropriate. Consult with CWS Staff Psychologist for appropriate resources if neither Optum TERM nor BHS can provide the service and a CBO is being considered.

For youth under age 5, SW will follow the recommendations made by Developmental Screening and Enhancement Program (DSEP) for mental health treatment services in lieu of referring to an Optum TERM provider.

Youth ages 5-21 who need individual therapy may be referred to an Optum TERM provider via the 04-176 when one or more of the following conditions apply:

- Youth is involved in a 300 (e, f, i) case
- Youth is considered a Highly Vulnerable Child (HVC)
- Youth's primary presenting issue is a reaction to physical or sexual abuse
- Youth is presenting with behavioral dysregulation or lack of resiliency (e.g., self-harming behaviors, tantrums, impulsivity, emotional lability)

SWs may consult with the CWS Staff Psychologist as needed to determine the need for Optum TERM oversight.

Referring Youth for Individual Therapy, (cont.)

If none of the above conditions apply, the SW can refer directly to the Behavioral Health Services (BHS) Contracted Providers for Youth or a CBO. To obtain treatment plans and progress reports from BHS and CBO providers, the SW will need to send the provider one of following authorization forms:

- 04-24A-P
- 04-29
- Order Authorizing Release of Health Information (for dependent youth only)

NOTE: Reports obtained from BHS and CBO providers do not receive Optum TERM oversight and quality review prior to sending to the SW.

See Therapeutic Interventions for Youth section below for additional information on interventions that can be provided by an Optum TERM provider.

Mental Health Treatment and Services Considerations for Parents

Optum TERM will primarily provide the mental health treatment and services for parents via group, individual, or conjoint therapy in open cases depending on the safety/risk issue identified and included in the case plan.

In some instances, a CBO may also be appropriate to provide the treatment. Parents in Voluntary Services (VS) cases with individual or group therapy included in the Case Plan may be referred to a CBO:

- if an Optum TERM provider to address the identified safety/risk issue is not available to provide the service or
- to provide added support to the parent to address mental health as a complicating behavior identified in the SDM assessments.

Refer to the Mental Health of Parent/Guardian in Appropriate Cases section of the Voluntary Services Protocol for factors to consider when determining appropriateness of mental health services for VS cases.

CBO providers can be obtained through the parent's own resources (e.g., health insurance, parent's Employee Assistance Program, regional community-based clinics, Access and Crisis Line, 2-1-1 San Diego, etc.) The parent will need to sign the 04-29 to allow the CBO therapist to provide treatment plan and progress reports to the SW.
If Serious Mental Illness (SMI) is present, consult with CWS Staff Psychologist regarding criteria and services for an SMI diagnosis and if referring for mental health services. SMI is defined as a mental, behavioral or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of SMI include current psychotic symptoms, severe major depression, and severe bipolar disorder. If the parent suffers from SMI, ***Optum TERM therapists will need parents to be stable*** i.e., on medication.

Mental Health Treatment and Services Considerations for Parents (cont.)

Parents active to the military are to be referred to providers on the Optum TERM panel**.** If there are specific clinical reasons why a parent who is active duty military or a military veteran should see a provider through military resources (e.g., has been diagnosed with combat-related Post Traumatic Stress Disorder (PTSD) and/or Traumatic Brain Injury (TBI)), consult with the CWS Staff Psychologist and CWS Regional Military Liaison (see Military Investigations policy for roster).

Group Therapy for Parents

Optum TERM Group Therapy is **not a class**. Providers are mental health clinicians that render Group Therapy as the evidence-based approach to treating the identified protective concerns. Group treatment includes psychoeducation and therapeutic interventions aimed at reducing mental health symptoms and safety risks.

An offending or non-protective parent of a youth who has experienced the safety/risk factor(s) listed below **must** be referred to **group therapy first**:

- Physical abuse
- Severe Neglect
- Sexual abuse
- Domestic Violence (DV)/Intimate Partner Violence (IPV)

When safety and risk is due to General Neglect, the parent may be referred to the most appropriate hands-on parenting intervention or Individual Therapy.

All group treatment facilitators complete an initial mental health assessment to determine if the parent is appropriate for group treatment. If the group facilitator determines that the parent is not appropriate for group treatment, the parent will be referred to an individual therapist to address the group therapy content.

In general, group therapy is the modality of choice for the following reasons:

- It provides parents an opportunity to learn from their peers
- Peers are often better able to address denial, minimization of the protective issues, and defensiveness.
- In most cases, peers are able to appropriately confront parents in ways that cannot be done as effectively by therapists in one-to-one sessions
- Allows the therapist to see the interpersonal dynamics between the clients, which frequently reflects dynamics outside of group and provide coaching on those interactions
- Peers can model protective behaviors to facilitate learning by other group members

The length of a parent's participation in group therapy is determined by the SW, based on the parent's progress as documented in the progress report updates provided by the therapist. Because of the stringent W&I Code time frames, parents are not required to complete 52-session programs before they can reunify or have their CWS case closed. The SW will continue to make those determinations based on SDM Assessments, feedback from the CFT during the CFTM, consultation with the supervisor, and MDT case consultation as warranted.

Group Therapy for Parents (cont.)

All Child Abuse (CA), Domestic Violence (DV), and Sexual Abuse group facilitators must be Optum TERM approved. If Probation requires a parent to attend a 52-week DV offender group or a CA group, the SW will coordinate with Probation to refer the parent to an Optum TERM approved provider.

NOTE: Adult Probation certifies and has oversight of the Optum TERM approved DV offender and Sexual Abuse groups. Optum TERM verifies Probation certification of providers seeking approval for Optum TERM referrals for the groups that are overseen by Probation (DV Offender, Child Abuse) but is not involved in services coordinated directly by Probation.

See Service Modalities to Address Safety and Risk Factors section below for additional information on best practice service modality.

Individual Therapy for Parents

Individual therapy as a modality with Optum TERM for the parent may be considered when one or more condition(s) below applies:

- The group therapy facilitator determines that the parent is not appropriate for group treatment and recommends individual therapy as the modality to address the group therapy content/curriculum
- Mental health (including documented SMI) is identified as a need in the CANS (Caregiver/Resources Domain) and included as a Case Plan item (i.e., directly relates to safety/risk factor(s) and contributed to harm/danger identified)
- Mental health impacts parenting or is interfering with case plan progress
- Individual therapy is determined as appropriate or a recommended treatment/service to address or enhance safety in consultation with any of the following:
  - PSS
  - CWS Staff Psychologist
  - Member(s) of the CFT
  - MDT/Case Consultation
  - Other treatment providers (e.g., parent's substance abuse counselor or group facilitator)
- Individual therapy is court ordered and an Optum TERM provider can best match the parent's need

Individual therapy with a CBO may be considered when one or more condition(s) below applies:

- The CFT believes the parent would benefit from individual therapy and the CANS identify the parent's mental health need as a complicating factor (e.g., does not directly relate to the safety/risk factor(s))
- Parent wish to receive or continue with their own individual therapists and individual therapy is not part of their case plan
- Individual therapy is court ordered and a CBO provider can best match the parent's need

Individual Therapy for Parents

A consult with the CWS Staff Psychologist may be needed if a referral for Individual Therapy with Optum TERM cannot accommodate a parent and a CBO is being considered as the provider.

Refer to the Mental Health Treatment and Services Considerations for Parents section for additional information when referring to CBOs.

Conjoint Therapy for Parents Without the Youth

Consider conjoint treatment for parents without the youth when:

- each parent has successfully completed their own group treatment or at the recommendation of the individual therapists **and**
- conjoint treatment is determined to be needed to continue addressing the safety/risk factors for the youth to be safely returned to the parent's care (after consultation with the supervisor, case consultation, etc.).

The CWS Staff Psychologist can consult regarding other times when conjoint therapy is recommended if it does not meet the criteria above.

A third-party provider who has not worked with either parent in the past (in group or any other modality) will be identified to provide the conjoint treatment.

NOTES:

- Parents with any type of restraining order (even those that indicate peaceful contact) should not be referred to conjoint therapy as a case plan service.
- For parents who are actively on probation, conjoint treatment is currently prohibited by California State Law within the 52-week DV offender program pursuant to PC1203.097 (c)(1)(G). Parents who are court ordered by Criminal Court to DV/IPV offender groups must complete the 52 program prior to being referred to conjoint treatment. Consult with the parent's probation officer to discuss the provision of conjoint counseling depending on each parent's probation requirements.

Conjoint Therapy for Youth with Parents

The purpose of conjoint therapy for a youth with a parent is to support the youth's therapeutic healing process and to help when the youth is transitioning back into the home.

The following are required when referring a youth to conjoint therapy with a parent:

- Conjoint therapy requires a recommendation from the CFT
- The parent is actively demonstrating actions of protection
- The youth's therapist documents youth is clinically ready for conjoint with parent. (The youth's therapist may require an atonement letter written by the parent as a condition of conjoint treatment; if so, the youth's therapist may review the letter and ensure it is appropriate before agreeing to conjoint treatment between youth and parent)
- If the parent has not completed treatment, a therapist has assessed the parent for readiness to engage in conjoint treatment with their youth and approves.

Conjoint Therapy for Youth with Parents (cont.)

Consult with CWS Staff Psychologist prior to referring youth to conjoint therapy with the parent if:

- the parent was non-protecting or offending but has successfully completed group services, which is documented in written progress report, verified, and supported by SW regarding parent's behavioral indicators, or
- the youth is in a permanent plan because the parent did not initially engage in or complete services for reunification, but many years have passed and the parent's circumstances have changed; they are re-engaged appropriately with the youth and are demonstrating acts of protection, or
- there are additional situations that are not included in this policy, e.g., a biological parent being considered for placement but does not know the youth.

Service Modalities to Address Safety and Risk Factors

The table below shows common safety threats and risk factors and the best practice service modality for parents to ameliorate current and future risk of abuse and/or neglect:

If the safety threat/risk factor is…	then refer to…
Family Violence Protocol (DV/IPV) exposure and/or the parent is a DV/IPV victim,	DV/IPV victim group treatment. **NOTE:** Provider will complete evidence based IPV/DV assessment tool(s) and provide recommendations for treatment to the PSW.
Serious Physical Abuse Protocol inflicted by the parent, which could include: • the parent made a plausible threat to cause serious harm, • the parent has used excessive discipline or physical force, • the parent failed to protect a youth from serious physical harm, • or the parent has severely neglected the youth,	Child Abuse (CA) group treatment. **NOTES:** • CA groups are for both offending and non-protective parents. If the parent is part of a WIC 300(e) (f) or (i) case, a determination of whether or not offering services is in the best interests of the child(ren) must be made. This decision must be made in a 300(e) MDT consultation that includes County Counsel.
Severe Neglect, which caused physical injury to a youth,	CA group treatment. **NOTE:** The CA group will help the parent understand the impact of severe neglect, but the parent might also need a hands-on parenting class.

Service Modalities to Address Safety and Risk Factors (cont.)

If the safety threat/risk factor is…	then refer to…
Severe Neglect due to the physical living conditions being hazardous to the safety of the youth **AND** the parent has suspected mental illness that may be impacting their ability to meet the youth's basic needs,	CA group treatment. The CA group facilitator will assess the parent's ability to benefit from group therapy or will refer the parent to individual therapy, if needed.
Sexual Abuse and the parent failed to protect, denied, minimized, and/or further exposed the youth to sexual abuse,	Non-Protective Parent (NPP) sexual abuse group treatment.
Sexual Abuse by the parent (even if the parent is denying the allegation),	Sexual Abuse offender group treatment.
Physical Abuse, Sexual Abuse, Severe Neglect or Exposure to DV/IPV **AND** a group facilitator has assessed the parent and is recommending individual therapy in lieu of group,	Individual therapy with the group facilitator.
Physical Abuse, Sexual Abuse, Severe Neglect or Exposure to DV/IPV **AND** the parent has a current mental health diagnosis,	• an Optum TERM provider for individual therapy, to address the parent's mental health needs **AND** • refer the parent to the appropriate group treatment to address the safety and risk factors. **NOTE:** The group facilitator will assess if the parent is appropriate or not to continue in group.
Severe psychological/emotional/physical harm to a youth (other than exposure to DV/IPV) (e.g. non-organic failure to thrive),	Consult with CWS Staff Psychologist to determine most appropriate service modality. • **NOTE**: Child Abuse Group may be an appropriate modality.

Service Modalities to Address Safety and Risk Factors (cont.)

If the safety threat/risk factor is…	then refer to…
• General Neglect due to the physical living conditions being hazardous to the safety of the youth **AND** • the caregiver has a mental health diagnosis or symptoms of mental illness that is likely impacting the parent's ability to meet youth's basic needs,	• an Optum TERM provider for individual therapy to address the parent's mental health needs **AND** approved hands-on parenting class (parent demonstrates what they have learned).
• General Neglect of a youth because the parent is unable to maintain sobriety due to suffering from PTSD or other mental illness,	a substance abuse program that includes dual diagnosis treatment.
• General Neglect of a youth because the parent has been unable to provide the basic needs and/or supervision required to keep the youth safe,	an evidence-based Community Services for Families (CSF) parenting program, or Intensive Family Preservation Program (IFPP) **NOTE:** If the neglect was related to improper medical treatment for an ongoing condition, refer to appropriate education program for the parent through Rady Children's Hospital.
• General Neglect of a youth because the parent has been unable to provide the basic needs and/or supervision required to keep the youth safe **AND** • both parenting education and attachment are the primary concerns, consider	Incredible Families (if the youth does not already have a therapist), or Parent-Child Interaction Therapy/Parent-Child Attunement Therapy (PCIT/PCAT) with an Optum TERM approved provider.

BHS Contracted Mental Health Providers for Youth

The table below lists mental health providers contracted through Behavioral Health Services (BHS) that youth can be referred to if they do not qualify for an Optum TERM provider:

BHS Provider	Program Description
SchoolLink	SchooLink is a partnership between the County of San Diego and local school districts to provide behavioral health services at schools.
Our Safe Place	Serves LGBTQ youth up to age 21, who are: • in need of individual and family therapy, • in need of 24-hour crisis support and psychiatry services.
STEPS	• Group and individual therapy for youth with sexual behavior concerns • Day Treatment for Males age 12-18 • Outpatient therapy for Males or Females ages 6-18 **NOTE:** Consult with CWS Staff Psychologist before referring to STEPS.
Therapeutic Behavioral Services (TBS)	Serves foster youth up to age 21 with: • Serious emotional problems that could benefit from short term one on one behavioral coaching/support to decrease the likelihood of out of home placement in congregate care or psychiatric hospital **NOTE:** This is a supplemental Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit; youth must also have an individual therapist who is billing Medi-Cal.
Comprehensive Assessment and Stabilization Services (CASS)	Provides youth up to age 18 on MediCal with: • Comprehensive Assessments • Individual, family, and group therapy and support groups • Psychiatric services • Crisis intervention and stabilization services Services are short-term and generally last between 3-4 months, depending on treatment goals. Referrals can be completed via the 04-28.
BHS Outpatient Clinics	• Regional clinics provide outpatient behavioral health services including individual, family and group therapy, case management, psychiatric services, and crisis intervention

BHS Contracted Mental Health Providers for Youth (cont.)

BHS Provider	Program Description
BHS Outpatient Clinics	• Medi-Cal beneficiaries and uninsured youth who present with moderate to severe needs up to age 21 and their families are served • Youth who present with mild needs are referred to their health plans Insured persons are referred to their own providers

Referrals are made directly to BHS contracted providers. Each program has a referral form, and all BHS referrals are faxed directly to the program.

See Referring Youth (Children, Youth, and Nonminor Dependents (NMD)) for Therapy section above for obtaining treatment plans and progress reports from BHS provider.

Therapeutic Interventions for Youth

The table below describes therapeutic interventions available to youth through Optum TERM.

Therapeutic Intervention	Description
Cognitive Behavioral Therapy (CBT)	• CBT can help the youth replace negative thought patterns with more productive ones.
Trauma Focused Cognitive Behavioral Therapy TF- CBT	• Any youth (typically ages 6-17) exposed to trauma, who is having an inward or outward reaction to the trauma • Identified as best practice for victims of sexual abuse ages 3 and over • Therapy will work through the associations/triggers/responses to the traumatic event(s) • Requires a protective parent or supportive caregiver • TF-CBT is a conjoint therapeutic intervention (consult with CWS Staff Psychologist if no protective/support adult available).
Child Parent Psychotherapy	• Conjoint therapy (typically for ages 0-5) with a supportive adult with focus on safety, affect regulation, and trauma.
Parent Child Attunement Therapy (PCAT)	Youth (typically age 0-3 years old) having attachment or relationship issues with caregiver or parent.
Parent Child Interaction Therapy (PCIT)	Youth (typically age 3-5 years old) having attachment or relationship issues with caregiver or parent.

Therapeutic Interventions for Youth (cont.)

Therapeutic Intervention	Description
Play Therapy	• For very young youth (typically ages 2-5 years old) who have experienced trauma but have limited verbal and cognitive reasoning ability.
Cognitive Behavioral Therapy (CBT)	• CBT can help the youth replace negative thought patterns with more productive ones.
Trauma Focused Cognitive Behavioral Therapy TF- CBT	• Any youth (typically ages 6-17) exposed to trauma, who is having an inward or outward reaction to the trauma • Identified as best practice for victims of sexual abuse ages 3 and over • Therapy will work through the associations/triggers/responses to the traumatic event(s) • Requires a protective parent or supportive caregiver • TF-CBT is a conjoint therapeutic intervention (consult with CWS Staff Psychologist if no protective/support adult available).
Child Parent Psychotherapy	• Conjoint therapy (typically for ages 0-5) with a supportive adult with focus on safety, affect regulation, and trauma.
Parent Child Attunement Therapy (PCAT)	Youth (typically age 0-3 years old) having attachment or relationship issues with caregiver or parent.
Parent Child Interaction Therapy (PCIT)	Youth (typically age 3-5 years old) having attachment or relationship issues with caregiver or parent.
Play Therapy	For very young youth (typically ages 2-5 years old) who have experienced trauma but have limited verbal and cognitive reasoning ability.
Behavioral Therapy	Therapy that focuses on addressing behavior concerns for youth ages 3-12 years old with limited cognitive reasoning ability.
Dialectical Behavioral Therapy (DBT) **NOTE:** DBT is evidence based only for those presenting with a pattern of suicidal ideation and/or self-harm	Typically utilized for youth age 13 and up, DBT focuses on: • Core Mindfulness/ relaxation techniques • Interpersonal effectiveness/ability to get needs met in a positive productive way • Distress Tolerance/ ability to tolerate stress • Emotional Regulation/ recognizing and managing impulsive emotionally driven behavior

Therapeutic Interventions for Youth (cont.)

NOTE: Services that are out of Optum TERM's scope include referrals for treatment for Applied Behavioral Analysis (ABA), Commercial and Sexual Exploitation of Children (CSEC), and eating disorders requiring a higher level of care. Consult with CWS Staff Psychologist for additional resources.

Foster Youth Mental Health Bill of Rights

The Foster Youth Mental Health Bill of Rights pamphlet must be provided to foster youth. In addition to providing the Foster Children's Personal Rights information to youth, as described in SW Expectations While the Child Is in Placement, Assembly Bill 1067, which went into effect January 1, 2017, requires that:

- SW inform the youth, the caregiver, and the CFT (if applicable) of the youth's rights at least once every six months and at each placement change, and to provide a written copy of the rights to the youth at the same time, and
- SW to document in the case plan that they informed the youth of their rights and provided the written copy to them.

Conflicts of Interest

To avoid conflicts of interest for mental health providers, it is required that:

- the youth and the parent have different providers. This means that the provider **cannot** supervise an intern (or multiple interns) each of whom is seeing a parent or youth in the same family. Consult with CWS Staff Psychologist if needed.
- a provider who has seen one parent in individual treatment **will not provide** any conjoint treatment, even if it is only for the parents.
- the youth's provider may offer conjoint treatment services, but the parent's provider **will not provide** conjoint treatment.
- the **provider** cannot conduct a psychological evaluation on any client with whom they already have a therapeutic relationship. Likewise, an evaluator cannot see a client in treatment if they have conducted the psychological evaluation for any member of that family.
- the parents **cannot have the same evaluator** complete both of their psychological evaluations (i.e., a provider can evaluate only one member of a family).
- providers **cannot see two or more family members** in separate services (such as two different Child Physical Abuse groups, a Domestic Violence Offender and Victim group, etc.).

NOTE: Best practice is to have a different licensed mental health professional for each youth in the family. CWS is often unaware of the full extent of family dynamics at the time youth are referred for services. For example, one youth may have been a scapegoat in the family; or a sibling may have participated in the abuse or neglect of another sibling.

Referring to a Non-Term Provider

Under certain circumstances, it is necessary to go outside the Optum TERM panel to secure mental health services, including but not limited to the following:

- A parent lives out of San Diego County
- A parent or youth lives out of state

Referring to a Non-Term Provider (cont.)

- A parent or a youth has linguistic or cultural needs that cannot be met through the Optum TERM panel
- A parent or a youth has other special needs such as specific clinical concerns or developmental needs
- A parent or a youth is already in treatment with a Non-TERM provider, prior to CWS involvement; the parent needs to notify their provider that CWS is requesting the provider to contract through the Non-TERM process with Optum TERM to provide oversight on treatment plan to ensure therapist is addressing CWS treatment goals
- A parent is Native American and resides on or near an Indian health clinic, which offers therapeutic treatment services by State licensed clinicians (the therapy services must address the protective issues and safety concerns)
- The family is participating in a VS case

For linguistic, cultural, or other special needs that are not able to be met by a Optum TERM panel provider, the Non-TERM Provider section of the 04-176a needs to be submitted for Optum TERM to set up a contract with a provider who is not on the panel.

Once a Non-TERM provider is identified and confirms willingness to engage in a single case agreement, the provider will have up to 30 days to submit the rate proposal and required documentation for vetting to Optum TERM. If Optum TERM has not received the required documentation, they will inform the SW to determine the next steps to find another provider.

Presumptive Transfer of Mental Health Services

For dependent youth and Nonminor Dependents residing out of San Diego county but remain in California, mental health services are to be set up through the Behavioral Health Services department in their county of residence via the Presumptive Transfer process.

If presumptive transfer is not appropriate, and the youth is residing out of state, mental health services are to be set up through Optum TERM.

SW Responsibilities

The SW is the case manager and is the only person who has knowledge regarding all parties, case history, and current circumstances. It is imperative for the SW to provide accurate, concise, and thorough information on all referrals to Optum TERM via a 04-176A; this is necessary for Optum TERM to accurately match the parent, youth with the most appropriate provider.

SWs are required to attach all mental health treatment progress reports to the court reports. This is important for the court to consider when determining the level of progress made by the parents. These reports are not confidential and can be attached to the court report for all parties.

SW responsibilities include the following:

- ensuring all required areas on the 04-176A are filled out thoroughly with accurate information so that Optum TERM can match the provider to the client's mental health needs

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SW Responsibilities (cont.)

NOTE: Optum TERM will return referrals within 2 business days to SWs and PSS that lack clear documentation of the protective issue and how the current needs of the client will be met through the service that is being requested.

- ensuring all services are consistent with CWS policy
- ensuring the provider has all necessary background information and reports **before** services are initiated with the client (detailed below)
- maintaining communication with the clinician about changes for the client (change of visitation, law enforcement involvement, compliance/changes with other case plan services, etc.)
- ensuring that mental health providers are made aware when there is a change to the assigned SW
- ensuring the 04-130C is completed to end the treatment authorization when therapy ends/case closes/parent refuses services and the therapist is notified

Refer to the Mental Health Services - Payment Authorization policy for steps and procedures on the following procedures:

- Authorizing Mental Health Treatment and Services with an Optum TERM Provider
- Continuing a Mental Health Treatment Authorization
- Ending a Mental Health Treatment Authorization

Provider Responsibilities

Optum TERM panel provider responsibilities include the following:

- being on the Optum TERM-approved provider list and meet the expectations as outlined in the TERM Provider Handbook
- accepting the true finding for the abuse allegations
- following professional ethics and standards regarding conflicts of interest and other standards and guidelines applicable to working in a forensic context
- if providing telehealth, when appropriate and available, commencing treatment only after:
    - the 04-176A is received from Optum TERM,
    - the authorization letter for payment is received from Optum TERM, and
    - supporting case documents from the SW are received and reviewed.
- directly addressing the specific protective issue for which treatment has been ordered for the parent
- addressing a youth's specific emotional and cognitive dysregulation
- submitting the completed Initial Treatment Plan (04-176/04-177) **14 calendar days** after the initial authorization date and provide a Treatment Plan Update (04-177) every **12 weeks thereafter**

NOTE: If a case meets Highly Vulnerable Children (HVC) criteria, interns are prohibited from providing treatment.

Optum TERM policy requires providers to submit all evaluations and reports directly to **Optum TERM only**. This procedure ensures that if an evaluation/report must be revised, all parties will have the same version of it. After the evaluation/report is reviewed and approved by Optum TERM, they will upload to JELS.

Provider Responsibilities (cont.)

Optum TERM providers are prohibited from:

- sending an un-reviewed copy of an evaluation/report to the SW and
- providing letters outside of the progress report.

Documentation of Progress

Verbal Communication and Updates from Providers:

- Telephone and encrypted email communication are an effective way to coordinate logistics and relay critical information that the SW or provider needs to know. Verbal updates alone are insufficient because they may circumvent the quality improvement process and because the provider can later state the SW is misrepresenting what was said.
- The expectation is that the provider and the SW are in ongoing communication, and the written reports solidify that communication. The SW will utilize the information in the reports for documentation. The SW should not request "letters" from the provider to verify treatment details.
- SW may ask the provider for updates and recommendations between written reports but should obtain the provider's permission when quoting or summarizing in the court report.

Written Reports from Providers:

Initial treatment plans, treatment plan updates, discharge summaries, and psychological evaluations are submitted to Optum TERM for quality review. SW should not ask for these reports directly from providers. Optum TERM will release the report to the SW after it passes review and stamped, "Reviewed by Optum." Optum TERM will send to the SW via CWS JELS to be received and distributed by a designated JELS Clerk in each region/program.

Optum TERM provides oversight and quality review on the following reports:

- Quarterly group treatment progress reports for:
  - DV Victim Group (04-182A)
  - Sexual Abuse Non-Protective Parent Group (04-183A)
- Initial Treatment Plan/Treatment Plan Updates (04-176/04-177c or 04-176/04-177p) for:
  - Individual Therapy
  - Conjoint Therapy
  - Discharge summaries
- Psychological/Neuropsychological/Psychiatric Evaluations

NOTE: SW will request progress reports for DV Offender, Sexual Abuse Offender, and Child Abuse Offender/Non-Protective Parent (04-181A) groups directly from the providers. While Optum TERM processes referrals for offender groups, they do not track or provide oversight and quality review on these reports.

Documentation of Progress

The table below displays how referrals and reports will be received and processed via CWS JELS:

Step	Who	Action
1	Optum TERM	Upload the following forms to CWS JELS as they become available after review: • 04-176A • 04-176/177c • 04-176/04-177p • 04-182 • 04-182A • 04-183 • 04-183A • Psychological/Psychiatric/Neuropsychological Evaluation
2	CWS JELS Region/ Program Designated Staff	• Log into CWS JELS site daily to check for uploaded documents • In "External Documents" view specific region/ program section • If documents have been uploaded, download from CWS JELS, save in designated H or S drive folder, and create new file name: ○ Change file name to: last name, first name, report type, and date (e.g.: SmithJoan-ITP-01012015.pdf) • Email document to SW and PSS and upload into the Electronic Records Management System (ERMS) **or** send to the ERMS Inbox and Cc: SW and PSS • Delete document from JELS once all tasks have been completed. (Place cursor near the document title to be deleted. A drop-down arrow appears to the right. Select "Delete.")

Telemental Health Treatment

Telemental health is an approved modality, however it requires the parent or youth to be both willing and able to participate and have the technology to do so. The SW may request telemental health for a parent or youth on the 04-176A, though it is not guaranteed they will receive this modality. Should the SW require this specific modality for a parent/youth, the SW must provide a rationale for this request (i.e. transportation barriers, physical limitations, resides out of county, etc.).

Telemental Health Treatment (cont.)

To encourage and plan for a successful telemental health session, SWs are requested to discuss with the youth or parent the following best practices, including but not limited to:

- dressing appropriately for the appointment,
- utilizing a room or space that allows for safety and confidentiality (e.g., not accessing telehealth while driving or in a store),
- ensuring childcare is available to allow youth and/or parent to focus on themselves, and
- minimizing distractions by using headphones, if needed.

There are Optum TERM providers who may be available to provide telemental health treatment to parents who live outside of San Diego County but remain in California.

See Presumptive Transfer of Mental Health Services for dependent youth placed outside of San Diego County and in need mental health services.

NOTE: To engage in telemental health services, including when referring to Non-TERM providers, youth or parent must be located in the same state that the provider is licensed during the time of the session.

Related Web Sites and Resources

The Optum TERM public website contains blank initial and updated treatment forms as well as the TERM Provider Handbook and examples of treatment plans, psychological evaluations, and other materials for reference.

Additional related web sites:

- TERM (Treatment/Evaluation Resource Management) Team (CWS Resources file)
- BHS Provider Resource Manual
- BHS Child Youth and Family Regional Community Clinics

To support staff in understanding how and where to refer parents and youth for mental health services that supports this policy, the following flow charts have been created as a resource:

- Therapy Flow Chart – Parent
- Therapy Flow Chart – Child/Youth

Alignment with SET

This policy supports SET Value 1 and the guiding principles of partnering with the whole family and incorporating their voices when assessing for mental health needs and providing mental health services to youths and family to create long-term safety, ongoing permanency, and well-being. It also supports SET Value 3 and the agency practices of valuing the need for ongoing needs assessment and identifying ways to mitigate the trauma using a trauma-informed perspective.
