

BELMONT COUNTY SERVICE COORDINATION PLAN

Revised May 2010

Proposed changes (September 2010)

I. Overview

As required by the Ohio Revised Code, sec. 121.37, the child serving agencies of Belmont County, in concert with parent representatives, have worked together to develop a county service coordination plan for multi-need children and their families. The plan was developed through the efforts of agency and family representatives who participate in the Belmont County Family and Children First Council. It relies on policies and procedures developed collaboratively over time and builds on existing structures and relationships within the community. The goal of the plan is to assure continuity and consistency in coordinating services to children who are abused, neglected, dependent, unruly, and/or delinquent, or to those whose families voluntarily seek services.

The goal of the Family and Children First Council is to provide Belmont County children and their families with well-integrated, quality services. The Council is the mechanism through which public and private child and family services agencies, working in concert with parents who are viewed as equal partners, can set directions, marshal resources around common goals, integrate service provider's efforts, and monitor success.

Members of the county family and children first council and members of the service coordination team collect and track data on the effectiveness of the county service coordination mechanism process. Upon request, service coordination data will be submitted to the state for the purpose of evaluation.

The Service Coordination Plan is driven by the needs and problems of the children and families who live and work in Belmont County. It is understood that the challenges in serving children with multiple needs may be unique, thus this plan has been developed on a local level and is reflective of the unique strengths and needs of Belmont County. Children are part of a family with cultural norms. Whenever possible, intervention with the child and his/her family will be viewed as the most successful means of treatment and reunification.

Belmont County is committed to providing services by maximizing all sources of revenue through a combination of fiscal strategies designed to make the best possible use of limited dollars along with best-practice, ethical programmatic and clinical intervention. These strategies include better use of current dollars and maximizing federal entitlement funds.

Paramount in the development of this plan is the county's commitment to keeping children in a treatment environment that is least restrictive, clinically appropriate to the needs of the child/family, and cost effective. To accomplish this, treatment is based on a multidisciplinary assessment utilizing both clinical and administrative expertise from each relevant system to its mandated population.

II. Target Populations

Belmont County has historically identified the system's target population by means of the service coordination team and Early Intervention Collaborative. A child who has multiple needs existing within their physical, emotional, developmental and/or intellectual functioning, which act as a primary obstacle to their optimum growth and development, falls into the category of "Service Coordination/Early Intervention Child".

The Ohio Revised Code, Section 121.37 defines the target population to be served by the Service Coordination Plan as children determined to be abused, neglected, dependent, unruly, and/or delinquent, or those whose family voluntarily seeks services. The target population includes any child 0-21 years of age with multiple system needs in which the families may need a higher level of coordinated cross systems. The plan makes the presumption that the needs of children and families who come in contact with the juvenile justice system, child welfare, mental health, drug and alcohol services and others, are being adequately met by those systems. It recognizes that each system has areas of responsibility and mandate, and that the collaborative approach is not intended to replace or usurp the primary role of any one of these systems. The critical aspect of this plan lies in the fact that it is a reinforcement and creative option for all the involved systems in the event that the resources available to one system are not adequate to address the needs of the child and family, regardless of the system through which the family first entered.

The Belmont County Family and Children First Council, in developing this Service Coordination Plan, recognizes the probable existence of unmet needs within the target population. In the past, county service providers have been creative in developing various wrap around services for those cases that require additional intervention. Not only will this practice continue through the implementation of the Service Coordination Plan, but the Council also commits to continuous efforts to implement systems and plans that afford intervention for individual children at the earliest possible time in the service delivery scheme. Court diversion intervention programs in Belmont County include youth diversion programs, respite care, B-Cap, C-Cap, and school programs.

III. Plan Description/Continuum of Care

Birth to three - Children who are at risk according to the previously noted criteria are identified through a variety of sources: WIC; HMG; Head Start; Belmont County Board of Developmental Disabilities. Infants are identified through hospitals and physicians. Once identified, infants and children are referred to the appropriate service provider and services are wrapped around child and family.

Services plans and the continuum of care for children birth to three are monitored by the Belmont County Early Childhood Collaborative Committee (ECCC), a sub-committee of

the Family and Children First Council. This group of service providers, members of the Family and Children First Council and parents ensures that children in need receive the services required to reduce their risk for later problems and to maximize the potential of each child.

The Family and Children First Council monitors the activities and outcomes for the ECCC and provider programs. Each program provides the Council with a quarterly (at the minimum) report of activities and with semi-annual reports on the outcomes pertinent to each program.

Three to Adolescence – At risk children are identified through previously described avenues along with new sources, including Head Start, pre-schools, schools, Children’s Services and other providers, i.e. mental health. During these childhood years, the entity that identifies the at-risk child is charged with developing a plan, in concert with parents and other family members to address the needs of the child through Individual Education Plans and linkages to service providers. (Ideally, and for the sake of continuity, there would be a mechanism through which such children could be monitored for progress by the Family and Children First Council.)

Adolescents – Adolescents at risk are identified through previously described avenues along with new sources, i.e. Juvenile Court and schools.

Service Coordination - Belmont County’s service coordination team is a sub-committee of the Family and Children First Council. The team meets on a regular basis to address the needs of certain identified members of the target population whose needs exceed the resources of the agency(s) serving them. The goal of the team is to maximize positive outcomes for multi-need children through collaboration between service providers and families. Members of the team include representatives from all child and family serving agencies that function within the county. Leadership consists of a triad representing the Belmont County Mental Health and Recovery Board, Belmont County Children’s Services, and Belmont County Juvenile Court. No Child is placed in any type of out of home placement without a team meeting and a decision by the family, Juvenile Court, DJFS and the Mental Health and Recovery Bd. In cases of emergency placement a meeting is scheduled within 10 days of placement. Decision-making is achieved through consensus with the exception of those decisions regarding the payment treatment services. In those cases, the final decision for payment rests with the leadership triad.

The team Chairpersons (Representative of Mental Health and Recovery Board, DJFS and Juvenile Court) are responsible for the overall functioning of the Service Coordination team. The Chairpersons schedules meetings, develops agendas, documents service plans, and monitors the implementation of service plans.

Children referred to service coordination are characterized as being a part of the target population as described above. An agency, juvenile court or parents will make a referral for service coordination in cases where the resources of the service agency are inadequate for addressing the needs of the child. The Children’s Services Director of DJFS or the

Family and Children First Council Coordinator will take initial referrals and schedule meetings.

The Lead Agency upon completion of the referral packet, notifies the Chairpersons who will convene a meeting of representatives from all agencies, members of the family and members of the school district, that are currently serving the child. The Clinical team will devise a Service Plan through which a strategy for addressing the needs of both the child and the family will be devised. The Service Plan will record family strengths, family needs and special family traditions or activities that the family participates. These activities can be faith-based, cultural or social activities. The Children's Services Director of DJFS, the Family and Children First Council Coordinator or the Lead Agency will assist the family in filling out the service plan and discuss the process with the family. This plan will be documented in writing and all service providers will signal their commitment to following through with the plan as written by signing it.

Agencies and parents referring children to service coordination will complete all required documents. The referral to service coordination is initiated when the referring agency submits those forms to the Chairpersons. If a family initiates the referral, the Chairpersons or the FCFC service coordinator will assist that family is completing the required documents and gathering the required information.

If the case is to be referred to service coordination, the lead agency will facilitate the presentation of the Clinical team's recommendation at the next regularly scheduled meeting. An Emergency meeting may be called in extreme cases. The referral procedure is for Children's Services or FCFC Coordinator to notify all required participants by e-mail, telephone or U.S. mail of the meeting. Prior to every meeting all attendees sign a confidentiality sign-in sheet. A safety plan is always discussed with the family and emergency contacts are given to the family.

A person from the lead agency that is the most involved with the family is the team lead. The team lead is approved by the family. If the family does not approve with the team lead the family has the right to ask for another team leader.

It is recognized that family commitment and involvement in the Service Plan is key to its success. Therefore, the Clinical Team will make every effort to involve family members in the planning process, including culturally appropriate activities and arrange for the Clinical team to meet at a time and location convenient to the family. Parents have the right to call a meeting with the service coordination team to develop, review or if needed, revise the plan at any point during the process. The Service Plan will list the specific actions agreed to by the family. The actions should be developed with family input with assistance from agencies and should not be prescriptive. Families will be informed that they may invite a family advocate or a support person of their choice to any and all meetings.

The Service Plan will set goals and objectives for meeting the needs of the child. Service providers will be identified and the plan will detail each provider's role and commitment.

Additionally, the plan will detail the specific actions required of the family, including time lines for completion. The Service Plan will include a plan for consequences for times when either family or provider fails to fulfill their commitment, and will address a plan for discharge from Service Coordination. The Service Plan will detail an implementation and review schedule. As the plan is implemented, deviations from the plan must be reported to the Chairpersons prior to the action except in the most extreme cases. The Chairpersons may reconvene the Clinical Team to approve the deviation and integrate it into the Service Plan. The Chairpersons are responsible for scheduling review meetings and providing the team with review information. They are also responsible for monitoring the case as the plan is implemented, and for informing the team if there are any problems. Copies of the Service Plan will be provided to all service providers and to the child's family. Along with the service plan, members will draft a crisis safety plan to assist the family in short-term crisis situations. The Clinical team may request copies of the plans.

The Clinical team may make the recommendation to either terminate Service Coordination or to recommend the case for more intense Service Coordination involvement (i.e. placement) when the goals and objectives defined through the Service Plan are achieved or when all possible local resources are exhausted. This recommendation will be facilitated through the Chairpersons and will include any and all required documents.

When all alternatives to out of home placement have been exhausted and the clinical team determines that the preferred intervention involves residential treatment, they will pursue residential placement. The Service Coordination Team consists of all current service providers and any potential service providers. The Service Coordination Team meeting will be convened, coordinated and documented by the Cluster Chairpersons. They will devise a Service/Discharge Plan through which a strategy for addressing the needs of both the child and the family will be devised, along with a plan for bringing the child back to the community. This plan will be documented in writing and all service providers will signal their commitment to following through with the plan as written by signing it.

The Service Coordination Team may make the recommendation to either terminate service coordination involvement or to recommend the case for less intense involvement (i.e. local treatment and wrap around services) when the goals and objectives defined through the Service Plan are achieved, or when residential placement is no longer feasible or appropriate. This recommendation will be facilitated through the Chairpersons and will include any and all required documents. If this is the case, the procedure for non-residential Clinical team will be utilized.

The Family and Children First Council monitors the activities and outcomes for the Service Coordination Team. The Chair group provides the Council with a monthly report regarding placements, and wrap-around plans. The Chair group provides council with a monthly report aggregating the number of children involved in Service Coordination, their disposition and the cost to the county.

IV. DISPUTE RESOLUTION PROCESS

Pursuant O.R.C 121.37 and 121.38 the three types of disputes concerning services or funding are disputes between agencies, family to agency disputes, and family disputes with the service coordination. In cases of family to agency disputes that agency's plan will be followed. In cases with service coordination disputes after the dispute resolution process is initiated Council shall make findings and issue a written determination not later than 60 days after parent or custodial initiation. If the family wishes to continue services each agency represented shall continue to provide those services and the funding for those services during the dispute resolution process.

Any family referred to Service Coordination is informed of the dispute resolution process.

If a dispute arises either between agencies on service provision, or if the family is not satisfied with the treatment plan the following dispute resolution process will be followed:

1. If there is significant and unresolved conflict regarding any aspect of the service plan by any participant (including parents) every attempt is made to resolve that conflict with the participating members. This keeps conflict mediation and resolution as close to the direct care level as possible at the first level of the process. If your child is birth to three or Part C eligible you have the right to by pass this dispute resolution process and go directly to the Procedural Safeguards and Dispute Resolution Process through the Ohio Department of Health.

Time Frame: A formal statement of conflict should be filed through the lead case manager at the time to the appropriate committee (Early Childhood Collaborative Committee or Service Coordination Committee).

2. Members of the committee are the mandated systems representatives as outlined in the statute. They will review all relevant information at their regularly schedule meetings, and will issue their recommendations within five working days of the meeting.

3. If resolution cannot be found then a referral of the situation is made to the Executive Committee of the FCFC. This committee cannot consist of any persons from the agency in which the dispute is regarding. The Executive Committee may require any additional information or ask any participation for future detail regarding this conflict. The Committee will prepare an outline of the options and recommendations. These are then voted on, with a majority vote required for acceptance. The decision of the Executive Committee is then conveyed to all parties.

The Executive Committee will issue results within 5 working days beginning the day after the notice is received to both the complainant and the FCFC.

4. Any member of the committee or parent may file and appeal of the resolution to the Executive Committee's level of Council presenting any additional compelling information. Those appealing may engage the services of an advocate on their behalf, as they deem necessary. After considering all appeal information, the Council again votes on recommendations. This final decision is considered binding.

An appeal of the final decision must be filed within 5 working days beginning with the day after the final recommendations are issued. The Council must issue its findings on the appeal within 5 working days beginning with the day after the appeal is filed.

The rationales for the noted time frames are: the need to resolve the conflict as soon as is practicable and yet allow sufficient time for concerns to be heard; keep the conflict moving quickly so as not to have the issue or the process get mired at any one junction; and bring swift resolution to the conflict so that service delivery or the child and family is minimally impacted. A reasonable request at any stage to extend the five-day limits can be made by those involved if additional time is needed to adequately respond.

5. If complainant disagrees with this decision they can appeal to the Belmont County Juvenile Court Judge within seven days following the dispute. Assessment and treatment information will be provided to the Court. The decision of the Juvenile Court Judge is final.

6. Emergencies. Though infrequent, there may be an occasional situation which is considered an "emergency" requiring the outlined process be modified so as to address the emergency in a timely and effective manner. An emergency may be considered any situation that requires immediate response due to the safety and well being of the child. In these instances, the immediate decision is made collaboratively with the parents/guardian any immediately accessible staff involved. The overriding consideration is the interest, safety, physical, and emotional well being of the child. The ultimate decision rests legally with the child's parents or guardians. Once the immediate emergency is handled, any continuing conflict will follow the outlined process, but may require being placed on a fast tract. Emergency conflict situations are to be monitored by the FCFC Chairperson so that swift resolution and access to key players is assured.

Once past immediate emergency, resolution of any continuing conflict should occur within 5 working days.

At any time during the process, any participant may involve the services of any advocate to assist them with the process.

BELMONT COUNTY FAMILY AND CHILDREN FIRST COUNCIL (FCFC)
FAMILY CENTERED SERVICES AND SUPPORTS (FCSS)
REFERRAL

Name _____ Date _____

School District _____ Placement/Grade _____

Mother's Name _____ Custody _____ yes _____ no

Address _____

Father's Name _____ Custody _____ yes _____ no

Address _____

Phone _____ Empolyment _____

Legal Custodian (if different from parents) _____

Foster Placement _____ yes _____ no Relative _____ yes _____ no Permanent _____ yes _____ no

Address _____ Phone _____

Referring Professional/Parent _____

Agency _____ Phone _____

Reason for Referral

Explain what informal or formal steps have been taken to resolve situation prior referring to FCSS, along with anticipated service needs:

Current Child/Family Strengths/needs/concerns

Include any supports systems, formal or informal

Is at least one parent/custodian willing to be a Clinical Committee Team Member?

_____ yes _____ no Most convenient meeting dates _____

Belmont County Family and Children First Council
Permission for Interagency Exchange of Information

I hereby give permission for the following local agencies, collectively working together as the Belmont County FCSS, through their designated representatives, to exchange information regarding _____, whose date of birth is _____ for whom I have legal authority to act:

- Belmont County Department of Job and Family Services
- Belmont County Health Department
- Belmont County Board of Developmental Disabilities
- Belmont County Juvenile Court
- Mental Health and Recovery Services Board
- Tri County Help Center
- _____ School District
- Community Parent Representative
- Belmont County Family and Children First Council
- Crossroads Counseling Center
- Southeast Inc. Counseling Center
- North Point Consulting
- New Horizon Youth Center
- Belmont County Help Me Grow
- Easter Seals
- Other _____

This information _____ does or _____ does not pertain to substance abuse.

It is my understanding that the sole purpose of this exchange of information is to develop a coordinated Family Service Plan for _____ and that I will be involved in the process.

Signature: _____ Relationship: _____

Date: _____

Witness: _____ Date: _____

THIS CONSENT TO DISCLOSE MAY BE REVOKED BY ME IN WRITING AT ANY TIME EXCEPT FOR INFORMATION THAT HAS ALREADY BEEN RELEASED IN ACCORDANCE WITH THIS AUTHORIZATION. THE CONSENT (UNLESS EXPRESSLY REVOKED EARLIER) EXPIRES 180 DAYS FROM THE DATE OF MY SIGNATURE

BELMONT COUNTY FAMILY AND CHILDREN FIRST COUNCIL (FCFC)
FAMILY CENTERED SERVICES AND SUPPORTS (FCSS)
MEETING NOTES:

CASE NUMBER	TEAM LEADER	DATE
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<u>Team Members Present</u>	<u>Team Members Absent</u>
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DISCUSSION:

Steps needed to achieve Family Service Plan Goals	By Whom:	When:
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NEXT MEETING DATE:	TIME:	LOCATION:
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Crisis/Safety Plan

A crisis/safety plan is needed to address possible safety/crisis situations at home and at school.

Name of Child: _____

Date prepared: _____

Past Behaviors/Situations considered safety concerns: _____

List interventions to respond to crisis/safety situation. (who is involved, contact information and responsibilities): _____

Who will be notified:

Time Frame:
