

Pathways to Mental Health Services

CORE PRACTICE MODEL GUIDE



CDSS

CALIFORNIA
DEPARTMENT OF
SOCIAL SERVICES



DHCS
California Department of
HealthCareServices

**UC DAVIS
EXTENSION**
CENTER FOR HUMAN SERVICES
Resource Center for Family-Focused Practice



State of California



Greetings Colleagues:

We are pleased to provide you with the first in a series of valuable resources for the child welfare and mental health systems intended to assist with the implementation of the Core Practice Model (CPM). The CPM Guide describes the core practice model elements and how they can be useful to both child welfare and mental health administrators and practitioners. Over the last several years, California's child welfare and mental health systems have been experiencing systemic change in incremental and meaningful ways. Several state initiatives and new federal legislation as well as the implementation of the Katie A. v. Bonta et. al Settlement Agreement have become the most recent catalysts for both systems to become more holistic and comprehensive in meeting the needs of our children, youth, and families.

The CPM should be seen as a process, not an event and not another program but a different way of thinking about, relating to and working with children and families based on shared values and principles. The shared values and principles described in the guide are crucial to effecting shared practices between child welfare and mental health. We hope that the CPM Guide and its companion document, the "Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A. Subclass Members," will be useful to county mental health and child welfare in helping to renew thinking about how to work within each other's systems.

As your partners, we will continue to play a supportive role in this statewide transformation effort. We also recognize that local realities require a unique set of responses given the unique needs of children and families within your county as well as the political, social and economic situations. Our hope is that this guide will assist you with strengthening collaboration and teaming, moving your systems closer to integrating practice and effective service delivery. The CPM Guide is a living document and is the first step in implementing a CPM. It is anticipated that the practice standards and activities will be augmented, refined, and revised as counties develop and test strategies for providing services and supports in accordance with the CPM. The California Department of Social Services and the Department of Health Care Services over the coming months will be working with stakeholders to develop additional materials to further promote and support the installation of CPM across the state.

To all who contributed, thank you and we are very grateful for your willingness to share your time, energy, and expertise to further advance ongoing efforts to improve outcomes for children and families with mental health needs.

Sincerely,



TOBY DOUGLAS, Director
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WILL LIGHTBOURNE, Director
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CHAPTER 1: INTRODUCTION

A. PURPOSE AND BACKGROUND

The purpose of the Core Practice Model (CPM) Guide is to provide practical guidance and direction for county child welfare and mental health agencies, other service providers, and community/tribal partners who will be implementing the CPM when working with children and families involved with child welfare who have or may have mental health needs. The CPM guide is the first step in articulating the values, core components, standards of practice and activities for a cross-system CPM for California. This guide identifies specific required components that support the standards and expectations for practice behaviors by child welfare and mental health staff. It is intended to facilitate a common strategic and practical framework that integrates service planning, delivery, coordination and management among all those involved in working with children involved in multiple service systems. In the future, additional tools and resources that support the integration of the values, core components and practice standards in day-to-day practice behaviors for child welfare and mental health service delivery will be developed and made available through the Statewide Training and Education Committee and other training and technical assistance resources and venues.

In California, practice is changing with regard to the way child welfare and mental health staff and service providers work with children, parents and families who need both child welfare and mental health services and supports. The systems that serve these children and families must work together to improve outcomes for children, youth and families who have mental health needs and are involved

with child welfare. California counties will be implementing a CPM that provides a framework for integrated practice for all child welfare and mental health agencies, service providers and community/tribal partners working with youth and families. Adoption and implementation of the CPM across child welfare and mental health systems will require time, resources, system patience and support at all levels and the involvement of parents, families and youth. The on-going development and refinement of the CPM is critical at all stages of rollout of this model across California and will be supported by a number of state and local strategies and activities.

All counties, agencies and individuals that serve children and their families in both child welfare and mental health will use this practice model.

Overall, there has never been a better opportunity to undertake the work of systems transformation. At the State level, both the child welfare and mental health systems are committed to system redesign and transformation through current major initiatives such as the Mental Health Services Act, The Affordable Care Act, California's Child and Family Services Review process, the Child Welfare Federal Grant Initiative California Partnership for Permanency (CAPP) and the most recent catalyst is the settlement of the Katie A. v Bonta lawsuit.

The CPM is about working together to improve outcomes for child welfare youth and families, a value that California has articulated in both child welfare and mental health initiatives over the last several decades.

There are striking similarities between the core elements, values and practices embodied in these initiatives, including¹:

- **Shared Responsibility** - Supporting the safety, permanency, education, mental health and overall well-being of children and families requires a shared government and community responsibility.
- **Collaboration** - The process by which various stakeholders including groups of individuals and families, citizens, agencies, organizations, and businesses work together to share information, effort and resources in order to accomplish a shared vision.
- **Cultural competence and humility** - A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among providers, that enables that system, agency or those providers to work effectively in cross-cultural situations with awareness of and respect for the diverse experiences, customs and preferences of individuals and groups.
- **Child Centered and Family Focused/Driven Systems** - The concepts that children have a right to be safe, loved, and nurtured and to live with their families (biological and/or extended) whenever possible; and when that is not possible, to live in a **permanent**, loving and nurturing family home with caring and committed adults who will be there for a lifetime. This is supported by the belief that services must be focused on the family with supports that empower families and enhance their ability to access internal and natural community resources. Child centered and family focused/driven services cross agency boundaries and provide integrated service experiences.
- **Permanency** - A concept that incorporates but goes beyond the legal definition of permanency and refers to the importance of youth having at least one sustained relationship in their life with an individual who provides unconditional positive commitment and support.
- **Evidence-Based Practices** - Evidence-based practices are those that have empirical research supporting their efficacy. Child welfare and mental health agree on the importance of using practices that have proven effectiveness; both systems have identified a number of evidence-based practices relevant for use in both systems' service delivery.
- **Transparency** - The ability to ensure that intentions, decisions and actions related to planning, service delivery, communication and any other behaviors are fully defined and explained in a way that is easily understood, candid and open to families and stakeholders.
- **Disproportionality/Disparity** - *Disproportionality* refers to an under- or overrepresentation of individuals/children of a particular racial or ethnic group experiencing a particular child welfare event or receiving a mental health service compared to their representation in the general U.S. population that may reflect bias or other conditions beyond the circumstances or facts of the individual situation.
Disparity refers to the comparison of information across racial and ethnic groups to better understand how the representation of one group compares to another. *Disparate treatment* refers to the unequal treatment or services provided to individuals/children of one ethnic group as compared to those provided to similarly situated individuals/children/families of another ethnic group. Both systems strive to eliminate or reduce both disproportionality and disparate treatment.

¹ Values and concepts are taken from materials on the current mental health and child welfare initiatives.

- **Accountability** - The responsibility of individuals and systems to assess and manage performance, self-correct, innovate and enhance their ability to achieve positive outcomes. Both systems are interested in outcome-based performance measures as ways of assessing and managing performance.

The CPM is about changing the way one works; from working with children and families in an individual system or agency to working within a team environment to build a culturally relevant and trauma-informed system of supports and services that is responsive to the strengths and underlying needs of families being served jointly by child welfare and mental health.

This change will take time, commitment, strong partnerships and effort at all levels, both state and county. The building blocks for this kind of transformation include an active involved community partnership, shared commitment to the practice model, capacity building, and implementation with effective supports. More about implementation of the CPM is discussed in Chapter Three of this guide.

The guide is intended to assist leadership and management in mental health and child welfare as they work to implement a comprehensive and integrated approach that children and their families will receive when served jointly by child welfare and mental health.

It is an introduction to the CPM for the people who will be responsible for building system and community commitment to integrated child welfare and mental health practice, and developing

strategies for implementation of the model. The CPM articulates an approach to service delivery with the statewide expectations and parameters needed to promote effective practice that achieves desired outcomes for children and families within and across systems.

The CPM guide is also intended to provide initial guidance for direct service staff; those child welfare and mental health service providers who provide services to children, youth and their parents/families who need services from both systems. While the information in this guide will be supplemented with additional detailed practice information for direct service staff, it will provide an initial introduction to new and transformative service delivery expectations.

The CPM will be part of a dynamic process that will result in more effective ways of partnering among child welfare, mental health and children and families in order to achieve positive outcomes for youth and families who are involved with child welfare and have mental health needs.

This guide is a first step in defining the CPM. It is anticipated that the practice standards and activities will be augmented, refined and/or revised as counties develop and test strategies for providing services and supports in alignment with this CPM guide.

Additional practice tools, training curriculum, practice improvement protocols, and quality control systems will further define and support the CPM. As noted above it will be augmented with more detailed materials for front-line staff, as well as for children, youth and families.

The California Department of Social Services (CDSS) and the California Department of Health Care Services (DHCS) will develop cross-system training curricula and educational materials for use

by child welfare and mental health staff across the State. New resources as well as existing resources will be identified to assist counties to understand and integrate the foundational concepts, teaming requirements and the practice standards and activities into routine practices of service delivery. In order to achieve the success and improvement for children and youth, this guide speaks to what must be done to support children in the child welfare system with mental health needs. It does not prescribe who should do it, as that will vary from county to county and family to family; nor does it change or eliminate existing mandates for child welfare and mental health practitioners. However, there is an expectation that services will be developed and delivered in partnership with children, youth and families, and individualized to address the unique needs of each child and family. The initial practice standards reflect in-depth input derived from Children’s System of Care (CSOC), the Mental Health Services Act, (MHSA), MHSA Full Service Partnerships (FSPs), Wraparound Programs (Wraparound) and the California Partnership for Permanency (CAPP) initiative which includes information created by community and tribal partners. The guide also highlights the importance of culture and community in service delivery that produces successful and sustainable outcomes. There is room for local flexibility within the CPM parameters.

The CPM Guide is organized in three main sections:

1. Chapter One provides background, purpose and context, and introduces the concept of an integrated system-wide practice model.
2. Chapter Two defines the practice model itself; the values and principles, the strategies of teaming and trauma-informed practice, and integrated standards of practice and activities.
3. Chapter Three provides a framework for

adopting and implementing the model and changing practice at the local level.

A note about terminology: This guide uses the terms child/children, youth and family to describe people who are involved with, at risk of involvement with, or eligible to receive services from the child welfare and mental health systems. The terms “children and youth” may be used interchangeably. The term “family” includes blood and adoptive parents and relatives, step-families and unrelated persons that have emotionally significant relationships. For American Indian youth and families this term includes their tribe and tribal relations as understood under the tribe’s customs and traditions. Youth, family and for American Indian youth, tribes, are considered best and uniquely qualified to identify who fits this description. There are also times when a caregiver may be assuming the role of a surrogate or co-parent. In those instances they should be considered to be included when “family” is referenced. When children and youth are included in an activity or process, it is assumed that their involvement will be as developmentally appropriate.

Besides this guide, a Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) developed with the Department of Health Care Services will be released and is consistent with the CPM. These two resources are intended to complement and link to one another. The CPM guide defines the model and provides the context within which the eligible specialty mental health services described in the Medi-Cal Manual, including the additional services of ICC and IHBS will be delivered.

B. CALIFORNIA'S CHILD WELFARE AND MENTAL HEALTH SYSTEMS FOR CHILDREN AND FAMILIES

County child welfare and mental health systems are far more complex than these general descriptions might imply. Since the specifics of programs and services vary from county to county, it is essential for staff members of these two agencies to be cross-trained at the local level, so that they will better understand each other's systems. They can then begin to identify potential "service integration points" where the two systems intersect. The CPM Guide provides a framework to help counties build effective partnerships among child welfare, mental health and the children and families they mutually serve in order to improve safety, permanency and well-being.

CALIFORNIA CHILD WELFARE SYSTEM AND SERVICES

California counties are the primary governmental bodies that directly interact with children and families to address child abuse and neglect. The county department or agency of social services through its child welfare division administers and provides child welfare and foster care services under Sections 300 et seq. and 16500 of the California Welfare and Institutions Code (WIC). The county child welfare division investigates reports of child abuse and provides case management and other services to help families stay together whenever possible.

Each County maintains a hotline to receive reports of suspected child abuse and/or neglect. Once a call or report is received, a Child Welfare Social Worker (CSW) will evaluate the referral and find that more information is needed, or that it does not rise to the level of abuse and the referral will be closed. If more information is needed, a CSW will go out to the child's home and assess for risk and safety factors.

Initially, the CSW works with the family to find the least intrusive approach to support the child and family with ameliorating the issues that brought them to the attention of child welfare. If the CSW assessment of the home indicates that formal supports are needed the child may be removed or remain in the home to receive family maintenance services. It is important to note that not all counties offer family maintenance services. If the child is provided any services by the Child Welfare System (CWS), the CWS is responsible for coordinating their care through a family-focused and needs-driven approach.

When a child must be removed for their safety, the CSW will provide Family Reunification services to the family to support the safe return of the child back home. The CSW is responsible for reporting the progress of the family to the Juvenile Dependency Court every six months until the child can be returned, or placed in a permanent home. If the child can safely be returned to their family, the CSW will work on transitioning the family out of the system. If a child is unable to reunify with family, the CSW will work on identifying a permanent home through adaption or guardianship. If a child remains in care and turns 18 years of age, the child may be eligible for extended foster care services up to age 20. Appendices D illustrates a basic understanding of the child welfare process: acronyms and abbreviations are defined in the Glossary.

CALIFORNIA MENTAL HEALTH SYSTEM AND SERVICES

The California mental health system organizes and delivers services through each local county mental health authority. The County Mental Health Plan (MHP) provides an array of programs and services to consumers of all age groups. Children and adolescents up to age 21 who are Medi-Cal

beneficiaries and meet medical necessity² criteria are eligible for Early and Periodic Screening Diagnosis and Treatment (EPSDT) Rehabilitation and Specialty Mental Health Services. Service components include: outpatient mental health services, medication support, case management, therapeutic behavioral services (TBS), crisis intervention, crisis stabilization, psychiatric hospitalization, day rehabilitation and day treatment intensive services.²

For members of the Katie A. subclass, two services have been added: in-home behavioral services (IHBS) and intensive care coordination (ICC), which are discussed in detail later in this document.

Mental health services are typically provided by both licensed and non-licensed personnel through county operated programs or community based organizations (CBO's), and by individual practitioners in private practice who contract with county mental health. Children may also receive mental health services through the primary care system, including primary care physicians or Federally Qualified Health Centers (FQHC's).

Children and families are provided with appropriate and medically necessary mental health services regardless of their initial point of contact with a mental health staff member; a "no wrong door" approach. Service planning and implementation take into account the needs, strengths and choices of the child and family and are driven by their identified goals and/or desired results. They are designed to build on strengths and are focused on achieving specific measurable objectives that support the primary goals.

C. WHAT CHILDREN, YOUTH AND PARENTS/FAMILIES CAN EXPECT IN THEIR INTERACTIONS WITH CHILD WELFARE AND MENTAL HEALTH

Active parent/family involvement and input is essential to developing assessments, identifying services, and developing plans. Careful attention should be given by both systems to enhance parents' engagement in the ongoing planning and services delivery processes including providing support by way of a peer mentor, and likewise for youth support and involvement. In the CPM, children, youth and parents/families are active team partners and:

- Will be included in the entire process from beginning to end.
- Will be encouraged to voice their wants and needs.
- Will be given information in a clear way so that they can understand the roles of all the service providers and other people involved, and the reason they need to be involved.
- Will have a safe place to talk about the issues without fear of being judged or treated like "bad" people, rather than people who, like everyone, have both strengths and challenges.
- Will be encouraged to identify natural supports and the people they want as members of their child and family support team.
- Will have a realistic plan for them to access the supports they need when they feel they need them after services end.
- Will have the opportunity to build relationships with their child's foster parents in cases where reunification is the jointly agreed-upon plan.

² For detailed definitions and descriptions of these services, please refer to the Mental Health Medi-Cal Billing Manual, Version 1.0, July 17, 2008:

http://www.dhcs.ca.gov/services/MH/Documents/Mental_Health_Medi-Cal_Billing_Manual_v1-0_07-17-08.pdf

CHAPTER 2: THE CORE PRACTICE MODEL (CPM)

A. DEFINITION

The CPM is a set of practices and principles for children/youth served by both the child welfare and the mental health system that promotes a set of values, principles, and practices that is meant to be shared by all who seek to support children/youth and families involved in the child welfare system, including, but not limited to education, probation, drug and alcohol and other health and human services agencies or legal systems with which the child/youth is involved.

The CPM requires collaboration between child welfare and mental health staff, service providers, and community/tribal partners working with the children, youth, and families.

It articulates a family-centered approach that is intended to improve coordination and collaboration among mental health, child welfare, and children and families involved with the child welfare system who have mental health needs.

In addition, the practice model honors local flexibility to reflect the cultural diversity of families, communities and tribes which is needed for successful implementation. Further, it promotes respect for the values, beliefs, and behaviors of the individual and his/her community and/or tribe.³

The CPM should not be viewed as a practice model specific to a single agency, nor is it a program.

No single individual, agency or service provider works independently.

The CPM describes “how and what is done” when working across systems with children, youth, and their families—specifically, child welfare and mental health. This shift will require significant change in administrative policies and procedures, in day-to-day tasks and assignments, and in supervisory and coaching/field interactions with direct services staff. It is expected that implementation of the CPM will improve services for children, youth and families involved with child welfare. Implementing the CPM with fidelity will promote consistent practice that is guided by values and principles, standards and activities and therefore increases the likelihood of positive outcomes for children, youth, and families.

There are statewide efforts that require similar approaches: the California Partners for Permanency (CAPP) initiative, the MHSA funded projects and Children’s System of Care initiatives. The CAPP initiative reflects the input of youth and families, as well as all of the stakeholders involved in service planning and delivery and others, and was used to inform some of the standards of practice that make up the CPM.

Well-defined outcomes are a key component of a practice model. CDSS and DHCS are charged with developing outcomes in order to evaluate the effectiveness of the practice model. The establishment of joint accountability and shared outcomes among collaborative team partners is essential to the CPM’s success. Both mental

³ Excellent resources in this area can be found in the CAPP materials and the “FSP Cultural Relevance Took Kits” developed by the California Institute for Mental Health.

health and child welfare will be held accountable under a shared accountability structure. Without agreement on shared outcomes, each partner is likely to measure only its own progress from its own perspective. System partners need to create ways that the system can measure treatment and service outcomes for families in both the mental health and the child welfare systems. These shared standards will guide refinement of the CPM through a continuous quality improvement process by providing a performance- and measurement-driven framework for working with children and families. Shared performance indicators or benchmarks will allow the partners to measure their joint impact on their systems. Ultimately, an outcome component will be added to the CPM that includes both short-term and long-term outcomes. Fidelity assessment for the CPM is another critical component that will be added to the outcome component. One cannot measure the effectiveness of the CPM unless there is assurance that it is being implemented with fidelity.

B. VALUES AND PRINCIPLES

The CPM is guided by specific values and principles related to working with children, youth and families in the child welfare and mental health systems. Child Welfare and Mental Health practice should demonstrate and support the following:

Children are first and foremost protected from abuse and neglect, and maintained safely in their own homes.

Keeping children safe is one of the primary goals of the CPM. Services are designed to help protect children while providing supports to strengthen families to prevent abuse and neglect. Safety includes both the absence of an imminent or immediate threat of harm to the child and the absence of endangerment by self. Neglect is the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats). Educational neglect includes failure to provide appropriate schooling, special educational needs, or allowing excessive truancies. Psychological neglect includes the lack of any emotional support and love, chronic inattention to the child, exposure to spouse abuse, or drug and alcohol abuse.⁴

Before a decision is made to remove a child, efforts are made to safely maintain children with their families, including providing necessary supports and services that may include mental health services when needed. When children must be removed from their homes, the focus is on working in partnership with the child and family to return them home as soon as is safely possible. Children experience trauma when they are separated from their families. When children must be removed to be

⁴ Child Protective Services: A Guide for Caseworkers Office on Child Abuse and Neglect, Children's Bureau. DePanfilis, D., Salus, M. K, 2003.

protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports.

Services are needs driven, strength-based, and family focused from the first conversation with or about the family.

Needs driven services, as opposed to services driven by symptoms, provide the best guide to effective intervention and lasting change. Plans that are needs based, rather than service driven, are more likely to produce more positive outcomes. When children and parents/families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change. When service providers focus on strengths they provide hope for healing and recovery.

Family-focused services emphasize working with the family unit to strengthen family capacity and ensure the best possible outcomes for children. The most fundamental needs of children, such as safety, nurturing, and belonging, cannot be addressed effectively without attending to the entire family's needs. Assessments that focus on underlying needs, as opposed to behaviors (symptoms), provide the best guide to effective intervention and lasting change. Plans that are needs based, rather than service driven, are more likely to produce safety, stability and permanency.

Services are individualized and tailored to the strengths and needs of each child and family.

The services available to families involved with both child welfare and mental health should be sufficiently flexible to be adapted to the unique needs of each child and family. When tailoring services, it is important to look at both strengths and the underlying needs, which are causing the

behaviors or symptoms of the child and/or parent. Careful needs identification leads to more effective interventions. To assess and plan effectively, the child and family strengths and causes for behaviors needing attention should be identified first, followed by matching of services and supports to the person's specific needs.

Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.

Collaboration goes beyond just coordinating, sharing information or meeting together. By bringing together a diverse set of people and perspectives, including youth and families, service agencies and providers and community/tribal partners, collaborative approaches enable development of a holistic view of a complex situation. Such "big picture" and inclusive thinking helps to identify the many causes of problems, how those causes are connected, and the underlying needs reflected in their situations.

The results from collaboration are greater than the sum of each individual's contributions. This process is the major advantage of a multi-agency collaborative approach, as it creates something that could not have been achieved by any one of the individuals or member organizations working in isolation.

Parent/Family voice, choice, and preference are assured throughout the process.

Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. The quality of this relationship is essential to engaging the child and family in a process of change. A true parent/family/service provider partnership is based upon shared beliefs and commitment to a

collaborative effort. Parents and service providers must trust and respect one another. Both parents/families and workers must be open to new ideas and willing to change. The role of parents and families must be real, not just tokenism. Under a partnership parents/families are supported and encouraged to voice their ideas, their needs and their goals for themselves and their children. Decisions about child and family interventions are more relevant, comprehensive and effective when the family's team makes them. Parents/families should always be core members of the team. Finally, children and families are more likely to pursue and maintain a plan or course of action that they have a key role in designing.

Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success.

Systems should have a broad array of resources and services that can be provided in whatever combination or manner is needed by the child and family. One major advantage of a team approach is that each member of the team can bring both resources and the knowledge of how to access a range of both traditional and non-traditional resources that others may not be aware of. The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time.

Services are culturally competent and respectful of the culture of children and their families.

Cultural competence and humility embody the understanding that while cultural differences will affect a provider's interaction with individuals, each person remains an individual and should be treated as such.⁵ Cultural humility is also an important step in helping to redress the imbalance of power inherent in relationships between those providing services, and children and families who are service recipients.

Approaching each encounter with a child/youth and family with knowledge that one's own perspective is full of assumptions and prejudices can help one to maintain an open mind and remain respectful of the child and family.⁶

Providers need to always recognize that extensive knowledge about a given culture is not the same as having assimilated oneself into that culture, and therefore should be aware of the differences that will still exist between their own perspective and the perspective of the members of that culture.⁷

⁵ Miller, S. (2009). Cultural humility is the first step to becoming global care providers. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 38(1), 92-93.

⁶ Borkan, J.M. et. al. (2008). Towards cultural humility in healthcare for culturally diverse Rhode Island. *Medicine and Health: Rhode Island*, 91(12).

⁷ The California Institute of Mental Health's Full Service Partnership Cultural Relevance Toolkits are excellent resources and discuss the concept of cultural competence or abilities in three areas:

Services and supports are provided in the child and family's community.

Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture.

Services and supports best meet child and family needs when they are provided in the family's natural setting, or for children removed from their parents/families, in the child's current placement. Children should not have to move in order to receive a specific type of service. Services should be flexible enough to be delivered where the child and family reside.

Children have permanency and stability in their living situation.

Permanency is not just a process, plan, or foster care placement, nor is it intended to be a family relationship that lasts only until the child turns age 18. Rather, permanence is about locating and supporting lifelong family connections. It is a safe, committed, loving relationship that is intended to last forever between a young person and adult where the young person receives positive emotional support and acceptance based on trust and respect, providing for the physical and emotional well-being of the young person.

Permanence can be the result of preservation of the family, reunification with birth family, or legal guardianship or adoption by relatives or other caring and committed adults. In addition, permanency includes the achievement or maintenance of other lifelong relationships, like siblings, extended family members, mentors, and childhood relationships. Permanency and stability is *not* remaining in a foster care situation for an

extended period of time. Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time.

C. TEAMING

Teaming has been a traditional practice in social work, child welfare, and mental health. Working in a team process requires the integration of varying perspectives of individuals with diverse educational, professional and personal life experiences. Teaming guards against individual bias, and promotes better-informed decision making and learning based on what works and what does not to improve or refine plans and approaches.

Over the past several decades the definition of teaming has evolved from a process of bringing together professionals working with a particular child and family to one that includes and values youth and families as equal partners and decision makers. Systems of care serving children, youth and families with complex needs have made efforts to incorporate youth and family participation at every level of program development, planning, implementation, and service delivery.

In California over the past two decades, teaming efforts in child welfare services have merged professional multidisciplinary teams with the family and youth involvement have advanced and transformed systems of care. While the use of inclusive teams has become more common in the State, it is critical that the team members operate with fidelity to the values and philosophy embedded in this CPM guide; professional expertise is a resource, not the answer. Children, youth and families are recognized as the best experts about their own lives and preferences; and natural supports have valuable information and resources to share.

I. ELEMENTS OF SUCCESSFUL TEAMING

Teaming is the process of a group of people coming together who are committed to a common purpose, approach and performance goals for which they hold themselves mutually accountable. Experience suggests that the teaming process is most successful when

- Teams embrace the foundational concept of collaboration. Within a team collaboration is only truly gained when everyone is working toward common goals, with a shared understanding of the means to reach them. This has to be based on mutual respect between team members; understanding, recognizing and valuing each other's' contributions to the team. Transparency within teams is important and members of the team need to be clear about their own roles and values and how to communicate these to other team members.
- Team membership must include the child, youth and family and, for those youth and families involved with child welfare and mental health, the formal supports from mental health and child welfare. Teams may include extended family; informal support persons such as friends, coaches, faith-based connections; and other formal supports such as educational professionals and representatives from other agencies providing services to the child and family.
- Team composition is guided by the family's input and their needs and preferences.
- Team meeting schedules and locations are guided by the family's needs and preferences.
- All team members participate in the development and implementation of the plan.

Multicultural knowledge, which refers to specific cultural knowledge about the history, traditions, customs, values, beliefs and the languages of cultural group; awareness of one's own cultural heritage, values, practices and beliefs, and how a person's worldview affects the work they do with others, and communication and practice skills to be flexible and responsive to cultural differences.

- The team meeting process is standardized to include
 - A clearly defined purpose, goal and agenda for each meeting;
 - An agreed-upon decision-making process;
 - Identification of family strengths and needs;
 - A brainstorming and option-generating process; and
 - Specific action steps to be carried out by team members according to a timeline.

All of these factors result in increased satisfaction among participants and better outcomes.

II. THE CPM CHILD AND FAMILY TEAM

The practice of teaming for all youth and families is at the heart of the CPM. The concept of a Child and Family Team (CFT) is central to the CPM.

The CFT is a team of people—it is comprised of the youth and family and all of the ancillary individuals who are working with them toward their mental health goals and their successful transition out of the child welfare system.

The CPM makes a distinction between the CFT, which describes the members involved in a shared vision with the family, and a CFT meeting, which is one way in which the members communicate.

What is transformational in the CPM is that it requires all parties to recognize that it takes a team of people to ensure that children, youth and families successfully transition out of the system and achieve positive outcomes. Working as part of a team involves a different way of decision-making. Child welfare, mental health staff, and service providers need to become knowledgeable about and comfortable working within a team environment that engages youth and families as partners in that environment. This is a skill that will take time to acquire and will require training and coaching.

Each individual team member has his or her unique role and responsibilities, but they are always working as part of the team.

III. BUILDING A TEAM

The team process begins with the initial interactions between the child welfare worker and the youth and family, a small informal team working together to identify the youth and family's strengths and underlying needs. As these strengths and needs are identified, the original team expands to include other members as necessary and appropriate. The process of putting together a CFT for children and families involved with both child welfare and mental health must include at least the child welfare worker and mental health worker and the child and family. It is also essential to engage the youth and family in a discussion about their support systems and who they might want to be on their CFT. Natural supports should always be explored for the CFT. These support people can include extended family members, neighbors, clergy, tribal members and other individuals that will commit to support the child, youth and family. Natural supports are critical to continuing the support of the family once formal support systems such as child welfare and/or mental health are no longer needed. For some families, even one natural support person can make a difference in the family's success in achieving their goals.

Starting with the first contacts with the family, child welfare and mental health workers should introduce the values and principles of the CPM and the fact that they work as part of a team together with the child, youth, family and their identified supports. It is important at the point of building a team for everyone to discuss issues of privacy and confidentiality and obtain and review all consent and release forms with the child, youth and family. Adhering to the CPM principles of honesty and transparency, it is critical for the youth and family to understand what information must be shared and what information they can choose to share or keep confidential from other team members. Although the

ultimate decision lies with the family, it is important to engage them in a discussion about the pros and cons of sharing information among team members so that they can make informed decisions about what information they want to share. As new members join the team, these discussions should be revisited.

Throughout the child, youth and family's involvement with the system, team members work together to ensure access to needed services, and monitor the child, youth and family's progress, making individualized adaptations as necessary so that the family's goals and team-identified outcomes can be achieved. In working together to solve problems, support the family, and achieve plan goals, the CFT should be creative in devising interventions/solutions. Reliance on informal supports, peer services, and paraprofessionals should be emphasized. Moreover, the CFT should not limit itself to child welfare and Medi-Cal funded services, but should look at ways to blend and leverage funding and identify and draw down additional public and private resources and funds to the greatest extent possible. In addition, all team members work to help youth and family members find their voice and advocate for themselves. In team meetings, the team coordinator/facilitator acts to engage all team members, soliciting their input, coordinating their participation and follow-through, and promoting accountability to the team for their commitments to specific action steps.

A CFT evolves over time, as effective strategies are put in place and goals are achieved. Some members may fulfill their purpose on the team and decide to leave. Over time, new members with the skills and strengths to address emerging needs will join the process. This dynamic is essential to a healthy CFT. For instance, if a child is receiving individual therapy and this service is no longer needed, then the therapist that once was a part of the team may not continue to participate if their role on the team

is completed. New members should be welcomed into the team and departing members should be acknowledged for their contributions.

Teaming recognizes and appreciates the key contributions of a family's community and/or tribe in providing strength and support. The process therefore encourages and assists the family in building and/or enhancing their circle of support. Outreach efforts are made to engage extended family members, neighbors and friends, faith-based and other community/tribal connections, as well as relevant representatives of other child/family-serving systems and agencies, such as education, primary care, substance abuse, developmental disabilities, and juvenile justice. Transition-age youth, who may soon be exiting the system, need to have a strong voice in determining who participates on their team and in their team meetings. Acknowledging young peoples' strengths and encouraging them to actively advocate for their own needs within the team helps them to be more successful in achieving independence.

As the CFT works together to identify strengths and needs and develop action plans that connect the two, team commitment and cohesion are greatly strengthened. Team members start taking responsibility for contributing to the family's success, as they observe achievements in the areas of safety, permanence, and well-being. At its best, teaming embraces family empowerment and inclusion, respects family culture and values, and honors diversity of perspectives and culture among all team members.

IV. MODELS AND APPROACHES FOR TEAM MEETINGS

Team members may communicate with one another or with the whole team in various ways, such as phone calls, conference calls, and/or emails (following child welfare services confidentiality standards, HIPPA, PHI and Public Information standards). In order for teams to operate efficiently and effectively, they also need to meet together in person on a regular basis to enhance engagement, build familiarity and trust, integrate their work, develop service plans, monitor results, create accountability and deal with changing situations and transitions. When team members meet, meetings should be structured so that they are both effective and efficient, demonstrating respect for the participants.

It is important to distinguish between CFTs, which are people, and CFT meetings, which are the vehicles the CFT uses to communicate and coordinate their work.

The composition, meeting frequency, and/or use of a specially trained facilitator for meetings should be based upon the youth and family's needs. For example, Katie A. subclass members, by definition, have more intensive needs and challenges and presumably need more structured, formal and facilitated team meetings. Children and families with less complex needs may have more informal team meetings.

Team membership is dynamic and flexible. A specially trained facilitator may not always be required to lead team meetings. At a minimum, youth and families involved with both child welfare and mental health should have the child welfare worker, their mental health service provider

and whatever family and/or other community supports the youth and family identify on their CFT. Depending on the level of complexity of the child and family's needs, the team may not meet frequently and/or may come together only around special tasks. All team members may not need to be present in person at all meetings, but the "working together" aspect of teaming, with the focus on partnership with the youth and family team members should always be evident in real time and in the documentation of service.

The CFT may choose to use specific approaches for team meetings, such as Team Decision Making, Family Group Decision Making or a Wraparound team process.⁸ Some counties currently use several or all of these structured types of team meetings to make decisions, join with families and create case plans. Some or all of these may be appropriate frameworks to be used by the CFT. In all instances, however, the key factors in determining how formal and frequent a team meeting process or structure is used should be based upon the youth and family's needs and desires.

D. TRAUMA-INFORMED PRACTICE

In any given year, over 30,000 children come into the care of California's Child Welfare System.⁹ Most are victims of abuse or neglect and live with caregivers who are impaired, and/or deal with school and community violence as a fact of life. In addition, many of the families that come to the attention of the child welfare system have experienced multigenerational or historical trauma—collective emotional and psychological injury both over the individual lifespan and across generations, resulting from massive group trauma experiences. Identifying these traumas, preventing further trauma and providing interventions are crucial to assisting children traumatized by maltreatment and other stressors.

Understanding the impact of trauma on individuals is essential in meeting the needs of children, youth and their families in the child welfare system and therefore it is foundational to the implementation of the CPM. Trauma experiences affect brain function, the attainment of developmental milestones, social perceptions and relationships, health, emotion and behavior.

The Chadwick Trauma-Informed Systems Project (CTISP) defines a trauma-informed system as "one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and

⁸ Brief descriptions of these approaches are given in the glossary, with links to places where more in-depth information is available.

⁹ Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Yee, H., Hightower, L., Lou, C., Peng, C., King, B., & Henry, C. (2012). *Child welfare services reports for California*. The University of California at Berkeley Center for Social Services Research. Retrieved December 11, 2012, from http://cssr.berkeley.edu/ucb_childwelfare.

skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.”¹⁰

Trauma-informed practice focuses upon what has happened to a child and his/her family rather than what is wrong with that child or family. It means using knowledge of trauma and recovery to design and deliver services.

The National Child Traumatic Stress Network Child Welfare Committee has defined the following essential elements of trauma-informed practice:

- Maximize physical and psychological safety for children and families
- Identify trauma-related needs of children and families
- Enhance child well-being and resilience
- Enhance family well-being and resilience
- Partner with youth and families
- Enhance the well-being and resilience of those working in the system
- Partner with child-serving agencies and systems¹¹

E. PRACTICE COMPONENTS, STANDARDS AND ACTIVITIES

The CPM has five key practice components. The practice components are the basic activities of collaborative work with children, youth and families involved with child welfare and mental health. They are:

- Engagement
- Assessment
- Service planning and implementation
- Monitoring and adapting
- Transition

The first step in implementing the CPM values, principles and core components is to identify standards of practice and activities for each of the core components. The standards of practice describe the ways in which child welfare and mental health are expected to work together as part of a team with children, youth and families who are involved with both the child welfare and mental health systems. The practice activities described provide guidance to frontline staff and service providers about how to implement practice standards effectively. Together, they reflect the CPM values and principles.

This guide is an initial attempt to articulate CPM standards of practice and practice activities. As noted earlier, additional standards and activities will be added and revisions to those described in this document will occur as training materials are developed and counties get involved in the process of implementing the CPM in their local jurisdictions. The initial standards and activities

¹⁰ Chadwick Trauma-Informed Systems Project. (2012). Creating trauma-informed child welfare systems: A guide for administrators (1st ed.). San Diego, CA: Chadwick Center for Children and Families, 11.

¹¹ Chadwick, 49.

are drawn from practices and initiatives that have been developed with broad stakeholder and family and youth input. As noted earlier, these standards of practice and activities are consistent with the values, principles and practices embodied within the California Partnership for Permanency (CAPP), the Mental Health Services Act (MHSA), Full Service Partnerships (FSP), California Wraparound Program (Wraparound), and Children’s System of Care (CSOC).

I. ENGAGEMENT

Engaging families is the foundation of building trusting and mutually beneficial relationships.

It is also a critical characteristic relating to mental health treatment success. Family engagement is a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, and achieving desired outcomes. It is founded on the principle of respect—communicating openly and honestly with families in a way that supports disclosure of preferences, family dynamics and culture, and individual experiences, so that the individual needs of every family and child can be met. The goal is to ensure that the children and families are active and influential participants in identifying their needs, and finding solutions to their unique and very personal issues and concerns.

It is important to recognize how challenging the engagement process can be, particularly among minority cultures and families dealing with serious mental illness and/or substance use disorder. The historical impact of racism and historical trauma within groups such as African-Americans and American Indians is still deeply felt in our current society. Trauma resulting from these experiences continues and is transmitted through intergenerational transfer of traumatic responses. Parents traumatized as children may pass on trauma response patterns to their offspring. Parents with serious mental illness and/or substance use disorder may have overwhelming fears about interacting with the legal system and government agencies. When a family’s mistrust interacts with the mistrust, cultural misunderstanding or bias of a service provider,

constructive engagement is severely hampered. Current practice improvement initiatives such as FSPs, Wraparound and CAPP have developed training materials which can aid workers to successfully engage with child welfare youth and families.

Not every child or youth will need mental health services at the beginning of his or her involvement with child welfare services. However, child welfare social workers need to determine with the family when to bring in mental health services when it appears through screening or other means that mental health assistance may be appropriate. Similarly, some children and families who are getting mental health services may enter the child welfare system. Once both child welfare and mental health become jointly involved, they become members of the CFT and an integrated part of the ongoing process of engagement.

At every point in a child and family's involvement with child welfare and mental health—whether it is the initial contact; the initial assessment process, service planning, monitoring, or transition—successfully engaging everyone involved is a key ingredient for promoting positive outcomes.

For this reason, not only are specific standards and activities included for engagement, but engagement activities are included within other core elements as well.

Standards of Practice for Engagement

- Engagement begins with the initial contact and is continuous throughout the time of the family's involvement with the child welfare and mental health systems.

- Engagement seeks out, invites in, values and makes central the power, perspectives, abilities and solutions of youth and families and their supportive communities/tribes in every aspect of practice.
- Engagement is based on honest, respectful and ongoing communication among everyone involved in the process.
- Engagement includes using approaches that are sensitive to and responsive to cultural differences.
- Engagement acknowledges the impact trauma has had and continues to have on youth and families.
- Engagement supports hope, healing and recovery throughout the child and family's involvement with the system.

The following activities are recommended in order to promote and enhance the engagement process:

Practice Activities for Engagement

- Be diligent in reaching out to children and families in ways that are welcoming, appropriate and comfortable for them.
- Listening to the family's description of life experience.
- Model honest and respectful communication. Use language and body language that demonstrates a non-judgmental approach to understanding the family's situation.
- Be open and honest about mandated reporting requirements, the role of child welfare and mental health and regulations and choices about sharing of information among team members.
- Recognize and acknowledge the effects of trauma in the lives of these children and families.
- Ensure that the child and family receive needed information, preparation, guidance, and support during their involvement with the child welfare and/or mental health systems.

- Communicate regularly with CFT members and make sure each team member has the information s/he needs to make informed decisions.
- Create an atmosphere of hope, promote healing and recovery in all interactions with children and families and share a commitment to the positive power of change and choice.
- Encourage and support the participation of children and families in defining and/or determining their individual treatment and services. Ensure that they understand what is and is not in their control.

II. ASSESSMENT

Assessment is a continuous process. The initial child welfare assessment should be comprehensive enough to obtain information about the relevant events and behaviors that brought the children and families into services, and their underlying needs. This discovery process helps children and families identify issues that affect the safety, permanency and/or well-being of children; helps children and families recognize and promote strengths they can use to resolve issues; determines the child and family's abilities to complete tasks and achieve goals; and ascertains a family's ability to seek and utilize resources that will support them as they resolve their issues. Assessing also includes determining the capability, willingness and availability of resources for achieving safety, permanence, and well-being of children.

In the CPM, the term "assessment" includes both the assessment activities that are done by child welfare, which include screening for mental health needs, and the more formal mental health assessment that is done by a mental health professional.

Children and families may enter the child welfare system and/or the mental health system in different ways and at different times. If the initial contact with either system begins with child welfare, the child welfare worker will ensure that a mental health screen is done. If the child is already in the mental health system and is entering the child welfare system, the mental health service provider may be the person to initiate the coordination between the two systems. Or, if the child welfare worker learns about the child/family's mental health involvement during the child welfare intake process, he or she

may make the initial contact with the mental health service provider.

The CPM includes a practice standard of screening for mental health needs every child/youth who enters the child welfare system.¹² A mental health screening is a brief assessment for identifying individuals who may have needs for mental health services. Screening instruments are available which have been designed to be used by non-mental health professionals. It is important to emphasize that this type of screening only indicates the possible need for a more in-depth mental health assessment done by a mental health professional. By itself a screen does not determine either the actual need for mental health services or the kinds of services that may be needed.

A mental health assessment is a more comprehensive assessment done by a mental health professional and is tied to the mental health care plan. It provides a more in-depth evaluation of underlying needs and mental health concerns, as well as a broad assessment of psychosocial risk factors related to a child's environment. It should include a trauma assessment component, as well as a clinical assessment of current functioning.

The process from screening to assessment for mental health needs to actually getting services when needed will vary from county to county. Counties should make this process as efficient, integrated and seamless as possible, minimizing the time it takes and number of individuals a family has to meet.

Technical support will be made available to assist counties with this responsibility.

Standards of Practice for Both Assessments

- All children and youth involved with the child welfare system will receive comprehensive strength/needs-based assessments, including screening for trauma exposure and mental health service needs.
- If the child/family is not already involved with mental health, when a mental health assessment is needed, it will be an integrated part of the full assessment process and coordinated with mental health through the child welfare worker and/or the CFT.
- The mental health assessment will be comprehensive, assess underlying needs, be strength based and trauma informed.
- The mental health assessment will assess both youth and family strengths and underlying needs, in order to effectively match services and supports to these needs.

¹² A child with an open child welfare case is defined as any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which emergency response referrals are only made.

Practice Activities for Assessment

- Child welfare is responsible for seeing that a mental health screening tool is completed for all children in open cases¹³ at intake and at least annually. If the child welfare worker determines that there is a potential mental health crisis, he or she makes an immediate and urgent referral to mental health.
- When the referral to mental health indicates a potential mental health crisis, the mental health department will evaluate as follows:
 - If it is determined that a W&I Code 5150 assessment is necessary, mental health will inform the legal guardian, and arrange for the assessment to occur.
 - If mental health determines that the safety concern does not meet the level of a W&I Code 5150, the mental health staff will meet with the child, family, caregiver and child welfare worker to stabilize and develop a safety plan for the immediate concern.
- When the child welfare worker and/or the results of a mental health screening or other team decision indicate the need for a non-emergent mental health assessment, the child welfare worker, the child and family and other team members as appropriate decide on the best way to approach initial contact with mental health.
- As part of the mental health assessment, the mental health worker should again engage the youth (when appropriate) and/or family in a discussion about the CPM team approach, confidentiality, privacy, mandated reporting and releases of information. When the mental health

assessment is completed, the mental health worker communicates the results of the assessment to the child and family. This includes reviewing with the child and family what part of the assessment, if any, must be shared with child welfare and which parts the family may choose to share. Although the decision to share the latter information ultimately rests with the family, the mental health worker engages the family around understanding the CPM team approach and the positive aspects that sharing this information with the child welfare worker and/or members of their CFT will have in helping to achieve the youth and family's desired outcomes.

- When the child is already known to have a mental health service provider, the child welfare worker works with the family and their team to obtain the necessary releases and permissions before contacting the service provider. As with the assessment, the mental health service provider also works with the family around the importance of giving permission to coordinate their mental health services with the child welfare worker and other team members.
- Assessments by child welfare and mental health include
 - Explaining the assessment process to the youth and family at the outset so they know what to expect
 - Engaging the child and family in communicating their experiences and identifying their strengths and needs

¹³ A child with an open child welfare case is defined as any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which emergency response referrals are only made.

- Giving the youth and family choices so that they can feel some control over the process (i.e., asking them if they would like to start with strengths or concerns.)
- Listening actively to the family's story, acknowledging and validating feelings of grief and loss and reflecting and reaffirming what was heard;
- Promoting self-advocacy by encouraging, supporting and providing opportunities for youth and families to actively share perspectives and goals, offer solutions, act as leaders, and be central in the assessment, planning and decisions about their own lives.
- Assessing the child and family's underlying needs. Although symptoms and functional impairments are used to establish a mental health diagnosis, services should be related to the needs underlying the symptoms and behaviors.
- Assessing the child, youth and family strengths. It is important for the team to identify strengths in functional terms that can support the success of the family in completion of their plan. For example, rather than creating a list of descriptive words and phrases – "Father is proud, independent, and has a great sense of humor," you might elaborate on each of these: "Father is proud of and knowledgeable about his Mexican heritage and talks about it with his children." "Father owns his own contracting business." "Father can really cheer up other family members when they are feeling down."

III. SERVICE PLANNING AND IMPLEMENTATION

Service planning involves creating and tailoring plans to build on the strengths and protective capacities of the youth and family members, in order to meet the individual needs for each child and family.

Strength-based individualized plans specify the goals, objectives, roles, strategies, resources and timeframes for coordinated implementation of supports and services for the child, family and caregivers.

Service planning and implementation include the design of incremental steps that move children and families from where they are to a better level of functioning. The plan should be flexible and respond to the child and family's issues and current needs. Service planning and implementation is part of the team's planning cycle of assessing circumstances and resources, making decisions on directions to take, encouraging and monitoring fidelity to the plan, evaluating the effectiveness of the plan, addressing consequences in response to lack of improvement, reworking the plan as needed, and celebrating successes.

Standards of Practice for Service Planning and Implementation

- Service planning occurs within the context of the CFT.
- Plans, services, and supports will be strength based, needs driven, and individualized.
- Plans are culturally responsive and trauma-informed.
- Plans will identify roles and responsibilities, and timeframes for accomplishing goals.

- There will be a single cross-systems planning process that coordinates all individual agency/ service provider/community/tribal partner plans.
- All individual plans need to be complimentary, consistent and coordinated, with steps toward goals and tasks prioritized by the team so the family is not pulled in different directions.
- Services and supports, both formal and informal, will be provided in the most appropriate and least restrictive settings within the community with family voice and choice being the primary factor in making decisions in intervention strategies.

Practice Activities for Service Planning and Implementation

- Child welfare and mental health staff engage the child and family in identifying their support team members who may include both formal/paid supports such as parent partners, health professionals, teachers, etc. and informal/natural supports such as relatives, friends, faith-based support persons, tribal support members, etc.
- Team members create shared agreement on critical areas:
 - Safety issues to be addressed
 - Culturally sensitive services, supports, practices, traditions and visitation plan that will address trauma, loss, behavioral health, drug/alcohol recovery, child safety, child and family well-being
 - Other needs identified by the family and their team, building on the strengths, resources, and perspectives of families and their supportive communities and/or tribes.
- The team works continuously to identify, locate, develop, identify funding for, advocate for, link the family to and support the use of the agreed-upon practices, services and supports.
- Team members design, tailor and implement a customized set of strategies, supports and services based on the child and family's expressed and underlying needs, and are clear about each member's roles and responsibilities related to the services/supports plan.
- When referrals are made to persons or services outside of existing team members, a person on the team must be designated to follow-up with that referral until a firm linkage is created with the family and the team.
- When formal mental health services are appropriate, mental health staff work with the child, family and other team members to determine the type, frequency and duration of mental health services that are needed.
- Team members identify and offer trauma-informed services.
- Team members identify, build on, and enhance the capabilities, knowledge, skills and assets of the child, youth, family, their community and/or tribes, and other team members.

Team members strive for consensus, but recognize that differences and conflicts will occur and will need to be dealt with productively.

IV. MONITORING AND ADAPTING

Monitoring and adapting are part of the practice of continually monitoring and evaluating the effectiveness of the plan while assessing current circumstances and resources. It is the part of the planning cycle where the plan is reworked as needed. ***It is noted that child welfare will have to overcome the obstacle presented by case plans being incorporated into court orders, making it more difficult to revise the child and family plan times as circumstances change. Plans should clearly reflect current family needs and circumstances, a principle which is often at odds with the practice in child welfare of amending the plans every six months.***

Standards of Practice for Monitoring and Adapting

- Monitoring and adapting the plan is a responsibility shared among all team members.
- Monitoring includes on-going assessment for further trauma exposure which may impact the child and family's progress.
- The CFT identifies and ties goals and interventions to observable or measurable indicators of success, continually revisits progress on tasks and goals, and revises the plan accordingly.

Practice Activities for Monitoring and Adapting

- Team members focus on positives – things that the youth and family are doing and can do to move toward achieving their goals, rather than what they are doing that is not productive.
- The team actively engages and encourages the family members to express their views about how they see their progress toward their identified goals.

Team members work together at times of transition (i.e. from one placement to another or one type of mental health service to another) to ensure that these transitions go smoothly and are understood by all team members.

- The team routinely measures and evaluates child and family status, intervention process, progress and problems, and change results.
- Teams celebrate milestones achieved by the child, youth and family as they progress toward their identified goals.
- Teams maintain appropriate documentation of goals, action steps and indicators of progress in order to aid the continuous improvement planning process, and designate a person or persons responsible for this documentation as a whole.
- Team members persist in working toward their goals, despite challenges, until the team reaches agreement that the goals have been achieved or are no longer appropriate.

V. TRANSITION

Transition is the process of moving from formal supports and services to informal supports, when intervention by the formal systems is no longer needed. The successful transition away from formal supports can occur when informal supports are in place, and the support and activities needed to ensure long-term stability are being provided.

For transition to be successful, careful planning and preparation is required, starting early in the child and family's involvement with the system.

Children and families who are involved with both mental health and child welfare, may not exit both systems at the same time. Transition plans may vary, depending on whether the family is exiting both systems or just one of them.

Standards of Practice

- Transition planning begins with the child and family's first involvement with child welfare.
- Transition plans must reflect the child and family's voices and choices and must ultimately delineate action plans that they have identified as working for them.
- The importance of the family support team continuing beyond the time of child welfare and/or mental health involvement is emphasized from the beginning process of engagement.

Practice Activities

- The team acknowledges that team members may change as the family nears transition out of one or both systems, with the addition of more community/tribal support team members and the loss of formal members from child welfare, mental health and possibly agency-linked providers.
- The team ensures that youth and family members are actively engaged in voicing their needs during transition planning and implementation.

Before the family's involvement with the child welfare and/or mental health systems end, team members reach a shared understanding and agreement on team member roles and commitments in maintaining a post-permanency circle of support for the child and family.

- The team identifies a person or persons who are aware of agency supports and services in both child welfare and mental health, who will act as an ongoing liaison and advocate for the family team when contacted about system supports and the services the child and family may need.
- The transition plan should be documented, with copies available to all team members.

Appendix B is a Practice Standards and Activities Matrix that illustrates "at a glance" the integrated standards of practices and activities for each core component.

F. SERVICES

I. GENERAL ARRAY OF SERVICES

Services are the specific individualized activities and interactions between providers and youth and families that are designed to improve the likelihood of achieving positive outcomes.

An effective practice model encompasses an array of services that generally includes culturally responsive and trauma-informed or trauma-responsive, evidence-based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.

They may be provided, by child welfare workers, by mental health providers, by community providers and/or by other community/tribal partners. Services should be provided in a timely manner and provided consistent with the service plan that is matched to the underlying needs identified in the assessment process and should be individualized and dynamic, changing in response to the changing needs of the child and family.

II. SPECIFIC SERVICES FOR KATIE A. SUBCLASS MEMBERS

Three specific services shall be provided to children/youth with more intensive needs, Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC). These services must be implemented within the context of the CPM. The ICC and IHBS services are defined in the Medi-Cal Documentation Manual for the Subclass members as follows:

Intensive care coordination (ICC) is a targeted case management (TCM) service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of Katie A. Subclass. An ICC coordinator serves as the single point of accountability to:

- Ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the child/youth.
- Facilitate a collaborative relationship among the child/youth, his/her family and involved child-serving systems.
- Support the parent/caregiver in meeting their child/youth's needs.
- Help establish the CFT and provide ongoing support.
- Organize and match care across providers and child serving systems to allow the child/youth to be served in his/her home community.

Intensive home-based mental health services (IHBS) are mental health rehabilitation services provided to members of the Katie A. Subclass. IHBS are individualized, strength-based interventions designed

to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family ability to help

the child/youth successfully function in the home and community.

The third service, Therapeutic Foster Care, will be added later.



CHAPTER 3: IMPLEMENTING THE CORE PRACTICE MODEL

The first part of this guide defines the CPM and the standards of practice that describe what is expected when working with children, youth and their families involved with multiple systems, specifically, in this instance, child welfare and mental health.

This section of the guide addresses how to support the development and delivery of a service structure that will ensure that the CPM is implemented and supported in California counties as it is intended—that is, with fidelity to the model.

It has been well documented that over the years California has had effective practices, programs and services that have not been effectively implemented. Or, if they have been effectively implemented on a small scale, when organizations try to replicate them, the programs are not sufficiently supported or they are changed in some ways to “fit the system,” with the result that they are either not successful or not sustained.

Recent research in the field of implementation science has shown that it takes both effective practice and effective implementation to achieve positive outcomes.

For this reason, implementation activities related to the CPM will be based upon the principles of implementation science. Specific information about implementation science is included in the References Section, which follows this chapter.

A. SERVICES

Implementation science recognizes that implementation does not and cannot occur all at once. Rather, implementation occurs in stages and can take a number of years to complete. Four stages have been identified in the implementation process:

- **Exploration Stage** – This is the stage where information is collected and analyzed to identify the needs, available resources, and potential solutions, and a decision to proceed occurs. With regard to the CPM, this stage began at the state level during the Katie A. negotiation and settlement process and will continue at the local level as counties become more familiar with the CPM and its practices and activities. Each county will undergo its own individual process with regard to implementation of the CPM.
- **Installation Stage** – Staff and systems plan, prepare and organize to build the necessary supports to promote utilization of the intervention. The readiness assessment being developed by CDSS and DHCS will assist counties in determining their level of readiness and the additional structures, policies and activities they need to take in preparing to implement the CPM. This guide and the training and materials that will follow are intended to further assist counties at this stage as well as the Initial Implementation stage below.
- **Initial Implementation Stage** – First implementers are carrying out the new innovation, and teams are monitoring the intervention and implementation supports and making whatever

improvements are necessary. Counties who become part of the initial CPM learning communities will move into the Initial Implementation Stage as they begin implementing and testing the CPM.

- Full Implementation Stage – The majority of staff are using the CPM with fidelity.

At all stages in the process, financial and programmatic sustainability must be considered, planned for and executed.

B. COMPONENTS FOR IMPLEMENTATION

Just as there are key practice components for the practice model, there are also necessary conditions for implementation. Fixsen, et. al. identify these as follows:

Staff selection – Staff selection extends beyond practitioners. Every staff member must be selected to suit his or her role (including practitioners, trainers, coach/consultants, evaluators, and administrators).

For the CPM, it is important that mental health staff working with the child welfare population have specific knowledge of this population.

This goal can best be achieved by having staff dedicated to work with this population, which can be structured in a number of ways.

- Counties may create collaborative child welfare/ mental health units.
- Counties may co-locate mental health and child welfare staff.
- Counties may dedicate certain mental health staff to work with this population.
- Counties may contract with community-based organizations and/or providers to work with this population.
- Counties may combine any or all of the above.

Unless the practitioners who are carrying out the interventions with clients are doing so effectively and with fidelity, the program will not be effective.

Pre-service and In-service Training – When implementing the CPM, all staff need to learn and become familiar with CPM values, principles, key components, practice standards and behaviors. Pre-service and in-service training are efficient ways.

- To provide knowledge of background information, theory, philosophy, and values.
- To introduce the components and rationales of key practices.
- To provide opportunities to practice new skills and receive feedback in a safe training environment.

Child welfare staff, mental health staff and service providers should participate in joint training about the CPM, as well as the standards of practice and activities.

Collaborative training helps to develop collaborative skills and values.

Whenever possible, youth and family members should be part of the training teams.

As noted earlier in this guide, the State is developing training curricula and a plan to facilitate joint training.

Research demonstrates that training, in and of itself, does not result in changes in practitioner behavior or improvement in client outcomes.

Ongoing Consultation and Coaching – Research reveals that most skills needed by successful practitioners can be introduced in training, but really are learned on the job with the help of a consultant/coach.

Training without coaching (or coaching without training) is insufficient to produce actual changes in practice.

Coaching refers to an ongoing professional development process designed to

- Acquire and improve the skills and abilities needed to implement the practice with fidelity, and as intended;
- Move from successfully demonstrating skill in training to demonstrating skill in the real world.

For example, effectively engaging children and families, achieving proficiency in building a CFT and becoming comfortable and effective working within a team environment will require coaching as well as training.

Staff and Program Evaluation – Youth and families will not realize the desired benefits of the CPM unless it is implemented as intended. Evaluation is critical in providing evidence that there is adherence to the model.

- Fidelity assessment is designed to assess the use and outcomes of the skills that are reflected in the selection criteria, are taught in training, and reinforced and expanded in consultation and the coaching process.
- Program evaluation assesses key aspects of the overall performance of the organization to help assure continuing of the CPM components over time.

Facilitative Administrative Support – Facilitative administration provides leadership and makes use of a range of data inputs to inform decision-making, support the overall processes, and keep staff organized and focused on the desired clinical outcomes. Facilitative administration

- Provides support that is proactive, vigorous and enthusiastic in order to reduce implementation barriers and create an administratively hospitable environment for the new practice or model.
- It includes internal policy analyses and decisions, procedural changes, funding allocations and a culture that is focused on “whatever it takes” to implement with fidelity and good outcomes.

Systems Intervention – Systems interventions are strategies to work with external systems to ensure the availability of the financial, organizational, and human resources required to support the work of the practitioners. Examples of systems interventions that will support the CPM include

- The shared management structure described in the Katie A. Settlement that is charged with developing a shared vision and mission statement, policy and program direction, clear and consistent guidance, and outcomes and accountability measures consistent with the CPM.
- The joint development of policies and procedures at both the state and county levels that support the model and provide ways to avoid duplication and resolve conflicts between the involved agencies and service providers.

The key implementation components have been found to be essential to changing the behavior of practitioners and other personnel who are key providers of services and supports within an organization.

The necessary conditions do not exist in a vacuum. They are contained within and supported by an organization that establishes facilitative administrative structures and processes to select, train, coach, and evaluate the performance of practitioners and other key staff members; carries out program evaluation functions to provide guidance for decision-making; and intervenes in external systems to assure ongoing resources and support for the CPM.¹⁴

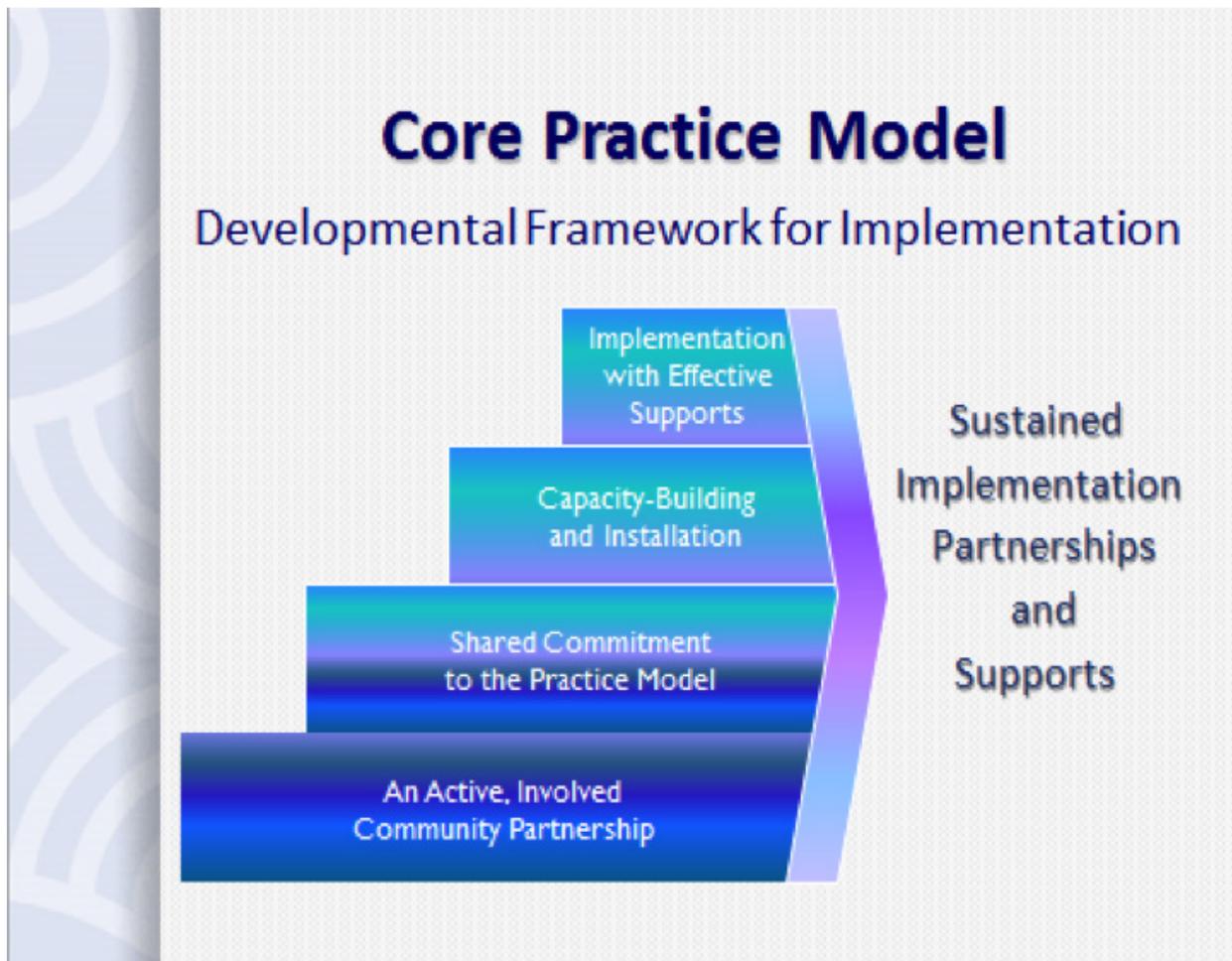
¹⁴ Fixsen, 28-29.

C. DEVELOPMENTAL FRAMEWORK FOR IMPLEMENTATION

Figure 1 illustrates the key building blocks of a suggested developmental framework for implementation.

As noted earlier in this guide - the CPM is more than replicating a program; it is about changing the way one works, from working with children and families in an individual system or agency to working within a team environment in order to build a culturally relevant and trauma-informed system of supports and services that is responsive to the strengths and underlying needs of families.

Figure 1: Implementation Building Blocks



With an active, involved community and local commitment with capacity and support for implementation, local child welfare and mental health organizations, providers and systems work in concert to address systemic barriers, support quality practices and positively impact outcomes for children and families.

An Active, Involved Community Partnership

Local child welfare and mental health agencies, organizations, leaders, service providers and partners demonstrate commitment to community partnerships that respect and incorporate the unique contributions of communities and tribes. These partnerships guide ongoing local practice and system changes. The following are suggested partnership activities:

- Community meetings, forums and listening sessions to learn about and begin to address historical trauma and mistrust of agencies and systems.
- Working with community and tribal partners to conduct a systems analysis to identify system barriers to improved outcomes for children and families and to implement action plans to address those barriers.¹⁵
- Collaborating with community and tribal partners to establish culturally relevant and trauma-informed services to meet the underlying needs of children and their families.
- Meaningfully involving community and tribal partners in training, coaching and ongoing system supports for effective, sustained implementation of the CPM.
- Ensuring that partnership meetings, forums and feedback loops are sustained so that community and tribal partners are continuously connected to,

and help guide, ongoing child welfare and mental health practice and system changes, to achieve improved outcomes for children and their families.

Shared Commitment to the Practice Model

There is shared commitment by local child welfare and mental health agencies, organizations, leaders, service providers and partners to

- Adopt the CPM as the central framework for coordinated practice and service delivery for children, youth and families being served jointly by child welfare and mental health.
- Work together continuously to:
 - Develop internal and external communication and feedback loops to coordinate and support implementation of the CPM.
 - Align all parts of the system to support the practice and system changes reflected in the CPM. Identify, develop and support use of a broad, culturally relevant and trauma-informed service array responsive to the underlying needs of local children and their families.
 - Dedicate staffing resources to form local Implementation Teams and employ Implementation Science to “drive” successful implementation and support of the CPM locally. Local implementation teams are comprised of individuals both outside and within the organization or system (in this case child welfare and mental health) with the knowledge, skill, freedom, and authority to act. They should include community members who have or have had experience with child welfare and mental health, and other community/tribal partners/stakeholders.

¹⁵ CAPP has developed an “Institutional Analysis” process that engages youth, families and community partners. More information about this is available on the CAPP website:

<http://www.reduceFostercarenow.org/>

Capacity-Building and Installation

Local Implementation Teams work with staff, supervisors, trainers, coaches, agency and community partners, administration and leadership to

- Educate, prepare and meaningfully involve staff and partners in implementation planning, cross-system coordination, capacity-building, and readiness activities.
- Adapt or enhance the CPM training and coaching curricula and service delivery plans in partnership with community and tribal partners to support practice model integration and implementation, building on local strengths, resources, strategic direction and needs.
- Train and prepare practitioners' supervisors, and others identified to act as internal and external coaches, in
 - Practice Model mastery – building fluency in applying the Practice Model in the context of families, communities, and tribes, as well as within child welfare and mental health agencies, provider organizations and systems;
 - Behaviorally Focused Coaching – understanding the coach's role in building skills in using the Practice Model and in supporting system alignment, implementation and fidelity use of the practice model;
 - Strategies for incorporating coaching into supervision (for supervisors).

Effective, Sustained Implementation Support

Community and tribal partners are connected to and support implementation in meaningful ways, such as acting as key advisors, playing roles in training or coaching, or acting as members of Implementation or Fidelity Assessment Teams, etc.

Local Implementation Teams carry ongoing responsibility for the day-to-day management and coordination of all activities that support, assess and improve implementation of the CPM, including

- Participating in internal and external communication and feedback loops to ensure ongoing coordination and support for implementation of the Practice Model.
- Ensuring that all staff and partners who have been trained in and are implementing the Practice Model receive ongoing behaviorally focused coaching to support high-fidelity use of the Practice Model.
- Ensuring that fidelity to the model is assessed for each practitioner every 6 to 12 months and the results are used continually to improve training, coaching and system support for the Practice Model, as well as to assure that practice remains consistent and effective over time.

Each building block in this developmental framework supports the others, creating a firm foundation and an enriched environment for the successful implementation of the CPM. This process takes time, patience and the ability to adapt and adjust as the implementation evolves and takes hold in organizations and communities.

REFERENCES

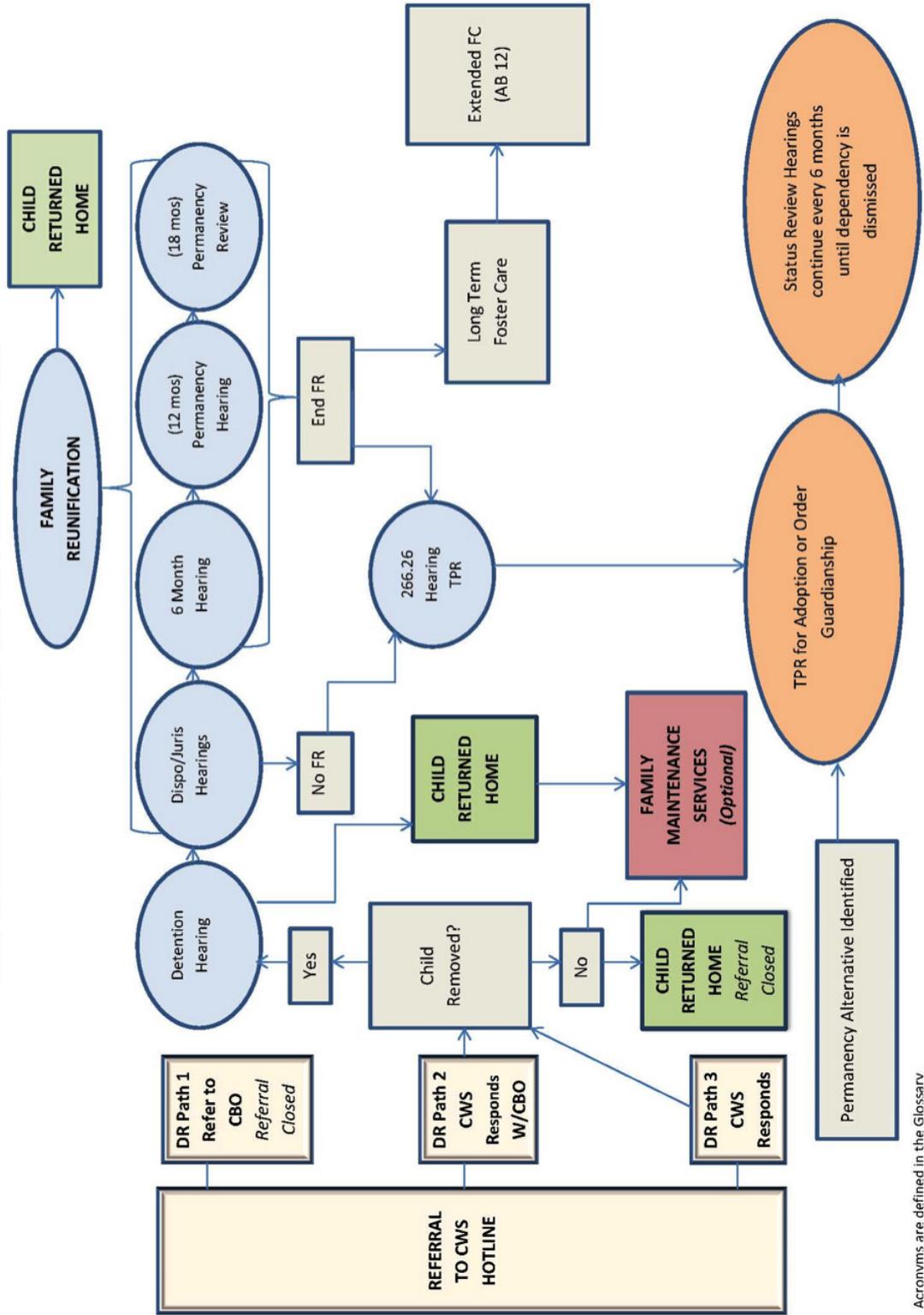
- Bell, L. (2001). Patterns of interaction in multidisciplinary child protection teams in New Jersey. *Child Abuse and Neglect*, 25, 65-80.
- Berzin, S. C., Thomas, K. L., & Cohne, E. (2007). Assessing model fidelity in two family group decision-making programs: Is this child welfare intervention being implemented as intended? *Journal of Social Service Research*, 34, 55-71.
- Borkan, J. M., et al. (2008). Towards cultural humility in healthcare for culturally diverse Rhode Island. *Medicine and Health: Rhode Island*, 91(12).
- California Health Advocates. (2007, April). *Are You Practicing Cultural Humility?—The Key to Success in Cultural Competence*.
- California Institute for Mental Health. (2012). *Full Service Partnership Tool Kit, Child, Youth, Family, Cultural Relevance*.
- California Partners for Permanency. www.reducefostercarenow.org
- Chadwick Trauma-Informed Systems Project. (2012). *Creating trauma-informed child welfare systems: A guide for administrators* (1st ed.). San Diego, CA: Chadwick Center for Children and Families.
- Children and Family Futures. (2011). *The collaborative practice model for family recovery, safety and stability*. Irvine, CA: Author.
- Crampton, D. S. (2003). Family group decision making in Kent County, Michigan: The family and community impact. *Protecting Children*, 18, 81-83.
- Crampton, D., & Jackson, W. L. (2007). Family group decision making and disproportionality in foster care: A case study. *Child Welfare*, 86, 51-69.
- Epstein, M. H., Nordness, P. D., Kutash, K., Duchowski, A., Schrepf, S., Benner, G. J., & Nelson, J. R. (2003). Assessing the wraparound process during family planning meetings. *The Journal of Behavioral Health Services & Research*, 30, 352-362.
- Fixsen, D. L., Naomi, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).
- Israel, Nathan., *CANS Engagement Competencies by Program: A Process Document*. Office of Quality Management for Community Programs, San Francisco Department of Public Health, March, 2012
- Keast, R., & Mandell, M. (2009). *Why collaborate and why now?* Australian Research Alliance for Children and Youth.
- Miller, S. (2009). Cultural humility is the first step to becoming global care providers. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 38(1), 92-93.
- Pennel, J., Edwards, M., & Burford, G. (2010). Expedited family group engagement and child permanency. *Children and Youth Services Review*, 32, 1012-1019.

- Snyder, E., Lawrence, C. N., & Dodge, K. (2012). The impact of system of care support in adherence to wraparound principles in child and family teams in child welfare in North Carolina. *Child and Youth Services Review*, 34, 639-647.
- Stark, D. (1999). *Strategies from six communities engaged in collaborative efforts among families, child welfare, and children's mental health*. Washington, DC: Georgetown Child Development Center, National Technical Assistance Center for Children's Mental Health.
- Vincent, P. (2011, July). Understanding underlying needs. *The Child Welfare Policy and Practice Group Newsletter*, 1(1).
- Walker, J. S., & Bruns, E. J. (2008). *Phases and activities of the wraparound process: Building agreement about a practice model*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.
- Walker, J. S., Bruns, E. J., VanDenBerg, J. D., Rast, J., Osher, T. W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group. (2004). *Phases and activities of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.



APPENDIX A

CALIFORNIA CHILD WELFARE SYSTEM



Acronyms are defined in the Glossary

APPENDIX B

PRACTICE STANDARDS AND ACTIVITIES MATRIX

Core Practice Components	Standards of Practice	Practice Activities
Engagement	<ul style="list-style-type: none"> • Engagement begins with the initial contact and is continuous throughout the time of the family’s involvement with the child welfare and mental health systems. • Engagement seeks out, invites in, values and makes central the power, perspectives, abilities and solutions of youth and families and their supportive communities/tribes in every aspect of practice. • Engagement is based upon honest, respectful and ongoing communication among everyone involved in the process. • Engagement includes using approaches that are sensitive to and responsive to cultural differences. • Engagement acknowledges the impact trauma has had and continues to have on youth and families. • Engagement supports hope, healing and recovery throughout the child and family’s involvement with the system. 	<ul style="list-style-type: none"> • Be diligent in reaching out to children and families in ways that are welcoming, appropriate and comfortable for them. • Listen to the family’s description of life experiences. • Model honest and respectful communication. • Be open and honest about mandated reporting requirements, the role of mental health and the sharing of information among team members. • Recognize and acknowledge the effects of trauma in the lives of children and families. • Ensure that the child and family receive needed information, preparation, guidance and support. • Communicate regularly with team members and make sure the team has the information it needs to make informed decisions. • Create an atmosphere of hope, healing and recovery. • Encourage and support the participation of children and families in determining their individual and ongoing treatment and services.

Core Practice Components	Standards of Practice	Practice Activities
<p>Assessment</p>	<ul style="list-style-type: none"> • Children and youth involved with the child welfare system will receive comprehensive, strength-based and trauma-informed assessments, including assessment of their mental health needs. • If a child/family is not already involved with mental health, when needed, a mental health assessment will be an integrated part of the full assessment process and coordinated with mental health through the child welfare worker and the CFT. • The mental health assessment will be comprehensive, assess underlying needs, and be strength based and trauma informed. • The mental health assessment will assess both child and family strengths and underlying needs, in order to effectively match services and supports to these needs. • Team members may communicate with one another or with the whole team in various ways, such as phone calls, conference calls, and/or emails (following child welfare services confidentiality standards, HIPPA, PHI and Public Information standards). 	<ul style="list-style-type: none"> • Child welfare is responsible for seeing that a mental health screening tool is completed for all children in open cases at intake and at least annually. If the child welfare worker determines that there is a potential mental health crisis, he or she makes an immediate and urgent referral to mental health. • When the referral to mental health indicates a potential mental health crisis, the mental health department will evaluate as follows: <ul style="list-style-type: none"> ■ If it is determined that a W&I Code 5150 assessment is necessary, mental health will inform the legal guardian, and arrange for the assessment to occur. ■ If mental health determines that the safety concern does not meet the level of a W&I Code 5150, the mental health staff will meet with the child, family, caregiver and child welfare worker to stabilize and develop a safety plan for the immediate concern.

Core Practice Components	Standards of Practice	Practice Activities
<p><i>Assessment continued</i></p>		<ul style="list-style-type: none"> • When the child welfare worker and/or the results of a mental health screening or other team decision indicate the need for a non-emergent mental health assessment, the child welfare worker, the child and family and other team members as appropriate decide on the best way to approach initial contact with mental health. • As part of the mental health assessment, the mental health worker should again engage the youth (when appropriate) and/or family in a discussion about the CPM team approach, confidentiality, privacy, mandated reporting and releases of information. • When the mental health assessment is completed, the mental health worker communicates the results of the assessment to the child and family and discusses the pros and cons of sharing information with other team members.

Core Practice Components	Standards of Practice	Practice Activities
<p><i>Assessment continued</i></p>		<ul style="list-style-type: none"> • Assessments by child welfare and mental health include <ul style="list-style-type: none"> ■ Explaining the assessment process to the youth and family at the outset so they know what to expect. ■ Engaging the child and family in communicating their experiences and identifying their strengths and needs. ■ Giving the youth and family choices so that they can feel some control over the process (i.e., asking them if they would like to start with strengths or concerns). ■ Listening actively to the family's story, acknowledging and validating feelings of grief and loss and reflecting and reaffirming what was heard. ■ Promoting self-advocacy by encouraging, supporting and providing opportunities for youth and families to actively share perspectives and goals, offer solutions, act as leaders, and be central in the assessment, planning and decisions about their own lives. ■ Assessing the child and family's underlying needs. ■ Assessing the child, youth and family strengths. It is important for the team to identify strengths in functional terms that can support the success of the family in completion of their plan.

Core Practice Components	Standards of Practice	Practice Activities
<p>Service Planning and Implementation</p>	<ul style="list-style-type: none"> • Service planning occurs within the context of a CFT. • Plans, services and supports will be strength based, needs driven and individualized. • Plans will be culturally competent and trauma-informed. • Plans will identify roles and responsibilities, and timeframes for accomplishing goals. • There will be a single cross-systems planning process which incorporates all individual agency/service provider/community/tribal partner plans. • Individual plans need to be complimentary, consistent and coordinated, with steps toward goals and tasks prioritized by the team so the family is not pulled in different directions. • Service and supports, both formal and informal, will be provided in the most appropriate settings within the community, with family voice and choice being the primary consideration. 	<ul style="list-style-type: none"> • Child welfare and mental health staff engage the child and family in identifying their support team members. • Team members create shared agreement on critical areas including safety, culturally sensitive services and supports and other needs identified by the family and their team. • The team works continuously to identify, locate, develop, identify funding for, advocate for, link the family to and support the use of the agreed-upon practices, services and supports. • Team members design, tailor and implement a customized set of strategies, supports and services based on the child and family's expressed and underlying needs, and are clear about each member's roles and responsibilities related to the services/ supports plan. • When referrals are made to persons or services outside of existing team members, a person on the team must be designated to follow-up with that referral until a firm linkage is created with the family and the team. • When formal mental health services are appropriate, mental health staff works with the child, family and other team members to determine the type, frequency and duration of mental health services that are needed.

Core Practice Components	Standards of Practice	Practice Activities
<p>Service Planning and Implementation <i>continued</i></p>		<ul style="list-style-type: none"> • Team members identify and offer trauma-informed services. • Team members identify, build on, and enhance the capabilities, knowledge, skills and assets of the child, youth, family, their community and/or tribes, and other team members. • Team members strive for consensus, but recognize that differences and conflicts will occur and will need to be dealt with productively.
<p>Monitoring and Adapting</p>	<ul style="list-style-type: none"> • Monitoring and adapting services is a shared responsibility among mental health, child welfare and the youth and family. • Monitoring includes on-going assessment for further trauma exposure. • The CFT identifies and ties goals and interventions to observable, measurable indicators of success, assesses progress, and revises the plan as necessary. 	<ul style="list-style-type: none"> • Focus on positives – things that the youth and family are doing and can do to move toward achieving their goals. • Actively engage and encourage the family to express their views about how they see their progress. Work together at times of transition to ensure that these transitions go smoothly and are understood by all team members. • Routinely measure child and family status, interventions, and change results. • Celebrate milestones achieved by the youth and family. • Maintain appropriate documentation of goals, action steps and indicators of progress, and designate a person or persons responsible for this documentation. • Persist in working toward goals, despite challenges, until and unless the team decides they are no longer appropriate.

Core Practice Components	Standards of Practice	Practice Activities
<p>Transition</p>	<ul style="list-style-type: none"> • Transition planning begins with the family’s first involvement with child welfare. • Transition plans must reflect the child and family’s voices and choices and ultimately delineate action plans that they have identified as working for them. • The importance of the family support team beyond system involvement is emphasized from the beginning process of engagement. 	<ul style="list-style-type: none"> • Acknowledge that team members may change as the family nears transition out of one or both systems, with the addition of community/tribal support team members. • Ensure that youth and family members are actively engaged in voicing their needs during transition planning and implementation. • Reach shared understanding of team members’ roles and commitments in maintaining a post-permanency circle of support for the child and family. • Identify a system navigator as an ongoing liaison and advocate for the family team. • Document the transition plan.

APPENDIX C

GLOSSARY OF ACRONYMS AND TERMS

366.26 – Refers to California Welfare and Institutions Code (W&IC) section 366.26, which specifies the court hearing related to children who are dependents of the juvenile court, and the presumption is that the child is likely to be adopted and family reunification is no longer provided to the parents. The court may make findings and orders to terminate the rights of the parent or parents and order that the child be placed for adoption.

CAPP – California Partners for Permanency (CAPP) is one of six projects in the nation participating in a \$100 million Presidential Initiative to reduce the number of children in long-term foster care. The project's efforts aim to help build a foundation for a statewide movement to improve outcomes for children and youth in foster care by ensuring they have loving and lasting permanent relationships and families.

California Wraparound – Wraparound is an intensive, individualized care planning and services management process. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans and services that are effective and relevant to the child and family.

CBO – A Community-Based Organization (CBO) is a provider within the community that offers concrete services to individuals and families to ameliorate issues and to provide support as needed. Services they offer may include mental health therapy, Wraparound, Therapeutic Behavioral Services, etc.

C-CFSR – The California Child and Family Services Review (C-CFSR) is the Child Welfare Services Outcome and Accountability System, which focuses

primarily on measuring outcomes in the areas of safety, permanency, and child and family well-being. By design, the C-CFSR closely follows the federal emphasis on safety, permanency and well-being. The new system operates on a philosophy of continuous quality improvement, interagency partnerships, community and/or tribal involvement, and public reporting of program outcomes.

CDSS – The California Department of Social Services (CDSS) is the state agency charged with serving, aiding, and protecting needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence.

CPM – The Core Practice Model defines the values, principles, teaming model and standards of practice and activities for all child welfare and mental health agencies, service providers and community/tribal partners working with child welfare children, youth and families.

CPM (CPM/CFT) – The CPM child and family team is the group of people who are involved with and working with the child and family to achieve their goal of successfully transitioning out of the formal child welfare system and achieving positive outcomes of safety, permanency and well being. Individuals working as part of the CFT each have their own roles and responsibilities, but they work together as members of a team. The CPM CFT is an integral part of the Practice Model.

CSOC – Children's System of Care is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access, and expanding the array of coordinated

community-based, culturally and linguistically competent services and supports for children and youth who have a serious emotional disturbance, and for their families.

DHCS – The California Department of Health Care Services is the state agency charged with preserving and improving the health status of all Californians. DHCS works closely with health care professionals, county governments and health plans to provide a health care safety net for California’s low-income and persons with disabilities. Beginning in FY 2012/13, some programs of the Departments of Mental Health, Public Health, Alcohol and Drug Programs and California Medical Assistance Commission became a part of DHCS.

DR – Differential Response is a strategy that allows a California child welfare services (CWS) agency to respond in a more flexible manner to reports of child abuse or neglect. DR affords a customized approach based on an assessment of safety, risk and protective capacity that recognizes each family’s unique strengths and needs, and addresses these in an individualized manner rather than with a “one size fits all” approach. DR has three referral paths, which are assigned by the social worker based on information taken from the initial call or intake report from the CWS hotline.

- Path 1: Community Response, referral is closed in the child welfare system
- Path 2: Child Welfare Services and Agency Partners Response, joint response
- Path 3: Child Welfare Services Response, most similar to the Child Welfare Services traditional response

Dispo/Juris – Disposition and Jurisdiction Hearings are often held together; however, they have separate functions. Jurisdiction Hearings determine

whether or not abuse and neglect allegations are true and if intervention is warranted under W&IC 300. At a Disposition Hearing, the court determines a child’s placement and establishes a service plan.

EPSDT – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need, diagnostic and treatment services are provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additional medically necessary services. These additional services are known as EPSDT Supplemental Services, and include mental health-related diagnostic services and treatment (other than physical health care). These services are available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United State Code, are services that have been determined by the State Department of Health Care Services to meet the criteria of Title 22, Section 51340(e) (3) or (f); and are not otherwise covered as specialty mental health services. EPSDT services include rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication services, crisis intervention, day care intensive, and day care habilitation offered in local and mental health clinics or in the community. EPSDT services include Therapeutic Behavioral Services (TBS) for children/youth with serious emotional challenges, as well as mental health evaluations and services. www.dhcs.ca.gov

EQR – External Quality Review is an independent evaluation conducted by persons or organizations external to the entity, practice or service being reviewed.

FGDM – Family Group Decision Making is a decision-making process to which members of the family group are invited and joined by members of their informal network, community groups and/or tribe, and the child welfare agency that has become involved in the family's life. FGDM acknowledges the rights and abilities of the family group to make sound decisions for and with its children and youth and actively engages the community and/or tribe as a vital support for families.

Foster Care Placement – 24 hour substitute care for all children placed away from their parent(s) or guardian(s) and for whom the State agency has placement and care responsibility. (Section 1355.20 Code of Federal Regulations)

ICC – Intensive Care Coordination is a Medi-Cal-covered service that is responsible for facilitating assessment, care planning and coordination of services, including urgent services for children/youth who meet the Katie A. Subclass criteria. (For additional information please see the Medi-Cal Manual on ICC, IHBS & TFC for Katie A. Subclass Members)

IHBS – Intensive Home-Based Services are individualized, strength-based mental health treatment interventions designed to ameliorate mental health conditions that interfere with a child's functioning. Interventions are aimed at helping the subclass-member-eligible child and their identified support network build and support the skills necessary for successful functioning in the home and community, and improving the child's family's ability to help him/her function successfully.

Integrated Practice Components – Integrated Practice Components are the essential elements of collaborative practice. They provide the overarching framework for what multiple agencies or systems do, based upon and driven by fundamental values and principles.

Implementation Science – Implementation Science is the study of methods to promote the integration of research findings and evidence into policy and practice.

Katie A. Lawsuit – The Katie A. Lawsuit, *Katie A. et al. v. Bonta et al.*, refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011. www.cdss.ca.gov

MHP – A Mental Health Plan is an entity that enters into a contract with the DHCS to provide directly or arrange to pay for specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.

MHSA – The Mental Health Services Act is a voter-approved initiative to develop a comprehensive approach to providing community-based mental health services and supports for California residents. To accomplish its objectives, the MHSA applies a specific portion of its funds to each of six system-building components:

- Community program planning and administration
- Community services and supports
- Capital Facilities (buildings) and information technology

- Workforce Education and training (human resources)
- Prevention and early intervention
- Innovation

None of the funds can substitute for existing fund allocation and all funds have to be put towards expansion or creation of programs and services.

MHSA FSP – The Mental Health Services Act Full Service Partnership is defined in the California Code of Regulations, Title 9, Section 3200.130 as “the collaborative relationship between the County and the client, and when appropriate, the client’s family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.” FSPs provide a “whatever it takes” approach to service delivery.

Open Child Welfare Case – A child with an open child welfare case is defined as any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which emergency response referrals are only made.

Parent Partners/Advocates – Parent Partners/Advocates are key individuals who work with children and families within the public child welfare, juvenile probation or mental health systems. Parent Partners/Advocates are past consumers or caregivers of past consumers and can convey information on how systems and programs can instill the family-centered and family-driven philosophy and principles necessary to engage children, youth and families.

Practice Activities – Practice Activities are the strategies and behaviors that carry out the standards

of practice on a daily basis.

Standards of Practice – Standards of Practice are the guidelines that govern how the workers in an organization function and how they do their work. Integrated standards of practice are the guidelines that govern how systems, organizations, agencies, communities and tribes work together.

SMHS – Specialty Mental Health Services – Per Title 9, Chapter 11, Section 1810.247, means:

- (a) Rehabilitative Mental Health Services, including:
 - (1) Mental health services;
 - (2) Medication support services;
 - (3) Day treatment intensive;
 - (4) Day rehabilitation;
 - (5) Crisis intervention;
 - (6) Crisis stabilization;
 - (7) Adult residential treatment services;
 - (8) Crisis residential treatment services;
 - (9) Psychiatric health facility services;
- (b) Psychiatric Inpatient Hospital Services;
- (c) Targeted Case Management;
- (d) Psychiatrist Services;
- (e) Psychologist Services;
- (f) EPSDT Supplemental Specialty Mental Health Services; and
- (g) Psychiatric Nursing Facility Services.

TCM – Targeted Case Management services are provided as part of a comprehensive specialty mental health services program available to Medi-Cal beneficiaries who meet medical necessity criteria based on the beneficiary’s need for targeted case management established by an assessment and documented in the client plan. Targeted Case Management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, alcohol and drug treatment, social, educational and other services. Targeted Case Management includes a comprehensive assessment and periodic reassessment, development and periodic revision of a client plan, referral and related activities, and monitoring and follow-up activities.

TDM – Team Decision Making is one of four core strategies articulated in the Annie E. Casey Family to Family Initiative. TDM is a process of decision making that involves child welfare workers, foster parents, birth families and community and/or tribal members in all placement decisions to ensure a network of support for children and the adults who care for them.

TFC – Therapeutic Foster Care , also known as Treatment Foster Care, consists of intensive and highly coordinated mental health and support services provided to a foster parent or caregiver in which the foster parent/caregiver becomes an integral part of the child’s treatment team.

WIC – The California Welfare and Institutions Code contains Section 300, which provides the legal basis for juvenile court jurisdiction and authorizes the court to remove children from the care and custody of their parents if it is necessary for their safety.

APPENDIX D

KATIE A. SETTLEMENT BACKGROUND

On July 18, 2002, a lawsuit entitled *Katie A. et al. v. Bonta et al.* was filed seeking declaratory and injunctive relief on behalf of a class of children in California who (1) are in foster care or are at imminent risk of foster care placement, (2) have a mental illness or condition that has been documented or—if an assessment had been conducted—would have been documented, and (3) need individualized mental health services, including, but not limited to, professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

In December, 2011, a settlement agreement was reached in the case. As part of this agreement, the California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) agreed to perform a number of actions, including the development and distribution of this Documentation Manual, with the following objectives:

- To facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery and transition into a coherent and all-inclusive approach, hereinafter referred to as the Core Practice Model or CPM, as defined in Chapter 2.
- To address the need for subclass members with more intensive needs to receive medically necessary mental health services that include Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC). (The descriptions for IHBS and ICC are described fully in Chapter 3, *supra*)
- To clarify and provide guidance on the coverage and documentation requirements under Medi-Cal of IHBS and ICC so that counties and providers can understand these requirements and consistently apply them.

The Katie A. settlement further provides that:

- CDSS and DHCS, in consultation with the joint management taskforce, will develop and endorse practice tools, training curriculum, practice improvement protocols, and quality control systems to support the shared CPM, in order to support service integration and/or coordination of mental health services for class members.
- CDSS and DHCS will develop cross-system training curriculum and educational materials for child welfare and mental health staff.

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Members of the Core Practice Model Subgroup

California Mental Health Directors Association

California Welfare Directors Association

Counties

Parent Partners

Providers

Resource Center for Family-Focused Practice