



Core Practice Model Guide

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**California Department of Social Services
And
California Department of Health Care Services**

Core Practice Model Guide

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Core Practice Model Guide

Chapter One – Introduction and Purpose

The purpose of the Core Practice Model (CPM) Guide is to provide direction to county mental health and child welfare agencies, other service providers, and community/tribal partners in implementing a Core Practice Model for working with children and families involved with child welfare who also have mental health needs, as agreed upon in the Katie A. et al v. Bonta Settlement. The CPM articulates the statewide parameters needed for effective practice to improve and achieve desired outcomes for child welfare children and families within and across systems. This guide is intended to assist leadership and management in mental health and child welfare as they begin to implement this 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 the CPM's integrated child welfare and mental health practice, and developing strategies for implementation of the model. The practice model is based on family-centered principles and values and describes how they will be utilized by child welfare and mental health systems. All counties, agencies and individuals that serve children and their families in both child welfare and mental health will be expected to use this practice model. The CPM focuses on the interaction and collaboration among mental health, child welfare, and children and families involved with the child welfare system who also have mental health needs. It is intended that the guide will improve coordination of resources and services and promote greater uniformity in statewide practices by child welfare, mental health and other service providers.

The CPM represents what we know about best practice and ways of working across systems and in partnership with children and families involved with both child welfare and mental health systems. **It is important to emphasize that this guide is the first step in defining a Core Practice Model. 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 accordance with the CPM.** As called for in the Katie A. settlement agreement, this Guide will be followed by "... practice tools, training curriculum, practice improvement protocols, and quality control systems..." which will further define and support the CPM. In the future, we plan to augment this guide with materials for front-line staff, as well as children, youth and families. **This guide should be viewed as part of a dynamic process which will ultimately result in more effective ways of partnering among child welfare, mental health and children and families to achieve positive outcomes for youth and families who are involved with child welfare and have mental health needs.**

The CPM speaks to what should be done; it does not prescribe who should do it, as that will vary from county to county. Mental health, child welfare and families need to be clear with each other about their individual roles and responsibilities in order to ensure that the practice standards are adhered to. In developing and defining the model it is

also important to recognize the importance of culture and community. The practice standards reflect in-depth input derived from community and tribal partners involved with Children's System of Care (CSOC), the Mental Health Services Act Full Service Partnerships (FSPs), Wraparound Programs (Wraparound) and the California Partners for Permanency (CAPP) initiative. In addition, within the CPM parameters there is room for local flexibility. It is expected 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 CPM Guide is organized in four main sections:

- 1) Chapter One provides background and context, and introduces the concept of an integrated system-wide practice model.
- 2) Chapter Two defines the practice model itself, the values, principles, integrated standards of practice and activities.
- 3) Chapter Three focuses on quality improvement, including outcomes, accountability, and monitoring.
- 4) Chapter Four provides a framework for about adopting and implementing the model and changing practice at the local level.

This guide is one of two products required by the settlement agreement that will promote the adoption of the CPM. The other product is a Documentation and Claiming Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Foster Care (TFC). These two products are intended to complement one another. The CPM guide defines the model and provides the context within which the services described in the Documentation Manual, including the new services of Intensive Care Coordination (ICC) and Intensive Home-Based Services, will be provided, documented and claimed.

A. Background and Context

On July 18, 2002, a lawsuit entitled *Katie A. et al. v. Diana Bonta et al.* was filed seeking declaratory and injunctive relief on behalf of a class of children in California. The lawsuit sought to make Wraparound services and Therapeutic Foster Care available to all class members.

The class members are defined as children in California who

- Are in foster care or at imminent risk of foster care placement, and
- Have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented, and
- Who 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 home-like setting, to treat or ameliorate their illness or condition.

For purposes of this case, “imminent risk of foster care placement” means that within the last 180 days a child has been participating in voluntary family maintenance services or voluntary family reunification placements, and/or been the subject of either a telephone call to a Child Protective Services hotline or some other documentation regarding suspicions of abuse, neglect, or abandonment. Members of this class include children who are living with their parents or relatives or in any of a variety of placements such as group homes or foster homes will be served by the core practice model

In December 2011, a settlement agreement was reached in the case. The settlement agreement further defined a subclass of children and youth who:

- Are full-scope Medi-Cal eligible, meet medical necessity, have an open child welfare services case, and meet either of the following criteria:
- Child is currently in or being considered for Wraparound, Therapeutic Foster Care or other intensive services, therapeutic behavioral services, specialized care rate due to behavioral health needs or crisis stabilization/intervention; or
- Child is currently in or being considered for a group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility, or has experienced his/her 3rd or more placements within 24 months due to behavioral health needs.

The settlement stipulated that members of the subclass who “need a more intensive approach and service delivery to address their array of needs and strengths...” would best be served through a formally organized Child and Family Team. We are referring to this formal Child and Family Team as the Intensive Care Coordination Child and Family Team (ICC/CFT). Appendix C of the Katie A. stipulated judgment further describes the ICC/CFT.

- The Child and Family Team (CFT) assembles as a group of caring individuals to work with and support the child and family and, in addition to the various agency and provider staff involved in service delivery to the family, includes at a minimum a facilitator and a family support partner or family specialist for youth.
- A mental health provider, social worker or probation officer can do team facilitation. The facilitator maintains a committed team and is qualified with the necessary skills to bring resources to the table in support of the child and family.
- An effective CFT continues the process of engagement with the family and/or caregivers about their strengths and needs, ensures that services are well coordinated, and provides a process for transparent communication.

The California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) agreed to perform a number of actions to meet the following objectives:

- 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 Two.
- 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). (IHBS and ICC are defined and described fully in Chapter 2, supra)¹.

- Support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that supports the practice and fiscal models.
- Support the development and delivery of a service structure and a fiscal system that supports the core practice and services models.

The Katie A. settlement further provides that

- CDSS and CDMH, 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 CDMH will develop cross-system training curriculum and educational materials for child welfare and mental health staff.

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¹ This manual only includes guidance for ICC and IHBS. A supplement or addendum to the Documentation Manual will be published at a later date to provide guidance on TFC.

B. Overview of California's Child Welfare and Mental Health Systems for Children and Families

The Roles of Children, Youth and Families in their Interactions with Child Welfare and Mental Health

Children, youth and families involved with child welfare and mental health are active partners in the CPM. As part of the CPM, it is expected that

- They will be included in the entire process from beginning to end.
- They will be encouraged to voice their wants and needs.
- They 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.
- They will have a safe place to talk about the issues without fear of being judged or treated like "bad" people, rather than people who may have made some bad decisions.
- They will be encouraged to identify natural supports and the people they want as members of their child and family support team.
- There will be a realistic plan for them to access the supports they need when they feel they need them after services end.
- They will have the opportunity to build relationships with their child's foster parents in cases where reunification is the jointly agreed-upon plan.

California Child Welfare System and Services

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, partially funds, and provides local child welfare and foster care services under Sections 300 et seq. and 16500 et seq. of the California Welfare and Institutions Code. The county child welfare division investigates reports of child abuse and provides case management and other services to help families stay together whenever possible.

Initially the Child Welfare Social Worker (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 child is provided services through the Child Welfare System (CWS), the CSW is responsible for coordinating their care through a family-focused and needs-driven approach.

When a child and family enter into the CWS, they are assessed for safety and risk factors for child abuse and/or neglect. A CSW may investigate to identify what the child and family needs. If there are risks but no immediate safety factors, the family may be provided the following services:

- Community-Based Services without an open child welfare case (CSW closes the referral).
- Voluntary Family Maintenance services with appropriate safety plans.
- Court-Ordered Family Maintenance Services with appropriate safety plans.

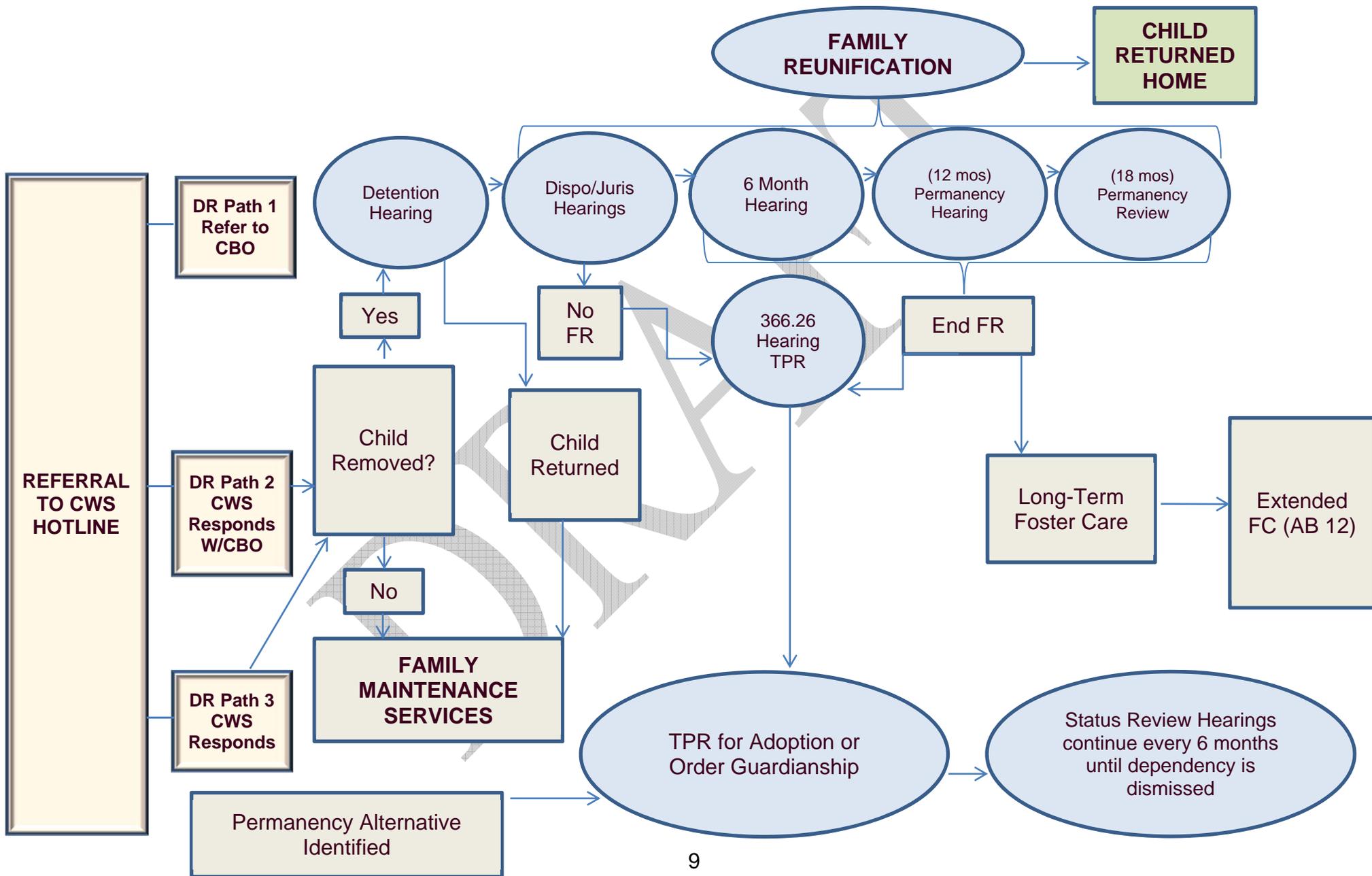
If there are safety factors that require detaining a child, the following services may be provided to the family:

- Voluntary Family Reunification
- Court-Ordered Family Reunification
- Permanency Planning

If the child is placed in out-of-home care, the CSW will work with the child and family to develop a case plan with a goal to return the child home, and concurrently the CSW will develop a permanency plan of guardianship or adoption if the child is unable to be returned 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 a child remains in care and turns 18 years of age, s/he will be eligible for extended foster care services up until age 20. Figure 1 illustrates the child welfare system process; acronyms and abbreviations are defined in the Glossary.

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Figure 1: California Child Welfare System



California Mental Health System and Services

The California public mental health system is designed to ensure the accessibility of quality, cost-effective mental health care that is consumer and family driven, resiliency based and culturally competent.

Mental health services for children and families are provided pursuant to the Bronzan-McCorquodale Act of 1991, which transferred responsibility for administering mental health programs from the State to local counties. Mental health services are funded through three primary sources: 1) Federal Medicaid (Medi-Cal) dollars matched at the State or local level; 2) State realignment revenues, including a dedicated percentage of the State sales tax and the State Vehicle License Fee; and 3) the Mental Health Services Act (MHSA), which provides additional funds for developing and implementing a comprehensive approach to providing community-based mental health services and supports for California residents.

Each county is responsible for developing and coordinating a comprehensive system of care to meet the needs of children and adolescents with serious emotional and behavioral challenges and their families. According to the Short-Doyle/Medi-Cal Manual, mental health services and programs operated through the system of care are grounded in the following set of values and principles:

- Child/adolescent-centered and family-focused services
- Community-based services
- Culturally competent services
- Services provided in the least restrictive environment
- Interagency coordination and collaboration
- Family participation
- Services that are developmentally and age appropriate, and relevant to the individual child and family
- Caring, well-trained and sensitive staff
- Partnership between service providers and family
- Preserving the family
- Protecting the rights of children/adolescents

In order for a child/adolescent to receive mental health services, he/she must first meet eligibility criteria for medical necessity. Medical necessity means that the child/adolescent's level of functioning due to a serious emotional disturbance interferes with community living to the extent that without services the individual would be unable to maintain residence, attend school, engage in relationships, and participate in age-appropriate activities and daily responsibilities.

In addition, medical necessity requires a five-axis mental health diagnosis from the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, commonly referred to as the DSM. Substance use disorders, developmental disabilities, physical disabilities, and traumatic brain injury are not considered mental health diagnoses and therefore do not qualify a child/adolescent for these services.

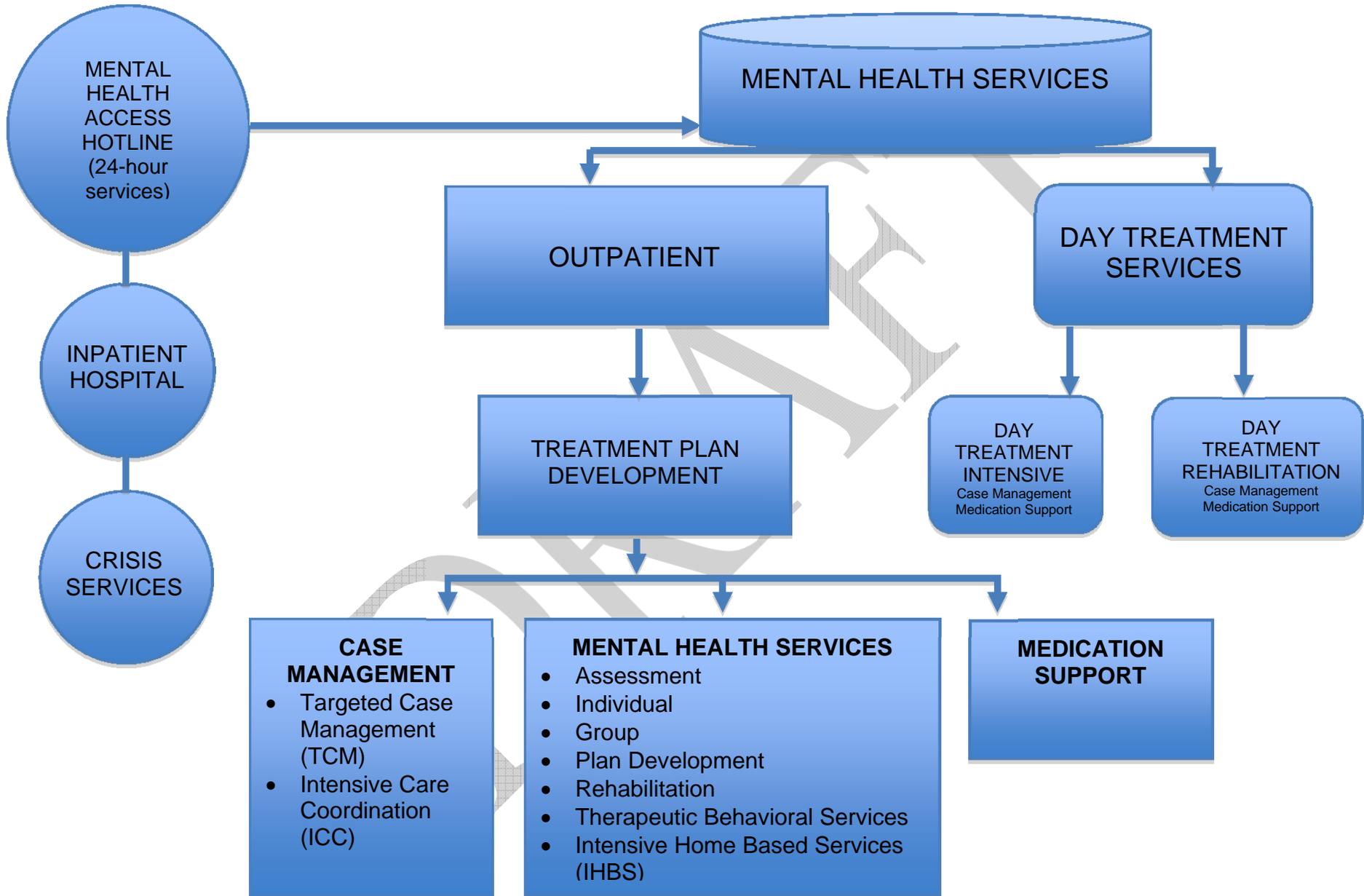
Medi-Cal Specialty Mental Health Services (SMHS) provide a range of interventions to assist the child/adolescent with serious emotional and behavioral challenges to gain the social and functional skills necessary for appropriate development and social integration. They are designed to reduce institutionalization and promote living at home or in another family-like setting in the community. Listed below in increasing levels of intensity and restrictiveness, these services include

- Mental Health Outpatient Services
 - Assessment
 - Evaluation
 - Plan Development
 - Therapy
 - Rehabilitation Services
 - Collateral Services
- Targeted Case Management
- Medication Support Services
- Therapeutic Behavioral Services (TBS)
- Day Treatment, Intensive
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Psychiatric Hospitalization (Inpatient)

Mental health services focus on the needs, strengths, choices and participation of the child/family in service planning and implementation. The goal is to help the child and family take charge of their lives through informed decision-making. Services are based on the child and family's identified goals and/or desired results related to the child's diagnosis and functional impairments. Services are designed to build on child and family strengths and are focused on achieving specific measurable objectives that support the accomplishment of the primary child/family goals. Significant support persons in the child and family's life, such as relatives, friends, and staff from other human service agencies, should be encouraged to participate in the ongoing service planning and implementation process.

Mental health program staff typically represent a variety of professional backgrounds and disciplines, and staff should reflect the cultural, linguistic, ethnic, religious, age, and sexual/gender diversity of the community which the program serves. Staff may consist of both licensed and non-licensed personnel who are experienced in providing mental health services to children and families. Services may be provided by any combination of directly operated county programs, contracted private community-based agencies, and/or individual mental health practitioners contracted with county mental health. Since specific programs and services vary from county to county, it is important to contact the local county mental health agency to get a complete description of programs and services available in the area. Figure 2 provides a general illustration of services.

Figure 2: Children’s Mental Health Decision Points



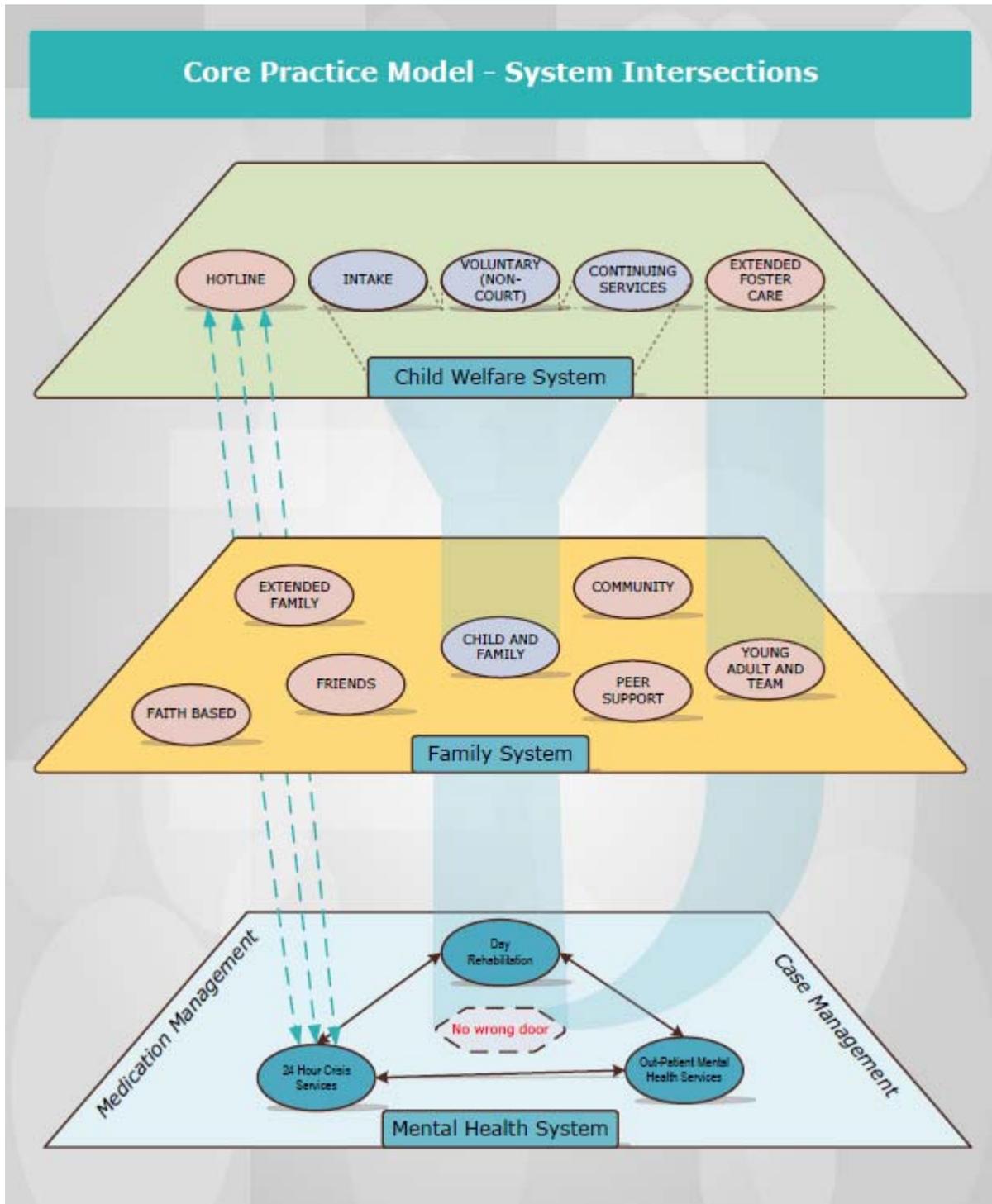
For purposes of understanding how the two systems intersect in terms of decision points Figure 3 attempts to illustrate the intersections among the child welfare system, the family system (within the Katie A. class) and the mental health system. The intersections among the three systems show the family in the center, along with the informal support team of extended family, friends and community members. Resources for the family may flow from Child Welfare to the family, who may also need mental health services, or from Mental Health to the family, who may need child welfare services.

The child welfare system “plane” illustrates the organizational structure and identifies the major service components or units: the “hotline” that receives calls of suspected abuse; intake services, which meets face-to-face with the child and family to evaluate the safety of the child and the capacity of the family to provide care and support; voluntary services, which provides oversight and supportive services to the family to ensure child safety and well-being, without court involvement; continuing services, which provides ongoing support and case management with the goal of reunifying and/or maintaining children with their families; and extended foster care, which provides long-term support and services to children who cannot be reunified with their families.

The family system includes all the internal and external supports that a family may possess. Internal supports include the immediate family members and extended family members. The family’s community supports include friends, members of their church, members of other community-based organizations (e.g., coaches, teachers, mentors). Participants in the family system are identified by the family itself based on the idea that families are able to identify their own needs and will benefit from building a support team that will sustain the family when the child welfare system is no longer needed.

The mental health system shows the three service components for children, adolescents and families: 24-hour/crisis services, which includes psychiatric emergency services and inpatient hospitalization; day treatment services; and outpatient mental health services. Medication support and case management are generally not “stand-alone” services, but are available as needed to clients receiving services in one of the three component areas. “No wrong door” emphasizes mental health’s commitment to providing children and families with the appropriate and necessary services regardless of their initial point of contact with a mental health staff member.

Figure 3: Core Practice Model System Intersections



Chapter Two – The Core Practice Model (CPM)

A. Definition

Practice models contain several elements:

- Values and principles
- Core components
- Standards of practice
- Activities, strategies, methods and tools to integrate all of the above

The Core Practice Model (CPM) set forth in this guide defines how mental health and child welfare integrate their practice. It defines the values, principles, standards of practice and activities for all child welfare and mental health agencies, service providers and community/tribal partners working with child welfare youth and families. It is not a practice model specific to a single agency. The guide defines “how we do what we do” when working *across systems* with children and their families—specifically, in this instance, child welfare and mental health. In addition it further defines the conceptual map of how a system or organization should conduct itself in order to achieve specified outcomes, both in its administrative policies and procedures, and in its day-to-day tasks and interactions at the supervisory and line staff levels. As such, it addresses integrated collaborative standards of practice for child welfare and mental health staff and providers when working with child welfare youth and families.

The CPM guide also addresses specific activities which support the standards, and it references practice behaviors specific to child welfare being developed through the CAPP initiative. Taken together, these standards of practice, activities and behaviors will facilitate a common strategic framework that integrates service planning, delivery, coordination and management among all those involved in working with child welfare youth and families with mental health needs. Child welfare, mental health, community and/or tribal partners and youth and families will work together within the CPM to achieve agreed-upon desired outcomes.

Some of the standards and activities currently exist in many county systems serving child welfare youth and families. Several counties are already implementing the child welfare practice behaviors developed through CAPP. The standards of practice that make up the CPM reflect the input of youth and families, as well as all of the stakeholders involved in service planning and delivery. In addition, the model provides for local flexibility in order to reflect the cultural diversity of families, communities and tribes needed for successful implementation. Further, it promotes respect for the values, beliefs and behaviors of the individual and his/her community and/or tribe. (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.)

This guide is the *first step* in articulating the values, core components, standards of practice and activities for a cross-system Core Practice Model for California.

Further work will be required to develop, articulate and implement additional activities, strategies, methods and tools to integrate the values, core components and practice standards into day-to-day activities and practice behaviors for child welfare and mental health. In child welfare, some of this work is beginning through the CAPP initiative, where four California counties (Los Angeles, Fresno, Santa Clara and Humboldt) have identified and are testing and evaluating 23 practice behaviors which define, in behavioral terms, the interactions between caseworkers and families, children, youth, communities and tribes².

As noted earlier, the Statewide Training and Education Committee will work with stakeholders and community/tribal partners to identify day-to-day practice activities and behaviors, as well as training and coaching materials for effective implementation of the CPM.

B. Vision, Mission, Values, and Principles

CPM Vision Statement

Adopting the Core Practice Model will improve the safety, stability, well-being, and permanency of our children, youth, and families.

CPM Mission Statement

Application of the Core Practice Model will create a process by which communication is strength based, culturally competent, collaborative, empowering, and goal focused. This model will result in the use of timely, effective services in the most natural setting possible in order to achieve each child, youth, and family's individualized goals.

² California Partners for Permanency (CAPP) is a federal initiative designed to reduce long-term foster care. California is one of six projects in the country funded through this initiative.

CPM Values and Principles

The CPM is guided by the following values and principles:

- Services are needs driven, strength based, and family focused from the first conversation with or about the family.
- Services are individualized and tailored to the strengths and needs of each child and family.
- Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.
- Family voice, choice, and preference are assured throughout the process.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success.
- Services are culturally competent and respectful of the culture of the children and their families.
- Services and supports are provided in the child and family's community.
- Children are first and foremost protected from abuse and neglect, and maintained safely in their own homes.
- Children have permanency and stability in their living situations.

C. Foundational Concepts

In addition to the values and principles, four foundational components have been identified that are interrelated, cross-cutting and fundamental to the Core Practice Model.

i. Collaboration

The concept of collaboration is central to the CPM for child welfare youth and families with mental health needs. Children and their families who come to the attention of the child welfare system can have complex issues and challenges. Complex issues call for a different approach to identification of those issues, solution development, and action. Collaboration has core characteristics that challenge conventional individual and organizational thinking and practice. These characteristics include

- Trusting relationships
- A holistic problem perspective
- Pooling of resources
- Harnessing collective synergy and expanding skills

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 how they build on each other.

Collaboration draws individual and organizational knowledge, expertise and resources into a “collective space” that sits between organizations and sectors. The synergies

identified and created from this pooling of resources can be harnessed to create innovative responses and ideas for social change, as well as generate outcomes beyond the participants' initial investments. This synergistic process is the major advantage of collaboration, as it creates something that could not have been achieved by any one of the individuals or member organizations working in isolation.

Key advantages of a collaborative approach include

- A focused application of knowledge and expertise
- More effective use of resources
- A higher level of commitment to action
- More relevant and effective solutions³

The following collaboration principles were identified as strategies from six communities engaged in collaborative efforts among families, child welfare and children's mental health.⁴

- Build and maintain trust so collaborative partners are able to share information, perceptions, and feedback, and work as a cohesive team.
- Agree on core values that each partner can honor in spirit and practice.
- Focus on common goals that all will strive to achieve.
- Develop a common language so all partners can have a common understanding of terms (e.g., "family involvement," "culturally competent services").
- Respect the knowledge and experience each person brings.
- Assume the best intentions of all partners.
- Recognize strengths, limitations, and needs, and identify ways to maximize participation of each partner.
- Honor all voices by respectfully listening to each partner and attending to the issues they raise.
- Share decision making, risk taking and accountability so that risks are taken as a team and the entire team is accountable for achieving the goals.

ii. Teaming

Teaming has been a traditional practice in social work, child welfare, and mental health. This process of integrating the varying perspectives of individuals with diverse educational, professional and personal life experiences guards against individual bias, while promoting better-informed decision making and transmission of learning.

Over the past several decades the definition of teaming has evolved from a process of collaboration among professionals working with a particular child and family to one that includes and values families and youth as equal partners. In particular, systems of care serving children, youth and families with complex needs have made efforts to

³ Keast, R., & Mandell, M. (2009), *Why Collaborate and Why Now?* Australian Research Alliance for Children and Youth.

⁴ 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.

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 that has so effectively advanced and transformed systems of care. Several teaming models commonly used in child welfare, such as Team Decision Making (TDM) and Family Group Decision Making (FGDM), emphasize the importance of family presence and participation.

Our experience suggests that the teaming process is most successful when

- Team membership includes the child/youth and family; extended family; informal support persons such as friends, coaches, faith-based connections; formal supports such as mental health, child welfare and educational professionals; and representatives from other agencies providing services to the child and family. These may include Regional Center case managers, probation officers, substance abuse specialists, health care professionals, and many others.
- 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 care plan.
- The 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.

While the Katie A. Settlement Agreement only stipulates a formal child and family team for subclass members (the ICC/CFT), the CPM integrates the practice of teaming for all youth and families. Every child and family can benefit from some kind of child and family team. The difference between the ICC/CFT and the child and family team for all children and families is that the ICC/CFT process is more structured. As noted in the Documentation Manual, the ICC requires a skilled facilitator specifically trained in leading/facilitating the child and family team. This facilitator takes the team through a structured process that includes orienting the child and family to the ICC/CFT process, identifying and assembling the CFT, and leading the CFT through the process of plan development, plan implementation and finally, transition.

In contrast, the child and family team concept in the CPM is less prescriptive. The team may use specific approaches such as Team Decision Making or Family Group Decision Making. The team itself may be less formal, membership may be more dynamic and

flexible, and a specially trained facilitator may not always lead the team. Depending on the level of complexity of the child and family's needs, the team may not meet as frequently as an ICC/CFT and/or may come together only around special tasks. In all instances, however, through teaming the youth and family, child welfare social worker, mental health clinician, and other team members collaborate on developing a plan that coordinates the necessary supports and services.

Further information on aligning the CPM child and family team with other teaming approaches can be found in Appendix C.

iii. Trauma-Informed Practice

In any given year, 30,000 children come to the attention of California's Child Welfare System.⁵ Most are victims of abuse or neglect, 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 and providing interventions are crucial to assisting children traumatized by maltreatment and other stressors.

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 skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.”⁶

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 systems⁷

⁵ 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.

⁶ 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.

⁷ Chadwick, 49.

iv. Cultural Competence and Humility

Training in cultural competence focuses on teaching service providers about traditional cultural concepts and practices of the racial and ethnic minority clients/communities they serve in order to identify and prevent disparities. If staff/providers are more aware of the cultural backgrounds and beliefs of their clients, communication will be easier. They can build mutual understandings that improve both delivery of services and client outcomes.

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

1. Multicultural knowledge, which refers to specific cultural knowledge about the history, traditions, customs, values, beliefs and the languages of cultural groups;
2. Awareness of one's own cultural heritage, values, practices and beliefs, and how their worldview affects the work they do with others, and
3. Communication and practice skills to be flexible and responsive to cultural differences.⁸

Cultural humility goes beyond the concept of cultural competence and embodies 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.⁹ 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.

Approaching each encounter with the 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.¹⁰

Acknowledging the differences between cultures is in itself an important first step toward cultural humility, but it is certainly not sufficient. It is possible to know everything that one could possibly know about a culture without demonstrating true cultural humility. As the California Health Advocates aptly point out in a recently published article on cultural humility, cultural humility is a kind of "reflexive attentiveness" that requires a great deal of "self-awareness" and goes far beyond "knowledge of the details of any given cultural orientation."¹¹ Care providers must always be aware of the fact that even extensive knowledge about a given culture is not the same as having assimilated oneself into that culture, and therefore one must be aware of the differences that will still exist between their own perspective and the perspective of the members of that culture.

Cultural competence and cultural humility are embedded in the CPM, and the practice standard and activities reflect these concepts.

⁸ California Institute for Mental Health. *Full Service Partnership Tool Kit, Child, Youth, Family- Cultural Relevance*, 16-17.

⁹ 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.

¹⁰ Borkan, J.M. et. al. (2008). Towards cultural humility in healthcare for culturally diverse Rhode Island. *Medicine and Health: Rhode Island*, 91(12).

¹¹ California Health Advocates. (April 2007). *Are you practicing cultural humility?—The key to success in cultural competence*.

D. Practice Components, Standards and Activities

The Core Practice Model has five key practice components. The practice components are the basic elements of our 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 with children, youth and families who are involved with both the child welfare and mental health systems. Practice activities 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 and activities. As noted earlier, additional standards and activities will probably be added and more specificity 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 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. 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 respectfully communicating openly and honestly with families in a way that supports disclosure of culture, family dynamics, and personal experiences in order to meet the individual needs of every family and every child. The goal is to ensure that the children and families are active participants in identifying their child and family needs, and finding solutions to their issues and concerns.

Not every child or youth will need mental health services at the beginning of their involvement with child welfare services. 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. Once mental health is involved, they should become 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; or service planning, monitoring, or transition—successfully engaging everyone involved is a key ingredient for promoting positive outcomes. For this reason, we not only include specific standards and activities for engagement, but include engagement activities for the 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 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.

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

Practice Activities for Engagement

- Model honest and respectful communication.
- Be open and honest about mandated reporting requirements, the role of mental health and 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 child and family team members and make sure the team has the information it needs to make informed decisions.
- Create an atmosphere of hope; promote healing and recovery in all interactions with children and families.
- Encourage and support the participation of children and families in determining (or influencing) their individual treatment and care.

ii. Assessment

Assessment is the skill of obtaining information about the relevant events that brought the children and families into services, and the underlying causes bringing about their situations. 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, “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.

The CPM includes a practice standard of screening every child entering the child welfare system for mental health needs. 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 note that positive screening results are not intended to constitute a determination that a problem is actually present. They only indicate a need for a comprehensive assessment by a mental health professional that will more fully assess underlying needs.

A mental health assessment is a more comprehensive assessment done by a mental health professional. 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 an assessment of current functioning. When a mental health assessment is indicated, the goal of the assessment is to help the child and family identify their underlying needs, and then engage the child and family in a decision about eligibility for and appropriateness of mental health services.

Standards of Practice for Both Assessments

Child Welfare Assessments:

- All children and youth involved with the child welfare system will receive comprehensive strength/needs-based assessments, including screening for their mental health service needs.
- When indicated, 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 child and family team.

Mental Health Assessments:

- The mental health assessment will be comprehensive, assess underlying needs, be strength based and trauma informed, and uses trauma-informed evidence-based tools whenever possible.
- The mental health assessment will assess both child and family strengths and causes for behaviors needing attention, in order to effectively match services and supports to these needs.

Practice Activities for Assessment

- 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, s/he makes an immediate and urgent referral to mental health.
- When the referral to mental health indicates a potential mental health crisis, the mental health worker
 - Identifies immediate and/or potential crisis and safety concerns with the child, family, caregiver and child welfare worker;
 - Conducts a brief functional assessment about the potential crisis and safety concerns;
 - Develops, with the child, family, caregiver and child welfare worker a stabilization or safety plan that address the immediate safety and crisis concerns.
- In non-emergent situations, child welfare staff contacts mental health when the child welfare worker and/or the results of a mental health screening or other team decision indicate the need for a mental health assessment.
- The child welfare worker and the child and family decide on the best way to approach initial contact with mental health.
- Assessments by child welfare and mental health include
 - Engaging the child and family in communicating their experiences and identifying their needs;
 - Listening actively to the family's story, and acknowledging and validating feelings of grief and loss that they share, by reflecting and reaffirming what was heard;
 - Promoting self-advocacy by encouraging, supporting and providing opportunities for youth and families to actively share their voice, offer solutions, act as leaders, and be central in the assessment, planning and decisions about their lives.
- When the mental health assessment is completed, the mental health worker communicates the results of the assessment to the child and family. Although the decision to share the results of their assessment is ultimately with the youth and family, the mental health worker engages the family around understanding the importance of sharing this information with the child welfare worker and their child and family team.
- When the child is already known to have a mental health service provider, the child welfare worker works with the family to obtain the necessary releases and permissions before contacting the service provider. 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.

iii. Service Planning and implementation

Service planning involves 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. The strength-based individualized plan specifies 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 planning cycle of assessing circumstances and resources, making decisions on directions to take, 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 and implementation occur within the context of a child and family team.
- Plans, services, and supports will be strength based, needs driven, and individualized.
- Plans will identify roles and responsibilities, and timeframes for accomplishing goals.
- Whenever possible, there will be a single cross-systems plan which incorporates the individual agency/service provider/community/tribal partner plans.
- Services 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 factor.

Practice Activities for Service Planning and Implementation

- Child welfare and mental health staff engage the child and family in identifying their support team members.
- Team members create shared agreement on the safety issues to be addressed and the 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 and other needs identified by the family and their team, based on the strengths, resources, and perspectives of families and their supportive communities and/or tribes.
- The team works continuously to identify, locate, develop, fund, 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 needs, and are clear about each member's roles and responsibilities related to the services/supports plan.
- Team members identify and offer trauma-informed, evidence-based services whenever possible.
- Mental health staff works with the child, family and other family-identified team members to determine the type, frequency and duration of mental health services that are needed when the mental health assessment determines, in conjunction with the youth and/or family, that formal mental health services are appropriate.
- Mental health staff ensures that Katie A. subclass members receive Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) when it is determined by the county mental health plan (MHP) or contracted provider to be medically necessary in accordance with federal and state law, the State Medicaid Plan and state policies and procedures governing SMHS.
 - ICC is a covered Medi-Cal SMHS targeted case management (TCM) service for children certified by the MHP as being Katie A. "subclass" members. ICC, as a case management service, facilitates implementation of the cross-system/multi-agency collaborative services approach described in the CPM.
 - IHBS are individualized, strength-based rehabilitative specialty mental health services designed to ameliorate mental health conditions that interfere with a child's functioning, which have been identified in the child's specialty mental health client plan. 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.
- 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 is the practice of continually tracking and evaluating the effectiveness of the plan and assessing circumstances and resources. It is the part of the planning cycle where the plan is reworked as needed.

Standards of Practice for Monitoring and Adapting

- Monitoring and adapting the service plan is a shared responsibility among mental health, child welfare and the youth and family.
- The child and family team 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

- The team actively engages and encourages the family members to express their views about how they see their progress toward their identified goals.
- The team routinely measures and evaluates child and family status, intervention process, progress and problems, and change results.
- Teams maintain appropriate documentation of goals, action steps and indicators of progress in order to achieve a continuous improvement planning process, and designate a person or persons responsible for this documentation as a whole.
- Team members persist in working toward the goals in the plan, 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 at the beginning of the child and family's involvement with the system. In instances where children and families are involved with both mental health and child welfare, they may not exit both systems at the same time. For example, families that no longer need to be involved with child welfare may continue with mental health services, or vice versa. 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 family's first involvement with child welfare.
- The importance of the family support team 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 community/tribal support team members.
- 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 system ends, 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 A is a Practice Standards and Activities Matrix that illustrates “at a glance” the integrated standards of practices and activities for each core component.

E. 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 evidence-based practices, promising practices, innovative practices, and culturally specific healing practices and traditions. They may be provided by mental health providers, by child welfare workers, by community providers and/or by other community/tribal partners. Services should be matched to the 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

In addition to the current array of services within the child welfare and mental health systems described previously, the Katie A. settlement identified three specific services for certain class members with more intensive needs (defined as the “subclass”).

Intensive Care Coordination

Intensive Care Coordination (ICC) is a Medi-Cal-covered service that includes the following activities facilitating mental health assessment, care planning and coordination of services, including urgent mental health services for children and youth who meet the Katie A. subclass criteria. ICC provides

- A single point of accountability for ensuring that medically necessary mental health services are accessed, coordinated and delivered in a strength-based, individualized, family/youth-driven, and culturally and linguistically relevant manner;
- Mental health services and supports that are guided by the needs of the youth;
- Facilitation of and participation in a collaborative relationship among the youth, his/her family, and involved child-serving systems;
- Support for the parent/caregiver in meeting the youth's mental health treatment and care coordination needs;
- Participation in and facilitation of a care planning process which ensures that a care coordinator organizes and matches mental health care across providers and child-serving systems to allow the youth to be served in his/her community;
- Facilitated development of the CFT.

ICC specialty mental health service components are as follows:

- Initial ICC case management assessment
- Planning: Development of an Individual Care Plan (ICP)
- Referral, monitoring and related activities
- Transition

ICC may be provided to children living and receiving services in the community, as well as to children who are currently in a group home, foster care, relative placement, adoption, hospital, or other congregate or institutional placement, as part of discharge planning.

More detail about providing and claiming for ICC may be found in the Medi-Cal Documentation and Claiming Manual referred to earlier in this document.

Intensive Home-Based Services

Intensive Home-Based Services (IHBS) are individualized, strength-based rehabilitative specialty mental health services designed to ameliorate mental health conditions that interfere with a child's functioning, which were identified in the child's specialty mental health client plan. Interventions are aimed at helping the subclass member eligible child and their identified support network to 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. IHBS may be provided in any setting where the child is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, childcare centers, and other community settings.

IHBS include but are not limited to

- Educating the child's family about, and training the family in managing, the child's identified mental health disorder;
- Medically necessary skill-based remediation of behaviors, including developing and implementing a behavioral plan with positive behavioral supports directed toward the child's diagnosed mental health condition included in the child's SMHS client plan and modeling for the child's family and others how to assist the child in implementing behavior strategies;
- Improving self-care and self-regulation by addressing behaviors and social skills deficits resulting from the child's diagnosed mental health condition (included in the child's SMHS client plan) that interfere with daily living tasks, with the additional goal of avoiding exploitation by others;
- Improving self-management of symptoms resulting from the child's diagnosed mental health condition (included in the child's SMHS client plan), including assisting with self-administration of medications;
- Improving social decorum (e.g., by addressing social skills deficits resulting from, and anger management needed due to, the child's diagnosed mental health condition included in the child's SMHS client plan);
- Supporting the development and maintenance of social support networks and the use of community resources needed to address the child's diagnosed mental health condition included in the child's SMHS client plan;
- Supporting employment objectives, by identifying and addressing behaviors resulting from the child's diagnosed mental health condition included in the child's SMHS client plan that interfere with seeking and maintaining a job;
- Supporting educational objectives, through identifying and addressing behaviors resulting from the child's diagnosed mental health condition included in the child's SMHS client plan that interfere with succeeding in an academic program in the community;
- Supporting transitional independent living objectives, by identifying and addressing behaviors resulting from the child's diagnosed mental health condition (as included in the child's SMHS client plan) that interfere with seeking and maintaining housing and living independently.

Further details on IHBS may be found in the Medi-Cal Documentation and Claiming Manual referred to earlier in this document.

Treatment Foster Care

Guidance on Treatment Foster Care will be added as an addendum or supplement to the Medi-Cal Documentation and Claiming Manual at a later date.

Chapter Three – Continuous Quality Improvement

A. Outcomes and Accountability

The purpose of implementing the CPM is to promote consistent practice that is evidence informed and guided by values and principles, and therefore increases the likelihood of positive outcomes for children, youth, and families. Ultimately, it is expected that implementation of the CPM will improve services for children, youth and families involved with child welfare services overall, demonstrated by improved outcomes including, but not limited to, the following areas:

- Parent, child, youth and caregiver involvement in case and treatment planning.
- The degree to which parents, children, youth and caregivers feel fully engaged and involved as partners in all of their experiences with child welfare and mental health.
- Assessing and addressing service needs.
- Child safety at home or in foster care.
- The number and percentage of children in long-term foster care.
- The number and timeliness of permanent exits.
- Decrease in re-entry into foster care.
- Decrease in non-permanent exits.
- Improved lifelong connections for children and youth.
- Increase in well-being of families and children.

The establishment of joint accountability and shared outcomes among collaborative partners is essential to the CPM's success. Without agreement on shared outcomes, each partner is likely to measure only its own progress from its own perspective. Partners need to create ways that the system can measure treatment outcomes for families in the child welfare system. The partners need to develop joint accountability and shared outcomes using a collaborative process. These shared standards will guide the partners' work 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 the partners' joint impact on their systems, and to determine how much a single project may be affecting outcomes across an entire system.

Developing these standards will also strengthen the partners' commitment to achieving comprehensive family outcomes, such as permanency for children and recovery for parents. The partners need to monitor their joint outcomes to hold themselves accountable for improving results across agencies. Establishing these outcomes conveys a commitment from the partners' leaders that the collaborative work is important enough to measure its progress and impact on improving outcomes. Agreement on joint accountability and shared outcomes will also drive the partners to

develop methods to share information, understand how each system collects data, and, ultimately, measure cross-agency outcomes.¹²

The settlement agreement speaks to the outcomes to be measured in order to evaluate the effectiveness of the CPM. CDSS and DHCS are charged with:

- (4) Determining what will be measured that reflects intended outcomes. The measured outcomes will be used to evaluate progress on implementing the CPM and access to intensive home-based mental health services and intensive care coordination for mental health services. Relevant data may include
 - A. *Clinical status data*, including assessments of symptoms, risks, functioning, strengths, and other information on how the class member is doing in his or her life.
 - B. *Utilization data*, including disposition information such as aftercare from hospitals and group homes, etc.
 - C. *Treatment facility data* that reflect what is happening within the episode of treatment, monitoring the degree to which CFT, intensive home-based mental health services, and intensive care coordination for mental health services are provided and the extent to which they are provided within the CPM.

When developed, the specific outcomes to be measured in order to assess effectiveness of the CPM will be integrated with the CPM guide.

B. Monitoring and Review

Part (c) under the specific objectives of the Katie A. agreement states that the parties agree to:

“Support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models.”

More specifically, the agreement also provides that DHCS, CDSS and CDMH will establish a Data and Quality Task Force and produce a report with recommended actions and timelines to:

- (1) Establish a method to track the use of ICC and IHBS services arrays and TFC for subclass members.
- (2) Utilize the External Quality Review and California Child and Family Services Review (C-CFRS) requirements to develop a plan for the collection of data and information about children in the class who receive mental health services.
- (3) Collect data elements in DHCS, CDSS and CDMH data systems specific to the class (and subclass) in order to evaluate utilization (patterns, type, frequency, intensity of services) and timely access to care.

When completed, these work products will also become a part of the CPM guide.

¹² Children and Family Futures. (2011). *The Collaborative Practice Model for Family Recovery, Safety and Stability*. Irvine, CA: Author, 23.

Chapter Four – Implementing the Core Practice Model

The first three objectives of the Katie A. settlement are:

1. To facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combine service access, planning, delivery and transition into a coherent and all-inclusive approach,
2. To support the development and delivery of a service structure and a fiscal system that support an integrated practices and services model, and
3. To support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models.

The first part of this guide addresses Objective 1 and defines the Core Practice Model and the standards of practice that describe what we do 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 Objective 2: how we 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 which 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.

A. Implementation Science

Implementation science is the study of what it takes to move from a good idea, program or practice model to established practice within an organization or system. Research has shown that the effective use of implementation science results in more successful establishment of an intervention of practice than simply letting it happen or helping it happen through methods such as policy directives, training or organizational changes.

Implementation can be defined as a specified set of activities designed to put into practice an activity, program or model of known dimensions. According to this definition, implementation processes are purposeful and are described in sufficient detail such that independent observers can detect the presence and strength of the

“specific set of activities” related to implementation.¹³ The CPM and its standards of practice are the activities or the “what” we are trying to put in place. The “How” we do it are the activities that we undertake to implement the model.

Implementation science also 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.
- Installation Stage – Staff and systems plan, prepare and organize to build the necessary supports to promote utilization of the intervention.
- 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.
- Full Implementation Stage – The majority of staff are using the intervention effectively.
- Sustainability – Financial and programmatic sustainability are considered, planned for and executed.

With regard to the CPM, the stage of Exploration 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. This guide and the training and materials that will follow are intended to assist counties in moving to the second or Installation Stage. 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.

¹³ Fixsen, D. L., Naoom, 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), 5.

B. Core Components for Implementation

Just as there are core components for the practice model, there are also core components or drivers for implementation. Fixsen, et. al. identify these as follows:

Staff selection – Staff selection extends beyond practitioners. Every staff member must be selected to suit their 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.

The bottom line is that 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, core 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. Wherever possible, youth and family members should be part of the training teams.

However, 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 does reveal 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.

Staff and Program Evaluation – Youth and families cannot benefit from 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 Core Practice Model 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 what 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 which will support the CPM include

- The shared management structure described in the Katie A. settlement which 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 core implementation components appear to be essential to changing the behavior of practitioners and other personnel who are key providers of services and supports within an organization. The core components 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 Core Practice Model.¹⁴

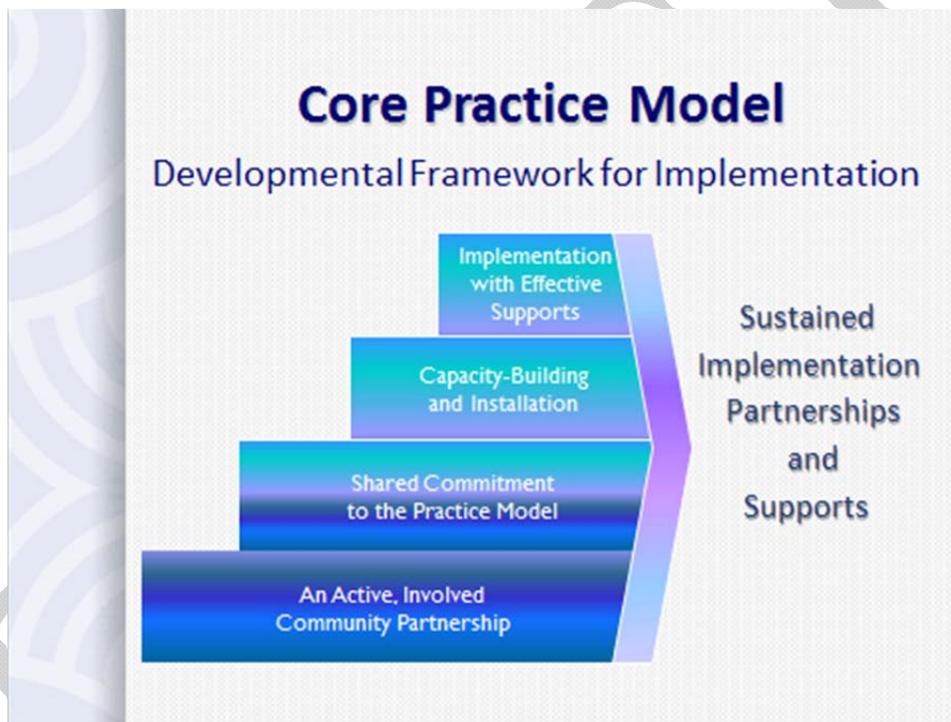
¹⁴ Fixsen, 28-29.

C. Developmental Framework for Implementation

As local and statewide system improvement efforts evolve, lessons have been learned about the optimum context and preparation for the successful and efficient implementation of the Core Practice Model. It is more than replicating a program; rather it is about working in partnership 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 in your jurisdiction.

Figure 4 illustrates the key building blocks of the developmental framework for implementation.

Figure 4: 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 mental health and child welfare 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 core 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 identify system barriers to improved outcomes for children and families and to implement action plans to address those barriers.
- 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 Core Practice Model.
- Ensuring that partnership meetings, forums and feedback loops are sustained so that community and tribal partners are continuously connected to, and help guide, ongoing mental health and child welfare 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 mental health and child welfare agencies, organizations, leaders, service providers and partners to

- Adopt the Core Practice Model 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 Core Practice Model.
 - Align all parts of the system to support the practice and system changes reflected in the Core Practice Model.
 - 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 Core Practice Model locally.

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 Core Practice Model 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 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 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 Core Practice Model. This process takes time, patience and the ability to adapt and adjust as the implementation evolves and takes hold in organizations and communities.

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Appendix A – Integrating and Aligning the Core Practice Model Child and Family Team with Other Teaming Approaches

As noted in this guide, the Core Practice Model (CPM) incorporates the practice of teaming. Although the CPM child and family team does not have to meet all the formal requirements of the ICC/CFT, it functions as the family's primary support team and is comprised of members who are important to the success of the child/youth and family. It includes both those formally involved and those who provide informal support. Teaming recognizes and appreciates the key contributions of a family's community and/or tribe and culture 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 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 will soon be exiting the system, need to have a strong voice in determining who participates 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.

The child and family team begins by considering all relevant information about family concerns and needs across broad areas of daily living, in order to prioritize those that are most critical. These needs are then addressed, with the guidance of a facilitator, through a shared decision-making process. Particularly with regard to families in the child welfare system, this process must be informed by and responsive to the traumatic life experiences of the child and family, and it must address safety, health, educational, cultural, and spiritual issues, and any specific family concerns.

The child and family team meets as often as needed to make and review decisions about services and supports for the child and family. Throughout the decision-making process, the team assures access to needed services, and monitors the success of the plan, making individualized adaptations as necessary so that the goals of safety, permanency and well-being can be achieved. In addition, all team members work to help youth and families find their voice and advocate for themselves. The team 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 functioning child and family team evolve 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 and functioning child and family team.

As the child and family team 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.

Multiple Teaming Approaches

Some counties use multiple teaming approaches to make decisions, join with families, and/or create case plans. County agencies, service providers and community/tribal partners are encouraged to examine these approaches ***within the context of the Core Practice Model*** and to make informed decisions about combining teaming models into a single CPM child and family team. Organizations should consider augmenting the CPM child and family team if a teaming model requires representation from specific groups. They need to provide clarity to families and other participants about why another teaming model may be used in conjunction with the child and family's primary support team. In any case, the CPM child and family team should continue to function as the family's primary team, the one with which it identifies most strongly.

Team Decision Making (TDM)

When combining an existing TDM with the CPM child and family team, the TDM facilitator, child welfare services supervisor and any other TDM-specific representatives should join the child and family team meeting. The team should be oriented to the TDM process and its purpose, which is to reduce the removal of children from their parents/caregivers. Similarities between TDM and the CPM child and family team, such as the identification of family strengths, should be emphasized for participants, and any differences should be noted. Once the TDM process has been completed, the facilitator and any other TDM-specific participants should depart to allow the CPM child and family team to complete its work.

Since TDM may not always be combined with the CPM child and family team, a county may wish to routinely include a mental health practitioner as a regular member of TDMs. Doing so will promote early identification of behaviors that may be symptomatic of mental health issues and may shorten the referral time for an indicated mental health assessment.

Wraparound Child and Family Teams

The Wraparound Child and Family Team will find great affinity with the child and family team as described in the CPM. Counties are encouraged to merge the CPM child and family team and the Wraparound Team, incorporating Wraparound aspects as appropriate.

Family Group Decision Making (FGDM)

Family Group Decision Making is structured to ensure that families have the lead role in making decisions and developing action plans concerning their members. The CPM child and family team can be brought into the opening and closing parts of an FGDM meeting. First, however, the CPM child and family team members would need to be oriented to the meeting structure and purpose, much as the family is prepared by the family partner and the coordinator.

In the first part of the FGDM meeting, family concerns are discussed with the entire team, and potential action steps are proposed. Then the family meets privately to consider what they have heard and to decide on a course of action. The family then returns to the larger team, presents their decision and plan, and asks for support from the rest of the team.

Some counties use other teaming structures. Important issues to address include

- Purpose of the meeting
- Representation and participation (must include mental health, child welfare, and the family)
- Process and facilitation

Efforts to integrate current teaming structures, processes and meetings within the CPM child and family team process are encouraged, in order to reduce the investment of time and the burden that multiple meetings place on families, their support persons and service providers.

Appendix B – Practice Standards and Activities Matrix

Core Practice Components	Standards of Practice	Practice Activities
<p>Engagement</p>	<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 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. 	<ul style="list-style-type: none"> • 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 these 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. • When indicated, 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 child and family team. • The mental health assessment will be comprehensive, assess underlying needs, and be strength based and trauma informed, using trauma-informed evidence-based tools whenever possible. • The mental health assessment will assess both child and family strengths and causes for behaviors needing attention, in order to effectively match services and supports to these needs. 	<ul style="list-style-type: none"> • The child welfare worker completes a mental health screening tool for all children in open cases at intake and at least annually. • When there is a potential mental health crisis, the child welfare worker makes an immediate referral to mental health and the mental health worker identifies crisis and safety concerns with the child, family and child welfare worker, and they develop a stabilization and safety plan. • In non-emergent situations, mental health staff, the child welfare worker and the child and family decide on the best way to approach the initial contact with mental health. • Assessment includes <ul style="list-style-type: none"> ▪ Engaging the child and family in communicating their experiences and identifying their needs; ▪ Listening actively to the family’s story and support how the family’s life experience may be impacting the current situation and needs; ▪ Promoting self-advocacy by encouraging family voice and choice. • When the mental health assessment is completed the mental health worker communicates the results of the assessment to the child, family and child welfare worker, and/or the child and family team. • When the child is already known to have a mental health services provider, the child welfare worker works with the family to obtain the necessary releases and permissions before contacting the service provider. The mental health service provider and child welfare worker coordinate services with the family and other team members.

Core Practice Components	Standards of Practice	Practice Activities
<p>Service Planning and Implementation</p>	<ul style="list-style-type: none"> • Service planning and implementation occur within the context of a child and family team. • Plans, services and supports will be strength based, needs driven and individualized. • Plans will identify roles and responsibilities, and timeframes for accomplishing goals. • Whenever possible, there will be a single cross-systems plan which incorporates the individual agency/service provider/ community/tribal partner plans. • 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"> • Engage the child and family in identifying their support team members. • Create shared agreement on safety issues and culturally sensitive services and supports, based on the strengths, resources and perspectives of families and their supportive communities and/or tribes. • Work continually to identify, locate, develop, fund, advocate for, link the family to, and support the use of agreed-upon practices, services and supports. • Design, tailor and implement a customized set of strategies, supports, and services based on the child and family’s expressed needs, being clear about each member’s roles and responsibilities related to the services/supports plan. • Determine type, frequency, and duration of services, identifying and offering trauma-informed evidence-based services whenever possible. • Ensure that Katie A. subclass members receive ICC and IHBS when determined by the mental health staff or a contracted provider to be medically necessary. • Identify, build on, and enhance capabilities, knowledge, skills and assets of the child/youth, family, their community and/or tribe, and other team. • Strive for consensus; deal with conflict.

Core Practice Components	Standards of Practice	Practice Activities
<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. • The child and family team 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"> • Actively engage and encourage the family to express their views about how they see their progress toward their identified goals. • Routinely measure child and family status, interventions, and change results. • 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	Standard 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. • 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 Partnership 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.

CalSWEC – The California Social Work Education Center (CalSWEC) is the nation's largest coalition of its kind working together to provide professional education, student support, in-service training, and workforce evaluation research working together to developing effective, culturally competent public service delivery to the people of California. CalSWEC's goals are

- To prepare a diverse group of social workers for careers in human services, with special emphasis on the child welfare, mental health, and aging fields;
- To define and operationalize a continuum of social work education and training;
- To engage in evaluation, research, and dissemination of best practices in social work.

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.

CDMH – The California Department of Mental Health (CDMH) became the California Department of State Hospitals in FY 2012/13. The community mental health functions of CDMH have been transitioned to the California Department of Health Care Services.

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 (CPM) defines the values, principles, 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 Child and Family Team (CPM/CFT) – The Core Practice Model child and family team is an informal team comprised of the child and family's support persons and service providers, which serves as the primary support to the child and family and is the main vehicle for assuring collaboration among those persons providing support and services to the child and family. The CPM child and family team is an integral part of the Practice Model.

CSOC – Children's System of Care (CSOC) 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 (DHCS) 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 individuals and families, 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 (DR) 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.

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

FGDM – Family Group Decision Making (FGDM) 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.

FSP – Full Service Partnerships (FSP) provide intensive mental health care coordination to address the total needs of the child or youth with a serious emotional disturbance (SED) or a serious mental illness (SMI). FSP programs are capable of providing an array of services beyond the scope of traditional clinic-based outpatient mental health services. Services and linkages are provided in the home or community at the convenience of the participating individual/family. FSPs provide or link to a wide array of services and supports, guided by a commitment to do "whatever it takes," to help an individual and his or her family achieve self-defined goals of resilience and well-being.

ICC – Intensive Care Coordination (ICC) is a Medi-Cal-covered service for subclass members that includes the following activities facilitating mental health assessment, care planning and coordination of services, including urgent mental health services for children and youth who meet the Katie A. subclass criteria defined in this Chapter. ICC provides the following:

- A single point of accountability for ensuring that medically necessary mental health services are accessed, coordinated and delivered in a strength-based, individualized, family/youth-driven, and culturally and linguistically relevant manner;
- Mental health services and supports that are guided by the needs of the youth;
- Facilitation of and participation in a collaborative relationship among a youth, his/her family, and involved child-serving systems;
- Support for the parent/caregiver in meeting the youth’s mental health treatment and care coordination needs;
- Participation in and facilitation of a care planning process which ensures that a care coordinator organizes and matches mental health care across providers and child-serving systems to allow the youth to be served in his/her community;
- Facilitated development of the ICC/CFT.

ICC/CFT – An Intensive Care Coordination Child and Family Team is a formally facilitated team required for all children, youth, and families receiving Intensive Care Coordination services.

IHBS – Intensive Home-Based Services (IHBS) 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. Diana 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.

MHP – A Mental Health Plan (MHP) is an entity that enters into a contract with the Department 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 (MHSA) 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 (buildings) and information technology
- 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 (MHSA FSP) 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.

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 (SMHS) are services provided by mental health specialists, including such as psychiatrists, psychologists, licensed clinical social workers (LCSWs), licensed marriage and family therapists (MFTs), psychiatric technicians, and peer support providers. They are provided to Medi-Cal beneficiaries through Medi-Cal Mental Health Plans (MHPs). All of the MHPs are part of county mental health or behavioral health departments. The MHP can provide services through its own employees, or through contract providers.

STEC – The Statewide Training and Education Committee (STEC) is a statewide group of participating organizations that develops and/or recommends standards for statewide public child welfare training and coordinates their implementation with CalSWEC’s in-service training partners.

TCM – Targeted Case Management (TCM) 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 (TDM) 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 (TFC), 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.

W&IC – The California Welfare and Institutions Code (W&IC) 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.

Wraparound – Wraparound is an intensive, individualized care planning and 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.