Children and Youth
System of Care

OPERATIONS MANUAL
AND POLICY GUIDE

2023-2024

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Acknowledgements

Individual child-serving systems, such as child welfare, education, juvenile justice, and behavioral health hold mandated responsibilities to meet certain needs related to specific populations. The Santa Clara County's Children and Youth System of Care governance focuses on all of the areas where individual systems do not have the capacity to act independently to achieve desired results. Collaborative decision-making among discrete systems requires structures and processes, as well as clarity about those being served by each individual system. This operational manual and its chapters are designed to address particular carefully defined responses to functional needs that cross system boundaries. The driving force behind the development of it all has been the experiences of children, youth, and families that are shared across systems to promote collaborative practices.

The compilation of all this work is a prime example of collaboration, partnership, and building relationships towards a common goal and mutually reinforcing activities that provide hope for more positive outcomes.

We want to acknowledge that all this work could not have been achieved without the active participation of each of the systems partners that are part of Santa Clara County's Children and Youth System of Care work.

Overview

Vision

All Children and Families in Santa Clara County thrive in safe, healthy, and stable homes, workplaces and communities

Mission

Strive to keep children safe and families strong and ensure all children and youth at risk are safe, cared for and grow up in a stable loving family.

Values

1. Tribe, Parent and Youth Driven

2. Community-Based and Least Restrictive

3. Culturally Linguistically Competent

4. Racial Equity

5. Prevention and Early Intervention Focused

INTRODUCTION

This Children and Youth System of Care Operations Manual was developed under the direction of the Santa Clara County interagency Children and Youth System of Care collaborative, in support of AB 2083. It includes the guiding principles, integrated processes, and procedures for the delivery of foster care services to children, youth, and families from entry or re-entry to permanency, reunification, or transition to independent living. While foster youth are a primary focus of the system, the success of any interagency effort for foster youth requires connecting departments and teams across the county on behalf of all youth. It serves as the guiding reference for all COUNTY employees and contractors in the delivery of foster care services.

The Operational Manual shall also set forth the existing roles and responsibilities of all county and contractor employees directly involved in the delivery of services.

While the Memorandum of Understanding contains 11 elements, this manual is practice-level guidance for staff and teams, focusing on the essential teaming processes and linkages necessary to make the CYSOC work effective.

Each chapter represents an element of the MOU and is rooted in both the vision and mission of the CYSOC and the state's ICPM.

Chapter A:
INTERAGENCY STRUCTURES, LEADERSHIP AND SHARED VISION

Table of Contexts:

1.1 Introduction

Santa Clara's Children and Youth's System of Care (CYSOC) is one of a number of interagency collaboratives in the county which seek to bring together agencies and departments in pursuit of the most effective services for children, youth, and families. Its formation occurred in 2020, with the completion of the AB 2083 required Memorandum of Understanding (MOU).

This chapter of the Operations Manual seeks to establish the structures and processes needed to collaborate collectively and consciously to shape a partnership culture that affirms and models the work of frontline staff. Partners across systems, as well as staff within organizations, respectfully engage each other with the intentional desire to build on shared strengths and collaboratively address shared needs to promote community and systemic wellness, to include prevention and early intervention services. Among these systems, risk is named, managed, and shared.

Each partnering agency has committed to the Santa Clara County healing agreements outlined in the countywide MOU. As such, each is responsible for shifting organizational mindsets that will be necessary in the implementation of cross-system coordination to address service gaps and deliver the continuum of care supports the community expects and deserves.

There are three functional teams which meet regularly as part of the Children's & Youth System of Care (CYSOC). Each are defined in detail, either in the system's Memorandum of Understanding or in this chapter:

- Interagency Leadership Team (ILT)
- Executive Advisory Committee (EAC)
- Technical Working Group (TWG)

System partners are engaged in shared leadership and governance in order to set forth a service plan that defines how CYSOC partners will work together as an administrative team with joint authority over the interrelated child welfare, juvenile justice, education, developmental, and behavioral health services for children and youth.

All CYSOC partners are committed to the county's mission, which is to keep children safe and families strong.

The county, along with partners from a diverse provider community, strives to ensure that any child or youth who is at risk or has suffered abuse or neglect is safe, cared for, and grows up in a stable, loving family.

This includes efforts and partnerships to provide supportive services to prevent child maltreatment among families at risk; to provide preservation services to ensure children's safety within the home and preserve intact families; provide reunification services to address the needs of families whose children have been placed in foster care so that reunification may occur in a safe and stable manner; provide home-based foster care services, including respite, to support family findings for placement and connection; to secure timely permanent adoptive or guardianship families when children do not reunify; and lastly, to provide services to support family maintenance and prevent recidivism.

Central to these pursuits, the CYSOC leadership structures are inclusive of the voices of those with lived expertise as participants in the child serving system. The Executive Advisory Committee serves as the system's hub and includes tribal representation and both parent and youth expertise.

1.2 The System of Care MOU

The Santa Clara County CYSOC is anchored by and collectively committed to a shared MOU, which serves as a framework that will guide the operations and activities, decisions, and direction of each of the system partner's workforces. The goal is to provide, promote, align, and monitor these services in an integrated, comprehensive, culturally, and racially responsive, trauma-informed, neuro-sequential, reflective, and best practice manner, regardless of the agency by which children and families enter.

The MOU is consistent with the vision of the County of Santa Clara in that all children and their families thrive in safe, healthy, and stable homes, workplaces, academic settings, and communities. The vision and mission are guided strongly by the belief that interdepartmental and interagency leadership is essential for successful collaboration and to address systemic barriers to the traditional provision of services and will be monitored and delivered to the community by the staff of each agency.

The MOU was executed in the fall of 2020 and will be reviewed and revised by June 30, 2024.

1.3 Leadership Structures in Santa Clara's Children and Youth System of Care
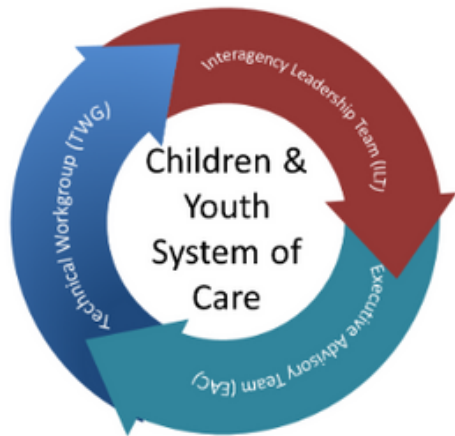
There are three leadership teams that provide the backbone for the CYSOC's collective effort. The Interagency Leadership Team (ILT), the Executive Advisory Committee (EAC) and a Technical Working Group (TWG).

1.3.1 Interagency Leadership Team (ILT)

The ILT serves as the governing and coordinating body with the overarching goal of working together to ensure that coordinated, timely, and trauma-informed services are provided to children and youth in or at risk of entry to foster care and probation. The ILT recognizes that while youth in the foster care system are uniquely identified as a focus of the CYSOC effort, to be effective, the system must address issues and challenges, and inform service delivery in all departments and sectors.

The ILT shall primarily be responsible for establishing and overseeing the execution of this MOU to meet the overarching goals of a coordinated system of care for children, youth, and families. The ILT's objectives include, but are not limited to:

- Provide direction and vision to the EAC and TWG teams.
- Ensure that the county's other integrated care efforts are linked to and in support of the CYSOC work.
- Advocate for system related supports with the state, county, and federal partners.
- Model an authentic commitment to the leadership behaviors as found within the Integrated Core Practice Model (ICPM).
- Consider and resolve any disputes that cannot be addressed at the Interagency Placement Committee (IPC) or EAC levels of the system.
- Ensure that the voices of youth and parents with lived experience and expertise are appropriately integrated into and supported by the system

ILT Membership is comprised of the following members or their designees:

a) Social Services Agency Director
b) Department of Child and Family Services Director
c) Juvenile Probation Chief or Deputy Chief
d) Behavioral Health Services Director
e) Public Health Director
f) County Superintendent of Schools
g) Office of Children & Families Policy Chief Children's Officer
h) Presiding Judge of the Juvenile Courts or designated Judicial Officer assigned to Juvenile

i) Justice and Family Law calendars (advisory, non-voting)
j) San Andreas Regional Center Executive Director or their designee
k) First 5 Santa Clara County, Executive Director

While membership of the ILT is noted above, EAC members, as well as other designated experienced staff members or other senior managers from system partners or other involved agencies, tribal partners, or identified contractors, may also attend ILT meetings to support the membership.

ILT Governance Procedures

The ILT shall utilize a shared decision-making process for all programs and services. Consensus will be the preferable model; however, if consensus cannot be reached, decisions may be made by a simple majority vote of the total non-advisory ILT members.

The members shall attend all meetings, retreats, and planning sessions to mutually carry out their shared approach.

One member of the ILT serves as the System Administrator, a position rotated amongst the membership every two years to ensure consistent interagency leadership practices. The ILT Administrator, supported by the EAC, will serve as the designated communication authority when working on inter-county requests and correspondence.

The ILT has designated key operational aspects of the CYSOC MOU to the EAC, as defined below.

1.3.2 Executive Advisory Committee (EAC)

The EAC functions similarly to the ILT and supports the overall design and implementation of the CYSOC framework. The EAC was formed in part, as the agencies learned that greater focus on the design and implementation were needed than could be supported by the ILT alone. The EAC membership includes the following or a designee:

1. Social Services Agency Director
2. DFCS Director
3. Juvenile Probation Chief
4. Behavioral Health Services Program Manager III
5. Public Health Director
6. County Superintendent of Schools
7. Presiding Judge of the Juvenile Courts or designated Judicial Officer assigned to
8. Juvenile Justice and Family Law calendars (advisory, non-voting)
9. San Andreas Regional Center System of Care
10. FIRST 5 Executive Director
11. Office of Children & Families Policy Chief Children's Officer
12. Parent Representative—Dependency Advocacy Center
13. Youth Representative--Law Foundation of Silicon Valley

The EAC meets twice a month as a committee and leads, facilitators and project manager meet twice a month for agenda and action planning. Each System Partner assigns one member and one alternate to the EAC. The EAC is also attended by a parent partner/leader and youth partner/leader with lived experience and expertise in the system of care.

Among the EAC membership, there will be a designated Chair and Vice Chair. These roles are rotated by and between the EAC membership on an annual basis. The Chair will be responsible for the calendaring, convening, and capturing of the EAC meetings and the preparation and support for the TWG. The department who has chair responsibilities will ensure that an administrative professional from the department is assigned to hold the support duties for the EAC and TWG, as outlined below in section 1.4.

The EAC membership will identify strategies and mechanisms to promote the integration and coordination of resources as well as information sharing, staff guidance, identification, and resolution of conflicts. The EAC's Mission is to ensure that foster children, youth, and their families receive the services they need and achieve the system's goals of safety, permanency, well-being, and to allow the children and youth to live in the least-restrictive environment. To effectively carry out this mission, the EAC has shared responsibility to address the following:

- Ensure that all staff assigned to shared joint service delivery is provided the necessary technical assistance, training, support, and staff resources to ensure mandates are fulfilled.
- Provide governance and oversight to the county's Comprehensive Prevention Plan and Family First Prevention Services Act work.
- Participate in the review and discussion of best practices related to the hiring or promotion of any leadership positions directly assigned to system partner functions.
- Provide recommendations regarding the Managers and Supervisors assigned to the Interagency Placement Committee (IPC), ensuring that the critical function of IPC has the experience, depth, and wisdom to make decisions and recommendations in keeping with the purposes of this agreement.
- Monitor and oversee the IPC process, review outcomes and ensure that the IPC functions are effective and necessary appeals are processed in a timely manner.
- Review and, as necessary, recommend program direction for applicable community partners or providers. Discuss/approve requests from providers, including Letters of Recommendation and other critical information for Short-Term Residential Treatment Program (STRTP) providers and other youth serving facilities. Invite providers to present annual reports on program successes, challenges, and outcome measures.
- Participate on related coordinating councils, other advisory committees, multi-disciplinary teams which affect the system partner processes or services.
- Appoint staff to support and serve as liaisons on various shared projects to ensure full continuum of care and linkages back to system partner services.
- Monitor programs by providing guidance and technical assistance on statutory and regulatory requirements and ensure program practice is consistent with the VISION, MISSION, and PRINCIPLES of this interagency partnership. (See Pages 1-3 of the CYSOC MOU)
- Coordinate and develop additional agreements or MOUs, as necessary, to assist in program coordination and problem solving.

- Work with community agencies to ensure collaborative and integrated strategies are utilized and promote and utilize strength-based, family-focused, Trauma-Informed, and reflective practices that incorporate racial and social equity principles and practices on a systems-wide basis.
- Review and revise the MOU as deemed necessary, based on expiration date, which will become effective only upon written agreement of all system partners.

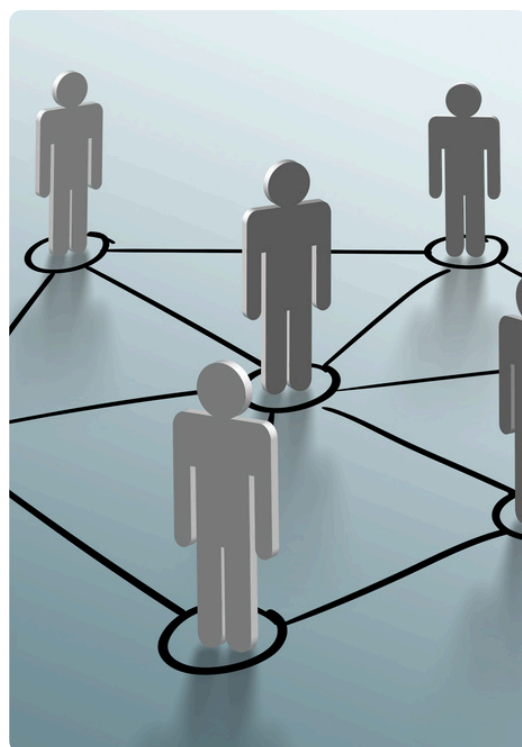## 1.3.3 Technical Working Group (TWG)

To support the ILT and EAC in achieving the goals of this MOU, department executives have appointed representatives to the Technical Working Group (TWG). The TWG shall serve as the technical body to provide the governance with the creative and strategic support in carrying out its duties and responsibilities of the system as a whole.

TWG Duties and Responsibilities

The TWG shall be primarily responsible for drafting, updating and practical application of this Operational Manual. The TWG shall serve as the oversight body responsible for drawing up the specific policies, procedures and standards as set forth by the ILT to achieve the goals of the systems of care collaborative and ensure its successful implementation.

TWG Membership:

a) DFCS Assistant Director

b) BHSD Program Manager III or Designee

c) Juvenile Probation Department Division Manager or Designee

d) Public Health Department Designee

e) County Superintendent of Schools Designee

f) COURT Presiding Judge of the Juvenile Courts
   Designee assigned to Juvenile Justice and Family Law calendars (advisory, non-voting)

g) Youth Partner

h) Tribal Partner

i) Parent Partner

j) Interagency Placement Committee Chair

k) County Counsel Designee

l) Community based providers, as needed (i.e.,
   STRTP, RFA, and/or other providers)

m) SARC Director of Consumer Services or their
   designee(s)

n) FIRST 5 Designee

o) Parent Representative (DAC Designee)

p) Child Representative (Law Foundation Designee)

TWG Governance Procedures

The EAC Chair and Vice Chair will serve as the joint Chairs of the TWG. Similar to the ILT and EAC, the TWG will utilize a shared decision-making process with consensus as the preferred mode.

The TWG will meet twice a month and any such time as the EAC deems necessary to perform duties and meet projected project timelines.

1.4 Administration and Operations of the System of Care

The administrative support is primarily to distribute meeting agendas, scheduling, minutes, and provide other information management to the three teams that comprise the system's leadership structure. The assigned administrative professional works in collaboration with the Project Manager assigned to support the system of care to ensure the above functions are effectively coordinated.

Administrative staff will support the Project Manager in maintaining all content materials in a centralized shared point and ensure those materials are properly organized for ease of access and reference. This means that after each meeting, immediately uploading agendas, meeting notes, video recordings etc. to the dedicated folder for the respective ILT, EAC and TWG teams, and ensuring consistency in the naming convention of documents (i.e., group name, agenda or notes, and date (EAC agenda 1.26.23)).

Executive Advisory Committee (EAC), Technical Workgroup (TWG) and Interagency Leadership Team (ILT) Administrative Support

DFCS will provide operational and administrative support for the EAC, TWG and ILT via scheduling, agenda and meeting distribution, and other supports for the process. Co-facilitation of EAC and TWG meetings will be rotated among members for the term of 12 months. EAC co-leads will facilitate the TWG for the 12-month term. ILT facilitation will be rotated every 2 years as stipulated in MOU.

The primary duties needed in support of the CYSOC process include:

1. **Meetings:**

   a. Interagency Leadership Team meets monthly for 60 to 90 minutes. The ILT team has two Co Chairs, which are rotated approximately each year.

b. Each meeting requires attendance of the admin professional assigned in order to both host the remote connection, publish agendas, take minutes, and otherwise serve the critical role of ensuring attendees have the necessary documents an information to complete their collective work.

c. Agendas –The agendas for meetings are discussed and agreed to in the EAC meeting each month, and as a standing item on each respective agenda
.
d. The agenda is to be emailed to all attendees at the ILT or EAC approximately 4 business days ahead of the calendared meeting if possible. Agendas shared at least 48 in advance of the meeting.

e. Maintain up to date the Shared Drive and ensure there is accurate document retention for every workgroup and deliverable
f. Minutes and agendas are all located and saved in the shared drive.
g. Collecting and maintain all archeological and historical documentation of the CYSOC work.

1.5 Leadership and the Integrated Core Practice Model (ICPM)

The System of Care leaders have embraced the state's Integrated Core Practice Model Guide as a shared set of guidance about system effectiveness, both in working with youth and families and in its relationships by and between partners. ICPM leadership behaviors are a building block of this success and are outlined here. (See ICPM Chapter 4 for a full articulation of ICPM leadership behaviors.)

- Be honest, clear, and respectful in communications—using person-centered, and blameless language.

- Be accountable and transparent about roles, responsibilities, and expectations of your agency, taking responsibility for your own decisions and biases.

- Create a learning-centered environment by demonstrating a commitment to the professional development of staff through a wide range of opportunities to gain knowledge, skills, and abilities.

- Solicit ongoing feedback from partners, children and families, tribes, and community members, and use that feedback to address and improve staff practice and supervision.

- Involve staff and partners in implementation and system improvement efforts, by communicating the purpose, importance, and your commitment to the ICPM implementation and what they can expect from you to support and sustain the ICPM.

- Involve system partners, including tribes and community-based organizations, to establish clear and measurable agency and system goals that are documented and made actionable.

- Demonstrate authentic empathy for staff and peer agency leaders, and consistently model empathy for youth and parents.
- Focus on strengths and assets, modeling a strengths-based communication approach to motivate, encourage, and recognize staff and partner implementation efforts.

- Foster leadership by staff at all levels, helping them recognize and gain confidence in their strengths.

- Seek feedback by meeting regularly with department leadership, tribes, staff, partner agencies, including CBOs, and other stakeholders (children, families, and community members) to gather information, listen to understand their perspectives and demonstrate openness to changing your position based on information you receive.

- Ensure that regular supervision meetings with team members occur to assess direct service effectiveness and fidelity with ICPM principles and practices.

- Use the EAC and other mechanisms, to provide frequent and regular opportunities for tribes, system and agency partners, staff, youth, families, and caregivers to share their voice and provide information about what is working and what needs attention.

- Become a champion for the ICPM by advocating for resources that support ICPM practice and establishing policies and practices that eliminate barriers for staff.

- Ensure senior agency staff regularly meet with the Juvenile Justice Court, Behavioral Health Department and County management to raise awareness and develop an understanding of ICPM and identify actions they can take to support implementation and use of the ICPM by your teams.

- Recognize that challenges presented by partner agencies are often reflective of unmet agency needs, and that your division or department's resources may be useful to meet shared objectives.

- Demonstrate willingness to share resources and responsibility for all youth and families, regardless of legal responsibility.

- Model inclusive and shared decision-making within your agency/division and across your system partnerships to support effective implementation and support of the ICPM.

- Develop policies and processes that facilitate and promote teaming across divisions, across agencies and tribes and with external partners.

- Pause and reflect before making organizational decisions, as to whether a partner agency's leadership team, a tribe, or other community partner should be informed or consulted before making your decision.

- Have a communication plan for ongoing dialogue with all department/division staff and provide clear, frequent communication to the whole organization and/or other stakeholders.

- Hold self and others to shared accountabilities by Identifying and implementing agency specific and shared tools (including, but not limited to, dashboards, data elements and reports, satisfaction surveys and chart reviews) to monitor individual, team, program, agency, and system level outcomes.

- Accept personal, agency, and interagency responsibility for the successful implementation of the ICPM.

- Monitor organizational and practice effectiveness by Identifying and implementing transparent processes to monitor program and organizational effectiveness using defined aggregate data at the appropriate level.

- Using Interagency Leadership processes, and outcomes from the Interagency Placement Committee, identify and implement a transparent process to monitor practice model fidelity and effectiveness across the system.

- Ensure service delivery across partnerships is aligned, including in court reports or other documentation, as the result of strong communication and pre-work with youth, parents, and tribes, and across provider organizations.

ATTACHMENT A (SAMPLE AGENDAS):

EAC Agenda

Item:	Purpose:	Notes:
1. Introductions and Welcoming	Use chat to introduce selves; welcome any new attendees	(5) Team
2. The Good and Great Stuff in Santa Clara	Partners share celebrations, strengths, assets	(5) Team
3. Announcements	Partners share updates and opportunities related to SOC work	(10) Team
4. Draft or Create ILT agenda	Inform ILT process	(10) Team
5. Agency Partner Overview	Orient Partners to the collective continuum of services available	(20) Partner
6. Other Topics Identified		(XX) Partner/Team
7. Agenda Topics for Next Month	Develop Agenda for next meeting	

ILT Agenda

Item:	Purpose:	Notes:
1. Introductions and Welcoming	Use chat to introduce selves; welcome any new attendees	(5) Team
2. Acknowledgements or Celebrations	Partners share celebrations, strengths, assets	(5) Team
3. Announcements	Partners share updates and opportunities related to SOC work	(10) Team
4. Report from the EAC	Various topics and content as prepared by the EAC	(20) EAC reps
5. New Opportunities, Funding, or Issues to Discuss		Team
8. Agenda Topics for Next Month	Develop Agenda for next meeting	

TWG Agenda

Agenda Items	Who and Time	Notes
Welcome, Agenda and Check in-Updates	5 min	
Review of Operations Manual Content	All 20 min	
Consideration and Discussion of Developmental Items in Support of the TWG or System	All 20 min	
Interagency Coordination Issues	10 minutes	
Next meeting		

INTEGRATED CORE PRACTICE MODEL

Table of Contexts:

1.1 Background and Context:

The Integrated Core Practice Model (ICPM) provides practical guidance and direction to support Children and Youth System of Care (CYSOC) partners and community-based providers in Santa Clara with the most current best practices for the delivery of timely, effective, person-centered, collaborative services to children, youth, nonminor dependents (NMDs), and their caregivers. The ICPM, when used consistently among and between partners and professionals in all engagement opportunities, is the organizational and relational glue for the System of Care.

The ICPM, originally released in 2018, contains a wealth of information for leaders and practitioners across the system. It is a unifying framework for child and family serving systems across the state, as it seeks to align and integrate key trauma informed practices and system improvement initiatives across an array of other systems. The ICPM will continue to evolve to include behaviorally specific expressions of its values, principles, and behaviors for each of the child and family serving agencies and organizations within the Children and Youth System of Care. Here is a link to the ICPM—

https://www.cdss.ca.gov/Portals/9/CCR/ICPM/ICPM%20document%20with%20CDSS%20and%20DHCS%2012-17-2018%20FINAL.pdf?ver=2019-01-14-094317-290

The intent of implementing ICPM's leadership and practice behaviors across the CYSOC is to provide staff at all levels of the system with the essential principles and professional behaviors that lead to relationships with each other and with children and family that foster healing and wholeness. Consistent use of the ICPM's practice guidelines, with an emphasis on authentic and aligned trust and engagement, will be implemented to support the success of the CYSOC and the children and families it serves.

Santa Clara County's CYSOC members have agreed to work toward shared training and implementation of the ICPM as the guiding practice document.
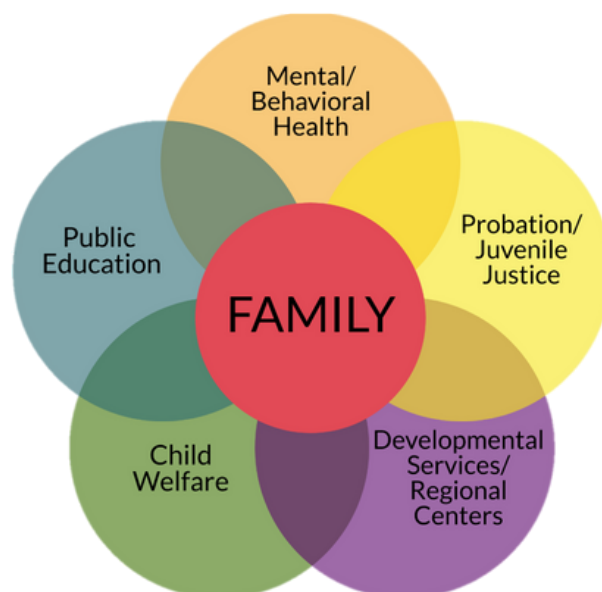
2.1 ICPM Components

The ICPM contains a rich font of narrative guidance for teams and leaders across the system, along with a logic model to guide its implementation and its connection to the System of Care. It is rooted in neurobiological and social learning theory, and its primary components are:
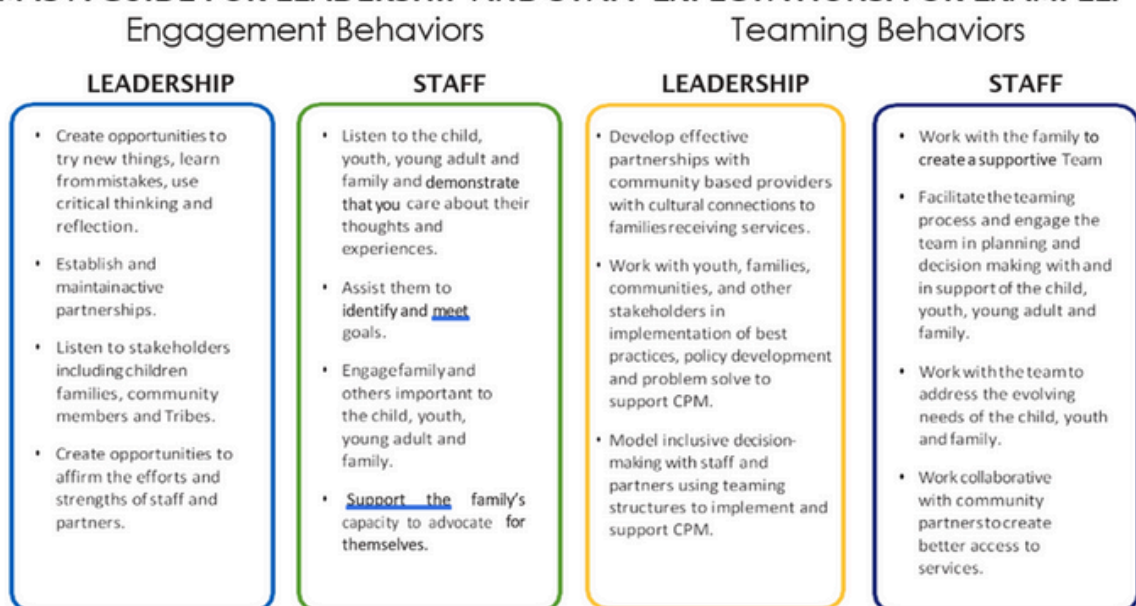
Five Principles of Effective Care
1. Four Values which drive Teaming and Successful Service Outcomes.
2. Practice Behaviors and Leadership Behaviors
3. An evidence-informed set of five elements, into which the principles, values and practice behaviors are applied on behalf of a child and family.
4. Engagement, Assessment, Planning and Plan Delivery,Monitoring and
5. Adapting, and Transitions

The 2024 ICPM version has been updated, based on stakeholder engagement and listening sessions over the last three years, and the thoughtful content generated, the changes to ICPM can be summarized to include:

1. <u>Race, Equity and Access to Care Focus</u>—Content has been enhanced to support the need for attention to disproportionality and over-representation, and how the System of Care and high collaborative services support social justice pursuits.

2. <u>Prevention Focus</u>—Content reflects the value and need to engage early, offer resources and supports that prevent entry to the system of care, including services based in empirically established programs such as "Family Strengthening".

3. T<u>he Voice of Lived Expertise</u>—Content supports the role and inclusion of parents and foster youth.

4. <u>Tribal Emphasis</u>—With the help of high-level input from tribes, many improvements are now present reflecting connections to the Indian Child Welfare Act and providing support for how public agencies should work with tribes in effective ICPM-based service delivery to ensure the protection of the rights of tribes and their children

5. <u>Community-Based Organizations and/or Providers</u>—Content references the role of providers in teaming and service delivery.

6. **Developmental Connections**—Content provides context for the critical role for teaming and planning with regional centers and the Intellectual and Developmental Disabilities system, to support the coordination of
person-centered services and supports.

7. **New Practice Principles**—Two practice principles have been added based on national System of Care research and the stakeholder input. These are "equity based" and "trauma Informed".

8. **The Role of Neuroscience**—Based on cutting edge practice research and the impact of trauma and secondary trauma, content was added to support the relational and emotional intelligence demands of staff in the systems

THE ICPM IS A GUIDE FOR LEADERSHIP AND STAFF EXPECTATIONS. FOR EXAMPLE:

Engagement Behaviors

LEADERSHIP
- Create opportunities to try new things, learn from mistakes, use critical thinking and reflection.
- Establish and maintain active partnerships.
- Listen to stakeholders including children families, community members and Tribes.
- Create opportunities to affirm the efforts and strengths of staff and partners.

STAFF
- Listen to the child, youth, young adult and family and demonstrate that you care about their thoughts and experiences.
- Assist them to identify and meet goals.
- Engage family and others important to the child, youth, young adult and family.
- Support the family's capacity to advocate for themselves.

Teaming Behaviors

LEADERSHIP
- Develop effective partnerships with community based providers with cultural connections to families receiving services.
- Work with youth, families, communities, and other stakeholders in implementation of best practices, policy development and problem solve to support CPM.
- Model inclusive decision-making with staff and partners using teaming structures to implement and support CPM.

STAFF
- Work with the family to create a supportive Team
- Facilitate the teaming process and engage the team in planning and decision making with and in support of the child, youth, young adult and family.
- Work with the team to address the evolving needs of the child, youth and family.
- Work collaborative with community partners to create better access to services.

Chapter C:
Engagement, Screening, Assessment and Entry to Care

Table of Contents:

1.1 Introduction and Purpose

The essential intent of a unified care entry and engagement process within Santa Clara's Children and Youth's System of Care (CYSOC) is to create a "no wrong door" approach in principle and practice. Children, youth, families, and caregivers should have access to a system that is agile and responsive to their needs rather than having to navigate separate and disconnected access points. Given the statutes and rules governing each partner's service delivery system, this is a significant challenge.

Underscoring this challenge is recognizing that the assessment process is not a singular act or function performed by one professional but occurs as part of a teaming process, consistently throughout the lifespan of care, and includes youth/family as equal partners.

Finally, aligning services and care coordination is essentially an outcome of other processes, particularly engagement and assessment, and the timely and fluid sharing of family-specific information and case management. This is especially critical for youth who are served in another county or outside the region.

Assessment begins as part of the initial engagement process. It allows professionals to understand what happened to the child/youth and family members, identify their strengths, and prioritize needs. The assessment begins at the first contact with the parent(s), child/youth, when the assigned staff provider begins to elicit the family's story as individual strengths and needs are identified. It continues during the identification and involvement of other sources of information and support during the development of the team's process and is ongoing throughout service delivery.

This discovery process is intended to help and empower children and families to self-identify the needs that brought them into care and develop a vision of what the family members' lives might be like if they could achieve a better life as they define it. Assessment shall also include determining the willingness, capability, and availability of resources to achieve safety, permanency, and well-being for children and safety for the community.

Good assessment work requires that professionals and others on the team understand what is behind the behavior that resulted in the need to act. This is often thought of as an underlying need.

Durable change happens when underlying needs are addressed by using and building strengths, which is why needs and strengths are identified. Assessment accuracy deepens in the context of the relationship and continues throughout the service process.

1.1.1 California Integrated Core Practice Model for Children and Youth

The Integrated Core Practice Model (ICPM) outlines five essential elements or phases of care in any service delivery process. The initial process in any service episode is based on a set of principles and practices that invites inquiry and exploration of each youth's strengths and needs, as well as those of their caregivers, and an understanding of how they and their family came into care with the Santa Clara County CYSOC.

The ICPM has practice behaviors that inform these engagement, teaming, and assessment processes, emphasizing that engagement is more than being connected to or in contact with the youth and their family. It is a highly relational process, imbued with and demanding trust, understanding, empathy, and the actions of professionals that elicit and support power on the part of the youth, their family, and community.

Engagement strategies shall be based on recognizing that the beginning is the most potent time in the service delivery process to set expectations for what is likely to occur, create the context for developing positive, helpful relationships, and support or hinder the potential for positive outcomes.

Engagement strategies must serve as an opportunity to establish the family's orientation to various service activities. They are recognized as an integral part of the process in which their needs and strengths are identified, any crises are addressed, and preferences are prioritized.

1.2 Assessment across the System of Care

Multi-agency assessment process demands that organizations limit the secondary trauma and redundancy that accompanies their inquiry process by fluidly sharing assessment information.

Youth receiving services from multiple system partners will have assessment information that may vary in focus. There are many situations wherein CYSOC partner agencies and staff are required to share the assessment process and the information obtained. For example, the court may request a hearing for probation youth if it seems that child welfare should be involved; schools can refer for behavioral health services through their School Linked Services (SLS) coordinators; and Regional Center staff may enlist support from BHSD when there are co-occurring mental health and Developmental Disabilities/Intellectual Disability (DD/ID) concerns, and of child welfare when there are safety concerns.

Involvement of the child's tribe, for an Indian child, is essential to coordinate services or support from the tribe's medical services provider, social services entity, or other programs.

While children and youth in the Probation, Child Welfare, and Behavioral Health Systems will be assessed via the state's approved Child and Adolescent Needs and Strengths (CANS) tool, other assessments may augment the use of the CANS, as described below.

- The **Child Welfare** assessment process is based on a family strengthening/prevention framework while investigating child safety, permanence, and well-being concerns. It includes the identification of factors present within the family to mitigate risk and reduce trauma via entry/re-entry. Safety Organized Practice (SOP) and Structured Decision Making (SDM) provide concrete tools and strategies for child welfare staff to operationalize or "live" the practice behaviors of ICPM with children and families. An assessment is not just a written document that contains information relevant to the case, family, or individual and an appraisal of case service needs, but rather is a process of engagement and holistic evaluation of risk factors, protective factors, and set of circumstances identified to develop a safety plan, case plan or safe care plan with specific goals, objectives, and services needed

    - **The Welcoming Center** is a 23-hour receiving center, which serves as the non-residential receiving facility for children placed in temporary custody by law enforcement officers and/or social workers. The Welcoming Center initiates the Pathways to Well-Being mental health screening for children brought into care. In addition to serving as the intake center, the Welcoming Center is also used to assess and evaluate the medical and mental health needs of the children brought there and to provide brief therapeutic support to address the trauma of removal and/or a placement disruption and support the transition to the child's next living situation. Medical needs are assessed at the SPARK Clinic.

    - **Plans Of Safe Care (POSC)** is a plan developed to ensure the safety and well-being of infants born or identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug or alcohol exposure (or diagnosed with neonatal abstinence syndrome [NAS] or fetal alcohol spectrum disorder [FASD]). POSC will result in a safe care plan before the infant is released from the hospital to address the health and treatment needs of the infant and affected family or caregiver. It is best practice that POSC are developed by healthcare practitioners or medical social workers in collaboration with the affected parents or caregivers.

- **Behavioral Health** assessments seek to understand an individual's mental health and social-emotional development by identifying patterns in cognition, perceptions, emotions, and behaviors. In turn, the clinician assesses how these patterns impact a child or youth's daily functioning at home, meaningful activities, relationships with others, and the community. In addition to the CANS, additional standardized tools help guide the assessment process depending on the child's age, developmental level, and presenting concerns to help formulate a diagnostic impression, determine eligibility for mental health services, and support the development of a transformational care plan and individualized treatment intervention strategies.

CANS 5+ serves beneficiaries aged 6 to 18, including an 18+ module for TAY youth over age 18. CANS-Early Childhood (CANS: EC) is used for staff that serve children from birth through age 5. The Pediatric Symptom Checklist-35 (PSC-35) will be completed with every beneficiary aged 3 to 18 served in the BHSD's Children, Youth, and Family (CYF) System of Care treatment programs.

Through this assessment, the qualified professional can provide a diagnosis, as applicable, which helps guide the team in developing and selecting effective intervention strategies. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

Per state guidance, the Specialty Mental Health Services/Early and Periodic Screening, Diagnostic, and Treatment (SMHS/EPSDT) assessment contains at least seven required domains, which must be documented and retained during service. The assessment should have interoperability between providers to reduce duplication and ensure all providers have the necessary information to assist beneficiaries (children, youth, parents, and caregivers) and allow the best ease of access to specialty mental health services.

The domains include: Presenting Problem(s) and Mental Status; Trauma; Behavioral Health History; Social and Life Circumstances; Strengths, Risk Behaviors, and Safety Factors; Clinical Summary and Recommendations; Diagnostic Impression and Medical Necessity Determination/Level of Care.

- **Probation** assessments focus on identifying youth and family's criminogenic risk factors to inform interventions targeted at increasing pro-social assets and lowering the risk of reoffending. The Juvenile Assessment and Intervention System (JAIS) is the assessment tool used in Probation, which allows the team to understand the level of intensity of services needed and informs the planning process. When a probation youth receives Behavioral Health or Child Welfare Services, this information helps inform the CANS and ensures cross-system collaboration.

- **Public Health** offers home visitation case management services by specially trained nurses. Public health nurses (PHNs) perform health and development assessments, provide education, and develop strength-based care plans to address the needs of the child, youth and/or family or caregivers. In addition to comprehensive health assessments, other assessment tools used include Ages & Stages Questionnaires that screen developmental milestones (ASQ-3) and social emotional health (ASQ:SE-2). PHNs also use validated screening tools to assess for depression, anxiety and suicidal ideations including GAD-7, PHQ-9, and Edinburgh Postnatal Depressions Scale (EPDS). With the consent of the client or parent/caregiver, PHNs work collaboratively with other agencies and partners to aid in linkage to resources and services as needed.

- **Schools** are a central partner in a child/youth's healthy development. Identifying needs and strengths within the school environment is essential to a comprehensive assessment. While academic attainment is necessary, the behavioral, social, emotional, and other aspects of school life are also significant when completing a thorough assessment process, and school assessment information must inform the team's planning. School assessment in relationship to Foster Care focuses on the best interest determination of the student and seeks to establish school and relational stability as paramount outcomes. When a student is already receiving Behavioral Health or Child Welfare Services, this information helps inform the CANS and ensures cross-system collaboration.

- **Student Study Teams--** The Student Study Team (SST) is a general education function comprising a group of professionals and parents who will discuss pupil strengths, concerns, and possible interventions. It is a process of reviewing individual student concerns and planning alternative instructional strategies to be implemented in the regular classroom. An SST process can be utilized to brainstorm an intervention plan for a student struggling in academics, attendance, or behavior. It can also be used to document interventions that have been attempted and a formal process for review of those interventions. If a student continues to struggle following the development and implementation of an SST, the SST follow-up may include a discussion of assessment for special education with the education rights holder.

Members of the team may include the following:

- At least one regular education teacher
- Bilingual personnel
- Principal or administrator
- Parent / Education Rights Holder
- Special Education teacher
- School Psychologist
- School Nurse
- Counselor or specialists
- Speech/Language pathologists
- Interpreters (as needed)
- Pupil (as appropriate)
- Others

While each district and school may have differences in their SST processes, an SST generally would include the following:

     - Identification of strengths
     - Identification of areas of concern
      - Intervention strategies (including a person responsible and a timeline for implementation)
     - A review of the SST plan (usually 45-60 days after the initial SST)

- **Regional Center** assessment focuses on developmental issues that may persist over a lifetime. Early identification and intervention seek to mitigate developmental delays to the greatest extent possible.

1.3 Role of the Child and Adolescent Needs and Strengths (CANS) within the assessment process:

The CANS is a state-required tool for Child Welfare and/or Behavioral Health that creates a shared, comprehensive summary of information about the family unit's well-being, safety, educational, social, behavioral, or other needs. The CANS is an engagement, teaming, and communication tool that prioritizes the youth and family voice in identifying their strengths and needs. As such, it must be used with every child, youth, and family receiving services from Child Welfare or Behavioral Health and can be helpful to all agencies serving the family. The CANS is completed in draft form by a certified CANS practitioner who gathers information from various sources in collaboration with the youth and parents and is finalized in consensus ratings by the Child and Family Team at the start of service planning.

During the service process, the CANS gets updated to capture progress and newly identified needs. CANS ratings must accurately reflect **the shared collaborative agreement** of CFT members. For families receiving services from other partners, the CANS should include information from assessment or screening processes used by those partners. Each child/youth and family receives one CANS shared among providers to avoid duplication and overassessment for families.

CANS supports prioritizing needs for collaborative decision-making and care coordination and allows monitoring of service delivery outcomes through routine scoring revision. The use of an integrated cross-agency CANS process creates the use of common language, supports shared understanding within the team membership, provides youth and parents an ongoing opportunity to reflect on their perspectives about the strengths and needs of the Plan, helps shared decision-making, and results in more comprehensive, integrated, and successful service plans.


CANS results shall be used to assist the CFT to determine the following, which includes, but is not limited to:

     a) Identification of needs and strengths in a manner that informs the Needs and Services Plan and the action steps therein;

     b) Placement and housing decisions;

     c) Identifying services and supports needed by the child/youth;

     d) Determination if the child or youth is impacted by trauma and has unmet mental health needs;

     e) Development of basic and advanced life skills for transitional-age youth;

     f) Determination of educational needs, including request for IEP assessment when needed;

     g) Identify any immediate required support for the family and/or care provider, such as childcare, medical, or dental care.

     h) Determination of developmental needs, including a request for regional center assessment when needed.

Assessment describes continuous formal and informal processes that occur across all disciplines within the system and over time. It begins as part of the initial engagement process. It allows staff to engage with the child/youth and family to understand what happened and identify their strengths and prioritized needs. Simply put, the identification of need tells us why to act. Understanding what is behind the behavior that resulted in the need to act defines an underlying need.

When a family enters SOC services, they are asked to undergo a significant life restructuring. Without mindful attention to the psychological safety landscape, the child/youth and parents can find themselves in fear and uncertainty as they seek to understand what the experience means to them.
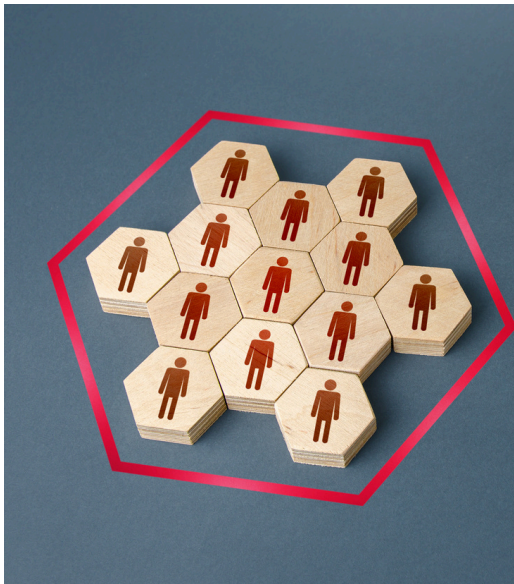
All children and youth receiving services from multiple system partners will have assessment information that may vary in focus. It is important to integrate information from various perspectives for children, youth, and families entering Santa Clara's Child Welfare, Probation, and Behavioral Health Services. Screening for and identifying adverse childhood experiences and trauma, medical, and mental health needs, is critical to the initial and ongoing assessment that might impact children's behavior, emotional well-being, academic attainment, and developmental milestones. The initial screening is completed in partnership with the child/family; when involved with system partners, it will be done in partnership and collaboration with DFCS and BHSD via Pathways to Well-Being staff.

DFCS will ensure that a CANS assessment is done for every child coming into care by either DFCS staff or its designee. The initial CANS will be completed in collaboration with all providers and utilized at the CFT for case planning purposes. It is the responsibility of the CANS practitioner (the person who does the CANS) to complete the CANS summary and provide it to the primary social worker/probation officer and CFT team 24 business hours prior to the CFT. It is the responsibility of the CANS practitioner that the CANS is part of the CFT and that they also participate in the CFT. In addition, a CANS assessment will be completed every six months and/or when there are critical changes in the case. In order to ensure fidelity to the CANS process, it is the expectation from DFCS that all social workers are trained in completing the CANS assessment.

The intention of the CANS tool is to replace the SDM-Family, Strengths, and Needs Assessment (FSNA) tool for case planning purposes. In addition to CANS helping with case planning, the role of the CANS is also meant to be a tool to support supervisors in the review of the case with staff and ensure fidelity, as well as support with evaluation efforts to inform child welfare metrics such as entry to care, gaps in services and areas of improvement in service delivery for system improvement outcomes. When the CANS indicates significant action items, particularly in the risk domain, the child/youth will be referred to BHSD for an assessment.

Interagency Assessment of Foster Children & Youth:

Santa Clara BHSD, Probation, and DFCS have unique system-related obligations and partnerships for the assessment of foster youth.
Behavioral Health Coordinators (BHC) are assigned to DFCS-specific functions, are co-located, and many have bilingual Spanish language competency. They provide the following:

- Completion of mental health screenings initiated by DFCS social workers and The Welcoming Center.

- Provide linkages for youth and young adults for mental health services through a robust continuum of care and provide care coordination as needed.

- Make direct referrals for Katie A. Intensive mental health services.

- Provide clinical consultation to social workers and partners as needed.

- Provide training for social workers on Pathways to Well-Being, behavioral health services available, and related issues.
- Provide training and support for behavioral health providers on the child welfare system.

-
- Coordination of screening for Presumptive Transfer for youth placed in Santa Clara County who are dependents from another county in California to determine the level of care and make a referral for mental health services as needed. The coordinator works in partnership with Juvenile Probation and DFCS to track youth referred for services across county lines.
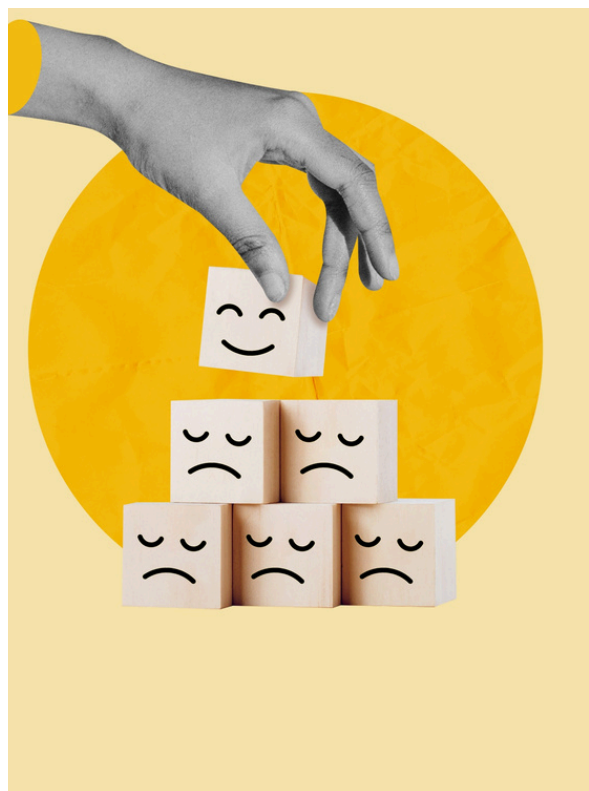
- Completion of Qualified Individual assessments as required by the state as part of the Families First Prevention Services Act (FFPSA) to assess if Short Term Residential Therapeutic Placement is an appropriate level of care.

Inter-Agency Care Coordinators work in partnership with the Child and Family Team to help ensure that children and youth with significant behavioral health concerns receive timely, trauma-informed, culturally responsive, and coordinated services to promote stabilization, successful transitions, and permanency. These youth may receive or need intensive therapeutic services, such as Wraparound, Specialized Therapeutic Homes, Short Term Residential Therapeutic Programs, or Therapeutic Foster Care. The Inter-Agency Care Coordinators may also serve as the Behavioral Health Services representative on the Interagency Placement Committee (IPC).

1.4 Trauma and Assessment

Identifying adverse childhood experiences and trauma is a critical aspect of the initial and ongoing assessment process because of the impact on children's and adults' behavior, emotional well-being, academic attainment, and developmental milestones. It is equally critical to help the youth and family identify their strengths and to understand how those strengths and assets do or could mitigate the adverse conditions that have affected their lives. It is the responsibility of all individuals and/or staff working with children to ensure that trauma exposure and responses are recognized throughout the service process and are not improperly labeled as a lack of cooperation or attributed to some other misidentified motive. The CANS is a trauma-informed tool that captures information learned by other providers, the family, and the CFT on trauma that has occurred.

Resources:

- CFT Brochure

Chapter D:
Child and Family Teaming and Unified Service Planning

Table of Contents:

1.1 Introduction:

This chapter of the Children and Youth System of Care (CYSOC) Operational Manual outlines how system partners envision an effective use of teaming, both as it relates to their department-level teaming and to the interagency work that is the essence of collaborative practice. Because the System of Care places high priority on foster youth, this chapter also provides information about the processes which inform when a CFT meeting for foster youth in Child Welfare or Juvenile Probation should be convened, by whom, and how partner agencies can support the work of the team. The chapter references aspects of policy and procedure for cross-system planning and coordination to ensure that there is only one team process for any single youth or family in care. This means that departments will coordinate in such a manner that no child or youth will have multiple service team meetings.

(Note that additional specific policy and practice guidance for teaming is available within each system partner's guidelines)

1.2 Teaming in Santa Clara's System of Care

Effective teaming, engagement and service planning are foundational hallmarks of Santa Clara County's Child and Youth System of Care (CYSOC). The **Interagency Children and Youth System of Care** Memorandum of Understanding is clear in its collective commitment to "ensure collaborative and integrated strategies are utilized and to promote and utilize strength-based, family focused practice, trauma-informed, and reflective practices that incorporate racial and social equity principles and practices on a system-wide basis."

At the core of teaming is the idea that families are the focus of the work. This means that the system partners center the work around the needs of youth and families and in an integrated manner in such a way that the systems are not working out of silos, responding to competing needs (i.e., court mandates from multiple courts and are focused on wellness and permanency). Youth and families are engaged with and understood with acknowledgment of their strengths, needs and resiliency.

Teaming Partner agencies in Santa Clara County include:

Core operating values outlined in the MOU

Family-driven and youth-guided

Community-based

Culturally humble and linguistically competent

Racially Equitable

Social Services Agency (SSA) – Department of Families and Children's Services (DFCS)	Juvenile Probation Department (JPD)	Behavioral Health Services Department (BHSD)	Public Health Department (PHD)
Santa Clara County Office of Education (SCCOE)	Santa Clara County Superior Court (COURT)	San Andreas Regional Center (SARC)	First Five Santa Clara County (FIRST 5)

Teaming, engagement and planning processes of member and partner agencies may take different forms, as informed by state practice expectation and may have various purposes. However, in order to maximize planning, youth and family engagement, CYSOC partners are committed to the most unified teaming process possible. CYSOC members recognize that: 1) identification of persons with natural supportive relationships, partner agencies, and other services and supports ensure cross-system planning and coordination are effective in helping families identify and achieve their goals; and 2) child/youth and family voice and choice, and the active involvement of natural supports in teaming, are critical to universal and effective service delivery.

CYSOC members agree to ensure that every effort is made to invite relevant partner staff, including but not limited to community contractors or other providers, to their respective teaming meetings to engage in teaming and planning and ensure that youth and family agree with the composition of the team.

Regardless of which department or agency is providing services, the youth and family will be engaged and empowered in a trauma-informed, strength-based, and culturally humble manner using the ICPM's essential teaming behaviors.

Most often, Child and Family Teaming (CFT) is the term used to describe the teaming, engagement and service planning process for children, youth and families served by the **county's Social Services Agency, Juvenile Probation Department, and the Behavioral Health Services Department.** School and Regional Center personnel will also be invited to any and all identified CFT meetings for shared planning. (CFT practices are described further later in this chapter.)

Keeping with the Integrated Core Practice Model, and with focused effort toward use of its teaming behaviors, teaming processes require the team to build positive relationships across various departments and agencies. The idea is to share resources that will result in an integrated approach to serving families.

Most often, the agency with legal jurisdiction will convene the teaming meetings and document all meeting outcomes. In addition to members' direct facilitation and delivery of teaming services, the BHS division and some youth in Probation status obtain facilitation and documentation for teaming and planning meetings through contracted agencies. In some instances, there are mandates to have CFTs at certain time intervals, below is a graphic of the County's Continuum of Care with programs identified in orange that have a mandate to have a CFT within 90 days.
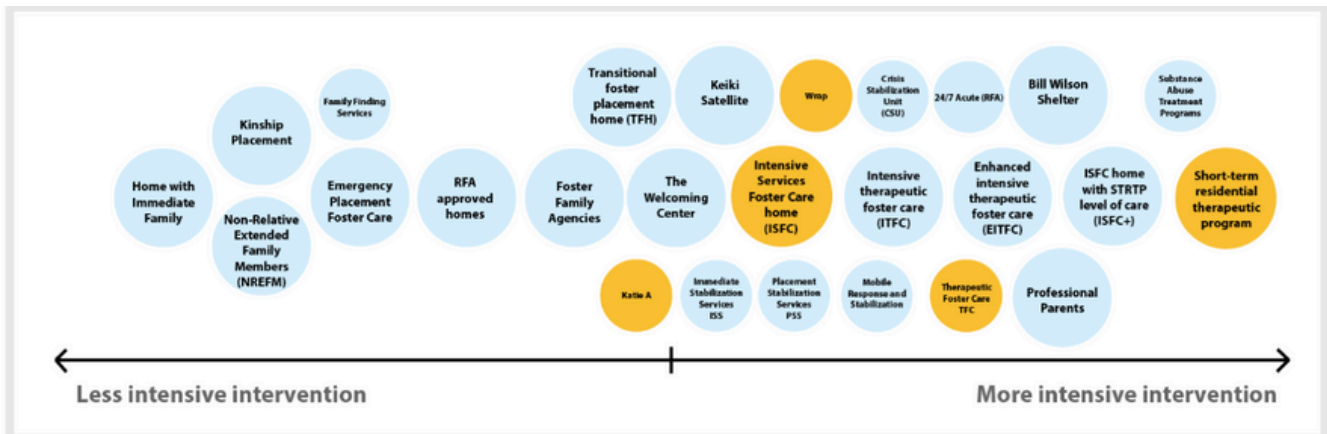
The Child and Family Team meeting is an opportunity for system partners to hear the youth and family's voice, explore and identify ways for youth and family to genuinely inform the plan and make decisions as it pertains to their care and services. The CFT meeting allows for the child/youth, parents or caregivers, natural supports and others that can offer support, a time to come together to collectively identify the strengths and needs of the youth and family, address concerns or issues, and develop a plan informed and supported by the youth and family to meet their needs and assist with transitioning out of the child welfare or juvenile probation systems.

It is imperative that families and caregivers are effectively and consistently notified about their rights to request a CFT meeting and informed about what a CFT is, how and why teaming is important to the successful attainment of their goals. The agency with jurisdiction is responsible to educate the families, caregivers and youth about what a CFT is, the purpose and process, their rights and what to expect of the process.

Teaming in parallel partner agencies:

While the CFT is the typical way that teaming is delivered for foster youth or juvenile justice involved youth, other youth being served by partner agencies have teaming processes in place as well. There are different types of teaming that take place at the county level and across the various system partners. This section breaks out common types of teaming. Below is a table listing these teams.

Children who are served in education-based services, either at the district level or directly by the **Santa Clara County Office of Education,** also have a high need for teaming and coordinated service planning. While each district may use a slightly different approach, all districts are committed to utilizing a Multi-Tiered System of Supports framework designed to bring together general and special education supports, with the goal of providing a comprehensive, proactive, and unified system of education to meet the needs of, and improve results for, all students.

Students in Santa Clara County schools are also served via education-centric team-based processes associated with their Individual Education Programs (IEP), Student Study Teams (SST), Student Attendance Review Team (SART), School Attendance Review Boards (SARB), or other Special Education services. The table below captures the teaming continuum:

Teaming Type	Agency	What is it?	Who attends?
Student Study Team (SST)	Education	The Student Study Team (SST) offers immediate assistance for teachers, parents and support staff for individual students who not making progress or exhibiting various types of problems in the classroom or school. The SST serves as a group of professionals and parents, who will discuss pupil strengths and problems and possible interventions.	Teacher, Administrator, Parent, Special Education teacher, School Psychologist, Counselor or specialists, Interpreters (as needed), Pupil (as appropriate), Others
Individualized Educational Program (IEP)	Education	The IEP will show a direct relationship between the present levels of academic achievement and functional performance, any assessments, the student's goals and benchmarks, and the educational services to be provided.	Parent(s)/Family, educational team, educational service providers
Student Attendance Review Team (SART)	Education (school site)	SART is a School Site Team which includes the parent and the student, Principal and relevant personnel who works with the student. The goal of this team is to identify possible solutions to improving the students' attendance.	Administrator, Teacher, Parent/Family, Student

Student Attendance Review Board (SARB)	Education (School District)	SARBs provide intensive guidance to students and families and link them to focused services to address the underlying causes of poor attendance and lack of school success. SARBs monitor and engage with families over time to ensure that directives are being followed and that services are effecting needed change.	At a SARB hearing, students and their parents/guardians will meet with a panel that may consist of the following: Referring School Site Representative, District SARB Coordinator, Mental Health Staff Member, Community Agency Representatives Representative from District Attorney's Office, etc.
County SARB (School Attendance Review Board)	Justice	SARBs help truant or recalcitrant students and their parents or guardians solve school attendance and behavior problems through the use of available school and community resources. County SARBs are convened by the county superintendent at the beginning of each school year.	Parent, Representatives of school district(s), probation department, social services department, the county superintendent of schools' office, law enforcement, community-based youth service centers, school guidance personnel, child welfare and attendance (CWA), school or county health care personnel, the county district attorney's office, the county public defender's office, Other representatives as needed.
Educational Consultations	DFCS	Address Intensive Educational concerns to strategize for improvement tailored to the child with youth's team	DFCS EdSU, Social Worker, Youth, LACY, Morrissey-Compton, SCCOE Ed Manager, School Rep.
Ed CFT	DFCS	Best practice Child Family Teaming to provide opportunity for foster youth to explore the possibility of postsecondary education or career and technical education as a goal, create an educational plan, assign who will support with achieving tasks outlined and supports/services needed	DFCS EdSU, Social Worker, Youth, SCCOE Ed Manager, Pivotal Coach, ILP Case Manager,

The **Santa Clara Public Health** department actively participates in care delivery via teaming with other system partners to ensure that medical, dental and other health related services and supports are available and necessary to youth in the system.

San Andreas Regional Center (SARC) delivers and documents teaming and planning via an individual program plan (IPP) or individual family service plan (IFSP) process. For children with an established diagnosis of a substantially impairing intellectual or developmental disability and who are known to the Regional Center, or who participate in Early Start early intervention services, the Service Coordinator is the point of contact for system members and partners. Regional Center services are lifelong and available in every county in the State of California. Service Coordinators utilize a person-centered planning process to develop program plans that are based on client preferences, needs, and strengths.

SARC is additionally committed to conjointly participating in collaborative teaming for foster youth. The assigned service coordinator shall be the Regional Center's designee to the child's CFT.

1.3 What is a Child and Family Team and why are they used?

Teaming, engagement and planning processes from member and partner agencies may take different forms, as informed by state expectations or historic practice. However, in order to maximize planning and family engagement, a unified team will serve each child and family. CYSOC members agree to ensure that every effort is made to invite relevant partner staff, including but not limited to community contractors or other providers, to their respective teaming meetings to engage in teaming and planning. Acknowledging the Integrated Core Practice Model's emphasis on child and family voice and choice, school and Regional Center personnel will also be invited to any and all identified CFT meetings for shared planning.

A Child and Family Team (CFT) is a unified teaming process to engage with, empower and plan alongside youth, parents, caregivers and family members. There can be many goals and purposes of a CFT meeting, depending on the needs of the youth, family and their caregivers, and the status of the service delivery and court processes.

The CFT is comprised of the youth (age 10 or older), family and all the individuals they have agreed to invite and participate on their team, along with the professionals who will help and support them toward their successful transition out of the child welfare or juvenile probation systems, this may include attorneys or members of their team that are engaged with the youth and families. The team should limit the number of professional staff that are directly included in planning and resource development and ensure that the youth and family agree with the composition of the team.

A CFT's composition is guided by the family's input, their needs and preferences, with a high emphasis on identifying and connecting community-based, informal support to the family, so that the family's support system will continue to exist after formal services are completed. The youth's attorney or other designated legal advocates are always welcome in a CFT.

Who participates in any particular CFT meeting may vary depending on the stage of team formation, the phase of service delivery, the focus of the meeting agenda, or what supports and resources are required at a given moment in time.

1.4 Child and Family Team Policy

State regulations, system partner's policies, and the CYSOC's Memorandum of Understanding all indicate that teaming services are the primary method of engagement and service coordination. As a best practice, CFT meetings are held as often as the youth and family need or request. More practically, social workers, Intensive Care Coordination (ICC) coordinators and probation officers will schedule and convene a CFT meeting as often as necessary to address emerging issues. If no existing Child and Family Team meetings are occurring, staff and family will jointly determine the need for and participate in a CFT meeting. The generally suggested or sometimes required timelines include:

- Within the first 60 days of initial placement into foster care
- Once every six (6) months for children/youth in out-of-home placement who are not receiving Intensive Care Coordination (ICC)
- For initial placement decision and/or change in placement
- For development of a transition plan and care plan of a child/youth currently transitioning to a lower level of care or a Short Term Residential Therapeutic Program (STRTP)
- At least every 90 days for youth receiving:
  - Short Term Residential Therapeutic Program (STRTP) services
  - Intensive Care Coordination (ICC) services including Katie A, and Wraparound
  - Intensive Home-Based Services (IHBS)
  - Therapeutic Foster Care (TFC)

Social workers are also required to attend a minimum of one CFT meeting facilitated by an outside provider (Wraparound, Katie A Intensive Services)

During the CFT meeting the focus will be on the strengths of the child/youth/family in order to create an action plan. The family may be encouraged to and can request "family alone time" in which they have the option to meet without non-family team members in order to develop and coordinate their responsible elements of the case plan or develop additional actions.

1.5 CFT Process and Principles

Child and Family Teaming is a process intended to support engagement, collaboration, planning and effective service delivery. Each CFT meeting is rooted in principles that value the child/youth/family's voice and choice in making decisions for themselves and creating their action plan in their own voice. The family's culture and value system is honored during this process. Each participant will commit to supporting the family's successful completion of the action plan.

Each CFT is designed to meet the individual mandates for child welfare, juvenile probation, and behavioral health practitioners within the system of care. According to the Integrated Core Practice Model (ICPM), effective services in a teaming setting consists of elements that include: 1- Engagement, 2-Assessment; 3- Service Planning and Delivery, 4- Monitoring and Adapting and 5- Transition.

Engagement — Assessment — Initial Service Planning — Monitoring & Adapting — Transition

1.5.1 Engagement

Developing the team and planning the initial CFT meeting is an important activity. Among the most critical first processes is to engage with the youth and family to understand who they want, or who needs to, be on the team. For some youth and parents, it may not be initially clear who their natural supports and partners might be. The entire team must sometimes invest time before, during or after the meeting, listening to and exploring with the youth and family, to identify existing or new persons who can be invited to support the team. As best practice, it is worth noting that the engagement stage is on-going and should be monitored and adjusted on a consistent basis to ensure best outcomes.

The process of engagement sets the tone for a positive meeting and outlines the process and expectations of the CFT. Engagement extends beyond the youth and family to the other members of the meeting and sets the tone for teamwork across systems. The engagement process is when the team prepares and orients itself to the purpose of the meetings, the forms that are used to document and communicate the plan to one another and to otherwise establish the youth and family's vision.

Engagement is a process that requires professionals to be open, vulnerable, and empathetic, listening and embracing the youth and family's stories without judgement. The engagement phase is an opportunity to orient the youth and family to services and ensure they are the driving force behind this process. It is important that the youth and family's needs and strengths are identified, and their voice is prioritized. If a youth or family is in crisis, those needs need to be addressed immediately and the youth and family empowered and motivated to engage in the process. It's important to note that the engagement phase is ongoing. There will be times when families and other parts of the system become disengaged, it is up to all team members, and particularly to professionals on the team to continually demonstrate the openness and the willingness to continuously engage the youth and family.

1.5.2 Assessment

Assessment occurs in each department and across the continuum of the system of care. Regardless of the tools or forms used, the assessment process allows for an understanding of what has happened to the child/youth and family, what are the strengths and needs which have or will help them move forward and make progress, what is working well, what is interfering with their goals and what they would like to work on.

The assessments within juvenile probation and child welfare should also include information as to what brought the children, youth and families into care. The assessment also determines the youth and family's willingness, capability and available resources to achieve safety, permanency, and well-being.

The Child and Adolescent Needs and Strengths (CANS) is the service planning and care coordination tool utilized within the CFT to gather and align information and serves as the foundation for case planning and service-related decisions. The CANS helps to evaluate well-being, identify numerous social and behavioral healthcare needs, supports collaborative decision-making, care coordination, and monitor outcomes of individuals, providers and the overall system. A team-centered CANS completion process is the way the youth and parents can effectively assess their own strengths and needs and participate as equal partners with professionals in the assessment process.

The initial CANS assessment is used to develop a collaborative and integrated treatment and/or service plan by identifying what is working well for the youth and family, what they would like to work on, and what is interfering with their goals. It's important to gather the youth and family's voice by engaging them in the process.

The CANS enhances care coordination, family engagement, and decision-making across systems. The results of the CANS can assist the team in determining placement decisions, identifying services and supports needed by the child/youth, parents, family; and assess any impacts of trauma and the need for behavioral health services; determining life skills, educational needs and identifying immediate supports needed for the youth, family and or care provider. When possible and with youth and family agreement, assessment should be shared with the team for enhanced care coordination and service outcomes.

It is important to note that in child welfare, the main task is identifying risks to safety, maltreatment, parental protective capacity, and child well-being. In juvenile probation, the assessment includes identifying the youth's and or family members' justice-involved behavior. In behavioral health, it is to identify risks and behavioral challenges and perceptions that may respond to treatment. If the CANS identifies mental health needs, the child/youth is referred for a mental health assessment.

1.5.3 Service Planning and Delivery

Trust and mutual respect across the team are deepened as professionals continue to meet with CFT members and express empathy, vulnerability and focus on authentic listening of one another. Members focus on their collective strengths and create an initial plan of care that reflects family preferences, choices and prioritizes the needs indicated by CANS scores. Needs chosen for initial focus are ones the family members want to work on, potentially in addition to any that are legally mandated. The discussion of CANS ratings with youth and family during and in between team meetings helps achieve agreements about plan priorities and needs.

Likewise, the team must demonstrate respect for family member's preferences when choosing intervention strategies. Interventions should rely consistently on informal supports and resources, which are likely to be more stable and less stigmatizing for family members. Participation in activities and resources that can be used by anyone in the community should be preferred over formal services and resources. Prevention services offered in the community or school sites may be part of that array and the role and support that could be provided by educational partners and others and should not be overlooked.

The initial planning phase should be completed during one or two meetings that take place, within 2 weeks, after the initial intake process is completed. Urgent safety plans may be developed sooner, potentially before the first team meeting is convened. A rapid time frame is intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal. Debriefing after the meetings allows youth to ask additional questions or seek clarity about the process and plan.

1.5.3.1 CFT Procedures: (For Additional Practice Guidance, see internal policy on CFT

CFTs are required under certain circumstances, and it is also best practice to refer families for a CFT meeting as frequently as needed to address emerging issues and needs, safety concerns, behavioral issues, or when family request one.

1. The teaming process shall begin with the initial interactions between identified partner agencies, their community-based contractor team members and the child/youth, parent and family. As the strengths and needs are identified via the CANS, the team should expand to include other members as necessary and appropriate, with a focus on expanding the network of informal and natural supports.
2. The social worker or probation officer will ensure that parents and caregivers are informed about the CFT process, how they can request a CFT meeting, how times and locations of meetings are determined, what should be included in CFT meeting minutes and planning documents.
3. Each CFT meeting shall have a designated facilitator who will set the meeting purpose with pre-meeting input from the members; convene, and ensure the meeting runs smoothly and with fidelity to the ICPM. The facilitator shall also be responsible for ensuring that members of the team use the CFT structure to work across the systems, building positive relationships, and sharing creative energy and resources that result in an integrated approach and a unified or aligned plan. The facilitator shall likewise ensure that members of the team contribute based on their specialized expertise and experience in identifying child and family needs that may potentially and unintentionally, not be identified or addressed by other service delivery systems. (see CSOC policy on Facilitation)

During CFT meetings, all members participate in the development and implementation of the care plan and shall be responsible for supporting the child/youth and family in attaining their goals. The process shall be standardized to include:

      a. A clearly defined purpose, goals for each meeting;
      b. An agreed-upon decision-making process;
      c. Identification of youth and family strengths and needs.
      d. A brainstorming and option-generating process
   e. Specific action steps to be carried out by certain team members according to an action plan and a timeline.

Confidentiality will be discussed, and ultimately, **the decision to share information lies with the family or holder of privilege.** If the child/youth and family are being served by more than one system, it is important to discuss the importance of an integrated approach to planning and service delivery and the benefit of including all providers in the CFT
.

1.5.4 Monitoring and Adapting

The use of the Child Adolescent Needs and Strengths within the teaming process is paramount. CANS ratings are updated routinely as part of the teaming and monitoring process. Throughout, CFT members work together with the youth and/or family to ensure the integrated plan provides access to needed services or resources, monitors the child, youth, and family's progress, and makes individualized revisions to the plan, the supports and interventions as they learn together what does or does not work.

During this time, successes are celebrated, and progress is continually reviewed, all while maintaining team cohesiveness and mutual respect. As goals are met, new goals are prioritized and added to the Child and Family Team plan. The revised plan is implemented, and the process repeated until each of the family's goals for change are met, ongoing resources and supports are in place, and the team's mission is substantially achieved.

1.5.5 Transition Management

A transition can reference any significant change in care or membership on the team. It does not simply refer to a change in living situation. Accordingly, from the beginning of care, and more urgently as the teaming process unfolds, plans include discussion about resources needed for purposeful and seamless transition out of formal services. This may include a potential mix of formal and natural supports in the community (and, as appropriate, access to services and supports for ongoing or emerging needs). Transitions throughout the process occur as issues are resolved and/or others emerge or are prioritized.

When formal services draw to a close, the family should be able to manage a planning and monitoring process on their own as challenges arise in everyday life. Effective transition management requires professionals not to lose contact with or disengage from the child, youth or family **until ensuring** that continuing and new providers and natural supports are completely established and engaged. Good transition work invites professionals and their supervisors to exercise a "warm handoff", taking the additional step of confirming or verifying that the new team or new provider is fully and completely engaged with the youth/family and that new services are being delivered. No assumptions are allowed in pursuit of good transitional care

1.6 Wraparound Continuum

Santa Clara County has a rich continuum of intensive community-based services which collectively comprise its Wraparound continuum. That continuum includes:

- Full-Service Partnership
- Pathways to Wellbeing Services for Child Welfare and Probation youth

Wraparound in Santa Clara County is provided by Community-Based Organizations (CBOs) through joint contracts developed and managed by Social Services Agency (SSA) and Behavioral Health Services Department (BHSD), with input from Juvenile Probation Department (JPD). Other system partners, including education and San Andreas Regional Center (SARC), participate in Multidisciplinary Team Meetings (MDTs) and Child and Family Team meetings for Wraparound youth as needed and based upon preference of youth and family.

Wraparound is currently the default program for youth exiting from STRTP's, the Ranch and re-entering society. A referral to the IPC for wraparound services is made at least two weeks, and up to a month, prior to the anticipated discharge date from the STRTP. The assigned wraparound team will begin to engage with the youth and family as soon as possible and will participate in CFT meetings for the purpose of creating a transition planning and identifying needed supports and services for when the youth transition's back to the home/community.

All of the wraparound programs in SCC currently utilize a team approach consisting of ICC/CFT facilitator, family specialist and family partner. Some of the providers additionally utilize clinicians, peer mentors, and family finding staff ("Family Search and Engagement" or "Connections" specialists). All of the County's Wraparound providers are required to be Wraparound Fidelity Assessment System (WFAS) collaborators, administering the Wraparound Fidelity Index (WFI)-EZ on an ongoing basis and entering the results into WrapStat. Two of the Wraparound providers (Pacific Clinics and Starlight Community Services) additionally complete the Team Observation Measurement (TOM). The Wraparound providers additionally utilize their supervisory and management staff to train and coach to the standards of High-Fidelity Wraparound and utilize specific outcome measures to evaluate staff performance.

1.7 Special Issues in Teaming

- Intimate Partner Violence may be present in the lives or relationships for young people in care. Staff and team members must be mindful of the interpersonal and inter-relational dynamics by and between family members and be able to appropriately and sensitively support the needs for boundaries and safety planning in a team environment.
- Understanding Impact of Trauma and decision making and how trauma can often impede a person's capacity to predict or envision outcomes, or even process information. CFT team members should be thoroughly trained to effective trauma-informed practice.

- Sexual Orientation, Gender Identify and Gender Expression (SOGIE) invites team members to awareness and reflection of a better understanding of the lives, experiences, and possible unique challenges of LGBTQ and gender non-conforming youth served within the System of Care

- Cultural Humility—Is a hallmark expectation for team members and is referenced in the ICPM. It invites team members to think about one's own values, beliefs, and social position within the context of the teaming moment and the dynamics. In order to practice true cultural humility, team members must also be aware of and sensitive to historic realities like legacies of violence and oppression against certain groups of people. By recognizing the failures of the past, team members, clinicians, providers, and others can all contribute to building a better future for the family that is founded in practices of cultural humility.

1.7 Resources/Links

The links below have been provided to contextualize the information in this chapter in the broader efforts and practices of teaming.
- Memorandum of Understanding
- Integrated Core Practice Model (ICPM)

Chapter E: Alignment and Coordination of Services and Supports

Table of Contents:

1. Introduction to the System of Care Continuum

Alignment and coordination of services and supports is both a conceptual and pragmatic goal of Santa Clara's System of Care. They are also aspirational goals of the partners and the system overall, and they result from effectively teaming, cross-training, sharing information and data and holding a shared vision for youth in the county.

The system partners accomplish this alignment by attending to the above practices, some of which are further captured in adjacent chapters of this operations manual, and by aiming towards addressing the children and youth needs while in care, focusing on how crisis and emergency care are delivered, how Resource Caregivers and providers are supported, how care is monitored and plans are adapted, and how transitions are managed for youth in care. These practices are supported, as always, by the state's Integrated Core Practice Model guide for Children and Youth.

The partnerships of the System of Care are further extended by working closely with Behavioral Health, Community Based Organizations, and Non-Government Agencies in Santa Clara County, which ensures a seamless and non-redundant delivery of services and supports and reduces demand on both systems and caregivers. Many parents and families need care and support, and that care and support must be well coordinated and seamlessly accessed and applied

Teaming guidance is additionally available in Chapter D of this Operations Manual

2. Prevention and Early Intervention Services

Prevention services are to promote and provide services, which are outcome-focused, family- centered, culturally responsive and integrated to the extent possible to support one case plan, which encourages and directs families to use their own natural resources to resolve problems within their community network of support. Teaming, engagement and planning processes from member and partner agencies may take different forms, as informed by state expectations or historic practice. However, in order to maximize planning and family engagement, a unified team will serve each child and family. CYSOC members agree to ensure that every effort is made to invite relevant partner staff, including but not limited to community contractors or other providers, to their respective teaming meetings to engage in teaming and planning. Acknowledging the Integrated Core Practice Model's emphasis on child and family voice and choice, school and Regional Center personnel will also be invited to any and all identified CFT meetings for shared planning.

- Differential Response: staff partner and team with key community agencies to provide alternative responses in some referrals. Differential Response is held as a partnership with Behavioral Health. SSA and BHSD hold contracts with community-based providers to provide home based services to families in the community. Differential Response is a fundamental tenet of DFCS prevention and early intervention efforts, helping families and caregivers find supports and services that prevent child welfare involvement.

- Cultural Brokers: Short-term (60 day) program to support in decreasing disproportionality and increasing well-being among at-risk children and families by helping families to understand DFCS as a system and improve communication and coordination of care between DFCS and families. Serving families residing in Santa Clara County. Priority is given to zip codes: 95111, 95112, 95116, 95122, 95127 and 95020

- <u>Behavioral Health Services:</u> a wide range of services from prevention to residential treatment to support children, youth and their families are provided. Clinicians are specifically assigned in a liaison role with child welfare and juvenile probation system partners to facilitate access, communication, treatment and consultation.

- <u>School-Based Services:</u> in partnership with Santa Clara County Office of Education (SCCOE) CYSOC partners to support a multi-tiered system of support (MTSS) and interventions that help school staff identify and respond to student needs and mobilize resources when necessary. MTSS helps unify practices across school district so students get the same access to support no matter what school or classroom they are in. Tier 1 supports are referred to as "universal" as they are provided to every student. Tier 2 supports are targeted, and additional interventions are delivered to students who are not responding to Tier 1 supports, typically around 15 to 20% of the students receive Tier 2 support. Tier 3 interventions are more intensive and up to 5% of students receive these supports if they are struggling and require even more support. It is also for students who are undergoing more of an acute crisis. SCCOE in partnership with other CYSOC partners supports schools and helps coordinate Wellness Centers that are provided to school campuses throughout the county. Each Wellness Center provides Behavioral Health support and a welcoming, comfortable space on campus for students and families to receive a multi-tiered level of support.

- <u>Individual Education Program (IEP):</u> Children who are served in **education-based** service settings also have a high need for teaming and coordinated service planning. Many students have social emotional learning needs which are addressed by their school, via SB 504, Student Study Teams, or in Individual Education Program planning processes. While each school or district may use a slightly different approach, all districts are committed to utilizing a Integrated Systems/Multi-Tiered System of Supports framework designed to bring together general and special education supports, with the goal of providing a comprehensive, proactive, and unified system of education to meet the needs of, and improve results for, all students. While based on clear statute which guides its intent and process, IEP meetings are an opportunity for professionals to engage and support students and caregivers using ICPM based and research proven, principle-based and effective practice.

- Ed Manager Program: Through a partnership with SCCOE and SSA, 6 Managers, Foster Youth Education Services ("Ed Managers") and one Coordinator, Foster & Homeless Youth Educational Services, are co-located at DFCS. Ed Managers care caseloads of children and youth who are dependents of child welfare or children and youth who are the subject of a 300 petition or a voluntary placement agreement. Ed Managers navigate the educational system on behalf of youth, parents, caregivers, social workers, and education rights holders. Ed Managers also work with school districts within Santa Clara County to increase district capacity to serve students who are involved in the child welfare and juvenile court systems. Ed Managers monitor educational data for all youth on their caseloads, attend school and CFT meetings, and provide referrals for transportation, school-based counseling, and educational coaching, as appropriate. Ed Managers work with the Educational Services Unit at DFCS to provide a continuum of services for all youth.

- Educational Services Unit at DFCS (EdSU). The EdSU unit provides services to families and social workers involved at all levels in DFCS services. Educational Services include Education Consults with education attorneys from LACY and educational specialists from Morrissey-Compton, as well as short-term transportation services for eligible youth. For youth assigned to an Education Manager, the social worker or Ed Manager can make a referral for services from EdSU for those students who need a more intensive level of educational intervention.

- Community Schools. A Community School is any school serving pre-Kindergarten through high school students using a "whole-child" approach, with "an integrated focus on academics, health and social services, youth and community development, and community engagement." As a school improvement strategy, community school initiatives enable the local educational agency (LEA) and school to work closely with educators, students, and families to understand and address the unique needs, assets, and aspirations of the school community. (California Community Schools Partnership Program Framework).

- Campus Wellness Centers. School Wellness Centers provide safe, supportive environments on school campuses where students can go to de-stress. Mental health is an incredibly important part of overall health and deserves the same amount of attention and support. The Santa Clara County Office of Education has worked in partnership with schools and community-based organizations to support 18 Wellness Centers and programs. At the Wellness Center, students can engage in self-led relaxation activities and/or connect with wellness staff. Wellness Center staff provide screening, individual and group counseling in order to prevent and intervene early. Wellness Centers have a "No Wrong Door" policy: students can drop-in before and after school, during break and lunch.

- **MHSA Prevention and Early Intervention (MHSA PEI)**: services promotes wellness and prevents the development of mental health problems through early intervention services to screen and intervene in early signs of mental health issues. PEI services conducts outreach to increase recognition of early signs of mental health needs, reduce stigma and discrimination; and increase access and linkage to medically necessary care.

- **First Five Prevention Services**....are delivered through an expansive set of contracts with Community Based agencies and organizations.

- **Juvenile Probation Services:**

  - Prevention and Early Intervention (PEI): These services include prevention, assessment, early intervention, and diversion programs to all areas of the county and targets at risk and low-level youth referred by police agencies. PEI seeks to address youth's needs and refer for appropriate services at the earliest stage possible to lower risk of reoffending.

  - Probation Officer Informal Supervision: Based on an eligible alleged offense (Misdemeanor or Felony) and as an alternative to appearing before the Court on a filed Petition, a Deputy Probation Officer can place a youth with a pending Citation on an Informal Supervision Contract for six months.

3. Treatment, Intervention and Other Services and Supports

- **Supports for Resource Caregivers** (See Chapter J)-- Child and Family teams, and lead case management personnel strive to inform kin, CFT members and their natural supports of this continuum of support as part of their service delivery and planning processes. Resource Parents in particular, have significant need to information about what Education (i.e. school enrollment, school stability, general education plans such as 504s and SSTs), Mental Health and Substance Abuse recovery and Developmental and Intellectual services are in place for a youth in their care.

- **Public Health Nursing Services**—Public Health Nurses provide home visitation services across the County, for vulnerable populations across the lifespan, from newborns to older adults. Public Health Nurses conduct comprehensive nursing assessments, monitor for growth and development, provide health education, and ensure linkage to medical/dental care and needed resources. In addition, there are dedicated Public Health Nurses who are dedicated to work closely with children/youth who have been placed in foster care.

- **Behavioral Health Services**: offers a full range of services from prevention to residential treatment, including but not limited to:
  - Wellness and Prevention Services
  - School Linked Services and School Based Behavioral Health
  - Outpatient Continuum Services for mental health and substance use
  - Katie A Intensive Services
  - FSP continuum services
  - Wraparound Services
  - STRTP Services
  - SUTS residential treatment
  - Specialized Residential Treatment Homes

- Crisis Services, including
  - FURS
  - Mobile Response and Stabilization Services (MRSS)
  - Crisis Supports via assigned Behavioral Health providers
- Short-term highly intensive placement stabilization services:
  - Placement Supportive Services (PSS)
  - Intensive Stabilization Services (ISS)

- Therapeutic Behavioral Services

- ERMHS Services from School Districts---

- Probation Services: delivers services within the CYSOC to youth on varying levels of supervision, including but not limited to:

  - Domestic Violence/Family Violence Services: The Juvenile Justice Domestic Violence Court provides a collaborative approach to the adjudication, supervision, and rehabilitation of youth with domestic or family violence offenses. The purpose is to increase victim safety and support, while providing youth with the specialized services for the reduction of relationship violence.

  - Dually Involved Youth (DIY): Provides a coordinated approach between the Department of Children's Services (DFCS), Behavioral Health, and Probation. This model enables social workers, probation officers, and Youth Advocates to be co-located to provide intensive services for youth and their families and a united case management approach.

  - Juvenile Service Units (JSU): These units provide supervision and case management services including referral to community and school services for compliance with Court orders. Probation Officers conduct youth needs assessments for the completion of Court reports with a recommendation to the Court for disposition.

  - Placement and Foster Care: Probation seeks to keep kids in their homes with their families as often as possible with community based, family driven services. Placement staff locate short-term residential facilities for youth with specific treatment needs and who are ordered by the Juvenile Justice Court. They also identify permanent families, while providing ongoing transitional services, within the community and/or to support family reunification efforts. This is consistent with the California Department of Social Services, Continuum Care Reform Act, which seeks to reduce the number of kids in foster care placements/residential facilities

- Re-Entry Services (RSU): This program focuses upon the success of youth re-entering the community from the Juvenile Rehabilitation Facility-James Ranch Enhanced Ranch Program. RSU emphasizes the support of the youth and family for successful transition into the community from a custodial setting.

- Neighborhood Safety/Services Unit (NSU): The NSU leverages existing school linked services infrastructure, and utilizes a public health approach to foster community cohesion and provide services to high-need neighborhoods. This work is accomplished through the use of community engagement, leadership development, activities for youth and families, and a focus on health and wellness.

- Substance Abuse and Co-Occurring Services: "Progress Achieved Through Hope and Holistic Services" (PATH2Services) seeks to teach youth the skills needed to succeed, and manage mental health and/or substance abuse disorders throughout their lives. A team approach is used for the adjudication, supervision, and rehabilitation of youth with specific mental health diagnoses, substance abuse disorders, or both.

- Regional Center Services: focus on services and supports to support the child or youth in their home and community. Services are based on individual needs and what, if any, generic or natural supports are available.
  - Behavioral respite provides temporary and intermittent relief to primary caregivers for children and youth who have aggressive or unsafe behaviors.

- Respite care: In-home and out-of-home respite care may be available in order to provide protection and supervision to ensure the child's health and safety and to provide temporary and intermittent relief to the child's caregiver.

- Enhanced Behavior Services Homes are residential care facilities for children and youth who require intensive behavioral and adaptive intervention by a unified team of professionals.

  - Children's residential care: The regional center oversees a continuum of licensed care homes that provide shelter and care for children and youths whose developmental disabilities require care more than what could reasonably be expected for a child in the home.
  - Independent living skills training: May be available for youth who are preparing to leave their home or who require additional skills development to encourage independence in their home environment.
  - Supported living services: May be available for youth exiting their current residential setting due to reaching adulthood but who require regular or continual supervision and/or support in their home environment.

- Intensive Behavior Intervention may be available through a network of regional center providers if private and public health care providers or health insurance providers are unable or unwilling to provide services.

  - Day care: A subsidy for day care for differences in cost to provide care relevant to the child's developmental disability may be available.
  - Community integration training: May be available to youth who require additional transportation, self-care, and/or social skills training to access their community.
  - Social recreation: Subsidies may be available in order to ensure access to community-based social and recreational opportunities that might otherwise not be accessible.

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  - Systemic, Therapeutic, Assessment, Resources and Treatment (START): This program provides person-centered, trauma-informed, evidence-based positive support for children and youth six or older.

4. Coordination of Care

Within any pursuit of aligned and well-coordinated services is a need for teams to coordinate, monitor and adapt the effectiveness of their planning process, as well as the interventions and supports captured in the plan.

This is done for many youth in the system primarily via use of the Child Adolescent Needs and Strengths (CANS) tool. In a Santa Clara, the teams involved create and use the same, singular CANS, regardless of who or how it is drafted.

The CANS is completed in <u>draft</u> form by a professional certified in completing the CANS, who gathers information from a variety of sources in collaboration with the youth and caregivers. The CANS is finalized in consensus ratings by the CFT members at the start of service planning. During the service process, the CANS gets updated to capture progress made and newly identified needs. CANS ratings must accurately reflect the shared collaborative agreement of CFT members. For families receiving services from other partners, the CANS should include information from assessment or screening processes used by those partners.

The use of CANS supports prioritization of needs for collaborative decision-making and care coordination and allows for monitoring of the outcomes of service delivery through routine revision of the scoring. The use of an integrated cross-agency CANS process creates use of common language, supports shared understanding within the team membership, helps shared decision-making, and results in more comprehensive, integrated, and successful service plans.

The social worker can then use the CANS to help support the process of screening and linking youth to mental health services, in partnership with dedicated BHSD coordinators out stationed at DFCS via the Pathways to Well-Being process. Youth who are interested in substance use treatment can be referred directly via the Behavioral Health Call Center. The mental health provider, social worker, or probation officer may also refer youth to substance use treatment services by completing a referral packet with a signed release of information.

For children and youth with unmet acute needs, the social worker or probation officer may consider referring the youth to the Interagency Placement Committee (IPC), for consideration of intensive behavioral health services. The Behavioral Health services department also provides a Qualified Individual to provide an independent clinical assessment for any youth being considered for an STRTP.

For additional Assessment guidance, See Chapter C and Chapter J.

5. Transition Services

There are many types of transitions during care delivery. Any change, addition of or loss of a team member or professional associated with the youth's care is a transition. Any change in the service location or ecology is also a transition. These changes are often traumatizing, and system partners seek to minimize them whenever possible.

The focus on transition is continual during the service process, and preparation for transition is apparent even during the initial engagement activities. Transitions throughout the process occur as issues are resolved and/or others emerge or are prioritized. As progress is achieved and celebrated, discussion about resources needed to sustain and build on change is included in planning.

A purposeful transition out of formal services is the goal of service provision and planning. It should not be taken lightly or as the result of arbitrary time pressures. The team should decide when transitions occur. Maintaining the empathetic attunement of team members throughout transitions supports the biochemical environment required to promote positive neural plasticity, allowing for the creation of new neural networks throughout the nervous system that reflect being important and safe in the world.

 Transition planning may include a potential mix of formal and natural supports including access to services and supports for continuing needs. When all formal services draw to a close, the family should be able to manage a planning and monitoring process on their own as challenges arise in everyday life. Effective transition management requires that professionals not lose contact with or disengage from the child, youth, or family until assuring that continuing and new providers and natural supports are completely established and engaged.

Some useful transition related questions that team members and care coordination staff might ask include:

- Has the new provider received all necessary Health, Education, Developmental or related records to begin care?

- Has our youth been engaged by the new service provider(s)?

- Has our youth been seen for her/his intake or first service session?

- Does the provider have a CFT scheduled or are you/your provider aware of the current CFT schedule?

- Does the provider have the current CANS scores?

Behavioral Health Services Department has a dedicated Transition Support Coordinator, co-located at DFCS to support families, caregivers, and the team with thoughtful, trauma- informed transition planning as children/youth transition though living situations.

6. **Resources/Links**

- ICPM Primers on Service Planning, Transition
- Guidance at DHCS in MediCal Documentation and Billing Guide for Transitions for Foster youth
- CANS resources

Chapter F:
Information and Data Sharing

Table of Contests:

I. 1 Introduction and Background:

The success of the County of Santa Clara's Interagency Children and Youth System of Care (CYSOC) is highly dependent on a shared commitment to both process and practice for timely and fluid information and data sharing. All aspects of the care coordination and service delivery process, as outlined in the Integrated Core Practice Model and the County's Interagency CYSOC Memorandum of Understanding, including the referral, assessment, delivery of programs, services and supports, monitoring of care, and coordination of transition services are all dependent on a consistent and committed practice and on timely response to youth and family information sharing requests. In other words, good care is connected and directly related to strong, compliant information sharing practices.

The system partners seek to share in a legally compliant manner child/youth specific data necessary for care delivery and coordination. There is also a need to improve service delivery through program evaluation by analyzing data at the program, system and community levels.
It can be important to understand the various terms used to discuss the use of information and data. Generally, data can be thought of as identifiable data, de-identified data, and aggregate data.

When sharing data, the concept of de-identification is critical. The state Department of Social Services and the federal HHS offices, offer guidance (see resource links below) as to steps an organization might take when sharing its reporting data with others.

De-identifying data is more than just removing names. Care and attention is needed to ensure that even when aggregating data for reporting and assessing program effectiveness or efficiency, it does not unintentionally allow identification of specific child, youth or family members.

The County of Santa Clara's Children and Youth System of Care partner agencies seek to build a legally compliant information sharing process around the following components: (1) the ability to collect, monitor and analyze clinical and administrative data to generate data-informed decisions and policies; (2) joint governance responsibility for targeted outcomes; (3) shared outcome responsibility for an integrated system, which refers to the expected or desired impacts of strategies, whether these result from changes in system infrastructure, changes in programs, changes in practice or changes in finance; (4) collective responsibility for continuous quality improvement across systems.

1.1. 1 Information and Data Sharing Values, Principles and Systems Connections

The County of Santa Clara's CSYOC's collective commitment is to a data system that can answer the fundamental questions: "How well are we serving children, youth and families?" and "How do we know it?" This seeks to address issues of Efficiency, Effectiveness and Equity in service delivery with the community. This pursuit is bolstered by additional System of Care values and principles, including being family/youth focused, integrated, trauma informed, and culturally humble.

The County of Santa Clara's CSYOC's goals also involve using sensitive information in a manner that is legally compliant, informed by the best practices of data governance, and respectful of family and child preferences and desires. To this all, all information will be informed by the Minimum Necessary concept, meaning that only the minimum amount of sensitive information is accessed as needed for a particular purpose and only shared with those that have a need to access that Information to complete the tasks at hand. Team members will use information constantly in order to complete countless tasks throughout their days. However, this standard seeks to set the precedent of minimizing the handling or exchange of information of any type, as much as possible. These practices decrease the risk of a breach or unauthorized use.

1. 1. 2   The County of Santa Clara's Interagency Children and Youth System of Care Memorandum of Understanding.

Subsection (IV)(F) of the County of Santa Clara's Interagency Children and Youth System of Care Memorandum of Understanding (MOU) contains important context and guidance for leaders and practitioners in each agency. Critical elements of that MOU are included here for emphasis, and to guide practice.

"1. *The SYSTEM PARTNERS hereby agree, to the fullest extent allowed by law, to share necessary and relevant client specific information and program data in order to conduct, evaluate, and improve treatment and care coordination systems to ensure that the highest quality care is available to children, youth, families and caregivers.*

2. *To the extent permitted under federal law and WIC Section 16521.6, which waives certain otherwise applicable confidentiality requirements in state law, members of the ILT may share confidential information if the member of the team having that information or writing reasonably believes it is generally relevant to the identification, reduction, or elimination of barriers to services for, or to placement of, children and youth in foster care or to improve provision of those services or those placements."*

I. 1. 3 Additional flexibility for information sharing under AB 2083

AB 2083, by enacting California Welfare & Institutions Code section 16521.6, created additional flexibility for information sharing within the structure of the interagency leadership team. 1 Specifically, members of the interagency leadership team or their designees are authorized to share information with one another that they are not otherwise authorized to share under state law when a member "reasonably believes it is generally relevant to the identification, reduction, or elimination of barriers to services for, or to placement of, children and youth in foster care or to improve provision of those services or those placements."2 It is important to note that this authority to share information is only applicable when the barrier is state law; it does not apply when federal law prohibits the information sharing.

The member(s) or designee(s) that receives the information pursuant to this authority are required to "destroy or return that information or writing once the purposes for which it was disclosed or exchanged are satisfied." 3 The information must remain confidential and can only be used for the purpose which it was shared.4   The information can only be redisclosed if it is "aggregated and deidentified in a manner that prevents the identification of an individual."5

The below table summarizes the information sharing additional authority authorized under AB 2083. Please note that each member of the Interagency leadership team may also have other authority outside of AB 2083 to engage in information sharing, such as client written authorization or a statutory mandate in another legal framework.

Information Sharing Authority under AB 2083	
Who can share information?	Members of the interagency leadership team or their designees.
When can information be shared?	When there is a reasonable belief that the information is relevant to the identification, reduction, or eliminations of barriers to: a) Services for children in foster care, b) Placement of children in foster care, c) To improve services for children in foster care, or d) To improve placement for children in foster care.
What can be shared?	Information about children in foster care to assist with services and placement.
Does this apply to information that cannot be shared because of federal confidentiality law?	No, the authority to share information is only when the legal prohibition is limited to state law, not federal.
How can the information be used?	It can only be used for the purpose for which it was shared.
How long can the information be kept?	As long as needed for the purpose for which it was shared. After that, the information must be destroyed or returned.
Can the information be redisclosed?	Only if it is aggregated and deidentified.

2.1 Purpose of information and data sharing--Honoring individual choice/limitations

The primary purpose and importance of information sharing is care coordination, with a particular emphasis on sharing information to reduce over assessment, make timely referrals for care, and ensure transitional services are seamless.

Each system partner maintains policy and guidance on electronic access to, sharing or exchanging and storage and retention of private information. All professionals are required to be informed about their own policy and practice, and to understand how application of those policies in a multi-agency System of Care requires timely, respectful and active consideration of information management to support youth and family service delivery and care coordination.

When legally authorized to share information, it is important to remember the importance of timely sharing -- delays in receiving information can result in delays of service, and can result in compliance issues and ineffective care, and on occasion, may even compromise safety of those served or those serving.

There are many situations which invite awareness to the need for timely exchange of information by and between System of Care partners.

- Teaming and Service Planning Meetings,
- Assessments and treatment plan documents,
- Transitions between providers including entry to Juvenile Hall, hospital admissions, and other settings.

Confidentiality and information sharing practices are key elements throughout the Child and Family Teams (CFT) process, and they are designed to protect families' rights to privacy without creating barriers to care. California Welfare and Institutions Code section 832 was added to promote sharing of information relevant to case planning between CFT members.

Assessment of youth strengths and needs is a critical process which demands timely and seamless sharing of information. As the Child and Adolescent Strengths and Needs tool is the System of Care's primary service planning device, the CDSS has provided guidance around how to share CANS and related assessment information.

"County placing agencies and county MHPs are required to share the CANS assessment tool as allowed under state and federal privacy laws. In order to ensure compliance with Part 2 of Title 42 of the Code of Federal Regulations, while sharing the CANS assessments as expeditiously as possible, county MHPs or county placing agencies must redact items seven and 48 in the CANS Core 50, and item 41 in the Early Childhood module of the CANS assessment that discuss or evaluate the family's problems with substance abuse until an authorization or release is obtained. Any redacted, substance use disorder specific information must be shared promptly upon obtaining the necessary authorization or release. "(ACL 18-09/MHSUDS IN 18-007)

2. 1. 1   Collection, Retention, Equity and Access—Information is power and responsibility

The responsibility for holding and sharing of private or otherwise confidential information has significant implications for the healing relationships which effective care delivery require. When professionals invite or when law requires the use of authorizations for the release of information, the voice and power of the holder of the privilege is primary and paramount and must be honored by all team members.

Often parents or caregivers are overwhelmed with forms and documents, particularly at very stressful moments and may not fully comprehend what they are agreeing to disclose or share. The purpose and intended use of information requires transparency and accessibility (e.g., will this information be used in the court report or just for helping connect me to services). For true informed consent, individuals need to have a clear understanding of how the information will be used, their ability to decline to release the information, and confident that the information will only be release for the purposes they agree to.

Your department or agency policy will inform your practices in regard to collection, retention and access to private and sensitive information. Additionally, the law also includes specific requirements regarding retention:

 The information shared must be destroyed or returned after used for the limited purpose for which it was shared. The information shared will be treated as "confidential and shall not be open to public inspection, unless the information or writing is aggregated and deidentified in a manner that prevents the identification of an individual who is a subject of that information or writing.

. See Cal. Welf. & Inst. Code § 16521.6(a)(5).

3. 1 Procedures for Youth and Family Information Sharing

Each system partner has similar, but varying procedures in place to support staff members in collecting, retaining, safeguarding and sharing youth and family information. It is not possible, at present, to merge all partners policy and practice into a single set of guidance.

There are a number of sources of guidance from state and federal sources on the legal requirements applicable to information sharing. The applicable legal frameworks included, but are not limited to Health Insurance Portability and Accountability Act, Family Educational Rights and Privacy Act, 42 C.F.R. Part 2, California Welfare & Code sections 827, 10850, and 5328 et seq., and California Civil Code section 56 et seq.

3.1.1 Use of Release of Information/Authorization for Release or Disclosure Forms

System of Care partners are committed to the timely sharing of youth information to support care coordination and service delivery. Each department has its own approved form which, when properly executed and signed, supports this goal. Staff will respond to requests for information from system partners in a timely manner, while ensuring accountability for their department informed practice.

A Release of Information Form is available which partners may find useful in facilitating a timely sharing of youth and family information.

- The Santa Clara County Health System Authorization for Use or Disclosure of Protected Health Information form is to be used to support two critical partner-required functions—to share CANS-related and CANS-derived clinical information when planning, assessing and coordinating the care of youth in the foster care system; and to allow members of the Interagency Placement Committee to attend and consider the needs and services of youth from any partner agency as part of the IPC process. (Need Link)

- Santa Clara County's Children and Youth System of Care Technical Working Group drafted a county ROI form. While not required, it contains language and content which may be useful to supporting an effective sharing practice. Each system partner is encouraged to review their existing ROI/Authorization forms to identify where content from this form may improve or enhance their own form's use. (Add link to county draft here)

While other release of information (ROI) forms may be specific to each partner agency, the youth and family's experience when being asked to share Information should be consistent and reflective of trauma-Informed and culturally responsive practice, with respect for individual rights to privacy and their sense of agency. Discussion with youth and families regarding Information sharing should ensure that the youth and family understand exactly what Information will be disclosed and by whom, the purpose and benefit of the Information sharing, the period of time the ROI will remain in effect, and their right to decline consent to release Information or to revoke that consent at any time without negative consequence to them.

The Executive Advisory Committee (EAC) in Santa Clara functions as the primary System leadership body, as designated by the ILT, and in its leadership role, will regularly and consistently review partner's experiences with and feedback about the sharing of information. When challenges are apparent, the EAC will work collectively to explore how the system can and will enhance or improve its response.

5. 1 Resources and Support

- Sample Information Sharing Scenarios - The State Health Information Guidance (Revised September 2021) State Health Information Guidance (ca.gov)
- Data De-Identification Reference Guide - California Department of Social Services (Revised September 2019) Data De-Identification Guidelines DSS Reference Guide_FINAL.pdf
- Guidance regarding methods for de-identification of protected Health Information in Accordance with the Healthy Insurance Portability and Accountability Act (HIPPA) Privacy Rule (Revised October 2022) Methods for De-identification of PHI | HHS.gov
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- National Website with Wellbeing Measures - <u>Well-being of People – Well-being in the Nation Measures (winmeasures.org)</u>
- California Alliance of School-Based Health Centers Consent and Confidentiality Guidance - <u>Consent & Confidentiality | California School-Based Health Alliance (schoolhealthcenters.org)</u>
- Equity in CalAIM: How to identify the patients who will benefit the most - <u>Equity in CalAIM: How to Identify the Patients Who Will Benefit Most - Center for Health Care Strategies (chcs.org)</u>
- This resource outlines steps to help health systems and community-based providers build relationships that draw on each other's strengths, put patients first, and support ecosystem development in local communities: https://www .bettercareplaybook .org/sites/default/files/2019-10/Shared%20Outcomes%20with%20 CBOs%20Play_102819_3 .pdf

6. 1 Future thinking/planning for Information and Data Sharing

- System partners see great value in development of a shared data base for signatories to use in providing coordinated care. This is a large and complex undertaking, but would yield a higher level of care coordination, reduced wait times, and more seamless care for youth.
- Executive Advisory Committee will continue to consider and seek solutions to the challenges of having multiple Release of Information forms in use, and has established an objective of having a universal ROI in use for the Children and Youth System of Care no later than June of 2023.

Appendix 1--Cross Agency Information Sharing Matrix

This matrix summarizes the data elements, privacy law and use of a Release of Information as understood within the System of Care.

Entity	Data	Privacy Law	Release of Information
DFCS, Probation Dept.	Child welfare and delinquency case files. Foster Vision	Cal. Welf. & Inst. Code section 827 and 10850.	Section 827 allows information to a number of parties/entities that are listed in the statute, including: • The superintendent or designee of the school district where the minor is enrolled or attending school. • **Members of children's multidisciplinary teams,** persons, or agencies providing treatment or supervision of the minor. Information about public benefits subject to Section 10850 can be released pursuant to the ROI or for purposes directly connected with administering the public benefit programs. An ROI cannot be used to release child welfare information. If an entity is not listed within Section 827, they must petition to juvenile court for access.
Pediatric medical care (*e.g.,* SPARK Clinic)	Medical care. Adverse Childhood Experiences (ACEs) Assessment. Pediatric ACEs and Related Life Events Screener (PEARLS).	Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub.L. 104–191, 45 C.F.R. parts 160 & 164. Confidential Medical Information Act, Cal. Civ. Code section 56 *et seq.*	An ROI can be used to release information.

BHSD	Mental health treatment and substance use treatment information. School-Linked Services. Child and Adolescent Needs and Strengths (CANS). Ages & Stages Questionnaires (ASQ). (Is also used by other county partners, including First 5	HIPAA. 42 C.F.R. Part 2. Lanterman-Petris-Short Act (LPS Act), Cal. Welf. & Inst. Code § 5328 *et seq.*	The CANS information can be shared with DFCS without a consent or a completed ROI, **except for the substance use related questions** that require consent/completed ROI pursuant to ACL NO. 18-85. An ROI for can be used to release information.
SCCOE	Education information, including special education information (*e.g.*, IEPs). Foster Vision. School-Linked Services.	Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g; 34 C.F.R. Part 99. Every Student Succeeds Act	An ROI for can be used to release information.
SARC	Individual Program Plan.	HIPAA as a business associate to the California Department of Developmental Services. Cal. Welf. & Inst. Code § 4514.	An ROI for can be used to release information.

Chapter G:
Staff Recruitment, Training and Coaching

1.1 Intro to Staff Recruitment, Training and Coaching

Santa Clara's Children and Youth System of Care (CYSOC) seeks to establish and reinforce workforce competency and stability, recognizing that healing and recovery, and the ultimate goals of all department partners are contingent on a well-supported and highly trained group of system partners. These processes require all system partners to recruit and orient team members to the essential principles and values to the system of care. This pursuit is captured in the Children and Youth System of Care Memorandum of Understanding.

"The system partners acknowledge the value of having highly trained and competent staff teams. As such, the system partners do hereby commit to ensuring that social workers, probation officers, therapists, doctors, clinicians, educators, support, and administrative personnel are fully prepared to deliver the seamless and integrated services as outlined in this agreement, and agree to share best practices regarding the recruitment, training and coaching of staff."

A commitment to the state's Integrated Core Practice Model (ICPM) for Children, Youth and Families is the foundation for this approach, as it provides a framework based on a culture of learning for all system partners. The unique nature of the CYSOC and the ability to work within its flexible structures requires a deep and broad understanding of the many principles and practices and focus on the skills necessary to engage families and youth in a collaborative and participant-friendly manner. This approach is based on a core set of beliefs about training and the relationship between employees, their supervisors and agency leaders.

This chapter of the CYSOC Operations Manual outlines system partner recruitment, orientation, training, and skills acquisition, for reaching larger system goals. It also informs the system's major improvement initiatives in all sectors including Child Welfare, Behavioral Health, Education, Regional Centers, Probation, the court, and First 5. To this end, training plans and activities are created to address the System of Care regardless of agency assignment, department training standards or funding source to maximize the benefit and impact to Santa Clara's youth and their caregivers.

This Operations Manual chapter is additionally informed and connected by a collective commitment to Continuous Quality Improvement (CQI) and informed by shared collaboration and teaming at all levels. This organizational learning supports both a trauma-informed system and the delivery of caring services that are centered on equity and fairness and informed by the voices of youth and parents served.

Partnerships are integral to the success of training. The departments in the CYSOC are committed to community-based training resources with a host of key local and state partners including community-based organizations, private providers, youth and parents and caregivers, resource families, and the public. Most training is delivered via approved contracts with state and local partners.

Key partners include CalSWEC, the Bay Area Training Academy, the Standards in Training and Corrections, California Standards Authority (CSA), and the California Mental Health Services Authority (CalMHSA).

The primary purposes of this shared training approach include the desire to support system connectivity and employee comfort when working in multidisciplinary, multi-agency teams; increase consistency of practice; strengthening staff/team engagement and trust through shared learning; increasing resources availability; allow staff the space to become aware of the collective continuum of expertise of system's partners and contractors; and reduce training and workforce development costs.

1.1.2 Trauma Informed and Healing Focus in the Workforce

The nature of the sensitive and critical work performed by staff requires CYSOC leaders to ensure staff recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, families, community, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

All staff are aware that some reactions to trauma result in behaviors and beliefs that impede wellness and recovery. System partners are committed to support further development of trauma informed response in the continuum of care for children, youth, and families to maximize recovery through accessible treatments, compassion, and empowerment.

Training for staff, anchored in the state's Integrated Core Practice Model (ICPM) will support a trauma-informed teaming process, and will reduce compassion fatigue and secondary stress associated with the work. (See Appendix #).

1.1.3 Training Values

The beliefs which support this approach and commitment to training may include but not be limited to:
- Each staff member is whole and unique, and possesses assets and strengths, which contribute to the team's success.
- Each staff member is the architect of his/her own professional growth, and training is essential to that development.
- The nature of the coaching and supervisory relationship is primary to the growth of the staff and the success of the team.
- Equity, fairness, and inclusion as central to creating trauma-informed system.
- Objective assessment and self- appraisal are necessary for continued growth and development.
- Knowledge transfer, from person to person, and team to team is the essence of organizational growth and stability.
- Continuous Quality Improvement, learning and oversight.
- A need for collaboration with labor and personnel representatives.

1.1.4 Training Goals

CYSOC partners have a host of training goals and desired outcomes. These include, but are not limited to:

- Delivery of orientation and ongoing training, including ICPM behaviors, to staff and community partners, relative to all key practices within CYSOC.

- Delivery of family-centered, strength-based practices that incorporate a broad array of services and supports.

- Delivery of services that are culturally responsive and supportive, inclusive, and diverse.

- Delivery of services that are individualized, provided in the least restrictive appropriate setting, coordinated at all levels, and which emphasize prevention and early identification.

- Delivery of Evidence-Based or Best Practices.

- Integration of Trauma Informed Care practices for children and families.

- Integration of recovery and resiliency focused practices.

- Integration of collaboration and shared decision-making.

- Increased staff knowledge of all applicable state and federal regulations.

- Provide learning opportunities across disciplines to provide the most consistent care for shared children, youth, and families focusing on training, consultation/coaching, and peer support toward enhanced integration of supervisory and leadership best practices.

- Establish the culture and engagement of ICPM foundational behaviors in a supported peer and supervisor consultation environment that promotes professional practice growth.

- Collaboration across systems with ICPM behaviors as a common language.

- Use various adult learning environments that foster skills acquisition.

1.2 Recruitment into the System of Care

System partners embrace an awareness that recruiting employees and team members who possess an understanding of System of Care values and principles is important. To that end, job postings, marketing and outreach, and related recruitment efforts will include reference information about those values and expectations for employees working in and around the CYSOC. Some of those essential values, as captured in the county's MOU and the Integrated Core Practice Model, include, but are not limited to:

- Collaboration
- Teaming
- Equity and Inclusion
- Accountability and Responsivity
- Empowerment of youth and caregivers
- Access to care

Additionally, whenever possible, system hiring managers or other responsible staff will look for opportunities to share job openings and opportunities, and to construct hiring processes and panels which include partners. Doing so supports a high degree of "job-fit" and enhances stability of the workforce for all partners.

1.3 Onboarding of new Staff to System of Care

While each agency has unique practices to welcome, orientate and onboard team members, all partners share a commitment to communicating to new team members that they are part of a unique system, with a strong commitment to teaming and partnership as invited by the MOU. Processes that support this collective orientation include, but may not be limited to:

- The use of employee orientation materials that reference both the CYSOC work, as well as the ICPM to highlight their role as a team member within the system.
- A commitment to periodically review orientation/training processes to identify areas needing to be enhanced or improved.
- New team members whose roles include attendance at the CYSOC's Technical Workgroup, Executive Advisory Committee or Interagency Leadership Team, will participate in a 45 minute System onboarding presentation, which is available in recorded form (20220811 Onboarding Meeting Recording.mp4 (sharepoint.com))

The CYSOC departments have identified a subset of trainings which lend themselves to interagency delivery. Some of these are required trainings per the MOU required.

- Trauma Informed Care
- Mandated Reporting
- Cultural sensitivity and Implicit Bias
- Equity, Inclusion and Fairness
- Integrated Core Practice Model (Module 1 & 2)

1.4 Recommendations for Shared Training Practices

Each department requires an essential CORE set of training competencies and provides or obtains these core essentials for all new staff. Most departments also maintain a training calendar. In general, the "system" trainings which comprise the bulk of these cross-training activities are in addition to foundational trainings. In some cases, attendance in CORE trainings facilitated jointly with partner agency staff is possible and encouraged. With approval of management.

Each department, through the Executive Advisory Committee (EAC), will employ the following as essential building blocks of its shared training approach:

- Hiring Managers will convene cross-agency hiring panels.
- Creation and Implementation of a CSOC Orientation Toolkit, to include this Operations Manual
- EAC members will make their respective training calendars accessible to partners and discuss training opportunities at least semiannually.
- Managers will make known and intentionally share promotional opportunities across the system.
- Prior to recruitment, review job descriptions, roles, and duties for "System" level language and intent (ex. the inclusion of ICPM behaviors and CSOC related duties).
- The Executive Advisory Team's Management Tracker tool contains information and process that guides this training development and delivery.
- Departments where training supports are available, have aligned their team into a cross system development process, driven through EAC.

Transfer of Learning:

- No training, by itself, will generally change or improve the quality of a particular service or the quality of a staff member's performance. The transfer of knowledge or skill acquired in formal training to actual practice is what makes any training methodology effective. Effective transfer of knowledge is accomplished by facilitating the practice of the new skill in appropriate clinical settings, in conjunction with collaborative supervision, timely review, and field-based coaching. The transfer of knowledge will provide regular opportunities for professional growth coupled with humility and compassion from leadership.

- The acquisition of and verification of core competencies is ultimately rooted in the need for leaders to be able to answer the question...How do we know that staff are capable of delivering the scope and breadth of needed and required services?

- The role of coaching is paramount to the success of the workforce effort. Each system partner will ensure that appropriate coaching practices are applied and available. This includes field based, or "in vivo" coaching by supervisors or other designated coaches and advisors.

1.6 Supervision and Performance Management

As captured by the Children and Youth System of Care Memorandum of Understanding (MOU), "The system partners also agree to share best practices and recommendations regarding the Performance Evaluations and supervision of certain key manager, supervisor positions, and employees namely in direct service roles. The Operational Manual shall include or summarize the Performance Review processes of system partner agencies to the extent allowed by state and federal employment laws."

The intent of the annual appraisal is:

1) to provide a positive system for employee development,
2) to provide a forum for discussion between supervisor and employee,
3) to recognize strengths and areas of needed growth for the employee, and
4) to provide an opportunity to create an action plan for professional development.

1.6 Additional Training Resources

California's Integrated Training Guide for Children, Youth and Families-- https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-022%20Integrated%20Core%20Practice%20Model%20and%20Integrated%20Training%20Guide/Integrated_Training_Guide_CDSS_and_DHCS.pdf

Santa Clara's Child Adolescent Needs and Strengths (CANS training manual)

Chapter H:
Financial Resource Management

Table of Contents:

1.1 Introduction and Purpose

An essential cornerstone of all Systems of Care for children and youth is the partner's capacity to identify essential opportunities to share the numerous fiscal resources and allocations that the state and federal government provide. Each CYSOC partner has state or federal funds which in many cases, while categorical on their face, can be effectively blended or braided into a more sustainable and effective model. Other funding streams are entirely categorical and immune to creative use.

Research suggests that when well developed, financial sharing creates an insulated continuum of supports and services, which is less subject to changes in funding policy at both state and federal levels. Essentially, without a comprehensive approach to sharing of financial resources, the programmatic success of the System of Care is limited and short lived.

Public funding in support of services and care delivery is nearly always dis-integrated at the federal and state level. This process dates back many years and likely has its roots in the government's intent to account for services to a specific subset of youth or students with particular needs. While understandable, this segregation of financial resources leads to equally dis-integrated service structures, redundancy and inefficiency, with particular impact on participants and service recipients. Essentially, the dollars determine what youth and family receive, rather than the youth or family's needs determining their services. This is deeply flawed and is at the root of all ineffective system efforts. It therefore falls to county leaders to effectively re-integrate the discrepant resources in support of efficient, effective and seamless care delivery.

The state of California has long prioritized an array or specific supports and services for its' young people and families, and counties and schools in California have far more resources than nearly every other state. This creates both burdens, in terms of taking full advantage and ensuring compliant use of those resources, and opportunities to leverage them to the greatest outcome. One of the primary barriers to creating and sustaining comprehensive integrated systems, inclusive of school partners, is identifying funding streams that support interventions within and around school systems, which have, in recent years, sought to adapt their practices and supports in seeking to support the social emotional learning and well being of all students.

Relatedly, there are often identifiable redundancies in oversight and administration, which, when identified and analyzed, yield cost savings in some forms.
The interagency sharing of financial resources is supported by the CYSOC MOU.

"The partners hereby commit to collaborative cost sharing and management of financial responsibility to minimize delays in services and breakdowns in timely, appropriate, and necessary supports and interventions for children and their families. The partners shall consider a child-family centered approach to planning and openness to creative, streamlined and flexible financial solutions when determining solutions to local financial responsibility barriers."

Some funding mechanisms require a clear and concrete process of either joint planning and/or sharing of actual dollars. These include:

- Family First Prevention Services Act, Part 1
- Local Control Funding Formula
- Title 4E For Justice Involved Youth
- Speciality Mental Health Services, delivered under EPSDT

Section 1.2 ILT and EAC Responsibilities:

Partner agencies have committed within their MOU, to several practices which support the sharing of resources. These include, but are not limited to:

- Informing the ILT membership about available funding, state and federal revenues including on-going funding, one-time funding opportunities, revenue enhancements and Request for Proposals (RFP), and grant opportunities for programs and services for children, youth and families.
- The monthly ILT agenda will include a placeholder for members to share funding announcements and opportunities.
- Invite partners, wherever applicable, to jointly submit or apply for grants and other appropriate funding.
- Seek ILT approval for funding decisions. Funding decisions subject to approval by the governing body of each partner agency shall be brought to those governing bodies with a recommendation to approve as joint decision of ILT.
- Foster relationships with State agencies to support local understanding and interpretation of statutes and regulations.

Section 1.3   Training:

The TWG, as captured in the MOU, will initiate for its key members, joint interagency trainings on financial statutes and regulations to "reduce antiquated processes and misinterpreted statutes and regulations. Such trainings shall be designed to foster relationships understanding and interpretation of statutes and regulations to assist them in making informed recommendations to the ILT".

The trainings shall include opportunities to assess current financial practices and determine where regulations and statutes financially confine agencies and where space is available to be financially creative and flexible while ensuring that confidential and privileged information regarding members' financial practices are not shared or discussed.

In addition to these trainings, the TWG shall also be responsible for identifying best or promising financial practices from other counties or states that may be adopted for use in the COUNTY.

The TWG shall also support community-based organizations in encouraging them to avail of private financial resources for programs that are deemed to be valuable in complementing the system of care.

- Work with local partner agencies to cross-train both service delivery and budget and finance professionals and conduct joint interagency trainings on financial statutes and regulations to reduce antiquated processes and misinterpreted statutes and regulations.

Section 1.4 Recommendations for Shared Financial and Resource Management

Shared fiscal management can generally be thought of as the multi-agency responsibility for the development, management and leveraging of disparate funding streams across systems. Shared management of financial resources is necessary to develop and sustain an integrated system, (i.e. financial strategies with potential for addressing multiple determinants of well-being; leveraging, braiding, blending, and pooling of categorical—federal, state, and local government, philanthropic and private funding to improve client and system outcomes).

The System partners support this intent by:

- Making one another's budget staff available to the Technical Working Group or EAC as needed for consultation and connection to programming and planning.
- Preparing training for other department's fiscal and program leaders as outlined in Section 3 above.
- Create and maintain a System of Care funding map of all partner's revenues and income which support the system.
- Periodic analysis of the funding map, with an emphasis on identifying where federal FFP, if more effectively or completely "matched" could be increased or expanded or used more efficiently.
- Establishing a method for local School Districts to engage the TWG or EAC teams, to identify how critical services and supports can be both leveraged programmatically, and sustained through periods of fiscal scarcity.
- Identifying the role of Managed Care Plans to ensure both care continuity and availability of critical Enhanced Care Management Services.

Section 1.5 Resources for Shared Financing and Revenue Management

Public Funding for School-Based Mental Health Programs: This resource is intended to identify and explain the public mental health funding streams in California that can support the full continuum of school-based mental health services. It should also help illustrate how schools can best leverage public mental health funding streams and community partnerships to maximize existing resources.

https://www.schoolhealthcenters.org/funding/mental-health/

- ESPDT Realignment for Districts: The purpose of this paper is to increase understanding of how counties administer children's mental health services and to explore how the 2011 Realignment of mental health services has created new opportunities for collaboration between schools and counties. The authors hope that school districts and their partners will use this information to initiate and guide collaborative planning efforts at this pivotal juncture. http://www .teachersforhealthykids .org/wp-content/uploads/2017/12/EPSDT- Realignment-for-Districts_Dec2015 .pdf

- Return on Investment in System of Care Report: This national compendium of research on program effectiveness comes from SAMHSA, and is the only nationwide study of System of Care to date. It outlines numerous economic benefits associated with effectively designed and delivered Systems of Care. https://gucchd .georgetown .edu/products/Return_onInvestment_inSOCsReport6-15-14 .pdf

- This four-page fact sheet from Health Management Associates is a very recent primer in MediCal and Behavioral Health funding in California. https://www .chcf .org/wp-content/uploads/2019/02/MediCalExplainedBehavioralHealth .pdf

- This Center for MH in Schools and Student Learning Supports at UCLA has many good resources. http://smhp .psych .ucla .edu/practitioner .htm

- National Center for School Mental Health funding guide. https://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Funding-and-Sustainability-1.27.20.pdf

- National Technical Assistance Center funding guide for Systems of Care... https://nyssoc.com/wp-content/uploads/2023/01/NTTAC-SOC-Guidance-for-Financial-Plan_.pdf

YEILD MANAGEMENT

RESOURCES · PRISING STRATEGY · CONSUMER BEHAVIOR · PRODUCT · BUYERS · FINANCE · PRICE DISCRIMINATION · REVENUE

Chapter J:
Collaboration and Delivery of Support Services to Resource Families

Table of Contents:

I. Introduction and Background:

Resource Family Approval Program (RFA) is a family-friendly and child-centered caregiver approval process that combines elements of the foster parent licensing, relative approval, and approval for adoption/guardianship, streamlining the process. When children or youth need out-of-home care within Santa Clara County's Children and Youth System of Care, partners strive diligently to place them with family members or extended kin. In some cases, caring and competent surrogate families are needed. In those circumstances, system partners are committed to recruiting, training, and supporting all Resource Families to be active partners in healing and loving young people and protecting them from further trauma.

The associated functions are not simply a Child Welfare or Probation mandate. System partners acknowledge that beyond the recruitment, retention, and support by Child Welfare and Probation Systems, resource families also interact with and are dependent upon the services of other partner agencies and systems to meet the health, mental health, developmental, and educational needs of the children and youth in their care. Having access to educational, developmental, and mental health support is an essential part of all resource caregiving. Many Systems of Care partners play a vital role in this process and the success of maintaining a safe family living environment for the children and youth in care. The County's CYSOC MOU states clearly:

"The system partners agree to collaboratively, uniformly and consistently agree to protocols for identifying, recruiting, and supporting family-based caregivers and therapeutic care environments for foster safe, permanent and healthy out-of-home placement when necessary and delivery high quality, trauma-informed care to children, youth and their families."

This chapter contains the necessary collaborative, uniform, and consistent protocols for identifying, recruiting, and supporting family-based caregivers and therapeutic care environments to foster safe, permanent, and healthy out-of-home placement when necessary and deliver high-quality, trauma-informed care to children, youth, and their families.

The partners also work together to establish the characteristics and qualifications to ensure the recruitment of quality resource families to care for children and youth at all placement levels but with a particular focus on those with complex needs.

The partners also identify and resolve barriers and determine the strategies to ensure successful recruitment, retention, and support by resource families. Such support shall include short-term or long-term, intensive, highly coordinated, trauma-informed, and individualized intervention provided by a parent to a child or youth with complex emotional and behavioral needs, such as services provided by trained caregivers in specialized therapeutic

placements, including intensive services foster care (ISFC) and therapeutic foster care (TFC). It shall also include stabilization services to support children and youth in the placement environment.

Resources families are respected team members and play an invaluable role in the life of a child separated from their parents/legal guardians. Resource Families are responsible for providing care for children or youth in foster care 24 hours per day while ensuring all their basic physical, emotional, cultural, behavioral, educational, spiritual, medical, and other needs are met. Children/youth need normal childhoods as well as loving and skillful parenting to assist in healing the trauma they may have experienced and thrive. Resource Families work in partnership with social workers, all service providers, and biological families. When appropriate, they ensure the child/youth's needs are met and surrounded by a team of caring individuals collectively working in their best interest.

2. Recruitment and Approval of Resource Family Applications

The Resource Family Approval (RFA) program was mandated in 2017 and has four RFA units and a full RFA family recruitment team within the Department of Family and Children Services (DFCS). The RFA program has English, Spanish, Vietnamese, Mandarin, and Korean language capacity. As part of the RFA program, RFA investigators investigate complaints against families approved by DFCS.

As part of the RFA Program, there are investigators that work with Resource Parents when there are concerns/issues with resource parents. One unique aspect of the RFA investigators is that they also complete all the standard exemptions for the DFCS's RFA program. This has proven beneficial as there is more consistency in DFCS's exemption process. In addition, DFCS continues to collaborate with the Kinship, Adoptive, and Foster Parent Association (KAFPA), where members have access to the Foster Parent Resource Center, donations, activities, support groups, and training for continued education to meet the yearly requirement of eight hours.

DFCS continues to offer a robust respite care program for all approved families and for those relatives/NREFMs who take children under emergency care. Resource parents and caregivers have available to them 300 hours per fiscal year to utilize to help the resource parent meet the demands of everyday parenting and provide them with much-needed breaks. Additionally, resource families are covered by Foster Parent Liability Insurance, which DFCS delivers at no cost to the family.

In August of 2021, DFCS implemented Binti, a software program that supports RFA approvals and case management. Binti is an extensive program that makes it easier for RFA workers to track what is missing from the application process and what is needed for approval. Binti is used by the applicants to start their application process online and by RFA social workers to keep track of the progress toward full approval. For community members wanting to learn more about becoming a resource family, they access Binti and complete an intake. That intake is then routed to a recruitment supervisor to be assigned to a recruiter. The recruiter schedules a virtual informational meeting for the applicant and reviews all program requirements. The recruiters assist the applicant in enrolling in the Pre-Approval RFA Training. During session four,

applicants are provided a passcode to create their account in Binti and begin the application process. Applicants can complete the application on the Binti website or submit a paper application.

For Relatives and NREFMs who take placements on an emergency basis, the RFA social workers provide the passcode for the Binti website immediately, as a completed application must be received within five days after placement. Unlike the community members, relatives and NREFMS with emergency placements are assigned RFA social workers immediately, as there is a 90-day timeline to approve the family entirely.

Approval for Probation

The Probation Department works closely with the Department of Family and Children's Services to approve families who want to care for youth in foster care. Probation gathers as much information about the proposed caregiver, including other occupants and frequent visitors to the home (such as name, address, date of birth, driver's license number, social security number, etc.)

- Within 24 hrs. of placing the youth, the assigned staff completes the RFA Referral and emails it DFCS RFA program.
    - Included is the youth's name, DOB, and anticipated placement date in the body of the email.
- When a recruited family is identified, Probation staff email DFCS.
    - Included in the email that the recruited family wants to be an RFA.
  b. Include the family name, occupants in the home, address, telephone number, etc.

3. Training
County-Based Resource Parent Training

Families are required to complete 27 hours of RFA pre-approval training related to resource parenting and child development. The curriculum used is a combination of the Presley Ridge Treatment Foster Care Curriculum and the Trauma Informed Parenting (TIP) from the National Child Trauma Stress Network. The 27-hour training program is facilitated by the Foster Kinship Care Education (FKCE) program of Hartnell College.

The training sessions cover the knowledge and skills you will need to become a Resource Family and focus on the following:

- Provide Safety, Security, and Nurturance for children in out-of-home care.
- Understand and Address the Effects of Trauma on a Child
- Support the Child's Developmental and Cultural Needs
- Work in Partnership with DFCS and Other Professionals

<u>Post-Approval Training:</u> Families are required to attend 8 hours of training per year (anniversary year post-approval)

- Could attend training offered by various providers such as KAFPA, etc.

<u>FFA Based Training</u>

All FFAs have the basic requirements through the RFA program (FFA Interim Licensing Standards) to have families complete 12 hours of mandatory training. CDSS allows each FFA to have other training stipulations to certify and approve their families. Depending on the FFA, they might have different levels of resource parenting, which will require additional training from basic training.

Opting for certification through a foster family agency allows for a strong partnership with a local non-profit that specializes in foster care. These agencies offer an extensive support network, including specialized training, a full continuum of resources, and a personalized approach to help ensure a strong healthy relationship between resource parents and children/youth. FFAs provide a personalized, connected team, with a close network of services to support each family though their unique journey within the foster care system. In addition, each of the FFAs also offer family approval at the Intensive Services Foster Care (ISFC) level, meaning that for a youth with higher needs, a caregiver will receive additional training and a higher monthly stipend. This is not an option for families going through RFA approval with DFCS, as they do not operate the ISFC program.

4. Support and Services for Resource Families

The Department of Family and Children's Services (DFCS) aims to ensure that every child, youth, and Non-Minor Dependent in out-of-home care and their caregivers receive the necessary supportive services to ensure stability and successful placements. Listed below are supportive services available to Resource Families:

Services to support child/youth in out-of-home care:

1. Gift Cards for RFA Emergency Placements- At the time of initial placement, caregivers can receive a $100 gift card to Target per child/youth to support their needs.

    a. For information, contact the Placement Unit at 408.501.6868.

2. Behavioral Health services are available for children and youth in care to address mental health or substance use needs. Social Workers or Probation officers assist youth with being screened for and linked to needed services.

a. See Chapter E for a detailed review of those services and supports.

b. For information and referral, contact the child/youth's social worker.

Supportive services for caregivers:

1. Seneca's Resource and Advocacy Support Services (RASS) - The team supports resource families and serves as a liaison between the resource family and the child's social worker. The team makes home visits when children are placed in a resource home as needed, assists resource families with coordinating Respite care, and helps resource families navigate the Child Welfare System. RASS assists in identifying community services for foster children, such as tutoring, placement support, birthday cakes, school supplies, shoes, and clothing. Staff help resolve issues with Medi-Cal, health services, RFA, and reimbursement concerns. Team members may attend court/staffing/CFTs and compliance complaint meetings with resource families.

For information, contact the RASS Program Coordinator at rass@senecacenter.org

2. Kinship Support Services Program (KSSP) -This program provides non-financial support services to relative caregivers and the children placed in their homes. KSSP offers post-permanency services for relative caregivers who have become the adoptive parent or legal guardian of a formerly dependent child. This program aims to further strengthen a family's ability to maintain a supportive and stable environment for a child in their care. Services may include case management, support groups, behavioral management services, financial assistance, educational and advocacy services, recreation, respite, and information and referrals to other community resources.

For information and referral, contact – 408-200-0995.

3. Respite Care - Respite care services are offered as part of a case plan to allow a temporary respite to resource families to take a break to fulfill other responsibilities necessary to continue placement stability.

Contact the RASS Respite Care Coordinator at (Robin_Cairns@senecacenter.org).

4. Kinship, Foster & Adoptive Parent Association (KAFPA) Resource Center – KAFPA's mission is to work together to provide resources and advocate for the needs of Santa Clara County kinship, adoptive, and resource families. They provide families with a space for meetings, training, support groups, and a kiosk of resource information from legal aid to summer camps. KAFPA is Northern California's largest kinship, adoptive, and foster parent nonprofit association. The Resource Center is located at 373 W. Julian St., San Jose, CA 95110

For information, please call (408) 501-6365.

5. Foster Kinship Education Services (FKCE) – Hartnell College- Provides Resource Family Approval (RFA) Pre-approval Training and continuing education and support opportunities for caregivers of children and youth in out-of-home care. The training/classes support resource families that meet the Written Directive (WD) educational, emotional, and developmental needs of children and youth in their care.

To register for training/classes/workshops, contact 408-299-KIDS (5437).

6. Medical Appointments – Same-day appointments at Valley Health Center - SPARK Clinic 408-977-4504. South County caregivers may call (408) 885-2272 for expedited access staff in the Valley Health Center – Gilroy.

7. Dental Appointments – Dentists can serve the needs of children at the Valley Health Center - SPARK Clinic 408-977-4504

8. Childcare: Caregivers may qualify to receive subsidized childcare through DFCS for children 12 and under. Childcare may also be available for children over 12 years old who qualify based on particular needs

For information and referral, please email RFchildcare@ssa.sccgov.org or call (408) 271-7444.

9. Transition Support Coordinator: Behavioral Health has a licensed clinician who provides transition support coordination for children and youth transitioning from different placement types including but not limited to: RFA homes, FFA homes, relative homes and reunification to birth family. Services include support such as coordinating transition plans and meetings, coordinating services with the CFT, brief caregiver support, and facilitation of a caregiver support group.

For information and referral, please email Marie.Canete@hhs.sccgov.org

Resources available to support Resource Families before full RFA approval:

10. Smoke detectors - The department provides free Smoke/Carbon Dioxide – Co2 Alarm(S) for Relatives and NREFM caregivers or potential caregivers going through the RFA process.

5. Resources

- Support & Assistance to DFCS Resource Families - Social Services Agency - County of Santa Clara (sccgov.org)
- FosterParentCollege.com: Online Training for Foster, Adoptive, and Kinship Parents and Carers
- JIT California Just in Time Training | Home
- https://capacity.childwelfare.gov/sites/default/files/media_pdf/prepermanency-services-support-cp-00056.pdf
- https://cacfs.memberclicks.net/assets/docs/ab1790_public_child_welfare_.pdf

CONTACT
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