WASHINGTON STATE INTEGRATED CASE MANAGEMENT (ICM)

Multi-system collaboration and coordination for youth involved in the child welfare and juvenile justice systems

A REPLICATION TOOLKIT

January 2013

Washington State Department of Social & Health Services

TABLE OF CONTENTS

Introduction 1

Emergence of ICM in Washington State 3

Youth and Families Involved in Child Welfare and Juvenile Justice 3
- Data Supports the Need
- Action Strategies

The ICM System Integration Process 6

Four Implementation Sites in Washington State 8
- Guiding Principles
- Definition
- Purpose
- Target Population
- Outcome
- Youth and Family Goals
- System Goals
- Program Management

The ICM Collaborators 9
- Washington State Department of Social and Health Services
- Okanogan County
- Pierce County
- Skagit County
- Thurston County

ICM Case Examples 11

The Future of ICM and MSCC in Washington State 12
- Challenges
- Sustainability
- Replication

Resources 13

Attachments

A. Wraparound Principles 15
B. Memorandum of Understanding 29
C. Multi-Agency Integration Matrix 51
D. Local Multi-System Integration 55
E. DSHS Charter 59
F. Multi-Agency Integration Flow Chart 63
G. ICM Implementation Site Charter 67
H. Implementation Site Leadership and Target Population 73
I. ICM Target Population 77
J. ICM Goals, Objectives and Outcome Measures 81
K. ICM Referral Form 87
L. ICM Pierce Authorization for Release and Exchange of Information Form 91
M. Confidentiality Pledge Form 95
N. ICM Site Descriptions 99

INTRODUCTION

A message from the Washington State Department of Social and Health Services, Juvenile Rehabilitation Administration and Children's Administration:

We are pleased to present this Toolkit on the Integrated Case Management (ICM) work at the Washington State Department of Social and Health Services (DSHS), Juvenile Rehabilitation Administration (JRA), Children's Administration (CA), and at the four implementation sites of Okanogan, Pierce, Skagit and Thurston Counties. It is through shared partnerships at the state and local level that we are improving the lives of youth and families in Washington state.

At DSHS, we stress that we are "One Department with One Vision, One Mission and One Core Set of Values." The ICM accomplishments within DSHS and the four county implementation sites have affirmed this overarching value of working together across systems. The four implementation sites focused on the needs of the children and families and established collaborative and coordinated approaches utilizing ICM guiding principles.

All of the ICM implementation site members deserve our gratitude for the extraordinary work they have done to provide and/or refer our most vulnerable youth and families to the treatment, education, resources and support they need to become more productive citizens.

Washington State has a rich history of Multi-System Collaboration and Coordination (MSCC) attracting the involvement of national leaders in this work, including the MacArthur Foundation - Models for Change, Casey Family Programs, Robert F. Kennedy Children's Action Corps, Annie E. Casey Foundation - Juvenile Detention Alternatives Initiative, Center for Children & Youth Justice, Center for Juvenile Justice Reform - Crossover Youth Practice Model and others. We are grateful for their countless contributions to furthering the best of this work in Washington State.

Given ICM's positive impact on the lives of others, we felt it important to memorialize and share this toolkit to encourage the replication of MSCC for children in the Child Welfare and Juvenile Justice Systems.

Sincerely,

John Clayton, *Assistant Secretary*
Junenile Rehabilitation Administration

Denise Revels Robinson, *Assistant Secretary*
Children's Administration

THE EMERGENCE OF ICM IN WASHINGTON STATE

In July of 2010, DSHS embarked on increasing cross system work for youth involved in the child welfare and juvenile justice systems, called Integrated Case Management (ICM). DSHS leadership, along with the Special Assistant on Juvenile Justice Policy, Bonnie Glenn, funded by a Models for Change Grant, established an internal infrastructure within DSHS to facilitate and support the ICM/MSCC efforts. This internal infrastructure consisted of an Executive Team, which provides governance from headquarters at DSHS, a Steering Committee comprised of senior level staff, and Subcommittees, which assist to advance ICM work and identify and alleviate barriers.

The creation of this internal infrastructure consisting of executive level leadership, along with senior leadership from state and local government and community providers, is imperative to the success of the model. As ICM sites are developed, regional support to facilitate local meetings, etc. is also necessary to ensure the successful implementation of the model at the local level. DSHS reached out to local communities and their leadership in looking for potential partners. In partnering with the implementation sites DSHS examined factors including: available data for multi system involved youth, a representation of rural vs. urban areas and areas that had a familiarity or interest for embedding wraparound principles (Attachment A – Wraparound Principles) and a commitment to collaborate.

DSHS was fortunate to have funding from the Mental Health Transformation Grant to provide wraparound training to the sites as the work began to ensure all sites were grounded in wraparound principles.

At the local level, Okanogan, Pierce, Skagit and Thurston counties have partnered as ICM implementation sites. These and other counties have established MSCC activities such as: a child and family consortium, wraparound, drug and mental health courts, policy committees, etc.

MSCC has been acknowledged and promoted as an essential and most effective practice to work with children who are involved in the juvenile justice, child welfare, and other systems such as mental health and substance abuse. As a national initiative, successful models have been developed, promoted, and implemented by:

- The MacArthur Foundation (Models for Change)
- Child Welfare League of America and Robert F. Kennedy Children's Action Corps (Systems Integration Initiative)
- Casey Family Programs and Center for Juvenile Justice Reform (Crossover Youth Practice Model)
- Annie E. Casey Foundation (Juvenile Detention Alternatives Initiative)
- United States Department of Justice, Bureau of Justice Assistance (Mental Health Collaboration Program)
- United States Substance Abuse and Mental Health Services Administration (Systems of Care)

Another integral piece of the ICM structural foundation in DSHS is a Memorandum of Understanding (MOU) between Juvenile Rehabilitation Administration (JRA) and Children's Administration (CA) (see Attachment B) containing specific practices, protocols and expectations regarding communication and collaboration in the service of youth and families who are dually involved with CA and JRA.

Collectively, these state, local and national initiatives serve as a solid foundation from which ICM is able to emerge with differing levels of development affirming the uniqueness of each implementation site.

YOUTH AND FAMILIES INVOLVED IN CHILD WELFARE AND JUVENILE JUSTICE

Data Supports the Need

One of the most important first steps when developing an ICM site is to understand the target population the region and/or state ICM is intending to serve. To that end, in February 2011, a statewide analysis was conducted by Liz Kohlenberg, PhD, Barbara Lucenko,

PhD, Lijian He, PhD, and Barbara E. M. Felver, MES, MPA from the Washington State DSHS Research and Data Analysis Division (RDA).

Results of the statewide analysis revealed 5,784 youth (ages 7 to 17) and 6,010 transition age clients (ages 18 to 21) were involved with law enforcement (either through arrest and/or through JRA) AND who were DSHS clients in State Fiscal Year (SFY) 2007 AND who had received abuse and neglect services between SFY 1999 and 2007 OR were in Community Protection under the Division of Developmental Disabilities in SFY 2007. The total size of the group was 11,795 youth.

Of these 11,795 youth, the following numbers in the four ICM implementation sites are:

1. Okanogan County – 65 youth
2. Pierce County – 740 youth
3. Skagit County – 242 youth
4. Thurston County – 386 youth

The analysis resulted in the following findings:

- These youth have varying levels of involvement with criminal justice and child abuse and neglect.
- 70 percent of both age groups are male.
- Over half are minorities in the youth age group.
- Exactly half are minority in the transition age group.
- In SFY 2007, over half of the younger youth and moms and one-fourth of the transition clients received child abuse/neglect services. Half of the younger youth and moms and almost 60 percent of transition clients received Basic Food. Sixty percent of both young and transition age clients were part of support enforcement cases. Almost 30 percent of the younger youth and 20 percent of transition clients received alcohol/drug services. A third of the younger youth and one sixth of the transition clients received mental health services from Regional Support Network (RSN).
- Seventy-six percent of the younger youth had DSHS medical coverage in SFY 2005, declining to 68 percent in SFY 2009. Sixty-eight percent of the transition youth had DSHS medical coverage in 2005, declining to 40 percent in SFY 2009, probably as they "aged out" of medical eligibility as children. About half the birth moms had coverage. About one in five of the birth dads had coverage.
- Among those with medical coverage: Two out of three younger youth (66 percent) and moms (67 percent) had a mental health need flag. Many did not receive mental health services. Many of these youth and parents did not receive alcohol/drug services in SFY 2007.
- Half of moms and one third of dads are employed. Annual earnings are over $18,000 for moms and $27,000 for the dads. Half of the transitional age youth were employed, but annual earnings were low – just over $5,000 a year.
- Chronic disease is rising over time for the youth – beginning in SFY 2005 at 3 percent for the younger youth, and rising to 8 percent in SFY 2009 for the transitional age clients.
- Treatment for injuries for younger youth and transitional youth are very high compared with the average for all youth.
- Very high rates of emergency room visits, and rising.
- Homelessness for transitional youth rises sharply over time and peaks at two out of four in SFY 2009. Homelessness for younger youth increases over time to one in four in SFY 2009.
- Arrest rates for birth moms and dads are at about 10 percent and do not change much over the five years. Arrest rates for both groups of youth peaked at over 83 percent (younger) and 93 percent (transition) in the focus year – and then dropped to 38 percent and 45 percent, which is still high. JRA receives approximately 3 percent of juvenile justice youth, with counties retaining the remaining 97 percent.
- Four of 10 of the youths' dads, where the birth dad is known, have been incarcerated in a state Department of Corrections facility. Two in 10 of the moms have histories of incarceration.

- These youth have HIGH rates of unmet needs for alcohol/drug and mental health treatment.

In 2011, a Juvenile Justice Annual Report developed by the Washington State Partnership Council on Juvenile Justice (WA-PCJJ) presented the following data for youth in Washington State:

- Juveniles make up 23.5 percent of the total state population, or about 1.58 million.
- Over half of the total youth population is children 0 to 9 years old, with 45.8 percent in the age group of 10 to 17 years old.
- Male youth represent slightly over half of the total youth population.
- Minority youth make up over one-third of the state's youth population with 18.9 percent Hispanic or Latino, 8.6 percent Asian, 5.9 percent Black and 1.9 percent American Indian.
- Black and American Indian youth are over-represented in juvenile arrests, court referrals and incarceration.
- The U.S. Census Bureau estimates the poverty rate among Washington's children age 0-17 was 18.2 percent in 2010.
- During 2011, 75,412 children were referred to Child Protective Services.
- Data from the Juvenile Court Pre-Screen Risk Assessment shows approximately 21 percent of youth on probation from 2006 to 2009 had been diagnosed with a mental health problem, and the state's Juvenile Rehabilitation Administration (JRA) reports that up to 70 percent of youth in their care were identified as having mental health service needs.
- In 2010, there were 25,772 juvenile arrests, for an arrest rate of 36.2 per 1,000 youth age 10-17 in 2010 with 22,767 admissions to county detention facilities and the JRA had an average daily population of 662.

Consistent with other research regarding youth involved in the child welfare and juvenile justice systems, Gregory Halemba and Gene Siegel from the National Center for Juvenile Justice published findings in *Doorways to Delinquency: Multi-System Involvement of Delinquent Youth in King County* (Seattle, Washington), in September of 2011. Overall, their study showed that two-thirds of the youth referred to the King County Juvenile Justice System on an offender matter in 2006 have had some form of involvement in the Department of Social and Health Services (DSHS) Children's Administration (CA) system. The study also found that:

- The more extensive the history of CA involvement, the greater the proportion of females and minority youth (specifically, African-American and Native American youth).
- The likelihood of at least some history of CA involvement increases even more dramatically when controlling for prior history of offender referrals.
- Youth with multi-system involvement begin their delinquent activity earlier and are detained more frequently (and for longer periods of time) than youth without such involvement.
- Youth with no history of CA involvement were referred on offender charges much less frequently compared to youth with more extensive CA involvement.
- Youth who experience multiple offender referrals are much more likely to have records of Becca and CA involvement than youth without such records.
- A multi-system youth's first offender referral often precedes the filing of a first Becca petition.
- First-time offenders with records of multi-system involvement have much higher recidivism rates than youth without CA involvement.
- Youth with histories of both Becca and CA involvement have high recidivism rates.
- Multi-system youth experience frequent placement changes and there are substantial costs associated with such placements.

In summary, the study states that:

"A growing body of research examining the crossover youth population continues to confirm the important challenges presented by these cases. These include considerably higher recidivism rates (markedly so for female offenders), earlier onset of delinquent behavior, more and longer detention stays, deeper and faster juvenile justice system penetration, substantially higher out-of-home placement rates, frequent placement changes, poor permanency outcomes and substantial costs in the face of shrinking budgets."

Action Strategies

Based on thorough research and tested practices, Janet K. Wiig and John A. Tuell, ICM consultants for Washington State, wrote the Guidebook for Juvenile Justice & Child Welfare System Coordination and Integration: A Framework for Improved Outcomes (Child Welfare League of America, Inc., 2004, rev. 2008), which has served as an excellent framework for ICM with four phases identified to achieve effective and lasting multi-system collaboration and coordination. They are:

Phase 1: Mobilization and Advocacy

- Assessment of political and environmental readiness for systems reform
- Identification of and commitment to strategic goals and objectives of the collaboration
- Identification of and commitment to addressing potential barriers to teamwork

Phase 2: Study and Analysis

- Data collection, management, and performance measurement (e.g., establishment of a governance structure for data collection, identification of necessary aggregate data reports, development of procedures for use of reports and consideration of development of an integrated information-sharing system).
- Resource inventory and assessment (e.g., inventory of program and fiscal resources and common screening and assessment instruments, identification of key decision points and decision makers, review of best practices or evidence-based strategies, and identification of the potential for blending funds).
- Legal and policy analysis and information sharing (e.g., examination of statutory, regulatory, formal, and informal

policies, procedures, and protocols; clarification of laws, regulations, and policies that impact systems collaboration and information sharing; and identification of data-sharing impediments and capacity to share information).

Phase 3: Action Strategy Development

- Identification of priorities for all program, service and administrative components
- Development of priorities for an action agenda
- Development of funding mechanisms necessary to support integrated approaches

Phase 4: Implementation

- Agreement on timelines, phasing, milestones and task assignment
- Outcome evaluation with incremental measurement

With each phase, the Guidebook has provided helpful checklists to steer the process and provide tools for quality control and accountability for DSHS and the ICM implementation sites.

THE ICM SYSTEM INTEGRATION PROCESS

In order to build the structural foundations for ICM/ MSCC work and to create a new, integrated and sustainable process, DSHS utilized the research practices of existing models.

1. **Key stakeholders were identified, engaged in the development and ongoing review of the initiative, and kept informed through periodic reports.**

The Secretary of DSHS charged the Assistant Secretaries of JRA and the CA to engage all administrations in the department to launch and collaborate as a team on ICM (Attachment C – Multi-Agency Integration Matrix).

At the ICM implementation sites, local partners were identified to include: juvenile probation; community based providers; prosecutors; defense; law enforcement; tribes; courts; parents; youth; natural and community supports; DSHS; education; employment; housing; economic services; mental health; substance abuse; developmental disabilities and others (Attachment D – Local Multi-System Integration).

Action plans, functional goals and objectives for ICM leadership, and timelines were established with specific areas in:

- Governance
- Structure
- Project management
- Workforce development
- Practice, policy
- Outcome and performance
- Local teams
- Communication plan
- Fiscal/resources
- Legal issues
- Toolkit development

Each area had an assigned responsible person, due date, progress report and acknowledgement of activities completed. The foundation for ICM was established in a Charter which set forth the background, purpose, target population, outcome, guiding principles, youth and family goals, system goals, team structure and team decision-making process (Attachment E – DSHS Charter).

2. **Key leaders are driving the effort, cross-system teams and committees are in place, and governance has been formalized.**

DSHS established an ICM Executive Team to provide governance. Membership includes executives from DSHS administrations under the guidance of the Secretary of DSHS.

Established pursuant to the adopted Integrated Case Management Charter (Attachment F - Multi-Agency Integration Flow Chart), a Steering Committee with similar membership for support and resources was identified and further enhanced by our Subcommittees: Data Sharing and Information, Policy and Procedure, Legal Analysis, and Practice. Each of the subcommittees is led by key staff with expertise in their focus area. The Steering and Subcommittees have an established schedule of meetings, record minutes of the meetings and work with a 360 degree flow of communication within DSHS and the four ICM implementation sites.

At the ICM implementation sites, committees with key stakeholders were established to plan and implement ICM with local charters and agreements (Attachment G – ICM Implementation Site Charter). The charters include information on background, purpose, target population, outcomes, guiding principles, phases and activities of ICM, signatures of the partners and are unique for each county.

3. **The questions about multi-system youth were developed, local sources of data identified, state and national databases reviewed and the mechanism for ongoing data collection to support performance measurement has been implemented.**

The DSHS Research and Data Analysis (RDA) Division conducted a comprehensive analysis of the target population entitled: *Washington State's Youth and Families Involved in Child Welfare and Juvenile Justice*, confirming multi-system involvement and needs of youth in child welfare and juvenile justice for all of Washington state and specifically for the four ICM implementation sites. Information on youth receiving ICM services is recorded on a tracking log and collected by RDA for analysis to better understand ICM and youth receiving the services. It is hoped that this continued analysis will lead to better identification of at-risk youth and how the ICM sites can best meet their needs for improved outcomes.

4. **A clear statement of the problem or need is articulated and embraced, the target population(s) has been specified and the desired system and child outcomes have been identified.**

Based on the analysis conducted by RDA, the overall target population was identified as youth and young adults who have a history of child abuse and/or neglect with current juvenile or criminal justice involvement. Within this identification, the DSHS, JRA, and CA further specified the target population as high risk adolescents and their families who are involved jointly in the Children's Administration and the Juvenile Rehabilitation Administration. The local ICM implementation sites also refined their specific target populations based on their unique demographics (Attachment H – Implementation Site Leadership and

Target Population and Attachment I - ICM Target Population).

The overall outcome desired for ICM is that youth and families receive improved holistic services across multiple systems including DSHS and community partners.

Specific youth and family goals include increases in:

- Health and wellness
- Safe and stable housing
- Job readiness and stable employment
- Life skills acquisition and generalization
- Education - attendance and completion
- Safe and stable in-home care
- Seamless transitions from out-of-home placement
- Stable and safe families
- Safe healthy communities that include natural supports

Specific system goals include:

- Removing barriers that inhibit services
- Maximization of funding through shared resources
- Streamlining services to create efficiencies that reduce duplication
- Creating seamless case management to provide holistic care for youth and families

JRA and CA added to the ICM goals forming a strategic alliance to:

- Work collaboratively with youth that CA and JRA jointly serve
- Safely divert more high risk youth from JRA
- Safely divert more high risk youth from out-of-home care
- Leverage resources across systems in working with shared youth
- Provide a wrap-around approach to integrated case management
- Bring in other administrations as needed to assist in this joint integrated case management approach

For each of the goals, specific objectives and outcome measures were identified and established (Attachment J - ICM Goals, Objectives, and Outcome Measures).

5. **An inventory of assessment tools was compiled and opportunities to consolidate tools and or the assessment process identified.**

As part of the referral and screening process, ICM implementation sites have established procedures to identify potential clientele and to identify needed assessments (Attachment K - ICM Referral Form). The ICM Referral Form provides information about:

- The referred youth, primary parent or caregiver
- Current living situation
- What are the concerns regarding the youth
- What strategies have worked well in the past for a addressing these concerns
- What help the family is requesting
- Identified desired outcomes of the team meeting
- Identification of people desired to attend the team meeting

6. **An inventory of resources, including programs and services, has been compiled and analyzed against standards of best practice and opportunities to share resources and blend funds has been identified.**

As part of the formal ICM structure, a Policy and Procedures Subcommittee has been established at DSHS to:

- Identify multi-system resources/assets
- Identify gaps in system
- Identify policy, practice and statutory barriers

The ICM implementation sites have established partnerships to provide services and activities which reflect a representation of youth and families unique to their counties. These partnerships enable identification of appropriate and available services in their communities, as well as opportunities to access and share existing resources and identify gaps.

For example, the ICM implementation site in Thurston County uses a Resource Assessment Questionnaire form which documents the name of programs, age ranges of youth served, target populations, demographic information about youth served, service delivery modality of the programs, approximate number of youth served, target outcomes, other systems and/or agencies involved, data and evaluation and notes.

7. **A legal and policy analysis has taken place to highlight the legal mandates, funding, court processes and other policies that serve as supports or barriers to systems integration, and any needed policy changes have been identified.**

As part of the formal ICM structure, a Legal Analysis Subcommittee has been established at DSHS led by an Assistant Attorney General to:

- Identify and analyze relevant federal and state statues
- Examine current practices, policies and procedures
- Development/draft interagency agreements and MOU's

This provides for a fluid process within DSHS and between DSHS and the ICM implementation sites to present and consider legal and policy issues related to the effective implementation of ICM.

8. **An analysis and determination of the capacity to share information across agencies has been made and information sharing agreements are in place.**

With support from the Legal Analysis Subcommittee, ICM implementation sites have identified what information they need to share and how this can be accomplished in compliance with applicable laws and regulations.

Written documents for the authorization for release and exchange of information have been developed (Attachment L – ICM Pierce Authorization for Release and Exchange of Information Form). A Confidentiality Pledge Form (see Attachment M) has also been created for ICM partners to utilize in the service of collaborating to best serve ICM youth and families.

9. **A set of strategies for handling multi-system youth has been developed and examined for potential application and corresponding policies, protocols, and training have been established for the strategies employed.**

A Practice Subcommittee has been established at DSHS as part of the formal structure for the ICM. This subcommittee works on the following issues:

- DSHS training and staff development
- Work force development
- Identify missions and case flow (the actual practice case flow)

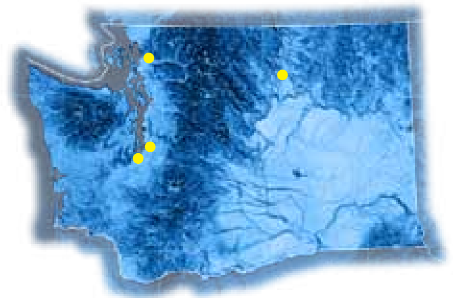
At the ICM implementation sites, regular meetings of the partners are held to discuss and formalize processes for handling multi-system youth with applicable policies, protocols, and procedures that work best for their site. Training on wraparound was provided and an ICM Summit was held for the ICM participants to increase collaboration and information sharing.

10. A communication strategy has been developed and a schedule of inter-agency and public reporting has been established.

An integral part of the established structure is regularly scheduled meetings of all ICM groups (Executive Team, Steering Committee, Subcommittees, and each Implementation Site) with established agendas and recorded minutes. Additionally, the ICM Juvenile Justice Program Manager attends meetings and works to ensure that meetings are conducted, minutes are taken and information is shared.

An important part of the communication strategy is the establishment and use of a shared ICM website. This share point site contains information about meetings, charter(s) and related documents, key links, committee agendas and minutes, listing of committee members and site users, and ICM resources. A brochure has also been produced for each implementation site.

FOUR IMPLEMENTATION SITES IN WASHINGTON STATE



Guiding Principles

ICM adopted the principles of wraparound to inform the ICM process and application of case management. The principles are, in essence, a compass to decision making. The principles are:

- Youth and Family Centered – The system of care honors and reflects the voice of youth and family needs
- Communication – Communication across administrations and systems clearly demonstrates collaborative relationships with youth and families by reflecting youth and family voice
- Culturally Competent – Promote respect and understanding of diverse cultures, social groups, and individuals while providing culturally responsive services to improve client outcomes for all and reflect the diversity of the communities we serve
- Outcome Based – Demonstrate system of care improvements by identifying outcome indicators to analyze impact of service delivery for youth and families.
- Capacity and Leadership – ICM builds sustainable capacity and leadership by affirming and nurturing dynamic partnerships across systems of care
- Strength Based – Value and engage the strengths of youth, families, communities and system partners
- Team Work – Emphasize a culture of collaboration to guide positive outcomes for youth and their families
- Social Justice – Promote and model equality and respect to reduce issues that adversely impact youth, such as disproportionally, and to improve fairness in sentencing
- Collaboration – Work in partnership to cooperatively share responsibility of the development, implementation, monitoring, and evaluation of an integrated system of care
- Natural Supports – Promote the use of relationships and supports for youth and families in their communities

Definition

Integrated Case Management (ICM) is a multi-system infrastructure that embeds wraparound principles and guides the process of coordinating services for vulnerable youth with complex needs and their families who are served in Child Welfare and Juvenile Justice.

Purpose

ICM will achieve a level of effective collaboration statewide by creating a multi-system infrastructure that coordinates policy, programs and services for youth and their families served in Child Welfare and Juvenile Justice.

Target Population

The target population for ICM is comprised of youth and young adults who have a history of child abuse and/or neglect with current juvenile or criminal justice involvement.

Outcome

Through ICM, youth and families will receive improved holistic services across multi-systems including DSHS and community partners.

Youth and Family Goal to Increase:

- Health and wellness
- Safe and stable housing
- Job readiness and stable employment
- Life skills acquisition and generalization
- Education, attendance and completion
- Safe and stable in-home care
- Seamless transitions from out-of-home placements
- Stable and safe families
- Safe healthy communities to include natural supports

System Goals:

- Remove barriers that inhibit services
- Maximize funding through shared resources

Program Management

With funding from a John D. and Catherine T. MacArthur Foundation Models for Change grant, the JRA hired a Juvenile Justice Program Manager, reporting to the JRA Director of the Division of Community and Parole Programs, responsible for management and support of ICM. Specific duties include:

- Support the implementation efforts of ICM at the four county sites.
- Facilitate communication and coordination between the implementation sites the DSHS ICM Leadership Teams (Executive Team, Steering Committee and Subcommittees).
- Coordinate Models for Change National Resource Bank consultant involvement
- Maintain regular contact with the Center for Children & Youth Justice, administrator of the Models for Change grant, for progress reporting and project needs.
- Assist local sites with ICM implementation, including traveling to and staffing regularly scheduled meetings.
- Collect and disseminate progress information to the ICM Steering Committee and Subcommittees via written and oral reports.
- Assist with the maintenance and updating of the ICM intranet website for sharing and managing ICM data and materials.
- Maintain a regional list serve to facilitate communication between the implementation sites and between the implementation sites and the DSHS ICM leadership teams.
- Assist with the bridging of work for implementation sites laterally as well as vertically with DSHS ICM leadership teams.
- Facilitate ICM implementation sites' replication
- Attend relevant stakeholder, committee, and Models for Change meetings; assist in the staffing of those meetings when necessary and recording information discussed at those meetings.

THE ICM COLLABORATORS

Washington State Department of Social and Health Services (DSHS)

DSHS is a state integrated organization of high-performing programs working in partnership for statewide impact to help transform lives. It includes the Children's Administration, Juvenile Rehabilitation Administration, Economic Services, Medicaid Purchasing Administration, Planning, Performance and Accountability, Behavioral Health & Recovery, and Developmental Disabilities.

The Department's mission is to improve the safety and health of individuals, families and communities by providing leadership and establishing and participating in partnerships with core values of:

- Excellence in service
- Respect
- Collaboration and partnership
- Diversity
- Accountability

Each year, more than 2.2 million children, families, vulnerable adults and seniors come to DSHS for protection, comfort, food assistance, financial aid, medical and behavioral health care and other services.

DSHS provides services from multiple programs to meet the multiple needs of the majority of clients. Its practice of collaboration and coordination both within the agency and outside of the agency with partners such as the Models for Change, Cross-Over Youth Practice Model and the ICM implementation sites encourages and provides structure for integrated case management.

DSHS is committed to serving youth in an efficient and effective manner for the betterment of youth and always envisions children and families at the center of ICM/MSCC work.

Okanogan County

Located in North Central Washington and bordered by British Columbia, Canada, Okanogan County has a population of 41,120 (U.S. Census Bureau 2010).

Target Population

The primary population continues to be children/families with present (preferred) or history with CA and some level of Juvenile Justice Involvement. Juvenile Justice Involvement may include JRA or Diverted, Petitioned or Adjudicated youth with Okanogan County Office of Juvenile Court.

Many of these families are involved in multiple other systems as well, including Education, The Confederated Tribes of the Colville Reservation, Community Service Office (CSO), Division of Developmental Disabilities (DDD), Okanogan Behavioral Health Care and other community networks/services. Some families may also be referred if the youth is currently in detention with unmet needs, has been referred to Children's Long Term In-patient Program (CLIP), or is referred by local schools, other DSHS agencies or Mental Health as a child with complex needs. Age groups include children/youth 8-21, primarily 8-17 year olds.

Pierce County

The second most populous county in Washington, with a population of 795,225 (U.S. Census Bureau 2010), Pierce County has been utilizing wraparound principles and values working collaboratively across system for over 20 years

Target Population

The target population is comprised of African American or Native American children/youth and young adults who have involvement with Child Welfare and/or juvenile justice systems. Other considerations include:

- Mental health diagnosis (allows us to access already funded parent advocates)
- At risk of school dropout due to truancy, behavior and/or poor academic performance
- Younger siblings that are at risk of involvement with Child Welfare and juvenile justice systems.

Skagit County

As the county that helped sparked the creation of the ICM with DSHS, Skagit County has a population of 116,901 (U.S. Census Bureau 2010). Pursuant to its Charter, Skagit County states:

Target Population

The primary population continues to be children/families with present (preferred) or history with CA and some level of Juvenile Justice involvement. Juvenile Justice involvement may include JRA or Diverted, Petitioned or Adjudicated youth with Skagit County Office of the Juvenile Court.

Many of these families are involved in multiple systems as well, including education, Skagit County Community Services, DSHS – Economic Services, DDD, mental health and other community networks/services. Some families may also be referred if the youth is currently in detention with unmet needs, has been referred to Children's Long Term In-patient Program (CLIP), or is referred by local schools, other DSHS agencies or Mental Health as a child with complex needs. Age groups include children/youth 8-21, primarily 8 to 17 year olds.

Thurston County

Thurston County has a population of 252,264 (U.S. Census Bureau 2010). Its ICM Charter includes the following provisions:

Target Population

The target population includes families with young children in school who are at risk of becoming truant; youth and families involved in community services but not yet linked with DSHS services, and youth and families with multiple system involvement.

For a full listing of site information, see Attachment N – ICM Site Descriptions.

ICM CASE EXAMPLES

As of January 2013, the ICM implementation sites have worked with 47 cases. The following are case examples from the ICM implementation sites.

Case 1

- A Native American father asked if we could assist his five children with getting back into school and also remain out of the juvenile justice system. They all reside within the boundaries of an Indian Reservation and the family is considered lost by many within the community.
- The first daughter is in the JRA system. She has a criminal history, but in fact is also the victim of a very serious crime and has acted out violently, partially due to not receiving services to deal with what happened to her. She has agreed to the family plan of all siblings attending school nearby that allows all of them in the same building to accommodate her father's desire to go back to school to get his GED and then technical college. This young lady is doing very well and is excited about going back to public school and getting a part-time job as well.
- The second daughter is younger, but is also often kicked out of school for long periods of time for negative responses to her teacher's requests. This youth has also agreed to attend a different school that allows for dad to get his GED and then attend college.
- The middle son has anger issues relating to his mother being in prison for years and repeatedly gets kicked out of school and eventually arrested. This youth is currently not in school, but has agreed to attend regular school and accept a tutor for two hours a day. The tutor has agreed to tutor all of the children at their home for two hours each week to support their education, if covered by Tribal Temporary Assistance for Needy Families (TANF). This youth was in detention, but should have been released to begin his agreement as well. He also agrees to reduce his issues at school to allow for his father to get his GED and go to college to support his family. He also agrees to remain in compliance with probation and the family plan.
- The youngest boy has an IEP and receives tutoring through the Tribal TANF program. The youth's attorney states no schools want this youth in the school district, or any of his siblings. The ICM Team will make contact with the school district, the tribal school, the Social Skills Program, and the Tribal Attendance Program to arrange an agreement that supports the family plan and also allows the school to protect all of its students and teachers equally.
- The Division of Children's and Family Services and the Child and Family Welfare Services workers have almost single-handedly case managed this family into a positive direction that includes a vast array of social service supports. This family was considered lost by most folks and this ICM team specifically wanted to make sure that they helped them to the fullest as demonstration of a "no wrong door" policy.
- As of January 2013, all siblings and the father have bought into the family plan created through ICM and have began working on their first goal.

Case 2

- A 17 year-old African-American/Native American male who, at the age of 14, was placed into foster care along with his 11 year old sister, due to neglect and prostitution allegations against their mother.
- While in foster care, the youth committed a robbery and was placed in the JRA system.
- His sister was temporarily placed with a maternal aunt. This placement was successful until the aunt was financially unable to support her niece.
- The Integrated Case Management team became involved at this time, which also coincided with the oldest sibling's transition from a Juvenile Rehabilitation institution to parole supervision in the community.
- Both youth were placed into treatment foster care.
- The oldest youth enrolled in a high school completion program at a community college and completed parole with no violations. In addition, he successfully used the ICM team to process his anxiety in a healthy manner when his sister had several issues including suicidal ideation.
- The youngest was placed into an inpatient facility and was released with community mental health support.
- During this time, the ICM team was also successful in supporting the mother with her Children's Administration requirements including a drug and alcohol assessment.
- A judge ruled that the youngest child could transition home with her mother after completion of a transition plan which will end January 2013.
- The oldest child will successfully age out of treatment foster care in March 2013, allowing him to participate in their Independent Living Skills program, which is assisting him with a transition to independent living.
- The ICM team continues to support the family as their formal support systems are transitioning out of their lives.

Case 3

- In February 2012, our ICM team staffed a case regarding a 16, almost 17-year old girl, who had recently been involved with Children's Administration, county youth and family services, a local mental health agency, and prior JRA involvement.
- The youth had been adopted at a very young age and her behaviors had progressed to a point where the family no longer felt they could parent her.
- The youth had not lived in the home for several months due to the parents obtaining a no-contact order preventing her from being in the family home.
- The youth was on probation for criminal charges and was compliant with her probation but was not in a stable living situation.
- There were concerns regarding her being sexually exploited, drug usage and continued criminal activity.
- A recent Child Protection Services report had been received regarding the youth being admitted to the emergency room at a local hospital displaying concerning behavior and with no parent available to care for her.

- The youth had expressed to those involved in her case her desire to get a job, continue her education or receive her GED and be emancipated.
- At the ICM meeting, the youth presented with a much older gentleman that she had been living with. Her parents also attended the meeting. Staff from the various agencies at the table all explained what services each agency could offer to assist the youth in meeting her goals, while getting her off the streets and into a safe environment.
- Through the ICM process, agency staff were able to re-engage the parents in the youth's life, re-affirming to them that they were still responsible for ensuring the safety and wellbeing of their child, while partnering with them to have their child receive a consistent message about how her current choices would not allow her to meet her goals.
- The plan made at the ICM meeting included the youth being temporarily placed into DCFS custody for 30 days through a voluntary placement agreement with her parents. Through this placement, community, county and Children's Administration were able to join together to work with the youth's caregiver, her parents and the youth to help her meet her goals.
- By the end of the 30-day placement period, the youth received her GED, obtained employment and was able to be emancipated from her parents, enabling her to qualify for housing options that previously were not available.
- By the various agencies working closely together, providing the youth with a consistent, unified message, being clear about what was expected of her and her family, this youth went from being homeless and sexually exploited to being able to reach her goals and be set on a path to success in the future.

Case 4

- A 13-year old Caucasian male who has lived with his adoptive family since infancy often acts out scenes from the video game Call of Duty and movies like Batman.
- He has been arrested for running through the neighborhoods naked with a knife and has also come to school on several occasions with a knife.
- Issues that concerned the family and related to the referral included; being diagnosed with ADHD, autism, reactive attachment disorder, intermittent explosive disorder, and mild mental retardation.
- The youth is receiving services from Crisis Stabilization Services, county wrap-a-round initiative and Behavioral Health Resources. The Crisis Stabilization services ended in November 2012 and the family wanted support to prevent the youth from being hospitalized as a result of his aggressive behavior. The family thought the following support might help; continuation in the Open Door Autism Social Skills group and they also want the youth to have a mentor to continue helping him understand his boundaries.
- The family and ICM Team goal for having the meeting was to be able to connect the youth and his parents to the appropriate services in order to assist with keeping him out of systems such as juvenile justice or hospitals. The parents also wanted counseling to help them with the trauma associated with dealing with the youth's aggressive behavior.
- The youth and his family wanted help from DSHS – Division of Developmental Disabilities and child welfare, mental health counseling and education services.
- The youth and his family received referrals directly to all of the services they requested and were placed on the top of the Big Brothers Big Sisters list for a mentor.

THE FUTURE OF ICM AND MSCC IN WASHINGTON STATE

Challenges:

- ICM implementation sites received no additional funding for ICM and operate on shared resources with partners willing to work with ICM in addition to their specific work responsibilities. This sometimes creates an inability to complete ICM work at a level needed and desired.
- Changes in DSHS and ICM implementation sites' participants creates a need for continued education and communication. This takes dedicated time and attention to ensure resources are up to date and contact information is accurate.
- Relationship between DSHS and the ICM implementation sites is important to cultivate and support. With little to no funding, expectations for data collection and information sharing need to be considered and matching the unique needs of the implementation sites is paramount.
- Follow-up research is needed to determine the effectiveness of ICM, however, there are no funds set aside for research.

Sustainability:

- DSHS would benefit from a long term ICM Program Manager and ICM implementation sites would benefit from a dedicated local coordinator.
- Additional training (such as the training that was acquired during the 2011 ICM/MSCC Summit at Tulalip) on multi-system integration would help the implementation sites with their infrastructure and processes.
- Additional infrastructure work is needed on the relationship between DSHS and the implementation sites and ICM with other multi-system integration initiatives.
- Follow-up research to confirm what has/has not been achieved by ICM.

Replication:

- Several counties and tribes have already inquired about becoming an ICM implementation site.
- The experiences of DSHS and the four ICM implementation sites can provide a wealth of information and assistance for new sites.

In summary, it is our hope that this toolkit will be useful in multiple ways. First and foremost is to highlight the extraordinary benefits to youth, families and communities achievable with Multi-System Collaboration and Coordination efforts utilizing ICM principles and practices. Second, to engage and motivate potential sites and get them excited about developing the comprehensive framework of ICM. Finally to show evidence of successful implementation within a department and between social services and local communities to better meet the unique needs of Washington's youth and families.

RESOURCES

Addressing the Needs of Multi-System Youth – Strengthening the Connection between Child Welfare and Juvenile Justice, A Symposium, Center for Juvenile Justice Reform, Robert F. Kennedy Children's Action Corps, Georgetown University, March 1, 2012
http://cjjr.georgetown.edu/pdfs/msy/MSYPowerPoint.pdf

Annie E. Casey Foundation, Juvenile Detention Alternatives Initiative
http://www.aecf.org/
www.jdaihelpdesk.org

Casey Family Programs
http://www.casey.org/

Center for Children & Youth Justice
http://www.ccyj.org/

Center for Juvenile Justice Reform, Crossover Youth Practice Model
http://cjjr.georgetown.edu/

Child Welfare League of America
http://www.cwla.org/

Council of State Governments, Justice Center, Criminal Justice & Mental Health Consensus Project
http://consensusproject.org/

Doorways to Delinquency: Multi-System Involvement of Delinquent Youth in King County (Seattle, WA), Models for Change, prepared by Gregory Halemba and Gene Siegel, National Center for Juvenile Justice, September 2011)
http://www.ncjj.org/pdf/MFC/Doorways_to_Delinquency_2011.pdf

Guidebook for Juvenile Justice & Child Welfare System Coordination and Integration, A Framework for Improved Outcomes, Janet K. Wiig with John A. Tuell, Child Welfare League of America, 2004, revised 2008.

John D. and Catherine T. MacArthur Foundation, Models for Change
http://www.macfound.org/programs/juvenile_justice/

King County Uniting for Youth Implementation Evaluation, prepared by Linda Rinaldi, Rinaldi & Associates, Nancy Ashley, Heliotrope, December 2012.

National Center for Juvenile Justice
www.ncjj.org

Robert F. Kennedy Children's Action Corps
http://www.rfkchildren.org/

United States Department of Justice, Bureau of Justice Assistance, Mental Health Collaboration Program
https://www.bja.gov/ProgramDetails.aspx?Program_ID=66

United States Substance Abuse and Mental Health Services Administration (SAMSA)
http://www.samhsa.gov/

Washington State Department of Social and Health Services, including the Juvenile Rehabilitation Administration, Children's Administration, and the Partnership
http://www.dshs.wa.gov/

TEN PRINCIPLES OF THE WRAP AROUND PROCESS

ATTACHMENT A

Ten Principles of the Wraparound Process

Family voice and choice • natural supports • team based • collaboration • community based • culturally competent • individualized • strengths based • persistence • outcome based

Funders

The work of the National Wraparound Initiative has received support from several sources, including ORC Macro, Inc.; the Child, Adolescent, and Family Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Center for Medical and Medicaid Services (award no. 11-P-92001/3-01); the Maryland Department of Juvenile Services and Governor's Office of Crime Control and Prevention; and the National Technical Assistance Partnership for Child and Family Mental Health. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of SAMHSA.

Suggested Citation

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Acknowledgments

We would like to thank the following Advisory Group members for contributing materials to this product and for participating in interviews and the Delphi process through which we received feedback on initial drafts:

A. Michael Booth
Beth Larson-Steckler
Bill Reay
Carl Schick
Carol Schneider
Christina Breault
Christine S. Davis
Collette Lueck
Constance Burgess
Constance Conklin
David Osher
Dawn Hensley
Don Koenig
Eleanor D. Castillo
Frank Rider
Gayle Wiler
Holly Echo-Hawk Solie
Jane Adams
Jane Kallal
Jennifer Crawford
Jennifer Taub
Jim Rast
John Burchard
John Franz
John VanDenBerg
Josie Bejarano
Julie Becker
Julie Radlauer
Kelly Pipkins
Knute Rotto
Kristen Leverentz-Brady
Lucille Eber
Lyn Farr
Marcia Hille
Marcus Small
Mareasa Isaacs
Maria Elena Villar
Marlene Matarese
Mary Grealish
Mary Jo Meyers
Mary Stone Smith
Michael Epstein
Michael Taylor
Neil Brown
Norma Holt
Pat Miles
Patti Derr
Robin El-Amin
Rosalyn Bertram
Ruth A. Gammon
Ruth Almen
Theresa Rea
Trina W. Osher
Vera Pina

Ten Principles of the Wraparound Process

Introduction

The philosophical principles of wraparound have long provided the basis for understanding this innovative and widely-practiced service delivery model. This value base for working in collaboration and partnership with families extends from wraparound's roots in programs such as *Kaleidoscope* in Chicago, the *Alaska Youth Initiative*, and *Project Wraparound* in Vermont. In 1999, a monograph on wraparound was published that presented 10 core elements of wraparound, as well as 10 practice principles, from the perspective of wraparound innovators.[1] These elements and practice principles spanned activity at the team, organization, and system levels; in other words, some elements were intended to guide direct work that happens with the youth, family and hands-on support people (team level); some referred to work by the agency or organization housing the wraparound initiative (program level); and some guided the funding and community context around the wraparound activities (system level). For many, these original elements and principles became the best means available for understanding the wraparound process. They also provided an important basis for initial efforts at measuring wraparound fidelity.

Many have expressed a need to move beyond a value base for wraparound in order to facilitate program development and replicate positive outcomes. However, wrap-

1. Goldman, S.K. (1999). The Conceptual Framework for Wraparound. In Burns, B. J. & Goldman, K. (Eds.), *Systems of care: Promising practices in children's mental health, 1998 series, Vol. IV: Promising practices in wraparound for children with severe emotional disorders and their families.* Washington DC: Center for Effective Collaboration and Practice.

around's philosophical principles will always remain the starting point for understanding the model. The current document attempts to make the wraparound principles even more useful as a framework and guide for high-quality practice for youth and families. It describes wraparound's principles exclusively at the youth/family/team level. In doing so, we hope the organizational and system supports necessary to achieve high-quality wraparound practice[2] will always be grounded in the fundamental need to *achieve the wraparound principles for families and their teams.* By revisiting the original elements of wraparound, we also capitalized on an opportunity to break complex principles (e.g., "individualized and strengths-based") into independent ones, and make sure the principles aligned with other aspects of the effort to operationalize the wraparound process.

The current document is the result of a small team of wraparound innovators, family advocates, and researchers working together over several months. This team revised the original elements and practice principles and provided them to a much larger national group of family members, program administrators, trainers, and researchers familiar with wraparound. Through several stages of work, these individuals voted on the principles presented, provided feedback on phraseology, and participated in a consensus-building process.[3]

Though far from complete, consensus on the principles as presented here was strong. Nonetheless, you will see as you read descriptions of these 10 principles that there are several key areas where the complexity of wraparound itself hindered realization of a clear consensus among our advisory group. Commentary provided with each principle highlights such tensions and goes into much greater depth about the intentions and implications of each principle.

Considered along with its accompanying materials, we hope that this document helps achieve the main goal expressed by members of the *National Wraparound Initiative* at its outset: To provide clarity on the specific characteristics of the wraparound process model for the sake of communities, programs, and families. Just as important, we hope that this document is viewed as a work in progress, and that it remains a living document that can be updated as needed based on feedback from an even broader audience of reviewers.

Acknowledgments

Ten Principles of the Wraparound Process

> ***1. Family voice and choice.*** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

The wraparound process recognizes the importance of long-term connections between people, particularly the bonds between family members. The principle of family voice and choice in wraparound stems from this recognition and acknowledges that the people who have a long-term, ongoing relationship with a child or youth have a unique stake in and commitment to the wraparound process and its outcomes. This principle further recognizes that a young person who is receiving wraparound also has a unique stake in the process and its outcomes. The principle of family voice and choice affirms that these are the people who should have the greatest influence over the wraparound process as it unfolds.

This principle also recognizes that the likelihood of successful outcomes and youth/child and family ownership of the wraparound plan are increased when the wraparound process reflects family members' priorities and perspectives. The principle thus explicitly calls for family voice—the provision of opportunities for family members to fully explore and express their perspectives during wraparound activities—and family choice—the

2. Another component of the National Wraparound Initiative, originally described in detail in Walker, J.S., Koroloff, N., & Schutte, K. (2003). *Implementing high-quality collaborative individualized service/support planning: Necessary conditions.* Portland, OR: Research and Training Center on Family Support and Children's Mental Health

3. Description of the Delphi process used can be found on the National Wraparound Initiative's web page at www.rtc.pdx.edu/nwi/NWIMethod.htm.

structuring of decision making such that family members can select, from among various options, the one(s) that are most consistent with their own perceptions of how things are, how things should be, and what needs to happen to help the family achieve its vision of well-being. Wraparound is a collaborative process (principle 3); however within that collaboration, family members' perspectives must be the most influential.

The principle of voice and choice explicitly recognizes that the perspectives of family members are not likely to have sufficient impact during wraparound unless intentional activity occurs to ensure their voice and choice drives the process. Families of children with emotional and behavioral disorders are often stigmatized and blamed for their children's difficulties. This and other factors—including possible differences in social and educational status between family members and professionals, and the idea of professionals as experts whose role is to "fix" the family—can lead teams to discount, rather than prioritize, family members' perspectives during group discussions and decision making. These same factors also decrease the probability that youth perspectives will have impact in groups when adults and professionals are present. Furthermore, prior experiences of stigma and shame can leave family members reluctant to express their perspectives at all. Putting the principle of youth and family voice and choice into action thus requires intentional activity that supports family members as they explore their perspectives and as they express their perspectives during the various activities of wraparound. Further intentional activity must take place to ensure that this perspective has sufficient impact within the collaborative process, so that it exerts primary influence during decision making. Team procedures, interactions, and products—including the wraparound plan—should provide evidence that the team is indeed engaging in intentional activity to prioritize the family perspectives.

While the principle speaks of *family* voice and choice, the wraparound process recognizes that the families who participate in wraparound, like American families generally, come in many forms. In many families, it is the biological parents who are the primary caregivers and who have the deepest and most enduring commitment to a youth or child. In other families, this role is filled by adoptive parents, step-parents, extended family members, or even non-family caregivers. In many cases, there will not be a single, unified "family" perspective expressed during the various activities of the wraparound process. Disagreements can occur between adult family members/ caregivers or between parents/caregivers and extended family. What is more, as a young person matures and becomes more independent, it becomes necessary to balance the collaboration in ways that allow the youth to have growing influence within the wraparound process. Wraparound is intended to be inclusive and to manage disagreement by facilitating collaboration and creativity; however, throughout the process, the goal is always to prioritize the influence of the people who have the deepest and most persistent connection to the young person and commitment to his or her well-being.

Special attention to the balancing of influence and perspectives within wraparound is also necessary when legal considerations restrict the extent to which family members are free to make choices. This is the case, for example, when a youth is on probation, or when a child is in protective custody. In these instances, an adult acting for the agency may take on caregiving and/or decision making responsibilities vis-à-vis the child, and may exercise considerable influence within wraparound. In conducting our review of opinions of wraparound experts about the principles, this has been one of several points of contention; specifically, how best to balance the priorities of youth and family against those of these individuals. Regardless, there is strong consensus in the field that the principle of family voice and choice is a constant reminder that the wraparound process must place special emphasis on the perspectives of the people who will still be connected to the young person after agency involvement has ended.

2. Team based. The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

Wraparound is a collaborative process (see principle 3), undertaken by a team. The wrap-

around team should be composed of people who have a strong commitment to the family's well-being. In accordance with principle 1, choices about who is invited to join the team should be driven by family members' perspectives.

At times, family members' choices about team membership may be shaped or limited by practical or legal considerations. For example, one or more family members may be reluctant to invite a particular person– e.g., a teacher, a therapist, a probation officer, or a non-custodial ex-spouse—to join the team. At the same time, not inviting that person may mean that the team will not have access to resources and/or interpersonal support that would otherwise be available. Not inviting a particular person to join the team can also mean that the activities or support that he or she offers will not be coordinated with the team's efforts. It can also mean that the family loses the opportunity to have the team influence that person so that he or she becomes better able to act supportively. If that person is a professional, the team may also lose the opportunity to access services or funds that are available through that person's organization or agency. Not inviting a particular professional to join the team may also bring undesired consequences; for example, if participation of the probation officer on the wraparound team is required as a condition of probation. Family members should be provided with support for making informed decisions about whom they invite to join the team, as well as support for dealing with any conflicts or negative emotions that may arise from working with such team members. Or, when relevant and possible, the family should be supported to explore options such as inviting a different representative from an agency or organization. Ultimately, the family may also choose not to participate in wraparound.

Universally, families and youth were more positive and hopeful when they felt in charge of their lives and were not dependent on the system to meet their needs.

When a state agency has legal custody of a child or youth, the caregiver in the permanency setting and/or another person designated by that agency may have a great deal of influence over who should be on the team; however, in accordance with principle 1, efforts should be made to include participation of family members and others who have a long-term commitment to the young person and who will remain connected to him or her after formal agency involvement has ended.

> 3. ***Natural supports.*** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

This principle recognizes the central importance of the support that a youth/child, parents/caregivers, and other family members receive "naturally," i.e., from the individuals and organizations whose connection to the family is independent of the formal service system and its resources. These sources of natural support are sustainable and thus most likely to be available for the youth/child and family after wraparound and other formal services have ended. People who represent sources of natural support often have a high degree of importance and influence within family members' lives. These relationships bring value to the wraparound process by broadening the diversity of support, knowledge, skills, perspectives, and strategies available to the team. Such individuals and organizations also may be able to provide certain types of support that more formal or professional providers find hard to provide.

The primary source of natural support is the family's network of interpersonal relationships, which includes friends, extended family, neighbors, co-workers, church members, and so on. Natural support is also available to the family through community institutions, organizations, and associations such as churches, clubs, librar-

ies, or sports leagues. Professionals and paraprofessionals who interact with the family primarily offer paid support; however, they can also be connected to family members through caring relationships that exceed the boundaries and expectations of their formal roles. When they act in this way, professionals and paraprofessionals too can become sources of natural support.

Practical experience with wraparound has shown that formal service providers often have great difficulty accessing or engaging potential team members from the family's community and

informal support networks. Thus, there is a tendency that these important relationships will be underrepresented on wraparound teams. This principle emphasizes the need for the team to act intentionally to encourage the full participation of team members representing sources of natural support.

> ***4. Collaboration.*** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

Wraparound is a collaborative activity—team members must reach collective agreement on numerous decisions throughout the wraparound process. For example, the team must reach decisions about what goals to pursue, what sorts of strategies to use to reach the goals, and how to evaluate whether or not progress is actually being made in reaching the goals. The principle of collaboration recognizes that the team is more likely to accomplish its work when team members approach decisions in an open-minded manner, prepared to listen to and be influenced by other team members' ideas and opinions. Team members must also be willing to provide their own perspectives, and the whole team will need to work to ensure that each member has opportunities to provide input and feels safe in doing so. As they work to reach agreement, team members will need to remain focused on the team's overarching goals and how best to achieve these goals in a manner that reflects all of the principles of wraparound.

The principle of collaboration emphasizes that each team member must be committed to the team, the team's goals, and the wraparound plan. For professional team members, this means that the work they do with family members is governed by the goals in the plan and the decisions reached by the team. Similarly, the use of resources available to the team—including those controlled by individual professionals on the team—should be governed by team decisions and team goals.

This principle recognizes that there are certain constraints that operate on team decision making, and that collaboration must operate within these boundaries. In particular, legal mandates or other requirements often constrain decisions. Team members must be willing to work creatively and flexibly to find ways to satisfy these mandates and requirements while also working towards team goals.

Finally, it should be noted that, as for principles 1 (family voice and choice) and 2 (team-based), defining wraparound's principle of collaboration raises legitimate concern about how best to strike a balance between wraparound being youth- and family-driven as well as team-driven. This issue is difficult to resolve completely, because it is clear that wraparound's strengths as a planning and implementation process derive from being team-based and collaborative while also prioritizing the perspectives of family members and natural supports who will provide support to the youth and family over the long run. Such tension can only be resolved on an individual family and team basis,

and is best accomplished when team members, providers, and community members are well supported to fully implement wraparound in keeping with all its principles.

5. Community-based. The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

This principle recognizes that families and young people who receive wraparound, like all people, should have the opportunity to participate fully in family and community life. This implies that the team will strive to implement service and support strategies that are accessible to the family and that are located within the community where the family chooses to live. Teams will also work to ensure that family members receiving wraparound have greatest possible access to the range of activities and environments that are available to other families, children, and youth within their communities, and that support positive functioning and development.

6. Culturally competent. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

The perspectives people express in wraparound—as well as the manner in which they express their perspectives—are importantly shaped by their culture and identity. In order to collaborate successfully, team members must be able to interact in ways that demonstrate respect for diversity in expression, opinion, and preference, even as they work to come together to reach decisions. This principle emphasizes that respect toward the family in this regard is particularly crucial, so that the principle of family voice and choice can be realized in the wraparound process.

This principle also recognizes that a family's traditions, values, and heritage are sources of great strength. Family relationships with people and organizations with whom they share a cultural identity can be essential sources of support and resources; what is more, these connections are often "natural" in that they are likely to endure as sources of strength and support after formal services have ended. Such individuals and organizations also may be better able to provide types of support difficult to provide through more formal or professional relationships. Thus, this principle also emphasizes the importance of embracing these individuals and organizations, and nurturing and strengthening these connections and resources so as to help the team achieve its goals, and help the family sustain positive momentum after formal wraparound has ended.

This principle further implies that the team will strive to ensure that the service and support strategies that are included in the wraparound plan also build on and demonstrate respect for family members' beliefs, values, culture, and identity. The principle requires that team members are vigilant about ensuring that culturally competent services and supports extend beyond wraparound team meetings.

7. Individualized. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

This principle emphasizes that, when wraparound is undertaken in a manner consistent with all of the principles, the resulting plan will be uniquely tailored to fit the family. The principle of family voice and choice lays the foundation

for individualization. That principle requires that wraparound must be based in the family's perspective about how things are for them, how things should be, and what needs to happen to achieve the latter. Practical experience with wraparound has shown that when families are able to fully express their perspectives, it quickly becomes clear that only a portion of the help and support required is available through existing formal services. Wraparound teams are thus challenged to create strategies for providing help and support that can be delivered outside the boundaries of the traditional service environment. Moreover, the wraparound plan must be designed to build on the particular strengths of family members, and on the assets and resources of their community and culture. Individualization necessarily results as team members collaboratively craft a plan that capitalizes on their collective strengths, creativity, and knowledge of possible strategies and available resources.

> ***8. Strengths based.*** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

The wraparound process is strengths based in that the team takes time to recognize and validate the skills, knowledge, insight, and strategies that each team member has used to meet the challenges they have encountered in life. The wraparound plan is constructed in such a way that the strategies included in the plan capitalize on and enhance the strengths of the people who participate in carrying out the plan. This principle also implies that interactions between team members will demonstrate mutual respect and appreciation for the value each person brings to the team.

The commitment to a strengths orientation is particularly pronounced with regard to the child or youth and family. Wraparound is intended to achieve outcomes not through a focus on eliminating family members' deficits but rather through efforts to utilize and increase their assets. Wraparound thus seeks to validate, build on, and expand family members' psychological assets (such as positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (such as social competence and social connectedness), and their expertise, skill, and knowledge.

> ***9. Persistence.*** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

This principle emphasizes that the team's commitment to achieving its goals persists regardless of the child's behavior or placement setting, the family's circumstances, or the availability of services in the community. This principle includes the idea that undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to eject the family from wraparound. Instead, adverse events or outcomes are interpreted as indicating a need to revise the wraparound plan so that it more successfully promotes the positive outcomes associated with the goals. This principle also includes the idea that the team is committed to providing the supports and services that are necessary for success, and will not terminate wraparound because available services are deemed insufficient. Instead, the team is committed to creating and implementing a plan that reflects the wraparound principles, even in the face of limited system capacity.

Undesired behavior, events, or outcomes are not seen as evidence of child or family "failure" and are not seen as a reason to eject the family from wraparound.

It is worth noting that the principle of "persistence" is a notable revision from "unconditional" care. This revision reflects feedback from wraparound experts, including family members

and advocates, that for communities using the wraparound process, describing care as "unconditional" may be unrealistic and possibly yield disappointment on the part of youth and family members when a service system or community can not meet their own definition of unconditionality. Resolving the semantic issues around "unconditional care" has been one of the challenges of defining the philosophical base of wraparound. Nonetheless, it should be stressed that the principle of "persistence" continues to emphasize the notion that teams work until a formal wraparound process is no longer needed, and that wraparound programs adopt and embrace "no eject, no reject" policies for their work with families.

> ***10. Outcome based.*** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

This principle emphasizes that the wraparound team is accountable—to the family and to all team members; to the individuals, organizations and agencies that participate in wraparound; and, ultimately, to the public—for achieving the goals laid out in the plan. Determining outcomes and tracking progress toward outcomes should be an active part of wraparound team functioning. Outcomes monitoring allows the team to regularly assess the effectiveness of plan as a whole, as well as the strategies included within the plan, and to determine when the plan needs revision. Tracking progress also helps the team maintain hope, cohesiveness, and efficacy. Tracking progress and outcomes also helps the family know that things are changing. Finally, team-level outcome monitoring aids the program and community to demonstrate success as part of their overall evaluation plan, which may be important to gaining support and resources for wraparound teams throughout the community.

INTRA-AGENCY AGREEMENT BETWEEN CHILDREN'S ADMINISTRATION AND JUVENILE REHABILITATION ADMINISTRATION

ATTACHMENT B

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
INTRA - AGENCY AGREEMENT
BETWEEN
CHILDREN'S ADMINISTRATION
AND
JUVENILE REHABILITATION ADMINISTRATION

Effective Date: November 1, 2012 **Sunset Revision Date: November 1, 2014**

The Department of Social and Health Services (DSHS) Children's Administration (CA) and Juvenile Rehabilitation Administration (JRA) recognize there are children served by both administrations consecutively or at the same time. CA and JRA are committed to working together to serve each of these children in an effective and coordinated fashion to ensure that DSHS meets the needs of the child and family.

The purpose of this agreement is to define the roles and the division of responsibilities between the Children's Administration and Juvenile Rehabilitation Administration when providing services to youth and families together. The intent is to ensure a high level of systems integration using wraparound principles. The outcomes are to overcome service barriers, expedite services, strengthen families, reintegrate youth into their communities, safely reduce out of home placements, reduce youth recidivism, identify safe stable housing options when necessary, and have a zero tolerance for youth not being offered an opportunity that prevents them from becoming homeless.

CA is responsible for protecting children from abuse and neglect and providing for the safety, permanency and well being of dependent children. JRA is responsible for the care, treatment, custody, transition and reintegration of committed youth and the post-release supervision of parolees. The responsibility of both administrations intersects when a youth committed to the custody of JRA is a dependent youth, or a non-dependent youth who cannot safely return to their home due to abuse or neglect as defined by RCW 26.44.020.

Both CA and JRA are committed to keeping youth safely at home whenever possible. To that end both administrations will use the following guiding principles in our work together:

- Support families to safely care for their own children.
- Utilize integrated case management and wraparound principles when both administrations are involved with a youth and family.
- Collaborate and share information to provide joint case planning including user access to data systems.
- Jointly attend and participate at youth/ family meetings.
- Jointly intervene as needed to resolve issues such as non-compliance with case plans, parole conditions and placement disruptions.

- Share information regarding youth and family progress to assist in case planning.
- Mutually apply wraparound principles with joint case work to increase positive outcomes for youth and family.
- Mutually hold youth accountable for their actions.
- Employ ongoing efforts to identify family and natural supports that can assist youth and families with placement, support and other resources.

1. General Conditions:

a) Information can be shared within the continuum of care without the consent of a youth for the purposes of treatment, care, case planning, or supervision.

b) This agreement does not apply to youth who will be 18 years of age or older when released from JRA's residential confinement.

c) **CA is authorized to place a youth in foster care when the youth has been abused or neglected under RCW 26.44.020 and is given placement and care authority by the court.**

d) **JRA will follow the protocols defined in appendix 1 of this agreement when unable to participate in placement due to a court order or protection order.**

e) **JRA is not authorized to extend residential confinement beyond the maximum release date based on the lack of appropriate release destination or youth with a court or protection order preventing contact with a victim living in the home as stated in RCW 13.40.210. JRA may extend the release date for up to 30 days for certain eligible youth releasing up to their maximum sentence to allow for appropriate community placement/release planning[1]. CA is not authorized to provide placement of youth who have not been abused and neglected as defined in RCW 26.44.020.**

f) Treatment Services for Youth

1) JRA shall be financially responsible for providing treatment services for youth where treatment is a requirement of the parole contract, in accordance with the youth's parole conditions.
2) When youth receive community services supported by JRA funds, treatment services will be provided by JRA contracted treatment or service providers.
3) JRA will share contact information with CA regarding the JRA contracted provider(s) who deliver services to Dependent youth.

g) JRA staff does not have the authority to place youth in foster care upon or after release to parole.

h) A dependency may continue while a youth who is 17 years of age or younger is committed to JRA, unless the dependency is dismissed by the court. **JRA and CA shall continue to actively collaborate as long as the dependency remains open.**

[1] JRA Interim Directive dated April 24, 2012: Process to Consider Release of Youth Prior to Maximum Sentence.

i) CA's placement and care authority over children who entered care or were provided services under a CHINS, ARY, or VPA terminates on date of incarceration to JRA (RCW 13.32.180(2); CA Practices and Procedures Guide 4207).

2. Special Circumstances

It is recognized that youth and family need for services can change at various points in time prior to release. In such cases, CA and JRA may suspend the timelines and actively work together to determine the best plan which may or may not include out of home placement for the youth.

3. Coordination

a) CA and JRA headquarters will share policy and procedure manuals, memoranda, fee schedules, eligibility criteria, information brochures or other written material which affect the administrations and provision of program services for cross-systems youth.

b) CA and JRA staff will collaborate to provide ongoing cross training and education concerning agency policy, programs, and other relevant information. This includes principles of Wraparound and Integrated Case Management practices. CA will provide JRA staff with training on conducting Family Team Decision Making meetings and on assessing parent/guardian capacity to safely care for their children.

c) CA and JRA will each designate and provide contact information for a liaison to work with the other administration in implementing this agreement.

d) CA and JRA will distribute and provide training for this MOU with staff. Each Administration will designate a location to provide ongoing access to the MOU.

4. Time Period for this Agreement

a) The effective period of this agreement shall begin October 1, 2012 **with a sunset revision to occur every two (2) years.** In the event circumstances change, either party to this agreement shall provide written notification of the intent to terminate or re-negotiate this agreement to signatories, or successors, as follows:

b) Written notification of the intent to terminate shall be provided 180 days in advance of proposed termination effective date.

c) Written notification of the intent to re-negotiate any term in this agreement shall be provided 90 days in advance of proposed change.

d) Written notification shall include the basis for the action and identify the desired effective date for termination or proposed change.

5. Disputes

If a dispute takes place regarding the transition services, dependency status, or placement for a youth, the following process shall occur:

a) CA Social Workers and JRA Residential and/or Community Counselors shall work to resolve transition or dependency issues. If no resolution is possible, the dispute shall be referred to supervisory staff.

b) CA and JRA supervisors or designees will work to resolve transition or dependency issues. If no resolution is possible, the dispute shall be referred to the CA Regional Administrator or designee and JRA Regional Administrator and/or Superintendent, or designee.

c) The CA Regional Administrator or designee and JRA Regional Administrator and/or Superintendent, or designee, will work to resolve transition or dependency issues. If no resolution is possible, the dispute shall be referred to the CA and JRA DSHS Assistant Secretaries or their designees.

d) DSHS Assistant Secretaries or their designees shall maintain authority for final transition or dependency resolution issues.

JUVENILE REHABILITATION ADMINISTRATION

John Clayton 11-14-12

John Clayton Date
Assistant Secretary

CHILDREN'S ADMINISTRATION

Denise Revels Robinson

Denise Revels Robinson Date 11-26-12
Assistant Secretary

<u>Appendix 1: Integrated Case Management Protocols</u>

a) **<u>DEPENDENT YOUTH</u>, Service Delivery Provisions and Responsibilities:**

The following provisions and responsibilities are for youths that are dependents of the State of Washington and under the court-ordered placement and care authority of CA and concurrently committed to and/or on parole with JRA. Wherever possible, coordinated efforts begin at the time of JRA Commitment or as soon as possible. The timelines outlined below are intended to be minimum expectations with the hope that early and frequent communication occurs throughout the joint case work.

Pre-Release Integrated Case Management Protocols for Dependent Youth		
Time Frame/ Concern	**CA Responsibility**	**JRA Responsibility**
As required or every 6 months	Notify JRA at least 30 days prior to a Dependency Review Hearing. In preparation for court reviews, the social worker will: • request treatment progress, assessments, and input from JRA reports and youth regarding proposed case plan • incorporate assessments and treatment goals into youth's case plan and • attend hearing and provide results of hearing to the JRA counselor	Provide all current treatment reports and assessments within seven days of the notification from CA.
	Contact youth to notify them of the upcoming hearing and discuss the contents of the ISSP.	Arrange youth's contact with CA and participation in the hearing, as available.
	When CA intends to recommend dismissal of a dependency for a youth in JRA confinement, CA will provide JRA with the ISSP and any supporting	JRA Residential Counselor informs the JRA Community Counselor if shared planning meeting pertains to release transition planning and/or

CA and JRA Intra-Agency Agreement

	documentation and request feedback.	potential release destination.
	Invite JRA Residential and/or Community Counselor to Shared Planning Meetings. If a 17.5 staffing is required the youth will be provided information regarding the Extended Foster Care program and the requirements for eligibility when a youth is in JRA custody.	JRA Residential and/or Community Counselor participate in all scheduled Shared Planning Meetings as requested and available.
Every thirty days	The CA Social Worker will conduct a Health and Safety Visit as arranged through the assigned JRA Residential Counselor. This visit may be conducted telephonically.	JRA Residential Counselor will assist with coordination of the Health and Safety Visit.
60 days prior to release from JRA Residential Confinement	Social worker reviews JRA written reports concerning the youth (treatment, assessments, and transition planning) and participates in discussion with JRA Residential and/or Community Counselor regarding transition planning including any reasonable cause to believe that minors may be at risk of abuse or neglect when a JRA youth is being placed in the home. CA Social worker schedules Family Team Decision Meeting (FTDM) if appropriate and notifies JRA Community Counselor.	JRA Residential Counselor contacts social worker and JRA Community Counselor to provide written reports concerning the youth (treatment, assessments, and transition planning) and discuss transition plans. JRA Community Counselor will participate in the CA-scheduled Family Team Decision Making (FTDM) meeting regarding the child. If the JRA Community Counselor cannot participate in the meeting, they will provide feedback to the Social Worker prior to the meeting. JRA Residential and/or Community Counselor shall notify CA Social Worker if there is reasonable cause to believe that minors may be at risk of abuse or neglect when a JRA youth is being placed in the home.
No later than 45 days prior to the release	Once notified by JRA, CA will identify if the youth will be returning home or to an out of home placement.	JRA Residential Counselor completes Transition Report (TR) and sends TR to JRA Community Counselor and provides written notification to assigned CA Social

		Worker of the youth's release date.
Earliest possible date	Social worker schedules Family Team Decision Making (FTDM) meeting and notifies JRA Residential and/or Community Counselor. Seek least restrictive resource for the youth's placement. Actively coordinate with JRA to best match placement resources with the youth's risk and protective factors. Provide placement resource contact information to JRA as soon as possible.[2]	JRA Residential Counselor and/or Community Counselor will participate in the CA-scheduled Family Team Decision Making (FTDM) meeting regarding the child. Actively coordinate with CA to best match placement resources with the youth's risk and protective factors.
	Update youth's Individual Service and Safety Plan (ISSP) to include a recommendation that the youth follow the conditions of JRA parole and provide copy to JRA staff.	Upon receipt of TR from JRA Residential Counselor the JRA Community Counselor completes Response to Transition Report (RTR) including home investigation and forwards parole conditions to CA Social Worker.
15 days prior to release	The JRA Residential and Community Counselors communicate with the CA Social Worker to arrange the youth's release, including transportation, destination, supervision, and any other factors necessary for a smooth transition from the facility.	

Post-Release Integrated Case Management Protocols for Dependent Youth

Time Frame/ Concern	CA Responsibility	JRA Responsibility
Initial parole phase change or six week case review, whichever comes first	CA Social Worker communicates with JRA Community Counselor to determine if they can attend the meeting or provide feedback if they cannot attend.	JRA Community Counselor notifies CA Social Worker of upcoming phase change review or six week case review (whichever comes first) two weeks, or as soon as possible, prior to the meeting.
If a placement concern arises and a FTDM may be	CA Social Worker shall communicate with JRA Community Counselor if there are concerns regarding the parent/guardian managing and	JRA Community Counselor shall notify CA Social Worker if there is reasonable cause to believe that minors may be at risk of abuse or

[2] JRA is required to provide 35 days notification to law enforcement for violent and sexual offenders.

needed.	controlling safety threats to children in the home with the JRA youth present in the home environment. CA Social worker schedules Family Team Decision Making (FTDM) if appropriate and notifies JRA Community Counselor. Actively coordinate with JRA to best match placement resources with the youth's risk and protective factors	neglect with a JRA youth having been placed in the home. JRA Community Counselor will participate in the CA-scheduled Family Team Decision Making (FTDM) meeting regarding the child. If the JRA Community Counselor cannot participate in the meeting, they will provide feedback to the Social Worker prior to the meeting. CA may also be contacted by JRA staff or the family if the family is in need of other services offered by CA. Actively coordinate with CA to best match placement resources with the youth's risk and protective factors
Quarterly staffing for Youth in a BRS placement	CA Social worker schedules BRS Staffing and notifies JRA Community Counselor.	JRA Community Counselor will participate in the CA scheduled BRS Staffing regarding the child. If the JRA Community Counselor cannot participate in the meeting, they will provide feedback to the CA Social Worker prior to the meeting.
Final JRA parole phase change	CA Social Worker communicates with JRA Community Counselor to determine if they can attend the meeting or provide feedback if they cannot attend.	JRA Community Counselor notifies CA Social Worker of upcoming final phase change review two weeks, or as soon as possible, prior to the meeting.
Six month Youthful Sex Offender (YSO) Review for JRA youth	CA Social Worker communicates with JRA Community Counselor to determine if they can attend the meeting or provide feedback if they cannot attend.	JRA Community Counselor notifies CA Social Worker of upcoming six month YSO review two weeks, or as soon as possible, prior to the meeting.
JRA YSO 90-day parole extension review	CA Social Worker communicates with JRA Community Counselor to determine if they can attend the meeting or provide feedback if they cannot attend.	JRA Community Counselor notifies CA Social Worker of upcoming 90-day YSO parole extension review two weeks, or as soon as possible, prior to the meeting.

CA and JRA Intra-Agency Agreement

Six month ISSP updates	Update youth's Individual Service and Safety Plan (ISSP) to include information and feedback from JRA Community Counselor on youth's progress on parole.	JRA Community Counselor provides feedback and information relevant to parole progress to CA Social Worker.
Parole Warrants, Unauthorized Leave (UL) and Revocations	CA Social Worker receives information and communicates with JRA Community Counselor as needed.	JRA Community Counselor notifies CA Social Worker when youth is placed on warrant or UL status and when a youth is revoked.
Children Missing from Care Report	CA Social Worker notifies JRA Community Counselor when youth is identified as a runaway and report has been filed.	JRA Community Counselor receives information and communicates with CA Social Worker as needed. JRA Community Counselor issues Parole Warrant if necessary.
Additional services are identified as needed to support youth and family.	CA Social Worker initiates the conversation or receives information from the JRA Community Counselor that generates the conversation to assess and identify additional services the youth and family need to support successful placement.	JRA Community Counselor initiates the conversation or receives information from the CA Social Worker that generates the conversation to assess and identify additional services the youth and family need to support successful placement.
Dependent youth at immediate risk of homelessness	CA Social Worker contacts JRA Community Counselor or receives information from JRA and initiates FTDM or other appropriate staffing. CA local office provides to the CA Regional Administrator, Field Service Director, and CA Assistant Secretary a summary of the case situation and the specific placement options identified for the youth.	JRA Community Counselor contacts the CA Social Worker or receives information from CA and participates in staffing on the case situation. JRA local office provides to the JRA Regional Administrator, the Community and Parole Programs Director, and the JRA Assistant Secretary a summary of the case situation and the specific placement options identified for the youth.

b) **<u>NON -DEPENDENT YOUTH</u>, Service Delivery Provisions and Responsibilities:**

The following provisions and responsibilities are for youths that are not dependents of the State of Washington. These provisions apply to youth who will be 17 years of age or younger at time of release from JRA's residential confinement and may be in need of services. Whenever possible, coordinated efforts begin at the time of JRA Commitment or as soon as possible thereafter. The timelines outlined below are intended to be minimum expectations

with the hope that early and frequent communication occurs throughout the joint case work.

Pre-Release Integrated Case Management Protocols for Non-Dependent Youth		
Time Frame/ Concern	**CA Responsibility**	**JRA Responsibility**
If a placement concern arises and an FTDM may be needed at time of commitment, any time during commitment, or earliest possible date	CA will process CPS Referral (intake request) and assign to local field office if appropriate. CA will notify JRA Residential and/or Community Counselor within 10 days of request and ask for additional information as needed. CA Social Worker shall communicate with JRA Community Counselor if there are concerns regarding the parent/guardian managing and controlling safety threats to children in the home with the JRA youth present in the home environment. CA will invite JRA to Family Team Decision Making (FTDM) meeting if placement is being considered. Notify JRA regarding case status and any services CA will offer.	JRA staff will make every effort to find a suitable alternative placement resource for youth and clearly documenting all reasonable and ongoing search efforts for alternative placement resources. JRA staff will actively engage the youth's parents/guardians to ensure the youth's planful release to the community. JRA staff will emphasize the parent/guardian responsibility to safely care for their children and to meet their mental health, education and other needs. As needed, these pro-active efforts will include identifying areas of risk to children to be further assessed by CA, addressing barriers to the youth's return to home/community, and exploring/determining alternate family or community placement options. If a specific placement resource is not identified following reasonable search efforts, a CPS referral to CA for services can be requested by the JRA Residential or Community Counselor. Request must be made to the CA office where parents or guardians reside. [3]

[3] Referral information must include: Release plan attempted and obstacles; Parents/legal guardian plan for discharge; Reasonable efforts to identify alternative transition plans and placement options.

CA and JRA Intra-Agency Agreement

	If CA is placing the youth, actively coordinate with JRA to best match placement resources with the youth's risk and protective factors.	Such a request should only be made when there is reasonable cause to believe that any minor, including the JRA youth, may be at risk of abuse or neglect. CA may also be contacted by JRA staff or the family if the family is in need of other services offered by CA. JRA will notify CA of any known court orders or protection orders. JRA Community Counselor will provide information and participate in any scheduled meetings regarding the youth. If CA is placing the youth, actively coordinate with CA to best match placement resources with the youth's risk and protective factors.
Within 5 days of decision	Notify JRA regarding case status and any services CA will offer. Notify JRA if a Dependency Petition will be filed. Notify JRA of the location, if a placement is authorized. Notify JRA if no placement is authorized.	JRA Community Counselor participates in discussions with the CA Social Worker regarding service needs for youth and family. JRA Community Counselor will participate in any scheduled Family Team Decision Making (FTDM) meeting regarding the youth and family, if possible.

Post-Release Integrated Case Management Protocols for Non-Dependent Youth

Time Frame/ Concern	CA Responsibility	JRA Responsibility

If a placement concern arises and an FTDM may be needed	CA will assist (if appropriate) through relative search resources to identify options for alternative placement. CA Social Worker shall communicate with JRA Community Counselor if there is reason to believe that the parent/guardian cannot manage and control safety threats to children in the home with the JRA youth present in the home environment. CA will process *CPS referral and assign to local field office if appropriate. CA will notify JRA Community Counselor within ten (10) days of request and ask for additional information as needed. CA will invite JRA Community Counselor to Family Team Decision Making (FTDM) meeting if placement is being considered. Notify JRA regarding case status and any services CA will offer.	JRA staff will make every effort to find a suitable alternative placement resource for youth and clearly documenting all reasonable and ongoing search efforts for alternative placement resources. JRA staff will actively engage the youth's parents/guardians to ensure the youth's planful release to the community. JRA staff will emphasize the parent/guardian responsibility to safely care for their children and to meet their mental health, education and other needs. As needed, these pro-active efforts will include identifying areas of risk to children to be further assessed by CA, addressing barriers to the youth's return to home/community, and exploring/determining alternate family or community placement options. If a specific placement resource is not identified following reasonable search efforts, a CPS referral to CA for services can be requested by the JRA Community Counselor. Request must be made to the CA office where parents or guardians reside. [4] Such a request should only be made when there is reasonable cause to believe that any minor, including the JRA youth, may be at risk of abuse or neglect.

[4]Referral information must include: Release plan attempted and obstacles; Parents/legal guardian plan for discharge; Reasonable efforts to identify alternative transition plans and placement options.

*AKA: CA Intake Referral

		CA may also be contacted by JRA staff or the family if the family is in need of other services offered by CA. JRA will notify CA of any known court orders or protection orders. JRA Community Counselor will provide information and participate in any scheduled meetings regarding the youth.
Within 5 days of decision	Notify JRA regarding case status and any services CA will offer. Notify JRA if a Dependency Petition will be filed. Notify JRA of the location, if a placement is authorized. Notify JRA if no placement is authorized.	JRA Community Counselor participates in discussions with the CA Social Worker regarding service needs for youth and family. JRA Community Counselor will participate in any scheduled Family Team Decision Making (FTDM) meeting regarding the youth and family, if possible.
If placement is authorized by CA and youth becomes Dependent – see section 3 "Post Release Integrated Case Management Protocols for Dependent Youth"	If placement is authorized by CA and youth becomes Dependent – see section 3 "Post Release Integrated Case Management Protocols for Dependent Youth" Actively coordinate with JRA to best match placement resources with the youth's risk and protective factors.	If placement is authorized by CA and youth becomes Dependent – see section 3 "Post Release Integrated Case Management Protocols for Dependent Youth" Actively coordinate with CA to best match placement resources with the youth's risk and protective factors.
If CA is providing services during Initial JRA parole phase change or six week case review, whichever comes first	CA Social Worker communicates with JRA Community Counselor to determine if they can attend the meeting or provide feedback if they cannot attend.	JRA Community Counselor notifies CA Social Worker of upcoming phase change review or six week case review (whichever comes first) two weeks, or as soon as possible, prior to the meeting.
If CA is providing services during Final JRA parole phase change	CA Social Worker communicates with JRA Community Counselor to determine if they can attend the meeting or provide feedback if they cannot attend.	JRA Community Counselor notifies CA Social Worker of upcoming final phase change review two weeks, or as soon as possible, prior to the meeting.

CA and JRA Intra-Agency Agreement

If CA is providing services during JRA Six month Review for youth on YSO Parole	CA Social Worker communicates with JRA Community Counselor to determine if they can attend the meeting or provide feedback if they cannot attend.	JRA Community Counselor notifies CA Social Worker of upcoming six month YSO review two weeks, or as soon as possible, prior to the meeting.
If CA is providing services during Parole Warrants, Unauthorized Leave (UL) and Revocations	CA Social Worker receives information and communicates with JRA Community Counselor as needed.	JRA Community Counselor notifies CA Social Worker when youth is placed on warrant or UL status and when a youth is revoked.

Disclaimer: Nothing in this agreement should be construed to limit or alter in any way CA and JRA's duty to act as mandatory reporters and contact Child Protective Services or law enforcement when abuse, neglect, or financial exploitation is suspected as required by RCW 26.44.030 and 26.44.040.

Appendix 2: Definitions

a) **Alternative release destination** means; any placement resource identified by the parent or guardian with another suitable person to include kin, presumed fathers, or family friends.

b) **At Risk Youth (ARY) means a juvenile who;**

1) Is absent from home for at least 72 consecutive hours without consent of his or her parent.
2) Is beyond the control of his or her parent such that the child's behavior endangers the health, safety, or welfare of the child or any other person.

Has a substance abuse problem for which there are no pending criminal charges related to the substance abuse. (RCW Chapter 13.32A)

c) **Behavior Rehabilitation Services (BRS);** is a temporary intensive wraparound support and treatment program for youth with extreme, high level service needs used to safely stabilize (in home or out of home) youth and assist in achieving a permanent plan or a less intensive service.

d) **Child abuse and Neglect:** Under RCW 26.44.020, Child Abuse and Neglect means; Sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW

9A.16.100; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section

e) **Child In Need of Services (CHINS);** Under RCW 13.32A.030, a Child in Need of Services means a child;

1) Who is beyond the control of his or her parent such that the child's behavior endangers the health, safety, or welfare of the child or other person;

2) Who has been reported to law enforcement as absent without consent for at least twenty-four consecutive hours on two or more separate occasions from the home of either parent, a crisis residential center, an out-of-home placement, or a court-ordered placement; and
   (i) Has exhibited a serious substance abuse problem; or
   (ii) Has exhibited behaviors that create a serious risk of harm to the health, safety, or welfare of the child or any other person;

3) Who is in need of: (A) Necessary services, including food, shelter, health care, clothing, or education; or (B) services designed to maintain or reunite the family;
   (ii) Who lacks access to, or has declined to utilize, these services; and
   (iii) Whose parents have evidenced continuing but unsuccessful efforts to maintain the family structure or are unable or unwilling to continue efforts to maintain the family structure; or

4) Who is a "sexually exploited child"

f) **Child Protective Services (CPS);** Under RCW 26.44.020, Child Protective Services means; those services provided by the department designed to protect children from child abuse and neglect and safeguard such children from future abuse and neglect, and conduct investigations of child abuse and neglect reports. Investigations may be conducted regardless of the location of the alleged abuse or neglect. Child Protective Services includes referral to services to ameliorate conditions which endanger the welfare of children, the coordination of necessary programs and services relevant to the prevention, intervention, and treatment of child abuse and neglect, and services to children to help each child to have a permanent home. In determining whether protective services should be provided, the department shall not decline to provide such services solely because of the child's unwillingness or developmental inability to describe the nature and severity of the abuse or neglect.

g) **Continuum of Care means;** a plan of services for youth served **concurrently** by CA and JRA. The care includes treatment and other services provided by organizations and entities through contracts with CA or JRA while the youth is in a JRA commitment, CA placement, or under parole supervision. Information may be shared between CA and JRA and with service providers within the continuum of care without the consent of a youth, and subject to federal and state law to the extent needed for treatment, care and/or supervision

h) **Custodian; Under RCW 13.32A.030,** Custodian means; the person or entity who has the legal right to the custody of the child.

i) **Dependent Child; Under** RCW 13.34.030, Dependent Child means; any child who:

1) Has been abandoned;
2) Is abused or neglected as defined in Chapter 26.44 RCW by a person legally responsible for the care of the child;
3) Has no parent, guardian, or custodian capable of adequately caring for the child, such that the child is in circumstances which constitute a danger of substantial damage to the child's psychological or physical development; or
   Is receiving extended foster care services, as authorized by **RCW 74.13.031**

j) **Dependency Review Hearings;** are periodic judicial hearings to review the status of each dependent child, the progress of the parties and to determine whether court supervision should continue. Dependency reviews must be held by the court at least every six months.

k) **Extended Family Member;** Under RCW 13.32A.030, Extended Family Member means; an adult who is a grandparent, brother, sister, stepbrother, stepsister, uncle, aunt, or first cousin with whom the child has a relationship and is comfortable, and who is willing and available to care for the child.

l) **Family Reconciliation Services (FRS)** are provided by CA staff who work with families to help find solutions to their conflict by referring to services aimed at keeping families together. Services are voluntary, family-focused, and rely on the family's participation.

m) **Family Team Decision Making (FTDM) Meetings;** bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home.

n) **Foster Care; Under WAC 388-25-0010,** Foster Care means; twenty-four-hour per day temporary substitute care for the child placed away from the child's parents or guardians and for whom the department or a licensed or certified child placing agency has placement and care responsibility. This includes but is not limited to placements in foster family homes, foster homes of relatives, licensed group homes, emergency shelters, staffed residential facilities, and pre-adoptive homes, regardless of whether the department licenses the home or facility and/or makes payments for care of the child.

o) **Guardian;** Under **RCW13.34.030,** Guardian means; the person or agency that: (a) Has been appointed as the guardian of a child in a legal proceeding, including a guardian appointed pursuant to chapter 13.36 RCW; and (b) has the legal right to custody of the child pursuant to such appointment. The term "guardian" does not include a "dependency guardian" appointed pursuant to a proceeding under this chapter.

p) **Health and Safety Visit means;** Monthly visits are face-to-face visits conducted by the assigned social worker that provide ongoing assessment of the health, safety, permanency

and well-being of children and promote achievement of case goals. The visits are well-planned and involve the child, out-of-home caregiver, and all known parents in all cases of children in CA custody and cases that are open for in-home voluntary services.

q) **Individual Service and Safety Plan (ISSP) means;** The Individual Service and Safety Plan, DSHS form 19-335D (X), which is the document presented to juvenile courts for dependency and permanency reviews, identifying the service plans for children, parents foster/relative caregivers, agencies and DSHS.

r) **Integrated Treatment Plan (ITP);** is the primary written treatment planning tool for youth in JRA residential programs. Developed by the JRA Residential Counselor, the ITP includes:

1) The youth's history of relevant behaviors and the highest priority treatment targets to be addressed in the next several months.
2) Strategies and plans for engaging the youth and family in a working therapeutic relationship and increasing motivation to work toward goals.
3) Specific strategies for helping the youth increase skillful behavior to solve problems effectively.
4) Plans to help the youth successfully transition throughout the JRA Continuum of Care and for re-entry back into the community.

s) **Integrated Case Management (ICM);** is a multi-system infrastructure that embeds wraparound principles and guides the process of coordinating services for vulnerable youth with complex needs and their families who are served in Child Welfare and Juvenile Justice. DSHS is committed to integrating systems and collaborating with community partners to improve the trajectory of successful outcomes for youth as they transition to adulthood. ICM principles are embedded in cross systems work and include:

1) Youth and Family Centered - The system of care honors and reflects the voice of youth and family needs.
2) Communication - Communication across administrations and systems clearly demonstrates collaborative relationships with youth and families by reflecting youth and family voice.
3) Culturally Competent - Promote respect and understanding of diverse cultures, social groups, and individuals while providing culturally responsive services to improve client outcomes for all and reflect the diversity of the communities we serve.
4) Outcome Based - Demonstrate system of care improvements by identifying outcome indicators to analyze impact of service delivery for youth and families.
5) Capacity and Leadership - ICM builds sustainable capacity and leadership by affirming and nurturing dynamic partnerships across systems of care.
6) Strength Based - Value and engage the strengths of youth, families, communities and system partners.
7) Team Work - Emphasize a culture of collaboration to guide positive outcomes for youth and their families.

8) Social Justice - Promote and model equality and respect to reduces issues that adversely impact youth such as disproportionality, and to improve fairness in sentencing.
9) Collaboration - Work in partnership to cooperatively share responsibility of the development, implementation, monitoring, and evaluation of an integrated system of care.
10) Natural Supports - Promote the use of relationships and supports for youth and families in their communities.

t) **Out-of-Home Placement or Care means;** a placement in a foster family home or group care facility or placement in a home, other than that of the child's parent, guardian, or legal custodian, not required to be licensed under 74.15 RCW. RCW 74.14C.010. Also see RCW 13.34.030 (14).

u) **Response to Transition Report (RTR);** is a report developed by the JRA Community Counselor prior to the youths release to parole that describes the release destination environment, family involvement, parole conditions, specialized treatment, education and employment referrals and transportation arrangements.

v) **Shared Planning Meeting means;** bring individuals together to help make decisions for children about safety, permanency and well-being.

w) **Special Sexual Offender Disposition Alternative (SSODA);** is a community disposition alternative for youth as defined in RCW 13.40.162.

x) **Transition Plan means;** a plan which ensures continuity of care as youth move within systems and from a JRA residential placement to the community with or without parole aftercare services.

y) **Transition Report (TR);** is an electronic report generated by the JRA Residential Counselor no later than 45 days prior to the youth's release from residential placement. This report notifies the JRA Community Counselor of the release destination of the youth, family involvement, treatment progress and continued service needs when released.

z) **Voluntary Placement Agreement means;** a time-limited written agreement between the department and a child's parent or legal guardian authorizing a short-term placement of the child.RCW 74.13.350

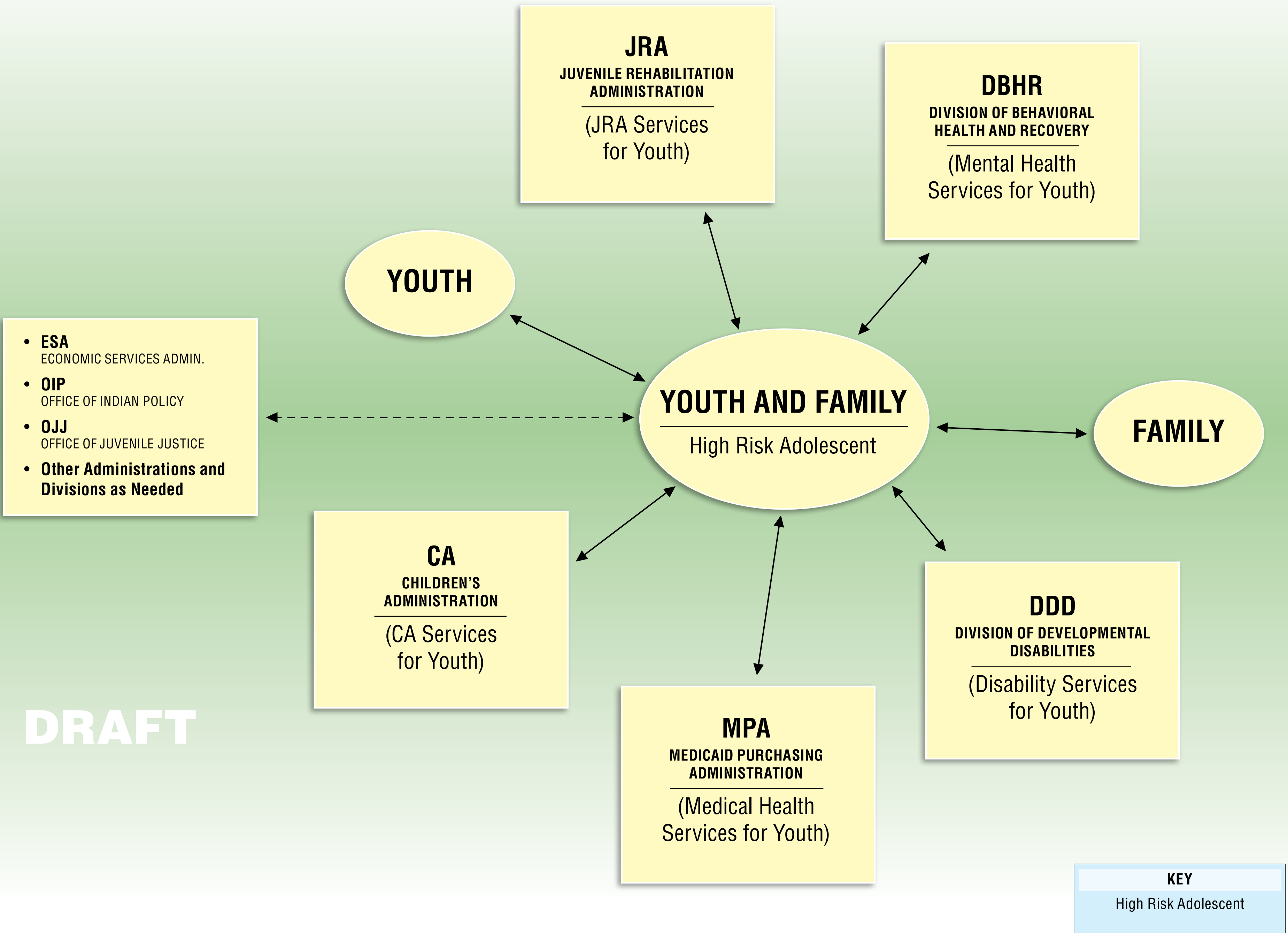
aa) **Wraparound Process;** is an intensive, holistic process that includes a team of people who are relevant to the lives of the youth and family and work collaboratively to develop an individualized plan of care, implement this plan, monitor the efficacy of the plan and work towards success over time (National Wraparound Initiative, 2012). Ten principles guide the process of Wraparound and include:

a. Family Voice and Choice - Family & youth/child perspectives are intentionally elicited & prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options such that the plan reflects family values & preferences.
b. Team Based - Consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.
c. Natural Supports - The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal & community relationships.
d. Collaboration - Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources.
e. Community Based - The team implements service and support strategies that take place in the most inclusive, most responsive, accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
f. Culturally Competent - Demonstrates respect for and builds on the values, preferences, beliefs, culture, & identity of the child/youth and family, and their community.
g. Individualized - The team develops & implements a customized set of strategies, supports, and services.
h. Strength Based - Identify, build on, and enhance the capabilities, knowledge, skills, & assets of the child and family, their community, & all team members.
i. Persistence – despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.
j. Outcome Based - The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

bb) Youthful Sex Offender (YSO) – Youth adjudicated for a sex offense.

MULTI-AGENCY INTEGRATION MATRIX

ATTACHMENT C



Washington State
Department of Social & Health Services
One Department, One Vision, One Mission, One Core Set of Values
Integrated Case Management (ICM)
Multi-Agency Integration Matrix
Susan Dreyfus
Secretary
JRA
JUVENILE REHABILITATION ADMINISTRATION
(JRA Services for Youth)
DBHR
DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
(Mental Health Services for Youth)
YOUTH
ESA
ECONOMIC SERVICES ADMIN.
OIP
OFFICE OF INDIAN POLICY
OJJ
OFFICE OF JUVENILE JUSTICE
Other Administrations and Divisions as Needed
YOUTH AND FAMILY
High Risk Adolescent
FAMILY
CA
CHILDREN'S ADMINISTRATION
(CA Services for Youth)
DDD
DIVISION OF DEVELOPMENTAL DISABILITIES
(Disability Services for Youth)
MPA
MEDICAID PURCHASING ADMINISTRATION
(Medical Health Services for Youth)
DRAFT
KEY
High Risk Adolescent
September 29, 2010

LOCAL MULTI-SYSTEM INTEGRATION
Implementation Sites

ATTACHMENT D

Washington State Department of Social & Health Services

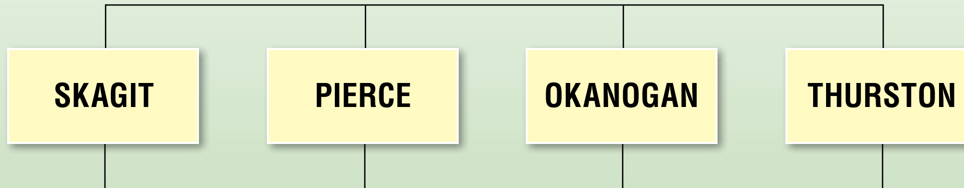
One Department, One Vision, One Mission, One Core Set of Values

Integrated Case Management (ICM)

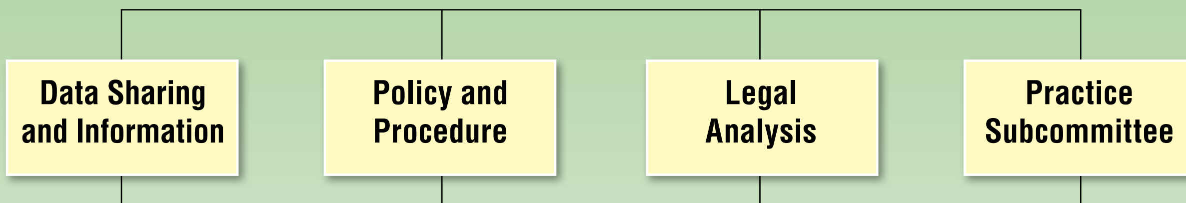
Susan Dreyfus
Secretary

Local Multi-System Integration

Implementation Sites



Integrated Case Management Subcommittees



The Executive Team – Governance

DRAFT

Februrary 23, 2011

INTEGRATED CASE MANAGEMENT CHARTER

ATTACHMENT E

Integrated Case Management Charter

Integrated Case Management (ICM) is a multi-system infrastructure that guides the process of coordinating services for vulnerable youth with complex needs and their families who are served in Child Welfare and Juvenile Justice.

BACKGROUND

The Department of Social and Health Services (DSHS) is committed to collaborating with Community Partners to improve the trajectory of success for vulnerable and complex youth served in Child Welfare and Juvenile Justice as they transition to adulthood.

PURPOSE

ICM will achieve a level of effective collaboration statewide by creating a multi-system infrastructure that coordinates policy, programs, and services for youth and their families served in Child Welfare and Juvenile Justice at the state and local level.

TARGET POPULATION

The target population is comprised of youth and young adults who have a history of child abuse and / or neglect with current juvenile or criminal justice involvement.

OUTCOME

Youth and families will receive improved holistic services across multi-systems including DSHS and Community Partners.

GUIDING PRINCIPLES:

Youth and Family Centered

The system of care honors and reflects the voice of youth and family needs.

Communication

Communication across administrations and systems clearly demonstrates collaborative relationships with youth and families by reflecting youth and family voice.

Culturally Competent

Promote respect and understanding of diverse cultures, social groups, and individuals while providing culturally responsive services to improve client outcomes for all and reflect the diversity of the communities we serve.

Outcome Based

Demonstrate system of care improvements by identifying outcome indicators to analyze impact of service delivery for youth and families.

Capacity and Leadership

ICM builds sustainable capacity and leadership by affirming and nurturing dynamic partnerships across systems of care.

Strength Based

Value and engage the strengths of youth, families, communities and system partners.

Team Work

Emphasize a culture of collaboration to guide positive outcomes for youth and their families.

Social Justice

Promote and model equality and respect to reduces issues that adversely impact youth such as disproportionality, and to improve fairness in sentencing.

Collaboration

Work in partnership to cooperatively share responsibility of the development, implementation, monitoring, and evaluation of an integrated system of care.

Natural Supports

Promote the use of relationships and supports for youth and families in their communities.

YOUTH AND FAMILY GOALS: (increase)

- Health and wellness
- Safe and stable housing
- Job readiness and stable employment
- Life skills acquisition and generalization
- Education, attendance and completion
- Safe and stable in-home care
- Seamless transitions from out-of-home placements
- Stable and safe families
- Safe healthy communities to include natural supports

SYSTEM GOALS:

- Remove barriers that inhibit services
- Maximize Funding through shared resources
- Streamline Services to create efficiencies that reduce duplication of work and services.
- Seamless Case Management to provide holistic care for youth and families.

TEAM STRUCTURE

The DSHS internal structure of ICM will be made up of an:

- Executive Team

  The Executive Team is appointed by the Secretary of DSHS. The Executive Team will provide Governance for the Integrated Case Management. The Executive Team will consist of the Assistant Secretary of Children's Administration, the Assistant Secretary of the Juvenile Rehabilitation Administration, the Assistant Secretary of Economic Services, the Assistant Secretary of the Medicaid Purchasing Administration, the Senior Director of Planning, Performance and Accountability, the Director of the Division of Behavioral Health & Recovery and the Director of the Division of Developmental Disabilities. Other members may be appointed as needed by the Secretary.

- Steering Committee

  The Executive Team will appoint one member from their respective administration or division, other members may be appointed as needed by the Executive Team. The Steering Committee will provide support and resources for Integrated Case Management. Final approval of Steering Committee members will be confirmed by the Secretary of DSHS.

- Subcommittees

  The Executive Team will designate the chairs and approve the membership of each subcommittee with final approval by the Secretary of DSHS. The four subcommittees will be created to carry out the work of Integrated Case Management. Other subcommittees and members may be appointed as needed by the Executive Team. Final approval of Subcommittee members will be by the Secretary of DSHS:

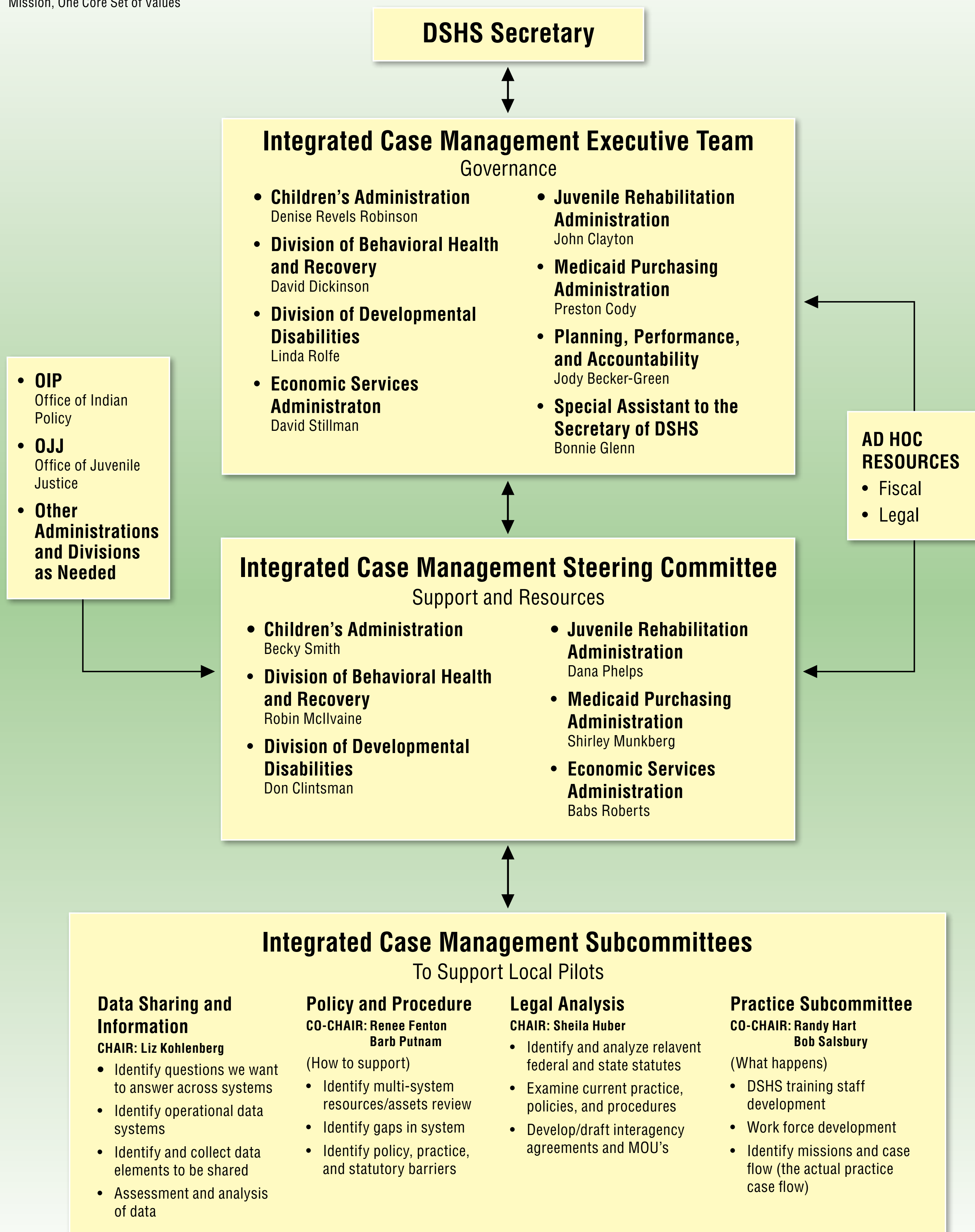
  - Data Sharing & Information Subcommittee
  - Policy and Procedure Subcommittee
  - Legal Analysis Subcommittee
  - Practice Subcommittee

TEAM DECISION-MAKING PROCESS

Collaboration is required to identify issues, provide guidance and expertise to answer questions and come to consensus for policy recommendations. Decision will be made by consensus whenever possible. When consensus cannot be reached a majority and dissenting positions will be shared with the Executive Team for approval before submission to the Secretary of DSHS.

MULTI-AGENCY INTEGRATION FLOW CHART

ATTACHMENT F



Washington State Department of Social & Health Services
One Department, One Vision, One Mission, One Core Set of Values
Integrated Case Management (ICM)
Multi-Agency Integration Flow Chart
Susan Dreyfus
Secretary
DSHS Secretary
Integrated Case Management Executive Team
Governance
Children's Administration
Denise Revels Robinson
Division of Behavioral Health and Recovery
David Dickinson
Division of Developmental Disabilities
Linda Rolfe
Economic Services Administraton
David Stillman
Juvenile Rehabilitation Administration
John Clayton
Medicaid Purchasing Administration
Preston Cody
Planning, Performance, and Accountability
Jody Becker-Green
Special Assistant to the Secretary of DSHS
Bonnie Glenn
OIP
Office of Indian Policy
OJJ
Office of Juvenile Justice
Other Administrations and Divisions as Needed
AD HOC RESOURCES
Fiscal
Legal
Integrated Case Management Steering Committee
Support and Resources
Children's Administration
Becky Smith
Division of Behavioral Health and Recovery
Robin McIlvaine
Division of Developmental Disabilities
Don Clintsman
Juvenile Rehabilitation Administration
Dana Phelps
Medicaid Purchasing Administration
Shirley Munkberg
Economic Services Administration
Babs Roberts
Integrated Case Management Subcommittees
To Support Local Pilots
Data Sharing and Information
CHAIR: Liz Kohlenberg
Identify questions we want to answer across systems
Identify operational data systems
Identify and collect data elements to be shared
Assessment and analysis of data
Policy and Procedure
CO-CHAIR: Renee Fenton
Barb Putnam
(How to support)
Identify multi-system resources/assets review
Identify gaps in system
Identify policy, practice, and statutory barriers
Legal Analysis
CHAIR: Sheila Huber
Identify and analyze relavent federal and state statutes
Examine current practice, policies, and procedures
Develop/draft interagency agreements and MOU's
Practice Subcommittee
CO-CHAIR: Randy Hart
Bob Salsbury
(What happens)
DSHS training staff development
Work force development
Identify missions and case flow (the actual practice case flow)
DRAFT
Februrary 4, 2011

INTEGRATED CASE MANAGEMENT USING WRAP AROUND PRINCIPLES
Pierce County

ATTACHMENT G

Integrated Case Management Using Wraparound Principles Charter Pierce County – June 26, 2012

Integrated Case Management (ICM) is a multi-system infrastructure that guides the process of coordinating services for vulnerable youth with complex needs and their families who are served in Child Welfare and Juvenile Justice.

BACKGROUND

For over 20 years, Pierce County has been utilizing Wraparound principles and values working collaboratively across systems. In efforts to formalize this process between state and community agencies, the city of Tacoma was selected by DSHS as an implementation site for Integrated Case Management.

PURPOSE

ICM will achieve a level of effective collaboration citywide by creating a multi-system infrastructure that coordinates policy, programs, and services for youth and their families served in Child Welfare and Juvenile Justice at the state and local level.

The ICM Tacoma membership acknowledges that systemic change is needed to change policy and practice from provider-driven to family-driven. Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes but is not limited to:

1. Choosing culturally and linguistically competent supports, services, and providers;
2. Setting goals;
3. Designing, implementing and evaluating programs;
4. Monitoring outcomes; and
5. Partnering in funding decisions.

TARGET POPULATION

The target population is comprised of African American or Native American children/ youth and young adults who have involvement with Child Welfare and/or juvenile justice systems.

Other considerations include:

- Mental health diagnosis (allows us to access already funded parent advocates)
- At risk of school dropout due to truancy, behavior and/or poor academic performance
- Younger siblings that are at risk of involvement with Child Welfare and juvenile justice systems.
- Repeated involvement with multiple systems.

OUTCOMES

Families and youth involved in this work may experience a:

- reduction or prevention of the use of juvenile detention facilities at both the county and state level
- reduction in the amount of time families are involved in public Child Welfare
- reduction of future involvement in Child Welfare and juvenile justice
- reduction of the number of out of home placements
- reduction of the number of changes to a child's living arrangements
- school attendance and academic performance improvement
- reduction of school disciplinary sanctions
- reduction or prevention of psychiatric hospitalization

WRAPAROUND PRINCIPLES EMBEDDED IN THIS PROCESS

Youth and Family Centered

- Family Voice and Choice
- Individualized
- Persistent

Communication

- Team Based
- Strengths Based
- Collaboration and Integration

Culturally Competent

- Community Based
- Natural Supports

Outcome Based

- Outcome Based and Cost Responsible

GUIDING PRINCIPLES

The ICM Tacoma membership believes in the responsibility and power of positive family partnership in the care of a child or youth care. We believe family-driven care is crucial to the success of a child or youth and is integral to our commitment to use Wraparound principles in our work. We adopt these principles of family-driven care in support of our goals.

- Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes.
- Families and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their families.
- All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf and may appoint them as substitute decision makers at any time.
- Parents, their families and their support systems play a critical role in ensuring that all children in the family are safe from harm and they are included in child safety decision making processes.
- Families and peer support specialists engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
- Families and peer support specialists provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven.
- Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
- Community attitude change efforts focus on removing barriers and discrimination created by stigma.
- Communities and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of the diverse populations are appropriately addressed.

PHASES AND ACTIVITIES OF INTEGRATED CASE MANAGEMENT

1) Identification and Assessment for Program
   - Assess nominated families against DSHS and Tacoma site target population criteria

2) Engagement and Team Prep
   - Orient family to ICM with Wrap principles Stabilize crises
   - Develop strengths, needs, and culture discovery
   - Engage team members
   - Make meeting arrangements

3) Initial Plan Development
   - Develop a plan of care
   - Develop a detailed crisis and safety plan

4) Implementation
   - Implement the plan
   - Revisit and update the plan
   - Maintain team cohesiveness and trust
   - Complete documentation and handle logistics

5) Transition
   - Plan for cessation of ICM
   - Conduct commencement ceremonies
   - Follow-up with the family after graduation

We, the undersigned partners of Integrated Case Management - Tacoma, agree to support, and advocate for the implementation of Integrated Case Management Using Wraparound Principles in the City of Tacoma. In recognition of ICM outstanding benefits to children and families, we pledge our collaboration toward the vision of implementing Integrated Case Management in the City of Tacoma.

Partner Name and Title	Partner Agency
	DSHS Children's Administration
	DSHS Juvenile Rehabilitation Administration
	Pierce County Juvenile Court
	Tacoma Public Schools
	Comprehensive Life Resources
	University of Washington – Tacoma
	A Common Voice
	Safe Streets
	Puget Sound Educational Services District
	Youth 'N Action
	Youth Representative
	DSHS – Economic Services Administration, R3
	DSHS – Division of Developmental Disabilities, R3

DSHS INTEGRATED CASE MANAGEMENT (ICM)
Implementation Site Leadership and Target Populations

ATTACHMENT H

LEADERSHIP MEMBERS

Okanogan County

- Russ Haugen, Area Administrator, Children's Administration
- Bob Salsbury, Regional Administrator, Juvenile Rehabilitation Administration
- Peria Duncan, Coordinator, JRA
- Evelyn Perez, Regional Administrator, DDD
- Dennis Rabidou, Court Administrator, Okanogan County Juvenile Court
- (Sandy Howe will be secondary)
- Paul Bjur, DCFS
- Susan Danielson, DCFS
- Myrna Abrahamson, CCT
- Julia O'Connor, Readiness to Learn Program
- Mental Health – representative to be determined
- Parent – to be identified by next meeting
- Stacy Coronado (DCFS) will serve as the Care Coordinator

Pierce County

- David Charles, Regional Administrator, JRA
- Nancy Sutton, Regional Administrator, CA
- TJ Bohl, Assistant Administrator, Pierce County Juvenile Court
- Gregory Benner, Professor, UW – Tacoma
- Dawn Cooper, CA
- Kathy Hagen, Community Life Resources
- Patty King, Parent Advocate, A Common Voice
- Ghasem Nahvipour, Comprehensive Mental Health
- Sherry Lyons, A Common Voice
- Jim Madsen, DSHS JRA
- Brian Shirley, DSHS JRA
- Miguel Villahermosa, Tacoma Public Schools, Director of Security
- Jill Patnode, Puget Sound Service District
- Tamara Johnson, Program Director, Youth 'N' Action
- Youth Member – TBD

Skagit County

- Patti Omdal, JRA Regional Administrator
- Joel Odimba, CA Regional Administrator
- Kelly Dahl, JRA Program Manager
- Lisa Rumsey, Director, Skagit County Office of Juvenile Court
- Jennifer Kingsley, Director, Skagit County Community Services
- Janet Simpson, Executive Director, Skagit Family Center, Catholic Community Services
- Dawn Scott, Wraparound Program Supervisor (SWIFT), Catholic Community Services
- Sheila Woods, Assistant Director, Special Programs, Northwest ESD
- Angela Fraser, Quality Specialist, North Sound Mental Health Administration
- Julie de Losada, Quality Specialist, North Sound Mental Health Administration
- Debbie Davis, Work First Program Supervisor/CSO
- Mary Larson, Field Services Administrator, DDD
- Theresa Responte, Supervisor, DDD
- Patty Turner, Area Administrator, CA
- Marjorie Forbes, Supervisor, CA
- Annie Taylor, Supervisor, CA (ICM Facilitator)
- Michael Tyers, Program Manager, CA, ICM Lead for CA
- Carol Worrell, Family Support Partner, Catholic Community Services
- Laura Stephens, Care Coordination Supervisor, Skagit County Community Services
- Sarah Hinman, Program Coordinator, Drug/Alcohol, Skagit County Community Services
- Brian Paxton, County Commissioner, Skagit County,
- Tim Collins, DSHS Office of Indian Policy, Region 2 Manager

Thurston County

- Bob Ritchey, Program Manager, Juvenile Rehabilitation Administration
- Heidi Williams, Catholic Community Services
- Hieu Dang, Area Administrator, Children's Administration
- Mike Fenton, Thurston County Juvenile Court Administrator
- Gary Enns, Thurston, Mason RSN – Mental Health
- Miri Murayama – BHR Mental Health/Children's Administration Liaison
- Donna Obermeyer – Mason Thurston Wraparound Initiative, Family Alliance for Mental Health
- Shelly Willis – Family Education and Support Services
- Karen Kremkau – Region Three Children's Administration BRS Program Manager
- Maddy DeGive – North Thurston School District
- Ed Pong – Director of Secondary Special Education, Olympia School District
- Devyna Aguon-Mang – North Thurston County School District Mental Health Social Worker
- Lynn Nelson, RN, MSN, NCSN – Program Administrator, Health and Student Support ESD 113
- Scott Hanauer, Community Youth Services
- Gary Endler, Program Manager, Division of Developmental Disabilities

TARGET POPULATION

ICM sites have developed a shared target population definition and eligibility criteria; however, each site has prioritized certain areas. See below for overall Target Population including ICM site specific criteria.

- Juvenile Justice Arrests – local court arrests (Misdemeanors, Gross Misdemeanors, and Felonies)
  - w/ CA history of investigations
  - or with history of legal activity and services (petitioned or otherwise placed in CA custody)
- JJ involvement may be diverted, petitioned, adjudicated and JRA
- Across three age groups: 8-11, 12-17 and 18-21
- Includes youthful DDD community protection clients – youth not arrested but involved in unlawful behaviors
- Partners
  - Employment
  - Housing
  - Education *(to include early learning, K-12, vocational tech., and higher education)*
  - Economic Services
  - Mental Health
  - Substance Abuse
  - Developmental Disabilities
  - Health Care
- Community Partners & ID Stakeholders beyond partners above
  - Family & Youth
  - Community Based Providers
  - Court Personnel
  - Prosecutors, Defense
  - Law Enforcement
  - Tribes
  - Natural and Community Supports *(e.g., mentoring, youth groups, faith based community)*
  - Others *(to continue to identify)*

Okanogan

In addition to the above criteria, they are focusing on the 8-11 year old population, diverted youth with CA histories.

Pierce

They are continuing with the established criteria with a lens toward reducing DMC and a focus on youth voice.

Skagit

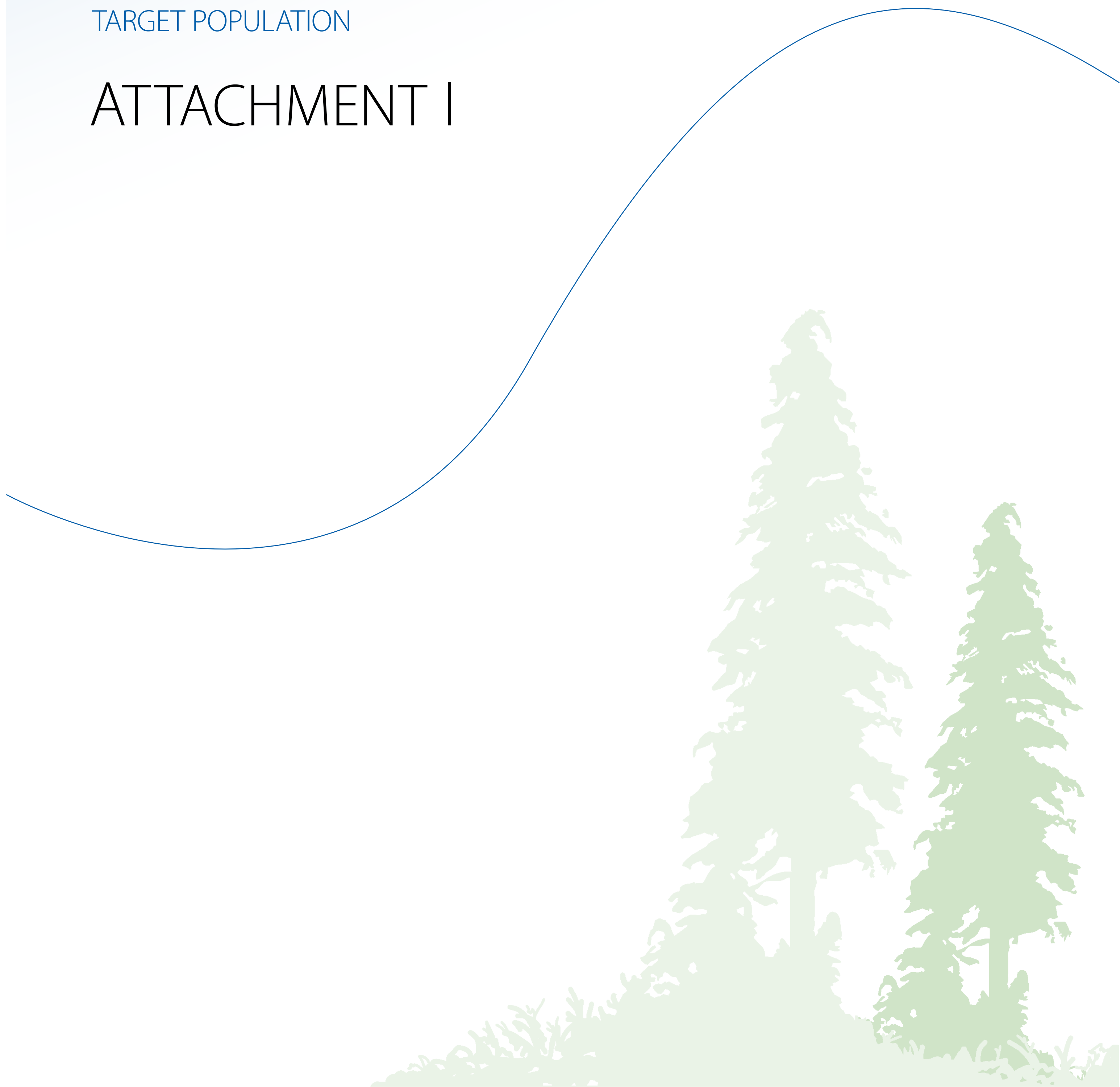
In addition to the above criteria, they are also looking at families where the youth is currently in detention with unmet needs, has been referred to Children's Long Term In-patient Program (CLIP), or is referred by local schools, other DSHS agencies or Mental Health as a child with complex needs. Age groups include children/youth 8-21, primarily 8-17 year olds.

Thurston

They are continuing with the established criteria and have expanded to include early prevention efforts for youth not involved in child welfare or juvenile justice systems with education and mental health referrals being the priority.

TARGET POPULATION

ATTACHMENT I



TARGET POPULATION

JJ arrests – local court arrests (Misdemeanors, Gross Misdemeanors, and Felonies)

- w/ CA history of investigations;
- or with history of legal activity and services (petitioned or otherwise placed in CA custody)

JJ involvement may be

- Diverted
- Petitioned
- Adjudicated
- JRA

Across three age groups

- 8-11
- 12-17
- 18-21

Includes youthful DDD community protection clients – (kids not arrested but involved in unlawful behaviors)

Partners

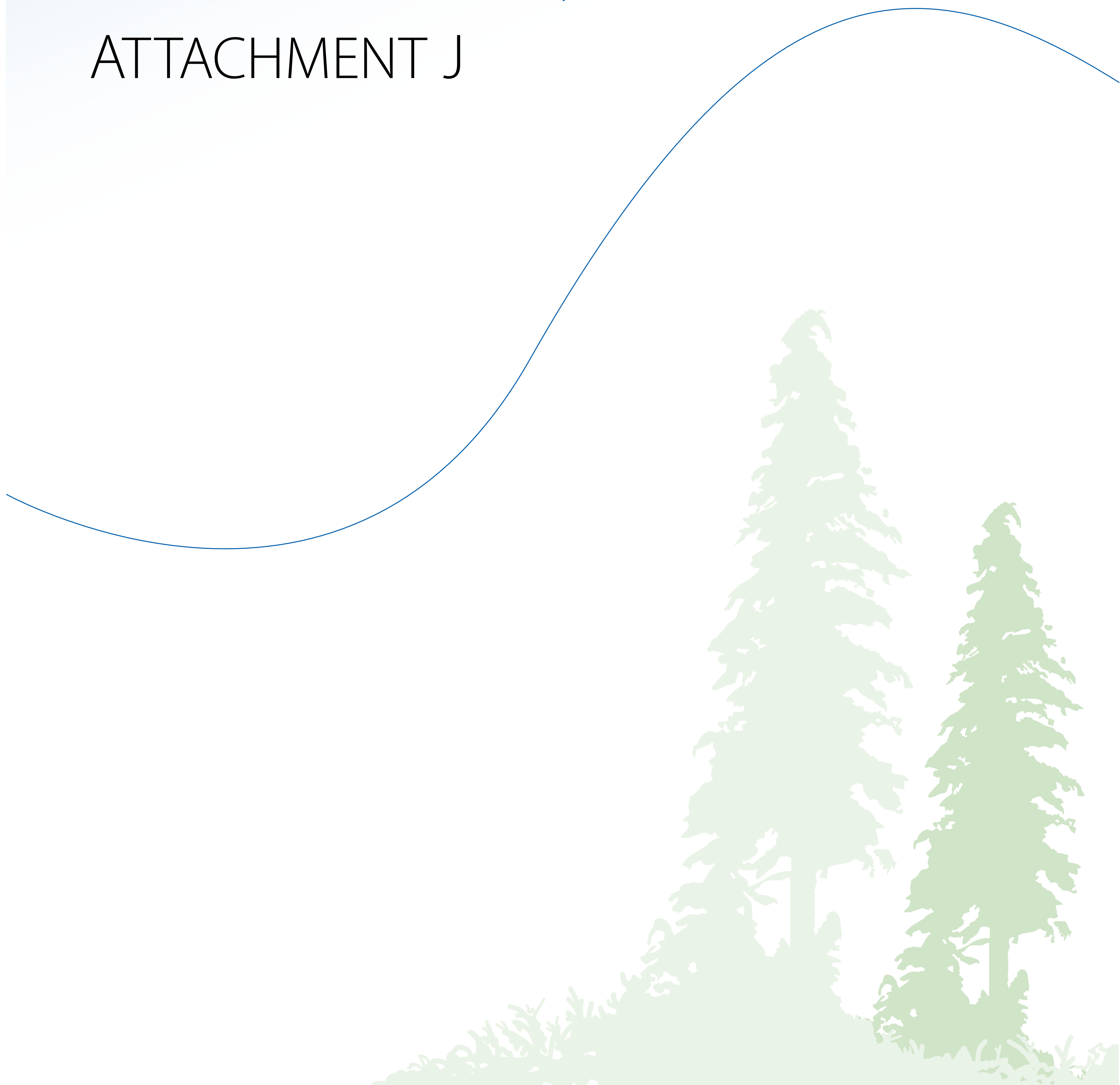
- Employment
- Housing
- Education (to include early learning, K-12, vocational tech., and higher education)
- Economic Services
- Mental Health
- Substance Abuse
- Developmental Disabilities
- Health Care

Community Partners and ID Stakeholders beyond partners above

- Family and youth
- Community based providers
- Court personnel
- Prosecutors, defense
- Law enforcement
- Tribes
- Natural and community supports (i.e. mentoring, youth groups, faith based community)
- Others (to continue to identify)

ICM GOALS, OBJECTIVES, AND OUTCOME MEASURES
for Youth, Families, Communities, and Systems

ATTACHMENT J



ICM Goals, Objectives, and Outcome Measures

for Youth, Families, Communities, and Systems

(As of August 18, 2011 – this is an evolving document)

YOUTH GOALS	OBJECTIVES	OUTCOME MEASURES (How Do You Know)
(1) HEALTH AND WELLNESS		
• Access health, mental health and substance abuse treatment as needed	• Increase screening, identification, and referral for youth who need primary health care, substance abuse, or mental health services	• Youth have health insurance • Youth who need mental health or AOD services receive them
(2) EDUCATION		
• Complete High School or equivalency Program • After high school completion, either work fulltime or attend and complete post-secondary education	• Increase rate of school attendance and decrease dropout rates • Increase rate of graduating from high school or equivalency • After high School, older youth not working fulltime begin and complete post-secondary education	• Youth stay in or return to school • Youth complete grades and classes • Youth increase high school completion rates • Older youth with high school completion who are not employed fulltime attend and complete post-secondary education
(3) JOB READINESS, EMPLOYMENT AND LIFE SKILLS		
• Increase job readiness skills and employment experience • Acquire life management skills	• Access job readiness programs • Increase work opportunities in local communities • Improve youths' handling of emotions, independent living skills and management of finances • Reduce criminal activity and recidivism	• Local and state job readiness data and life skill planning data; report if available • Youth are employed • Youth are arrested less • Youth are convicted less

08-18-11

FAMILY AND COMMUNITY GOALS	OBJECTIVES	OUTCOME MEASURES (How Do You Know)
(4) SAFE AND STABLE HOUSING		
• Increase living stability, safe housing options, and environment	• Increase community placement options • Increase Family Unification Vouchers	• Youth and families are using housing programs to reduce homelessness • Youth and families have fewer homeless spells
(5) SAFE AND STABLE IN-HOME CARE AND NATURAL SUPPORTS		
• Stay safely in family home with services in community • Connect to natural supports and healthy community activities • Access social and interpersonal supports with positive and healthy attachments to family & community	• Reduce out-of-home placement • Connect the family to needed individualized service in their community • Increase the natural supports for families • Increase youth involvement in after-school activities	• Youth have fewer and shorter out-of-home stays • Families use needed services • Families report that they have help from their friends and family when needed (SURVEY) • Youth report they have friends and participate in after school activities (SURVEY)
(6) SEAMLESS TRANSITIONS BETWEEN PLACEMENT AND COMMUNITY		
• Develop transition plans from out-of-home placement that are individualized and collaborative, with youth and family voice. • Develop services and supports and put in place before youth leaves placement	• Provide for participation of the community and families together with the facilities to create a viable transition plan • Establish health insurance for youth prior to release • Identify stable housing prior to release	• Families report that they feel supported and are involved in transition decisions (SURVEY) • Youth are quickly connected to health insurance after out-of home placement • Youth homelessness is reduced

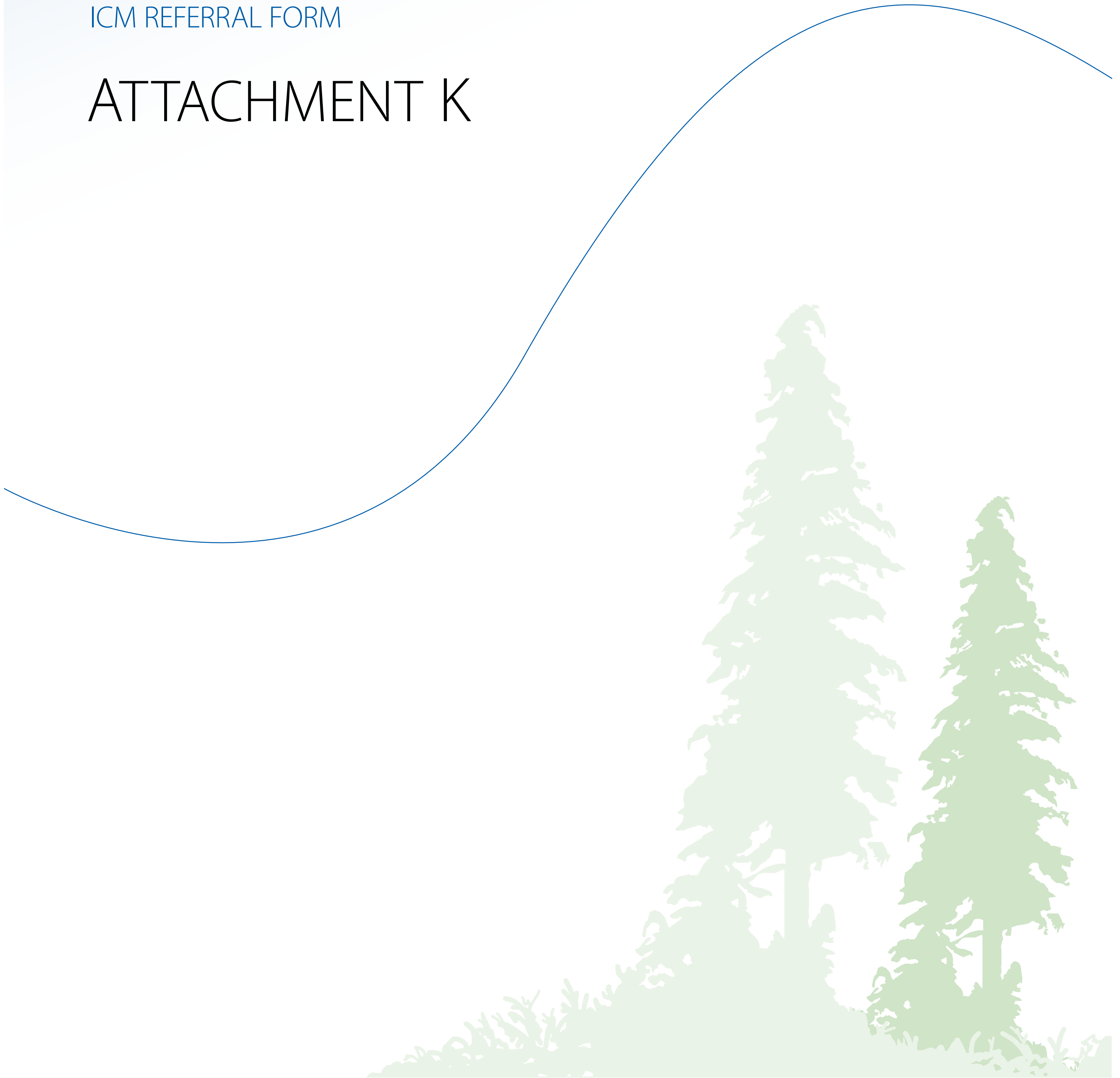
08-18-11

SYSTEM GOALS	OBJECTIVES	OUTCOME MEASURES (How Do You Know)
(7) SEAMLESS CARE MANAGEMENT TO PROVIDE HOLISTIC CARE AND BEST PRACTICES		
• Team develops coordinated care plan in which client needs are assessed and services are tailored to needs	• Develop case plans that are family driven, individualized, and coordinated by multi systems • Revise case plans as needed • Reduce number of crisis events that disrupt service provision	• ICM youth have a plan • ICM youth and families understand their plan and say it is responsive to their changing needs (SURVEY) • ICM youth have fewer crisis events
(8) STREAMLINE SERVICES AND REMOVE BARRIERS		
• Reduce service duplication • Remove barriers to coordinated care	• Reduce number of appointments with separate case managers • Communities identify barriers that inhibit services and either resolving them locally or forwarding them to HQ	• ICM youth and families have fewer separate appointments during ICM services • Barriers reported upwards are addressed (INTERVIEWS WITH STAFF)
(9) USE DATA TO INFORM PRACTICE DECISIONS		
• Develop pathways and agreements to share data between systems as needed to better serve youth and families	• Provide regular cross-system reports at the community and state level on needs, services and outcome measures	• Reports are developed and provided as the numbers served increase and resources permit • Reports improve service delivery (INTERVIEWS OR STAFF SURVEY)

08-18-11

ICM REFERRAL FORM

ATTACHMENT K



(ICM) Referral Form

FOR FSP ONLY Family Support Partner:	Referral Source/System: Children's Administration
Date Referral Started:	**Scheduled Team Meeting Date**

1. Referred Youth's Information

Name:	Gender: ☐ Male ☐ Female
Address:	Date of Birth: Phone 1: Phone 2: Best time to call: anytime May we leave VM? ☐ Y ☐ N
My Primary Language: English	My Secondary Language:
I need an interpreter. ☐ Y ☐ N	I can read English: ☐ Y ☐ N
Medicaid? ☐ Y ☐ N Insurance? ☐ Y ☐ N	Other:

2. Primary Parent or Caregiver Information

Name:	Relationship to Youth:
Name:	Relationship to Youth:
Address of Primary Caregiver(s):	Phone 1: Phone 2: Best time to call: anytime May we leave VM? ☐ Y ☐ N
My Primary Language: English	My Secondary Language:
I need an interpreter. ☐ Y ☐ N	I can read English: ☐ Y ☐ N

3. Additional Parent or Caregiver Information

Name:	Relationship to Youth:
Address:	Phone 1: Phone 2: Best time to call: anytime May we leave VM? ☐ Y ☐ N
My Primary Language: English	My Secondary Language:
I need an interpreter. ☐ Y ☐ N	I can read English: ☐ Y ☐ N

4. Current Living Situation of Youth and for How Long?

☐	Two-Parent Family: CHINS Placement	☐	Adoptive Family 14 years
☐	One Parent Family	☐	Grandparent(s)
☐	Other Relative	☐	Family Foster Care
☐	JRA Facility	☐	Group Foster Care
☐	County Detention	☐	Shelter/Homeless
☐	CLIP Facility or Psychiatric Hospital	☐	Other:

5. What are you most worried about for your child?

6. What's works well for you/your family when addressing these concerns?

7. What help might your family need?

8. What is your hope for your team meeting?

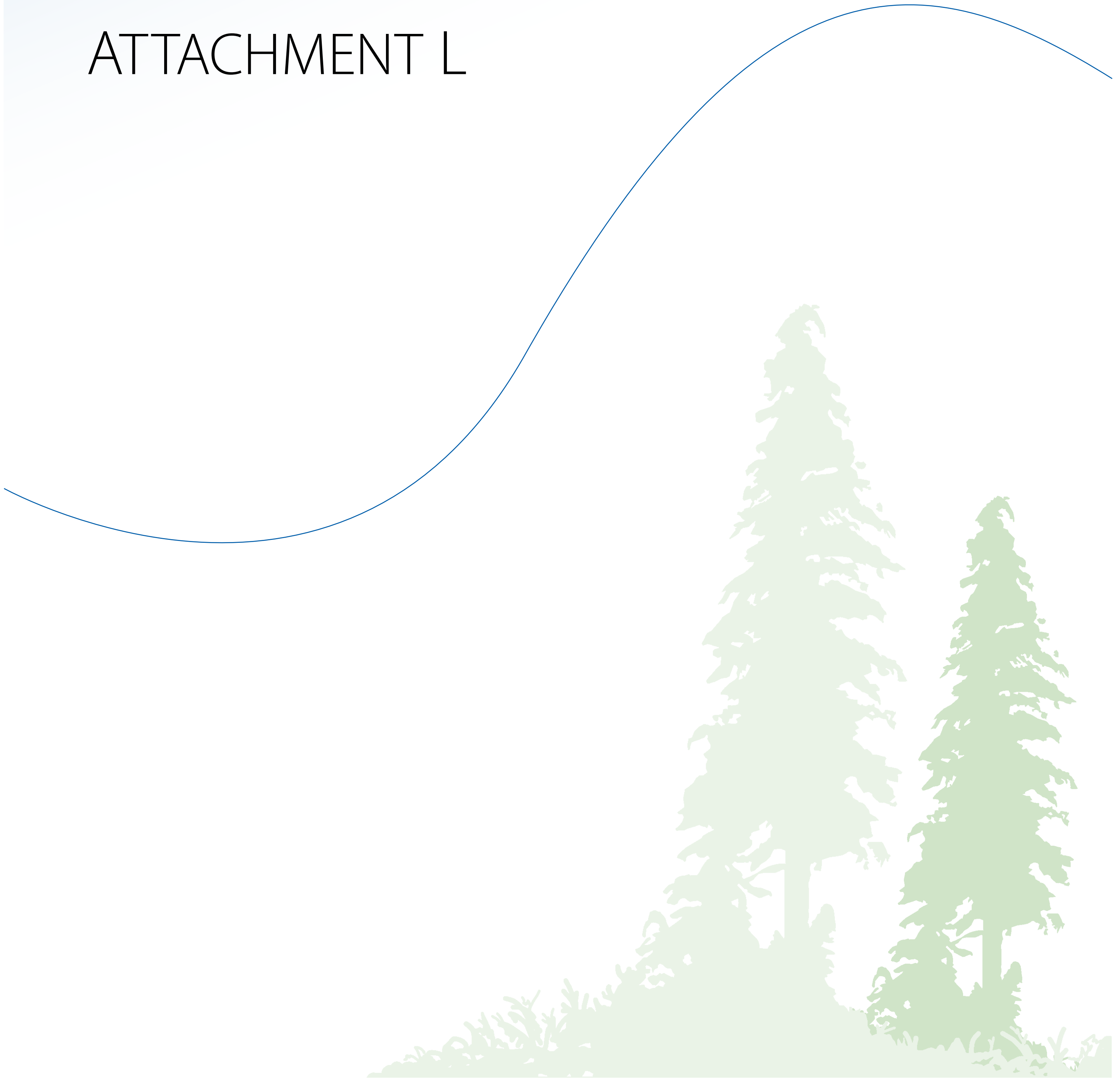
Develop an interagency team of folks that will provide services and help mother plan for future and develop more informal, natural supports.

9. Please identify whom you would like to attend the team meeting?

☐	Mental Health	Agency/Contact:
☐	Child Welfare	Agency/Contact:
☐	Substance Treatment	Agency/Contact:
☐	Division of Developmental Disabilities	Contact:
☐	Juvenile Rehabilitation	Site/Contact:
☐	Parole	Contact:
☐	County Detention	Contact:
☐	Probation	Contact:
☐	Education	School/Contact:
☐	Tribal System	Tribe/ Contact:
☐	Economic Assistance (CSO)	Contact:
☐	Other	Contact:

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION
ICM Pierce County - Tacoma Site

ATTACHMENT L



ICM Pierce County - Tacoma Site
Authorization for Release and Exchange of Information

Client Name________________________________ Date of Birth___________

SERVICE TEAM
(NOTE: This form must be completed before it is signed by the clients.)

This document authorizes release/exchange of the information identified below, between Care Coordination Team members for the purpose of service/treatment planning coordination, and delivery. This release authorizes the designated person(s)/ agency (ies) listed below to release/exchange information and reports with each other as needed to assess/determine individual and family service needs and to coordinate/monitor/evaluate individual and related family services delivered to client. We will not condition the provision of treatment on execution of an authorization form, except where the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I specifically authorize the following individuals or agencies:

- ☐ Medical Provider :______________________
- ☐ Mental Health: _______________________
- ☐ Pierce County Juvenile Court
- ☐ Tacoma Public School District
- ☐ Children's Administration
- ☐ Juvenile Rehabilitation Administration.
- ☐ Other:___________________________
- ☐ Safe Streets:____________________________

Families: ______________________________
Wrap-Around Evaluation Team
Other: ________________________________
Other: ________________________________
Other: ________________________________
Other: ________________________________
Other: ________________________________

To exchange the following information:

- ☐ Medical Records
- ☐ Psychiatric Treatment/Reports
- ☐ Educational Reports
- ☐ Other _______________
- ☐ Mental Health Assessment &Treatment Plans
- ☐ Psychological Records/Reports
- ☐ Legal/Court Records
- ☐ JRA Records
- ☐ Drug & Alcohol
- ☐ Child Welfare Records
- ☐ Communicable Disease

With the following exceptions:

_______________________________ may not be exchanged with ______________________________.
(Individual/Agency)

_______________________________ may not be exchanged with ______________________________.
(Individual/Agency)

Alcohol /Drug, Mental Health, and Medical Records include all aspects of diagnosis, treatment, and prognosis. Educational records indicate both behavioral and progress records.

This authorization is good for one (1) year from date of signature.
I can cancel this authorization in writing at any time prior to the specified expiration, but I understand that the cancellation will not affect my information that was already released before the cancellation. I will let a Care Coordination Team member know if I want to cancel my authorization. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so. I understand that information that has been release by an agency is no longer protected by that agency and may be subject to re-disclosure by the recipient, even though further disclosure of this information is prohibited unless permitted by the written authorization of the client, or their parent, guardian, or personal representative.

____________________	______	______________________________	______
Signature of Client	Date	Signature of Guardian or Personal Representative	Date
____________________	______	______________________________	______
Signature of Witness	Date	Description of Representative's Authority to act for the Client	Date

To those receiving information under this authorization: The information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

CONFIDENTIALITY PLEDGE

ATTACHMENT M

CONFIDENTIALITY PLEDGE
(To Be Signed By All Volunteers)

I, _______________________________, do hereby pledge myself to hold in strict confidence all information, verbal or written, concerning present and former clients, which comes to me as a volunteer of this organization.

I realize that the work of the organization is highly confidential and that failure on my part to recognize this may result in harm to those the organization seeks to serve.

It is understood that this pledge covers unnecessary discussion on my part with fellow staff members, discussion with personal friends and fellow citizens, in private, semi private and public areas.

It is further understood that this pledge does not refer to general interpretation of the organization's program. Such interpretation is a desirable and necessary part or may work as a member of the staff.

This pledge refers to specific person information received in connection with those receiving assistance from this department, a discussion of which is clearly a violation of confidence.

______________________ ______________________________________
Date Signature

____
Signature

CPT Mount Vernon
August 2011

ICM SITE DESCRIPTIONS

ATTACHMENT N

ICM SITE DESCRIPTIONS

Okanogan County

Located in North Central Washington and bordered by British Columbia, Canada, Okanogan County has a population of 41,120 (U.S. Census Bureau 2010). As stated in their Charter as one of four implementation sites in Washington State, the purpose of the Okanogan County Integrated Case Management (ICM) is to:

- Build a sustainable infrastructure to support and strengthen the ICM work in Okanogan County.
- Streamline and increase collaboration for serving cross-systems youth and families.
- Provide training in best practices for serving cross-systems youth/families.
- Provide cross-system youth/families with direct access to an array of potential supports and services. This includes facilitated family team meetings resulting in action plans, multi-agency and family action plan follow up and family support partners to support families over a several month period.

Target Population

The primary population continues to be children/families with present (preferred) or history with CA and some level of Juvenile Justice Involvement. Juvenile Justice Involvement may include JRA or Diverted, Petitioned or Adjudicated youth with Okanogan County Office of Juvenile Court.

Many of these families are involved in multiple other systems as well, including Education, Colville Confederated Tribes, Community Services Office (CSO), Division of Developmental Disabilities (DDD), Okanogan Behavioral Health Care, and other community networks/services.

Some families may also be referred if the youth is currently in detention with unmet needs, has been referred to Children's Long Term In-patient Program (CLIP), or is referred by local schools, other DSHS agencies or Mental Health as a child with complex needs. Age groups include children/youth 8-21, primarily 8-17 year olds.

Desired Outcomes

The Okanogan County ICM team is dedicated to a number of outcomes related to improving service access and delivery for cross-systems youth and families, including:

- Identify and articulate common missions of the agencies and resources involved with this project.
- Examine and address barriers to increased cross-systems collaboration.
- Identify and provide key training which supports ICM and Wraparound Principles. This includes training in Wraparound Principles and Practices, cross-systems agency training and other strategies which improve client outcomes for youth/families with complex needs.
- Continually refine and improve the ICM Case Staffing model and other case flow practices to improve service delivery to target population.
- Actively participate in statewide ICM activities and practices. Meet statewide requirements for data reporting on collaborative efforts and direct service.
- Realize learning opportunities from other Implementation Sites and other models of change in cross-systems initiatives.
- Record, analyze and use lessons learned and data to continually improve ICM practices.

Meetings

Leadership Team meetings are held for two hours on the fourth Tuesday of the month.

Membership

Membership is a purposeful blend of key leaders, supervisory and direct service staff from represented agencies and includes:

1. Regional Administrator, DSHS - JRA
2. Regional Administrator, DSHS - CA
3. Program Manager, DSHS - JRA

4. Director, Okanogan County Office of Juvenile Court
5. Program Manager, Colville Confederated Tribes Social Services
6. Program Manager, Colville Confederated Tribes, Tribal Attendance Office
7. Attorney, Colville Confederated Tribes Legal Services
8. Clinical Director, Okanogan Behavioral Health Care
9. Director, Family Empowerment Program
10. Area Administrator, DSHS - CA
11. Work First Program, DSHS - Economic Services Administration
12. Supervisor, DSHS - CA
13. Supervisor, DSHS - CA
14. Social Service Specialist (ICM Coordinator), DSHS - CA
15. Social Service Specialist, DSHS - CA
16. Community Counselor, DSHS - JRA
17. Regional Manager, DSHS - Office of Indian Policy
18. Juvenile Justice Policy Administrator, DSHS - JRA

Connections with local Tribal Nations

The Omak CA office is currently working closely with the Colville Confederated Tribes Office of Child and Family Services to insure that tribal children have access to the ICM model.

Sponsors

Sponsors include the DSHS Secretary, DSHS Assistant Secretaries across multiple administrations, and the ICM Practice Sub-Committee of the ICM Executive Steering Committee.

Process for Decision Making

Consensus/majority vote (needs discussion).

Roles and Responsibilities

Leadership members and their staff, as appropriate, will;

- Attend monthly Leadership meetings or send a designate whenever possible.
- Facilitate referrals of youth/families to receive ICM staffings and other ICM resources.
- Attend ICM staffings and/or send their designated staff as appropriate to each youth and family.
- Complete action items involving their organization that result from ICM staffings.
- Actively participate in efforts to continually improve and refine ICM work products, resources and case flow practices.

Pierce County

The second most populous county in Washington, with a population of 795,225 (U.S. Census Bureau 2010), Pierce County has been utilizing wraparound principles and values working collaboratively across system for over 20 years. In efforts to formalize this process between state and community agencies, the city of Tacoma was selected by DSHS as an implementation site for ICM with the following contained in their Charter.

Purpose

ICM will achieve a level of effective collaboration citywide by creating a multi-system infrastructure that coordinates policy, programs, and services for youth and their families served in Child Welfare and Juvenile Justice at the state and local level.

The ICM Tacoma membership acknowledges that systemic change is needed to change policy and practice from provider-driven to family-driven. Family driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes, but is not limited to:

- Choosing culturally and linguistically competent supports, services, and providers.
- Setting goals.
- Designing, implementing and evaluating programs.

- Monitoring outcomes.
- Partnering in funding decisions.

Target Population

The target population is comprised of African American or Native American children/youth and young adults who have involvement with Child Welfare and/or juvenile justice systems. Other considerations include:

- Mental health diagnosis (allows us to access already funded parent advocates).
- At risk of school dropout due to truancy, behavior and/or poor academic performance.
- Younger siblings that are at risk of involvement with Child Welfare and juvenile justice systems.
- Repeated involvement with multiple systems.

Desired Outcomes

Families and youth involved in this work may experience:

- Reduction or prevention of the use of juvenile detention facilities at both the county and state level.
- Reduction in the amount of time families are involved in public Child Welfare.
- Reduction of future involvement in Child Welfare and juvenile justice.
- Reduction of the number of out-of-home placements.
- Reduction of the number of changes to a child's living arrangements.
- School attendance and academic performance improvement.
- Reduction of school disciplinary sanctions.
- Reduction or prevention of psychiatric hospitalization.

Wraparound Principles Embedded in this Process

- Youth and Family Centered (Family Voice and Choice, Individualized, Persistent)
- Communication (Team Based, Strengths Based, Collaboration and Integration)
- Culturally Competent (Community Based, Natural Supports)
- Outcome Based (and Cost Responsible)

Guiding Principles of Family-Driven Care

The ICM Tacoma membership believes in the responsibility and power of positive family partnership in the care of a child or youth care. We believe family-driven care is crucial to the success of a child or youth and is integral to our commitment to use Wraparound principles in our work. We adopt these principles of family-driven care in support of the following goals.

- Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes.
- Families and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their families.
- All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf and may appoint them as substitute decision makers at any time.
- Parents, their families and their support systems play a critical role in ensuring that all children in the family are safe from harm and they are included in child safety decision making processes.
- Families and peer support specialists engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
- Families and peer support specialists provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven.

- Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
- Community attitude change efforts focus on removing barriers and discrimination created by stigma.
- Communities and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of the diverse populations are appropriately addressed.

Phases and Activities of Integrated Case Management

1. Identification and Assessment for Program (assess nominated families against DSHS and Tacoma site target population criteria).
2. Engagement and Team Prep (orient family to ICM with wrap principles; stabilize crises; develop strengths, needs, and culture discovery; engage team members; make meeting arrangements).
3. Initial Plan Development (develop a plan of care; develop a detailed crisis and safety plan).
4. Implementation (implement the plan; revisit and update the plan; maintain team cohesiveness and trust; complete documentation and handle logistics).
5. Transition (plan for cessation of ICM; conduct commencement ceremonies; follow-up with the family after graduation).

Membership

1. Regional Administrator, DSHS – CA
2. Regional Administrator, DSHS – JRA
3. Social Worker Supervisor, Comprehensive Life Resources, DSHS – CA
4. Program Director, Pierce County Juvenile Court
5. Detention Manager, Pierce County Juvenile Court
6. Tacoma Public Schools
7. Program Manager, Comprehensive Life Resources, DSHS – CA
8. Parent Advocate, Comprehensive Life Resources, DSHS – CA
9. Program Manager, Fab Five
10. Program Manager, DSHS – JRA
11. Coordinator, DSHS – JRA
12. Functional Family Therapist, DSHS – JRA
13. School District Security Administrator, Tacoma School District
14. Program Director, Youth n' Action, University of Washington – Tacoma
15. Executive Director, A Common Voice
16. Safe Streets
17. CEO, Puget Sound Educational Services District
18. Youth Representative
19. DSHS – Economic Services Administration
20. DSHS – Division of Developmental Disabilities

Skagit County

As the county that helped sparked the creation of the ICM with DSHS, Skagit County has a population of 116,901 (U.S. Census Bureau 2010). Pursuant to its Charter, Skagit County states:

Purpose

As one of four implementation sites in Washington State, the purpose of the Skagit County Integrated Case Management (ICM) project is to:

- Build a sustainable infrastructure to support and strengthen the ICM work in Skagit County.
- Streamline and increase collaboration for serving cross-system youth and families.
- Provide training in best practices for serving cross-systems youth/families.
- Provide cross-system youth/families with direct access to an array of potential supports and services. This includes facilitated family team meetings resulting in action plans, multi-agency and family action plan follow up and family support partners to support families over a several month period.

Target Population

The primary population continues to be children/families with present (preferred) or history with CA and some level of Juvenile Justice involvement, which may include JRA or Diverted, Petitioned or Adjudicated youth with Skagit County Office of the Juvenile Court.

Many of these families are involved in multiple systems as well, including education, Skagit County Community Services, DSHS – Economic Services, DSHS – Developmental Disability, Mental Health and other community networks/services. Some families may also be referred if the youth is currently in detention with unmet needs, has been referred to Children's Long Term In-patient Program (CLIP), or is referred by local schools, other DSHS agencies or Mental Health as a child with complex needs. Age groups include children/youth 8-21, primarily 8 to17 year olds.

Desired Outcomes

The Skagit County ICM team is dedicated to a number of outcomes related to improving service access and delivery for cross-systems youth and families, including:

1. Identify and articulate common missions of the agencies and resources involved with this project.
2. Examine and address barriers to increased cross-systems collaboration.
3. Identify and provide key training which supports ICM and Wraparound Principles. This includes training in Wraparound Principles and Practices, cross-systems agency training and other strategies which improve client outcomes for youth/families with complex needs.
4. Continually refine and improve the ICM Case Staffing model and other case flow practices to improve service delivery to target population.
5. Actively participate in statewide ICM activities and practices. Meet statewide requirements for data reporting on collaborative efforts and direct services.
6. Realize learning opportunities from other implementation sites and other modes of change in cross-systems initiatives.
7. Record, analyze and use lessons learned and data to continually improve ICM practices.

Meetings

Family Case Staffing occurs on the fourth Wednesday of each month with Leadership Team meetings following.

Membership

1. Regional Administrator, DSHS – CA
2. Program Manager, DSHS – JRA
3. Director, Skagit County Office of Juvenile Court
4. Director, Skagit County Community Services
5. Director, Skagit Family Center, Catholic Community Services
6. Wraparound Program Manager, SWIFT, Catholic Community Services
7. Assistant Director, Special Programs, Northwest Educational Services District
8. Quality Specialist, North Sound Mental Health Administration
9. Quality Specialist, North Sound Mental Health Administration
10. Supervisor, Work First Program, DSHS – ESA
11. Field Services Administrator, DSHS – Division of Developmental Disabilities
12. Supervisor, DSHS – Division of Developmental Disabilities
13. Supervisor, DSHS – CA
14. ICM Facilitator, DSHS – CA
15. Program Manager, DSHS – CA
16. Family Support Partner, Catholic Community Services
17. Care Coordination Supervisor, Skagit County Community Services
18. Program Coordinator, Drug/Alcohol, Skagit County Community Services
19. Commissioner, Skagit County Superior Court
20. Regional Manager, DSHS – Office of Indian Policy
21. ICW Case Manager, Upper Skagit Tribe

Connections with local Tribal Nations

In addition to participation by the DSHS Office of Indian Policy, the Skagit ICM model has been presented at multiple DSHS meetings with local tribal nations, who have indicated an interest in future involvement.

Sponsors

Sponsors include the DSHS Secretary, DSHS Assistant Secretaries across multiple Administrations, and the ICM Practice Sub-Committee of the ICM Executive Steering Committee.

Process for Decision Making

Consensus/majority vote (needs discussion)

Roles and Responsibilities

- Attend monthly Leadership meetings or send a designate whenever possible.
- Facilitate referrals of youth/families to receive ICM staffings and other ICM resources.
- Attend ICM staffings and/or send their designated staff as appropriate to each youth and family.
- Complete action items involving their organization that result from ICM staffings.
- Actively participate in efforts to continually improve and refine ICM work products, resources, and case flow practices.

Thurston County

Thurston County has a population of 252,264 (U.S. Census Bureau 2010). Its ICM Charter includes the following provisions:

Purpose

- To provide integrated family support for youth and families with multiple service needs.
- To positively impact youth and families through prevention and early intervention efforts by creating a multi-system infrastructure that coordinates policy, programs, and resources.

Outcomes

- To prevent youth and families from entering the child welfare and/or juvenile justice systems.
- To assist youth in maintaining active school attendance and participation.
- To support families in engaging in proactive community participation.
- To reduce further system involvement for youth and families already being served by DSHS.

Target Population

Includes families with young children in school who are at risk of becoming truant, youth and families involved in community services but not yet linked with DSHS services, and youth and families with multiple system involvement.

Guiding Principles

In this process, guiding principles of Integrated Case Management utilized include:

- Youth and family centered
- Communication and collaboration
- Team based
- Culturally competent
- Strength based
- One family, one vision, one plan
- Natural supports

Leadership Team

Core leadership represents local community organizations and state agencies and includes but is not limited to:

1. Program Manager, DSHS – JRA
2. Olympia School District (1)
3. Mason/Thurston Wraparound Initiative
4. Olympia School District (2)
5. Mason/Thurston Regional Services Network (RSN)
6. Program Manager, DSHS – Division of Developmental Disabilities
7. Catholic Community Services
8. Regional Administrator, DSHS – CA
9. Regional Administrator, DSHS – JRA
10. Program Manager, Behavioral Recovery Services, DSHS – CA
11. Health and Student Support Program Administrator, School District Educational Services
12. North Thurston School District
13. Juvenile Court Administrator, Thurston County
14. Liaison, Behavioral Health Resources, DSHS – CA
15. Community Youth Services
16. Family and Education Support Services

Meetings

Members meet for two hours on the first Tuesday of each month.

Decision Making

A majority vote.

Team Roles and Responsibilities

- Leadership Team members will regularly attend and actively participate in meetings.
- Scribe duties will be assigned or rotate.

January 2013