

The California Integrated Core Practice Model for Children, Youth, And Families



Dear Colleagues:

We are very pleased to be able to provide *The California Children, Youth, and Families Integrated Core Practice Model (ICPM)* guide. This resource is intended to provide practical guidance and direction to support county child welfare, juvenile probation, behavioral health agencies, and community partners to improve delivery of timely, effective, and integrated services to children, youth, and families.

The State of California, in collaboration with counties across the state, has made significant progress in the implementation of the Katie A. Settlement Agreement. Building on the same core values and expected practices, the Continuum of Care Reform legislation has provided the statutory and policy framework to ensure services and supports provided to every child or youth and his or her family achieve the goals of developing and maintaining a stable, permanent family. The intent of this legislation is to ensure not only access to necessary services, but also to ensure integrated service delivery, reflecting findings of current research across the disciplines that tell us how integrated, collaborative services which demonstrate engagement and partnership with children, youth, and families are most effective in meeting the complex needs of children and families involved in multiple, government-funded service organizations.

The companion [*Medi-Cal Manual for Intensive Care Coordination \(ICC\), Intensive Home Based Services \(IHBS\), and Therapeutic Foster Care \(TFC\) Services for Medi-Cal Beneficiaries*](#) has been updated and includes detailed information about Therapeutic Foster Care as well as other updates. *The California Integrated Training Guide* has been developed and will provide support to staff development activities that will ensure fidelity to this practice model. Additionally, the ICPM describes observable and measurable Practice Behaviors intended to assist practitioners and their supervisors in the development of effective skills through the supervisory and coaching process.

As partners, we will continue to play a supportive role in this statewide transformation effort. We recognize that local realities require local responses to meet the unique needs of children and families in each county, as well as the unique political, social, and economic circumstances that you face. We anticipate that as we implement and learn from our data and experience locally and statewide, this guide will be augmented, refined, and revised.

To all who contributed with your time and expertise as we continue to improve California's Systems of Care, thank you.

Sincerely,

Original signed by

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I. CHAPTER 1: INTRODUCTION

A. Purpose and Background

The California Integrated Core Practice Model for Children, Youth, and Families (ICPM) provides practical guidance and direction to support county child welfare, juvenile probation, behavioral health agencies, and their partners in delivery of timely, effective, and collaborative services to children, youth, and families. The first part of this ICPM provides background and context as to the purpose and intent of an integrated model for California's youth-serving agencies. The second chapter defines the ICPM and the standards of practice that describe what is expected when working with children, youth, and their families. The third section of the guide addresses how to support the development and delivery of a service structure that will ensure that the ICPM is implemented and supported with fidelity to the model. Fidelity can be defined as adherence, integrity, and quality of implementation to the ICPM.

The Continuum of Care Reform (CCR) draws together existing and new reforms to California's child welfare services and related programs. CCR reflects the understanding that children who must live apart from their biological parents do best when they are cared for in committed, nurturing, family homes that provide stability and permanence. CCR also provides the statutory and policy framework to ensure services and supports provided to every child or youth and his or her family achieve the goals of developing and maintaining a stable, permanent family. To accomplish these efforts, public agencies, tribal and community partners, and contractors will practice the values, principles, and practices articulated in this guide.

The fundamental principles of CCR are:

- All children deserve to live with a committed, nurturing, and permanent family that prepares youth for a successful transition into adulthood.
- The experiences and viewpoints of children, youth, and families are important in assessment, placement, and service planning. A process known as the "child and family team," which includes the child or youth and family, and their formal and informal support network, will be the foundation for ensuring these perspectives are incorporated throughout the duration of placement.
- Children should not have to change placements to get the services and supports they need. Research shows that being placed in foster care is a traumatic experience. For home-based placements to be successful, services, including substance use disorder and mental health (also known as behavioral health) interventions, should be available in a home setting.
- Agencies serving children and youth, including child welfare, juvenile probation, mental health, education, and other community service providers, must collaborate effectively to engage and surround the child and family with needed services, resources, and supports, rather than requiring a child, youth, and caregivers to navigate multiple service providers.
- The goal for all children and youth in foster care is normalcy in development while establishing permanent, lifelong, familial relationships. Therefore, children should not remain in a group living environment for long periods of time.

This manual is a compilation of the *Pathways to Mental Health Services: Core Practice Model Guide* and California's Child Welfare Core Practice Model. Additionally, this manual reflects CCR legislative enhancements, updates for Intensive Care Coordination (ICC), Intensive Home

Based Services (IHBS), and Therapeutic Foster Care (TFC) services per the recently released *Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, Third Edition*, and the continuing evolution of best practices in the field. Furthermore, this manual provides specific expectations for best practices for staff in child welfare, juvenile probation, mental health, and their community partners as they work collaboratively to serve the child, youth, and family members and/or caregivers in achieving their goals.

The manual outlines implementation of a strategic and practical framework which invites county agencies to integrate initial and ongoing **engagement, assessment, service planning, delivery, coordination, and care management, monitoring and adapting services, and transitioning** when care is completed. This framework is built on the adoption of System of Care and Wraparound values and principles that guided the Katie A. Settlement Agreement, as well as other key values and theories that inform human services work, including:

Orienting and Biodevelopmental Theories that help us understand:

- How and why key factors such as current and historical trauma and other stressors lead to maltreatment, criminological, and other dysfunctional coping behaviors that hamper intervention efforts.
- The importance of protecting and promoting attachment bonds, family connections, and their cultural group as we work with family members.
- That parenting is challenging, and all parents need help at times with structure, transitions, and milestones.

Using these theories leads to:

- Greater empathy and a shift in emotional reactions to families who enter the system.
- Development and use of strategies for building on strengths and working to enhance motivation and support for change.

Intervention Theories help us to:

- Work with families to find and use services that will address the key factors that can interrupt unsafe patterns such as life situations, thinking patterns, emotions, and triggers. Intervention theories can promote effective parenting, prosocial supports, and effective coping behavior.
- Understand what may have happened so we can help individuals and entire families recognize and define for themselves what needs to change and how to change it, so children can be safe and remain in the immediate or extended family.
- Understand the needs of children and youth in foster care and adoption, including those in juvenile probation, to help them keep ties to family and community, develop new attachments, and an enhanced prosocial support network.
- Understand how to help families, children, and youth through transitions. This includes proactive planning for trauma reactions that prevent or respond effectively to maladaptive behaviors which may cause placement disruptions.

Organizational Theories help us understand how our system must change to support and sustain the ICPM at practice and leadership levels to:

- Support opportunities to gain new knowledge and skills; try new things; acknowledge and learn from mistakes take time to use critical thinking and reflection, even in times of crisis.
- Support workforce development efforts that ensure the success of direct service staff and their managers. This includes training; field-based coaching and mentoring; direct strengths-based feedback and supervision, as well as routine assessment and evaluation processes. All are required elements to ensure excellent service delivery to children, youth, and family members.
- Engage in frequent communication that encourages active partnership with staff at all levels of implementation and system improvement activities.
- Listen to stakeholders inside and outside of the organization to hear successes, concerns/worries, and ideas for working together to celebrate success and overcome barriers.
- Affirm the efforts of staff and agency partners to build on skills and abilities, increase confidence, and advance opportunities to mentor others.
- Implement and model inclusive decision-making inside the organization with staff at all levels across agencies and with partners, using team-based strategies that are key to the ICPM implementation.
- Promote frequent and regular opportunities for Tribes, agency partners, staff, youth, and caregivers to share their voice, identifying barriers and opportunities for solutions that improve services.
- Implement, monitor, and refine data collection that is integrated into practice tools and structures to provide transparent information about practice fidelity, service effectiveness, and informs continuous quality improvement efforts.
- Ensure support for staff and leadership who hold each other accountable for sustaining the ICPM practice with a practice-to-policy feedback loop that engages staff and stakeholders in data collection and evaluation.

The ICPM is a framework that sets the child and family team ([ACL 16-84](#)) as the primary vehicle for a team-based process built on ten principles of family engagement as described in Chapter 2, Principles and Values. It is typically implemented in four phases with related activities that describe what is to be done, and that fit the four components of the theory of change that explain its effectiveness.

This ICPM recognizes learning by counties and providers over the last two decades, as they have moved from working with children, youth, and their families from within a single agency perspective to working in a cross-system, cross-agency team environment that more effectively and efficiently addresses concurrent and complex child, youth, and family needs. Successful service planning, implementation, and monitoring require the commitment of teams whose members understand the unique roles of parents and caregivers and each other. Each member has specialty knowledge, skills, and resources to help identify and meet underlying needs, and provide services to ensure access to resources that are culturally and linguistically competent, trauma-informed, evidence-based, and responsive to the unique goals and preferences of the family members.

Evidence-based practice research from child welfare, behavioral health, and juvenile probation indicates that highly integrated and coordinated cross-system service planning and delivery

better meet the needs of children, youth, and families, result in improved outcomes, and lower rates of re-entry or recidivism.

Coordinated integrated assessment and care reduces redundancy of effort, increases access to specialty expertise and resources, and can significantly improve the care experience for the family. Adoption and implementation of the ICPM in California across the child welfare, juvenile probation, and behavioral health systems will continue to require the investment of time, resources, patience, and system support at all levels, including direct involvement from parents, families, and youth with lived-experience. It also represents a commitment to spread the philosophy and practices to other service sectors and stakeholders that touch and influence the lives of children, youth, and families.

While this guide speaks to the values, principles, and practices which support children and their families as they strive to achieve their goals, it does not generally prescribe who should do each specific task. However, there is a clear expectation that services are developed through a single assessment process, to capture a shared view of the family's strengths and needs, as well as a shared planning process. The California Department of Social Services (CDSS) has selected the Child and Adolescent Needs and Strengths (CANS) as the functional assessment tool to be used with the Child and Family Team (CFT) process to guide case planning and placement decisions for child welfare. The Department of Health Care Services (DHCS) has also selected the CANS, as well as the Pediatric Symptom Checklist, to measure child and youth functioning. The CANS results provide a platform for the CFT to guide conversations and support the process of learning more about the child or youth and family's needs, as well as identifying behavior patterns.

The single assessment process creates and establishes an authentic partnership with children, youth, and families, which results in coordinated and integrated plans that are individualized to address the unique needs of each child and family member.

B. ICPM Development Process

The practice standards referenced in this document have been enhanced by a very thorough, thoughtful, and comprehensive articulation of a Child Welfare Core Practice Model (CW-CPM) for California. In developing its model, welfare partners in the county and the County Welfare Director's Association included not only what had been described in the 2013 Pathways to Mental Health CPM, Wraparound, and the California Partnership for Permanency (CAPP), but also other initiatives like FAMILY to FAMILY, Linkages, Quality Parenting Initiative, and Safety Organized Practice. They identified and reviewed the theoretical framework underlying modern human services work, defined the related values and principles, casework components, and practice elements. Finally, they described observable practice behaviors for both direct service and leadership.

Building on this welfare focused work, workgroups from the California Behavioral Health Directors Association (CBHDA) and Chief Probation Officers of California (CPOC) reviewed and offered added perspective to the CW Practice Behaviors that articulate and expand "*enhanced*" practice behaviors held in common across all three disciplines. The workgroups additionally identified their own role and discipline specific behaviors when participating as a member of a CFT that may, at a later point, be developed into a role specific matrix to support shared understanding and support practice fidelity. These *Child Welfare* and *Enhanced* descriptions were mapped to the major practice elements that define the Integrated Core Practice Behaviors document. As a draft, this ICPM was reviewed by CDSS and Department of Health Care Services (DHCS) Shared Management Systems' Community Team, a representative key

stakeholders team required by the Katie A. Settlement Agreement, and various additional stakeholder groups that included state and county government, provider, family, and youth.

Critical to successful implementation of the principles and practices of this ICPM is also the involvement and readiness of all public agency leaders to work in a consistent and aligned manner. The idea of ready and involved leaders invites a supposition that the organizations they lead are also ready for change. To support leader and organizational readiness, included in this ICPM, as Addendum G are *Leadership Behaviors* developed as part of and contained within the CW-CPM. These thoughtfully crafted guidelines, while reflecting a CWS perspective, contain useful suggestions about how supervisors, managers and director level staff from mental health and juvenile probation can also put theory and concept to action. These same leadership behaviors will also prove most useful in counties where efforts to develop or sustain collaborative services via an Interagency Memorandum of Understanding are present.

In addition, the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) & Therapeutic Foster Care (TFC) services for Medi-Cal Beneficiaries (Third edition) from DHCS has been updated and is consistent with this ICPM. These manuals are intended to complement each other.

It is important to note that there is substantial room for local flexibility within this ICPM guide, so long as the values, principles, and the practice elements are consistently reflected in local implementation. In this ICPM guide, child and family team-based practices and descriptions are built upon the National Wraparound Institute¹ (NWI) model, as it was used to inform the Katie A. Settlement Agreement, and because it is among the most widely accepted practice standards for family-centered planning and service delivery. Counties may choose to use other specific approaches for CFT meetings, such as Team Decision Making, Family Group Decision Making, Safety Organized Practice, or others if the values and principles of the structured approach include using a CFT to engage families to make decisions, create integrated plans, monitor and adapt those plans, and together decide when goals are achieved.

A note about terminology: This guide uses the terms child, children, youth, and family to describe people who are involved with, at risk of involvement with, or eligible to receive services from, the child welfare, juvenile probation, and behavioral health systems. The terms “child, youth, and children” may be used interchangeably and additionally may include non-minor dependents and parenting teens. The term “family” includes biological and adoptive parents and relatives, stepfamilies, and unrelated persons that have emotionally significant relationships. For American Indian youth and families, this term includes their tribe and tribal relations as understood under the tribe’s customs and traditions. Youth, family, and for American Indian youth, tribes, are considered best and uniquely qualified to identify who fits this description. When a caregiver other than family is assuming the role of a surrogate or co-parent, they should typically be included when “family” is referenced. When children and youth are included in any activity or process is referenced in this guide, it is assumed that their involvement will be as developmentally appropriate.

C. California’s Child Welfare, Behavioral Health and Juvenile Probation Systems

County child welfare, behavioral health, and juvenile probation systems are complex and challenging. Since the specific programs and services available at the county level vary, it is essential for county public agency staff members of all systems to be cross-trained at the local

¹ National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University

level, so that they will be best prepared to engage families consistently and work collaboratively to plan and deliver services to children and youth served across systems. This ICPM Guide provides a framework to help counties build effective partnerships among child welfare, behavioral health, juvenile probation, and the children, youth, and families they mutually serve to improve sustainable safety, permanency, and well-being.

1. Child Welfare System and Services

California counties are the primary governmental bodies that directly interact with children, youth, and families to address, and intervene when necessary, cases of child abuse and neglect. The county social services department or agency, through its child welfare division, administers and provides child welfare and foster care services under Sections 300 et seq. and 16500 of the California Welfare and Institutions Code (WIC). The county child welfare division investigates reports of child abuse and provides case management and other services to help families stay together, whenever possible. The principles, values, and practice behaviors contained in this guide apply universally to all children and youth served by the welfare authority, regardless of their jurisdictional or case status.

Each county is responsible to receive reports of potential abuse or neglect and respond to that referral based on state law and the circumstances of the referral. If services are delivered, staff works with the family to find the least intrusive approach to support the child, youth, and family with ameliorating the issues that brought them to the attention of child welfare. If the assessment of the home indicates that formal supports are needed, the child or youth may be removed or may remain in the home to receive family maintenance services. It is important to note that not all counties offer family maintenance services. If the child or youth is provided any services by the child welfare system (CWS), the CWS is responsible for coordinating their care through a family-focused and needs-driven approach.

The county social worker (CSW) is responsible for reporting the progress of the family to the Juvenile Dependency Court every six months until the family maintenance case is dismissed, the child can be reunified, or is placed in a permanent home. If the child can safely be returned to their family, the CSW will work on transitioning the family out of the system. If a child is unable to reunify with family, the CSW will work on identifying a permanent home through adoption or guardianship. If a child remains in care and turns 18 years of age, the child may be eligible for extended foster care services up to age 21.

Appendix A provides a basic illustration of the child welfare process; acronyms and abbreviations are defined in the Glossary.

2. Behavioral Health Services

Behavioral health services², including Substance Use Disorder (SUD) services, mental health services provided by Medi-Cal Managed Care Plans (see Appendix B for more information on covered mental health services) or through Medi-Cal Fee for Service providers and Specialty Mental Health Services (SMHS), are available to Medi-Cal beneficiaries, including children and youth under the age of 21.

The Department of Health Care Services (DHCS) contracts with county Mental Health Plans (MHPs) and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries (children, youth, and adults) who meet SMHS medical necessity criteria. SMHS are provided by county

² The terms mental health and behavioral health may be used inter-changeably in this document.

staff and/or by contracted community based organizations, organizational providers, and/or individual providers.

For children and youth who are in child welfare or are involved with juvenile probation, child welfare departments or juvenile probation screen and refer children and youth who may be in need of services. For children who are referred to MHPs, MHPs conduct an assessment to determine if a child or youth meets medical necessity criteria for SMHS. For children and youth who meet medical necessity criteria, SMHS are provided or arranged for by MHPs. Children and youth who do not meet medical necessity criteria may receive non-SMHS through Medi-Cal Managed Care Plans or through Medi-Cal Fee-for-Service providers.

Service planning and implementation consider the needs, strengths, and choices of the child and family and are driven by their identified goals and/or desired results as well as by Court orders.

Appendix B provides a basic illustration of how to access services from the MHP or Medi-Cal Managed Care Plans for children and youth; acronyms and abbreviations are also defined in the Glossary.

3. Juvenile Probation Services

The responsibility of juvenile probation services is delivered through the county's probation department. Probation departments provide services to youth under WIC Section 602, specifically youth who are alleged and/or have been found to have committed law violations. Probation services include pre- and post-adjudication services to youth who have been arrested. Services may vary county to county. Some counties provide diversion services to prevent youth from entering the juvenile justice system. After arrest, each youth is assigned a probation officer who investigates the circumstances of the arrest and all relevant social and family issues. The intake officers investigate each case and recommend the most appropriate course of action. Youth who have been arrested will be brought to juvenile hall. Based on the charges, the probation officer may decide to counsel the youth and dismiss the charges, recommend informal probation to divert the youth to services from a community based organization, and/or assign community service hours and restitution in lieu of filing a petition, or refer the case to the District Attorney for formal prosecution.

Post-adjudication services include ongoing supervision and enforcement of the imposed conditions of probation for youth under the jurisdiction of juvenile probation by the Court. Most youth on probation remain in their home, however, some youth may be declared wards of the court and are subject to the dual jurisdiction of child welfare and juvenile probation. Youth who are placed by juvenile probation outside of their home must receive services that meet all of the Title IV-E requirements, including the provision of services to families, efforts to reunify or find other permanent placements, as well as ensuring placement in the least restrictive setting in the community. The deputy probation officers supervise youth in the community by visiting the youth and their families or caregivers, at the office or in their homes, schools, and/or community based organizations, and may refer to other agencies for a variety of supporting services.

More intensive supervision will be typically provided for repeat violent offenders or those whose crimes involve a serious violent act. Some youth are referred to community based organizations or community schools where probation officers may be assigned and may be in the classroom on a regular basis. At times, youth may be removed from their homes by the court and placed in foster homes or residential programs based on the needs of the youth and community safety. Youth ordered to placement are placed by the probation officer in the most

appropriate placement based on the needs of the youth. While in placement, the probation officer will monitor suitability of the placement and prepare aftercare plans for youth completing programs. Higher risk youth may be placed in a camp or ranch.

Appendix C illustrates the juvenile justice service process; acronyms and abbreviations are defined in the Glossary.

D. What Children, Youth, and Families Can Expect in Their Interactions with Child Welfare, Behavioral Health, and Juvenile Probation

Active participation on the part of the child, youth, parent, and other family is essential to developing an accurate and shared assessment, identifying needed services, and developing an integrated intervention and service plan. Careful attention should be given by all system partners to enhance youth's and parents' engagement, reflected in the ongoing assessment, planning, and service delivery processes. Often, the addition of a parent and/or youth mentor to the team increases support, adds emotional safety, models empowered decision-making, and increases involvement of family members. In all cases, children, youth, and family members are active, equal team partners and:

- Will be authentically included in decisions throughout the entire service delivery process from beginning to end.
- Will be asked and supported to voice their strengths, preferences, and needs to guide the plan development.
- Will be given information in a clear way so that they understand the roles of all the service providers and others involved, and the reason they are involved.
- Will be actively involved in the CANS assessment process, including opportunities to confirm that information as understood by team members reflects their experiences and perspectives.
- Will have the opportunity to build relationships with their child's resource parents when reunification is the jointly agreed-upon and court-approved plan.
- Will have a safe place within the team to talk about issues and needs without fear of judgment.
- Will be asked and supported in identifying their natural support system and the people they want as members of their child and family team.
- Will have a realistic plan that will ensure access to the supports they need, whenever they feel they need them after services end.

II. CHAPTER 2: THE INTEGRATED CORE PRACTICE MODEL (ICPM)

A. Definition

This Integrated Core Practice Model is an articulation of the shared values, core components, and standards of practice expected from those serving California's children, youth, and families. It sets out specific expectations for practice behaviors for staff in direct service as well as those who serve in supervisory and leadership roles in child welfare, juvenile probation, and behavioral health as they work together in integrated teams to assure effective service delivery for California's children, youth, and families. Additionally, the ICPM promotes a set of values, principles, and practices that is meant to be shared by all who seek to support children, youth,

and families including tribal partners, education, other health and human services agencies, or community partners.

The drive for improved outcomes and more efficient services for children, youth, and families receiving care from government supported systems requires improved tracking and data-informed decision-making at all levels - policy, program, and practice. At the same time, ensuring access to individualized child and family-centered planning must respect and demonstrate cultural and linguistic competence, recognize the social determinants of health including the impact of poverty, distinguish exposure to violence and trauma, including the effects of historical and secondary trauma, and promote the power of hope, resilience, and recovery.

The implementation of the ICPM will continue to require adaptation of administrative policies and procedures, in day-to-day tasks and assignments, and in supervisory and coaching practices with direct services staff. Assuring fidelity in the implementation of the ICPM will result in consistent practices statewide, guided by values and principles, standards, and activities which will increase the likelihood of positive and enduring outcomes for children, youth, and families.

B. Trauma-Informed Practice

In any given year, over 30,000 children come into the care of California's child welfare system³. Most are victims of abuse or neglect and live with caregivers who are impaired, and/or deal with school and community violence as a fact of life. In addition, many of the families that come to the attention of the child welfare system have experienced multigenerational or historical trauma— collective emotional and psychological injury both over the individual lifespan and across generations. Identifying and understanding these traumas, preventing further trauma, and providing effective interventions are crucial to assisting children and youth traumatized by maltreatment and other stressors.

Identifying and understanding the impact of trauma on individuals is foundational to the implementation of this ICPM. Trauma experiences that occur in childhood affect brain function, the attainment of developmental milestones, social perceptions, relationships, health, emotion, and behavior throughout the individual's lifetime, as first identified the Adverse Childhood Experiences (ACE) Study⁴.

The identification of trauma and its impacts on behavioral responses and developmental milestones of children and adults is a critical aspect of the initial and ongoing assessment process. It is the responsibility of practitioners to ensure that trauma exposure and responses are recognized (through engagement and assessment processes) and treated (through services and intervention strategies).

³ Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Yee, H., Hightower, L., Lou, C., Peng, C., King, B., & Henry, C. (2012). *Child welfare services reports for California*. The University of California at Berkeley Center for Social Services Research. Retrieved December 11, 2012, from http://cssr.berkeley.edu/ucb_childwelfare

⁴ Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS.; Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study; American Journal of Preventive Medicine. 1998 May; 14(4):245-58

The Chadwick Trauma-Informed Systems Project (CTISP) defines a trauma-informed system as “one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.”

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

The National Child Traumatic Stress Network Child Welfare Committee has defined the following essential elements of trauma-informed practice⁵:

- Maximize physical and psychological safety for children and families.
- Identify trauma-related needs of children and families.
- Enhance child well-being and resilience.
- Enhance family well-being and resilience.
- Partner with youth and families, enhancing the child, youth, and family’s sense of control through choice.
- Enhance the well-being and resilience of those working in the system.
- Partner with child-serving agencies and systems.

C. Values and Principles

This ICPM is informed by nationally recognized core values and principles, derived largely from research about how collaborative and integrated family services work best. These guidelines, with the use of complementary evidence-informed practices, suggest that a spectrum of community-based services and supports for children, youth, and families with, or at risk of, serious challenges, will improve the outcome of services.

1. Values

Family-driven and youth-guided: Family-driven and youth-guided practices recognize that no one knows more about the family’s story and their specific needs than the family members themselves. The family members can best describe their history, culture, and preferences. About themselves, they are the experts. Consistent with the important developmental task of personal individuation, the choices of a child or youth should be solicited and respected, whenever possible, during the process.

While addressing the needs and building on the strengths of the child or youth may be the primary target or purpose of interventions, services must focus on the needs of the whole family, with supports that empower families and enhance their ability to access internal, natural, and community resources. When family members see their own choices reflected in integrated service plans, even when that plan requires that a child and/or youth be placed outside their biological family to ensure safety, plans are more likely to be successful.

⁵ Chadwick Trauma-Informed Systems Project. (2012). Creating trauma-informed child welfare systems: A guide for administrators (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

Community-based: The locus of service and resources reside within an adaptive and supportive structure of systems, processes, and relationships at the community level. Services and support strategies should take place in the most inclusive, responsive, accessible, and least restrictive settings where safety, permanence, and family members' participation in community life is maximized. Children, youth, and family members need access to the same range of activities and environments as other families, children, and youth within their community to support positive functioning and development.

Culturally and linguistically competent: Culture includes a broad range of factors that shape identity, including, but reaching beyond, racial, ethnic, gender, and linguistic differences. It is critical that members of the team demonstrate respect for diversity in expression, opinion, and preference, especially as they come together in teams to make decisions. Words and body language must demonstrate an accepting and curious approach to understanding the family, including their needs and strengths. It is critical that communication meets language and literacy needs, with the use of plain language that everyone can understand, and the use of a translator or interpreter whenever language barriers exist.

A family's traditions, values, and heritage are sources of strength. Relationships with people and organizations with whom they share a cultural or spiritual identity can be essential sources of support. These resources are often "natural" in that they potentially endure as sources of support after formal services have ended; it is important that the team embrace these organizations and individuals, strengthening and nurturing positive connections to assist the family members to achieve and maintain positive change in their lives.

2. Ten Guiding Practice Principles

Family voice and choice. Each family member's perspective is intentionally elicited and prioritized during all phases of the teaming and service process. The team strives to find options and choices for the plan that authentically reflect the family members' perspectives and preferences.

Team-based: The team consists of individuals agreed upon by the family members and committed to the family through informal, formal, and community support, and service relationships. At times, family members' choices about team membership may be shaped or limited by practical or legal considerations, however, the family should be supported to make informed decisions about who should be part of the team. Ultimately, family members may choose not to participate in the process if they are unwilling to accept certain members.

Natural supports: The team actively seeks and encourages full participation of members drawn from the family members' networks of interpersonal and community relationships. The plan reflects activities and interventions drawn on sources of natural support. These networks include friends, extended family, neighbors, coworkers, church members, and so on.

Collaboration and integration: Team members work cooperatively and share responsibility to jointly develop, implement, monitor, and evaluate an integrated, collaborative plan. This principle recognizes that the team is more likely to be successful 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. Members must be willing to provide their own perspectives with a commitment to focus on strengths and opportunities in addressing needs, and work to ensure that others have opportunity to provide input and feel safe doing so. Each team member must be committed to the team goals and the integrated team plan. For professional team members, interactions are governed by the goals in the plan and the decisions made by the

team. This includes the use of resources controlled by individual members of the team. When legal mandates or other requirements constrain decisions, team members must be willing to work creatively and flexibly to find ways to satisfy mandates while also working toward team goals.

Community-based: The team will strive to implement service and support strategies that are accessible and available within the community where the family lives. Children, youth, and family members will receive support so that they can access the same range of activities and environments as other families, children, and youth within their community that support their positive functioning and development.

Culturally respectful: The planning and service process demonstrates respect for, and builds on the values, preferences - including language preferences, beliefs, culture- and identity of the family members, and their community or tribe. Culture is recognized as the wisdom, healing traditions, and transmitted values that bind people from one generation to another. Cultural humility requires acknowledgement that professional staff most often cannot meet all elements of cultural competence for all people served. Professionals must ensure that the service plan supports the achievement of goals for change and is integrated into the youth's and family's cultures. Cultural humility and openness to learning foster successful empowerment and better outcomes.

Individualized: The principle of family voice and choice lays the foundation for individualization and flexibility in building the plan. While formal services may provide a portion of the help and support that a family needs, plans and resources must be customized to the specific needs of the individual child, youth, and family members. Each element of the family's service plan must be built on the unique and specific strengths, needs, and interests of family members, including the assets and resources of their community and culture.

Strengths-based: The service process and plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child, youth, and family members, their tribe and community, and other team members. The team takes time to recognize and validate the skills, knowledge, insight, and strategies that the family and their team members have used to meet the challenges they have encountered in their lives - even though sometimes these strengths have been inadequate in the past. This commitment to a strengths-based orientation intends to highlight and support the achievement of outcomes not through a focus on eliminating family member's deficits, but rather through an effort to utilize and increase their assets. This begins with a uniform and singular use of the CANS assessment. Doing so validates, builds on, and expands each family members' perspective (e.g., positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (e.g., social competence and social connectedness), and their expertise, skill, and knowledge.

Persistence: The team does not give up on, blame or reject children, youth, or their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the team's goals. Undesired behavior, events, or outcomes are not seen as evidence of youth or family "failure" but, rather, are interpreted as an indication that the plan should be revised to be more successful in achieving the positive outcomes associated with the goals. At times, this requires team commitment to revise and implement a plan, even in the face of limited system capacity or resources.

Outcomes-based: The team ties the goals and strategies of the plan to observable or measurable indicators of success, monitors progress consistent with those indicators, and revises the CANS and service plan accordingly. This principle emphasizes that the team is

accountable – to the family and all the team members, to the systems of care which serve the children, youth, and families, and to the community. Tracking progress toward outcomes and goals keeps the plan on track and indicates need for revision of strategies and interventions as necessary. It also helps the team maintain hope, cohesion, and effectiveness and allows the family to recognize that things are, indeed, changing and progress is being made.

Historically, the ability to retain children, youth, and family members in treatment services to completion has been a problem. Particularly, children, youth, and families from vulnerable populations (e.g., children of single parents, children living in poverty, minority families) are least likely to stay in treatment. When asked about reasons for dropping out, parents often identify stressors associated with getting to appointments, a sense that the treatment or service offered is irrelevant to their needs, and a perceived lack of connection with the service provider.

While a provider may have little control over a child and family's daily life stressors or difficulties in accessing care, they clearly have control over the relevance and opportunity to avoid redundancy of services offered to families (supporting the principles of voice and choice and individualized), as well as their efforts in relationship building (also known as engagement). Within the CFT process, including a focus on the needs identified as highest priority by the child, youth, and family members themselves is a critical component of initial and sustained engagement during the service delivery process.

An additional practical construct to this approach is the reality that families with complex needs often receive services directed by multiple and competing service plans. Bringing service plan expectations and resources together, as well as following a shared CANS, single and functional structured assessment process, will result in a simplified, coordinated plan that will greatly improve the prognosis of success and dramatically lower the stress on family members.

D. Teaming

Working as part of a team in the ICPM framework requires the ability to keep an open mind while integrating the various educational, professional, and personal life perspectives of all other team members. There are multiple advantages in working as a team; it helps guard against individual bias, promotes better informed decision-making through consideration of multiple perspectives and approaches, and shares risk.

Over the past several decades, the definition of the child and family team has evolved from the process of bringing together professionals to provide services to an identified child or youth and family (i.e. multidisciplinary teams), to one that includes youth and families as equal partners and decision makers within the team. Effective team-based practices encourage inclusion of youth and families with lived-experience in participation at every level of program development, implementation, evaluation, and service delivery.

1. Elements of Successful Teaming

Successful teams are comprised of people who come together, committed to common missions and goals to which they hold themselves mutually accountable. Experience suggests that the teaming process is most successful when:

- Team membership includes the child, youth, and family. For those youth and families involved with child welfare, behavioral health, and/or juvenile probation, include the formal support person(s) from those disciplines. It is important that family members understand

that including professionals on their team is the best way to get those professionals and the court out of their lives.

- For families with very young children who may not be developmentally able to participate (e.g., ages 0-5), the child's voice may have to be elicited through proxy representatives on the team such as parents, caregivers, siblings, and professionals.
- Team membership may also include extended family members, informal support persons such as friends, neighbors, coaches, faith-based connections, and other formal supports such as educational professionals and/or other agencies providing service to the child and family.
- The family ultimately decides who should be members of their team.
- The team has agreed-upon ground rules and a defined decision making process.
- A brainstorming and option generating process occurs during the planning process to ensure that multiple methods of meeting a need are considered and explored.

2. Collaboration and Integration

Teams must embrace the foundational concept of collaboration and integration of effort. Collaboration requires a willingness to share the power and responsibility for decision-making with others when working toward common goals, seeking mutual understanding of perspectives based on shared respect between members, recognizing and appreciating the importance of divergent opinions in finding effective and individually customized solutions to complex problems.

- Roles and motives within team membership are transparent and clear to all. Members of the team must be able to differentiate personal values and preferences from role responsibility so that the family members can lead the effort.
- Team meeting schedules and locations are guided by the family's needs and preferences.
- Team meetings have a clearly defined purpose, goal, and agenda for each meeting.
- All team members participate in the development and decisions about implementation and revision of the plan. When planning within constraints of court orders or sanctions, the team continues to honor family members' culture and preferences as they consider options for compliance.
- The strengths of all team members are identified and serve as resources to the plan, which includes the strengths of the professional team members.
- Specific action steps to be carried out by team members are clearly defined within a timeframe and tracked.

These factors, when implemented with fidelity, result in increased satisfaction among participants and better outcomes for children, youth, and families.

E. The ICPM Theory of Change

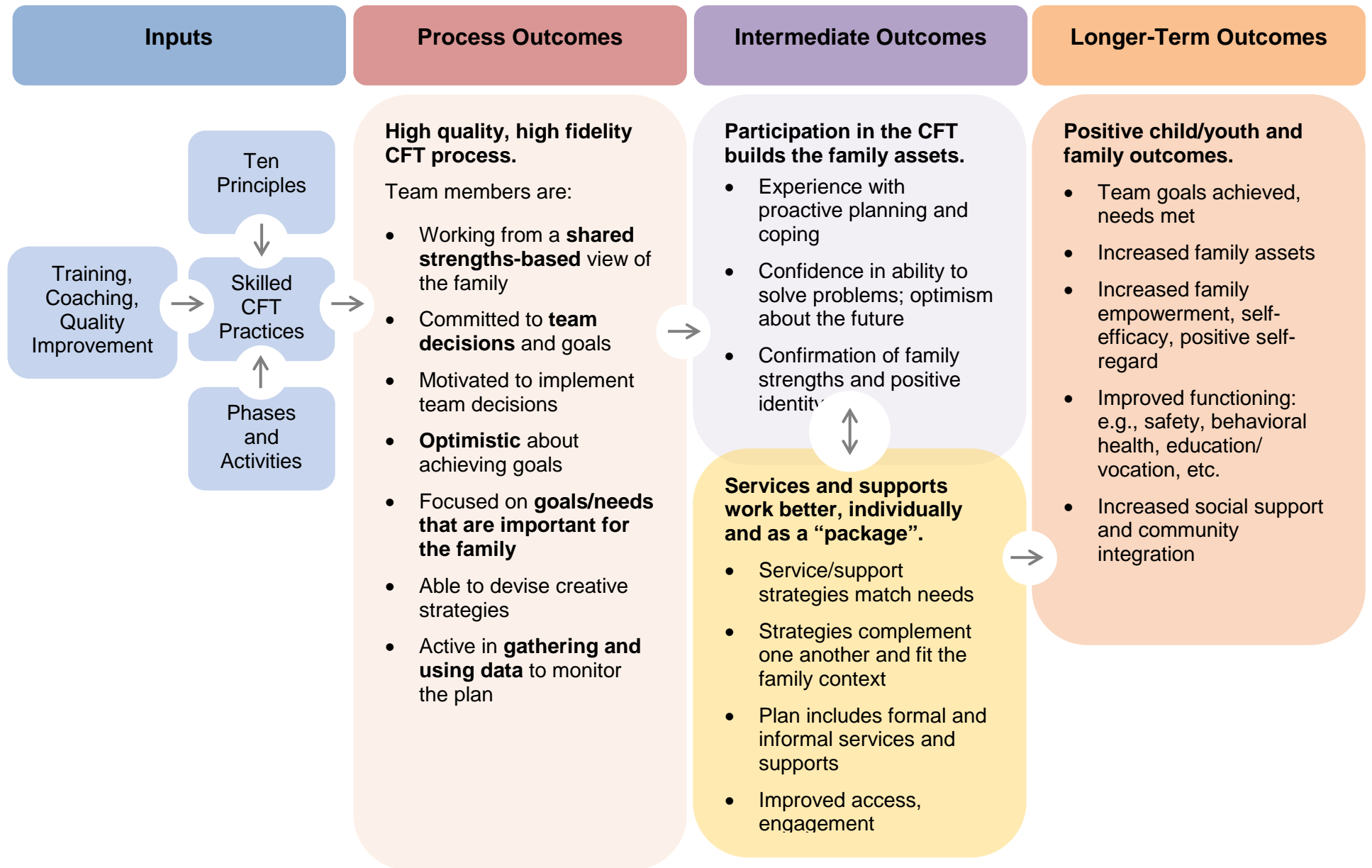
A Theory of Change is a specific and measurable description of a social change initiative that forms the basis for strategic planning, ongoing decision-making, and evaluation. This is also sometimes referred to as a Logic Model. Like any good planning and evaluation method for social change, it requires participants to be clear on long-term goals, identify measurable indicators of success, and formulate actions to achieve goals. It differs from any other method of describing initiatives in a few ways:

- it shows a causal pathway from here to there by specifying what is needed for goals to be achieved, including inputs and outputs;
- it requires the articulation of underlying assumptions which can be tested and measured;
- it changes the way of thinking about initiatives from what you are doing to what you want to achieve.

A Theory of Change provides a roadmap to get you from here to there. The roadmap can be read by others to show the planned course of change. This is helpful when communicating to stakeholders including staff, partner, organizations and others. It also provides the chance to demonstrate success and lessons along the way⁶.

⁶ <https://nwi.pdx.edu/>

The ICPM Theory of Change



III. CHAPTER 3: INTEGRATED CORE PRACTICES AND BEHAVIORS (ICPB)

A. Working Within the Child and Family Team

The practice of working together as a team with children, youth, and families is at the heart of this ICPM and central to the implementation of family-centered practice. In this practice, it is important to distinguish between the child and family team (CFT) and the meetings, which are a primary way the team shares responsibility for assessing, coordinating care, and delivering services.

The CFT describes the child, youth, and family members plus the people they have agreed will participate on their team who will help and support them, as well as a plan to help them achieve change in their lives. This includes figuring out options and making decisions about the activities, interventions, and supports that will help them achieve success, monitoring how well that plan is working, and changing the plan when interventions and strategies do not work as envisioned, and deciding when they are ready to transition away from the intensive support of the service systems.

The CFT meeting is an efficient way to support close communication and integrated activity within the team. Who participates in a CFT meeting may vary depending on the stage of team formation, the phase of service delivery, the focus of the meeting agenda, or what supports and resources are required at a given moment in time. Whether or not every team member is physically participating at a meeting, it is critical that all team members have the information they need to fulfill their role on the team.

A member of the team should serve as the CFT facilitator. The facilitator's role is to set the meeting agenda with prior input from the members, convene, and ensure the meeting runs smoothly and with fidelity to the ICPM. A comprehensive integrated training plan to ensure effective practice has been developed to support staff development in the required skills.

What is different about the ICPM from practice as usual is commitment from the professionals working with the child, youth, and family to recognize they are not working alone within their own disciplinary silo. Rather, the commitment to using the CFT structure requires working across the systems, building positive relationships, and sharing creative energy and resources that result in an integrated approach to meet the family's needs.

B. Practice Phases, Activities and Standards

1. Phase 1 - Engagement, Assessment and Team Preparation

a. Engagement:

The most powerful time in the service delivery process is the beginning. It sets expectations for what is likely to occur, creates the context for development of positive, helpful relationships, and will support or hinder the potential for positive outcomes.

Engagement should be thought of as the range of activities, behaviors, and style of interaction with CFT members that creates an effective working alliance for change. The initial activities of family engagement, particularly through the initial conversations about strengths, needs, and culture, set the tone for teamwork and team interactions that are consistent with ICPM principles. The engagement process is also where a clear understanding of the family's vision for a better future is established. Everything that follows, including the development of

measurable goals and intervention strategies, will support the achievement of that personal family vision.

The Engagement, Assessment, and Team Preparation phase provides the opportunity to establish the family's orientation to service access as one in which they are recognized as an integral part of the process in which their needs and strengths are identified, and preferences are prioritized. If necessary, crisis needs are addressed immediately and safety plans established. The activities of this phase are completed relatively quickly. However, if engagement fails, it is likely that the plan will fail. If at any time the family or other team members become disengaged, the active effort and focus of engagement must be repeated. Often, hearing the family's story again will help to identify key strengths and needs that may have been missed. Disengagement often indicates that an important need is not being met.

b. Assessment:

Assessment refers to both formal initial and informal continuous processes that occur across all disciplines within the system of care. It is a part of the engagement process that allows practitioners to understand what has happened to the child/ youth and family, including their current priority needs and the strengths that have helped them to survive their past.

CDSS has selected the Child and Adolescent Needs and Strengths (CANS) as the functional assessment tool to be used with the CFT process to guide case planning and placement decisions for child welfare. The CANS is a multi-purpose assessment tool developed to assess well-being, identify a range of social and behavioral healthcare needs, support care coordination and collaborative decision-making, and monitor outcomes of individuals, providers, and systems.

The assessment process begins at the first contact with the parent(s), child, and/or youth when the provider begins to elicit the family's story, as individual strengths and needs begin to be identified. It continues during the identification and involvement of other potential sources of information and support during the development of the CFT. The initial CANS assessment is created to identify prioritized views of the strengths and needs of the family, including the reconciliation of perspectives within the team when differences occur. This shared understanding can be used to guide development of an integrated service plan for the family.

In child welfare, the focus of the assessment process is on identification of risks to the child's safety, the risk of future maltreatment, parental protective capacity, and child well-being. In juvenile probation, assessment includes identification of the youth's and/or family members' criminogenic needs (antisocial attitudes, values and beliefs; low self-control; criminal peers; substance abuse; and family issues that may be dysfunctional to successful family life). As a part of the formal assessment process, all children and youth must be screened for indications of mental health needs ([ACL 15-11](#)). Standardized screening may indicate the need for a more in-depth mental health assessment done by a credentialed professional. By itself, a screening does not determine either the actual need for mental health services or the kinds of services that may be needed.

If the screen is positive, the child/youth must be referred for a mental health assessment which will include a psychosocial assessment to evaluate the status of a child or youth's mental, emotional, or behavioral health to support a diagnosis that substantiates medical necessity, as appropriate, and includes a broad assessment of psychosocial risk factors related to the child's environment and trauma exposure.

The specific child welfare and juvenile probation assessments should be comprehensive enough to obtain information about the relevant events and behaviors that brought the children and families into service, as well as an initial identification of the child, youth's, and family members' underlying strengths and needs. This discovery process can help children and families self-identify the needs that brought them into care, but also begin to develop a vision of what the family members' lives might be like if they could achieve a better life as they define it. Assessment also includes determining the willingness, capability, and availability of resources to achieve safety, permanency, and well-being for children and safety for the community. This assessment information should be used to inform the shared CANS assessment process.

The shared standardized CANS assessment process enhances care coordination, family engagement, collaborative decision-making and consensus-building across systems, and provides the opportunity for shared monitoring of child and family outcomes and well-being. The use of a cross-agency CANS process creates a common language and shared understanding across disciplines, and the CFT membership facilitates shared decision-making and results in more comprehensive, integrated service plans.

The CANS will serve as the formal initial and continuous child welfare assessment tool used within the CFT to inform the case plan goals and placement decisions for the child, youth, and family. Case plan "means a written document which is developed based upon an assessment of the circumstances which required child welfare services intervention; and in which the team has identified goals and the objectives to be achieved, the specific services to be provided, and case management activities to be performed." See MPP 31-002(c)(2). The CDSS and DHCS have adopted the 50 Core Items, known as the CANS Core 50, as the State required assessment data fields. Counties will have the option to add questions specific to their local needs, if desired. The CANS scores must accurately reflect the consensus of the CFT members.

At times, information may be most appropriately gathered in individual conversations outside of the CFT meetings, protecting privacy and confidentiality as needed. There are a variety of tools and techniques that are part of Safety Organized Practice such as the Three Houses, as well as scaling questions and motivational interviewing techniques that can help elicit necessary information and provide opportunity for individuals to decide how to share information with the CFT in ways that do not compromise their right to privacy. The CANS scores should be discussed and understood within the CFT meeting environment to inform decisions made by the team.

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

- Placement and housing decisions;
- Identifying services and supports needed by the child or youth;
- Determine if the child or youth is impacted by trauma and has unmet mental health needs;
- Developing basic and advanced life skills for transitional age youth;
- Determine educational needs; and/or
- Assist in identifying any immediate supports needed for the family and/or care provider, such as childcare.

Counties may develop models of collaborative CANS development sharing responsibility to complete sections of the CANS consistent with their role and taking advantage of information

gleaned in the first encounters with the family during the engagement process. Generally, for any child or youth in care who is receiving SMHS, completion of CANS scoring document will be the responsibility of mental health, assuming that the contracted or county CFT facilitator will be responsible for coordinating with the county social worker and/or juvenile probation officer and facilitating the CFT meeting.

For children or youth who are already in care and not currently receiving SMHS, the county social worker and/or juvenile probation officer will complete an updated MH screen. If the child/youth does not meet the criteria for referral to mental health, the CFT facilitator will have the responsibility to ensure that the CANS scoring document is completed.

The CFT works together to identify the child or youth and family's strengths, as well as needs. This information is comprised of team members' input, mandates, requirements, and safety recommendations. Information should also be included from any formal assessments. Actionable items will be addressed in the plan in priority order, with urgent items addressed first, and deliberately including those identified by the family as priority. The CFT will assign responsibility to team members for follow up activities related to accomplishment of the plan, (with due dates) and incorporated by the county social worker and/or juvenile probation officer into the case plan, as appropriate.

The informal assessment process, and the use of an updated CANS assessment as clinically indicated, continues throughout the service delivery process, as well as when circumstances change, or new information becomes available.

c. Team Preparation:

The team building process begins with the initial interactions between the child welfare worker or the probation officer and the child, youth, and family. From the initial conversations, engagement is critical. By eliciting the family's story, the worker can begin to understand the child, youth, and family member's strengths, self-identified needs, culture, and vision for the future. The tone for teamwork begins to be established. As staff learns about the family, they will also ask about the family members' support system to identify the important family resources and potential members of the CFT including the strengths and resources they may bring to the team.

The importance of natural supports cannot be overstated. In addition to continued support and resources when formal service is over, these natural supports can add wider perspectives about the family's strengths and needs. Identification of relationships with extended family members, neighbors, clergy, tribal members, and other individuals should be explored early in the process, so that the team can be developed, begin meeting, and feel their ownership and investment in the CFT process as quickly as possible. As the strengths and underlying needs of the child, youth, and family are identified over time, the original team may expand or change to include other members as necessary and appropriate to increasing the positive assets of the team. Additionally, changes in professional work assignments may require members be replaced, or members may leave as specific needs are resolved.

Starting with the first contacts with the family, staff introduces the values and principles of the ICPM, including how they will create a team with the child, youth, family, and their identified supports to make plans and share decisions. It is important to discuss the pros and cons of sharing information among team members, so the child, youth, and family members understand their rights to privacy and confidentiality, and can make informed decisions about information they want to share. The ultimate decision lies with the family members. Necessary and appropriate consents to share or releases of information should be obtained. As the team is

established and individual members outside of the family are being prepared to participate, the issues of privacy and confidentiality should be openly discussed, including team ground rules about protecting private information. As new members join the team, these discussions should be revisited.

There is significant flexibility in who must be included on the team in addition to the child, youth, and family, with the exception of those individuals whose role requires responsibility to provide care coordination, especially if the court is involved, and who must be on the team to ensure the plan for services is integrated and service strategies and activities are coordinated. Another common guideline is that there should be more informal support persons than professionals on the team.

If the child, youth, and the family is already being served by one or more of the child serving systems, the practitioner should discuss the importance of integrated planning and service delivery in achieving positive outcomes, and the benefit of including the other practitioners as members of the CFT. This conversation must include shared access to, and understanding of, how the CANS assessment and outcomes tracking will be coordinated. Again, inclusion of the professional responsible to the court for service planning and coordination must be a member of the CFT.

2. Phase 2 - Initial Service Planning

Team trust and mutual respect are built while the team creates an initial integrated plan of care using a high-quality planning process that reflects the practice principles. Children, youth, and family members should feel consistently heard, that the needs chosen for initial focus are ones the family members want to work on (potentially in addition to any that are legally mandated and identified as urgent in the initial CANS process), and that the options chosen to implement interventions or other activities have a reasonable chance of helping them meet these needs. The team must recognize that respect for the family's preference in choosing intervention strategies is important. Even if those strategies do not work, freely chosen mistakes provide an important opportunity for learning.

When planning intervention strategies, reliance on informal supports and resources are emphasized. Participation in activities and resources that can be used by anyone in the community should be preferred over formal services and resources if similar outcomes can be achieved. This initial planning phase should be completed during one or two meetings that take place quickly (within 2 weeks) after the initial intake process is completed. A rapid time frame is intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.

3. Phase 3 - Monitoring and Adapting

Throughout the CFT process, team members work together to ensure that the integrated plan provides access to needed services, monitors the child, youth, and family's progress, and makes individualized adaptations as they learn together what does or does not work, so that the family's goals and team-identified outcomes can be achieved.

During this phase, successes are celebrated, and progress continually reviewed, all while maintaining, or building, team cohesiveness and mutual respect. Revisions to the plan are based on what the team has learned and included in updates to the CANS assessment. The revised plan is implemented, and the process repeated until the family's goals are met, the team's mission is achieved, and formal services are no longer needed.

4. Phase 4 - Transition

As progress moves forward, plans include discussion of the resources needed for purposeful transition out of formal services. This may include a potential mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult systems). The focus on transition is continual during the CFT process, and the preparation for transition is apparent, even during the initial engagement activities. The family should be able to manage a planning and intervention process on their own, should new challenges arise. Services are not closed until the transition plan has been implemented and all necessary connections for the future have been made.

C. Models and Approaches for Child and Family Team Meetings

The ICPM recognizes that counties must be empowered to design and implement approaches which will most effectively and efficiently meet mandates for child welfare, juvenile probation, and behavioral health practitioners within their systems of care. However, there are expectations that whatever approaches are used, they reflect fidelity to the values, principles, and practices described in this manual.

The team-based practices described in this ICPM are based on learning from the delivery of wraparound services that informed the Katie A. Settlement Agreement. That said, counties may choose to use other specific approaches to meet CFT requirements such as Team Decision Making, Family Group Decision Making, Safety Organized Practice, or others, as long as the approach authentically engages with families to make decisions, create integrated plans, monitor, and adapt those plans and together decide when goals are achieved. In all instances, the key factors in determining how formal and frequent a team meeting process or structure is used should be based upon the youth's and family's needs and preferences.

Team members communicate with one another in various ways: phone calls, conference calls, emails or texts, or team meetings (ensuring confidentiality standards, including HIPPA, are followed per departmental policies). Teams also meet regularly in person to ensure engagement and trust across the membership, coordinate, and integrate their perspectives to make decisions, develop plans, monitor results, assure accountability, and deal with changing situations and transitions. When team members meet, meetings should be structured so that they are both effective and efficient, demonstrating respect for the participants. Team meetings should typically last no longer than 90 minutes.

The use of a specially trained facilitator for meetings should be based upon the child, youth's, and family's needs, but every practitioner responsible to ensure coordination of service delivery should have the basic skills to facilitate a CFT meeting. The person who facilitates the CFT meeting acts to engage all team members in participation, soliciting their input in making decisions, coordinating their contribution to the activities in the integrated plan, and promoting accountability to the team for their commitments to specific action steps.

Children, youth, and families that have more intensive needs and fewer resources may benefit from more structured, more frequent, and more professionally facilitated team meetings. Children and families with less complex needs and more resources may do just as well with more informal team meetings. All CFT meetings may be able to move from more to less structure and facilitation over time.

Every team member does not need to be present in person at every meeting, nor participate in every communication. The "working together" aspect of teaming, with the focus on partnership

with the youth, family, and team members should always be evident in real time: in the documentation of service and in routine effort to ensure that every member of the CFT has the information they need to make informed decisions.

D. Integrated Core Practice Model Behaviors

As stated earlier, building on the Pathways to Well-Being Core Practice Model, a Child Welfare Core Practice Model was developed by a team comprised of County Child Welfare Directors from across California with input from hundreds of their stakeholders. In addition, the design team developed specific, observable core practice model behaviors intended to inform direct service provision and be used by administrators and supervisors in the training, coaching, and evaluation of child welfare workers. Those child welfare behaviors are captured here, as written, to maintain the integrity of their work.

Using the child welfare behaviors as a template, with support from CBHDA and CPOC, and stakeholders, including family and youth, Enhanced Practice Behaviors have been added to specifically delineate the expectations for behaviors in integrated practice settings. Together, the Child Welfare specific and Enhanced Practice behaviors can be viewed as universal expectations for integrated core practice behavior.

Foundational Behaviors — Child Welfare

Be open, honest, clear, and respectful in your communication.

1. Use language and body language that demonstrate an accepting and affirming approach to understanding the family.
2. Ask people how they prefer to be addressed, and address individuals by the name or title and pronouns they request in person and in writing.
3. Show deference to Tribal leadership and their titles in written and verbal communication.
4. Be open and honest about the safety threats and circumstances that brought the family to the attention of the agency, what information can be shared among team members, and what information will be included in court reports.
5. Be transparent about the role of the court and the child welfare agency.
6. Ask family members what method of communication they prefer, use age-appropriate language that everyone can understand, and confirm with family members that your communication meets their language and literacy needs.

Be accountable.

1. Model accountability and trust by doing what you say you're going to do, be responsive (including returning calls, texts, and emails within 24 business hours), and be on time (including submitting reports on time and being on time for appointments) and follow ICWA and other federal and state laws.
2. Be aware of, and take responsibility for, your own biases, missteps, and mistakes.

Foundational Behaviors — Enhanced

Be open, honest, clear, and respectful in your communication.

1. Be open and honest about the safety threats and/or other circumstances that brought the family to the attention of the convening agency, requirements of mandated reporting, what information will be shared among team members, and what information will be included in court reports, as required.
2. Be transparent about the role of the court and any involved public agency, as applicable.
3. If children must be removed from their family of origin's home, ask parents who they would recommend caring for their children, on an emergency basis or for a longer placement; be transparent that services to make and finalize a permanent placement for the child will be provided concurrently with services to reunify the family in case efforts to reunify fail.
4. Use a translator or interpreter whenever language barriers exist, especially avoiding the use of children for that purpose, and with attention to family relationship and gender as culturally appropriate.

Promote accountability.

1. Look for, and admit, your own biases, missteps, and mistakes when they occur, making corrections as needed.
2. Adhere to the professional standards, ethics, and practice of your discipline; respect the right to confidentiality and privacy of information.
3. Routinely assess your own knowledge and competency levels, including emerging evidence-informed or evidence-based practice areas; obtain necessary training to improve skills or provide access to and/or consult with competent experts to ensure that the needs of children and families served are met.
4. Engage, encourage, and support youth or family members, as applicable, to take accountability for the actions and concerns that precipitated their contact with the public service agency including any necessary changes required to address those actions and concerns.
5. Support and enhance juvenile court practice by providing guidance and input to advance the use of evidence-based practices in crafting expectations, requirements for treatment, and intervention plans into applicable court orders.
6. Expect all team members to be accountable for what they say and do within the child and family team (CFT) process, consistently demonstrating that the purpose of the team is to collaborate in getting things done that are helpful to the child, youth, and family members in achieving their goals for change.

Engagement Behaviors — Child Welfare

Listen to the child, youth, young adult, and family, and demonstrate that you care about their thoughts and experiences.

1. Listen attentively and use language and concepts that the family has used.
2. Use a trauma-informed approach to acknowledge and validate venting, expressions of anger, and feelings of grief and loss.
3. Reflect what you heard so the child, youth, young adult, and family can see that you understood.

Demonstrate an interest in connecting with the child, youth, young adult, and family, and help them identify and meet their goals.

1. Express the belief that all families have the capacity to safely care for children and youth.
2. Use positive motivation, encouragement, and recognition of strengths to connect with youth and express the belief that they have the capacity to become successful adults.
3. Reach out to children and families in ways that are welcoming, appropriate, and comfortable for them, and make a special effort to engage fathers and paternal relatives to build connections and engage them as family members and team members.
4. Affirm the unique strengths, needs, life experience, and self-identified goals of each child, youth, young adult, and family.
5. Show your interest in learning about the family and their culture, community, and tribes.
6. Ask global questions followed by more descriptive questions that encourage exchange.
7. Honor the role of important cultural, community, and tribal leaders the child, youth, young adult, and family have identified.

Identify and engage family members and others who are important to the child, youth, young adult, and family.

1. Ask questions about relationships and significant others early and often.
2. Search for all family members, including fathers, mothers, and paternal and maternal relatives through inquiry, early and ongoing Internet search, and review of records.
3. Work quickly to establish paternity and facilitate the child or youth's connection with paternal relationships.
4. Contact family, cultural, community, and tribal connections as placement options, team members, and sources of support.

Support and facilitate the family's capacity to advocate for themselves.

1. Coordinate with the family's formal and informal advocates to help the family find solutions and provide ongoing support.
2. Promote self-advocacy by providing opportunities for children, youth, young adults, and families to actively share perspectives and goals.
3. Incorporate the family's strengths, resources, cultural perspectives, and solutions in all casework.

Engagement Behaviors — Enhanced

Listen to the child, youth, family members, and others who have responsibility to care for a child or youth and demonstrate that you care about their thoughts and experiences.

Engagement is a continuous service process that lies at the heart of this practice model and recognizes that family members are the best experts about their own life and story.

1. Use trauma-informed approaches when talking with children, youth, and family members so they feel heard and experience that their information is being used to understand their circumstances without judgment. Begin to identify actual or suspected trauma exposure while hearing the story.
2. Educate family members and others about how trauma and loss may drive child/youth behaviors that functionally allow them to control their experiences. Explain normal trauma reactions and how those reactions can be helpful or create barriers to healing.
3. Be responsive to each person's temperament, learning style, motivation, gender, and culture throughout the service process; demonstrate respect for the diverse experiences, customs, and preferences of each individual.

Demonstrate an interest in connecting with the child, youth, and family to help them identify and meet all their goals across all systems from which they are receiving services.

1. Ask questions that encourage exchange; work to build relationships that support the development of trust.
2. Encourage hope by conveying belief that each family member can make changes and achieve success.
3. When a youth is placed in a detention or placement facility, support continued contact and involvement of the family in the development of service plans and post-detention/placement planning.
4. As you learn about the child, youth, and family, identify what they think are their most pressing concerns, and prioritize those needs early in the planning process as tangible demonstration of your understanding of what they have told you is important to them.
5. Recognize that proactive engagement is the responsibility of the provider(s); failure to engage means that the provider(s) must commit to learn from what didn't work as well as identify and try new strategies until they are successful.

Identify and engage family members and others who are important to the child, youth, and family.

1. Help youth, parents, and others identify prosocial people or other connections to help with team development and activity planning later in the process; work to engage these identified connections to support the family.
2. Ask children, youth, and family members about other people who might be a source of support or information.

Support and facilitate the family's capacity to advocate for themselves.

1. Coordinate with the family member's formal and informal advocates to help the family find solutions and provide ongoing support.

2. Promote self-advocacy by providing opportunities for children, youth, young adults, and families to actively share perspectives and goals.

Meet the child, youth, and family at times and in locations that are convenient for them and where they are comfortable.

1. In advance, prepare the child or youth and family members to participate in formal meetings and/or hearings where decisions are made so that they can speak for themselves.
2. Build trust by ensuring that children, youth, and family members understand what is said in therapeutic settings is kept confidential unless there is specific permission to share; when content arises that is important information for the team, support appropriate sharing by the individual; be sure they know this does not apply to situations requiring mandated reporting.
3. Educate the family on how trauma experiences can impact development over a lifetime and drive behaviors that serve to provide a method for the child, youth, or adult to regain control of their environment, even when that control has negative consequences.
4. Let them know about available services, supports, and resources that may be available to them in their community.

Assessment Behaviors — Child Welfare

From the beginning and throughout all work with the child, youth, young adult, family, and their team, engage in initial and ongoing safety and risk assessment and permanency planning:

1. Explain the assessment process to the child, youth, young adult, and family so they know what to expect. Check in early and often to be sure they understand.
2. Explore the child, youth, young adult, and family's expressed and underlying needs by engaging them in communicating their experiences and identifying their strengths, needs, and safety concerns.
3. Talk to children, youth, and young adults about their worries, wishes, where they feel safe, where they want to live, and their ideas about permanency, and incorporate their perspective.
4. Use tools and approaches that amplify the voices of children and youth.
5. Ask the family what is working well and what they see as the solution to the circumstances that brought them to the attention of the child welfare agency.
6. Apply information to the assessment process using the child or youth's and family's cultural lens.

Assessment Behaviors — Enhanced

From the beginning and throughout all work with the child, youth, family, and their team, engage in initial and ongoing formal and informal safety and risk assessment, trauma assessment, and permanency planning:

1. Check in with the child, youth, and family to be sure that they agree with, or at a minimum understand, what the assessment indicates and why it is important to what happens next.
2. Help the child, youth, and family understand that child safety, community safety, and criminogenic risk factors are non-negotiable areas of concern for the duration of their child welfare and/or juvenile probation involvement; risk factors are also non-negotiable areas of concern for the duration of service for their family; check in early and often to be sure they understand what that means.
3. Provide a comprehensive assessment that includes risks to the child's safety, the risk of future maltreatment, parental protective capacity, and child well-being. Provide routine informal assessments on an ongoing basis and identify the youth and/or family member's criminogenic needs (antisocial attitudes, values and beliefs, low self-control, criminal peers, substance abuse, and family issues that may be dysfunctional to successful family life).
4. Identify prior exposure to trauma and loss, including historical trauma, for the child, youth, and family members.
5. Ensure that a behavioral health screening has been provided to all children and youth. If the behavioral health screen is positive, ensure that a thorough psychosocial assessment is provided to evaluate the status of a child's mental, emotional, or behavioral health to support a diagnosis to substantiate medical necessity as appropriate; update based on new information or at least annually.
6. Update the assessment when the family faces new challenges, when safety concerns arise for the child or other family members, and when reviewing service effectiveness and case progress.
7. Identify child/youth's self-protective behaviors that create barriers to achieving a permanent family and ensure that the CFT plan addresses those barriers to permanency.
8. Identify specific concerns where additional resources may allow the child or youth to remain with their biological, adoptive, or guardianship family including permanency and post-permanency services and supports.
9. Conduct a functional assessment to identify barriers for the achievement of normal developmental milestones and/or the development of effective coping mechanisms or alternative behaviors that support healthy emotional and behavioral health for the child/youth within family and community environments; specifically identify behavioral defenses to the development of attachments resulting from vulnerability to loss.
10. Identify how the youth spends their free time and evaluate what additional structure they may need to be clearly occupied with a delineated routine and appropriate services including prosocial and permanency supports.

Teaming Behaviors — Child Welfare

Work with the family to build a supportive team.

1. With the family's permission, contact family, cultural, community, and Tribal connections, and ask them to serve as team members as early as possible.
2. Ask initially, and throughout the family's involvement, if they would like a support person or peer advocate on their team.
3. Explore with the family how culture might affect the development of the team and the teaming process.
4. Facilitate early and frequent sharing of information and coordination among parents, caregivers, and agency partners.
5. Facilitate development of a mutually supportive relationship between the parents and caregivers.

Facilitate the team process and engage the team in planning and decision-making with, and in support of, the child, youth, young adult, and family.

1. Make sure team members have the information they need.
2. Facilitate critical thinking, discussion, mutual exploration of issues, and consensus building toward the goal of shared decision-making.
3. Help the team recognize that differences will occur and assist them to work through conflicts.
4. Develop a shared understanding about safety, permanency, and well-being issues to be addressed with the team.
5. Ensure that all team members understand that legal, regulatory, and policy constraints may limit shared decision-making options available to address the family members' needs, including placement options, reunification, and service options.
6. Build connections to identified services and supports by designating a team member to follow-up with that referral.

Work with the team to address the evolving needs of the child, youth, young adult, and family.

1. Facilitate dialogue about how supports and visitation plans are working.
2. Explore with team members what roles they can play over time to strengthen child safety and support the family.
3. Help the team adapt to changing team member roles.

Work collaboratively with community partners to create better ways for children, youth, young adults, and families to access services.

Teaming Behaviors — Enhanced

Work with the family to build a supportive team.

1. Facilitate development of a mentoring relationship between the parents and resource family or other service provider when children are placed outside of their permanent home.
2. With permission, reach out to the child/youth's teacher or educational resources to invite participation on the team, or at a minimum, to identify educational needs, strengths, and resources within the planning process.
3. Support family members who hold rights to their information to decide how much, and what, information they want to share with team members, ensuring that they understand the benefit of an integrated team approach whose members commit to holding their information in a confidential manner.
4. Facilitate the process for authorization to release, receive, and share information; facilitate consent for treatment, as appropriate and necessary.

Demonstrate the skills required to facilitate the team process, engaging the team in planning and decision-making with, and in support of, the child, youth, and family irrespective of your role on the team.

1. Develop a shared understanding about safety, permanency, and well-being issues to be addressed within the child and family team. Explain court orders and placement decision requirements that include concurrent planning and the full range of specialized permanency service elements; do the same for youth regarding community safety and accountability, including expectations from court orders and sanctions for children involved in juvenile probation.
2. Provide information and context related to diagnoses and symptoms of behavioral health disorders that impact day to day functioning, including the many impacts of trauma and loss on an individual's behavior and general health, and support shared understanding among team members that inform approaches to intervention planning.
3. Make sure team members have the information they need to make informed decisions and review the effectiveness of plans.
4. Ensure that system resource constraints are identified so advocacy or alternative resources can be explored.
5. Help the team develop basic, consensual ground rules for the meeting process; revisit the rules over time to ensure the agreements are working so that meetings are productive.
6. Unless otherwise constrained by safety concerns or court orders, youth's and family members' preferences should drive the plan decisions; recognize and support the importance of learning from mistakes, as well as successes for all team members.
7. Facilitate mutually supportive relationships and an assumption of "good will" among team members that ensures respect for the perspectives of all members, including family members, multidisciplinary professionals, and invited others; promote understanding of the needs and strengths of all members on the team consistent with their role.

Work with the team to address the evolving needs of the child, youth, and family.

1. Facilitate prioritization of issues to be addressed, taking the most urgent items first (e.g. child safety, community safety, basic needs for food, clothing, shelter, etc.), especially as defined by the child, youth, and family.
2. Develop and modify plans and assign specific roles and tasks to team members who agree to be held accountable by the team for how they contribute to the success of the plan. When there is a failure in follow-through, seek to understand what may have gone wrong and refine the plan and assignments based on that learning.

Work collaboratively with community partners to create better ways for children, youth, young adults, and families to access services.

1. Actively engage prosocial supports for children, youth, and family members in their community that can provide positive reinforcement for desired behaviors and improve ties to prosocial community members, including members of the CFT.
2. Build connections to identified services and supports, designating a team member to follow-up with that referral and checking back to ensure that the connection was made and the resource is helpful.
3. Communicate on a consistent basis with the child's team to monitor and ensure the child's behavioral health concerns are being addressed within the home, community, and educational settings; support and encourage the child, youth, and family team members to follow through with plan assignments and support their efforts with demonstrated interest and practical help.
4. Support youth and family members practice new skills and behaviors that they may be learning from other service providers; provide positive reinforcement for prosocial attitudes and behaviors wherever you observe them.
5. Advocate for, link the family to, and help family members access the services, supports, and visitation activities identified in the plan; include effective specialized permanency services for children and youth unable to reunify.

Service Planning and Delivery Behaviors — Child Welfare

Work with the family and their team to build a plan that will focus on changing behaviors that led to the circumstances that brought the family to the attention of the child welfare agency and assist the child, youth, young adult, and family with safety, trauma, healing, and permanency.

1. Describe how family strengths, safety threats, and priority needs will be addressed in the plan.
2. Describe strengths in functional terms that can support the family members in completing their plan.
3. Share information about agency programs, providers, resources, and supports.
4. Encourage and support the participation of children, youth, young adults, family, Tribe, and team in identifying culturally sensitive services, supports, visitation activities, and traditions that address family members' unique underlying needs even if this means accepting practices that may be unfamiliar to the social worker.
5. Ask the family members if they need help meeting basic needs for food, shelter, and medication so they can focus on addressing the problems underlying their involvement with the child welfare agency.
6. Advocate for, link the family to, and help family members access the services, supports, and visitation activities identified in the plan.
7. Assure the family receives needed information, preparation, guidance, and support.
8. Adapt services and supports to meet changing family needs based on ongoing assessment, progress toward goals, and decisions made by the family and their team.

Service Planning and Delivery Behaviors — Enhanced

Work with the family and/or youth and their team to build an integrated plan that will focus on changing behaviors that led to the circumstances that brought the family to the attention of the service agency or agencies; assist the child, youth, and family to achieve safety, permanency, and to heal from trauma.

1. Support the development of a single integrated CFT plan that maximizes the integration and coordination of goals and intervention strategies across service systems with defined desired outcomes and specific timelines for activities.
2. Support the family to develop their goals, including how to address issues that may be non-negotiable due to court orders or other circumstances related to safety, trauma, illegal behavior, or permanency needs.
3. Help family members learn and practice skills that allow them to advocate on their own behalf in court or other settings where decisions are made.
4. For high risk, multi-agency involved children and youth, utilize the team process to share risk and increase coordination.

Goals, strategies, and interventions are tied to observable progress that is important to the to the child, youth, and family members. Plans are monitored and revised as needed to ensure that successful outcomes remain the focus.

1. Team members demonstrate a “hang in there” persistence and do not give up when challenges occur. On every level, teams work through difficulties discovered during planning and implementation, and continue to monitor and make changes in the plan.
2. When interventions are not successful in producing the desired outcome, evaluate and strengthen what was successful and/or learn from what didn't work to design something different; research evidence-based and model programs to find new approaches when necessary.
3. Ensure the use of evidence-based interventions whenever possible and support court orders.
4. Work to ensure that the shared CFT plan is consistent with the treatment and sentence/sanction requirements and aid the youth and family in following all terms and conditions of the court, including recognition of emotional needs that may drive resistance to achieving permanency with birth family or others.
5. Assist the child/youth and adults to develop skills and strategies that improve emotional and behavioral regulation; assist youth and adults to understand the functional impact of trauma on their behavior, and support their ability to change behaviors that no longer meet their needs.
6. Ensure that interventions support the child in their home and family setting, or assist a move to a permanent or other family setting at the earliest time possible; use adoption/permanency informed interventions to address emotional needs that form barriers to achieving permanency.
7. Adapt services and supports to meet changing family needs based on ongoing assessments, progress toward goals, and decisions made by the family members and their team.

Transition Behaviors — Child Welfare

Work with the family to prepare for change in advance and provide tools for managing placement changes, social worker changes, and other significant transitions.

1. Reduce the role of child welfare and professional services over time and facilitate an increased role for the family's network and natural supports to help the family build an ongoing support system.
2. Coordinate with the family's formal and informal advocates to help the family find solutions and provide ongoing support after the child welfare agency is no longer involved.

Transition Behaviors — Enhanced

Work with the family to prepare for change in advance and provide tools for managing placement changes, social worker changes, and other significant transitions.

1. When it is known that a member(s) of the CFT will change, work with the team to plan how to support the new member(s) to come up to speed quickly, understanding their role, and what has been accomplished. When that is not possible, new members should take responsibility with the family and other CFT members outside of the meeting structure to understand what is going on with the team and the shared planning process.
2. When placement or permanency plan changes are necessary, work to ensure that the CFT agrees with the plan, or, at a minimum, understands why a decision is being made; create proactive safety and support plans to ensure successful transitions.
3. Involve the family's formal and informal support systems to prepare for life after formal care is no longer involved.
4. Make sure that any referrals for continuing care or supportive resources are in place and working before the transition is complete.

IV. CHAPTER 4: IMPLEMENTING THE INTEGRATED CORE PRACTICE MODEL

Effective implementation and replication of successful service models and new programs for family services is nearly always challenging. Research in the field of implementation science has shown that it takes both effective practices and effective implementation to achieve positive outcomes. For this reason, organizational and administrative activities related to the ICPM will be based upon the principles of implementation science. Specific information about implementation science is included in the References Section, which follows this chapter.

A. Transition to the Service Model

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

Exploration Stage: This is when information is collected and analyzed to identify the needs, available resources, and potential solutions, and a decision to implement occurs. Specific to this ICPM, this stage began at the state level during the Katie A. negotiation and settlement process and will continue at the local level as counties become more familiar with the ICPM, its practices, and activities. This document reaffirms the commitment to the Katie A. Settlement Agreement, and serves as a guiding document to effectively implement Continuum of Care and related reforms, including a focus on decreasing the use and length of stay in group care, increasing resources for permanence, and increasing focus on the necessity to collaboratively integrate plans and services when working with families. It is assumed that counties will build on the work already completed as it moves to fully implement the expectations of CCR with integrated policies and practices consistent with the ICPM.

Installation Stage: Staff and systems plan, prepare, and organize to build the necessary supports to promote utilization of the intervention. The Katie A. readiness assessments assisted counties in determining their level of readiness and to identify additional structures, resources, policies, and activities that were needed to prepare to implement the CPM. While there will not be a required readiness assessment for CCR, self-directed readiness efforts are needed as counties plan for reduction in use of group care for children and youth, and related regulatory and rate structure changes within the foster care system. Additionally, through CCR, juvenile probation formally becomes a partner in this practice model.

Initial Implementation Stage: First implementers are carrying out the innovations, and teams are monitoring the intervention and implementation supports and making whatever improvements are necessary to meet practice standards and regulatory expectations.

Full Implementation Stage: Most staff persons are using the ICPM with fidelity across the county system. Monitoring processes (including the components described below) and service outcomes are routine; quality improvement practices are in place and functioning.

At all stages in the process, financial and programmatic sustainability must be considered, planned for, and executed so that no child, youth, or family members are left without necessary and required services.

B. Components for Implementation

Just as there are key practice components for the integrated practice model, there are also necessary conditions for implementation. Implementation Science identifies these as:

1. Staff Selection

Every staff member must be selected to suit his or her role. This means that position descriptions and staff selection should include appropriate personal characteristics identification along with education and experience. Candidates who meet most, or all, of the personal characteristics profile for the specific job will find more success than those who meet few or none. Some personal characteristics to consider are:

- Accepting and nonjudgmental
- Committed for the long-term
- Flexible and creative
- Genuine empathy for children, youth, and their families
- Interested in others
- Nurturer, not enabler
- Organizational and time management skills
- Outgoing
- Passion for the work
- Personal Stability
- Team player
- Willingness to share

2. Staff Training and Development

Staff must receive appropriate training to do their job. Staff working within this ICPM must understand the integrated nature of the work they are being asked to perform and learn the common practice behaviors that demonstrate practice fidelity. *California's Integrated Training Guide* (CITG) has been developed to support counties and statewide training partners in this implementation. The ITG supports cross-system practice and service delivery by providing guidance and recommendations about both the content and process of training that advances collaboration among child welfare agencies, affiliated social service organizations, families, tribes, and related support networks.

The term “integrated training” refers to training whose content crosscuts agencies and organizations that serve children, youth, and families involved in the child welfare, behavioral health, and/or juvenile probation systems. This guide is rooted in wide-spread evidence that services are more effective and efficient when practitioners and family members collaborate as a child and family team, with the meaningful participation of the family in formulating objectives and planning services to accomplish implementation of their goals.

To strengthen the integration of public service systems and partnering organizations, the ITG plan recommends topics that build awareness of common practice concerns, outline basic organizational functions of the collaborating agencies, and describe methods for working collectively. The integration of training topics and audiences among multiple sectors support consistent practice standards and values, and mutual goals for improving short- and long-term outcomes for individuals and families. In addition, the plan provides guidance for workforce development that reflects a changing practice environment, which honors the complexities of

the individual, the diverse life experiences of children, youth, and families as embedded in their social and economic realities, and their desires for self-determination.

The ITG was developed with broad stakeholder, family, and youth and service provider participation, with support from the Statewide Training and Education Committee (STEC) whose members include training partners from the Regional Training Academies (RTAs) for child welfare, the Resource Center for Family Focused Practice (RCFFP), the California Institute for Behavioral Health Solutions (CIBHS), the Child and Family Policy Institute of California (CFPIC), DHCS, CDSS, and advocates, including parents and youth from the Community Team, a stakeholder group established by the Katie A. Settlement agreement.

The integrated curriculum of the ITG will be built through adaptation of current existing training content and resources available for members of the workforce from each of the disciplines that are held in common. Additionally, training will be further adapted whenever possible for joint audiences with diverse needs and affiliations, able to replace some of the current 'siloed' training. It is not intended to replace other training for discipline specific skills that are necessary to fulfill agency responsibilities. Whenever possible, youth and family members should be included on training teams. The integrated training approach will support:

- Shared understanding of California's Integrated Core Practice Model including the values, principles, key components, practice standards, and behaviors;
- Creation of opportunity to learn the new shared practice skills and behaviors and receive feedback in a safe training environment;
- Shared understanding of the 3 service systems including mandates and regulatory context of practitioner responsibility: child welfare, behavioral health, and juvenile probation;
- Opportunity to build cross-system relationships;
- Collaborative skills and values.

3. Ongoing Consultation and Coaching

Research reveals that the skills needed by successful practitioners can be introduced in training, but are most effectively learned and integrated into day to day practice with the help of a coach. Coaching refers to an ongoing professional development process designed to:

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

The coach can be a supervisor, a peer with demonstrated mastery of the skills, or a defined position within the work team who observes and provides feedback in the field based on the defined practice behaviors. Most important is that the coach recognizes the skills of this ICPM, and can provide feedback from a strengths perspective that encourages deeper understanding and support for improved performance. Effectively engaging children and their family members, achieving proficiency in building a CFT, and becoming comfortable and effective working within a team environment will require coaching in addition to training for a practitioner who may not have experience working with this approach in a complex, cross system service environment.

4. Staff and Program Evaluation

Children, youth, and families will not realize the desired benefits of the ICPM unless it is implemented as intended. Evaluation is critical in ensuring adherence to the model.

Fidelity assessment is designed to assess the use and outcomes of the skills that are reflected in the selection criteria, are taught in training, and reinforced and expanded in routine supervision consultation and the coaching process. Fidelity feedback should be framed as support to achieve the intended goals of personal effort, trusting the process and principles to produce the desired outcomes of service. Aggregate assessment results should serve as feedback to the training, supervision, and coaching resources. Program fidelity evaluation assesses key aspects of the overall performance of the organization to inform system and individual unit improvement efforts. There are several guides or tools available for fidelity assessment at the practitioner and program levels.

5. Administrative Structures

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

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

6. System Collaboration

Systems interventions needed to practice effective teaming include strategies to ensure the availability of the financial, organizational, and human resources required to support the work of the practitioners. Examples of systems interventions that will support the ICPM include:

- A shared management structure comprised of lead department decision makers who can assure the development of a shared vision and mission statement, integrated policy and program direction, clear and consistent guidance, and outcomes and accountability measures consistent with the ICPM.
- The joint development of policies and procedures at both the state and county levels that support the model and provide ways to avoid duplication and resolve conflicts between the involved agencies and service practitioners.
- Interagency Placement Committee function, which not only considers and reviews requests for STRTP level services, but also provides all partner agencies an opportunity to coordinate care and leverage their combined service and fiscal resources.
- Interdepartmental revenue sharing and budget processes, which allow the county to effectively leverage all resources and flexibly meet program needs.

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

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

C. Developmental Framework for Implementation



As noted earlier in this guide, the ICPM is more than implementing a program; it is about fundamentally changing the way staff engage with, view, and relate to every child and family and move from working in an individual system or agency with responsibilities and mandates to working within a team environment that commits to build a culturally relevant and trauma-informed system of supports and services that is responsive to the strengths and underlying needs of families.

Active and involved statewide leadership holds the vision across systems and departments; this includes leadership at the related state level departments, the California Welfare Directors Association (CWDA), the California Behavioral Health Directors Association (CBHDA), and the Chief Probation Officers of California (CPOC), the California Community Behavioral Health Agencies (CCCBHA), The California Alliance of Child and Family Services (CAFCS) and other statewide organizations and stakeholders. Together they can provide the advocacy to ensure policy and fiscal structures that support necessary resources for effective quality service practices and address systemic barriers to positive outcomes for children and families.

1. An Active, Involved Community Partnership

Child welfare, behavioral health, and juvenile probation agencies, in partnership with their statewide organizations, local leaders, service providers, and partners demonstrate commitment to community partnerships that respect and incorporate the unique contributions of communities and tribes. These partnerships guide ongoing local practice and system changes. The following are suggested partnership activities:

- Community meetings, forums, and listening sessions to learn about and begin to address historical trauma and mistrust of agencies and systems, with feedback to statewide leadership and policy development.
- Working with community and tribal partners to conduct a systems analysis to identify barriers to improved outcomes for children and families and implement action plans to address those barriers from both local and statewide perspectives.

- Collaborating with community and tribal partners to establish culturally relevant and trauma-informed services to meet the underlying needs of children and their families.
- Meaningfully involving community and tribal partners in training, coaching, and ongoing system supports for effective, sustained implementation of the ICPM.
- Ensuring that partnership meetings, forums, and feedback loops are sustained so that the statewide and local community and tribal partners are continuously connected to, and help guide ongoing child welfare, behavioral health, and juvenile probation practice and system changes, to achieve improved outcomes for children and their families.

2. Shared Commitment to the Practice Model

There must be shared commitment by child welfare, juvenile probation, and behavioral health agencies, statewide and locally, with organizations, leaders, service providers, and partners to adopt the ICPM as the framework for coordinated practice and service delivery for children, youth, and families in California. Therefore, they must work continuously with the relevant departments at the state and local levels to:

- Develop internal and external communication and feedback loops that coordinate and support implementation of the ICPM.
- Align all parts of the system to support the practice and system changes reflected in the ICPM. Identify, develop, and support use of a broad, culturally relevant, and trauma-informed service array responsive to the underlying needs of local children, youth, and their families.
- Dedicate staffing resources to form local Implementation Teams and employ Implementation Science to “drive” successful implementation and support of the ICPM locally. Local implementation teams are comprised of individuals both outside and within the organization or system with the knowledge, skill, freedom, and authority to act. They should include community members who have lived-experience with child welfare, juvenile probation, and behavioral health, and other community and tribal partners and stakeholders.

3. Capacity-Building and Installation

State and local Implementation Teams work with state and local staff, supervisors, trainers, coaches, agency, and community partners, administration, and leadership to:

- Educate, prepare, and meaningfully involve staff and partners in implementation planning, cross- system coordination, capacity-building, and readiness activities.
- Adapt or enhance the ICPM training and coaching curricula and service delivery plans in partnership with community and tribal partners to support practice model integration and implementation, building on local strengths, resources, strategic direction, and needs.
- Train and prepare practitioners’ supervisors and others identified to act as internal and external coaches.
- Practice Model mastery – building fluency in applying the ICPM in the context of families, communities, and tribes, as well as within child welfare, juvenile probation and behavioral health agencies, provider organizations, and systems.
- Provide Behaviorally Focused Coaching – understanding the coach’s role in supporting practitioner skills development with fidelity to the ICPM.

- Create strategies for incorporating coaching into supervision.

4. Effective, Sustained Implementation Support

State leadership and statewide associations of county and provider organizations are connected to, and support, the implementation of the ICPM in meaningful ways, ensuring that:

- Service and outcome data is collected, analyzed, and used to inform continuous quality improvement efforts at the state and local levels.
- Data is routinely published to provide transparency and chronicle improvement efforts, even when cause and effect or other reasons for data trends are not clear.
- Fidelity to the model is assessed in local counties and reported not less than every 12 months. The results are used continually to improve training, coaching, and system support for the ICPM, as well as assure practice remains consistent and effective over time.
- County leadership, community, and tribal partners are connected at the local level to support implementation in meaningful ways, such as acting as key advisors, playing roles in training or coaching, or acting as members of implementation or fidelity assessment teams.
- Organizational practice is supported which includes routine assessment of provider skills with fidelity to the practice model to enhance skill development and improve outcome of service delivery.

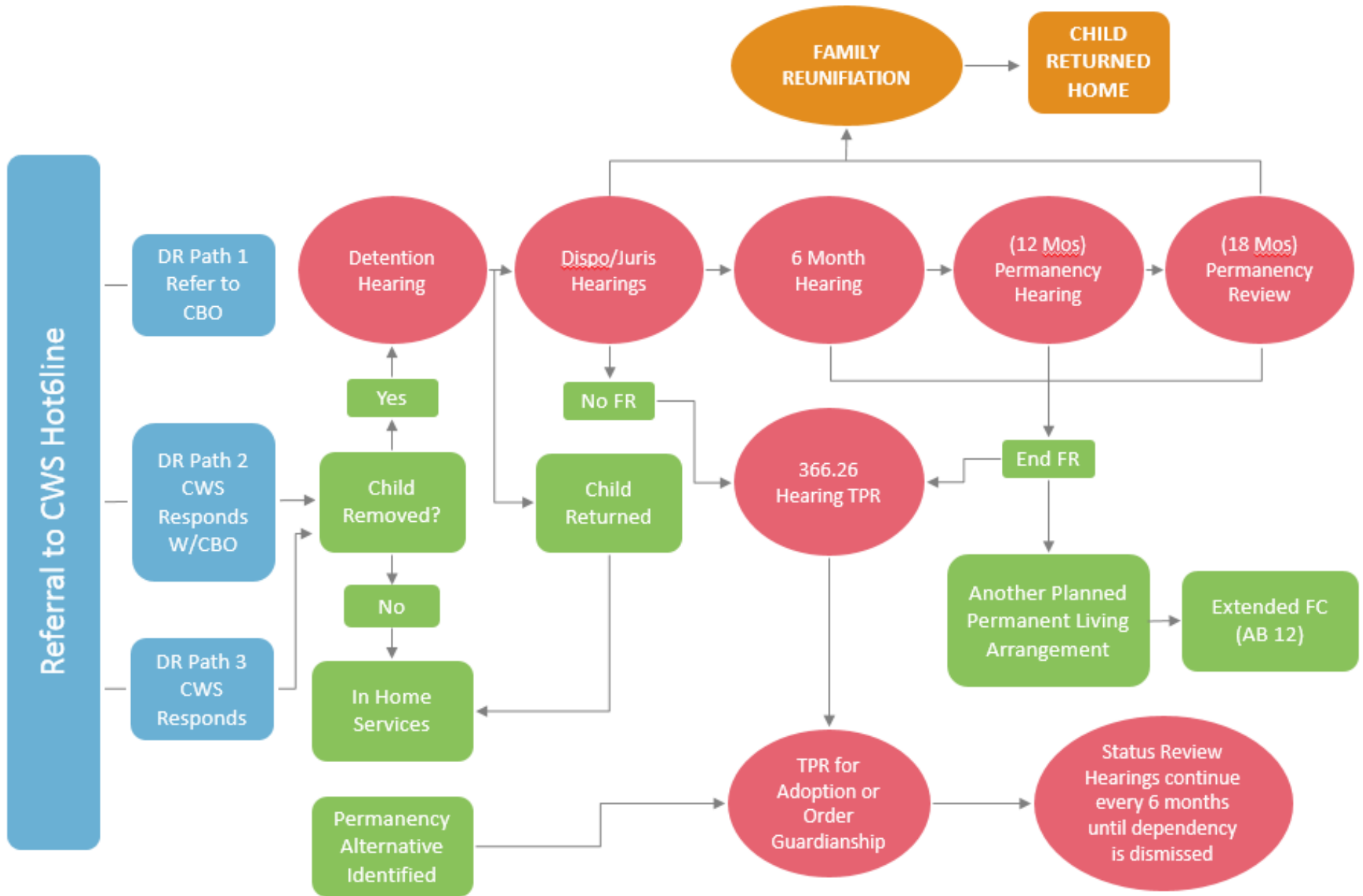
Each building block in this developmental framework supports the others, creating a firm foundation and an enriched environment for the successful implementation of the ICPM. This process takes vision of success plus time, patience, and the ability to adapt and adjust as the implementation evolves and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

V. REFERENCES

- Bell, L. (2001). Patterns of interaction in multidisciplinary child protection teams in New Jersey. *Child Abuse and Neglect*, 25, 65-80.
- Berzin, S. C., Thomas, K. L., & Cohne, E. (2007). Assessing model fidelity in two family group decision-making programs: Is this child welfare intervention being implemented as intended? *Journal of Social Service Research*, 34, 55-71.
- Borkan, J. M., et al. (2008). Towards cultural humility in healthcare for culturally diverse Rhode Island.
- California Health Advocates. (2007, April). Are You Practicing Cultural Humility? –The Key to Success in Cultural Competence.
- California Institute for Mental Health. (2012). Full Service Partnership Tool Kit, Child, Youth, Family, Cultural Relevance.
- California Partners for Permanency. www.reducefostercarenow.org
- Chadwick Trauma-Informed Systems Project. (2012). Creating trauma-informed child welfare systems: A guide for administrators (1st ed.). San Diego, CA: Chadwick Center for Children and Families.
- Cherry, K. (2016). Self-Efficacy: Why Believing in Yourself Matters. www.verywell.com/what-is-self-efficacy-2795954
- Child Protective Services: A Guide for Caseworkers Office on Child Abuse and Neglect, Children's Bureau. DePanfilis, D., Salus, M. K, 2003.
- Children and Family Futures. (2011). The collaborative practice model for family recovery, safety and stability. Irvine, CA: Author.
- Crampton, D. S. (2003). Family group decision making in Kent County, Michigan: The family and community impact. *Protecting Children*, 18, 81-83.
- Crampton, D., & Jackson, W. L. (2007). Family group decision making and disproportionality in foster care: A case study. *Child Welfare*, 86, 51-69.
- Epstein, M. H., Nordness, P. D., Kutash, K., Duchowski, A., Schrepf, S., Benner, G. J., & Nelson, J. R. (2003). Assessing the wraparound process during family planning meetings. *The Journal of Behavioral Health Services & Research*, 30, 352-362.
- Felitti VJ, A. R. (1998 May). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4):245-58.
- Fixsen, D. L., Naomi, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

- Israel, Nathan., CANS Engagement Competencies by Program: A Process Document. Office of Quality Management for Community Programs, San Francisco Department of Public Health, March 2012
- Keast, R., & Mandell, M. (2009). Why collaborate and why now? Australian Research Alliance for Children and Youth.
- Miller, S. (2009). Cultural humility is the first step to becoming global care providers. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 38(1), 92-93.
- National Wraparound Initiative – Portland State University. <https://nwi.pdx.edu>
- Pennel, J., Edwards, M., & Burford, G. (2010). Expedited family group engagement and child permanency. *Children and Youth Services Review*, 32, 1012-1019.
- Snyder, E., Lawrence, C. N., & Dodge, K. (2012). The impact of system of care support in adherence to wraparound principles in child and family teams in child welfare in North Carolina. *Child and Youth Services Review*, 34, 639-647.
- Stark, D. (1999). Strategies from six communities engaged in collaborative efforts among families, child welfare, and children's mental health. Washington, DC: Georgetown Child Development Center, National Technical Assistance Center for Children's Mental Health.
- Stroul, Beth A, M. G. (2010). Updating the System of Care Concept and Philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
- Vincent, P. (2011, July). Understanding underlying needs. *The Child Welfare Policy and Practice Group Newsletter*, 1(1).
- Vroon VDB, LLC. www.vroonvdb.com
- Walker, J. S., & Bruns, E. J. (2008). Phases and activities of the wraparound process: Building agreement about a practice model. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.
- Walker, J. S., Bruns, E. J., VanDenBerg, J. D., Rast, J., Osher, T. W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group. (2004). Phases and activities of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

A. APPENDIX A: California Child Welfare System



B. APPENDIX B: Accessing Mental Health Services for Medi-Cal Youth (Ages 0 to 21)

This document is designed to assist foster youth, caregivers, and county staff serving foster youth in navigating the mental health benefits available to youth through the Medi-Cal program. Mental health services provided to children in foster care should be informed and coordinated through a child and family team process. The child's client plan should be revised as the child's needs change over time. Anyone with legal responsibility in the child's life (or a child over age 12) can request mental health services through Medi-Cal by contacting the local county Mental Health Plan (see contact link below).

Foster children under age 21 who are enrolled in Medi-Cal have an entitlement to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which provides comprehensive screening, diagnostic, treatment, and preventive health care services. Medi-Cal recipients may receive "non-specialty" mental health services through Medi-Cal Managed Care Plans, or fee-for-service Medi-Cal Providers. For Medi-Cal beneficiaries who meet medical necessity criteria for "specialty" mental health services, services are provided or arranged or by County Mental Health Plans. "Specialty mental health services" provide a different array of services than those provided under Medi-Cal Managed Care Plans, which may be important for foster youth. The differences between the two are described on the next page.

County Mental Health Plan Contacts:

<http://www.dhcs.ca.gov/individuals/Pages/MHPContaktList.aspx>

County Medi-Cal Managed Care Plans:

<http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx>

**In an emergency, Call 9-1-1 or
the National Suicide Prevention Lifeline: 1-800-273-8255**

Mental Health Screening

- ▶ A Screening usually includes a short series of questions or observations that help determine whether a child should be more formally assessed for any potential mental health conditions.
- ▶ Screening may be provided by any licensed health care provider, child welfare social worker, probation officers, the Child Health Disability and Prevention (CDPH) program, a Foster Family Agency, or Short Term Residential Therapeutic program.
- ▶ For children enrolled in Medi-Cal managed care plans, plans are required to ensure children receive ongoing screening to identify any physical or mental illness or conditions.
- ▶ Anyone with legal responsibility in the child's life (or a child over age 12) may request a child receive a screening.



MANAGED CARE PLAN COVERED MEDI-CAL

Mental Health Services

- ▶ Individual and group mental health evaluation and treatment (psychotherapy)
- ▶ Psychological testing
- ▶ Monitoring medications
- ▶ Consultation with psychiatrists
- ▶ Lab tests, supplies
- ▶ Medications and supplements

The plans also provide:

- ▶ Diagnosis of any mental health conditions
- ▶ Treatment planning
- ▶ Referrals to the county mental health plan when a child meets criteria for "specialty" mental health services
- ▶ Targeted case management to assist children in accessing necessary medical, social, educational and other services
- ▶ Help scheduling appointments
- ▶ Transportation assistance
- ▶ Health education to parents or guardians
- ▶ Behavioral Health Therapy for children with Autism Spectrum Disorder

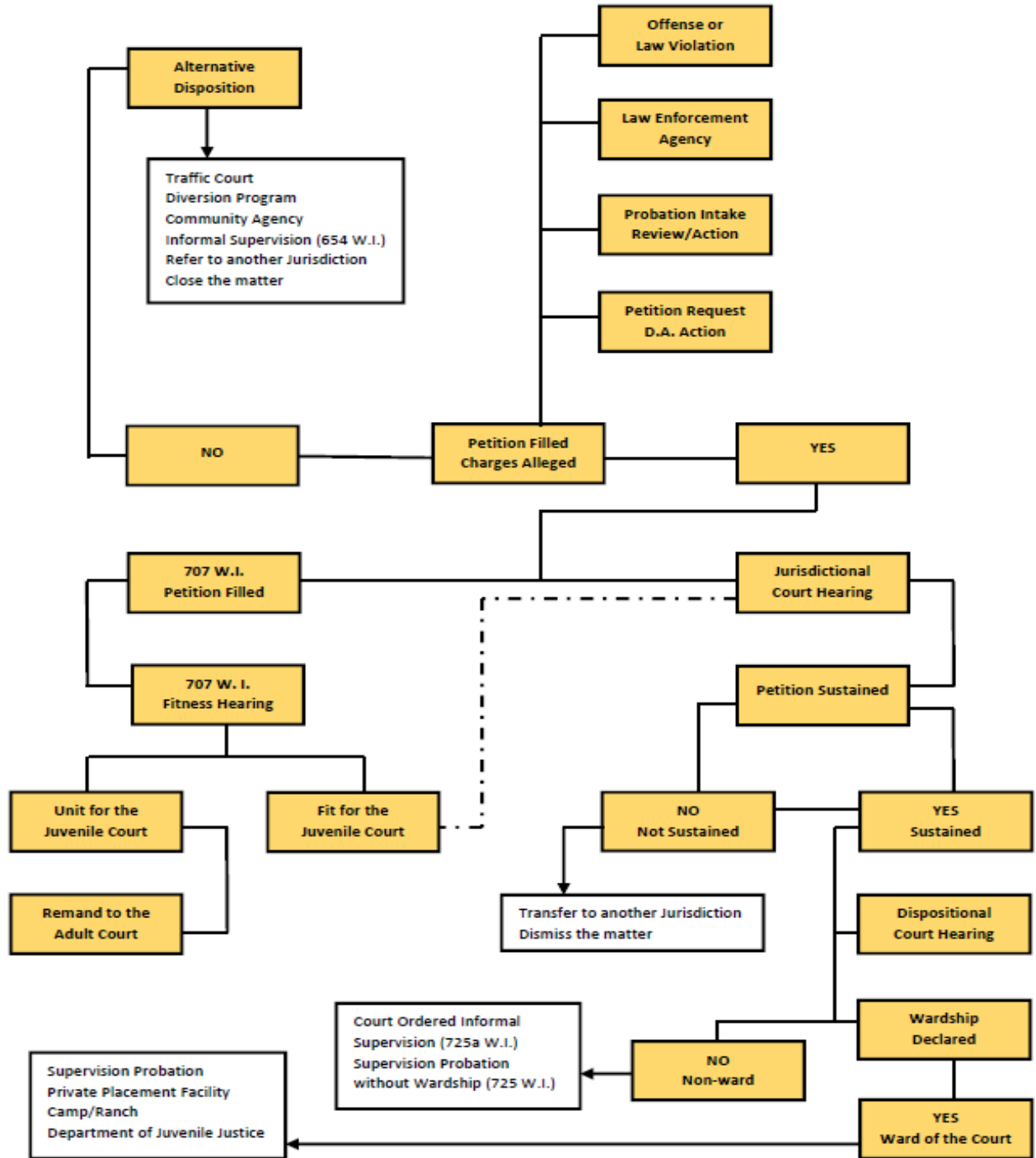
ASSESSMENT

- ▶ An assessment includes an interview by a licensed mental health professional to identify any mental health conditions
- ▶ A child may be assessed by a county mental health, Medi-Cal managed care plan, or Medi-Cal fee-for service provider
- ▶ The assessment helps the provider determine the Medi-Cal delivery system to which a child should be referred for mental health services

MENTAL HEALTH PLAN COVERED MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES

- ▶ Diagnosis of any mental health conditions
- ▶ Treatment planning
- ▶ Individual and group mental health evaluation and treatment (psychotherapy)
- ▶ Monitoring medications
- ▶ Targeted case management to assist children in accessing necessary, medical, social, educational and other services
- ▶ Rehabilitative services to enable a child to achieve age-appropriate growth and development
- ▶ Collateral services to a significant support person
- ▶ Day treatment intensive
- ▶ Day rehabilitation
- ▶ Intensive home-based services
- ▶ Intensive care coordination
- ▶ Therapeutic Foster Care
- ▶ Crisis residential
- ▶ Crisis intervention
- ▶ Crisis stabilization
- ▶ Acute psychiatric inpatient
- ▶ Psychiatric health facility
- ▶ Referrals to the Medi-Cal managed care plan when a child does not meet criteria for "specialty" mental health services

C. APPENDIX C: California Juvenile Probation – Juvenile Offender Court Process



D. APPENDIX D: Glossary of Acronyms and Terms

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

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

California Wraparound: Wraparound is an intensive, individualized, care planning, and services management process for children and youth who would otherwise be at risk for intensive out of home placement. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that results in plans and services that are effective and relevant to the child and family.

Community-Based Organization (CBO): A CBO is a provider within the community that offers concrete resources and/or services to individuals and families to ameliorate issues and to provide support as needed. CBOs are typically not for profit (501(c)3 organizations).

California Child and Family Services Review (C-CFSR): The C-CFSR is the Child Welfare Services Outcome and Accountability System, which focuses primarily on measuring outcomes in the areas of safety, permanency, and child and family well-being. By design, the C-CFSR closely follows the federal emphasis on safety, permanency, and well-being. The system operates on a philosophy of continuous quality improvement, interagency partnerships, community and/or tribal involvement, and public reporting of program outcomes.

Continuum of Care Reform (CCR): CCR, also known as AB 403 and passed in 2015, provides the statutory and policy framework to ensure services and supports provided to the child or youth and his or her family are tailored toward the ultimate goal of maintaining a stable, permanent family. Reliance on congregate care should be limited to short-term, therapeutic interventions, which is just one part of a continuum of care available for children, youth, and young adults

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

Child and Family Team (CFT): The CFT is the group of people who are involved in supporting the child and family to achieve their goals and successfully transition out of the formal child and family systems of care. Individuals working as part of the CFT each have their own roles and responsibilities, but they work together as members of an integrated team to plan, implement, refine, and transition services.

Children's System of Care (CSOC): CSOC is a policy and practice framework that involves integrated collaboration across agencies, families, and youth for the purpose of improving access and service effectiveness by expanding the array of community-based, culturally, and

linguistically competent services and supports for children and youth involved in the public youth serving systems.

Department of Health Care Services (DHCS): is the state agency charged with preserving and improving the health status of all Californians. DHCS works closely with health care professionals, county governments, and health plans to provide a health care safety net for California's low-income and persons with disabilities. The DHCS is the state agency responsible for the Medi-Cal program.

California's Integrated Training Guide (CITG): The CITG has been developed to support counties and statewide training partners in the implementation of the ICPM. The CITG supports cross-system practice and service delivery by providing guidance and recommendations about both the content and process of training that advances collaboration among child welfare agencies, affiliated social service organizations, families, tribes, and related support networks. The term "integrated training" refers to training whose content crosscuts agencies and organizations that serve children, youth, and families involved in the child welfare, behavioral health, and/or juvenile probation systems.

Child and Adolescent Needs and Strengths (CANS) assessment tool – The CANS is a multi-purpose tool developed for children serving agencies to support decision-making, including level of care and service planning. The CANS allows for monitoring of services and progress over time towards desired outcomes. This assessment tool fosters input from all parties, ensuring the service plan is individualized and behaviorally based, while incorporating child and family voice and choice. Standard versions of the CANS can be modified to fit the needs of an individual county.

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

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

Disposition and Jurisdiction Hearings (Dispo/Juris): In Child Welfare, these hearings are often held together; however, they have separate functions. Jurisdiction Hearings determine whether or not abuse and neglect allegations are true and if intervention is warranted under W&IC 300. At a Disposition Hearing, the court determines a child's placement and establishes a service plan.

In Juvenile Probation, the purpose of these hearings is similar; at the jurisdictional hearing, the court decides if what the petition alleges is true based on the evidence before the court, while during the Disposition Hearing, the judge decides what to do for the minor's rehabilitation, treatment and guidance, including sanctions.

Diversion (654.2 WIC): The District Attorney's Office has filed a formal petition with the Juvenile Court, however, the Court has decided that instead of proceeding with disposition, the case is placed on hold to allow the juvenile to participate in a six-month diversion program with the Probation Department. If the juvenile successfully completes the program, the Court dismisses the alleged charges and the case is closed. If the juvenile fails to successfully complete the program, then the Court proceeds with disposition of the case.

Dual Jurisdiction: Each county's probation department and child welfare department, in consultation with the presiding judge of its juvenile court, may develop a written protocol permitting a child who meets specified criteria to be designated as both a dependent child and a ward of the juvenile court.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): EPSDT is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. Medicaid law requires states to provide EPSDT services to beneficiaries under the age of 21 who are eligible for the full scope Medicaid services, as medically necessary, to correct or ameliorate defects and physical and mental illnesses or conditions. This requirement obligates states to provide Medicaid-covered services, whether included in a State's Medicaid State Plan or not. SMHS, including Therapeutic Behavioral Services (TBS), Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC), are available to children and youth under the age of 21 as an EPSDT benefit.

Fitness Hearing (707 WIC): A fitness hearing is a legal proceeding where a juvenile court judge decides whether a minor who has been accused of violating a criminal law is "fit" for the juvenile court system. The judge will look at factors, including the seriousness of the alleged crime, to determine whether the minor is likely to benefit from the rehabilitative services of juvenile delinquency court. If the judge decides that the minor won't benefit from those services, the minor is transferred to adult court.

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

Foster Care Placement: 24-hour substitute care for children placed away from their parent(s) or guardian(s) and for whom the State agency has placement and care responsibility. (Section 1355.20 Code of Federal Regulations). Wards of the Court (602 WIC) are considered foster youth.

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

Intensive Care Coordination (ICC): ICC is a SMHS available to Medi-Cal eligible children and youth under the age of 21 who meet medical necessity criteria. ICC is a targeted case management service that facilitates assessment of, care planning for, and coordination of, services. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services must be delivered using a CFT to develop and guide the planning and service delivery process.

Integrated Child and Family Team Plan (ICFTP): The ICFTP is developed by the child and family team and integrates the process of planning, monitoring, implementation, and refinement of services across all involved disciplines intended to meet the needs of family members including any court requirements of children, youth, and their families, by identifying and building on strengths of the individuals on the team and closely coordinating and integrating interventions strategies into a single plan intended to improve outcomes and help the family members to achieve their goals.

Intensive Home Based Services (IHBS): IHBS is a SMHS available to Medi-Cal eligible children and youth under the age of 21 who meet medical necessity criteria. Services are intensive, individualized, strengths-based, and needs-driven activities that support the engagement and participation of the child or youth and his/her significant support persons, and help the child or youth develop skills and achieve the goals and objectives of the plan. Service is expected to be of significant intensity to address the mental health and behavioral needs of the child or youth, consistent with the mental health and integrated CFT plan, and will be predominantly delivered outside an office setting, in the home, school, or community.

Informal Supervision (654 WIC): The Probation Officer has determined that the juvenile may benefit from services. This is a voluntary contract between the probation officer, the juvenile, and the parents/guardians only. The juvenile may be placed on informal probation for up to six months. If the juvenile successfully completes this program, the case is then closed and filed away. If the juvenile is unsuccessful, the Probation Department may make a referral to the District Attorney's office for a formal petition to the Juvenile Court.

Integrated Core Practice Behaviors (ICPB): ICPB describe specific, observable behaviors intended to inform direct service provision and be used by administrators and supervisors in the training, coaching, and evaluation of direct service staff working in integrated service settings. While there are additional specific tasks that are defined by role and discipline, these ICPB describe how multiple agencies or systems do their work based upon and driven by fundamental values and principles of the ICPM.

Integrated Core Practice Model (ICPM): The ICPM defines the values, principles, and expectations for team-based practice behaviors and activities for all child welfare, juvenile probation, and mental health agencies, service providers, and community/tribal partners working with children, youth, and families who are being served by more than one public agency.

Katie A. et al v. Bontá et al Lawsuit: Commonly known as *Katie A.*, refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children in California, who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011. The settlement agreement formally ended, with the jurisdiction of the federal court ceasing, in December 2014.

Mental Health Plan (MHP): A MHP is an entity that enters into a contract with the DHCS to provide directly or arrange to pay for Specialty Mental Health Services to beneficiaries in a county. A MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.

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

Parent Partners/Family Advocates: Parent Partners/Family Advocates are individuals with lived-experience and work with parents receiving services from the public child welfare, juvenile probation, or mental health systems, and other members of the CFT, to provide support and mentoring that results in the individual's ability to speak for themselves, expressing their own vision for their future, and their strengths, needs, and preferences, during the service process. They may additionally serve on committees or participate in public forums to advocate for necessary changes in policy or systems' programs to better meet the needs of the children and youth who are served in their communities.

Petition (707 WIC): When a youth enters the juvenile delinquency system, the District Attorney files a petition. A "petition" in juvenile court is the same thing as a "charge" in the adult court.

Practice Activities: Practice Activities are the consistent application of the ICPM behaviors, with strategies and interventions identified in the ICFT plan, and result in positive engagement of families and youth, recognize and prioritize the strengths and preferences of children, youth, and family members, and result in the achievement of the goals of the ICFT plan.

Specialty Mental Health Services (SMHS): SMHS are Medi-Cal services available to children, youth, and adults. SMHS include medically necessary services to correct or ameliorate defects and mental illnesses or conditions available through the Medi-Cal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is available to beneficiaries under the age of 21 who are eligible for full scope Medi-Cal. (42 U.S.C. § 1396a (a) (43) and 42 U.S.C. § 1396d (r)). The following resources include descriptions and additional information on SMHS:

- California Code of Regulations (CCR), Title 9, Division 1, Chapter 11
- California Medicaid State Plan
- California Department of Health Care Services (DHCS) contract with the MHPs
- DHCS Mental Health Substance Use Disorder Services (MHSUDS) Information Notices, as well as former Department of Mental Health Policy Letters and Department of Mental Health Information Notices
- Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, Third Edition

Targeted Case Management (TCM): TCM is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to: communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; and monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons, and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

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

Therapeutic Foster Care (TFC): TFC is a short-term, intensive, highly coordinated, trauma-informed, and individualized service available for children and youth, up to age 21, who have complex emotional and behavioral needs, and who are placed with trained, intensely supervised, and supported TFC parents working through, and under, the direction of a TFC Agency. The TFC parent is a provider in the therapeutic treatment process of the child or youth, providing medically-necessary interventions that are described in the child/youth's mental health client plan.

Youth Partners/Youth Advocates: Youth Partners/Youth Advocates are individuals with lived-experience and work with children and youth receiving services from the public child welfare, juvenile probation, or mental health systems to provide support and mentoring that results in the child/youth's ability to speak for themselves, expressing their own vision for their future, and their strengths, needs, and preferences during the service process. They may additionally serve on committees or participate in public forums to advocate for necessary changes in policy or systems programs to better meet the needs of the children and youth who are served in their communities.

E. APPENDIX E: Katie A. Settlement Background

As a result of the Settlement Agreement in *Katie A. v. Bontá*, the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services. The settlement specifically changed the way a defined group of children and youth with the most intensive needs, referred to as “Katie A. subclass members”, are assessed for mental health services.

Pursuant to the settlement, subclass members were required to be provided an array of services, and specifically medically necessary ICC, IHBS, and TFC, consistent with the Core Practice Model (CPM).

The Settlement Agreement had the following objectives:

- Facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach;
- Support the development and delivery of a service structure and a fiscal system that supports a core practices and services model, as described in the previous bullet;
- Support an effective and sustainable solution, that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models;
- Address the need for certain class members with more intensive needs (hereinafter referred to as “Katie A. subclass members”) to receive medically necessary mental health services in the child or youth’s own home, a family setting, or the most homelike setting appropriate to the child or youth’s needs, in order to facilitate reunification, and to meet the child or youth’s needs for safety, permanence, and well-being;

Utilize the CPM principles and components, including:

- A strong engagement with, and participation of, the child/youth and the family;
- Focus on the identification of child/youth and family needs and strengths when assessing and planning services;
- Teaming across formal and informal support systems; and
- Use of child and family teams (CFTs) to identify strengths and needs, make plans and track progress, and provide intensive home-based services; Assist, support, and encourage each eligible child/youth to achieve and maintain the highest possible level of health, well-being, and self-sufficiency; Reduce timelines to permanency and lengths of stay within the child welfare system; and
- Reduce reliance on congregate care.

While the *Katie A. Settlement* only concerned children and youth in foster care, or at imminent risk of placement in foster care, **membership in the Katie A. class or subclass is no longer a requirement for receiving medically necessary ICC, IHBS, and TFC.** Therefore, a child or youth need not have an open child welfare services case to be considered for receipt of ICC, IHBS, or TFC.

F. APPENDIX F: Continuum of Care Reform Background

Continuum of Care Reform (CCR), including the public policy changes brought about by Assembly Bill 403 (Stone, Chapter 773, Statutes of 2015), brings together new and existing reforms to the child welfare services program designed in response to an understanding that children who must live apart from their biological parents do best when they are cared for in committed, nurturing family homes. Additionally, services delivered through involvement of multiple publicly funded organizations are most successful when services are coordinated by a single integrated service plan.

The Fundamental Principles of CCR Are:

- All children deserve to live with a committed, nurturing, and permanent family that prepares youth for a successful transition into adulthood.
- The child, youth's, and family's experience and voice is important in assessment, placement, and service planning. A process known as a "child and family team," which includes the child, youth, and family, and their formal and informal support network will be the foundation for ensuring these perspectives are incorporated throughout the duration of placement.
- Children should not have to change placements to get the services and supports they need. Research shows that being placed in foster care is a traumatic experience and in order for home-based placements to be successful, services including behavioral and mental health should be available in a home setting.
- Agencies serving children and youth including child welfare, probation, mental health, education, and other community service providers must collaborate effectively to surround the child and family with needed services, resources, and supports rather than requiring a child, youth, and caregivers to navigate multiple service providers.
- The goal for all children in foster care is normalcy in development while establishing permanent lifelong, familial relationships. Therefore, children should not remain in a group living environment for long periods of time.

Implementation Efforts for CCR will Occur in Stages Between Now and 2021 in Child Welfare Services and Probation Foster Care.

- Group care will be primarily utilized only for short term residential treatment in Short-Term Residential Therapeutic Programs (STRTPs) that will provide intensive individualized treatment interventions. STRTP placement option will be available to children and youth requiring highly intensive 24-hour supervision and treatment, designed to quickly transition children back to their own or another permanent family.
- Facilities seeking licensure as a STRTP must meet higher standards of care, be accredited, and be able to deliver or arrange for a set of core services including the mental health services that children need.
- Foster Family Agencies (FFAs) are re-envisioned to provide various levels of care to meet a broader range of individual child needs. Like STRTPs, FFAs will make available a core set of services that are trauma-informed and culturally relevant, including specialty mental health services. The FFAs, at the request of a county, may provide supports and services to county approved families, including relatives.
- Statewide implementation of the Resource Family Approval (RFA) process will improve selection, training, and support of families under a streamlined, family-friendly process for

approving families (including relatives) seeking to care for a child in foster care, whether on an emergency, temporary, or permanent basis. All families will receive necessary training and support.

- Resources are provided to counties to support the development and implementation of creative strategies for supporting, retaining, and recruiting quality relative and non-relative resource families.
- Services and supports are tailored to the strengths and needs of a child and delivered to the child/youth in a family-based environment. These services and supports will be informed by an integrated assessment, planning, and delivery process developed within an individualized child and family team structure.

Accountability and transparency of FFAs and STRTPs will be increased. This approach includes:

- Accreditation by a national accrediting body.
- Publicly available provider performance measures will be developed including consumer satisfaction surveys and defined service outcome data.
- An interdepartmental oversight framework will support local implementation.

G. APPENDIX G: Child Welfare Core Practice Model Leadership Behaviors

Foundational Behaviors for Leadership and All Agency Staff

1. Be open, honest, clear and respectful in your communications

- a. Use language and body language that demonstrate an accepting and affirming approach to all staff.
- b. Address individuals in person and in writing by the name, title and pronouns they request.
- c. Show deference to Tribal Leadership and their titles in written and verbal communications.
- d. Be transparent about your role and responsibilities and expectations of the agency.

2. Be Accountable

- a. Model accountability and trust by doing what you say you're going to do, being responsive, being on time and following federal and state laws.
- b. Be aware of and take responsibility for your own biases.

Engagement Behaviors for Leadership

3. Create a learning environment

- a. Demonstrate commitment to the professional development of staff by providing opportunities for staff to gain new knowledge and skills through multiple strategies (training, coaching, and leadership opportunities).
 - i. **Directors:** Ensure staff at all levels have the training, coaching and system support needed to consistently use the practice model.
- b. Create a learning environment in which mistakes are seen as opportunities to learn and grow.
- c. Foster a culture of thinking about the work, trying new things and new approaches for everyone that will make the agency more efficient and effective.
- d. Pause and take time to use the practice model to guide response and interaction, even in times of crisis.

4. Engage staff in implementation and system improvement

- a. Participate with staff on implementation and identify what you are doing to support and sustain the CPM.
 - i. **Supervisors:** Participate on the CPM implementation team.
 - ii. **Supervisors:** Establish unit CPM goals and communicate them in unit meetings and individual supervision.
 - iii. **Managers:** Create and participate in implementation team(s) for CPM.
 - iv. **Directors:** Establish division CPM goals and communicate them at every opportunity.

- v. **Directors:** Establish and maintain regular and frequent communication between the leadership team and the implementation team.
 - vi. **Directors:** Establish agency CPM goals and communicate them at every opportunity.
 - vii. **Directors:** Include staff in creation of the vision for CPM and explain how staff roles play a key part in creation of the vision.
- b. Use positive motivation, encouragement and recognition of strengths to show your support of staff implementation efforts.
 - c. Engage staff and managers at all levels to identify ways to improve system efficiency and remove barriers for staff.

5. Show that you care

- a. Demonstrate that you hear and care about the thoughts and experiences of staff and stakeholders (children, families, community members and Tribes) as they implement and sustain the CPM by establishing feedback loops and regular mechanisms to report progress and outcomes.
- b. Communicate hope and understanding by listening to staff challenges and engaging in solution-focused strategies to work together to solve problems.
- c. Show compassion and provide support and encouragement by listening to staff at all levels in the organization to hear their successes, concerns/worries and ideas about implementing, supporting and sustaining the model.
 - i. **Supervisors:** Provide a mechanism for unit staff to voice their challenges and successes with CPM and share those challenges and success with managers and directors.

6. Recognize staff strengths and successes

- a. Create regular opportunities to affirm agency organizational strengths and the efforts of staff and partners in their daily work.
- b. Foster leadership by staff at all levels, helping them recognize and gain confidence in their strengths.
 - i. **Supervisors:** Foster leadership of staff, helping them recognize and gain confidence in their strengths, for example, by providing opportunities in unit meetings to share some of the successful outcomes of their casework and the casework skills they utilized.
 - ii. **Managers:** Foster leadership of staff, helping them recognize and gain confidence in their strengths, for example, by providing opportunities to take on lead assignments that demonstrate their skills and abilities such as meeting with community stakeholders to describe CPM.
 - iii. **Directors:** Foster leadership of staff, helping them recognize and gain confidence in their strengths, for example, by providing opportunities to share their experience and mentor new managers.

Inquiry/Exploration Behaviors for Leadership

7. Seek feedback

- a. Meet regularly with staff and stakeholders (children, families, community members and Tribes) to understand their perspectives, develop consensus and create a path forward that is sensitive to the varied needs and concerns of all parties.
- b. Regularly elicit feedback from staff and stakeholders (children, families, community members and Tribes) by means of focus groups, surveys and community meetings.
 - i. **Supervisors:** Explore with staff any concerns they might have with the CPM in their child welfare role.
 - ii. **Supervisors:** Explore with staff barriers and solutions to implementing and sustaining the model.
 - iii. **Managers:** Keep track of and acknowledge barriers and challenges impacting the division and be transparent with staff about what can be accomplished and what cannot.
 - iv. **Managers:** Explore with supervisors and directors barriers and solutions to implementing and sustaining the model.
 - v. **Directors:** Keep track of and acknowledge barriers and challenges impacting the organization and be transparent with staff and partners about what can be accomplished and what cannot.
- c. Seek out and invite in input from staff in the organization:
 - i. **Supervisors:** Hold regular supervision meetings with staff to review casework for fidelity to the CPM and to actively seek input and develop solutions for issues that impact the social worker's ability to work effectively with children, youth and families.
 - ii. **Managers:** Hold regular supervision meetings with supervisors to review their unit's work and to actively seek input and develop solutions for issues that impact the ability of their unit to work effectively within the Division and with children, youth and families.
 - iii. **Directors:** Hold regular supervision meetings with managers to review the work of their division and to actively seek input and develop solutions for issues that impact the ability of their division to effectively deliver services to children, youth and families consistent with the CPM.

Advocacy Behaviors for Leadership

8. Promote advocacy

- a. Provide frequent and regular opportunities for Tribes, agency partners, staff, youth, families and caregivers to share their voice.

9. Advocate for resources

- a. Advocate for the resources needed to support and develop staff.
 - i. **Supervisors:** Provide information to management about gaps in staffing and necessary resources needed to implement CPM.
 - ii. **Managers:** Provide information to executive leadership regarding staffing gaps to support requests for additional resources to fill the gaps.
 - iii. **Directors:** Become a champion for the CPM by advocating for resources to support CPM practices and working to establish policies and practices that eliminate barriers for staff.
 - iv. **Directors:** In partnership with the implementation team, review planning goals and timeframes for training, coaching, policy and practice change so that expectations for staff are clear and realistic.
- b. Advocate for the resources needed to provide effective, relevant, culturally responsive services for families.
 - i. **Supervisors:** Provide information about gaps in services and resources needed to implement CPM.
 - ii. **Managers:** Actively seek information about gaps in services for families and advocate to executive leadership for resources.
 - iii. **Directors:** Ensure that all contracts are supportive of CPM practices and aligned with the CPM.
 - iv. **Directors:** Realign existing resources to support CPM.
 - v. **Directors:** Review existing and new initiatives to ensure that key components are congruent with and integrated into the CPM implementation and planning.

Teaming Behaviors for Leadership

10. Build partnerships

- a. Develop partnerships with effective community-based service providers with cultural connections to families receiving services from the CWS agency.
 - i. **Supervisor:** Gather information from staff and families about the services available in the community and work to identify new potential service partners.
 - ii. **Manager:** Under the direction of the child welfare director, sustain partnerships with effective community-based service providers with cultural connections to families receiving services from the CWS agency.
 - iii. **Managers:** Develop partnerships with stakeholders to support CPM implementation.
 - iv. **Directors:** Actively establish and facilitate community partnerships by initiating, attending, and participating in inter-agency collaborations to implement, support and sustain the CPM.

- v. **Directors:** Meet with the Court to develop an understanding of CPM and identify actions the Court can take to support implementation and use of the CPM.
- vi. **Directors:** Actively establish and facilitate partnerships with other Divisions in the Agency (such as Staff Development and Fiscal) to implement, support and sustain the CPM.
- vii. **Directors:** Ensure partner agencies receive information about the CPM and support them in aligning their work with the practice model.

11. Work with partners

- a. Work collaboratively with families, youth, resource families and cultural, community and Tribal representatives as active partners in the local implementation of the CPM and in ongoing policy development and operations.
- b. Engage with peers from other counties to share best practices and problem-solve.

12. Model teaming

- a. Model inclusive decision-making.
- b. Model and stress the importance of teaming by developing partnerships and MOUs and talking with staff about relationships and teaming efforts across divisions, across agencies and with external partners.
- c. Model use of teaming structures and approaches to implement and support the CPM.
 - i. **Supervisors:** Model teaming behaviors with other supervisors within the division and with internal and external partner agencies (Linkages).
 - ii. **Supervisors:** Model teaming at unit meetings through thoughtful listening, being respectful, including unit members as partners in the work.
 - iii. **Supervisors:** Develop and follow collaborative team-based processes for transition points within the system.
 - iv. **Managers:** Encourage teaming behaviors among supervisors and across divisions.
 - v. **Managers:** Develop policies and processes that facilitate and promote teaming across divisions, across agencies and with external partners.

Accountability Behaviors for Leadership

13. Listen and provide feedback

- a. Explore complaints, barriers and problems through a transparent process of inquiry that includes listening to those involved, identifying others who need to be included, developing a shared expectation about follow-up and reviewing other data and information in order to make balanced assessments and informed decisions.

- b. Be transparent to staff and stakeholders about barriers and why some requested changes cannot be made.
- c. Provide regular updates on any findings regarding complaints, barriers and problems, and share action steps that have been taken to address concerns.
- d. Respond to inquiries from staff and stakeholders (families, caregivers, agency partners, community and Tribes) within 24 business hours to acknowledge the concern or question and establish a shared expectation for follow-up.
- e. Meet with the workforce regularly and frequently to hear concerns and address them in a transparent manner, using a defined process and demonstrating actions taken to **address concerns**.
 - i. **Supervisors:** Provide information from staff to management.
 - ii. **Managers:** Inform executive leadership of the needs of the Division.
 - iii. **Directors:** Have a communication plan for ongoing dialogue with all Department staff and provide clear, frequent communication to the whole organization and be open to input.

14. Hold each other accountable

- a. Engage in a CQI process to evaluate the process used to implement the CPM, model fidelity and the effectiveness of the CPM.
- b. Identify and implement tools (dashboards, data points, charts) to monitor outcomes and measure effectiveness of the CPM.
- c. Engage stakeholders (families, youth, caregivers, Tribes and agency partners) in data collection and evaluation efforts.
- d. Support staff and hold each other accountable for sustaining the practice model by holding regular supervision meetings at all levels, and including practice behaviors in performance evaluation, professional development, coaching and mentoring activities, and progressive discipline.
 - i. **Supervisors:** Use supervision and coaching to address casework practices that are inconsistent with the CPM.
 - ii. **Supervisors:** Provide tools that help staff understand the link between the CPM and what is expected of them in their casework; use these expectations in supervision meetings, unit meetings and performance reviews.
 - iii. **Managers:** Provide regular updates or reports to stakeholders and partners as appropriate.
 - iv. **Directors:** Provide regular updates to agency partners and the Board of Supervisors as appropriate.

15. Monitor organizational effectiveness

- a. Identify and implement a transparent process to monitor for staffing gaps and plan organizational changes to ensure staff can meet demands of caseloads.
 - i. **Supervisor:** Review casework through individual supervision meetings and tracking logs, and provide information at unit meetings

and at division meetings to transparently develop recommendations for the manager and director about the work in the unit and the need for staffing increases or workload modification.

- ii. **Manager:** Review workload of the division through regular supervision and division meetings, review staffing and caseloads through tracking logs, and work to balance caseload by fair distribution of case assignments and by informing the director of needed staffing increases.
- iii. **Director:** Review the workload of the Department through regular supervision and through review of reports submitted outlining workload and staffing needs.

16. Monitor practice effectiveness

- a. Identify and implement a transparent process to monitor for practice model fidelity and effectiveness.
 - i. **Supervisor:** Gather information from staff and families about the quality of services delivered.
 - ii. **Supervisors:** Use tracking tools to follow practice model fidelity and outcomes on families being served by the staff in their unit.
 - iii. **Managers:** Develop and track measures that evaluate fidelity to and effectiveness of CPM.
 - iv. **Directors:** Accept responsibility for the implementation of CPM.
 - v. **Directors:** Monitor fidelity to and outcomes of CPM, and adjust implementation processes as needed.

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