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.

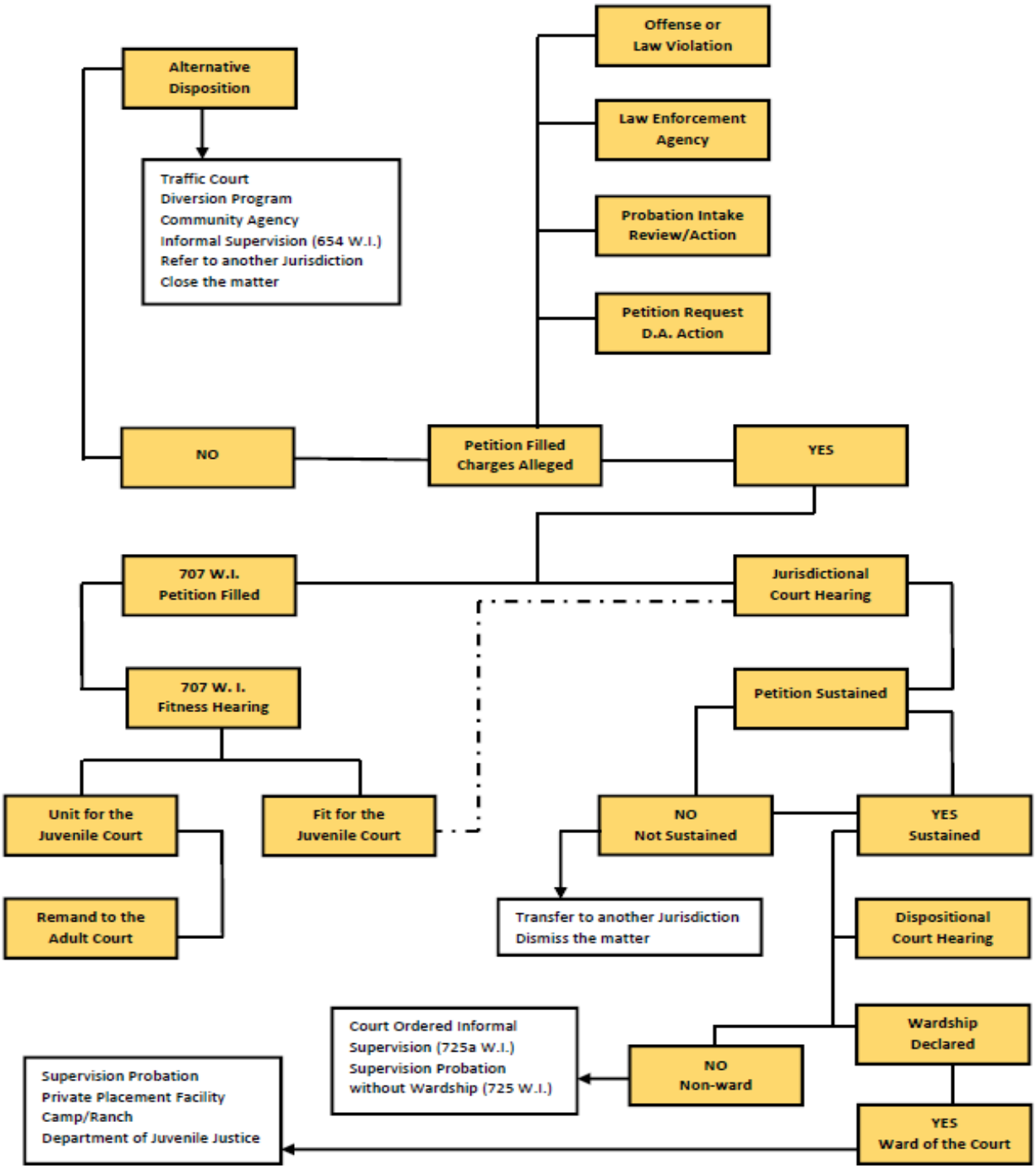
Crampton, D., & Jackson, W. L. (2007). Family group decision making and disproportionality in foster care: A case study. Child Welfare, 86, 51-69.

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).

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.

VI. ACKNOWLEDGMENTS

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Pathways to Well-Being Community Team

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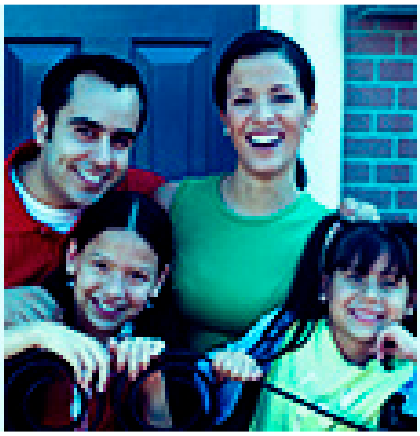
Chief Probation Officers of California

INTEGRATED CORE PRACTICE MODEL

Child Welfare, Juvenile Probation, and Behavioral Health

A Guiding Framework for Partners