

Permanency, Partnership and Perseverance:

Lessons from the
California Residentially-
Based Services
Reform Project

JUNE 2013

LESSONS LEARNED

ACKNOWLEDGEMENTS

California's RBS Reform Project has been a collective effort by hundreds of people. In the 8 years since the first planning meetings were convened, staff from at least a dozen counties, more than 20 private agencies, many school districts and every human services-related state agency, plus scores of parents and family members, youth representatives, and parent and youth advocates all worked together to develop first the framework for reform, and then the strategies for implementing the framework.

They attended meeting after meeting, collected data and prepared reports, attended and conducted focus groups, debated alternatives, talked with colleagues and friends, built spreadsheet after spreadsheet, and in general immersed themselves in the long-term learning and change processes needed to translate the initial vision of RBS into a pragmatic reality.

Because it would be impossible to accurately list every participant and her or his affiliation, this report must instead recognize the efforts of most of the participants *en masse*. Their commitment, energy and creativity made RBS happen.

Some of those providing leadership and technical support and serving as primary contacts at the state, local and provider levels during the course of this project and for the preparation of this report include:

From the California State Senate and Assembly, including the offices of Senate President Pro Tempore Darrell Steinberg and the Speaker of the Assembly John Perez:

Gail Gronert and Jennifer Troia

From or working with the California Department of Social Services:

Greg Rose, Karen Gunderson, Barbara Eaton, Will Sanson, Beth Fife, and Megan Stout

From the California Alliance of Child and Family Services:

Carroll Schroeder, Doug Johnson, and Debbie Clore-Myers

From Casey Family Programs:

David Sanders, Miryam Choca, Cheryl Blanchette, Peter Percora, and Dana E. Blackwell

From Sierra Health Foundation:

Diane Littlefield

In Los Angeles County:

Michael Rauso, Angela Shields, Lisa Parrish, Sherman Mikle, Jana Trew, Rachel White, Bill Martone, Debbie Manners, Bob Ketch, Regina Bette, John Hitchcock and Aaron Zaima

In Sacramento County:

Luis Villa, Lisa Bertaccini, Paul Vossen, Karen Dodrill, Geri Wilson, Gina Ramirez, Terry Clauser, Jim Martin, Dave Ballard, Glynis Butler-Stone, and Carmen Maroney, and Mark Conroy

In San Bernardino County:

Norm Dollar, Kathy Watkins, Christa Banton, Jeany Zepada, Michael Schertell, Michelle Williams, Neal Sternberg, David Monroe, Doug House, Tim Hougan, and Khush Cooper

In San Francisco City and County:

Debby Jeter, Bob Cabaj, Sai-Ling Chan-Sew, Liz Crudo, Mark Lane, Sue Ferren, Lisa Ellis, Ken Berrick, Katherine West, Nancy Rubin, Ken Epstein, Matt Madaus, Dan Gallagher, and Kent Eagleston

Contributing consultants:

Fred Molitor, Martha Kaufman and Patricia Miles

The lead consultants for the RBS project and the authors of this report are **Leslie Ann Hay and John Franz.**

For more information, go to www.RBSreform.org or contact Dana E. Blackwell at Casey Family Programs.

LESSONS LEARNED

TABLE OF CONTENTS



Table of Contents

Executive Summary	6
The Genesis of RBS	12
The RBS Theory of Change	14
Implementation Challenges	15
Creating the Local RBS Designs	23
External Factors Influencing the Experiment	26
Setting the Stage for Change	31
Organizational Impact	34
Lessons Learned	38
Next Steps	46
Conclusion	49
Appendix A	52
Framework for a New System for Residentially-Based Services in California	
Appendix B	70
Overviews of the Four County Models	
Appendix C	79
Site Interviews Summary – Part One	
Appendix D	93
Site Interviews Summary – Part Two	
Endnotes	104

LESSONS LEARNED

Executive Summary

Transforming the nature of group care for children, the ambitious goal of California's RBS (Residentially-Based Services) Reform Project, required dedicated public-private partnerships at both the state and county levels. The challenge faced by these partnerships was to design, implement and test new models for addressing the complex needs of youth who present with such severe acting-out behaviors that a 24/7 staffed environment is temporarily needed to ensure their safety and that of their families and the public while the process of recovery and reconnection is begun. These models were founded on the concepts of maximizing family contact and participation, and providing continuity of care across multiple service environments.

Although at this point the available data are insufficient to evaluate the overall effectiveness of the RBS model for meeting the needs of youth who otherwise might experience lengthy stays in high-level group care, a 2012 interim evaluation conducted by an independent agency shows positive trends with the following benefits noted:

- The majority of sites indicated that more than half of all client exits resulted in permanency.
- The number of RBS clients who left the residential component of the program for lower levels of care and then returned to a restrictive level of placement was very small, although, as is typical for youth with such intensive needs, the youth placement direction and types of living situations following enrollment varied widely and were often complex.
- No clients experienced a substantiated re-occurrence of abuse.
- The rate of positive placements out of all placements experienced by RBS youth during their course of care was very high in all programs.
- Preliminary outcome measures derived from instruments like the Child and Adolescent Needs and Strengths, Child Welfare (CANS-CWW) (based on data from the relatively small number of youth with a sufficient time of enrollment when the interim evaluation was collected) show initial positive changes for the target RBS population, including functional status, risk behaviors, child safety, educational progress, and mental health.¹

A qualitative assessment using focus groups with 74 people in a variety of roles from all four programs conducted in the fall of 2011 found that:

- RBS staff approach families and youth with a strength-based perspective that is infused with realistic optimism;
- RBS staff and the services they provided taught families how to live, work, play, and disagree together, and to problem solve and fight in healthy ways; and,
- Labeling of families was avoided; instead RBS staff members emphasized gaining trust, managing disappointment, building relationships and not giving up.

EXECUTIVE SUMMARY

The focus group findings suggest an impressive enthusiasm and understanding of the commitments and work involved. These early stakeholder perceptions of service quality and family outcomes are promising and show that the program has potential for benefiting a much larger group of children.²

Each of these pilot programs, and each county where they are located, operates in a slightly different way in order to test alternative strategies for implementing the RBS reform. However, in one way or another all of the programs include the following 7 elements:

1. Intensive and immediate family finding, engagement and involvement.
2. Transformed campus environments designed to support shortened lengths of stay and extensive family inclusion.
3. Flexible staffing systems that permit the simultaneous delivery of parallel on-campus and home and community-based services to prepare youth, families and their community support networks for reunification.
4. Research-based individual and family therapeutic services with the specificity and intensity required to address the complex issues of attachment, trauma, parenting, family conflict, neurobiological challenge, and emotional and behavioral development faced by these children and those who are or will become their permanent family caregivers.³
5. The capacity to provide continuity of care and crisis response wherever a youth may be located during the course of care, including interim placements in community settings such as treatment foster care.
6. The ability to provide aftercare assistance as needed following reunification.
7. Comprehensive, family-centered and strength-based care coordination from intake to closure.

Underlying these new programs is a redesigned infrastructure established on the foundation of an innovative public-private partnership. Perhaps the most important lesson learned in the development of the RBS model is that the nature of congregate care for children and youth cannot be transformed solely through the actions of providers, or by the intervention of public agencies.

A group home provider can't open its campus to family members and provide meaningful continuity of care in the community as youth move through interim placements and into their permanency option unless the public agencies responsible for managing and funding the care and services the youth and her or his family receive have the authority, capacity and flexibility to endorse and support those actions. Similarly, public child welfare, juvenile justice and behavioral health agencies can't precipitously establish a new jointly funded and administered resource with the complexity and coordination required in order to be effective with this target population unless they (and the elected officials who guide them) have reasonable agreement on **what** works with these youth and their families, and **how** it works.

Despite the very difficult fiscal conditions in which the state and counties found themselves during the development and implementation of RBS, these public-private partnerships produced innovative designs that not only incorporated a rich array of practice and process elements associated with improved outcomes for this population, but also the contractual, management and fiscal components needed to insure that the new programs would operate effectively in the context of each county's larger human services system, while meeting state and federal requirements for licensure and funding.

Over the course of the project hundreds of people actively participated in the process, including youth and family members, administrators, managers and staff from county child welfare, juvenile justice and mental health agencies, managers and staff from the private, nonprofit agencies that operated the group home programs that were to be transformed, staff and leaders from several divisions of the California Department of Social Services, and liaisons from the state legislature. They were organized into local stakeholder groups in each participating county, and a state level team that coordinated and supported the overall effort.

These groups established 10 new child and family programs in 4 counties (Los Angeles, San Bernardino, Sacramento and San Francisco) and their efforts are now providing the foundation for a comprehensive redesign of group care throughout the state of California.

The first program began enrolling youth and their families in June of 2010, and all have been in operation since March of 2011. By December of 2012 the programs had served over 260 youth and their families, and they currently have the capacity to serve more than 160 youth and their families at any given time, across their residential and community components.

Over the two and a half years since the first program began operation much has been learned about how best to meet the needs of this population and what it takes to establish and support programs to address these needs on a statewide basis.

This report describes the history of the development and implementation of California's RBS programs and offers suggestions for other jurisdictions seeking ways to address similar needs in their communities. The key lessons can be summarized in five statements:

- **Committed and sustained leadership is essential**—RBS represents a fundamental change in how state administrators, referring agencies, private providers and community partners help children their families achieve more positive outcomes. Only with the encouragement, confidence and collaborative spirit that strong leadership can provide will a community be able to make this transition.

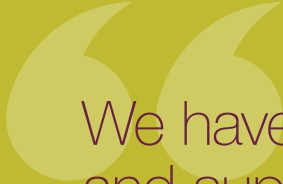
EXECUTIVE SUMMARY

- **Family involvement changes everything**—The traditional group home culture was characterized by a focus on meeting a child needs in a therapeutic environment in which family involvement was constrained; in contrast, RBS finds its strength in creating an organizational culture of inclusion that relentlessly values, seeks out, nurtures and honors family connections as the core of child well-being.
- **Permanency is a process, not an event**—Permanency is more than a placement, an address or a legal status. It takes perseverance and tenacity to build and support child-family relationships that can stand the test of time. RBS has created organizational, cultural and economic structures to ensure that children are safely connected to family with the belonging and sense of well being they deserve.
- **Clear and consistent communication drives success**—The rapid movement toward permanency that is the aim of RBS requires a high degree of coordination, communication and alignment among a multitude of players. This comprehensive approach relies on a tightly integrated team who can work seamlessly on meeting the complex needs of each child and their family.
- **Integrated programs require flexible fiscal systems**—Categorical funding streams in child welfare, juvenile justice and mental health are highly child-focused, making it difficult to respond in a truly family-centered manner. RBS represents an integrated model for reaching the goals of permanency, safety and well-being. Its innovations can only be implemented on a large scale if the constraints imposed by the inherent inflexibility of our current fiscal systems are overcome.

The California RBS Reform Project is demonstrating that while deep change is possible in human services, it requires enormous dedication by staff at all levels, a clear mission, a strong partnership, and consistent leadership. This change doesn't happen overnight, nor does it proceed smoothly; but it can be done. The local and state level RBS teams believe in what they are doing and are committed to developing better opportunities and outcomes for the children, youth and families whose complex needs are driving this effort. As their efforts and the independent evaluation proceed, more lessons will emerge.⁴

LESSONS LEARNED





We have a team to help and support us. Parents turn to other parents and tell us, make the most of the support to get your kids back.

— RBS PARENT PARTICIPANT

PERMANENCY PARTNERSHIP PRESERVERANCE

The Genesis of RBS

In November of 2004, as a result of growing frustration with the poor outcomes experienced by youth in long-term congregate care, the California Alliance of Child and Family Services convened a statewide coalition of concerned stakeholders to reassess the role of group homes⁵ in the public systems of care for children and youth. The diverse participants included family members, emancipated foster care youth, child and family advocates, county and state public agency officials, staff from the state legislature, and representatives from an array of private child and family service agencies.

Through a consensus process that continued over many months of meetings, the Stakeholders Coalition developed a framework for a new system of residentially based services (RBS) that would enhance services and expedite permanent family placement for youth needing time in a residential treatment setting.⁶ The RBS model was designed to reform the therapeutic environment in group homes in California, the way group homes are used, the range of services they offer, and the way they are reimbursed for these services.

The framework became the foundation for Assembly Bill 1453 (2007, Soto). This act authorized the California Department of Social Services to select four partnerships of county agencies and private providers to “develop voluntary agreements to test alternative program designs and funding models for transforming existing group home programs into residentially based service programs.” CDSS was directed to report back to the Legislature with a plan for statewide rollout of RBS based on the results produced by piloting these alternatives. Each of the four sites was able to propose its own approach as long as it contained certain key elements and was cost neutral based on what would have been spent had these children and youth remained in traditional, high-end, long-term congregate care.

At this time, Casey Family Programs became an active supporter of the RBS Reform effort, joining the Stakeholders’ Coalition and providing extensive strategic, evaluative and fiscal assistance with the hope that the lessons learned in the California experiment could be applied in other communities across the nation facing similar challenges.

After a rigorous application process, four counties were approved as demonstration sites: Los Angeles, San Bernardino, Sacramento and San Francisco. San Bernardino chose to develop its model with a single provider, the other counties each developed partnerships with 3 providers.

The impact of the recession on state and county budgets, two provider lawsuits related to payment rates, and the challenges that were encountered in creating funding models that met county, state and federal requirements delayed implementation of the new programs. However, all are now up and running and more than 260 children and youth and their families have been served through the 4 projects.

LESSONS LEARNED

As of January 1, 2013, the enrollment in each of the programs was as follows:

San Bernardino

Operations Began: **June 28, 2010**

Participating Provider: Victor Treatment Centers/Victor Community Services

Current RBS Census: 14 youth, 11 in residence, 3 in community

Sacramento

Operations Began: **September 16, 2010**

Participating Providers:

- Martin's Achievement Place
- The Children's Receiving Home of Sacramento
- Quality Group Homes

Current RBS Census: 24 youth, 16 in residence, 8 in community

Los Angeles

Operations Began: **December 2, 2010**

Participating Providers:

- Hathaway-Sycamore
- Hillside
- Five-Acres

Current RBS Census: 83 youth, 51 in residence and 32 in community

San Francisco

Operations Began: **March 7, 2011**

Participating Providers:

- Edgewood Center for Children and Families
- St. Vincent's School for Boys and San Francisco Boys' and Girls' Home
- Seneca Center

Current RBS Census: 27 youth, 14 in residence and 13 in community.

Because of the delay in start-up and the need to ensure a full evaluation of all four pilot sites, the California Legislature passed AB 2129 (Bass; Statutes of 2010) extending pilot project authority to January 1, 2015. The pilot project includes evaluation of client and cost outcomes of the four models to determine the feasibility of bringing a similar system to scale statewide.

The next section of this report will describe the questions that RBS has been designed to answer, and the programs that the demonstration sites developed to produce those answers.

The RBS Theory of Change

The RBS approach is based on the following theory of change:

- **If** intensive family involvement, transformed residential environments with shortened lengths of stay, intensive and individualized therapeutic interventions, parallel family and community services, and extensive post-placement follow-along and aftercare are combined in a well-coordinated model that insures continuity of care across service environments...
- **Then** children and youth who otherwise would experience multiple years in placement in high level group homes should be able to decrease their length of stay, return to their homes and communities, and achieve permanency, safety and well-being more quickly and reliably.

What makes RBS such an exciting and challenging experiment is that this hypothesis is being tested in on a large scale in multiple communities. Earlier research⁷ had shown the core elements of RBS (as stated in the “if” clause, above) are associated with better outcomes. The remaining questions that the RBS project is exploring include:

- What does it take to combine all of the elements in an integrated program?

And,

- Assuming these elements are combined, how can the use of that resource by public human service agencies be managed and funded?

LESSONS LEARNED

Implementation Challenges

Each of the program elements in the RBS Framework and the authorizing legislation⁸ represented an implementation challenge. Some of the challenges for each element are described below.

Intensive Family Finding, Engagement and Involvement

Family-centered care has become the foundation for reform throughout the human services system. Research gathered by the Stakeholder Coalition indicated that it might be the biggest driver of positive outcomes. But bringing families into the residential care environment presented logistical, philosophical and practical challenges for the group home providers who agreed to establish RBS programs.

Logistically, some of the questions were:

- 1. How to find and engage family members?** The relationships of many of the youth currently in long-term group home placement are highly disrupted, with little or no current contact. Some youth entering group home placement are doing so from challenging family situations. RBS staff had to find new and better ways to reach out to a wide network of people who care for and are willing to be part of a child or youth's recovery process, including but not limited to people who might be willing to become full-time caregivers.
- 2. Where would family members spend time when they came to the campus?** On most campuses there was no dedicated space for family members. The assumption had been that youth would generally see family on their visits home.
- 3. When would families come?** Group homes had previously scheduled activities that all of the residents were supposed to participate in, but hadn't necessarily arranged these events to include family members.
- 4. Who would spend time with the families while they were on campus?** Staff members would need to be available to greet and be with the family members.
- 5. What would families do while they were there?** It appeared that additional recreational and therapeutic activities that included family members would have to be added to the services provided in the residential units.
- 6. How would contact between family members and residents be managed, as well as contact between various groups of family members?** Group homes have regulations limiting contact between youth in residence and non-related adults, and there were issues of confidentiality and safety that had to be resolved.

The philosophical challenge was reflected in the reluctance on the part of some county and provider staff, both professional and paraprofessional, to encourage extensive family involvement. Many youth in high-level group homes have long histories of trauma and loss and have suffered harm carried out by some of their family members. These staff members saw the group home as a refuge

for the youth from all the bad things that had happened to them in the past. Many of the providers who joined the RBS process experienced a dynamic tension between the intellectual understanding that family involvement was essential and a fear that bringing in family could cause more problems than it might resolve.

The practical challenge was finding and engaging family members to become involved with some of the youth. Some of the demonstration sites had specifically chosen target groups of youth whose family connections were severely disrupted. There was a tendency on the part of some county and provider staff to say that these youth “had no family.” To overcome this challenge programs had to add extensive training on how to find parents and extended family members, determine whether contact with them would be safe for the children and youth, engage with them, and begin the process of helping them re-establish positive relationships.

More success comes from bringing together a larger network of family members, including non-biological kin and former foster parents who were all interested in the welfare of a given child or youth

Reaching out to find and engage family members and making room for them in the programs was a transformative experience for the provider agencies. They found that renewed and more extensive contact was associated with lower numbers of disruptive incidents in the group home and a decrease in the incidence of AWOL (absent without leave) behaviors. They also discovered that the family members were often able to figure out things to do with the children and youth. They played board games, baked cookies, made meals together, looked at family albums and just talked. They also found that family members of different youth began to form bonds with one another and developed natural support groups that continued to gather even after youth moved from the residential to the community component of the RBS program.

A key insight about family inclusion that emerged during the first years of operation was that it is important to look beyond trying to find one person or one couple to be the potential primary caregiver for the child or youth. More success comes from bringing together a larger network of family members, including non-biological kin and former foster parents who were all interested in the welfare of a given child or youth. Even when there is a specific

permanency target for a given child or youth (for example a parent or guardian who had maintained a positive relationship and was looking forward to being reunited) having extended family and friends involved to support that reconnection gives it more resilience. When there is no clear permanency target at the outset of planning, bringing together people who care about the child or youth creates a context from which a potential primary caregiver can emerge (for example an aunt may become more willing to bring a child into her home knowing that her relatives will be helping).

LESSONS LEARNED

Sometimes having the family network is essential even when there is a specific permanency target at the outset, because the family member or members who plan on becoming a child's primary caregivers find due to changed circumstances that they are no longer able to take the child into their home. Having the network in place provides alternatives when needed and back up support for those alternatives to give them more confidence in taking on the challenge of parenting the child or youth.

RBS Reform was driven by the goal of helping children and youth in or at risk of long-term group home placement achieve permanency, safety and well-being. The stakeholders quickly discovered that this goal could not be achieved without making the changes necessary to insure intensive family involvement for all enrolled children and youth.

this goal could not be achieved without making the changes necessary to insure intensive family involvement for all enrolled children and youth

Transforming the residential environment and shortening the length of stay: Becoming the “reconnection engine”

The second element of the RBS experiment was based on findings in the research that shorter lengths of stay were associated with better outcomes.⁹ The logic behind that principle was that the longer children and youth were away from their families and communities the harder it was for them to reconnect and the more they became socialized to a congregate care environment.

Transforming the group home environment to support rapid behavioral stabilization and reconnection with family and community required significant structural, procedural and philosophical changes by providers, as well as extensive training and support for program staff. Structurally, the facility had to be set up so that family members could come and go on a regular basis, and also so that children and youth would have more space to themselves while in residence so that they would have more room to resolve their own behavioral issues without accelerating the behaviors in the other residents.

Procedurally, the focus had to shift from creating a long-term stable living environment with a significant emphasis on positive peer culture to a short-term, intervention and change-focused environment with more individualization of plans and services as children and youth moved through the program.

Philosophically, the shift was from operating a safe place for children and youth to live together, to a transformative place where children and youth could begin a process of healing in partnership with their families that would continue with equal and perhaps even greater intensity after they left the facility.

The catch phrase that the Stakeholder's Coalition developed to capture the essence of this transformation was that through RBS group homes would be redesigned to become *reconnection engines* whose goal was to help children and youth and their families form positive and sustained

relationships. People began to say that a group home “was the train, not the station” to show that the children and youth in group homes should be seen as in transit to permanency.

Despite the apparent benefits of this new approach, several barriers stood in the way of implementing this component of the model.

- The residential care environment of most group homes was not designed with the goal of providing short, intensive interventions specifically intended to reduce a child or youth’s most challenging behaviors and rapidly return them to a community setting. Instead, group homes were designed to be just that – *homes*. Some of the programs traced their history back to orphanages founded by religious and philanthropic organizations in the late 19th and early 20th centuries. They were built to provide a safe and nurturing environment where destitute children could live and grow until they were adults or could at least care for themselves. Only in the second half of the 20th century did these agencies take on the role of behavioral intervention and the delivery of mental health services along with providing care and supervision.¹⁰ However, even with the shift to a behavioral health focus, many agencies retained the underlying culture of providing long-term care for children in a group setting through a process of alternative parenting interventions provided by paid staff.¹¹
- Some county and provider staff firmly believed that longer placements were better. When children and youth have severe emotional and behavioral problems based on a history of prior abuse and trauma, it was not unreasonable to expect that it would take years of treatment to resolve the underlying problems. RBS did not contradict the assumption that some of the children and youth would need an extended period of therapeutic support, but instead proposed that not all of this treatment needed to be provided in a residential setting. Thus to accomplish shortened lengths of stay it was necessary to make sure that other elements of the RBS model – continuity of care and support across multiple environments – were in place.
- Some of the children and youth needed a place to live after leaving the group home. Providers found that in many cases the behaviors that had required residential placement had stabilized before the caregivers who represented the permanency option for enrolled children and youth were ready to receive them on a full-time basis. Addressing this challenge required the implementation of another element of the experiment: intensive family finding and engagement to develop permanency options for the child or youth. But while necessary, intensive family involvement turned out to not be sufficient to achieve shortened lengths of stay. Besides bringing together a family network to support the youth, programs also had to develop interim community-based living options where youth could live while their primary caregivers got things into place for reunification. Some children and youth in the programs transition from the group home to regular or treatment foster homes, which came to be called “bridge care,” prior to moving into their permanent homes.

LESSONS LEARNED

- Attitudinal barriers on the public agency side presented another impediment to achieving shortened lengths of stay. Referrals to RBS came from the same county child welfare workers and probation officers who had sometimes worked years to find stable group home placements for the youth under their supervision. The children or youth might finally be attending school, participating in positive recreational activities and learning more pro-social skills. They did not want to lose all that had been gained on a gamble that a new approach could produce better long-term outcomes.

The answer to these attitudinal barriers was to overcome the assumption that all services would stop when children and youth left the group home and the belief that residential services were the only way to stabilize a child or youth's behavior. RBS implementers needed to convince the referral sources that a sense of belonging to family—knowing that someone besides paid service providers cares about them—could be a potent motivator. Continuity of care and intensive in-home treatment and support were necessary to insure a positive transition that maintained and built upon the gains made during the stabilization period in group care, but those things had to be offered in the context of building family involvement, competence and confidence.

RBS meant a shift from a readiness model that assumed that all of a youth's needs had to be resolved before she or he could leave the group home, to a recovery model that saw the residential stage as the first step in a larger course of care.

Intensive Use of Evidence-Based Therapeutic Interventions across the Environments of Care

The RBS Stakeholder's Coalition recognized that the children and youth enrolling in RBS and their families would present with serious emotional, behavioral and interpersonal concerns. For that reason the clinical component of RBS had to be robust and family-centered and the treatment and services had to follow the child or youth and family as the child or youth's living environments changed in order to continue the progress that was being made. Although it made sense to have continuity in the therapeutic alliances that were begun during stabilization in the residential component, implementing this continuity presented a significant challenge.

In traditional residential settings, therapeutic services were attached to the group home. When youth leave the group home it was expected that other providers would pick up their clinical needs. Most billing and regulatory protocols were based on this premise: when youth were living in the group home, they would receive clinical services from group home staff. When they moved to the community, they would get help from community providers. The providers implementing RBS had to restructure the roles and scheduling of their program's clinicians and work with the county mental health departments to make it possible to transition clinical and family support services with the child or youth and family as the child or youth's living situation changed.

In many conventional residential settings, clinical services were an adjunct to the overall activities of the group home. Youth visited clinicians with offices on the campus in much the same way as

they would an outpatient therapist, but the connection between that counseling and the program's other activities was limited. There was a treatment plan with the therapist and a separate behavioral plan with the residential staff: group homes were residential care with a clinical component. The intent of the RBS experiment was to invert that model. RBS would be an ongoing clinical and family reconnection intervention with a residential component. To implement this transformation, it was necessary to develop a comprehensive care plan that would align everything going on in a child or youth and family's life across service modalities and environments of care, and focus all of these efforts on achieving and sustaining permanency, safety and well-being.

interventions needn't all be formal services.

These interventions needn't all be formal services. For example, in the observations collected in Appendix C there is the story of a young person who needed a quiet place to go when he was feeling agitated. Rather than continue the use of an isolation room in the group home (which was dropped because families don't have seclusion rooms in their homes) staff gave the youth a pup tent where he could go and calm down. When he moved home, he took the pup tent with him and used it for a couple of weeks until he felt comfortable at home, then put it away.

Parallel Family and Community Services

The premise underlying this element of the RBS Reform model was simple: to be effective it was necessary to develop the landing pad for children and youth at the same time as the launching pad was being prepared. Especially when children and youth's relationships with their families and primary caregivers were highly disrupted and little or no contact had been taking place for years, whoever was going to care for the child or youth would need as much help getting ready to bring them into their home as the child or youth was going to need to get her or his behaviors sufficiently stabilized to be able to make that move.

The practical challenge in implementing this element of the model was figuring out how to have enough staff to cover both the residential and community service operations within the funding limits that had been established. The goal was to have some of the same staff members spending time in the community with the child or youth and family as well as working with them in the residential unit.

As the local implementation teams in the demonstration sites wrestled with this challenge they developed the concept of the "mobile therapeutic milieu." Traditionally, therapeutic milieus (meaning the overall atmosphere in which care was provided) were established within the walls of a hospital or residential treatment center and maintained by the patterns of staff interventions as well as the physical constraints of the closed ward. Instead, in the new models the staff who help children and youth stabilize their behaviors in the group home travel with the children and youth to their homes and there transfer the insights that have been gained in the residential unit to the people who will be caring for the child or youth in the community.

New parenting strategies can be practiced on campus with the family and tried out in the home with the support of the mobile RBS program staff who provide guidance and support and insure everyone's safety while the child or youth and family are working things out.

LESSONS LEARNED

Extensive Post-Placement Follow-Along and Aftercare

The practical experience of the RBS Stakeholders Coalition reinforced research findings that showed that much of the money invested in helping children and youth stabilize their behaviors in group homes and residential treatment was wasted if consistent follow-along and after care services were not in place to support reunification.¹² It was not unusual for children and youth to go back home and do okay for a while, only to have things blow up a few weeks or months later as stressors in the home built up once again because nothing was in place to help the family deal with emerging or re-emerging issues.

For that reason the RBS Reform model includes both intensive in-home services to stabilize placements immediately after reunification and ongoing aftercare support to help children or youth and families get through the inevitable ups and downs that will be part of the process of rebuilding the family system.¹³ The intent is that rather than being an abrupt change, the shift from the residential placement to the community placement will be more gradual with the parallel community services lasting longer each month until they become in-home services.

In order to support follow-along and after care services, every program's fiscal model had to include a community care component and the cost of community care had to be figured into the overall RBS rate.

Comprehensive Care Coordination

As noted earlier in the section on intensive therapeutic interventions, children or youth with complex needs and their families are usually involved with multiple service systems and as a result have multiple service plans. Often there is a lack of coordination among those plans. For this reason the RBS Stakeholders included the concept of comprehensive care planning in the model for reform.

The point of comprehensive care planning is not to establish a single plan of care that covers everything that every service and educational resource is providing, but to create a scaffold in which the key elements of all of the plans could be collected, compared and aligned and a process for helping everyone get on the same page.

In order to accomplish this, each of the programs developed a care coordination process, designated one or more staff persons who were responsible for facilitating this process, and a created a format for capturing the components of all of the plans affecting a child or youth and family and keeping track of the progress they were making in accomplishing the goals in those plans.

Coordinating planning with community partners was difficult because they had their own systems and approaches, timelines and mandates. But even implementing comprehensive care coordination within the agency operating the RBS program was difficult because:

- Adding any additional documentation tasks to the RBS program staff's workload was unpopular.

- Records for the individual residential, social services, clinical and on-grounds school units were usually kept separate from one another and controlled by different state and federal regulations.
- The processes for developing and reviewing each plan were on separate timelines.
- Each plan looked at different areas of the child and family’s life and so paid attention to different types of information.

To overcome these obstacles, the leaders of the local implementation teams in the pilot sites first had to convince both their community partners and other staff in their agencies of the importance of aligning everyone’s efforts. Intellectually this was easy to do. Everyone agreed that they should be on the same page when helping a child and family. But logistically the challenge was working with everyone to find the most efficient procedures for gathering critical information without pulling in too much. The answer was to use family team meetings¹⁴ strategically and show community and in-house partners how well-facilitated meetings could help everyone get the information they needed more accurately, effectively and efficiently than could be done by having many separate meetings. In addition, by working together, partners often found opportunities for synergy between their supports and interventions and also uncovered hidden conflicts between what they were trying to do and what another partner was working on with the youth or family.

This is not to say that continuity of care means that the staff from the RBS program will be the exclusive or permanent source of services and supports in the child’s transitional or ultimate living environments.

Continuity of Care Across Environments

Maintaining therapeutic relationships means that the staff who bond with a youth and family while the youth is stabilizing in the residential component continue to work with them after the youth moves home, or while the youth spends time in a treatment or regular foster home for bridge care prior to moving to her or his permanent home.

This is not to say that continuity of care means that the staff from the RBS program will be the exclusive or permanent source of services and supports in the child’s transitional or ultimate living environments. The goal is to help children, youth and families transition to more natural, informal and local supports and resources at a pace appropriate to each family’s specific situation and needs. From the outset of a youth’s enrollment, care teams engage with their families in developing a pattern of interventions and supports that will help the youth stabilize their most challenging behaviors, and re-establishing and expanding the positive connections and relationships that will be needed for the families to heal and prosper. The care teams learn from the families and the families learn from the teams as

over time family members increase their capacity to play roles and create similar conditions in the home to those that were tested and developed in the structure of the residential setting. All the while the families, with the assistance of the RBS staff, are building a community-based network of formal and informal support to sustain them post enrollment.

LESSONS LEARNED

In developing their models for implementing this component of the RBS Framework, the participating programs had to wrestle with a number of practical challenges such as:

- Working out staff schedules and roles
- Addressing funding issues
- Cross-training staff so they are able to work effectively in both the residential and community environments.

An additional challenge began to emerge as programs were up and running and children and youth began leaving the group homes for community placements – especially when the move was into a transitional placement in a treatment foster home.

A few of the providers had their own treatment foster homes and so could provide continuity of care by adjusting staff assignments within their agency. But when the treatment foster home was operated by a different agency, that agency naturally expected to take over care of the child or youth, develop and implement its own treatment plan, and receive reimbursement for the delivery of the care in that plan.

From this experience the RBS Stakeholders have learned that continuity of care means more than providing staff with sufficient training and flexibility to work in multiple environments. It also means establishing partnerships with community providers to insure this continuity while respecting the roles, boundaries and responsibilities of all of the partners.

continuity of care means more than providing staff with sufficient training and flexibility to work in multiple environments.

Creating the Local RBS Designs

Besides authorizing a pilot study to test the effect of integrating the core elements of RBS, AB 1453 was also designed to compare and contrast different approaches to putting those elements into action. The legislation directed each applicant site to propose its own strategy for operating and funding an RBS system. CDSS was then to review what worked and didn't work in the designs and use that information to develop a new statewide model for group home services.

In order to be authorized to put an RBS system into action, each site had to develop a voluntary agreement signed by the provider agencies and the participating county departments, including at least the mental health and child welfare departments. These agreements described in detail the target population to be served, how county agencies would select children or youth for referral to the RBS providers, how the providers would insure the provision of the core RBS elements, and how the ongoing operation of the system would be managed to ensure compliance with the approach described in the voluntary agreement and to protect the safety and well-being of the children and youth being served.

In addition, each site had to develop a funding model for their RBS system that included a rate structure and a demonstration of projected cost containment. The rate structures had to take into account the fact that children and youth might live in a variety of locations during their course of care, including the residential setting, treatment and regular foster homes in the community, and at home with their permanent caregivers. The billing process had to be sufficiently detailed to insure that appropriate and accurate claiming could be made for federal Title IV-E reimbursement for the statutorily allowable portion of the costs of care and supervision for group and foster home placements. The funding models also had to distinguish between services that were eligible for federal out of home care reimbursement, those that could only be funded by state and county child welfare funds, those that could be paid for through Title XIX Medi-Cal under the Early and Periodic Screening, Diagnosis and Treatment benefit (EPSDT), and how the match for all those payments would be provided. The funding models also had to identify any services that would be paid for through other sources, such as county general funds, California's Mental Health Services Act (MHSA) funds, or IV-E Waiver provisions.

The alternative funding models developed by the demonstration site local implementation teams were in contrast to the Rate Classification Levels (RCL) system that has been used to determine payments for group home placements in California since 1990. In the RCL system, providers are assigned points based on their staff-to-child ratio, and the qualifications of staff members. The point score translates into a rate level of from 1 to 14 with different monthly payments for board and care of children at each level.¹⁵

The RCL system has remained in place for as long as it has because it is objective and the points are easily calculated. However, it had two shortcomings that motivated providers in the demonstration sites to work with the local implementation teams to come up with alternatives.

- The RCL system reinforced rigidity in staffing roles and functions because of the way the points were counted. This made it difficult to develop innovative service options, especially in programs that were serving children and youth with complex emotional and behavioral issues nor did it permit providers to be paid for portable service teams.
- Although the statute setting up the RCL system called for regular cost of living raises in the rates, those increases were not enacted, making it difficult for providers to deliver the amount and duration of care children and youth in the programs needed.¹⁶

AB 1453 allowed counties and providers to seek waivers as needed, including waivers of California's RCL rates and funding provisions. In exchange, each proposal had to be submitted for approval by CDSS to ensure compliance with other applicable federal and state laws and rules that could not be waived and to ensure that the safety and well-being of the children and youth in the pilot projects would be protected.

It took nearly two years for the sites to develop their program designs and funding models and for CDSS to process and approve them. This was because the existing funding systems are not designed to support the delivery of services that insure continuity of care across multiple living environments. Child welfare payments are based on the type of placement while mental health

LESSONS LEARNED

services are based on the mental health needs of the child. To get RBS off the ground as a unified resource, each of the Local Implementation Teams in the sites had to assemble ad hoc, manually-entered data management systems for parallel mental health and child welfare invoicing and contracting streams and then create collaborative management structures to reduce conflicts and contradictions in administration of the funding streams and the services they supported. While the work-arounds they developed were creative and sufficient to get the pilot projects up and running, the county agencies have said that they would not be sustainable if the projects were brought to scale. Something more efficient and more fully integrated with their automated systems would be needed.

The Four Models

The programs developed by the four sites for delivering the core elements of RBS varied in a number of ways, including:

- The characteristics of the target populations to be served
- The sources of referrals to the RBS programs
- How county agencies decided which children and youth to refer to the RBS programs and which staff would be responsible for supervising the care of children and youth once they had been enrolled in the program
- The funding rates established between the counties and the providers
- The expected duration of enrollment in the residential and community components of RBS as established in the contracts between the counties and the providers and any performance contingencies contained in the contracts
- How the providers staffed their programs
- The physical layout used by the providers for the on-grounds component of the program and additional services offered by the providers on their campuses or in the community
- The providers' relationships with community partners
- The process used by the provider for developing and implementing RBS services with each enrolled child and family
- The systems used by the providers for documenting and invoicing for services
- The relationship among the providers in the counties using multiple providers

Appendix B contains one-page summary descriptions of each of the four demonstration sites that list the public agencies and private agencies involved, the target population to be served, the funding rates that were established, and the capacities of the programs.

All four models include a provision that will allow youth who have been placed in the community to return to the group home for short periods (up to 14 days) of behavioral stabilization when necessary without a disruption of the RBS enrollment or their community placement.

One of the innovations found in several of the sites is a Family Connections Center, a place at the residential facility where families can spend time on an informal basis with their youth and with other families.

Each of the private agencies have developed an array of basic and specialized services for family finding, engagement and inclusion, onsite and community-based treatment, youth mentoring and supervision, care coordination, and linking with community service partners and schools. These innovations were shared with the other RBS providers at semi-annual RBS forums to insure cross-fertilization of insights.

One of the innovations found in several of the sites is a Family Connections Center, a place at the residential facility where families can spend time on an informal basis with their youth and with other families. Creating these welcoming spaces has had a big impact on the atmosphere on the campuses.

The San Francisco site has developed a set of manuals for the operation of their model, including a practice guide for the private agencies and a utilization guide for the county agencies. These manuals have been posted on a website shared by all of the participants (www.rbsreform.org).

Each county uses a different fiscal management system and service utilization approach, and each provider uses a different system for developing, documenting and tracking service plans. This makes detailed comparisons of the systems more difficult but does provide a ready test of different funding strategies. As implementation of the models proceeds, CDSS and a designated stakeholder group is assessing the results of the demonstrations to design a statewide framework for providing group home services.

External Factors Influencing the Experiment

As a large-scale system change effort, the RBS Reform Project has been influenced by a variety of factors in the external environment in California and the nation, many of which presented significant impediments. Staff members at the state and county agencies and the providers have demonstrated remarkable perseverance and dedication as they pushed ahead through each barrier. These factors include the impact of the 2008 recession, the federal lawsuits brought by the California providers to obtain an increase in the group home rates, the settlement of another long-running federal class action lawsuit brought to improve access to mental health services for children and youth in foster care, and dramatic changes in the state budget.

LESSONS LEARNED

The impact of the recession

The overarching challenge for the reform effort was finding ways to keep going in the midst of a recession. Dramatic budget cuts and staff reductions in the state and county agencies occurred each year while the projects were being established. This meant that the remaining county and state staff members had to cover many more responsibilities and diminishing administrative support.

Because the RBS Reform effort required big changes in the fiscal and program infrastructure in which group home care is provided, an immense amount of internal work was needed at the state and county levels to:

- Create new budget management protocols
- Design invoicing and quality assessment tools
- Develop alternative strategies for utilization management
- Open different channels for communication between fiscal and contract oversight offices at the state and county level
- Prepare and present proposals for approval by the county board of supervisors and state agency administrators
- Develop memoranda of understanding
- Prepare requests for proposals and carry out fair contracting procedures
- Award and monitor contracts
- Continually update budgets and fiscal models as circumstances and requirements changed
- Orient and train new partners

This work took place as departments, divisions and offices were combined or eliminated following reductions in staffing.

These challenges did result in attrition. Originally the demonstration site in the Bay Area was to be a consortium of 5 counties. Over the two years that it took to develop the fiscal and program foundation for RBS implementation, one after another of the consortium members dropped out because they didn't have the staff or resources to continue nor the local funding to match projected increases in EPSDT expenditures for RBS enrolled youth. In the end, only San Francisco was able to remain in the project.

Group home rate litigation

The same agency (California Alliance of Child and Family Services) that was coordinating the RBS Stakeholders Coalition also brought a sequence of two lawsuits against the California Department

of Social Services in federal district court arguing that the amounts being paid for group home care had not been raised as required under federal law to reflect increasing costs of care in the years since the RCL rates were first established. Some of the motivation for participation in the RBS model on the part of providers was to be able to negotiate a new rate that reflected actual costs, in addition to moving beyond the inflexibility in staffing imposed by the RCL point system. The lawsuits progressed slowly through the district and appellate courts but were always in the background during discussions about RBS Reform. Despite this, neither the state staff involved in the RBS project, nor the provider representatives ever let the legal actions stop them from working together to solve any of the fiscal and programmatic challenges involved in creating the new models.

In the spring of 2010, after a series of district and appellate court rulings, CDSS was compelled to implement a 32% increase in group home rates under the RCL system so that the payments received by group homes covered the current costs of care. The final decision came down in the midst of the rollout of the RBS projects.

This result influenced the negotiations around rates as the final contracts were being prepared in some of the sites and also had some collateral effects:

- The lawsuit changed the standard for measuring cost neutrality. During the two years that the fiscal models for each of the sites were being created, innumerable calculations were made to determine how much could be paid to providers for RBS services while still ensuring that the cost of operating an RBS program would be no more than the cost of maintaining a child or youth in an RCL 12 to 14 group home for the same period of time. With the results of the lawsuit the baseline for cost neutrality was raised by about 30% to reflect the new RCL rates, which made it less difficult for the providers to hit their cost neutrality targets.
- The lawsuit paradoxically reduced the net payments to RBS providers in certain circumstances. In addition to the lawsuits to increase group home rates, a similar lawsuit to raise foster care rates was also successful. This had an impact on the RBS projects. Many of the models established a community care rate that included the cost of foster care. When the foster home rate went up, the net received by the RBS provider was reduced for children and youth who were placed in foster care before transitioning home.
- While some providers and county placing agencies around the state were committed to the concept of transforming group home care to incorporate continuous family involvement and multi-environmental service delivery, others preferred the existing model but supported the RBS approach because it seemed like the only viable alternative when many providers were going out of business because of the low rates. With the rate increase, support from some of the reticent providers began to wane. However, faced with a requirement to pay higher AFDC-FC rates to group homes to cover the actual costs of care, more county placing agencies became interested in developing alternatives to the existing group home model. Still, none of the 10 providers or the 4 county placing agencies that had agreed to implement RBS chose to withdraw from the program as a result of this change in the fiscal environment.

LESSONS LEARNED

Class action litigation on behalf of foster children

Katie A. v. Bonta, a long-standing class action lawsuit on behalf of foster children in California, was resolved in 2011 with a settlement agreement that required improvements in the behavioral health services offered to children and youth in or at risk of foster home placement, including those in group homes.

Under the settlement, California will make two types of mental health services, “Intensive Home-Based Services” and “Intensive Care Coordination,” available to certain children under Medicaid. The state will also determine what parts of “Therapeutic Foster Care” services are covered under Medicaid and provide that service to certain class members.

The settlement also requires California to improve its system of care for providing mental health services to foster youth by coordinating decision-making among state and local agencies, improving guidance to mental health care providers, and developing a consistent team approach to meeting the needs of eligible children and youth and their families.

Under the settlement, a workgroup began preparing a plan for implementing a new mental health system of care that is to be established within 3 years. Since the youth served in group homes, including those in RBS programs, fall within the *Katie A.* class, and since several of the core features of RBS, including comprehensive care coordination, intensive therapeutic services, and the use of Intensive Treatment Foster Care, are in line with the *Katie A.* requirements, it is likely that experiences with implementing RBS will help inform that workgroup’s efforts. Conversely, the plan that the workgroup devises for implementing *Katie A.* will likely influence the approach taken by CDSS when they develop a statewide model for the reform of group home services based on the results of the RBS pilots.

State-wide group home redesign effort

When the RBS Reform effort began in 2007, it was assumed that the results of the evaluation of the demonstration sites would be available by 2011. The intent was to use that data to inform planning for a statewide reform of the group home system. But as the recession took its toll and the reality of the difficulty of restructuring the fiscal and program infrastructure set in, it became apparent that evaluation data from the demonstration sites was going to be delayed by about 2 years, which would have meant a similar delay in creating a new statewide model.

In the spring of 2010, driven by a growing consensus that more rapid action was needed to insure improved permanency and better long-term outcomes for the children and youth who were placed in group homes, CDSS launched a strategic planning process to address statewide group home reform. This ongoing project is staffed separately from the RBS effort, but will draw upon the knowledge that has been gained so far about the organizational and structural changes that will be needed for implementation of any new model. As results from the interim evaluations of RBS outcomes continue to emerge, they will be fed into the statewide reform effort to assist in the development of a new system to replace the existing group home and RCL model.

State Budget Changes

The 2011 California state budget had several major changes in funding for human services, the impact of which are still being determined.

The biggest change is realignment. Through realignment, responsibility for certain human services programs is being shifted from the state to the counties. Although mandated in the budget that passed at the beginning of 2011, the plans for implementing realignment are still being developed. Many in county government fear that it will mean a significant cost shift from the state budget to the counties' budgets. Other than the state retaining licensing authority, it is unclear who will be responsible for the other aspects of human services program administration, including group home services. The uncertainty around realignment is tending to stifle creativity until the parameters and effects of this change are known.

Another important change is the end of AB 3632. AB 3632 was a California state statute that established a school-based mechanism through which many children in California accessed mental health services. Essentially it was a follow-up to the Individual Education Plan (IEP) process in the schools that enabled families to develop mental health treatment plans for their children so that the children could make reasonable educational progress in their classes. These plans could be used to obtain outpatient mental health treatment, in-home treatment, and even residential treatment. They were administered through the county departments of mental health in cooperation with the schools. Eligible services were billed through the Medi-Cal EPSDT option.

School districts are now responsible for developing and implementing mental health plans for students. They can do this on their own or contract with county mental health departments for this service. Some of the RBS models included options for enrollment via AB 3632. Access will now have to be either through the child welfare or juvenile justice systems, since none of the RBS sites included school districts as referral options in their models.

The 2011 budget also dissolved the state level Department of Mental Health, transferred some of its functions to the California Department of Health Services and changed the way that California's mental health service funds could be accessed and used. Only one of the demonstration sites (San Bernardino) uses these specialized funds on an ongoing basis to help fund their program, but the change may impact sustainability planning for all of the sites and the statewide strategic planning process.

Taken together, all of these changes in the larger human services environment place RBS in uncharted waters heading into 2013 and beyond. The substantive elements of the model remain intact, but new strategies for combining, funding and managing those elements will be needed for the approach to continue after the demonstration period.

LESSONS LEARNED

Setting the Stage for Change

The RBS Reform project is testing the implementation of large-scale change on both the practice and the system levels. On the practice level it is an experiment to see if combining the multiple elements from the RBS Framework in a unified program will help children, youth and families achieve and sustain permanency, safety and well-being more effectively than traditional group home services. On the system level it is an investigation of a different approach to bringing about changes in the structures and procedures used to operate and fund group home services in California.

The need to improve our understanding of what it takes to translate evidence-based practices and concepts from controlled clinical settings to the field has taken on increasing importance. Study after study is showing that innovations in human service and mental health practice do not propagate easily or reliably. The more multifaceted the model, and the more it challenges or is in conflict with existing patterns of behavior, the more difficult it is to bring about large scale change.¹⁷

The discussion of the implementation of the individual elements of the RBS model in the previous section of this paper illustrates some of the diffusion challenges that each one of those practice changes encountered. The purpose of this section is to describe some of the organizational challenges the teams implementing RBS at the state and local levels had to address.

The System-Level Theory of Change

The theory underlying the system change aspects of the RBS hypothesis was that if the active involvement of multiple agencies, systems and stakeholders are needed at both the state and local levels of operation to develop and implement a complex service innovation, then the best way to bring about transformation was to assemble a coalition of change agents, generate a set of guiding principles for reform through a consensus process, and create a flexible playing field where local opinion leaders can develop different strategies for putting the principles into practice.¹⁸

This is a different approach than is generally used when practice innovations are being transferred into the field. Typically, an evidence-based practice model is developed and tested in a controlled setting by a specific group (called the “purveyor” in the implementation science literature) who then teaches the model to professionals and agencies in the field and monitors their practice for fidelity. This is an example of change from the top where there is a clear standard for what the practice should look like, and implementers can be rated on the degree to which they match that standard.

System change for RBS started from the middle. Rather than being asked to adopt a full-blown practice model, each of the demonstration sites was given the opportunity to craft their own methodology for putting the core concepts of RBS into operation. The advantage of using a change from the middle strategy is that it engenders a higher level of ownership in those who are carrying it out and encourages continuing innovation. The disadvantage is that it is harder to control fidelity.

The Stakeholders Coalition delegated the task of managing the system change process to three kinds of teams. There were two state level teams: an *Executive Team* (the ET) made up of

The advantage of using a change from the middle strategy is that it engenders a higher level of ownership in those who are carrying it out and encourages continuing innovation. The disadvantage is that it is harder to control fidelity.

leaders from CDSS, Casey Family Programs and the California Alliance of Child and Family Services, that provided overall leadership, and an *Implementation Leadership Team* (ILT) made up of the people coordinating the RBS programs in each of the four sites, managers from CDSS, and the state level program consultants, who met regularly to maintain communication, share insights and accomplishments, address challenges, and brainstorm solutions. Another type of team was formed in each of the four demonstration sites: *Local Implementation Teams* (LITs) consisting of public and private agency leaders and family and youth representatives who were responsible for establishing the RBS programs and putting them into operation.

Although the implementation process at both the state and local levels went through lots of ups and downs and often exhibited moments of conflict and chaos, the teams were ultimately successful in putting the RBS programs into operation. Looking back at this process, six strategies can be identified that summarize the approach they used to accomplish the necessary changes:

START WITH A BIG NEED EVERYONE AGREES IS IMPORTANT

Achieving better outcomes for the children and youth who now spend years in group homes is a mission that united people from a broad spectrum of perspectives. While different stakeholders had different opinions about what should be done, ranging from doing away with congregate care altogether to dramatically increasing the funding for group homes, everyone agreed that things had to change.

RECRUIT STAKEHOLDER CHAMPIONS

The RBS project would not have happened if not for the character, determination, skills, and knowledge of the champion leaders who devoted so much of their energy and resolve to making it happen. Because RBS Reform touched on many systems at multiple levels, champions were needed from the legislature, from CDSS, from the provider agencies, from the county child welfare, mental health and juvenile justice agencies and from consumer advocacy groups. Every time RBS reform seemed stuck at the state, county or provider levels (and given the barriers, this happened frequently) one or more of the leaders would step up and find a solution that would allow the process to continue.

DEVELOP A SHARED FRAMEWORK

The RBS Framework developed by the Stakeholders Coalition was a key document for implementing the change process. It was a social marketing tool that told new audiences what the problem was and how the stakeholders wanted to address it. This made it much easier to obtain legislative support for RBS Reform. (In fact the authorizing legislation specifically referenced the

LESSONS LEARNED

Framework.) It was helpful as a unifying set of principles to engage local partners. The document was also a road map that laid out a process for moving from the traditional group home practice model to the one envisioned by the stakeholders. The change from the middle approach would not have been possible without a foundation document that implementers could regularly reference as they built their local models.

INVEST IN THE CHANGE PROCESS

Casey Family Programs provided essential support for the change process by funding consultant positions at the state and county levels. At the state level, consultants helped CDSS staff coordinate and work through the development of policies for managing the RBS design and implementation process, review the proposed voluntary agreements, funding models and waiver requests that were submitted by the sites, conduct the required reviews of the projects, prepare information for the legislature, participate in the interagency coordination meetings, assure federal Title IV-E allowability and compliance with fiscal, accounting and audit requirements, and provide ongoing technical assistance to the sites. Each site was able to retain an expert consultant to help them develop, submit, and implement their proposals. Additional project-wide consultants were retained to provide coordination, research, technical assistance and materials development for the project. The state and county partners would have been hard pressed to carry out all the required tasks without this assistance.

CFP partnered with the Sierra Health Foundation (SHF) and the Child and Family Policy Institute of California (CFPIC) as philanthropic colleagues whose goals for system improvement were well aligned with the RBS principles. SHF and CFPIC provided logistical support to keep the project going, and SHF provided financial assistance for one of the sites that was within their geographic focus.

CFP is also funding the evaluation of the pilot projects through a contract with an independent firm and the state and counties. CFP staff are partnering with that firm to develop and implement the evaluation tools and protocols.

With its investment in RBS, CFP was able to leverage an enormous amount of additional effort at the state, county and provider levels by using flexible funding to encourage and support the process. Although CFP paid for consultants to facilitate the process and funded regular shared learning forums to build the community of practice, the longest hours were put in by state and county staff who weren't paid extra to carry out the design and implementation process.

UTILIZE BOUNDARY-SPANNING CONSULTANTS

Supported by CFP, consultants were placed in strategic locations at the state and county level to support communication across departmental borders, facilitate the planning process, and help write the documents needed to move the process along. By not being tied to a specific agency or bureau, they could make sure that everyone's voice, concerns and suggestions were being heard and addressed in the planning process. At the county level they helped prepare the voluntary agreements, funding models and waiver requests that each demonstration site had to submit, and facilitated the design of the alternative funding models.

At the state level they coordinated the involvement and actions of multiple program, fiscal and legal offices, kept things moving when state staff were buried under multiple mandates and initiatives, prepared formal policy and procedural instructions to guide the demonstration sites in implementing their alternative models and facilitated the resolution of complex program and fiscal problems raised by the integrated RBS model.

CONVENE AND SUPPORT A COMMUNITY OF PRACTICE

Change from the middle is impossible without an empowered and connected network of practitioners who share experiences, ideas and challenges, and provide one another with ongoing support and encouragement.¹⁹ From line staff to administrators in both private and public agencies, hundreds of people were involved in the process of designing and implementing RBS Reform. The informal lateral communication, shared knowledge, diffusion of innovations, and collaborative problem solving became the heart of the RBS community of practice and provided everyone on the effort with the energy and tools they needed to drive effective system change.

The shared concern for finding a way to help the children, youth and families in the RBS programs achieve improved permanency and well-being brought the community of practice together. The champions provided leadership to support and reinforce the community's efforts. The framework gave the community a way of focusing their actions. External investment by CFP provided the opportunity for them to spend time with one another away from the distractions of their regular work assignments, and boundary-spanning consultants helped with communication, problem solving and paperwork. Nonetheless, the community of practice would not have coalesced if each member had not made a personal choice to make RBS reform a priority and joined with the other members of the community to make it happen.

Organizational Impact

The public and private agencies involved underwent significant amounts of organizational change to implement RBS. This is because RBS was more than a new type of service option; it was a new way of doing business. The changes needed to put RBS into operation had a big impact on the providers, the county agencies and CDSS. The following sections will describe some of the changes that RBS brought about in each of these environments.

Organizational change – Provider Perspective

It is unlikely that any of the 10 providers who are now offering RBS services envisioned at the outset the amount of change that creating and delivering this new resource would entail. Early in the planning process RBS seemed like an enhancement of their existing group home services. But as the project moved from planning to implementation the true extent of the transformation they were embarking upon became clearer.

When the project started, a few providers in the state were experimenting with increasing family presence in their group homes but none had embraced the level of family involvement that RBS

LESSONS LEARNED

called for. Probably the biggest cultural change at the provider level has resulted from having family members around more of the time. Youth and staff begin to see themselves in a different light and found they were behaving differently as a result.

Integrating the operational components of RBS also resulted in significant changes in agencies' organizational cultures. Some of the RBS providers had already been testing models that would allow the same staff who worked with youth in the on-grounds program to continue the therapeutic relationship when the youth transitioned into the community. Many were looking for ways to incorporate evidence-based mental health practice into their clinical services. However, the residential, community and mental health components of most agencies still operated with separate staffing, administrative and billing systems.

To deliver the integrated package of services that RBS entailed, the providers had to bring these parallel components of their agencies together. On paper that seemed easier than it turned out to be in practice. The residential, community and clinical units each had their own subcultures within the overall organizational culture of the agency.²⁰ The subcultures within these units included:

- Their spoken and unspoken attitudes about children, youth and families;
- Their strategies for intervening with and supporting clients;
- The philosophical, technical, experiential and practical foundation for their practice models;
- The way they tracked their activities and measured client performance and improvement; and
- The language they used to talk about their work.

Many of the providers began implementation of RBS with the idea that they would augment their existing residential program with more robust family inclusion, community and clinical services, with the residential culture being dominant. However, this approach tended to result in difficulty hitting the targets for shortened lengths of stay and considerable conflict among the interacting cultures.

While this is a challenge that some of the providers are continuing to struggle with, others have found more success by allowing an independent culture to emerge in the RBS unit that might best be characterized as a family-inclusion and permanency system with residential, community and clinical service components – the reconnection engine mentioned earlier in this report. This has been accomplished by building the RBS program around a family-centered comprehensive care planning process and incorporating an individualized mix of the service elements based upon each child or youth and family's unique situation.

allowing an independent culture to emerge in the RBS unit that might best be characterized as a family-inclusion and permanency system with residential, community and clinical service components – the reconnection engine

This alternative culture has not fully taken hold in any of the agencies because the underlying structures to support it are still being worked out. Agency administrators have to find the best way to provide appropriate supervision and support for staff members who might be doing residential care one day, parallel community services the next, and may be part of an intensive in-home treatment team the next. They also have to figure out more efficient ways for staff members who fill multiple roles to document their activities when each of those roles is funded through different state and county systems.²¹



Organizational Change – County Agency Perspective

The county agencies participating in the RBS Reform also had to make significant changes in their practices to use the new model effectively. RBS required a different form of contracting with providers that addressed the residential, family support, community care and mental health components in unison even though separate offices within the county were responsible for managing these services. This meant that the county had to establish a procedure for collaborative decision-making across its bureaucratic boundaries.

RBS also required a different type of utilization management. Because multiple transitions in residence can occur during a single course of care, RBS cases are enrollment-driven rather than placement-driven. However, changes in placement still had to be monitored and documented even though they did not result in changes in program participation or in the agency responsible for care.

Information being reported from what was supposed to be an integrated program had to be taken apart and fit into different slots in order to properly claim back to different state and federal agencies for the appropriate reimbursement. This work had to be done manually in most cases because the counties' information management systems didn't have the data fields and calculation algorithms needed to handle RBS services as unique items, and RBS wasn't a big enough service to justify the cost of adding an RBS module to their systems. Moreover, even if a county might have developed a separate system for contracting and invoicing RBS services, the information would have had to have been broken down before being sent to the state because the state and federal systems aren't built to deal with something like RBS in an integrated fashion.

Besides the challenge of properly managing the fiscal and data elements of RBS, county agencies also faced their own cultural change issues.

LESSONS LEARNED

- Some county and court staff had difficulty with the core RBS elements of intensive family involvement and shortened lengths of stay. They saw these principles as being in conflict with their mandate to insure child, youth and community safety and well-being. Local RBS implementation teams had to develop internal social marketing plans to increase acceptance of the new approach.
- Managing services for a child or youth in RBS placed direct care child welfare staff and probation workers in a role that was different from what they were used to, and often different from what their units were set up to carry out. In some county agencies certain units manage residential care placements and other units manage community placements. RBS was both. The new model also called for workers to be more actively involved in RBS cases than in ordinary group home placements. They were asked to participate in the development and implementation of the comprehensive plan of care and in dealing with the transitions that children and youth were making from one service environment to another. County workers had to document and obtain permission for each proposed transition, and placement changes in RBS happen relatively quickly as children and youth move through the trajectory of care from the residential component through bridge care and to the family home.
- Boundary issues in human services administration had to be worked out in many of the participating counties. For example, a county's department of mental health might have methods and criteria for contracting for behavioral health services that are substantively and procedurally different from those used by the county's child welfare department to contract for residential care services. But to implement RBS, both departments had to find a way to work together to jointly contract with a provider for the delivery of the integrated program.

Organizational change – State Level Perspective

The complexities that were described in redesigning the operations and cultures at the provider and county level were multiplied at the state level. First, CDSS had to review 4 different RBS operating systems and determine whether each was viable and met the requirements of state and federal laws and regulations and lived up to the requirements in the bill authorizing the RBS project. Then they had to set up an RBS-specific fiscal tracking process and create RBS-specific documents for claiming AFDC-FC expenditures through the state. In addition, the state developed special project codes within the Child Welfare Services/Case Management System (CWS/CMS) for retrieving information on RBS youth as well as ad hoc reports for displaying aggregate data. Although the projects had enrolled a small number children compared to all those being served by child welfare programs throughout the state, RBS added an additional layer of administrative and oversight responsibilities.

Most of the stories about RBS, such as those captured in the Appendices, appropriately reflect the direct care experiences of children, youth, families and service providers. But the state and county employees, who worked endless hours behind the scenes building what was essentially a new system of care from scratch so that the people on the front lines could make RBS happen, are unsung heroes without whom those stories would not have happened.

Lessons Learned

In the years that the RBS Stakeholders and state and local teams spent imagining, designing, building and finally operating the four demonstration sites many lessons have been learned about what it takes to bring such a complex concept to fruition. Those lessons are as multifaceted and interwoven as the RBS model itself, reflecting elements that have worked, those that have needed adjustment, and the encouraging surprises that have emerged as hundreds of family members, advocates, and public and private agency staff, supervisors, managers and administrators have worked together to translate RBS from a vision to reality. New lessons continue to come to light as the fledgling programs adapt and adjust to better meet the needs of the children, youth and families they are serving, and to achieve improved efficiency and effectiveness in their operations.

This report will use two approaches to share some of these hard-won insights. First, this section will present five headline lessons that summarize big picture conclusions that have been identified across all of the projects. Then Appendices C and D at the end of this report will present observations, suggestions and challenges that representatives from the sites shared during interviews conducted in the fourth quarter of 2011.

The combination of an overview summary and more in-depth examples from the sites should help other communities interested in developing models similar to those used in the RBS pilots gain a better understanding of what is needed to implement this integrated approach, and what can be gained through its operation.

The five summary lessons are:

1. COMMITTED AND SUSTAINED LEADERSHIP IS ESSENTIAL

RBS represents a fundamental change in how state administrators, referring agencies, private providers and community partners help children their families achieve more positive outcomes. The encouragement, confidence and collaborative spirit that strong leadership can provide helps the entire system make this transition.

Even with research evidence supporting an alternative model, it still takes strong leadership and a leap of faith to take the risk to try something new.

Commitment to a new way of doing business

Long before the first youth is served in RBS, *all* partners who will have a role to play throughout the course of that youth's enrollment must reach a shared sense of the urgent need to change from "business as usual" to a new program and funding model that embodies the principles and values of RBS. It took time and courage for well-intentioned, hard-working, quality professionals and partners to recognize that while the current approach to congregate care was familiar, comfortable and effective in some situations, it was not achieving the permanency and well-being outcomes that all children, youth and their families deserved. Even with research evidence supporting an alternative model, it still takes strong leadership and a leap of faith to take the risk to try something new.

LESSONS LEARNED

Supporting the shift from competition to cooperation

To accomplish the shift to a new program and funding model, public and private agency representatives who have the credibility, power and interest to make change happen must join together in a coalition to guide the effort. This includes leaders from social services, mental health, probation, education, juvenile court, provider agencies, bridge care resources, and family-identified community supports. Members of the coalition need to be equally committed to maintaining a working partnership based on a clear and objective expression of interests, constraints and risks, the use of an agreed-upon conflict resolution process, and a willingness to renegotiate the agreement as new innovations arise and original assumptions and conditions of operation change. For this partnership to be effective competition for control of decision-making, risk management and resource utilization needs to be replaced with cooperation and teamwork grounded in accountability for the achievement of shared outcomes.

Continuous leadership support

Commitment at the Director level by each key partner organization needs to be visible, pragmatic and consistent. This is demonstrated by applying flexibility where possible, putting funds and resources where they are needed, assuming a reasonable amount of risk, and supporting agency staff to carry out the RBS philosophy and practice. When recession-driven budget cuts threatened the continued existence of the project and new barriers to implementation erupted on a near daily basis, it was the determination of the state, county and provider leaders that got the effort up and rolling again. Without these champions RBS wouldn't have lasted two years, let alone the eight that have passed since the Stakeholders first began meeting.

2. FAMILY INVOLVEMENT CHANGES EVERYTHING

The traditional group home culture is often characterized by a focus on meeting a child's needs in an environment separate from family; in contrast, RBS finds its strength in creating a culture of family involvement that relentlessly values, seeks out, nurtures and honors family connection as the core of child well-being.

Family finding and engagement is everyone's job

Every RBS success story has involved early, persistent and continuous activity to discover, engage, prepare, plan with, and involve family members to play various roles in the youth's life and ultimately re-establish the youth's network of family connections to support permanency, belonging and well-being. Parent Partners²² play an important role in brokering the delicate task of outreach and engagement of family members who may feel disconnected, disenfranchised and discouraged after having lost connection as a result of the circumstances that brought the youth into care in the first place or because of an ongoing erosion that took place as the youth moved through multiple placements. Nonetheless, the most successful programs have promoted the expectation that the other staff also carry some responsibility to reach out, welcome, engage and support families throughout the RBS experience.

To authentically invite family members into an environment to which they have been historically excluded, deliberate attention must be paid to creating the space, structures, purpose and interactions that welcome and define that new relationship.

Direct care staff need supportive supervision and leadership to resolve the dynamic tension between the intellectual understanding that family involvement is essential and the emotional fear that bringing in family members might cause more problems than it will resolve. Supervisors and leaders must acknowledge that trepidation and establish practical mechanisms to manage risks, while at the same time modeling strategies for helping families develop improved relationships with their children and build their competence and confidence as caregivers.

Making room for families

While all of the providers included intensive family involvement in their designs, the actual amounts and methods of family involvement varied among projects during the first years of operation. Some of the variation seems to have been driven by the amount of emphasis placed on family finding and engagement, and the degree to which programs used Parent Partners to support and encourage family participation. But it also seems to be related to how willing program staff members were to have family members spend time in the residential cottage and participate in the day-to-day activities of the unit.

To authentically invite family members into an environment to which they have been historically excluded, deliberate attention must be paid to creating the space, structures, purpose and interactions that welcome and define that new relationship.

Beyond family involvement to family influence

The RBS providers created welcoming spaces for family members in or near their residential cottages without being sure how families would respond. They learned that family members frequently took advantage of the opportunity to be closer to the children and youth in the programs. They came for family-style meals with other family members. They spent time informally meeting with children and youth. They began meeting and getting to know other families. This presence had an important influence on both the children and youth, and on the programs. Children and youth had fewer behavioral disruptions and a renewed belief that they would be able to leave residential care and return to their homes and communities. Staff began to see family members as partners rather than problems and gained more insights into strategies for creating an environment in the residential cottages that would be more effective in preparing youth for family and community living.

3. PERMANENCY IS A PROCESS, NOT AN EVENT

Permanency is more than a placement, an address or a legal status. It takes perseverance and tenacity to build and support the child-family relationships that can stand the test of time. RBS has created organizational, cultural and economic structures to help ensure children are safely connected to family with the belonging and well-being they deserve.

LESSONS LEARNED

Becoming permanency driven organizations

Focusing on permanency requires a shift to family-centered practice. Both the public and the private agencies involved in the demonstration projects have discovered that adopting RBS's family-centered model has required extensive organizational change. The residential cottages were remodeled to not only make room for family presence, as noted above, but also to reflect an environment that could be reproduced in a family setting. Providers eliminated their seclusion rooms because families wouldn't have them in their homes. They also reduced or eliminated the use of restraints because families wouldn't be able to do that either. They increased the individualization of services to accommodate differing schedules among children and youth and their families. Many programs shifted from two children per room residential formats to having each child in her or his own room to further increase individualization. Visitation and phone contacts were opened up so that families could contact children and youth on their schedules and as often as they needed to.

These changes were disruptive to the existing culture in the programs. Extensive training and support for staff was needed to help them understand and incorporate the new practice model, and to manage the turbulence that this change process engendered, including conflicts between the RBS staff and other agency staff who were still working in traditional group home settings.

Other system partners also had to adapt to the new perspective. Probation officers and child welfare social workers making placements in RBS often had difficulty moving from a system-oriented to a family-oriented perspective. The infrastructure also had to be adjusted to sustain a focus on permanency and to hold all parts of the system accountable. For example, one site did this by including a fiscal incentive in the contract, and another through a payment reconciliation process. Fundamentally, it meant not ever giving into the temptation to say that a particular child or youth will *never* have a family.

Fundamentally, it meant not ever giving into the temptation to say that a particular child or youth will *never* have a family.

Understanding permanency as a process

Reconnecting children and youth with their families is not an event, but a proactive process that requires ongoing nurturance of all parties as they join or rejoin together and learn how to sustain positive relationships over time. This requires dedicated, consistent resources to focus on cultivating these connections throughout the child or youth's enrollment in RBS.²³

The more disrupted the bonds between children and youth and their families are, the more time and the bigger the circle of support that is needed to repair them. Some of the participants from both public and provider agencies noted that they began the RBS project with a mental model of connecting each child or youth with a specific parent, nuclear family, or other primary caregiver and then working to blend or re-blend the child or youth with that specific permanency target. What they discovered is that in many cases, the initial net had to be spread much wider. Rather than focusing on a specific individual or family as the permanency goal, they began by building a broad circle of people who cared about the child or youth and were willing to contribute whatever they could to helping her or him have a better life. Eventually options for permanency would emerge from this extended family of biological and non-biological relatives but they would do so within the context of a much stronger network of informal support.

RBS shouldn't be a step down system.

RBS shouldn't be a step down system. The point is to achieve permanency, not simply to move from an institutional to a community setting for out-of-home care. While treatment foster home placements can be a useful setting for continuing the improvement in the relationship between a child or youth and the family who will be the primary caregivers on a permanent basis, a concerted effort must be made to maintain as strong a family reunification emphasis at this stage as was in place while the child or youth was in the residential setting.

Family-centered staffing and services

Several of the participating public and private agencies noted that the shift to a permanency focus also meant letting go of the child-centered assumption that children and youth should stay in out-of-home care until they were completely ready to live at home. Instead, they found that it was more useful to adopt a family-centered perspective where the focus was on helping children or youth and their families increase their ability to live together and manage things on their own. Helping families achieve permanency required the RBS programs to shift from a traditional institutional structure to one that fostered normalized family interactions across multiple environments—from the group home to foster homes to the family home—with an understanding that there were going to be significant ups and downs along the way.

To operate more effectively in a family-centered mode, programs redesigned staff roles, especially those of the direct care staff. In child-centered group home models that focused on getting children and youth ready to move to the community, direct care staff focused on managing behaviors in the residential setting. Under the family-centered approach fostered by the RBS reform effort, these direct care staff became Family Specialists who maintained their relationship with youth whether they were in the group home, a foster home, or the family home, continually building and supporting family connections across those environments. Helping direct care staff members learn how to function in this new way required extensive training and support as well as significant changes in staffing patterns.

The new job was no longer confined to helping youth behave well in the residential setting. Instead, the task was to do whatever they could to help children and youth and their families recover from the traumas and events that had disrupted their relationships and acquire the skills and confidence they would need to live together safely and successfully.

4. CLEAR AND CONSISTENT COMMUNICATION DRIVES SUCCESS

The rapid movement toward permanency that is the aim of RBS requires a high degree of coordination, communication and alignment among a multitude of players. This comprehensive approach relies on a tightly integrated team who can work seamlessly on meeting the complex needs of each child and their family.

Integration of multiple plans of care into a comprehensive whole

Implementing RBS requires multi-system integration at the system, program, and practice levels. The practical expression of this transformation is the comprehensive care plan that is developed

LESSONS LEARNED

with each enrolled child and his or her family, and that accompanies them and evolves with them throughout their time in the program, regardless of the locations in which care and support is provided. Each system participating in the RBS effort has specific mandates, goals, service interventions, timeframes and expectations. However, for RBS to be effective representatives from all of the participating systems must create a unified, family-centered planning framework and documentation system so that everyone involved can get on and stay on the same page.

Integration of child welfare social workers and probation officers into the RBS care team

Based on the premise of shared responsibility for desired outcomes, RBS relies on a comprehensive care team that is comprised of many individuals who have decision-making roles to play in the child's life. Clear definitions of roles, responsibilities, expectations and decision-making authority among the team members involved in care coordination for RBS youth is necessary for effective, responsive interventions throughout the course of care.

Building a common perspective among the professionals, family members and the family's natural system of support promotes decisions that are in the child and family's best interests. Establishing this shared perspective requires a significant culture shift for county agencies that follow a more traditional model of empowering the caseworker and their supervisor with the key decision-making authority in child welfare or probation cases. Multiple factors in the existing system reinforce this caseworker-centric model of practice, including: regulatory mandates, legal requirements, and professional training. The shift to a process where family voice and choice is valued, consensus is applied to decision-making, and shared accountability is established is a sea change for the profession that is continuing to manifest itself both in the literature and in the field.

Consistency in planning and service delivery

Due to a variety of factors comprehensive care planning has been implemented inconsistently across the sites and providers during the early stages of RBS implementation. To be effective, comprehensive care planning has to be more than just having strength-based meetings with family members, it has to be a structured process that brings all of the plans affecting the youth and family (Child Protective Services, Mental Health, Education, Probation, Adult Services, Residential, etc.) into alignment. The RBS care coordinators need sufficient clout and skills to ensure buy-in to this process from all of the agencies with which a youth and family may be connected. In addition, both the private and public agencies will need to provide their staff with the flexibility, support and training needed to both facilitate and participate in effective care planning and service implementation meetings.

5. INTEGRATED PROGRAMS REQUIRE FLEXIBLE FISCAL SYSTEMS

Categorical funding streams, separately administered mental health and social service systems and legacy payment systems all hinge on the presumption that child-focused protection and treatment, rather than family-centered practice is the preferred approach for achieving safety, permanency and well-being for children. RBS represents a new, integrated model for reaching these goals, yet many innovations are constrained by the inherent inflexibility of the fiscal systems upon which these programs must rely.

For RBS to transform the nature of group care in California, as was the stated goal of the Stakeholders in the Framework document, a new management infrastructure will be needed.

Integrating the infrastructure

Supporting the RBS multi-environmental care model required program and fiscal modifications at both the county and state level. Creating a temporary operational infrastructure to support the demonstration sites took two years and countless hours of work. The benefit of this effort was to expose the hidden wiring that underlies complex systems of care. The level of effort illustrates how hard it was to modify that wiring to accommodate RBS while still keeping the current running.

These adaptations were patches on existing circuits, not the creation of a new infrastructure. Although the jerry-rigged systems the counties created to run the RBS pilot projects have the capacity to manage the information flow of the expected enrollments in the demonstration sites for a few years, their present configurations are not sufficiently robust or efficient to support implementation on a statewide basis.

For RBS to transform the nature of group care in California, as was the stated goal of the Stakeholders in the Framework document, a new management infrastructure will be needed. Based on the experience of the demonstration sites, this new system will have to provide ways for:

- Providers to show that they have all of the core elements of RBS in place;
- County agencies to show that they are applying the correct criteria for making referrals to RBS programs and for monitoring and participating in the course of care their clients receive during enrollment; and,
- County, state and provider agencies to document the work being done and the outcomes being achieved, while invoicing, paying and claiming for this work efficiently and accurately.

Building a family-centered care system on a child-centered funding system is at best awkward, and in some circumstances impossible.

Paying for multiple components

Both the child welfare and mental health funding systems that are being used to support the RBS demonstration projects currently focus on services for children rather than families. Building a family-centered care system on a child-centered funding system is at best awkward, and in some circumstances impossible.

One of the key challenges for funding an integrated RBS infrastructure is developing a system for charting and paying for the family support aspects of the model, such as family finding, engagement and involvement, parallel family and community services while children and youth are still living in the residential component of the program, and intensive in-home and aftercare services once they have begun living with their permanent families. Some of these services can be charged to the EPSDT benefit (Early Periodic Screening, Diagnosis and Treatment) if the youth and family are Medi-Cal eligible, but if not, there is currently no clear mechanism for covering these costs.

LESSONS LEARNED

Managing the transition times

To obtain maximum benefit from shortened lengths of stay in the transformed residential environment, promote the movement to permanency, and assure cost containment, each of the RBS sites built their fiscal models around certain assumptions about how long youth would remain in the residential component before transitioning into bridge care or permanency. For example, the assumption in Los Angeles is that the average length of residential stay will be 10 months or less, and the San Francisco fiscal model is based on projected average residential stay of 5 months. However, some of the providers found it difficult to hit the shortened length of stay targets consistently with the first cohort of enrollees.

Several factors contributed to the lengths of stay being longer for the first cohort than expected. First, staff and managers were experiencing a steep learning curve as they figured out how to run their programs. Second, the initial cohorts for most of the programs were children and youth who had already been in group home placement for an extended period of time. For many of these youth the primary treatment issue was not behavioral stabilization so much as undoing institutionalized behaviors and finding, engaging and reconnecting family members who had lost touch and had limited involvement over the years of out-of-home placement.

One provider that was able to accomplish transitions out of the residential cottage to the community within the proposed time frame has its own Intensive Treatment Foster Care (ITFC) program and included the ITFC program manager in every step of planning and implementation to insure that treatment foster homes were available for youth who needed them as a bridge between the residential placement and moving home. It is likely that the other providers will continue to have difficulty until they make arrangements for a similar resource. Since the movement out of the residential cottage to an interim ITFC placement is not permanency, but only a step in that direction, other adjustments in the community service, crisis stabilization, and family support components of RBS will be needed for children and youth to achieve an enduring connection with a family and home.

One of the goals in the Framework document was to develop a system for gathering data on each child's progress towards safety, permanency and well-being and to explicitly incorporate the information generated by this system in both the contracts through which placements were made and also in the plans of care following placement. While there are elements of performance-based contracting and documentation in the programs developed by the demonstration sites that can inform the development of a more comprehensive approach, any plan for large-scale implementation of RBS will have to define more clearly the inputs, operations, outputs and outcomes expected of RBS systems, the key quality measures for those systems, and create a unified architecture for building those systems based on these parameters.

Fortunately, what is being learned through the extraordinary efforts of the implementation teams in the four demonstration sites and at the state level will provide a wealth of insights to inform the process of constructing a more coherent and efficient model for ongoing RBS reform.

Next Steps

Appendix D concludes with a list of practical next steps suggested by families and county and provider staff members during the recent site visit interviews. The demonstration sites will be looking for ways to include many of these suggestions in the successive years of their operations. At the same time a team at CDSS will be working on a strategic plan for the statewide reform of group home programs and funding that will be informed in part by the experiences to date in implementing RBS.

The independent evaluation of RBS will have to run for at least another year before there is enough data to assess the overall effectiveness of the model. Depending on how the evaluation and the statewide strategic planning turn out, CDSS, the current RBS providers and counties will have to decide whether and how to continue the demonstration programs. If the decision is to end them, they will have to find a way to do so while protecting the well-being and interests of the youth and families who are still enrolled in the programs at the time they either end or change. If the decision is to continue and expand, then the task will be to create a sustainable fiscal infrastructure for the successor to RBS, a consistent practice model, and a plan for migrating existing high-end group home operations and group home utilization protocols to the new service system.

Fiscal Next Steps

On the fiscal side of the model, next steps toward a sustainable model should include finding ways of increasing flexibility to allow more support for family-centered services and interventions in both the residential and community aspects of the program. Fortunately, California has a foundation for incorporating this flexibility in programs. In 1997, to provide a better alternative for meeting the needs of children and youth with severe emotional and behavioral issues, California began statewide implementation of the Wraparound approach through enactment of Senate Bill 163. Wraparound redirects the state and county funds that would have been used to help cover the costs of group home placement and uses them to provide intensive, community-based and family-centered care designed to prevent the need for placement in out-of-home care.

Wraparound and RBS share a common value base of using family-centered, strength-based, needs-driven care, and both use multi-domain plans of care developed by inclusive child and family teams. Many wraparound principles are echoed in the vision and values of the RBS program models developed by the demonstration sites.

LESSONS LEARNED

Wraparound is primarily a community-based service and has its own fiscal criteria and procedures and specific practice requirements. Nonetheless, some of the demonstration sites are bringing RBS children and youth and their families into their wraparound systems at the point of transfer from the residential to the community phase of the course of care. This is not a long-term solution, however, because it not only requires more fiscal manipulations, but also because it continues and reinforces the division between residential care and community care.²⁴

A fiscal model that supports the integration of these two elements will have to focus more on the needs of the clients and less on the place where the clients are living or placed. From this perspective, a temporary stay in a transformed group home would be one of an array of treatments, interventions and supports that a child and family team might include in the comprehensive plan of care that it was developing to address the full range of needs that had led to or was threatening to produce family disruption and harm to the health and welfare of the children and youth in the family. Rather than the treatment plan and its funding being driven by the placement in a residential care facility, the use of that facility and the funding for that use as part of a more extensive course of care would be driven by the plan.

Practice Next Steps

On the practice side, next steps should focus on continuing to improve the therapeutic and permanency interventions offered through the course of care in the RBS programs, including:

- Family finding, engagement, involvement and empowerment;
- Helping parents increase their competence and confidence in caring for the complex behavioral and emotional needs of their children and youth;
- Helping youth ameliorate and resolve the underlying driving forces behind the challenges they are experiencing and expressing;
- Developing and implementing consistent and effective safety and crisis plans and interventions;
- Incorporating formal and informal neighborhood and community partners in the families' comprehensive plans of care;
- Reaching out to and including school staff in the planning and service implementation process, especially during the transition to the community; and,
- Continuing the enhancement of the therapeutic environment in the residential components of the programs to shorten lengths of stay by building and sustaining positive and effective permanent family connections.

Organizational Change Next Steps

The greatest challenge in expanding the RBS model may be developing a strategy for guiding the state's existing group homes through the process of transforming their programs to focus on helping children and youth and their families rapidly achieve and sustain permanency, safety and well-being. The RBS experiment has shown that a significant gulf remains between the culture and values of many of California's child-centered and readiness-oriented residential programs and those of the state's family-centered, recovery-oriented community-based programs. As is noted in the stories summarized in Appendices C and D, even the provider agencies that had both residential and community-based programs found it difficult to combine the two approaches as they implemented the RBS model. Both the literature on implementation science and the direct experience of designing and implementing RBS in the four demonstration sites reinforce the need for a clear vision; committed leadership; adequate resources; the recruitment and involvement of key opinion leaders; and consistent, practical, ongoing training and support for managerial, supervisory, professional and direct-service staff in the programs. And even more fundamentally, the RBS Project has shown that this change will only be successful if families and youth are actively involved in every step of the redesign process.

LESSONS LEARNED

Conclusion

RBS is an ongoing field experiment involving the California Department of Social Services, four counties, ten providers and hundreds of children, youth and families. On one level it is testing whether the consistent use of the core RBS elements will help youth who are at risk of long-term group home placement and their families achieve safety, permanency and well-being more effectively than traditional treatment options. But on another level it is also exploring what changes at the state, county and provider level are needed to undertake any new service approach that does not fit into the fiscal and programmatic niches that have been carved into our nation's child welfare, juvenile justice and mental health systems.

Even though the early indications are positive, more research and evaluation is needed to understand and improve the impact of the core RBS elements. However, the years that it has taken to bring the RBS system on-line have taught the participants much about what it takes to accomplish large-scale multi-system changes.

In particular, they have learned that deep system change is possible but requires enormous dedication by staff, a clear mission, a resilient partnership, and consistent leadership. This project has been fortunate to have all four of these elements across all of the levels of operation, from the state, to the counties, to the providers.

States, counties and providers throughout the United States are looking for effective ways of transforming congregate care. Currently most of the efforts are focused on program design, and many are still looking for better ways of providing care in the residential setting, rather than on finding new ways to meet the full range of needs of youth and families when that array includes both short-term 24/7 staff supervision in a congregate care setting and also community-based supports and services to help families with complex needs reconnect and thrive.

California's RBS project demonstrates how much work it takes to break through the residential-community service barrier in publicly funded programs. Other jurisdictions and agencies seeking to test or implement innovations that bridge those two worlds will now have strategic information to help explain what will be needed at every level to create a functional infrastructure for creating and sustaining reconnection engines in their communities.

APPENDICES



Appendix A:

Framework for a New System for
Residentially-Based Services in California

Appendix B:

Overviews of the Four County Models

Appendix C:

Site Interviews Summary – Part One

Appendix D:

Site Interviews Summary – Part Two

LESSONS LEARNED

APPENDIX A

FINAL

March 2006

Framework for a New System for Residentially-Based Services in California

Introduction

A critical goal in the effort to improve outcomes for children and youth who receive services through California's child welfare, juvenile justice and mental health systems is insuring that group home placement is used judiciously, appropriately and effectively in order to obtain specific, affirmative outcomes that cannot be reached using services provided while a child or youth lives in her or his own home, the home of a relative, or in a community-based, family setting such as a foster home.

Rather than being used as a proactive intervention designed to achieve specific results, group home placement far too often has been used as a default alternative when effective community-based services have not been available or when a succession of other less restrictive options have been tried unsuccessfully. Consequently, some children and youth remain in care for extended periods of time, experience multiple changes of placement, and frequently reach adulthood without being part of a family.

Currently, although only 11% of the children in out of home care are placed in group care settings, California spends nearly 50% of its total foster care maintenance funds on these placements. As of July 2005 this included about 7,000 children placed through the child welfare system, 4,000 youth placed through the juvenile justice system, and 1,000 children placed through the mental health system. There is wide variation in the utilization of group homes between the three systems and additional variation in utilization between county-administered departments within each system.²⁵

Improving this situation has proved challenging. In June of 2001, after two years of work, a stakeholder group that had formed under the auspices of SB 933 produced a comprehensive set of recommendations for the reform of group care for children and youth.²⁵ For a variety of reasons, these recommendations were not implemented.

Despite this setback, the goal of establishing a new vision for California's group home services has not faded. Finally in the spring of 2005, a new workgroup that included family members, young adults who experienced residential placements as youth, child and family advocates, public agency representatives and provider representatives was convened by the California Alliance of Child and Family Services and began meeting monthly with the goal of producing a workable consensus for improving the quality and effectiveness of group home services and for clarifying the role of these services within the broader continuum of child and family care in the state.

APPENDICES

After a year of deliberation, this second workgroup has produced a framework for change that begins by redefining group homes as programs that provide residentially based services. The intent of this redefinition is to change the construct used when choosing a group home as a potential resource for helping a child or youth. Instead of a destination – a place to be – the framework assumes that a group home placement is better viewed as an intervention – a place where something happens. Residentially-based services should be a specific option chosen as a means to achieve a specific outcome. This new construct reconnects group care with the rest of California’s system of care for children and families and the system’s overarching goals of permanency, well-being and safety.

The framework produced by the workgroup consists of nine sections: intent, definition, roles of the placing agency and the service agency, placement criteria, program criteria, service criteria, outcome criteria and implementation.

Intent

The intent of this framework is to inspire a transformation of California’s current system of group care for children and families. This system should provide effective and reliable interim resources specifically designed to facilitate the ongoing movement of children and youth who have complex emotional and behavioral needs toward more permanent and positive connection or reconnection with their families, schools and communities. At the same time it is critical that the safety and well-being of these children and youth and those around them continues to be protected during the change process. This goal cannot be achieved by group home providers alone, but requires an integrated effort of everyone involved: families, placing agencies, decision-making bodies, provider agencies, regulatory and funding agencies, community stakeholders, and the children and youth themselves.

Definition

Residentially-based Services

For the purpose of this framework, residentially based services (RBS) are behavioral and therapeutic interventions delivered in congregate care settings in which 6 or more children or youth per housing unit live with and are supervised by professional staff, including but not limited to:

- **Environmentally based interventions** designed to establish a safe and structured living situation where children and youth can receive the comfort and attention needed to help them reduce the intensity of their behaviors so that their caregivers can identify and address their underlying unmet needs.

- **Intensive treatment interventions** to facilitate the rapid movement of children and youth toward connection or reconnection with appropriate and natural home, school and community settings by addressing their critical unmet needs and helping them find ways to understand, reduce and replace the persistent and difficult behaviors that have been associated with those needs with positive and productive alternatives.
- **Parallel, pre-discharge community-based interventions** to simultaneously help people in the children’s family, school and community settings prepare for the children’s return. These preparations should be initiated upon placement and proceed apace with the care and intervention being provided within the residential setting.
- **Follow-up, post-discharge support** as needed to insure the stability and success of the connection or reconnection with home, school and community.

Role of the Placing Agency

When a child or youth whose current behavior or situation suggests that placement out of the home in a structured group setting may be necessary, a representative of the placing agency should meet with the child and family, establish an initial relationship with them if one does not already exist, and together with them decide that there is a need for some type of formal intervention. The placing agency must then complete, or cause to be completed, a thorough assessment of the child or youth and family’s strengths, needs and situation to inform the decision about which intervention will be most effective.

Placement in a residential program should occur only after a team²⁷ gathered by the placing agency that reflects the perspectives of the child, the family, the community and professionals with expertise in assisting children and families with needs similar to those under consideration has learned enough about the situation, strengths and needs of a child or youth and her or his family to make three determinations:

- First that this option provides the most effective, appropriate and safest environment in which to address the needs that are the driving force behind the behaviors that are the focus of concern,
- Second, that the specific program chosen for placement has structures, interventions and services that are well-matched with the strengths and needs of the child or youth and family, and
- Third, that there is no available community-based service arrangement that would adequately address the needs of the child and family without placement in a group setting.

APPENDICES

When referring the child to the provider agency, a representative of the placing agency should prepare a service plan that clearly identifies the strengths, needs and situation of the child and family and the specific outcomes that are being sought through placement.

Once referral for residentially-based services is accepted and the child is enrolled for treatment, a representative of the placing agency should have continuing involvement as a key member of the planning and treatment team formed by the provider agency in order to:

- Insure accurate sharing of information;
- Collaborate in the development, implementation and revision of the plan for meeting the needs of the child or youth and her or his family, including the parallel, community-based components;
- Assist in monitoring and recognizing progress;
- Help facilitate an effective transition to a family-based living setting; and,
- Help insure that effective follow up supports are in place.

Role of the Provider Agency

Agencies that provide residentially-based services must operate well-structured programs that insure consistency and quality in the treatment environment, and use a thorough and effective service planning process that insures that each child and family will receive assistance designed to address the specific needs that formed the basis for the placement.

Upon accepting a child or youth for enrollment the provider agency should:

- Engage the child and family in the process and introduce them to the program's service environment in a way that helps them understand how the time spent in placement will be used to help them accomplish the goals that were the basis for the placement.
- Provide the necessary protection and structure to insure that the child will be safe while enrolled in the program.
- Expand on the pre-placement assessment in order to form a clear understanding the strengths and needs of the child and family and help them choose the interventions that will provide the greatest likelihood of helping them obtain the benefits they are seeking through the placement.
- Provide, or arrange for the provision of, a complete range of therapeutic, educational, behavioral and social interventions as needed, to address the needs that have been identified through the pre- and post-placement assessments, including parallel services in the community to prepare for the child's transition from placement.

- Assist the placing agency with the development of a permanency plan to insure that the placement process will include activities to help the child or youth reinforce, re-establish or establish positive lifelong connections with their families, if possible, or with a caring adult in a familial relationship, if reconnection with the family cannot be accomplished.
- Monitor progress, adjusting the plan and services as needed and preparing the child and either the child's family or the caregiver who will be providing a family setting for the child following placement for the child's transition home or to that setting.
- In cooperation with the representative of the placing agency as well as other formal and informal sources of support in the community, assist in the child's transition from placement back to his or her family or to a more normal, family setting.

The provider agency cannot carry out these functions without the active and collaborative involvement and support of the placing agency and other educational and service providers from the community.

Placement Criteria

The fundamental question underlying the decision about whether or not to refer a child for residentially-based services is what is it about the needs of this child and her or his family that requires an intervention that can only be offered in a group care setting?

This decision is dependent on the current state of the art. As community-based services have improved, agencies have had to place fewer children in group homes. In the future, the system of care may develop to a point at which many more children can receive the help they need at home or in family settings. At present, however, there are times when children and youth have such deeply unmet needs that they are compelled to express them through repeated actions and behaviors that cannot be safely and effectively addressed in the community using our existing service options.

APPENDICES

The following table outlines the criteria that a decision-making team should apply when determining whether a residentially-based service is the best option for a given child or youth:

Decision	Criteria
<p>1. What are the situation, strengths and needs of the child or youth in the context of their family and community?</p>	<ul style="list-style-type: none"> • Level of danger/risk presented to self, others and community • Presence and persistence of behaviors that prevent the child or youth from participating in or benefiting from services and supports provided in the home, school and community • Educational strengths and needs • Mental/emotional health • Physical health • Immediate and extended family connections • Child or youth's other sources of social support
<p>2. What intervention best meets the needs of this child or youth and family?</p>	<ul style="list-style-type: none"> • What natural and informal support and assistance is available to the child or youth through their family, school, social network and community? • What has been helpful for this child and family in the past, and what has not been helpful? • What service options have demonstrated the ability to meet the type of needs this child or youth presents? • How might these service options enhance the family's ongoing capacity to meet their child or youth's needs? • What level of service intensity is required to understand and address the child or youth and family's needs? • Which service options are most likely to help the child or youth and family achieve the goals they have for themselves? • Which service options are best matched with the family's culture, preferences and strengths?

Decision	Criteria
<p>3. Where can this child or youth and family be most successful in receiving this intervention?</p>	<ul style="list-style-type: none"> • What environment is required to suspend and replace any barrier behaviors that the child or youth is currently using to express her or his needs? • What about the nature or severity of those behaviors requires interventions in an environment other than the child or youth’s existing home, school and community? • Has an objective and informed inquiry into strategies for using community-based interventions to address the child or youth’s behavioral challenges and other needs been conducted? • Is the child or youth or family requesting a non-family treatment setting for safety or other reasons?
<p>4. Which residential program can best meet the needs of the child or youth and family?</p>	<ul style="list-style-type: none"> • Does the program offer an environment that is designed to safely manage the kind of behaviors that are the focus of concern for this child or youth? • Does the program have intensive treatment options designed to understand and address the specific unmet needs of the child or youth that are driving those behaviors and to help the child or youth learn and acquire new ways of acting that are safer and more pro-social and effective? • Does the program have the capacity to simultaneously assist those in the child or youth’s home, school and community environments to prepare for and welcome the child or youth’s return and to continue to support the child or youth’s reconnection until it is stable and sustainable? • Is <i>this</i> option the one most likely to produce desired results for the child or youth and family compared to other options? • Can the necessary resources be found to cover the cost of treatment?

Program Criteria

The following inquiries are intended to identify programs that have the capacity to safely and effectively serve children and youth with such complex emotional and behavioral needs that a residentially-based intervention must be used:

Mission

Do the program's services and operations demonstrate a commitment to a mission of:

- Insuring that all children or youth who receive services are ultimately able to connect or reconnect with family, school and community following placement, and
- Providing for active family involvement, behavioral stabilization, intensive treatment, parallel community services and follow-up support to help bring this about?

Values

Does the program's service environment reflect the values of:

- Respect for the culture, individuality and humanity of children, youth and families.
- Maintaining a focus and building plans of care on the individual strengths, needs and goals of each child, youth and family member.
- Providing for and insuring active and equitable family participation in all phases of intervention and treatment.
- Helping children and youth develop and sustain positive connections with family, school and community.
- Understanding and supporting the emotional, behavioral, intellectual and physical development of children and youth.
- Providing positive and supportive assistance to guide children and youth in replacing the behaviors that required residential placement with pro-social alternatives that better express and address their unmet needs.
- Helping children and youth in placement quickly return to and remain safely with their families, schools and communities.

Administration

Does the provider have the administrative capacity to insure that all children youth and families enrolled in its programs receive high quality, cost-effective care?

- Do the provider's RBS programs have adequate fiscal, material and personnel resources to carry out its mission?

- Does the provider's administrative structure include opportunities for ongoing input by representative family members and service consumers?
- Does the provider have a well-structured and reliable system for data management that accurately reflects its operations, costs, service delivery and outcomes?
- Is there evidence of an independent financial audit that demonstrates that financial resources are appropriately managed and accounted for?

Management

- Do the provider's management structures insure effective oversight of program operations?
- Does the management structure support effective coordination of service delivery both among the provider's internal programmatic units and also with the agency that is contracting for and supervising the provision of services and other community resources that may also be involved with the children, youth and families the provider is serving?
- Do the provider's managers and supervisors have the qualifications and experience necessary to insure the delivery of effective, consistent and appropriate services and to provide skilled support and guidance for program staff?
- Does the provider have a communication network sufficient to insure that accurate information about issues and challenges regarding program operation or child, youth or family needs are noted and responded to in a timely and effective manner?

Staffing

- Does the provider have a well-managed human resources system that insures that qualified RBS staff are recruited, hired, trained, coached, evaluated, retained and advanced in a manner consistent with the mission, values and goals of the organization?
- Is there evidence that currently employed staff have the skills, qualifications, experience and personal characteristics necessary to carry out their roles appropriately and effectively?
- Does the provider have adequate and appropriate professional and paraprofessional positions in its RBS programs to address and respond to the needs of the children or youth and families it is designed to serve?
- Is there evidence that the RBS programs are able to retain skilled and effective staff and maintain adequate and consistent staffing levels, and that staff understand and are able to put into action the mission and values of the agency?

APPENDICES

Quality Assurance

- Does the provider have an effective system for measuring the quality and effectiveness of its RBS operations and services and the satisfaction that children, youth, families, placing agencies and community stakeholders have with the organization's operations and services, including input from independent, outside evaluators?
- Does the provider have a system for improving quality and satisfaction in its RBS programs based on the information produced by these assessments?
- Is there evidence that the provider has used information drawn from its assessment of quality and satisfaction to improve program performance?
- Is there evidence that the provider has linked its quality assurance system and goals with those of the broader community, including, for example, the county and state program improvement plans, where appropriate.

Service Criteria

The following inquiries are intended to help determine whether a provider's residential services are sufficient to help children and youth with complex emotional and behavioral needs and their families achieve and sustain positive outcomes:

Engagement

- Does the provider maintain a living environment that effectively addresses, manages and reduces the expression of the type of behaviors most frequently exhibited by the children and youth who are accepted for placement?
- Do staff have explicit processes for engaging the children, youth and families who are referred for care, and accurately determining their strengths, needs, and goals?
- Are there supports, such as the use of parent partners and peer advocates, provided to insure that children, youth and family members understand the program's nature and processes and have adequate and effective voice and participation?
- Is the engagement process used consistently and effectively with each child or youth who is referred for services and with her or his family members?

Planning

- Is there an explicit process for developing individualized, strength-based needs and services plans that includes active and equitable participation by children, youth and family members?
- Does the process include a means to adapt the program's general service interventions, treatment and support options to address each child or youth's specific unmet needs and those of her or his family?
- Is this individualized service planning process used consistently and effectively with each child or youth who enters care and her or his family?
- Do the plans identify strategies for understanding and replacing the behaviors that led to placement with functional alternatives that will help children and youth safely and effectively participate in and benefit from ongoing community-based assistance?
- Do the plans identify strategies for providing or obtaining parallel services in the home and community to prepare for the return of the child or youth and for delivering follow-up services to maintain the community placement once it occurs?

Implementation

- Is a system in place to insure that each component of the service plan is put into action, a feedback mechanism that quickly indicates when planned services are not implemented or are no longer being provided, and a means for immediately addressing gaps in plans of care?
- Does the system monitor the impact and outcomes of the services that children, youth and families receive and provide a means for quickly modifying plans of care to improve their effectiveness when necessary?
- Is the implementation assurance system used consistently and effectively with each child or youth who enters care?

Coordination

- Is there a method to coordinate planning, decision-making, implementation, and the delivery of parallel and follow-up services among the components of their own operations and with other formal and informal agencies and individuals who are involved in the care, support and treatment of the children or youth who are enrolled in the RBS program and their families?
- Does the service coordination methodology include support for effective access and use of formal and informal resources by the child or youth and family?
- Is the service coordination methodology used consistently and effectively with each child or youth who enters care?

APPENDICES

Permanency

- Does the program include services and strategies for reinforcing, re-establishing or establishing positive and lifelong connections between the child and her or his family, if possible, or with a caring adult in a familial relationship if reconnection with the family cannot be accomplished?
- Do the processes for service planning, implementation, coordination and outcome monitoring include mechanisms for managing transition to other services and service locations when appropriate and for preparing for discharge and successful connection or reconnection with family, school and community?
- Are plans and timelines for discharge developed concurrently with the treatment and service plans?
- Are the transitions for all children or youth and their families carried out in the context of the provider's treatment planning, implementation, coordination and monitoring systems?

Parallel and Follow-Up Services

- Are parallel services with the family and community offered to insure that an appropriate family and community-based care setting will be available and ready for each child or youth upon discharge?
- Are follow-up services available in varying degrees of intensity and duration to stabilize and maintain the return to home and community based on the individual needs of the child or youth and family after they have been discharged?
- Are parallel and follow-up services available for all children and youth and their families who need them?

Evaluation and Quality Improvement

- Is there a system for accurately assessing the outcomes achieved by children, youth and families both while they are receiving residentially based services and following discharge, and for identifying and responding to important events that may indicate a need for changes in services or program structure?
- Does the outcome assessment system measure safety, well-being, developmental progress, improvement in the child or youth's condition, stability of post-placement living situation, movement toward or establishment of permanency, and the replacement of the behaviors that led to placement with more functional alternatives?
- Does the outcome assessment system include a process for gathering accurate, specific and unbiased information about the satisfaction that children and families have with the services and supports they have received and the outcomes that have been achieved?

- Does the outcome assessment system include measures and means for obtaining and accurately recording the satisfaction that referring agencies and other community stakeholders have with the services offered by the provider and the outcomes that were achieved?
- Is accurate outcome and satisfaction information gathered for each child or youth and family that is enrolled, and is it used to improve both individual services as well as program operations?
- Is the outcome and satisfaction assessment system directly connected with the provider's quality improvement system?
- Are there feedback loops in place that keep staff informed about what is working and not working both with individual families and also at a program level and assists them in developing more effective alternatives?

Outcome Criteria

Placing agencies and providers should develop a system for collecting and maintaining data that identify each child's progress within the three domains of safety, permanency and well-being.

The parameters, intervals and criteria to be used should:

1. Be aligned with the Child Welfare Services Accountability and Outcomes System that is being implemented under AB 636,
2. Insure confidentiality and accuracy,
3. Be developed collaboratively by representatives of the licensing agencies, placing agencies, courts, family member representatives, parent and youth advocates, and the provider agencies, and,
4. Be explicitly incorporated in both the contracts through which placements are made and reimbursed and the format used to document the plans of care generated through those placements.

Information gathered through this system should include the following elements within each of the primary outcome domains:

Safety

Residentially based service programs should be able to demonstrate that the behaviors that were the focus of concern leading to the placement of a child or youth have been stabilized and replaced with more functional and pro-social alternatives. In addition, the programs should be able to show that they are able to maintain an environment where children and staff are free from harm and the threat of being harmed.

APPENDICES

Examples of outcome indicators in this area include:

- Documented improvement in behavior both within the residential setting and in the home, school and community environments as shown by changes in objective measures of the specific actions that were the focus of concern leading to placement.
- A cessation of further legal involvement both within the residential setting and while receiving support in the family and community settings.
- Documented reductions in symptoms and other expressions of emotional and behavioral disorders from objective baseline measures established at the time of placement.
- No development of new behaviors that prevent return to the community.
- Measurable increases in specific social and behavioral competencies from objective baseline measures of the strengths of the child or youth and her or his family.
- Reports by children or youth that they feel safe while living in the residential program and as they begin to return to community-based settings.
- Reports by children or youth and their families that they feel safer and more confident in their ability to manage and address the unmet needs that were the driving forces behind the behaviors that were the focus of concern.

Permanence

Programs offering residentially based services should demonstrate that they have helped the child or youth develop or re-establish and maintain positive and supportive relationships with family members (or with primary care givers if the child or youth will be living in a non-relative, family setting after leaving the residential placement), educational staff and key individuals in the community. It is particularly important that programs are able to establish connection or reconnection in areas of the child or youth's life where there have been substantial disruptions or severing of relationships.

Examples of outcome indicators in this area include:

- Documentation of an increase in the quality and quantity of positive family, school, peer and community relationships from an objective baseline measure of the child or youth's level and nature of involvement at the time of placement.
- For children and youth who have left the program, documentation that they are now living in a positive, lifelong relationship with a parent or family member or in a lifelong familial relationship with a caring and committed non-relative caregiver.
- For children and youth who are still in placement, documentation that a parent or other family member or a non-relative primary caregiver has made a commitment to provide a home for the child or youth, and documentation of progress toward accomplishing the specific steps needed for the child or youth to come to live in the home of the parent, family member or non-relative caregiver.

- For each child or youth leaving placement but who will be living in a non-family, community-based setting, that there is a caring family member or other adult who has made a commitment to stay in a life long and supportive relationship with that child or youth while a permanent placement is being developed.

Well-Being

Residentially-based service programs should demonstrate that a child or youth has made significant progress in her or his growth and development, including: the ability to enroll in, attend and benefit from an appropriate educational program; the ability to use and express age appropriate social and life skills; and the achievement or maintenance of good physical and emotional health.

Examples of outcome indicators in this area include:

- Documentation of the acquisition of developmentally-appropriate social and life skills from an objective baseline measure of the child or youth's strengths and needs made at the time of placement in the program.
- Documentation that the child or youth has acquired or maintained a reasonable and appropriate degree of physical well-being, based on objective records of the assessment and treatment of any identified medical needs.
- Documentation that the child or youth has acquired or maintained a reasonable degree of emotional well-being, based on objective records of the assessment and treatment of any identified emotional and behavioral needs.
- Documentation that the child or youth is making reasonable educational progress, based on objective records of the assessment of her or his educational needs, the instructional interventions made to address those needs, and the enrollment of child or youth in an appropriate educational program with regular attendance; or documentation of a plan to accomplish educational connection or reconnection and objective measurement of progress toward accomplishment of that plan.
- Reports by children and youth and their families that the children or youths' physical and emotional health care needs are being understood and addressed, that their overall sense of well-being is improving and that they feel more confident in their ability to attend and participate in appropriate educational activities.

Implementation

The intent of this framework is not only to transform the nature of residentially-based services for children and youth, but also to contribute to the development of comprehensive, effective and integrated systems of care that use these services wisely and well.

These are changes that provider agencies cannot institute alone. Implementation will require action on several fronts. First, the process for deciding when and how residentially-based services are used must reflect a consistent expectation that placement is to address a specific need and accomplish a specific purpose. Second, placing agencies must have the resources and capacity to make these focused and intentional assessments and judgments. Third, community-based services must have the capacity and resources needed to insure that group home placements no longer have to be made simply because there was no place else where children and youth could be safely cared for. In concert with these other efforts, residential providers must have the capacity and resources to adjust their programs to accomplish the tasks that have been identified in the preceding sections of this framework.

Many of the system of care changes proposed in this framework are already occurring as part of California's ongoing performance improvement process and the recommendations proposed by this workgroup should be implemented in concert with these other efforts.

Some components of the framework will, however, require new action. Principally, the legislative and regulatory framework for licensing and funding group homes must be amended to:

- Create a mechanism for accurately, objectively and consistently measuring and comparing the progress toward outcomes, and the achievement of outcomes, by children and families who receive services from any component of the system of care, including residentially-based services.
- Reflect and reinforce the contribution that residentially-based services should make toward helping families achieve these outcomes.
- Clarify the process and criteria to be followed when deciding what service options to use when children and youth have complex emotional and behavioral needs, as well as the roles and responsibilities of those who should be participating in this process.
- Insure that agencies offering residentially-based services have the resources and competency necessary to address the type and depth of needs displayed by the children and families for whom they are accepting referrals.

Because regulatory agencies, placing agencies, provider agencies, families, courts, advocates, and community stakeholders will have to cooperate in the design and implementation of this new vision, because there is no pre-existing template for putting all of these components into action and because the transformation proposed in this framework is fundamental and wide-reaching, a necessary first step will be to sponsor legislation that would enable, endorse and support the change process.

This legislation would authorize the state to receive and approve requests from partnerships formed by counties and service providers interested in establishing innovative alternative approaches to using residentially-based services to waive existing funding and regulatory provisions as long as the new approach continues to guarantee the fundamental safety and well-being of children and youth in placement, reflects the criteria established in this framework and demonstrates a reasonable likelihood of promoting improved outcomes for children, youth and families.

Adjustment in funding strategies will be necessary to test the recommendations in this framework because residential programs are currently not funded to provide some of the proposed services and are specifically prohibited from using existing funding streams to support parallel and follow-up services. In addition, the framework is intended to create a funding and regulatory environment that links reimbursement with the quality and outcomes achieved by programs, and insures sufficient resources to address the full range of needs presented by the children and youth who are referred for placement.

A formal workgroup should be convened under the auspices of the legislature to monitor, coordinate and assess the developments and results that occur during this phase of guided innovation, and to present recommendations for permanent legislation based on these results. In order to be more than a passive participant in this process, this workgroup should have sufficient resources to provide technical assistance and support to counties and providers who are attempting to develop alternative approaches and to analyze the results that they produce.

Ultimately, after a defined period of time, the workgroup should coalesce the insights and experiences from the initial test period into a new set of regulatory and funding provisions that would be implemented on a statewide basis.

Conclusion

California has been attempting to reform its group home services since 1998. It is time to move to action. This framework is the result of an ongoing exchange among the diverse membership of an informal work group who share a common mission of helping California's children and families get the right assistance, at the right time, in the location and using the approach most likely to help them achieve productive life outcomes. While they share a common mission, the participants in the work group have distinct and sometimes conflicting perspectives about how to accomplish this mission. Although most of the members of the work group agree with many of the provisions in this framework, none are in a position to completely endorse all of them. This document does, however, reflect the best consensus the group was able to achieve after many hours of deliberation.

The framework's redefinition of group homes as residentially-based services is designed to improve their focus and effectiveness and incorporate them as consistent and reliable resources within the comprehensive array of family-centered, strength-based services that are being made available for children and families in California's emerging new systems of care.

All of Appendix A can be found online at www.RBSreport.org.

APPENDIX B

Overviews of the Four County Models

Each of the county implementation teams has developed one-page summaries of their programs to help observers gain a quick overview of how their designs for delivering RBS services during the demonstration phase.

Los Angeles County Open Doors Program Overview

RBS Objective

The goal of Los Angeles County's Open Doors program is to shorten timeframes to durable permanency for children and youth who face a residential stay in out of home care. By infusing residential care with Wraparound principles (active family voice and choice, facilitated planning process, care coordination) the goal is to transform the residential milieu into a therapeutic community without walls creating a coherent, seamless arc of care.

RBS Partners

County Agencies

- Los Angeles County Department of Children and Family Services (DCFS)
- Los Angeles County Department of Mental Health (DMH)

Provider Agencies and Population Served

- **Five Acres**
RBS Population: 18 boys, ages 6 – 14, supervised by DCFS
- **Hathaway-Sycamores**
RBS Population: 16 boys, ages 10 – 18, supervised by DCFS
- **Hillside**
RBS Population: 18 boys and girls, ages 6 – 17, supervised by DCFS

Target Population

- Youth ages 6-18 under supervision of the county child welfare agency who are residing or at risk of residing in RCL 12-14 group home care
- Youth who need 24 hour care at least 50% of the time
- Youth who have a need for intensive development of connections with family and community
- Youth who need intensive services after residential discharge to maintain permanency
- Youth who meets minimum threshold of therapeutic needs (DMH/CANS) and would benefit from a therapeutic community and peer interaction

RBS Start: December 2010

Current RBS Census:

83 youth: 51 in residence;
32 in community

RBS Services

The Open Doors program utilizes the following array of services and supports:

- Short-term stabilization, treatment and support via a transformed residential milieu and parallel community services;
- Comprehensive care coordination through a Child and Family Team;
- Permanency services including family finding, connection building, engagement, preparation and support;
- Respite and crisis stabilization to promote durable reunification with family/community; and
- Community-based aftercare services following the youth's return to family, or entry into another permanent placement, to assure connection stability.

RBS Funding Model

Several funding streams support RBS: AFDC-FC, EPSDT, SB 163 Wrap, SB 163 Wrap Trust Fund and IV-E Waiver Trust Fund. The funding model consists of a residential rate (\$10,194; 10 month cap) that will be paid to the provider for the length of time a youth is in the Residential Care component of RBS and a community care rate (\$2,000 placement + \$2,184 wrap) that will be paid for the length of time the youth and family receive Community-Based Family Services.

Providers may claim up to \$2,667 per month for EPSDT eligible services per youth enrolled in Open Doors.

This funding design is linked to provisions of the Title IV-E Child Welfare Waiver Demonstration Capped Allocation Project.

Enrollment Capacity and Length of Stay

The RBS Program will start with 52 slots for RBS enrollment. As youth transition to Community-Based Care, additional youth will be enrolled and placed in the residential component of the program. It is projected that 160 youth will be served throughout the demonstration period.

Open Doors is based on an estimated 10 month average length of stay in the Residential Care component and an estimated 12 month average of services and support in the Community Based Care component of the program for a total of 22 months RBS enrollment. It is expected that actual length of stay will vary for individual youth.

Sacramento County RBS Reform Program Overview

RBS Objective

Improve permanency outcomes for youth in group home care by enhancing the quality and scope of care and services and through the integration and coordination of the services and efforts of families, placing agencies, providers and other key stakeholders.

RBS Partners

County Agencies

- Sacramento County Department of Health and Human Services/
- Child Protective Services and Mental Health Divisions
- Sacramento County Department of Probation

Provider Agencies and Population Served

- **The Children's Receiving Home of Sacramento**
RBS Population: 10 females supervised, by child welfare
- **Martin's Achievement Place**
RBS Population: 6 males, history of sexually abuse behaviors, supervised by child welfare and probation
- **Quality Group Homes**
RBS Population: 6 males, supervised by probation

Target Population

- Youth ages 12-16 who are residing or at risk of residing in RCL 12-14 group home care
- Youth who have had no more than 1* group home placement
- Youth who have a current connection to a family or non-related extended family member who is a viable permanency option
- Youth who have a family member that is willing to participate in the RBS Program
- Youth who are not currently receiving wraparound services

**exceptions to criteria will be considered*

RBS Start:

September 16, 2010

Current RBS Census:

24 youth: 16 in residence;
8 in community

RBS Services

RBS Services are tailored to the strengths and needs of each child enrolled in RBS and their family and include an array of services within the following program components:

- Family Engagement and Empowerment
- Comprehensive Care Coordination
- Intensive Short-Term Residential Stabilization and Treatment
- Parallel Community Interventions and Support
- Community-Based Aftercare

RBS Funding Model

The two primary funding streams for RBS services and supports are AFDC-FC and EPSDT funding. The funding model consists of a residential rate (\$8,031) that will be paid to the provider for the length of time a youth is in the Residential Care component of RBS and a community care rate (\$4,594) that will be paid for the length of time the youth and family receive Community-Based Family Services.

Providers may claim up to \$2,667 per month for EPSDT eligible services per youth enrolled in the RBS Program.

Additional one time sources of funding:

- \$50,000 Sierra Health Foundation grant used in combination with County funds for the EPSDT match
- \$50,000 MHSA funding used to provide training for RBS provider clinicians in Functional Family Therapy

Enrollment Capacity and Length of Stay

The RBS Program will start with 22 slots for RBS enrollment. As youth transition to Community-Based Care, additional youth will be enrolled and placed in the residential component of the program. It is projected that 72 youth will be served through the demonstration period.

The RBS program model is based on an estimated 9 month average length of stay in the Residential Care component and an estimated 9 month average of services and support in the Community Based Care component of the program for a total of 18 months RBS enrollment. It is expected that actual length of stay will vary for individual youth.

San Bernardino County RBS Reform Program Overview

RBS Objective

The mission of San Bernardino County's RBS system is, "working together to safely build and sustain positive, successful family connections and children's futures." The goal of RBS is to create a community/family reconnection engine for highly disconnected foster youth with significant mental health challenges. The RBS program will help these youth permanently re-establish safe, nurturing family, educational and community connections and establish a new system of care that will prevent any more youth from reaching this point of disconnection.

RBS Partners

County Agencies

- San Bernardino County Human Services Agency/Children and Family Services Division
- San Bernardino County Department of Behavioral Health
- San Bernardino County Department of Probation
- Inland Regional Center

Provider Agencies and Population Served

- **Victor Treatment Centers/Victor Community Services**
RBS Population: 24 male and female youth

Target Population

- Youth ages 13-18 under the supervision of the referring agency who are residing or at risk of residing in RCL 14 group home care;
- Youth who have had multiple placement failures or psychiatric hospitalizations and/or administrative days in psychiatric hospital;
- Youth in an out-of-state placement that is failing;
- Youth highly disconnected from viable permanency options;
- Youth with a history of running away and likely to remain in institutional care until the age of majority absent RBS intervention.

RBS Start: June 28, 2010

Current RBS Census:

14 youth: 11 in residence
and 3 in community

RBS Services

RBS Services are tailored to the strengths and needs of each child enrolled in RBS and their family and include an array of services within the following program components:

- Family finding, support and engagement to prepare for youth reconnection;
- Portable Care Coordination Team that follows youth throughout enrollment;
- Intensive short-term residential stabilization and treatment using a trauma-informed approach;
- Permanency services, including ITFC;
- Parallel community interventions, support, and in-home services; and
- Community-based aftercare with family support for reintegration and crisis management after youth has returned home, including crisis stabilization, if needed.

RBS Funding Model

Primary funding streams for RBS services and supports are AFDC-FC, EPSDT, SB 163 Wraparound and MHSA.

The funding model consists of a residential rate (\$12,732, with an offset of \$3,897 in MHSA funding, for a new rate of \$8,835) that is paid to the provider for the length of time a youth is in the Residential Care component of RBS and two different bridge care rates: (\$4,028) is paid while the youth is placed in Intensive Treatment Foster Care (ITFC) or (\$1,679) is paid while the youth is placed in foster care. (\$3,571) is paid to the provider once the youth is reunified with parents or relatives while the youth and family receive Community-Based Family Services.

Target Population

- Youth ages 13-18 under the supervision of the referring agency who are residing or at risk of residing in RCL 14 group home care;
- Youth who have had multiple placement failures or psychiatric hospitalizations and/or administrative days in psychiatric hospital;
- Youth in an out-of-state placement that is failing;
- Youth highly disconnected from viable permanency options;
- Youth with a history of running away and likely to remain in institutional care until the age of majority absent RBS intervention.

San Francisco County Family Connections Program Overview

RBS Objective

The mission of the Family Connections Program is to ensure that all children and youth who receive services are ultimately able to connect or reconnect with family, school and community following placement. The traditional barriers between residential treatment and intensive in-home services have been broken down and replaced with an integrated, family-based intervention that delivers continuity of care in whatever environment a child or youth might temporarily be living.

RBS Partners

County Agencies

- San Francisco County Human Services Agency/Family and Children Services Division
- San Francisco County Department of Public Health/Community Behavioral Health Services Division

Provider Agencies and Population Served

- **Edgewood Center for Children and Families**
RBS Population: 6 male and female youth supervised by HSA
- **St. Vincent's School for Boys and San Francisco Boys' and Girls' Home**
RBS Population: 6 male youth supervised by HSA
- **Seneca Center**
RBS Population: 6 male and female youth supervised by HSA

Target Population

- Youth ages 6-16 under supervision of the county child welfare agency who are residing or at risk of residing in RCL 12-14 group home care
- Youth who have a combination of family disruption, abuse or dangerous behavior that at present cannot be managed in the community using wraparound or other intensive community-based services
- Youth who have a family member that can provide a permanent home and is willing to participate in RBS
- Youth who are unlikely to achieve permanency within 6 months in traditional group care

RBS Start: March 7, 2011

Current RBS Census:

27 youth: 14 in residence;
13 in community

RBS Services

RBS Services are tailored to the strengths and needs of each youth enrolled in RBS and their family and include:

- Residential interventions to help address and stabilize a youth's challenging behaviors;
- Intensive treatment interventions that facilitate safe and stable reunification with the family and community;
- Parallel family and community services while the youth is in the residential component to prepare for reunification; and
- Follow-up services after the youth returns to family, or enters another permanent placement, to assure connection stability while the gains made during the intensive services phase are generalized to everyday life.

RBS Funding Model

The two primary funding streams for RBS services and supports are AFDC-FC and EPSDT funding.

The funding model consists of a residential rate (\$11,000) that is paid to the provider for the length of time a youth is in the Residential Care component of RBS and two different community care rates: (\$4,028) is paid while the youth is placed in Intensive Treatment Foster Care (ITFC) and (\$3,500) paid while the youth and family receive Community-Based Family Services.

A payment reconciliation process after 24 months requires providers to repay the County for claims exceeding an average total of \$122,500 per child.

Target Population

- Youth ages 6-16 under supervision of the county child welfare agency who are residing or at risk of residing in RCL 12-14 group home care
- Youth who have a combination of family disruption, abuse or dangerous behavior that at present cannot be managed in the community using wraparound or other intensive community-based services
- Youth who have a family member that can provide a permanent home and is willing to participate in RBS
- Youth who are unlikely to achieve permanency within 6 months in traditional group care

APPENDIX C

Site Interviews Summary – Part One

In September of 2011 a series of interviews were conducted with managers and direct service staff from some of the agencies that had started RBS programs to obtain an in-depth look at the impact of implementation on the youth, families and staff who have been at the heart of the change process. This appendix and the one following it contain excerpts from those conversations. Differences between some of the suggestions and strategies mentioned reflect variations in approach among the agencies participating in the interviews.²⁸

A. What has RBS done that other approaches have been unable to do?

1. **RBS has created a fundamental shift in the way we serve this population—we are creating a response that is truly family-centered as opposed to system-centered.** We do everything to accommodate the youth and family and their needs, rather than what is easiest for the system to do. This makes it more expensive, but also more successful.
2. **It's important to know how to interface with so many different partners and to have processes in place to make effective collective decisions.**
3. **We were surprised at how well our RBS youth functioned in the community.** Although the professionals in our program expressed significant fear and apprehension about youth “readiness” to transition to community, for the most part those worries turned out to be unfounded.
4. **Being able to reunite youth with their biological families has been challenging because many families are limited and often difficult to reach.** However, we've been able to work on finding more family connections for youth.
5. **Being adaptable with the model to fit the different needs of each youth and family has been important.**
6. **Brainstorming with colleagues helps providers feel supported in making this transformation.** We've developed camaraderie across all of the providers in our site to vent/exchange ideas about how to put this program in place in different environments.
7. **It is essential to use Intensive Treatment Foster Care (ITFC) more deliberately as a 'bridge' between residential and home.** Having an ITFC program as part of the provider organization makes it easier to use this resource more effectively for kids.
8. **We underestimated the challenge in converting a traditional RCL program to an RBS model.** Both youth who have been in an RCL program, and the staff who have worked in that program have to let go of the conventions of traditional congregate care and embrace the more flexible, family-centered and community-based aspects of RBS. This takes a lot of work.

B. What has helped youth find permanent connections and move successfully into the community?

1. **The attitudes of the youth are shifting because the adults are making it possible for them to go home again.** The youth then start thinking, “I’m normal again, I belong back in the community,” rather than receiving subtle messages that they can’t return to the community and will have to stay in an institutional setting for a long time.
2. **It makes a difference when youth are included in the process along with their families: their exercise of voice and choice is visible in team decision-making.** You can tell that they know that they’ve been heard. However, it is also important to conduct follow-up meetings to ensure that the needs that they’ve expressed have been met.
3. **There’s greater acceptance by everyone involved that families need support to be successful.** Creating a more gradual transition from one environment to the other with ongoing support helps families and youth feel supported and encouraged to succeed.
4. **Starting parallel community-based activities while youth are still in the residential cottage is important to making a smooth transition.** The youth begin to build connections within the community they will be transitioning to well before they make the move. This also involves teaching families how to network and cultivate their own natural support systems.
5. **At the beginning of enrollment we have to devote a lot of time and energy to help the family get stronger and more confident, but gradually they are able to do more and more for themselves.**
6. **Having the same staff move with the family between the cottage and the community is a key component to successful transitions.**

C. What has helped families prepare to have youth from the RBS program move into their homes?

1. **Engagement of all parties with each other creates a strong community around the youth and family.** For example, hosting gatherings to bring together everyone in child’s life with all staff increases a family’s familiarity with the entire staff. This supports later interaction with anyone, not just the “assigned” staff person.

APPENDICES

2. **Crisis stabilization has worked—families are being ‘held’ by the same team that they’ve built relationships with while the child was in residence.** This provides for immediacy of response—when family needs help they can depend on a familiar, trusted person responding right away. And having continuity of team lends to a high degree of familiarity and trust between family and staff. Other elements of crisis support and stabilization include:
 - a. Early outreach to de-escalate behavioral problems or other incidents.
 - b. Safety contracts are established, and everyone understands what the plan means.
 - c. Multiple Family Specialists available to play interchangeable roles.
 - d. Quality of relationship between staff and families is strong because they have a history together of having been responsive to family’s needs.
 - e. Having a higher degree of interaction between family and staff while youth is in the residential cottage builds rapport prior to crisis happening.
 - f. Teaching “it’s okay to ask for help.” This idea is set up as an expectation for youth and families prior to youth’s transition from residential. For example when things are rough during an early home visit the youth may pick up the phone and ask the RBS staff for help. The family witnesses this and sees that it’s okay for them to ask for help, too.

3. **The role of the Family Specialist has been essential to supporting successful transitions.** Some of the things we’ve learned in this area include:
 - a. It is critical to have diversity in staffing to reflect the diversity of our families. This leads to an improved ability to relate to the parents’ perspectives. We can’t hire only college grads without parenting experience who can only relate to youth and not other family members.
 - b. Families really appreciate the strategic intervention of Family Specialists when families have conflict. The family specialists start by paying attention to how family members interact at welcoming events on campus, at trial home visits, and at family team meetings to gain a better idea of how best to intervene as needed in a way that fits with the culture and situation of each youth and family.
 - c. Family Specialists help families recognize what resources they have within their own support network. For example, a Family Specialist may visit a family at home and see cousins, aunts, and uncles all present in the house. The Family Specialist might then have a conversation with the youth’s mother about all the people she has around her from whom to draw support.

D. What has helped families and youth have stronger voices in decision-making for their children?

1. **Obtaining authentic family engagement is critical.** To do this we have to take the time to get to know the family, and in doing so show a willingness to negotiate, avoid making judgments, and constantly work to build and maintain trust. To achieve permanency, engagement of families has to continue throughout the enrollment period. It's not just something that we do at the beginning and then forget. Some of the steps that we include in engagement are:
 - a. Introducing the idea of RBS and orienting families to what it's all about at point of intake for newly enrolled youth and families, or during conversion when youth from our regular RCL units move into the RBS program.
 - b. Building rapport and relationship; preparing and supporting families as decision-makers while the youth is in the residential phase of the program; and encouraging development of each family's own support network.
 - c. Helping the family increase its confidence in itself and its capacity to manage challenges throughout the community phase of RBS and gradually transferring the support role from the family specialists to the family's natural support network.
2. **The Family Specialist plays the important boundary-spanning role of balancing the tension between youth's needs and family's needs both during the residential and community care phases of RBS.**
3. **The Family Specialist and/or Clinical Care Coordinator should spend time with the family in advance of family team meetings to help them identify what they want to bring up across their various life domains.**
4. **Family team meetings should model effective communication and problem solving strategies.** The facilitator should repeatedly guide the team through a basic process in which needs are identified, an action plan for addressing the needs is developed, and follow-through takes place to make sure the action steps have been carried out.
5. **In the early stages of RBS implementation, most of the youth who were enrolled had lived in congregate care for years.** They had become so adapted to institutional life that we had to help them re-learn how to live in a family and community. One of the tasks of the Family Specialists are to remind youth what a family is and how to interact within a family, and what it's like to live in a community. As the boundary spanning person the Family Specialist helps the youth and family get used to one another and can teach both the youth and family how to ask for and accept support from one another and from others.

E. What has helped to make your family team meetings more effective during the course of a child and family's enrollment? What are some challenges you've had to deal with?

1. **The geographic spread of families presents a logistical challenge for setting up team meetings in or close to the family home.** One thing that has helped a little in this regard has been matching Family Specialists to families in certain geographic areas when possible; but no matter what you do, having effective meetings in the community requires lots of miles and gas.
2. **Scheduling of family team meetings should be based on what works for the family, not what works for staff and agency.** We are exploring the use of teleconferencing to promote family team communication. We have also found that Skype is an option when a family has this resource.
3. **During first part of youth's time in residence, family team meetings usually occur at our residential facility.** Then they move to a community setting chosen by the family. As youth transition to the community, so do the location of the meetings. Once trial visits home happen, family team meetings typically occur in the family home or another nearby community location.
4. **Family team meetings provide a good opportunity to observe natural interaction patterns and to identify ways of helping families connect with local natural support systems.**
5. **Our goal is to have two family team meetings per month while a youth is in the residential component and one each month while in community.** However, we are still working to improve the consistency with which these meetings occur.

F. What innovations in the residential environment, physical facilities or staffing structures have been helpful in improving the effectiveness of RBS operations?

1. **It has been critical to open up the residential cottage to family members.** We invite family members into the cottage to cook meals for all the kids, visit their child, participate in on-site activities, etc.
2. **Our cottage has a front door with a doorbell and welcome mat; that helps it seem more like a home.**
3. **We removed some of the RCL 14 structures.** For example, we eliminated the isolation room and now transport youth in staff cars rather than vans. This has led us to become more tolerant of some challenging behaviors, but has also required us to learn how to catch triggers before the behavior escalates – this also helps youth do the same for themselves.
4. **We reduced our numbers from 12 youth per cottage to 6.** Youth have reacted very positively to this change. They like that it's quieter, calmer, easier to think, and to express themselves. Also that way a particular youth's disruptive behavior has less of a ripple effect in a smaller group; fewer kids lowers the energy and noise levels. The reduction in numbers also helps staff do more 1 on 1 work; and helps youth adapt to living a more family-like setting.

5. **We shifted to having a single child per room.** Beforehand we thought this would prompt negative reaction from youth who were used to always having a roommate. Instead youth have adjusted well and the new arrangement creates space for 1-on-1 times with staff, talking about their day at bedtime, etc.
6. **RBS innovations have caused some tensions within our agency as a whole:**
 - a. Staff in our non-RBS residential program reacted negatively to the philosophical shift toward family-centered practice. They were concerned that this takes away from focusing on the youth.
 - b. Staff in other programs wonder why the staffing level is the same in the RBS unit if there are fewer kids in an RBS cottage? We explained that the new staffing model was needed for more intensive work to expedite transition from residential to community.
 - c. At first, the non-RBS staff frequently criticized the RBS staff. They were concerned that the RBS staff will be unable to manage youth's behaviors without the traditional controls in place and that inviting family into the facility will agitate the youth, among other things.
7. **Even with some increases in staff-to-youth ratios we remain concerned about having enough staff to meet needs of youth and families.** Within the constraints of our current funding model, there's not a lot of extra staff to work with youth when needed. Our response is to find ways to be flexible and creative in doing the work. One benefit of having limited resources is that it compels us to ask our families to do more and take more responsibility. This becomes a capacity building opportunity for the family.
8. **We have moved away from our traditional specialized staffing structure.** Now everyone is a Family Specialist regardless of shift.
9. **Other observations about staffing for RBS provided during the interview included:**
 - a. Insuring flexibility and a family-centered philosophy in staff is essential. Supervisors should negotiate with staff to get their needs met, but everything must be centered on meeting the family's needs first.
 - b. We look for staff with broad, diverse experiences to cross-fertilize expertise. Some of our recent hires worked previously at community-based organizations, in wraparound programs, as in-home support counselors for Intensive Treatment Foster Homes, and some came from traditional residential treatment programs.
 - c. When we move childcare staff from traditional residential treatment positions to have them become Family Specialists in the RBS program, they needed intensive re-learning to catch onto the Family Specialist role.
 - d. You have to be creative with scheduling to promote staff portability. For example often one of our Family Specialists may spend half of her or his shift in residential unit and the other half in community.

- e. We have to support a lot of formal and informal communication among staff to help everyone stay informed and to support interchangeability of staff to meet families' needs effectively.

G. What insights about implementing and running an RBS program do you have now that you wish you would have known about when you started?

1. **We would have handled the transition from traditional group care to RBS differently for youth who had been living in our regular residential programs and their families:**
 - a. We would have implemented a gradual transition from the routines in the regular program to the way things run in RBS, loosening the structure more slowly rather than all at once.
 - b. In general we learned that you don't make sudden changes—kids don't react well to abrupt changes in rules, routine, environment or structure.
 - c. Similarly we would have spent more time helping parents and other primary care givers prepare for their role as being in charge with the youth and making her or him a part of their family again, or in some cases for the first time.
2. **We would have spent more time preparing the Family Specialist role in terms of training, skill building, and coaching.**
3. **We could have used more timely access to other needed training as well, such as learning how to capture EPSDT billing on the Avatar system.**
4. **We also could have used better access to elements of wraparound training that are relevant to RBS.** It would have been better if there was a less time-consuming and more flexible format for this training and if the training was specifically focused on the transfer of key skills from the wraparound programs to RBS programs.
5. **We would have started even earlier to find family members and cultivate community placement resources.** It is hard to find bridge care families and develop permanency options within shorter time that youth spend in the residential component in RBS.
6. **It would have been better if there were more flexibility on the state level to accommodate RBS.** Strict CCL interpretations are restrictive for RBS implementation.
7. **Programs that have their own Intensive Treatment Foster Care have a definite advantage.** Establishing bridge care options and maintaining consistency of care after the transition to the community goes much more smoothly.
8. **We would have done more preparation to engage community resources to support aftercare.**

H. How have the day-to-day routines and overall organizational culture in the residential component of your RBS program changed since it shifted from being a regular group home cottage? What are some successes and challenges that you have experienced in carrying out this change?

- 1. The RBS cottage is more homelike.** We eliminated our seclusion room since families don't have this option in their homes. We emphasize alternate behavioral management methods that are practical at home. For example, our team decided to give one youth a pup tent to use during his residential stay when he "needed a break". He took the tent home with him when he transitioned to community and used when he was adjusting to living with family. This lasted for first few weeks he was home, but he hasn't needed to use it since.
- 2. We had to keep structure in place, including clear, consistent rules to encourage pro-social behavior, but they did have to be adapted.** For example one youth struggled with going to bed and became very agitated at bedtime. Staff started reading a bedtime story to this child while in residence; this became a routine that calmed her down and that could be continued by the primary caregiver at home.
- 3. We struggled with finding the right level of structure for the RBS cottage.** Initially, we loosened structure too much. Youth converting from the traditional RCL program had hard time adjusting to this much change. This taught us that more preparation is needed to explain how the environment is going to be different, especially for conversion kids. We have developed a better balance between flexibility and structure now. This provides sufficient 1-on-1 times with youth, but still keeps order within the unit. This balance requires a greater use of negotiation to empower youth to self-manage. Maintaining the balance is easier now that staff are more confident in the model after some successful experiences with youth.
- 4. We found alternatives to restraining kids who in the recent past were restrained daily in the regular group home environment.** Instead, staff followed them, coached them through difficult situations, taught them to recognize their own behavioral triggers, and helped them practice alternate pro-social behaviors.
- 5. An interesting change is that there are now no more "goodbye parties" when a youth leaves residential because staff follow youth through the transition to community care.**

6. This is our headline success story:

“If K can go home, then anybody can go home.”

K was a youth with a history of daily behavioral outbursts at mealtime. He was always removed and placed in seclusion. In the RBS cottage, he was kept as part of the group and started building relationships with peers. Mealtimes improved fairly quickly, but he still had behavior problems at other times like pulling the fire alarm when no one was looking, and playing music in his room at night. Staff stuck with him to work through these behaviors as well. However, the real transformation came when staff began to partner with K’s aunt and extended family. The Family Specialist developed a strong relationship of mutual trust with the family through little acts like having dinner with the youth and family at their home. The relationship was tested when the youth went for a weekend visit with the family. Things started getting challenging and K’s aunt called to say, “Come take him back.” The Family Specialist immediately went out to the home to resolve the conflict. As the family continued to gain trust in the Family Specialist, they opened up more and continued to ask for help, knowing that support and respite will be provided when needed.

7. Here is a sample of some of the big and small changes in our RBS cottage:

- a. We have a new philosophy: RBS has become a model of treatment, rather than a place that holds onto kids ‘for their safety’.
- b. Instead of the family perceiving the residential team as the ‘enemy’ (that group who’s keeping my kid), the residential team is now seen as being a support resource for the family (these are people who care about me, too).
- c. There is a culture of openness, transparency, inviting in, building family and youth capacity.
- d. We have shifted from a rigid group structure in the RCL cottage to individualized structure in the RBS cottage
- e. Shifted from a ‘dining hall’ set up to a ‘family table’ in the RBS cottage.
- f. We added a family connection room to the RBS cottage that includes couches, computer, TV, books, rocking chairs, board games and bathroom. This is a place for youth and their families to gather, have visits, and practice new behaviors and interactions.
- g. Each youth has her or his own bedroom with home-style (not institutional) furniture.
- h. Each room has a locked box in the closet for personal items; youth can choose to put valuables in this secure space.
- i. Youth select their bedding, arrange the furniture, and can decorate their bedroom.
- j. We have a small white board outside each bedroom where staff can leave individualized messages for each youth: Ex: “Good Morning J! Don’t forget to clean up your room before breakfast and pack your science project for school. Have a great day!” Similar messages are left in the afternoon for when they come home.
- k. Eliminated the isolation room.
- l. No more restrictions about phone use either for youth or family members.

8. Here are some challenges that we faced in making these changes:

- a. It is difficult to shift from a readiness model to a recovery model. We still need clearer, more objective criteria to support decision to transition from residential care to community care.
- b. Using a hands off (no restraints) policy forces staff and youth to use verbal skills more; requires more tolerance of challenging behaviors; mimics what it will be like when youth is at home.
- c. The RBS cottage still needs to function as a residential unit in some ways: managing shift crossovers and keeping track of what is planned for each shift so that there is clarity about what everyone is doing. It was necessary for us to re-create these structures behind the scenes.
- d. It takes work to strike a balance that provides enough structure while preparing youth to live in a family setting.

I. What innovations have you introduced to increase family involvement in the residential cottage?

1. We developed an “at home” safety plan early in the residential stay:

- a. Prior to first visit home, the RBS team and family work together on developing safety plan.
- b. As home visits increase, the family usually starts to see the same behaviors from the youth as she or he expressed in the residential unit.
- c. When this happens the RBS team can often walk through the safety plan with the family and de-escalate the situation over the phone, without the need for a crisis stabilization visit.
- d. Events like these help the team and family develop stronger relationships so that they can implement even better safety plans.

2. We created more opportunities to connect the residential team with the family, such as:

- a. Welcome events
- b. Transporting family to different meetings
- c. Spending time in home with parents and youth (e.g., eating dinner together, promoting family interaction and communication)
- d. Tying the level of engagement to increasing familiarity between youth and family—grows over time
- e. Build rapport by meeting needs of the family as well as the youth

APPENDICES

3. **We encourage relationship-building between the family and the RBS team as way for family to practice asking for help and accepting support:**
 - a. When we find someone on staff that a parent connects well with, this staff member is used as part of family's relational network and helps keep the family engaged with the RBS process.
 - b. Through these relationships the family builds their own capacity, trust and communication skills.
 - c. The RBS team also recognizes which staff youth are connected with and let that drive staff assignments.
 - d. Although the Clinical Care Coordinator is assigned from day one, we let assignment of Family Specialists evolve naturally from staff-youth, and staff-family connections that emerge, while also identifying extra staff that have good relationships as back up.

4. **The characteristics we look for in staff who fill the Family Specialist role include:**
 - a. Critical thinker
 - b. Ability to creatively problem solve and think 'outside the box'
 - c. Good communicator verbally and in writing
 - d. Flexible and nimble—comfortable with ambiguity; can't be too linear, rigid
 - e. Independent worker
 - f. Reliable
 - g. Committed to family-centered practice

5. **In our program we try to insure that everything that happens in the RBS cottage can be replicated at home.**

6. **We have integrated family visits into day-to-day routines in the cottage and increased coordination and flexibility between on campus involvement and community activities.** This helps the family be involved with youth's plan and helps youth stay on track with plan.

7. **Role of the Parent Partner has been key in our program:**
 - a. This person plays a critical role in outreach to family—brings staff to the home environment and welcomes families into residential environment.
 - b. Our parent partner helps to re-create a sense of community at the family's home. For example, on one visit to a family home to help the family and youth prepare a meal together, it turned out that 7 cousins were also present along with the caregiver. The parent partner responded by giving every child a chore, including the youth from our program. Having that youth work together with his cousins to serve his Auntie was very special. That helped the youth feel like he belonged and could contribute to the family in a meaningful way.
 - c. The Parent Partner also provides a 1-on-1 connection with parents and caregivers who are less likely to have support network in place and helps them build one.

8. **Our Family Specialists help find local connections to keep youth engaged in pro-social activities when they go home and also mediate conflicts between youth and parents.**

J. What role does the team in the RBS cottage play as the youth transitions from the residential component of the program to a community setting?

1. **Our Family Specialists who work in the residential cottage also work with youth in the community and are essential to effective transitions.** They engage with youth immediately to help them develop pro-social skills while they are in the cottage and also start getting to know the families from the beginning of enrollment. They then work with families and youth throughout the course of care. They develop rapport and trust with the family and youth and an understanding of each person's strengths and needs.
2. **Our Family Specialists work from a family systems perspective.** For example, a family may have 4 or 5 other children at home, so the Family Specialist has to relate to all of the family members as well as the parents and the youth who is in the program.
3. **The role of our Family Specialists is to promote family confidence, capacity and self-sufficiency:**
 - a. They start by providing strong support at beginning, and then taper that slowly over the course of enrollment.
 - b. They encourage each family's interdependence with their natural support system.
 - c. They use the wraparound model to diminish family's dependency on the provider agency and increase self-sufficiency.
4. **The criteria we use to adjust the degree of family support our Family Specialists provide include:**
 - a. Is it a need?
 - b. Is there another way to fulfill it?
 - c. Is it a one-time need or ongoing?
 - d. Is there a self-sufficiency opportunity for the youth?

APPENDICES

5. **Our family team meetings always include RBS cottage staff.**
6. **At the meetings there has been a shift from an “us (professionals) vs. them (families)” approach to a “we’re all in this together” perspective.**
7. **Each youth leaves our RBS cottage with a Safety Plan and a Support Plan for the family.** Everyone in the RBS program, including cottage staff, has a relationship with the family, so the family can call on whomever they feel connected with for support.
8. **We have found that having a good relationship with all of the staff, including those in the cottage gives youth hope that there are people who care about them and their family.** It’s now about accumulating connections, rather than breaking youth apart with each move between environments.

K. How has the relationship between your team and other agencies and individuals involved with the youth and family changed as a result of the shift to the RBS approach?

1. **Under the old model, the county agency decided when a youth was ready to leave residential placement;** under RBS, the social worker is part of the family team process and works with them to reach agreement that a good community placement option has been developed and to develop a plan for transition.
2. **Some social workers have difficulty accepting the RBS philosophy.** At the moment we are seeing stronger acceptance at the supervisor level than among line staff.
3. **The staff who work in the residential cottage now have a much greater and more fluid relationship with community partners.**
4. **At first some of our community partners (social workers, lawyers, etc.) were shaking in their boots about the risk—“there’s no way these kids can go home!”** This required lots of re-education regarding RBS. Fundamentally there had to be a change in language, from talking about ‘discharge from residential’ to ‘transition to the community.’ So they knew our program was going to continue to provide intensive help, support and supervision.

L. What advice would you give another provider agency that was getting ready to start an RBS program?

1. Always emphasize building better communication and stronger trust between staff and youth and families.
2. Focus on the transition to permanency.
3. Teach staff to rely on proactive rather than reactive intervention.
4. Find a way to switch from a readiness to a recovery philosophy.
5. Remind the staff that we are all working together for the benefit of the youth and their families.
6. Remember that the family team includes the youth and their parents or primary caregivers surrounded by other adults who are there to support their success.
7. Have all staff (Family Finder, Care Coordinator, Family Specialist, Parent Partner, etc.) in place at start and get everyone on same page to move forward with program.
8. Make sure staffing model, roles, responsibilities, and coverage are all clear among the core group who are implementing the program.
9. Some programs focus on transition from the beginning of program startup; we think it may work better to focus on, “How do we build a safe, comfortable, and portable structure for the youth?” Then bring family into this environment.
10. Don’t necessarily start by enrolling youth who have been in out of home placement for years. Try to identify youth earlier, before significant disconnection from family has occurred.
11. Get the community on board with all changes involved in implementation of RBS (e.g., program, fiscal, cultural).
12. Work with the family as a whole and always consider youth in the context of their families.

APPENDIX D

Site Interviews Summary – Part Two

This appendix contains the summary of reflections provided by county and provider agency staff at two of the demonstration sites. These interviews were conducted using a different approach from the one reflected in Appendix C, and this is reflected in the format that follows:²⁹

What's working?

FAMILY ENGAGEMENT STRATEGIES THAT WORK:

- Engineering a culture shift to have staff view the family as part of the solution rather than as the problem, and to change terminology to refer to the group home as a “transition home”.
- Strong use of parent partners to support family engagement efforts.
- Communicating successes to help overcome family resistance to RBS.
- Making physical and structural changes at the residential facility to make it welcoming and easy for families to visit at the cottage.
- Pre-TDM, TDM, first 30 – 60 days are critical junctures for engagement to occur.
- Building relationships between families and Parent Partners.
- Providing concrete, individualized support to families to help them overcome barriers to participation (e.g., transportation, scheduling events when convenient for families to attend, etc.). One of our agencies is doing this particularly well.
- Create welcoming group social events to help families feel at home in the residential environment (e.g., families cook for youth on site, social nights, support groups).
- Relationship between families and Parent Partners is critical for relating to where families are, helping with concrete needs, brokering issues in their lives that may impact their ability to keep stability in family. One provider attributes this role to being able to cut time in treatment in half due to quicker engagement through Parent Partner's relationship with family.
- Parent Partners play a big role in keeping connection through transition to community.
- Utilize the relationships on the child and family team to identify the best team member to make the outreach and engagement bridge with family.
- Conduct targeted orientation activities such as “strengths chat”, 1-on-1 outreach, and family-friendly RBS Pamphlet to help prepare families for participating in a more collaborative, family-centered involvement in their child's care.

- Concrete services and supports, family support groups, on-campus activities and supportive outreach to families in their own communities are all strategies that work to build trust and commitment with families.
- Parent Partners and other team members have assumed a non-judgmental, strength-based attitude that puts meeting the family's needs on par with meeting the child's needs.

PERMANENCY STRATEGIES THAT WORK:

- When circumstances have significantly changed for the better with a parent whose rights were terminated, explore option of reinstating parental rights.
- Follow the lead of youth and family to determine pace of leaving residential component and going home. If youth and family request it, the team moves faster to make permanency happen.
- When families are engaged, staff members now consult with parent/relative and build collaborative unit to support the child's care and growth.
- All providers have more liberal visitation policies in place, plus on-campus visitation centers make overnight visitation for families a common occurrence. These elements contribute to building stronger bonds between youth and families in preparation for transition home.
- Linkages to informal natural supports other than agency based supports and services have strengthened permanency. Team members focus on helping family link to natural systems of support in their own communities. Helps families recognize who their natural support network is and practice how to keep these people connected and engaged in their success.
- Supportive, progressive visitation helps youth and family develop stronger bonds that reinforce permanency. Staff proactively maintains contact with family at times of increased visitation to help them practice new behaviors, determine where family needs support and be actively responsive to those needs in planning and proactive follow-up. Allows visits to continue and progress at a good pace, knowing that team will be there for them.
- One provider provides training and support to establish relative caregivers who have an existing relationship with specific RBS youth as ITFC providers.

APPENDICES

CARE COORDINATION STRATEGIES THAT WORK:

- Family team meetings are very family-driven and a forum in which parents are learning to express their needs, define their goals and utilize support.
- Having specialized RBS child welfare workers ensures commitment and flexibility about worker participation in family team meetings.
- Assigning all RBS Probation cases to one Probation Officer to facilitate the commitment of the Probation agency to the RBS principles and the active participation of Probation in the RBS program.
- Plans are documented and shared quickly (w/in first 30 days). This gives families a reason to celebrate right away.
- A second level interagency review process in our county provides a broader perspective to prevent unilateral disenrollment decisions; helps providers stick with youth for whom they are running out of ideas for how to assist or are not seeing sufficient progress with their available interventions.
- Good attendance of youth and families at Child and Family Teams (CFTs) meetings.
- Various strategies are helping make CFTs attractive for youth and family to attend (e.g., hold meeting at location convenient for youth/family, provide meal/food during meeting, parent partners engage 1-on-1 prior to and following meeting).
- The Interagency Screening Committee (ISC) has been helpful in reducing administrative barriers and providing QA (ensuring all planning domains are addressed, voice and choice present, family signed the plan)
- Involving the Intensive Treatment Foster Care (ITFC) provider in the CCT meetings to ensure collaboration and communication in meeting the needs of the youth as they transition from residential group care to an ITFC home.

UTILIZATION MANAGEMENT STRATEGIES THAT WORK:

- Clear understanding of criteria for enrollment in RBS; finding the right fit for youth who can benefit from RBS intervention.
- Close tracking of cases by the RBS Local Implementation Team (LIT) has resulted in staying on pace with expected timelines for transition from residence to community.
- Having a local oversight team that brings all the partners together on a regular basis to solve problems, County staff now understand their role in RBS, especially those staff who were involved with the initial planning process, participated in the LIT and were a part of RBS implementation. Good partnership with Mental Health, Probation and Social Services has been important. Our local implementation coordinator has really held this group together and it has become very cohesive.
- When people get confused about their role or new system issues come up, they use the LIT meeting forum to resolve these issues.

THERAPEUTIC INTERVENTIONS THAT WORK:

- Our county has negotiated significant adaptations of the Functional Family Therapy (FFT) model so that it can be utilized for RBS families.
- It is important to ensure that crisis intervention for families is individualized for each family, not just for therapeutic crises, but also for practical needs for support.
- One provider shared its FFT resources to fill another provider's gap resulting from staff turnover of their trained FFT therapist. This required significant cooperation between Social Services, Mental Health and Providers to develop this creative solution so that services to families would not be interrupted.
- Crisis stabilization has been effective and provides an important tool for CSWs to help prevent family disruption: response to a crisis is rapid, no paperwork to change placement, and the intervention works to stabilize youth.
- Team develops crisis management plan for each case to guide what actions will be taken in the event of a crisis. Plans developed well in advance, team agrees on triggers for initiating action; designates best people to be crisis responders based on individual case relationships and families are given opportunities to practice what they will do if a crisis occurs.
- Mobilization team does pre-planning with communities from which kids come. Team will go to community, engage and introduce themselves to family members who are designated as support resources. Team also goes to the school to orient them to the safety plan, so they are aware of what the triggers are, what the response plan is, answer questions, etc.
- There are several evidence-based practices that have been implemented by our county (aggression replacement therapy, trauma focused CBT, functional family therapy). Each provider decides which EBP fits the child's need the best. This offers menu to choose from to meet the individual needs of youth.
- Employ multiple therapeutic interventions such as addiction treatment, family therapy and Trauma-Informed Care Model (Risking Connections), resulting in reduction of Absent Without Leave (AWOL) incidents, enhanced conflict resolution and increased stability.

Training and Support approaches that work:

- Having an extensive pre-service training schedule (40 hours for new staff) has made a difference. Also we had RBS staff take responsibility for training traditional staff to promote common understanding and clarity about differences between RCL and RBS programs.
- An RBS practice community of about 50 or 60 people has been built through joint training experiences as providers trained together.
- Youth from the child welfare system are generally harder to work with than probation kids. We have had to respond to culture change implications for staff and deal with an

APPENDICES

increased incidence of behavioral disruptions. This has led to frank discussions about safety issues for staff.

- The round of RBS foundational training, youth specialist training and facilitator training were very effective.
- Provider agencies themselves have invested in RBS training to supplement project supported training resources (e.g., UC Davis and RBS consultants).
- New skills and attitudes developed in RBS staff have informally influenced residential treatment center staff (non-RBS) due to former staff relationships

What's challenging?

BARRIERS TO FAMILY ENGAGEMENT:

- Providers need a chance to work with families long enough to build trust so families who are reluctant to participate know this isn't the same old system.
- Encouraging family involvement with probation youth as they transition to the community.
- We need more attractive options to keep families engaged after children and youth have completed the transition to the community.
- County line staff could do more to facilitate and endorse family engagement as part of plan for the youth.
- Lots of internal family conflict can sometimes interfere with cooperating to support child. Need to teach families the skills and communication strategies to resolve these conflicts and work together for the best interests of the child.

BARRIERS TO PERMANENCY ACHIEVEMENT:

- Our demonstration site didn't have family finding built into the program like other RBS sites—that's a missing piece for us.
- Difficult to predict level of participation and commitment of families at intake. Many of the children and youth have experienced a break down of family ties, following enrollment. There is no guarantee that someone who is available at the beginning will remain that way. Likewise, there are children and youth who appear at the outset to have nobody, who in fact can do very well once family connections are found or made.
- Some families are homeless, have criminal records or have other barriers that need to be cleared out of the way for permanency to work.
- Need to understand why some families have been unable to access, participate and utilize services and support to continue their commitment as a permanency resource for the youth.

- More families in the child welfare system than those with children and youth in the probation system discontinued their involvement.
- Court processes don't necessarily move as quickly as we need them to for timely RBS transitions to occur.
- Inconsistent participation from DCFS social workers at CFTs—this has been frustrating and burdensome on the provider staff to keep CSWs informed about key decisions of the team. Their participation is critical to support reunification plans. Providers often need to resort to requesting a Team Decision-Making (TDM) meeting, since CSWs are required to attend these meetings.
- Youth who are simultaneously involved in Child Welfare and Probation have been challenging. Because Probation has not been a partner in the RBS process, they are not as involved.
- Challenge with 10-month target date for transition to community. Crisis-driven culture of DCFS works against prioritizing CSWs time for advance planning to prepare for transition. Instead, CSW unavailable to engage in transition planning until 1 day prior to deadline (or even 2 weeks after).
- Sense of urgency for child to transition from residential to community also constrained by attitudes of some CSWs at DCFS who believe, "If the child is doing well and they're stable, why move them?"
- Fewer ITFC homes than needed.
- Preparing kids and linking them to their community is a barrier due to geographic distances.

BARRIERS TO CARE COORDINATION:

- Logistics around the family team meetings: lots of up front work to clarify roles; lots of coordination for multiple workers in different systems; and challenges getting families to the meetings.
- There is reluctance by providers to refer cases to our second level review and conferencing process. The lack of referrals to this process may also be an indicator that the forum itself may not be as helpful as originally thought.
- Shift to family-centered practice requires deep culture change. Struggling to shift from independent (but less coordinated) decision-making before to sharing responsibility for decisions with family leading the way.
- Need more participation in CFTs from line workers. Consistency and degree of participation is variable across individual workers. CSWs intimately involved in cases can help drive timing of transition to community and build trust in the team's recommendations.

APPENDICES

BARRIERS TO THERAPEUTIC INTERVENTIONS:

- Trying to maintain integrity with the RBS principle of family voice and choice given the rigid parameters of the evidence-based FFT model we are trying to use. It may be that RBS will need more flexibility than FFT can offer.
- FFT may not work for every family and there should be other options to achieve the same purpose.
- Continued reliance on traditional models of behavior management such as level systems and point systems do not provide a portable therapeutic milieu.
- Our second level review and conferencing model—depending on how it's handled—can potentially disrupt the integrity and autonomy of the family team process. The hierarchical nature of review process can be perceived as threatening.
- Since providers can choose from a menu of available evidence-based practices, no clear expectation that some minimum level of family-focused therapeutic services is a required element of RBS.
- Non-traditional therapies are also being employed frequently. Adequately documenting these services to be claimed to Mental Health Services Act (MHSA) or Early Periodic Screening, Diagnosis and Treatment (EPSDT) fund sources is a challenge.

BARRIERS TO UTILIZATION MANAGEMENT:

- Not enough referrals are being made to keep RBS providers at full capacity; need more awareness of RBS as a service resource among social workers and probation officers.

BARRIERS TO TRAINING AND SUPPORT:

- It has been a challenge to get CSWs trained fully in RBS. Foundational training open to CSWs, but haven't had much success in getting social workers to attend.
- Staff turnover at County level makes it difficult to retain knowledge base about RBS among new staff.
- Recently completed our county's RBS Site Review (shared learning experience based on local oversight) observed that some provider staff not fully clear about their role, especially staff who transitioned from residential to community setting.

What adaptations to the model were made?

ADAPTATIONS TO FAMILY ENGAGEMENT:

- The steep learning curve for RBS implementation has required some slipping of our original target goal of 9 month stays in residential. This has made us rethink when to start family finding and engagement—we need to start those activities as soon as possible.
- Changing our language to “relationship building that may or may not result in permanency” helps with the engagement process.

ADAPTATIONS TO THERAPEUTIC INTERVENTIONS:

- We had to re-negotiate our use of FFT so that it could be more flexible and fit better with RBS program model without compromising the integrity of FFT’s evidence-based model.
- We had to pay increased attention to how we work with families within first 90 days to help prepare them for participation in FFT and other family-driven activities in RBS.

ADAPTATIONS TO INTERPRETING RULES AND REGULATIONS:

- We had to deal with an initial misconception about the extent of restrictions on co-mingling between youth in the RBS program and those in our traditional RCL units. This was later clarified to only barring co-mingling with regard to staffing, funding and services, not to interactions between youth for friendship purposes.

ADAPTATIONS TO CARE COORDINATION:

- Creating formal guidelines for CCTs to ensure quality, consistent structure, and timely follow-up.
- Including the ITFC provider in the CCTs has helped address the issue of confusion occurring between the roles of the group home staff and the community placement staff when youth step down from the residential group home component.
- Safety Plans have list of numbers, but no priority about who to call first. Protocol was changed to identify 1 contact phone number of someone who can act as screener. The screener recommends others on the list to call depending on the situation.

What’s next?

- **Consider adding the family finding function to our county’s RBS program.** Even if a family member has been identified for the youth at one point in time, family finding is not a one-time event, but rather an activity that may need to be resumed at anytime during the course of the youth’s enrollment. If cost is a barrier to adding a specific position, this function could be infused as a philosophy and role that everyone takes on throughout the team. This may work better than only having a single dedicated person or couple as the permanency focus anyway.

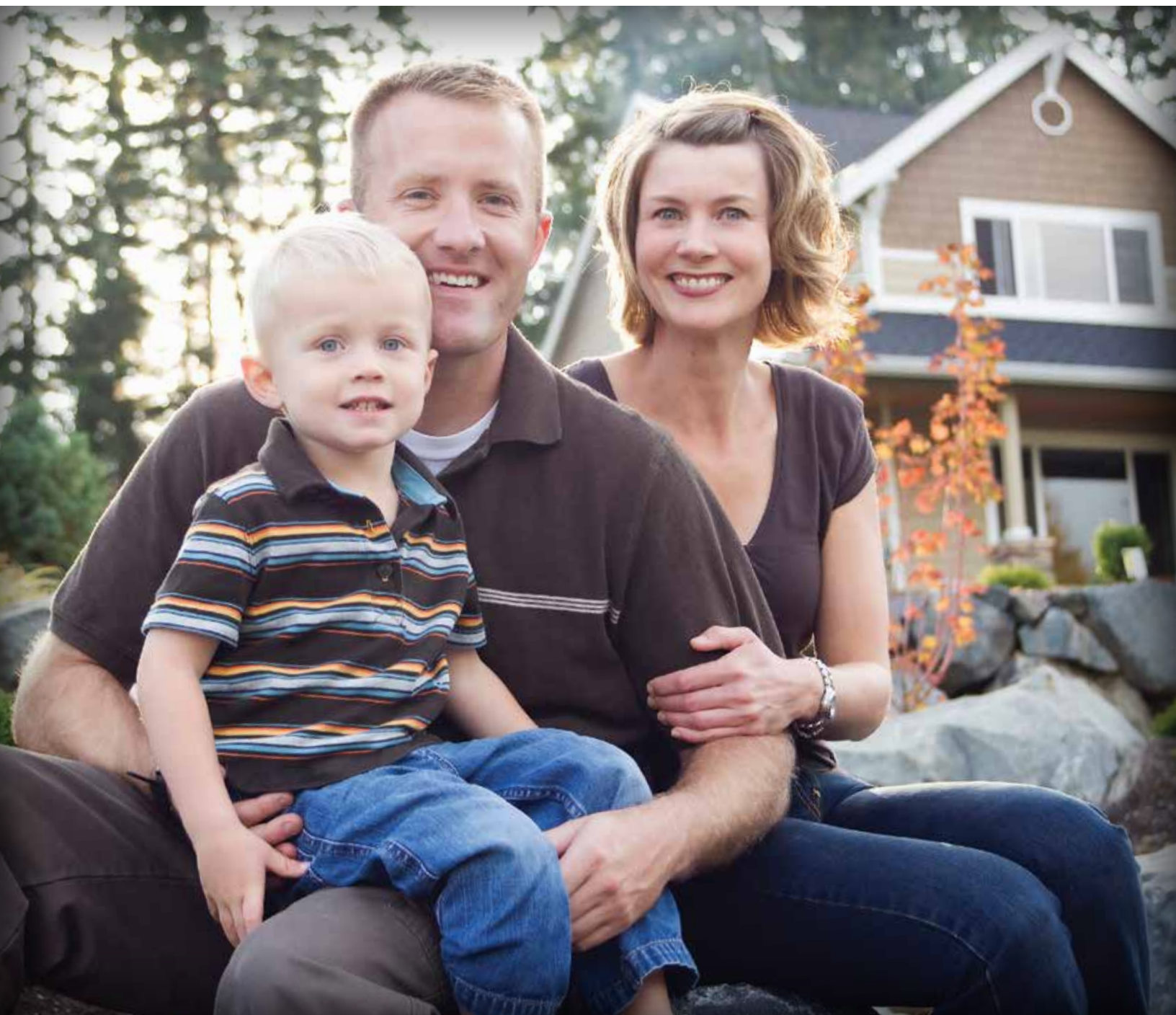
APPENDICES

- **Consider more emphasis on concurrent planning.** Identify more than one permanency option for youth, so that everyone is invested in the primary family's success, while at the same time developing a back-up plan if the original family falls away.
- **Consider feasibility of additional therapeutic models as alternatives to FFT.** Allowing multiple options for therapeutic work with families may better align with ensuring that family voice and choice directs the way intervention looks. It is the ability to individualize treatment that makes RBS different. Some providers suggested looking at other models that are more flexible, effective and more cost-effective and that may be a better fit for RBS.
- **Consider ongoing training needs.** Need refresher training quarterly to keep skills sharp, support staff and respond to turnover. It works best to have team-based training outside of the residential milieu and away from clients.
- **Consider how referrals are being identified and defined.** RBS needs to be understood more broadly throughout the county system. Placement referrals are not forthcoming as quickly as necessary to keep funding model sustainable. It might be helpful to broaden the criteria so that more kids can be considered for the program, including those who may not have family immediately available. It may be helpful to survey the County to see which kids are in need of the RBS service resource now that we have a better idea of what it entails and what it offers.
- **Consider creating more emphasis on building natural support networks for families** as an engagement strategy as opposed to bringing children and youth back to the residential program for support and stabilization. The ultimate goal is for the families not to need the RBS program, so more efforts should be placed on helping them connect to natural supports in their communities that will be there after the program ends. (This has been a problem for many Wraparound programs in our community as well. The families do OK as long as the program is wrapping them, but they are left just as alone after the program pulls out as they were before it began.)
- **Consider possible resolutions to a CalWIN³⁰ issue.** We need to improve the alignment of CalWIN so that it provides better support for RBS. Sometimes a caregiver's CalWORKs eligibility is impacted by payments to the provider to help support reunification when the child or youth is in the community. The problem seems related to the lack of a separate RBS code in the CalWIN payment system.
- **Consider creating an expedited process to waive minor infractions found on criminal background clearances of families** so they can be approved as permanency options. Utilize DCFS liaisons on ISC to diminish the system barriers that slow down ASFA approval of relatives as placement resources. Engage ASFA county manager in developing an expedited, streamlined process for reviewing criminal clearance issues.

- **Consider reviewing disenrollments to determine what factors may have contributed to unplanned discharge from RBS** and what refinements to assessment, matching, intervention or care coordination may be implied by this analysis. Conduct more thorough analysis of disenrollments against successful graduations.
- **Consider using CWS/CMS to document family connections** and maintain a history of family
- **Consider developing protocols to more closely monitor progress of movement toward transition to community** as a means of improving achievement of target timeframes in residential component.
- **Consider revising social marketing materials to include more tangible success stories from the youth and families with positive outcomes from RBS** so far to build trust and confidence among the line staff in the RBS program model. May also identify champions within DCFS line staff that can help change the attitudes of their colleagues.
- **Consider utilizing geographically based interagency referral and review teams** to cover the various areas that our county serves, so that they will have better knowledge of local community resources and have an easier time following the youth and families into their own communities.
- **Consider future training on the following topics:**
 - Refresher on values and principles of strength-based, family-centered care, especially for county staff. It is still a cultural shift to respect families (the same families who may have harmed the child in the past).
 - Due to longer arc of care that providers are now responsible for across different environments (residence and community) DMH clinicians for example have a need more skill building on compassion fatigue, time management, in-depth training on how to get targeted MH needs met ('fix it' syndrome).
 - Trauma-informed practice principles for CSWs.
 - County already considering advanced training module on CFT meeting facilitation.
- **Establish expectations for CSWs to allow providers timely access to case files to mine for family connections.**



ENDNOTES



Deep system change
is possible but requires
enormous dedication by
staff, a clear mission, a
resilient partnership and
consistent leadership.

LESSONS LEARNED

Endnotes

1. Abstracted from Molitor, F., Lichtenstein, C., Stevenson, A. M. and Pecora, P. J. (2012). *Year Two Interim Evaluation Report for the California Residentially Based Services (RBS) Reform Project*. Sacramento: Walter R. McDonald and Associates, and Seattle: Casey Family Programs. As such, these data are insufficient to draw definitive conclusions about the impact of RBS. More extensive statistical tests will be used to determine whether changes over time are significantly different. Ideally, sufficiently large samples will allow for the inclusion of demographic and possibly other measures in the analyses to control for potential confounding effects. Moreover, future reports will provide information on more longer-term and fundamentally important outcomes in line with the goals of RBS, including lasting connections with family members.
2. Pecora, P.J. and Ayer, H. (2012). *Parent, Staff, and Stakeholder Perceptions of California Residentially Based Services: First Findings*. Seattle: Casey Family Programs. Both the quantitative and qualitative interim evaluations are available from Casey Family Programs, contact: Ppecora@casey.org.
3. Each site and provider included a different mix of therapeutic services based on the population they were serving and the training and certifications of the clinical staff. They included Functional Family Therapy, Motivational Interviewing, Structural Family Therapy, Family Finding and Engagement, Trauma-Informed Cognitive-Behavioral Therapy, Multi-Dimensional Treatment Foster Care, Anger Replacement Training, Life Space Crisis Intervention, and Managing and Adapting Practice, a new approach designed by Professor Bruce Chorpita that helps providers match strategies from a wide variety of evidence-based practices with each client's specific needs.
4. This report is one of a series of documents that will chronicle the progress of this exceptional reform effort. Updated project information can be found on the CDSS website at www.childsworld.ca.gov/PG2119.htm.
5. In California the term "group home" is used to describe a variety of congregate care settings for children and youth. A group home can be a single house in a neighborhood that provides care for 4 to 6 children or youth at a time, or a campus-based facility with multiple buildings and an on-grounds school where thirty or more children or youth are living and a variety of other services and programs are offered. A group home provider might have several community-based homes as well as a campus program. The term "residential treatment center" does not have a statutory or regulatory basis in California, but is often used to refer to higher-level group homes that offer mental health services as part of their service package. California also has "Community Treatment Facilities" or CTFs. These are facilities with a locked perimeter that require approval by the county department of mental health and the consent of parents or guardians and of older youth for admission, and that provide psychiatrically based care for children and youth with severe mental illness who also frequently run away.

6. “A Framework for a New System for Residentially-Based Services in California,” included in this report as Appendix A.
7. Some of the sources used in developing the model included:
 - Burns, B. J., Hoagwood, K., and Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Review*, 2, 199– 254.
 - Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies*, 14(4), 551– 575.
 - Landsman, M. J., Groza, V., Tyler, M., and Malone, K. (2001). Outcomes of family-centered residential treatment. *Child Welfare*, 80, 351– 379.
 - Leichtman, M., Leichtman, M. L., Barber, C. C., and Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry*, 71(2), 227– 235.
 - McCurdy, B.L. and McIntyre (2004) “And what about residential...?” Reconceptualizing residential treatment as a stopgap service for youth with emotional and behavioral disorders. *Behavioral Interventions*, 19, 137-158.
 - U.S. Surgeon General. (1999). *Mental health: A report of the surgeon general*. Retrieved May 16, 2009, from www.surgeongeneral.gov/library/mentalhealth/toc.html.
 - An article published later that has been a useful resource during the implementation of RBS is Walter, U.M. and Petr, C.C. (2008) Family centered residential treatment: Knowledge, research, and values converge. *Residential Treatment for Children and Youth*, 25(1), 1-16.
8. The Framework document and the statute that created the RBS Reform Project (AB 1453) did not have an explicit outline of 7 elements for RBS programs. The documents described 4 RBS services (*Environmental Interventions* in the residential cottage to reduce challenging behaviors, *Intensive Treatment Interventions* to facilitate reconnection of children and youth with their families and communities, *Parallel Interventions* to help the family, school and community prepare for the child or youth’s return, and *Follow-Up, Post-Discharge Support* to insure stability and success of the reconnection with family and community. However, the Framework document and the statute in other sections referenced other requirements for RBS programs including family involvement, continuity of care, care coordination, and shortened length of stay. Over the years that the local and state level teams have been designing and implementing the RBS programs, the 7 core elements listed here have emerged as a clearer statement of what they are trying to accomplish.

9. The research literature is not specific as to what constitutes a shortened length of stay. Hair, *ibid*, in the seminal paper on which RBS was based, referenced studies showing that most of the gains in residential treatment occurred within the first 6 months of placement. The four RBS pilot sites vary in their expectations for shortened length of stay from 5 months to 12 months. Most of the children and youth in the target populations being served in these sites have experienced lengths of stay of 2 years or more, with multiple placements during that time.
10. Leichtman, M. (2007) The Essence of Residential Treatment: Part I, Core Concepts. *Residential Treatment for Children and Youth*, 24(3), 175-196. In the late 1940's the term "residential treatment centers" began to be used more frequently, and by the 60's most states treated these facilities as primarily mental health resources.
11. Leichtman, M. (2007) The Essence of Residential Treatment: Part II, Implications for the Ideology and Structure of Treatment Teams. *Residential Treatment for Children and Youth*, 24(4), 283-298. Leichtman points out that the central therapeutic modalities in residential treatment centers were helping troubled children negotiate tasks of daily living effectively through situation-specific guidance and life-space interviews provided by many individuals who comprise the residential team. He contrasts the parenting – oriented modality of the residential treatment center with the treatment of diseases and syndromes through the application of defined procedures in the medical model.
12. Cf. Landsman, et al., *ibid* and Whittaker, J. K., and Pecora, P. J. (1984). A research agenda for residential care. In T. Philpot (Ed.), *Group care practice: The challenge of the next decade*. Surrey, UK: Community Care/Business Press International.
13. For example, see the story of "K" in Appendix C: K was a youth with a history of daily behavioral outbursts at mealtime. In the regular group home setting he was always removed and placed in seclusion when this happened. In the RBS cottage, he was kept with the group and started building relationships with peers. Mealtimes improved fairly quickly, but he still had behavior problems at other times like pulling the fire alarm when no one was looking, and playing music in his room at night. Staff stuck with him to work through these behaviors as well. However, the real transformation came when staff began to partner with K's aunt and extended family. The Family Specialist developed a strong relationship of mutual trust with the family through little acts like having dinner with the youth and family at their home. The relationship was tested when the youth went for a weekend visit with the family. Things started getting challenging and K's aunt called to say, "Come take him back." The Family Specialist immediately went out to the home to resolve the conflict. As the family continued to gain trust in the Family Specialist, they opened up more and continued to ask for help, knowing that support and respite will be provided when needed.

14. The RBS programs in all 4 sites used a strength-based child and family team planning process. The names each program gave to the teams varied from site to site. All included active family involvement, as well as the inclusion of formal, informal and natural supports. Much of the structure and function for the RBS family team meetings was drawn from the extensive experience many of the providers had with delivering community-based wraparound services. Although there is no corresponding system for classifying the level of need of a given child or youth, county placing agencies often identify children and youth by the RCL that an agency feels the child needs. Hence, a social worker might refer to a given child as a “level 12” indicating a high level of need.
15. Providers around the state addressed the second problem through two lawsuits brought to compel the California Department of Social Services to increase the monthly payments to reflect the cost of living raises that hadn’t been made. As noted in other sections of this report, these companion lawsuits dragged on for most of the years that RBS was in development. A decision ordering the rate increases was finally entered shortly after the demonstration sites began serving their first children, youth and families.
16. The RBS Reform Project is an example of the application of the rapidly growing field of Implementation Science. Translating science into service requires an understanding of the principles of diffusion of innovations, organizational change, quality assurance and quality improvement, and staff training, support and supervision. Cf. Fixsen, D.L., Blasé, K.A., Naoom, S.F. and Wallace, F. (2009). *Core Implementation Elements. Research on Social Work Practice*, 19(5), 531-540.
17. Dearing, J. (2009). Applying diffusion of innovation theory to intervention development. *Research on Social Work Practice*, 19(5), 503-518.
18. The term “community of practice” was coined by cognitive anthropologists Jean Lave and Etienne Wenger in an article published in 1991, and further explored in Wenger’s 1998 book: “Communities of Practice: Learning, Meaning and Identity.” It has been used broadly to describe a group of people who share a common interest and desire to learn from and contribute to a community through a process of on-the-job discovery that is sometimes called “situated learning.”
19. Edgar Schein has explored the concept of organizational cultures, the interaction of subcultures within an organization and the impact of those cultures on organizational change in depth in several of his books, including *Organizational Culture and Leadership*. (4th Edition, 2010, San Francisco: Jossey-Bass).
20. CDSS staff put a great deal of effort into creating and implementing a time study system for organizing the reporting of multiple service roles in a single document that could be used by all of the RBS providers. However, even with that system, direct service staff report having difficulty deciding how to allocate efforts that could fit in a variety of roles. They hope that something simpler can be developed for any further rounds of implementation.

21. Parent partners are paid employees of the provider agencies whose life experiences as parents or primary caregivers of system involved children with severe emotional disorders give them a unique perspective and ability to connect with other parents and help them navigate the formal elements of the program.
22. Gerald Mallon of Hunter College has put it this way: “Permanency is about locating and supporting a lifetime family.” Mallon, Gerald, (2010). “Unpacking the “No”:
Planning for Youth Transitioning from Foster Care to Adulthood. National Resource Center for Foster Care: Power Point presentation retrieved November 2, 2011 from www.hunter.suny.edu/socwork/.../Unpacking%20the%20No.ppt.
23. One of the demonstration sites, Los Angeles, had for a time prior to the beginning of the RBS project, attempted to blend its residential and wraparound services in a model called Res-Wrap. Because wraparound in California was funded by diversion of the state and county portion of what would have been spent for group home placement, it was not possible to pay to both house a child or youth in a group home and also have a child and family team and develop and implement a flexible plan of family-centered supports and services. Los Angeles attempted to get around this by using some of the savings generated by their regular wraparound program to pay for adding wraparound teams and services for children and youth in group homes. The program was successful in shortening lengths of stay, but had to be discontinued because county fiscal managers determined that this was not a proper use of these funds. Res-Wrap was a precursor to RBS, but its discontinuation teaches that a successful fiscal model for large scale implementation of RBS must have more of a Wrap-Res orientation that puts the residential component within the larger scope of a multi-environmental and multi-dimensional response to the needs of children, youth and their families, and explicitly address the barriers between funding community and residentially based services.
24. While there is a single licensing category for group homes and a single payment system, group homes range in size and complexity from single homes located in the community with 6 children or fewer to large campus-like settings with 50 children or more. Group home programs may provide virtually no treatment services or may offer a wide range of highly sophisticated service options. .
25. Children and Family Services Division, California Department of Social Services (June, 2001). Re-examination of the Role of Group Care in Family-Based System of Care. Report to the Legislature. At page 6, this report notes that “Over the past 15 years there have been no attempts to systematically and comprehensively examine or reform the group care system. Any changes that have occurred were reactive, addressing immediate issues requiring resolution rather than proactive.”

ENDNOTES

26. The team making this decision should have input from:
 - The placing agency responsible for developing and monitoring the service plan,
 - The family and the child or youth and their natural supports and advocates,
 - The county counsel or other prosecuting attorney,
 - The judge in delinquency and child welfare matters,
 - Agencies that provide court-ordered pre-disposition evaluations, and,
 - Any treatment providers who may currently be serving the child or youth and family.
27. Examples of team structures that could be adapted or expanded to serve this purpose include the Team Decision Making procedures that are being piloted in several California counties, the counties' Inter-agency Placement Committees, and Wraparound child and family teams.
28. The excerpts have been edited to eliminate references to specific agencies or individuals, and to maintain a smooth flow from one item to the next.
29. This summary was developed by conducting a content analysis of the notes from the interview with providers and county staff, followed by further refinement of the themes based on input from the interviewers. The themes are organized into aspects of the RBS program that are working well, those areas are challenging or could be improved, key areas that have required adaptation and finally recommendations for future program refinements based on the opinion of the interviewers.
30. CalWIN is a computer program that is used to support the administration of public assistance programs such as Food Stamps, Medi-Cal, General Assistance, Foster Care and some case management functions in about 18 California counties. Two of the RBS sites are in counties that use CalWIN. CalWIN runs eligibility and benefit determinations and sometimes requires manual interventions to prevent erroneous determinations and actions.

Casey Family Programs is the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope for children and families across America. Founded in 1966, we work in 50 states, the District of Columbia and Puerto Rico to influence long-lasting improvements to the safety and success of children, families and the communities where they live.

P 800.228.3559
P 206.282.7300
F 206.282.3555

casey.org | contactus@casey.org



follow us | twitter.com/CaseyPrograms
like us | facebook.com/Casey.Family.Programs