



**MONDAY, JUNE 6, 2011
HYATT REGENCY NEWPORT**

**Understanding National Trends and Best Practices:
Rhode Island's Family Care Community Partnerships**

Presented by:

Janet Anderson, Ed.D

Assistant Director of DCYF for Community Services and Behavioral Health



Putting RI's System of Care Transformation into the Context of National Trends and Best Practices

- ▶ In December of 2008, DCYF signed into operation contracts with four lead agencies and their partners. This act launched a new era in how DCYF does business with providers to achieve the best outcomes for children and families in the State of Rhode Island



DCYF Mission & Vision:

Vision:

- ▶ **As active members of the community, we share a vision that all children, youth and families reach their fullest potential in a safe and nurturing environment.**

Mission:

- ▶ **It is the mission of DCYF to assist families with their primary responsibility to raise their children to become productive members of society. We recognize our obligations to promote, safeguard and protect the overall well-being of culturally diverse children, youth and families and the communities in which they live through a partnership with families, communities and government.**



Transforming RI's System of Care for Children and Families:

What is SOC?

- ▶ **System of care is, first and foremost, a set of values and principles that provides an organizing framework for system reform on behalf of children, youth and families**



SOC: Culture Change, Values & Principles

- ▶ **Family-driven and youth guided**
- ▶ **Home and community-based**
- ▶ **Strength-based and individualized**
- ▶ **Culturally and linguistically competent**
- ▶ **Integrated across systems**
- ▶ **Connected to natural support networks**
- ▶ **Data-driven, outcomes-oriented**



Characteristics of Systems of Care as Systems Reform

FROM

Fragmented service delivery



Categorical programs/funding



Limited services



Reactive, crisis-oriented



Focus on out-of-home placements



Children out-of-home



Centralized authority



Creation of “dependency”



TO

Coordinated service delivery

Blended resources

Comprehensive services/supports array

Focus on prevention/early intervention

Individualized services & supports in least restrictive, normalized environments

Children within families

Community-based ownership

Creation of “self-help”

Pires, S. (2002). *Building systems of care: A primer*. Washington, D.C.: Human Service Collaborative.



System Change Focuses On....



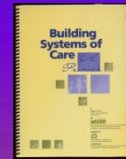
Policy Level
(financing, rates, statutory, regulatory)

Management Level
(data, quality improvement, human resources development, system organization)

Direct Practice Level
(assessment, care planning, care management, service/supports provision)

Community Level
(partnership with families, youth, natural helpers, community built-in)

Pires, S. (2006). *Building systems of care: A primer*. Washington, D.C.: Human Service Collaborative.



The Concept of System of Care:

“ The original concept was offered to guide the field in reforming child-serving systems, services and supports to better meet the needs of children and youth with serious mental health challenges and their families.”

Beth A.Stroul, M.Ed

Gary M. Blau, Ph.D..

Robert M. Friedman, Ph.D.

Issue Brief: Updating the SOC Concept and Philosophy, 2010

**Published by: National Technical Assistance Center for Children’s Mental Health, Georgetown University
Center for Child and Human Development**

In Partnership With:

Child, Adolescent and Family Branch Center for Mental Health Services Substance Abuse and Mental Health
Services Administration

U.S. Department of Health and Human Services



The Concept of System of Care:

“The concept has shaped the work of nearly all states, communities, tribes, and territories to the extent that at least some elements of the system of care philosophy and approach can be found in nearly all communities across the nation.”

Stroul et al., 2008

Stroul, B., Blau, G., & Sondheimer, D. (2008).

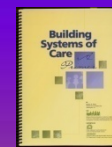
Systems of care: A strategy to transform children’s mental health care. In B. Stroul & G. Blau (Eds.), *The system of care handbook: Transforming mental health services for children, youth and families* (pp. 3-24). Baltimore: Paul H. Brooks Publishing Co.



National System of Care Activity

- ▶ **CASSP - Child and Adolescent Service System Program**
- ▶ **RWJ MHSPY – Robert Wood Johnson Mental Health Services Program for Youth**
- ▶ **Casey MHI – Annie E. Casey Foundation Urban Mental Health Initiative**
- ▶ **Statewide Family Network Grants**
- ▶ **Youth Move - Center for Mental Health Services grants**
- ▶ **CMHS SOC and Tribal Soc Grants – Center for Mental Health Services**
- ▶ **CSAT Grants – Center for Substance Abuse Treatment**
- ▶ **ACF Grants – Administration for Children and Families**
- ▶ **CMS Grants – Center on Medicare and Medicaid Services**
- ▶ **President’s New Freedom Mental Health Commission**
- ▶ **State Child And Adolescent Infrastructure Grants**
- ▶ **SAMHSA Transformation Grants – Substance Abuse and Mental Health Services Administration**

Pires, S. (2002) *Building systems of care: A primer*. Washington, D.C.: Human Service Collaborative.



Rhode Island System of Care History

- ▶ 1989, CASSP – Child and Adolescent Service System Program (Infrastructure) Grant , SAMHSA
- ▶ 1991-Present, Statewide Family Network Grant
- ▶ 1992, Project REACH grant – Center for Mental Health Services (youth with serious emotional disorders and their families)
- ▶ 1997, Project HOPE grant – Center for Mental Health Services (youth adjudicated) SAMHSA
- ▶ 2003, Report of RI System of Care Task Force: Toward An Organized System of Care for RI's Children, Youth and Families
- ▶ 2005, RI Positive Educational Partnership – Center for Mental Health Services (early childhood and positive behavior supports and interventions) SAMHSA
- ▶ 2009, RI Family Care Community Partnership Implemented
- ▶ 2011/2012, RI Networks of Care (Current RFP)



Focus on Change

- ▶ **The Department has led an intensive multi-year effort to educate the staff, all branches of government, the community and the providers that a system transformation is needed.**
- ▶ **System transformation reflects “best practices”, cost efficiencies and is aligned with our federal Program Improvement Plan goals.**
- ▶ **The system is changing because system partners are committed to the change in philosophy. The commitment is to provide services in the least restrictive, community-based setting appropriate for the child and their family.**
- ▶ **As a result of the system changes, including implementation of Phase I of the System of Care, between 2007 and 2011, the average DCYF funded residential census has been reduced by 37% from 1012 to 641. (All residential placements have been reduced 38% from 1202 to 746 today.)**



A System in Transformation

Over the past five years, the Department of Children, Youth and Families has:

- ▶ Reduced the number of children in residential care by over 30%
- ▶ Reduced the number of youth placed out of state by over 50% from 2007 -2010
- ▶ Reduced the number of child maltreatment victims 18% from 4,400 in 2006 to 3,620 in 2010
- ▶ Lowered the number of children entering out of home care by 27% from 1,893 in 2006 to 1,380 in 2010
- ▶ Developed and implemented Phase I of the System of Care (FCCP) as a front end diversionary program that has successfully reduced the number of families becoming open to the department and reduced the number of children in our care



RI's Practice Method

What is Wraparound?

- ▶ **A team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of children and youth who are at risk of becoming involved or who are involved with one or more of DCYF's divisions:**
 - Child welfare
 - Children's behavioral health
 - Juvenile corrections services
- ▶ **The Wraparound process requires that families, providers and key members of the family's social support network collaborate to build a creative plan to:**
 - Respond to the particular needs of the child and family
 - Identify services that are flexibly adjusted as the family's needs change



10 Principles of Wraparound

- ▶ Family voice and choice
- ▶ Team based
- ▶ Culturally competent
- ▶ Collaboration
- ▶ Community-based
- ▶ Individualized
- ▶ Strength based
- ▶ Persistence
- ▶ Outcome based
- ▶ Natural supports



Why Did RI Choose Wraparound?

Simply:

The outcomes over many years are outstanding!



Wraparound Puts SOC Values and Principles into Practice for Service Planning and Provision

Wraparound History

Wraparound began in the mid 1970's with greatest success seen in Chicago, North Carolina and Alaska in bringing youth back into their states and into a home and community setting.

In Chicago, Karl Dennis and his colleagues found that “84% of those youth could be kept at home with their own families if we correctly provided services to those families, which means if those services were intensive enough, ...and most importantly if we asked the families what they needed and were willing to provide those services.” (pg. 5, Dennis & Lourie, 2006).



Wraparound Milwaukee:

Over the years, the successes of utilizing a Wraparound process has been documented repeatedly with outcomes indicating children and youth being served successfully in their homes and community settings with increasingly shortened lengths of stay out of home, if at all.

Wraparound Milwaukee was awarded the Innovations in American Government Award in 2009 for its highly individualized family directed services to youth with serious emotional and mental health needs and their families. (Ash Institute for Democratic Governance and Innovation (Harvard Kennedy School). This model system successfully works across child welfare, juvenile corrections and behavioral health utilizing the Wraparound approach.



Current Research Results on Wraparound:

- ▶ Susan Mears and her colleagues describe a quasi-experimental effectiveness research study of wraparound for youth served in Nevada's child welfare system.
- ▶ Outcomes were compared for N=93 youth receiving wraparound compared to a matched comparison sample of N=30 youth served via traditional child welfare case management.
- ▶ Youth in the wraparound group approach showed significantly greater improvement in functioning as assessed by the Child and Adolescent Functional Assessment Scale (CAFAS) compared to youth receiving traditional child welfare services.
- ▶ Youth in the wraparound group showed significantly greater movement toward less restrictive residential placements as assessed by the Restrictiveness of Living Environment Scale (ROLES).
- ▶ Youth in the wraparound group experienced more placement changes during the 6 month follow up period (23% vs. 49%); however, this was due to youth in the wraparound group being more likely to move to less restrictive placements during the study period. No differences were found for child behavior as assessed by the Child Behavior Checklist (CBCL), school, or juvenile justice outcomes.

Full citation:

Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of wraparound services for severely emotionally disturbed youths. *Research on social work practice*, 19, 678-685.

Reported By: National Wraparound Initiative, Portland State University, Research Update 2011



Current Research Results on Wraparound cont'd...

- ▶ **Jesse Suter of the University of Vermont and Eric Bruns of the University of Washington published the first ever “meta-analysis” of the effects of the wraparound process.**
- ▶ **Effects in favor of the wraparound group were significant in all four categories and were largest for the category of youth living situation (effect size = 0.44) and smaller (but still significant) for mental health outcomes (ES = 0.31), overall youth functioning (ES = 0.25), school functioning (ES = 0.27), and juvenile justice-related outcomes (ES = 0.21).**
- ▶ **The overall average effect size across studies was 0.33, which is similar to the average effect size found for evidence based practices implemented in “real world” settings. The authors concluded that, though the published wraparound research base continues to be in a preliminary state of development, controlled research on wraparound is expanding and findings are largely positive.**

Full Citation:

Suter, J.C. & Bruns, E.J. (2009). Effectiveness of the Wraparound Process for Children with Emotional and Behavioral Disorders: A Meta-Analysis. *Clinical Child and Family Psychology Review*, 12, 336-351.

Reported By: National Wraparound Initiative, Portland State University, Research Update 2011



Current Research Results on Wraparound cont'd...

- ▶ Kathy Cox and her colleagues from EMQ-Families First analyzed data gathered on 176 youth who participated in the wraparound process to examine client and service factors associated with outcomes. Results of logistic regression analyses revealed that youth who possessed higher numbers of collateral supports were more likely to attain treatment goals.
- ▶ Analyses of the associations between implementation fidelity and outcomes showed that youth and family involvement in community activities were important to both achieving treatment goals as well as maintenance in the community over time.
- ▶ High adherence to this element of practice was found to predict both goal attainment and youth success in transitioning to a home setting. Overall, youth who exhibited lower levels of impairment at service entry also were most successful in transitioning to and preserving a home placement. The article goes on to discuss implications for the implementation of the wraparound process with youth who are in residential care or at risk of out-of-home placement.

Full Citation:

Cox, K., Baker, D., & Wong, M.A. (2010). Wraparound retrospective: Factors predicting positive outcomes. *Journal of Emotional and Behavioral Disorders*, 18, 3-13

Reported By: National Wraparound Initiative, Portland State University, Research Update 2011



Federal Support for RI's SOC Transformation:

- ▶ RI's current Comprehensive Community Mental Health Services for Children and their Families Cooperative Agreement (SAMHSA) is specially designed as an infrastructure building agreement with the State. This six year, \$9,000,000 agreement will end September 30, 2011
- ▶ This Cooperative Agreement began in 2005. This federal support both spanned and helped to guide RI's current System of Care transformation efforts



Positive Educational Partnership (PEP) Overview

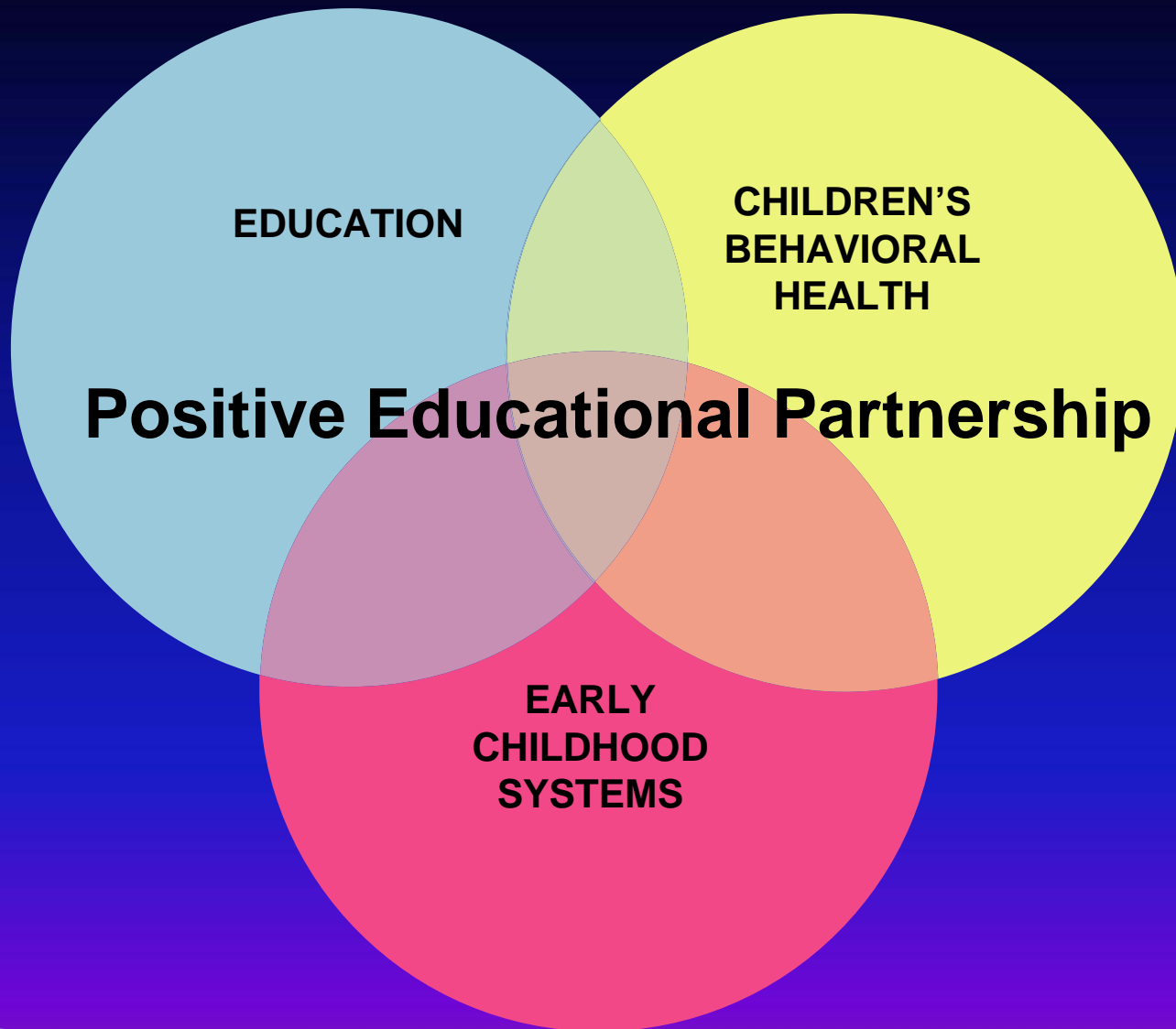
- ▶ Partnership among DCYF, RIDE, Sherlock Center, family organizations, early childhood systems and community providers.
- ▶ Integration of RI PBIS statewide initiative, the continuum of children's behavioral health services, and early childhood systems.
- ▶ Children aged birth to 12 years with serious emotional, behavioral and/or mental health challenges, and their families.



Federal Support for RI's SOC Transformation:

- ▶ **Building and sustaining a shared infrastructure and services targeted children with SED across child serving agencies.**
- ▶ **Shared infrastructure that allows the state to better integrate the full range of supports for all children and their families at the school building level.**





Positive Educational Partnership (PEP)

Participating Schools and Early Childhood Programs

- ▶ **39 PBIS/PEP elementary schools**
- ▶ **36 Early childhood centers**
 - Including several large Head Starts with multiple sites
 - Training in an Early Childhood version of PBIS
 - Incredible Years teacher training module
- ▶ **6 Birth to three programs**
- ▶ **81 Total Schools and Early Childhood Centers**
- ▶ **Over 370 Children & families served to date**
- ▶ **1 School District**



PEP Outcomes



DSM–IV Axis I and Axis II Diagnoses^[a]

Diagnosis ^[b] (n = 326)	%
Attention-Deficit/Hyperactivity Disorders	63.5%
Oppositional Defiant Disorder	17.5%
Mood Disorders	15.0%
Adjustment Disorders	12.3%
Anxiety Disorders	10.1%
Learning, Motor Skills, and Communication Disorders	9.2%
Other	9.2%
PTSD and Acute Stress Disorder	8.9%
Pervasive Developmental Disorders	8.6%
Disruptive Behavior Disorder	4.6%
Mental Retardation	1.8%
Impulse Control Disorders	1.5%
Conduct Disorders	1.2%
Schizophrenia and Other Psychotic Disorders	0.0%
Substance Use Disorders ^[c]	0.0%
V code ^[d]	0.0%
Personality Disorders	0.0%
Substance Induced Disorders	0.0%

[a] Data reported were collected using the Enrollment and Demographic Information Form (EDIF).

[b] Because youth may have more than one diagnosis, percentages for diagnoses may sum to more than 100%.

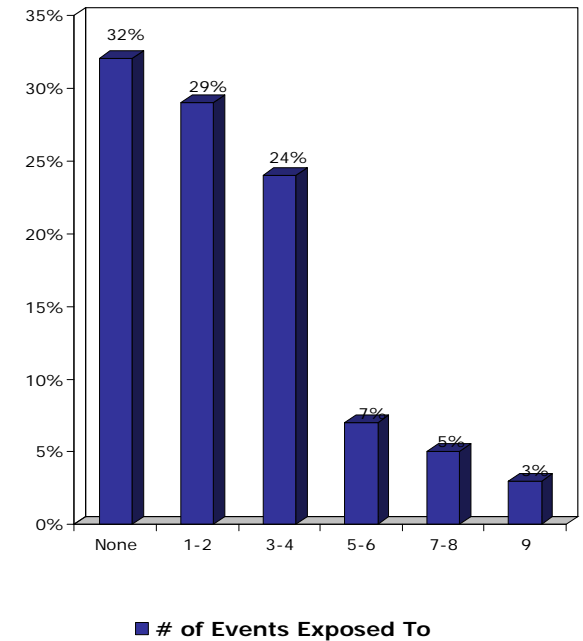
[c] Substance Use Disorders include caffeine intoxication.

[d] V Code refers to Relational Problems, Problems Related to Abuse or Neglect, and additional conditions. Percentage excludes V71.09 (No Axis I or II diagnosis).

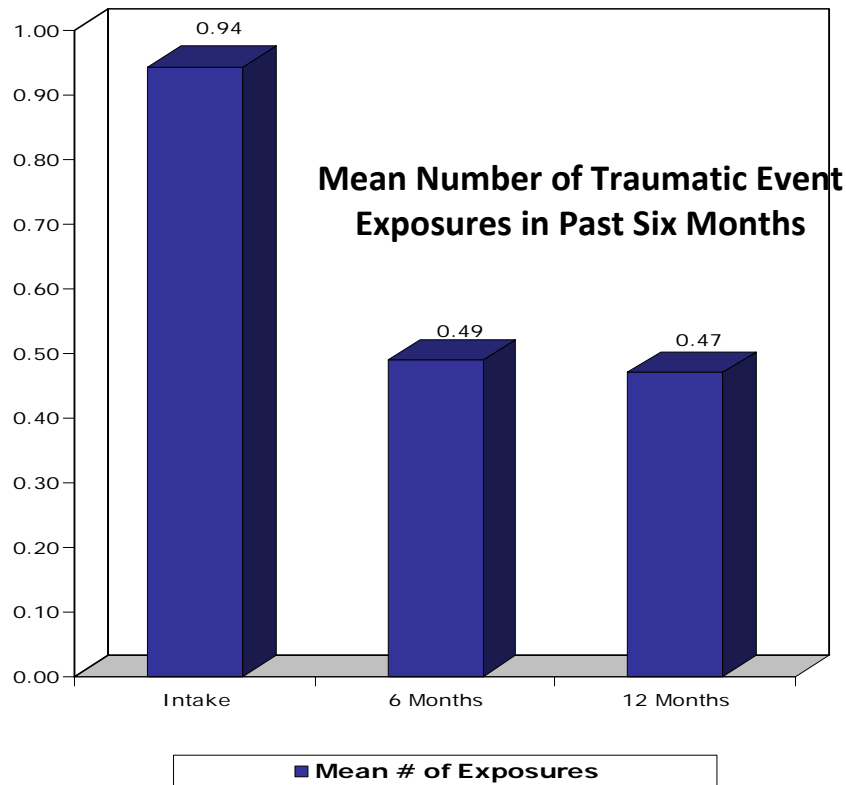


Traumatic Events Screening Inventory (TESI) at Intake

TESI (n=362)		
Mean Number of Traumatic Events	2.96 (SD=2.31)	MIN: 0 MAX: 9
Most Frequent Type of Event Reported		
Has the child ever...		
Witnessed or heard physical assault		29%
Been separated from caregiver		37%
Witnessed or heard family member being threatened with physical harm		23%
Known or seen a family member arrested/taken away		21%
Experienced severe illness of someone close to him/her		27%
Undergone a period where child lacked appropriate care (being left alone, lacking shelter...)		14%
Undergone a serious medical procedure or had a life-threatening illness		12%
Been physically assaulted		11%
Other: unspecified		23%



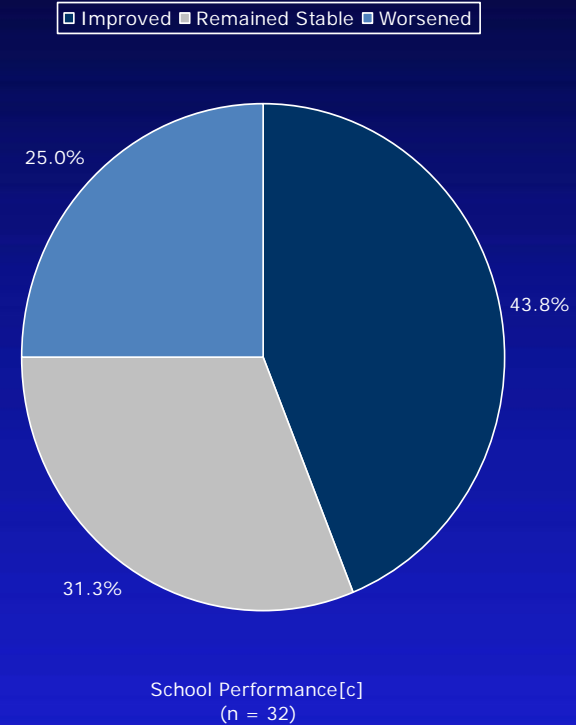
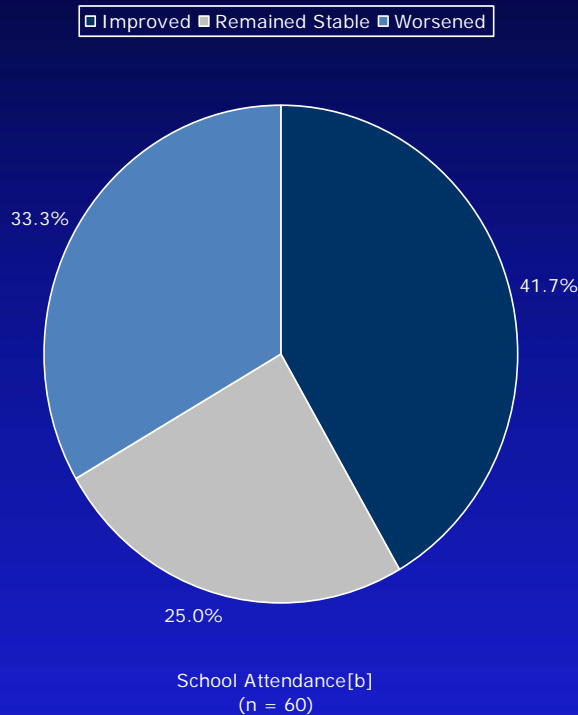
Traumatic Events Screening Inventory (TESI) from Intake to 12 Month Follow Up (n=48)



Caregivers reported that their children were exposed to fewer traumatic events in the six months prior to the interview timeframe from intake to the 12 month follow interview ($p=.01$).



Change in School Attendance and Performance^[a] from Intake to 12 Months



[a] Data reported were collected using the Education Questionnaire–Revised (EQ–R). This instrument collects data on the status of the child/family in the 6 months prior to the interview.

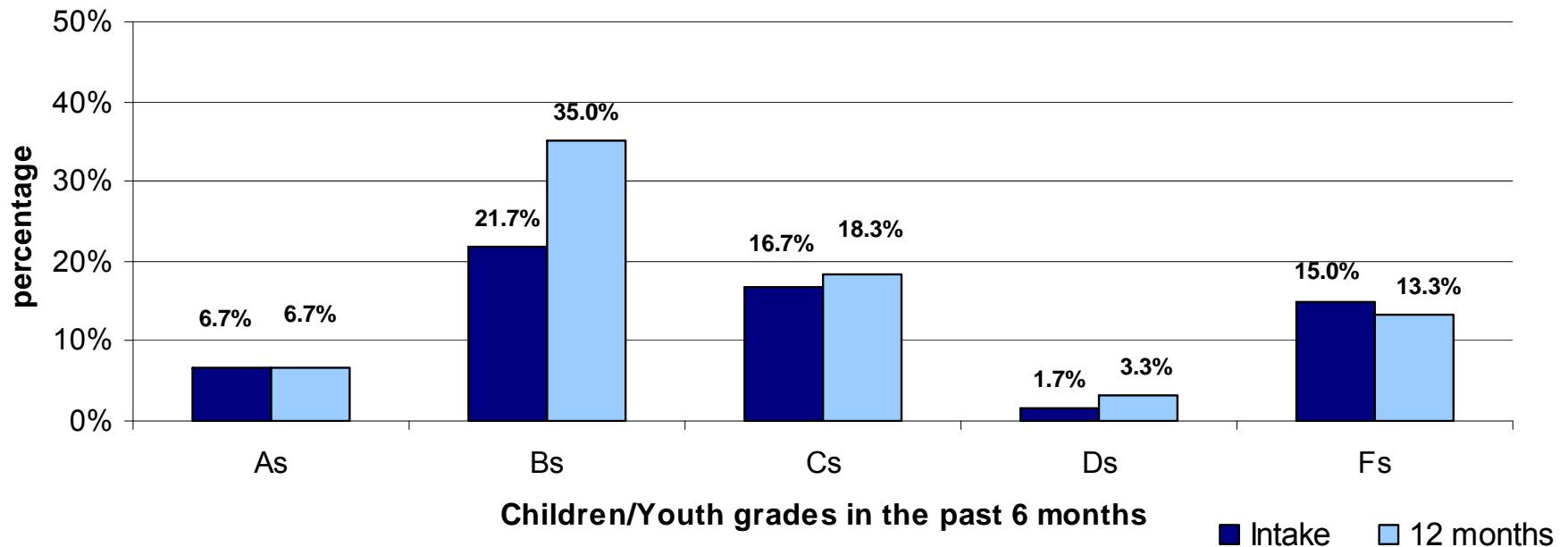
[b] Change in school attendance is defined as the following: 1) improved: children attending school more frequently at the second data collection point than at the first data collection point, 2) remained stable: children attending school at the same frequency at both data collection points, 3) worsened: children attending school less frequently at the second data collection point than at the first.

[c] Change in school performance is defined as the following: 1) improved: children receiving a higher grade point average at the second data collection point than at the first data collection point, 2) remained stable: children receiving the same grade point average at both data collection points, 3) worsened: children receiving a lower grade point average at the second data collection point than at the first.



Academic Performance [a]

Academic Performance at Intake and 12 Months



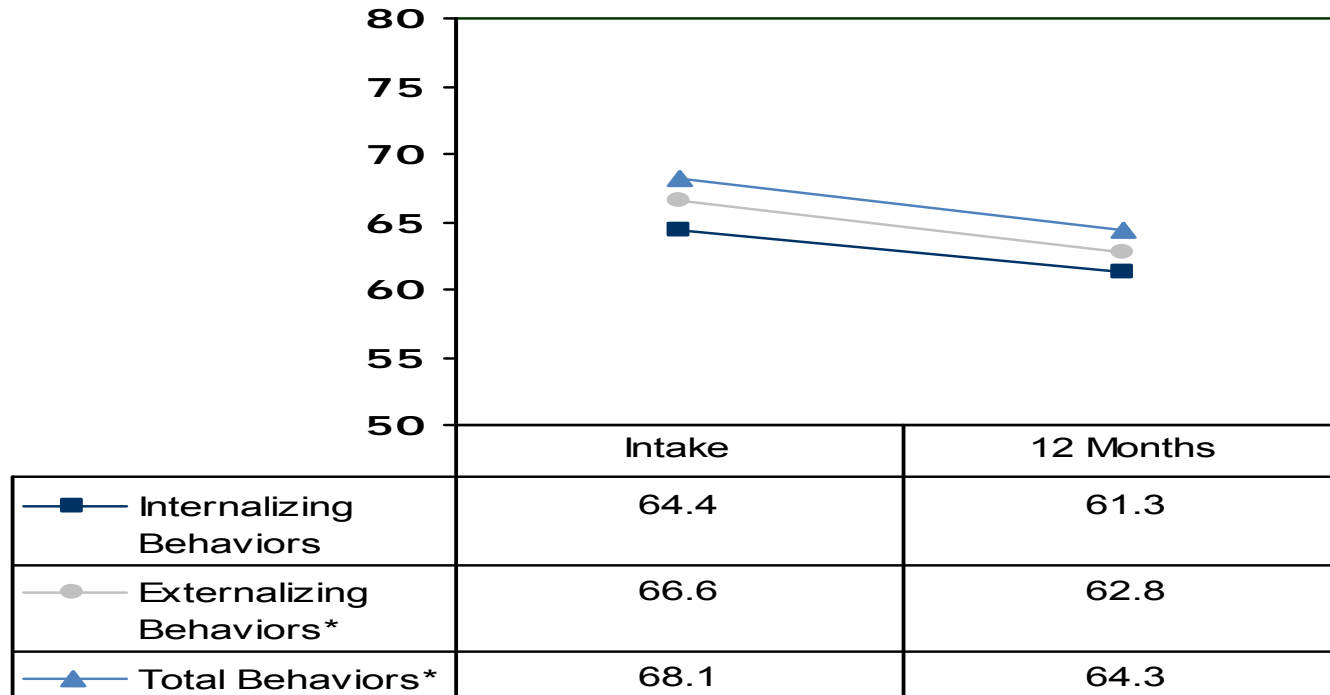
n = 60

[a] Data reported were collected using the Education Questionnaire–Revised (EQ–R). This instrument collects data on the status of the child/family in the 6 months prior to the interview.



Average Scores of Child Behavioral and Emotional Problems[a] for Children Ages 6 to 18 at Intake and 12 Months

Internalizing & Externalizing Scores[b]



n = 48

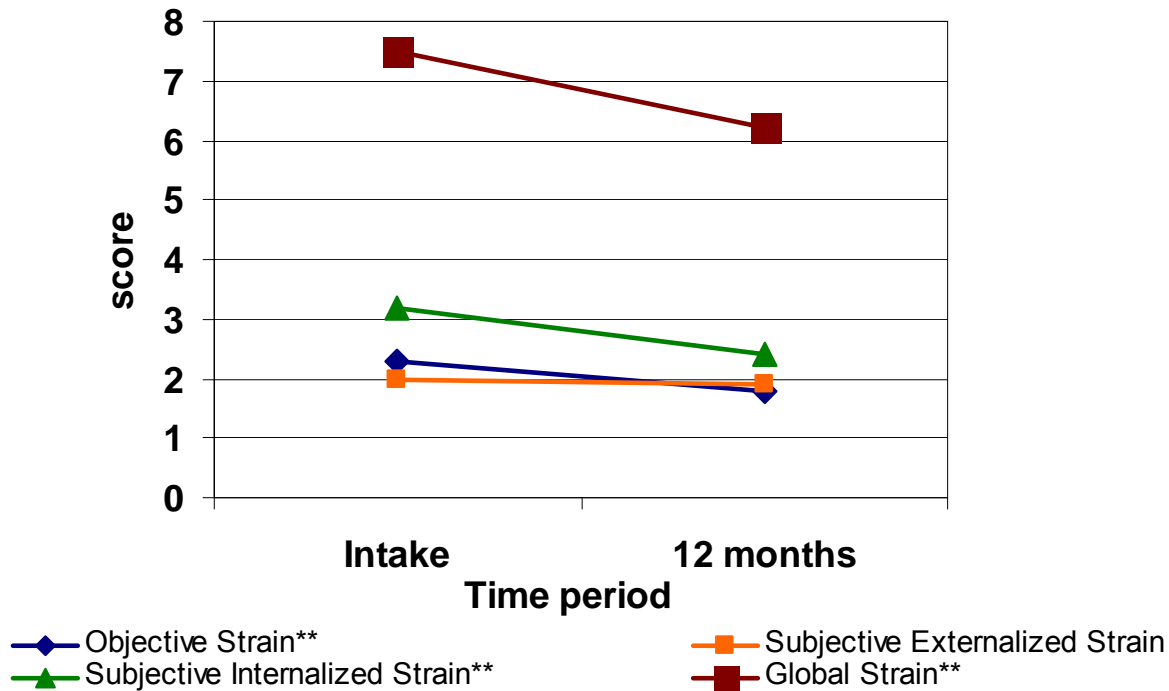
[a] Data reported were collected using the Child Behavioral Checklist 6–18 (CBCL 6–18). This instrument collects data on the status of the child/family in the 6 months prior to the interview.

[b] Internalizing and externalizing scores 64 or above are in the clinical range. Scores on the eight syndrome scales 70 or above are in the clinical range.



Caregiver Strain

Caregiver Strain at Intake and 12 months



n = 48

**p < .01

[a] Data reported were collected using the Caregiver Strain Questionnaire (CGSQ). The range in scores for each subscale is 0 to 5; the range in scores for the Global Strain scale is 0 to 15. Higher scores indicate greater strain. This instrument collects data on the status of the caregiver in the 6 months prior to the interview.



PEP

- ▶ **The PEP success teams school-based model is now being piloted in the Coventry School District and integrated into the FCCP's and Phase II of the SOC Design**



Implementation:

- ▶ An entire discipline and body of research has developed on implementation which the Department has relied on to inform and guide our timelines for our System of Care transformation

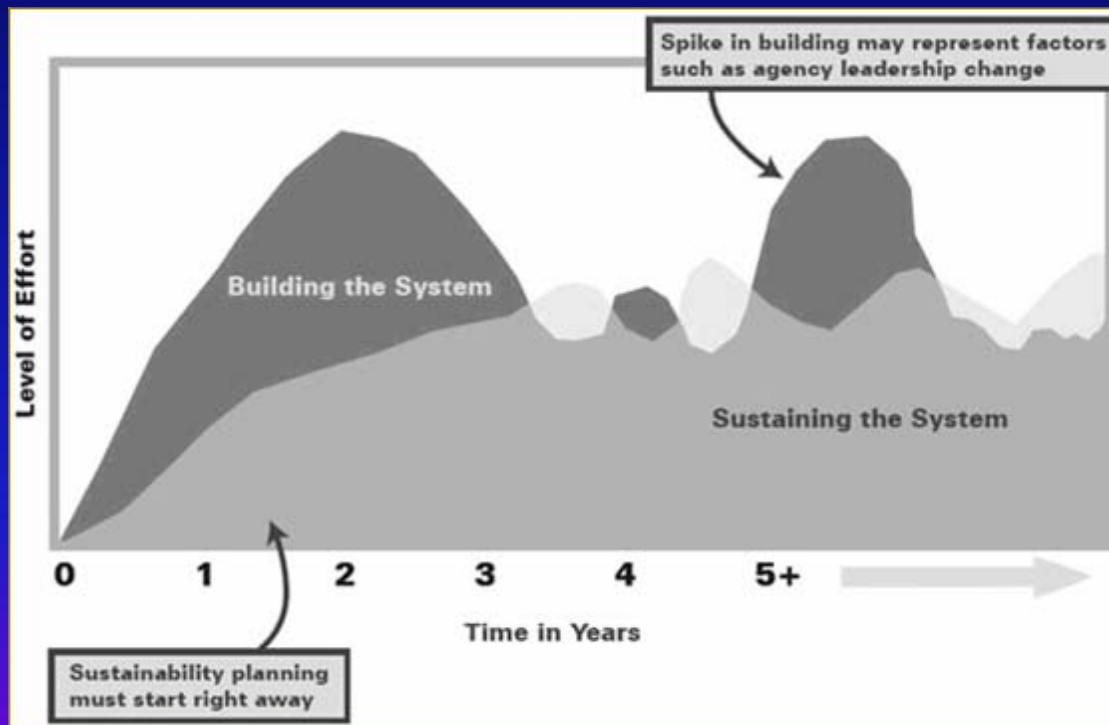


Ref: National Implementation Research Network

www.fpg.unc.edu

Implementation Research:

The systemic change necessary to achieve improved outcomes for children and their families takes considerable time to mature. Often supported by Federal, State, or private foundation funding, the initial stages of establishing a system of care may take 3—6 years.



Author(s): National Technical Assistance and Evaluation Center for Systems of Care;
Year Published: 2009, "A Closer Look: An Overview of Systems of Care in Child Welfare"



Transforming RI's System of Care - Components of the RI SOC:

- ▶ **Phase I - Family Care Community Partnerships (FCCP)- Implemented January of 2009**
- ▶ **Phase II - Family and Community Networks of Care- RFP issued June 2, 2011**



DCYF: Transforming care for the brighter
future of Rhode Island children.

Working Together to Strengthen RI Families



**Family Care
Community
Partnership**

Family care community partnership is funded by:



DCYF



Family Care Community Partnerships

Urban Core

Family Service of Rhode Island
134 Thurbers Avenue
Providence, RI 02905
(401) 331-1350
www.familyserviceri.org

Partner Agencies:

John Hope Settlement House

Children's Friend

Comprehensive Community
Action Program

TIDES Family Services

The Providence Center

Serving:

Providence
Central Falls
Pawtucket
Cranston

Northern

Family Resources Community Action
245 Main Street
Woonsocket, RI 02895
(401) 766-0900
www.famresri.org

Partner Agencies:

Comprehensive Community
Action Program

NRI Community Services, Inc.

Gateway Healthcare, Inc.

Serving:

Burrillville
Cumberland
Foster
Glocester
Johnston
Lincoln
North Providence
North Smithfield
Scituate
Smithfield
Woonsocket

East Bay

Child & Family Services
of Newport County
31 John Clarke Road
Middletown, RI 02842
(401) 849-2300
www.childandfamilyri.com

Partner Agencies:

Child and Family Services
of Newport County

East Bay Community Action Program

East Bay Center

Newport County Community
Mental Health Center

Serving:

Barrington	Middletown
Bristol	Newport
East Providence	Portsmouth
Jamestown	Tiverton
Little Compton	Warren

West Bay

South County Community Action Agency
1935 Kingstown Road
Wakefield, RI 02879
(866) 840-6532
www.sccainc.org

Partner Agencies:

Family Service of Rhode Island

West Bay Community Action

Thundermist Health Center

WellOne

South Shore Mental Health Center

The Kent Center

Serving:

Charlestown	North Kingstown
Coventry	Richmond
East Greenwich	South Kingstown
Exeter	Warwick
Hopkinton	West Greenwich
Narragansett	West Warwick
New Shoreham	Wakefield
	Westerly



Phase I – State-Wide Structure

Executive Office of Health & Human Services

DCYF

State Wide
Family & Community Advisory Board

FCAB

FCCP
Strengthening
Families through
community-based
individualized
wraparound
services and
supports

FCAB

FCCP
Strengthening
Families through
community-based
individualized
wraparound
services and
supports

FCAB

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Phase I: Family Care Community Partnerships

- ▶ Redesigning service delivery by utilizing wraparound and natural supports to preserve families, enhance home and community based intervention, prevent out-of-home placement and formal involvement with DCYF
- ▶ FCCP Standards may be found on the DCYF website:

http://www.dcyf.ri.gov/docs/notice_fccp_standards.pdf



Family Care Community Partnerships cont'd...

Definition

- ▶ A formal collaborative structure for joint planning and decision-making through which community partners take collective responsibility for development and implementation of system of care and high fidelity Wraparound process.

- ▶ Service delivery processes are organized through four regional “FCCP Lead” agencies who are the fiscal agents responsible for:
 - Building partnerships
 - Developing a comprehensive network of available formal and informal services and supports

- ▶ FCCP providers, including all formal and informal community partners take collective responsibility for the development and implementation of system of care and high fidelity Wraparound process for eligible families.



Who is Eligible for FCCP?

Children and families who are:

- ▶ **At risk for child abuse, neglect and/or dependency and DCYF involvement**
- ▶ **Children birth to age 18 years old who meet criteria for having a serious emotional disturbance to youth with SED 18 to 21 years old in accordance with DCYF Policy 700.0240, Services to Youth Ages 18-21**
- ▶ **Youth concluding sentence to the RITS who agree to participate, including youth leaving the RITS and youth leaving temporary community placement (TCP)**



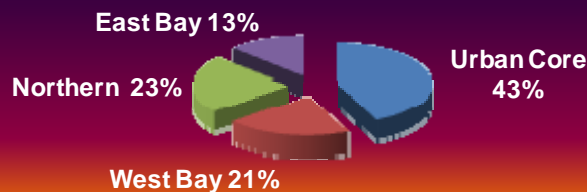
FCCP Outcomes Implementation Data



The outcomes of the FCCP thus far is extremely impressive. To date, the following results have been reported in CY 2009:

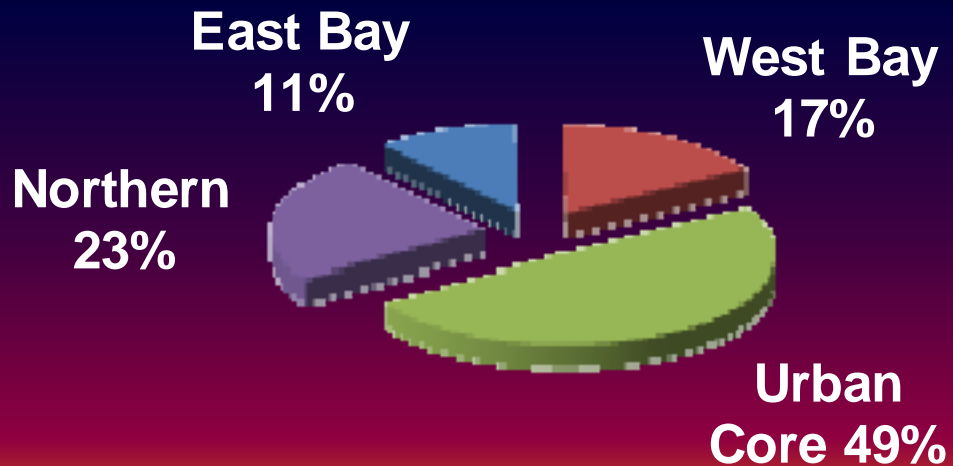
- 1,208 families have been seen by the FCCP's in the community
- Of these families, 75% were at risk for involvement with DCYF; and
- About 23% met the criteria for "serious emotional challenge" and about 7% were involved with the Juvenile Corrections System. Apart from being at risk for DCYF involvement, the three primary reasons for referral are: mental/behavioral health concerns, stressful life events (most often poverty), and school concerns.

Calendar Year 2009 - Percent of Families By FCCP

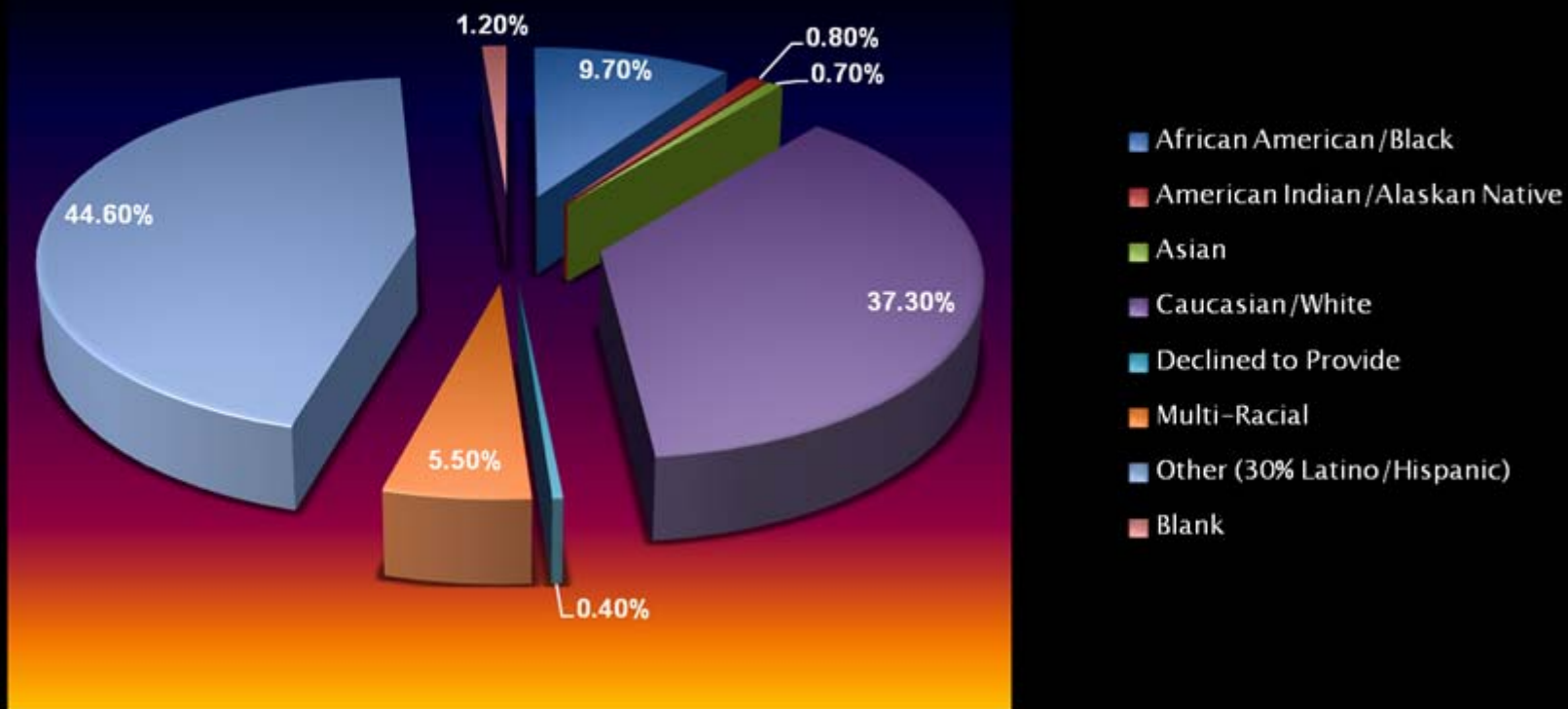


FCCP Families

All data displayed reflects 2010, CY 4th Quarter
(1198 families)



Race and Ethnicity of Active Children – CY 2010, 4th Quarter



FCCP CY 2010, 4th Quarter

Table 2. Age of Active Children

Data Source: RIFIS: Consumer Base Report

	Mean	Median	Range : Low	Range: High
Age of Child/Youth	8.1	8.0	0	19

Eligibility Criteria

Table 3. Percent of Eligibility Criteria by Practice Model, CY 4th Quarter

	State (N=346)	
	Wrap	Non Wrap
Risk for DCYF	70.8%	85.9%
Serious Emotional Disturbance	26.0%	14.6%
RITS	4.2%	1.8%

Data Source: RI Family Information System (RIFIS)

FCCP Intake 1A was completed during October 1 to December 31, 2010. The numbers are not mutually exclusive because the end user can check all that apply. This table does include closed cases.



FCCP CY 2010, 4th Quarter

Response Priority: Response severity among families and face-to-face contact time

Of the 1198 families, the greatest proportion of active families were classified as “routine” rather than emergency or urgent within response priority (response severity). This trend has been consistent across quarters since the FCCP inception.

Families referred by DCYF to the FCCP are classified by response priority. Each of the 3 DCYF severity-level response categories (Emergency, Urgent, and Routine) has a corresponding first face-to-face contact response time as defined in the FCCP Practice Standards.

Table 4 shows the percentage of families broken down by their respective response priority/category at the time of intake. **Table 4. Percent of Response Priority, CY 4th Quarter**

Response Priority	State (N=1198)
DCYF Child Protective Services Emergency:	0.8%
DCYF Child Protective Services Urgent:	3.1%
DCYF Child Protective Services Routine:	44.9%
Routine Referral (a non DCYF referral):	41.4%
Crisis (without DCYF involvement):	1.8%

Data Source: RIFIS



FCCP CY 2010, 4th Quarter

Wrap Versus Non Wrap Practice Model: Percentage of Families in Wrap

The largest proportion of active families experienced Non Wrap Practice model vs. Wrap Practice Model. However, the proportion of families in a Wrap Practice Model has increased since the inception of the FCCPs.

Table 7. Percent of Practice Model, CY 4th Quarter

	State (N=1198)
Non Wrap Practice Model:	39.9%
Wrap Practice Model:	27.9%
Wrap + ¹PEP¹	6.7%
Pending: ² (Family Undecided:	25.5%

Data Source: RIFIS

¹PEP: Positive Educational Partnership

²RIFIS learning Curve



FCCP CY 2010, 4th Quarter

FCCP Referral Source and Wrap Vs Non Wrap Practice Model

To inform whether families referred by DCYF to the FCCP experience different practice model approaches compared to those families not directly referred by DCYF.

Table 8. Percent of Referral Source by Practice Model

Referral Source	State (N=1198)	
	Wrap	Non Wrap
DCYF (excluding YDC ²)	44.6%	66.5%
(DCYF) YDC	4.1%	2.5%
Self-referral	9.5%	9.9%
School	10.8%	8.1%
All other ³	31.1%	13.0%

Data Source; RIFIS

³All other: the remaining 19 referral sources combined as each of these 19 sources have very low percentages. These categories are collected separately and combined for this table only.



FCCP CY 2010, 4th Quarter

Length of Time in Practice Model

The data compares the length of time a family is in their respective Practice Model (among families closed in CY 4th quarter).

Table 10 Practice Model by Median Length of Time in Practice Model, CY 4th Quarter

Practice Model: Median Length of Time (days)	State (N=375)
Wrap	207 days
Non Wrap	130 days

Data Source: RIFIS



FCCP CY 2010, 4th Quarter

Outcomes

FCCP Close Reason – Differences by the Referral Source

To inform the exit reason outcomes, below is data on the FCCP close/transition reasons and if there are differences amongst the different referral sources. Among the families closed during this quarter (State: N= 375):

Table 13. Percent of State's Top 5 close reasons by practice model, CY 4th Quarter

FCCP Close Reason	State	
	Wrap	Non Wrap
FCCP Non Wrap Completed	4.5%	39.8%
Family withdrew without notice	28.8%	16.8%
Team agrees Wrap completed	39.2%	8.1%
Family Declined Service	0.0%	4.3%
Family withdrew with notice	4.5%	6.8%



FCCP CY 2010, 4th Quarter

Functional Assessments are Beginning to be Collected:

When the baseline North Carolina Family Assessment Scale (NCFAS) is administered, it is administered among most FCCP's within the timeframes set out in the FCCP Standards.

Table 14. Average Number of days for NCFAS completion, CY 4th Quarter

	State (N=352)
Average number of days to completed NCFAS baseline	30 days

Data Source: RIFIS



FCCP's: What We Do Know to Date:

- ▶ **Families are successfully being diverted from becoming opened to DCYF when they do not rise to the level of legal status**
- ▶ **The largest percentage of referrals are from DCYF with community schools second; and a small percentage from Youth Development Center (YDC).**
- ▶ **The percentage of families choosing Wrap vs. those not being served by Wrap is about equal – This is expected to shift with developing competency in Wraparound**



Where We Are : Successes

- ▶ **Prevention and early intervention are significant aspects of systems of care, serving as a significant change agent (i.e., reduction in caregiver strain, increase in numbers of children able to remain safely in their home and community settings).**



Where We Are : Successes (Cont'd)

- ▶ Families staying together at an increasing rate
- ▶ Children are remaining safely at home and in their schools
- ▶ Youth are Transitioning from the Youth Development Center (YDC) to home
- ▶ Children with behavioral health challenges and their families are receiving supports to help ensure growing stability and wellness
- ▶ Prevention and early intervention with early childhood and elementary school settings is occurring at an increasingly coordinated and integrated manner
- ▶ The RI System is continuing to develop skilled Wraparound Facilitators and recognizes the significant need for a Family Leadership and Family Support Partners



Where We Are : Successes (Cont'd)

- ▶ Agencies are working together in partnerships to reduce duplication and identify the appropriate resources for families
- ▶ Prevention dollars are being utilized across the state for mental health awareness and prevent child abuse events to support families in healthy, fun and “normalized” activities



Where We Are : Successes (Cont'd)

- ▶ **State inter-agency collaborative work is demonstrating fruitful results:**
 1. **DCYF and DHS are working to ensure the best use of State and Federal Funds**
 2. **The Activities of the Wraparound process are now billable through the Consumer Global Waiver, “Cost Not Otherwise Matchable” (CNOM)**

- ▶ **The PEP model, utilizing Positive Behavior Interventions Supports (PBIS) and Wraparound has established the first District-wide model.**



Where We Are: The Challenges:

Practice Shift:

System wide change: Putting the principles of system of care and wraparound into practice in our day to day lives is a challenging process.

- ▶ **Requires administrative leadership who support and drive the move toward new collaborative business practices, requiring providers to listen, identify differences and find avenues of common ground to work together to serve children and families**
- ▶ **Requires administrative leadership to recognize that this is not a one time event but requires on-going, persistent and creative new structures that support this developmental process**



Where We Are: The Challenges:

- ▶ Requires learning how to share power; recognize the fundamental value change required to adjust practice to reflect System of Care principles
- ▶ The need to reconcile definitions and requirements for Medicaid billing with a family focused practice model, Wraparound documentation and data reporting;



Where We Are: The Challenges:

- ▶ **The need for continued training and coaching, training and coaching, across all levels of the system to ensure new skills are learned and maintained and new learning is incorporated as new definitions are clarified**
- ▶ **The use of data for measuring our success and telling us where and how to ensure continuous improvement in the functioning of our system to improve outcomes for children and families.**



Closing

- ▶ While RI had developed many of the elements of Systems of Care over the past 15 years, it began the effort to fully transform children's services into an integrated system of care for children, youth and families with the launch of the Family Care Community Partnerships in 2009.
- ▶ By taking the risk to braid the department's Prevention and Earliest Intervention and community-based dollars to support the preservation of families, early childhood and school-based programs with the health and wellness of the children who live in those families; the state established the foundations of an evolving infra-structure to support the strengths of families, develop and connect families to effective, evidence based practices, and to identify kinship and protective factors, ensuring that families are connected to natural helping networks.



Are we there yet?

- ▶ **No. This work is difficult and the challenge of building partnerships across agencies, integrating systems and learning to relinquish power in order to reach the best outcomes for the children and families, is still with us.**
- ▶ **We are, however, well on our way. We join with and rely on the experiences and research of many other states and jurisdictions that are currently practicing as fully integrated systems of care. With persistence, an openness to continued learning and a willingness to listen carefully to the families and children we serve, we will get there. Our hope is in the voice of the families.**



Family Story



References:

Dennis, Karl and Lourie, Ira (2006) Everything is NORMAL Until Proven Otherwise, A Book About Wraparound Services. CWLA Press, Washington D.C.

Family to Family (2007) "Becoming Family Driven with High Fidelity Wraparound," Parent Support Network of Rhode Island Educational Publication funded by Federal Statewide Family Network Grant, Federation of Families for Children's Mental Health.

Kagen, Ellen and Horan, Neal (June 3, 2003) Avoiding Fatal Flaws, Strategic Insights on Sustainability from the First Generation of System of Care Leaders of the Comprehensive Community Mental Health Services for Children and their Families Program. National Technical Assistance Center, Georgetown University Center for Child and Human Development. Washington D.C.

Kim, Hyun; Viner-Brown, Samara; and Garcia, Jorge (February, 2007) "Children's Mental Health and Family Functioning in Rhode Island." Pediatrics (vol 119, Supplement 1) www.pediatrics.org/cgi/doi/10.1542/peds.2006-2089E.

Melius, Patrick; Black, Sharri and McCarthy, Maryrose (April, 2009) A Closer Look: An Overview of Systems of Care in Child Welfare. The National Technical Assistance and Evaluation Center for systems of Care, funded by the Children's Bureau under contract with ICF International.

National Wraparound Initiative, Research Update (2011) Portland State University. Portland Oregon.
<http://www.nwi.pdx.edu/wraparoundresearch.shtml>.

Pennell, Joan; Shapiro, Carol and Spigner, Carol (May 2011) Safety, Fairness, Stability: Repositioning Juvenile Justice and Child Welfare to Engage Families and Communities. The Center for Juvenile Justice Reform, Georgetown University, Washington, D.C.



References:

Pires, Sheila; Conlan, Lisa; and Lazear, Katherine (December, 2008) Building System of Care: Rhode Island Primer Training. West Valley Inn, West Warwick RI.

Pires, Sheila (2001) Integrating Care for Children with Special Needs in Publically Financed Managed Care. Paper supported by funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services.

Stroul, Beth; Blau, Gary and Friedman, Robert (2010) Issue Brief: Updating the System of Care Concept and Philosophy. The National Technical Assistance Center for Children's Mental Health. Georgetown University Center for Child and Human Development in Partnership with The Child, Adolescent and Family Branch Center for Mental Health Services Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

VanDyke, Melissa (2011) Closing the Gap between Science and Practice: Implementing Evidence-Based Programs. National Implementation Research Network, University of North Carolina, Chapel Hill, NC.



Resource:

- ▶ National Wraparound Initiative
www.nwi.pdx.edu
- ▶ Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov
- ▶ Child Welfare, Administration for Children and Families (ACF)
www.acf.hhs.gov
- ▶ Maryland Child & Adolescent Innovations Institute & Mental Health Institute
<http://medschool.umaryland.edu/innovations/>
- ▶ National Center for Children in Poverty (NCCP)
www.nccp.org
- ▶ Center for Juvenile Justice Reform
cjjr.georgetown.edu
- ▶ National Implementation Research Network (nirn)
www.fpg.unc.edu
- ▶ Child Welfare Information Gateway
www.childwelfare.gov
- ▶ The Report of the Rhode Island System of Care Task Force, January 2, 2003
- ▶ RI DCYF, The RI Partnership for Family and Community System of Care Phase II, Concept Paper, May 2009
- ▶ RI DCYF Family Care Community Partnership Practice Standards, June 2009



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