Overview of the National Building Bridges Initiative (BBI)

Beth Caldwell, Director, Building Bridges Initiative (MA)

Madge “Pat” Mosby, Family Peer Advocate, Building Bridges Initiative (MD)
Top 10 Trends To Expect in the next 3-5 years

• Everyone expecting less money from local, state and federal governments.
• The Public sector-saying they want to buy results instead of services.
• Most funders wanting to buy evidence-based or evidence-informed services.
• Emphasis on results that can be sustained for at least 6-24 months.
• Safe children, stable families, strong communities and reduced poverty.
• Emphasis on developing systems of care over more traditional service delivery.
• Movement from a child-centered focus toward family-focused perspectives.
• Greater emphasis on permanency and success with a stable family as the goals.

* From Tom Woll’s and William Martone’s 40 Trends Report, January 2018
Randomized clinical trial/1st study to rigorously compare an outpatient, community treatment to residential treatment for seriously psychiatrically impaired drug-involved adolescents who were referred for residential treatment (RT).

Findings include:

• RT did not demonstrate greater effects than MDFT on any measure either in the short or long term.

• 18 months after the start of treatment, youth in MDFT had maintained their treatment gains in substance use and delinquency more than youth in RT.

• Results counter conventional wisdom that youth with severe psychiatric and substance use comorbidities can only be adequately treated in a residential setting; findings demonstrate that MDFT is a highly effective alternative to RT.
Many Compelling Reasons To Reduce Overreliance On Congregate Care.

Youth placed in congregate care are less likely to find permanent homes than those who live in family settings.

Youth who live in institutional settings are at greater risk of developing physical, emotional, and behavioral problems.

Current law requires that children be placed in the least restrictive setting possible while maintaining the child’s safety and health.

Congregate care placements cost child welfare systems three to five times the amount of family-based placements, and for poorer outcomes.

Rightsizing Congregate Care: A Powerful First Step in Transforming Child Welfare Systems, Annie E. Casey Foundation, 2000–
http://www.aecf.org/resources/rightsizing-congregate-care/


Family First Legislation: What’s Coming?
Family First

The Family First Prevention Services Act was passed into law on February 9, 2018 as part of the Bipartisan Budget Act of 2018.

The law, P.L. 115-123 expands the use of Title IV-E child welfare entitlement dollars to prevent entry into foster care.
Prevention Services

Services and programs must be trauma-informed and be classified as “promising”, “supported”, or “well-supported” based on an evidence structure developed by the California Evidence-Based Clearinghouse for Child Welfare.

All qualified three program categories must be:

- Provided under an organizational structure and treatment framework that uses a trauma-informed approach and provides trauma-specific interventions that address trauma’s consequences and facilitate healing.
- Documentation of what the practice consists of and how it is administered.
- No evidence of harm or risk of harm.
- Overall evidence supports the benefits.
- Outcome measures are reliable, valid and administered consistently and accurately.
Restrictions on Federal Reimbursement Other than Foster Family Homes

Eligible Settings for Title IV-E reimbursement:

1. Licensed (state or tribal approved) foster family home with six of fewer children that adheres to the reasonable and prudent parenting standard
   - Exceptions can be made for youth with a child they are parenting, sibling groups, children with severe disabilities

2. Licensed private, or public child care institution with no more than 25 children:
   - A Qualified Residential Treatment Program (QRTP) for children with serious emotional or behavioral disorders or disturbances
   - A setting that specializes in prenatal or parenting supports
   - A supervised independent living program for youth over 18
   - A high-quality residential care program for youth at risk of or found to be a victim of sex trafficking
Restrictions on Federal Reimbursement Other than Foster Family Homes

Eligible Settings for Title IV-E reimbursement:

3. A licensed residential family-based substance use treatment facility for families

- The child is eligible for Title IV-E maintenance payments for up to 12 months regardless of eligibility under the AFDC link
- The child must have a case plan that recommends such a placement
- The child must be considered a candidate for foster care
- Facility meets requirements: substance abuse, parent education, individual family counseling services under treatment framework that understands & recognizes types of trauma and provided in a trauma-informed approach
BBI Core Principles

- Family Driven & Youth Guided Care
- Cultural & Linguistic Competence
- Clinical Excellence & Quality Standards
- Accessibility & Community Involvement
- Transition Planning & Services *

*between settings & from youth to adulthood
For More Information on Family First Prevention Services Act P.L. 115-123


- Children's Defense Fund -
BBI Mission

Identify and promote practice and policy initiatives that will create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive services and supports are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes.
BBI has MANY Partners, several listed:

- The Annie E. Casey Foundation
- NWIC (National Wraparound Implementation Center)
- ACRC
- Alliance for Strong Families and Communities
- Youth Move National
- National Council for Behavioral Health
- CWLA
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- The TA Network
- NACBH (National Association for Children’s Behavioral Health)
- Magellan Health
- Fredla

#LEADINGCHANGE
Endorse the BBI Joint Resolution

• Go to BBI Web Site (www.buildingbridges4youth.org)

• Read BBI Joint Resolution (JR)

• E-mail Dr. Gary Blau (Gary.Blau@samhsa.hhs.gov) or Beth Caldwell (bethcaldwell@roadrunner.com) or Sherri Hammack (svhammack@sbcglobal.net) that You Would Like to Endorse BBI JR

• Be Put on List Serve to Receive BBI Newly Developed Documents

• Be First to be Invited to BBI Events
BBI Joint Resolution

Includes a commitment to:

“...strive to eliminate coercion and coercive interventions (e.g., seclusion, restraint and aversive practices)…”

(http://www.buildingbridges4youth.org/sites/default/files BB-Joint-Resolution.pdf)
BBI Resources Available to Support You
Examples of BBI Documents to support the field:
- Guide for Judges on Best Practices in Residential (w/ ACRC)
- How-to Guide for Transforming to Short-term Residential
- Case Study: Leading Innovation Outside the Comfort Zone: The Seneca Family of Agencies Journey
- Successfully Engaging Families Formed by Adoption: Strategies for Residential Leaders
- Fiscal Strategies that Support the Building Bridges Initiative Principles
- Cultural and Linguistic Competence Guidelines for Residential Programs
- Handbook and Appendices for Hiring and Supporting Peer Youth Advocates
- Numerous documents translated into Spanish (e.g., SAT; Family and Youth Tip Sheets)
- Engage Us: A Guide Written by Families for Residential Providers
- Promoting Youth Engagement in Residential Settings
BBI Web-Based Training Programs Available

https://theinstitute.umaryland.edu/onlinetraining/programcategory.cfm?ottype_id=38

• Best Practices in the Use of Psychiatric Medications for Youth During Residential Interventions (1.5 CEUs)
• Cultural and Linguistic Competence (Part 1): Why Does it Matter? (2 CEUs)
• Cultural and Linguistic Competence (Part 2): Implementation Strategies (2 CEUs)
• Cultural and Linguistic Competence (Part 3): On a One-to-One Level (1.5 CEUs)
• First Steps for Leaders in Residential Transformation (2 CEUs)
• Including Family Partners on Your Team (2 CEUs)
• Pre-hiring, Hiring, Supporting, and Supervising Youth Peer Advocates in Residential Programs (2 CEUs)
• Successful Strategies for Tracking Long-term Outcomes (1 CEU)
• Youth-Guided Care for Residential Interventions (2.5 CEUs)
2014 Book: Residential Interventions for Children, Adolescents and Families: A Best Practice Guide

There are several options for ordering:
• toll free phone: at 1-800-634-7064
• fax: 1-800-248-4724
• email: orders@taylorandfrancis.com
• website: www.routledgéentalhealth.com
• (20% discount w/ web orders using code IRK71;
• free global shipping on any orders over $35)

Orders must include either: the Title: Residential Interventions for Children, Adolescents and Families: A Best Practice Guide OR the ISBN: 978-0-415-85456-6

Note: As a federal employee, Gary Blau receives no royalties or any other remuneration for this book. Any royalties received by Beth Caldwell and Bob Lieberman will be used to support youth and family empowerment consistent with BBI.
Coming in 2019 ~ A New Book!

Transforming Residential Interventions: Practical Strategies and Future Directions
BBI Core Principles

• Family Driven & Youth Guided Care

• Cultural & Linguistic Competence

• Clinical Excellence & Quality Standards

• Accessibility & Community Involvement

• Transition Planning & Services (between settings & from youth to adulthood)
Some Of The Critical Issues

- **Recidivism** — All Categories of Children/Youth
  - 68% in One State (2009) for all Licensed Residential Programs vs. Damar Services (BBI implementer) with ranges from 3-15%

- **Lengths of Stay** — Children/Youth in MH System
  - NYS (Average: 14 months in 12+ years) vs. Florida (<6 months in 3 years)
From the Research

Residential-Specific Research Shows Improved Outcomes With:

• Shorter Lengths of Stay
• Increased Family Involvement
• Stability and Support in the Post-Residential Environment (Walters & Petr, 2008).
THINK ABOUT:

Your state/system of care community/county/program- What are the strengths of your residential program or programs in your geographical area serving children and families specific to ensuring long-term positive outcomes for youth and families served?

Share one or two strengths with your neighbor!
SOME EXAMPLES OF WHERE BBI IS HAPPENING
Examples of Where BBI/Residential Transformation Work HAS/IS Happening

• Comprehensive State Initiatives (DE, IN, MA, CA - Initially 4 Regions/Pilots – going statewide by county in 2017/2018)

• State Level Activities Happened or Currently Underway (AZ, FL, IL, KY, LA, MI, NC, ND, NH, NJ, NM, NV, ND, NY, OK, RI, SC, TX, VA, WA, WV & Georgia; in CA & MD—Provider Associations Led)

• Current or Previous County/City Level Initiatives (Cities: NYC, Philadelphia; Counties: Monroe/Westchester, NY; Maricopa, AZ; PA: cluster of four counties in NE part of state)

• Many Individual Residential and Community Programs Across the Country
NEW HAMPSHIRE
NFI North, Inc.

NFI North - Davenport School takes great pride in the Building Bridges Initiative and decided from the start of this project that the only way to evoke on this journey was to due so through a lens that allowed for *open and honest examination of practices as well as open and honest communication* amongst Family, Youth, and Staff.
NFI North Contact Information

NFI North Array of Services
Jennifer Altieri
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BBI in Massachusetts: Caring Together

- Adoption of BBI framework for reprocurement of all DMH & DCF residential services for youth
- Adoption of interagency restraint/seclusion initiative & Six Core Strategies©
- Commitment to trauma-informed care
- Development / expansion of family & youth roles
  - Parent Partners
  - Peer Mentors
- Development of:
  - Continuum (in-home residential service with team)
  - Occupational Therapy in more intensive programs
  - High intensity community services
Plummer Youth Promise

The Vision

A community committed to providing all children the support necessary to successfully navigate into adulthood

Adopted 2009

The Dream

Every young person has a family unconditionally committed to nurture, protect, and guide them to successful adulthood

Adopted 2015

#LEADINGCHANGE
Plummer Youth Promise

• Better programming did NOT = better outcomes
• Primary Focus on Permanency
• Focus on Family Search and Engage & Parenting Support/Education
• Focus on Building Community Support Network
Contact Information

**BBI Massachusetts**

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**Plummer Youth Promise**

James E. Lister  
Executive Director  
Plummer Youth Promise  
37 Winter Island Road  
Salem, MA 01970  
978.744.1099 ext. 113  
978.744.9772 fax  
https://plummeryouthpromise.org  
jlister@plummerhome.org
Vision: LA County RBS Project

The creation of a strength-based, family-centered, needs-driven system of care that transform residential facilities from long-term placements to short-term family driven open therapeutic communities, which are not place-based and concurrently provide for seamless transitions to continuing community care, which support the safety, permanency and well-being of children and their families.
Key Elements of Practice Model

- One Child and Family Team Across all Environments
- Care Planning Unifies Residential and Community Treatment (Wraparound)
- Family Search, Engagement, Preparation and Support from Day 1
- Building Life Long Connections and Natural Supports from Day 1
- Concurrent Community Work While in Residential
- 24/7 Mobile Crisis Support When in Community Phase
- Crisis Stabilization Without Replacement (14 days)
- Respite in the Community
Important CA RBS Study Findings

• The negative relationship between the total number of RBS placement changes and achieving permanency is highly significant, indicating that the chance of achieving permanency decreased by 84% with each additional placement. In addition, the chance of achieving permanency decreased by 28% with every additional month of a youth’s average length of stay in an RBS placement.

• The chance of completing RBS decreases by 15% with every additional month of a youth’s stay in an RBS placement, based on average length of stay, and the chance of completion decreases by 66% with each additional placement.
Seneca Family of Agencies

Mark Nickell
Regional Executive Director

Coming in 2018:
Journal of Residential Treatment for Children & Youth:

The Changing Role of Residential Intervention

by: LeBel, Galyean, Nickell, Caldwell, Johnson, Rushlo & Blau
FAMILIES TAKE CARE OF KIDS BEST
Family Perspective

What are the residential practices that would help families the most to reunite with their child successfully?

What are residential practices that do not help families?

What are staff skills/qualities that successfully engage families?
Questions & Discussion
So Far
Additional CA RBS Resources

Information on the California RBS Reform Coalition project and other County models can be found at:  [www.rbsreform.org](http://www.rbsreform.org)
CA Contact Information

Los Angeles County

Dr. Michael J. Rauso, Division Chief  
Department of Children and Family Services  
Resource Management Division  
425 Shatto Place, Suite 303  
Los Angeles, CA 90010  
(213) 351-5861/rausom@dcfs.lacounty.gov

William P. Martone, Former/Long-term President & CEO  
Hathaway-Sycamores Child and Family Services  
210 South De Lacey Ave. Suite #110  
Pasadena, CA 91105  
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San Francisco/Santa Clara County

Mark Nickell, Regional Executive Director  
San Francisco & Santa Clara Seneca Family of Agencies  
mark_nickell@senecacenter.org- m. (510) 432-278
Family Adolescents and Children Therapy Services Inc (FACTS)/MN
Key Elements of Practice Model

Collaborative Intensive Bridging Services℠ – CIBS

- **Builds Collaborative Partnerships between:**
  
  *Case Manager, Family Therapist, Child and Family, and RTC*

- Ecology is the target of intervention not just the family

- CIBS is a 3 Phase Intensive Systemic In-home Therapy Model Integrated with a 30 day Residential placement

  - **Phase 1:** Initial engagement and assessment of family and child in-home, 2 to 4 weeks
  
  - **Phase 2:** Intensive RTC services, continuation of intensive in-home and RTC therapy 30-45 days, child has home visits so family can practice skills being learned in RTC
  
  - **Phase 3:** Intensive in-home therapy with child home
Key Elements of Practice Model

- CIBS is not RTC as usual – RTC focus during Phase 2 30 days is on:
  - Skills Practice not Mastery
  - Intense Family Focus
  - Frequent Home Time
  - Co-Therapy with Child and Family with Family Therapist and RTC Therapist
  - 3 Staffing within 30 days with all partners and child and family.

- Same Family Therapist stays with the family from beginning to closing through all 3 phases of CIBS, Family Therapist has 5 to 7 weekly contacts

- Family Therapist has small case loads between 4 to 5
Key Elements of Practice Model

• Focus is on building skills of children to better manage their emotions and behavior and to increase parents’ capacity to manage their child’s emotions and behaviors

• 2014 Dakota County MN Data Evaluation 24 months after RTC 30 day placement to compare CIBS Youths with Youth in Residential Placement.
  - CIBS youths – 58     Comparison Youth – 34
    • Subsequent RTC Placements 24 months after RTC:
      - CIBS 76% youth had no further placements
      - Comparison youth 35% had no further placement
    • Costs for additional services during 2 years post RTC placement
      - CIBS (14 youth) $236,928.10
      - Comparison Group (22 youth) $689,780.89
      - Cost Savings of $452,852.80

• Services are paid through Insurance and County
Contact Information

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lynn@facts-mn.org
Examples from the New BBI Guide!
The Children’s Village

- CEO, COO and all VPs/Directors required to have open door policy to any family member
- Hired Parent Advocates (full-time, salaried and with benefits)
- Provide evidence-based parent education in English and Spanish
- Trained and launched Family Team Conferences (FTC)
  - Since some parents could not attend, developed mobile FTC Conference Centers
- Developed a variety of successful short-term (21-day, 28-day, 40-day, 100-day) residential models to provide stabilization and crisis respite for teens
- Beginning in 2005, secured “flex funds” for family support (available to all staff and Parent Advocates)
- Outcomes:
  - Overall median, annual length of stay for teens drop from over 24 months to under 6-months
  - Last year, over 800 teens were discharged in under 40-days
The Children’s Village

Outcomes for MST Intervention for 15% at “highest risk” (who previously consumed 75-85% of all aftercare/flex resources)

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<th>Outcomes 2008 – 2010 6-month treatment</th>
<th>MST/WAY Treatment 25 youth and families</th>
<th>Comparison 23 youth and families</th>
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<tr>
<td>In School</td>
<td>19 (76%)</td>
<td>10 (43%)</td>
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<tr>
<td>Arrests</td>
<td>4 (16%)</td>
<td>12 (52%)</td>
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<tr>
<td>Failure to remain at home</td>
<td>5 (20%)</td>
<td>16 (70%)</td>
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CV privately funded specialized MST teams to provide these families with the intensive support they needed.
Contact Information

The Children’s Village

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INDIANA
“You never change things by fighting existing reality. To change something, build a new model that makes the old model obsolete.”

- Buckminster Fuller
Focus on Families:
• believing that youth belong with their families
• rapid engagement is essential
  ▫ “every day matters!”
• creating multiple modes of engaging youth & families
  ▫ insisting on daily contact
• clinicians offices are in the community – not in the program(s)
• empowering families to choose their staff and be arbiters of interventions with their child
• recognizing families as experts in need of additional skills and support
• harnessing ‘youth power’ and actively including their expertise and/or developing new roles
## Long-Term Outcomes (Recidivism)

- Data dynamically collected to 5-years post “discharge”

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<tbody>
<tr>
<td></td>
<td>4%</td>
<td>11%</td>
<td>9%</td>
<td>3%</td>
<td>8%</td>
<td>6%</td>
<td>9%</td>
<td>6%</td>
<td>11%</td>
<td>12%</td>
<td>15%</td>
<td>12%</td>
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- Recidivism typically occurs within the first 12 months post discharge
Damar: Practice Improvement

Definition of “Recidivism”

During the 5-years post “discharge” from the residential care setting, the youth is not placed in a similar or higher level of care.
Damar Services, Inc.

Critical Incident of Primary Concern

If 24 hours goes by and a youth is not with his/her family and/or in his/her home community, it is considered a Critical Incident for the Agency and a plan of action/correction must be submitted to the COO*. (Note: Phone calls do not count.)

*Internal Quality Plus Threshold is 95% for Agency. If it’s not measured, it’s not managed.
Damar: Now We Know!!

Our Job is not to cure kids but rather to help kids and their families negotiate the basic tasks of everyday life.

“Residential treatment” should be oriented not so much around removing problems kids bring to care but toward establishing conditions that allow children and families to manage symptoms and crises more effectively at home and in the community.
COULD YOUR RESIDENTIAL PROGRAM OR PROGRAMS IN YOUR GEOGRAPHICAL AREA DO THIS?
If a youth requires re-admission post "discharge,"

it is FREE.

What if you guaranteed your outcomes?
Damar Contact Information

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Damar Services, Inc.
www.damar.org
(317) 856-5201
jimd@damar.org
Kansas
KVC: Committed to change

• “Think nimble and continually adapt”
• Increasing LOS and difficulty treating youth with acute behavior - so KVC went on learning journey
• Implemented TST systemwide
• All assessments done within 72 hours
• Active outreach/engagement with families at least 7-10 times/week
• Reduced LOS >1 year (1996) to 59 days (2015)
KVC Contact Information

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Wayne Sims
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Do You Take Big Steps? Small Steps?

• Take Any Step!
• Take Many Steps! A Number of Family-Driven & Youth-Guided Practices Have Been Identified That Support Better Outcomes
Steps Being Taken across the Country...

- Using BBI documents to provide guidance to residential and community providers
- Holding regional and/or statewide BBI forums
- Rewriting regulation/licensing based on BBI principles/practices
- Developing BBI teams and developing plans for state-specific projects
- Revising fiscal strategies to support replication of BBI informed practices/program models
Consistent Challenges Faced

- Most state agency/regulatory oversight documents (e.g., contracts; licensing; Medicaid) do not have best practice expectations and often have practices contra-indicated for effective outcomes
- Different systems (e.g., probation officers; child welfare workers) not supportive of focus on reunification/working w/ family in home/community
- Many residential programs have not had opportunity to learn/understand/implement effective practices to engage families/promote family-driven care
- Permanency Practice Models not in place and/or no urgency, and/or CW has not developed framework/agreement for sharing with providers
- Insufficient community based resources & supports
- Residential programs still struggling with coercive interventions and high # of incidents (e.g., restraint/seclusion/police calls/runaways/aggression)
After review of Residential Research

- Dr. James Whittaker: “I have more faith in a whole cloth approach where we start with a set of principles, change theory, structure and then select a limited array of key interventions to implement it .... This seems to me more consistent with what successful non-TRC EBP’s such as Multi-systemic Therapy and Multi-Dimensional Treatment Foster Care have done, than simply an approach that aggregates ever greater numbers of EBP’s in a residential setting.”

Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care | Research Brief/Casey Family Programs (2016)
Expect to flip the residential paradigm: bring residential intervention into the home and FULLY incorporate family & youth voice and choice into the program!
Questions & Discussion
Small Group Activity

- Get together with 2 to 3 of your table mates
- Each person share with the group:
  - What are one or two strategies you heard about that felt exciting and you would like to consider for your program/agency?
  - What are one or two strategies you heard about that you feel like there are too many barriers to ever implement in your program/geographical area?
  - Name a couple of the barriers for one of the strategies you are most interested in.
  - Discuss possible strategies to address the biggest barrier for your desired strategy – call on a faculty to support this portion if it would be helpful.
Pat Mosby Contact Information

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References


