
Overview and Highlights of the Building Bridges Initiative
Presented by: Beth Caldwell: Director, Building Bridges Initiative (BBI)

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.

Strengths of your own agency
• Specific to ensuring long-term positive outcomes for youth and families served, what are one or two current practice strengths of your own organization/agency?

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)

Recently released BBI documents – available: www.buildingbridges4youth.org
• BBI Tip Sheet: Youth Advisory Councils
• BBI Tip Sheet: Working with and Supporting Siblings
• BBI Report: Building Consensus on Residential Measures: Recommendations for Outcome and Performance Measures

New 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.routledgementalhealth.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.
Some of the Critical Issues

- Research on residential effectiveness
  - Recidivism/Readmissions
    - 68% in one state (2009) for all licensed residential programs vs. Damar Services (BBI implementer) with ranges from 3-11%
  - Lengths of Stay
    - NYS (Average: 14 months in 12+ years) vs. FL (<6 months in 3 years)

Examples of where BBI/ residential best practices are happening?

- Comprehensive State initiatives (DE, IN, MA, CA – initially 4 regions)
- Initial State level activities (NH, AZ, LA, NM, ND, OK, WA)
- County/City level initiatives (City: NYC; Counties: Monroe/Westchester, NY & Maricopa, AZ)
- Many individual residential and community programs across the country

California Residential Project

- Transformation from long-term congregate care and treatment to short-term stabilization and treatment with follow along community-based services

Critical elements

- Residential-specific research shows improved outcomes with shorter lengths of stay, increased family involvement, and stability and support in the post-residential environment (Walters & Petr, 2008).

BIG STEPS AND SMALL STEPS

- All count
- A number of family-driven & youth-guided practices have been identified that support better outcomes

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.
Additional RBS Resources

Information on the California RBS Reform Coalition project and other County models can be found at: www.rbsreform.org

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Indiana – Damar Services, Inc.

• Collection of recidivism data for 5 years post-discharge
  2005  4%
  2006  11%
  2007  9%
  2008  3%
  2009  8%
  2010  6%
  2011  7%
  2012  8%

Recidivism typically within first 12 months after 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.

Indiana – 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.

• Take youth/family back for free if requires placement post-discharge

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.
New York – The Children’s Village

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

<table>
<thead>
<tr>
<th>Outcomes 2008 – 2010 6-month treatment</th>
<th>MST/WAY Treatment 25 youth and families</th>
<th>Comparison 25 youth and families</th>
</tr>
</thead>
<tbody>
<tr>
<td>In School</td>
<td>19 (76%)</td>
<td>10 (43%)</td>
</tr>
<tr>
<td>Arrests</td>
<td>4 (16%)</td>
<td>12 (52%)</td>
</tr>
<tr>
<td>Failure to remain at home</td>
<td>5 (20%)</td>
<td>16 (70%)</td>
</tr>
</tbody>
</table>

CV privately funded specialized MST teams to provide these families with the intensive support they needed.

Other steps being taken in other places...

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

- Buckminster Fuller

Implementing the Building Bridges Framework: Massachusetts’ Experience

Residential Interventions and Systems of Care:
Building Bridges Initiative
Strategies for Improving Practice, Outcomes and Integration
July 20, 2014 ~ National Harbor, MD

Outline

• Getting Started
• Beginning Steps
• Building the Bridge
• Next Steps & New Expectations
• What Have we Learned?
• Our Strokes of Brilliance

How we got Started

• The Foundation Was Established:
  – Trust and common goals were clear based on prior successful efforts in implementing collaborative assessment project and R/S prevention with BBI & trauma-informed care
• A New Opportunity Arrived:
  – Provider litigation for service contract ($) parity & equity required DMH & DCF to recontract residential services. The agencies decided to recontract together with these shared values and new expectations = Caring Together

Beginning Steps: We Did our Homework

• Researched, Reviewed, & Analyzed Data to Determine the Needs & Direction
  – Examined National trend data
  – Examined State & Regional information
  – Traveled and met with other states & leaders involved in residential change
  – Examined population data: 5,500 youth served each year: 5,000 by DCF, 500 by DMH
  – Examined service data: 69% of residential service providers/contracts ‘map’ to both agencies
  – Examined fiscal data: 240M worth of residential service

Beginning Steps: We Talked A Lot

• Began asking a lot of questions, listening to the answers & most importantly DOING SOMETHING with the new information
  – Many focus groups with parents/families & youth (500+)
  – Many focus groups with providers, partners, & other constituents
  – Many focus groups with staff from both agencies
  – Organized youth survey teams & developed tool, met with youth peers in residential services and delivered real time recommendations for service redesign
Providers challenge the state agencies at an early public forum:

“There are a lot of unanswered questions here! It doesn’t sound like the Agencies have this all figured out!”

DMH Deputy Commissioner, Joan Mikula replies:

“Well, we’re building this bridge as we’re walking across it!”

Next Steps:
We Identified New Expectations

- Family-driven, Youth-guided values & orientation
- Focus on Permanency from Day 1
- Trauma Informed Practice
- Goals of Educational & Community Tenure / Stability
- Focus on “Residential” as intervention - not a placement
- Permeability and portability between levels of service (including residential and community) leading to improved transitions between services
- Focus on return to community/community-based service
- Focus on maintaining family/community connections: pediatricians, dentists, friends, schools, activities

Next Steps: We Prepared Our State for the New Conceptual Framework: BBI +

- Conducted 3 statewide, stakeholder trainings on BBI with national experts – included youth, families, licensors, schools & other agencies & funders!
- Conducted large stakeholder training on implementing the BBI SAT
- Solicited BBI expertise & guidance for consultation in service design / changes
- Issued an RFI looking for feedback on preliminary conceptual framework
- Message saturation & prep. for change:
  - Conducted multiple concurrent Grand Rounds on Y/F inclusion, roles, & perspective
  - Conducted parallel trainings on R/S Prevention/Six Core Strategies©, TIC, & OT

Imbedded New Expectations

- Youth-guided/Family-driven practice:
  - Imbedded in programmatic Joint Standards & individual service standards for ALL new contracts/services & new y/f roles in several services
  - Demonstrated through ensuring youth/family perspective and involvement in every step of the process: data collection, service design, service writing, proposal review, proposal selection, contract negotiations and new service implementation
  - Ensured by Creating 4 new regional oversight teams (responsible for: UM, QM, Contracts) with DMH & DCF staff and new team roles: Coordinators Of Family-Driven Practice & Peer Mentors

Made General System Enhancements

- Examples of Requirements:
  - BBI
  - Adoption of Interagency R/S Initiative / Six Core Strategies©
  - Provider Board Members with lived experience (Family/young adults)
  - Families be taught what staff are taught
- Developed/expanded:
  - Family roles / Parent Partners & Youth roles / Peer Mentors
  - OT in intensive services
  - RN Oversight Model for Med. Admin.
  - A rate for/budgeting for Service Dogs
- Created new models:
  - to facilitate community transitions & ensure success: “Stepping Out” & “Follow Along”

What we Have Learned?

1. We wished we had done this years ago
2. Inclusion of all stakeholders is key – it’s not just about youth/families – it’s about all of us feeling valued and working together
3. We should have planned a larger implementation advisory committee earlier on – anxiety and questions percolated too long. We needed a venue to support providers in the change process in ‘real time’
4. Implementation of the law resulting from the provider litigation (C.257) has made it more difficult to be ‘fiscally flexible’
5. It is very hard work – harder than we thought. Every step is slower but every step is more powerful & impactful – because we are “Caring Together”
What Else we Have Learned?
6. Planning to deliberately become youth-guided, family-driven and change the philosophic framework was much more than a values shift. It forced us to look at EVERYTHING we do. This was unexpected.
7. We had to look at the basics: decision-making for services, how to reconcile protective concerns with consumer choice, and what to do when families do not want y-g/f-d care but want agency-driven decision making.
8. We also had to look at more complex matters, e.g. how to: speak the same language, communicate, and share data with each other: DMH has strict state privacy laws and HIPAA limitations but DCF does not.
9. We learned early resisters think: Y-G/F-D care means “the youth/family gets their way all the time”. This is not so.

Our Strokes of Brilliance
1. Committed to a direction - publically
2. Didn’t profess to have all the answers
3. Planned for a long-term effort
4. Actively and continually (and still do!) solicit feedback
5. Changed our standards to mirror the direction and priority
6. Lived our values: shifted $/resources to create new youth/family roles
7. Connected the effort to all services with a common language and framework

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When we commit to a vision to do something that has never been done before, there is no way to know how to get there. We simply have to build the bridge as we walk on it
- Robert E. Quinn -

How State/County Agencies & Systems of Care Communities Can Support:
- Family Finding/Family Search & Engage
- Family Team Conferencing/Child & Family Team/Wraparound to Fidelity
- Flexible Fiscal, Policy and Practice Models that Support Residential as a short-term Intervention, w/ long-term support in community (i.e. Damar - 2 years)
- Funding Flexible Community Programs & Supports
- Funding Training & Supervision for Clinical Staff in Family Systems (i.e. MST)

How State/County Agencies & Systems of Care Communities Can Support:
- Family/Youth Advocates in every Community who can follow in & out of residential
- Family/Youth Support Services in every Community
- All Staff from all state agencies trained in focus on BBI Principles/Best Practices (e.g., FDC; YGC; Moving from Control to Collaboration; TIC; Do whatever it takes) and Permanency
- FDC/YGC Training/Consultation for Staff/Programs
- Permanency Round Tables for High Need Youth
- Cross agency data systems that support tracking long-term outcomes
Issues to be aware of:

- Maslow’s Hierarchy (i.e. acuity issues must be addressed first – example of hiring multiple family advocates but program toxic with R/S)
- Watch out for ALL models of care (e.g., Sanctuary; PEM; Love & Logic) “Is it about the program or about the youth?”
- Only models identified to date that are consistent with research on FDC & YGC & TIC: Collaborative Problem Solving (Greene) and Trauma Systems Therapy (Saxe)
- Need leadership expertise in Culture Change (i.e. Six Core Strategies©)

Consistent Challenges Faced

- Other systems (e.g., probation officers; child welfare workers) not supportive of focus on reunification/working w/ family in home/community
- Family Search & Engage/Family Finding/Expanding Support Network – no urgency
- Insufficient community based resources & supports

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The Building Bridges Initiative (BBI):
Residential Interventions and Systems of Care: Building Bridges Initiative Strategies for Improving Practice, Outcomes and Integration
Georgetown University 2014 Institutes

The Building Bridges Initiative
Family-driven Care
Presented by: Joe Anne Hust, Co-Chair BBI Youth and Family Partnership Workgroup

Whose job is it to ensure family involvement?
No matter who the family is or what challenges they are presenting?

IT IS OUR JOB – EACH AND EVERY ONE OF US
• The research in out-of-home care consistently shows that the processes and outcomes of care improve in correlation with the degree of family involvement.

And...

"the effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when, and why families or caregivers are engaged in the delivery of care. While traditional forms of care approached mental health treatment in a hierarchical top down approach (with the clinician maintaining some distance from the recipients of treatment), this approach is not reflected in newer forms of service delivery. It is becoming increasingly clear that family engagement is a key component not only of participation in care, but also in the effective implementation of it" (p. 238). (Burns, B. et al, 1999)

Family-driven Care Results

Residential-specific research shows improved outcomes with shorter lengths of stay, increased family involvement, and stability and support in the post-residential environment. (Atkinson & Petr, 2008).

What is Family-driven Care

“Family-driven means families have a primary decision making role in the care of their own children .... This includes: choosing supports, services, and provider; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; …”

Examples of Guiding Principles of Family-Driven Care

• Families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
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• Providers take the initiative to change practice from provider-driven to family-driven.

• Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.

Examples of Characteristics of Family-Driven Care

• Family and youth experiences, their visions and goals, their perceptions of strengths and needs, and their guidance about what will make them comfortable steer decision making about all aspects of service and system design, operation, and evaluation.

• All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

• Meetings and service provision happen in culturally and linguistically competent environments where family and youth voices are heard and valued, everyone is respected and trusted, and it is safe for everyone to speak honestly (i.e. Beardsley).

• Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, responsibility, and control with them.

Family Driven and Youth Guided

• Create and advance a philosophy that the commitment to a child, youth and family is on-going, does not allow for a premature discharge, strives to provide continuity, supports transitions, promotes individualized and culturally competent service delivery and goals, eliminates blame and supports the strengths of each family member, and incorporates a “whatever it takes” and “never give up” attitude to providing help and support.

• Ensure that sibling bonds are maintained and that assistance to siblings is incorporated into treatment and support plans as indicated.
Family Driven and Youth Guided

- Commit to finding ways to ensure that children and youth grow up in families. If a youth requires treatment in a 24-hour out-of-home treatment setting, it should be understood that placement occurs only for as short a period of time as is necessary, and is appropriate to meet the clinical needs of the child and family.

Examples of agreements in BBI Joint Resolution:

- In keeping with family driven and youth guided principles, basic rights, including visits (spending time together) between families and children, should not be denied or restricted for either clinical or punitive purposes at any point in the treatment process.

- Ensure that families receive whatever services and supports they identify as necessary to provide for the well-being of their child.

CA Reform: Benefits to Child and Family

- One Child and Family Team Across all Environments
- Care Planning Unifies Residential and Community Treatment
- 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
- Respite in the Community

Hire Family Partners

Most Important Step:

- They serve as co-trainers in staff orientation and ongoing training programs
- They serve as part of hiring groups to hire staff
- They serve as part of evaluation teams to evaluate each individual staff
- “Nothing about us without us!”

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2ND Most Important Step: Develop Strategic Plan to Successfully Engage Families and Operationalize Family-driven Care

Go to the BBI website (www.buildingbridges4youth.org), download, review and plan to use the BBI Self-Assessment Tool as part of your strategic plan.

Examples of Practices you would see:

- Every Staff is ‘Director of First Impressions’
- Families can come to program 24/7
- Warm and comfortable physical environments
- Families can go to every part of the program – spending time in their child’s room and classroom and activities

Examples of Opportunities you would see:

- Create opportunities (i.e. weekend camping) for families to be proud of their children/to create positive memories
- Support siblings
- NO MORE GROUP REC – all recreation focused on youth individual interests/talents and any ‘group’ activity involves siblings/families/extended families- i.e. cousins
- Gather tickets/freebies for families to use with children (maybe with a staff for support)
- Develop close collaborations with clinical expertise in community (e.g., trauma; SA; DV) & supports (e.g., housing; community activities; peer mentors; respite)

As part of Strategic Plan

Have all leadership team members read and read and read:

- BBI Family Tip Sheets (long and short versions) & BBI Engage Us: A Guide Written by Families for Residential Providers (www.buildingbridges4youth.org)
- Massachusetts Department of Mental Health Creating Positive Cultures of Care Guide Chapters:
  - Successfully Working with Family Partners
  - Embracing Family-driven Care
- A variety of other materials to support increased understanding and improved knowledge-base

Examples of Practices you would see:

- Lose the words ‘home-visits’
- Family focus groups decide education offerings for families
- Families called everyday to share child strengths – not just about issues & encouraged to call multiple times daily
- Youth call different family members multiple times daily
- Ensure families have dedicated time to talk with front line staff
- Make it a practice to consult with families to seek counsel and engage in decision-making

What to be cautious of:

- Events on residential campuses (why?)
- Lack of sophisticated/committed Clinical Supervisors
- Group residential recreation (why?/who to invite? (build memories with families)
- Residential holiday traditions (“Is it about the program or about the youth/family?”)
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