



Hampton Virginia  
Comprehensive Services Act  
Community Policy and  
Management Team

**Historical Perspective, Data,  
Outcomes and  
Practice Improvement Project**

*“We have each come from a single-agency, somewhat specialized approach to serving children and families. CSA challenges us to create a new approach, to reinvent the way services are provided”*

*Walt Credle/October 31, 1994*

Report Commissioned By: Hampton CPMT  
Prepared By: Triad Training and Consulting Services  
Supported By: Hampton FAPT and DSS

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# **ACKNOWLEDGEMENTS**

Triad Training and Consulting Services would like to acknowledge the following people for their involvement with this project:

## **Case File Reviewers and Interviewers**

- Amanda Blakeslee HCSU
- Teresa Brooks CPMT Parent Representative
- Latoya Colbourne Triad
- Rachel Gholston Lutheran Family Services
- Tiffany Hassell HDSS
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- Jack Mincey HDSS
- Jessica McClary Lutheran/FAPT
- Maria Parker Specialized Foster Parent
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## **Specialized Foster Parents**

- Annie and Robert Harrell
- Marlun and Laura Hart
- Mark Hinson
- Derrick and Yonnie McElwain
- Darnell and Maria Parker
- Michael Burke (our newest specialized foster parent)

## **The FAPT Office Team**

- Denise Sterling Gallop
- Helen Holt (has been helping FAPT work since the early days)
- Renee Garner (thanks for all of your help!)

## **Interviewees**

- Thanks to all who gave of their time to be interviewed for this project.

## **Families and Children**

- Thanks to the children and families who allow us to be part of their lives and a special thanks to kids and families who took part in this project.

Mike Terkeltaub, Executive Director  
Triad Training and Consulting Services

## Executive Summary

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The City of Hampton has been lauded as a leader in Systems of Care reform throughout the state of Virginia. This praise is evidenced by an article that appeared in the Richmond Times Dispatch in 2004, historical limited utilization of residential treatment services, several innovative approaches to community based service delivery and the historical and present utilization of the City's Comprehensive Services Act (CSA) staff as ad hoc consultants to communities around the state.

The Hampton Community Policy and Management Team (CPMT) and Family Assessment and Planning Team determined that there was a need to gather data, measure success and develop practice improvement activities to support continued success for children, families and communities. CPMT commissioned Triad Training and Consulting Services to develop this report; to review existing data available in the system; develop processes to review data on a consistent basis; develop systemic, individual and process outcome measures; review the services and outcomes for children and families served in the Specialized Foster Care Project; and develop practical recommendations for practice improvement activities.

Hampton CPMT worked in collaboration with Triad staff to develop a comprehensive approach to reviewing the Hampton Comprehensive Services Act system in accordance with CSA and Systems of Care principles that all services for children and families should be child centered, family focused, community based, strength based and culturally and linguistically competent.

Triad has worked with communities in Arizona and Kansas to develop similar child serving systems systemic assessments that serve to inform present and future practice.

Key data, outcomes and practice improvement activities in developing this project included the development of review tools and community buy-in to the process; the creation of a historical perspective of the development of Systems of Care approaches in Hampton including semi-structured interviews with 15-20 key individuals involved in CSA development; interviews with children, family members, foster parents and key stakeholders throughout the system to add depth to the information provided in the case file review process; the development of a comprehensive report including each of the aforementioned activities and at least 3 presentations of the report to CPMT and designated stakeholders; and the utilization of key findings in the *Systems of Care Data, Outcomes and Practice Improvement Project* to insure that successful activities are continued and areas needing improvement are addressed.

Hampton CSA staff worked with Triad staff to determine a cohort of children and adolescents to review as part of this project. The team decided to review children and families supported by the Hampton Specialized Foster Care Project developed in 1997 to serve three children living in residential treatment. More than 40 children returning from residential treatment or at imminent risk of residential treatment placement have been successfully supported by the Specialized Foster Care Project. 26 children are presently living in Specialized Foster Homes and during the past year 92 % of these children have remained in their homes, moved to less restrictive environments or have been adopted. One Specialized Foster Home closed when the family adopted the children living in the home.

The child serving agency leadership in Hampton implemented CSA in 1994 as a Systems of Care approach and sought the wisdom and experience of national leaders in Systems of Care and Wraparound including Karl Dennis from Kaleidoscope in Chicago. This report will also relate that Hampton was well positioned to implement CSA as the city's child serving agencies were already meeting to collaborate regarding service development and firmly believed that children should be served in their communities.

Walt Credle, the Hampton Director of Social Services, communicated to the CPMT on October 31, 1994 with a memorandum titled "Reinventing Service Delivery." This memorandum stated, in part, "we have each come from a single-agency, somewhat specialized approach to serving children who are at-risk. CSA challenges us to create a new approach, to reinvent the way services are provided."

Significant findings of this report include:

- Hampton seldom utilizes residential treatment as a service option. 2% of all services funded by Hampton in the third quarter of 2005 were residential treatment services. This was the lowest percentage of all communities measured for this report utilizing the Office of Comprehensive Services Data Set information for third quarter of 2005.
- Hampton significantly utilizes community based services as an alternative to out of home and out of community placement. 36% of all services funded by Hampton in the third quarter of 2005 were community based services. It should be noted that the total 100% of CSA Expenditures includes categories such as foster care maintenance, day care etc.
- The rate of increase in CSA funded services has been significantly lower than Virginia statewide increases. From 1994-2005 the cumulative statewide increases in CSA expenditures were 161%. The Hampton cumulative increases for the same time period were 39%.
- Hampton and Newport News were the only localities reviewed for this report that had **no** children placed out of state as reported by the third quarter 2005 CSA Data Set.
- There has been a strong commitment to multi-agency collaboration since 1993 to support children and families remaining together in the community. Multiple collaborations have resulted in the development of innovative programs by all CPMT member agencies. Projects include intensive care management, specialized foster care, the teaching parent approach, family reunification and intensive in-home services.
- Hampton has long emphasized prevention and early intervention services. The Hampton Healthy Family Partnership has played a significant role in inter-agency collaboration and reducing the need for intervention services.
- The Specialized Foster Care Project has supported children with significant needs remaining in the community as evidenced by 84% of the youth having academic problems; 80% of the youth having physical aggression issues; 61% of the youth having depressive symptoms; and 30% of the youth having suicidal or self-harmful behaviors.
- The Specialized Foster Care Project has shown significant success as evidenced by 92% of the children in the project during the past 12 months remaining in their specialized foster home, moving to a less restrictive environment or being adopted.
- One specialized foster home "closed" last year after the family adopted the children in the specialized home.

- The Specialized Foster Care project serves children and families with complex needs. One year ago 38% of children in specialized foster homes had a CAFAS score of 100 or higher. 42% of children in specialized foster homes at the time of this report had CAFAS scores of 100 or higher. This demonstrates the Hampton CPMT and FAPT's ability to support children with complex needs in community settings.

Results of this report indicate that Hampton CPMT has been successful at accomplishing the goals established in 1993-1994 of serving children in the community and providing cost-effective services that supported children and families moving toward self-sufficiency. The results also indicate that Hampton CPMT has continuously designed effective community based programming to serve children and families with the most complex needs.

The report also outlines potential practice improvement activities for the coming year including increasing family and youth involvement in the FAPT process, increasing the involvement of fathers in the FAPT process, increasing documentation of the utilization of natural supports, seeking potential new innovative programming to further reduce the utilization of residential care, and developing a plan to support sustainability for the *Data, Outcomes and Practice Improvement Project*.

This report will offer opportunities to celebrate successes as well as develop practice improvement opportunities for the future. The State Executive Council, State and Local Advisory Team, and The State of Virginia Office of Comprehensive Services have taken a leadership role in defining and implementing outcomes as part of the future direction of CSA activities at the state and local levels. Hampton CSA staff are part of this state-wide development and future state and local outcomes related activities should be integrated whenever possible.

# Introduction

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The Hampton, Virginia Community Policy and Management Team commissioned Triad Training and Consulting Services to develop this report to review existing data available in the system; develop processes to review data on a consistent basis; develop systemic, individual and process outcome measures; review the services and outcomes for children and families served in the Specialized Foster Care Project and develop practical recommendations for practice improvement activities.

Significant findings of this report include:

- Hampton seldom utilizes residential treatment as a service option. 2% of all services funded by Hampton are residential treatment services. This was the lowest percentage of all communities measured for this report utilizing the Office of Comprehensive Services Data Set information for third quarter of 2005.
- Hampton significantly utilizes community based services as an alternative to out of home and out of community placement. 36% of all services funded by Hampton in the third quarter of 2005 were community based services. It should be noted that the total 100% of CSA Expenditures includes categories such as foster care maintenance, day care etc.
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- Hampton and Newport News were the only localities reviewed for this report that had **no** children placed out of state in the third quarter 2005 CSA Data Set.
- There has been a strong commitment to multi-agency collaboration since 1993 to support children and families remaining together in the community. Multiple collaborations have resulted in the development of innovative programs by all CPMT member agencies. Projects include intensive care management, specialized foster care, the teaching parent approach, family reunification and intensive in-home services.
- Hampton has long emphasized prevention and early intervention services. The Hampton Healthy Family Partnership has played a significant role in inter-agency collaboration and reducing the need for intervention services.
- The Specialized Foster Care Project has shown significant success as evidenced by 92% of the children in the project during the past 12 months remaining in their specialized foster home, moving to a less restrictive environment or being adopted.
- The Specialized Foster Care project serves children and families with complex needs. One year ago 38% of children in specialized foster homes had a CAFAS score of 100 or higher. 42% of children in specialized foster homes at the time of this report had CAFAS scores of 100 or higher. This demonstrates the Hampton CPMT and FAPT's ability to support children with complex needs in community settings.

This report will provide additional data and outcomes information regarding the children and families

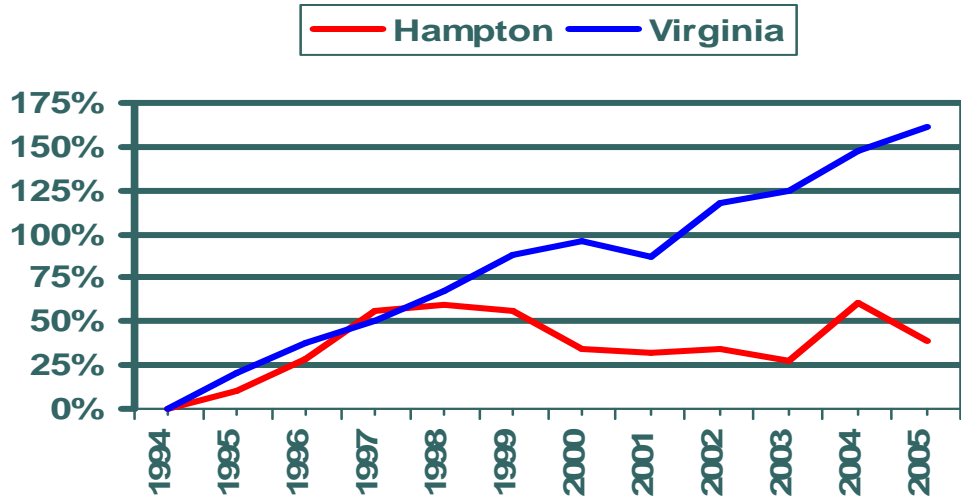
More than 40 children, returning from residential treatment or at imminent risk to be placed in residential treatment, have successfully been served in the project. Some of these children are now adults and have succeeded or struggled as adolescents moving toward adulthood. 26 children are presently living in Specialized Foster Homes.

who have been supported by the Hampton, Virginia *Specialized Foster Care Project* created in 1997 to serve 3 children. More than 40 children, returning from residential treatment or at imminent risk to be placed in residential treatment, have successfully been served in the project. Some of these children are now adults and have succeeded or struggled as adolescents

### CSA Cumulative Percent Increases: Hampton and Virginia 1994 - 2005

**Hampton**  
 1994 - \$2,561,087  
 2005 - \$3,570,767  
 39% increase

**Virginia**  
 1994 - \$104,554,892  
 2005 - \$259,323,434  
 161% increase



moving toward adulthood. 26 children are presently living in *Specialized Foster Homes*. This report will also trace the history of the development of the Comprehensive Services Act activities in Hampton and offer commentary regarding why Hampton has succeeded in keeping children and adolescents in the community. This report will also utilize the data gathered to offer practice improvement recommendations to CPMT.

It is also important that this report shares the stories of children, families and specialized foster families who have developed hope and skills for children and their families to succeed long term as productive members of the Hampton community. It is the story of one young woman living in a specialized foster home who “ran and ran and ran” according to her specialized foster parents. She had failed in multiple programs and bounced from relative to relative. She said to her specialized foster parents “I want to be in the street. This is my world!” She ran away from the specialized foster home and was gone for 3 months. The foster mother made multiple attempts to find her to no avail. One day the young woman called the foster mother and said “I am scared. Come get me.”

The young woman had taken refuge with a female pimp in the Bronx. She had been put out on the street and was in the middle of drugs, weapons and violence. The specialized foster parent and a Hampton DSS social worker didn’t think twice. They left at 7 P.M., drove all night and secured New York Police Department support (after significant convincing) to bring the young woman home. This “unconditional care” approach led to this young woman being able to stop running; get her GED; and today live and work successfully in the community.

The Specialized Foster Parent and a Hampton DSS social worker didn’t think twice. They left at 7 P.M., drove all night and secured New York Police Department support (after significant convincing) to bring the young woman home. This “unconditional care” approach led to this young woman being able to stop running; get her GED; and today live and work successfully in the community.

Over the past 20 years there have been national, state and local efforts to develop Systems of Care approaches for children adolescents and their families served by multiple child serving agencies. Sheila A. Pires notes that “a system of care incorporates a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally

and linguistically competent, and builds meaningful partnerships with families and youth at the service delivery and policy level (Pires, Building Systems of Care: A Primer, 2002).

The development of Systems of Care approaches was supported by the National Institute of Mental Health's creation of the Child and Adolescent Service System Program (CASSP) in 1983 to provide funds and technical assistance for all 50 states to plan and develop systems of care for at-risk children and their families. In 1989 the Federation of Families for Children's Mental Health's creation marked the beginning of an organized family voice supporting family voice choice and access to services. In 1989 the Robert Wood Johnson Foundation developed the Mental Health Services Program for Youth (MHSPY) which funded 12 states and cities to develop systems of care approaches and introduced managed care technologies to the development of systems of care.

Congress passed legislation in 1993 creating the Comprehensive Community Mental Health Services for Children and Their Families to build systems of care. In 1993 the Anne E. Casey Foundation began the Mental Health Initiative for Urban Children which focused system-building efforts at the neighborhood level in inner cities.

Virginia's service delivery system during this time period mirrored other systems around the country. There was a significant lack of interagency planning, over-reliance on inpatient hospitals and residential treatment centers and disagreements between state and local governments regarding programming and funding for children's services. In 1986 the Virginia *First Lady's Forum*, comprised of senior state leadership at all child-serving agencies began to identify creative, effective and efficient opportunities to improve the System of Care for children, adolescents and their families (Cohen and Cohen 1999).

A 1990 study by the Department of Budget and Planning determined that 5,000 children in residential care included many children and adolescents with significant and multiple issues:

- 89% with emotional or behavioral disorders
- 77% with school suspensions or expulsions
- 68% with adjudicated delinquency
- 58% aggressive or assaultive
- 49% alcohol or drug abuse
- 45% runaways from home or treatment
- 43% emotionally abused or neglected
- 28% suicidal or self-injurious
- 25% physically or sexually abused

There was also the realization that children bounced from agency to agency with as many as 4 different state agencies (DOE, DSS, DJJ and DMHMRSAS) involved in some cases. This potential duplication of services led to the discovery that 14,000 cases identified by these 4 child-serving agencies actually represented no more than 5,000 children. Additionally, 16 different federal and state programs funded treatment and each of the funding streams had different local matches. Residential care was often utilized even when less restrictive community based services would have been sufficient. Costs across the state were increasing at about 20% each year. (CSA briefing for the House Appropriations Committee January 26, 2003)

In response to the study in 1991 Virginia's Governor created the Council on Community Services for Youth and Families " a public-private consortium charged with developing a new service-delivery model, funding mechanisms, and training programs for state and local government staff; tracking caseloads and expenditures; and evaluating the proposed system (Ledford 2001). Following public hearings being held

across the state in the summer of 1991, the Comprehensive Services Act was passed by the 1992 General Assembly.

The General Assembly set goals for CSA which included:

- ❖ Preserve and strengthen families
- ❖ Provide services in the least restrictive setting
- ❖ Identify children in need of services and intervene early
- ❖ Create new services for unmet needs of children and families
- ❖ Grant local flexibility and require local accountability
- ❖ Encourage public and private partnerships in services delivery
- ❖ Increase interagency collaboration and family involvement

The interagency collaboration required the development of interagency state teams known as the State Executive Council and the State Management Team, since renamed the State and Local Advisory Team (*SLAT*) and local interagency teams to develop, implement and monitor treatment plans for children and families known as Community Policy and Management Teams (*CPMT*) and Family Assessment and Planning Teams (*FAPT*). *FAPT* is named the Community Assessment Team (*CAT*) in some communities.

Funding was simplified as multiple funding streams were consolidated into one pool with a local match rate based on each locality's ability to pay. Funds were distributed based on each locality's measure of need that built on the locality's historical expenditures.

Hampton joined other localities around the state in both determining the impact of CSA on local public and private child-serving agency practices and ascertaining how to manage potentially competing local and state agency agendas.

The child serving agency leadership in Hampton and around the state implemented CSA as a Systems of Care approach and sought the wisdom and experience of national leaders in Systems of Care and Wraparound such as Karl Dennis, John VanDenBerg and Mary Grelish to provide technical assistance in CSA development and implementation. This report will also relate that Hampton was well positioned to implement CSA as the child serving agencies were already meeting to collaborate regarding service development. (See Appendix A: Building Resilient Families and Communities: An Interview with Karl Dennis)

The City of Hampton has been lauded as a leader in Systems of Care reform throughout the state of Virginia. This praise is evidenced by an article that appeared in the Richmond Times Dispatch, historical limited utilization of residential treatment services, several innovative approaches to community based service delivery and the historical and present utilization of the City's Comprehensive Services Act staff as ad hoc consultants to communities around the state (See Appendix B: Help Without Losing Custody – Richmond Times-Dispatch Dated February 10, 2004).

The Hampton Community Policy and Management Team (*CPMT*), in May 2006, sought to develop comprehensive data assessments, outcomes collection and practice improvement activities to insure that the success outlined in the aforementioned areas was substantial and sustainable. The *CPMT* secured the services of Triad Training and Consulting Services to take a leadership role in the development of this project.

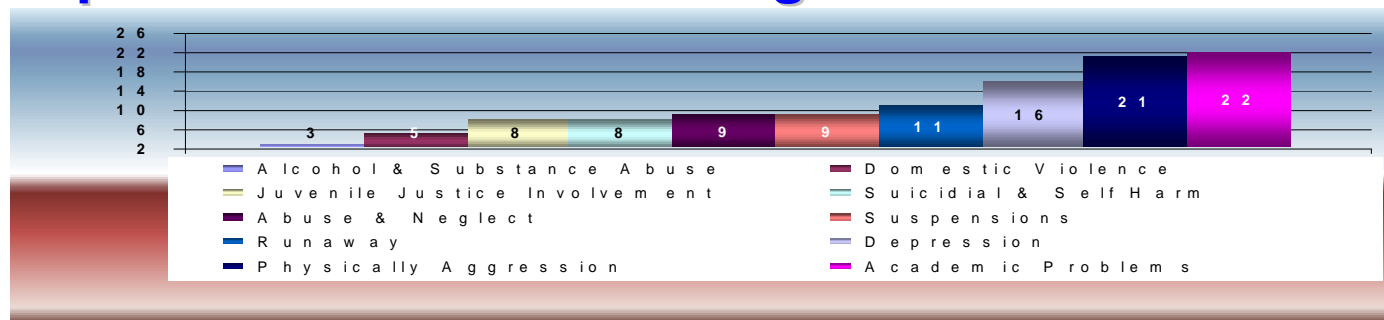
Mike Terkeltaub, the Executive Director of Triad Training and Consulting Services has over 25 years of experience working with at-risk children and their families. He has been a leader in the development of

community based services in Eastern Virginia and nationwide. He served as the Director of Comprehensive Services in Hampton, Virginia from 1995 to 1998. For the past seven years he has been a consultant to public and private agencies in the development, implementation and sustainability of Systems of Care Approaches. This work includes the implementation of a practice improvement process in Hampton similar to the process developed in both central Kansas and Maricopa County, Arizona.

There are 10 significant practice activities that are key components of the Hampton CPMT project. These include:

- *Development of review tools and community buy-in to the process which includes the modification of review tools (please see attached Systems of Care Site Review Tool and Systems of Care Interview Questionnaire), meetings with CSA staff to develop key processes and Systems of Care training.*
- *The determination by CSA staff and CPMT of which cohort of children and families will be measured.*
- *The creation of a historical perspective of the development of Systems of Care approaches in Hampton including semi-structured interviews with 15-20 key correspondents involved in the development, implementation and sustainability of Systems of Care approaches in Hampton.*
- *Utilizing the above information to inform key stakeholders regarding potential systemic influences on systems of care activities in Hampton. These include, but are not limited to, the highly successful Healthy Families program, Court Best Practices processes, innovative school programs, a comprehensive Community Services Board children's services division and a robust community based provider network.*
- *A group interview with families involved in the Specialized Foster Care program that has served many of Hampton's children and families with the most complex needs.*
- *Training and implementation of the Systems of Care Site Review Tool (SOCSRT) modified for the specific needs of the Hampton community. Versions of this tool have been utilized in both Central Kansas and Maricopa County, Arizona. The tool is trained and implemented in a group environment to allow open communication among review team members. The tool is implemented by a broad cross-section of community members including family members, foster parents, public and private agency staff and Triad staff. The tool includes demographic information, risk factors, services provided, child and family outcomes and systemic outcomes.*

## Specialized Foster Care Significant Risk Factors



This graph measures the number of risk factors for each of the 26 children identified as Specialized Foster Care children in 2006 (n=26). For example 21 of 26 children (80%) had physically aggressive behaviors identified. The 1990 DBP study determined that 58% had aggressive behaviors.

- *Interviews with children, family members, foster parents and key stakeholders throughout the system to add depth to the information provided in the case file review process. Teams of two including family members, foster parents and key stakeholders administer the semi-structured interview process.*
- *The development of data and outcomes information utilizing existing data. The data utilized will include information provide by communities to the state Office of Comprehensive Services as well as data collected via the Voices for Children KidsCount project.*
- *The development of a comprehensive report including each of the aforementioned activities. This also includes at least 3 presentations of the report to CPMT and designated stakeholders.*
- *The utilization of key findings in the “Systems of Care Data, Outcomes and Practice Improvement Project” to insure that successful activities are continued and areas needing improvement are addressed.*

## Systems of Care and Wraparound

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In 1982, Dr. Jane Knitzer authored a landmark book, *Unclaimed Children*, which introduced the need for the development of an integrated service approach for children and family services. Knitzer’s research documented the failure of public systems to meet the mental health needs of children and highlighted the lack of services for at-risk (sometimes now identified as *at-hope*) children and families as well as the lack of coordinated services where services did exist. Beth A. Stroul, M. Ed and Dr.

Knitzer’s research documented the failure of public systems to meet the mental health needs of children and highlighted the lack of services for at-risk (sometimes now identified as *at-hope*) children and families as well as the lack of coordinated services where services did exist.

Robert Friedman introduced the term Systems of Care in their book *Systems of Care for Children and Youth with Severe Emotional Disturbances* published in 1986. The authors conceptualized a community based process for meeting the needs of children and families who required care from more than one of the public agencies providing children’s services. These agencies typically included child welfare, mental health, juvenile justice, education and health. Additionally other child serving agencies including private providers, agencies providing services for children with developmental disabilities, organizations providing services for substance abuse and community based organizations such as churches, the YMCA and Boys and Girls Club were viewed as important parts of systems of care development.

At about the same time a national movement of parents with children who had severe emotional disturbance was being developed and led by Barbara Friesen, PhD at the Families as Allies Initiative at Portland State University and others around the country (Lourie, 1994). Friesen maintained that full participation of the parents and caregivers in planning, implementing and evaluating services for their children with emotional, behavioral or mental disorders was a vital component of any system of care. The core values and principles of Systems of Care (SOC) include:

- The System of Care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
- The System of Care should be community-based, with the locus of services as well as the management and decision making responsibility remaining at the community level.

- The System of Care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.  
(Stroul and Friedman, 1986)

**The Wraparound Approach** is the development of Systems of Care philosophy and methodology at the practice level. Services and supports are developed by individualized Child and Family Teams (CFT) similar to Family Assessment and Planning Teams. Leaders in the Wraparound movement including Karl Dennis at Kaleidoscope and John VanDenBerg at the Alaska Initiative developed the following operational characteristics of Wraparound:

- Partnerships between families and professionals
- Collaboration across agencies
- Cultural competence
- Blended financing
- Shared governance across systems with families
- Shared outcomes across systems
- Organized pathways to supports and services
- Interagency and family planning and monitoring teams
- Individualized service plans
- One responsible case manager
- Individualized services and supports for each family
- Services provided in the family's home and community
- Flexible array of services available
- Linkages to natural supports and community based services
- Integration of evidence-based treatment approaches
- A cross-agency management information system (Pires, 2000)

The Systems of Care/Wraparound approach has received support from practitioners, families and researchers across the United States. *The Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (2000) reported that there have been important system improvements utilizing the model, including improvement in functional behavior, family satisfaction with services and the reduction in the utilization of residential treatment placements. The Center for Effective Collaboration and Practice views Systems of Care and Wraparound as one of the "promising practices" in children's mental health. The Comprehensive Community Mental Health Services for Children and their Families report the following outcomes (CMHS, 1999):

- The ACCESS Program in Arlington, Virginia showed a 48% reduction in out-of-city placements;
- The Sanoma County, California program reported a 34% reduction in acute hospitalizations in 1997;
- Wrap Around Milwaukee reported a reduction from 270 days average in residential placements to 112 average days per child;
- The Crossroads program of San Mateo, California reported a 61% reduction in crimes committed by youth in probation 12 months after entry to the program compared to 12 months prior to entry into the program.

# Hampton CPMT and FAPT: A Historical Perspective

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CSA leaders in Hampton were already collaborating prior to the inception of CSA in July 1993. Sue Laughrun, Hampton Court Services Unit Probation Supervisor, who has been involved in CSA since the inception as a member of the Hampton Court Services Unit, remembers multi-disciplinary teams as early as 1991. Lylas Cooper, who served as the Court Services Unit's FAPT member for 10 years, remembers that in the early days of CSA agency staff learned to be "FAPT members first and then agency representatives." Jim Thomas, the former Director of the Hampton Court Services Unit remembers that the first chairperson of the CPMT was Harry Campbell the Executive Director of Lutheran Family Services. The election of Mr. Campbell as the first CPMT chairperson signaled the commitment of the city of Hampton to a true public/private partnership in the development of services for children and families.

Jim Thomas, the former Director of the Hampton Court Services Unit remembers that the first chairperson of the CPMT was Harry Campbell the Executive Director of Lutheran Family Services. The election of Mr. Campbell as the first CPMT chairperson signaled the commitment of the city of Hampton to a true public/private partnership in the development of services for children and families.

All of the leaders interviewed for this report noted that there was longstanding trust and positive working relationships for all involved with the project. Keith Sykes, recently retired as the Director of Prince William County Department of Social Services, was assigned to organize and coordinate the Comprehensive Services Act efforts. This exhibited the additional commitment of Social Services, led by Walter Credle, to commit a division chief level staff to this still fledgling project. Mr. Sykes remembers the time of the inception of CSA was also a time when innovation and best practices were cornerstones of Hampton public policy initiatives. Hampton was lauded in *Reinventing Government* and received national recognition for the Healthy Families Partnership, the Youth Coalition and Human Resources best practices. Many of the leaders interviewed also noted that they believed that children have better outcomes when provided supports and services in their homes and communities rather than out of home and out of community residential treatment placements.

Interviews with key leaders involved in the Hampton CSA project throughout the years mentioned several common themes as reasons for the city's success with developing community based services for at-risk children and families. These include:

- The trust and strong working relationships between and among child-serving agency department leadership
- The trust and strong working relationships between elected officials and city government staff prior to the implementation of CSA
- City government's belief in innovation and best practices in serving children and families including viewing families as the primary "natural" community resource
- Local leaders, department directors and program staff's firm belief that children had better outcomes served in the community rather than in out of home and out of community placements
- Selection of the private provider representative as the first CPMT chairperson
- Selection of the Hampton Department of Social Services Chief of Services as the manager of the program
- Significant and consistent leadership and support from Hampton Juvenile and Domestic Relations Court Judges
- Development of a FAPT team dedicated to CSA and co-located at DSS

- Designation of quality staff to the FAPT team who also served as CSA ambassadors at their agencies and in the community
- Clear focus, from the beginning, on creating innovative community based services and bringing children home from out of community residential treatment centers
- Development of a FAPT support team including a strong CSA Coordinator
- The commitment of member agencies to offer additional resources to support CSA including the development of a robust children's mental health system by the Community Services Board; utilization of 294 Funding and VJCCA funding by the Court Services Unit; the development of a regional school approach for special needs students by Hampton City Schools; commitment of a dedicated FAPT staff by the Hampton Health Department and the development of a significant number of private agencies that provided strengths based, community based alternatives to out of home and out of community placement.

Despite the positive efforts by CPMT and FAPT to develop child centered, family focused and community based services the utilization of residential treatment continued to be an issue. Robert J. O'Neill, Jr., Hampton City Manager sent a memorandum to the CPMT dated October 11, 1994 requesting the development of "local options for providing quality services to our youth but at a more reasonable cost." On October 31, 1994 Walt Credle communicated to the CPMT with a memorandum titled "Reinventing Service Delivery." This memorandum stated, in part, "we have each come from a single-agency, somewhat specialized approach to serving children who are at-risk. CSA challenges us to create a new approach, to reinvent the way services are provided." The memorandum included a document entitled *Reinventing Services to At-Risk Children & Families*. This document included the following commentary:

1. The Traditional Single Agency Approach reviews and accepts community based options at the step before making a residential placement. ***The New Collaborative Team Approach creates community based options for specific children that do not now exist.***
2. The Traditional Single Agency Approach encourages parents to accept residential placements because community based options are not readily available. ***The New Collaborative Team Approach offers parents creative community based options for their children and commit to their development.***
3. The Traditional Single Agency Approach continues residential placements beyond the point of significant treatment benefit. ***The New Collaborative Team Approach establishes early discharge dates and rigorously pursues step-down plans.***
4. The Traditional Single Agency Approach states that residential placements are driven by statutory and judicial considerations which are external to CSA teams. ***The New Collaborative Team Approach states that residential placements are driven by the degree to which we take responsibility for creating alternatives.***

It should be noted that the Hampton CPMT took a leadership role in determining that children and their families were best supported in their homes, schools and communities. The research, at the time, was limited regarding the efficacy of any particular treatment approach and there were many proponents of residential treatment. The Pines Treatment Center in Portsmouth, Virginia and the Barry Robinson Center in Norfolk, Virginia were large residential treatment providers near Hampton. Local communities and localities across the state were using many in-state and out of state residential treatment providers.

The research supporting community based treatment and questioning the gains in residential settings has developed in the last 10 years. The Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda (1999) states that "for youth who manifest severe emotional or

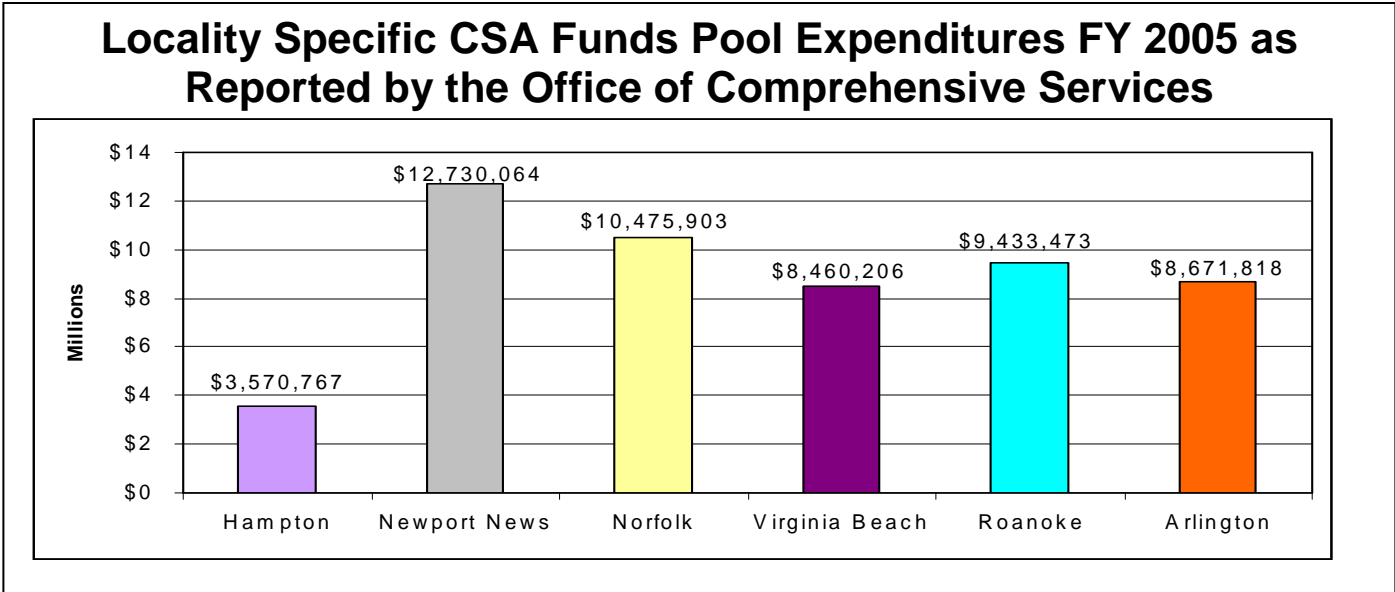
behavioral disorders, the positive evidence for home and community based treatments contrasts sharply with the traditional forms of institutional care which can have deleterious consequences (e.g., inpatient psychiatric hospital, residential treatment, group home).

Richard Barth’s *Institutions vs. Foster Care: The Empirical Base for a Century of Action* (2002) determines that “foster care and treatment foster care are more desirable and efficient than institutional care and their development should be treated as the priority of policy makers and program developers.

Barbara J. Burns Ph.D., Professor of Medical Psychology at Duke University and a leader in researching evidence based practices relates that institutional care including residential treatment, boot camps and detention centers have proven largely ineffective as interventions for children and their families. Treatment Foster Care, Intensive Case Management and behavioral approaches are among the services listed as effective for children and families based on recent research. (See Appendix F: *Effectiveness of Selected Community-Based Service Models*)

This information wasn’t available to Hampton and other Virginia localities in 1993 but there was the beginning of movement away from out of home and out of community placements and toward community based interventions. The Hampton Newport News Community Services Board, Lutheran Family Services, the Institute for Family Centered Services, Family Preservation Services, First Home Care, Barry Robinson Center and other community based agencies were developing individualized, family focused, community based, in-home approaches as alternatives to out of home and out of community placement. Therapeutic Foster Care was also being developed in Eastern Virginia by a variety of agencies and local Family Assessment and Planning Teams were accessing community based services.

In 1994 additional efforts included the hiring of the first full-time Hampton FAPT Coordinator; the development of the Utilization Review Committee; the development of individualized Intensive Treatment Teams; and the development of Intensive Case Management services provided by Hampton FAPT members.



There have been 6 full time CSA/FAPT Coordinators since 1994. There have also been a half dozen times where the role was managed by an individual or “committee.” Lylas Cooper remembers that, prior to the hiring of the first FAPT Coordinator FAPT members rotated the role for 3 month periods. There were also multiple opportunities for FAPT members to coordinate the FAPT office activities as the FAPT

members were co-located inside of DSS. Many FAPT members also had offices in their respective agencies but spent most of their time at the FAPT office.

The Utilization Review Committee and the Intensive Treatment Team were developed to reduce the utilization of residential treatment and develop creative plans. Walt Credle remembers that Pam Kendal-Daiber, the FAPT DSS representative was assigned a particularly complex case at an out of community residential treatment center working with children with autism and mental retardation related issues. Ms. Kendal-Daiber worked with FAPT to develop a creative plan to return the child to the community. This work was the beginning of a strong utilization of the intensive case management function by Hampton FAPT for complex children and their families.

## **The Hampton Healthy Families Partnership**

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When this reviewer travels to other communities there are comments related to the relationship between the limited utilization of out of home care in Hampton and the development of the Hampton Healthy Families Partnership (HHFP). These comments are echoed by leaders in child-serving agencies in Hampton. The HHFP began in October 1992 as part of Healthy Families America a program designed to support new families in helping their children get off to a good beginning (Galano and Huntington 1999). Hampton city leadership were committed to supporting children and families as the most important community resource and believed that if children were born healthy and ready to learn at an early age outcomes for children, families and communities would significantly improve. There was also the belief among Hampton city

leaders that there would never be enough resources to support at-risk children if the issues facing children and families were not mitigated prior to the need for intervention services.

Healthy Start is an intensive home based program working with children and families to maintain a stable home environment by strengthening parenting skills to prevent child abuse/neglect and prevent removal from the home. This service is similar to the in-home supports provided for older children through multiple private in-home services agencies. The significant difference is that the goal of the Healthy Families Partnership is to reduce the need for CSA-type intervention services by reducing and eliminating risk factors evident before the child is born and during the early years of the child's life.

The Hampton Healthy Families Partnership provides a comprehensive array of services from information sharing to intensive home-based services. Services include Young Family Centers, Healthy Stages, Child Fair, Parenting Education and Support, Welcome Baby and Healthy Start. Healthy Start is an intensive home based program working with children and families to maintain a stable home environment by strengthening parenting skills to prevent child abuse/neglect and prevent removal from the home. This service is similar to the in-home supports provided for older children through multiple private in-home services agencies. The significant difference is that the goal of the Healthy Families Partnership is to reduce the need for CSA-type intervention services by reducing and eliminating risk factors evident before the child is born and during the early years of the child's life. Carolyn Fair serves as the current Health Department representative for FAPT.

An evaluation of the Hampton Healthy Family Partnership in 1999 reported the following conclusions:

- Participation in Healthy Start resulted in reduced pregnancy risk status.
- Healthy Start services resulted in reduced delivery risk factors and birth complications.
- Healthy Start families demonstrated more effective parent-child interaction.
- Healthy Start children are immunized more effectively.

- Healthy Start families had more adequate home environments and provided increased developmental stimulation to their children.
  - Participation in Healthy Start resulted in improved child health and physical development.
  - Participation in Healthy Start led to reduced repeat teen births.
- (Galano and Huntington 1999)

The HHFP and the Hampton CPMT/FAPT were developed within the same year and had several leaders who were in leadership positions in both projects including the Assistant City Manager, Mary Bunting, Hampton Health Department Director Dr. Carol Hogg and Walter Credle, Director of the Hampton Department of Social Services. This has supported a cross-pollination of ideas and programming between the HHFP and HCPMT/FAPT. The opportunity exists in the future to study the direct impact of the services provided by the Healthy Families Partnership on reducing the need for CSA-funded services.

## **The Role of Juvenile Court Judges in the CSA Process**

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The Hampton Juvenile Court Judges have been instrumental in the implementation of CSA since it's inception in July 1993. The Judges working collaboratively with CPMT and supported by the Hampton Court Services Unit decided to not utilize court orders to order out of community placements. Instead, families and children were court ordered to FAPT and given the highest priority by FAPT. In the early days of FAPT it was not unusual for the CSA/FAPT coordinator to attend court hearings to work with the court and probation staff to problem-solve complex cases.

The Hampton Juvenile and Domestic Relations District Court Judges include the Honorable Nelson T. Durden, the Honorable Jay E. Dugger and the Honorable Robert B. Wilson. Four years ago, following the federal Child and Family Services Reviews and subsequent Program Improvement Plan, the Judges took a leadership role in developing “Best Practices” court activities. This included the development of the *Stakeholders Group*

consisting of the Hampton child-serving agencies including the Court Services Unit, the Department of Social Services, the Hampton/Newport News Community Services Board, the Hampton Family Assessment and Planning Team, Hampton City Schools, the Healthy Families Partnership, Guardians ad Litem

Yet another element of “Best Practices” is the Stable School Placement Order which allows a child or adolescent to remain in their same school if their foster home is disrupted. Foster youth have identified the school disruption process as one of the most important reasons for negative outcomes for foster children in school. If there are expenses attached to children remaining in their school due to distance from the new foster home or other reason the FAPT will pay for expenses incurred in the transportation process.

and private providers. A key activity of the *Stakeholders Group* is to expedite the permanency planning process for children and adolescents in the foster care system. The *Pathways to Permanency* project insures supervised visitation between children and their parents. This project is provided by Safe Harbor a project of the Center for Child and Family Services. Yet another element of “Best Practices” is the Stable School Placement Order which allows a child or adolescent to remain in their same school if their foster home is disrupted. Foster youth have identified the school disruption process as one of the most important reasons for negative outcomes for foster children in school. If there are expenses attached to children remaining in their school due to distance from the new foster home or other reason the FAPT will pay for expenses incurred in the transportation process.

Another important component of “Court Best Practices” is the concurrent planning process. This allows the court to seek two permanency plans simultaneously such as “return to parent” and “relative

placement”. During the concurrent planning process the Judge orders a *Parent Capacity Evaluation*. The parent capacity evaluation administered by the Hampton/Newport News Community Services Board provides an assessment of each parent’s ability to provide care for their child. Hampton also utilizes Family Group Conferencing (FGC) to ascertain if there are potential relatives who will provide a home for the child or children. The Judge orders a list of **all** relatives that is then utilized to determine if there are relatives available who might provide a permanent home for the child. Hampton has had success utilizing the Family Group Conferencing (FGC) process to place children and adolescents. The Team is facilitated by the DSS social worker and supports bringing services to the “front-end” of service delivery. The Judges have been collaborators and partners with CSA and the Family Assessment and Planning Team. Judge Durden serves as a standing member of the State and Local Advisory Team while Judge Dugger has presented in several venues regarding both Comprehensive Services Act and “Court Best Practices.”

## **The Role of the Hampton Court Service Unit (HCSU) in the CSA Process**

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Jim Thomas was the Director of the 8<sup>th</sup> District Court Service Unit at the time of the creation of the Comprehensive Services Act. Mr. Thomas was one of the first leaders to commit to a full-time court services liaison to the FAPT. Mr. Thomas also served as the third CPMT chairperson. The HCSU also took the lead in working with Judges to explain FAPT planning processes around complex cases. The FAPT and HCSU had the opportunity to collaborate programmatically and fiscally with the inception of Virginia Juvenile Community Crime Control Act (VJCCCA) funding. Sue Laughrun, who has been a senior level staff at the HCSU since the inception of CSA remarked that the relationship between FAPT and the HCSU was always collaborative and Lylas Cooper, the former long time FAPT HCSU representative noted that team members “were FAPT team members first and agency representatives second serving children and families not systems.” Lylas also served as a key member of FAPT for 10 years and often stepped into the role of “acting” coordinator when there was not a FAPT coordinator.

The Hampton Court Service Unit also was a leader in seeking innovative community based programming and nurtured the development of several quality in-home services agencies. Mike Morton is the Director of the Hampton Court Service Unit and an active member of the Community Policy and Management Team.

## **The Role of the H/NNCSB in the CSA Process**

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The community mental health center supporting Hampton is the Hampton/Newport News Community Services Board. Chuck Hall serves as the Executive Director of the H/NNCSB and served in that role at the inception of CSA. The H/NNCSB has been a significant provider of community based services including case management, in-home services, outpatient medication and therapy services and services

In the early 1990’s as CSA was being implemented the CSB was impacted by state funding decisions that reduced CSB state general funding by 50%. This development and the implementation of managed behavioral health care resulted in local Community Services Boards becoming “fee for service” entities. This had the consequence of separating the CSB from other public sector agencies that were not funded by “fee for service” methodologies.

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for service” methodologies.

Virginia Community Services Boards typically became providers of services or “administrative services organizations” managing mental health funding. Many Community Services Boards did not have robust children’s mental health services and the H/NNCSB decided to increase children’s mental health services. The movement to increase children’s mental health services offered the CPMT/FAPT increased community based options for children and families. Today the CSB has over 600 full-time employees, 13 full-time psychiatrists, 4 board certified child psychiatrists, over 40 licensed clinical staff and licensed nurse practitioners. The H/NNCSB is also the largest provider of case management services to Hampton FAPT. Additionally the CSB provides parental capacity evaluations for the court to support the permanency planning processes.

## The Role of Hampton City Schools in the CSA Process

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Hampton City Schools has been a significant member of the CSA process since the inception of CSA in 1993. The school system is the common denominator for almost all children served via CSA funding. In the early days of CSA Juanita Joyce was the CPMT member and Karen Davis was the FAPT

representative. They were instrumental in providing education to all CPMT and FAPT members regarding the complexities of Special Education, 504 plans and general school norms, policies and procedures. The Superintendent of Hampton City Schools, Dr. Billy Cannaday, provided the support and resources to insure Hampton CPMT and FAPT were fully supported by the school system. Hampton City Schools was a leader in developing classrooms for children with autism in the 1980’s. These “hard to serve” children were served in their home school or served at the regional school facility, New Horizons. Many communities struggled with supporting children with autism and mental retardation and co-occurring behavioral issues resulting in children being placed in residential treatment centers outside of the community and outside of the state. Sharon Warren, the Director of Special Education for Hampton City Schools noted **“community based is not a CSA philosophy it is a community agency philosophy.”**

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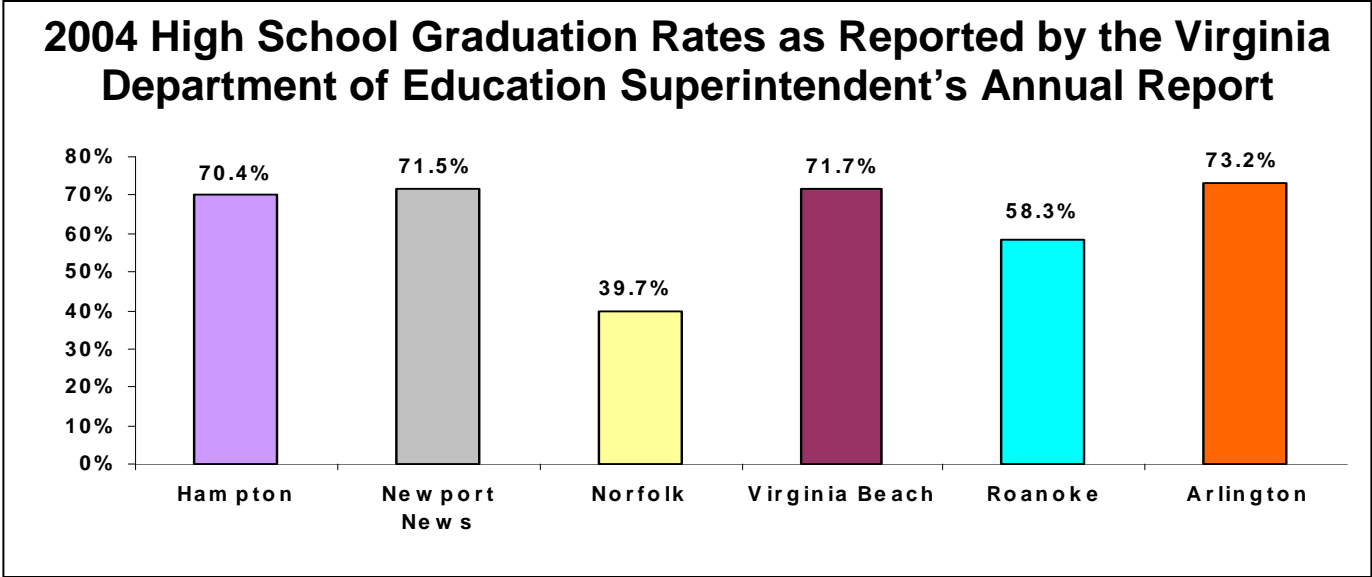
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Hampton City School’s philosophy is to support neighborhood schools and if children need to be placed outside of their home school to support their individualized educational needs placement at the nearest school is sought. Hampton City Schools also has a strong vocational program with high school job coaches for children with mental retardation in place for the past 10 years. Children are placed in jobs in such diverse work places as the school, T.J. Maxx, the V.A. Hospital laundry room etc.

Today there are 48 children in Private Day placement out of 3428 children receiving special education services (as of 6/08/06). While Hampton City Schools places children in several Private Day Placements, Hampton City Schools has had a strong relationship with Rivermont School. Rivermont has strong academics, a comprehensive social skills curriculum, GED prep courses, a horticulture class and canoeing, skiing and camping experiences. Rivermont has also collaborated with foster parents to support children and adolescents with significant behavioral health needs.

Hampton City Schools has developed a pilot project with Family Preservation Services to provide individual and group counseling, funded by Medicaid, at Tyler Elementary School. Sharon Warren, the Director of Special Education Services at Hampton City Schools has led the development for several of

these innovative concepts. Ms. Warren also serves as the present Community Policy and Management Team Chairperson. Denise Sterling Gallop, the Hampton CSA Coordinator and Mark Hinson Hampton Specialized Foster Parent, serve as members of the Hampton City Schools Special Education Advisory Committee.



## The Role of the Hampton Health Department in the CSA Process

The Hampton Health Department has been an important member of CPMT and FAPT since its inception in 1993. Dr. Carol Hogg served as an original CPMT member. The Health Department member on the FAPT team offered advice, guidance and referral for health related needs for children and families.

Dr. S. William Berg, Director of the Hampton Health Department has served as a member of CPMT since 1997 and served as the CPMT Chairperson. Dr. Berg views the role of CPMT as providing oversight of CSA processes, systemic reviews of budgets and placements, managing the appeal process and providing support for the CSA Coordinator. Dr. Berg also commented that it will be important to integrate “best practices” clinical services into community based organizations.

## The Role of Private Providers in the CSA Process

Private providers have played an integral role in the development of CSA since Harry Campbell from Lutheran Family Services served as the first CPMT Chairperson in 1993. It should be noted that there were concerns in the early years regarding conflicts of interests with private providers serving on CPMT and FAPT. Yet people interviewed universally stated that this has not been an issue in the Hampton CSA process. The H/NNCSB and Lutheran Family Services provided many of the same services yet worked well together as part of CPMT and FAPT in the early years of the project. CPMT/FAPT has teamed with multiple private agencies over the years to develop public/private partnerships including Lutheran Family Services, the Barry Robinson Center, Carpe Diem and First Home Care. FAPT contracts with over 30 community based organizations and a variety of residential treatment and group home providers. Additionally FAPT has signed “single case agreements” with multiple providers to develop individualized approaches to serving children and their families.

Jessica McClary, the FAPT Utilization Review Manager, is a Lutheran Family Services employee co-located at the FAPT office located inside of the Department of Social Services.

## Services Received by Specialized Foster Care Children



This graph measures the number of children receiving specific services. It should be noted that 11 of 14 children 16 years-old or above received Independent Living Support or Services and 7 of 12 children 15 years-old or less received Summer Camp Services.

## The Role of Families and Children in the CSA Process

Family members have been represented at FAPT and CPMT since the inception of CSA. There have been periods of time when CPMT and/or FAPT did not have family representation. Multiple CSA coordinators have sought to increase family voice as part of the CSA process. Denise Sterling Gallop, the present CSA Coordinator has secured a FAPT Family Representative, Joanne Tribus. The Federation of Families for Children's Mental Health Services articulates that family members should be involved in all aspects of policy development, program implementation and project review. This project utilized the CPMT family representative, Teresa Brooks and the FAPT representative, Joanne Tribus as reviewers and interviewers.

The role of children and adolescents as part of the CSA process is limited throughout the state. There are Systems of Care projects in other states that utilize youth as advisory groups and consultants to program development. This project interviewed several youth to determine their satisfaction with services.

One young man, interviewed by Teresa Brooks and Mike Terkeltaub, was articulate in what he believed had helped him. He was placed in foster care following aggressive and assaultive behaviors, a preoccupation with violence and poor school performance. He was eventually placed in a local residential treatment center. He believes that the treatment center did not help and, in fact, increased his aggressive and assaultive behaviors. He came to live with a specialized foster parent and additional supports and a special school placement were developed. He believes that the specialized placement is his home and that the foster brothers are his brothers. He calls his specialized foster parent "dad" yet wants to spend more time with his family. He says the specialized home has been "the best thing for him" and when Ms. Brooks asked him what was important to him he stated "God, my family, my foster family and basketball." He played basketball with us during the interview and this appeared to make it easier for him to talk to us.

He mentioned that he "hated" going to FAPT except for the "school person" and we were able to convince him to meet the new CSA Coordinator, Ms. Sterling Gallop. He asked his specialized parent to visit her the next day and came to the FAPT the following week. He appeared to be open and involved in the FAPT and the team praised him for his honesty and commitment.

One parent who was interviewed stated that specialized foster home services now being provided had been very helpful but that he wished more services were available at other times in the process. He also believed that, due to the complexity of issues facing his child, the system had not figured out the best

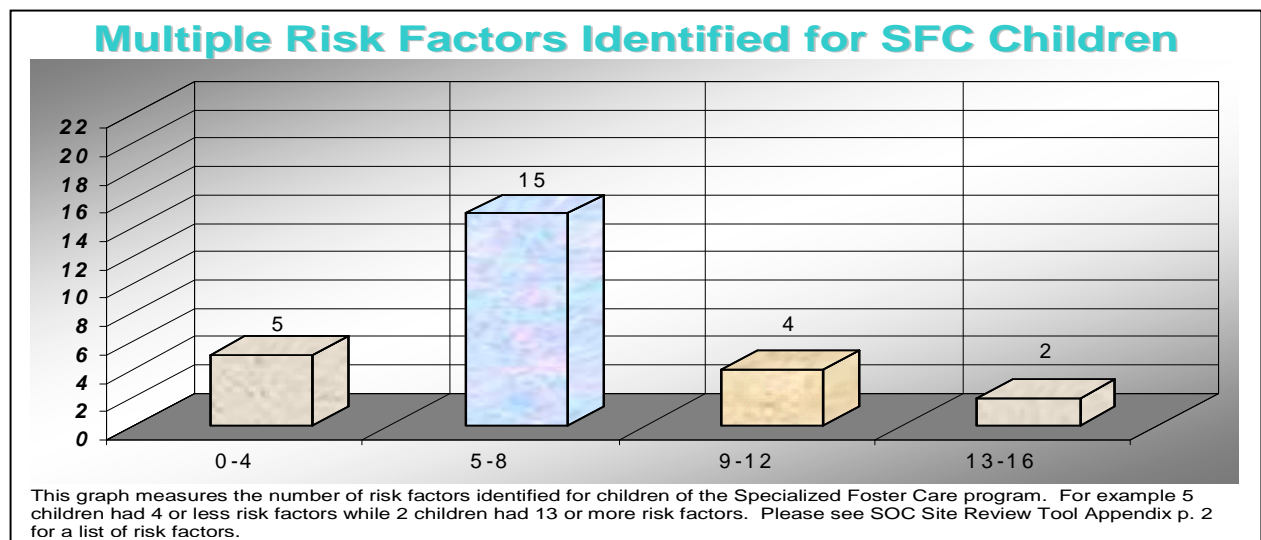
possible treatment options. He stated that he wanted to be part of the solution for future children and the team is deciding potential roles that this parent could take to increase family voice in the system.

## The Role of the Hampton Department of Social Services in the CSA Process

Walter Credle, the Director of Hampton Social Services, has been an integral member of the CSA process since the beginning of the project in 1993. He has also been a leader in the development of the Comprehensive Services Act initiatives locally, regionally and at the state level. He served as a member of the State Management Team and has served as an advisor to localities seeking to develop innovative CSA strategies.

Children involved with the Department of Social Services via child protective services, foster care, foster care prevention, adoption, and independent living make up a large percentage of children served by CSA. They are often children with complex needs and more likely to have less concrete resources available to support successful outcomes at home, school and in the community. The children with the most complex needs, living in specialized foster homes are the subject of a data and outcomes portion of this report.

Wanda Rogers, Hampton DSS Assistant Director, served as the FAPT DSS representative in the late 1990's. She was one of the key developers of Specialized Foster Care services and instrumental in a number of key CSA initiatives including the Teaching Parent Project, Family Reunification, Family Group Conferencing, Pathways to Permanency and Court "Best Practices". Kristi Howerton is the current DSS representative to FAPT.



## The Role of the CSA/FAPT Coordinator in the CSA Process

The role of CSA or FAPT Coordinator varies widely from locality to locality across Virginia. There are coordinators with significant authority and responsibility and coordinators with limited authority and/or responsibility. Hampton CPMT leadership set the tone early in the development of CSA by appointing Keith Sykes as the functional leader of the CSA process. While Keith's title was not CSA or FAPT Coordinator, his role as DSS Chief of Services lent significant clout to the importance of CSA to CPMT leadership. Day to day FAPT office responsibility has been led by 6 full-time Coordinators since 1993.

There have also been several short and extended periods of time where FAPT members managed day to day operations and several times when there was an acting CSA or FAPT coordinator. The first two CSA coordinators had reasonably short tenures. The third CSA coordinator, this writer, was hired in 1995 and served as the CSA Coordinator for 3.5 years. Mike Terkeltaub came to the role of CSA Coordinator after developing several early in-home services programs at the Barry Robinson Center and Carpe Diem. He also had many years experience working in residential treatment centers. His early involvement with CSA included training with Karl Dennis and Mary Grelish, nationally renowned leaders in systems of care and wraparound approaches.

The next 2 CSA coordinators, Kim Lewis and Deborah Turner Cooper had significant experience working with children and families. Ms. Lewis was a former H/NNCSB staff member who had sat on FAPT and was considered a significant contributor to the team as the CSB representative. Prior to coming to the CSA office she was a Therapeutic Foster Care Director at First Home Care and responsible for much of the early success of that project. Deborah Turner Cooper worked for Lutheran Family Services as a liaison with the Hampton Court Services Unit and had the respect of probation officers, HCSU leadership and court staff.

Today the CSA Coordinator is Denise Sterling Gallop who began her career as a DSS foster care worker in Newport News. Prior to coming to the CSA office she was the National Director of Therapeutic Foster Care (TFC) at First Home Care. She developed TFC programs in 4 Virginia sites, Florida, Nevada, Pennsylvania and Washington D.C. She also was actively involved with the Foster Family-Based Treatment Association and statewide foster care initiatives.

The CSA Coordinator has responsibility for accessing multiple funding streams which allows further flexibility in providing services for children and families. In addition to the funding streams attached to CSA, the CSA Coordinator accesses Medicaid funding, Program Improvement Plan Funding, Title IV-E funding, Mental Health Initiative funding, Adoption/Special Needs funding, Independent Living, Family Preservation funding, Court Service Diversion and VJCCCA funding. The CSA office's ability to collaborate with multiple agencies in the funding process offers opportunities for creative programming and cost effective service delivery. The commitment of all CPMT member agencies to blend and braid individual agency funding supports innovative systems of care initiatives.

There are several common threads among the four coordinators since 1995. These include:

- They all had significant experience working with at-risk (at-home) children and their families
- They all had significant experience working in program development
- They all had an understanding of the increasing financial complexities of CSA
- They all worked with other localities to brainstorm "best practices"
- They all had strong communication and collaboration skills to support success at CPMT and FAPT

The CSA Coordinator manages FAPT processes but FAPT members are employed by their individual agencies. The Coordinator is responsive to CPMT and works closely with the CPMT chairperson. CPMT develops policies and procedures, guides "best practices", provides leadership across child-serving systems, manages financial and outcomes data, reviews children and adolescents in residential placements, responds to appeals and manages the information provided by the CSA Coordinator in updated programmatic and financial reports. Hampton CPMT also has had a history of promoting innovative practices. This is evident by the individual work outlined above and evident from the creative programming outlined throughout this document. The FAPT team has also had the ability to design

project concepts; has been involved in the development of projects; and actively participates in strengthening existing projects. CPMT also worked closely with the FAPT representatives at each individual agency as the FAPT member typically maintains a position of experience and leadership at their agency. FAPT and CPMT each hold meetings to develop innovative programming and this cross-pollination of ideas led to the development of projects such as Specialized Foster Care. CPMT and FAPT also look for guidance from the CSA Coordinator to design the programs conceptualized by the teams. Both CPMT and FAPT provided ongoing support, advice and monitoring of these programs. Two things are most important to Hampton CPMT and FAPT in the development of new projects. Each project had to support children and adolescents remaining in the Hampton community and each project had to promote the move toward independence and self-sufficiency for children and their families.

## **Data Analysis Derived from the Office of Comprehensive Services and Voices for Virginia's Children Kids Count**

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Triad staff developed this data from two key sources. The first source is the CSA Data Set statistics. This is a quarterly report filed by localities with the Office of Comprehensive Services across multiple domains. There has been significant improvement in the data collected by the Office of Comprehensive Services over the past several years. Triad staff chose several data points to review. These include:

- CSA expenditures in FY 2004;
- CSA expenditures in FY 2005;
- Children out of state by locality;
- Percentage of services that were provided as community based interventions;
- Percentage of services that were provided in therapeutic foster care;
- Percentage of services that were provided in specialized foster care;
- Percentage of services that were provided in residential treatment facilities.

The second data source is the Voices for Virginia's Children Kids Count data set that includes over 75 child indicators. Kids Count is supported at a national and state level by the Annie E. Casey Foundation and offers key indicators across all life domains. Kids Count is completed every two years and the next version is due in 2006. TRIAD staff chose several Kids Count data points to review. These include:

- Children ages 0-17 by locality;
- Percentage of juvenile intakes by locality;
- Children in foster care per 1000 by locality;
- Percentage of high school graduates by locality as reported by the Virginia Department of Education;
- Percentage of children receiving free or reduced lunch in school by locality.

## Project Development

Project staff have had experience developing similar data/outcomes information in communities in several states. We are in agreement with Mark Friedman, Director of the Fiscal Policy Studies Initiative, that there are key elements to results-based decision making. These include:

1. Develop a set of key indicators for the community. Indicators should be kept simple and never include more than several indicators.
2. Create a baseline for each indicator
3. Tell the story behind each baseline
4. Assemble partners interested in turning the curve
5. Identify what works.
6. Develop the plan and measure the results. (Friedman, 2006)

The decision was made to look at possible intersections of data between the two sets of information. The CSA Data Set provides information regarding children at-risk of out of home placement. The Kids Count data set looks at the universe of children in a given locality. This will allow for several new “looks” at existing data.

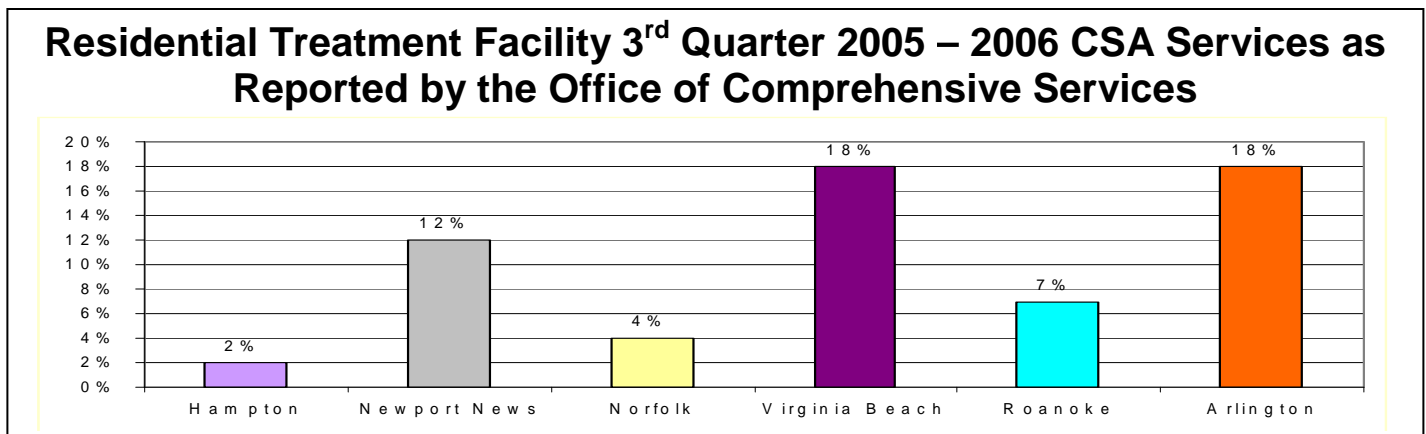
## The Localities Chosen

This report utilizes six Virginia localities and offers a snapshot of comparative data points across these six communities. Originally staff looked at 12 potential communities and reduced the report to six localities following potential data issues and locality demographic differences. Hampton and Newport News were included as they share geographic boundaries, resources and families. Norfolk was chosen because the city had been an early innovator in Systems of Care approaches. Virginia Beach was chosen because of geographic location and to provide a community with key differing statistics from others in the report. Roanoke was chosen as a key community in the western part of the state and Arlington County was chosen because of the significant data similarities to Hampton.

CPMT may want to offer guidance regarding localities to be included in future reports.

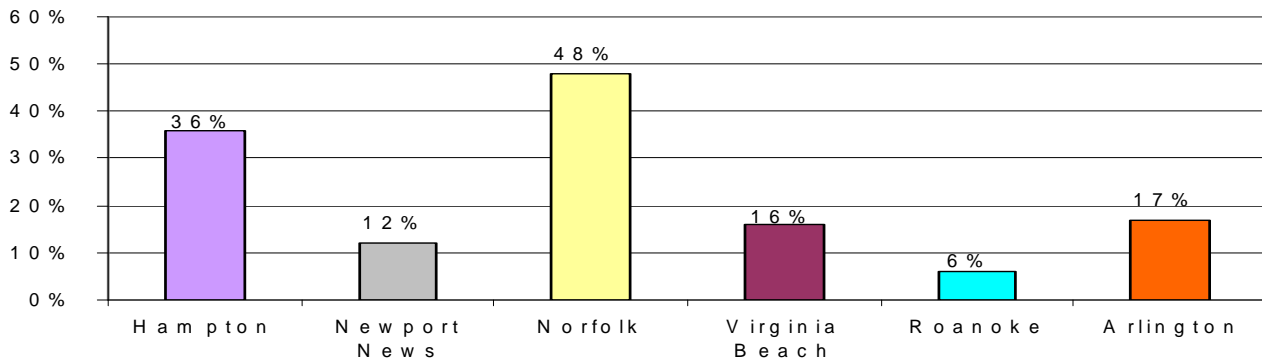
## Data Report

- The six localities measured had services for residential care ranging from 2% to 18% of total services.



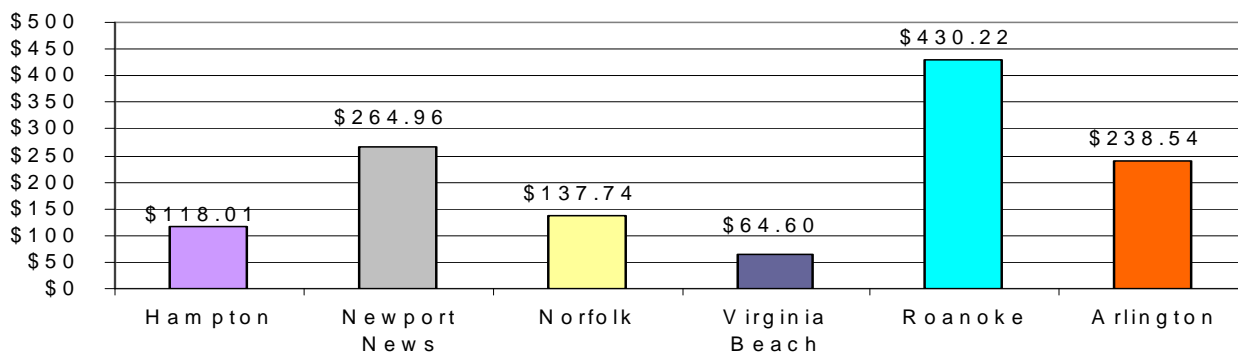
- Norfolk and Hampton utilized a significantly higher percentage of community based interventions (FY 2005 3<sup>rd</sup> Quarter) than the other communities. Norfolk utilized 48%, Hampton 36%, Arlington 17%, Virginia Beach 16%, Newport News 12% and Roanoke 6%.
- Hampton and Newport News were the only communities to report **no** children placed out of state. Norfolk has 14 children placed out of state, Roanoke 8, Arlington 8, and Virginia Beach 4 children placed out of state. Hampton has had a strong commitment to serving children locally to support families being active participants in all aspects of the treatment process. When children can not be served in the community or in a local out of home setting out of community settings are viewed a short term interventions and families are supported in continuing active participation in the treatment process.
- Hampton utilizes community based services organizations that share a similar belief in child centered, family focused, community based, strengths based and culturally and linguistically competent service delivery. This has resulted in Hampton CPMT and FAPT challenging providers to develop new and innovative service delivery approaches.

**Percentage of Services that were Community Based Services by Locality 3<sup>rd</sup> Quarter 2006 as Reported by the Office of Comprehensive Services**



- Triad developed a new cost per child data point. Triad staff divided the 2004 CSA total locality costs by the number of children 0-17 (Kids Count 2004) in the locality to arrive at cost per each child living in the community. This was developed with the hypothesis that if other community data points were similar (for example high school graduation rates, children per 1000 in foster care, percentage of children receiving free or reduced lunch, juvenile intakes) this would offer a potential key statistic

**Locality Specific costs Per Child Ages 0 – 17 Living in the Community 2004 Determined by Dividing number of Children 0 – 17 in Community by Total CSA Expenditures**



regarding fiscal responsibility. This data point crosses the two data sets as the “cost of services” is based on the CSA funding report for FY 2004 and the “children 0-17” in each locality is derived from 2004 Kids Count data.

**The CSA cost per child living in the community** is determined by dividing number of children 0 – 17 living in the community (Kids Count) by total CSA expenditures. The cost per child for each child living in the locality is Virginia Beach \$64.60, Hampton \$118.01, Norfolk \$137.74, Arlington \$238.54, Newport News \$264.96 and Roanoke \$430.22.

**This is apparently the first utilization of this statistical analysis by a locality in Virginia.**

- High School graduation rates based on statistics provided by the Virginia Department of Education Superintendent’s Annual Report were Arlington at 73.2%, Virginia Beach 71.7%, Newport News 71.5%, Hampton 70.4%, Roanoke 58.3% and Norfolk 39.7%.
- Children receiving free or reduced lunch based on KidsCount Data were 62% in Roanoke, Norfolk 60%, Newport News 51%, Hampton 45%, Arlington 42% and Virginia Beach 29%.
- Children in foster care per 1000 based on KidsCount Data were 3 in Virginia Beach, 5 in Norfolk and Arlington, 6 in Hampton, 7 in Newport News and 15 in Roanoke.

## **Specialized Foster Care: A Historical Perspective**

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The Hampton CPMT and FAPT struggled in early 1997 with planning for several children who had been placed in residential treatment. One young man had been placed at a local residential treatment center after assaulting several school staff and running out into traffic. CPMT and FAPT decided to pay the agency a 9 month case rate to support the child whether he “needed” residential treatment, a therapeutic group home, therapeutic foster care or could be maintained in the community with in-home services. The hope was that this would stimulate RTC providers who had multiple levels of care to place the child in the least restrictive environment (with approval from the Judge, DSS and the team). Three months later the child was still in the RTC and the RTC came to FAPT and asked for additional funding for a mentor. FAPT’s sense was that the case rate concept was not ready to be fully embraced.

A second young man was placed at another RTC and had a history of aggressive behaviors, suicidal and homicidal ideation and significant life-threatening health issues. The RTC was doing a good job of working with the young man but he had stayed there 14 months and the CSA Coordinator had been asked to develop a plan for the Judge as soon as possible. CPMT was also questioning the likelihood of successful outcomes if the young man remained in the RTC.

There were several other cases that fit this profile. By this time Hampton CPMT had determined that placement out of home and out of community was, in essence, “a treatment failure.” The CPMT challenged FAPT to develop a new plan for these children and others like them to come before the team in the future.

The work of several noted researchers reinforces the belief that community based services provide better outcomes than out of home and out of community programs. Richard Barth’s *Institutions vs. Foster Care: The Empirical Base for a Century of Action* (2002) determined that “foster care and treatment foster care are more desirable and efficient than institutional care and their development should be treated as the priority of policy makers and program developers.

Barbara J. Burns Ph.D., Professor of Medical Psychology at Duke University and a leader in researching evidence based practices related that institutional care including residential treatment, boot camps and detention centers have proven largely ineffective as interventions for children and their families. Treatment Foster Care, Intensive Case Management and behavioral approaches are among the services listed as effective for children and families based on recent research. (See Appendix C: *Effectiveness of Selected Community-Based Service Models*)

A recently released study from the University of Minnesota (Lawrence, Carlson and Egelend, 2006) suggests that “foster care may lead to an increase in behavioral problems that continues after exiting the system. The study also suggests foster children are more likely to have increased behavioral problems than children with similar issues who remain in their homes. (See Appendix D: The Impact of Foster Care on Development).

The Hampton FAPT, challenged by CPMT, was composed of a talented and experienced group of child-serving professionals. Dr. Judy Pantilides represented Hampton City Schools and was strong advocate for children with special education needs. The H/NNCSB representative rotated but included Brenda Garrett and Ron Clark both experienced, creative mental health professionals. Lutheran Family Services’ FAPT member, Chauncey Strong, was an innovative program manager, who had been involved in several creative projects that provided intensive case management and intensive community supports for the FAPT. Lylas Cooper represented the Hampton Court Services Unit and had been an original FAPT member. Ms. Cooper also had significant clinical skills and supported a restorative process when working with children involved in the juvenile justice system. Parent representation was uneven but one of the FAPT parent representatives had a son who had similar issues to the children identified for the project. Wanda Rogers was the DSS FAPT representative and Hampton DSS was her second job out of college. She joined FAPT after many years in the foster care unit. Mike Terkeltaub was the CSA Coordinator and was supported by an administrative assistant and Helen Holt who was responsible for managing CSA fiscal processes.

FAPT put out an urgent request for therapeutic foster homes for several of the children. The Coordinator also asked all FAPT team members to ask their staff for available resources to support these children. The team began to believe that CPMT and FAPT would need to develop “Hampton specific” homes.

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Daphne Eaton was an employee of Lutheran Family Services who carried only Hampton Cases and was co-located at Hampton DSS. She was a wizard of resources and the team asked her to make finding a “Specialized Foster Parent” a priority. The FAPT also utilized interns from Christopher Newport University’s school of social work and intern Shannon Mitchell was working with Ms. Eaton on the case of the young man with suicidal and homicidal ideation. Ms. Eaton and Ms. Mitchell were visiting the young man at the treatment center when they met a behavioral tech named Mark Hinson. Mark had worked as an RTC behavioral tech in several programs. He was also working at the United Way to make ends meet. Daphne and Shannon encouraged Mark to contact Mike Terkeltaub. That night Mike contacted Mark and a meeting was set up the following Tuesday with Wanda, Mark and Mike.

In the meantime Daphne was looking for a potential location for the first (and at the time it was believed only) “Specialized Foster Home.” She found a terrific location within two weeks and the hard work began to develop the home, provide training and support for Mr. Hinson and begin to place children into

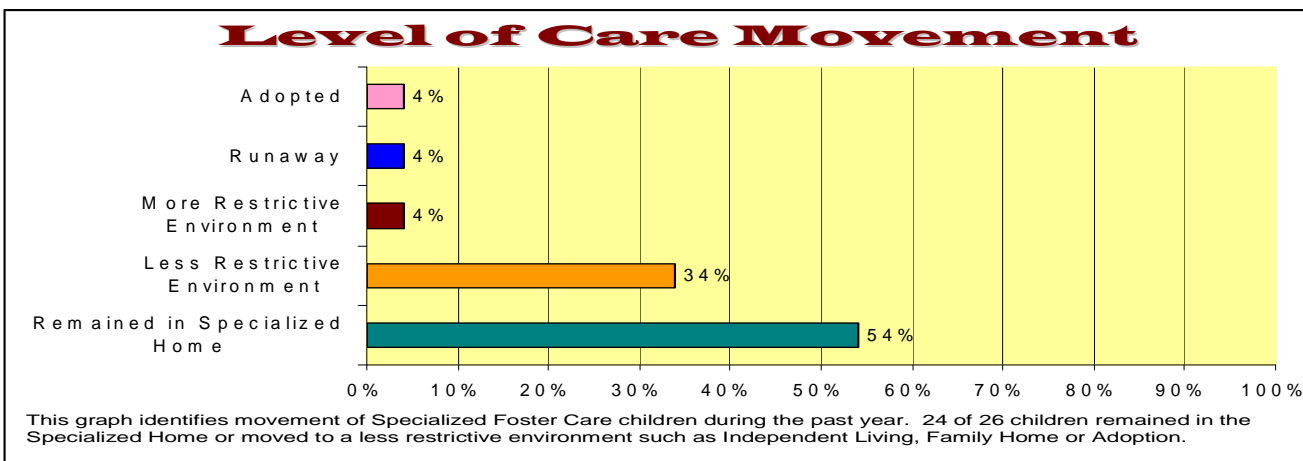
the home. Wanda and Mike co-managed these processes for the first 6 months. Mike moved on in early 1998 and Wanda and the DSS/FAPT team have supported the Specialized Foster Home Project for the past 9 years.

Hampton had recently won a grant to provide specialized training for foster parents working with children and families with complex needs and Mike and Wanda taught two of the 8 week sessions. The FAPT called on positive relationships with the provider community who taught classes on managing aggression, medication and your child, understanding diagnoses, strengths based strategies and rebuilding trust and attachment. A skilled and seasoned foster parent co-facilitated several classes as did DSS staff. A key component of all trainings was to stress the concept of “unconditional care” as articulated by Karl Dennis. Foster parents had to read materials related to Mr. Dennis’ work at Kaleidoscope in Chicago and be able to speak to strengths based approaches, family focused service delivery and “unconditional care.” Mark went through this training and took his first child less than 45 days after first meeting the team.

Mark tells two particularly interesting stories about those early days developing *Specialized Foster Care*. Mark went to the RTC to take the first child to come into the project on a “pass.” As they were leaving the building the young man said to Mark “I am going to call you dad!” Mark’s response was “panic”. He had spent years working in an RTC and knew that this would be forbidden and potential grounds for termination of employment. Mark told the boy to wait one minute with staff and ran to call Wanda. Wanda alleviated Mark’s concerns and this particular young man is now an adult, keeping a job, and still in touch with Mark. Prior to living with Mark he had been in multiple RTC and out of home placements.

The second story Mark tells regards his initial meetings with Wanda and Mike. Mark found the first meeting overwhelming but was excited about the prospect of leaving the RTC work and working in the community with kids. Between the first and second meeting he had the opportunity to talk with a level headed friend who gave him a series of questions to ask Wanda and Mike. These questions ran the gamut from finances to support to what to do in the case of an emergency to what would happen if things didn’t work out. There were more than 20 questions in all and at some point Mark recalls Mike saying “*you will just have to trust us.*” Wanda and Mike did give Mark their home phone numbers.

*In 2003 Mark Hinson was a finalist for National Foster Parent of the Year.*



On May 30, 2006 five Specialized Foster Families representing over forty “at-hope” children and adolescents met with Hampton DSS staff and Hampton CSA staff. Mike Terketaub, the former Hampton CSA Coordinator, served as the facilitator. Mr. Terketaub had not met most of the parents as the only Specialized Foster Parent when he left Hampton CSA in 1998 was Mark Hinson.

*Denise Williams, a former Specialized Foster parent, was not available. It is important to note that she adopted the Specialized Foster Children living in her home.*

Attendees included:

- Annie Harrell/Specialized Foster Parent
- Marlun Hart/Specialized Foster Parent
- Mark Hinson/Specialized Foster Parent
- Derrick McElwain/Specialized Foster Parent
- Maria and Darnell Parker/Specialized Foster Parents
- Denise Sterling Gallop/Hampton CSA Coordinator
- Wanda Rogers/Hampton DSS Assistant Director
- Allyson Bailey-Leonard/Hampton DSS
- Yvonne Gaynor/Hampton DSS
- Mike Terkeltaub/Executive Director Triad

**Following are stories from this open ended dialogue:**

Ms. Harrell (her husband and support is Robert) recounted that she was “haunted” by a radio advertisement telling her to be foster parent. She remembers wanting boys and not knowing if she was comfortable with teenagers. Her first child came wearing a mini-skirt, sporting long nails and was pregnant. She has worked with teenage girls ever since. Ms. Harrell talks about the joy she gets from watching young woman who have had multiple struggles graduate. One such young woman had 37 placements before coming to the Harrell home. She brought adults with guns into a previous home and terrorized the neighborhood. Ms. Harrell, utilizing an unconditional care approach, supported this young woman for 3 years and watched her get her GED. Her sister also lived at Ms. Harrell’s home, graduated high school and went into the service.

The Harrell’s began to ask “what happens to kids that don’t have family resources as they get older?” This question led to the Harrell’s development of an independent living project for older adolescent young woman. In this project Ms. Harrell serves as the case manager for the young women. Two of the young women have their babies with them as they learn the skills necessary to become better parents and successful adults.

Mr. Hart (his wife and support is Laura) worked at Colonial Hospital and was an in-home services provider for Carpe Diem. Mr. Hart provided customized support for Mark’s children and saw this project having a more positive impact than the RTC. The Harts became Specialized Foster Parents.

Darnell Parker also was a veteran of residential treatment centers and had also worked in juvenile justice programs. Maria Parker was working in the business world. Darnell knew Marlun and began hearing about Mark’s program and the creative work being done with children and families. Wanda and Mark came up with the idea that Darnell and Maria should become specialized foster parents and provide respite and support services for Mark instead of “shift” workers. The Parkers asked questions and recall Mark and Wanda telling them similarly to what Mark heard several years before, “*you will just have to trust us.*”

The Parkers have worked with 11 Specialized Foster Children as either foster parents or customized supports over the past 5 years. Ms. Parker has left the business world and is a full-time specialized foster parent. Some of Ms. Parker’s favorite moments are calling kids on their birthdays and when kids come

back after they leave to visit. Mr. Parker related that one of the most successful moments was when the Parkers were able to convince one young man's grandparents to become involved in his life. Derrick McElwain (his wife and support is Yonnie) also worked at an RTC. Derrick had a specific interest in working with older adolescents transitioning out of foster care into independent living. He works with several of the young men who have lived in Specialized Foster Homes and helps them develop independent living skills in a variety of areas including developing vocational skills, job placement and retention, transportation, accessing community based supports, developing social and recreational activities and increasing social and conflict resolution skills.

Allyson Bailey-Leonard, Hampton DSS Social Work Supervisor, noted that specialized foster parents work with the adolescents that therapeutic agencies tell DSS to "come and get them." They work with young people utilizing unconditional care and sometimes unconventional approaches.

*Unconditional Care* is based on the concept by Karl Dennis that agencies must do "whatever is necessary" to support children and families in their communities Allyson also noted that the young people in the project stay connected to the specialized foster parents after they leave foster care asking for advice and continued support.

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Reports from specialized foster parents regarding children who have left the project:

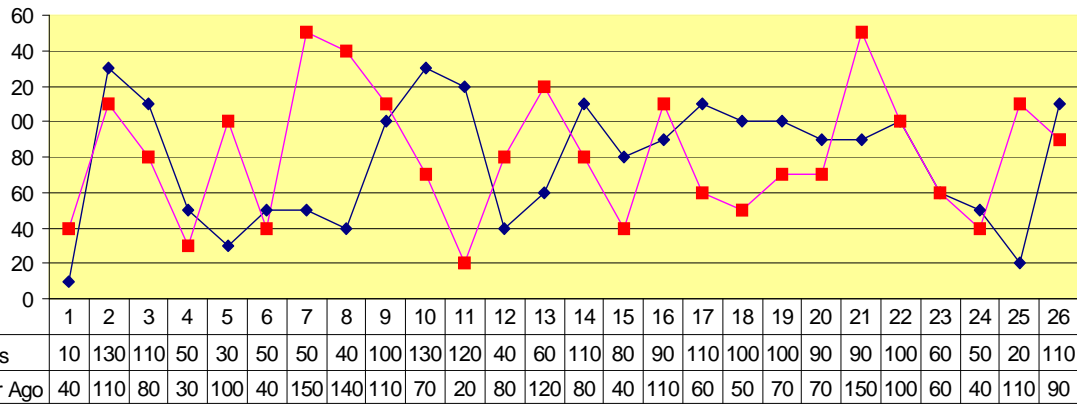
- One young man who had struggled while in the project entered Job Corps, successfully completed the program, entered the military, served in Iraq and is now a sergeant in the United States Marines.
- One young woman who had significant issues including physical aggression, substance abuse and acting out behaviors was adopted by her grandmother in another state, manages a fast food restaurant and keeps in constant contact with her specialized foster parent.
- One young man, diagnosed as autistic, non-verbal and requiring significant hygiene support is living with his parents out of state. The family visited the specialized foster family several years ago.
- One young woman who was expelled from school, stayed out all night, became involved with drugs and became pregnant continues to struggle. She works episodically and has been in jail several times. The specialized foster mother reports that she made a good decision to have family members raise her child until she is "ready."
- One young man had his father, living in another state, come back into his life and take him home. He is working at a full-service restaurant, struggling with substance abuse and working on his GED.

## Collecting Data and Developing Outcomes

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The Hampton CSA office has been collecting and utilizing data since the inception of the program in 1993. Keith Sykes provided regular reports to CPMT regarding local CSA expenditures, utilization of residential placements, utilization reports of placements over \$50,000 annualized per youth and ad hoc reports to support practice improvement. CPMT continues to receive similar reports and the ability to provide timely and useful data has been increased by the implementation of the Harmony Information Systems, Inc. software system and the utilization of CAFAS as a decision support tool.

## CAFAS Scores for Specialized Foster Care Children



This graph measures the most recent CAFAS Scores for each specialized child as well as his/her CAFAS Score 12 months prior to the most recent score.

This report will utilize narrative data developed in the Harmony Information Systems software system and CAFAS scores as part of the data analysis and outcomes development process. This report will also utilize data and outcomes information available in existing data collected by the Office of Comprehensive Services as well as data collected via the Voices for Children KidsCount project.

Hampton CPMT and FAPT also decided to take a more comprehensive look at available data and potential outcomes information. Triad Training and Consulting Services was contracted to develop both child specific and systemic outcomes information. Triad worked closely with Hampton CSA staff to modify a tool utilized in Central Kansas and Maricopa County Arizona to develop outcomes information and inform potential practice improvement activities. Mike Terkeltaub has developed and modified the tools to support local and regional differences in information sought and build community consensus regarding the utilization of outcome information to inform practice improvement activities.

The Hampton CSA Case File Review Tool (See Appendix E & F: SOC Site Review Tool and SOC Site Review Tool Guide) was trained and implemented in a group environment to allow open communication among review team members. The tool was implemented by a broad cross-section of thirteen community members including family members, foster parents, FAPT members, public and private agency staff and Triad staff. The tool includes demographic information, risk factors, services provided, child and family outcomes and systems outcomes.

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Triad staff believe, based on previous review processes, that it is important to interview multiple people involved in the CSA process to increase the richness of the review process and offer support to the case file review and data analysis

process. Interviews with children, family members, foster parents and key stakeholders throughout the system add depth to the information provided in the case file review process. Teams of two including family members, foster parents and key stakeholders provide the semi-structured interview process. (See Appendix G & H: System of Care Interview Process and Systems of Care Interview Questionnaire)

Hampton CSA staff and Triad staff are actively involved in outcome initiatives led by the Virginia State Office of Comprehensive Services (OCS). Kim McGauhey, OCS Executive Director has brought together key stakeholders from across the state to develop potential outcome indicators. Mark Friedman

has served as a consultant to the state in this outcomes development project. Mr. Friedman has spoken extensively across the United States and abroad on the subject of results based decision making, budgeting and accountability, and financing human services reform, and has authored a wide range of papers on these topics, including: *Reforming Finance, Financing Reform for Family and Children's Services* (The Foundation Consortium, January 2000). Hampton CPMT has been committed to working with OCS and other Virginia localities to develop a comprehensive outcomes management process.

## The Interview Process

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Interviews with children, family members, foster parents and key stakeholders throughout the system were chosen by the case file reviewers based on people they believed would be important to interview to increase understanding of the child and family following the case file review. Teams of two including family members, foster parents and key stakeholders administer the semi-structured interview process. (See Appendix G & H: System of Care Interview Process and Systems of Care Interview Questionnaire)

It should be noted that at the time of the “draft” version of this document there were still 6 interviews to be completed. This is in addition to the 20 interviews conducted with children, parents, foster families and stakeholders across the system to develop the history of the project.

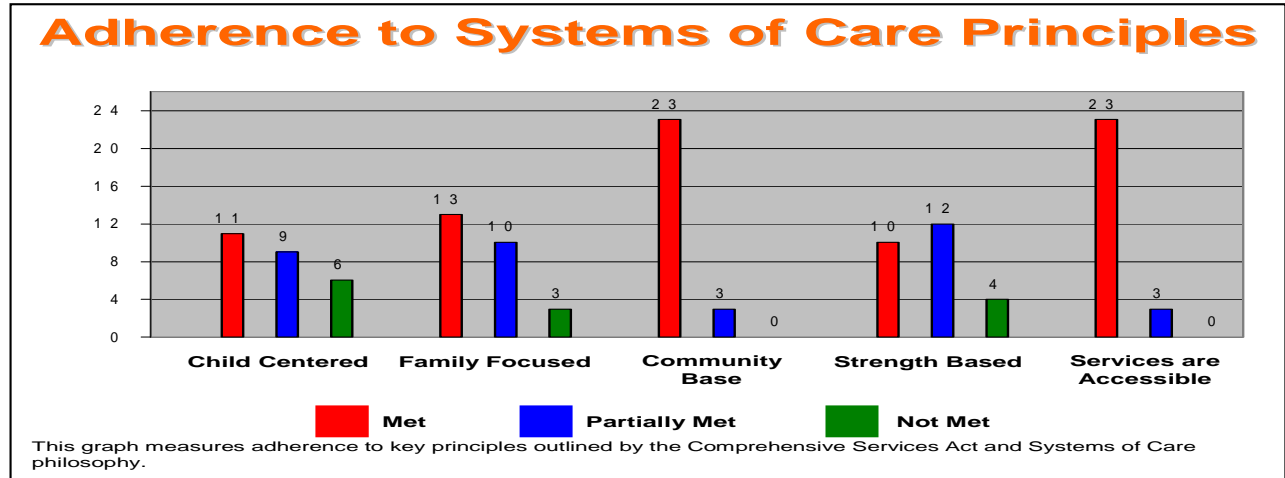
One young man, interviewed by Teresa Brooks and Mike Terkeltaub, was articulate in what he believed had helped him. He was placed in foster care following aggressive and assaultive behaviors, a preoccupation with violence and poor school performance. He was eventually placed in a local residential treatment center. He believes that the treatment center did not help and, in fact, increased his aggressive and assaultive behaviors. He came to live with a specialized foster parent and additional supports and a special school placement were developed. He believes that the specialized placement is his home and that the foster brothers are his brothers. He calls his specialized foster parent “dad” yet wants to spend more time with his family. He says the specialized home has been “the best thing for him” and when Ms. Brooks asked him what was important to him he stated “God, my family, my foster family and basketball.” He played basketball with us during the interview and this appeared to make it easier for him to talk to us.

He mentioned that he “hated” going to FAPT except for the “school person” and we were able to convince him to meet the new CSA Coordinator, Ms. Sterling Gallop. He asked his specialized parent to visit her the next day and came to the FAPT the following week. He appeared to be open and involved in the FAPT and the team praised him for his honesty and commitment.

One parent who was interviewed stated that specialized foster home services now being provided had been very helpful but that he wished more services were available at other times in the process. He also believed that, due to the complexity of issues facing his child, the system had not figured out the best possible treatment options. He stated that he wanted to be part of the solution for future children and the team is deciding potential roles that this parent could take to increase family voice in the system.

Melanie Galloway, the Hampton DSS Transitional Social Worker, was interviewed and stated that FAPT was instrumental to the success of children she served. Ms. Galloway supports children and families as the child is transitioning from child protective services to foster care when a removal is ordered. Ms. Galloway stated that if children and families are to be reunited strengths-based services are necessary for successful outcomes.

Further interviews and the scores to the interview questions will be available in the final version of this document.



The above graph measures adherence to key Systems of Care principles and the results include:

- Services were accessible or partially accessible for 100% of children and families reviewed.
- Services were provided in the community during the previous year fully or partially for 100% of the children reviewed.
- Services were viewed as met or partially met for the “child centered” domain in 77% of cases reviewed.
- Services were viewed as met or partially met for the “family focused” domain in 88% of the cases reviewed.
- Services were viewed as partially met or not met for utilization of strengths for 61% of the cases reviewed. Partially met accounted for 46% of the “utilizing strengths” score.

## Significant Findings

Hampton CPMT/FAPT has had significant successes keeping children in their homes, schools and communities.

- 36% of all services provided in the third quarter of 2005 (CSA Data Set) were community based service while 2% of all funded services were residential treatment services.
- Hampton CPMT has no children placed out of state.
- The strong commitment, long standing collaborations and positive working relationships between all child-serving agencies has supported the community based philosophy in Hampton.
- Juvenile Court Judges have taken a leadership role in the development of “best practices approaches” that have supported children and families’ successful outcomes at home school and in the community
- Innovative programming at member FAPT agencies has supported children and adolescents remaining in the community and supported cost-effective service delivery.
- The Healthy Family Partnership prevention and early intervention focuses have reduced the need for more intensive services for children and families.
- The single FAPT has supported individualized and intensive case planning.
- The central role of the CSA coordinator has supported increased creativity and accountability at the FAPT level.

- The Specialized Foster Care Project has supported children with significant needs remaining in the community as evidenced by 84% of the youth having academic problems; 80% of the youth having physical aggression issues; 61% of the youth having depressive symptoms; and 30% of the youth having suicidal or self-harmful behaviors.
- The Specialized Foster Care Project has shown significant successes as evidenced by 92% of the children in the Project the past 12 months have remained in their present specialized foster home, moved to a less restrictive home or been adopted.
- 38% of the children in specialized foster homes had CAFAS scores 100 or higher one year ago. 42% of the children in specialized homes have CAFAS scores 100 or higher during this review process. This may indicate that while CAFAS scores remain relatively high, specialized foster parents can support children and adolescents with significant issues while they remain at home, school and in the community.
- One specialized foster home “closed” last year after the family adopted the children in the specialized home.
- The scores of “partially met and not met” on several of the Systems of Care principles offers opportunities for new strategies to increase family and youth voice and more clearly identify and utilize strengths and natural supports.

## Practice Improvement Recommendations

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Triad staff are committed to the concept that data collection and outcomes development are most important when informing practice improvement activities. The following recommendations are developed by Triad based on stakeholder interviews, specialized foster family interviews, child and family interviews, data collection and case file reviews.

1. **Increase the involvement of families in the FAPT process.** Hampton FAPT has active family representation at team meetings. There is the opportunity to increase family voice and choice in the service delivery process. Families should be encouraged to become “educated consumers” in helping FAPT choose services for the family. Families can also be partners in the development of new services and reviewers in future activities similar to this review. FAPT should also seek further opportunities to have team meetings outside of the CSA office.
2. **Increase the involvement of fathers in the FAPT process.** There are several mentions in this report of fathers’ active involvement in the lives of their children and in the FAPT process. Seek opportunities, such as Fatherhood Initiatives, to increase fathers’ involvement in FAPT.
3. **Increase youth involvement in the FAPT process.** There were cases where the child or adolescent was not involved in the FAPT process either as an active participant or by documentation of the child’s voice being “heard” in the FAPT process. Schedule FAPT particularly for children with active and complex needs at a time when the child is available. CPMT should seek potential opportunities to involve youth as active advocates for systems change and program development.
4. **Increase identification, documentation and utilization of “strengths” in the FAPT process.** Researchers and practitioners agree that utilizing children and family’s strengths as treatment components increase the likelihood of successful outcomes at home, school and in the community. Provide specific training in documenting and utilizing strengths both at FAPT and for agencies providing services for Hampton FAPT.
5. **Increase the identification, documentation and utilization of natural supports in the FAPT process.** 58% of case files review scored either partially met or not met for the utilization of natural supports. Many of the services identified in the service plan are the “formal” or funded services. One of the goals of the CSA process is to identify and support children and families

identifying and utilizing natural supports as funded supports are reduced and as an alternative to funded services. Natural supports include family and relatives, friends and neighbors, spiritual supports, co-workers, the YMCA, Boys and Girls Club, Hampton Parks and Recreation, NA/AA, support groups and other community supports. CPMT and FAPT should consider including natural supports at the initial service planning process and in ongoing service plans.

6. **Seek new potential innovative programming.** There are several programming opportunities mentioned in interviews and discovered as part of the review process. These include Teaching Parent Homes or Family Oriented Group Homes for children served by the Juvenile Justice system, potential innovative programs to keep families together in foster care and community based programming to identify and address substance abuse issues.
7. **Develop “Transition to Adulthood” plans and strategies.** There are significant issues facing children transitioning to adulthood from the foster care system as well as youth transitioning into the adult system serving people with developmental disabilities. CPMT and FAPT should work together to begin transition planning as early as possible and insure transition planning is an active component of all FAPT meetings.
8. **Explore issues related to cultural and linguistic competence.** There was little documentation found related to cultural and linguistic competence. Cultural and linguistic competence relates to each child and family’s unique culture including the family’s strengths, language, cultural norms, celebrations, rites of passage and important family rituals and activities. There was documentation of work in this area by specialized foster parents and one particularly strengths based involvement by the foster parent with a lesbian teenager. CPMT and FAPT should explore opportunities to increase cultural and linguistic competence in documentation and service delivery.
9. **Develop a plan for sustainability of the Data, Outcomes and Practice Improvement Process.** Much of the material developed in this report is available from existing data sources. There will be the need to develop protocols to continue this process which should become an internal review process. Attention should also be paid to the work being done by OCS, SEC and SLAT regarding outcomes development and wherever possible integrate the work between Hampton and the state regarding outcome development.

## Conclusions

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Results indicate that Hampton CPMT has been successful at accomplishing the goals established in 1993-1994 of serving children in the community and providing cost-effective services that supported children and families moving toward self-sufficiency. Research regarding evidence based and “best” practices supports the philosophy developed by CPMT leadership that children do best in their homes and communities. This philosophy has been emphasized in the Surgeon General’s Conference on Children’s Mental Health (2000) and the work of Barbara Burns at Duke University and Richard Barth at the University of North Carolina supporting community based services as providing the most positive outcomes for children and families.

This report utilized a wide ranging variety of data sources. These included the CSA Data Set, Kids Count, CAFAS scores, case file reviews and community interviews. The data strongly suggests that Hampton serves children in their home, schools and communities as evidenced by 2% of services being provided in residential treatment; provides cost effective services as evidenced by a 39% cumulative increase in CSA funded services from 1994-2005 against the backdrop of a 161% increase statewide during the same timeframe; supports high risk children and families as evidenced by 42% of children served in specialized foster care having CAFAS scores of 100 or higher in the past year; and interviewees consistently agreed that child-serving agencies in Hampton have worked together since the inception of

CSA to develop child centered, family focused, community based, strengths based and culturally and linguistically competent services for children and families in the Hampton community.

There are also opportunities to utilize this report to improve practice across a variety of domains including increasing family and youth voice in all aspects of the CSA process, documenting and emphasizing children and families strengths, increasing the documentation of natural supports, developing new innovative programming and developing a plan to sustain the data, outcomes and practice improvement process.

Hampton CPMT and FAPT have been successful in achieving the goals outlined by CPMT in 1994 but only by changing and strengthening the service delivery process via ongoing practice improvement activities. The continued success of the Hampton CSA process will be driven by continuing the development of dynamic community based programming.