The Evaluation of Wraparound as part of California's Title IV-E Child Welfare Waiver Demonstration Project Evaluation

Selected chapters from *California's Title IV-E child welfare waiver demonstration project evaluation: Final Report.*

Suggested citation for full report:

Cohen, E., Ferguson, C., Berzin, S., Thomas, K., Lorentzen, B., & Dawson, W. (2004). *California's Title IV-E child welfare waiver demonstration project evaluation: Final report.* Berkeley, CA: University of California, Berkeley, School of Social Welfare, Child Welfare Research Center.

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CHAPTER 1 CALIFORNIA'S TITLE IV-E CHILD WELFARE WAIVER DEMONSTRATION PROJECT, FINAL REPORT

INTRODUCTION AND BACKGROUND

1.1 The California Title IV-E Child Welfare Waiver Demonstration

This report summarizes the evaluation findings of the California Title IV-E Child Welfare Waiver Demonstration Project evaluation of Intensive Services Components. The Waiver is a collaborative effort involving the U.S. Department of Health and Human Services (DHHS), California Department of Social Services (CDSS), county child welfare services agencies and the contracted evaluators at the University of California at Berkeley's Center for Social Services Research (UCB). The Waiver permitted the State and selected counties to waive federal and State restrictions on the use of Title IV-E funds in order to use funds flexibly to implement child welfare service innovations. Participating counties used funds to provide intensive, individualized services, thereby permitting children to remain at home, return home sooner or to be placed in permanent family settings. As with other Title IV-E Waiver projects the intent was to provide cost-neutral services.

1.2 California's Demonstration Projects

California's Title IV-E Waiver Demonstration Project was approved by DHHS on August 19, 1997. During the first two years of the project, a number of challenges and unanticipated circumstances led to the redesign of California's original plan. Originally, California proposed to implement and evaluate three new approaches to child welfare services: the Kinship Permanence Component (KPC); the Extended Voluntary Component (EVC), and the Intensive Services Component (ISC). Counties submitted responses to a Request for Proposals covering a variety of proposals under these categories. The KPC was designed to provide subsidized guardianship to kin caregivers, thereby increasing support to families, encouraging more stable permanency plans, and preventing further reentries into the system. After approval of the Waiver projects, California concurrently implemented the statewide KinGap Program, which precluded the KPC program since an experimental design with random assignment was no longer viable. The EVC was designed to allow participating counties to extend the time period of voluntary placements from six to twelve months without a court dependency hearing or loss of federal foster care payment eligibility. Seven counties were selected to participate. However, in the 21-month enrollment period following the start of the project, three counties withdrew due to implementation difficulties, and no more than 10 children were enrolled from all participating counties. The lack of enrollment and county withdrawals led to a decision to phase the program down on August 31, 2000. A Final Report on EVP was submitted in May, 2002.

The Intensive Services Component originally consisted of the following innovative services and sub-studies: a) Family Group Decision Making/Family Conferencing (FGDM)[1]; b) Wraparound Services; c) Community Mentoring (ISCM); and d) Shared Family Care. FGDM and Wraparound will be described in more detail below. The Community Mentoring component was to provide family mentoring, emergency support, and other services to maintain and/or reunify

[1] Throughout the remainder of the report, we use "FGDM" to refer to the program, and "conferences" to refer to the specific family decision-making meetings.

families. By June 2002 the one participating county decided to close its ISCM program, before adequate data on the program's impact could be collected. The primary factor in deciding to close the program was the cost. The results of a final focus group revealed, for example, that implementation costs, which relied on in-kind contributions from community collaborators, did not materialize.

The Shared Family Care Component, originally conceived to be evaluated under the experimental randomized control design, yielded too few participants in the two counties to implement the study design. As a result, a pre-experimental evaluation design was incorporated into the ongoing evaluation by the National Abandoned Infants Resource Center (NAIRC) located at UCB, with additional private foundation funding.

This Final Report will summarize findings on the remaining Intensive Services components, FGDM and Wraparound. Five counties (Alameda, Humboldt, Los Angeles, Sacramento, and San Luis Obispo) implemented Wraparound programs. Two counties (Fresno and Riverside) implemented FGDM. While both types of programs are needs-driven, strength-based, family-centered approaches, there are marked differences between them.

Wraparound has been defined as a philosophy of care characterized by a planning process that results in a set of services and supports (S.K. Goldman, 1999). Wraparound involves professionals, family and others in an ongoing planning process to provide the services necessary to assist the child and family in changing and/or managing the child's behavior and increasing the family's self-sufficiency. While grounded in specific values and elements, the process of Wraparound is responsive to contextual characteristics, resulting in some degree of model variation. Initially developed in the field of mental health for children with severe emotional disorders and their families, Wraparound was implemented in this Demonstration Project with children and their families involved with the child welfare system. The two populations of children being served under the Wraparound portion of the Waiver were children residing in the most restrictive levels of group care in California, and children at-risk of being placed in the most restrictive levels of group care. Each county developed specific criteria for eligibility within the two target populations. In addition to the five counties participating in the Demonstration Project, Wraparound is currently being implemented throughout most of the State under Senate Bill 163, California's legislation enabling flexible use of State and county funds for child welfare placements, primarily for non-Title IV-E eligible children. As a result, each of the counties in the Demonstration Project concurrently provided Wraparound to federally-eligible children and state-eligible children. However, only Title IV-E federally eligible children are included in this evaluation.

FGDM is defined as a planned process in which parents/caregivers are joined by family, friends, and providers of community resources to decide what is best for the children and families involved with the child welfare system (Harper & Coburn, 1998). The values, philosophies, and recommended procedures are well documented. Because of FGDM's roots in both restorative justice and child welfare fields (Hassall, 1996), its targeted populations are highly varied among children, youth and families throughout many activities of the criminal justice and child welfare systems (see, for example, Buford & Hudson (2000)). FGDM in the context of child welfare denotes a family-centered approach to making decisions, in contrast to the traditional approach characterized by professionals maintaining complete control over the assessment and planning phases. More specifically, in the U.S. FGDM has been used to capitalize on family strengths to develop service plans. Although the available literature does not specify the "dose" or the

number of family conference meetings required to achieve specific outcomes, the intervention is meant to support the development of plans to assure child safety and/or placement decisions in the early phases of involvement. FGDM was also implemented for various purposes in many of the State's county agencies. Two counties, Fresno and Riverside, participated in the Waiver study testing the efficacy of FGDM in different contexts. Fresno opted to implement FGDM in its Voluntary Family Maintenance Unit as a means of preventing out-of-home placements for children at-risk. Riverside used its Waiver FDGM program to facilitate placement stability and permanence for a population of children already in placement.

1.3 The Waiver Evaluation

The overarching hypothesis for the Waiver evaluation is that the flexible use of Title IV-E funds permitted implementation of service models that are at least as effective and cost-effective as standard services. In order to test these assertions and related questions, the Intensive Services study includes (a) an Impact Study involving random assignment to treatment and comparison groups that measures outcomes related to the treatment intervention; (b) a Process Study that examines the changes required to implement the interventions and the context in which county programs operate; (c) Model Fidelity assessment measures that explore the extent to which program implementation remained consistent with the defining philosophies and implementation objectives of each intervention; (d) a Cost Study that enumerates the costs of the Fresno County FGDM program, and (e) a Cost-Neutrality Study that addresses the Federal requirements for cost-neutrality in the use of waivered Title IV-E dollars.

1.4 Purposes of Final Report

This report was produced as a requirement of the federal Waiver Demonstration contract between CDSS and the Children's Bureau. The purpose of the report is to summarize and/or update findings from the following:

1) The Process Studies
2) Model Fidelity Studies
3) The Impact Studies in the areas of Child Safety, Permanence, Placement Stability, Child and Family Well Being, and Youth and Family Satisfaction
4) The Cost Study (FGDM in Fresno County)
5) The Cost-Neutrality Results

The Center for Social Services Research at the University of California, Berkeley, conducted all studies except the Cost-Neutrality Study, which was conducted by CDSS. This report will include a discussion of the findings, recommendations for further study, and a summary of "lessons learned" for future child welfare service delivery innovations. Note: many of the study documents referenced, such as interview protocols and instruments or annual process study reports, have been submitted previously and will not be included as appendices in this Final Report. Some of these documents can be found in previous reports at the study's web site (http://cssr.berkeley.edu/childwelfare/projectdetails.asp?name=waiver). Inquiries can be made to the Principal Investigator (ecohen@berkeley.edu).

In addition, summaries of the Extended Voluntary Placement results and the Community Mentoring Study are included in this report.

A few general notes about this report:

1) Regarding terminology, in the FGDM and Wraparound studies we have tried to use child- and family-friendly research language throughout when characterizing our research participants. For example, at the suggestion of stakeholders in the early planning, we refer to the "experimental" and "control" groups as "treatment" and "comparison" groups, despite the latter terms' more typical use in quasi-experimental research designs.

2) In the absence of specific focus groups with State agency staff and managers, the UCB evaluation team provided CDSS staff an opportunity to review the UCB sections of the draft Final Report. The FGDM Process Study section contains some comments from their review as footnotes.

3) The FGDM and Wraparound study chapters can be read as "stand alone" studies. We separately discussed each study's general methodology and those methodologies specific to their respective chapters. (The two Fidelity Studies, for example, were both highly unique and used different methodologies.) The Summary and Conclusions addresses both studies together.

4) The $\underline{p}$ value threshold for statistical significance testing was set at $\underline{p} \leq .05$. Due to the small sample nature of some of the analyses, when an observed $\underline{p}$ value was higher (i.e. $\underline{p} < .10$) some of the analyses were flagged as "trends" worthy of note, albeit "not statistically significant".

1.5 Acknowledgements

The authors of this *Final Report* wish to thank those people, both past and present, who have contributed to the development, design, implementation and management of this study. The following have comprised the Study Team during 2003-2004.

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In addition, many thanks to our interviewers in the field, the staffs of Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento and San Luis Obispo Counties, and provider partners, who all worked very hard to participate in this complicated study.

CHAPTER 5 WRAPAROUND STUDY

5.1 General Research Design

5.1.1 Target Populations

Wraparound was being targeted to two groups of children eligible for Federal Title IV-E foster care funds: (a) children residing in the highest levels of group care in California, and (b) children at risk of placement into the highest levels of group care. California's group care is defined by a rate classification system. Fourteen rate classification levels (RCL) correspond to amounts paid to group care providers and level of environmental restrictiveness, with RCL 1 being the least costly and least restrictive and RCL 14 being the most expensive and most restrictive. Three counties—Alameda, Los Angeles, and Sacramento—targeted children residing in RCL 12-14 group care and those at risk of such placement, while Humboldt County and San Luis Obispo County targeted children residing in RCL 10-14 group care and those at risk of such placement. Children who were eligible for Wraparound under State of California provisions (i.e., SB 163) were not included in the Demonstration Project.

5.1.2 Eligibility Criteria

A child's fiscal eligibility to receive Title IV-E foster care funds was the primary eligibility criteria for all Wraparound counties. Remaining programmatic eligibility criteria were based generally on behavioral considerations but were specific to individual counties. County representatives were responsible for determining the fiscal and programmatic eligibility of children prior to the random assignment process.

5.1.2.1 Alameda County

Children and families eligible for Wraparound in Alameda County required one or more of the following: (a) 24 hour supervision to ensure safety and/or public safety, (b) intensive services needs likely to exceed six months in duration, or (c) intensive hospitalization or hospital alternative assessment and diagnostic services. Children must also have exhibited one of the following behavioral characteristics: active suicidal behavior, dangerously assaultive behavior, major incidents of property destruction, sexual acting out behaviors, firesetting, excessive runaways, or multiple and frequent placement disruptions. The presence of an identified caregiver at the time of enrollment into the study was not a criterion established by the county. Eligible children from Alameda County were child welfare dependents.

5.1.2.2 Humboldt County

Humboldt County representatives used behavioral indicators associated with entrance into RCL 12-14 group care. These indicators included aggressive behavior, suicidal behavior, chronic truancy, substance abuse, and involvement with multiple agencies. The presence of a caregiver at the time of enrollment was a consideration for eligibility but not a requirement. Eligible children from Humboldt County were child welfare dependents.

5.1.2.3 Los Angeles County

Los Angeles County representatives focused on a number of eligibility criteria. Children who had been hospitalized or at risk of hospitalization were eligible. Generally, children were eligible if they exhibited impairment or difficulty fulfilling family, school, or community roles. Children who had a history of multiple placements, psychiatric hospitalizations, juvenile facility incarcerations, or emergency shelter placements were also included. Eligible children from Los Angeles County were child welfare dependents or probation wards.

5.1.2.4 Sacramento County

Sacramento County representatives did not use specific behavioral characteristics for eligibility determination, relying instead on a more general notion of impaired functioning and multiple behavioral, emotional, or social needs. For a period of time, an identified caregiver willing and able to care for the child was a condition for referral to the program; that requirement was later dropped. Eligible children from Sacramento County were child welfare dependents or probation wards.

5.1.2.5 San Luis Obispo County

San Luis Obispo County representatives used a standardized risk assessment tool to determine whether a case is "high risk." The presence of an identified caregiver at the time of enrollment is a factor for determining eligibility. Eligible children from San Luis Obispo County were child welfare dependents or probation wards.

5.1.3 Random Assignment Procedures

Once a referral had been deemed appropriate for any of the county Wraparound projects, the enrollment information was sent via fax to UCB evaluation staff for enrollment into the Project evaluation study and random assignment into either the treatment group or comparison group. Children were randomly assigned in a ratio of 5:3, treatment vs. comparison group. The ratio ensured that a greater number of children received the experimental intervention while maintaining a large enough control group for comparison purposes. Random assignment was accomplished by entering the child's name and identifying information into an Excel database containing a computer-generated, predetermined, concealed assignment list. As the names were entered in order of receipt, the group assignment for that child was revealed. Group assignment information was then sent back via fax to the county representative, usually within several hours of receipt by UCB evaluation staff. Wraparound provider representatives used various methods to determine which of the three providers were to be assigned the case, from a simple "next in line" approach to a more sophisticated random assignment approach.

There is an important distinction to be made between the children enrolled in the Demonstration Project and the children enrolled in the evaluation study. Because Wraparound is considered a family intervention, children could be enrolled as a part of a sibling group, provided that all meet the eligibility criteria. The outcomes of interest for the evaluation, however, were individual in nature, not familial. Therefore, siblings within sibling groups could not be the subjects of analyses as the siblings were not independent of one another, unless the relationship could be statistically accounted for. To simplify the analyses for the Demonstration Project and this study, when a sibling group was referred to UCB evaluation staff for enrollment and random assignment, a child was randomly selected from the sibling group to serve as the evaluation

study child; his/her data were the data used for analyses. As a result, there are two samples: (a) a Demonstration Project sample that includes all children who meet the eligibility requirements and are enrolled in the Demonstration Project, and (b) an evaluation study sub-sample of children included for analyses. The evaluation study sub-sample of children is the sample used for the remainder of Wraparound report.

The first enrollment into the Demonstration Project was in June 1999. Enrollments were "rolling," meaning they occurred continuously, depending upon the number of referrals and the capacity of the Wraparound providers to absorb new cases. County representatives were in control of the pace of cases sent to UCB evaluation staff for enrollment into the Demonstration Project.

Table 1.

Enrollment Start-Dates

County	Enrollment Start-Date
Alameda	June 1999
Humboldt	June 2000
Los Angeles	December 2000
Sacramento	June 1999
San Luis Obispo	September 2000

5.1.4 Sample

5.1.4.1 Demographics

Methods

The following section reports on the characteristics of the children identified as study children for the purposes of the evaluation (i.e., not including siblings enrolled in the study). The samples do not include children/caregivers (a) who declined to participate in the evaluation after being enrolled, or (b) who never had services commence under the Demonstration Project as indicated by county representatives. Four children in Alameda County were excluded, five children in Los Angeles County were excluded, and four children in Sacramento County were excluded.

Only child welfare dependents are included in the sample analysis and in subsequent outcome analyses (Section 5.4). Probation children were not included in either set of analyses due to a lack of data. County probation departments are not required to provide detailed information on wards being served using Title IV-E funds, nor are they provided access to State's child welfare system data management system (CWS/CMS), the source of child data for this evaluation.

The following analysis provides a descriptive look at the analyses samples in each county. The variables include gender, ethnicity, age, most recent reason for removal, number of placements prior to enrollment, target population, and time in study. A number of variables require clarification. The most recent reason for removal variable refers to the removal most recent prior

to enrollment into the Demonstration Project. The target population variable includes two categories: (a) in RCL 12-14 group care at time of enrollment and (b) at risk of such placement. RCL Unknown refers to children who are in group care at the time of enrollment, but the RCL could not be determined due to missing data. The time in study variable was calculated by subtracting the child's enrollment date from the study data cut-off date (December 31, 2002). Where appropriate, the Pearson chi-square test for association, the two-sample *t*-test, or the Wilcoxon Two-Sample Rank Sums test were used to assess differences between the two groups.

The analysis also provides a check on random assignment. As indicated by the non-statistically significant differences reported below, it appears that process of random assignment was successful at distributing child characteristics evenly between the groups.

Results and Discussion

Alameda County

Table 40 shows the characteristics of the 212 child welfare children in Alameda County. The majority of children in the treatment and comparison groups were male (60.90% and 63.29%) and African-American (78.20% and 75.95%). Neglect was the most likely reason for most recent removal, though the comparison group had a larger proportion of children removed for physical abuse, 24.05% compared to 12.03%. Children ranged between the ages of 4 years old and 17 years old, with both groups having an average age of roughly 12 years old. The median number of placements prior to enrollment was 6.00 for both groups. Roughly 20% (n=42) of Alameda County's sample was in RCL 12-14 group care at the time of enrollment.

Table 2.

Alameda County Study Children Demographics: Child Welfare (N = 212)

	Treatment (n=133)		Comparison (n=79)	
	%	n	%	n
Gender				
Female	39.10	52	36.71	29
Male	60.90	81	63.29	50
Ethnicity				
Black	78.20	104	75.95	60
White	12.78	17	18.99	15
Hispanic	7.52	10	5.06	4
Asian/Other	1.50	2	0.00	0
Target Population				
RCL 12-14	21.05	28	17.72	14
At-Risk of RCL 12-14	78.95	105	81.01	64
RCL Unknown	0.00	0	1.27	1
Most Recent Reason for Removal				
Sexual Abuse	6.02	8	5.06	4
Physical Abuse	12.03	16	24.05	19
Neglect	80.45	107	69.62	55
Other	1.50	2	1.27	1
Age at Enrollment	(n= 133)		(n= 79)	
M/Mdn (years)	12.29 / 12.50		11.92 / 12.30	
Min-Max	4.50 – 17.10		4.80 – 16.80	
SD	2.82		2.82	
Time in Study	(n= 133)		(n= 79)	
M / Mdn (months)	23.29 / 24.00		23.39 – 25.00	
Min-Max	1.00 – 42.00		0.00 – 42.00	
SD	11.85		12.05	
Number of Placement Moves Prior to Enrollment	(n= 126)		(n= 75)	
M / Mdn	6.50 / 6.00		7.16 / 6.00	
Min-Max	1.00 – 27.00		1.00 – 20.00	
SD	4.84		4.67	

* $p < 0.05$.

Humboldt County

Table 41 shows the characteristics of the 16 child welfare children in Humboldt County. The majority of children in the treatment group were male (83.33%) while in the comparison group the distribution was evenly split between males and females. The largest proportion of children in both groups were White. Neglect was the most likely reason for removal in the treatment group (75.00%), while the most likely reason for removal in the comparison group was sexual abuse (75.00%). The difference was statistically significant. Children ranged between the ages of 9 years old and 17 years old, with both groups having an average age of roughly 13 years old. The median number of placements prior to enrollment was 6.50 for the treatment group and 3.00 for the comparison group. Roughly 20% (n=3) of Humboldt County's sample was in RCL 12-14 group care at the time of enrollment.

Table 3

Humboldt County Study Children Demographics: Child Welfare (N = 16)

	Treatment (n=12)		Comparison (n=4)	
	%	n	%	n
Gender				
Female	16.67	2	50.00	2
Male	83.33	10	50.00	2
Ethnicity				
Black	0.00	0	0.00	0
White	58.33	7	100.00	4
Hispanic	0.00	0	0.00	0
Asian/Other	41.67	5	0.00	0
Target Population				
RCL 12-14	25.00	3	0.00	0
At-Risk of RCL 12-14	66.67	8	100.00	4
RCL Unknown	8.33	1	0.00	0
Most Recent Reason for Removal *				
Sexual Abuse	0.00	0	75.00	3
Physical Abuse	16.67	2	0.00	0
Neglect	75.00	9	25.00	1
Other	8.33	1	0.00	0
Age at Enrollment	(n=12)		(n=4)	
M/Mdn (years)	13.18 / 12.95		13.55 / 13.40	
Min-Max	9.10 – 17.10		10.20 – 17.20	
SD	2.32		3.05	
Time in Study	(n=12)		(n=4)	
M / Mdn (months)	16.83 / 21.00		12.50 / 10.00	
Min-Max	2.00 – 30.00		8.00 – 22.00	
SD	10.27		6.40	
Number of Placement Moves Prior to Enrollment	(n=12)		(n=4)	
M / Mdn	8.00 / 6.50		6.00 / 3.00	
Min-Max	1.00 – 31.00		2.00 – 16.00	
SD	8.30		6.68	

* $p < 0.05$.

Los Angeles County

Table 42 shows the characteristics of the 102 child welfare children in Los Angeles County (forty-three probation wards were not included). A slight majority of children in the treatment were female (51.61%) while in the comparison group the majority were males (63.89%). Hispanic children made up the largest percentage of children in both groups (treatment=46.15%,

comparison=40.54%). The most likely reason for removal in the treatment group was neglect (46.15%), while 59.46% of the comparison group was removed for neglect. Children ranged between the ages of 6 years old and 18 years old, with both groups having an average age of roughly 13 years old. The median number of placements prior to enrollment was 5.00 for both the treatment group and comparison group. Roughly 17% (n=17) of Los Angeles County's sample was in RCL 12-14 group care at the time of enrollment.

Table 4.

Los Angeles County Study Children Demographics: Child Welfare (N =102)

	Treatment (n=65)		Comparison (n=37)	
	%	n	%	n
Gender				
Female	51.61	32	36.11	13
Male	48.39	30	63.89	23
Ethnicity				
Black	32.31	21	29.73	11
White	16.92	11	21.62	8
Hispanic	46.15	30	40.54	15
Asian/Other	0.00	0	5.41	2
Target Population				
RCL 12-14	13.85	9	21.62	8
At-Risk of RCL 12-14	86.15	56	78.38	29
RCL Unknown	0.00	0	0.00	0
Most Recent Reason for Removal				
Sexual Abuse	3.08	2	2.70	1
Physical Abuse	16.92	11	10.81	4
Neglect	46.15	30	59.46	22
Other	23.08	15	24.32	9
Age at Enrollment	(n=65)		(n=37)	
M/Mdn (years)	13.43 / 14.20		13.74 / 14.30	
Min-Max	6.20 – 18.90		6.70 – 18.00	
SD	3.07		2.67	
Time in Study	(n=65)		(n=37)	
M / Mdn (months)	10.31 / 9.00		10.24 / 8.00	
Min-Max	0.00 – 25.00		0.00 – 24.00	
SD	7.32		7.61	
Number of Placement Moves Prior to Enrollment	(n=53)		(n=36)	
M / Mdn	6.75 / 5.00		5.78 / 5.00	
Min-Max	1.00 – 23.00		1.00 – 12.00	
SD	5.41		3.28	

Sacramento County

Table 43 shows the characteristics of the 188 child welfare children in Sacramento County (twenty-nine probation wards were not included). The majority of children in the treatment and comparison groups were male (61.54% and 69.01%) and White (50.43% and 63.38%). Neglect was the most likely reason for removal in the treatment group (61.21%) and comparison group (61.97%). Children ranged between the ages of 5 years old and 17 years old, with both groups having an average age of roughly 12 years old. The median number of placements prior to enrollment was 6.00 for both the treatment group and comparison group. Roughly 40% (n=76) of Sacramento County's sample was in RCL 12-14 group care at the time of enrollment.

Table 5

Sacramento County Study Children Demographics: Child Welfare (N = 188)

	Treatment (n=117)		Comparison (n=71)	
	%	n	%	n
Gender				
Female	38.46	45	30.99	22
Male	61.54	72	69.01	49
Ethnicity				
Black	32.48	38	25.35	18
White	50.43	59	63.38	45
Hispanic	15.38	18	9.86	7
Asian/Other	1.70	2	1.41	1
Target Population				
RCL 12-14	41.03	48	39.44	28
At-Risk of RCL 12-14	47.01	55	50.70	36
RCL Unknown	11.97	14	9.86	7
Most Recent Reason for Removal				
Sexual Abuse	5.17	6	5.63	4
Physical Abuse	13.79	16	12.68	9
Neglect	61.21	71	61.97	44
Other	19.83	23	18.31	13
Age at Enrollment	(n=117)		(n=71)	
M/Mdn (years)	12.61 / 13.00		12.43 / 12.40	
Min-Max	5.40 – 17.50		7.70 – 17.00	
SD	2.70		2.41	
Time in Study	(n=117)		(n=71)	
M / Mdn (months)	17.72 / 19.00		16.75 / 18.00	
Min-Max	1.00 – 43.00		0.00 – 41.00	
SD	10.24		9.58	
Number of Placement Moves Prior to Enrollment	(n=112)		(n=68)	
M / Mdn	7.13 / 6.00		6.85 / 6.00	
Min-Max	1.00 – 29.00		1.00 – 21.00	
SD	4.75		4.60	

San Luis Obispo County

Table 44 shows the characteristics of the 7 child welfare children in San Luis Obispo County (three probation wards were not included). Generally, the children in the county's sample were male, White, and between 7 and 12 years old at the time of enrollment. None of the children in the sample were living in RCL 12-14 group care at the time of enrollment.

Table 6

San Luis Obispo County Study Children Demographics: Child Welfare (N = 7)

	Treatment (n=4)		Comparison (n=3)	
	%	n	%	n
Gender				
Female	50.00	2	0.00	0
Male	50.00	2	100.00	3
Ethnicity				
Black	0.00	0	0.00	0
White	50.00	2	100.00	3
Hispanic	50.00	2	0.00	0
Asian/Other	0.00	0	0.00	0
Target Population				
RCL 12-14	0.00	0	0.00	0
At-Risk of RCL 12-14	100.00	4	100.00	3
RCL Unknown	0.00	0	0.00	0
Most Recent Reason for Removal				
Sexual Abuse	-	-	-	-
Physical Abuse	-	-	-	-
Neglect	-	-	-	-
Other	-	-	-	-
Age at Enrollment	(n=4)		(n=3)	
M/Mdn (years)	12.05 / 13.45		11.13 / 10.60	
Min-Max	7.10 – 14.20		10.50 – 12.30	
SD	3.33		1.01	
Time in Study	(n=4)		(n=3)	
M / Mdn (months)	19.75 / 19.00		19.00 / 19.00	
Min-Max	16.00 – 25.00		17.00 – 21.00	
SD	3.86		2.00	
Number of Placement Moves Prior to Enrollment	(n=2)		(n=1)	
M / Mdn	12.00 / 12.00		4.00 / 4.00	
Min-Max	5.00 – 19.00		4.00 – 4.00	
SD	9.90		.	

5.1.4.2 Target Population Comparability and Behavior

Method

Purpose

The primary purpose for the CAFAS in the Demonstration Project Evaluation was to assess the behavioral functioning of children in the two target populations (in RCL 12 – 14 group care and at risk of such placement) for differences. Basing a service decision on a predicted event is difficult (see Schuerman, Rsepnicki, and Littell(1994)) and can complicate evaluation analysis efforts. UCB evaluation staff were concerned about the potential dissimilarity between the two groups and the subsequent difficulty in combining the groups for analyses. The CAFAS was instituted as the means of determining whether the groups could be analyzed together.

The analysis of the behavior of children in the two target populations was conducted in Alameda County, Los Angeles County, and Sacramento County for child welfare dependents (children included in the outcome analyses). Humboldt County declined to collect CAFAS information and no children from the San Luis Obispo County sample resided in RCL 12-14 group care.

Description[1]

The CAFAS (K. Hodges, 1997)was developed to measure the functional impairment of children and adolescents between the ages of 6 and 17 years old (1st through 12th grade) who have emotional, behavioral, or psychological problems.[2] Impairment is defined as the extent to which functioning is negatively affected by behavior. The scale rates impairment across a number of domains and sub-domains: (a) role performance—school/work, home, and community; (b) behavior toward others/self; (c) moods/self-harm—moods/emotions, and self-harmful behavior; (d) thinking; and (e) substance use. Each of the eight scales (domains and sub-domains) contains a list of observable behaviors organized by level of severity (severe, moderate, mild, minimal/no).

The CAFAS is not administered to the child but instead completed by an individual involved with the child and knowledgeable of his or her behavior over a specified time period, generally within the previous 1 to 6 months from the time of assessment. A rater can be a clinician or a non-clinician trained in the use of the CAFAS and may use any sources of information the rater deems reliable and valid regarding the child's behavior.

The rater scores each of the eight scales by reviewing the list of behaviors and assigning the level of impairment score corresponding with the most severe behavior exhibited by the child. The level of impairment scores are as follows: (a) Severe—severe disruption or incapacitation (30); Moderate—major or persistent disruption (20); Mild—significant problems or distress (10); and Minimal or No Impairment—no disruption of functioning (0). A CAFAS scale score is determined by totaling the individual scale scores, either an 8-scale score that includes the eight domains (0 – 240) and sub-domains or a 5-scale score that includes only the five domains, with the highest sub-domain score determining the score for that domain (0 – 150). The 8-scale total score was used in the Demonstration Project Evaluation and is interpreted as follows: (a) youth

[1] This section is summarized from Hodges (1997).

[2] The CAFAS includes a section to assess the child's caregiver. This portion of the CAFAS was not used in the Demonstration Project Evaluation and will not be included in the description.

exhibits no noteworthy impairment (0 – 10); (b) youth likely can be treated on an outpatient basis, provided that risk behaviors are not present (20 – 40); (c) youth may need additional services beyond outpatient care (50 – 90); (d) youth likely needs care which is more intensive than outpatient care and/or which includes multiple sources of supportive care (100 – 130); (e) youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and community (140 and higher).

UCB evaluation staff received training on the CAFAS using the training materials developed by Hodges (1997). Staff subsequently trained the individuals responsible for CAFAS data collection in the various counties using training materials developed by Hodges.

Reliability and Validity

Hodges and Wong (1996) reported relatively strong CAFAS interrater reliability (Pearson product moment correlations of .74 and above) and moderate concurrent validity. Hodges (1995) reported good test-retest reliability. In a study by Hodges, Doucette-Gates, and Kim (2000), the CAFAS was found to have high predictive validity.

Data Collection

The CAFAS was selected for use in the Demonstration Project Evaluation for several reasons. First, the CAFAS does not need to be administered to the child; instead it can be completed by a person knowledgeable about the child's behavior or by someone collecting that information from someone knowledgeable. Additionally, the CAFAS is relatively easy to use, the training can be done independently, and it can be completed in a short amount of time (between approximately 15 and 45 minutes depending on the sources of information). Finally, the CAFAS is intended for use with children identified as having serious emotional disturbances (SED) and was found to be appropriate for use with children of varying demographic characteristics (i.e., gender, age, and ethnicity) (K. Hodges & Wong, 1996).

CAFAS data collection in Alameda County began October 1, 2000. CAFAS data collection in Los Angeles County began December 1, 2000. CAFAS data collection in Sacramento County began May 1, 2001. Delays in identifying and implementing an appropriate assessment tool meant that CAFAS data collection did not begin until after the start of enrollments.

CAFAS data collection was the responsibility of a county representative in Alameda County. In Los Angeles County and Sacramento County, the data collection responsibilities were divided between county representatives (treatment group) and UCB evaluation staff (comparison group). Data collectors identified at the time of the child's enrollment the appropriate individual—caregiver, social worker, or therapist—to conduct a CAFAS interview.

Results and Discussion

CAFAS scores were analyzed two different ways. In the comparison of CAFAS overall scores, a Wilcoxon Two-Sample Rank Sums test was used. The Pearson chi-square test for association was used to assess the different distributions of CAFAS categories of dysfunction.

Preliminary respondent analyses indicated that there were no statistically significant differences between CAFAS respondents and non-respondents regarding age, gender, and ethnicity.

Alameda County

Table 45 and Table 46 show the overall CAFAS score and CAFAS score by the categories of dysfunction for Alameda County. Seventy-five children were included in the CAFAS analysis. Both the mean and median scores fell within the moderate range of dysfunction, characterized by Hodges (1997) as youth needing additional services beyond outpatient care. Scores ranged from 0 to 210, well into the severe dysfunction category. The differences in the CAFAS overall score, as well as the differences in the distribution of scores across categories of dysfunction, were not statistically significant.

Table 7.

*Alameda County CAFAS Analysis: CAFAS Overall Score by Target Population (*N = *75).*

	n	M	Mdn	Min	Max	Range	SD
In RCL 12-14	16	85.00	65.00	30.00	210.00	180.00	53.54
At-risk RCL 12-14	59	84.75	80.00	0.00	200.00	200.00	46.55

Wilcoxon Rank Sums, $p = 0.8054$.

Table 8.

*Alameda County CAFAS Analysis: Frequencies and Proportions of CAFAS Categories of Dysfunction by Target Population (*N = *75).*

CAFAS Score	None/Min 0-10	Mild 20-40	Moderate 50-90	Marked 100-130	Severe 140+	Total
In RCL 12-14	0	5	5	4	2	16
	0.00	31.25	31.25	25.00	12.50	
At-risk RCL 12-14	3	9	23	17	7	59
	5.08	15.25	38.98	28.81	11.86	
Total	3	14	28	21	9	75

$\chi^2(4) = 2.8100$, $p = 0.6070$ (Exact).

Los Angeles County

Table 47 and Table 48 show the overall CAFAS score and CAFAS score by the categories of dysfunction for Los Angeles County. Sixty-five children were included in the CAFAS analysis. Both the mean and median scores fell within the marked range of dysfunction, characterized by Hodges (1997)as youth likely needing care more intensive than outpatient care and which includes multiple sources of supportive care. Scores ranged from 10 to 190, well into the severe

dysfunction category. The differences in the CAFAS overall score, as well as the differences in the distribution of scores across categories of dysfunction, were not statistically significant.

Table 9.

*Table Los Angeles County CAFAS Analysis: CAFAS Overall Score by Target Population (*N = *65).*

	n	M	Mdn	Min	Max	Range	SD
In RCL 12-14	11	120.00	120.00	50.00	180.00	130.00	37.68
At-risk RCL 12-14	54	110.00	110.00	10.00	190.00	180.00	38.90

Wilcoxon Rank Sums, $p = 0.4502$.

Table 10.

*Los Angeles County CAFAS Analysis: Frequencies and Proportions of CAFAS Categories of Dysfunction by Target Population (*N = *65).*

CAFAS Score	None/Min 0-10	Mild 20-40	Moderate 50-90	Marked 100-130	Severe 140+	Total
In RCL 12-14	0	0	3	4	4	11
	0.00	0.00	27.27	36.36	36.36	
At-risk RCL 12-14	1	2	15	22	14	54
	1.85	3.70	27.78	40.74	25.93	
Total	1	2	18	26	18	65

$\chi^2(4) = 1.0152$, $p = 0.9511$ (Exact).

Sacramento County

Table and Table show the overall CAFAS score and CAFAS score by the categories of dysfunction for Sacramento County. Fifty-nine children were included in the CAFAS analysis. Both the mean and median scores fell within the moderate range of dysfunction, characterized by Hodges (1997)as youth needing additional services beyond outpatient care. Scores ranged from 0 to 200, well into the severe dysfunction category. The differences in the CAFAS overall score, as well as the differences in the distribution of scores across categories of dysfunction, were not statistically significant.

Discussion

The analyses of CAFAS scores seemed to indicate that children residing in RCL 12-14 were similar behaviorally to children at risk of such placement. The findings support the strategy of aggregating the target populations for outcome analyses.

5.1.5 Services Tracking

Overview

The tracking of services received by children and families participating in the Wraparound sub-study was instituted in response to concerns regarding the integrity of the comparison group. The intent of the evaluation is to compare the outcomes of children and families receiving Wraparound to the outcomes of children and families receiving traditional Child Welfare services. However, representatives from the five counties participating in the sub-study indicated at the start of the evaluation their intention to provide "Wraparound-like" services to children and families randomly assigned to the comparison group. If children and families in the comparison group were to receive similar enough services to children and families in the treatment group, this contamination of the comparison group could potentially mask the possible benefits of Wraparound, leading to the incorrect conclusion that Wraparound was no more effective than traditional Child Welfare services. In order to assess whether children and families in the treatment and comparison group were receiving similar services, the UCB evaluation staff developed and implemented the Services Tracking data collection procedures.

Wraparound is a philosophy of care characterized by an individualized planning process that results in a unique set of services and supports (Susan K. Goldman, 1999). As a philosophy, the most accessible component of Wraparound to measure and quantify are the services received by children and families. In addition to service variety, Services Tracking sought to capture the frequency of services, the duration of services, and the identity of the service provider in order to determine the mix of formal (i.e., professionally provided services) versus informal (i.e., non-professionally provided services) service providers.

The centerpiece of the Services Tracking data collection process was the services tracking form and related codes. The UCB evaluation staff, in consultation with Wraparound practitioners, developed a list of 72 distinct services organized into three categories: concrete services, therapeutic services, and case management services. For each specific service provided during a tracking period, the form contained information on the recipient of the specific service, the provider of the service, the location of where the service was provided, the number of times the service was provided during the tracking period and the length of time of the service. Services were tracked for children and families in the treatment group and comparison group for one week each of the first three months a child and family are participating in the study, then for one week of the sixth month of participation, and then again every subsequent six months for one week until the child and family exited the study.

Data Collection

The starting dates of services data collection and the responsibility for data collection vary by county (Table 49). Services Tracking began in September 2000 in Alameda County and Humboldt County. San Luis Obispo County representatives began tracking services in October 2000. Services Tracking in Los Angeles County and Sacramento County began in 2001, in January and May, respectively. In Humboldt County and San Luis Obispo County representatives are responsible for collecting services data for children and families in both the treatment and comparison groups in their respective counties. In Alameda County, Los Angeles County, and Sacramento County, the responsibility for services data collection is divided between respective county representatives and UCB evaluation staff. The private non-profit agencies contracted to provide Wraparound in each of those respective counties collects services

data for children and families in the treatment group. UCB evaluation staff collect services data for children and families in the comparison groups in those three counties.

Table 11.

Data Collection Start Dates and Responsibilities

Data Collection	Alameda	Humboldt	Los Angeles	Sacramento	San Luis Obispo
Start Date	September 2000	September 2000	January 2001	May 2001	October 2000
Responsibility					
Treatment	Alameda	Humboldt	Los Angeles	Sacramento	San Luis Obispo
Comparison	UCB	Humboldt	UCB	UCB	San Luis Obispo

Each child and family in the sub-study was assigned a unique data collection schedule determined by the date of their enrollment into the study. UCB evaluation staff notified county representatives on a weekly basis (via fax) regarding the children and families whose services were to be tracked that week, whose services were to be tracked the subsequent week, and whose services tracking information was overdue (i.e., not yet received by UCB evaluation staff). In Humboldt County and San Luis Obispo County data collection was handled internally and the resulting completed forms were sent via fax to UCB. In the three counties where data collection responsibility was shared, a representative from the contracted agency collected the information and sent it via fax to UCB evaluation staff. UCB evaluation staff were responsible for data collection of children and families in the comparison group in those counties. Generally, a contact person for each child was identified (e.g., foster parent, group home worker, child welfare worker) and services information was collected from the contact via phone.

The Services Tracking analyses included children who were enrolled into the study and had at least one tracking period prior to July 1, 2002 (Table 50). In Alameda County, 131 children were in the treatment group and 81 children were in the comparison group. Twelve children were in the treatment group and four children were in the comparison group in Humboldt County. Los Angeles County's project had 75 children enrolled in the treatment group and 54 children in the comparison group. In Sacramento County, 125 children were in the treatment group and 83 were in the comparison group. Seven children were in the treatment group and 3 children were in the comparison group in San Luis Obispo County.

Table 12.

Number of Children in the Services Tracking Analyses

	Treatment	Comparison	Total
Alameda	131	81	212
Humboldt	12	4	16
Los Angeles	75	54	129
Sacramento	125	83	208
San Luis Obispo	7	3	10
Total	350	225	575

It is important to note that children and families were not the sample for analyses; instead, sample totals were the number of completed Services Tracking forms (i.e., data collection points) (Table 51). As noted earlier, services are tracked during the first, second, and third month after enrollment into the study, again at six months post-enrollment, and then every six months thereafter until exit from the study. Because Services Tracking began after the onset of enrollments in each county, and because children enter into the study at various points-in-time (i.e., "rolling" enrollment) children may not have a "tracking" completed from all of the various collection points. For example, a child in Alameda County who enrolled in the study in mid-June 2000, would have a completed tracking for the third-month, sixth-month, and one-year data collection points. Because the child was enrolled prior to the onset of Services Tracking in Alameda County (September 2000), her first- and second-month trackings were skipped. The two-year tracking was not included because it did not occur prior to the July 1, 2002, cut-off date for these analyses.

Completed Services Tracking data collection points are shown in tables in Appendix 4. Alameda County has the largest number of collection points even into the later months of data collection. Sacramento County has a large number of data collection points, particularly in the first several collection points. Services Tracking did not begin in Los Angeles County until January 2001, resulting in missing data collection points in the later tracking dates. The limited amount of Services Tracking data in Humboldt County and San Luis Obispo County are a direct result of the small number of children and families enrolled in their respective portions of the study.

As noted previously, county representatives and UCB evaluation staff were responsible for collecting Services Tracking data. In an analysis of data collected across counties conducted in April 2003, the proportion of collected data points was no different between the treatment groups (94%) and the comparison groups (93%), indicating that data collection techniques were equally successful in both groups (Table 51). This is particularly important for counties where data are collected by county representatives (treatment group) and UCB evaluation staff (comparison group). The analysis factored out the data collection points that were skipped because data collection had not yet begun in any given county and focused on data collection points missed due to non-response.

Table 13.

Percentage of Collected Services Tracking Points by Group

	Collected	Missing	Total	%
Treatment	1274	60	1334	96
Comparison	804	60	864	93
Total	2078	120	2198	95

* Significant at p≤ .05

The same analysis showed that data collection was highly successful across the various counties (Table 52). The response rate in Alameda County was 96% and the response rate in Humboldt County was 99%. The response rates in Sacramento County and San Luis Obispo County were both 94%. The response rate in Los Angeles County was slightly lower at 86%.

Table 14.

Percentage of Collected Services Tracking Points by County

	Collected	Missing	Total	%
Alameda	933	59	619	94
Humboldt	69	2	71	97
Los Angeles	388	32	420	92
Sacramento	649	27	676	96
San Luis Obispo	39	0	39	100
Total	2078	120	2198	95

Despite the high response rates, the preliminary results are potentially subject to a number of limitations. First is the issue of the total number of collected trackings in any given county and the subsequent impact on analysis. The number of collected trackings in Humboldt County and San Luis Obispo County are low due to the relatively low number of children and families enrolled in those counties. As a result, discerning similarities or differences between the groups will be difficult. In this analysis, Los Angeles County suffers from a low number of trackings at the later data collection points, though this will improve over time as data collection continues.

The second issue is a concern about the reliability of the data collection methods in the three counties where data collection responsibilities were shared between the agencies implementing Wraparound and UCB evaluation staff. Data collection may be biased in a number of ways. In Alameda County, Los Angeles County, and Sacramento County, where the responsibility for Services Tracking data collection usually falls to the facilitator of the team working with a particular child in the treatment group, it may be that that individual is too busy with other duties

to accurately collect tracking data for that child. The result would be less reliable data for the treatment group. A counter concern is that because the data collection was completed by the individual with the most knowledge about the child and their services, that, in fact, the data may be more reliable than data collected for the comparison group.

Similar concerns exist for data collected for the comparison group. First, because data were collected by UCB evaluation staff dedicated to Services Tracking data collection, the data may be more reliable than that collected for the treatment group. Second, and again conversely, because UCB evaluation staff relied on contacts for data collection (e.g., child welfare workers, therapists, etc.) with higher caseloads and a potentially more diffuse relationship with the child in question, the data collected about services may be less reliable. A reliability check using randomly selected case records for review was investigated by UCB evaluation staff but ultimately deemed unworkable due to the limited type of information collected in written case records. While not answering concerns about reliability questions, the non-difference between the treatment and comparison groups regarding response rates indicates at minimum an equality of access to Services Tracking data.

Results

The research question guiding the analyses is whether the treatment and comparison groups were receiving different interventions. While the measurement of services was guided by the tenets of Wraparound, additional questions regarding the fidelity of the treatment intervention to that philosophy will be answered in subsequent analyses. The service models and county characteristics are sufficiently different to preclude aggregation of the data for analysis. As a result, Services Tracking data analyses were conducted on each county. Bivariate assessments of association (chi-square) and difference (Wilcoxon-rank sum) were made where appropriate with statistical significance set at $p \leq .05$.

The treatment and comparison groups from the various counties were assessed on a number of variables. First, the groups were compared by their distribution of service type. After the frequency of each various type of service was summed across the collection periods (e.g., group therapy occurred 348 times in Alameda County), the proportion of service frequency accounted for by a particular service was calculated for each group (e.g., group therapy accounted for 1.76% of all the services provided to children in the treatment group and 5.94% of all services provided to children in the comparison group). In the remaining comparisons, the four service codes for visitation were excluded from the analyses due to the bias of such services in favor of children in more restrictive levels of care (i.e., group homes).

The second comparison collapsed the 72 distinct services into 3 service categories: concrete, therapeutic, and case management services. The distribution of services across the categories for the treatment group and comparison group were compared for each data collection point.

The third assessment compared the proportion of formal and informal services received by the two groups at each data collection point. Formal services are those services provided by the Wraparound provider or another service provider. Informal services are services provided by family members (including extended family members) or members of the community (e.g., neighbor, clergy). Services that are necessarily provided by a professional—medical/dental and individual, group, and family therapy—were excluded from the analysis.

The fourth, fifth, and sixth Services Tracking analyses were concerned with service recipients, service providers, and service location, respectively. In the fourth assessment, the groups were compared on the proportion of services provided to the child only versus a variety of service recipients. Variety of service recipients was defined as any other service recipient other than the child (parent, kin caregiver, foster caregiver, sibling, other family member, or other), or the child in combination with at least one other service recipient. The fifth analysis compared the two groups on the proportion of services provided by one service provider versus the proportion of services provided by at least two service providers. Possible service providers were listed in the previous discussion regarding formal and informal services. The sixth assessment compared the groups on the distribution of services provided at an agency, the family home, in the community, or via the telephone. The services of travel and transportation were excluded from this analysis.

The final analysis assessed service time. Average service time for each group at each data collection point was calculated. However, independent sample t-tests or ANOVAS could not be conducted due to the strong violation of the assumption of normally distributed data in both groups at each point in time. Instead, non-parametric Wilcoxon-rank sum tests were conducted.

Alameda County. The ten services most frequently utilized by the treatment and comparison groups in Alameda County are presented in Table 53. The table also presents the percentage of total services accounted for by each of the top ten services. The most frequently utilized service was transportation. In the treatment group, the service accounted for 8.32% of the entire range of services provided to children in the treatment group. The service accounted for 26.36% of the total range of services provided to children in the comparison group. Documentation was the second most frequently utilized service overall and accounted for 12.69% of the entire range of services provide to the treatment group. Medication management, fourth on the frequency list, accounted for the second highest percentage (15.70%) of services provided to the comparison group. The third most frequently used service in the treatment group was one-on-one support counseling (5.89%), compared to recreational/social activities (13.48%) in the comparison group. Children and families in the treatment group received a wider variety of services than children in the comparison group. While the ten services most frequently provided accounted for 48.88 % of the total range of services provide to the treatment group, those ten services accounted for 77.35% of the total services provided to the comparison group.

Table 15.

Alameda County-Total Services by Group: Top 10

Service Type	Frequency	% Treatment	% Comparison
Transportation	2287	8.32	26.36
Documentation	1314	12.69	1.68
Recreational/Social	1038	2.88	13.48
Medication Management	959	0.76	15.70
Individual Therapy	703	4.12	5.44
1-on-1 Support Counseling	649	5.89	1.47
Case Conference/Staffing	588	5.54	0.99
Group Therapy	549	2.00	6.33
Tutor/Educational Support	501	1.86	5.71
Travel	474	4.82	0.19
Total	9062	48.88	77.35

In the second analysis, the services were collapsed into three categories: concrete services, therapeutic services, and case management services (Table 54). The distribution of services across service categories for the two groups was compared, with the difference being statistically significant ($p \leq .05$) at each of the data collection points. Across the range of collection points, children and families consistently received a higher percentage of case management services. Children and families in the comparison group received a higher percentage of both concrete and therapeutic services than the treatment group, with the exception of the point at 18 months, where they received a lower percentage of therapeutic services compared to the treatment group.

Table 16.

Alameda County-Service Categories by Group (%)

	Treatment			Comparison		
Collection	Concrete	Therapeutic	Case Management	Concrete	Therapeutic	Case Management
1 month*	26.70	23.87	49.43	61.28	28.79	9.93
2 months*	22.55	25.57	51.88	57.77	34.73	7.50
3 months*	21.39	29.22	49.39	51.47	39.90	8.64
6 months*	22.20	32.03	45.78	53.85	39.33	6.83
12 months*	23.18	31.57	45.25	49.93	40.03	9.91
18 months*	26.24	27.63	46.13	59.52	26.91	13.57
24 months*	27.89	29.55	42.57	43.64	41.32	15.04
30 months*	36.08	25.04	38.88	42.17	52.29	5.54
36 months*	31.03	31.03	37.93	24.50	71.52	3.97
42 months*	29.51	22.13	48.36	41.38	52.41	6.21

* Significant at $p \leq .05$

Children and families in the comparison group received a greater percentage of informal services than did children and families in the treatment group during the first seven data collection points. (Table 55). These differences were statistically significant at each of the seven data collection points (one month through 24 months collection points). This finding reversed at the 30 months, 36 months and 42 months data collection points, with treatment group members receiving a statistically significant greater percentage of informal services than children in the comparison group. In both of the groups, with one exception, greater than 75% of the services were provided by formal service providers.

Table 17.

Alameda County-Formal/Informal Services by Group (%)

	Treatment		Comparison	
Collection	Formal	Informal	Formal	Informal
1 month*	92.43	7.57	78.09	21.91
2 months*	90.46	9.54	80.90	19.10
3 months*	92.60	7.40	84.84	15.16
6 months*	89.08	10.92	76.85	23.15
12 months*	90.75	9.25	84.80	15.20
18 months*	90.80	9.20	77.72	22.28
24 months*	85.66	14.34	80.04	19.96
30 months*	83.96	16.04	90.25	9.75
36 months*	86.51	13.49	96.03	3.97
42 months*	92.37	7.63	60.63	39.37

* Significant at p≤ .05

Services in the treatment group were provided to a greater variety of individuals than services provided to the comparison group (Table 56). At all data collection points, the differences between the groups were statistically significant. Over time, between approximately 41 to 49% of services were provided to the child and another individual, or someone other than the child, in the treatment group. Over the same period in the comparison group, the range fell between 0 and approximately 4%.

Table 18.

Alameda County-Services Provided To by Group (%)

	Treatment		Comparison	
Collection	Child Only	Variety	Child Only	Variety
1 month*	59.43	40.57	99.01	0.99
2 months*	52.16	47.84	96.34	3.66
3 months*	59.84	40.16	98.10	1.90
6 months*	51.46	48.54	98.81	1.19
12 months*	51.36	48.64	96.79	3.21
18 months*	55.60	44.40	95.84	4.16
24 months*	57.43	42.57	99.34	0.66
30 months*	55.68	44.32	99.52	0.48
36 months*	57.24	42.76	98.68	1.32
42 months*	52.46	47.54	100.00	0.00

* Significant at p≤ .05

At all but the last data collection point, a statistically significant greater percentage of services were provided to the members of the treatment group by a variety of service providers (Table 57). Between approximately 2% and 25% of services were provided by a variety of providers in the treatment group compared to between approximately 1% and 6% in the comparison group. In both groups, the great majority of services were provided by a single service provider.

Table 19.

Alameda County-Services Provided by Group (%)

	Treatment		Comparison	
Collection	Single	Variety	Single	Variety
1 month*	89.77	10.23	94.53	5.47
2 months*	85.51	14.49	93.92	6.08
3 months*	87.60	12.40	98.32	1.68
6 months*	90.61	9.39	98.78	1.22
12 months*	88.40	11.60	93.71	6.29
18 months*	84.72	15.28	97.53	2.47
24 months*	82.73	17.27	97.69	2.31
30 months*	80.87	19.13	99.52	0.48
36 months*	75.17	24.83	99.34	0.66
42 months	97.54	2.46	97.24	2.76

* Significant at $p \leq .05$

The location of service provision also varied in Alameda County (Table 58). The comparison of the distribution of the location of service provision indicated a statistically significant difference between the groups, with the treatment group having a more even disbursement of services across the location categories. A greater percentage (66.33% versus 45.71%) of services in the comparison group were provided at an agency. The treatment group had a higher percentage (18.28%) of services provided by phone than did the comparison group (7.82%). The percentage of services (25.45%) provided in the community was also greater for the treatment group compared to the comparison group (18.37%). The percentages of services provided in the family home were similar between the groups.

Table 20.

Alameda County-Location of Services Provision

	Treatment		Comparison	
Collection	Frequency	Percent of Total	Frequency	Percent of Total
Agency	3490	45.71	2401	66.33
Family Home	806	10.56	271	7.49
Community	1943	25.45	665	18.37
Phone	1396	18.28	283	7.82
Total*	7635	100.00	3620	100.00

* Significant at $p \leq .05$

In the analysis of service time in Alameda County, both the average service time and the median service time are reported (Table 59). A small number of cases with high service times were present across the data collecting points, influencing the average service times in both groups. The median service times offer a different look at the same information. The statistical analysis of service time found only one statistically significant difference: at the 30 months data collection point.

Table 21.

Alameda County-Average and Median Service Time (minutes)

	Treatment		Comparison	
Collection	Average	Median	Average	Median
1 month	1227.85	540.00	863.28	682.50
2 months	1471.98	645.00	726.70	660.00
3 months	1052.30	606.00	884.13	592.50
6 months	1187.61	690.00	960.96	900.00
12 months	1012.86	625.00	940.67	675.00
18 months	1199.57	609.00	815.33	540.00
24 months	1154.06	547.50	772.05	600.00
30 months*	1021.49	480.00	657.86	540.00
36 months	975.00	765.00	680.63	487.50
42 months	595.00	345.00	906.00	1020.00
Total	10897.72		8207.61	

* Significant at $p \leq .05$

The analysis of Services Tracking data in Alameda County indicates that the treatment and comparison groups received a different service package. Of the seven comparisons made, only the analysis of service time did not indicate a significant difference between the two groups. Children and families in the treatment group received a wider variety of services and a greater proportion of those services were case management services. They received a smaller proportion of informal services but a larger proportion of services were provided to a wider variety of service recipients. A smaller percentage of services overall were provided in an agency setting while a larger percentage of services were provided via the telephone.

Humboldt County. The analysis, results, and subsequent interpretation of Services Tracking in Humboldt County are severely limited by the amount of data available. As noted in Table 61, Humboldt County has a small number of collected trackings. In the 3 months and 6 months data collection points for the comparison group, only a single tracking was collected for each point in time. Assessments of group differences is not possible past the 6 months data collection point due to the unavailability of data. The analysis and results should be interpreted with caution.

The ten services most frequently used by the treatment and comparison groups in Humboldt County are presented in Table 60. The most frequently utilized services fell under the category of in-home support/behavior modification. In-home support accounted for 20.37% of the entire

range of services for the comparison group, and 8.89% of services provided to the treatment group. Recreational/social activities was the second ranking service for the treatment group (9.17%), while documentation took up the corresponding slot in the comparison group (12.04%). Documentation was the third ranking service for the treatment group (6.21%) while logistical coordination was the third most frequently utilized service for the comparison group (11.11%). The ten most frequent services accounted for 77.78% of the total services received by the comparison group, indicating that the members of that group received a more limited range of services than children in the treatment group.

Table 22.

Humboldt County-Total Services by Group: Top 10

Service Type	Frequency	Percent Treatment	Percent Comparison
In-home Support/Behavior	85	8.89	20.37
Recreational/Social	74	9.17	8.33
Documentation	57	6.21	12.04
Transportation	43	5.22	5.56
Case Conference w/ Family	42	4.94	6.48
Logistical Coordination	38	3.67	11.11
Individual Therapy	32	3.81	4.63
Day Care	26	2.96	4.63
Travel	26	3.24	2.78
Case Conference/Staffing	25	3.24	1.85
Total	448	51.35	77.78

In the analysis collapsing services into three categories (concrete, therapeutic, case management), comparisons could be made between the groups only at the first five data collection points (Table 61). In those five comparisons, the difference in the distribution of services across these categories was statistically significant at the two months, six months, and twelve months data collection points. In the two comparisons with the most data available (1 month and 2 months), the treatment group received a larger proportion of concrete services and therapeutic services while the comparison group received a greater proportion of case management services.

Table 23.

Humboldt County-Service Categories by Group (%)

	Treatment			Comparison		
Collection	Concrete	Therapeutic	Case Management	Concrete	Therapeutic	Case Management
1 month	22.39	35.82	39.55	18.42	23.68	57.89
2 months*	38.85	40.13	21.02	27.27	27.27	45.45
3 months	33.11	31.08	35.81	36.36	45.45	18.18
6 months*	39.77	31.82	28.41	5.00	65.00	30.00
12 months*	45.76	33.90	20.34	0.00	0.00	100.00
18 months	55.26	21.05	23.68	-	-	-
24 months	19.35	25.81	54.84	-	-	-
30 months	31.25	25.00	43.75	-	-	-
36 months	-	-	-	-	-	-
42 months	-	-	-	-	-	-

* Significant at $p \leq .05$

- = data not available

Children and families in the treatment group received a greater percentage of informal services than children and families in the comparison group (Table 62). The difference was statistically significant at the 2 months data collection point where informal services accounted for 39.04% of treatment group services compared to 16.13% in the comparison group. Though not statistically significant, this finding reversed at the three months data collection point only, where informal services accounted for 36.36% of comparison group services and 23.13% of treatment group services. The majority of services in both groups were provided by formal service providers.

Table 24.

Humboldt County-Formal/Informal Services by Group (%)

	Treatment		Comparison	
Collection	Formal	Informal	Formal	Informal
1 month	77.69	22.31	80.56	19.44
2 months*	60.96	39.04	83.87	16.13
3 months	76.87	23.13	63.64	36.36
6 months	67.53	32.47	78.95	21.05
12 months	76.36	23.64	100.00	0.00
18 months	90.32	9.68	-	-
24 months	69.23	30.77	-	-
30 months	46.15	53.85	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at $p \leq .05$

- = data not available

Services in the comparison group were provided to a wider variety of individuals than services provided to the treatment group (Table 63). In the first two months of tracking, over half of the services (57.89% and 54.55%, respectfully) were provided to the child and another individual, or someone other than the child, in the comparison group. In the treatment group, the percentages of "child only" as service recipient versus a "variety" of service recipients was roughly reverse that of the comparison group at the two months data collection point. During the three months data collection point this finding reversed, with a greater percentage (47.97%) of "variety" recipients in the treatment group than in the comparison group (18.18%). The only statistically significant data collection point is at twelve months, where 100% of services in the comparison group were provided to a variety of recipients, as compared to 18.64% of the treatment group.

Table 25

Humboldt County-Services Provided To by Group (%)

	Treatment		Comparison	
Collection	Child Only	Variety	Child Only	Variety
1 month	50.00	50.00	42.11	57.89
2 months	47.13	52.87	45.45	54.55
3 months	52.03	47.97	81.82	18.18
6 months	56.82	43.18	35.00	65.00
12 months*	81.36	18.64	0.00	100.00
18 months	76.32	23.68	-	-
24 months	41.94	58.06	-	-
30 months	75.00	25.00	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at p≤ .05

- = data not available

The majority of services provided in Humboldt County were provided by a single service provider (50% to 100%) (Table 64). The groups differed at the first data collection point where almost 17% of services were provided to the treatment group by a variety of service providers compared to 2.63% in the comparison group.

Table 26.

Humboldt County-Services Provided By Group (%)

	Treatment		Comparison	
Collection	Single	Variety	Single	Variety
1 month*	83.33	16.67	97.37	2.63
2 months	80.15	19.85	84.85	15.15
3 months	69.15	30.85	63.64	36.36
6 months	86.84	13.16	100.00	0.00
12 months	100.00	0.00	100.00	0.00
18 months	94.74	5.26	-	-
24 months	87.10	12.90	-	-
30 months	50.00	50.00	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at p≤ .05

- = data not available

The location of service provision in Humboldt County was almost identical between the two groups (Table 65). The majority of services in both groups were provided at an agency (approximately 40%), while just over 50% of the services were split between the family home and the community.

Table 27.

Humboldt County-Location of Services Provision

	Treatment		Comparison	
Collection	Frequency	Percent of Total	Frequency	Percent of Total
Agency	235	44.09	36	41.38
Family Home	126	23.64	25	28.74
Community	146	27.39	23	26.44
Phone	26	4.88	3	3.45
Total	533	100.00	87	100.00

* Significant at p≤ .05

The average and median service times for Humboldt County appear in Table 66. None of the differences were statistically significant.

Table 28.

Humboldt County-Average and Median Service Time (minutes)

	Treatment		Comparison	
Collection	Average	Median	Average	Median
1 month	1210.09	900.00	911.25	667.50
2 months	1857.46	1350.00	1965.00	540.00
3 months	1818.30	-	9645.00	9645.00
6 months		-		-
12 months	-	-	-	-
18 months	-	-	-	-
24 months	-	-	-	-
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-
Total	4885.85		12521.25	

* Significant at p≤.05

- = data not available

Given the lack of consistent data across the data collection points and the two groups, it is difficult to determine the nature of service implementation in Humboldt County. With the data

available, it appears the groups were not different in regards to the service package available to children and families.

Los Angeles County. Similar to Humboldt County, the analysis, results, and subsequent interpretation of Services Tracking in Los Angeles County are limited by the amount of data available. As noted in Table 68, the county has a small number of collected trackings at the 12 months collection point and no data available for comparisons between the groups in the last three data collection points. The analysis and results should be interpreted with caution.

The ten services most frequently used by the treatment and comparison groups are presented in Table 67. Medication management was the most frequent service and accounted for 25.71% of the total range of services in the comparison group. Documentation made up the largest percentage (13.38%) of services used by the treatment group. Transportation was the second most frequently used service by children in the comparison group (24.26%), followed by recreational and social activities (8.90%). Travel by professionals and logistic coordination and planning were the number two (6.12%) and three (6.04%) services for the treatment group. Children and families in the treatment group received a wider variety of services than children and families in the comparison group, with the top ten services only accounting for 49.50% of the total range of services compared to 73.28% in the comparison group.

Table 29

Los Angeles County-Total Services by Group: Top 10

Service Type	Frequency	Percent Treatment	Percent Comparison
Transportation	822	5.06	24.26
Medication Management	763	2.44	25.71
Documentation	510	13.38	0.61
Recreational/Social	314	2.19	8.90
Logistic Coordination/Plan	258	6.04	1.34
Travel	234	6.12	0.31
Individual Therapy	233	3.33	4.20
Group Therapy	216	2.11	5.27
1-on-1 Support Counseling	203	4.09	1.99
Case Conference w/ Family	193	4.74	0.69
Total	3746	49.50	73.28

In the comparison of the distribution of services across the three categories, the differences between the treatment and comparison groups was statistically significant at each point of measurement (Table 68). Children and families in the treatment group received a larger proportion of case management services and a smaller proportion of therapeutic and concrete services than did children and families in the comparison group, with the exception of the 24 months data collection point, where the treatment group received more concrete services. In

stark contrast, the case management made up less than 8% of the services provided to the comparison group.

Table 30.

Los Angeles County-Service Categories by Group (%)

	Treatment			Comparison		
Collection	Concrete	Therapeutic	Case Management	Concrete	Therapeutic	Case Management
1 month*	15.91	29.37	54.72	45.41	50.47	4.11
2 months*	16.06	29.75	54.19	42.89	51.19	5.93
3 months*	16.69	29.47	53.85	35.84	56.84	7.32
6 months*	25.00	32.69	42.31	48.51	46.07	5.42
12 months*	22.46	37.68	39.86	38.84	55.36	5.80
18 months*	30.99	51.41	17.61	39.32	53.88	6.80
24 months*	33.58	53.28	13.14	20.00	80.00	0.00
30 months	-	-	-	-	-	-
36 months	-	-	-	-	-	-
42 months	-	-	-	-	-	-

* Significant at $p \leq .05$

- = data not available

With the exception of the last two data points where data were available, children and families in the comparison group received a greater percentage of informal services than did children and families in the treatment group (Table 69). Informal services comprised between roughly 0% and 35% of the total for the comparison group, compared to between roughly 10% and 22% in the treatment group. These differences were statistically significant at the first three data collection points and the final data collection point for which data were available. Overall, formal service providers provided the majority of services in both groups.

Table 31.

Los Angeles County-Formal/Informal Services by Group (%)

	Treatment		Comparison	
Collection	Formal	Informal	Formal	Informal
1 month*	88.40	11.60	65.04	34.96
2 months*	89.64	10.36	68.43	31.57
3 months*	87.33	12.67	64.73	35.27
6 months	78.91	21.09	74.40	25.60
12 months	86.53	13.47	85.57	14.43
18 months	79.84	20.16	87.37	12.63
24 months*	77.87	22.13	100.00	0.00
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at p≤ .05

- = data not available

Services in Los Angeles County were provided to a greater variety of individuals in the treatment group than in the comparison group (Table 70). The differences between the groups were statistically significant at all but the last data collection point for which information was available. In those six comparisons, between roughly 11% and 50% of services in the treatment group went to the child and another individual or someone other than the child. For those same four assessments, the percentage in the comparison group was between 0% and roughly 6%.

Table 32.

Los Angeles County-Services Provided To by Group (%)

	Treatment		Comparison	
Collection	Child Only	Variety	Child Only	Variety
1 month*	54.20	45.80	98.73	1.27
2 months*	49.58	50.42	98.02	1.98
3 months*	59.88	40.12	94.61	5.39
6 months*	54.33	45.67	97.83	2.17
12 months*	75.00	25.00	94.20	5.80
18 months*	89.44	10.56	100.00	0.00
24 months	89.78	10.22	100.00	0.00
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at p≤ .05

- = data not available

Overall, services in the treatment group were provided by a greater variety of service providers than those services provided to the comparison group (Table 71). The differences between the groups were statistically significant at six of the data collection points. In both groups, no more than 20% of services at any collection point were provided by a variety of providers.

Table 33.

Los Angeles County-Services Provided By Group (%)

	Treatment		Comparison	
Collection	Single	Variety	Single	Variety
1 month*	89.12	10.88	99.21	0.79
2 months*	93.70	6.30	97.04	2.96
3 months	92.54	7.46	94.80	5.20
6 months*	85.42	14.58	99.46	0.54
12 months*	94.20	5.80	99.55	0.45
18 months*	92.25	7.75	99.51	0.49
24 months*	80.29	19.71	100.00	0.00
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at p≤ .05

- = data not available

The location of service provision in Los Angeles County varied significantly between the treatment group and the comparison group (Table 72). A larger percentage (23.32%) of all services were provided in the family home for children and families in the comparison group. A larger percentage (17.70%) of all services for children and families in the treatment group were provided by phone.

Table 34.

Los Angeles County-Location of Services Provision

	Treatment		Comparison	
Collection	Frequency	Percent of Total	Frequency	Percent of Total
Agency	1668	54.47	1079	59.48
Family Home	361	11.79	423	23.32
Community	491	16.04	239	13.18
Phone	542	17.70	73	4.02
Total*	3062	62.80	1814	37.20

* Significant at p≤ .05

In the analysis of service time in Los Angeles County, both the average service time and the median service time are reported (Table 73). None of the comparisons made across the first six data collection points for which data were available were statistically significant.

Table 35

Los Angeles County-Average and Median Service Time (minutes)

	Treatment		Comparison	
Collection	Average	Median	Average	Median
1 month	903.95	375.00	1051.18	652.50
2 months	880.23	420.00	727.30	510.00
3 months	867.70	435.00	885.77	375.00
6 months	1113.22	420.00	998.08	337.50
12 months	1744.77	420.00	970.83	882.50
18 months	1450.00	600.00	1001.67	840.00
24 months	-	-	1170.00	1170.00
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-
Total	6959.87		6804.83	

* Significant at $p \leq .05$

The analysis of Services Tracking data in Los Angeles County indicates that the treatment and comparison groups received a different service package. Of the seven comparisons made, only the analysis of service time did not indicate a significant difference between the treatment and comparison groups. Children and families in the treatment group were provided a greater variety of services and a larger proportion of services were received by a variety of service recipients. Additionally, larger proportions of their services were case management services, were provided by formal service providers, and were provided via the telephone.

Sacramento County. The ten services most frequently used by the treatment and comparison groups in Sacramento County are presented in Table 74. Documentation was the most frequently used service in the treatment group accounting for 16.57% of their total services. Case conference/Staffing (8.52%) and travel by staff (7.21%) accounted for the next highest percentages of total range of services in the treatment group. Medication Management was the most frequently accessed service in the comparison group accounting for 32.92% of the total range of services. Transportation (22.47%) and recreational and social activities (11.60%) were the next two most frequently used services in the comparison group. The findings indicate that children and families in the treatment group in Sacramento County received a wider variety of services than did children and families in the comparison group. The top ten services accounted for 58.40% of the total range of services for the treatment group, contrasted with the 80.40% reported for the comparison group.

Table 36.

Sacramento County-Total Services by Group: Top 10

Service Type	Frequency	Percent Treatment	Percent Comparison
Medication Management	2107	0.70	32.92
Transportation	1895	7.70	22.47
Documentation	1083	16.57	0.56
Recreational/Social	908	2.86	11.60
Case Conference/Staffing	587	8.52	0.77
Group Therapy	471	2.74	4.76
Case Conference w/ Family	440	6.17	0.80
1-on-1 Support Counseling	433	5.33	1.53
Travel	418	6.45	0.16
Express/Activities Therapy	389	1.36	4.83
Total	8731	58.40	80.40

In the analysis collapsing services into the three categories of concrete, therapeutic, and case management services, the treatment and comparison groups were significantly different at each of the data collection points where sufficient data were available (Table 75). Children and families in the treatment group received a greater percentage of case management services at each of data collection points than did children and families in the comparison group. Children and families in the comparison group consistently received a greater percentage of therapeutic and concrete services than did members of the treatment group.

Table 37.

Sacramento County-Service Categories by Group (%)

	Treatment			Comparison		
Collection	Concrete	Therapeutic	Case Management	Concrete	Therapeutic	Case Management
1 month*	17.77	23.64	58.58	40.83	53.39	5.78
2 months*	19.81	26.82	53.37	31.26	64.41	4.33
3 months*	22.49	28.89	48.62	43.04	51.14	5.82
6 months*	26.53	23.71	49.76	44.56	50.44	5.00
12 months*	21.81	29.70	48.49	43.79	51.05	5.15
18 months*	15.43	27.03	57.54	36.76	56.30	6.93
24 months*	18.68	28.02	53.30	39.46	54.66	5.88
30 months*	32.39	22.54	45.07	32.26	64.52	3.23
36 months	57.14	28.57	14.29	-	-	-
42 months	-	-	-	-	-	-

* Significant at p≤ .05

Children and families in the comparison group in Sacramento County consistently received a greater percentage of informal services than did children and families in the treatment group (Table 76). The differences were statistically significant at each of the first seven data collection points. Overall, the majority—more than 73% at each point—of services received by children and families in both groups were formal in nature.

Table 38.

Sacramento County-Formal/Informal Services by Group (%)

	Treatment		Comparison	
Collection	Formal	Informal	Formal	Informal
1 month*	91.67	8.33	83.53	16.47
2 months*	95.24	4.76	78.80	21.20
3 months*	92.78	7.22	83.60	16.40
6 months*	87.91	12.09	75.00	25.00
12 months*	91.38	8.62	81.64	18.36
18 months*	89.80	10.20	66.83	33.17
24 months*	95.25	4.75	83.47	16.53
30 months	76.56	23.44	73.17	26.83
36 months	66.67	33.33	-	-
42 months	-	-	-	-

* Significant at p≤ .05

Services in the treatment group were provided to a wider variety of individuals that services provide to the comparison group (Table 77). The differences between the groups were statistically significant at each data collection point where sufficient data were available. Less than 2% of service recipients in the comparison group were the child and another individual or someone other than the child. In the treatment group, services provided were almost evenly divided by the 18 months collection point between those provided to the child only versus a variety of recipients.

Table 39.

Sacramento County-Services Provided To by Group (%)

	Treatment		Comparison	
Collection	Child Only	Variety	Child Only	Variety
1 month*	62.65	37.35	98.37	1.63
2 months*	61.05	38.95	98.10	1.90
3 months*	61.81	38.19	98.63	1.37
6 months*	63.39	36.61	99.29	0.71
12 months*	58.72	41.28	99.41	0.59
18 months*	53.95	46.05	99.37	0.63
24 months*	56.20	43.80	99.75	0.25
30 months*	53.52	46.48	100.00	0.00
36 months	100.00	0.00	-	-
42 months	-	-	-	-

* Significant at $p \leq .05$

At all but the last data collection point where data were available for both groups, a significantly larger percentage of services were provided to the members of the treatment group by a variety of service providers (Table 78). In the first seven collection points, between approximately 10% and 20% of services were provided by a variety of service providers in the treatment group compared to between roughly 1% and 3% in the comparison group. Overall, the majority of services in both groups were provided by a single provider.

Table 40.

Sacramento County-Services Provided By Group (%)

	Treatment		Comparison	
Collection	Single	Variety	Single	Variety
1 month*	80.12	19.88	98.64	1.36
2 months*	86.39	13.61	98.42	1.58
3 months*	84.17	15.83	97.60	2.40
6 months*	86.77	13.23	96.58	3.42
12 months*	86.60	13.40	98.13	1.87
18 months*	88.16	11.84	98.32	1.68
24 months*	89.69	10.31	99.26	0.74
30 months	98.59	1.41	96.77	3.23
36 months	100.00	0.00	-	-
42 months	-	-	-	-

* Significant at p≤ .05

The groups in Sacramento County also differed significantly on the location of service provision (Table 79). The comparison group received a greater percentage (72.57%) of their services in an agency setting that did the treatment group (58.70%). The treatment group received a greater percentage of their services in the community (20.18%) and via the telephone (11.43%) than did the comparison group (9.45% and 3.17%, respectively).

Table 41.

Sacramento County-Location of Services Provision

	Treatment		Comparison	
Collection	Frequency	Percent of Total	Frequency	Percent of Total
Agency	2882	58.70	3278	72.57
Family Home	476	9.69	669	14.81
Community	991	20.18	427	9.45
Phone	561	11.43	143	3.17
Total*	4910	100.00	4517	100.00

* Significant at p≤ .05

In the analysis of service time in Sacramento County, both the average service time and median service time are reported (Table 80). The differences were significant at the 1 month, 2 months, and 6 months data collection points, with the comparison group having a greater average and median service time.

Table 42.

Sacramento County-Average and Median Service Time (minutes)

	Treatment		Comparison	
Collection	Average	Median	Average	Median
1 month*	709.30	300.00	840.38	780.00
2 months*	1020.62	450.00	988.24	720.00
3 months	933.83	489.00	825.92	765.00
6 months*	872.63	630.00	1245.77	1050.00
12 months	918.30	600.00	898.98	975.00
18 months	914.29	435.00	658.64	450.00
24 months	1358.57	900.00	669.55	555.00
30 months	554.17	577.50	894.00	765.00
36 months	330.00	330.00	-	-
42 months	-	-	-	-
Total	7611.71		7021.48	

* Significant at $p \leq .05$

The preliminary analysis of Services Tracking data in Sacramento County indicates that the treatment and comparison groups received a different service package. Statistically significant differences were found in the six analyses where such tests were conducted. Differences between the groups were also found in a seventh analysis. Children and families in the treatment group received a wider variety of services and had less service time. They received a greater proportion of case management services than therapeutic or concrete services. A smaller percentage of their services were from informal providers, but a larger percentage of services were provided to a variety of service recipients and by a variety of providers. A larger proportion of the treatment group's services were provided in the community and via the telephone.

San Luis Obispo County. The analysis, results, and subsequent interpretation of Services Tracking in San Luis Obispo County are severely limited by the amount of data available. As noted in Table 82, San Luis Obispo County has a small number of collected trackings. Assessments of group differences are not possible past the 18 months data collection point due to the unavailability of data. The analysis and results should be interpreted with caution.

The ten services most frequently used by the treatment and comparison groups in San Luis Obispo County are presented in Table 81. The services of in-home support/behavior management, and professional travel, account for the largest percentages of total services in the treatment group (14.44% and 13.70%, respectively). In-home support/behavior management accounted for the greatest percentage (14.89%) of total services in the comparison group as well, followed by shadowing (12.77%). The variety of services offered to both groups appeared slightly lower for the treatment group, with the top ten services accounting for 69.42% of total services offered, as compared to 60.11% for the comparison group.

Table 43.

San Luis Obispo County-Total Services by Group: Top 10

Service Type	Frequency	Percent Treatment	Percent Comparison
In-home Support/Behavior	106	14.44	14.89
Travel	79	13.70	2.66
Case Conference w/ Family	71	9.63	10.11
Documentation	69	10.74	5.85
Shadowing	44	3.70	12.77
Transportation	29	4.81	1.60
Case Conference/Staffing	28	4.81	1.06
Linkages/Coordination	23	3.70	1.60
Case plan development	20	3.33	1.06
Arranging Placement	19	0.56	8.51
Total	488	69.42	60.11

In the analysis collapsing the service types into three categories, the groups were significantly different at the 2 months and 12 months data collection points (Table 82). With the exception of the first collection point, a greater proportion of services provided to the treatment group were case management services. With the exception of the 12 and 18 months data collection points, the treatment group also received a greater proportion of concrete services.

Table 44.

San Luis Obispo County-Service Categories by Group (%)

	Treatment			Comparison		
Collection	Concrete	Therapeutic	Case Management	Concrete	Therapeutic	Case Management
1 month	7.08	29.20	63.72	0.00	21.74	78.26
2 months	20.51	29.49	50.00	19.57	50.00	30.43
3 months*	22.77	24.75	52.48	8.00	70.00	22.00
6 months	9.52	36.51	53.97	9.38	50.00	40.63
12 months*	15.19	29.11	55.70	17.86	53.57	28.57
18 months	17.39	28.26	54.35	33.33	16.67	50.00
24 months	22.81	26.32	50.88	-	-	-
30 months	-	-	-	-	-	-
36 months	-	-	-	-	-	-
42 months	-	-	-	-	-	-

* Significant at $p \leq .05$

- = data not available

Children and families in the treatment group received a greater percentage of informal services than did children and families in the comparison group at the first three data collection points (Table 83). This trend reversed for last three data collection points where the comparison group received a greater percentage of informal services. The difference was statistically significant at the fourth data collection point. Overall, the majority of services in both groups were provided by formal service providers.

Table 45.

San Luis Obispo County-Formal/Informal Services by Group (%)

	Treatment		Comparison	
Collection	Formal	Informal	Formal	Informal
1 month	85.45	14.55	100.00	0.00
2 months	80.52	19.48	93.33	6.67
3 months	85.00	15.00	93.18	6.82
6 months*	100.00	0.00	93.10	6.90
12 months	80.77	19.23	76.92	23.08
18 months	79.07	20.93	60.00	40.00
24 months	91.23	8.77	-	-
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at $p \leq .05$

- = data not available

Both the treatment and the comparison groups had a high percentage of services provided to a variety of service recipients (Table 84). In the case of the treatment group, at all of the data collection points where sufficient data were available, over 57% of services were provided to a variety of recipients. The differences between the groups were statistically significant at the first three data collection points, and then again at the fifth point.

Table 46.

San Luis Obispo County-Services Provided To by Group (%)

	Treatment		Comparison	
Collection	Child Only	Variety	Child Only	Variety
1 month*	31.86	68.14	69.57	30.43
2 months*	26.92	73.08	54.35	45.65
3 months*	36.63	63.37	70.00	30.00
6 months	42.86	57.14	34.38	65.63
12 months*	21.52	78.48	53.57	46.43
18 months	28.26	71.74	50.00	50.00
24 months	24.56	75.44	-	-
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at p≤ .05

- = data not available

At five of the six data collection points, a greater percentage of services were provided to the members of the treatment group by a variety of service providers in San Luis Obispo County (Table 85). The differences were statistically significant at two of those collection points. At the 6 months collection point, however, members of the comparison group received a statistically significant greater percentage of services from a variety of service providers. The majority of services in both groups were provided by a single service provider.

Table 47.

San Luis Obispo County-Services Provided by Group (%)

	Treatment		Comparison	
Collection	Single	Variety	Single	Variety
1 month*	75.61	24.39	100.00	0.00
2 months	76.56	23.44	89.13	10.87
3 months*	51.49	48.51	100.00	0.00
6 months*	98.41	1.59	81.25	18.75
12 months	68.35	31.65	85.71	14.29
18 months	95.65	4.35	100.00	0.00
24 months	94.74	5.26	-	-
30 months	-	-	-	-
36 months	-	-	-	-
42 months	-	-	-	-

* Significant at p≤ .05

The analysis of location of service provision indicated that comparison group members had a greater percentage of services provided in the community (33.90%), than did members of the treatment group (20.20%). In contrast, the treatment group had a greater percentage of services provided via the phone: 23.15% in the treatment group compared to 6.78% in the comparison group. The overall difference in service location distribution was statistically significant.

Table 48.

San Luis Obispo County-Location of Services Provision

	Treatment		Comparison	
Collection	Frequency	Percent of Total	Frequency	Percent of Total
Agency	122	30.05	56	31.64
Family Home	108	26.60	49	27.68
Community	82	20.20	60	33.90
Phone	94	23.15	12	6.78
Total*	406	100.00	177	100.00

* Significant at p≤ .05

In the analysis of service time in San Luis Obispo County, both the average service time and the median service time are reported in Table 87. None of the differences were statistically significant.

Table 49.

San Luis Obispo County-Average and Median Service Time (minutes)

	Treatment		Comparison	
Collection	Average	Median	Average	Median
1 month	915.00	622.50	990.00	990.00
2 months	2880.00	810.00	3310.00	2850.00
3 months	4832.50	2652.50	3130.00	2220.00
6 months	1901.25	1657.50	1155.00	1140.00
12 months	1317.50	1405.00	3088.5	3088.50
18 months	-	-	225.00	225.00
24 months	-	-	-	-
30 months	-	-	-	-
36 months				
42 months				
Total	11846.25		11898.5	

* Significant at p≤.05

The limited amount of data available for analysis complicates the interpretation of the results in San Luis Obispo County. It does appear that the two groups received different service packages. The groups did not appear different on service variety or service time, but differences between the groups were found on service categories, formal/informal services, service recipients, service providers, and the location of service provision.

Conclusion

The analysis of Services Tracking indicates that children and families in the treatment group and the comparison group received different service packages in Alameda County, Los Angeles County, and Sacramento County. The analysis of San Luis Obispo County resulted in a similar finding, though less robust due to the limited amount of data available. The analyses of Humboldt County Service Tracking data indicated that there was no difference between the treatment and comparison groups. However, the analyses were severely hindered by a limited amount of available data.

5.2 Process Study

5.2.1 Purpose

The Wraparound process study has dual purposes: first, to describe the implementation of Wraparound over the course of the project, and second, to articulate the key lessons learned from the various county implementation efforts. Process studies are important evaluation components in longitudinal studies because of the complexity of the goals, tasks, and activities associated with the intervention (Connell, Kubisch, Schorr, & Weiss, 1995), as well as the expectation that all may shift to some degree in response to changing community needs and family involvement. The process study is designed to provide a narrative to describe these conditions and shifts in programs. The issues encountered during implementation and the solutions developed in response may prove useful to future Wraparound implementation endeavors.

The process study was conducted in each county implementing Wraparound in 1999, 2001, 2002, and 2003. The 1999 process study focused on pre-implementation activities, while 2001 - 2003 focused on implementation activities. Budget constraints precluded a process study in 2000.

5.2.2 Methodology

5.2.2.1 Research Questions

The process study questions are organized into several categories of inquiry. The first category focuses on identifying the population of children targeted for the intervention by the various counties. The second category includes the numerous aspects of the implementation efforts, including the intake process into the project, case closure protocols, services offered, supervision and monitoring of the implementation and program, attitudes towards the program and the implementation, and implementation difficulties and solutions. The third category highlights the staffing patterns used by the counties and the training received by staff. The fourth category describes the use of the flexible pool of funds for services and supports. The final category focuses on the contextual factors surrounding the implementation efforts. These include the client and community characteristics; the county agency, State, and Federal factors; as well as possible political and evaluation factors.

5.2.2.2 Sampling Procedures

Participants in the Wraparound process study included a convenience sample of representatives from the public and private agencies and organizations involved with the implementation of Wraparound in their respective county. The public agencies participating in the Waiver Project varied by county and included child welfare, mental health, probation, and/or education. Public agency representatives generally ranged from mid-level administrators (i.e., child welfare supervisors, special projects coordinators) to child welfare or probation workers. The private community-based organizations involved in the project were the service providers contracted by the counties to provide Wraparound. Private organization representatives ranged from the Chief Executive Officer of the organization to the direct service staff working closely with the children and families.

During each year of the process study, evaluation staff from UCB worked with the evaluation liaison from each county (the evaluation liaison was a representative of the lead public agency) to identify a broad range of participants to ensure that all aspects of the intervention and implementation were represented. Given time and meeting space constraints, not every individual involved with a county's implementation could be included. The county evaluation liaison was ultimately responsible for identifying and securing the participation of agency and organization representatives.

5.2.2.3 Data Collection Procedures

Focus groups were used as the primary means of data collection for the Wraparound process study. Conducted annually, they were organized around a set of questions focused on the county's implementation efforts. The focus group conversations were led by UCB evaluation staff and were loosely structured; while guided by the questionnaire protocol, it was not necessarily strictly adhered to in a way that would inhibit the flow of the discussion.

The focus groups were conducted annually in each county, with the previously noted exception in 2000. In 1999, the focus groups were conducted as part of county specific site visits designed to assist each county with understanding the procedures of the Waiver Project evaluation and they county's responsibilities. From 2001 through 2003, the questions used in the focus groups were concerned with project implementation activities.

In 2002 and 2003, the focus groups held with representatives from Humboldt County and San Luis Obispo County were conducted via telephone conference due to budget constraints. In Alameda County, Los Angeles County, and Sacramento County, two focus groups were conducted, each lasting approximately 2 hours. One focus group was conducted with administrative-level staff participants, while the second was conducted with direct-service level participants. After consulting with the county liaisons, UCB evaluation staff determined that conducting two focus groups in those three counties would allow for broad participation and dividing the two by staffing level would allow for focused questioning and preclude the potential for inhibited responses due to staff-level disparities. Single approximately two-hour focus groups were conducted in Humboldt and San Luis Obispo counties. The county liaisons and UCB evaluation staff concluded that small number of staff involved in implementation necessitated a single focus group format.

At the beginning of each focus group, participants were made aware of the purpose and nature of the discussion, and were asked to read and sign a consent form allowing their participation. UCB evaluation staff developed a set of interview questions for administrators and for direct service staff to explore the implementation of the specific county's project, including the target population, services provided, staffing, supervision and monitoring, attitudes, implementation difficulties, funding, and contextual issues (i.e., client and community characteristics; county, State, and Federal government characteristics; political factors; and evaluation factors). All focus groups were recorded on audiotape and during the majority of focus groups an evaluation staff member took notes.

5.2.2.4 Data Analysis Strategy

Focus group audiotapes from each year were transcribed and the resulting data were coded using Atlas.ti qualitative data analysis software. The coded data were used to prepare a descriptive report of each county's activities for each year of the annual process study. Each county's yearly

report was then analyzed and coded using Atlas.ti for key themes and lessons that emerged across counties as well as those specific to a particular county's implementation experience.

5.2.2.5 Limitations of the Process Study

The process study has a number of limitations. First, the process study is limited by the annual point-in-time nature of the data collection. The implementation of each county's Wraparound program is a complex endeavor involving any number of organizations and individuals. Data were collected yearly during approximately four hours of conversation with participants. While capturing the generalities of implementation, the process study was not able to capture a great deal of nuance.

Second, the extent to which the people participating in the focus group were representative of the larger population of people involved in the implantation of Wraparound in any given county is unclear. This creates the possibility of bias in the results, either a more positive or negative appraisal of the implementation process, or creates a problem of incomplete information. While county liaisons endeavored to ensure that a representative sample of staff attended the focus groups, it is possible that some participants were disinclined to attend due to attitude about the project or difficulties in scheduling.

Third, an attempt was made in each focus group to cover as many of the questions as possible in the time allowed, in each of the counties. However, UCB evaluators allowed the focus group conversation to delve more deeply into particular topics if such action seemed warranted; this method allowed for variation between the counties in data collected, resulting in reports that answer many but not all of the same questions.

Finally, the purpose of the process study was to describe the implementation of Wraparound as part of the Waiver Demonstration Project. The process study only provides a description of the team approach used by counties (e.g., how it was staffed) and does not provide detailed information about the operation of each county's Wraparound intervention and how it interacted with children and families to improve their outcomes.

5.2.3 Results

5.2.3.1 Alameda County

1999 Process Study

Pre-waiver services

Intensive Services. Focus group participants in Alameda County viewed the Title IV-E Waiver Demonstration Project as an opportunity to expand a service model, Project Destiny (PD), which began under a State waiver authorized by AB 1741 legislation. Under AB 1741, the county developed a two year pilot project with the goal of moving the county's most intensive needs children to lower levels of care, and improving placement stability when high end care is deemed an appropriate placement. PD is a partnership between the county Interagency Children's Policy Council (ICPC) and three private providers known collectively as the Flexcare Consortium—Seneca Center, Fred Finch and Lincoln Child Center.

The original PD model has several unique features that have informed the development of the IV-E Waiver service delivery model. First, PD originally served youth who were already in the

county's most restrictive placement settings. The target population for this pilot project was 24 randomly selected youth—eight from each of the three participating agencies—who were residing in the residential treatment programs operated by Flexcare agencies. The majority of these children were placed in care under child welfare auspices, though some children were placed through the mental health department, and one was a probation placement. Placement at the Flexcare agencies was considered a proxy for behavioral criteria, due to the standards that the counties and private agencies use to determine the need for admission at each of the three agencies' RCL 12-14 placements.

Second, the AB 1741 waiver allowed the county to contract out a portion of case management responsibility to the Flexcare agencies. The county retained responsibility for liaising with the court and, ultimately, for the safety of the child. All of the PD cases were assigned to one Department of Children and Family Services (DCFS) child welfare worker (CWW). Consolidating the cases allowed for increased collaboration between Flexcare and DCFS, as well as logistical ease in terms of communicating with one CWW who was dedicated to PD cases. The PD CWW had a somewhat reduced caseload, allowing for increased attention to PD cases. Despite initial hesitation to relinquish portions of case management authority, respondents indicated that social services maintained a high level of involvement in placement decisions, crisis consultation, and clinical decisions relating to parent visitation and other matters. Under the waiver, intensive case management provided by Flexcare was a substitute for the normally prescriptive visits that CWW's must conduct within the standard timeframes under Division 31 requirements. Flexcare caseworkers also became responsible for placement decisions, though these were largely made in consultation with the PD CWW. Flexcare case managers, who were MSW-level social workers, were able to make placement and treatment decisions about the children and families with an increased level of flexibility due to the unique funding structure of PD, described below. Respondents indicated that due to increased control over placement decisions, Flexcare case managers had a higher sense of satisfaction in procuring placement options that were truly in the best interest of the child. Due to the high profile of the project, PD also had a high level of administrative involvement at the Flexcare agencies, including CEO's sometimes involved in case management decisions.

Third, the fiscal model of PD is inextricable linked to its program operations. PD is based on funding under a capitated rate that was determined by the cost of services for a comparable group of children looking back over a two-year period. The cost of service for PD was then projected using this look-back method to determine the level of funding for PD necessary for the duration of the pilot project. Rather than basing a funding formula on the costs associated with individual children's care, the funding assumption of PD is that over time a portion of this intensive needs group would improve, resulting in cost savings, while another subset of the population would maintain a high level of treatment needs or require increased services. A key aspect of the capitation method was that once children enter the project they remained part of the capitated rate for the duration of the two-year pilot. As a result, cost savings associated with stepping children down from high levels of care was reinvested into services for the group of children that had increased service needs or stable high-level needs.

Respondents reported that the county fiscal person has been highly involved in determining the funding for PD, which has been beneficial for the county. The county is invested in testing the efficacy of capitation as a means of fiscal reform.

Finally, respondents described the treatment approach of PD as highly individualized, depending on the circumstances and needs of the child and family. The agencies emphasized providing community-based services where possible, such as conducting therapy groups off-site, and in-home family therapy sessions. Parents were engaged in the process, and educated about the goals of PD. Some agencies held parent functions, such as a picnic, so that parents could also get to know each other during the process of learning about PD. For children who could potentially return home, a plan was immediately put into action to explore parental involvement as an option.

Rather than providing services within the time and services confines of a traditional approach, interventions such as structured weekend activities were implemented to support children returning home who may be at risk of social isolation. Parent-focused interventions were also implemented. For example, PD provided financial assistance for one mother to support her decision to move out of a living situation with a boyfriend who had sexually molested her daughter, who was in placed in out-of-home care. Overall, respondents reported that the service intensity level varied with need. For example, when a child returned home to live with a biological parent, in-home family therapy was provided for 10 hours per week during a crisis period, and then decreased gradually to an hour per week after the crisis had subsided. PD also aimed to prevent psychiatric hospitalization in extreme situations by using the agencies' own residential placements with 1-1 24-hour supervision if necessary rather than allow children to be placed in the county's psychiatric placement alternative.

Respondents felt that PD brought improved services to the children and families involved in the pilot project.

Non-Intensive Services. Focus group participants described the most common service modality for non-Destiny intensive needs youth as increased treatment intensity as the child fails progressively more restrictive placement settings. Specifically, in order to receive services in an RCL 12-14, children typically move down a standard pathway beginning with the initial removal due to abuse and/or neglect. As a result of trauma associated with the circumstances of removal, the child begins to act out and exhibit behaviors that are not tolerated in a standard foster care environment. After multiple disruptions, the child is then placed in group care, usually at a lower to mid-level initially. If the child then continues to exhibit behaviors that result in expulsion from group homes, they are then placed in a higher level RCL 12-14 placement. Though this pattern of events commonly precedes placement in restrictive settings, there are numerous other ways that children may enter RCL 12-14 care. Under certain circumstances, when acting out is extreme, children may be accelerated into high-level placements without progressive placement failures.

In addition to the informal criteria of multiple placement failures, DCFS also conducts psychological evaluations to determine the need for group homes as a long-term placement. The case is then transferred to the DCFS group homes unit, for slightly more intensive case management.

Standard services in RCL 12-14 care include on-going counseling and mental health services and 24-hour care. Despite the rate setting system that requires a certain number of points for a setting to be considered an RCL 12-14 placement, the points can be accumulated in different ways, resulting in variation among program structures. For example, whereas one program might have a 1:2 staff to client ratio in the milieu, another program might have a higher number

of social workers on staff but a lower level of supervision in the milieu. Despite this variation, there is an assumption of service intensity at the 12-14 level of care.

Respondents estimated that the duration of services for youth in residential care is approximately 14-16 months. However, the outcomes experienced by this population upon discharge from residential care are typically negative, such as aging out of care from group settings, AWOL status, and placement changes within group settings. Successful reunification from RCL 12-14 care is rare, with dependency status terminating more frequently from emancipation due to aging out, or a jurisdictional change to juvenile justice involvement. Overall, residential placement is associated with poor outcomes, according to focus group participants.

Program Planning

Planning Group. The initial planning group for the IV-E Waiver was built out of the ICPC group that was responsible for AB 1741 implementation. ICPC consists of representation from the county Board of Supervisors, Behavioral Health, DCFS, Probation, the affiliated CBO's, and the Child Planning Council. The ICPC sub-committee that planned PD also began the planning process for the IV-E Waiver.

Planning Process. The planning group had begun to pursue a Federal waiver before the current Demonstration Project was proposed. The county was looking to reform its system and discussed the possibility of a IV-E Waiver and a Title XIX waiver with Federal Region 9 representatives. When the opportunity for a waiver emerged with the AB 1741 legislation, policy councils that later evolved into the ICPC began to meet, as early as 1993. Planning for the IV-E Waiver proposal began as soon as the waiver was announced, as the county was already primed to participate in a flexible funding project.

Internal county workgroups met once every two weeks, with an additional county-Flexcare meeting on a monthly basis. For the first year of implementation of the original PD program, the implementation workgroup met weekly. Respondents expected enrollment for the first wave of IV-E Waiver enrollment to begin on May 1st, 1999.

Target Population

In contrast to the original PD target population that consisted entirely of children already residing in RCL 12-14 care, PD plans to expand its target population to include youth at risk of that level of placement. This "at risk" category includes two sub-populations: One group of youth are already residing in RCL 6-9 care and are at risk of stepping up; a second group of children targeted by the project are those who could be identified in the "front end" of the system—children who have not yet entered out-of-home care, but who are considered at risk of immediately entering a high level of care due to dramatic acting out behaviors.

Overall, respondents expected the majority of children to be able to successfully maintain lower levels of care with the assistance of the Wraparound approach. However, respondents also emphasized that for children considered to be the most difficult to serve due to extreme behavioral and emotional disturbances, an RCL 12-14 placement might be the most appropriate placement type if stepping down would result in placement failure. For these youth, creating stability of care would be considered a successful outcome. In contrast, the expected outcomes for youth in this sub-group who are in the control group would be to move in and out of high levels of care more frequently.

Pre-Implementation

Intake Process. Focus group participants described two principal methods by which they planned to identify and enroll eligible youth for the study. The first level of screening that the county has planned is to survey case-carrying CWW's in the group homes unit. The PD CWW will describe the project to workers in the unit, informing them of the criteria for participation and what services would look like. Respondents were hopeful that these CWW's would identify children on their caseload who fit the PD profile. The PD CWW will then request supporting documentation, such as a psychological evaluation, IEP, and court report, in order to move the cases through the screening process. After consulting with a co-screener at one of the provider agencies, the PD CWW will forward the referral to the county Placement Assessment Team (PAT). PAT is comprised of DCFS and mental health administrators, responsible for the final approval of PD cases.

After gaining informed consent from either parents and/or the courts, the case will be transferred to Flexcare following an assignment to the treatment group from the UC Berkeley randomization process. Respondents indicated that they have already identified the first wave of youth to be enrolled in the study.

In addition to targeting youth who are already placed in congregate settings, the county and its Flexcare partners plan to screen children and families in the "front end" of the system, who meet behavioral criteria for the project. Respondents hoped to streamline eligibility processes so that they could serve this sub-section of the population following the detention hearing but preceding the lengthy jurisdictional hearing process which typically takes four to six months due to continuances. The county is currently in the planning stages of creating a front end referral system.

Difficulties/Solutions. Respondents discussed the complications with Probation involvement in the study. While the Department of Probation (DOP) was involved in the initial planning stages of the project, the lead person from DOP is no longer at the agency. DOP is not currently participating in ICPC, and has recently expressed resistance to participating in the project due to the need to separate out IV-E eligible youth. Currently there is no plan to serve probation youth in PD because there is no intake mechanism for entering them into the study.

Funding. The funding structure for PD is based on the capitated rate model developed for the original AB 1741 waiver. The initial rate will be set at the level of the original PD group. The capitated rate will be adjusted periodically based on the look-back costs of the control group. This continual adjustment process will ensure the cost neutrality of the project. Unlike the original PD funding model, mental health costs (EPSDT expenditures) will not be factored into the capitated rate.

The programmatic correlates of this managed care approach to Wraparound result in an emphasis on continuing care beyond the point when a child is returned home, or dependency is dismissed. Once a child enters the study their treatment costs are factored into the capitated rate whether they step up or down. This extended treatment approach allows the providers to continue services after a child returns home in order to prevent them from bouncing back into the system. Respondents were hopeful that, over time, the capitated rate would prove a cost-effective method to improving long-term outcomes for children and families. Focus group participants expressed

concern that the evaluation would need to compare counties on both fiscal and child welfare outcomes criteria.

Staffing

Though the county currently has one PD-dedicated CWW, respondents anticipated that a separate unit will be built to carry PD-only cases, beginning slowly with two CWW's and a supervisor. It may not be a full unit of case-carrying workers, but there will be a supervisor designated for PD. There is also an administrative staff person that oversees the project, as well as ICPC involvement. Relative to previous pilot projects that the county has undertaken, there are more staff dedicated to the IV-E Waiver Demonstration Project.

Each of the three private Flexcare agencies has a separate programmatic structure specific to PD. While each agency employs a slightly different configuration, each agency has some combination of MSW-level casemanagers, also known as facilitators or liaisons, BA-level support counselors, and administrative project coordinators. For children who are already in the provider agencies' residential treatment programs, or who enter these programs, PD case managers will maintain the cases just as if the child were entering another provider's foster family agency or group home. At one of the agencies there is a liaison working between the residential and PD components so that children entering PD through residential will not have to have a new casemanager.

Providers expected that as the project ramps up they will need to hire a substantial number of new staff in all positions in order to be able to keep up with the continuing enrollment process. With continued growth, the providers may consider hiring an administrative coordinator for the three agencies, or creating a separate Flexcare non-profit entity. Providers also emphasized the need to establish relationships with other providers in the community, particularly for services that the agencies do not provide themselves, such as certain age-specific components.

Training. The county and Flexcare have put on a training series for staff from both the public and private agencies primarily as an educational tool about what the program is. Respondents recognized that ongoing outreach and training for county workers would be particularly important for maintaining a referral network. Respondents hoped to engage CWW's from both the front and back ends of the system so that they are aware of how the program could potentially benefit their clients.

2001 Process Study

Target Population

The target population has shifted from children residing in RCL 12-14 placements to include those at risk of that placement level. The original Project Destiny (PD) pilot targeted only youth who were already placed in the most restrictive settings. With the IV-E Waiver, the county intends to use PD not only as a means of stepping children down, but also as a preventive measure for those children whose characteristics indicate that they are on the pathway to residential treatment. Respondents hoped to be able to serve this "at risk" population in a more holistic way through intensive services as a method to prevent placement in a residential facility.

Focus group participants described the reason for targeting this population as both fiscal and clinical. From a financial standpoint, the county would like to be able to find cost effective methods of improving outcomes for children who require the most intensive placement levels.

Clinically, respondents hope to use the Wraparound approach to facilitate stability in the most family-like settings possible for children who would otherwise be placed, or have already been placed in an institutional setting that doesn't allow for children to form long-term healthy attachments.

The selection criteria for children to be considered eligible for PD services are centered on behavioral elements that indicate the need for intensive services. Children eligible for the project require 24 hour supervision due to safety concerns; intensive services are required for more than six months; children have experienced frequent and multiple placement disruption. These children must display at least one of eight behaviors including: physical aggression, fire-setting, sexual acting out, excessive running away, truancy, property destruction, and behaviors resulting in hospitalization. Children must also live within an area that is reachable by Flexcare staff—within an hour and a half—in order for service provision to be feasible. Though having an identified caregiver is not a criteria for a child's participation in the study, respondents indicated that PD services would not begin for a child who had a temporary placement such as hospitalization until the child was moved to a more permanent placement. Even if the child was subsequently placed in a group home, PD would then begin by engaging adults at that placement, and anyone that the child considers to be family, to make a service plan for the child.

Implementation

Intake Process. The process for entering a child into the study begins with an initial referral from the case-carrying child welfare worker (CWW) to a screener within the Department of Children and Family Services (DCFS). Upon determination that the child meets county criteria for enrollment, the Flexcare providers then review the case and either accept or reject it based on the same criteria used by the DCFS screener. For approved cases the county then seeks informed consent either from the parent or legal guardian if appropriate, or through an ex parte court order approved by the judge in cases where parental rights have been terminated. The case is then sent to UC Berkeley for random assignment. For cases assigned to the PD treatment group, the case is then transferred to Flexcare and the CWW is notified of the transfer. The county Project Destiny Intake Coordinator is largely responsible for moving the case through each of these steps until Flexcare takes over.

On the provider side, cases are then randomized among the agencies to make sure that each agency has an equally difficult caseload. Providers agree on exceptions to their internal randomization process, such as staffing shortages in a particular agency, keeping sibling groups together, or a strong relationship between a child and one provider. Respondents reported that the first contact with the child and/or caregivers is typically made within a week of the initial referral. If contact cannot be made within that timeframe then the provider notifies the county. In the mean time, provider agencies review the case, get additional consents needed for case management purposes, and locate the child, since placement changes occurring since the initial referral are commonplace. The Flexcare case manager then sets up the first meeting with the child and other relevant parties such as group home staff, family members, or foster family agency providers. The first Child and Family Team (CFT) meeting occurs within a month, though it is done as soon as possible given scheduling difficulties of setting up this first meeting time.

Child and Family Team Process. The CFT consists of the child, Flexcare case manager, and whomever the child identifies as their family. Respondents indicated that this can be difficult at

times because group homes can limit the people with whom the child can maintain contact. Sometimes the adults in the child's life that are part of the CFT are group home staff or Court Appointed Special Advocate (CASA) volunteers. The CWW makes sure that court documents are complete and that safety needs are being met. After participating in the initial CFT meeting, the CWW attends CFT meetings quarterly, though they continue to collaborate with the Flexcare case manager through cross-operational meetings. The CWW gives final approval for the service plan developed by the CFT and Flexcare.

The structure of CFT meetings typically includes an agenda with room for CFT members to add items. However, respondents reported that the family's level of involvement in the process also determines whether a formal or informal meeting structure is more effective. Though families participate in the project voluntarily, respondents emphasized that their involvement in child welfare is involuntary, leading to highly variable reactions to PD involvement and processes.

During the first meeting, the facilitator begins by explaining the role and purpose of PD, and what the family and team members should expect, and what their individual roles are in creating and implementing the service plan. Team members then go through the process of identifying child and family strengths, developing initial goals, and determining what other people they want to be part of the CFT. The team also identifies child needs among different life domains, such as school and health. A child safety plan is also created during the first meeting in order to plan ahead for a crisis situation and to assess current safety issues. Emergency 24-hour contact information for PD staff is also distributed to family members.

CFT meetings typically take place on a monthly basis though they may occur more frequently during crisis periods. Meetings may decrease over time if the child and family are stable.

Flexible Funding Pool. According to respondents, compared to other program components in each of the Flexcare agencies, PD staff are more aware of the cost of treatment decisions because of the fiscal and programmatic integration inherent in the PD model. As the project has grown, and roles have become increasingly differentiated (program directors also carried cases during the pilot project), respondents speculated that staff have become less aware of the impact of individual child costs since there is a larger pool of money to work with overall. PD case managers are aware that the availability of resources in the flexible funding pool is contingent upon controlling the costs of treatment, but they would not make a treatment decision based on fiscal reasons when it is not in the best interest of the child.

There is no set amount of flexible funding for each case, as individual child and family needs vary. Flexible funding has been used to buy cars for families, to pay rent, for additional services outside of PD, and to supplement income. All flexible funding requests go through an approval process to ensure that flexible funds are used in a manner that is supported by the treatment plan. Fund requests over $500 must be approved by the program director. Respondents emphasized that using the flexible funding pool to assist families also has to be balanced by a plan to facilitate transferring responsibility back to the family so that they do not become reliant upon these additional funds. The risk of creating reliance upon the flexible funding pool is evaluated within the context of the family's service plan and immediate needs.

In the PD model, children and families would continue to be included in the capitated rate even if dependency were to be dismissed. The size of the flexible funding pool available for families with high cost needs is therefore somewhat reliant upon the diminishing cost of treatment for some children and families over time.

Services. Respondents reported that it was initially difficult for PD staff to think creatively about services outside of the standard options of foster care and residential treatment. Staff have now adjusted to applying flexible funds to creative services plans. In contrast to treatment planning in group homes, the parent perspective is incorporated into the PD service planning process even when the child is not residing at home, allowing the parents or caregivers to become re-involved in the child's life situation.

While services are highly individualized and determined by the CFT, common services have included 1-1 support in school, at home and in the community; supervising and coordinating family visits; parent education on behavioral management techniques; linking children to after-school activities; concrete assistance such as rent payment; advocacy in the school system, and traditional mental health services. Flexcare works in partnership with families to determine what services will be responsive to their needs. Sometimes Flexcare performs a coordination role to facilitate improved services that are already in place. For example, a support counselor met with professionals at one child's school to determine what interventions could be used to assist the child in that setting. The support counselor also provided 1-1 support for the child in school to help target anxiety symptoms and to identify solutions within that setting that the child could draw upon when experiencing distress. A large proportion of case management time is spent locating and stabilizing placements.

Funding. The funding structure for PD is based on the capitated rate described previously, which will be adjusted every six months to reflect the cost of the control group. Cost neutrality is therefore interpreted as paying Flexcare the same amount that the county would be paying otherwise if the PD children were in the control group. The county pays Flexcare a per child rate that PD uses to pay for the cost of placement and services for children in the treatment group. Children are only excluded from the capitated rate if the family withdraws from the project, or if the child is placed in a long-term psychiatric care facility for two months or more.

Funding for the control group is based on the standard child welfare allocation, which is determined by the cost of out of home care placement type. Respondents reported that they are still ascertaining possible hidden costs associated with the control group that should be included in the capitated rate. Participants indicated that mental health funding (EPSDT) is the only outside source accessed for supplementary funding for both the experimental and control groups to the extent that providers bill for mental health services. Flexcare also shares a small grant to help with the administrative costs associated with the project.

Case Closure. Due to the reinvestment model of PD that necessitates lower cost clients remaining in the project, there are no PD discharge criteria. While the goal of PD is to assist families in becoming reliant upon natural support systems rather than the PD professionals, cases are never closed from PD even when dependency is dismissed—families remain in the project until the IV-E Waiver sunsets. In cases where dependency has been dropped, respondents have observed families demonstrating an increased sense of control over their situation. With continued PD involvement, these families utilize services less frequently and determine on their own when to access PD assistance.

At this time, it is unknown how long it will take for children to be able to transition safely to family-like settings, given that their behaviors at the time of enrollment require or are anticipated to require the most restrictive residential placement levels for one to two years. Even once children step-down from high levels of care, it is anticipated that intensive PD involvement will

be needed to support these types of placement transitions. The first wave of children to enter the study in 1999 continue to require PD intensive services.

Supervising and Monitoring. At the case level, the CWW provides oversight, ensuring that court orders are followed and that any crisis situations that arise are resolved. Though the Flexcare case managers are responsible for the day to day work with the children and families, CWW's play a consultative role, participating in the decision-making process when necessary.

As PD has expanded, respondents reported that the administration is less involved in the day to day program operations, but that issues affecting staff at the line level become policy discussions at the CEO's meeting (meeting between Flexcare CEO's and county administration). For example, staff expressed concern upon learning that, after a period of time, Flexcare doesn't get paid for children while they are AWOL, even when staff continue to work with the youth while they are technically out of placement. This concern became a policy level issue for the county and CEO's to resolve.

Attitudes. Respondents reported that direct care staff are highly invested in the program, in part because of the excitement of working within a new service model that they have a chance to shape and mold into a program that provides better services for this population. However, focus group participants also noted that burnout is a big concern for the Master's level Flexcare staff in particular because they are playing so many roles with few natural boundaries due to the nature of Wraparound. Some participants felt that it was important to consider delegating increased responsibilities to paraprofessional support counselors to alleviate some of the stress placed on Flexcare social workers.

On the county side, respondents reported that the experience of inviting families to participate in the project was a transforming experience for parents who have felt shunned by the system. Even if the case is subsequently assigned to the control group, the process of having a role in the child's life, even just being asked for consent to participate in the study, opened up the door for some families to re-engage with the child welfare agency.

Difficulties/Solutions. Respondents reported contending with difficulties in several key areas. First, developing processes for informing eligibility about how to calculate foster care payments for PD children in various placement settings lagged behind project implementation. Respondents have had to create policies to address the confusion that arises in eligibility based on the various PD scenarios that emerge. For example, due to the capitated rate structure, a child who is placed at home under PD would still have a foster care payment associated with their case, whereas in standard child welfare, payment would stop. The capitated rate has also led to philosophical debate about the appropriateness of keeping children in the project for funding purposes even if they are not able to receive services because they are placed in juvenile hall or are AWOL for an extended period. Due to the limited capacity of PD, an argument was made to exit children who AWOL for some period of time, so that a child can be brought into the study who could benefit from the services. However, this argument is balanced against both the program's unconditional care philosophy and the fact that it retains legal responsibility for the child even while they are not physically in the program. Focus group participants thought that the resolution would come from the need to have the same payment standards for the PD group as the control group in order to maintain the integrity of the fiscal model. Respondents are still determining how to resolve this issue from both a programmatic and fiscal standpoint.

A second difficulty reported by public child welfare representatives has been the process of redefining the roles of the public agency staff. Though mutual collaboration has been a strength of the project, the county has struggled to develop procedures for overseeing this new type of service model. Lines of responsibility have been unclear at times, such as what must be documented, and which aspects of case management will be taken on by Flexcare staff versus still require CWW involvement. This temporary role confusion has been tempered by an overall shared belief among most parties that PD will ultimately lead to better services for children.

Third, developing collaborative relationships with other providers has been challenging on several fronts. The Flexcare providers reported difficulties in finding placements for the portion of children for whom they are unable to care for in their own agencies as a temporary solution. For example, one agency does not serve latency age children, and was unable to work with FFA's to accept some of the children they were looking to place. The lower level group homes proved more amenable to accepting intensive needs youth with the additional support of PD services. However, the relationship between PD and non-PD group homes has at times been tenuous—group homes staff and administrators are sometimes wary of being scrutinized by an outside agency. Focus group participants emphasized that developing relationships with the group homes staff depends, in part, on the approach of the Flexcare case manager. Relationships have been more cooperative when the Flexcare staff respect the group home structure and align themselves with the adults caring for the child rather than overriding disciplinary consequences, or other group home activities. At times tension has been somewhat inevitable when PD has had to make reports to Community Care Licensing. PD has also tried to work directly with group home providers to address problems with the care being provided for children.

Interestingly, PD participants also noted that they sometimes prompt staff in the Flexcare agencies' own residential programs to think in a more family-based context, particularly when it comes to PD children placed in Flexcare residential treatment. PD administrators hold the other programs to the philosophy of engaging the family rather than viewing the child as the sole treatment focus.

Finally, contending with disparate philosophical views about the role of biological families in the child's care between PD and other providers has also resulted in tension at times. Respondents felt that some FFA's and group homes frequently view biological parents as the problem, not a potential means to a solution for the child's long-term prospects. Participants speculated that negative attitudes towards biological families are a result of the fact that these providers' daily work excludes parental contact; they view treatment in the context of the child whose problematic behaviors are attributed to poor home circumstances. Given the central focus on the child, there is no exposure to biological family strengths. To contend with these differing perspectives on family involvement, PD staff continually educate and engage providers as to the goals and purpose of the Wraparound process, and the importance of viewing biological parents as a resource and a potential caregiver for the child when appropriate.

Status. Respondents reported that the program is well established and functional, though the nature of the services being provided is somewhat lacking in structure. Since services are highly individualized and every family situation is different, the program is still finding new approaches to providing and facilitating treatment. The program has proceeded without certain policies in place, resulting in a reactive county response to develop procedures where necessary.

Staffing

The individualized and flexible service approach of PD has led to new roles for both families and staff in the treatment context. Flexcare staff have multiple roles and responsibilities in coordinating care, facilitating case plans and responding to crises, to name a few aspects of the Master's level position. Respondents speculated that the intensity of the service model coupled with the new and multiple roles that Flexcare case managers assume puts them at risk of burnout. To cope with the demands of the job, staff have to create personal boundaries for themselves in order to preserve their personal lives outside of the project. For example, one respondent reflected that she refrains from checking her voice mail on weekends in order to take care of herself and to remember that the role of PD overall is to become less involved, not overly-involved in families' lives, barring the occurrence of a crisis situation. To learn these multiple roles, respondents indicate that there is a certain portion of the job that cannot be trained formally but is learned through experience. Beyond the philosophy, much of the approach cannot be manualized due to the variability among family situations and the fact that the family drives the process as well.

The professional structure in each of the Flexcare agencies is configured somewhat differently. In general, the Master's level social worker does case management, therapy and sometimes facilitation. Paraprofessional support counselors, typically Bachelor's level staff with experience in the field, provide 1-1 support for the child in various community settings. Some agencies have a facilitator that does not carry cases, while others use case managers in this role (case managers do not facilitate CFT meetings for their own cases). Two agencies have a community resource specialist who develops community-based resources and activities for children and families and performs some case management responsibilities.

Though numbers of staff per team differ across agencies, in general there are teams comprised of social workers, support counselors, a program coordinator and clinical supervisor (in some agencies). A program director and/or clinical director oversee day-to-day project operations. The staffing configurations have changed over time as the program expanded and more administrative oversight became necessary. Some roles have also required increased differentiation due to the volume of work that became associated with any one position. Respondents emphasized that the program structure is somewhat theoretical, since none of the programs have been fully staffed. Respondents attributed staffing shortages in part to the difficulties in keeping pace with the monthly expansion in the number of children entering the project. The rate of enrollment into PD is based on the number of available slots designated for Alameda County in conjunction with a PD policy decision that children and families will receive a minimum of two years of services.

Individual supervision is provided for all staff in the Flexcare agencies, though the supervisory structure differs across agencies. Both individual and group supervision is seen as necessary because though staff largely work in isolation in the community with no apparent institutional boundaries, there are issues that transcend individual family situations. Common experiences are also used as examples in staff-wide trainings. Supervision is also viewed as a means of getting support in an extremely demanding work environment. Respondents reported a strong feeling of cohesiveness among their teams. Staff share experiences and frequently consult with each other informally as a means of getting support and a different perspective on the issues at hand. Administrators also build in staff retreats and other formal events to promote positive working relationships between and among teams.

Inadequate staffing has plagued the private agencies during expansion periods, as shortages in both the Bachelor's and Master's level positions have presented barriers to implementation. Respondents attributed staffing problems to a combination of the difficulties in recruiting a significant initial applicant pool due to economic factors, the demands of working within the Wraparound intervention, and high turnover rates. Recruitment became especially difficult when Alameda County raised its compensation package for CWW's, and the private agencies could not offer similar benefits. High turnover was attributed to the demanding nature of the work coupled with the wide availability of other MSW-level jobs. Respondents lamented that the inability of the Flexcare agencies to retain a core group of staff has led to a program that lacks cohesion, making optimal service delivery a challenge. Turnover is particularly damaging given the nature of the attachment problems that many PD children exhibit. When a case manager leaves after six months, the child does not always want to engage in the process of trusting and forming a new attachment.

Respondents also reported that they have had a difficult time recruiting a diverse workforce reflective of the population served by PD. In addition to a small proportion of people of color on staff, respondents noted that the professional teams are largely characterized by young staff that do not yet have families of their own. Respondents noted that the ability of the case managers to relate to the difficulties of parenting is inhibited by their lack of parenting experience. However, the nature of the program and its demands for a flexible schedule makes it an unattractive position for parenting professionals, reinforcing the younger applicant pool who can adjust to the demands for flexibility.

On the county side, respondents noted the importance of consolidating all the PD cases amongst four PD-dedicated CWW's. This staffing configuration has improved collaboration with Flexcare, whereas previously not all CWW's knew what the program was, despite carrying a PD case. The CWW's are overseen by a CWW supervisor. Respondents reported that turnover has been an issue for the public agency as well, resulting in continually re-educating staff about the project.

Training. Staff from both the county and Flexcare, along with local group home providers attended a training series sponsored by the State. Each agency also provides ongoing internal training and participates in some cross-training between agencies as well. Internal training topics focus on thematic elements that staff will have to continually consider throughout their work with children and families in the community based context, such as boundary issues and working across cultural differences.

Client and Community Characteristics

Respondents noted that Alameda County's foster care population is largely drawn from an urban setting, though a large proportion of children brought into care have been placed out of county. Out of county placements have been a factor in implementation of the intervention because children must live within the vicinity of the county so that Flexcare can reasonably provide services. Children eligible for PD come from low-income households with complex family systems—families are typically struggling with multiple issues such as domestic violence and substance abuse issues that compound child abuse factors. The majority of the county's foster care population is African-American, in contrast with Flexcare's largely White professional staff. Respondents indicated that crossing cultural barriers to create a trusting working relationship between families and clients has been a critical factor during implementation.

Respondents named the lack of available low-income housing as the most salient feature at the community level inhibiting the success of the Wraparound intervention. Adequate housing is a particularly critical issue given that it is a requirement for parents to regain custody of their children. Community violence is another factor that both clients and staff must contend with. Flexcare takes the necessary precautions to address safety concerns for both children and staff while in the community. For example, staff carry cell phones at all times, and more than one staff may be sent on a home visit when needed. Lastly, focus group participants described a somewhat problematic relationship in working with local school districts. Some difficulties have stemmed from the fact that PD serves clients across a scattered geographical region with multiple school districts, thus limiting Flexcare's collective ability to form intensive working relationships with a particular fixed set of school districts.

Agency Factors

Respondents reported that county administrators are very supportive of the program—ideally they would like to be able to expand the program to the larger foster care population. Administrators are also aware that some children are inappropriately placed in high levels of care when no other placement options are available. On the county side, balancing the demands of a new project such as PD with the numerous mandated programs is always a challenge, especially because it requires sufficient staffing to be able to reduce caseloads for staff associated with one small project. The county has experienced significant turnover at the administrative level, with recent changes at the director, and program manager levels, along with a new supervisory structure. Turnover among CWW's is also problematic at the county, necessitating continual re-education about the PD intervention. Much of the public agency's efforts are currently focused on resolving its order of Division 31 non-compliance issued by the State. This extra strain on all county child welfare units potentially saps energy away from the project.

At the private agencies, programs operated within a single agency are all in competition for the same staff. To some degree, the agencies' own needs to ensure that all of its programs (residential treatment, day treatment and school-based programs) remain viable interfere with optimal implementation of the project. Conversely, agencies also reported that their other programs have been informed by the Wraparound approach—the agency's identity as a whole has shifted to incorporate the principles of a community-based approach, despite funding limitations that prevent its operationalization in other programs.

Political Factors

A continual influx of new politicians, administrators and staff necessitates that the county continually educate these stakeholders about the project. Respondents also reported that there is a new pressure and frenzied atmosphere about PD at the courts because there is frustration that the intervention cannot be accessed by all the families that could potentially benefit from it.

Evaluation Factors

Some case-carrying CWW's are initially resistant to randomization. However, the Intake Coordinator, who has contact with all CWW's referring potential cases to the study, explains the need for a comparison group and effectively quells concern among CWW's.

2002 Process Study

Target Population

Alameda County Wraparound continues to target children who are currently in an RCL 12-14 placement, and children at risk of entering this placement level or psychiatric hospitalization. For example, children who are disrupting in current placements are targeted because they are likely to move to a higher placement level. Though the whole family is taken into consideration during the referral process, the criteria for acceptance into the project rests on child-centered criteria. The program expects to serve children with severe emotional disturbances who tend to require a disproportionate amount of the referring CWW's case management time. Family involvement is not a criterion for program participation. Children with no identified caregivers may be in even greater need of the type of services offered through Wraparound. Respondents indicated that the role of Wraparound is to identify a caregiver for the child if none exists, and they look to create a family for the child in the absence of identified relatives.

Respondents reported that there is some bias as to who is referred to Wraparound due to the fact that the project is located within the group homes division of the Department of Children and Family Services (DCFS). As a result of this co-location, referrals are actively solicited from group homes unit CWW's, leading to fewer children enrolled from other family services divisions. Focus group participants felt that the project could benefit from more concrete selection criteria to minimize the discretion among intake workers as to who is recruited for participation. Respondents indicated that not all CWW's are aware of the program. Some CWW's find out about the program because they have a child on their caseload whose sibling is already enrolled in the project, therefore entitling that child to services.

Implementation

Intake Process. To refer a child for Wraparound, the case-carrying CWW completes a screening form that is then submitted to the decision-making body, the Interagency Placement Review Committee (IPRC), that determines whether or not the case meets criteria for Wraparound. The IPRC is comprised of representatives from the county and Flexcare providers. Once the case is accepted, the county then determines eligibility in consultation with Flexcare providers. Following randomization at UC Berkeley, cases assigned to the treatment group continue to be randomly assigned to one of the three Flexcare agencies. Respondents indicated that the expected time frame for services to be initiated remains the same—seven days from the time that the provider is assigned the case.

Child and Family Team Process. The size of the CFT depends on the family's preferences. Some prefer to have neighbors, church members, teachers and other community supporters involved, while other families prefer to limit the involvement of outside people. Professional staff membership on the CFT includes the Flexcare team leader (also called the case manager, liaison or care coordinator), 1-2 support counselors, the county CWW, and a community resource person (some agencies).

Services. There is no expectation for the length of time a child should receive Wraparound services. Since families are not exited from PD due to the fiscal model, families whose needs diminish over time receive fewer services when the CFT determines that tapering services is appropriate. Eventually these families may be seen as seldom as once per month. The fact that they are still part of PD allows families to access services should a crisis occur, but without

mandating them to maintain a high level of unnecessary involvement with professional staff. County respondents viewed this arrangement as somewhat problematic due to the fact that they continue to pay Flexcare the full capitated rate for services that may only amount to a monthly visit. Respondents were also concerned about the lack of incentive to close cases resulting from the fiscally driven program model.

Funding. The program continues to operate under a managed care model whereby Flexcare receives funding for placement and services for the treatment group that is equivalent to the cost of the control group. Service decisions are based, in part, on the level of funding received by the agencies. The funding for the PD group is scheduled to be adjusted every six months to reflect the control group costs. County respondents expressed concern that the model does not sufficiently encourage improved child welfare outcomes such as dependency dismissal since children remain in the funding pool no matter how low their need for services. Additionally, respondents indicated that funding children in PD after dependency is dismissed may present an issue for cost neutrality because children in the comparison group are not funded post-dependency.

Case Closure. Cases are closed from PD when no contact has been made between Flexcare and the child for two months. Lack of contact could occur for several reasons: the child is AWOL, hospitalized, placed in juvenile hall, or placed in the county's psychiatric treatment facility. Families can also voluntarily withdraw from the project, with no mechanism to reenter. Adjudication into the juvenile justice system may lead to dismissal from PD, as would aging out of care. In the case of dependency dismissal a child would still receive some Wraparound services.

Children in the comparison group no longer receive services following dependency dismissal or emancipation.

Supervising and Monitoring. At the program level, county and Flexcare administrators meet every other week. There are also weekly meetings to review new intakes and case plans. Policy and program issues continue to be reviewed monthly at the CEO's meetings. Informal interactions also allow the county to monitor program implementation. Each Flexcare agency also has monitoring and supervision mechanisms in place, such as regular case reviews.

The county currently does not have the resources available to monitor the project to the degree that they would like to be able to. As a result, they are not able to assess the benefits that may or may not be accruing from the program. The county only has information about the number of children served.

Attitudes. On the county side, the project has met with mixed reactions from administrators, supervisors and staff. New administrators are not yet familiar with the broad vision of Wraparound, and there is no data available to support or refute the program's success. As a result, staff at all levels base their opinions somewhat on anecdotal outcomes. Line staff directly involved with the program are supportive of it, and others seem to have a positive attitude toward the project, though many staff are still not aware of its existence. There is some question as to the benefits of the fiscal model, though there is overall support for the program's philosophy and the partnership with providers.

Difficulties/Solutions. Respondents bemoaned the lack of overall vision guiding the project's implementation for the county. It has been difficult to maintain the momentum necessary to

retain a high level of support for the project with so much turnover at the county. There has also been a limited sufficient county infrastructure built in to monitor and evaluate the project as it progresses. Without evidence of PD's success it has become increasingly difficult to rally enthusiasm for the project among newer workers. Respondents estimated that approximately 80% of the county's staff have been with the county for two years or less. Many of the original proponents of the project are no longer with the public agency, and newer administrators and staff have not embraced the project as their own. The fiscal person, who was the strongest proponent of testing the managed care model, has left the county. As a result, respondents reported that the fiscal model has not yet been fully implemented. Marketing PD within the county has been one of the major difficulties for the county during implementation.

For Flexcare, staffing continues to be the most formidable barrier to implementation. Agencies are challenged to find staff who are experienced enough to be able to take on the leadership role required by the team coordinator role, able to work in the community rather than an agency setting, and willing to work with the intensive needs population. It has been difficult for providers to match the experience required to assume this level of responsibility with staff who are not too entrenched in operating under traditional service models. Building team cohesion has been a crucial means of addressing some of the staff burnout concerns such as feelings of isolation and a sense of being overwhelmed by the responsibilities associated with working under this service model.

Status. The regularly increasing enrollment has stretched the capacity of both Flexcare and the county to keep up with the demands of the expanding project. For example, on the county side, determining eligibility for a growing number of children is a time consuming process. Also, the PD-dedicated CWW's are unable to be regularly involved in the CFT process. Some county respondents also felt that additional providers should be brought on board rather than relying solely on the three Flexcare agencies.

Staffing

Flexcare agencies have retained the same general professional team structures, with a team coordinator (also called a liaison or case manager), support counselors, and community resources person. The coordinator takes on the majority of case management responsibilities that the county CWW would normally assume, with the exception of approving visits and maintaining court contact. The coordinator may or may not also conduct individual therapy sessions with the child. The CWW peripherally supervises the case, and provides guidance and consultation, particularly as it pertains to legal child welfare issues.

CFT meetings are run by a Master's level facilitator who is not a member of that team. Support counselors work intensively with the child and family in the home and other community-based settings. The child may have an outside therapist or a therapist provided by the Flexcare agency—either the coordinator or another social worker. Respondents emphasized the importance of the team structure, frequently comprised of 4-5 staff, in providing and coordinating comprehensive services to the child and family.

Agency Factors

The strong momentum created by the coalition of County Board members and ICPC representatives that backed the project's initial stages has waned as turnover and competing priorities have chipped away at the county's overall support for the program. Respondents felt

that without widespread support and buy-in from DCFS and other county entities that the project has come up against resistance both programmatically and philosophically. The lack of priority given the project has undoubtedly affected implementation.

Political Factors

Alameda County's relationship with the State coupled with the current threat of State takeover due to Division 31 non-compliance have limited the amount of attention and resources that can be directed to PD. The Board of Supervisors originally demonstrated a tremendous amount of support for the project. Respondents felt that while the Board still believes in the project, their support is now less substantive or visible.

2003 Process Study

Target Population

The emphasis on target populations has shifted over time from children residing in RCL 12-14 group homes to children at-risk of such placement. Respondents reported that this shift in focus was anticipated, as the population of children residing in RCL 12-14 group homes was relatively finite and the program would eventually reach a point of saturation in reaching children in this population.

Implementation

Intake Process. Beginning in January 2002, Alameda County implemented changes to enhance the structure of the intake process in order to strengthen the fiscal and programmatic eligibility determination. Changes were implemented primarily to reduce complex payment situations necessitated when fiscal eligibility had not yet been determined. County CWW's continue to make the original referral, completing a packet of information as they would for a more routine placement recommendation. County child welfare supervisors have placed a greater emphasis on securing the referred child's eligibility status. The process now includes a case assessment by the Interagency Placement Review Committee (IPRC), the body charged with reviewing eligibility for RCL 12-14 placements. The IPRC is staffed by representatives from Alameda County's Department of Children and Family Services (DCFS), Department of Behavioral Care, and Department of Probation, along with representatives from Flexcare (Seneca Center, Fred Finch Youth Center, and Lincoln Child Center), and Stars Behavioral Health Group. Upon IPRC approval, the referral is sent to a PD review committee to determine whether the case meets Project Destiny eligibility criteria. Approved referrals are then sent to UC Berkeley for randomization.

Respondents reported that the enhancement in the process has had a number of effects. First, the amount of time from initial referral to random assignment has increased from approximately 1-2 weeks to approximately 4-6 weeks. Correspondingly, some respondents felt that the new intake process and the length of time needed to determine fiscal eligibility has slowed the rate of enrollments. Second, the new intake process has limited the amount of the direct contact previously enjoyed by DCFS and Flexcare representatives. As a result, representatives have found it necessary to work harder to maintain their avenues of information sharing.

Child and Family Team Process. According to respondents, there has been an increased focus on the development of a child safety plan during the CFT meetings, along with an increase in the frequency of meetings. One Wraparound provider agency has implemented the use of a grid-

template in CFT meetings as way to organize goals, responsibilities, and tasks and has found it useful at keeping team members focused on making progress. Additionally, providers have found that the CFT is more productive when the responsibility for scheduling team meetings is not left to the family. Team facilitators have also become more mindful of the length of CFT meetings and have made efforts to keep them on-task and focused on the main issues.

Case Closure. Unlike the Wraparound models used in other counties, DCFS and Flexcare do not close a child's case for Wraparound when the child's court dependency ends. The fiscal model of PD necessitates that children exit Wraparound for a limited number of reasons, including AWOL status for two or more months, the child becomes a Section 602 ward of the court (Welfare and Institutions Code), the child reaches age 18 and will not complete high school or a GED by age 19, the child reaches age 19, or the child's court dependency is transferred to another county or state. Children whose court dependency has ended, or whose families have attained a level of self-sufficiency that allows for minimal Wraparound team involvement, continue to be part of the funding "pool" in order to offset the service expenditures of children who have greater service needs.

Respondents described a number of issues pertaining to the inherent tension between the fiscal model and the service model. Because a child stays in Wraparound for fiscal reasons (except in limited circumstances) the service model is not driven by the goal of removing the professional staff of Flexcare from a child and family's life, and may, in some cases, foster a certain co-dependent relationship between Flexcare and families. Additionally, an extension of the Title IV-E Waiver Project beyond its current termination date (September 30, 2003) that did not require the existence of a comparison group would weaken the logic for the fiscal model, as the comparison group determines the rate for the group receiving Flexcare services. If a managed care model was not maintained in another fashion (i.e., setting a capitated rate based on historical data) there would be less pressure to retain "successful" children and families in Wraparound as the offset they provide would no longer be needed. The service model could shift to one that was driven more by the desire to, over time, lessen the involvement of social service professionals in the lives of children and families.

Respondents reported that on a case-by-case basis, a case closed because of an AWOL status might be reopened and Wraparound reactivated if a child returns.

Children in the comparison group exit the Waiver Project when their dependency status is concluded.

Flexible Funding Pool. Respondents reported that the process for accessing funds from the small, flexible pool of funds used to make purchases for children and families has become more structured over time. Respondents described an increased effort to access other resources in the community, greater oversight in approving fund requests, and a greater awareness of the potentially enabling aspects of providing funds directly to the family.

Services. Respondents felt it was difficult to provide an estimate of the average length of time for Flexcare services given the number of variables involved in each child's situation. They described serving several groups of children: (1) children (and families) who were likely to need Flexcare services through age 18, (2) children (and families) who would stabilize fairly quickly and whose service needs would decline, and (3) children (and families) somewhere in between groups (1) and (2) whose service needs would likely fluctuate.

Respondents also reported that the service delivery approach had recently shifted from Flexcare staff providing certain services to retaining other social service providers or community members to provide the services. Respondents described how services such as tutoring, mentoring, shadowing, and transportation had become extremely time and labor intensive and that the Flexcare agencies did not have the resources to continue to provide these types of services without assistance from other organizations and individuals.

Supervising and Monitoring. Alameda County's implementation of the Waiver Project, according to respondents, is guided by the contract negotiated between DCFS and Flexcare. The implementation is supervised and monitored through a regular series of meetings, notably a monthly meeting of DCFS and Flexcare administrators that provides policy oversight and a biweekly meeting of DCFS and Flexcare managers responsible for policy implementation. DCFS and Flexcare representatives also convene meetings within their respective organizations.

Some respondents described a historical disparity between DCFS and Flexcare in the amount of focus provided to the project, due in part to size of the project relative to the other responsibilities of DCFS. DCFS representatives indicated that the agency would be very active in the project, reflecting the true nature of a partnership.

At the program level, respondents reported that each Flexcare agency and DCFS has a structure in place to supervise and support direct service staff through meetings and one-on-one contact. Flexcare agencies have a program coordinator (though the nomenclature is different across agencies) responsible for supervising the Flexcare teams. Weekly meetings are held to review cases. Staff working in a clinical capacity with children and families also receive clinical supervision.

Respondents reported that efforts were underway to increase contact across Flexcare agencies to encourage information sharing around working with children and families. Efforts were also underway to include direct service staff representatives in the biweekly meetings of DCFS and Flexcare managers.

Attitudes. Respondents were generally positive in their comments regarding attitudes toward the Wraparound philosophy, though their responses indicated a level of variability. Some respondents indicated that Wraparound was well-accepted, but that the acceptance was somewhat narrow; however, they reported that acceptance was growing as more people became aware of Wraparound. Respondents reported enjoying their jobs, participating in the Wraparound process, and feeling that they were being effective, though some expressed reservations about various aspects of the intervention program (e.g., its efficacy with particular sub-populations, general program improvements needed). Respondents also reported a certain amount of tension around the way in which Wraparound is being implemented in Alameda County—philosophical tensions that were more specific to the fiscal model and contracted case management than the merits of the intervention.

Difficulties/Solutions. Respondents reported a number of difficulties related to the managed care model used by Flexcare. First, the policy interplay between foster care funding and the Temporary Assistance for Needy Families (TANF) program has not been accounted for: the Flexcare model is designed to provide services to a child until he or she turns 18; however, should dependency end, there is a question whether or not a child and family remaining in Flexcare and receiving foster care funds are eligible for TANF. Second, respondents reported that the model creates a certain tension in making programmatic decisions, in that children

cannot be thought of independently, but as part of a collective. Third, some respondents expressed a concern regarding whether all costs for the comparison group can be accounted for, resulting in an under-representation of service cost and an inaccurate reduction in the rate funding Flexcare services. Similarly, respondents discussed the difficulty in projecting budgets, and planning based on those projected budgets, under the current structure.

There is sometimes a divergence in policy goals—difference in philosophy according to respondents—between DCFS and Flexcare. For example, is the goal of placement stability more important the restrictiveness of living environments; should a stable placement in a group home be disrupted to attempt a placement in a less-restrictive environment? Other tensions have emerged, such as the extent to which DCFS can turn over case management responsibilities (i.e., contracted case management) to Flexcare and, correspondingly, how much control does Flexcare receive for assuming fiscal risk. One struggle for DCFS representatives is the size of the project relative to the substantial number of responsibilities held by the agency; this issue, according to respondents, has on occasion left DCFS representatives feeling a step behind on some implementation issues. The agency has been making efforts to play a more active role in the partnership and assume a more active oversight function regarding case management.

Despite these tensions at the philosophical and policy levels, respondents consistently reported that functioning between DCFS and Flexcare at the programmatic level was going well. Respondents suggested that training for Flexcare workers on court issues and an increased amount of education provided to regular DCFS social workers would only enhance a solid working relationship between the two groups.

Similarly, respondents felt outreach and education to organizations outside of DCFS and Flexcare would continue to foster acceptance of Wraparound and the strengths-based approach to providing services. Respondents reported that the project enjoyed varying degrees of cooperation with the Alameda County Departments of Behavioral Care and Probation, along with the various county school districts, but that the lack of more concrete agreements with these organizations presented burdens to working holistically with children and families.

Flexcare has a symbiotic relationship with group homes that, according to respondents, has sometimes been troubled by philosophical differences about how best to work with children. A group home's activities with a particular child are generally based on the child's past behavior; Wraparound is not. Respondents reported that group home staff sometimes view Flexcare as being protective of the individual child, impeding the work of the group home and its more collective approach to service delivery for the children in its care. On a more practical level, group home staff sometimes simply do not know what Flexcare is, and are only aware that some of the children in their care are receiving something that others are not. In a small number of cases, this has resulted in the child being caught between two services structures, inhibiting effective service delivery.

Finally, despite the success of the three Wraparound providing agencies collaborating to form Flexcare while maintaining their independence, that independence can lead to non-conformity within the Flexcare model. Respondents indicated that families and group homes will sometimes request to work with one of the Flexcare agencies over another—something not easily accomplished—and that differences in terminology and procedures among the providers adds a perhaps unnecessary challenge to working with Flexcare.

Status. Respondents were generally enthusiastic about the status of their project, indicating that felt like they were in an adolescent stage of development. Some felt the programmatic side of the project was more mature than the policy side and that efforts were needed to bring the two in line with one another. Other respondents felt as if the project had been through the developmental process of forming, norming, storming, and performing several times. Respondents also emphasized the progress made between the Flexcare agencies to remain independent yet work as a collaborative. All of the respondents agreed there was still work to be accomplished to make the program more successful and operate more efficiently.

Staffing

Each Flexcare agency uses a professional team (different from, but part of, the CFT) structure consisting of MSW-level social workers (also known as care coordinators, liaisons, or case managers), support counselors, and community resource specialists. Social workers perform case manager/therapist/CFT facilitator functions as part of their duties, though not necessarily all functions in each case. Support counselors work directly with the child and family. Community resource specialist provides children and families with connections and access to resources in their community. The exact configuration of the professional team depends on child and family needs, as well as staffing constraints, but respondents indicated the optimal team structure would include 2 social workers with approximately seven cases each, two support counselors, and one community resource specialists. The support counselors and community resource specialist would be assigned across cases determined by need.

Respondents described a number of encouraging features related to staffing. First, respondents reported on the advantage of having DCFS social workers retain responsibility for only Flexcare cases. This policy has allowed for a greater consistency in care over time and was cited as a major part of the project that is successful. Similarly, the stability in the staffing of the DCFS positions has provided continuity for children as well as the program. While Flexcare provider agencies have experienced staff turnover (although, according to respondents, no more than other organizations doing similar work), the agencies now have a core group of staff who have been with Flexcare for several years. Fourth, participants cited the level of connectedness and commitment that staff from DCFS and Flexcare have for their jobs, and how that sense of commitment has assisted in the process of problem-solving.

Respondents also noted a number of issues related to staffing. Flexcare agencies continued to have difficulties in recruiting MSW-level case managers who are appropriate for the position. Working in Flexcare requires a particular skill-set not usually taught in MSW degree programs and does not offer the clinical hours opportunities sought after by social workers interested in attaining licensure. In addition, Flexcare agency MSW-level positions are relatively low-paying, making them less competitive in comparison to public agency positions. The disparity has adverse ramifications for staff retention and the ability of Flexcare to maintain a diverse staff. Flexcare support counselor positions (BA-level positions) are lower-paying still and experience turnover as individuals return to school for advanced degrees and the opportunity for higher salaries and responsibility.

In response to these issues, Flexcare agencies initiated a well-funded recruitment program and corresponding screening and hiring process to employ individuals who had the necessary mindset and skill-set to be successful. Respondents also proposed altering the Title IV-E child welfare training funds agreement to allow non-profit organizations the same access to candidates

afforded public child welfare agencies. Respondents also discussed the possibility of including Wraparound training as part of a MSW-level curriculum, as well as developing a more concerted effort to use non-BA degree individuals in certain positions.

Training. Program staff (DCFS and Flexcare) participate in trainings held once a month for two hours. Respondents cited a need for trainings for support counselor staff, clinical training, court issues, diversity training, and training in working with gay/lesbian/transgendered populations. Cultural/diversity trainings have been scheduled and will be held every 6 weeks. Respondents felt that the Flexcare training committee should increase its activities given the diversity of the client population, the non-traditional nature of the work, and the turnover of staff.

Client/Community Characteristics

Substance abuse—particularly crack cocaine and the laissez faire attitude towards preadolescents and adolescents smoking marijuana—was cited by respondents as a salient client issue. Respondents indicated that the lack of affordable housing was the primary community characteristic they contended with in their work. They reported having been unsuccessful on a number of occasions to create housing availability. Families often move to outlying areas that have affordable housing but move away from natural supports and into areas that often lack an adequate social service infrastructure and economy (e.g., mental health and health services, training and employment opportunities). Long travel times place an addition stress on Flexcare staff.

Respondents also spoke of the richness of resources in the immediate community and that staff only needed to get better at accessing them. Examples included the music industry, slam poetry events, and political action opportunities relevant to older youth.

Agency Factors

A number of respondents expressed a desire for DCFS to develop a Supportive Transitional Emancipation Program (STEP) in Alameda County to assist youth as they transition from foster care to independent living. Other respondents would like to see increased coordination between DCFS's program for kinship foster caregivers and Flexcare, and greater access to kinship program resources.

Political Factors

Respondents reported that Flexcare's relationship with judges from the family court system was improving. They also indicated that there would need to be sizeable political changes in the Federal government if the program hoped to be operating in five years.

Evaluation Factors

Respondents expressed concern about the use of random assignment in the evaluation. They reported that the frustration around candidates for Wraparound being assigned to the comparison group was a deterrent to the process of enrolling children and families into the project.

5.2.3.2 Humboldt County

1999 Process Study

Pre-Waiver Services

Intensive Services. Humboldt County representatives reported some experience providing intensive services, which respondents referred to as "little wrap". The program is similar in structure to Wraparound, though it lacks the flexible funding component. Through the Juvenile Crime Enforcement and Accountability Challenge (JCEAC) grant awarded to the Probation department for early intervention, agency administrators established multi-disciplinary teams (MDT) including members of the Departments of Social Services (DSS), Probation (DOP), Education (DOE), as well as community representatives. Driven by input from the community, the grant also established four neighborhood service centers, known as "hubs", where the MDT's provide services. The target group for this grant is youth below age 15.5 considered to be at risk of juvenile delinquency based on a set of four risk factors: family problems, school trouble, previous delinquency, or substance abuse problems. In order to be considered eligible, the youth must meet three of these four risk factor criteria. Schools, police or the youth's parents may refer a child to the program.

Additionally, the JCEAC grant is undergoing an evaluation with an experimental design. Accordingly, youth are randomly assigned to the control group, receiving a one-time consultation and referral service, or to the experimental group that receives services at the hub. Service type and duration vary based on the individual needs of both the youth and the family, as is determined by the family and MDT.

While the program's outcomes were unknown as of yet, respondents indicated that the team-driven approach that DOP employed under the JCEAC grant has changed the service orientation from a case management focus to a model where families are involved in their own case planning, and probation officers receive input from a team of professionals. This shift in service provision philosophy is consistent with the strengths-based approach that is an essential component of the Wraparound model.

Non-Intensive Services. Humboldt County currently places all children in need of residential treatment and therapeutic foster care outside of the county due to a lack of placement options within the county. Respondents indicated that non-intensive services are limited to foster care and standard child welfare services within the county. As an additional resource, respondents reported that mental health intervention teams comprised of a clinician and case manager provide services within the home in order to help stabilize a placement when possible.

Program Planning

Planning Group. The Intensive Services Program planning group began as a small team of public agency representatives within the Department of Social Services, which includes both Child Welfare Services and Mental Health. In response to the original members' recognition of the importance of collaborating with other public agencies, the group was expanded to include staff associated with the regional service hubs, including representatives from DOP, DOE, and other MDT members associated with the JCEAC grant. The planning group also presented the concept of Wraparound to community members, by holding community forums at each of the four hubs. Respondents were disappointed in the low turnout at the community forums, which were attended primarily by professionals rather than community residents. However, the group

hypothesized that turnout was low primarily due to the fact that meetings were scheduled during the day. While focus group participants stated a desire to include community members on the planning team, they indicated some hesitation in expanding the planning group in this manner due to a conflicting need for the group to remain small. There was only one member of the planning group, a Healthy Start representative, who was not associated with DSS or the other public agencies.

The planning group in its current iteration is known as the Humboldt Regional Wraparound Committee. This group is also the body that will coordinate implementation of SB 163, the State version of Wraparound, as well as continued planning for the hubs. Respondents indicated that this group, in a slightly different form, has had experience planning for other experimental and pilot programs in the County.

Planning Process. Planning for the Intensive Services Component of the Waiver began in November, 1998, with project implementation scheduled to begin July 1, 1999. The group conducts weekly planning meetings, which will continue throughout the implementation of the project. At the time of the initial site visit, the Humboldt Regional Wraparound Committee was in the process of considering how services would be provided. Respondents anticipated purchasing services from some MDT participants who are also services providers, as well as using flexible funds to purchase services through private community-based providers when county services are unavailable. Respondents also discussed the possibility of using the MDT's to serve as a liaison between the Child and Family Team (CFT) and community-based resources. The MDT's would assist the CFT in accessing needed services identified in case plans developed by the CFT.

Target Population

The target population for Wraparound services is children who are currently placed in out of county residential treatment programs, RCL 12-14, as well as children whose placements within the county are in jeopardy due to intensive services needs. Respondents also indicated that Wraparound services would be utilized as a buffer to support youth returning to a lower level of care within the county, for whom an out-of-county group care placement had been necessary. Participants indicated a strong desire to improve the public agency's capacity to support children within a therapeutic foster care setting within Humboldt County.

Pre-Implementation

Intake Process. Respondents indicated that they plan to use the Family Intervention Teams (FIT), the body that currently makes all out-of-county placement decisions, as the review mechanism for determining whether or not a case is appropriate for Wraparound. The FIT is comprised of the child's social worker, a child welfare supervisor, and representatives from the Mental Health and Probation departments. Following a review of all current out-of-county placements as well as case plans for children who have extensive placement histories, the FIT will make case by case placement recommendations.

Specifically, the intake process will build off of the county's current placement review process. The FIT typically reviews cases that the case-carrying social worker identifies as at risk of placement failure. Following this initial input, the FIT also considers the child's placement history, diagnosis, treatment reports, school records and other relevant information. In addition, the FIT uses formal assessment tools, such as the Achenbach Child Behavior Checklist to obtain

a standardized measure of the child's functioning. After considering all aspects of the case, the FIT makes a recommendation for the appropriate placement level and identifies the child's specific treatment needs. Through this screening process, children who are at risk of RCL 12-14 placement are identified. Additionally, the FIT team reviews each case currently placed out-of-county every three months; these cases will be considered for the study as well. Respondents suggested that permanency planning cases would be prioritized for Wraparound services because these children generally have the longest placement histories.

With the implementation of Wraparound, the FIT will implement an extra step, determining which of the intensive treatment cases are most appropriate for Wraparound, given the child's level of functioning and whether or not their needs could be met by the supplemental services available within the community and public agency. Upon determination that a case is eligible, County representatives will seek consent for the child to participate in the study, either from the biological family (if the case is in family maintenance or family reunification) or from the court in permanency planning cases. Once informed consent has been gained, county staff will refer the case to UC Berkeley for randomization.

While anticipating that some children will still require "high end" residential treatment, respondents were optimistic about the possibility of serving children in a therapeutic foster care setting with the aid of ancillary services made possible by the flexibility of Wraparound.

Supervision and Monitoring. The Waiver Project will be supervised by the planning group and a lead DSS Administrator. Additionally, the hubs will supervise service implementation at the program level, and will utilize Wraparound principles as guidelines for oversight. On a broader agency level, the Human Services Cabinet, comprised of the heads of each county department, will have project oversight responsibilities.

Difficulties/Solutions. Respondents predicted problems associated with the stress added to the hubs and the local school system as a result of returning intensive needs youth to the county. Given that the most "difficult" children are currently placed outside of the county, resources such as day treatment classrooms may become strained, resulting in difficulties meeting youths' educational needs and maintaining their behavior in mainstream classrooms. Additionally, respondents anticipated challenges in securing a sufficient number of appropriate placements within the county in order to accommodate a higher foster care population, when placement resources are already stretched thin. To address this problem, respondents indicated that efforts were underway to develop additional placements within the county, including an increase in utilizing kinship care as a placement resource.

In terms of inter-organizational relationships, respondents reported that the county department heads have set a standard for inter-departmental collaboration that has fostered a positive relationship between the various public agencies. While respondents indicated that there may be a need to set up a grievance process for consumers, they did not anticipate conflict between the public agencies that could not be resolved through the current channels used for problem resolution, specifically, inter-agency teams.

Staffing

The implementation of Wraparound in Humboldt County will require additional staff to be added to the public child welfare agency. Respondents reported that the Board of Supervisors has given approval to add staff specifically designated for Wraparound. Respondents indicated that

they had identified two distinct new positions—facilitator and coordinator, though the specific job duties of each type of position were still in development.

Client/Community Characteristics

Participants depicted Humboldt County as a patchwork of distinct subcultures spread throughout the county. In addition, geographically sub-divided communities face unique challenges based on remote locations. For example, respondents characterized Humboldt County as inaccessible by public transportation, leaving remote communities isolated in extreme poverty, oftentimes lacking running water and electricity, with little opportunity for employment within a reasonable distance. Additionally, participants reported that many of the county's ethnic populations are underserved by public agencies due to a combination of a shortage of culturally appropriate services as well as mistrust of public agencies on the part of some ethnic populations. Participants indicated that while the public agencies have interpreters available to work with the Latino population, few services are available in Spanish. This hindrance, combined with a large number of people without legal residence who avoid county and State agencies for fear of deportation, leads to low service utilization among the Latino population. Respondents described the county's Hmong population as similarly insular, with few culturally appropriate services available to them. Participants also discussed the large Native American population within the county, with seven reservations and rancherias (tribal lands recognized only by the State but not the Federal government, according to participants). Each tribe and rancheria has had a different historical relationship with the department and the community, leading to varying levels of trust toward the public agencies.

Finally, respondents described the influence of Humboldt County's illegal drug economy. Illegal drug growers choose to isolate themselves to avoid contact with law enforcement and public agencies, leading to difficulties when social workers attempt to conduct home visits during harvest season.

Political Factors

Participants felt that the public agency had a positive relationship with both the county Board of Supervisors as well as the court system, and that both entities were supportive of the Wraparound implementation process. The court meets with child welfare services on a quarterly basis to discuss the Waiver Project, in addition to periodic meetings with the FIT. Both the Board of Supervisors and a Court Commissioner attended a Wraparound training. Conversely, respondents indicated that both the defense counsel and Court Appointed Special Advocates (CASA) may be resistant to the Wraparound philosophy of providing intensive services to children within the context of a community-based setting, fearing that moving a child to a lower level of care or returning them to their community of origin would jeopardize child safety.

2001 Process Study

Target Population

The target population for intensive services is youth in RCL 10-14 placements, or those at risk of placement at that level. This target population is different from the original RCL 12-14 group, and reflects legislative changes at the state level that lowered the criteria to include youth placed in RCL 10 care. Originally, the county probation department was also going to participate in the project. However, respondents reported that certain requirements came into conflict with the evaluation design and precluded the department's participation.

Respondents indicated that behavioral indicators that are commonly associated with entrance into RCL 10-14 facilities, such as aggressive behavior, suicidal behavior, chronic truancy, substance abuse, and involvement with multiple agencies are the primary means of determining eligibility for the study. Respondents reported that the child's prognosis is also considered in terms of whether or not they are likely to benefit from the Wraparound intervention. In addition, the presence of a caregiver willing to be involved in Wraparound is an additional consideration. Finally, while there are no age limits, respondents indicated that if a youth were older than age 16.5, the case would be closely considered for appropriateness given the short length of time that the youth would be eligible to receive services.

Respondents indicated that the county chose to target this population for three primary reasons: First, due to the lack of treatment facilities above RCL 10, youth with intensive treatment needs are placed out of county, frequently causing difficulties for parents to be able to maintain regular contact with their children. Respondents expressed a strong desire to be able to provide treatment for children within their own communities. Second, through the use of flexible funds spent within the community, respondents were hopeful that resources invested in community supports within the county would improve the capacity of the county and communities to care for their own children. Third, respondents felt that this is an appropriate target population for the Wraparound approach because of an assumption that if traditional services were going to work for these youth, then they would have already demonstrated more success in treating this population.

Implementation

Intake process. The majority of referrals for the study come from case-carrying social workers who identify a child on their caseload who would potentially benefit from the Wraparound intervention. The referral goes to the "FIT 3" out-of-county placement committee, comprised of supervisors from the departments of probation, child welfare and mental health. The Wraparound referral process is similar to the steps that are taken when a child requires a "high-end" residential placement. The social worker completes a form that specifies which behaviors a child exhibits that are the impetus for recommending a structured placement setting, or, in this case, Wraparound. The FIT 3 team reviews the list of behaviors, taking into account additional factors such as previous placement history, and situational factors.

Upon the FIT 3 team's determination that the child is eligible for Wraparound, the process of gaining informed consent takes place. The facilitator is responsible for explaining the study and intervention to the family and child (if appropriate), and getting consent for participation. Ideally the mental health social worker accompanies the facilitator on this initial visit to explain the mental health component of Wraparound, which includes services offered through Access. Respondents indicated that this "team" approach to presenting the intervention is reflective of the larger partnership created between mental health and child welfare that is evident in the Wraparound approach. After describing the intervention and gaining informed consent, the child's information is then sent to UC Berkeley for random assignment.

Respondents explained that after a child is assigned to the experimental group, they begin to explain the process of Wraparound. During this time, the family has a chance to elaborate on their situation, and to consider who they might want to support them on the Child and Family Team. Respondents reported that this initial meeting typically occurs without delay, except in the event of logistical difficulties.

Child and Family Team process. Participants indicated that the first Child and Family Team (CFT) meeting is oftentimes difficult to schedule within the first week of entry into the study due to the remote locations of many families, as well as the fact that the child may be placed out of county. The goal for the CFT meeting is to include a high proportion of non-professionals while balancing the coordination efforts needed to bring everyone together in a timely manner. Respondents reported that the organizing efforts to arrange the meeting begin immediately, but that the logistical delays are somewhat outside of the control of the agency.

Respondents also explained that some delays in beginning the CFT are related to families adjusting to this new service delivery approach. Asking community members and friends to join a team of service professionals who are all going to discuss the family's situation is a daunting process for most families. The CFT requires families to engage others in their personal struggles, a task that respondents described as difficult because it runs contrary to the individualistic mentality of our society, and standard child welfare. Respondents reported that building trust with the family during the initial stages of the CFT is essential because it leads to the development of more meaningful CFT plans as the process progresses.

The development of the crisis safety plan occurs sometime during the initial CFT meetings, or sometimes before the CFT is initiated if there is a current child or family crisis. Respondents reported that the process of assessing strengths is done informally during the second CFT meeting. Following the Family Unity model, each CFT member is asked to explicitly describe what they believe to be the family's strengths.

In regards to child welfare worker involvement in the CFT process, respondents indicated that efforts are being made to improve consistent involvement of child welfare workers. Participants reported that several factors have inhibited participation among case-carrying workers: First, high turnover rates in the permanency planning unit (where the majority of Wraparound cases are located), has led to difficulties in consistent social worker involvement in the CFT process because it necessitates Wraparound staff to continually re-educate social workers about the responsibilities of carrying a Wraparound case. Second, sometimes communication or scheduling difficulties occur, and the child welfare worker may indicate that the CFT should proceed without them. However, respondents acknowledged that child welfare worker participation is essential to the CFT because, ultimately, it is the child welfare worker that must be able to take the CFT plan to court for approval and articulate its merits if necessary.

Flexible Funding pool. The process for accessing flexible funds begins with the CFT plan. Respondents reported that ideally, the FIT 3 team reviews the plan before any funds are spent. The FIT 3 members make recommendations for covering treatment costs through the community hubs or within the human service agency when possible. For example, rather than paying for respite care out of the flexible funding pool, a therapeutic behavioral aide could work with a child after school, using the agency's own mental health services. However, in reality, family crisis sometimes subverts the lengthy flexible fund approval process. Respondents reported that immediate needs are covered through the flexible funds on an emergency basis, and then approved after the fact.

Participants also reflected that they want to move toward a process where community resources are considered as the first option for supporting child and family treatment needs. Rather than spending flexible funds simply because they are available, respondents expressed a desire to instill the Wraparound approach with a more community-based focus during the initial stages of

the CFT. In the long-term, families will benefit more from supports that are stable, resulting in less reliance upon the temporary Waiver Project funding.

Services. Respondents reported that the first step for beginning Wraparound services is to identify who is in the child's family, based on the child's definition of who they consider to be family members. After determining additional CFT members, meetings begin. The child and family plan, developed by the team over the course of the CFT process, determines what services will be put into place. Respondents reported that services are always linked to the child's longer-term goals such as placement stability.

As the Wraparound providers, the public agencies are responsible for locating needed services. Respondents reported that they compiled a list of community services to form a resource book used by the Wraparound staff to identify possible community-based options for families. The MPT's at the regional hubs are also frequently consulted as a possible service provider. Respondents noted that the main challenge of running Wraparound as a public agency is that services are still contracted out per each service, leading to complicated accounting procedures, rather than forming a contract with a particular provider who will cover a continuum of services.

Respondents reported that services for the Wraparound group are creatively tailored to meet the child and family's needs. A mental health clinician and case manager assist with counseling needs and brokering services in the community. Additional services have included temporary financial assistance to cover car repair costs, rent payments or medical expenses. Recreational activities for youth are also included, such as summer camps, and horseback riding lessons.

According to respondents, there is no expected duration for Wraparound services. Participants noted that none of the cases were at the point where the children could be safely maintained in the community without support from the public agency service system.

The comparison group receiving standard child welfare services includes children's mental health services, 1-1 support from therapeutic behavioral aids, transportation, services associated with the group home placement, and parent services determined by the court. Some families may also participate in family unity meetings, though this is not a uniform practice. Respondents indicated that there are neither flexible funds for the control group, nor CFT meetings.

Supervision/Monitoring. Respondents indicated that the project is monitored on two levels. Child and family progress in the project is discussed during weekly facilitator meetings. Facilitators also have an opportunity to provide feedback concerning the project's implementation, and to make suggestions for needed changes, thus promoting open communication between the direct service staff and the administration.

The overall project implementation is discussed during "big wrap" meetings, which take place twice a month. This meeting primarily serves as a forum to clarify structural issues with implementation, such as the referral process, policy questions, and other barriers that emerge throughout during the process of implementation. Respondents reported that community partners are also included in the "big wrap" meeting, such as schools, foster parents and other community stakeholders that were part of the implementation team.

Difficulties/Solutions. Respondents reported that most of the project's difficulties have been the result of communication barriers. Participants noted that both child welfare services and mental health were operating outside of their usual frameworks in providing Wraparound services, resulting in new roles for each agency. In order to navigate the Wraparound process, the mental

health and child welfare departments meet regularly, as described above, to improve administrative processes for the project. Respondents felt that most problems have been resolved through creating the necessary open channels of communication during these joint-agency meetings. Additional problems are addressed within each agency. For example, the child welfare agency has found that continuous education for social workers is necessary due to high turnover and the need for social workers to understand the Wraparound process for optimal participation on CFT's. The mental health department works internally to resolve financial issues that emerge from the limitations posed by mental health funding streams.

Status. According to respondents, the project is in an intermediate stage of development. Most program processes are in place, though certain procedures are in need of further refinement, such as coordinating service initiation as new families come into the project. Respondents also indicated that mental health and social services each contend with internal barriers to implementation that arise throughout the course of the project. For example, the mental health department is still in the process of determining how to provide services within the constraints of the billable time funding system.

Staff Attitudes. Respondents reported that, in general, when staff are resistant to Wraparound, it is due to the workload requirements associated with the project, rather than negative perceptions of the Wraparound concept in itself. Interest in the project has increased as child welfare workers see that families enrolled in the study receive additional assistance that would otherwise not be available to them in standard child welfare. Respondents also indicated that some staff discount Wraparound as a temporary project that simply supplements child welfare services without changing the long-term orientation of the system toward working with children and families.

Training. The county trains its staff using funds provided by the State for Wraparound training. Funding from the county's Challenge grant is also used to cover staff training costs. Additionally, the foster parent association is paying for Wraparound training for kinship caregivers, foster parents and parents so that they can become facilitators.

Funding

Respondents reported that the county has established separate accounting procedures for the Wraparound program. The fiscal structure of Wraparound has required a full-time position from the county's fiscal department to ensure that costs are claimed correctly, a complex process due to the county's role as service provider. Respondents also emphasized that the fiscal person attends staff meetings and has attended Wraparound trainings as well, in order to better understand the rationale supporting fiscal requests made by the facilitators.

Participants also reported that, in addition to flexible Title IV-E funds, the county accesses EPSDT, System of Care, and other funding sources to provide services to children enrolled in the Wraparound project.

Client Characteristics

Respondents felt that the youth in out-of-home care exhibit many of the same problem behaviors as youth from other counties. However, due to the lack of placement resources within the county, intensive needs youth are isolated from their families, friends and community. High poverty and substance abuse rates also create challenges for developing community support systems for intensive needs youth.

Community Characteristics

Participants highlighted the problems with the educational system in particular, which they described as extremely underfunded. There are few special education resources, so youth are placed in community schools rather than non-public schools or other alternatives that may be more appropriate to their needs. Additionally, respondents reported that the youth placed in the county's group home are frequently placed in schools throughout the district, leading to transportation difficulties for the group home.

Respondents also reported that programs and services for youth are just now beginning. Whereas previously it was difficult to find after-school activities for youth, there is now a teen center, a mentoring program through Humboldt State University, and other options that will be utilized as Wraparound resources.

Political Factors

Participants indicated that one of the major challenges of project implementation is balancing the Wraparound process with court requirements. Despite having made efforts to educate the bench about the principles and services associated with Wraparound, respondents felt that there was still some misunderstanding on the part of the court about the Wraparound process and the need for flexibility rather than prescriptive services. Probation representatives indicated that the juvenile court had been cooperative with Wraparound plans thus far, though the context is different from child welfare because the locus of change is seen as residing within the child rather than the family.

Respondents described a second type of challenge related to the dependency court—the policy of seeking reimbursement from families for foster care placement costs. When the child is returned to the family after making necessary improvements in the home environment, the court frequently asks the family to pay around $500 per month for the child's cost of care. Respondents indicated that they have had difficulty working with the court to reduce this amount to allow families a chance to get back on their feet and pay their rent and bills without using flex funds. Respondents felt that saddling recently reunified families with huge child welfare bills significantly increases the chances that some parents will return to substance abuse or other negative coping mechanisms in response to this added stress.

Evaluation Factors

The Services Tracking Form (STF) has been difficult for some providers who have a high proportion of youth in the study. Respondents reported that providers felt scrutinized by the STF, and that they would somehow be judged by their responses. The evaluation coordinator then discussed an alternative way of presenting the STF to providers to avoid this misperception. Respondents resolved to explain the study and the reason for the STF as soon as the child is placed, thus framing the purpose of the STF ahead of time.

2002 Process Study

Target Population

Humboldt County Wraparound continues to target youth who are below the age of 16.5 years, and who are in RCL 10-14 residential placements or considered at risk of that level of placement. Respondents reported that the majority of children identified for the project are referred by county social workers. Referrals can also come from a foster parent interested in Wraparound, a

judge, another service provider, or the family themselves. While an identified family is not a requirement for a child to be considered appropriate for the intervention, respondents indicated that they believe the program is more effective when a primary caregiver is involved. 'Family' then is defined broadly as anyone who provides care and support for the child.

Implementation

Intake Process. After completing a referral form consisting of a behavioral checklist, the social worker submits the referral to the Family Intervention Team (FIT) for approval. If the case is considered appropriate for Wraparound by the FIT, the social worker, ideally accompanied by a mental health worker as well, seeks informed consent from the family after explaining the intervention, study, and randomization process. The referral and consent are then forwarded to UC Berkeley for random assignment to either the treatment or experimental group. If the case is assigned to the experimental group, the facilitator assigned to the case notifies the family within 1-2 days. The facilitator arranges a meeting with the family as soon as possible, typically within one week.

Child and Family Team Process. Child and Family Team (CFT) meetings are more frequent during the initial stages of the Wraparound intervention, sometimes scheduled weekly. Over time, respondents reported that meeting frequency is typically reduced, with CFT's convening only once every two months, depending on the family's needs.

Services. Respondents reported that both the comparison and treatment groups have a similar set of base services available to them as part of standard child welfare, including counseling, school services, case management, transportation and Therapeutic Behavioral Services (TBS). Children receiving Wraparound have a more extensive array of services available to them based on individual needs. For example, Wraparound services have included tutoring, respite, housing assistance for the family and extracurricular activities. The comparison group has Family Unity meetings which are similar to the CFT process, and 1-1 behavioral services.

There is no general expectation for Wraparound service duration, though 12 to 18 months is the current norm. The individual children and families' circumstances will determine the length of service.

Case Closure. Respondents indicated that the county has struggled over the issue of case closure for the treatment group. The topic will be addressed in-depth at an upcoming retreat. For the comparison group, the case is closed if the child leaves the State or leaves the child welfare system.

Flexible Funding pool. Emergency cash is available to the facilitators, though all funds must ultimately be approved by the FIT. Overall, the CFT typically determines the fiscal needs of the family through the creation of a six-month plan. The family's income and community resources are always tapped first, before accessing flexible funds is considered. The facilitators can request up to $500 from the FIT, which is then disbursed quickly, sometimes within three days. If the request exceeds $500, the facilitator must get approval from both the FIT as well as the county's fiscal department.

Supervision/Monitoring. The primary means of program monitoring is a weekly multi-disciplinary meeting focused on the provision of Wraparound services. Representatives from child welfare, mental health and probation discuss the Wraparound process, with facilitators and social workers sometimes presenting specific cases for consultation. The project is also monitored by the original implementation team, which has been transformed into a steering committee. Respondents reported that this group does not meet on a consistent basis.

Difficulties/Solutions. Communication and dividing responsibilities between the three departments continues to constitute the predominant barrier for project operations. Respondents also noted that they have come up against policy-level difficulties in implementing Wraparound. However, as Wraparound has gained credibility in the county, Wraparound teams have successfully informed departmental policy decisions to assist the project's implementation.

Status. The implementation was described as "in the middle of the process". The county is looking back toward the beginning and also looking towards being in a more mature stage. The number of children served is still small, but it is increasing.

Staff Attitudes. The two primary concerns noted by case-carrying staff relate to inter-departmental issues that led direct service staff to make policy recommendations to administrators. The first issue concerned the need to develop a new procedure for sharing client information between departments because there were no multidisciplinary client information forms. Second, staff called into questions the rigid scheduled hours for mental health department staff, a practice that seemingly conflicted with the flexibility required to provide Wraparound services.

Overall, the attitude toward Wraparound has improved among social workers, as evidenced by an increase in referrals from CWS social workers. Though some staff feel that Wraparound cases require more work than control group cases, there has been a general increase in support for the project from direct service and administrative staff in both the child welfare and probation departments.

Staffing

The primary staff for Wraparound come from the county departments, though outside providers may participate on the CFT if they had previously provided services to the child or family, such as a clinician or TBS aids. The mental health department has a dedicated clinician, case manager, supervisor and program manager for Wraparound. From the child welfare services department, there are two full-time and one part-time facilitators, a supervisor, program manager, and fiscal person. The Wraparound team serves children and families in both the IV-E Waiver Demonstration Project as well as those eligible for Wraparound through SB 163 State-only Wraparound.

Training. The State provides training for the county, which was offered frequently during the first year of Wraparound. Participants noted that in the current stage of the project they have a greater need for mid-level and advanced training to continue to educate experienced staff. These training needs have not been met by the State, in part due to budget cuts. Internal training occurs through pairing new Wraparound staff with seasoned Wraparound staff who are familiar with the process.

Funding

The county continues to struggle with complex accounting procedures associated with the cost neutrality requirement of IV-E Wraparound. Fiscal personnel were included in the development of the project during the initial stages so that funding procedures would mirror the needs of the program's flexibility. Respondents reported that the accounting department has become more accepting of the program over time.

Client/Community Characteristics

Participants specifically noted that low income levels coupled with decreasing job opportunities, particularly in the lumber and fishing industries, has negatively affected implementation of Wraparound. As a rural county, Humboldt lacks an extensive public transportation system, resulting in isolating portions of the population from supportive services. At the same time, respondents reported that the community has a strong network of resources such as churches and other faith-based groups. The community "hubs" also provide a vital connection to local resources in their respective areas—they serve as a primary access point for local service referrals. Respondents also noted a strong community sentiment and willingness to provide assistance to those in need. At the client level, respondents reported that a high rate of substance abuse among parents has been particularly problematic for implementation.

Agency Factors

Respondents felt that Wraparound philosophy has had a broad impact on county services beyond the scope of the project. Viewing families in the context of their strengths and needs has transformed the way that staff are talking about families. The use of the structured decision making and a more data-driven process has paralleled project implementation in a positive manner. However, participants also noted that some county policies lag behind the movement toward "wrap-like" processes.

The co-location of the departments involved in providing Wraparound has also facilitated smooth project implementation because, according to respondents, it ensures that each department is sufficiently involved in the project. Coordination and problem-solving are also made easier by the proximity of the departments to each other.

Political Factors

Respondents reported that while the courts and Board of Supervisors support the project overall, their backing is contingent upon Wraparound meeting certain requirements. For example, the Board of Supervisors is particularly concerned with cost neutrality, the requirement that has led to particular difficulties for the county—frequent placement changes, probation overlap and blending other funding sources tend to obfuscate the cost claiming process. Respondents noted that the court's involvement guides the CFT process to some extent because the family must ultimately answer to the court and its requirements of demonstrated progress. Finally, respondents noted that the CWS Stakeholder's meetings have had a positive impact on project implementation at the State level. However, respondents reported that the State tends to ask for Wraparound reports on short notice, putting some strain on administrators.

Evaluation Factors

The increased workload created by the STF has been especially burdensome for social workers and facilitators, along with other required communications concerning case closures. Respondents also expressed reservations concerning the randomization process, primarily due to the disappointment that families and social workers experience when a child is assigned to the control group.

2003 Process Study

Target Population

Humboldt County Wraparound seeks to serve children who are currently in an RCL 10-14 group home, or are at risk of such placements. The county is without this level of group home care, so placements of this magnitude result in the child being placed outside of the county.

Implementation

Intake Process. A multidisciplinary team with representation from child welfare services, mental health, and the probation department determine the child's eligibility after a referral is received. The family intervention team assesses the behavioral characteristics that led to the child's placement or risk of placement in an RCL 10-14 outside of the county. They provide the results of the assessment to the Wraparound supervisor, who then informs the facilitator. The facilitator meets with the family to sign consent forms. After consent is received, the information is faxed to UC Berkeley. After UC Berkeley randomly assigns the child to the treatment or comparison group, the family is notified. If the child is assigned to the treatment group, the process of building the child and family team begins with a meeting to develop a list of strengths and identify members the family would like to have on their team. If a child is assigned to the comparison group, the child receives standard social services.

The time between receiving random assignment results and the process of starting services for families assigned to the treatment group is approximately two weeks. During those two weeks the team is developed. As the team facilitators have developed their skills, they've helped the families to include more non-service providers, including family and friends.

Case Closure. Respondents indicated that case closure is seen as a process that begins at the outset of the intervention by discussing the limited nature of the program with the family and developing specific goals. Progress toward these goals is assessed at each team meeting. The entire group, including the family, determines whether or not goals have been met.

Flexible Funding. Participants reported that the flexible funding process had not changed. Petty cash is available through the facilitators and used for crisis situations or inexpensive items.

Services. The service duration, on average, for a child receiving Wraparound services is one year, though this varies from family to family. A child assigned to the treatment group may have a Wraparound case closed but continue to receive child welfare services. Children in the comparison group receive services until dependency has been terminated. Facilitators track services for children in the comparison group.

Supervising and Monitoring. In the beginning of Wraparound implementation a collaborative county group (including schools, child welfare services, mental health and others) provided oversight. A single analyst now tracks each child's placement changes and monthly expenditures for the duration of service provision. Weekly supervision with the facilitator is provided to discuss administrative factors and review cases. This process is facilitated by the co-location of the mental health clinician, facilitator, and probation officer in the same office.

Attitudes. Participants reported that communication has been a key factor in implementation. Initially few referrals were received for Wraparound services because the community wasn't aware of the program. To raise awareness, supervisors and facilitators have periodically

attended unit meetings to provide information about the Wraparound program, explain the referral process, and discuss examples of work with families. The participants felt that positive outcomes for children involved in Wraparound was one of the most effective mechanism for spreading news of the program. Referrals are now made frequently, though some children don't meet the eligibility criteria.

The Wraparound process has been embraced and integrated into other Department of Mental Health programs as part of larger movement towards collaborative practice that has evolved over the past ten years. Wraparound is still seen as separate from the larger children, youth, and family services system, but provides an example of the direction that mental health services are moving towards.

Status. Participants described their current implementation status as, "beyond adolescence", in a stage of maturation.

Staffing

The core Wraparound team consists of the facilitator and the clinician with other service providers determined by each family's needs. Other service providers on the team may not necessarily be focused on Wraparound. For example, the family may have a probation officer or a social services staff member on the team if they receive public assistance or domestic violence services. School representatives are also often present on a child and family team.

Participants felt that the consolidated child welfare services/Wraparound model had been useful when thinking about the way bureaucracies usually operate. Collaborative work with other professionals, along with memorandums of understanding with the Departments of Mental Health and Probation, has smoothed the way. Participants noted that the adjustment of mental health staff schedules was an issue initially but now they are able to meet after regular work hours.

Meetings are generally co-facilitated by the facilitator and the mental health clinician, with the facilitator generally taking the lead role. Co-facilitation was considered valuable because of the combination of the mental health clinician's specific expertise with the family and the facilitator's more general focus on facilitation and goal setting. The clinician generally works as the family's therapist, a role that emerges from the family plan if a clinician is not involved already. The program has retained the same 2.5 facilitators for the past three years.

Training. Participants had attended numerous trainings considered useful in terms of content and the opportunity to network with Wraparound providers in other areas. They felt budgetary issues would restrict their ability to take advantage of training opportunities in the future. Since all staff had attended the "train-the-trainers" session they felt they could train new staff if necessary.

Funding

Participants described how the level of fiscal oversight for the Wraparound program has shifted over time. A period of strong oversight—coinciding with the outset of the program—was followed by a year long period of less stringent oversight. It became clear to participants during this period that more fiscal involvement was necessary for the program to run properly. Because a portion of the Wraparound program is not part of IV-E foster care funding, it forced a larger discussion about fiscal oversight and a return to previous levels. Concerns about the governor's proposed budget realignment and caps on foster care were also discussed.

Client and Community Characteristics

Participants noted that families served through the program are typically low income and have lower levels of education, and drug use has frequently affected individual and family development. Past or current domestic violence and mental health issues often play a role in family problems. The child population served through Wraparound has tended to be predominately White with a subset of Native American children.

Participants noted that client transportation is often a barrier to accessing services and fulfilling welfare and court related mandates in Humboldt County. The area economy is construction- and service-based, with few opportunities for advancement for low-wage workers.

Agency Factors

The departments of Health, Public Health, Mental Health, and Social Services merged into a single department shortly after the Wraparound program implementation began. Participants suggested that enhanced communication and collaboration resulting from this merger has been beneficial to the implementation process. One participant mentioned that child welfare services came into the Wraparound process with a strength-based perspective; social workers were already familiar with the concept of working with family strengths. In the probation department, implementation of the Challenge Grant prior to Wraparound helped in Wraparound implementation. Mental health services were somewhat challenged by the strengths based model initially. A new director has brought in a "recovery wellness discovery" model that participants felt was very consistent with the Wraparound approach and philosophy.

State Factors

The budget was cited as the major economic factor at the state level that has had an impact on the Wraparound program.

5.2.3.3. Los Angeles County

1999 Process Study

Pre-Waiver services

Intensive Services. Respondents reported that Los Angeles County has operated a small, 10-child Wraparound pilot program through its children's shelter, McClaren Children's Center (MAC). Following an independent investigation of Los Angeles DCFS and MAC specifically, the county was ordered to implement a Wraparound model for children at MAC. Following this review, county administrators developed a consortium of mental health, health, education and probation representatives, as well as a central administrative unit, to implement an intensive services program at MAC.

The target population for this pilot project are children who have had long, repeated placements at MAC, a history of placement failures, and who have someone in the community that is willing to care for them. The public agency coordinates treatment planning for these youth, beginning with an initial planning meeting with the child, caregiver, a family advocate, and the youth's social worker to determine an appropriate service plan. Respondents felt that this pilot program is analogous to the Wraparound model that will be implemented under the Title IV-E Waiver. In addition to the family-centered treatment planning, individualized services are contracted out to private providers through the use of flexible funds. For example, in one case, the county used

flexible funding to pay a father's salary to allow him to stay at home and supervise his child. In another instance, a youth was able to stabilize in her grandmother's care while continuing to receive mental health service.

Respondents reported that the program began in December 1998, and has no known termination date. Currently, five children have been placed with caregivers in the community, four are still residing in MAC, and one is deceased. Aftercare services are uniquely tailored to each child's needs, and have no set duration.

According to respondents, the Title IV-E Waiver is a natural successor to this small-scale mandated Wraparound program. Respondents indicated that they planned to utilize the pre-existing infrastructure established for the pilot program as a tool to implement the Waiver Project.

Non-Intensive Services. Respondents characterized the youth residing in MAC as intensive needs youth, who have typically experienced numerous placement disruptions. Children are placed at MAC when other services options have been exhausted, usually resulting in an RCL 12-14 placement following a temporary stay at MAC. Youth who reside at MAC for longer than 30 days are considered the most "difficult" to serve in the county, and are generally an older segment of the child welfare population. Respondents reported that the average length of stay at MAC is 58 days, with an average of 84 days among children who reside in MAC for over 30 days. According to respondents, between 35 and 40% of youth are discharged from MAC to either group homes or psychiatric hospitals. An additional 6-10% enter the juvenile justice system upon discharge, while 20-30% are placed in either kinship care or non-relative foster care.

Two inter-agency review teams, consisting of representatives from the Department of Mental Health, Department of Children and Family Services, and Department of Probation assess cases to determine which youth will be placed in RCL 14 care. One review team works on-site at MAC and coordinates placements with one RCL 14 provider. The other review team coordinates placements with the other five RCL 14 providers in the county. Respondents reported that there are 270 RCL 14 beds within the county, leading to frequent bed shortages for the county's most difficult to place children. However, participants indicated that provider applications to provide RCL 14 are reviewed stringently to ensure quality. High county standards coupled with a dearth of qualified provider applicants has led to finite RCL 14 resources within the county.

Respondents indicated that there is a separate intake process for Level 12 placements. The Resource Utilization Management unit (RUM) is housed in MAC, and works in conjunction with regional consultants to determine if a child is in need of an RCL 12 placement. The RUM, which receives referrals from case-carrying social workers, takes into consideration factors such as severity of behavioral problems and placement history as part of the criteria for RCL 12 placement. Cases are reviewed monthly by RUM, the regional consultant, and a mental health representative, to assess the child's progress in treatment and to determine if the child could be supported in a lower level of care. Respondents reported that most Level 12 placements in the county have waiting lists, due to a similar shortage of beds for Los Angeles County's large out-of-home care population in need of residential treatment.

Program Planning

Planning Group. The Intensive Services Planning group, currently known as the Interagency Children's Services Consortium (ICSC), has had numerous iterations. The ICSC stems from the committee and task force developed to implement the MAC community integration project. Respondents reported that this committee then merged with members of the county's regional advisory groups that represent each of the county's service planning areas. The committee responsible for the original waiver proposal also included MAC staff, mental health service providers, child advocates and private providers. The ICSC now responsible for project implementation and oversight includes representatives from DCFS, DOP, DMG, Health Services, and the County Office of Education.

Planning Process. Respondents reported that the ICSC and its numerous sub-committees have consistently held weekly planning meetings throughout the development of the waiver proposal.

In order to engage a broad spectrum of Wraparound partners and stakeholders simultaneously, DCFS conducted four regional three-day orientation and training sessions with parents, educators, providers, and public agency staff from probation and mental health. The ICSC utilized the Eastfield Ming-Quong (EMQ) CDSS training program to engage participants in the Wraparound philosophy, focusing on the core components of Wraparound such as increasing family decision-making. Respondents indicated that they included representatives from multiple "systems" in order to introduce the collaborative nature of Wraparound.

Participants hoped to begin the process of selecting lead agencies in June 1998. Currently, County Council is reviewing the RFP that will be issued to the community of providers following a review by all of the public agencies. Respondents anticipated selecting one lead agency for each geographic area of the county, allowing the lead agency to sub-contract services as needed. In contrast to Family Preservation in Los Angeles County, which has a prescriptive set of available services, respondents expect Wraparound services to vary by the strengths and resources of each lead agency and community. Following two bidders conferences and the establishment of a Community Oversight and Review Team, respondents forecasted that services would begin in the latter half of December 1998.

Pre-Implementation

Supervision and Monitoring. Respondents indicated that the ICSC body would continue to oversee the project, while each service planning area (SPA) would have its own cross systems team. Though the details of program monitoring had not yet been determined, respondents emphasized the need for oversight bodies with representation from each public agency involved with the project. However, respondents expressed concern regarding the resources it would require the public agencies to expend in order to manage Wraparound, particularly given the lack of new incoming funds. Currently, the ICSC is determining whether project oversight should further encumber already existing county structures, or necessitate the creation of a new administrative body.

Difficulties/Solutions. While respondents reported that ICSC has not yet established specific procedures for inter-organizational problem resolution, other models for resolving difficulties already existed within the agency. For example, Family Preservation has a monthly roundtable meeting where providers and county administrators can discuss issues of mutual concern. The regular ICSC meetings also serve as "conflict prevention", according to respondents, because

staff from each public agency work together to bridge service gaps to youth with multi-agency contact. At the regional level, the cross-systems team within each SPA will bring together county administrators and representatives from the lead agency in each area. Additionally, respondents reported that providers are asked to describe in their proposals how they would resolve difficulties in obtaining services outside of the network, as well as how they would address problems in general. Finally, respondents reported that a Community Review and Oversight team, a public and private partnership established during the MAC Community Integration pilot program, may also have oversight responsibility for the project.

In contrast, respondents also acknowledged that numerous complexities will arise during implementation, by the nature of operationalizing an approach across five departments, and without the assistance of additional funding to do so.

Respondents anticipated similar challenges with the collaborative process within the provider network. Each provider is specialized in one aspect of Wraparound, such as mental health services, leveraging community resources, or providing residential placement resources. However, in order to successfully implement Wraparound, service providers will have to form a collaborative effort in order to form a comprehensive approach that no one single agency can achieve. Respondents view the role of the public agency, in part, as that of a catalyst intended to spark the process of collaboration among service providers. Accordingly, the planning group has initiated preliminary discussions with a group of providers to spur the formation of provider partnerships and alliances.

Funding. Respondents reported that several funding sources would by utilized to supplement the Title IV-E funding for Wraparound. Specifically, respondents anticipated using EPSDT, System of Care and Supportive Therapeutic Option Program (STOP) funds to enhance Wraparound. STOP is state-funded with a county match, and is intended to provide mental health services to children in the child welfare system with the goal of preventing entry into group home care. According to respondents, STOP addresses the need for mental health services among children who are not eligible for services under Medi-Cal. Respondents indicated that after developing EPSDT capability for Wraparound, they will eventually look to pool funding sources for greater flexibility.

Staffing

Respondents reported that no new staff had been added for the Waiver Project, though each public agency department had committed a full-time management staff person to a central administrative unit. Respondents anticipated re-assigning existing staff to support the project as needed rather than hiring new staff in the public agencies. Additionally, some staff will be designated as "multi-departmental" to fill new functions necessitated by the Wraparound approach

Training Respondents expected to provide comprehensive training for the groups involved in Wraparound. Training sessions will be tailored to the function that each group plays in project implementation. In addition to training the core elements of Wraparound, respondents emphasized that each "structural element" of the project would have implementation guidelines and procedures. The ICSC had already received approximately three weeks of EMQ Wraparound training.

Client/Community Characteristics

Respondents reported that one of the challenges of implementing Wraparound in Los Angeles is the large number of smaller communities within the county, each with their own complex web of services. Respondents also indicated that these diverse communities have varying needs and that in the areas where need is greatest, the inherent service capacity within that community is frequently low. For example, while a community may have a strong network of group care providers and mental health services, it may have a shortage of community-based resources. Other areas might lack both formal and informal services, resulting in children being placed outside of their communities of origin. As a result, respondents foresaw competing objectives and disparate levels of pre-existing service infrastructure as one potential barrier to project implementation at the community level.

Respondents also reported that language needs could have an impact on the implementation of Wraparound, as Los Angeles County has a large population of non-English speaking children that are largely underserved.

Political Factors

Respondents reported that the planning group has worked closely with the court system throughout the process of developing the waiver proposal. The court was involved with the MAC Community of Care Integration project, as well as other initiatives that have required both DCFS and DOP participation. In addition to this history of collaboration with the courts, respondents reported that they have also attended judicial meetings to keep the court informed of progress with the Waiver Project. Beyond reporting progress to the court, respondents indicated that the next step would be to fully engage the court in the Wraparound process, beginning with developing "wrap orders" modeled after those used in the Santa Clara County courts.

Respondents described numerous political factors that could affect implementation of the Intensive Services component in Los Angeles County. Due to the county's large size, it is divided up into regional SPA's. Respondents indicated that the SPA's frequently compete for resources, vying for projects to be implemented in their region regardless of the region's capacity to implement the project or need for the particular service type. The plan to implement Wraparound incrementally, beginning with two or three SPA's, exacerbates the political competition between SPA's because not all areas will be able to begin the project at the same time. In addition to competition across different districts within the public agency, respondents anticipated competition among private providers as well, given that only one lead agency will be selected for each area implementing the project.

As a related issue, respondents relayed political concerns about the difficulties of returning children placed in high end residential settings to their communities of origin when those communities may lack the necessary resources to maintain the child safely in a less structured setting. Currently, respondents reported that intensive needs youth are typically placed in a few residential treatment settings that tend to be in outlying areas of the county. Respondents worried about the public agency's ability to commit enough resources and support to adequately improve a community's ability to care for its own children. Following a tragedy at MAC that led to increased scrutiny over the department's services to the county's most seriously troubled youth, respondents indicated that there continues to be a tense atmosphere across all the public agencies in regards to the risks associated with placing high end youth in the community. Respondents felt pressured to begin the project quickly, and to do so successfully.

Finally, external forces such as children's advocacy groups and provider associations may have their own agendas, according to respondents, that may interfere with implementation of Wraparound depending on each group's unique interests and sway with the County Board of Supervisors. In addition to external groups, respondents indicated that numerous initiatives and programs are initiated in DCFS at any one time, creating challenges for full integration of each project's approach to child welfare services. Additionally, individuals with decision-making power within the county may have ties to one initiative, leading to competition for resources to be allocated to one initiative over another.

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Target Population

Respondents reported that the Wraparound sub-study continues to target the original population of children in RCL 12-14 placements, or at risk of that placement level, at risk of going to the psychiatric hospital or emergency shelter (MAC), as well as youth who are stepping down from RCL 12-14 placements, or who have multiple failed placements. Participants considered this population to be both the most in need of intensive services as well as the least likely subset of the child welfare population to be receiving services. Through targeting these populations with intensive services, respondents hope to decrease the population of youth at MAC by assisting youth in the transition to a lower level of care. Additionally, respondents hope to shorten lengths of stay in "high end" placements in general. Respondents indicated that the philosophical approach of Wraparound is one that lends itself well to serving youth who would otherwise grow up in group or institutional settings. Participants reported a belief that the increased ability to meet children's individualized needs as a result of decreased service delivery limitations will ultimately lead to more children being raised in families rather than being placed in long-term care.

Implementation

Intake Process. Child welfare workers or probation officers typically begin the process of enrolling a child in the study through identifying youth who they believe would likely benefit from the intervention. These front-line staff then make a referral to the Resource Utilization Management team (RUM), to begin the intake process. System of Care (SOC) and RUM coordinate the intake process, so that all children who are referred for services are funneled through one system. As a result, if a child is assigned to the comparison group, they still may receive services similar to Wraparound through SOC services.

Respondents described several different intake processes depending on the child's current placement. For example, for children who are already in MAC, there must be a commitment on both the part of the child as well as an identified caregiver to be able to care for the child. If multiple children are appropriate for the limited number of cases that providers can carry at any one time, names are put in a hat to determine the child that will be referred.

When children are referred from other out-of-home placements or from a crisis situation at home, the child welfare worker describes the Wraparound intervention to the family, and refers the child to the RUM if there is interest on the part of the family. After the case is reviewed by the Internal Review Team (IRT) and determined that the child meets eligibility criteria for Wraparound, the child welfare worker then explains the experimental nature of the study and

seeks informed consent. Respondents reported that this process causes numerous delays, and that it is sometimes difficult to reach the family the second time to gain informed consent.

Participants reported that they felt like the assumption that youth who are not already in placement are at lower risk of ending up in long-term high end care than youth who are already in residential placements is false because crisis situations at home can be even more volatile than a situation where the youth is already in out-of-home care. Additionally, working with group home providers where youth may already be placed poses challenges and delays in initiating services depending on the priorities of the group home. Respondents indicated that the time it takes for services to begin once enrollment is confirmed has fluctuated greatly due to issues such as difficulties making successful contact with the family or provider to set up an initial meeting, as well as delays on the provider end due to staffing shortages or other agency issues. Respondents reported that services could begin as early as the next day or as late as six weeks after intake, depending on the child and agency circumstances.

Child and Family Team Process. Similar to the variations in the intake process among different providers, respondents described different processes for beginning services. At MAC, after a child is enrolled in the study, staff begins by engaging the child and family through a discussion of what they should expect from this new service structure. The CFT is then formed with input from the child and family on who should be included on this team. CFT members may include adult children in the family, church members, neighbors, teachers, and extended family members. The CFT conducts a strengths and needs assessment, which then translates into a child and family plan, based on the prioritization of the child's needs. CFT members are assigned specific roles to assist in the implementation of the child and family plan.

In contrast, other respondents expressed difficulties and delays in arranging initial meetings with the child and family. Unlike the arrangement at MAC, other providers do not necessarily have a pre-established relationship with the child and family, the IRT process is lengthier since IV-E eligibility has to be established, and the child may be in a variety of locations and placement types, ranging from group homes to residing at home. As a result, respondents indicated that the safety and strengths assessment may take several weeks, and is typically done before the CFT is formed due to the necessity of assessing current risk and safety issues.

Respondents reported that child welfare worker participation on CFT's has taken various forms. The child welfare worker is a part of the CFT as well, though the degree to which the CWW is involved varies according to respondents. Some CWW's attend all CFT meetings, while others are not actively involved and prefer to be informed of the CFT's progress. Respondents also reported that some CWW's try to control the CFT process, and mandate that different services be offered, rather than allowing the team approach to operate.

Services. Respondents described the Wraparound intervention as a process whereby specialists facilitate the acquisition of needed services through linking the child and family to community-based non-traditional services. Respondents indicated that they did not view themselves as service providers, but rather as facilitators operating within the team approach of the CFT to determine creative ways of meeting child and family needs using flexible funds and a strengths-based approach to service. For example, one plan involved paying a neighbor to provide respite care during the summer in order to relieve some of the stress that a mother was experiencing.

Respondents also indicated that children and families in the comparison group receive more intensive services than those receiving traditional child welfare services who are not referred to

the study. After a child is assigned to the control group, the IRT immediately tries to develop an alternative service plan to help the family, using resources such as System of Care and EPSDT.

Participants expected that the time a child would receive Wraparound services would vary considerably; service length has already ranged from as short as two months to as long as 18 months. Overall, expectations ranged from 12 to 18 months, in accordance with the timelines established under the Adoptions and Safe Families Act.

Difficulties/Solutions. Respondents reported that the implementation process has been difficult due to the vast geographical area that comprises Los Angeles County's jurisdiction, as well as the correspondingly large workforce of child welfare workers who must "buy in" to Wraparound as a potentially effective approach in order for it to be successfully implemented across the agency. Respondents indicated that maintaining consistency during expansion has been particularly challenging, especially in terms of ensuring that the model is implemented with robustness as it expands. Finally, participants noted that changing such a large system with a high population of children in out-of-home care is a slow process, resulting in a gradual implementation process.

One strategy that respondents have employed as a means of garnering support for Wraparound throughout the agency has been to conduct outreach events throughout the agency by having Wraparound staff present the philosophy and mechanics of the intervention to child welfare workers in several regional locations. Creating excitement about Wraparound has been an effective means of gaining support for the project in an environment where workers struggle to meet the obligations associated with high caseloads. Child welfare workers have seen numerous projects and initiatives pass through the county without having a substantial impact on child welfare services. Presentations may help to address concerns on the part of child welfare staff that Wraparound is different from previous projects that have proven to simply be another passing trend in child welfare.

Participants indicated that initial difficulties with the MOU process have been resolved, allowing an RFP to go out in order to begin the selection of the next six Wraparound provider agencies. Respondents indicated that the requirement that the county designate providers according to Service Planning Area (SPA) leads to difficulties because, while some SPA's are smaller, they may have a dense population. Despite delays with a cumbersome MOU process with the Federal government, respondents felt that the project was picking up its implementation pace—respondents were hopeful that there would be at least one provider in each of the eight SPA's by the summer of 2001.

Respondents described the development of multiple initiatives targeting the same population as a barrier to service coordination. Numerous efforts to serve "high-end" youth, such as Children's System of Care overlap with Wraparound, potentially creating service duplication. In order to prevent multiple bureaucratic systems from emerging in order to implement each pilot project, respondents described efforts to coordinate service systems as a means of establishing an integrated service structure.

Finally, respondents noted a lack of cooperation from the seven Regional Centers located in the county. Participants noted that the Regional Centers should be providing services to some of the same children targeted by Wraparound, but were refusing to contribute resources toward treatment efforts for these youth. Additionally, while funding is not at stake, participants noted that not all group home providers are amenable to working with Wraparound providers, leading

to difficulties in fully implementing Wraparound services for children in the care of a non-cooperative residential provider.

Status. Respondents felt that the project was still in a ramp-up stage.

Staff Attitudes. While child welfare workers recognize Wraparound as a means of better serving the most troubled children on their caseloads, there are several factors that may deter them from referring youth to the study. First, child welfare workers' perceptions of Wraparound seem to be partially linked to their experience of the referral and random assignment process. Rather than carrying caseloads where all children have intensive needs, child welfare workers in Los Angeles County have a variety of case types, only some of which would are appropriate Wraparound candidates. As a result, workers may only refer one family to Wraparound, and may not understand the possibility that the child could be assigned to the control group. If the child is assigned to the control group, the worker may not want to make the effort to refer additional children in order to avoid potential disappointment on the part of both the family and the child welfare worker themselves.

Respondents noted that in order to successfully "market" Wraparound to child welfare workers, there must be some insurance that children assigned to the control group will receive some type of enhanced services beyond standard child welfare services. Otherwise, respondents noted that child welfare workers would see the consent process as cumbersome due to the fact that it requires two steps: the child welfare worker first has to get parental consent as part of the screening process, and then has to obtain consent a second time for enrollment into the study.

Respondents indicated that efforts to coordinate System of Care services with Wraparound may help to ensure that children assigned to the control group receive additional services.

Additionally, the impact of Wraparound on a child welfare worker's workload and schedule may serve as an additional deterrent to referring youth to the project. If a Child and Family Team meeting is scheduled during the weekend, or a day when the worker typically has flex-time, there are concerns that labor union agreements will not be met. Workers who are unwilling to create flexibility in their schedule may choose not to pursue Wraparound.

Staffing

Respondents described several types of staffing difficulties that have led to delays and difficulties in service provision. First, respondents noted that it is difficult to find masters level staff who are able to shift from the traditional deficit-focused model where the professional in many ways guides the treatment process, to a more strengths-based, flexible, family-driven process. There is an inherent tension in the facilitator role due to the need to, on one hand, give up power and control to the Child and Family Team, and, on the other hand, ensure that the child's safety is maintained. Respondents noted that the necessary qualities for a facilitator are difficult to assess during the interview process, especially given the numerous qualifications that an applicant brings with them that might, in fact, make the transition to the Wraparound model more difficult.

Second, challenges in successfully coordinating the hiring process with the timing of training sessions has led to delays in the implementation process. Facilitators have to be trained by state-certified Wraparound trainers because there are no locally certified trainers. As a result, respondents described delays between hiring facilitators and providing the necessary training for

them to be able to start, since the training schedule is outside of the control of the provider agencies.

Third, respondents indicated that the original plan of hiring teams, or "pods", of staff to serve a caseload of families has been problematic because staff turnover has resulted in some pods lacking key team members. The pod concept has been abandoned, and team members are assembled to respond to the caseload as needed, leading to some variability in the number of cases carried by individual staff members. Also, respondents noted that teams are able to come together faster to serve children who are already in out-of-home care, whereas the process of building a team to serve a child who is still at home is more complex because the child and family may not be receiving any services at the time of entry into the study.

Training. As noted above, the state-certified trainers do not offer training regularly, leading to delays in the ability of providers to begin services for children and families in a timely manner. In some cases, respondents are faced with a decision of whether or not to hire needed staff, because the training delays will lead to payroll expenses for staff who are hired but unable to provide services. Currently the county is beginning a train the trainer sequence, which will eventually provide respondents with the latitude to structure hiring practices in response to the pace of enrollment rather than the timing of the State's training schedule.

Respondents noted that the county's training needs are unique due to the fact that they have eight providers as well as MAC. With so many providers on board, turnover is particularly problematic, because when the trained facilitator at any given provider leaves, a team may be left without a trained professional, resulting in either delays in service provision, or restructuring teams.

Funding

Respondents reported several differences in funding for the experimental group as compared to the control group in the Wraparound study. First, whereas the rate paid to providers varies by placement type for the control group, the experimental group is funded at a fixed rate, equivalent to the cost of an RCL 13 placement. Additionally, funds for the comparison group are categorical, only financing the actual cost of placement. In contrast, funding for the experimental group is flexible, and can be used for services other than placement.

Additionally, funds from SB 90, AB 3632, and EPSDT are utilized to supplement services for the experimental group. Substance abuse treatment for parents is funded through TANF, and some Family Preservation funds are also used. The comparison group is eligible for many of these same funding sources, which will eventually be tapped for this group as well. Respondents reported that funding for the experimental group has led to complicated accounting procedures that are not yet efficiently operating; new accounting structures are in the development process to ensure a more effective reimbursement process.

Client and Community Characteristics

Respondents discussed several client and community characteristics that have presented challenges for Wraparound implementation. Respondents commented that families come to the system with multiple and complex issues, which are compounded by their children's mental health problems. In applying the Wraparound model of care, respondents must therefore contend with a highly complex set of issues in their work with children and families.

Second, while respondents noted that many barriers to implementing Wraparound are still unknown due to the project's current small scale, the linguistic diversity of the population served has already proven challenging in the context of service provision. Specifically, respondents noted that there is a large Spanish-speaking population that is not adequately served by the child welfare system and Wraparound providers because of a lack of Spanish-speaking child welfare professionals. Respondents noted that providing services through a translator leads to difficulties and is certainly a less than an ideal means of communicating about service provision issues.

Third, respondents indicated that implementing Wraparound in areas where community resources are particularly scarce presents challenges to developing natural supports for a family, particularly given the complex needs of the child and family. Additionally, respondents noted that community factors combined with the youth's behavioral issues leads to concerns in terms of the safety of both the child as well as the community.

Agency Factors

Respondents reported that while child welfare workers are generally supportive of the values and philosophy embodied in the Wraparound model, competing concerns inhibit the ability of staff to implement the Wraparound approach on a practical level. For example, the court may have a different view than the CWW and CFT about an appropriate placement type within the context of Wraparound, which may alter how the CWW views their responsibility in determining a child's placement type. Additionally, the CWW role in Wraparound requires a shift in the professional role of the CWW, in terms of increased collaboration with outside agencies and individuals. In order to adjust to the demands of the Wraparound model, the CWW must be willing to examine their own role in service provision and allow flexibility in their concept of their own professional identity.

Additionally, respondents noted that the organizational culture of the public agencies leads to barriers to implementation because it is difficult to create buy-in for the project across each department. Respondents indicated that there are pockets of dissent within each public agency, but that each area of the agency is also working under different mandates. These varying orientations toward the project result in different concerns about the project, all of which must be considered when respondents are attempting to market the project across these agencies. For example, DCFS' concern of child safety and DOP's concern for community safety both must be addressed in the context of Wraparound in order for staff from these departments to develop a shared sense of ownership for the project.

Political Factors

Respondents reported that both the County Board of Supervisors and the courts are supportive of the county's efforts to implement Wraparound. However, respondents expressed concern that support for the project would evaporate if negative media coverage were to occur. Respondents expressed concern that any type of incident that could be construed as having occurred because a youth was returned to a community setting would have a large negative impact on implementation.

At the Federal level, respondents expressed concern that a conservative administration would reduce Title IV-E funding, or eliminate the Waiver entirely. Respondents also noted that impending TANF time limits are negatively affecting families on the child welfare caseload, an issue that child welfare workers are already noticing.

Evaluation Factors

Respondents expressed concern that the requirement for random assignment has a negative impact on implementation in several ways. First, child welfare workers, in general, do not understand the necessity of a control group. If a CWW refers a child to the study that is then assigned to the control group, they may be reluctant to referring other children. As a result, children who are eligible for the study may not be referred due to a previous negative referral experience on the part of the CWW.

Additionally, the agency's unique SPA configuration led to difficulties during start-up due to an imbalance of experimental vs. control group assignments concentrated in a specific SPA. As a result, referrals and random assignment are now done in a SPA specific process.

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Target Population

The target population for the intensive services component of the IV-E Waiver Demonstration Project includes youth in RCL 12-14 placements or at risk of that placement level, as well as youth in or at risk of being placed at McClaren (MAC) or Metropolitan State hospital. Included in this target population are also youth who have previously been placed in a high level of care but are currently at home and considered at risk of returning to RCL 12-14 placements. Children who have not been previously placed in a "high level" of care are eligible for Wraparound if they exhibit extreme behaviors that put them at risk of a residential treatment placement or psychiatric hospitalization. However, respondents also reported that children who exhibit violence are screened out for the project due to concerns about child safety issues for the youth and community.

In addition to criteria related to the child's placement history, respondents reported that the child and family's commitment to participation in Wraparound has become an increasingly important criterion for acceptance into the study due to previous experiences where two children were un-enrolled due to lack of family participation in the Wraparound effort. However, respondents also indicated that exceptions have been made in instances where the child was committed to the effort despite the family's resistance. Respondents also reported that children who are "in crisis" are prioritized for selection relative to children who are stable in a high level of group care.

Implementation

Intake Process. Currently, only children from MAC and the two participating SPA's are identified for the program by DCSF or MAC caseworkers. Probation also refers youth that are identified by mental health staff working in the central placement unit. According to respondents, DCFS caseworkers are sometimes hesitant to refer families for Wraparound due to concerns that the family will experience profound disappointment if they are assigned to the comparison group after learning about the possibility of Wraparound. As a result, caseworkers screen out a portion of eligible children and families who they choose not to refer for the project.

Respondents reported that referrals are then reviewed by screening committees called Internal Review Teams (IRT). Currently, there is one IRT for each of the two participating SPA's. The IRT includes representation from DCFS, Probation, Mental Health, System of Care, Education, participating providers and the Regional Center if applicable. The case-carrying DCFS or

Probation worker presents the case to the screening committee, highlighting current and previous treatment needs and other relevant information about the child's status.

Once the IRT has determined that the case is appropriate for Wraparound, the case information is sent to UC Berkeley for random assignment. If the case is assigned to the comparison group, the IRT discusses other available alternatives for increasing service intensity, such as System of Care, Family Preservation or intensive mental health services. If none of these additional services is available, the child may continue to receive standard child welfare services. Cases assigned to the treatment group are immediately referred to the provider. For youth who are placed at MAC, Wraparound services may begin on-site as a means of facilitating reunification. The child and family would then continue to receive services when the child is returned home as well.

Depending on the family's level of stability and the availability of a Wraparound caseworker, the provider may contact the family the same day the case is assigned. In less urgent situations, the family is typically contacted two to three days after the case is referred to the provider. Respondents reported that the time to initial contact has decreased over time. In part, the start time for services has been improved due to contractual agreements with group homes.

Child and Family Team Process. The Child and Family Team (CFT) is formed as soon as possible following the initial family contact. The CFT is led by a facilitator, and includes a parent partner, a BA level child and family specialist, the child, and the parents or other caregivers. The referring DCFS worker may also participate as a CFT member. Additional family members, friends or other community members may also be included on the CFT.

After the CFT is formed, the initial meeting takes place as soon as possible. Respondents reported that it is ideally set up within one week, but sometimes takes as long as six weeks to arrange. During the initial meeting, CFT participants discuss the family's situation, identify strengths, needs and relevant resources. The child and family's needs are prioritized in the action plan. A crisis safety plan is also developed during the first meeting.

Respondents reported that the teams meet regularly and as frequently as is needed, depending on the family's situation; meeting frequency ranges from once a week to once a month. During the ongoing CFT meetings, participants discuss progress made since the last meeting, as well as any barriers that might be preventing the current need from being met.

Flexible Funding Pool. Respondents indicated that while each provider has a slightly different process for disbursing flexible funds, facilitators generally have access to funds up to 500 dollars, and funds for emergency situations. Higher sums of flexible funds require additional approval from agency directors. In general, facilitators must demonstrate how the flexible funds are to be used in the context of the treatment plan, and that other community resources were not available to meet the need.

Services. Respondents reported that services are highly individualized, and depend on the needs and strengths of the child and family. For example, in one case, a mother was connected to services that helped her learn to manage financial resources, and to access government assistance such as SSI and AFDC. In another case, services focused on the child's psychiatric needs.

Children in the comparison group may also receive a range of services, ranging from treatment associated with a residential program, to a formalized system of care alternative.

Case closure for the experimental group is determined by the ability of the family or alternative caregiver to safely maintain the child at home and in the community through utilizing community supports. There is no set expectation of how long a case will remain open in Wraparound due to variations among families' ability to remain stable without formal assistance, as defined by professional child welfare or probation involvement. Similarly, there is no expectation for the length of time a child in the control group may remain a dependent of the court. Case closure for the control group is defined by the termination of dependency or juvenile court jurisdiction.

Supervision and Monitoring. Respondents described several levels of monitoring and supervising the program. At the program level, there are weekly meetings to track each child in the project in terms of major incidents, placement status, and enrollment date. Bi-weekly meetings are also conducted with the providers as one group to discuss programmatic issues such as coordination efforts between the public and private agencies. On a monthly basis, providers submit reports with enrollment, placement status, case plans, and financial information. Currently, the screening committee does not review each individual case plan, though the county plans to build this process in to the function of the screening committee. An annual audit was also recently implemented in which providers will participate in a self-evaluation and subsequent external evaluation by the county's interagency quality improvement committee. The evaluation addresses six domains, including fiscal, program, training, human resources, administration and evaluation.

Respondents reported that the most significant challenge of the monitoring process has been the formal review process and the contradiction of evaluating a project such as Wraparound with a system that feels punitive by nature of the auditing process. A secondary barrier to implementing optimal monitoring processes has been the lack of sufficient dedicated resources. For example, participants reported that ideally the county and providers would regularly review all case plans jointly. Currently, there is only time to review critical incidents.

Difficulties/Solutions. Respondents reported that maintaining quality and consistent staffing has been the most formidable obstacle during implementation. In particular, it has been difficult to find qualified applicants to fill the facilitator positions. Once hired, the process for teaching clinicians the skills required for facilitation requires an extensive and time-consuming training series. Respondents reported that after completing the training process, facilitators sometimes then recognize that they do not want to make the commitment necessary to provide Wraparound services. One solution to this problem has been to develop facilitation skills amongst paraprofessional staff who have demonstrated commitment to the program and who are already aware of the time commitment associated with Wraparound.

An additional difficulty noted by participants concerns the time delays associated with probation officers enrolling youth who have not had a previous DCFS placement. Respondents indicated that there is a two-month lag in determining IV-E eligibility for these youth, a delay that serves as a deterrent for probation referrals, particularly given the subsequent possibility that the youth may be referred to the control group.

Finally, respondents reported that large caseloads frequently hinder DCFS workers' ability to be full participants in the Wraparound process. These county line staff are generally unable to play as active a role on the CFT as they may want to, due to the multiple responsibilities they carry outside of Wraparound cases.

Status. Currently, two SPA's and MAC have Wraparound programs operating.

Staff Attitudes. Respondents reported that both at the micro and macro level there is widespread support for the project, which, in some cases, is viewed as a potential "cure" for the problems encountered in standard child welfare. Participants expressed that the downside to the degree to which the program has been embraced by county board members, agency directors and line staff is that there has not been sufficient education to provide a realistic picture to these stakeholders about the amount of resources, collaboration, and level of change that must occur for Wraparound to prove an effective intervention. While case-carrying DCFS and probation workers see Wraparound as a potential solution for the children on their caseload, respondents indicated that they also have a difficult time sharing decision-making power with the CFT members, primarily due to concerns about child safety.

Staffing

In the Wraparound provider agencies, the facilitator oversees the treatment planning and service coordination process for the families on their caseload. The facilitator is also available to the families at all times. Child and family specialists also provide direct services, as do parent partners. Providers also have a community development specialist who assists the facilitator in cultivating and identifying community resources appropriate to the particular needs of the child and family. Each family team is also supervised by a clinician, who may or may not be the Wraparound program director.

Training. As discussed above, there is a significant learning curve for the facilitators in particular. The training program consists of formal training, shadowing and observed facilitation prior to taking on an independent caseload of families. Respondents indicated that there is also on-going training for all positions to strengthen the connection between the Wraparound model and its practical implementation for each function that staff perform.

Funding

For children in the experimental group, the Wraparound providers bill the county for the cost of overall program services. Placement costs are then deducted from the total service cost. Respondents reported that they also access EPSDT funds to cover the cost of mental health services. However, it has been difficult to access other non-flexible funding sources with the exception of EPSDT.

Funding for children in the comparison group is based on a categorical allocation for services that the child receives, such as foster care or family preservation. While EPSDT can also be accessed for children in the comparison group, respondents indicated that children who may qualify for coverage under EPSDT may not actually gain access to mental health services due to long waiting lists.

Client/Community Characteristics

Respondents reported difficulties in adequately serving the Hispanic population. Providers noted that Hispanic families frequently do not want to involve others in what are considered to be private family issues. This cultural norm conflicts with the Wraparound process particularly in terms of the team's efforts to link the family to community resources. Language barriers have also hindered optimal implementation as respondents reported difficulties in hiring facilitators and staff that speak the family's language.

Wraparound providers have also encountered difficulties in serving families when the child had probation involvement. In some cases respondents reported that these difficulties stem from situations in which the parents are engaging in criminal behavior, and therefore do not want increased scrutiny placed upon their family setting. Conversely, other families in which the parents have no criminal involvement may feel ashamed of their child's status in the probation system, and want to keep family issues contained.

At the community level, respondents reported challenges associated with accessing resources and social activities for youth in a community that is so broadly defined and amorphous. Gang activity has a particular impact on certain neighborhoods, and sometimes restricts youth willingness to participate in activities that are located in a rival gang territory. Respondents also reported difficulties in accessing intensive day treatment and other educational services in some communities. Some providers have also experienced resistance from churches in becoming involved as a support system for families, though this tended to vary somewhat.

Agency Factors

As previously discussed, both agency executives and county officials are in full support of Wraparound. In both cases, respondents expressed concern that there is an overall lack of understanding for the project, particularly the amount of resources necessary to fully support the project's goals. Further education is necessary to create realistic expectations for the project on the part of agency and county administrators.

Political Factors

Though some problems have occurred in relation to resolving differences between State and Federal rules concerning categorical funding, respondents reported an overall positive relationship with CDSS, the county Board of Supervisors and courts. Despite a historically complicated relationship between the Board of Supervisors, child advocacy groups and the commissions, in the case of Wraparound there is support along each of these fronts. There is some disagreement, however, about which providers should be contracted for the project, and how the project should be monitored. Overall, concerns about children's safety permeate the political front, but have not substantially hindered implementation.

The primary barrier to implementation for probation is the restrictions associated with immigration laws. Specifically, children who enter probation without previous DCFS involvement are more likely to continue to be undocumented, therefore restricting their access to Federal services such as those funded through Title IV-E.

Evaluation Factors

The random assignment component of the evaluation has affected implementation of the Wraparound intervention, because some case-carrying DCFS and probation workers are effectively screening out eligible children from the project due to fears that the child will be assigned to the comparison group. Many of these direct service staff consider the process unfair because families hopes are raised that they will get the service, which could ultimately be denied to them because of the random assignment process.

Respondents also expressed concern that the evaluation is not tracking youth longitudinally to evaluate the long-term success of the program.

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Target Population

Los Angeles County's target populations continued to be children referred from the Department of Children and Family Services (DCFS) and the Probation Department who were residing in RCL 12-14 group homes, or at-risk of placement into RCL 12-14 group homes. Participants reported that children with identifiable family members were initially targeted for enrollment as a way to ease the transition into implementation. After the first several families were enrolled, however, caregiver status became an irrelevant criterion for enrollment. Respondents reported an increased emphasis on providing Wraparound to children residing at MacLaren Children's Center (MCC).

Implementation

Intake Process. Participants reported that the program eligibility determination process has become decentralized over time as the County's project expanded from two SPA's to a county-wide system (eight SPAs). While referrals arrive at the same screening teams—the IRT—within a SPA, they originate from different departments, each with their own internal referral (pre-screening) process. At DCFS, the case-carrying child welfare worker makes the referral. Review teams knowledgeable about Wraparound at MAC (also a DCFS referral) make the referral. Probation referrals are made by the probation officer and may involve a central placement office with a unit of licensed clinicians that work with the most mentally impaired clients in a consulting capacity. Clinicians, at the request of the probation officer, review the client's case and assist the probation officer in placement and referral decisions. This referral process was commended for its training requirements and level of collaboration. Participants suggested that the probation department's referral process was influenced by individual officers' attitude toward the Wraparound process and sometimes by the officers' supervisor. Participants noted that Wraparound staff sometimes request that the case be transferred to an officer that is willing to work within the team process.

Respondents indicated that there has been an increased emphasis on referring children to Wraparound. Participants reported that the Probation Department administration has been encouraging officers to refer to Wraparound prior to the child's placement. The screening protocol now includes a question specifically inquiring whether the child had been referred to Wraparound. Participants reported that the family court places similar pressure on DCFS to explain why a child was not referred to Wraparound in the event that a referral was not made.

Once a referral has been received, an IRT at the SPA level determines program eligibility. An IRT will meet within 72-hours from the time of the referral for children referred from MAC or juvenile justice facilities, provided there is Wraparound provider capacity within the SPA. Participants reported that the increased emphasis on using the correct forms, having the proper referrals, and having the multiple agency staff present at meetings has increased obstacles. At the same time, however, participants reported that the referral process has quickened and is more efficient. Once the IRT accepts the child for Wraparound, the DCFS representative faxes the information to UC Berkeley for random assignment. Generally within hours the information is communicated back to the lead representative agency and the SPA coordinator knows whether the child has been assigned to the treatment or comparison group. To avoid extended service delays in cases where fiscal eligibility (i.e., Title IV-E eligble) is not already known, CDSS has authorized the enrollment of cases prior to Los Angeles County's determination of fiscal

eligibility. The average amount of time between referral to the SPA and provision of services is 1-4 days once the information is returned from UC Berkeley.

Child and Family Team Process. Participants reported the need to be more creative in locating family members and accessing community resources. A facilitator and a parent partner meet with the child and family to establish rapport and begin the process of developing trust. More recently, as part of that process, staff have placed a greater emphasis on assessing the functional strengths of the family based on the perspectives of the facilitator and the parent partner. The strengths and needs assessment forms used in the process vary by providers; however, participants reported using the same standard elements of assessment.

Participants reported that families often have limited resources at their disposal and are often ashamed of their situation, resulting in a reluctance to reach outside of the immediate family for assistance. However, as the team matures and as family members become more involved and trusting of the process, the dynamic begins to shift and additional natural supports emerge and become accessible. Participants reported that they are focused on integrating natural supports that will continue after the professional staff no longer provide assistance.

Case Closure. Participants reported that a case might be closed for a number of reasons. Primarily, a case is closed when the child and family team conclude that the plan has been completed, the goals have been met, and the family is ready to function without the ongoing assistance of professionals. Participants reported that when there are sufficient natural supports in place providing the assistance that would normally be provided by professionals, then the active role of the professional staff is completed. Progress on short and long-term goals developed by the child and family team are monitored as part of the case closure process.

In other cases, families have chosen not to continue with services early on after gaining a fuller understanding of the Wraparound approach, or have chosen to terminate Wraparound after a more extended period of time. Cases are also closed when Title IV-E funding ceases. This may be the result of the child's dependency or ward status ending due to reunification or turning age 18, or if a child's case becomes the responsibility of another county. A case may also close when child is place outside of the county where the provider is unable to provide Wraparound. In the latter situation participants reported difficulty in the transition with a case that is sometimes artificially closed without a transition plan in place.

In some probation cases, a family has enrolled but then consented to a probation setting for the child of 6 months or one year's duration, making the child unavailable for participation in Wraparound. In these special cases, participants reported suspending (stopping, then renewing services) the case until the child returned to the community. Child welfare cases may also be suspended for long-term AWOL situations.

Flexible Funding. In general, participants suggested that use of the small pool of flexible funding has shifted over time. As staff have gained knowledge of the Wraparound philosophy they have become less liberal with the fund, realizing the importance of accessing all other sources of funding and resources first. The priority is on funding short-term services or services that the family will be able to maintain after professional services end. Matching loans are also provided to inspire sense of investment with families and to gain family investment in the process. Some staff have used flexible funds to hire family members to provide program services.

A number of participants reported experiencing community pressure to pay for goods and services once knowledge of the funds became available. Some families started their participation with Wraparound with the expectation that funds would be provided to them. Providers have responded by changing the manner in which they present the program. In some cases, child and family specialists teach families to find their own free or inexpensive items. Participants mentioned other creative ways of obtaining goods for families, such as estate sales, and bargain boutiques.

Services. Participants reported that they initially expected to serve families over a period of 16 to 18 months. They have found service duration to be closer to 18 to 24 months from intake to case closure, though the total time allotment varies depending on the family's needs. The longer service duration was attributed to the complexity of the cases that are now served.

Supervising and Monitoring. Participants reported that changes have occurred in moving from smaller scale start-up status to large-scale operation. Monitoring the project has become more complex, requiring a completely different structure for oversight and review that is still in the process of development. A more formal process will be established at the SPA level as well as centrally. It is hoped that each IRT will assume the responsibility for oversight for the providers in their area. Other parts of the monitoring system will be centralized. Participants cited the project's partnership as critical to monitoring due to the complex nature of the cases and the lack of fit with the typical county contract monitoring process, and an effective mechanism for sharing lessons learned. Respondents also reported a need to strengthen the linkages and partnerships between the provider agencies and the respective public agencies. Meetings continue to be the primary mode of project oversight and information sharing.

Programmatically, participants reported that currently a staff member or review team observes facilitators and child and family specialists for two weeks as part of supervision. This method is used as part of the larger monitoring process and has been effective in highlighting trouble areas. Other participants reported weekly meetings with directors to keep records updated and to obtain program change information. Meetings might involve the executive director, the clinical executive director, facilitators, and the child and family specialists. In other situations, the management team may meet on case conferences weekly, to include a parent perspective.

Attitudes. Respondents reported a general enthusiasm for Wraparound. Individuals from direct service staff to top-level administrators in the participating agencies were excited about the intervention, even after discovering the shift from conventional thinking and practice required to do the work. Several participants described how individuals who had initial reservations about the program were converted in their opinion after witnessing the work being conducted with children and families. Enthusiasm for Wraparound was not wholesale across participating agencies and respondents felt more educational outreach regarding Wraparound was necessary.

Status. When asked how they would describe the current status of their program, participants reported that it depended largely on the SPA, as some providers have just come on board and others have been providing services for up to two years. The staggered stage of implementation has been beneficial for agencies implementing later. Respondents also suggested that differences in implementation status related to differences in levels of experience working with the target population.

As a collective, progress was reported as moving in a forward direction, but not necessarily linearly. Progress was being made, notably in the area of the public and private partnerships

being developed within each of the SPAs. Development of the project's infrastructure had spread throughout the county and was expected to provide the capacity of an increase in the numbers of children and families served by the program.

Staffing

Participants reported that in general, each team has a facilitator, child and family specialists and parent partners. The specific configuration of the professional team is dependent upon the needs of the family. Whether individuals always work in tandem or are assigned as needed is dependent upon the agency, though respondents reported that team structures were usually in flux as agencies learned how to best manage their resources. For example, a parent partner may not be available. In these cases an agency may rely on the child and family specialist for related duties. It was noted that some parents prefer a child and family specialist to a parent partner. These types of modifications are made at the family's request.

In general, staff recruitment and retention were reported as major challenges to Wraparound program implementation. The issues affecting recruitment and retention included the paradigm shift required by the Wraparound philosophy and the collaborative, team-based orientation, the in-home nature of Wraparound interventions, the scheduling demands of the Wraparound program staff, and the need for bilingual professional and paraprofessional staff. The pool of potential staff candidates is made up primarily of mental health professionals with traditional social work training and a focus on therapy. Some agencies have also found it difficult to find male facilitators, parent partners and child and family specialists. Retention challenges described were similar to the recruitment issues identified.

To overcome some of these barriers, agencies have successfully recruited staff from programs within their own agencies. Other providers have assisted individuals with a background in more traditional social work (i.e., therapy-focused) in making the transition to more community-based, eclectic practice. To address the need for bilingual staff, agencies have utilized interpreters for child and family team meetings and other resources such as AT&T's "language line." The service interprets over 150 different languages and has been met with positive reactions from families. Without this service, participants reported that the bilingual parent partner would become the default interpreter, potentially jeopardizing the parent partner's relationship with the family. One participant noted that retaining a paid translator has sometimes compromised the process because of difficulties in translating some of the terminology of Wraparound.

Training. Participants suggested that the amount of ongoing training and supervision required for Wraparound is substantial. Some felt that the 16 days of basic training for team staff may need to be modified. Additional training needs mentioned included safety planning for new team members and cross-systems trainings for agency provider staff.

A unique training feature discussed concerned the commitment from providers who had been operating for some time to train newer providers. Assistance was made available through formal training and informal discussions. The process was helpful to new programs and something that participants were hopeful to see in place as they head towards further expansion of the program.

Funding

Confusion about whether EPSDT can be billed for Wraparound and the conflict in billing language between strength based Wraparound services and EPSDT's clinical billing requirements were discussed as funding challenges. Participants cited a need for training on

proper billing to protect against future audits. Participants noted the need to include the Department of Mental Health in this training. Concerns about cuts in funding for mental health services were expressed.

Client/Community Characteristics

When asked if the social or economic characteristics of the county's child welfare client population had changed since the inception of the program, some participants suggested that these changes might be difficult to detect with different agencies coming on board at different stages. Others suggested that no changes had taken place.

Transportation, respite care, education, and behavior modification were cited as ongoing issues with housing and homelessness described as the biggest difficulties for families. The distance between SPAs was cited as a community level factor that programs have adjusted to.

Foster care providers were mentioned as a major community resource that could be more successfully utilized to support children and families.

Agency Factors

Several participants cited the need to create stronger linkage and partnership between the operations of the county departments and the Wraparound provider agencies, and their respective management structures, and much earlier in the implementation process.

Several agency factors, such as agency culture and relationships with other systems of care or providers, were cited as having an impact on program implementation as well. Participants suggested that within the county there has been a push to enroll children in Wraparound services. This is seen as a positive influence on program implementation generally, though some participants expressed concern about the sense of urgency the push creates and the need to make decisions in the child's best interest and safety. Participants noted some departments have been more flexible than others, with varying levels of willingness to allow flex time for workers to participate. Respondents also acknowledged the caseload constraints that hindered child welfare worker participation.

In general, participants noted that many of the individuals that make decisions about children's lives do not understand the Wraparound program and this is a major educational problem in the county. For example, hearing officers are not aware of how wrap services operate and will send children home regardless of wrap. Attorneys will tell people that services are in place when they are not. The more that Wraparound appears before the court system, however, the more knowledgeable the court system becomes and the more cooperation providers receive. On the other hand, once a judge knows about the program and a worker says a referral has been made, the judge may assume that a particular set of services is underway.

Participants cited successful Wraparound experiences with children in residential care, though in some cases the process could be more collaborative. Participants reported that the level of cooperation usually depended the group home worker's understanding of Wraparound (where they were on the learning curve) and the group home's willingness to innovate.

Another factor mentioned was the importance of the interface with the school system and keeping schools engaged as partners in the Wraparound process. One participant mentioned that their Wraparound population has several children that are out of school because the services

offered by the school are not working for them. Participants cited a need for more educational alternatives.

Political Factors

When asked if any additional political factors, such as mandated programs, regulations, relationships with the CDSS, or the county Board of Supervisors, influenced their agency's ability to implement the Wraparound program, participants reported that the level of government support for the Wraparound program has become stronger in the last six months. Top-level county agency administrators have requested that the program be expanded quickly.

State support has focused participants on making the Wraparound program a stronger and more viable operation. The program has been getting increased positive publicity. Several participants emphasized the power of the disseminating information about early successes and positive program experiences.

Evaluation Factors

Participants suggested that randomization continues to affect confidence and momentum in the program; the rigorousness of resistance to randomization had been underestimated. Some felt the program was limited in size due to its demonstration project status.

5.2.3.4 Sacramento County

1999 Process Study

Pre-waiver services

Intensive Services. Sacramento County respondents reported that efforts to provide flexible mental health services had been thwarted by the lack of available flexible funding sources. Limited to Medi-Cal billing (EPSDT), intensive services were offered to children with involvement in multiple systems, who were identified due to mental health needs. The Bridges program eases the transition for children stepping down from a high level of care by means of individualized treatment planning that is strengths-based and family driven. Through bolstering support services, Bridges also attempts to improve placement stability for youth who are at risk of entering a high level of care. Despite funding constraints, mental health services are individually tailored, ranging from therapy to in-home support services. Services were provided for approximately 6-14 months, with the goal of achieving permanency for intensive needs youth. In addition to goals related to permanency the program focuses on increasing school attendance and achievement and engaging the child in pro-social activities.

Non-Intensive Services. Respondents indicated that when a child requires residential treatment at an RCL 13-14, the child welfare worker refers the case to the Interagency Management Referral Committee (IMAC) team, to determine if the case meets the State regulated criteria for RCL 13-14 cases such as presenting an imminent danger to self or others. For lower level placements, the placement worker in the given system (child welfare, mental health or probation) makes a direct referral to the out-of-home care provider. Children placed in RCL 12-14 care receive mental health and psychiatric services, as well as direct services from agency social workers. However, respondents reported that provider capacity within Sacramento County does not meet the demand for youth requiring RCL 12-14 services, leading to out-of-county placements for many intensive needs youth.

Following these non-intensive services, focus group participants from private provider agencies estimated that approximately 75% of youth are placed in lower level group homes or foster care, while others either enter the juvenile justice system, emancipate from their out-of-home care placement, or, in some cases, reunify with their families. However, these outcomes are specific to children served by two private agencies, and are not known for the county at large.

While youth in RCL 13-14 placements receive mental health services and other supplementary resources available in these intensive treatment settings, there are few consistent aftercare services available to provide continuity of care for these youth. The Bridges program serves this function, along with a small pilot program called the Community Intervention Program and Access. However, respondents indicated that consistent aftercare services are not available system-wide, leading to reliance upon more mainstream community resources such as after school programs, to be able to care for youth returning to lower levels of care. Additionally, respondents reported that older youth have fewer community-based resources and aftercare services available to them.

Program Planning

Planning Group. The Intensive Services Program planning group started as the Family Resource Advisory Team (FRAT), comprised of mental health clinicians and other child care professionals. FRAT organized specifically for Wraparound, with the goal of learning the Wraparound philosophy and subsequently planning for both the Title IV-E waiver and SB 163 State-only Wraparound. The Department of Mental Health (DMH) is the lead agency for Sacramento County's Intensive Services Program, (also housed in the Department of Health and Human Services along with Child Welfare). Currently, the planning group is comprised of approximately 20 people, including CPS staff from long-term planning and placement divisions, the CPS program planner, probation administrators, administrators from the project's two lead private agencies, school district officials, parent consumers, and youth consumers from the Sacramento Advocates for Family Empowerment, a youth advocacy group. A subset of this membership works specifically on program design. Planning group participants were selected due to their status as key leaders in the county, who have a vested interest in the Waiver Project. Other members are involved either with IMAC or another part of the placement process. Finally, some members were selected to provide input from a consumer perspective, with the assumption that they will also play a vital role in developing community support for the project. The youth and parent consumers receive financial compensation for their participation on the planning team.

Planning Process. The planning for the Intensive Services component of the waiver began in December 1998, with four-hour weekly planning sessions. The original planning team will now be folded into the planning process, with emphasis on developing intake criteria in relation to the IMAC eligibility and placement function.

In addition to creating a planning group with broad agency and community representation, the Intensive Services planning group has also held regular meetings with public agency line-staff, and other stakeholders such as group home providers, a children's coalition, and parents and youth. Through these meetings, the planning group sought input into the Wraparound design proposal from those individuals who would be affected directly by the implementation of intensive services.

Respondents reported that they anticipate assigning three cases, one each from DOP, DSS, and DMH, by the end of March, 1999.

Target Population

Respondents reported that the target population for Wraparound services in Sacramento County is youth residing in RCL 12-14 placements, and youth who are at risk of this placement level. As an additional requirement, participants discussed the need for family participation in order for the Wraparound process to be successful.

Participants also mentioned specific criteria that narrow the target population into a segment of children whose needs cannot be met through lower levels of care, while at the same time excluding youth whose extreme risk behaviors would place a community-based support system at risk. For example, the child must demonstrate impaired functioning in two or more life domains; have multiple behavioral, emotional and social needs; a history of psychiatric hospitalization; and the capacity to function safely in both the home and school environment with intensive services support.

Pre-Implementation

Intake Process. Focus group participants indicated that the intake process will partially hinge upon DMH, DSS and DOP placement workers' (DMH and DSS) ability to evaluate whether or not a case is appropriate for Wraparound. Workers will be aided by either the Structured Decision Making tool or another assessment mechanism in order to promote consistency in this initial screening procedure. Placement workers will then refer cases to their respective departments' IMAC representative, who will ensure that the case is federally eligible. The referring system will then present the case to the IMAC team during the weekly case review meeting. The IMAC team will make the final determination of a case's Wraparound eligibility. Respondents pointed out that this intake process essentially replicates the current IMAC procedures for RCL 13-14 placement determination.

Supervision and Monitoring. Respondents reported that there will be several levels of program oversight. The Community Advisory Team will provide broad programmatic direction, while monitoring the progress of each case. Additionally, the Quality Assurance department will monitor service implementation. The Cross-systems operation team will establish services quality indicators, and ensure inter-agency cooperation. Participants cited the joint partnership between the public agencies and private providers as one challenge for project oversight. While providers will be evaluated for their capacity to provide Wraparound, the public agencies will need assurance that the network of providers is fully implementing the model rather than reverting back to more traditional treatment modalities once a case has actually been referred for services.

Difficulties/Solutions. Respondents anticipated difficulties in identifying cases appropriate for Wraparound. At the organizational level, participants forecasted complications in maintaining consistent project coordination. If problems do arise during implementation, the Cross-Systems Operations level resolution team, comprised of representatives from each of the public agencies, will meet to resolve issues specific to Wraparound implementation. The Management Forum under the Department of Human Services will mediate conflict that cannot be worked out at the Cross-Systems Operations level. Finally, the Community Advisory Team will intervene when policy issues arise.

At the program level, quality assurance indicators will be established based on the EMQ Wraparound guidelines. These indicators will be used to assess the Wraparound activities performed by the community providers. The Cross Systems Operations team as well as the Community Advisory Team will utilize the results of quality assurance reports to make needed adjustments to project implementation.

Funding. Respondents expected funding for Wraparound to begin imminently, upon completion of the MOU between CDSS, and Sacramento County. In addition to Title IV-E funds, respondents reported that EPSDT funding, charitable funding, and SB 1667 support would also subsidize the Wraparound project.

Staffing

Rather than creating new specialized units for Wraparound in the public child welfare agency, respondents indicated that self-selected staff will participate in providing Wraparound care. According to focus group participants, this strategy will allow continuity of care by avoiding the reassignment of social workers to a new unit. Additionally, the social workers that opt into Wraparound initially will presumably be more motivated to learn this new service orientation, leading to a smooth transition into the project. Eventually, all child welfare workers will be brought into the project so that all front-line staff will be comfortable with the Wraparound concept. Respondents reported that no staffing changes would be necessary on the mental health side of the project, where clinicians will follow the case across placements, per existing structure.

According to respondents, DOP has made the most significant changes to adapt to the new Wraparound philosophy. Structurally, a new unit was constructed to accommodate Wraparound, consisting of a placement manager, probation officer and supervisor, all of whom were motivated to move to this new service modality. Respondents emphasized the importance of the self-selection process, given the variety of demands presented by the flexible service orientation of Wraparound. Conceptually, Wraparound is a sizeable shift for DOP, whose standard method of working with youth is corrective rather than the strengths-based approach central to Wraparound. Additionally, probation officers are typically saddled with high caseloads, allowing little time to work concurrently with other service providers or families. However, staff in the new probation unit will attend Child and Family Team meetings and adjust services to work within the family-driven context of Wraparound.

The implementation of the Intensive Services Component will also lead to staffing changes in the private child welfare agencies. Representatives from EMQ and River Oaks, the two contract provider agencies, indicated that direct care staff will be added as needed once services begin. Additionally, positions will be created to liaise between the public and private agencies. Within the private agencies, River Oaks and EMQ view themselves as a partnership, and intend to have co-located teams operating under policies and procedures established jointly by an operations council. While the teams will be made up of agency-specific employees due to separate funding sources, some positions, such as research directors, will cut across both agencies. Currently, one Program Director serves both agencies. At the service provision level, each team will consist of a facilitator, three-four family specialists and a family partner. Teams will serve six families each, with the possibility of adding teams as the client population increases. In addition to the staff associated with specific teams, the private providers have also hired community

developments specialists, family development specialists, program development specialists, and a care and involvement coordinator who manages parent advocacy.

Training. Respondents described an extensive cross-training plan for public agency staff from DOP, DSS and DMH. Trainings will focus on both orientation to the model and engagement with core areas of the Wraparound approach. All county and provider agency staff will participate in skill-building sessions focused on five key concepts: Child and Family Team meetings, conflict resolution, parent partnerships, Wraparound treatment planning, and the strengths-based approach.

Additionally, private agency staff will receive extensive training provided by the lead agency, including a basic training, family-centered practice, collaborative team meetings, managing flexible dollars, measuring outcomes, facilitating service planning, and wraparound/juvenile justice crossover.

Client/Community Characteristics

According to respondents, Sacramento County's public agencies are challenged by increasing poverty, high rates of child abuse, large probation caseloads, and a child welfare population that one respondent characterized as younger and more severely impaired relative to children in other counties. Additionally, while public agencies struggle to hire a diverse staff reflective of the county's population, respondents reported that there are seven "threshold languages" in Sacramento County, making it increasingly difficult for agencies to provide adequate services to all members of the community. Finally, respondents reported that the prevalence of methamphetamine labs and other drug operations within the county exacerbate conditions of poverty and violence.

Political Factors

Respondents described DHHS' relationship with the juvenile court as an amicable one, with the court thought of as partners in the Wraparound implementation process. Respondents reported that the presiding judge was supportive of Wraparound during preliminary discussions. Respondents expected the court to take on a larger role once Wraparound implementation actually begins. Court officials had already received all the court orders that Santa Clara County judges use for Wraparound, establishing an important link to a court system with significant Wraparound experience. Respondents reported that the Dependency Bench, District Attorney's office, Delinquency Bench, and CASA have all agreed to participate in Wraparound trainings, and have been supportive of the Waiver Project, though the Dependency Bench is reportedly "nervous" that Wraparound will lead to children being reunified with their families pre-maturely. Recently, two children were killed while under the supervision of CPS, a tragedy that has led to increased caution and skepticism of efforts to preserve families.

Respondents reported that the Board of Supervisors has been supportive of Wraparound, and receives progress reports on implementation from the Children's Coalition, a body that advises the Board on children's issues. Similarly, respondents felt that CDSS has formed a working "partnership" with the county, and has been supportive of the county's proposal and progress toward implementing the waiver.

While focus group participants felt that there was a welcoming environment for collaboration in Sacramento County, they expressed concern about attitudes within individual departments that may hinder implementation plans. For example, following recent media exposure of high profile

child deaths in the Sacramento Bee newspaper, respondents described CPS as skeptical of Family Reunification services due to increased concern over child safety. Additionally, the traditional "corrections" approach taken by DOP could hamper efforts to span Wraparound services across both child welfare and juvenile justice. Finally, labor union politics could be a factor that inhibits the full-scale implementation of Wraparound because under the project, staff would be required to perform activities outside of their contracted job duties. Accordingly, the county will be utilizing staff who volunteer to do Wraparound rather than attempting to negotiate new contracts for all staff based on Wraparound.

As implementation proceeds, respondents indicated that county administrators will carefully consider how to present further potentially politically sensitive information to stakeholders, while simultaneously incorporating feedback from influential political bodies such as the courts. Respondents were encouraged by the fact that the Sacramento Bee had already provided positive media coverage of the county's intention to implement Wraparound, lending community support to the project. Participants also emphasized the strengths-based approach they had been using during their own planning process. Rather than focusing on the numerous potential problems that could arise during implementation, the planning group has attended to their own learning process, viewing setbacks as an opportunity to learn and improve the project during this pre-implementation stage. For example, the planning group has recognized that some units will be resistant to implementing Wraparound, allowing the group to intentionally address any negative attitudes toward the project preemptively.

2001 Process Study

Target Population

Respondents indicated that the target population for Wraparound is children who are either residing in RCL 12-14 placements or are considered to be at risk of placement in RCL 12-14 facilities. While a change in State legislation expanded the focus of Wraparound to include youth residing in Level 10 placements as well, respondents reported that Sacramento County has not altered their target population to include youth in this lower level of care. In addition to placement level, respondents reported that the target population for this study also must be designated as having severe emotional disturbance (SED). For a period of time, children also needed to have an identified caregiver with whom the child could live.

According to focus group participants, the project experienced significant delays in bringing children into the study due to the combination of the county's policy necessitating caregiver involvement as well as the slow process of realization that this policy was, in fact, responsible for excluding the majority of the child welfare population residing in high level group homes. Initially, respondents indicated that they had believed the shortage in referrals stemmed from a negative attitude toward Wraparound among CPS line-staff. However, upon examination of the IV-E eligible children in RCL 12-14 placements, it became apparent that most of these youth had no identified family member with whom they could reunify. As a result, respondents described a process of modifying the concept of Wraparound from an entirely family-focused model to one that allows the inclusion of youth who need the intensive support of Wraparound to be able to successfully transition to less restrictive environments, even if they cannot return to their families of origin.

Respondents viewed Wraparound as a promising option for youth stepping down from high levels of residential care, as well as a means of reducing the number of out-of-county and out-of-State placements. According to participants, these youth frequently do not experience successful outcomes in lower levels of care due to the lack of available supports during this tenuous transition process. Additionally, respondents favored the comprehensive and strenghths-based Wraparound approach, which emphasizes working with the child as well as their family or support network, rather than typical deficit-based and child-focused services. Respondents were hopeful that Wraparound would create a sufficient support system for these youth as they moved to less restrictive placements or returned home. While Family Preservation is considered unpopular in Sacramento County due to a tragedy that occurred when a child remained in an unsafe home environment, respondents viewed Wraparound as a safe means of monitoring children as they return home due to the oversight made possible by the intensive services model.

Ironically, respondents indicated that the segment of children that does have family resources—youth under the supervision of DOP—is no longer being referred to the study. According to respondents, the DOP population is more ideal for Wraparound services as compared to the CPS population, because, whereas in the CPS population abuse is a risk factor, in the DOP population the family would presumably be willing and able to safely care for the child in the home environment with the aid of intensive in-home services to focus on helping the family control the child's behavior. However, according to respondents, Probation has stopped referring eligible children to the study due to frustration among some DOP administrators and staff who perceive that a disproportionately high percentage of DOP youth are randomized into the control group. As a result, this portion of children eligible for the study no longer has the opportunity to potentially benefit from the Wraparound intervention.

Implementation

Intake Process. The primary source for referrals to the study is case-carrying child welfare workers. Supervisors in CPS regularly review cases with line-staff to determine which children on their caseload are at risk of RCL 12-14 placement, as well as cases where children may already be in these high level residential placements. Additionally, residential treatment providers identify youth in their care who could potentially benefit from Wraparound as a means of facilitating a transition to a family home setting. Less frequently, parents who have contact with other families who are receiving services through Wraparound may request to be referred for the study.

All referrals for Wraparound are reviewed by IMAC. IMAC reviews each case to determine eligibility for RCL 13-14 placement recommendations, as well as to assess whether or not the case meets intake criteria for Wraparound. As a standard part of the referral process for Residential Treatment Facilities, the referring caseworker must indicate whether or not they have considered Wraparound as an appropriate intervention for the case at hand. If not, the placement worker must justify the decision not to refer the case to Wraparound. Respondents indicated that this additional screening process ensures that line-staff are considering Wraparound as an option for any child for whom they have determined that an intensive treatment placement is necessary. IMAC then sends approved cases to UC Berkeley for randomization.

Respondents reported that cases assigned to the experimental group are now processed through the Mental Health Access Team, rather than referring new cases to the providers for distribution, as was done during the project's inception. The Access Team allocates incoming cases to the

three providers, EMQ, River Oaks, and Stanford Home. The Access Team also prioritizes cases when necessary, such as when a staffing shortage or influx of cases leads to a wait list rather than immediate case assignment. Additionally, if a child was identified within one of the provider agencies' residential programs, they would automatically be assigned to that agency rather than the provider with the next open space. Otherwise, cases are distributed evenly amongst the providers when each agency has spaces open. Respondents reported that the Access referral process takes place within a day. Each provider agency has a Clinical Program Manager (CPM) that coordinates the intake process with the provider agency.

After receiving intake information from the Access team, the CPM attempts to contact the family within the next 48 hours. If the child is in a group home, the CPM contacts the provider. During this initial conversation, the CPM attempts to engage the family in the process, providing a brief orientation to Wraparound and what the family can expect, as well as trying to form a connection with the family. Additionally, the CPM gathers information during this initial conversation in order to assess the family's current situation and level of need. Respondents indicated that while some families may be in crisis, leading to a Family Specialist providing in-home support the following day, other families might be more resistant to the process, leading to delays in service initiation.

Following this initial phone contact, the Family Specialist then takes over the case, setting up an in-home visit, which typically takes place within 10-12 days of the first contact with the family, depending on current level of need and the family's availability. According to respondents, services typically begin at a relatively slower pace for youth who are residing in group homes, because they are already in a stable environment, creating a less urgent situation compared to families struggling to safely maintain a child in the home.

Child and Family Team Process. The purpose of the Child and Family Team (CFT), according to respondents, is to bring the child and family together with a group of community members, extended family members and professionals primarily identified by the child and family, that are willing to form a supportive network for the family. While the process is family-driven, team members provide insight and input into developing strategies geared toward assisting the family in meeting its own needs by capitalizing on family strengths, including the ability to provide a safe and nurturing environment for the child.

The process of putting together the CFT begins with the facilitator engaging and orienting the family to the process, as well as assessing the family's strengths, resources and natural supports in the community. The facilitator contacts other providers who work with the family, as well as the other supports identified by the family, in order to develop membership for the CFT. The facilitator also conducts a formal needs assessment to gain an understanding of what the family will need in order to be able to maintain the child within the home, and what types of strategies might be effective in meeting that goal.

Respondents indicated that the time from intake to the first CFT meeting varies greatly by family. While some families may be open to the experience of the CFT, others may feel intimidated by the concept of bringing team members together from various facets of their lives to a meeting where the family is the central focus of scrutiny. In order to assuage potential anxieties about the CFT, facilitators recognize the need to prepare the family for what the CFT might discuss, and to communicate openly with the family about the purpose and goals of using the CFT. Additionally, participants reported that they have altered their approach to initiating

the first CFT meeting. During the project's inception, facilitators rushed to begin the CFT process right away, without sufficiently engaging the family and evaluating their immediate situation first. However, participants reflected that this approach resulted in an incomplete assessment of the family's situation, leading to an unclear agenda for the CFT and confusion among members as to what role they should play. As a result, the CFT meeting does not start until the facilitator has gathered enough information from the family, other team members as well as staff who may already be providing interim in-home support to help stabilize the family. Respondents indicated that the first team meeting typically takes place within two weeks of intake.

Respondents reported that the first few CFT meetings are devoted to developing a crisis plan for the family. In developing the crisis plan, the team considers family dynamics, school issues as well as community factors that may contribute to or inhibit a crisis situation. If the family is experiencing a period of stability upon intake, the crisis plan may not be addressed until a difficult situation arises, when an appropriate response is more apparent. Within this context, the CFT also evaluates how the child and family's strengths, as well as the ability of other CFT members to support the family, could be tapped during periods of instability. Rather than providing the family with as many necessary resources as possible, the CFT and associated agency respond to a parent-driven process where the family has "voice and choice" as to what types of resources will help them to achieve stability and self-sufficiency. Ultimately, the goal is for the family to be able to meet its own needs, and be able to seek help from the community when needed, without the assistance of professionals.

A central tenet of the CFT process is the use of a strengths-based approach. While facilitators can begin to assess a child and family's strengths beginning with the referral paperwork and initial conversations with the child and caregivers, a formal conversation about the strengths based approach takes place during the second or third CFT meeting. According to respondents, this approach can be difficult for families who have experienced the deficit-focus of the child welfare system or other public agencies for prolonged periods, and have come to view themselves through this lens. As a result, these families may resist reframing their situation or capacities in a positive light, requiring a period of adjustment to be able to view their own assets.

While the facilitators are MSW-level employees at the three contract agencies, the county child welfare workers (CWW's) still play a role on the CFT, especially if there are concerns regarding the child's safety or stability in the home. Respondents reported that the CWW also plays a central role in terms of ensuring that the CFT process meets any court mandates or other CPS requirements. Given the high turnover rate in CPS, respondents reported that some CWW's may need an orientation to the Wraparound process, which is recognized by the private provider agencies.

Representatives from the provider agencies indicated that the process of forming a CFT and initiating services begins somewhat differently with children who don't have an identified parent or caregiver. Respondents reported that for these children residing in group home care, the engagement process involves contacting the group home provider, as well as the CWW, and beginning to form a connection with these parties who serve as surrogate caregivers for this child. However, respondents agreed that the process of developing the CFT and initiating services has a slower start for children living in group homes, than for youth who have already returned home or to a foster care setting. Whereas there may be crisis or safety concerns for a child living in a family home, and a need to quickly stabilize the situation, children are assumed

to be safe in the controlled environment of a residential setting. Therefore, there is a lack of urgency on the part of providers to assess the child's current situation immediately upon referral.

While the three provider agencies (EMQ, River Oak and Stanford Home) share similar approaches to developing the CFT when a caregiver is identified, there are differences among how providers view the CFT when the child is in group home care and without an identified family setting. One of the providers does not assign a facilitator to the case until a permanent plan has been developed to move the child to a family setting. According to representative from this agency, the process of developing a CFT with group home staff before caregivers have been identified for the child does not help build a long-term plan for the child, so the process is delayed until the facilitator can work with family members or alternative caregivers. In contrast, among the other two providers, there is less differentiation between the CFT process for group home youth versus youth with an identified caregiver; both types of cases have a facilitator assigned to them right away. Participants from these agencies asserted the importance of connecting the facilitator to the child and placement staff upon intake, thereby promoting the process of assessing the child's needs and strengths in order to be able to develop appropriate resources for that child. Respondents agreed that the issue of developing the CFT process without identified family resources is relatively uncharted territory for the agencies, given that the adjustment to targeting more youth without identified caregivers was a recent one. Participants struggle to reconcile the fundamental goal of returning children to the most family-like setting possible with having to settle for a lower level group home placement if alternative caregivers have not yet been identified. As a result, the CFT process is somewhat in a state of flux for this segment of the Wraparound population.

Flexible Funding Pool. Respondents reported that flexible funding dollars are used as a last resort, when the family is in a crisis situation, or when there is ongoing need for a limited amount of time that cannot be met through community resources or a different avenue. The CFT determines if there is a need to support the family financially. The facilitator then fills out a request form, indicating the amount and the reason for the request. The CPM and program director either approve the request and disburse a check, or contact the facilitator if questions about the amount or appropriateness of the request arise. Some respondents indicated that in a crisis situation, the facilitator frequently has to ask for the request retroactively, having already spent the money to stabilize the situation. Respondents reported that it is often difficult to balance the desire to be responsive to family crises with a sense of apprehension that financial support will unintentionally promote a family's dependence on the system rather than developing self-sufficiency.

While smaller requests are handled by each agency internally, amounts that are $300 or larger are reviewed by the cross-systems operations team, comprised of representatives from CPS, DOP, and DMH. This includes requests that are ongoing in nature and will exceed $300 over a period of time. One such ongoing expense cited by participants is helping a family to pay rent in order to avoid eviction. As part of the procedure for approval, the facilitator presents the budget request in the context of the individualized child and family plan. The review team meets twice a month to review cases, which are set on a rotation schedule. If a request is particularly large, the facilitator presents the case at the next available meeting.

Respondents reported two primary challenges with disbursing money from the flexible funding pool. First, there were initial misconceptions as to the purpose of the flexible funding pool. Some staff members and families were under the impression that the pool could be accessed any

time there was an occasion to improve the family's well-being, with no plan to transition the fiscal responsibility to the family. According to respondents, this misunderstanding was corrected through training, ensuring that families receive a consistent message concerning appropriate uses of the flexible funding pool. Second, respondents described difficulties in connecting the CFT goals established for a child and family, as well as the goal of self-sufficiency to the use of funds. For example, if the facilitator requests that the agency purchase a vehicle for the family so that a parent can commute to work, the facilitator must clearly tie the request back to the child's goals.

Services. Respondents described the Wraparound intervention as a structured process driven by the family and CFT. This process results in highly individualized services based on an assessment of the resources that the family, or other identified caregiver, will need in order to safely support the child in their care. The family drives the process of identifying its own needs, with additional input put forth by members of the CFT. A central tenet of Wraparound is identifying and building upon the family's natural support network and community resources as a means of meeting identified needs. The goal of Wraparound is to bolster the caregiver's ability to care for the child in the home environment, by helping the caregiver to establish a supportive network that eventually replaces the need for professional intervention.

Services provided to children assigned to the treatment group vary depending upon the child's individual needs. Intensive in-home services may be provided to a child in the context of their family environment, but if the child returns to out-of-home care, the services will follow the child to the group home or other residential setting. Children also receive traditional mental health services, such as individual therapy, either within the context of an out-of-home placement setting, or from therapists in the community. Respondents also emphasized the non-traditional services that children receive in the treatment group due to the flexibility of Wraparound. For example, if the CFT identifies a need for the child to gain a better understanding of how to care for animals, the providers' resource department could try to make a connection with the Sacramento zoo to pair the child up with a zookeeper. According to respondents, priority is given to connecting families with community services, and providing services through the provider agency when gaps are identified, such as art therapy groups, psychiatric medication management, and a 24-hour crisis on-call system for families. Additionally, respondents stressed the comprehensive approach of Wraparound, which allows providers to develop non-traditional services for parents as well, with the goal of improving parenting skills and long-term self-sufficiency. Family partners help work with parents on balancing checkbooks, understanding the IEP process, and connecting them to community resources such as cooking classes. Respondents estimated that services, in the form of the first home visit, begin with the family approximately 10-12 days after the case is assigned to the experimental group. While no cases had yet closed, respondents predicted that children would receive Wraparound services for approximately 18 months.

Respondents described the services received by children in the comparison group as highly variable in terms of intensity level. Youth placed in a residential setting typically receive individual mental health services, either through the provider, or through Access. Some youth, placed in the highest levels of care, may receive intensive services comparable to those received by youth in the experimental group, but without the flexibility and seamless nature of Wraparound. After a youth is assigned to the comparison group, the case worker may also refer them to other intensive services at the Wraparound provider agencies, or to the Focus program

via Access, another intensive services program in the county. Though intake criteria are slightly different for the Focus program, with an emphasis on risk of hospitalization, many of the youth are eligible for this program as well. All three Wraparound providers also serve as Focus providers. Some participants expressed that there are few differences between the services received by youth in alternative intensive services programs and those received by youth in the Wraparound study, noting that even the CFT process had migrated to other intensive service programs within the agency. Contrastingly, other respondents indicated that while these alternative intensive services programs provided by the Wraparound agencies are beginning to apply the Wraparound philosophy to traditional programs, providers continue to face limits posed by inflexible funding, leading to fewer comprehensive services for families.

Supervising and Monitoring. Respondents reported that the project has numerous mechanisms to oversee the program, many of which are in a state of improvement and adaptation in response to the challenges posed by monitoring a non-traditional program such as Wraparound. The cross-systems team provides broad oversight of the project, as well as reviewing the status of individual children and families. Respondents felt that the review team was becoming more adept at critically examining the strategies, goals, and safety plans presented by facilitators. The family review team considers the CFT's approach within the context of the Wraparound model, and provides feedback to facilitators accordingly.

In addition to the cross-systems case review process, respondents reported several documentation and measurement tools used to monitor program implementation. Quality Management (QM) staff review cases through Medi-Cal charting, and assist staff in describing services in a manner that meets the documentation requirements of Medi-Cal, including demonstrating medical necessity. Respondents reported that it has been challenging to incorporate the strengths-based language and philosophy central to Wraparound into the traditional measurements and paperwork required for funding, such as the Child Behavior Checklist, Child and Adolescent Functional Assessment, and Youth Self-Report, which are all standard in Sacramento County, in addition to Medi-Cal requirements. In response, project administrators have implemented a few additional tools to capture the content of Wraparound. For example, the Wraparound Fidelity Index helps to gauge whether or not participants in the CFT perceive the services and process to be consistent with the Wraparound Philosophy. Additionally, a parent satisfaction survey helps providers to gain a sense of parental perception of the services and provider agencies.

The Wraparound approach has also required a change in staff supervision. Respondents reported that effective supervision requires clinical supervisors to observe facilitators in the field, during the course of CFT meetings. Rather than focusing on the clinical content of the meeting, CPM's focus on the facilitation process, and the staff's ability to engage CFT participants. Accordingly, supervision in Wraparound is frequently more time consuming than standard clinical supervision, and has required a great deal of adjustment on the part of clinicians, who have taken on a coaching role. In addition to observation and debriefing, respondents reported that group supervision is an effective means of working with the entire team of staff that serves a particular family. Facilitator meetings also provide a forum for the facilitators to give each other support, feedback and resource suggestions with guidance from two supervisors who also attend the meeting.

Difficulties/Solutions. Respondents reported difficulties in continually educating other agencies and providers about Wraparound. Mental health is the lead agency for the project, though the primary referral source is necessarily CPS. However, respondents indicated that extremely high

turnover rates in the long term care and group homes units in particular, have a negative impact on the referral process. The inability to form a close working partnership with CPS workers due to turnover combined with the need to adjust the target population to include youth with fewer community resources has had a cumulative negative effect on the referral process.

After transforming the Wraparound model to adapt to the characteristics of the group home population, respondents addressed the problem of high turnover in CPS with multiple solutions. First, a part time staff dedicated to the project reviews CPS cases to find eligible youth, creating additional referrals for the program as new CPS staff are still in the process of learning about Wraparound. Second, using flexible funding dollars, the community resource staff from the lead agencies recruit foster parents, kin, or other potential caregivers as resources for the youth who don't have a previously identified family that can care for them. Finally, respondents reported continuous efforts to educate CPS, the courts, and DOP about the benefits of Wraparound, beginning with an internal discussion of how to communicate the essence of Wraparound to other professionals. A regular meeting between CPS staff and Wraparound staff help to improve channels of communication, as well as serve as a forum for addressing concerns, and conceptualizing how Wraparound actually works. Additionally, the lead agencies have met with group home administrators to clarify the role of Wraparound staff within the context of the residential treatment facility. Lead agency providers also meet regularly with one another to ensure that services are consistent, and to address any other programmatic issues.

Staffing

The roles of Wraparound staff are comparable across the lead agencies, though the configuration of Wraparound teams varies slightly. The master's level facilitator is responsible for case coordination. Respondents felt that ideally the facilitator would focus entirely on the process of facilitating positive group dynamics, enabling the CFT to strategize and make decisions. However, realistically, the facilitator plays a more active role in moving the CFT forward, rather than playing assuming the neutral stance of a mediator. Ultimately, the facilitator is responsible for case management, and guides the process, though the team approach of the Wraparound model necessitates that the CFT determine the services and resources that will support the family's ability to care for the child. The facilitator also must consider the strategies that will serve the family in their current situation as well as their long-term goal of self-sufficiency.

In addition to the facilitator, family specialists are bachelor's level direct care staff that provide in-home support and one-on-one services. A family may work with several family specialists during the outset of services, before selecting a primary family specialist with whom they formed a connection. Participants reported that parent partners play a unique role in the Wraparound process. Parent partners are non-professionals who are previous clients of the social services system, and can relate to the families' experiences personally, lending them a different type of support. Finally, each agency also has a community resource department, with staff that assist the facilitators in finding services and supports in the community setting.

Respondents reported that there is a high turnover rate among staff, a problem that hinders effective service delivery, and negatively impacts families. In addition to challenges in retaining staff, participants noted that a statewide shortage of social workers has led to small applicant pools of qualified potential employees.

Participants felt that the Wraparound model itself creates challenges for recruitment and retention. Master's level social workers and counselors are not trained on Wraparound in the

university setting, therefore requiring them to shed much of their clinical training and approach when working within the Wraparound model. Some facilitators who eventually want to become licensed clinicians also leave to work in a setting where they can accrue the required clinical hours. The high turnover rate coupled with the lack of experience in facilitation leads to complex challenges in providing the quality of services that the lead agencies strive to reach. As a result, training and supervision become all the more essential to promoting high standards of care.

Training. Respondents reported that training for Wraparound is thorough and intensive. Training is specialized into modules that are specific to particular positions, in addition to a basic training on the core elements of Wraparound. Other specific units include training on advanced facilitation, implementing safety in the home, and crisis intervention. Administrators also receive training on how to do staff supervision in the unique context of Wraparound.

Supervision helps to focus on skill development in specific areas, such as how to apply the concept of strength-based services, and improving engagement skills to be able to form an initial connection with a child or family. One respondent compared the role of facilitator to that of a business manager, with the responsibility of coordinating a team of individuals with differentiated responsibilities each trying to work toward a common goal or product. Given the clinical backgrounds of most facilitators, a new set of skills centered around group motivation and engagement requires continually refinement.

Funding

Respondents reported that the biggest difference between funding used for the Wraparound group and the comparison group is the flexible IV-E dollars. Other funding sources such as EPSDT, mental health dollars, housing vouchers and family preservation, may be used to fund services for both groups. Respondents reported that the provider agency gets the IV-E money once the child is enrolled in the Wraparound study, indicating a fairly straightforward funding mechanism.

Participants reported some confusion over the interplay between Wraparound and CalWorks. Presently, families become ineligible for CalWorks when their child enters Wraparound. Respondents were under the impression that CalWorks was going to examine the issue and create a policy specific to Wraparound.

Client and Community Characteristics

Respondents described an array of problematic behavioral problems that youth in the Wraparound study typically display. These extreme behaviors, most often precipitated by a history of abuse, affect the implementation of Wraparound primarily in the realm of securing adequate community-based resources. According to participants, youth in the target population have frequently experienced multiple out-of-home placements. Respondents felt that securing stable placements for this population, specifically in a family setting, continues to be a challenge, as behavioral difficulties often jeopardize a placement. Respondents saw a need to improve support services to families in crisis to help stabilize the placement.

In addition to the child's behavioral characteristics, respondents discussed the cultural differences between providers and clients. Recently the providers had focused on improving staff sensitivity in working with families. According to respondents, the facilitators are typically younger than the parents with whom they are working, and they frequently do not have children

of their own. As a result, facilitators tend to center around the child, without completely understanding the parent's situation, or its impact on their parenting skills. In addition to increased attention toward this issue on the part of trainers and supervisors, the parent partners often help to mediate discussions that should be more inclusive of the parent's point of view.

Respondents reported that they strive to provide services that respond to the diverse language and cultural differences of their clients, a central value of Wraparound in itself. However, respondents reported that providers sometimes encounter a conflict where the professional staff may consider a situation to be a safety issue for the child or family, but the family may have a different perspective on the situation. Staff struggle to balance the family's perception of the situation with their own concerns regarding safety, and to navigate an ensuing discussion in a sensitive manner.

In addition to client features that influence the implementation of Wraparound, there are numerous community factors that either promote or inhibit the project's success. Due to Wraparound's central philosophy of integrating the child and family back into the natural support system of the community, the CFT's ability to assist the family in accessing community resources greatly influences the program's success. Respondents reported several community features such as a shortage of low income housing, poor public transportation systems, lack of affordable child care for special needs youth, drug problems, and other social problems that constitute barriers to implementation.

Conversely, respondents reported that service networks are rapidly developing in the county. For example, Sacramento didn't have a children's mental health system until five years ago, which has now evolved into a rich service delivery system. Additionally, respondents reported that, in general, there are strong neighborhood based community resources such as churches with socially active congregations. Recreational organizations such as the Boys and Girls Club are also numerous, a helpful resource for structured youth activities and after-school programs.

Respondents reported a need for improved communication between the providers and the county as to what services are available. Providers felt that improved information dissemination at the county level could improve their ability to match families with appropriate services. Finally, participants indicated that the families' motivation levels sometimes pose a formidable challenge to connecting them with both formal and informal resources. Some families have isolated themselves after having exhausted their natural support networks, appearing withdrawn and hopeless. After engaging the family in a manner that reflects upon their strengths, renewed energy on the part of the family helps the CFT develop plans to reconnect the family to community supports.

Agency Factors

Respondents reported that staff turnover among CPS, mental health and provider staff is the most critical barrier to Wraparound at the agency level. Given that multi-agency cooperation is needed to implement the project successfully, turnover within each of these agencies is problematic during different stages of implementation.

Additionally, not all the agencies involved in the project have the same philosophical orientation required by Wraparound. Respondents from CPS described their agency's orientation as primarily deficit-based, which counters Wraparound. Additionally, Wraparound has been

associated with the family preservation model, considered an unpopular service modality in CPS currently, due to the political climate caused by a child death in the home.

Political Factors

Respondents reported that children's advocacy organizations inadvertently lobby against Wraparound by means of a child-centered agenda. Concerned with child safety as a primary focus, these organizations tend to view families as the origin of pathology or abuse, rejecting a service orientation that seeks to engage families whenever possible. Respondents likened the children's advocacy position to that of residential treatment providers that often times focus solely on the child as an individual, excluding the importance of family context, or viewing the family as incapable of caring for the child.

Respondents indicated that, in general, there is reluctance on the part of CPS as well as juvenile courts to utilize Wraparound as a resource because it is viewed as a risky intervention. For example, project administrators encouraged the Family Reunification (FR) unit in CPS to increase referrals. However, there has been reluctance on the part of FR to refer children to Wraparound who were just brought into protective custody, for fear that they would be returned home prematurely to the same unsafe situation that led them to enter the child welfare system in the first place, and with little oversight. Respondents felt that additional efforts to educate the courts and other publics agencies as to how Wraparound actually functions would help to dispel some of the resistance to the project.

Evaluation Factors

Respondents reported that there has been a great deal of resistance to the random assignment requirement of the study. While this conflict has primarily resulted in attempts by the lead agencies and other providers to contaminate the experimental design by offering similar services to the control group as the Wraparound intervention being tested, frustrations with random assignment have resulted in a withdrawal from the study on the part of the Department of Probation. As a result, youth eligible for Wraparound who are under the jurisdiction of DOP are no longer referred to the program.

Respondents from the lead agency providers felt that the experimental model leads to an ethical dilemma for providers when they are convinced that Wraparound would be the best possible option for a child who is assigned to the control group. As a resolution, providers have begun to implement the Wraparound philosophy across their other programs as well, hoping to offer children in the control group services that are as similar to those received by youth in the experimental group as possible given the lack of flexible funds. Participants reported that while standard practice may not look like Wraparound in terms of the specific interventions used, the philosophical foundations of Wraparound are applied to the control group, leading to a family-driven, strengths-based, service orientation that attempts to connect families to community resources.

2002 Process Study

Target Population

Sacramento County Wraparound targets children residing in RCL 12-14 care. Children considered at risk of this placement level are also considered eligible for participation in Wraparound, though the majority of referrals are for children already in placement. Having an

identified caregiver is no longer a criterion for participation in Wraparound. If there is no consistent caregiver in the child's life, developing a stable parenting role in the child's life becomes the work of Wraparound. There are no specific behavioral criteria for inclusion in the project, other than the requirement that the child can be safe in the community.

Implementation

Intake Process. Children are identified for the project by child protective services (CPS) workers and by group home supervisors. CPS workers are responsible for completing the necessary referral forms. To expedite the referral process, which can be cumbersome for CPS workers with numerous other responsibilities, the county organized a "referral-a-thon" where a group of CPS workers and provider agencies set aside time solely dedicated to completing referral forms.

The referring CPS worker sends the referral to IMAC after gaining informed consent from the family. After IMAC approves a case, the information is forwarded to UC Berkeley for randomization. UC Berkeley sends the results to the IMAC secretary, who then informs the Access team if the case was assigned to the treatment group. Access determines the service provider, and authorizes services to begin. After the provider is notified by Access, the placement worker is also informed of the case's status.

Services begin within one to two days of notification to the provider. The facilitator initiates services by contacting the family within a few days of the referral to the provider. The first Child and Family Team meeting is then scheduled, which may take up to a few weeks to arrange and schedule.

Child and Family Team Process. Respondents reported that the service plan for the family evolves during the course of the Wraparound process in response to the child and family's changing needs and priorities. The service plan must meet documentation requirements for the county, such as standard treatment goals and mental health services. It also must be created within 30 days of service provision. As a result, two simultaneous processes emerge for the service plan—one for the county, and one with the Wraparound provider.

Child and family team meetings are typically more frequent during the initial stages of service, at once per week. The team then decides how frequently it should meet, depending on the needs of the family, and whether or not crisis situations occur. Meetings may then take place as often as twice per week, or as little as once per month depending on the child and family's status.

Case Closure. Respondents reported that there are no set criteria for closing a case. There are a number of circumstances under which a case may close: After reaching the goals stated in their service plan, a family can initiate service termination that then must be agreed upon by the referring CPS worker and the CFT; the CPS worker can initiate termination; a child who is AWOL for a few months may have their case closed from Wraparound; or the child could move too far away for providers to continue services. During family review meetings, which occur twice a month, Wraparound providers can present cases that they believe to be ready for closure. Ideally this is determined jointly between the provider and the referring CPS worker. Respondents reported that services could still continue post-dependency, but that this is contingent upon continued funding for that child. The county is still refining expectations for determining case closure.

Services. There is no expected length of service for Wraparound, as the child and family's circumstances will determine the need to continue or terminate services. Participants estimated

that the average duration is 18 to 19 months. Respondents described the Wraparound service in two components: the CFT provides case management, service planning, and assistance for the family in developing a supportive network; concrete services provided through Wraparound depend upon the individual child and family needs, and can include a range of services that may target the child and parents individually and as a unit.

Supervising and Monitoring. The Wraparound intervention is regularly monitored at programmatic and client levels. At a project level, the Executive Committee, comprised of county and provider representatives, determines programmatic policy and serves as a problem-solving entity. Quality Insurance tracks outcome measures and the financial status of the project. The Wraparound Fidelity Index, completed every six months, assesses measures that reflect the project's fidelity to the Wraparound model. During the Family Review process, providers and county workers are encouraged to exchange information and collaborate at the case level. County mental health staff also review four charts each month. Group home providers also meet every two months to discuss Wraparound issues as they pertain to group homes.

Difficulties/Solutions. The traditional child welfare services approach to serving children and families has been difficult to alter since practices and approaches have become entrenched. Engaging traditional CPS workers in the Wraparound process has been challenging, particularly in regards to the collaborative nature of case planning in Wraparound. CPS workers tend to be hesitant about returning children to the community due to safety concerns and because they are ultimately responsible for placement decisions. Along the same lines, the court system has also inhibited the Wraparound process in that it has ultimate authority over the child's placement and tends to restrict the family-driven principle of Wraparound.

Respondents reported that the referral process has been slow enough so that the contact information for the family may have changed by the time that services actually commence, sometimes 2-3 months from the initial time of referral.

Despite efforts on the part of the county and its private partners to educate other stakeholders about Wraparound, high turnover rates among staff in the provider community and county departments has been problematic. Wraparound staff themselves may be new to the program and have a difficult time educating others when they have recently completed training. Some group home providers also perceive Wraparound as a threat since it promotes stepping youth down from group homes as quickly as possible. To counter these concerns, CPS does a considerable amount of ongoing education and outreach to providers to educate them about the purpose and goals of Wraparound.

A shortage of foster care placements has also hampered implementation. When a child is ready to step down from a group home setting, other alternatives are sometimes unavailable. Older children are particularly difficult to place. Respondents suggested that foster care recruitment and placement development become a component of Wraparound in the future. Foster parents should also be provided with ample resources such as after-school program access, respite care, and drop-in services, which are currently of limited availability.

Status. There are three Wraparound providers currently on board with the project. The most recent provider to join the project has hired and trained staff, but is in the early stages of implementation.

Staffing

Respondents reported that hiring and maintaining staff, particularly at the facilitator level has been particularly problematic, especially as enrollment increases. The facilitator is a master's level position responsible for coordination, treatment planning, and documentation. A clinical program manager supervises facilitators. Focus group participants reported that the shortage of qualified facilitators has led to expanding the search to include bachelor's level facilitators as well. Professional teams also include bachelor's level family specialists who focus on child behavioral issues in the home and school. Family partners, who are parents familiar with the child welfare system, serve as family advocates. Each provider structures the professional teams differently, though they are all include the same staff roles.

Client and Community Characteristics

The primary client characteristic that respondents noted as hindering Wraparound implementation is a drug abuse among the parents served by the project. This problem is compounded by the lack of available treatment. Respondents also noted that dual diagnosis children have been challenging to serve in the Wraparound context. An overwhelming majority of children served by the project are White, causing concern amongst focus group respondents that some cultures are not adequately served by the project.

Focus group participants identified the lack of affordable housing as a significant barrier to Wraparound implementation. Despite having been approved for Section 8 housing subsidies, many families still cannot find adequate housing. As a result, sometimes there is no room for a child to move home, because the housing situation is overcrowded.

The county's educational system, spread across 16 school districts, also constitutes a challenge to providing educational continuity for children who are moving frequently. Each time a child crosses over into a new school district, they are forced to start over with a new IEP process. Finally, creating new placements for children within the county has been difficult, especially given residents' resistance to having group homes built in their neighborhoods.

Agency Factors

At the county level, the lack of crisis support resources such as mobile response or a crisis center, leaves providers sometimes feeling stranded when a child must be moved on short notice. A foster home shortage also contributes to this problem, leaving group homes as the only available placement option at times.

Respondents reported that the collaboration between CPS, mental health, probation and the three private providers is a strength of the project. The strong history of collaboration in this county has served as a precursor to the county's current efforts. Respondents felt that the partnership between the six agencies continues to be an effective approach to managing this project.

The county's dedication to executing Wraparound as a potential panacea to the problems plaguing child welfare has benefited the project operationally, in that the county dedicated a full-time director to the project. Respondents felt that strong leadership has been especially beneficial to Wraparound implementation.

Political Factors

Despite the findings of the SB 2030 workload study, caseload relief has not been granted by the State. CPS workers continue to be overwhelmed by the case management and documentation

requirements associated with high caseloads, leaving little time to complete Wraparound referrals or to be involved with Wraparound cases.

Respondents reported frustration that the State has not adequately provided guidelines for integrating eligible youth who are leaving juvenile hall or other locked facilities.

The State has not provided enough training or guidance regarding the fiscal requirements of Wraparound. Respondents indicated uncertainty about their ability to adequately install the fiscal mechanisms necessary to ensure compliance with this aspect of the project. Conversely, respondents reported enhanced funding and support from the State in regards to increased funding made available for Therapeutic Behavioral Services. A portion of these funds have been directed toward improved staff training.

Evaluation Factors

Focus group participants reported that the evaluation has had little overall impact on the program. The county is trying to use the Services Tracking Form for internal purposes as well. One provider hired a staff dedicated to the coordinating the evaluation process for UC Berkeley and the county's own evaluation. Respondents indicated that the frustration on the part of the families assigned to the comparison group constitutes the downside to the evaluation.

2003 Process Study

Target Population

Since February 2001, Sacramento County has been focused on providing Wraparound to children living in RCL 12-14 group homes. In the majority of cases, say respondents, the children are without identifiable families and, increasingly, the children referred have developmental delays.

Implementation

Intake Process. Child protective services (CPS) workers and probation officers refer children to the program. Several times over the last year, representatives from the Wraparound provider agencies have reviewed CPS case files for children meeting the eligibility requirements. This was implemented to assist CPS workers in referring cases. Long-term CPS cases have been found to provide greater flexibility with consents and court delays.

IMAC has increased its scrutiny of referrals regarding eligibility in response to an apparent increase in children entering RCL 12-14 homes. Respondents expressed a concern that a less than stringent application of eligibility criteria to children at-risk of an RCL 12-14 group home placement was artificially inflating the "true" size of the county's RCL 12-14 group home population.

The referral process takes approximately two to three weeks from the time IMAC reviews the case to when the Access team identifies a service provider, given that the case has been assigned to the treatment group. Depending upon openings, there is a wait of approximately seven days between the time a service provider is identified and the case is referred to that provider.

Children assigned to the comparison group cases are referred to Focus: Intensive In-Home Mental Health Services.

Child and Family Team Process. Respondents reported that there has been an increased emphasis on strengths identification as part of every CFT meeting, with some participants developing more systematic assessments to identify family strengths.

Case Closure. Cases are closed for a number of reasons, including (but not limited to) when a child "graduates" from services, after the CFT determines the child and family have met the objectives established by the team; when a child ages-out of the foster care system; when a child moves and their dependency status is transferred to another county or it is unfeasible to provide Wraparound in the new location; or when a child is AWOL for an extended period of time. A family review team determines the appropriateness of closure for treatment group cases 60 days from the date of the initial review and every 6 months thereafter, unless circumstances warrant more reviews. Some providers reported fighting proposals to vacate dependency orders to keep children enrolled in the Wraparound; some cases have been served after a child's dependency status has been terminated. Respondents noted that the period when a child is AWOL needs clarification.

Respondents reported that changes to the target group have made the goals of placement stability and prevention of out-of-home care harder to achieve. Focus group participants also reported that they had seen fewer children successfully complete the program since the change in the target population.

The Access team, in consultation with clinical team, makes determinations for the closure of comparison cases.

Services. The current expectation for service duration was described by respondents as varying by family, making it difficult to indicate a precise timeframe. Some children receive services for more than one year; most receive services for two to three years. Participants reported longer service durations for children with multiple needs and barriers and for children in inappropriate placements. Staff turnover among facilitators was reported to impact the duration of service provision.

Supervising and Monitoring. Participants reported that the model for leadership has evolved to meet challenges. Cross Systems, a consortium involving CPS, the Department of Mental Health, the Department of Probation and directors of provider agencies, monitors macro-level issues. A recent change within the consortium was to develop an executive committee to concentrate on policies, procedures, and internal monitoring. Team based subcommittees for quality improvement meet periodically to address changing needs arising from increased enrollment and changes to the target population.

Respondents reported that supervising and monitoring of specific cases was done primarily through weekly staff meetings for case reviews. The staff meetings also allowed participants to share resources and information. Participants suggested that a small team model utilizing clinical management was the most effective monitoring model and that weekly staff meetings were crucial to program success.

Difficulties/Solutions. Participants reported a need for community education about the Wraparound program to address confusion in the county and among service providers. Initially the program developed a poor reputation due to what was perceived as a lack of cooperation. It was viewed as a separate entity attempting to manage cases, which created conflict. Knowledge and acceptance of the program has grown however. Changes to the program's image and

working relationships have been facilitated through training, the interaction of direct service providers, and a better appreciation of roles across systems.

Respondents indicated that a particular challenge emerges between the Wraparound provider and CPS when the CPS family goal and the Wraparound team's goals differ. Wraparound requires a different process and the goals of various agencies, while seen as being in the best interest of the child, are sometimes in conflict. In these cases efforts are made to find a solution in the middle of the road.

Staffing

The basic staffing structure for Wraparound has remained the same since the program began, according to respondents. One facilitator carries a caseload of six to eight families. Two to three family specialists are assigned for each case. It was noted that the smaller team approach works better for families when the facilitator has case management responsibility.

Participants reported that staff turnover often changes the duration of services for the family, increases the work hours for other staff, and generally creates internal chaos within the program. A number of problems with the recruitment and retention of qualified staff was reported. In general, participants have experienced difficulty in recruiting facilitators, due to insufficient master's level applicants and insufficient funds for recruitment. Some suggested that social workers had not heard of Wraparound services and that master's level social work and counseling training tends to focus on preparing social workers for private practice.

Participants reported that some facilitators have had difficulty shifting from a clinical, expert-based, therapeutic orientation to the program's collaborative, team and strengths-based framework. A number of staff have left the program for clinical practice. Participants discussed the potential usefulness of the Tacoma model. Proponents of this model suggest that utilization of bachelor level facilitators (with four years experience) bypasses the need to teach master's level staff to "unlearn" their clinical training.

Participants reported little incentive for staff to move from a specialist position to a facilitator position: the pay increases minimally while responsibility increases exponentially. The long hours required of the facilitator (10 hours per day, six to seven days per week) were reported as another deterrent to both recruitment and retention.

Some participants felt that the staffing shortage was regional. One participant discussed a partnership to create Wraparound internships through Sacramento State University's MSW program, a process that has taken two years. One participant felt turnover within Wraparound was the lowest among human service agencies. Another reported that the upside of the economic downturn has been an increase in CPS applicants.

Participants reported that the program has encouraged changes in staff communication. Increasingly, staff have relied on faxes and voice mail when in-person communication is not possible.

Training. A training consortium has been developed among provider agencies. Some training sessions are open to all staff involved in the Wraparound process, including county social workers. In some cases agencies survey staff for training needs and provide their own trainings. Ad hoc training is also provided.

Some participants reported that Wraparound is a constant learning process and that initial trainings are somewhat ineffective. Instead, shadowing experienced staff was described as one of the best ways of learning the Wraparound process.

Funding

In the context of the economic downturn, participants have seen contract language strengthened as the program's presence has grown and more people have become aware of it. Recently, a focus group was held to look at high RCL expenditures and their relationship to the Wraparound program. A new budgetary strategy has been introduced to improve monitoring.

Participants suggested that there is not a good state or local budgetary model. Administration claim codes have only recently been developed, so the project is behind in collecting budget information. Fitting the strengths based Wraparound model into the county's medical model (i.e., deficit-based) for billing has been complicated. The budget committees also place pressure on the program to define success for each group; each funding entity defines success differently.

Client and Community Characteristics

Participants described several features of their clients and community that affected the implementation of Wraparound. Geographic expansion of the service area has required new procedures for gaining consent for participation and responding to crisis calls. Substance abuse is higher when compared to other counties and access to treatment services is insufficient. A lack of foster families in the community was also reported as a major barrier. Those care providers that are available, such as child care workers and foster parents, are frequently unable to address the needs of children enrolled in the Wraparound program.

Participants reported a need for childcare, transportation, and respite services in the community. It was noted that childcare and transportation services would likely create a decrease in the need for respite. To access respite funds, a great deal of paperwork must be processed. Increased funding has been provided for respite in some cases.

Agency Factors

Participants reported that CPS has had difficulty adjusting to the Wraparound program due to high caseloads and the level of work associated with referral and participation. Wraparound providers, with significantly smaller caseloads, have been willing to relieve the workload of CPS workers to enable children to participate. At the same time, smaller caseloads allow the Wraparound provider to move more quickly with a case because they have greater knowledge of the family's situation. Often they find themselves waiting for various approvals. Further, flex time has not been introduced to allow CPS workers to participate. CFT meetings are frequently held after regular business hours at the family's convenience and CPS workers must attend these meetings on their personal time.

Participants reported that in general, the court has been a barrier to program implementation, though particular judges recognize the program and involve the Wraparound team in proceedings. The Department of Probation has been difficult to involve, though the Department of Mental Health has embraced it fully. A concern was raised about the resignation of the Director of Mental Health and the attitude of any new replacement toward the program.

Political Factors

Participants reported that the newly formed Child and Family Policy Board has developed strengths based policy statements that may have a positive effect on Wraparound efforts.

Evaluation Factors

When asked about the effect of the evaluation on program implementation, participants suggested that though it was often seen as another piece of paperwork, some participants enjoyed reading the results, which sometimes helped to focus on program goals. Respondents also indicated that the randomization process placed staff in a difficult position of touting a helpful service that couldn't be provided to everyone.

5.2.3.5 San Luis Obispo County

1999 Process Study

Pre-waiver services

Intensive Services. Respondents described San Luis Obispo's pre-waiver enhanced services as "moderately intensive", with a placement prevention focus. Through Family Preservation services, families receive in-home support once per week for approximately six months in duration. Child welfare workers and their supervisors working in the front end of the child welfare system select these families. Families are identified who could, with the temporary support of Family Preservation, improve the circumstances of their child-rearing environments. Additional families are provided services through the multi-agency System of Care program, which provides an array of services such as intensive in-home mental health services, with the goal of preventing a more restrictive placement setting through inter-agency collaboration. Services are provided by System of Care staff as well as purchased through private providers.

Respondents lamented the fact that, while Family Preservation is a placement prevention program, the majority of families identified by the child welfare system do not receive these voluntary services, and are not supported until they reach a crisis point that necessitates court intervention. Furthermore, participants estimated that 80% of Family Preservation cases are dismissed from the child welfare system upon family stabilization, leading participants to conclude that expanded placement prevention services could reduce the number of children brought into the foster care system. Family Preservation services typically consist of weekly home visits as well as other services identified in the case plan, such as family conferencing, drug and alcohol treatment, mental health services, or one to one support for the child. Following this six to nine month intervention, "successful" cases are typically transferred to a community provider for follow-up services, thereby allowing Family Preservation to perform a triage function within child welfare, as new families in crisis are cycled into the program in place of those who no longer require the immediate attention of the public agency. However, respondents reported that the child welfare system does not have a systematized means of tracking which of these dismissed cases return to the system or have subsequent reports of maltreatment. For the 20% of families who are unable to safely care for their children with the support of Family Preservation services, court intervention becomes the next step, frequently resulting in dependency and child removal.

Non-intensive Services. Families that do not qualify for voluntary Family Preservation services, as determined by the Emergency Response child welfare worker, are either brought into the court

system when mandated intervention is deemed necessary, or referred to community resources when child welfare involvement was not merited. In cases where an imminent threat to child safety was present, the court process then determines whether the child will be brought into care or supervised at home through Family Maintenance services. Upon removal, the service focus shifts to either Family Reunification activities, or Permanency Planning for the child, depending on the circumstances of the case.

Once a child is brought into out-of-home care, respondents indicated that San Luis Obispo County has a strong FFA service provider network, while lacking traditional county foster care. Similarly, there is a shortage of group homes in the area, resulting in intensive needs youth being placed out-of-county. However, participants reported that, in an effort to prevent out-of-county placements, child welfare is using SB 969 and contracting with FFA's to provide enhanced services for intensive needs youth in order to maintain these children within the lower levels of care available within the county. Participants also indicated that recruitment efforts to increase the number of traditional county foster homes are underway.

Program Planning

Planning Group. Respondents indicated that the San Luis Obispo County planning group was established to work exclusively on the waiver proposal and implementation. The planning group members include representatives from DSS, Department of Mental Health (DMH), DOP, as well as private agency providers. The group was formed by invitation only to select service providers.

Planning Process. The planning group began to conduct meetings in late 1997. The group had three meetings to work on the proposal, and no longer meets. The waiver project is now discussed at management meetings.

Target Population

The planning group determined that the greatest intensive services need in San Luis Obispo County was for a pre-placement intervention that could successfully prevent the need for child removal among families with service needs that exceed the scope of Family Preservation services. In addition to serving a portion of the child welfare population that did not originally qualify for Family Preservation, respondents felt that this new Wraparound option would be able to reduce the proportion of Family Preservation cases, estimated at 20%, that result in court intervention. Participants envisioned a service that provides home visiting three times per week rather than once per week under Family Preservation, and once per month under other standard child welfare services.

Pre-Implementation

Intake Process. Participants indicated that, while the agency management team has not yet determined the intake process for Wraparound as a placement prevention project, they anticipate incorporating the Wraparound cases into the pre-existing Family Preservation unit. A small number of child welfare workers will probably be trained to provide these specialized services, as it was unclear whether or not additional funding would be available to allow for new project-specific staff to be hired.

Supervision and Monitoring. Similar to the intake process, a system for project monitoring has not yet been determined. Respondents envisioned a new project manager position that would have responsibility for programmatic oversight and contract monitoring. Additionally, an

internal group will manage the fiscal aspect of the waiver. Participants acknowledged that a heightened level of program monitoring would be necessary for the Waiver Project due to the complexity of the project.

Difficulties/Solutions. Respondents anticipated difficulties in training staff to implement the new Wraparound program, as well as fiscal complications brought forth by the flexible funding portion of the waiver. Additionally, complications in working with the court could prove problematic in implementing the program. Participants felt that using a timeline to implement the program will combat numerous problems by proceeding with project start-up in an organized manner rather than rushing the process.

Funding. According to respondents, funding for Wraparound would probably begin in September 1999, though it was conditional upon the implementation of the Structured Decision Making tool that child welfare workers will use to guide them is assessing child safety and risk. Respondents also described other funding sources that could be utilized in conjunction with the flexible funding component of the waiver. Specifically, child welfare and mental health were in the process of establishing EPSDT capability, allowing the two agencies to leverage Federal dollars applicable to mental health services. Beginning on July 1st, mental health clinicians will be paired with child welfare units to conduct mental health assessments as well as to provide short-term treatment. Additionally, FFA's providing in-home support services will be eligible for EPSDT billing, allowing for specialized intensive services to be reimbursed through Medi-Cal, thereby improving upon the cost benefit aspect of the Title IV-E Waiver.

Client/Community Characteristics

According to respondents, there are few community factors that would inhibit the implementation of the Waiver Project. Respondents indicated that San Luis Obispo has few non-English speaking residents, and bilingual workers in both CPS and private agencies adequately serve the small Spanish-speaking community. The only force that respondents identified as a possible hindrance to the project is a pervasive attitude by the general community that child abuse is not a problem is San Luis Obispo County. Accordingly, child welfare agency representatives will consider this factor in how they will present to the community the need for intensive services.

Political Factors

San Luis Obispo County Child Welfare Services enjoys strong political ties to both the local court system as well as the County Board of Supervisors, though some turnover in each of these respective public offices led to a hint of concern on the part of respondents as to how the Waiver Project would be received by new officials. There is a new presiding judge, who had already signed a letter of support for Waiver Project. However, respondents acknowledged that it would be necessary to do an additional presentation about the Waiver Project for the new judge as well as County Council, and the public defenders, considering that implementation is now in progress. Respondents reflected that the judicial system has historically supported efforts to preserve families. Similarly, the child welfare agency has clout with the Board of Supervisors, and had received a significant increase in their child welfare services allocation the previous year. Respondents were confident that the Board of Supervisors would support the fiscal aspect of the project, which would not require an additional allocation of county funds to provide Wraparound, given the flexible nature of funding under the Title IV-E Waiver. However, CWS

administrators were unsure of how the new County Executive Officer would respond to the Waiver.

2001 Process Study

Target Population

The target population was recently expanded from youth residing in RCL 12-14 placements or at risk of this placement level to include RCL 10 placements as well. This change was implemented as of January 1, 2001 in response to changes in State Wraparound legislation.

Respondents reported that referrals come from case managers who determine that the case is in a "high risk" category using the Structured Decision Making tool or other standardized risk assessment tools. These cases are then evaluated to determine whether or not Wraparound is an appropriate intervention that will either prevent the need for a high level residential placement, or will assist youth who are stepping down from an RCL 13-14 placement. Participants reported that factors such as safety risk, the presence of an identified caregiver willing to participate in the Wraparound process, and staff availability are considered as criteria for eligibility for study participation.

Implementation

Intake Process. After the case is determined to be eligible for Wraparound by the SAFE-SOC (Services Affirming Family Empowerment-System of Care) committee for children who are still residing at home, or the Interagency Placement Committee (IPC) if the youth is already in out-of-home care or protective custody, the intake process begins. First, consent is obtained from parents, and an additional screening tool is used to further assess what types of services may be needed by the child and family. Following the informed consent process, the case is then forwarded to UC Berkeley for randomization. Cases that are assigned to the treatment group are transferred Family Care Network (FCN), the lead agency provider, who makes initial contact with the family. A facilitator is then assigned to the family, who sets up an initial home visit within a week of intake. Before conducting the home visit, there is a pre-staffing meeting amongst agency members to coordinate case responsibilities and to update all relevant staff members on the status of the case. During the ensuing home visit, the facilitator begins to form a connection with the family, and conducts an initial assessment of the family's situation. The facilitator also seeks input from the family concerning membership on the Child and Family Team (CFT).

Children randomized into the comparison group are funneled into a specialized Intensive Unit within DSS. Though the case does not go to FCN for additional services, the specialized team within DSS attempts to emulate the Wraparound process as much as possible, including the creation of a child and family team. While flexible funding is not available to youth in the control group, the staff in the specialized unit seek to provide weekly services to youth in this group, as well as referrals for additional services, such as SAFE-SOC.

Child and Family Team Process. Respondents reported that the CFT is comprised of agency and community professional providers in addition to family members, and whomever the family identifies for support, such as representatives from faith-based groups, neighbors or other community members. Respondents described the numerous functions of the CFT, such as designing the case plan, developing a safety plan, assessing the family's strengths, and determining the types of interventions needed to meet the child and family's needs. The CFT

also implements recommendations or mandates given by the court. During the first CFT meeting, members are oriented to the strengths-based perspective of Wraparound, and the CFT goes through a collaborative process of identifying the most salient family strengths.

A critical part of the CFT process is developing a safety plan that addresses both immediate safety issues and anticipates future crisis situations. Safety concerns include both the child's behavioral propensities as well as an evaluation of safety in the home, such as the presence of weapons or former abusers in the home. Respondents reported that the facilitator utilizes two primary tools to conduct a thorough assessment of current and potential safety issues. The family is also given information about who to contact for support in a crisis situation. On-call crisis support is available to families 24-hours a day and seven days a week through the FCN social workers and support counselors.

Respondents reported that the CFT works collaboratively to create the services and support plan for the child and family, with all members providing input. As part of the planning process, CFT members address child and family needs across several life domains, such as health and links to the community. This standardized approach ensures that the team explores potentially unmet needs in multiple aspects of family life, and develops plans to address each area. Respondents reported that the long-term goal of transitioning the child and family from the professional service system to informal community supports is emphasized from the beginning of the planning process so that the intermediate objectives of the CFT plan are linked to this overall goal.

Flexible Funding Pool. Respondents reported that the flexible funding pool is accessed by FCN through a mental health contract. The flexible funding dollars are seen as a last resort for fiscal needs, after other resources are exhausted. The FCN community resources liaison helps to identify funding sources for activities that might otherwise draw from the funding pool. Staff are trained to explore alternative means of obtaining needed services or goods before accessing the flex funds, rather than viewing them as an entitlement. However, respondents reported that staff can access up to $300 per month per family for immediate funds, and larger amounts through an approval process.

Services. Respondents reported that the treatment group receives services through a public/private partnership that is unique within the county's social service structure. The case manager from the public agency and the facilitator from FCN work together to lead the CFT process and service coordination. According to respondents, this model functions well at the current caseload level, with public agency case workers carrying small caseloads with the understanding that more intensive services are being provided. However, the current model may not be sustainable if caseloads were to increase.

Participants reported that the high level of coordination between CFT members has provided an integrated approach that, in turn, has spurred greater cooperation from families during the planning process. Most families have not experienced a unified approach from the various agencies with which they might interact, such as DMH, DOP and CPS. The community liaison assists the CFT in enacting the services plan through accessing resources such as housing, youth mentors and food banks using the flexible funding pool when necessary. In this manner, the CFT and liaison develop a service plan that becomes increasingly centered in the community while decreasing the need for support from the public service system.

While children assigned to the comparison group receive services from a specialized unit in CPS as well, there is no contractual arrangement with FCN for these cases, leaving service provision and coordination to the public agency caseworkers. Respondents projected that the intensity of services for the comparison group will probably decline over time as more youth are enrolled in the project, thereby increasing caseloads for each caseworker. Overall, participants indicated that there are fewer resources available to the comparison group, less collaboration and less innovation. Even when specialized services such as Therapeutic Behavioral Services (TBS) are available, they are typically short-term and limited to the conditions for which they were accessed.

Respondents anticipated that Wraparound cases would stabilize at approximately 18 months. However, participants were hopeful that they would be able to close some cases, which had already shown signs of stability, earlier than the timeframe. Respondents felt that the highly integrated nature of other county programs such as System of Care may assist with early case closure. In general, respondents felt that cases were moving at a reasonable pace.

Supervising and Monitoring. Respondents described several levels of program oversight. The design team, comprised of administrators from DSS, DMH, DSS, Education, FCN and a parent partner, review the project's implementation, and promote the integration of services among these various public agency systems. Respondents reported that the Department of Probation has declined participation in the design team. The fiscal aspects of the project are managed jointly by DSS, DMH and FCN. Finally, program implementation is monitored and reviewed during weekly caseworker supervision meetings, where Wraparound staff discuss individual cases.

Attitudes. Respondents reported that Wraparound has become increasingly accepted among the public agency staff as it has begun to show positive results. While the collaboration between DMH, DSS and FCN has led to some difficulties, respondents reported that two inter-agency trainings called "wrap reality" have led to increased understanding among staff. In addition to training on Wraparound, this inter-agency training session provided a forum for staff to celebrate program successes, serving as a means of team building. Overall, respondents reported that staff are accepting of Wraparound, but due to changes occurring throughout the system, it can be difficult for staff to gauge the impact of Wraparound versus other programs being implemented at the same time.

Status. Respondents reported that while San Luis Obispo County is ahead of schedule for SB 163, the State Wraparound project, they have experienced difficulties in identifying appropriate IV-E eligible cases. Respondents also expressed that the experimental design of the project would be more appropriate for families receiving services voluntarily than for families involved with court-mandated child welfare services.

Staffing

The staffing structure for Wraparound is the result of a public/private collaborative between the public county social services agency and a private provider, FCN. The facilitator is a therapist from FCN. In addition, DSS, Probation and the lead case manager coordinate case responsibilities. Community-based support is provided by FCN, including in-home support counselors and a community resources coordinator. Finally, respite services are available through FCN's FFA program.

Training. Respondents reported that, in addition to the "wrap reality" trainings, Wraparound administrators plan to seek additional training and technical assistance from the State.

Funding

Respondents reported that the complex fiscal system that has been established for the project is unnecessarily complicated and burdensome. In addition to internal administrative processes, participants expressed that the State's fiscal processes for claiming reimbursement have also led to considerable difficulties in rolling out the project.

In addition to flexible IV-E dollars, respondents reported the other major funding source for the experimental group primarily included Therapeutic Behavioral Services (TBS), EPSDT funding, and System of Care. The experimental group is currently claiming costs at an RCL 13 rate.

While there are currently no youth in the comparison group, respondents indicated that they plan to use similar funding sources for the comparison group, including the same RCL 13 claiming process.

The process whereby comparison group youth are funneled into a specialized County unit may prove problematic, both in terms of a contamination threat to the study as well as for purposes of cost neutrality. Respondents indicated that children in the comparison l group would receive some services through FCN, as well as other services that are not typically provided as part of standardized child welfare services.

Client and Community Characteristics

According to respondents, there are several client-level characteristics that are exacerbated by community factors, serving as an impediment to Wraparound. First, methamphetamine addiction, according to respondents, is a prevalent problem in the county, coupled with a paucity of available treatment. There are only two treatment programs within the county, leading to extreme shortages in residential treatment, especially for women with children. As a result, many women remain in jail until an available slot opens up, while their children are in out-of-home care. Additionally, many women are forced to leave the county to seek residential treatment.

Second, respondents reported that there are few community-based services within the county in general. In particular, respondents mentioned a need for services for children under 12, programs for sex offenders, and appropriate mental health services. Respondents indicated that, due to budget cuts, the Regional Center was not accepting many of the children who were both developmentally disabled and emotionally disturbed. Accordingly, these children were being referred for Wraparound. In addition to a general shortage of services, those that do exist may be difficult for prospective clients to access, given the lack of public transportation within certain areas of the county.

Finally, the existing services within the county targeting youth with emotional disturbances are insufficient, a community factor that significantly limits the ability of professional staff to work with families in creating support systems based on community supports. For example, respondents reported that there are only a few day treatment providers in the county, resulting in extensive travel time for some parents or caregivers. Additionally, there are few child care or respite resources for special needs youth. The chronic shortage of foster care homes as well as lack of residential placements within the county leads to out-of-county placements. In short, the

county's service infrastructure appears to be insufficient in meeting the needs of parents and their children, a barrier to successful implementation of Wraparound.

Agency Factors

Respondents reported that the environment within the county public agency departments was collaborative, fostered by support from the management level within each level. Respondents indicated that the county Child Welfare Services Department prides itself on its capacity to implement innovative promising practices such as Structured Decision Making.

Respondents also described pre-existing services at the county that help facilitate the Wraparound process. For example, FCN has a short term out-of-home care program called CALM that is a 90-day stabilization placement. Additionally, a strong Independent Living Program and transitional housing services are available for older youth.

Shortages in foster care placements are an agency-wide challenge, according to respondents, a problem that participants felt is exacerbated by the practice of concurrent planning, which eliminates foster care beds as they become adoptive placements. The low rates of kinship care in San Luis Obispo, a factor respondents attributed to the county's primarily White child welfare population, also contributes to a shortage of placements.

Additionally, staffing shortages, especially in the area of licensed clinical staff, affects the project both programmatically and fiscally. Respondents reported that over the past year and a half they have seen a decline in the availability of licensed clinicians, thereby limiting the ability of organizations such as FCN to expand services capacity or to access EPSDT dollars, which require licensed staff. Respondents attributed these staffing difficulties to the high cost of living in San Luis Obispo County.

Political Factors

Respondents reported that the County Board of Supervisors as well as city officials continue to be supportive of Wraparound implementation, as evidenced by the fact that they backed the creation of a special unit designated for Wraparound. The Board of Supervisors also promotes the collaborative and community-based aspects of the project, and helps facilitate efforts to educate the public about Wraparound.

Respondents expressed frustration with the difficulties in providing adequate services to the incarcerated IV-E eligible population. Respondents felt that the fact that DOP cannot access Medi-Cal funds for mental health purposes leads to a disincentive to provide continuous care to incarcerated youth with emotional disturbances that are eligible for IV-E Wraparound. Furthermore, respondents were concerned that a new program in juvenile justice called "Turning Point Academy" was developed based on a punitive philosophy that runs counter to Wraparound and the strengths-based movement. According to respondents, this $9 million dollar program may influence the way that future funds are allocated for social service programs in the county.

The courts have passively supported the project's implementation, but their commitment to Wraparound has not yet been tested, according to respondents. Though court officials have been briefed about the program, participants reported that none of the judicial staff has attended a training session despite attempts to involve the court in educational meetings. Respondents speculated that judges would be willing to be more involved in the project once the results of Wraparound efforts were visible.

Community and advocacy groups have also been generally supportive of the Wraparound project. Both CASA and Child Service Network (CSN), a community council that addresses children's issues, have been supportive of the program, as well as the Juvenile Justice Commission. Only one community organization, made up of "disgruntled parents" has shown resistance toward the projects efforts.

Respondents indicated that they felt supported by the State, having sought technical assistance on numerous occasions. EMQ has also provided assistance in addressing the community level issues that emerge in the Wraparound implementation process.

Evaluation Factors

Respondents noted that they had entered the project late, and that they are facing difficulties in identifying eligible participants. While there are currently no children in the comparison group, participants expressed philosophical differences with the evaluation design, stating that it is difficult to know that they are unable to provide the best services possible to children in the control group.

2002 Process Study

Target Population

Respondents reported that the target population continues to be children who are currently placed in an RCL 10-14 residential setting, or children at risk of that placement level. Case-carrying professionals from child welfare, probation and the mental health departments identify youth who may benefit from the Wraparound intervention. The cases are then referred to the Interagency Placement Committee (IPC), a multi-agency team with representatives from DSS, mental health, education, probation and the private Wraparound provider. This committee is responsible for determining the need for all high level residential placements, inclusive of Wraparound.

Respondents emphasized the importance of caregiver involvement and support for the program. The caregiver could be a biological parent, extended relative, foster parent or other supportive adult in the child's life who is willing to take on a significant role in the child's life. Respondents also noted that if the parent or caregiver is using substances, they must be actively engaged in a recovery program in order to participate in Wraparound.

Implementation

Intake Process. The case-carrying professional completes a referral packet. After determining the child's eligibility status, the case is then referred to the IPC. If the case is approved, the referring caseworker, a representative from the Wraparound provider agency, and the eligibility worker meet with the family. After explaining the benefits and risks of the study, including the randomization process, the family and child have the opportunity to give informed consent. The case then goes back to the IPC for final approval, before submission to UC Berkeley for randomization.

Cases assigned to the experimental group are then referred to the Wraparound provider agency. Respondents reported that Wraparound services begin almost immediately, typically one to two days after randomization. A representative from the provider conducts an initial meeting with the family, prior to a facilitator being assigned to the case. During this initial meeting, the first CFT meeting is scheduled. The case is also transferred to a designated Wraparound unit within

DSS, so that a new social worker and case manager are assigned to the case. For cases assigned to the comparison group, a new team is assigned as well. Though the child and family do not receive intensive services through the private provider, nor do they have access to flexible funding, comparison group cases do receive services that are designed to be more intensive than standard child welfare services.

Child and Family Team Process. The CFT continues to be comprised of the facilitator, county social worker, caregiver, family members, and whomever the family identifies from the community. Though CFT meeting formats vary according to each team's preferences, there are common features as well. For example, each CFT goes through the process of identifying child and family strengths and needs, establishing a service plan, and creating a crisis/safety plan. Initially, CFT's meet frequently, either one or two times per week. After the first few months, meetings are typically reduced to one per month, depending on the needs of the family.

Flexible Funding pool. Respondents indicated that the process for accessing flexible funds remains the same: the provider disburses flexible funds for amounts up to $300.

Services. Respondents reported that services for the treatment group are completely individualized, depending on the child and family's needs. Family services include in-home support services, parent education and counseling. Children may receive one-to-one support in-home and in the community. Services are either contracted through the Wraparound provider or other community resources.

According to respondents, the primary distinctions between services received by the comparison group versus experimental group is the lack of flexible funding available to the comparison group, and that the facilitator role is absent from the case. Actual services may be similar to those received by the Wraparound group due to the proliferation of special programs available to children and families in the comparison group. For example, in addition to standard child welfare, the comparison group is eligible for in-home support services, Therapeutic Behavioral Services, the Path for Healthy Families program, help with housing, parenting groups, and other services that are remarkably similar to those received by the experimental group. However, respondents speculated that the comparison group services are less intensive than those received by the Wraparound group.

Case closure. The expectation for the duration of Wraparound cases is approximately two to two and a half years, though the county is hoping to shorten this estimate. Respondents indicated that a six-month review process may be implemented, at which point the IPC, in conjunction with the CFT, will determine whether or not the family continues to require Wraparound. Ideally, respondents expressed that a family would stabilize after a year of intensive Wraparound services, at which point the case could be closed.

Currently, cases are closed on an individual basis, as there are no set criteria for case closure. One case was closed out of Wraparound based on the family's decision that they did not want further services. Respondents indicated that there is no protocol for closing a case when a child is AWOL. With hospitalization and removal to foster care, the case is kept open.

For children in the comparison group, cases are closed based on the social worker's recommendation that services are no longer required. A comparison group case does not go through the IPC process prior to closure.

Supervising and Monitoring. The design team that created the program has since become the Oversight Committee. Since the agencies involved in the project have close working relationships, they are able to call impromptu meetings and solve problems as things arise. In addition, the Interagency Placement Committee meets weekly to discuss different issues. A monthly wrap services log is used to track who is in the program. Additional forms are used to assess and evaluate the cases. The supervisor for the facilitators at Family Care Network and the supervisor for county caseworkers communicate weekly or more, if needed, to discuss issues and problems that arise.

Ideally, the county would want six month reviews for every case by the Interagency Placement Committee to assess the goals and objectives, what is and is not working, the level of acuity, and overall progress. Currently, this review process is not in place.

Difficulties and Solutions. Respondents reported several difficulties that have hindered implementation. First, expanding the project has been challenging, particularly in terms of increasing the staffing capacity to meet the needs of increased referrals. Participants indicated that this has become less of a problem over time, but that there is still a shortage of in-home supports for families. Second, respondents discussed the lack of resources available in the school district to meet the needs of children with emotional disturbances in the appropriate setting. Bringing children with intensive needs back into the community presents a problem for the school district, which has not typically had to provide these students with the educational services that they require due to the high proportion of these youth who were placed out-of-county. Finally, training professionals to alter their treatment framework from a medical model to one that is more strengths-based and family-driven has been a challenge. Staff bring with them a philosophy of how to best guide the treatment effort with children and families. The Wraparound process frequently runs counter to the way that these professionals may have been trained, leading to difficult adjustments as they learn to share the decision-making power with the families themselves.

Attitudes. Respondents reported that at the management and administrative levels the county has been particularly supportive of the Wraparound approach. The philosophy of Wraparound fits well with the county's efforts to incorporate Family-to-Family practices into child welfare practices. However, respondents indicated that there has been resistance among case-carrying workers who are concerned that Wraparound does not adequately attend to children's safety issues, particularly in the context of family crises. As the project demonstrates success in returning children home, and Wraparound is considered as part of the standard assessment process, caseworkers are becoming less reluctant to referring intensive needs youth.

Staffing

Responsibility for Wraparound cases is shared by the facilitator, who is a master's level social worker employed by the private Wraparound provider, and the county social worker. There is also a bachelor's level in-home counselor that provides direct care for the child and works on behavioral issues. The private provider also employs a community resources liaison that is responsible for locating services in the community as well as donations. On the county side, the child is typically assigned to a new social worker in the Wraparound unit upon enrollment in the project. Exceptions are made if the child had a particularly strong bond with the referring social worker. Mental health staff are also associated with each case, though this person may be a case manager, therapist or case consultant. If children already have a therapist prior to participation

in Wraparound, they can continue to see that therapist. Otherwise, children may receive individual therapy coordinated by the private Wraparound provider—either a facilitator who is not associated with the case, or an outside provider.

At the supervisory level, there is a county supervisor who manages all the social workers in the Wraparound unit at the county. A clinician and the program director supervise the social workers employed by the Wraparound provider. The facilitators also assist in supervisory responsibilities by overseeing the in-home support staff.

Respondents reported that while turnover has not been a problem, the cost of living in this county has presented difficulties in the initial hiring process. Participants expressed concern that attracting and hiring master's level staff in particular could become increasingly difficult as the project expands.

Training. There is an extensive training program for new staff associated with the Wraparound project, consisting of a Wraparound-specific training protocol, First Aid/CPR, as well as a mentor training component. New staff complete 32 hours of mentor training prior to receiving their own clients. In addition to preliminary training, staff also attend weekly in-service trainings on different topics, as well as larger trainings in the community when relevant. Respondents reported that more training was necessary, particularly around the mechanics of services tracking.

Funding

For children in the treatment group, the allocation method is based upon the number of children enrolled in the project, and the projected costs for the placement type that the children would most likely be occupying in the absence of the Wraparound intervention. Respondents reported that it is difficult to calculate the funds necessary for Wraparound, and that they are relying upon the evaluation to determine whether or not Wraparound results in foster care savings. The public and private agencies also work together to access additional funding streams such as EPSDT, TBS, CalWorks, and community support services. In contrast, funding for the comparison group is calculated by the actual cost of services.

Client and Community Characteristics

Respondents lamented that the county's high cost of living coupled with the low employment wages that families receive is a challenge for Wraparound implementation. Though many clients have Section 8 vouchers to assist with housing costs, there is also a shortage of affordable housing. Additionally, the county lacks an extensive public transportation system, creating barriers to accessing services for families living in the rural parts of the county. Respondents also described a problem related to child support payments upon a child's entry into an out-of-home placement. Previous to the placement, child support payments would be made to the custodial parent. However, upon entry into foster care, the non-custodial parent then pays toward the cost of out-of-home placement, thereby reducing the amount of income that the custodial parent may have become dependent upon to cover housing costs and other living expenses.

Initially, the large number of Spanish-only speaking clients constituted a challenge for the project. Respondents reported that they were able to hire a sufficient number of bilingual staff to meet the language needs of their client population.

Participants also cited positive attributes of the program that have supported project implementation. Strong community links through local churches, volunteer mentors, and donations from local businesses have all assisted in bolstering the program's resources.

Agency Factors

As mentioned above, the county's simultaneous implementation of Family-to-Family philosophy and practices has complemented Wraparound efforts to return and to maintain children in their communities of origin. Additionally, strong supports through mental health programs such as TBS have assisted in efforts to stabilize children at risk of placement in their home environments. At an administrative level, respondents reported that there is a strong emphasis on reducing lengths of stay in out of home care, and for returning children home whenever possible.

Political Factors

Respondents reported that the Board of Supervisors and the courts have been encouraging and supportive of Wraparound's efforts. The Board of Supervisors has been particularly concerned with the costs associated with Wraparound, thus requiring Wraparound administrators to pay close attention to cost neutrality. The courts also have to be reminded that Wraparound is a voluntary component, and cannot be ordered as part of a case plan.

At the State level, the budget crisis has also affected project implementation. Also, Federal faith-based initiatives have influenced the program through encouraging partnerships with churches.

Evaluation Factors

Respondents expressed concern about the workload associated with the evaluation for county staff in particular. Also, they characterized random assignment as "unfriendly" toward families, who do not understand its purpose. Line staff have a difficult time explaining the necessity for this aspect of the evaluation.

2003 Process Study

Target Population

The program in San Luis Obispo County continues to serve children who are living in an RCL 10-14 group home or are at risk of being placed in this level of care. Referrals for service come from child welfare workers or probation officers. Participants reported that in the last year case assessment has changed to include issues of substance abuse problems, domestic violence, or other problems that are not conducive to the strengths based work in Wraparound. In family situations where there was high pervasiveness of these types of issues, the cases were not referred to the Wraparound program.

Implementation

Intake Process. Generally, a Wraparound facilitator and the social worker from the Wraparound unit meet with families to conduct a standardized interview, explain the Wraparound program, assess the family's interest in participation, and if interested, obtain consent. The IPC meets on a weekly to review new referrals, and make decisions regarding placing children into RCL 10-14 group home care. Upon IPC approval, the child's information is sent to UC Berkeley for random assignment. If the child is assigned to the treatment group, the case is referred to the Wraparound provider. The first CFT meeting is generally held within five working days. If the

case is assigned to the comparison group, the family is referred to Intensive Child Welfare Services (ICWS).

Participants described how an initial home visit is conducted to familiarize the family with the program, assess strengths, meet with the child, and conduct a home safety check before the first CFT meeting. The home safety check includes questions about weapons in the home, members of the family on parole, and other safety issues.

The first CFT meeting begins with strengths identification, the establishment of CFT roles, and the development of an intermediate crisis plan. The second meeting focuses more on needs and potential barriers. The pace of the Wraparound process depends on the family's progress during the early phases. Generally, the family meets once per week but might meet less frequently once the Wraparound process gains momentum. The amount of time a Wraparound worker spends in direct interaction with the family depends on the family's situation. Participants reported that cell phones allow for regular communication and consultation.

Case Closure. Treatment group cases are closed when the child "graduates" from care (i.e., when the child completes the program), or when an assessment indicates that the Wraparound process is not appropriate for the child (i.e., the child is referred to a higher level of care). Assessments are conducted and reviewed by the CFT every three months to monitor progress toward the goals and objectives, to identify barriers to achieving objectives, and to gauge the family's sense of ownership of the plan. A case is considered successful if the child graduates. If a child and family receiving Wraparound are "assessed out," they are referred to standard child welfare services or a group home.

Comparison group cases are closed when the child's dependency is terminated, the child is self-sufficient or when the child is moved to a group home. Comparison group cases receive ICWS, services of greater intensity than traditional child welfare services such as therapeutic behavioral services. If a child is closed from the comparison group for a reason other than dependency termination, they receive standard child welfare services after exiting the comparison group.

Services. In an effort to serve more children, the county has implemented an assessment process to monitor each child's progress to determine program appropriateness and shorten timeframes where necessary. Ideally, a child completes the program in one year. If a case is seen as not progressing, it is closed to minimize inappropriate service delivery and maximize program success.

Participants reported having a difficult time accessing Therapeutic Behavioral Services (TBS). Providing services through the billing of EPSDT has been successful, but agencies have been reluctant to access other sources of funding in response to the anticipated implementation of State cost control mechanisms.

Supervising and Monitoring. Monitoring of the project's implementation has been restructured to include the monitoring of SB 163 State-only Wraparound. Oversight meetings are held every two months.

On the programmatic side, weekly supervision is provided to social workers, in-home support counselors and Wraparound facilitators. A specific unit has been designated to handle all cases referred by child welfare services. Within this unit a single supervisor monitors placement changes, tracks expenditures, and maintains communication with UC Berkeley. Centralization

of these activities has facilitated coordination with other agencies, such as the foster family agency and the Wraparound provider.

Attitudes. The implementation of Wraparound was facilitated by the county's existing collaborative-based System of Care model and fit in well with attitudes and thinking about the most effective ways to work with children and families. Participants reported a number of strategies for generating enthusiasm for Wraparound. Participants have worked to create a "one-stop program" for families and Wraparound is part of this process. Participants have approached the community from a grassroots level to educate them about available services, including Wraparound services, with a focus on the need to maintain children in the community. Focus groups have centered on involving community partners in planning, "wrap reality" workshops at the direct service staff level to discuss the Wraparound process, and an agency wide "Together we Can" session to talk about the Wraparound paradigm shift. Wraparound was among the best practice philosophies discussed. Program successes have also helped to change attitudes. Respondents reported, however, that random assignment has generated negative views of the project by some service providers and some members of the child and family court system.

Status. When asked to describe the current status of their program implementation, participants reported that they considered their program's maturity to be analogous to a "mature young adult."

Staffing

Wraparound program staff includes three and a half full-time equivalent facilitators, two child welfare services workers, two probation officers, one to three in-home counselors, and an agency resource developer that also works on Wraparound cases. Counselors generally shift from case to case and may work with different facilitators. A team may include CDSS staff or probation workers depending on the family's needs. Over time, participants have found that families leaving the program have reported experiencing a great sense of loss at the termination of Wraparound. In response, participants have developed a mentoring program utilizing university interns to continue work with the family in the community after case closure.

Training. Participants have developed their own core curriculum to train in-home counselors, foster parents, and facilitators. New staff receive 40 hours of training and 24 to 36 hours of field experience. New Wraparound workers also spend several days with CWS to facilitate the team building process. "Wrap reality processes" were introduced to discuss strategies for addressing barriers that helped them to "turn the corner." Participants suggested that training provided by the California Department of Social Services and EMQ was helpful in getting the program launched.

Funding

Respondents reported that the fiscal process is now running smoothly after some initial confusion that may have been bypassed if the Wraparound program had been integrated into other billing systems. The Wraparound program's 50% county match was expensive and an extra cost when the program was launched. Participants reported that Wraparound services are now provided at a lower cost when compared to residential placement. Billing for EPSDT has worked well in the past fiscal year.

Client and Community Characteristics

Participants described San Luis Obispo as the least affordable county in the U.S., where the cost of living coupled with the high median income places families at risk. Though the county has the lowest unemployment rate, available employment consists largely of low paying service jobs. Housing, childcare, and transportation were cited as issues of concern. Participants reported that despite these problems, the community's strength lies in its value of the quality of life over economics.

Agency Factors

Participants reported several strengths in Wraparound program implementation, including collaboration and cooperation among agencies, direction from a management team that had a vision for the program and a desire for it to succeed, and cross-systems experiences on the part of program staff. Staff's knowledge of multiple service systems facilitated the understanding of the challenges associated with working in different structures. Further, participants reported that team members liked and respected each other. The Department of Education was reported as an important participant, despite the lack of a non-public school. The positive relationship with the courts was also reported.

Political Factors

Respondents expressed concern about the State of California's low national ranking in the delivery of mental health services and the lack of attention the issue is receiving. Respondents were also concerned about the State's fiscal crisis and its impact on the CDSS.

Participants reported experiencing a positive context for program implementation that stemmed from a unique children's services network council agency where child and family services are highly valued. High child welfare services credibility has resulted in support for these types of projects with the County Board of Supervisors. In San Luis Obispo County, the Wraparound program is considered on the front line of best practices due to the collaborative management team process. Participants expressed a hope to see the Wraparound program grow.

5.2.4 Discussion

Target Population

A major issue facing all the counties was the question of children having an identified caregiver at the time of enrollment into the Project. Wraparound is a family-focused intervention with a goal of helping the child to live in the most family-like setting as possible. The work of the Child and Family Team is predicated on the presence of at least a single caregiver, in combination with the child, to drive the service model. However, child welfare-involved children, particularly those children in the highest levels of group care in California are perhaps less-likely to have an identified caregiver.

This particular characteristic of child welfare-involved children presented a unique challenge to county representatives. One county implemented a more "mental health field" model of Wraparound—a model adamant about the presence of an identified caregiver at enrollment—until approximately two and a half years into their implementation when county representatives realized their low enrollments was due to the fact that they had significantly reduced their pool of children who would otherwise be eligible for the Project. Other counties were less stringent in their requirements but all have struggled with the issue; over time the concern has grown in

importance as counties have come to understand the level of work involved in establishing a primary caregiver relationship where one did not previously exist.

Unfortunately, at this time, the issue of an identified caregiver at enrollment remains unresolved, though it may be the salient question regarding the appropriateness of Wraparound for a child welfare population. It is unclear as to the capacity of the service providers to establish a primary caregiver relationship for the child. While it seems the best professional efforts have been made, the approach appears ad hoc in nature. A more systematic approach seems necessary, or at minimum, a better understanding of the process of securing caregiver involvement. Additionally, the further investigation is needed to understand the effect on child welfare outcomes of having an identified caregiver at enrollment versus not having an identified caregiver.

Implementation

The enrollment/intake process was a crucial point in each county Wraparound program and how that process was handled had ramifications for county's overall implementation. Counties took a number of approaches to handling referrals, explaining the Demonstration Project Evaluation to families, obtaining consent, and informing families of the results of random assignment (i.e., being assigned to receive Wraparound or traditional child welfare services). The county with the most successful intake process—stable, consistent enrollments, marked by few incidences of family or referring case worker anger and frustration—developed an intake coordinator position whose responsibility it was to meet with the child and family after they had been referred to the Project and to explain the evaluation and obtain their consent. The person conducting the enrollment process in this county was not a case-carrying social worker, so was not directly involved in the child's care at the time of enrollment. This more dispassionate approach seemed to serve the process well. In contrast, in counties where the process of enrollment intake was the responsibility of the case carrying social worker (i.e., child welfare worker or probation worker), problems were much more frequent. It appeared that case carrying workers, often in their well-intentioned desire for the family to receive Wraparound, did not fully explain the ramifications of the Project Evaluation and random assignment. In short, families were sometimes left feeling like they were going to receive Wraparound, when in fact they were to receive traditional child welfare services. This "set-up," inadvertent as it may have been, left families and the case-carrying worker with ill feelings toward the Demonstration Project and the evaluation in particular. There were reports from some counties that individual case-carrying workers had ceased making referrals to the Project. In one county, the Department of Probation ceased their involvement all together based on issues concerning the intake process, random assignment, and the way the study was explained to families.

The referral process—the process of a child's name and information moving through a county's Wraparound enrollment system prior to random assignment—also presented a challenge to some counties. Child welfare workers consistently carried high caseloads and their time was limited; the additional county paperwork (behavioral and fiscal eligibility) often required to make a referral to Wraparound sometimes restricted their ability to make referrals. One county devised a creative strategy for increasing their enrollments when they realized high caseloads and limited time were negatively affecting referrals. The county held "wraparound bazaars" where county and private provider social workers met on selected Saturdays and reviewed cases for appropriateness for referral to Wraparound and completed the necessary paperwork. Doing so

decreased the workload of the case-carrying child welfare worker and increased enrollments to the program.

Staffing

Perhaps the most difficult problem faced by the counties implementing Wraparound, especially for the Wraparound provider agencies, was the issue of staffing. The nature of Wraparound work provided a number of disincentives, making staff recruitment difficult, particularly for MSW-level positions. First, the salary for Wraparound facilitators was often not comparable to salaries for other MSW-level positions. Second, it was difficult, if not impossible for staff to earn the clinical hours needed for licensure, providing another economic disincentive. Finally, MSW-level positions require long hours with a great deal of responsibility. The same recruitment issues proved problematic for staff retention. For some staff, the level of commitment and the additional roles and responsibilities required by the Wraparound approach proved too much. Additionally, the MSW graduate training received by many staff often appeared to be too clinical in focus and did not prepare individuals in the generalist approach necessary for Wraparound.

The issues of staff recruitment and retention resulted, in some cases, in the slow implementation of the project. Children could not be enrolled unless the Wraparound staff were in place to serve them. Staff recruitment and hiring delays sometimes resulted in a delay in the onset of services to children and families. Staff turnover disrupted program continuity and reduced the stability of the professional team working with children and families. More importantly, staff turnover broke the bond between the facilitator and child/family, potentially losing the trust necessary for a successful working relationship between professionals and the family. While this is often the case in any new implementation effort, the problems for Wraparound counties were consistent over the years of the evaluation.

Wraparound providers also faced several other issues regarding staffing. The training of staff was an ongoing issue, especially as "un-training" new staff from their clinical focus to a generalist approach was often necessary. County representatives also reported the need for more advanced trainings as the project matured; that Wraparound was not a static intervention and the level of individual-focus required a broad range of skills. Securing a diverse work staff that resembled the children and families being served often proved challenging for a number of counties. Several Wraparound providers also discussed the tensions that sometimes arose regarding the age differential and parenting experience between Wraparound facilitators and the caregivers; facilitators were generally younger with no first-hand parenting experience, resulting in a sometimes less than empathetic understanding of the caregiver's thoughts or feelings, particularly as they related to the child.

Wraparound provider agencies were not alone in their struggles with staffing problems. The public agencies participating in the Project also contended with staff recruitment and turnover, though their issues were less directly related to the Project. Public child welfare agencies in particular had high rates of turnover that created problems for the Project. Staffing shortages created obvious problems, while new staff had to be educated about Wraparound and how it fit within the county's service matrix. Both situations—shortages and new staff—affected enrollments, mostly at the point of referral.

Wraparound also required changes in the way public agency staff worked. The participatory nature of the intervention was often at odds with the high caseload driven schedule of child

welfare workers; despite their intent and best efforts, their participation in the process was often limited by time constraints. Similarly, for mental health workers, the work environment created by the billable hours fiscal structure was often at odds with the more spontaneous service schedule of Wraparound.

Counties devised a number of solutions in response to the staffing issues. Several Wraparound providers implemented extensive advertising campaigns to increase staff recruitment along with an improved screening process to try and reduce turnover due to the incompatibility between worker skills and desires and the realities of Wraparound work. Other Wraparound providers attempted to recruit from within their own larger service organizations. Several Wraparound providers also explored the use of BSW-level individuals as facilitators. Training solutions included apprentice-like training periods and the "shadowing" of experienced facilitators for a period of time prior to assuming full facilitator responsibilities. Efforts were also made to encourage local MSW programs to incorporate Wraparound training in their curriculums, as well as to access Title IV-E training funds to develop training programs for Wraparound. Generally, these interventions were implemented during the latter stages of the Project, after counties became more confident regarding their programs and began to place greater focus on structural issues. At the end of the evaluation period, the effect of the staffing interventions was not known.

One staffing intervention that did seem to produce some improvement was the public child welfare agency dedication of child welfare workers to carry only Wraparound cases. A number of counties restructured caseload distribution so that several child welfare workers had only children receiving Wraparound on their caseloads. This allowed for greater participation in child and family team meetings and assured that at least a small portion of the overall agency staff were well-versed in the tenets of Wraparound.

Funding

Issues related to the topic of funding can be divided into two categories. The first concerns the overall funding of the Wraparound projects in the various counties and the shift away from funding streams tied directly to specific activities toward funding that was, at best, commingled, and, at least, braided together to provide a service package unencumbered by categorical constraints. In fact, this was the very point and emphasis of the Waiver Demonstration Project: to test whether providing waivers to funding expenditure requirements could foster innovations that would improve outcomes for children and families. A key lesson from the Project is the difficulty of operating a program with a fiscal structure quite different from its larger organizational environment and the importance of including fiscal representatives in the early stages of program development. In other words, implementing Wraparound provided counties with a fiscal challenge because its funding structure was different from the larger agency. Child welfare and mental health funding streams are for the most part categorical in nature. The agency infrastructure that supports programs—eligibility and fiscal/accounting departments—is designed to work with categorical funding streams that often leave the organization financially vulnerable if certain conditions are not met. Wraparound presented technical challenges to those structures. Counties who had accounted for the shift required of their agency fiscal departments and included them in development and implementation discussions seemed to have less difficulty with the shift in funding.

The second category concerns the use of the flexible funding pool, the small collection of money used by Wraparound staff to fund necessary services. The relatively general description of the flexible funding pool reveals its nature and its potential problem for Wraparound providers. The pool was developed to fund—in theory—short-term service needs and things for which an alternative funding source did not exist, say car repairs or a new refrigerator. The difficulty for providers was in making sure the use of the funds was tied directly to the goals of the child and family team, and in ensuring that it did not become a convenient funding source or develop ongoing expectation on the part of families. While problems seemed minimal, over time there seemed to be an increase in protocols regarding access to the funds. This seemed to indicate at least some concern that the funds did not become a source of dependency for families or an easier alternative for providers than the development of community resources.

The Wraparound Philosophy

The values and principles of Wraparound, along with the style of working with children and families, can present a challenge to the various systems working with it. While certain aspects are similar, the philosophical approaches—not to mention legal mandates—of agencies such as child welfare are sometimes at odds with Wraparound and those differences were evident in the counties implementing Wraparound. Perhaps the most significant tension between Wraparound and child welfare is the philosophical approach to child safety. Safety is paramount for the child welfare system; while also paramount for Wraparound, the emphasis on assisting the child to live in the most family-like setting as possible is often viewed to be at odds with the child welfare approach. However, the philosophical leanings of a child welfare agency—reunification versus removal—were not consistent across counties and could be influenced in either direction by events such as a child's death after reunification or while in foster care. It may be that the tension between the general approaches of Wraparound and child welfare was a healthy one, in that it assured that the issue of child safety was being discussed and attended to.

A second tension between the goals of child welfare and Wraparound sometimes arose around the objectives of placement stability versus less-restrictive placements: Do you disrupt a stable placement to move a child to a less-restrictive placement that may prove to be less stable? For a child welfare worker, the decision may lean towards a stable placement, while the Wraparound team would likely lean towards less-restrictiveness. Again, this tension may be healthy in that it presents an opportunity for discussion with the best outcome for the child as the hopeful result.

The Wraparound approach has sometimes been at odds with the child and family court system's approach to working with families. Judges are accustomed to issuing rulings and having those rulings followed. Wraparound requires a more collaborative approach and gives the child and family a primary role in determining their needs and goals. The Demonstration Project's evaluation has likely increased any underlying tension due to the fact that the court cannot mandate services for children served under the Project.

Wraparound has perhaps the most complicated relationship with the group homes where many of the children are living. The group home environment—particularly at the higher RCLs—is restrictive and based primarily on behavioral reinforcement. The caregivers of children in group care may sometimes be viewed as part of the problem and not as part of the solution. Perhaps the most profound difference in the two approaches is the individual focus of Wraparound and the collective focus of group care, potentially creating immediate tension in the working relationship. In some cases, Wraparound providers have been viewed with suspicion by group

home staff concerned that Wraparound exists to put group homes out of business. This has been exacerbated by Wraparound providers who sometimes did not take into account the positive work that group homes can do with children nor include them as partners in the effort to assist the child and family.

Finally, the Wraparound philosophy is a shift for children and families. Families are expected to embrace an intervention that asks them to open up and invite a host of people into their problems and to actively participate in a decision-making process. While these may be beneficial activities, families may be reticent to do the former, and may not have developed the capacity or are too overwhelmed to do the latter. The focus should be not just on the professionals shift in delivering services but also with the client's shift from service recipient to service participant.

County representatives worked on overcoming these tensions in two ways. First, in all counties, representatives from the various Wraparound projects were constantly working to educate others about Wraparound. This might include formal meetings and presentations to court judges or simple discussions held with coworkers from an individual's agency. The efforts were seen as the best way to assist others in their understanding of Wraparound and begin to ease the tensions that might arise between philosophical approaches to serving children. The second strategy to ease potential tensions was the long-term effort of building trust. Wraparound proponents realized that working collaboratively while being respectful of another organization's philosophy and mandates stood a good chance of developing the institutional trust necessary to make the project successful.

Wraparound Models

In general, the Wraparound models used by the various counties were similar in structure. As previously described in the county-by-county narrative, all five county interventions used a team of service professionals who worked with children and families and other key individuals as part of the child and family team. There were, however, some unique characteristics of each county worthy of discussion.

Alameda County's model was perhaps the most distinct of the five Wraparound models. Three community-based service providers worked in conjunction with the county child welfare department to implement a managed care model that included a fiscal strategy and programmatic strategy (i.e., Wraparound). The fiscal strategy was comprised of a capitated payment to the Wraparound providers that traded risk for fiscal flexibility. Under this model, Alameda County was able to provide Wraparound to children and families even after the termination of dependency. This characteristic of the model seemed to be something of a double-edged sword, with the obvious benefit of long-term service availability countered by concerns about programmatic slippage into the fostering of dependency on a service provider. The direction of the characteristic's influence was not clear-cut at the time of evaluation.

An additional innovation was the quasi-privatization of child welfare worker responsibilities made possible by an earlier waiver. Under this arrangement, the Wraparound facilitator assumed case management responsibility from the child welfare worker, though the county agency worker retained responsibilities to the court and were to be partners in planning for a child's care. This relationship added a layer of complexity to the affiliation between the providers and the county agency, though it appeared that both were satisfied with the progress of the innovation.

In Sacramento County, like in Alameda County, three community-based service organizations provide Wraparound to children and families participating in the Demonstration Project. In contrast however, the lead agency in Sacramento County was not the child welfare department, but was instead the county mental health department. While a partner in the Project, the child welfare department took a secondary role. The impact of this arrangement is not particularly profound, though it may have influenced the county's insistence during the early stages of implementation on the presence of an identified caregiver at the time of enrollment. Additionally, the management of information related to children participating in the Project was sometimes complicated by the fact that much of the information was held by the child welfare department and could not be accessed by Project administrators from the mental health department.

Wraparound in Los Angeles County looked similar to both Alameda County and Sacramento County in that the public agencies involved had contracted with community-based organizations to provide Wraparound. However, in Los Angeles, the Project took place on a much larger scale with greater practical and political complexity. The county is divided into eight service provision areas, each with their own infrastructure for enrollment and service provision. In essence, Wraparound in Los Angeles County took place in eight different "counties." The intricacy of the situation and the political ramifications of decision-making slowed the implementation of the Project until almost the end of 2000. However, some of the earlier difficulties seemed to have resided and allowed for a more rapid expansion of the Project in the latter stages of the Project.

The remaining two counties, Humboldt and San Luis Obispo, are much smaller in size and more rural in locale. The Humboldt County project was distinguished by the fact that the county child welfare agency also served as the Wraparound provider. Given the size of the county, this seemed to work well. San Luis Obispo County's Wraparound model fell in between Humboldt County's and the larger three counties; a single community-based agency worked with the county child welfare department to provide Wraparound to children and families.

Conclusion

Perhaps the most evident characteristic of all five counties' implementation efforts was the commitment of the individuals involved to improving the lives of children and families. Every year throughout the process study, the representatives from public and private agencies—both administrative-level staff and direct-service level staff—expressed through their conversations their dedication to the Wraparound process and their belief that it was the best way to improve outcomes for the children and families in question. That belief, dedication, and commitment has driven the implementation effort in each of the five counties.

A number of issues are problematic but it appears that they could be resolved over a period of time with a certain amount of effort. Certainly, on-going education activities are needed to ensure there is a continued and expanded understanding of Wraparound to avoid misconceptions that then foster tension with other philosophies. It may be that, over time, Wraparound finds its niche in the continuum of care options available for children in foster care. The current "panacea for all that ills foster care" phase may soon wear off to a more realistic assessment of Wraparound's strengths.

However, a number of previously discussed issues seem to offer greater cause for concern. First, the question regarding the necessity and availability of an identified caregiver at the time of

enrollment requires further investigation. Given the strong preference in the model for a caregiver to be present, there remains a question as to the appropriateness of Wraparound as an intervention for children in high levels of group care. Unfortunately, the impact portion of this evaluation will not be able to answer the question of whether there is a difference in outcomes for children with an identified caregiver compared to those without. In light of this shortcoming, continued use of the model in this way requires additional resources be committed to securing the participation of a caregiver who identifies with the child's well-being.

A second and more profound threat to the sustainability and expansion of Wraparound are the issues regarding staffing. As nearly all the counties indicated, there is a shortage of individuals willing and able to do the type of casework that is the hallmark of Wraparound. In addition, it appears that a large number of those individuals with the skills and temperament to work as Wraparound facilitators find it difficult to do so for more than several years, given the commitment of time and effort required by the model. Potential solutions such as employing BS/BA-level individuals as facilitators may provide a solution with limited dilution of the model. Otherwise, sustainability and expansion of the Wraparound model remains an open question.

5.3 Fidelity Study

5.3.1 Purpose

The primary purpose of the Wraparound Fidelity Index (WFI) in the Demonstration Project Evaluation was to provide an assessment of model fidelity of the Wraparound intervention being implemented. An important component of a clinical trial is determining the extent to which an intervention being tested meets established criteria for successful implementation. The lack of some type of fidelity measure would complicate the interpretation of the impact study results; it would be difficult to determine whether a finding of no difference between the treatment and comparison group was due to similarities in the levels of effectiveness or due to an incorrect or incomplete implementation of Wraparound. The secondary purpose of the WFI in the Demonstration Project was to provide a complementary measure to the services tracking analysis for assessing contamination of the comparison group.

WFI data collection was conducted in Alameda County with children and caregivers receiving Wraparound through Project Destiny and children and caregivers receiving traditional child welfare services. The slow implementation of Wraparound (i.e., the enrollment of children into the Demonstration Project) in the remaining counties precluded the use of the WFI in those counties.

5.3.2 Methodology

5.3.2.1 Research Questions

Two research questions guide this analysis. First, what was the fidelity of Project Destiny to the Wraparound model defined by the WFI? Second, was the fidelity measure for Project Destiny different from the fidelity measure of the intervention provided to children in the comparison group.

5.3.2.2 Sampling Procedures

The caregivers of children who had been enrolled in the Demonstration Project in Alameda County for nine months were eligible as respondents for WFI data collection. Caregivers were defined as the individual with primary responsibility for the care of the child. Wraparound team facilitators were not eligible to be respondents. UCB evaluation staff identified caregivers through contact with the child's child welfare case worker, Project Destiny staff, or other service professional contact person.

5.3.2.3 Data Collection Procedures

Description of the WFI

The WFI interview battery was developed by the Wraparound Vermont Research Team at the University of Vermont (2001) to provide a standardized the assessment of the fidelity of Wraparound interventions. Of the three respondent forms (facilitator, youth, and parent), only the parent (i.e., caregiver) respondent form (Version 2.1) was used in the Demonstration Project Evaluation.

The WFI parent respondent form is divided into 11 sections corresponding with the elements of Wraparound defined by Goldman (Susan K. Goldman, 1999). Each of the 11 sections contains 4 questions related to the specific element. Respondents rank each question or item on a 3-point scale: yes = 2; sometimes/somewhat = 1; and no = 0 (in some cases the response is reverse-scored). The four responses in each section are tallied to arrive at a score for that element; scores can range from 0 (low fidelity) to 8 (high fidelity). Scores are converted to a percent fidelity score by dividing the element score by 8 and multiplying by 100. For example, an element score of 7 corresponds to a percent fidelity score of 88 percent. An overall WFI score is calculated by averaging the 11 element scores. Similarly, a percent fidelity score can be calculated for the overall WFI score. A minimum score of 80% is considered "good adherence" to the fidelity of Wraparound.

The WFI battery was developed for use with families receiving Wraparound. As such, several additions needed to be made to the parent respondent form to make it appropriate for use with caregivers of children in the comparison group (not receiving Wraparound). Two questions were added to the preliminary portion of the interview to determine if families in the comparison group were working with an identifiable group of people and, if so, was the group formally recognized as a team. The option of team/worker was added to guide the interview based on how questions were answered in the preliminary section. Subsequently, questions were added to the sections on parent voice/choice, cultural competence, and collaboration to account for situations where families were not working with a team of individuals. A not applicable option was also added to the interview to accommodate asking questions of caregivers in the comparison group; however, not applicable responses were scored the same as a "no" response.

The WFI does not have an extensive training protocol. UCB evaluation staff who were responsible for collecting WFI data self-trained using the materials provided by the Wraparound Vermont Research Team (2001).

Reliability and Validity of the WFI

Due to the pilot-status of the WFI, there are limited reliability and validity data available for review. Bruns, Suter, and Burchard (2001) conducted an assessment of the internal consistency of Version 2.0, reporting a Cronbach's alpha of .78 on the overall WFI score for the parent respondent form. Cronbach's alphas ranged from .04 to .77 on the 11 elements. The researchers (who are part of the WFI development team) also reported a Pearson product moment correlation of .73 (significant at $p < .01$) between the resource facilitator and parent respondent forms on the overall WFI score. Pearson correlations ranged from -.28 to .66 on the 11 elements. Bruns, Suter, and Burchard also reported strong face validity for the WFI.

Bruns, Suter, Force, Burchard, and Dakan (Bruns, Suter, Force, Burchard, & Dakan, 2002) conducted a criterion validity assessment of the WFI, reporting on its association with behavioral outcomes as measured by the Behavioral and Emotional Ratings Scale (BERS), the CAFAS, the Restrictiveness of Living Environment Scale (ROLES), and the Family Satisfaction Questionnaire (FSQ). The authors reported relationships between the WFI and behavior scales in the appropriate direction (with one exception). The R^2 of .52 between the WFI and FSQ was significant ($p < .1$).

WFI Data Collection

WFI data collection began in July 2001, in Alameda County with a cohort of families from the treatment and comparison groups who entered the Demonstration Project Evaluation in September 2000. UCB evaluation staff (two over the course of the evaluation) were responsible for the administration of the WFI parent respondent form via the telephone with a caregiver, after the family had been enrolled in the evaluation study for nine months. Interviews took approximate 15 – 20 minutes to complete.

5.3.2.4 Data Analysis Strategies

The initial analysis of the WFI score consisted of a series of five respondent analyses. A list of the analyses and their variables are in Appendix 5. The Pearson chi-square test for association was used (SAS PROC FREQ), including the calculation of exact *p*-values in cases where more than 20% of the cells had an expected cell frequency of less than five. In other circumstances, two-sample *t*-tests were calculated after the assumptions of the test were validated.

The analysis of the WFI variables was conducted by comparing the treatment group to the comparison group on the distribution of service group identification and overall WFI score. The Pearson chi-square test for association (Exact) was used in the first instance and a two-sample *t*-test (SAS PROC TTEST) was used in the second, after the assumptions of the test were validated. The WFI element scores were calculated but tests for statistically significant differences between the groups were not conducted.

5.3.2.5 Limitations of the Study

A number of considerations limit the interpretation of the WFI. First, because the WFI was implemented in only one county, questions linger regarding the fidelity of the remaining counties Wraparound interventions. As a result, it will be difficult to determine whether possible results were due to Wraparound as an intervention, or due to an ineffectual implementation of Wraparound. Second, the timing of the implementation of the WFI data collection resulted in a portion of the total Alameda sample to be ineligible for participation. The impact of this limitation will be discussed in Section 5.3.3 Results. Finally, the WFI questionnaire (Version 2.1) was limited by its lack of established psychometric properties. The interview battery was still being evaluated at the time of its use in the Demonstration Project evaluation. While being the most widely regarded and used measure of Wraparound fidelity in the field, any resulting data must be viewed with the awareness of the measure's early developmental status.

5.3.3 Results

5.3.3.1 Sample

The sample for the assessment of model fidelity included children and their caregiver's who were enrolled in the Demonstration Project on or after September 1, 2000 and completed a WFI interview (Table 88).

A total of 79 caregivers were interviewed, with 49 (62%) of the children in Project Destiny and 30 (38%) children in the comparison group. The majority of respondents from both groups were group home staff members. Males comprised 59% of the Project Destiny sample and 67% of the comparison group sample. Regarding the ethnicity of children with completed WFI interview,

the Project Destiny sample had a larger majority of children (90%) who were Black and the comparison group a larger majority of children (19%) who were white ($p = 0.03$). The comparison group had a greater proportion of children who were white (19% compared to 6%). The average age of children in the Project Destiny group at their time of enrollment was 11.82 years of age, with the median at 12 years of age. Ages ranged from 6 to 17 years old. The average age of children in the comparison group at their time of enrollment was 12.20 years of age, with the median at 12.50 years of age. Ages ranged from 7 to 17 years old.

Table 1.

WFI Sample Demographics (N = 79)

	Treatment (n=49)		Comparison (n=30)	
	%	n	%	n
Gender				
Female	40.82	20	33.33	10
Male	59.18	29	66.67	20
Ethnicity				
Black	89.80	44	71.43	21
White	6.12	3	19.05	8
Hispanic	2.04	1	9.52	1
Asian/Other	2.04	1	0.00	0
Respondents				
Legal Guardian	8.16	4	0.00	0
Relative	14.29	7	16.67	5
Foster Parent	20.41	10	6.67	2
Group Home	48.98	24	70.00	21
Other	8.16	4	6.67	2
Age at Enrollment				
M/Mdn (years)	11.82 / 12.00		12.20 / 12.50	
Min-Max	6.00 – 17.00		7.00 – 17.00	
SD	2.86		2.83	

* $p < 0.05$.

Two sets of comparisons were done to assess potential differences between children who did not have a completed WFI and those who did. The first set of comparisons reviewed the group assignment (i.e., Project Destiny or comparison), gender, ethnicity, and age at enrollment of children who had a completed WFI and compared them to children who were not eligible for a WFI because they were enrolled in the Demonstration Project prior to September 1, 2000. A total of 83 children and their caregivers were not eligible to be interviewed due to the timing of the onset of interviews, compared to 79 caregivers of children who had completed a WFI interview. There were no statistically significant differences between those with a completed WFI and those without by group assignment, child gender, child ethnicity, or child age at enrollment.

The second set of comparisons reviewed the group assignment, gender, ethnicity, and age at enrollment of children who had a completed WFI and compared them to children who did not have a completed WFI due to the non-response of their caregivers. A total of 70 children and their caregivers in Project Destiny were eligible for a WFI interview, with 49 caregivers completing the interview for a response rate of 70%. The response rate in the comparison group was 73% (n=30). There 21 non-respondents in Project Destiny and 11 in the comparison group. Refusing to participate and termination from the Demonstration Project prior to the interview were the top two reasons for non-response in both groups. Analyses found no statistically significant differences between respondents and non-respondents regarding group assignment, gender and ethnicity. There was, however, a difference between the groups on age at enrollment: children in the non-respondent group (13.5 years old) were significantly older ($p = 0.01$) than children in the respondent group (11.96 years old).

An additional two sets of comparisons were done to better understand the Project Destiny sample and determine whether the portion who had a completed WFI were not different from the portion of the sample who did not. The first set of comparisons reviewed the gender, ethnicity, and age at enrollment of children in Project Destiny who had a completed WFI and compared them to children in Project Destiny who were not eligible for a WFI because they were enrolled in the Demonstration Project prior to September 1, 2000. A total of 51 children and their caregivers were not eligible to be interviewed due to the timing of the onset of interviews, compared to 49 caregivers of children who had completed a WFI interview. There were no statistically significant differences between the two groups by child gender, child ethnicity, or child age at enrollment.

The second set of comparisons reviewed the gender, ethnicity, and age at enrollment of children in Project Destiny who had a completed WFI and compared them to children in Project Destiny who did not have a completed WFI. Subsequent analyses found no statistically significant differences between respondents and non-respondents regarding gender and ethnicity. There was, however, a difference between the groups on age at enrollment: children in the non-respondent group (13.71 years old) were significantly older ($p = 0.01$) than children in the respondent group (11.82 years old).

5.3.3.2 Results

Table 89 shows that approximately 92% (n=45) of the respondents in the Project Destiny group reported that decisions regarding services and supports were made by a child and family team, compared to approximately 37% (n=11) of respondents in the comparison group ($p < 0.05$). The same proportion of respondents in the comparison group (37%) reported having no group making decisions regarding services and supports, compared to approximately 2% of the Project Destiny group.

Table 2.

*WFI Analysis: Frequencies and Proportions of Service Group Identification by Group Assignment (*N *= 79).*

	CFT	Formal Group	Group	No Group	Total
Treatment	45	2	1	1	49

	91.84	4.08	2.04	2.04	
Comparison	11	2	6	11	30
	36.67	6.67	20.00	36.67	
Total	65	11	2	1	79

$\chi^2(3)= 29.6957$, p = 9.370E-08 (Exact).

The analysis of the WFI Overall Score (Table 90) found a statistically significant (p = 0.002) difference between the average percentage score for the Project Destiny group (78%) and for the comparison group (67%). The median percentage scores were 80% and 72%, respectively. Scores ranged between 42% and 99% for the Project Destiny group and 25% and 99% for the comparison group.

Table 3.

*WFI Analysis: Overall Score by Group Assignment (*N = *79).*

	n	M	Mdn	Min	Max	Range	SD
Treatment	49	78.08	80.00	42.00	99.00	57.00	11.34
Comparison	30	66.53	71.50	25.00	92.00	67.00	16.96

Satterthwaite Unequal Variance t(45) = -3.30, p = 0.0019.

The analyses of the WFI Element scores (Table 91) showed Project Destiny with higher average and median scores on all elements with the exception of a slight difference in the average score on cultural competence.[1] The three elements with the highest scores (outcome-based services, cultural competence, and parent voice and choice) and the three elements with the lowest scores (community-based services, youth and family team, and natural supports) are the same in both groups, although the rankings are different. The average and median scores for Project Destiny were greater than 80% on all elements except youth and family team, community-based services, natural supports, and collaboration. In contrast, the comparison group had scores of 80% or greater for only the elements of. The Project Destiny group had median scores of 100% on the elements of parent voice and choice, cultural competence, individualized services, and outcome-based services while the comparison group achieved that score only on the element of cultural competence.

[1] Statistical tests of the differences were not conducted for the WFI Element scores.

Table 4.

*WFI Analysis: Element Scores by Group Assignment (*N = *79).*

	Treatment (n = 49)			Comparison (n = 30)		
	M	Mdn	Min-Max	M	Mdn	Min-Max
Parent Voice/Choice	85.51	100.00	25 - 100	83.50	88.00	25 - 100
Youth and Family Team	61.59	63.00	13 - 100	40.50	37.50	0 - 100
Community-based Services	71.49	75.00	38 - 100	58.00	50.00	0 - 100
Cultural Competence	87.80	100.00	0 - 100	89.63	100.00	0 - 100
Individualized Services	83.25	100.00	13 - 100	70.50	75.00	13 - 100
Strengths-based Services	81.80	88.00	13 - 100	63.90	63.00	13 - 100
Natural Supports	56.47	50.00	0 - 100	49.27	50.00	0 - 100
Continuation of Care	81.41	88.00	0 - 100	68.80	75.00	0 - 100
Collaboration	76.14	75.00	13 - 100	63.40	75.00	25 - 100
Flexible Resources	81.74	88.00	0 - 100	61.43	63.00	0 - 100
Outcome-based Services	92.12	100.00	25 - 100	83.00	88.00	25 - 100

5.3.4 Discussion

The results of the WFI analyses are important on two accounts. First, the findings provide initial evidence that the treatment and comparison groups were receiving different interventions. The significant finding on the WFI Overall score is a strong indication that the experience of caregivers receiving traditional child welfare services is quite different from caregivers receiving Project Destiny. More specifically, with the exception of parent voice and choice and cultural competence, there were differences in the experiences of Project Destiny caregivers and comparison group caregivers across the essential elements of Wraparound.

Perhaps more importantly, the WFI analysis findings provide strong support to Project Destiny's model of Wraparound. While the average WFI Overall score was approximately 2 percentage points below the 80% established by the instruments developers as "good adherence" to the elements of Wraparound, the median score places Project Destiny firmly at 80%.

The 11 elements in the WFI can be divided into three categories. The first category contains the three elements best described as focused most specifically on the interaction between the family

and Wraparound. In two important areas of interaction with children and families, Project Destiny scored well. Evidence of Project Destiny's respect of family cultural characteristics was established in their 88% (*Mdn* = 100%) fidelity score for cultural competence. This is particularly important given that 88% of the Project Destiny total sample of children were ethnic minorities. Project Destiny respondent scores averaged to an 86% fidelity score (*Mdn* = 100%) parent voice and choice, indicating that Project Destiny did well engaging families as active partners in the Wraparound process, deferring to the caregiver(s) at times where consensus amongst team members could not be achieved. Respondents did not feel, however, that Project Destiny was a team-driven process, giving a fidelity score of 62% (*Mdn* = 63%)to the youth and family team element. Given that 92% of Project Destiny respondents indicated they worked with a child and family team, the fidelity score seems to indicate an area in need of improvement. A model of service that requires developing consensus across a potentially diverse group of individuals is a challenge and requires skills much different from a traditional model (and therefore training) based on an achieving agreement between the professional and the client, or at minimum, overt instruction. It may be that the skill set of Project Destiny facilitators has not yet fully developed.

The second category of elements is focused more specifically on the programmatic interaction with families. WFI respondents reported strong fidelity scores for individualized services and supports (*M* = 83%, *Mdn* = 100.00) and for strengths-based services and supports (*M* = 82%, *Mdn* = 88.00). The scores indicate that Project Destiny was adept at responding to the unique situation of specific families and in using the family's positive attributes to craft together a set of services to meet both the safety needs and long-term goals of the family. Respondents were less positive in their responses regarding community-based services and supports (*M* = 71%, *Mdn* = 75.00) and natural supports (*M* = 56%, *Mdn* = 50.00). The low fidelity score for community-based services and supports may be due to a dearth of services available in the communities where children and families reside. The interpretation of this score may be further complicated by the fact that the caregiver respondent and the child may be living in different communities; in other words, services may be more community-based for the child, but not for the respondent caregiver. The natural supports element refers to the inclusion of informal family and community supports, coupled with formal professional services. The low fidelity score on this element may again be due to the dearth of informal supports in a family's community. Similarly, the family itself may have exhausted its informal resources contending with various crises (e.g., maltreatment, removal from the home, behavior issues) over time or a lack of proximity to inherent familial supports. The redevelopment of those resources takes time and the score may reflect that developing process, rather than a lack of effort on the part of Project Destiny. Finally, the natural support score may be impacted in a way similar to the youth and family team score: developing and nurturing informal services and supports requires a particular set of skills that Project Destiny staff may be learning on the job. Again, graduate training programs do not generally focus on the types of skills needed for these activities.

The last category of elements is focused more on what can be described as more the overarching program "infrastructure-type" elements. They are linked by their emphasis on the activities of the Wraparound program regarding program continuity, working with other organizations, strategies for fiscal resources, and monitoring the completion of goals. Perhaps not surprisingly, given the evaluation component of the Demonstration Project, Project Destiny attained its highest fidelity score of 92% (*Mdn* = 100%) on the element of outcome-based services and supports. Similarly, Project Destiny scored high on flexible funding and resources (*M* = 82%,

Mdn = 88.00), again not surprising given the focus of the Demonstration Project on fiscal waivers. Project Destiny's programmatic philosophy of continuing care even after child welfare dependency has been dropped makes the finding on the continuation of care element (*M* = 81%, *Mdn* = 88.00) seem likely. The fact that the score was not higher may be due the timing of the measure (i.e., nine months post enrollment); respondents may report a more profound experience of the continuity of care at a later point in time. Only the element of collaboration (*M* = 76%, *Mdn* = 75.00) did not meet the "good adherence" to Wraparound criteria of 80% fidelity score. The finding may be due to the difficulty in bringing about such a systemic change to the way services are delivered. Collaboration requires not only a change in the way Project Destiny organizations operate, but also changes in the way interacting organizations conduct their service delivery. Despite best efforts, this is an area that, based on the scores from respondents, still needs improvement.

All told, results from the WFI assessment indicate that Project Destiny has "good adherence" to the elements of Wraparound. A closer look at the element scores reveals that low scores on elements may be the result of influences (e.g., few community resources, different focus in graduate school training) less-directly under the control of Project Destiny. This does not mean that Project Destiny is absolved of responsibility for improvement; in fact, efforts by Project Destiny are underway to improve the access to existing resources and in the development of additional resources, coupled with ongoing efforts to train staff and provide curriculum suggestions to graduate school programs.

Chapter 5.4 Impact Study—Wraparound

5.4.1 Child Welfare Outcomes

(Note: Child and family well-being outcomes are discussed separately in section 5.4.2.)

5.4.1.1 Purpose

Wraparound was developed in the field of mental health in response to the dissatisfaction with group care and its effectiveness as an intervention. In other words, Wraparound was developed as a community-based (read non-institutionally focused) way of working with children whose severe behavioral difficulties and other mitigating factors precluded them from living with their biological families. The approach has been transferred to the field of child welfare, where the philosophy of Wraparound is generally targeted to a similar population of children: children in group care, or children who are at-risk of being placed in that type of out-of-home placement environment. The goal of Wraparound—as it pertains to the field of child welfare—is to change or manage a child's behavior in order to improve foster care placement outcomes; specifically, (1) to allow a child to move from a more-restrictive placement setting to a less-restrictive placement setting, or (2) to stabilize a current foster care placement, thereby preventing a placement into a more restrictive type of out-of-home placement (e.g., group care).

The Wraparound intervention model used in each county was similar (see section 5.2 Process Study for a more complete description of each county's Wraparound model). In all but one of the five counties, the county public child welfare agency contracted with community-based non-profit social service agencies to provide Wraparound. Generally, a team of professionals—a case manager, community resource specialist, and family support counselors—worked in concert with the child and family, the child welfare worker, and other individuals identified by the child and family as important to their lives to determine goals and objectives and the services necessary for success.

The efficacy of Wraparound requires further examination. A number of studies (Clark et al., 1998; Kamradt, 2000; Myaard, Crawford, Jackson, & Allesi, 2000) have been conducted assessing improvement on behavioral outcomes for children receiving Wraparound, with generally positive results. Similarly, numerous studies (Bruns, Burchard, & Yoe, 1995; Hyde, Burchard, & Woodworth, 1996; Illback, Nelson, & Sanders, 1998) have been conducted investigating Wraparound's ability to improve placement outcomes for children, again with generally position results. However, the studies usually faced several limitations, including the lack of a comparison group and/or small sample size, hindering the strength of their results.

The research on Wraparound's use with a child welfare population is limited. One study has sought to assess the impact of Wraparound on children in foster care with emotional/behavioral disturbances. Clark, Prange, Lee, Steinhardt-Stewart, Barrett-McDonald, and Boyd used a pretest posttest control group design with repeated measures and random assignment to either the treatment (Wraparound) group or comparison (standard foster care services) group in order to evaluate the effectiveness of the Fostering Individualized Assistance Program (FIAP) on the permanency status and functioning of children in the foster care system.

FIAP appeared to be successful in reducing the number of days spent on the run from home or incarcerated, as well as improving permanency outcomes (i.e., living with parents, relatives, or

adoptive homes; or living independently) for older youth. Secondarily, FIAP appeared to be more successful at improving behavioral outcomes for males than for females.

The current study builds on the existing literature—particularly the work begun by Clarke et al.—by examining the impact of Wraparound on maltreated children in foster care, specifically children in or at-risk of placement into highly restrictive residential care. The use of an experimental design will, again, allow for a strong assessment of Wraparound as an intervention, broadening the knowledge base for practitioners and policy-makers.

5.4.1.2 Methodology

Research Questions

The Wraparound Impact Study was guided by the question of whether children receiving Wraparound would have better child welfare outcomes than children receiving traditional child welfare services. Specifically, it was hypothesized that:

1. Children receiving Wraparound would have fewer incidences of substantiated maltreatment than children receiving traditional child welfare services, while in the study;
2. Children receiving Wraparound would have a fewer number of placement moves than children receiving traditional child welfare services, while in the study;
3. Children receiving Wraparound who were living in high-level group care would step-down to lower levels of care at a higher rate than children receiving traditional child welfare services, while in the study;
4. Children receiving Wraparound who were at-risk of placement into high-level group care would step-up to high-level group care at a lower rate than children receiving traditional child welfare services, while in the study;
5. A larger proportion of children receiving Wraparound would be living in a family-based setting, compared to children receiving traditional child welfare services, at the end of the study;
6. A smaller proportion of children receiving Wraparound would have exited from child welfare dependency due to incarceration, compared to children receiving traditional child welfare services, while in the study;
7. A larger proportion of children receiving Wraparound would have exited from child welfare dependency due to permanency, compared to children receiving traditional child welfare services, while in the study.

Sampling Procedures

The sampling frame provides an operational definition of the population. The general conditions for participation in the study include: (a) the child was Title IV-E eligible, (b) the child was in a RCL 12 - 14 placement, or at-risk of a RCL 12 - 14 placement at the time of enrollment, (c) the child was receiving services as a dependent of the county's child welfare agency, (d) written legal consent for the child to participate in the study was obtained, (e) additional intake criteria determined by individual counties, and (f) the child met the first six criteria between June 1, 1999 and December 31, 2002.

The establishment of the sample parameters was guided by a number of considerations. Criterion one was established by the DHHS as a condition for participation in the Demonstration Project. Criterion two and three were established by counties in cooperation with the CDSS as conditions for participation in the Wraparound component of the Demonstration Project. Criterion four was established for the protection of human subjects, a condition set by the University of California at Berkeley and the DHHS. The parameters under criterion five were established by counties to further define their target population. Criterion six was established to ensure an appropriate sample size while providing time for a preliminary analysis for the evaluation study.

The process of selecting and approving children for enrollment into the Demonstration Project had two components—initial referral and referral review—both of which have increased in structure over time. Throughout the course of the Demonstration Project children have been referred to the Demonstration Project by case carrying child welfare workers. Child welfare workers make the initial determination of eligibility for Wraparound, completing a required packet of information to complete the referral. Each county developed or utilized an existing collaborative review committee staffed by representatives from several public and private agencies to oversee to the referral process and render final approval on programmatic eligibility.

There is an important distinction to be made between the children enrolled in the Demonstration Project and the children enrolled in the evaluation study. Because Wraparound is considered a family intervention, children could be enrolled as a part of a sibling group, provided that all meet the eligibility criteria. The outcomes of interest for the evaluation, however, were individual in nature, not familial. Therefore, siblings within sibling groups could be the subjects of analyses as the siblings are not independent of one another, unless the relationship can be statistically accounted for. To simplify the analyses, when a sibling group was referred to UCB evaluation staff for enrollment and random assignment, a child was randomly selected from the sibling group to serve as the evaluation study child; his/her data were the data used for analyses. As a result, there are two samples: (a) a Demonstration Project sample that includes all children who meet the eligibility requirements and are enrolled in the Demonstration Project, and (b) an evaluation study sub-sample of children included for analyses.

The first enrollment into the Demonstration Project was in June 1999 for Alameda County and Sacramento County. The first enrollment for Los Angeles County was in November 2000. Enrollments are "rolling," meaning they occur continuously, depending upon the number of referrals and the capacity of Wraparound providers to absorb new cases. County agencies were in control of the pace of cases sent to UCB evaluation staff for enrollment into the Demonstration Project.

Data Collection Procedures

Enrollment Data

Essential identifying information was collected at the time of a child's enrollment into the study in order to retrieve administrative data for that child at a later point in time. Identifying information included the child's name, social security number, date of birth, case number, client number, and state identification number. The information, provided by county representatives, was used to connect a study child with their administrative child welfare placement information. Enrollment data also included group assignment (treatment group or comparison group),

Wraparound provider agency (if assigned to the treatment group), and intake date (date of start of Wraparound). The Wraparound agency and intake date information were provided to the UCB evaluation staff by the provider agency.

Administrative Data

Purpose. Quantitative data on the outcome variables of child safety and permanence form the basis of the present study and are the means with which comparisons were made between the treatment group receiving Wraparound and the comparison group receiving traditional child welfare services. These data were drawn from the California Children's Services Archive (CCSA) and the Group Homes Rates List (GHRL).

Description. The CCSA is a longitudinal relational database containing data from the CDSS's Child Welfare Services/Case Management System (CWS/CMS) management information system (formerly the Foster Care Information System [FCIS]). Data from CWS/CMS are sent to the Child Welfare Research Center on a quarterly basis. The CCSA contains demographic and placement histories on over 473,000 children in care in 1988 or who have entered care at any time between then and the end of 2000. The average number of new first entries into foster care is approximately 31,589 (Barbara Needell et al., 2003).

The GHRL is maintained by the CDSS's Foster Care Rates Bureau (FCRB) and includes point-in-time information on group home names, addresses, license number, capacity, and RCL. The data were provided to UCB evaluation staff by the FCRB for use in the Demonstration Project Evaluation.

Reliability and Validity. No formal studies have been conducted to assess the reliability of the data systems used in the present study. The CCSA data and the GHRL data are reliable to the extent that there are no systematic errors resulting from the entry of data into CWS/CMS.

A number of factors enhance the reliability and validity of the CCSA. CWS/CMS is the Statewide Automated Child Welfare Information System (SACWIS) used by the State of California for mandated Adoption and Foster Care Analysis and Reporting Systems (AFCARS) reporting. The system complies with the Adoption and Safe Families Act of 1997 (ASFA) as the way the child welfare system in California complies with Government Performance Results Act of 1993 (GPRA) (Barbara Needell, personal communications, July, 9, 2003).

Data Collection. The identifying information (i.e., client number, case number, social security number) collected at the time of enrollment was used to match study children with their information in the CSSA. The resulting datasets were used in the outcome analysis.

CWS/CMS does not contain information on group home RCL. Data from GHRL was linked to CSSA data by license number or facility name and address to incorporate that information into the datasets used for analysis.

Data Analysis Strategies

Independent Variables

The primary independent variable is group assignment into the treatment group receiving Wraparound, or into the comparison group receiving traditional child welfare services.

The secondary independent variable accounts for the amount of time each child was enrolled in the study. Because children had different amounts of time in the study due to the "rolling"

nature of the enrollment process, it was important to account for this variability. This variable is calculated in days by subtracting the enrollment date for individual children from the end-date for this study (December 31, 2002). The variable also serves as a proxy for duration of treatment. Duration of treatment means different things depending on the group. For the comparison group, treatment ended when child welfare system dependency ended (e.g., reunification, emancipation, incarceration, etc.). For the treatment group, what was considered time in treatment varied by county. Wraparound could continue in one county even after child welfare dependency was terminated. Wraparound services could be terminated for reasons such as "program completion" or "goal achievement" in other counties. Given the complexity of the duration of treatment, it was determined that the amount of time a child spent in the study was the best variable to account for the variation of time in the study and the amount of time receiving treatment.

The third independent variable captured the interaction between group assignment and the amount of time in the study.

Dependent Variables

The dependent variables included in this study are drawn from the child welfare placement domains specified by the U.S. DHHS and the CDSS: child safety, placement stability, and placement permanence.

Child Safety. The child safety variable is defined as the occurrence of at least one substantiated maltreatment report while in the study. Subsequent occurrences of substantiated maltreatment were not included.

Placement Stability. Placement stability was defined by several variables. First, the total number of placement moves for children over the course of the study were collapsed into four categories: (a) 0-1 moves, (b) 2-3 moves, (c) 4-5 moves, and (d) 6+ moves. Second, the number of placement moves for children over the course of the study were collapsed into two categories: 3 moves or less vs. 4 moves or more. County representatives had estimated that the average number of placements for children in the treatment group would be three.

Third, an important question of this study relates to the types of placement moves of the two target populations. For children in RCL 12-14 group care at their time of enrollment, a key event is whether the child eventually "steps-down" to a less-restrictive level of care, specifically care below RCL 12-14 group care. Similarly, for children at-risk of RCL 12-14 group care placement, a key event is whether the child eventually "steps-up" to a more restrictive or less secure living environment, including RCL 12-14 group care, incarceration, psychiatric hospitalization, or AWOL. For both target populations, a measure of time to the event combines with an indication of the event's occurrence to form the dependent variable. Time to the event is an important consideration because it provides information as to how long a child resides in a particular state: in RCL 12-14 group care for the first target population, and in a less-restrictive placement for children in the second target population.

Placement Permanence. Placement permanence is defined by two constructs: types of placements and exits from care. The types of placement categories (including the non-out-of-home placements, AWOL, and death) at enrollment and at the end of study were assessed. Types of placement categories were also collapsed into two categories: family-based and institution-based living environment, based on the notion of least restrictive living environment.

The family-based category included living at home, adoptive home, guardian home, relative home, foster family home, and foster family agency home. The institution-based category included emancipation, group care, incarceration, medical facility, AWOL, and death.

Exits from care include reunification, adoption, legal guardianship, emancipation, incarceration, psychiatric hospitalization, or runaway. A permanency variable combined the occurrence of reunification, adoption, or legal guardianship.

Data Analysis

Child Safety: Substantiated Maltreatment. The Pearson chi-square test for association was used to assess the association between group assignment and the event of substantiated maltreatment. Given the rare occurrence of the event of substantiated maltreatment in each of the counties, descriptive statistics were used to describe the age, gender, ethnicity, reunification status, placement location at the time of the substantiated maltreatment, the number of days from enrollment to substantiated maltreatment. Where appropriate, the Pearson chi-square test for association (Exact) or the Wilcoxon Two-Sample Rank Sums test were used to assess differences between the two groups.

Placement Stability: Number of Placement Moves.[1] The first analysis of the number of placement moves compared the treatment and comparison groups on the distribution of four categories of placement moves: 0-1 moves, 2-3 moves, 4-5 moves, 6+ moves while in the study. Pearson's Chi-Square statistic was used to test for differences between the two groups.

The second analysis of the number of placement moves used linear logistic regression to compare the treatment and comparison groups on the odds of having three or fewer placements over the course of the study. It is important to note the likelihood refers to the odds of the event occurring and not the probability of the event occurring. The effect of group assignment (treatment vs. comparison) on the log-odds having three or fewer placement moves while in the study was assessed, controlling for length of time in the study and the possible interaction between group assignment and length of time in the study.

Placement Stability: Types of Placement Moves. Event history analysis was used to assess the impact of group assignment on the time to different types of placement outcomes. The type of placement outcomes for children in RCL 12-14 group care were analyzed separately from children at risk of placement into RCL 12-14 level group care. The separation of the sample was necessitated by the different placement outcomes of interest for each target population. More specifically, the outcome of interest for children in RCL 12-14 group care was the time to "stepping down" to a lower, less restrictive level of care. The outcome of interest for children at risk of RCL 12-14 group care placement was the time to "stepping up" into a more restrictive or less secure level of care. The time to any other types of placement moves were not considered in these analyses.

Event history analysis was chosen because it takes into account the factor of time, assessing the influence of independent variables on not just whether an event occurred but when it occurred.

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[1] Model building procedures were not conducted and model fit assessments were not reported for any of the outcome variable analyses, given the comparative nature of the study. In other words, comparing the two interventions (Wraparound and traditional child welfare services) was the focus of each analyses, controlling for the amount of time a child was in the study and the possible interaction between intervention group and time in the study.

The Kaplan-Meier method was used to determine the survival functions of the treatment and comparison groups. The Cox Non-Proportional Hazards Model were used to further assess the differences between the treatment and comparison groups.

Placement Permanence: Types of Placements. The first analysis compared the treatment and comparison groups on the distribution of the types of placements children were residing in when they enrolled in the study and then again on December 31, 2002, the end of the study period for this study. Pearson's Chi-Square statistic was used to test for differences between the two groups.

The second analysis compared the treatment and comparison groups on the log-odds of residing in a family-based or institutional-based placement at the end of the study period. Placement types were categorized based on the notion of least restrictiveness.

Placement Permanence: Exits from Care. The permanency variable that combined the occurrence of reunification, adoption, or legal guardianship was analyzed using Pearson's Chi-Square statistic. The limited frequency of exits from care due to permanency precluded the use of logistic regression to assess the effect of group assignment on log-odds of exiting from care due permanency. Pearson's Chi-Square statistic was also used to test for differences between the two groups for incarceration. As no children exited care due to psychiatric hospitalization or runaway, analyses on these outcomes were not conducted.

Limitations

Data Collection Design

The use of a true experimental design is not without limitations, issues, and objections, some of which have had an impact on the present study. First, the emphasis on internal validity detracts from the capacity to generalize the findings beyond the sample used in the study (Campbell and Stanley, 1963), potentially limiting the study's usefulness to practitioners and policy-makers. Additionally, generalizability may be impacted if the sample becomes unrepresentative due to a systematic difference between those consenting to study participation and those not consenting to participation. This does not appear to be an issue in the present study as county representatives reported a small number of refusals to participate in the Demonstration Project evaluation.

Second, in a true experimental design there is always a risk of contamination of the comparison group. In applied social science research, it is difficult to combat the influence of the diffusion of innovative programs, particularly if the research takes place over several years. This is the case in the present study. In 1998, as the Demonstration Project was in its early implementation phase, the Legislature of the State of California passed and the Governor signed Senate Bill (SB) 163, authorizing the provision of Wraparound for children in RCL 12 – 14 or at risk of RCL 12 – 14 placement who did not meet federal eligibility requirements for foster care funding. As a result, Wraparound for state-eligible children who meet the target population and behavioral criteria runs concurrent to the Demonstration Project. While federal foster care dollars cannot be spent to provide Wraparound to children in the comparison group, it is more difficult to limit the influence of the less tangible aspects of Wraparound such as increased interagency collaboration or a more strengths-based approach to working with children and families that may develop systemically from the implementation of SB 163. It is unclear as to the full extent these types of shifts in policy and practice have taken hold in the various counties. However, the Services Tracking analysis seemed to indicate that the groups received different services.

Closely related to the issue of contamination, at least in the Demonstration Project evaluation, is the reluctance among social service practitioners—what Posavac and Carey (1992) call "professional sensitivity"—to the notion of random assignment. Professionals may view random assignment as denying access to an innovative treatment to individuals in need, despite a lack of empirical evidence to support the treatment's effectiveness. This professional sensitivity is what led county representatives to declare their intention to provide "Wraparound-like" services to children and families in the comparison group; this was most notable in Los Angeles County and Sacramento County, though again the Services Tracking analysis seemed to indicate that the groups received different services.

Finally, conducting an evaluation using a true experimental design can be time-, effort-, and resource-consuming, particularly when there is resistance to the design from service providers. While this was certainly the case with the Demonstration Project evaluation, it is not completely clear as to its impact. Ensuring the integrity of the process and maintaining the physical database required the resources of time and money that could have been put to use conducting other data collection. The intensity of the commitment to ensure an untainted process was compounded by the threats of contamination and concerns that the process would be actively subverted. However, other than the redirection of resources from additional data collection activities, it does not appear that technical and resource requirements of random assignment have limited the study.

Study Setting and Population

In a study that assesses the efficacy of an intervention, the fidelity of the intervention is always a concern. In other words, does the intervention, as implemented, look and act like the model it is meant to represent? The issue of Wraparound model fidelity is being assessed through the analysis of the WFI and Services Tracking. The results of these analyses and their implications for model fidelity will be discussed in a later portion of this report.

The heterogeneity of the target population—essentially two target populations—is a concern for the present study. The study sample combined a target population that has a particular characteristic (placement in high-level group care) with a population targeted to prevent it from acquiring the characteristic (preventing placement into high-level group care). The problem is the accuracy of the prediction, a question of whether the outcome will actually occur (see Schuerman, Rzepnicki, and Littell (1994), for a discussion of this issue). The CAFAS was implemented as a means of assessing the behavioral characteristics of children in both target populations to determine the level of heterogeneity, at least behaviorally. The results of this analysis will be discussed later in this report. However, regardless of the outcome of the CAFAS assessment, different outcomes for the different target populations necessitated separate analyses in some cases, resulting in a reduction in sample size and a reduction in the statistical ability to detect differences between the groups.

Sampling

A number of issues arise from the sampling plan and a reliance on convenience samples. Optimally, county representatives would have focused on children residing in RCL 12 – 14 group care, identifying those that met the sampling criteria and selecting a random sample of children to participate in the Demonstration Project. The presence of a second, less-defined population (i.e., children at risk of RCL 12 – 14 placement) made random sampling impossible. Instead, counties used a non-probability convenience sample of children meeting the sampling

frame criteria. Randomized experiments typically rely on convenience samples ((Rubin & Babbie, 1997; Singleton, Straits, & Straits, 1993)as they are often conducted in organizations (or situations) where clients are readily available. However, a number of issues arise from the implementation of the sampling plan and the reliance on convenience samples.

As discussed previously, the process of selecting and approving children for enrollment into the Demonstration Project has two components—initial referral and referral review. The initial referral process is potentially problematic in that the preliminary identification of an eligible child is left to an individual child welfare worker, which may result in a biased selection process (given the variability of their caseloads). Child welfare workers unaware of the Demonstration Project or disillusioned with Wraparound as an intervention would be unlikely to make referrals. Similarly, child welfare workers with strong sentiment regarding the ethical nature of random assignment would also be less likely to make referrals. Anecdotal evidence was found for each of the three scenarios but county representatives indicated that they felt the problems were isolated and not systematic.

5.4.1.3 Results

The following sections present the findings from the analyses of child welfare outcomes. Each county is reported independently. Humboldt County and San Luis Obispo County were not included in these analyses due to the small size of their samples. Only child welfare dependents were included in the analyses due to the unavailability of child welfare outcome data for probation wards.

Child Safety: Substantiated Maltreatment

Alameda County

The frequency of substantiated maltreatment for Alameda County is reported in Table 92. Seventeen children had at least one substantiated maltreatment report while in the study: ten children (7.52%) in treatment group and seven children (8.86%) in the comparison group. The difference was not statistically significant. In both the treatment and comparison groups, the majority of children (70.00% and 85.71%, respectively) who had at least one substantiated maltreatment were male (Table 93). The majority of children in the treatment group were Black (90.00%) as compared to the comparison group where the majority of children suffering substantiated maltreatment where White (85.71%) (Table 94). The median age in both groups was roughly 13 years old (

Table 95) but the range of ages was much larger in the treatment group (11.30 compared to 4.30).

Table 1.

Alameda County Substantiated Maltreatment:

Frequencies and Proportions of Substantiated

*Maltreatment by Group Assignment (*N *=212).*

	Yes	No	Total

Treatment Group	10	123	133
	7.52	92.48	
Comparison Group	7	72	79
	8.86	91.14	
Total	17	195	212

$\chi^2(1)=0.1210$. p =0.7279.

Table 2.

*Alameda County Substantiated Maltreatment: Frequencies and Proportions of Gender by Group Assignment (*N *=17).*

	Female	Male	Total
Treatment Group	3	7	10
	30.00	70.00	
Comparison Group	1	6	7
	14.29	85.71	
Total	4	13	17

Table 3.

*Alameda County Substantiated Maltreatment: Frequencies and Proportions of Ethnicity by Group Assignment (*N *=17).*

	Black	White	Hispanic	Total
Treatment Group	9	0	1	10
	90.00	0.00	10.00	
Comparison Group	1	6	0	7
	14.29	85.71	0.00	
Total	10	6	1	17

Table 4.

*Alameda County Substantiated Maltreatment: Age at Enrollment by Group Assignment (*N *=17).*

	N	M	Mdn	Min	Max	Range	SD
Treatment Group	10	12.40	13.10	4.50	15.80	11.30	3.48
Comparison Group	7	13.16	13.30	11.10	15.40	4.30	1.40

The majority of children in both the treatment and comparison groups were living at home or in a relative foster home (40.00% and 57.15%, respectively) at the time of the substantiated maltreatment (Table 96), though subsequent analysis indicates that no child from each of the two groups had been reunified by the time the substantiated maltreatment occurred. The majority of children in both groups—70.00% for the treatment group and 57.14% for the comparison group—were in a non-foster care placement at the time of the substantiated maltreatment (Table 97). Children in the treatment group were in the study for a longer period of time (Md = 564.00 days) before suffering a substantiated maltreatment than children in the comparison group (Md = 236.00 days) (Table 98).

Table 5.

*Alameda County Substantiated Maltreatment: Frequencies and Proportions of Placement Location by Group Assignment (*N *=17).*

	Foster Family Home	Foster Family Agency	Group Home	Relative Home	Trial Home Visit	AWOL	Missing	Total
Treatment Group	1	1	1	3	1	2	1	10
	10.00	10.00	10.00	30.00	10.00	20.00	10.00	
Comparison Group	0	1	2	1	3	0	0	7
	0.00	14.29	28.57	14.29	42.86	0.00	0.00	
Total	1	2	3	4	4	2	1	17

Table 6.

*Alameda County Substantiated Maltreatment: Frequencies and Proportions of Foster Care Placement by Group Assignment (*N *=17).*

	Foster Care Placement	Non-Foster Care Placement	Total
Treatment Group	3	7	10

	30.00	70.00	
Comparison Group	3	4	7
	42.86	57.14	
Total	6	11	17

Table 7.

*Alameda County Substantiated Maltreatment: Number of Days from Enrollment to Substantiated Maltreatment by Group Assignment (*N *=17).*

	N	M	Mdn	Min	Max	Range	SD
Treatment Group	10	514.90	564.00	271.00	709.00	438.00	143.52
Comparison Group	7	360.86	236.00	69.00	834.00	765.00	265.61

Los Angeles County

The frequency of substantiated maltreatment for Los Angeles County is reported in Table 99. Fifteen children had at least one substantiated maltreatment report while in the study: twelve children (18.46%) in treatment group and three children (8.11%) in the comparison group. The difference was not statistically significant. In the treatment group, the majority of children who had at least one substantiated maltreatment were female (66.67%), while in the comparison group all were male (100.00%) (Table 100). The majority of children in the treatment group were Hispanic (66.67%) as compared to the comparison group where the distribution across the three ethnicities was equal (Table 101). The median age in the treatment group was roughly 13 years old and 14 years old in the comparison group (Table 102) but the range of ages was much larger in the treatment group (10.50 compared to 0.80).

Table 8.

*Los Angeles County Substantiated Maltreatment: Frequencies and Proportions of Substantiated Maltreatment by Group Assignment (*N *=102).*

	Yes	No	Total
Treatment Group	12	53	65
	18.46	81.54	
Comparison Group	3	34	37
	8.11	91.89	
Total	15	87	102

$\chi^2(1)=2.0150$. p =0.1558.

Table 9.

*Los Angeles County Substantiated Maltreatment: Frequencies and Proportions of Gender by Group Assignment (*N *=15).*

	Female	Male	Total
Treatment Group	8	4	12
	66.67	33.33	
Comparison Group	0	3	3
	0.00	100.00	
Total	8	7	15

Table 10.

*Los Angeles County Substantiated Maltreatment: Frequencies and Proportions of Ethnicity by Group Assignment (*N *=15).*

	Black	White	Hispanic	Total
Treatment Group	4	0	8	12
	33.33	0.00	66.67	
Comparison Group	1	1	1	3
	33.33	33.33	33.33	
Total	5	1	9	15

Table 11.

*Los Angeles County Substantiated Maltreatment: Age at Enrollment by Group Assignment (*N *=15).*

	N	M	Mdn	Min	Max	Range	SD
Treatment Group	12	13.15	13.45	6.20	16.70	10.50	2.84
Comparison Group	3	14.73	14.60	14.40	15.20	0.80	0.42

Children from both groups were in a variety of placement locations at the time of the substantiated maltreatment (Table 103), and subsequent analysis indicates that no child from each of the two groups had been reunified by the time the substantiated maltreatment occurred. The majority of children (66.66%) in the comparison group were in a non-foster care placement at the time of the substantiated maltreatment (Table 104). Children in the treatment group were in the study for a shorter period of time (Md = 102.00 days) before suffering a substantiated maltreatment than children in the comparison group (Md = 171.00 days).

Table 12.

*Los Angeles County Substantiated Maltreatment: Frequencies and Proportions of Placement Location by Group Assignment (*N *=15).*

	Foster Family Home	Foster Family Agency	Group Home	County Shelter	Trial Home Visit	AWOL	Non-FC	Missing	Total
Treatment Group	2	0	3	1	1	1	3	1	12
	16.67	0.00	25.00	8.33	8.33	8.33	25.00	8.33	
Comparison Group	0	1	0	0	1	0	0	1	3
	0.00	33.33	0.00	0.00	33.33	0.00	0.00	33.33	
Total	2	1	3	1	2	1	3	2	15

Table 13.

*Los Angeles County Substantiated Maltreatment: Frequencies and Proportions of Foster Care Placement by Group Assignment (*N *=15).*

	Foster Care Placement	Non-Foster Care Placement	Total
Treatment Group	6	6	12
	50.00	50.00	
Comparison Group	1	2	3
	33.33	66.66	
Total	7	8	15

Table 14.

*Los Angeles County Substantiated Maltreatment: Number of Days from Enrollment to Substantiated Maltreatment by Group Assignment (*N *=15).*

	N	M	Mdn	Min	Max	Range	SD
Treatment Group	12	143.08	102.00	6.00	484.00	478.00	135.99
Comparison Group	3	185.33	171.00	144.00	241.00	97.00	50.06

Sacramento County

The frequency of substantiated maltreatment for Sacramento County is reported in Table 106. Sixteen children had at least one substantiated maltreatment report while in the study: eleven children (9.40%) in treatment group and five children (7.04%) in the comparison group. The difference was not statistically significant. In the treatment group, the majority of children who had at least one substantiated maltreatment were female (54.55%), while in the comparison group the majority were male (60.00%) (Table 107). The majority of children in both groups suffering substantiated maltreatment where White (

Table 108). The median age in both groups was roughly 14 years old (Table 109) and the range of ages was similar (6.60 compared to 7.20).

Table 15.

*Sacramento County Substantiated Maltreatment: Frequencies and Proportions of Substantiated Maltreatment by Group Assignment (*N *=188).*

	Yes	No	Total
Treatment group	11	106	117

	9.40	90.60	
Comparison Group	5	66	71
	7.04	92.96	
Total	16	172	188

$\chi^2(1)=0.3159$. p =0.5741.

Table 16.

*Sacramento County Substantiated Maltreatment: Frequencies and Proportions of Gender by Group Assignment (*N *=16).*

	Female	Male	Total
Treatment group	6	5	11
	54.55	45.45	
Comparison Group	2	3	5
	40.00	60.00	
Total	8	8	16

Table 17.

*Sacramento County Substantiated Maltreatment: Frequencies and Proportions of Ethnicity by Group Assignment (*N *=16).*

	Black	White	Hispanic	Asian/Other	Total
Treatment group	2	7	1	1	11
	18.18	63.64	9.09	9.09	
Comparison Group	0	4	1	0	5
	0.00	80.00	20.00	0.00	
Total	2	11	2	1	16

Table 18.

*Sacramento County Substantiated Maltreatment: Age at Enrollment by Group Assignment (*N*=16).*

	N	M	Mdn	Min	Max	Range	SD
Treatment group	11	12.73	14.30	8.90	15.50	6.60	2.61

Comparison Group	5	12.80	13.90	7.70	14.90	7.20	2.89

Table 110shows the placement location for children at the time of the substantiated maltreatment. Subsequent analysis indicates that no child from each of the two groups had been reunified by the time the substantiated maltreatment occurred. The majority of children (63.64%) in the treatment group were in a foster care placement at the time of the substantiated maltreatment, the majority of children (66.66%) in the comparison group were in a non-foster care placement (Table 111). Children in the treatment group were in the study for a longer period of time (Md = 432.00 days) before suffering a substantiated maltreatment than children in the comparison group (Md = 259.00 days) (Table 112).

Table 19.

Sacramento County Substantiated Maltreatment: Frequencies and Proportions of Placement Location by Group Assignment (N *=16).*

	Foster Family Agency	Group Home	County Shelter	Relative Home	Missing	Total
Treatment group	4	2	1	0	4	11
	36.36	18.18	9.09	0.00	36.36	
Comparison Group	0	2	0	1	2	5
	0.00	40.00	0.00	20.00	40.00	
Total	4	4	1	1	6	16

Table 20.

*Sacramento County Substantiated Maltreatment: Frequencies and Proportions of Foster Care Placement by Group Assignment (*N *=16).*

	Foster Care Placement	Non-Foster Care Placement	Total
Treatment group	7	4	11
	63.64	36.36	
Comparison Group	2	3	5
	40.00	60.00	
Total	9	7	16

Table 21.

*Sacramento County Substantiated Maltreatment: Number of Days from Enrollment to Substantiated Maltreatment by Group Assignment (*N *=16).*

	N	M	Mdn	Min	Max	Range	SD
Treatment group	11	482.09	432.00	216.00	889.00	673.00	216.47
Comparison Group	5	221.80	259.00	17.00	471.00	454.00	175.50

Placement Stability

Number of Placement Moves

Alameda County

The average number of placement moves (placement at enrollment was not counted) was 2.57 for children in the treatment group and 2.61 for children in the comparison group, with the median number of moves 1.00 and 2.00, respectively (

Table 113). For the treatment group, the minimum number of placements was 0 and the maximum was 15. For the comparison group, the range was from 0 to 14 placement moves.

Table 22.

*Alameda County Number of Placement Moves: Number of Placement Moves by Group Assignment (*N *=212).*

	N	M	Mdn	Min	Max	Range	SD

Treatment Group	133	2.57	1.00	0.00	15.00	15.00	3.37
Comparison Group	79	2.61	2.00	0.00	14.00	14.00	2.83

Due to the range of number of placement moves, four categories were developed for analysis. Table 114shows the frequency of placement moves across the four categories, by treatment and comparison group. Approximately 75% of children from both groups had three or fewer moves over the course of the study. Overall, the groups did not differ in their distributions of number of placement moves. The distributions did not control for a child's total time in the study.

Table 23.

Alameda County Number of Placement Moves: Frequencies and Proportions of Categories of Placement Moves by Group Assignment (N =212).

	0-1 Moves	2-3 Moves	4-5 Moves	6+ Moves	Total
Treatment Group	73	30	11	19	133
	54.89	22.56	8.27	14.29	
Comparison Group	36	23	8	12	79
	45.57	29.11	10.13	15.19	
Total	109	53	19	31	212

$\chi^2(3)=1.9075$. $p=0.5918$.

Logistic regression analysis was conducted to compare the odds of having 3 or fewer placements, controlling for a child's total time in the study. The analysis indicated (Table 115) that children in the treatment group had slightly higher odds (OR = 1.167) of having three or fewer placements, controlling for time in the study, though the difference was not significant.

Table 24.

*Alameda County Number of Placement Moves: The Effect of Variables on the Relative Odds of Having Three or Fewer Placements During the Study Period (*N *=212).*

Variable	Beta	SE	*P*	Odds Ratio	95% CI
Intercept	2.5937	0.5114	<0.0001		
Comparison Group				1.000	
Treatment Group	0.1541	0.3449	0.6551	1.167	(0.593, 2.293)
Time in Study	-0.0594	0.0159	0.0002		

(mo)

Los Angeles County

The average number of placement moves in Los Angeles County was 1.02 for children in the treatment group and 0.92 for children in the comparison group, with the median for both groups equal to 0.00 (Table 116). For the treatment group, the minimum number of placements was 0 and the maximum was 16. For the comparison group, the range was from 0 to 5 placement moves.

Table 25.

*Los Angeles County Number of Placement Moves: Number of Placement Moves by Group Assignment (*N *=102).*

	N	M	Mdn	Min	Max	Range	SD
Treatment Group	65	1.02	0.00	0.00	16.00	16.00	2.37
Comparison Group	37	0.92	0.00	0.00	5.00	5.00	1.34

Table 117 shows the frequency of placement moves across the four categories, by treatment and comparison group. Between 92% and 95% of children from both groups had three or fewer moves over the course of the study. Overall, the groups did not differ in their distributions of number of placement moves.

Table 26.

*Los Angeles County Number of Placement Moves: Frequencies and Proportions of Categories of Placement Moves by Group Assignment (*N *=102).*

	0-1 Moves	2-3 Moves	4-5 Moves	6+ Moves	Total
Treatment Group	56	4	2	3	65
	86.15	6.15	3.08	4.62	
Comparison Group	30	5	2	0	37
	81.08	13.51	5.41	0.00	
Total	86	9	4	3	102

$\chi^2(3)=3.5530$. $p=0.3139$.

The logistic regression analysis indicated (Table 118) that children in the treatment group had lower odds (OR = 0.683) of having three or fewer placements, controlling for time in the study, though the difference was not significant.

Table 27.

*Los Angeles County Number of Placement Moves: The Effect of Variables on the Relative Odds of Having Three or Fewer Placements During the Study Period (*N *=102).*

Variable	Beta	SE	*P*	Odds Ratio	95% CI
Intercept	3.4179	0.9789	0.0005		
Comparison Group				1.000	
Treatment Group	-0.3807	0.8669	0.6606	0.683	(0.125, 3.738)
Time in Study (mo)	-0.0483	0.0511	0.3438		

Sacramento County

The average number of placement moves in Sacramento County was 1.62 for children in the treatment group and 1.73 for children in the comparison group, with the median number of moves 0.00 and 1.00, respectively (Table 119). For the treatment group, the minimum number of placements was 0 and the maximum was 11. For the comparison group, the range was from 0 to 14 placement moves.

Table 28.

*Sacramento County Number of Placement Moves: Number of Placement Moves by Group Assignment (*N *=188).*

	N	M	Mdn	Min	Max	Range	SD
Treatment Group	117	1.62	0.00	0.00	11.00	11.00	2.45
Comparison Group	71	1.73	1.00	0.00	14.00	14.00	2.76

Due to the range of number of placement moves, four categories were developed for analysis. Table 120shows the frequency of placement moves across the four categories, by treatment and comparison group. Approximately 84% of children in the treatment group and 80% of children in the comparison group had three or fewer moves over the course of the study. Overall, the groups did not differ in their distributions of number of placement moves.

Table 29.

*Sacramento County Number of Placement Moves: Frequencies and Proportions of Categories of Placement Moves by Group Assignment (*N *=188).*

	0-1 Moves	2-3 Moves	4-5 Moves	6+ Moves	Total
Treatment Group	76	22	10	9	117
	64.96	18.80	8.55	7.69	62.23
Comparison Group	48	9	7	7	71
	67.61	12.68	9.86	9.86	37.77
Total	124	31	17	16	188

$\chi^2(3)=1.3810$. $p=0.7100$.

The logistic regression analysis indicated that children in the treatment group had greater odds (OR = 1.426) of having three or fewer placements, controlling for time in the study. The difference was not statistically significant.

Table 30.

*Sacramento County Number of Placement Moves: The Effect of Variables on the Relative Odds of Having Three or Fewer Placements During the Study Period (*N *=188).*

Variable	Beta	SE	*P*	Odds Ratio	95% CI
Intercept	2.8334	0.5326	<0.0001		
Comparison Group				1.000	
Treatment Group	0.3550	0.4089	0.3853	1.426	(0.640, 3.179)
Time in Study (mo)	-0.0764	0.0212	0.0003		

Types of Placement Moves

Alameda County

Stepping Down. Children who began their time in the study living in an RCL 12-14 group care facility were included in this portion of the analysis (*N* = 42).

Table 122 shows the sample frequencies and proportions of having the event (i.e., "failed") of stepping down to a less restrictive level of care—75.00% of the treatment group and 64.29% of the comparison group— and not having the event (i.e., "censored"). The cumulative probabilities of "surviving" to specific points in time (6, 12, 24, 30, and 36 months) are shown in Table 123. In other words, the table shows the probability of still being in RCL 12-14 group care at those points in time. **Figure 1** (all figures are located in Appendix A) show that the comparative relationship between the groups changed as a function of time (i.e., non-proportional). Children in the treatment group had lower cumulative probabilities of survival (CPS) from 0 to approximately 200 days (they were more likely to step down to less restrictive care). After approximately the 200-day point and until approximately the 400-day point (the last child in the treatment group to step-down did so 616 days after enrollment, while the last child in the comparison group to step-down did so 744 days after enrollment), the relationship reversed and children in the treatment group were staying in RCL 12-14 group care longer. The differences displayed in both the tables and the figure were not statistically significant.

Table 31.

*Alameda County Type of Placement Moves: Frequencies and Proportions of Children Stepping Down by Group Assignment (*N *= 42).*

	Total	# Stepping Down	% Stepping Down	Censored	% Censored
Treatment Group	28	21	75.00	7	25.00

Comparison Group	14	9	64.00	5	35.71
Total	42	30	71.43	12	28.57

Table 32.

*Alameda County Type of Placement Moves: Children Stepping Down, Cumulative Probabilities of Surviving to 6, 12, 24, 30, and 36 Months (*N = *42).*

	6 mo (95% CI)	12 mo (95% CI)	18 mo (95% CI)	24 mo (95% CI)	30 mo (95% CI)	36 mo (95% CI)
Treatment Group	0.82	0.49	0.33	0.16	0.16	0.16
	(0.67, 0.96)	(0.30, 0.69)	(0.14, 0.51)	(0.18, 0.31)	(0.18, 0.31)	(0.18, 0.31)
Comparison Group	0.92	0.55	0.37	0.37	0.25	0.00
	(0.78, 1.00)	(0.26, 0.85)	(0.08, 0.66)	(0.08, 0.66)	(0.00, 0.52)	(0.00, 0.00)

Test of Equality: Log-Rank $\chi^2(1)= 0.0807$, $p = 0.7764$; Wilcoxon $\chi^2(1)= 0.1706$, $p = 0.6796$.

Analysis using a Cox non-proportional hazards model yielded a risk ratio of 1.596, Table 124) indicating that "risk" of stepping down increased by roughly 60% for children in the treatment group, controlling for time. The finding was not statistically significant.

Table 33.

*Alameda County Type of Placement Move: Non-proportional Hazards Model of Stepping Down to Less Restrictive Care During the Study Period (*N = *42).*

Variable	Beta	SE	*P*	Risk Ratio	95% CI
Comparison Group				1.00	
Treatment Group	0.46750	0.73919	0.5271	1.596	(0.375, 6.796)
Time to Event (d)	-0.00101	0.00173	0.5609		

Stepping Up. Children who began their time in the study at risk of being placed in an RCL 12-14 group care facility were included in this portion of the analysis (*N* = 169). Table 125 shows the sample frequencies for having the event (i.e., "failed") of stepping up to a more restrictive level of care—26.67% of the treatment group and 28.13% of the comparison group— and not having the event (i.e., "censored"). The cumulative probabilities of surviving to specific points

in time (6, 12, 24, 30, and 36 months) are shown in. **Figure 2** shows that the comparative relationship between the groups changed as a function of time (i.e., non-proportional). Children in the treatment group had lower CPS's, meaning they were more likely to step up to a more restrictive living environment up until approximately 20 months. At that point, children in the comparison group became more likely to step up to RCL 12-14 group care, be AWOL, or incarcerated. The differences displayed in both the tables and the figure were not statistically significant.

Table 34.

*Alameda County Type of Placement Moves: Frequencies and Proportions of Children Stepping Up by Group Assignment (*N = *169).*

	Total	# Stepping Up	% Stepping Up	Censored	% Censored
Treatment Group	105	28	26.67	77	73.33
Comparison Group	64	18	28.13	46	71.88
Total	169	46	27.22	123	72.78

Table 35.

*Alameda County Type of Placement Moves: Children Stepping Up, Cumulative Probabilities of Surviving to 6, 12, 24, 30, and 36 Months (*N = *169).*

	6 mo (95% CI)	12 mo (95% CI)	18 mo (95% CI)	24 mo (95% CI)	30 mo (95% CI)	36 mo (95% CI)
Treatment Group	0.90	0.82	0.74	0.72	0.72	0.67
	(0.85, 0.96)	(0.74, 0.89)	(0.65, 0.83)	(0.63, 0.82)	(0.63, 0.82)	(0.56, 0.78)
Comparison Group	0.92	0.85	0.80	0.69	0.66	0.55
	(0.85, 0.99)	(0.75, 0.94)	(0.69, 0.91)	(0.56, 0.83)	(0.52, 0.80)	(0.37, 0.73)

Test of Equality: Log-Rank $\chi^2(1)= 0.0569$, $p = 0.8115$; Wilcoxon $\chi^2(1)= 0.0238$, $p = 0.8774$.

Finally, a risk ratio of 1.445 (Table 127), produced by a Cox non-proportional regression analysis, indicated that children in the treatment group had just over 1.4 times the "risk" (or hazard) of stepping up into RCL 12-14 group care, be AWOL, or incarcerated. The finding was not statistically significant.

Table 36.

Alameda County Type of Placement Move: Non-proportional Hazards

*Model of Stepping Down to Less Restrictive Care During the Study Period (*N = *169).*

Variable	Beta	SE	*P*	Risk Ratio	95% CI
Comparison Group				1.00	
Treatment Group	0.36827	0.49934	0.4608	1.445	(0.543, 3.846)
Time to Event (d)	-0.00117	0.00103	0.2573		

Los Angeles County

Stepping Down. Children in Los Angeles County who began their time in the study living in an RCL 12-14 group care facility were included in this portion of the analysis (*N* = 17). Table 128 shows the sample frequencies and proportions of having the event (i.e., "failed") of stepping down to a less restrictive level of care—66.67% of the treatment group and 75.00% of the comparison group— and not having the event (i.e., "censored"). The cumulative probabilities of "surviving" to specific points in time (6, 12, 24, 30, and 36 months) are shown in Table 129. Again, the table shows the probability of still being in RCL 12-14 group care at those points in time. **Figure 3** shows that the comparative relationship between the groups changed as a

function of time (i.e., non-proportional). Children in the treatment group had higher cumulative probabilities of survival (CPS) from 0 to approximately 500 days (they were less likely to step down to less restrictive care). The last child in the treatment group to step-down did so 527 days after enrollment, while the last child in the comparison group to step-down did so 616 days after enrollment. The differences displayed in both the tables and the figure were not statistically significant.

Table 37.

*Los Angeles County Type of Placement Moves: Frequencies and Proportions of Children Stepping Down by Group Assignment (*N = *17).*

	Total	# Stepping Down	% Stepping Down	Censored	% Censored
Treatment Group	9	6	66.67	3	33.33
Comparison Group	8	6	75.00	2	25.00
Total	17	12	70.59	5	29.41

Table 38.

*Los Angeles County Type of Placement Moves: Children Stepping Down, Cumulative Probabilities of Surviving to 6, 12, 24, 30, and 36 Months (*N = *17).*

	6 mo (95% CI)	12 mo (95% CI)	18 mo (95% CI)	24 mo (95% CI)	30 mo (95% CI)	36 mo (95% CI)
Treatment Group	0.44 (0.12, 0.77)	0.44 (0.12, 0.77)	0.22 (0.00, 0.57)	0.22 (0.00, 0.57)	0.22 (0.00, 0.57)	0.22 (0.00, 0.57)
Comparison Group	0.38 (0.04, 0.71)	0.38 (0.04, 0.71)	0.38 (0.04, 0.71)	0.19 (0.00, 0.50)	0.19 (0.00, 0.50)	0.19 (0.00, 0.50)

Test of Equality: Log-Rank $\chi^2(1)= 0.4340$, $p = 0.5100$; Wilcoxon $\chi^2(1)= 1.3461$, $p = 0.2460$.

Analysis using a Cox non-proportional hazards model yielded a risk ratio of 0.542, (Table 130) indicating that "risk" of stepping down was lower for children in the treatment group, controlling for time. The finding was not statistically significant.

Table 39.

*Los Angeles County Type of Placement Move: Non-proportional Hazards Model of Stepping Down to Less Restrictive Care During the Study Period (*N = *17).*

Variable	Beta	SE	*P*	Risk Ratio	95% CI
Comparison Group				1.00	
Treatment Group	-0.61168	0.69357	0.3778	0.542	(0.139, 2.112)
Time to Event (d)	0.00180	0.00291	0.5366		

Stepping Up. Children who began their time in the study at risk of being placed in an RCL 12-14 group care facility were included in this portion of the analysis (N = 70). Table 131 shows the sample frequencies for having the event (i.e., "failed") of stepping up to a more restrictive level of care—13.64% of the treatment group and 15.38% of the comparison group— and not having the event (i.e., "censored"). The cumulative probabilities of surviving to specific points in time (6, 12, 24, 30, and 36 months) are shown in

Table 132. **Figure 4** shows that the comparative relationship between the groups changed as a function of time (i.e., non-proportional). The differences displayed in both the tables and the figure were not statistically significant.

Table 40.

*Los Angeles County Type of Placement Moves: Frequencies and Proportions of Children Stepping Up by Group Assignment (*N = *70).*

	Total	# Stepping Up	% Stepping Up	Censored	% Censored
Treatment Group	44	6	13.64	38	86.36
Comparison Group	26	4	15.38	22	84.62
Total	70	10	14.29	60	85.71

Table 41.

*Los Angeles County Type of Placement Moves: Children Stepping Up, Cumulative Probabilities of Surviving to 6, 12, 24, 30, and 36 Months (*N *= 70).*

	6 mo (95% CI)	12 mo (95% CI)	18 mo (95% CI)	24 mo (95% CI)	30 mo (95% CI)	36 mo (95% CI)
Treatment Group	0.86	0.86	0.80	0.80	0.80	0.80
	(0.74, 0.98)	(0.74, 0.98)	0.65, 0.96)	0.65, 0.96)	0.65, 0.96)	0.65, 0.96)
Comparison Group	0.88	0.78	0.78	0.78	0.78	0.78
	(0.75, 1.00)	(0.56, 0.99)	(0.56, 0.99)	(0.56, 0.99)	(0.56, 0.99)	(0.56, 0.99)

Test of Equality: Log-Rank $\chi^2(1)= 0.0929$, $p = 0.7606$; Wilcoxon $\chi^2(1)= 0.1279$, $p = 0.7207$.

Finally, a risk ratio of 0.740 (Table 133), produced by a Cox non-proportional regression analysis, indicated that children in the treatment group were at lower "risk" (or hazard) of stepping up into RCL 12-14 group care, be AWOL, or incarcerated than the comparison group, controlling for time. The finding was not statistically significant.

Table 42.

*Los Angeles County Type of Placement Move: Non-proportional Hazards Model of Stepping Down to Less Restrictive Care During the Study Period (*N *= 70).*

Variable	Beta	SE	*P*	Risk Ratio	95% CI
Comparison Group				1.000	
Treatment Group	-0.30158	0.89900	0.7373	0.740	(0.127, 4.308)
Time to Event (d)	0.00088	0.00529	0.8684		

Sacramento County

Stepping Down. Children in Sacramento County who began their time in the study living in an RCL 12-14 group care facility were included in this portion of the analysis (*N* = 76). Table 134 shows the sample frequencies and proportions of having the event (i.e., "failed") of stepping down to a less restrictive level of care—54.17% of the treatment group and 53.57% of the comparison group—and not having the event (i.e., "censored"). The cumulative probabilities of "surviving" to specific points in time (6, 12, 24, 30, and 36 months) are shown in Table 135. **Figure 5** show that the comparative relationship between the groups changed as a function of

time (i.e., non-proportional). The last child in the treatment group to step-down did so 681 days after enrollment, while the last child in the comparison group to step-down did so 700 days after enrollment. The differences displayed in both the tables and the figure were not statistically significant.

Table 43.

*Sacramento County Type of Placement Moves: Frequencies and Proportions of Children Stepping Down by Group Assignment (*N = *76).*

	Total	# Stepping Down	% Stepping Down	Censored	% Censored
Treatment Group	48	26	54.17	22	45.83
Comparison Group	28	15	53.57	13	46.43
Total	76	41	53.95	35	46.05

Table 44.

*Sacramento County Type of Placement Moves: Children Stepping Down, Cumulative Probabilities of Surviving to 6, 12, 24, 30, and 36 Months (*N = *76).*

	6 mo (95% CI)	12 mo (95% CI)	18 mo (95% CI)	24 mo (95% CI)	30 mo (95% CI)	36 mo (95% CI)
Treatment Group	0.69 (0.55, 0.83)	0.45 (0.29, 0.62)	0.35 (0.17, 0.53)	0.22 (0.03,0.40)	0.00 (0.00, 0.00)	0.00 (0.00, 0.00)
Comparison Group	0.58 (0.39, 0.77)	0.42 (0.22, 0.63)	0.42 (0.22, 0.63)	0.34 (0.12, 0.56)	0.34 (0.12, 0.56)	0.34 (0.12, 0.56)

Test of Equality: Log-Rank $\chi^2(1)= 0.1718$, $p = 0.6785$; Wilcoxon $\chi^2(1)= 0.0382$, $p = 0.8450$.

Analysis using a Cox non-proportional hazards model yielded a risk ratio of 0.812, (Table 136) indicating that "risk" of stepping down was approximately 19% lower for children in the treatment group, controlling for time. The finding was not statistically significant.

Table 45.

*Sacramento County Type of Placement Move: Non-proportional Hazards Model of Stepping Down to Less Restrictive Care During the Study Period (*N = *76).*

Variable	Beta	SE	*P*	Risk Ratio	95% CI
Comparison Group				1.000	
Treatment Group	-0.20807	0.48476	0.6678	0.812	(0.314, 2.100)
Time to Event (d)	0.00180	0.00191	0.3472		

Stepping Up. Children who began their time in the study at risk of being placed in an RCL 12-14 group care facility were included in this portion of the analysis (*N* = 49). Table 137 shows the sample frequencies for having the event (i.e., "failed") of stepping up to a more restrictive level of care—28.57% of the treatment group and 38.10% of the comparison group—and not having the event (i.e., "censored"). The cumulative probabilities of surviving to specific points in time (6, 12, 24, 30, and 36 months) are shown in

Table 138. **Figure 6** show that the comparative relationship between the groups changed as a function of time (i.e., non-proportional). The differences displayed in both the tables and the figure were not statistically significant.

Table 46.

*Sacramento County Type of Placement Moves: Frequencies and Proportions of Children Stepping Up by Group Assignment (*N = *49).*

	Total	# Stepping Up	% Stepping Up	Censored	% Censored
Treatment Group	28	8	28.57	20	71.43
Comparison Group	21	8	38.10	13	61.90
Total	49	16	32.65	33	67.35

Table 47.

*Sacramento County Type of Placement Moves: Children Stepping Up, Cumulative Probabilities of Surviving to 6, 12, 24, 30, and 36 Months (*N = *49).*

	6 mo	12 mo	18 mo	24 mo	30 mo	36 mo

	(95% CI)	(95% CI)	(95% CI)	(95% CI)	(95% CI)	(95% CI)
Treatment Group	0.81	0.68	0.68	0.68	0.68	0.68
	(0.66, 0.96)	(0.50, 0.87)	(0.50, 0.87)	(0.50, 0.87)	(0.50, 0.87)	(0.50, 0.87)
Comparison Group	0.80	0.57	0.46	0.46	0.46	0.46
	(0.62, 0.98)	(0.31, 0.83)	(0.17, 0.75)	(0.17, 0.75)	(0.17, 0.75)	(0.17, 0.75)

Test of Equality: Log-Rank $\chi^2(1)= 0.5806$, $p = 0.4461$; Wilcoxon $\chi^2(1)= 0.1967$, $p = 0.6574$.

Finally, a risk ratio of 1.796 (Table 139), produced by a Cox non-proportional regression analysis, indicated that children in the treatment group were at greater "risk" (or hazard) of stepping up into RCL 12-14 group care, be AWOL, or incarcerated than the comparison group, controlling for time. The finding was not statistically significant.

Table 48.

*Sacramento County Type of Placement Move: Non-proportional Hazards Model of Stepping Down to Less Restrictive Care During the Study Period (*N = *49).*

Variable	Beta	SE	p	Risk Ratio	95% CI
Comparison Group				1.000	
Treatment Group	0.58564	0.93679	0.5319	1.796	(0.286, 11.265)
Time to Event (d)	-0.00555	0.00456	0.2240		

Placement Permanence

Types of Placements

Alameda County

Table 140 and Table 141 show the full range of placement types children were residing in at their time of enrollment into the study and at the end of the study. For subsequent analyses, placement types were collapsed into two groups: family-based placements vs. institution-based placements. Table 140 shows that a slightly larger proportion of children in the treatment group resided in a family-based setting than did children in the comparison group (39.10% and 32.91%, respectively) at time of enrollment. At the end of the study, the proportion of children in the treatment group who were in a family-based placement had increased to 56.76%, compared to only 33.33% children in the comparison group **(**Table 141**)**. The difference between the groups at the end of the study was statistically significant ($p = 0.0022$).

Table 49.

*Alameda County Types of Placements: Frequencies and Proportions of Family-based vs. Institution-based Placement at Enrollment by Group Assignment (*N *=212).*

	Family-based	Institution-based	Total
Treatment Group	52	81	134
	39.10	60.90	
Comparison Group	26	53	79
	32.91	67.09	
Total	78	134	212

$\chi^2(1)=0.8156$. $p=0.3665$.

Table 50.

*Alameda County Types of Placements: Frequencies and Proportions of Family-based vs. Institution-based Placement at the End of the Study by Group Assignment (*N *=183).*

	Family-based	Institution-based	Total
Treatment Group	63	48	111
	56.76	43.24	
Comparison Group	24	48	72
	33.33	66.67	
Total	87	96	183

$\chi^2(1)=9.6076$. $p=0.0019$.

When a logistic regression analysis was conducted (Table 142), controlling for time in the study, the relationship between group assignment and family-based placements stayed the same. Children in the treatment group had 2.646 times the odds of being placed a family-based placement as compared to children in the comparison group, controlling for time in the study ($p = 0.0021$).

Table 51.

*Alameda County Types of Placements: The Effect of Variables on the Relative Odds of Living in a Family-based Environment at the End of the Study (*N *=183).*

Variable	Beta	SE	p	Odds Ratio	95% CI
Intercept	-1.0204	0.4007	0.0109		
Comparison Group				1.000	
Treatment Group	0.9730	0.3163	0.0021	2.646	(1.424, 4.918)
Time in Study (mo)	0.0139	0.0130	0.2873		

Los Angeles County

Table 143 and Table 144 show the full range of placement types children were residing in at their time of enrollment into the study and at the end of the study in Los Angeles County. Table 143 shows that a slightly larger proportion of children in the treatment group resided in a family-based setting than did children in the comparison group (56.76% and 33.33%, respectively) at time of enrollment. At the end of the study, the proportion of children in the treatment group who were in a family-based placement had increased for both groups, to 69.77% of children in the treatment group and 68% of children in the comparison group **(**Table 144**)**.

Table 52.

*Los Angeles County Types of Placements: Frequencies and Proportions of Family-based vs. Institution-based Placement at Enrollment by Group Assignment (*N *=87).*

	Family-based	Institution-based	Total
Treatment Group	27	26	53
	50.94	49.06	
Comparison Group	15	19	34
	44.12	55.88	
Total	42	45	87

$\chi^2(1)=0.3865$. $p=0.5342$.

Table 53.

*Los Angeles County Types of Placements: Frequencies and Proportions of Family-based vs. Institution-based Placement at the End of the Study by Group Assignment (*N *=68).*

	Family-based	Institution-based	Total
Treatment Group	30	13	43
	69.77	30.23	
Comparison Group	17	8	25
	68.00	32.00	
Total	47	21	68

$\chi^2(1)=0.0231$. p =0.8791.

Logistic regression analysis was used to further examine the relationship between group assignment and placement location at the end of the study (Table 145). The analysis showed that children in the treatment group had slightly greater odds (OR=1.134) of being placed a family-based placement as compared to children in the comparison group, controlling for time in the study. The finding was not statistically significant.

Table 54.

*Los Angeles County Types of Placements: The Effect of Variables on the Relative Odds of Living in a Family-based Environment at the End of the Study (*N *=68).*

Variable	Beta	SE	p	Odds Ratio	95% CI
Intercept	1.0754	0.5477	0.0496		
Comparison Group				1.000	
Treatment Group	0.1253	0.5481	0.8191	1.134	(0.387, 3.319)
Time in Study (mo)	0.0345	0.0353	0.3274		

Sacramento County

Table 146 and Table 147 show the full range of placement types children were residing in at their time of enrollment into the study and at the end of the study in Los Angeles County. Table 146shows that approximately the same proportion of children in the treatment group resided in a family-based setting, as did children in the comparison group (20.00% and 17.86%, respectively) at time of enrollment. At the end of the study, the proportion of children in the treatment group

who were in a family-based placement had increased for both groups, to 41.38% of children in the treatment group and 42.37% of children in the comparison group **(**Table 147**)**.

Table 55.

*Sacramento County Types of Placements: Frequencies and Proportions of Family-based vs. Institution-based Placement at Enrollment by Group Assignment (*N *=146).*

	Family-based	Institution-based	Total
Treatment Group	18	72	90
	20.00	80.00	
Comparison Group	10	46	56
	17.86	82.14	
Total	28	118	146

$\chi^2(1)=0.1023$. $p=0.7491$.

Table 56.

Sacramento County Types of Placements: Frequencies and Proportions of Family-based vs. Institution-based Placement at the End of the Study by Group Assignment (N =146).

	Family-based	Institution-based	Total
Treatment Group	36	51	87
	41.38	58.62	
Comparison Group	25	34	59
	42.37	57.63	
Total	61	85	146

$\chi^2(1)=0.0143$. $p=0.9049$.

Logistic regression analysis (Table 148) showed that children in the treatment group had slightly lower odds (OR=0.940) of being placed a family-based placement as compared to children in the comparison group, controlling for time in the study. The finding was not statistically significant.

Table 57.

*Sacramento County Types of Placements: The Effect of Variables on the Relative Odds of Living in a Family-based Environment at the End of the Study (*N *=146).*

Variable	Beta	SE	p	Odds Ratio	95% CI
Intercept	-0.8523	0.4062	0.0359		
Comparison Group				1.000	
Treatment Group	-0.0614	0.3459	0.8591	0.940	(0.477, 1.852)
Time in Study (mo)	0.0318	0.0177	0.0728		

Exits from Care

Alameda County

Two analyses were conducted regarding exits from care: exit due to incarceration and exit due to permanency (i.e., reunification, adoption, or guardianship). The frequencies of exit from care due to incarceration are shown in Table 149. Five children in the treatment group (3.76%) exited care due to incarceration while two children in the comparison group (2.53%) exited from care for that reason. The difference was not statistically significant. The number of events was to small to allow for a logit analysis.

Table 58.

*Alameda County Exit from Care: Frequencies and Proportions of Incarceration by Group Assignment (*N *=212).*

	Incarcerated	Not Incarcerated	Total
Treatment Group	5	128	133
	3.76	96.24	
Comparison Group	2	77	79
	2.53	97.47	
Total	7	205	212

$\chi^2(1)=0.2340$. p =0.7149.

The frequencies for the second analysis, exit due to permanency, are shown in Table 150. Three children in the treatment group (2.26%) exited care due to reunification, adoption, or guardianship compared to four children in the comparison group (5.06%). The difference was

not statistically significant. Again, the number of events was too small to allow for a logit analysis.

Table 59.

*Alameda County Exit from Care: Frequencies and Proportions of Permanency by Group Assignment (*N *=212).*

	Permanency	Not Permanency	Total
Treatment Group	3	130	133
	2.26	97.74	
Comparison Group	4	75	79
	5.06	94.94	
Total	7	205	212

$\chi^2(1)=1.2236$. p =0.4283.

Los Angeles County

In Los Angeles County, the only exits from care were due to incarceration. Table 151 shows that one child from the treatment and comparison groups exited care for this reason.

Table 60.

*Los Angeles County Exit from Care: Frequencies and Proportions of Incarceration by Group Assignment (*N *=102).*

	Incarcerated	Not Incarcerated	Total
Treatment Group	1	64	65
	1.54	98.46	
Comparison Group	1	36	37
	2.70	97.30	
Total	2	100	102

$\chi^2(1)=0.1663$. p =1.0000.

Sacramento County

Two analyses were conducted regarding exits from care in Sacramento County: exit due to incarceration and exit due to permanency. The frequencies of exit from care due to incarceration are shown in Table 152. No children in the treatment group (0.00%) exited care due to incarceration while four children in the comparison group (5.63%) exited from care for that

reason. The difference was statistically significant (p=0.0193). The number of events was too small to allow for a logit analysis.

Table 61.

*Sacramento County Exit from Care: Frequencies and Proportions of Incarceration by Group Assignment (*N *=188).*

	Incarcerated	Not Incarcerated	Total
Treatment Group	0	117	117
	0.00	100.00	
Comparison Group	4	67	71
	5.63	94.37	
Total	4	184	188

$\chi^2(1)=6.7348$. p =0.0193.

The frequencies for the second analysis, exit due to permanency, are shown in Table 153. Three children in the treatment group (2.56%) exited care due to reunification, adoption, or guardianship compared to zero children in the comparison group (0.00%). The difference was not statistically significant. Again, the number of events was too small to allow for a logit analysis.

Table 62.

*Sacramento County Exit from Care: Frequencies and Proportions of Permanency by Group Assignment (*N *=188).*

	Permanency	Not Permanency	Total
Treatment Group	3	114	117
	2.56	97.44	
Comparison Group	0	71	71
	0.00	100.00	
Total	3	185	188

$\chi^2(1)=1.8500$. p =0.2911.

5.4.1.4 Child Welfare Outcomes Discussion

Alameda County, Los Angeles County, and Sacramento County were analyzed separately and their Results were reported as such. The three counties are grouped together by specific outcomes for the Discussion section, though the tenor of the section is not comparative.

Child Safety: Substantiated Maltreatment

In both Alameda County and Sacramento County the differences between the groups appear to be relatively small (approximately 1.3% and 2.3%, respectively), though the trend of the difference was positive in Alameda County. In Los Angeles County, the difference between the groups was approximately 10.3%, with a greater proportion of children in Wraparound suffering substantiated maltreatment. The comparison's p-value of 0.1558, while not statistically significant, indicates a possible trend that may be cause for concern.

The results of the analysis of substantiated maltreatment, however, are difficult to interpret. The small number of children experiencing an event of substantiated maltreatment in each of the counties—while positive in the real sense—disallowed the use of more powerful assessment tools to assess the differences between the groups; in other words, linear logistic regression analysis could not be used to assess the possible influence of Wraparound on the odds of the event of substantiated maltreatment due to a lack of "robustness" resulting from the rareness of the event in the three samples.

The child's placement location, while not necessarily where the substantiated maltreatment occurred, is an important consideration in interpreting the substantiated maltreatment results, given Wraparound's programmatic goal of "moving" children into (or keep them in) less-restrictive, more family-like placement settings, while keeping them safe. In Alameda County, a larger proportion of children from both treatment and comparison groups were in non-foster care placements at the time of their substantiated maltreatment. However, it is impossible to determine a total number of children from the Wraparound group living in a non-foster care environment in order to calculate the proportion of children living in a non-foster care environment who suffered substantiated maltreatment. (Substantiated maltreatment is a point-in-time event that allows for the identification of a placement location; however, a similar point-in-time placement location cannot be identified for children who did not suffer a substantiated maltreatment because there is no "point-in-time" per se and their placement location can change over time). It may be that Alameda County Wraparound has a larger number of children in their sample living in a non-foster care environment and, by comparison, a smaller proportion of that more at-risk group actually suffering substantiated maltreatment. The converse, of course, could also be the case. The groups in Los Angeles County were split almost evenly between foster care and non-foster care placements. In Sacramento County, a larger proportion of children from both groups were in foster care placements at the time of their substantiated maltreatment.

County representatives had expressed concerns throughout the study that a higher proportion of Wraparound children may have substantiated maltreatment reports for two reasons. First, that the intervention's focus on moving children home or into relative care would increase their risk for maltreatment. Second, representatives felt their proximity (i.e., consistent face-to-face contact) to the children and their families would result in a larger number of child protective referrals and incidences of substantiated maltreatment. It would be important to identify the type of substantiated maltreatment for Wraparound children to determine if perhaps less-severe forms of maltreatment were being reported and substantiated. In other words, did the more consistent presence of professionals create a lower reporting threshold for Wraparound children than there was for children in the comparison group resulting in a higher proportion of substantiated maltreatment?

Placement Stability

Number of Placement Moves

None of the counties' Wraparound programs appeared to be more effective than traditional child welfare services at reducing the number of placement moves experienced by a child, though in Alameda County and Sacramento County the trend was in a positive direction. This is consistent with the finding from Clark et al. who also found no difference between a group of children receiving Wraparound and children receiving traditional child welfare services.

Unfortunately, assessing the number placement moves is not particularly nuanced; it refers to the quantity of moves and not the quality of moves. Placement moves are, in and of themselves, disruptive and may require (among other things) the severing of connections with people; however, the move itself may be for the better. For example, a move to a place closer to family members or to a less-restrictive living environment would be considered "good" moves. In fact, the immediate goal for children in RCL 12-14 group care is to step them down to a less-restrictive level of care. Beyond that specific goal, Alameda County representatives have theorized that the nature of returning a child home or stabilizing them in a family-based placement is likely to be an incremental process; there may be several intervening placements between the initial placement and the final "placement" which would inflate the total number of placements. Although beyond the scope of the present study, if "lateral" or "good" placement moves were assessed and subtracted from the total number of placement moves, it may be that Project Destiny children experienced fewer "bad" moves.

Types of Placement Moves

Stepping Down. Approximately 20% of the total samples from Alameda County and Los Angeles County were included in the stepping down analysis, making interpretation difficult due to the small sample size. In Sacramento County, approximately 60% of the County's total sample was included. The results in Alameda County, while not statistically significant, were in a positive direction with children in Wraparound appearing to have a greater "risk" for stepping down to lower levels of care. Unfortunately, the analysis of stepping down did not include a follow-up to determine the stability of the placement. The trend of the findings in Los Angeles County and in Sacramento County was negative.

None of the results from counties seem to suggest some kind of fiscal policy "push" where children receiving Wraparound are stepped down to a lower level of care in a short amount of time in order to produce a cost savings that can be disbursed across the risk-pool. If there were some kind of "push," it seems likely a greater proportion of children in Wraparound would have stepped-down or stepped-down in a shorter amount of time.

Stepping Up. In Los Angeles County, the results suggest that children were at less "risk" of stepping up into a more restrictive level of care (i.e., RCL 12-14 group care, incarceration, AWOL, psychiatric hospitalization), though the finding was not statistically significant. The trend of the findings in Alameda County and Sacramento County were not positive. However, in each of the counties the difference in the proportions of children stepping up in levels of restrictiveness or the differences in the cumulative probabilities of surviving to various points in time in less restrictive living environments were not particularly large.

Placement Permanence

Types of Placements

Wraparound in Alameda County, compared to traditional child welfare services, was successful in the first measure of placement permanency: children receiving Wraparound had statistically significantly greater odds of living in a family-based environment than did children in the comparison group, controlling for the amount of time in the study. The Wraparound intervention was successful at moving children out of group homes in general: at the time of enrollment 39.10% of the children in the treatment group were living in some type of family-based placement; by the end of the study, 56.76% were living in a family-based placement. This finding suggests that some of the placement moves experienced by children receiving Wraparound in Alameda County are lateral moves or good moves, that within the 0-3 range of number of moves, children are moving down or moving laterally to perhaps one intervening placement before stabilizing in a relative, guardian, or home placement.

Los Angeles County also reported a positive trend (not statistically significant), though the relative gain in proportion of sample in a family-based placement between enrollment and the end of the study was greater for the comparison group. The trend of the result for this outcome was negative in Sacramento County.

Exits from Care

Incarceration. The overall proportion of children exiting care due to incarceration was small in both groups in each of the three counties. In Sacramento County, a significantly larger proportion of children in the comparison group exited care due to incarceration. The result of the finding Los Angeles County was also positive.

Permanency. The findings from the analysis of permanency are not surprising for a number of reasons. First, children in high level group care (or who are at risk of such placement) generally reunify at lower rates than children in other types of foster care (Courtney & Barth, 1996; Landsverk, Davis, Ganger, & Newton, 1996; Webster, 1999). Additionally, children may not have had an identified caregiver to whom the child may return home. Third, there is a fiscal disincentive for relative caregivers to move from kinship care to guardianship in cases where the kinship provider is receiving a supplement to the basic foster care rate (Specialized Care Increment), thereby reducing the chance for permanency status. These three factors, in combination with the relatively short amount of time children experienced Wraparound, make a possible transition to permanency particularly difficult.

The findings for permanency are not consistent with those of Clark et al. where children receiving Wraparound, particularly older children, had greater odds of achieving permanency. In that analysis, “living independently” was included as an indicator of permanency. In this analysis, “emancipation” was not included as a permanency indicator.

5.4.2 Well-Being Outcomes

5.4.2.1 Purpose

The Impact Study also addressed the impact of Wraparound on the well-being of youth and families.

5.4.2.2 Methodology

Research Questions

The research question regarding child and family well-being addresses the impact of the intervention on the following areas of well-being:

1) Child/adolescent functioning (from the perspective of both problem and strengths orientations)
2) Social skills
3) School performance and educational progress
4) Social relationships (peer group, family relationships)
5) Individual adaptation areas
6) Substance use and abuse
7) Health status

For a complete list of instruments used in the Wraparound indepth interviews, see Appendix A.3 Instruments Used in Study.

Sampling Procedures

Well-being was measured through repeated in-depth interviews conducted with youth and caregivers. These interviews were conducted in Alameda County only, due to budget constraints on collecting this data from the other four wraparound counties. Alameda County was chosen since at the time it had the most potential for larger sample size, and because of its geographic proximity. Initially, interviews were conducted at "baseline", i.e. within 30 days of enrollment in the study, with follow up interviews at 18 months. For interviews scheduled on or after 4/1/02 the follow up timeframe was changed to 12 months after baseline, in order to increase the number of responses. All youth and caregivers were eligible to be interviewed after October 1, 2000. The final cohort to be interviewed for wave 2 was enrolled before October 1, 2002. (Survey data collection ceased as of 9/30/03.)

Response rates are shown below in

Table 154.

Table 63.

In-Depth Interview Response Rates for Wave 1 and Follow Up Rates for Wave 2, Alameda County

	Wave 1 Response Rate N/# of total eligible (%)	Wave 2 Follow Up Rate N/# of Wave 1 (%)
Caregivers	79/118 (67%)	37/79 (47%)
Youth	53/118 (45%)	22/53 (42%)

Most of the reasons for non-response were listed as caregiver non-response to phone messages, no-shows for appointment, or the caregiver or youth declined or refused the interview. In some instances, new caregivers (e.g. foster parents) who were not provided an orientation when the youth was enrolled were more reluctant to participate in the survey. Some interview opportunities were also missed as a result of staffing changes in the evaluation team.

There were no statistically significant differences between groups in the characteristics (age and ethnicity of child) of respondents vs. non-respondents. There were also no differences between groups in these characteristics when comparing caregiver and youth respondents who had been interviewed at wave 1, but were not re-interviewed at wave 2.

Table 155 shows the types of caregivers interviewed, by survey wave.

Table 64.

Types of Caregivers Interviewed, by Wave

	Wave 1 N = 79	Wave 2 N = 37	Total
Biological mother	5	2	7
Grandmother	5	2	7
Aunt/uncle	5	3	8
Other relative	1	1	2
Foster parent	17	11	28
Public or private agency social worker	1	4	5
Other non-relative caregiver	44	13	57
Missing data	1	1	2
Total	79	37	116

Family members comprised 21% of those interviewed. The majority of "other non-relative caregivers" were group home staff or house managers. There were no apparent patterns of caregiver non-response in wave 2.

Data Collection Procedures

Interviews were scheduled upon enrollment through the use of the Enrollment/Data Collection spreadsheet program developed for the study. Field interviewers telephoned potential respondents who were eligible for being interviewed. Verbal Informed Consent was obtained prior to beginning the interviews (supplementing the original written Informed Consent forms completed upon enrollment in the study). The interview protocol was structured using the "Wraparound Youth Instrument" and the "Wraparound Caregiver Instrument". Both instruments were developed for this study, and were comprised of pre-existing scales and newly written questions. All interviews were conducted face-to-face and lasted approximately 1-2 hours each. Many interviews were conducted in the home, or at group home sites. Once the interview was completed, the forms were confidentially delivered to the Center for Social Services Research, scanned into secure computerized data collection files, and filed in locked cabinets. Checks for $15 were then mailed to respondents for their participation. (Youth respondents were given gift certificates at the time of the interview.)

Data Analysis Strategies

The research question asks whether change over time occurred as a result of the intervention, assuming two observations (at baseline upon enrollment, and follow up at 12 or 18 months). Separate bi-variate analyses were done for youth and caregiver responses. In general for continuous and most ordinal scales, mean total scores were calculated when appropriate, and the difference in means between experimental and control groups were tested for significant differences using either two-tailed t-tests or the Wilcoxon Two Sample Rank Sums Test, a nonparametric alternative to the independent samples t-test if the data did not meet normality assumptions. (Analysis of Covariance, which is often used in randomized pre- post-test measurements, was not appropriate for most of the analyses due to its assumptions about the data and requirements for larger sample size.) In addition, for most continuous or ordinal response items, analyses were conducted on "improved" vs. "improved" from wave 1 to wave 2 surveys. For dichotomous item response (i.e. "yes" or "no"), Chi-Square tests of association were used as appropriate (i.e. comparing the intervention and comparison groups in differences in counts or percentages between baseline and follow up) unless the number of responses was too small for Chi-Square (i.e. 5 or fewer responses in a cell), in which case the Fisher's Exact Test statistic was used as an alternative.

Analytic issues related to specific questions or scales are discussed in their respective Results sections.

Limitations of Study

The small response rate is the most serious limitation of the Indepth Interview component, resulting in a lack of statistical power to determine effects even when they might be present, as well as limit generalizability to the study population. This was especially true of the youth response data. In any survey involving respondents' memory of past events, there is always the potential for inaccuracy of reporting. In some cases, children and youth had different caregivers

by the time of the wave 2 interviews, resulting in further loss of validity of response. The same caregiver responding to both waves would al least allow for more accurate "before and after" observations. The use of a one-post-test observation (as opposed to repeated post-test observations) limits interpretation of change-over-time with these children and youth whose circumstances and emotional status can change so frequently, and for whom the intervention may have long-term as well as short-term impact.

5.4.2.3 Results

Child/Youth Individual Adaptation

Health Status

Caregivers were asked "How would you describe the health of your child or the child in your care?" While there was almost no change in the distribution of response in the comparison group from survey wave 1 to wave 2, the experimental group showed improved health status over time. In wave 1, six (31%) of the experimental children were reported to have "Very good" or "Excellent" health, and in the follow up interview the percentage increased to almost 45% (p = .11, Fisher's Exact Test).

There were no significant differences between groups in response to "Does the child have any health problems that last a long time…" Both groups reported a slight decrease in the number of these health problems, from 74% in wave 1 to 68% in wave 2.

We asked caregivers "Over the last seven days, on how many days…did your child…experience any of the following problems…?" Eight problem areas included such as loss of appetite, trouble getting to sleep, headache, dizziness or fainting, and other aches and pains.

In survey wave 1, the average number of days with one or more problems was 2.5 in the comparison group, and 3.0 in the experimental group (no significant differences between groups). In wave 2, the average number of days decreased similarly (only slightly) for both groups (comparison 2.4 days, and experimental 2.9 days).

Caregivers were asked if they had been told that the child has special needs or diagnosed with learning problems. Table 156 shows the number of "Yes" responses by survey wave and group.

Table 65.

Number and percentage of children reported to have special needs/learning problems

	Survey Wave 1 N / % of group		Survey Wave 2 N / % of group	
	Comparison N = 12	Experimental N = 19	Comparison N = 12	Experimental N = 19
"Yes" responses	6 / 50%	10 / 55%	7 / 58%*	17 / 89%*

Difference between groups p = .08 Fisher's Exact Test

In wave 1, there were no differences in affirmative response between groups, however by wave 2 the experimental group showed a much higher rate of children reported to have special needs or learning problems. In addition, the rate of increase in the experimental group over time (not shown in table) was statistically significant ($\underline{p}$ = .02 Fisher's Exact Test). Rather than implying changes in the actual number of children with special needs, the change by wave 2 may represent the result of closer diagnostic scrutiny of the children and youth in wraparound services, and the caregivers' increased attention to and willingness to report their children's special needs as a result of the intervention. Caregivers who answered "yes" were asked to list all types of problems or diagnoses.

Table 157 shows the frequencies of problems and diagnoses reported.

Table 66.

*Number of child's special needs or problems reported by caregivers**

	Comparison		Experimental	
Problem	Wave 1	Wave 2	Wave1	Wave 2
Attention deficit hyperactivity disorder	3	2	3	4
Behavior disorder/emotional disturbance	3	4	2	5
Hyperactive	1			
Language impairment				
Learning disability	1	1	1	5
Mental retardation	1		1	
Multiple handicaps				
Physical handicap				
Sensory motor disorder				
Serious hearing impairment/deafness				
Serious visual impairment/blindness				
Speech impairment				
Other				
Not informed of diagnosis	1	4		2

*Note—not all caregivers answered this question, and some children had more than one problem.

When youth were asked "How would you describe your health? Poor, Good, Very Good, or Excellent?" there were no differences in response between the comparison and experimental groups and no change over time. In both groups the majority of youth (about 70%) reported their health as "good" or better.

Youth were asked a set of questions beginning with "Over the last 7 days…" and addressed various symptoms, such as losing appetite, trouble falling asleep, have a headache, feeling other aches and pains, etc. Here, there was a significant difference between groups. Among the nine comparison group respondents, no youth reported any improvements in these symptoms over time while five out of nine of the experimental youth reported improvements ($\underline{p}$ = .01 Fisher's

Exact Test). Only five out of the 18 youth interviewed from both groups claimed that a medical condition or disability kept them from attending school, and for three youth this situation improved by wave 2.

Emotional Well-Being and Adjustment

The caregivers were asked a series of question related to child's/youth's emotional well-being. The first question was "Over the last seven days…how often did your child…feel the following: never, sometimes or often: a) successful, b) lonely, c) pleased with him/herself, d) sad, e) confident, and f) felt like crying.

After recoding so that all items were scored in the same direction, we then coded whether or not there was improvement in each item from wave 1 to wave 2. The groups differed—the experimental group had a higher proportion of children and youth who improved in these areas over time (11 children, or 58%, improved in the experimental group vs. only 2 or 17% in the comparison group, p = .03 Fisher's Exact Test).

Groups did not significantly differ at wave 1 and wave 2 when caregivers were asked if:

- The child received treatment for any emotional, personal or mental problems (both groups showed increased treatment by wave 2);
- Has the child taken any medication for any emotional or mental problems? (both groups showed a slight decline from wave 1 to wave 2)
- During the past 30 days the child thought seriously of running away (both groups of caregivers reported fewer instances at wave 2)
- During the past 30 days the child felt that no one cared about him/her (no change in either group over time)
- During the past 30 days the child felt seriously confused (no change in either group over time)

A significantly higher number of experimental group youth (6 out of 9) also showed improvement in responses to questions gauging how they felt successful, lonely, pleased with oneself, sad, confident and wanting to cry, over the past week. In the comparison group, only 2 out of nine saw improvements (p = .08 Fisher's Exact Test).

Experimental youth (all 7 respondents who in wave 1 answered negatively) also improved in feelings that no one cared about them, and feeling confused, over the past 30 days. In the comparison group, youth reported no change for the former question, and a higher number of worse response in the second question.

We asked youth a series of questions about the level of support they received from caregivers at home as well as other kinds of social support. There were no differences between the groups or in either group over time, of the level and kinds of support.

Ohio Scales

The Ohio Scales (Ogles, 2001) were developed as a practical outcomes instrument measuring multiple domains in the areas of problems, functioning and satisfaction. The Scales were designed for use by youth (age 11 and older), caregiver, and agency clinician respondents. For the Waiver study, we used the short version (20 items) of the problem severity inventory for the

Caregiver and Youth interviews. The respondent is asked to rate the occurrence of the problem area, e.g. “Getting into fights” from 0 (“not at all”) to 5 (“all the time”). Individual respondents’ scores are summed as a total raw score (the higher the score, the more severe the problem profile).

Table 158 shows the mean total scores for the experimental and comparison groups, at baseline and follow up measurements.

Table 67.

Ohio Scales Total Scores (Caregiver Report), By Group and Time Period

	Experimental		Comparison	
	Wave 1	Wave 2	Wave 1	Wave 2
Caregiver:	N = 19	N = 19	N = 12	N = 12
Total Score/ S.D.	33.32/ 20.40	25.95/ 18.82	23.08/ 16.34	22.08/ 17.62
Youth:	N =11	N = 11	N = 7	N = 7
Total Score/ S.D.	12.44/ 9.32	5.33/ 3.04	28.43/ 22.12	22.12/ 16.84

While experimental group caregivers report a greater improvement in functioning over time from the Ohio Scales questions (22% change in total scores vs. 4% in the comparison) the differences are not statistically significant in either group, nor was there any difference in the number of improved vs. not improved scores between the groups (not shown in table).

By youth report both groups differed statistically in wave 2 scores ($p = .001$, Wilcoxon Rank Sums) but not in wave 1 scores ($p = .14$). There is some evidence, then, that youth response scores decreased (towards improvement) in the experimental group by wave 2. However, the difference between groups in the number of improved vs. not improved scores (not shown in table) was not statistically significant.

Behavioral and Emotional Rating Scales (BERS)

The Behavioral and Emotional Rating Scales (BERS) (Epstein & Sharma, 1998) is a set of standardized and normed scales designed to assess the behavioral and emotional strengths of children and youth. The instrument was developed as an alternative to problem- or deficit-based instruments. Five domains are measured: Interpersonal Strength; Family Involvement; Intrapersonal Strength; School Functioning; and Affective Strength. The instrument was designed for interviews with caregivers, teachers, and other professionals. The respondent is asked to rate each item (e.g. “Child is self confident”) on a four point scale from “Very much like the child” to “Not at all like the child”. Raw scores are then summed over each domain and converted into standard scores. The sum of the domain standard scores comprises a “Strength Quotient” that can also be associated with a percentile rank based on the normed samples. The more strengths that characterize the child, the higher the strength quotient. (A separate set of standard scores are available for children with emotionally/behavioral disorders and those without the disorders. The former set of scores was used for this analysis.)

Table 159 shows the mean Strength Quotient for both assigned groups by assigned group and survey wave.

Table 68

Mean BERS Strength Quotient by Wave and by Assigned Group

	Wave 1		Wave 2	
Group	Treatment N=19	Comparison N=12	Treatment N=19	Comparison N=12
Mean Strength Quotient / Std Dev	113.16 / 23.69	119.58 / 16.03	119.63 / 23.88	118.42 / 40.66

The treatment group showed a trend towards improvement over time (5.7% improvement from wave 1 to wave 2), while the comparison group youth showed a slight decrease in strength quotient scores. Differences between groups in wave 1 and wave 2, as well as differences in change over time, were not statistically significant.

Social Skills

The Social Skills Rating System (SSRS) (Gresham & Elliot, 1990) assesses social skills and relational capacities across settings for pre-schoolers, elementary school children and adolescents. The instrument measures social skills in the domains of Cooperation, Assertion, Responsibility and Self Control. The respondent (separate instruments for teachers, caregivers and children/youth) is asked to rate how the item describes the child's social behavior (e.g. "Makes friends easily") on a three-point scale ("Never", "Sometimes", or "Very Often"). The Scale has been normed on large, national multi-ethnic samples of boys and girls, ages 3-18. (There are different interview questions for elementary vs. secondary school children.) Total scores for each domain are summed for an overall total raw score, which is then converted into a standard score based on the normed data. The higher the score, the stronger the social skills.

Table 160 shows the mean standard scores from caregiver and youth response, by group and wave.

Table 69.

*Social Skills Rating Scale Mean Standard Scores**

	Experimental		Comparison	
Respondent	Wave 1	Wave 2	Wave 1	Wave 2
Caregiver:	N = 19	N = 12	N = 19	N = 12
Mean Standard Score/ S.D.	83.32 / 18.68	123.63 / 158.08	84.42 / 15.35	90.25 / 19.62
Youth:	N = 9	N = 6	N = 9	N = 6
Mean Standard Score/ S.D.	98.67 / 18.58	98.78 / 12.46	87.67 / 5.89	109.67 / 14.17

*Note: this table aggregates both elementary and secondary school-age standard scores.

While the standard scores appear to have improved in both groups according to caregivers, the differences are statistically non-significant. In addition, the proportion of children improving in social skills from wave 1 to wave 2 (not shown in table) is higher in the experimental group (12 out of 19, or 63%) than the comparison group (7 out of 12, or 58%), however this difference is also not statistically significant.

The youth responses show generally higher estimations of social skills than their caregivers in both groups. However, differences in youth response between the two groups (apparent higher scores and number of youth improved) are statistically non-significant.

School Performance

School Attendance

While there were no differences between groups or change over time in youth reports of attendance problems, it should be noted that attendance continued to be a problem for 20%-40% of youth respondents, due to sickness or "family concerns or responsibilities."

Trouble Avoidance

Four out of nine experimental youth reported improvements in avoiding trouble at school, compared to 2 out of nine comparison youth respondents.

Grades & Academic Performance

Few youth in either group reported improvements in grades. By wave 2, only two out of nine experimental and no comparison respondents reported any improvement in grades. When compared to "other students in your classes" in the areas of grades and academic abilities, three out of nine experimental group youth reported improvements in their perceptions while only one out of nine comparison group youth reported the same.

Client and Family Satisfaction

Caregiver Satisfaction

The Client Satisfaction Questionnaire (CSQ-18) is a widely-used self-report questionnaire designed for use with a wide range of client groups and services (C. Clifford Attkisson & Greenfield, 1996). The CSQ-18 consists of eighteen questions covering nine domains of satisfaction: (a) physical surroundings; (b) procedures; (c) support staff; (d) kind or type of service; (e) treatment staff; (f) quality of service; (g) amount, length, or quantity of service;(h) outcome of service, and (i) general satisfaction. Each question is rated in a four-point Likert scale, typically from (1) "Quite satisfied" to (4) Very satisfied. Variations in questions require different values, and some questions are reverse-scored. (For analysis purposes, the reverse-scored questions were recoded to for consistency.)

The CSQ-18 was administered to caregivers at wave 1 and wave 2 of the surveys. We will report on the wave 2 results, after the caregivers have had the benefit of treatment in the comparison and experimental groups. If all questions were answered with a positive response (i.e. "Good" or "Excellent", or "Mostly satisfied" or "Very satisfied") then the minimum mean score for all 18 questions would be 54 (each question coded at least a "3" on the Likert scale). The mean satisfaction score for the comparison group was 57.63 (s.d. 16.30) and that of the experimental group was 68 (s.d. 6.74). The two groups were significantly different based on the Wilcoxon Rank Sum Test at $\underline{p} = .03$. While the comparison group mean score was slightly below the average expected score for satisfied participants, the experimental group caregivers averaged 10 points higher in overall satisfaction.

In response to the question about overall satisfaction with the service received, 13 of the 16 caregiver respondents in wave 2 indicated "Very satisfied", whereas in the comparison group, only 2 out of 8 responded "Very satisfied."

Youth Satisfaction

The Youth Satisfaction Questionnaire (YSQ) (Stuentzner-Gibson et al., 1995)was designed as a brief self-report measure for children and adolescents, assessing general satisfaction and satisfaction with specific services and service-related activities (such as treatment teams). The YSQ consists of 10 items with a five-point Likert response scale, e.g. from (1) "Very satisfied" to (5) "Very dissatisfied."

A total score of 22 is above average response in the five point likert scale (the lower the score, the higher the satisfaction. One question was recoded for reverse scoring). At wave 2 the mean response score for comparison youth was 26.25 (s.d. 5.72) and for the experimental youth 24.22 (s.d. 6.65). The difference in mean scores was not statistically significant.

We compared the number of youth who scored 22 or lower, and again there no differences between the two groups despite a modest difference in mean scores favoring higher satisfaction in the experimental group youth. In each group at wave 2, 8 out of 18 youth were "satisfied" as indicated by the score cutoff.

Another six questions asked more specifically whether youth like the help they received, whether it was the help they wanted, was the amount of services adequate, did they help with their lives, and are the youth satisfied with their lives now? In aggregate, there was no difference in response between the two groups at wave 2.

5.4.2.4 Well-Being Outcomes Discussion

Well-being outcomes for the Wraparound participants were either comparable to the comparison group or improved. Wraparound participants showed improved outcomes regarding health status (reported by caregivers); improvements in specific health symptoms (youth report); trouble avoidance at school (youth report); and emotional well-being (caregiver and youth response); improvements in problems (as measured by the Ohio Scales, youth report), and caregiver satisfaction.

These improvements in well-being are important indicators of Wraparound's attention to the strengths and needs of youth and families. However, we would liked to have seen stronger effects in other areas of well-being, such as social skills, overall problem reduction from the standpoint of caregiver response to the Ohio Scales, improvements in the BERS strengths inventory, and higher youth satisfaction in the treatment group.

Due to the response rate limitations, we cannot analyze differential well-being outcomes by subgroups (such as ethnicity, age, or the "in RCL" vs. "at risk" group).

5.5 Summary, Limitations and Conclusions—Wraparound Study

5.5.1 Summary Discussion

The evaluation did not find evidence of increased child safety, placement stability, or permanence for children receiving Wraparound. An assessment of the general trend of the findings across all counties also provided no support for the premise that children receiving Wraparound would have improved child welfare outcomes as compared to children receiving traditional services. However, there were some significant child welfare outcome findings in specific counties: (a) a larger proportion of children in Alameda County receiving Wraparound were living in family-based environments at the end of the study, and (b) a smaller proportion of children in Sacramento County receiving Wraparound exited from the child welfare system due to incarceration. Additionally, in Alameda County, where assessments of child well-being were conducted, youth respondents reported improved health status and both youth and caregivers reported improved youth emotional/behavioral adjustment. Caregiver respondents reported improved satisfaction with services.

There are a number of possible explanations for the neutral findings. The first possible explanation is that Wraparound is no more effective than traditional child welfare services. However, the fact that the only statistically significant findings in the study were in favor of Wraparound may indicate that the program theory, which states that a planning process coupled with professional/community services and supports will result in improved child welfare outcomes, is at least marginally sound. The explanation might lay elsewhere.

A second possible explanation relates to the implementation of the program. Each county had some experience with Wraparound prior to the Title IV-E Child Welfare Waiver Project and evaluation. Despite this advanced start, the development of the programs is continuing and their status as "mature" programs is questionable. Information collected from county respondents during focus groups conducted for the process study portion of the evaluation indicated the difficulty of professionals transitioning from the more traditional ways of working with child welfare children and families to the strategies and philosophies espoused in the Wraparound approach. This key characteristic, coupled with the collaborative nature of the endeavor, required time to develop, time not necessarily available under the timelines of the project and evaluation. In other words, it is quite possible the programs were evaluated prior to reaching the necessary maturity to be effective.

A number of county-specific implementation issues are worth noting. Alameda County's Wraparound practice philosophy of the continuance of services beyond the end of child welfare court dependency could potentially result in an unintended drift in the program. Without the main objective of achieving positive outcomes and ceasing treatment, particularly at the termination of dependency, developing and maintaining a treatment plan and working towards goals with children and families becomes more difficult, and may result in a sense of complacency and mutual dependency between the service providers and the service recipients. Los Angeles County's long delay in implementation resulted in a small analysis sample and a relatively short exposure to either intervention: the median time in the study for children in the treatment and comparison groups was nine months and eight months, respectively. Sacramento County's initial exclusion of children without an identified caregiver from their sample limited their overall enrollment. Because the children were excluded for programmatic reasons (i.e.,

based on the mental health model of Wraparound), it may be that the program lacked the sufficient program element needed to work with children without a primary caregiver.

The third possible explanation relates to the sample. The sample in this study has a high level of heterogeneity in a number of areas, a situation that may make influencing the selected outcomes more difficult. It may be that Wraparound is effective with children with particular characteristics. However, in this study, children were living in nearly every possible type of out-of-home placement or were living at home. Additionally, children were of a wide-range of ages at the time they enrolled in the study. Wraparound's possible impact may have been neutralized by the diverse nature of certain important child characteristics, given the size of the sample in each county. This was complicated by evaluation constraints that necessitated an earlier "cut-off" of the administrative-level child welfare outcome data than was originally intended. This also impacted each sample's exposure to either intervention.

Fourth, the possibility exists that counties were more successful at providing Wraparound-like services to the comparison group than the evaluation was able assess, resulting in similar outcomes between the groups. Again, the services tracking analysis seemed to indicate that children in the treatment and comparison groups were receiving a different package of services. However, it may be that contamination occurred through the diffusion of the elements of Wraparound that are more difficult to measure. Certainly with SB 163 being implemented concurrent to the Demonstration Project, and the counties stated commitment to the comparison group, the conditions for contamination were in place.

Finally, and what appears to be the most likely reason for the less than resounding findings is the distal nature of the outcomes selected for assessment in relation to the intervention. As previously discussed, Wraparound is an intervention designed to improve the behavior of children through a variety of means, with the logic model pathway leading ultimately to changes in child welfare outcomes (safety, stability, permanency). In fact, in Alameda County where a child well-being assessment was conducted, the trends were positive. It does not seem surprising, however, that positive changes would be undetectable in such a relatively short amount of time in variables somewhat removed from the direct intent of the intervention. Three issues seem to be at play here: the first issue is political, the second is methodological, and the third is programmatic. First, the outcomes for the Demonstration Project—and subsequently this study—were established by DHHS *prior* to any decisions regarding the specific intervention to be used in the Project. From an evaluation methodology standpoint, outcomes would ideally have been established after decisions about the intervention had been made; this would likely have resulted in a comprehensive investigation of child behavior outcomes, with a secondary look at child welfare outcomes. Second, the type of administrative-level data used in this study may have exacerbated the distal nature of the outcomes. The data were drawn from a large data archive used primarily for county-level and state-level reporting. Collecting child welfare outcome data through case record review or some other such procedure may have allowed for a more nuanced and subtle look at the outcomes, potentially improving the chances for detecting the expected changes. Lastly, it may be that there is a programmatic element missing from the Wraparound model (previously discussed in regards to Sacramento County) that limits its impact on these more distal outcomes. In its original conceptualization, Wraparound was designed to assist intact families in maintaining a child within the family living environment. The family status of children in the child welfare system is generally much less stable and in some cases may be non-existent, particularly for the children targeted for the Demonstration Project.

Wraparound may require further development to allow it serve these children and families more effectively.

5.5.2 Limitations

A number of limitations affect the outcomes and interpretation of the study. Perhaps the key limitation of the evaluation is the use of policy-level outcomes versus program-level outcomes. Child welfare outcomes such as safety, stability, and permanence are more appropriate for larger, aggregate, county- or state-level trend analyses. As stated in the previous section, such variables are removed from the intended target of the intervention, child behavior. While improved child behavior was the primary pathway to better child welfare outcomes, from an evaluation standpoint (i.e., distinct from a policy-making standpoint), the selection of outcome variables proximal to the intervention would have improved the ability of the evaluation to capture the impact of the intervention.

A second limitation of the study to be considered is the limited generalizability of findings to populations beyond those of the specific Wraparound counties. The strength of the design used in the study is its ability to account for the threats to internal validity (Campbell and Stanley, 1963). However, the tradeoff is relatively weak external validity; despite the strong desire to do so, it would be inappropriate to generalize the findings from this analysis beyond the sample described and the conditions under which the evaluation was conducted.

Third, the nature of the process and outcomes studies did not allow for an intensive assessment of how the specific Wraparound programs were implemented. In other words, there was not a systematic investigation of how the various Wraparound programs worked with children and families. Information about specific aspects of the child and family team meetings, concrete/case management/therapeutic services, and informal social supports were not collected and could not be used to develop a richer understanding of Wraparound and determine whether certain components were more useful than others.

Finally, a third set of limitations relate to the size of the sample, the size of the effects to be detected, and the power available in the analysis to detect them. The size of the sample was limited due to project implementation issues and the capacity of the Wraparound providers to absorb new cases. Although the use of an experimental design would allow for the inclusion of a single independent variable, the time varying nature of the enrollment process required that an additional independent variable be included in the analysis. The end result was a decreased capacity to detect differences between the treatment and comparison groups.

Despite these limitations, the analysis is bolstered by the strength and elegance of its design and the longitudinal nature of its implementation. The integrity of the process and the quality of the results was ensured by the great care taken by those involved—both researchers and practitioners. The findings provide important information for researchers, practitioners, and policy-makers.

5.5.3 Conclusions

The Waiver Demonstration Project contained two key conditions: first, children receiving new and innovative services were to be no worse off than children receiving traditional services over the course of the evaluation; second, the innovations should cost no more to implement than traditional services. As such, it appears that the Wraparound component of the Demonstration

Project has met the first requirement. We offer, given the results of the evaluation, a qualified endorsement for the continuation of Wraparound. A response to the number of issues raised by the evaluation may serve to strengthen current efforts as well as future endeavors.

The suggestions for practice and policy that emerge from the study of Wraparound can be divided into two categories. First, there are several important themes to consider when implementing demonstration projects that include some type of evaluation component. Implementing a new program is always a process fraught with difficulties, but those difficulties are perhaps compounded when an evaluation must be implemented simultaneously, and particularly when the individuals receiving services must be made much more active participants in the process as is the case in a study that includes random assignment. The county that was able to centralize their intake process into the project, making a single person responsible for explaining the study to the family, obtaining consent, and enrolling the child had the most stable and consistent enrollments, marked by few occurrences of anger and frustration on the part of families or professionals.

The minimal number of children and families participating in the project in the two smallest Wraparound counties, coupled with the evaluation requirements the counties were obligated to meet, raises the question of the practicality of smaller county inclusion in such projects. With advanced planning and appropriate funding, the evaluation activities of a large-scale, rigorous evaluation such as the one presented here could be tailored to meet the special conditions presented by counties with a small number of program participants. Or the projects themselves could be developed and implemented in a similar manner across counties that would allow for aggregating data for analysis.

As with most large-scale projects, planning was a crucial component of the process, beginning prior to implementation and continuing throughout the life of the project. This seemed particularly pertinent given Wraparound's alternative fiscal structure. Future endeavors should be certain to include in initial planning and on-going implementation discussions fiscal representatives from the agencies involved in the project, be they community-based service providers and/or public social service agencies.

The importance of an ongoing education program to explain Wraparound and the evaluation to a wide variety of constituencies cannot be overstated. The longitudinal nature of the demonstration project, coupled with the relative instability of professional positions within social services agencies and organizations, meant that individuals who nurtured the program into existence would likely not be involved as the project moved to its conclusion. In turn, a continual stream of individuals needed to understand and support Wraparound and the evaluation so that the intervention could be implemented as effectively as possible and that the evaluation maintained the necessary level of rigor.

Second, and perhaps most importantly, there are a number of programmatic suggestions. A possible drift-in-focus regarding the target populations for Wraparound may have resulted in a certain amount of heterogeneity in the group of children being served. If the various Wraparound programs can resist the desire to "be all things to all people" and focus on a more specific group of children and families, the intervention may show promise in subsequent evaluations (given the use of a similar sample size); however, the present study does not provide an indication of which specific group(s) Wraparound is effective in serving. If the various

programs maintain their desire to serve a heterogeneous population, then a much larger sample size will be needed in future evaluations to assess the intervention's effectiveness.

Second, counties need to respond programmatically to the question of children having an identified caregiver at the onset of Wraparound. Unless the decision is made to cease working with children who do not have an identified caregiver, Wraparound providers should develop an additional programmatic element to increase their capacity to establish a primary caregiver relationship for the child.

Third, results from the WFI analysis in Alameda County—and supported by the Services Tracking analysis there and in the remaining counties—indicated that greater efforts should be made to develop, and assist children and families in developing, informal sources of support and then assess them for effectiveness in improving outcomes.

Fourth, the Wraparound philosophy can sometimes be at odds, or create tension with, the philosophical approaches of other methods of working with children and families. Whether with the child welfare system concerning the questions of child safety and placement stability versus less-restrictive placements, or with group home staff concerning the questions of caregiver involvement or the merits of a collective versus individual approach to working with children, Wraparound's interaction with other interventions is sometimes complicated. Wraparound proponents would do well to continue the process of educating other professionals about Wraparound, as well as continue their efforts at working collaboratively while being respectful of another organization's philosophy and mandates.

Finally, the issue of staffing presents a serious concern for the continued viability and expansion of Wraparound. The shortage of individuals willing and able to do the type of casework that is the hallmark of Wraparound, combined with the attrition of those who try, calls into question Wraparound's capacity to move beyond a program on a continuum of services to something more systemic. Unless solutions are found to the staffing question—solutions that simultaneously maintain fidelity to the Wraparound model—the sustainability and expansion of the Wraparound model remains an open question.

Wraparound was implemented to assist with the difficulties faced by children living in group care and as a counter to the limited success traditional child welfare programs have had with ameliorating those difficulties. Wraparound has been proposed in some quarters almost as a panacea, an answer to the difficulties faced by children and their families. As the results presented here suggest, much can still be learned about the efficacy of Wraparound.

CHAPTER 7. CONCLUSIONS AND RECOMMENDATIONS

Our conclusions and recommendations will address the following three areas: a) The efficacy of FGDM and Wraparound; b) Program planning, implementation and operations, and c) Implications for further research.

The Efficacy of FGDM and Wraparound

The Waiver Demonstration Project contained two key conditions: first, children receiving new and innovative services were to be no worse off than children receiving traditional services over the course of the evaluation; second, the innovations should be cost-neutral, or cost no more to Federal Title IV-E funds than traditional services. (Conclusions from the cost-neutrality study are discussed separately in the "Cost-Neutrality" chapter.) FGDM and Wraparound appeared to have met the first criteria: the treatment group child and family outcomes in the areas of safety, permanence, placement stability, and well-being were, with one exception, no worse than those of the comparison group participants. The exception in FGDM was a non-statistically significant trend towards increased substantiated maltreatment reports. The effects of FGDM on rates of substantiated maltreatment require further confirmation in a larger sample.

If success is measured by *positive improvements* in outcomes, we did not find FGDM to be efficacious in the demonstration projects. Although the small sample size might indicate that the intervention did not receive a "fair test," the sample size was indicative of general implementation and design issues that may have predetermined the intervention's inability to result in improved outcomes. We found that FGDM did not maintain the family's involvement with services beyond the initial conference plan. The overall issue was that the intervention was implemented and operated without enough integration into other agency and community activities. We will discuss this issue in more detail below under "Program Planning, Implementation, and Operations." As we mentioned in the FGDM Process Study Discussion section, however, we were impressed by the ability of FGDM to facilitate collaborative relationships with families experiencing intractable problems, and entering a highly adversarial child welfare system. This positive relationship with those who are crucial in making decisions about children is the first step towards improving outcomes. In this regard the Waiver made an important contribution to those counties' treatment group participants.

In Wraparound, there were some improvements in outcomes: Alameda and Sacramento County treatment participants experienced improvements in the areas of living at home and exits due to incarceration, respectively. We offer a qualified endorsement of Wraparound, qualified in that while the Impact Study modestly support the efficacy of the intervention, there were nevertheless implementation and operational issues that may have muted Wraparound's overall effects. Although the nature of Wraparound implementation (i.e. the requirements for inter-agency planning and collaboration) served to better position it within the agency and community (compared to the FGDM projects), there were other implementation issues (summarized in the Wraparound Study's "Summary Conclusions" section) that lead to specific recommendations for the implementation and operation of subsequent projects.

Program Planning and Implementation

We will address both the State and county role in program planning and implementation. The crucial areas of implementation are a) Inter- and intra-agency collaboration and service integration; b) Clear program objectives; b) Clear criteria for enrollment and service conclusion; c) Staffing recruitment; and d) Policies and procedures for program operations (including fiscal issues).

Inter- and Intra- Agency Collaboration

We attribute the inability of the FGDM demonstration projects to provide adequate follow up for families, at least in part, to the insulation of the intervention from other agency activities and community efforts. Evidence was seen in agency reports of the constant need to protect FGDM program from budget cuts and outside skepticism. There was also a lack of sufficient community involvement in planning and ongoing monitoring of the program. Follow-through is an outreach activity that requires as intensive an effort on the part of agency staff as organizing the initial family meetings, if not more so. It also requires going beyond the natural boundaries between agency departments, and those between the agency and the community.

In this regard, Wraparound may be more successful since one of the core objectives (and one its important development principles) is to break down barriers that create service fragmentation, not only in planning implementation but also at every phase of involvement with the family. Wraparound was originally developed for a smaller subset of children and families with special needs (i.e. children and youth with severe emotional disturbances) however much can be learned and adapted from the Wraparound model into interventions designed for the larger number of children entering the child welfare system. The Family-to-Family Team Decision Making model, for example, requires meetings at all critical junctures of the child and family's interface with the system (i.e. for every placement-related decision), and is also integrally tied to community development and outreach activities as well as agency-wide reforms. This type of model could not be implemented successfully if it were limited to the activities of only one unit or department. Whether FGDM could perform better in the context of system reform remains to be seen. California has an opportunity to test the success of child welfare interventions in the context of child welfare reform.

The role of the State can be to provide leadership in modeling inter- and intra-agency collaboration, and require evidence of such collaboration of the counties. This is already happening in the new Outcomes and Accountability System (the State's response to the Federal Child and Family Service Reviews), which requires counties to write system improvement plans to address improvements in child welfare outcomes. Such plans will require evidence that interventions are not implemented in a vacuum, but make sense within an overall plan addressing needs of the local communities.

Clear Program Objectives

Program objectives tie together the expected outcomes with the desired program procedures. If the objectives are mapped out correctly, all other programmatic decisions can arise from them. As was stated in both the FGDM and Wraparound reports, there existed a chasm between the initial program goals and the distal child welfare outcomes

(safety, permanence, placement stability, and well-being). For reasons that vary from county to county, there were programmatic gaps in achieving the more proximal outcomes that eventually would lead to distal ones. In this regard, planning the program and planning the evaluation consist of a common set of tasks: to set milestones "along the road towards outcomes."

Our recommendation for the State role here is to provide technical assistance to counties in the establishment of program objectives that show a more clear relationship between program activities, target population characteristics, and desired outcomes. (This may also be regarded as a recommendation to the Children's Bureau to restructure the required Title IV-E Waiver evaluation plan so that linkages among the various components, i.e. Process, Impact, and Cost Studies, are more clearly delineated by the grantees and their evaluators.) Evaluators should be included in planning these objectives since the potential for finding "treatment effects" is much greater when the evaluation accurately addresses each of the proximal and distal outcome objectives, as well as their associated processes. Similarly, counties should strive to incorporate their objectives agency-wide and involve other agencies and stakeholders in their planning. The State's role in providing this type of leadership is made even more crucial considering that, in both studies, philosophical issues about the nature of child welfare objectives and program objectives were often at odds, i.e. the importance of child safety vs. reunification or family preservation.

Clear Criteria For Enrollment And Service Conclusion

A similar problem related to enrollment criteria was shared by both the FGDM and Wraparound programs: all counties used an "at-risk" category to define, in whole or in part, their respective target populations. For many risks being targeted, the risk assessment practice technology is in a nascent state-of-the-art. This not only affected the ability of the evaluation to measure treatment effectiveness (due to heterogeneity of the sample), it also made it difficult for counties to predict enrollment and utilization. This "drift in focus" seemed to affect FGDM more so. Criteria for FGDM enrollment were vague and diffuse, and had to be adjusted over the length of the evaluation period.

In addition, criteria for concluding services were under developed. The Wraparound report noted that in Alameda County the explicit programmatic objective of continuing to treat families beyond court dependency could paradoxically increase the dependence of families on formal providers, rather than the original Wraparound goal of decreasing the use formal services in favor of informal services.

We recommend a more formal planning period to develop criteria for enrollment and service conclusion. Mid-course corrections are inevitable, however, the more systematic the process of developing criteria in the early planning stages, the more accurate the criteria will reflect the target population.

We also recommend the adaptation or development of instruments to support risk assessment, so that clear criteria can be consistently followed on an ongoing basis.

Policies And Procedures For Program Operations (Including Fiscal Issues)

In line with our recommendations for the State's role so far, we also recommend that the State take a more aggressive role in establishing policies and procedures for the use of "waivered" Title IV-E dollars. The fiscal issues are very complicated, even without the existence of a Waiver. Despite initial attempts at training participating counties in the early consortia, confusion continued about when and how to spend the "waivered" dollars, especially in the FGDM counties. Although there were differences in program structure among counties, there were still many shared issues about the use of Title IV-E Waiver funds.

Specific recommendations for improving Wraparound programs are listed in the Wraparound report's Summary and Conclusions section. We will briefly summarize the salient points:

- A centralized intake process would make it easier to obtain informed consent, apply consistent enrollment criteria, and facilitate the enrollment process
- Including fiscal representatives in planning, especially in situations involving innovative financing strategies
- In a field characterized by high staff turnover, an ongoing education effort to train new people within and without the agency and provider about Wraparound
- Adapting Wraparound to accommodate children without an identified caregiver
- Allowing creativity and flexibility in staffing, including recruitment efforts to retain specialized Wraparound staff

For recommendations about other FGDM program issues, we look to some of the "lessons learned" from the focus group participants:

- Staffing recruitment is key to program success—new programs must proactively plan sufficient staffing and develop contingencies for inevitable staffing disruptions
- In line with integration of the intervention within the context of agency reform, community development is a necessary ingredient to ensure that there exist adequate resources for the target population, i.e. substance abuse services
- Build in ongoing training opportunities addressing increasingly more specialized topics that arise as staff develop closer working relationships with families

After having gone through the experience, the counties now have knowledge that did not exist prior to the Waiver. The more successful county practices in these areas can be showcased for others.

Implications for Further Research

Reports from both Wraparound and FGDM discussed the limitations of the respective studies, including the small sample sizes, the relatively brief time period of the study to measure outcomes, and the possibility of treatment contamination, among others.

In addition to the evaluation activities implied in the sections above, subsequent research topics and design improvements were identified in several of the report sections. They include:

- A larger sample size, which would confirm or disconfirm treatment effectiveness, as well as allow for sub-group analyses to determine whether the intervention is more or less effective with certain types of children and families. Finding an opportunity to aggregate county samples would provide more power to detect treatment effects, however this would also require uniformity of program design and target population among the counties
- A focus on more proximal outcomes (as discussed above) as well as the distal ones currently reported
- Lengthening the period of analysis, which in this study was truncated due to late startup as well as the need to cut off data collection to allow time for administrative data preparation
- Taking the Cost Study to the next level of cost-effectiveness analysis, which would incorporate data from the Impact Study and determine the differences in costs given the outcome results. In addition, the variables studied should be expanded to include those measuring caregiver burden
- Adding an additional Process Study component to the Wraparound Study, which would look more closely at how Wraparound was administered in each county

Treatment contamination is always a concern with experimental studies in the human services. The evaluation team developed instruments to measure the extent of treatment contamination, which would be useful in subsequent studies. With the knowledge gained from our experience, we also recommend a specific focus on treatment contamination as new programs are designed within the context of experimental research studies.

Regarding the viability of the experimental design, it is no less true that experimental research designs most effectively answer questions about whether or not a treatment intervention is efficacious. Other quasi-experimental designs are also effective, but less so. However, if the research question changes from “Does this intervention result in improved outcomes?” to “Are we helping our children and families’ outcomes improve?”, which is the direction of the State’s Accountability and Outcomes System, then other non-experimental designs may be more appropriate. Hopefully, within the context of statewide reform and the laudable efforts to improve outcomes for our children and families, there may still be opportunities to test specific interventions in a rigorous fashion. Such efforts can only serve to increase our knowledge of best practices in child welfare.

A.4 Services Tracking Respondent Analysis

Appendix 1

Frequencies and Proportions (%) of Collected Tracking Points by Group Assignment.

Alameda County

	Treatment (n = 661)			Comparison (n = 85)		
Collect	Collected	Missing	Skipped	Collected	Missing	Skipped
1 Mo	82 (63)	1 (1)	47 (36)	47 (60)	4 (5)	28 (35)
2 Mos	85 (65)	0 (0)	45 (35)	50 (65)	1 (1)	26 (34)
3 Mos	84 (66)	0 (0)	43 (34)	51 (67)	2 (3)	23 (30)
6 Mos	84 (73)	0 (0)	31 (27)	48 (71)	1 (1)	19 (28)
12 Mos	88 (92)	4 (4)	4 (4)	49 (88)	7 (4)	3 (5)
18 Mos	78 (100)	0 (0)	0 (0)	42 (95)	2 (5)	0 (0)
24 Mos	56 (98)	1 (2)	0 (0)	34 (97)	1 (2)	0 (0)
30 Mos	35 (100)	0 (0)	0 (0)	19 (90)	2 (10)	0 (0)
36 Mos	0 (0)	21 (100)	0 (0)	1 (7)	12 (92)	0 (0)
Total	592 (75)	27 (3)	170(21)	341(72)	32 (7)	99 (20)

Humboldt County

	Treatment (n = 54)			Comparison (n = 22)		
Collect	Collected	Missing	Skipped	Collected	Missing	Skipped
1 Mo	11 (92)	0 (0)	1 (8)	4 (100)	0 (0)	0 (0)
2 Mos	10 (91)	0 (0)	1 (9)	3 (75)	1 (25)	0 (0)
3 Mos	11 (100)	0 (0)	0 (0)	3 (100)	0 (0)	0 (0)
6 Mos	3 (100)	0 (0)	0 (0)	9 (100)	0 (0)	0 (0)
12 Mos	6 (100)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
18 Mos	6 (100)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
24 Mos	3 (75)	1 (25)	0 (0)	0 (0)	0 (0)	0 (0)
30 Mos	--	--	--	--	--	--
36 Mos	--	--	--	--	--	--
Total	50 (94)	1 (2)	2 (4)	19 (95)	1 (5)	0 (0)

Los Angeles County

	Treatment (n = 19)			Comparison (n = 11)		
Collect	Collected	Missing	Skipped	Collected	Missing	Skipped
1 Mo	65 (93)	5 (7)	0 (0)	50 (94)	3 (6)	0 (0)
2 Mos	59 (94)	4 (6)	0 (0)	41 (85)	7 (15)	0 (0)
3 Mos	57 (97)	2 (3)	0 (0)	30 (85)	5 (14)	0 (0)
6 Mos	35 (97)	1 (3)	0 (0)	19 (90)	2 (10)	0 (0)
12 Mos	10 (100)	0 (0)	0 (0)	11 (92)	1 (8)	0 (0)
18 Mos	6 (100)	0 (0)	0 (0)	4 (67)	2 (33)	0 (0)
24 Mos	1 (100)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
30 Mos	--	--	--	-	--	--
36 Mos	--	--	--	--	--	--
Total	233 (95)	12 (5)	0 (0)	155 (89)	20 (11)	0 (0)

Sacramento County

	Treatment (n = 626)			Comparison (n = 431)		
Collect	Collected	Missing	Skipped	Collected	Missing	Skipped
1 Mo	64 (51)	6 (5)	55 (44)	47 (57)	1 (1)	34 (41)
2 Mos	63 (53)	5 (4)	52 (43)	47 (58)	1 (1)	33 (41)
3 Mos	60 (53)	4 (4)	49 (43)	45 (58)	0 (0)	33 (42)
6 Mos	81 (79)	1 (1)	21 (20)	54 (76)	2 (3)	15 (21)
12 Mos	54 (78)	2 (3)	13 (19)	40 (78)	1 (2)	10 (20)
18 Mos	38 (83)	1 (2)	7 (15)	30 (86)	0 (0)	5 (14)
24 Mos	9 (90)	1 (10)	0 (0)	11 (100)	0 (0)	0 (0)
30 Mos	3 (100)	0 (0)	0 (0)	3 (100)	0 (0)	0 (0)
36 Mos	0 (0)	0 (0)	0 (0)	0 (0)	2 (100)	0 (0)
Total	372 (63)	20 (3)	197 (33)	277 (66)	7 (2)	130 (31)

San Luis Obispo

	Treatment (n = 32)			Comparison (n = 14)		
Collect	Collected	Missing	Skipped	Collected	Missing	Skipped
1 Mo	6 (100)	0 (0)	0 (0)	3 (100)	0 (0)	0 (0)
2 Mos	6 (100)	0 (0)	0 (0)	3 (100)	0 (0)	0 (0)
3 Mos	6 (100)	0 (0)	0 (0)	3 (100)	0 (0)	0 (0)
6 Mos	5 (100)	0 (0)	0 (0)	2 (100)	0 (0)	0 (0)
12 Mos	3 (100)	0 (0)	0 (0)	1 (100)	0 (0)	0 (0)
18 Mos	1 (100)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
24 Mos	--)	--	--	--	--	--
30 Mos	--	--	--	--	--	--
36 Mos	--	--	--	--	--	--
Total	27 (100)	0 (0)	0 (0)	12 (100)	0 (0)	0 (0)

A.5 WFI Respondent Analyses

Appendix 1

Analysis	Variables
Total study sample—Children enrolled prior to onset of data collection (09.01.00) compared to those children with a completed WFI.	Gender Ethnicity Age at Enrollment Group Assignment
Children in the WFI sample—Children with a completed WFI compared to those who do not (non-respondents)	Gender Ethnicity Age at Enrollment Group Assignment Non-Response Reasons
Children with a completed WFI—Children in Project Destiny compared to children in the comparison group	Gender Ethnicity Age at Enrollment Respondent
Children in Project Destiny— Children enrolled prior to onset of data collection (09.01.00) compared to those children with a completed WFI.	Gender Ethnicity Age at Enrollment
Children in Project Destiny— Children with a completed WFI compared to those who do not (non-respondents)	Gender Ethnicity Age at Enrollment Non-Response Reasons