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February 12, 2020

TO: Supervisor Kathryn Barger, Chair
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FROM: Dr. Wendy B. Smith, Chair
Los Angeles County Commission for Children and Families

SUBJECT: **REPORT ON THE OCP TRANSITIONAL SHELTER CARE PILOT PROJECT**

The attached report on the OCP Transitional Shelter Care Pilot provides a description of an innovative program designed to effectuate successful placements and permanency for some of the most vulnerable children and youth in foster care in our county. These are the young people with a range of emotional and behavioral challenges who cycle in and out of placements, spend long periods in shelter care, or return to it again and again. The pilot now has a nearly 4-year history, a long time to remain a pilot. Because the project employs practices that seem highly effective, having life-changing impact on many of the youth it serves, the Commission for Children & Families wishes to bring it to your attention in the hope that an evaluation of its work can be funded and implemented.

The report describes how and why the pilot project was initiated in 2016, its intent, its guiding principles and protocols, the (minimal) hard data that is currently available, some illustrative case examples, and our recommendations for next steps. We believe that the questions that need answering call for a rigorous study.

Questions include: (1). Should the project, and/or specific practices within it, move from pilot status to become standard parts of our child welfare practice? (2). Given that 900 children and youth contend with the same level of challenges as the youth currently in the pilot, and the understanding that they are therefore likely to experience negative outcomes associated with multiple placements, should the unit be expanded to serve a

greater number of children and youth? (3). What are the staffing and cost ramifications of expansion, in view of the extremely high touch nature of these practices (and the low caseload necessary to enable this)? (4). How and where in the system might some of the apparently effective practices described be applied to the work of other children's social workers?

An evaluation of this anecdotally life-changing pilot program could provide the department and the county, with the information necessary to deciding how best to expand and/or adapt extremely promising practices in the service of children and youth in foster care. If you have any questions, please contact me at wsmith@usc.edu or Dr. Tamara N. Hunter, Executive Director, Commission for Children and Families at huntet@dcfs.lacounty.gov.

Enclosure

c: Executive Officer, Board of Supervisors
Chief Executive Officer
County Counsel
Director, Department of Children and Family Services
Director, Department of Mental Health
Executive Director, Office of Child Protection
Children's Deputies
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REPORT ON THE OCP TRANSITIONAL SHELTER CARE PILOT PROJECT

By Wendy B. Smith, Chair

COMMISSION FOR CHILDREN AND FAMILIES
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Office of Child Protection

Transitional Shelter Care Pilot

Introduction. We stand at an important threshold for Los Angeles County. Invest LA, a comprehensive initiative to promote system improvements in safety, permanency, and well-being for children, has just launched. At the same time, the groundbreaking Family First Prevention Services Act heralds a promising era of prevention of entry into care. Both developments are a recognition that removing children from home and family and placing them into foster care is traumatic by its very nature, irrespective of and additive to the trauma that has precipitated it.

In Los Angeles County, children and youth for whom a placement cannot immediately be found enter Transitional Shelter Care (TSC), remaining for up to 10 days while an appropriate placement is identified. For some, however, the right placement cannot be found within this time frame, and others re-enter shelter care repeatedly when placements fail, for any one of a myriad of reasons. As a result, some children may be suspended in uncertain circumstances in psychologically traumatized states for extended lengths of time, only to be interrupted by additional placement disruptions. Los Angeles County has long struggled to find a way to protect children in its care from being subjected to such painful experiences.

History. Los Angeles County has struggled for over 15 years to find an effective way to make the entry into foster care for children and youth who need it safe, supportive, and facilitative of placements or reunifications that will be successful. After the closing of Maclaren Children's Center in 2003, social workers often had to keep children awaiting placement in their offices, a situation that was distressing for all concerned. In response, the Children's Welcome Center for temporarily housing children under 12 was opened in 2012, and the Youth Welcome Center for older children in 2014. By 2015, however, the Welcome Centers were seeing ever-increasing numbers of entries, repeated entries, and overstays of children of all ages. During the first six months of 2015, for example, 3,577[1] children and youth entered the Welcome Centers; the total number increased 40% from January to June, with a 21% increase in the second quarter over the first quarter. Entries of infants 0-2 rose alarmingly by approximately 59% in the second quarter over the first quarter, and repeat entries of adolescents

[1] This number may include multiple entries of individual child or youth.

increased 29% in the second quarter over the first quarter[2]. These disturbing statistics brought home the urgency of finding better solutions for children who could not be placed and had to return to the Welcome Centers for another night, sometimes repeating this pattern for many days and nights.

The Welcome Centers had been designed as 24-hour temporary shelters, but as became apparent during their short history, there are many children for whom appropriate placements cannot be found in that time frame. In 2016, in response to press reports, a report from the LA County Commission for Children & Families, DCFS's own recognition that the centers had not worked as intended, and pressure from the State, the Welcome Centers were closed. The 72-hour temporary shelter facilities that were then established in several locations to replace them could not in themselves address the underlying issues: high needs of the children and youth, lack of sufficient foster homes, need for support to caregivers and youth to make lasting connections. The challenges to the system persisted: children entered shelter care repeatedly or "overstayed" the 72 hours they were meant to be there.

The Office of Child Protection (OCP) TSC Pilot Project. One response to the continuing challenges was the establishment over three years ago of the Office of Child Protection (OCP) TSC Pilot Project, an innovative and effective approach to increasing permanency for children and youth at the very highest risk for placement disruption and ongoing instability. Over time, the project has expanded from two Children's Social Workers (CSWs) to eight, yet it continues to exist in pilot status. This may be due to the lack of a formal evaluation process that could elevate it to an ongoing and more widely rolled out practice at the Department of Children & Family Services. The social workers in the pilot project (CSWs who are referred to in this report, and in the pilot, as Case Coordinators) are enabled to deliver the highest standard of practice by a model designed to support great flexibility, access to resources, and a powerful relationship-centered approach. Each of the Case Coordinators serves a caseload of eight clients at any given time, as compared with the caseload of 20-24 carried by other children's social workers. There are estimated to be 900 children and youth in LA County who need the intensive attention and services that the pilot project can provide; currently, approximately 70 of these 900 can be served by the project. The following report provides context for the project, a description of its protocols, selected illustrative case examples, and recommendations for next steps for a project that has implications not only for the specific children served by it, but for the system in which they are served.

[2] Data provided by LA County Department of Children & Family Services

Guiding principle of the pilot project. "Each of the young people included in the project is essentially a walking emergency."[3] The nature of these "emergencies" is both urgent and continuing. In recognition of the dual nature of the needs of these children, the pilot provides immediate and ongoing time and intensive attention by Case Coordinators and other team members (mental health, case carrying social workers, school staff) to the needs of the youth and their caregivers and potential caregivers. Youth and caregivers come to know that their support team is dedicated and committed to them for as long as it takes to make placement successful.

Current snapshot of permanency in Los Angeles County. The OCP Permanency Workgroup reports on a variety of measures with the assistance of Dr. Wendy Wiegmann, project director of the California Child Welfare Indicators Project at the University of California, Berkeley, School of Social Welfare.

Reported measures include:

▪P1 Permanency within 12 months of entering foster care
▪P2 Permanency within 12 months for children already in care 12 to 23 months
▪P3 Permanency within 12 months for children in care 24-plus months
▪P4 Re-entry to foster care within 12 months of exit

In each of these categories, Los Angeles County is falling short of the standards set by the U.S. Department of Health and Human Services' Children's Bureau, but also and more importantly, of the department's own desire and intention to provide the children in its care with the stability and permanency that they deserve. Some of the children whose situations are reflected in these numbers are the very young people that the OCP Pilot Project seeks to assist.

Negative effects of multiple placements. Stability is critical for children and youth, especially for those whose problems are most serious. Research has shown that caregiver, child and agency behaviors all play an important role in placement instability[4],[5]. Placement instability is associated with potentially dangerous long-term negative outcomes such as increased likelihood of substance use among young adults,[6] increased risk of depression, life dissatisfaction, low self-efficacy, smoking, and criminal

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[3] Judge Michael Nash, personal communication.
[4] Cross, T., Koh, E., Rolock, N. & Eblen-Manning, J. (2013). Why do children experience multiple placement changes in foster care? Content analysis on reasons for instability. *Journal of Public Child Welfare, 7*(1), 39-58.
[5] Dregan, A.. & Gulliford, M.C. (2012) Foster care, residential care and public care placement patterns are associated with adult life trajectories: Population-based cohort study. *Social Psychiatry & Psychiatric Epidemiology, 47,*1517-1526.
[6] Stott, T. (2012). Placement instability and risky behaviors of youth aging out of foster care. *Child and Adolescent Social Work Journal, 29*, 61-83.

convictions.[7] And while placement changes in foster care have been found to disrupt the regulation of the stress response system, which is centrally involved in anxiety disorders, mood disorders, and disruptive behavior disorders, there is emerging evidence that the stress response system is amenable to environmental interventions.[8] In other words, placement experiences can have a direct impact on the brain in real time, either contributing to longer term problems, or helping the child make a successful transition and subsequent healthy growth.

Like early childhood, adolescence is a critical time for brain development and psychosocial development. Youth are especially sensitive to environmental cues and there is great neural plasticity, so that the environmental surround and the available opportunities and interventions can have a lasting neurobiological value. Advances in neuroscience underline the importance and crucial need for foster homes with trained caregivers who can understand the reactive behaviors and urgent needs of these children and youth. Los Angeles County is fortunate to have caregivers who step up to provide care for this vulnerable population; support given to those caregivers when they need it can make all the difference to their capacity to respond effectively to the children in their care and to creating and maintaining a relationship and placement that can last.

Launch of the OCP Transitional Shelter Care Pilot. Systematic efforts to intervene at the policy and practice level to prevent unnecessary placement changes (and to reduce the impact of those changes that are necessary) can profoundly impact the futures of the children in our care. In May of 2016, Judge Michael Nash, Director of the Office of Child Protection, convened a meeting to discuss just such changes. Michael Ross, ARA of the Accelerated Placement Team, proposed a pilot project to stabilize and find permanency for "hard-to-place" youth (those who repeat or overstay repeatedly, due to a variety of issues). At the time, 82% of children and youth coming into the TSCs were being placed within the 72-hour period; however, 18% needed more time and resources to effect successful placements. The project began in June with two CSWs and 10 youth; by the following June, there were four social workers and 32 youth in the program. Currently, eight CSW Case Coordinators work with up to 64 of the estimated 900 youth in LA County who are considered high risk.

<u>Eligibility criteria.</u> The Pilot Project serves youth who have exceeded or are at risk of exceeding a 72-hour stay in Transitional Shelter Care (TSC), as evidenced by multiple placements and/or hospitalizations

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[7] Dregan & Gulliford, op cit.
[8] Fisher, P., Ryzin, M., Gunnar, M. (2011). Mitigating HPA axis dysregulation associated with placement changes in foster care. *Psychoneuroendocrinology, 36*, 531-539.

within the preceding year; have been commercially sexually exploited; have acute mental health or behavioral issues; have engaged in or being at risk for delinquent behavior; have a developmental delay or disability; meet criteria for the Katie A subclass.[9]

The services provided by the Pilot Project are designed to enable youth to "step down" to a lower level of care by helping them to address their behavioral, emotional, and practical challenges in ways that are just not possible when social workers must distribute their time among 20 or more cases. The journey begins at the Transitional Shelter Care Facility (TSCF) following detention or a placement disruption, continues to a vetted placement, and eventually to long-term placement and permanency. The time needed to transition successfully to stability or permanency varies according to the specific needs of each child or youth.

Pilot Protocol. There are an infinite number of variations in the work with each young person, but certain steps are followed in every case. (A condensed snapshot of the protocol can be found at the conclusion of the report.)

1. **Recruitment of youth.** The APT CSW interviews eligible youth to determine their fit and willingness to participate, which includes acceptance of mental health services. If the youth agrees, an email is sent to the regional CSW and SCSW stating that the youth has chosen to participate in the Pilot Program, describing the program and services, and informing them that an APT Transition Team meeting will be scheduled within 7 business days.
2. **Creating the youth's team.** Once a youth is identified for the pilot, preparation begins for an appropriate placement and a mental health team is engaged to be part of the youth's team. The youth is assigned to Intensive Field Capable Clinical Services (IFCCS), an intensive mental health program that is funded through Mental Health Services Act or SB82.[10] A mental health team member meets with the youth to develop a therapeutic relationship and learn more about the youth's desires and needs related to placement. Other members of the youth's Pilot Project

[9] full-scope Medi-Cal eligible children/youth up to age 21 who: 1. Have an open child welfare services case; 2. Meet the medical necessity criteria for Specialty Mental Health Services; AND 3a. Are currently in or being considered for wraparound, TFC, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to TBS or crisis stabilization/interventions OR 3b. Are currently in or being considered for group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility or has experienced three or more placements within 24 months due to behavioral health needs. (As outlined in LA County Department of Mental Health Quality Assurance Bulletin, No. 13-04, June 26, 2013)

[10] Youth assigned to SB82 teams must have had three or more placement disruptions, be in crisis, and be willing to participate in this service.

team include the Case Coordinator (who is also a member of the APT or Accelerated Placement Team), the case carrying CSW and SCSW, and other individuals, such as extended family or mental health professionals, who can contribute to stabilizing the youth.

3. **Transfer to placement and 1st (Transition) team meeting**. Team members meet the youth at the placement to help prepare both youth and caregiver for the transition, providing information about specific needs and challenges. A complete physical, including FASD screening, takes place during the first week of placement. The initial Transition Team meeting is held, and includes the youth, a person or persons designated by the youth to provide support, mental health team members, the regional CSW and SCSW, the Case Coordinator, and the caregiver and/or members of the placement staff. The team works together to identify behaviors and triggers of those behaviors that may interfere with the youth's progress so that strategies can be developed to reduce negative outcomes and reinforce positive behaviors. A 24-hour window is provided to address any problem that arises in advance of considering a removal. The youth's involvement is at the center of the meeting, a critical piece of which is working with the youth to create both short- and long-term goals. The team meeting bears some similarities to a Child and Family Team meeting (CFT), but focuses more squarely on issues related to insuring transition and placement success. A summary of the team meeting is given to the Case Coordinator and is kept in the youth's file.
4. **Responsiveness to youth and caregivers.** Responsiveness to youth and caregivers is fundamental. The essence of the model is attentiveness to emerging needs and rapid response to threats to stability on either side of the placement equation. The workers attend simultaneously to immediate issues and to longer term goals, keeping both in mind as they create/sustain a holding environment for youth and caregivers, while problem-solving.
5. **2nd on site team meeting at the placement.** The second meeting aims to augment the capacities of both youth and caregivers to achieve a successful transition and placement. Caregivers are further helped to understand the needs of the youth, potential triggers of problematic behaviors, and interventions that have worked for the youth. All parties participate in a rich discussion of existing supports and those that will be needed to stabilize the youth in the new placement. Placement staff are foundational to these discussions and to planning for the future.
6. **Continuation of stabilization supports.** The DMH team continues to provide mental health services; the regional CSW remains the primary contact; and the Case Coordinator maintains

availability to provide rapid response if the need arises. The Case Coordinator continues to manage the case, ensuring effective communication so that the needs of the youth are met.

7. **Level of contact.** The Case Coordinator with a new client devotes 4-5 hours per day to engaging with and assessing the needs of the client, facilitating services, exploring placement options, managing crises, and working toward stability in the new placement. Case Coordinators are available to youth and caregivers in moments of crisis, responding even when those occur after hours or on week-ends or holidays. Once the client and situation have stabilized somewhat and risk of placement disruption is decreased, the worker's daily hours for that client can be reduced.
8. **"Graduating" from the pilot project.** Clients leave the pilot project in a number of ways. Hoped for outcomes include stability in a new placement with no desire for further services; successful reunification with a family member; attending college in another state. In some cases, however, clients age out of care.

Staff and supervision. The eight pilot project Case Coordinators have depth of experience ranging from 3 years to 26 years with the county. All were hand-selected, either identified by other DCFS staff or self-referred for this specialized job. Each carries a caseload of 8 clients, providing services tailored to the individual needs, strengths, and challenges of each young person. While the work is demanding, there is great flexibility and access to resources; it is this combination that enables workers to "do what we really need to do, be true social workers." The social work team is supported by two seasoned supervisors who meet with the group once per month, and with each social worker once per month, as well as providing on-call consultation. In addition, the entire group meets twice per month with Mike Ross internally, and a second twice monthly meeting with Judge Nash and other partners, including DCFS, DMH, CLC, and others.

Staff insights and practices. The Case Coordinators were asked to describe key practices in their work. Almost all point to the critical importance of the <u>initial engagement</u> with their clients, many of whom have experienced so much disruption and trauma that considerable <u>time and investment</u> are required to make a connection that is going to make a difference. Workers reach out to their clients, sometimes repeatedly in the face of indifference or rejection, and carefully observe and assess <u>their clients' underlying needs and challenges</u>. They demonstrate that they will be reliable, persistent, and youth-centered in their efforts to find the right placement, the plan that reflects the client's needs and goals, and the hope for a future of stability at least and permanency at best. They are <u>available (to youth and</u>

to caregivers) in ways and at times that are just not possible for workers carrying caseloads in the 20s. It is precisely this ability to respond quickly and outside of normal working hours that often prevents youth or caregivers from giving up on a placement. The Case Coordinators can, on their own or with the help of other team members, assist both youth and caregiver to understand and address the precipitant so that relationship is further developed and strengthened, rather than being disrupted or abandoned by either one.

Case Coordinators see themselves as members of the team that includes fellow pilot project social workers and supervisors, case carrying social workers, DMH staff, caregivers, and all other people connected with their clients. They work to be informed, and to keep other team members informed, planning together for the youth at the center of their work.

Case Coordinators express great job satisfaction, describing how rewarding it is to have the time and mandate to be able to do social work the way they were trained to do it. The ability to build trust with both young person and caregiver enables them to be effective in their interventions and to feel successful. They feel committed and appreciated, both important to job satisfaction and performance.

The bi-weekly meeting. The pilot project staff meetings with Judge Nash and other partners have provided supportive and shaping functions during the evolution and growth of the project. The interaction among all parties positively informs the forward development of the project, providing an arena for learning and generating ideas for problem-solving on cases, making changes where indicated, addressing challenges via tangible and intangible resources of the group, and not least, providing affirmation for the successful resolution of what are often extremely challenging situations and circumstances.

Pilot Project examples. The examples presented here, each of which has been greatly condensed, provide illustration of the unique and positive impact of the pilot project model. The lives of each of these young people have been dramatically affected by the support of the pilot project; their trajectories have been profoundly altered.

1. At age 17, IV had AWOLed from numerous group homes and had many stays in transitional shelter care. As a consequence of the many disruptions, she had fallen behind in school. Her relations with peers, school faculty, and other adults were often negative and confrontational. Soon after her entry into the pilot project, she was placed in an STRTP, and early on became so angry that she punched holes into the wall. Her Case Coordinator was able to respond

immediately after the incident. Her availability to speak with both the youth and the staff at the group home enabled all parties to resolve the issues and move forward together. The Case Coordinator established a collaborative relationship with the STRTP placement, whereby she was contacted if IV had difficulty at school or at the placement. IV remained in her placement, establishing school stability with the continued support of the Case Coordinator, and recovered enough credits to graduate high school on time. When her school cancelled the senior prom due to funding problems, the Case Coordinator enlisted a colleague and local restaurant and created a festive evening for this young woman, who is now stable enough to enter transitional housing and enroll in a community college.

2. RH, aged 14, had been placed at an STRTP, where he refused to attend school, engaged in substance misuse, had physical fights, was defiant of authority, and was deeply depressed. One of his fights with another youth led to intervention from law enforcement and several months in juvenile hall. From there he went to transitional shelter care, and to a small STRTP, where he came to the attention of the OCP pilot. Upon meeting his Case Coordinator, RH was immediately responsive to the increased attention to his feelings and needs, and reported feeling like a person "and not a case" for the first time in care. At this same meeting the worker was able to help RH de-escalate from a brewing fight with another resident. Following this experience, he turned to his worker repeatedly for help when defensive, aggressive impulses surfaced; their discussions resulted in insights about RH's lack of self-esteem and its role in his behavioral problems. A period of stability ensued, followed by resurgence of old behaviors. At a CFT meeting, when the staff suggested his behavior could result in removal, he was able to voice his self-hatred and need for acceptance and help, saying "the only places that accept me the way I am is jails, gangs, and Jason" (the Case Coordinator). The availability and commitment of the worker provided safety that RH was able to rely on, allowing him to remain in the placement as he continues his journey toward stability.
3. SW, aged 16, entered the pilot project less than one year ago, after a stay of 600 hours at the TSC. His history of suicidal and homicidal ideation, multiple hospitalizations, extreme aggression, stealing, extreme impulsivity, medication non-compliance, and defiance created substantial barriers to placement. His Case Coordinator engaged him and was able to locate a group home placement at which SW stayed for 6 months. Initial difficulties with staff were resolved over time with the help of the Case Coordinator, and staff grew to accept and value SW. However, an altercation with another youth brought law enforcement into the situation,

and the decision was made to remove SW. He returned briefly to the TSC and was placed in another group home, where he remains today (5 months later). During his tenure in the pilot project, SW has received necessary psychological testing and treatment, but refuses psychotropic medication and does not want to be seen as "crazy." The Case Coordinator has been critical in bringing together important people in his life, as well as attending his court hearings and CFTs, accompanying him to medical appointments, and supporting his athletic and other extracurricular activities. His attendance at school has improved substantially, and his work with his mental health team and CFT has had powerful positive mental health implications—no hospitalizations, no suicidal ideation. SW recently told his mentor that he loves his Case Coordinator.

4. MH, now 17, has been in and out of care since he was very small, with numerous referrals of physical and verbal abuse, and has experienced 18 placements, including at least 3 stays in Transitional Shelter Care due to failed group home placements. On a visit home from one of these, he and other family members returned from a family activity to find his mother dead from suicide. Not surprisingly, MH has been hospitalized for suicidality and major depression three times himself. He is two years behind his cohort in school. MH entered the pilot project in 2017, and was placed in a small group home where he remained for 9 months, his longest placement ever. Sadly, his time there came to a sudden end when the home closed. He is now in another 6-bed home and has been doing well there, attending school, working closely with his Case Coordinator and team. His biological adult siblings who had been placed in a non-family member's home were located and he met them for the first time. His paternal family came forward and he met his aunt and great uncle. During a CFT meeting, a D-Rate foster home was identified; MH and his team began to plan for this move. When a dinner engagement meeting was held with MH, his future foster mother and his Case Coordinator, MH was able to share his fears of negative responses if he had difficulties with the transition after so many group homes—and the foster parent was able to reassure him. At a team meeting with foster parents, the primary social worker, the Case Coordinators (he had had two) and mental health team, all parties discussed roles, triggers, coping tools, and mental health expectations, and soon after, MH moved to his new home. Three months later, MH has an academic plan toward graduation in June 2020, and, with tears in his eyes, told his CFT: "I think of her (foster mother) as my Mom." MH now has career aspirations and looks forward to his future.

Pilot Project Outcomes. Data on outcomes of the project to date are limited. Project staff members are now engaged in establishing systematic data collection methods, but have limited time and ability to devote to designing data collection tools or implementing them. What we know at this point is positive, but largely anecdotal. We do know that youth served by the project are spending less time in shelter care, and have much greater placement stability, as shown in the tables below. We do not have data on outcomes following exit from the project.

Table 1

Total Cases Seen in Pilot
Since 2016

Total Cases	69
Ongoing	42
Closed	25
AWOL	1
Hospitalized	1

Table 2

Pre- and Post-Pilot Numbers of Placements for
Children and Youth with Highest Number of Placements prior
to Entry into Pilot

# of placements pre-pilot	**# of placements post-pilot**	**Status of Case**
33	0	ongoing
33	2	ongoing
26	7	closed
22	6	closed
21	7	ongoing
19	1	ongoing
19	5	ongoing
18	3	closed
18	1	closed
17	2	ongoing
16	7	ongoing
15	4	ongoing
14	5	ongoing
14	1	ongoing
14	3	ongoing
12	3	closed
12	1	ongoing

Table 3
Pre-and Post-intervention Hours

Hours spent in shelter care pre-OCP intervention	Hours spent in shelter care post-OCP intervention
70, 462.66	37, 545.16

Conclusion and next steps. The OCP pilot project serves some of the most vulnerable children in our care, and does so with thoughtfulness, knowledge, commitment, skill, and importantly, the time that is required to truly serve their needs. The investment on the County's part has been considerable, and the return on investment is priceless: the lives of children for whom we have parental responsibility have been nurtured as they should be. They came into our care out of necessity, and they have survived both the original traumas that brought them to us, and the traumas of multiple removals and dashed expectations. We should not be at all surprised that helping them is a substantial undertaking, and we must not be slow to provide the care that is needed. The benefits of this approach are demonstrated in Tables 2 and 3 above, showing the dramatic decrease in numbers of placements for the young people served and the sharp decrease in hours spent in Transitional Shelter Care.

The pilot project is now nearly three and one-half years old. Results are promising, and outcomes for individual youth have been life changing. The approach is and must be resource intensive, with social workers carrying caseloads of eight clients, requiring substantial investment by the county. A rigorous formal evaluation could provide the County with the data needed to determine answers to the below.

1). Should the project move from pilot status to a standard part of practice?

2). Given the estimated 900 children and youth who contend with difficulties of the same nature as those in the pilot project, and the fact that without increased support, these children are likely to experience the negative outcomes associated with multiple placements, should the unit be expanded to serve a considerably greater number of children and youth?

3). How might some of the apparently effective practices adopted by the pilot project be applied to the work of other children's social workers? Examples of practices that might be applied elsewhere include: rapid response (within 24 hours) to caregivers or children experiencing difficulty to avoid placement

disruption could be developed as an adjunct in field offices; more focused use of teaming between DCFS and DMH workers to plan for placement and potential triggers of problematic behaviors.

In the absence of a formal evaluation, it is not possible to say with certainty which of the project elements account for success, nor to measure effectiveness in a meaningful way. Our recommendation is that a consultant be hired to design and implement a program evaluation of the pilot project, and that consideration be given both to expansion of the program, and to adaptation of its lessons for wider use within the system.

OCP Transitional Shelter Care Pilot Protocol Snapshot

FOUNDATIONAL PILLARS OF THE PILOT		
Responsiveness to youth & caregivers	**Ongoing provision of stabilizing supports**	**High level of youth contact & engagement**

PROCESS OVERVIEW		
Recruitment of Youth	72hrs+ in Transitional Shelter Care	• Youth is interviewed to determine eligibility & willingness to participate in the program
Creation of Youth's Team	Within 7 days of entry into pilot	• Team will provide ongoing support to youth & caregiver to facilitate placement success • Team Members – Youth – Case Carrying Children's Social Worker – Case Carrying Supervising Children's Social Worker – OCP TSC Pilot Project CSW (also a member of APT) – DMH Intensive Field Capable Clinical Services Staff – Informal sources of support
Initial Placement and 1st On-Site Team Meeting	1st day of placement	• All team members meet the youth at the placement • Team Meeting Focus: – Support youth & caregiver during the transition – Identify behaviors & triggers that may interfere with the youth's progress – Develop strategies to reduce negative outcomes & reinforce positive behaviors – Create short- & long-term goals
Physical Examination	First week of placement	• Youth undergoes a complete physical exam, including a Fetal Alcohol Spectrum Disorders screening, to identify physiological factors that may be important
2nd On-Site Team Meeting	Early weeks of placement	• Builds on the 1st on-site team meeting • Team develops strategies and identifies interventions to support the youth's ongoing success