Caring Together
Group Home Models

2019 Stakeholder Engagement Sessions
June 28, 2019
Agenda

- Welcome Back
- Feedback Summary on Intensive Tx Family Placement Models
- Data handout
- Group Home Discussion
Feedback Summary

- Strong endorsement of DMH adding Intensive Tx Family Placement to its service array.
- Family Residence model not endorsed. Would not meet the intense needs of DMH-involved youth.

Clarify goals of service and population to be served
- Reunification, independent living, and/or getting “unstuck” from residential are possible goals. Each drives a different program design.
- Need a strong assessment and comprehensive homestudy in order to ensure right match.
- Consider tiered system to reflect levels of clinical acuity and support.
- Would most likely be adolescent focused given ages of youth served in CT programs at DMH.
Program Components

- Case manager to support foster parent and youth; in the home multiple times/week
- Members of a team could include OT, psychiatry
- 1:1 or 1:2 ratio is the maximum
- Back up for foster parent in emergency
- Respite
- Overnight support, e.g., for a youth with intensive needs including sleep problems
Feedback Summary

Business Considerations

• To ensure availability, pay stipend to keep bed open (e.g., DYS)
• A ratio of approximately 8 beds for 4 kids required to ensure good match. Ratio shifts for larger programs, e.g., 25 beds for 18 kids.
• One Example: a program with 16 kids in 10 homes has to close because it is too small to be viable (@ DCF’s rate)
• To be viable / affordable, a program must spread management/administrative costs over other foster programs (e.g., those purchased by DYS, DCF). Cannot serve DMH only.
• Consider pairing with Continuum Programs. Could Continuum have a # of beds available? Use Continuum Wrap only to enhance supports to the home / youth.
Recruiting Qualified Foster Parents

- Current residential or IRTP staff might be ideal as foster parents
  - Allow for more robustly trained person, they have modeling/coaching/experience versus just training
- Provide flexibility re: whether parent can have a job or not
- Child-specific foster care might be ideal
- Use of Family Partners as foster parents
- Role of foster parent would be to partner with family/parent
- Employees versus foster parent – issue of salary/rate and health coverage
- Provide respite and support for foster parent
- Rate should be high enough to secure foster parent commitment
## Areas for Feedback

### Focus Areas of Improvement

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- Clinical specialization / capacity
- Short-term use
- Respite
- MAP/ Nursing
Clinical Specialization / Capacity

What we’ve learned

• DMH has lost some of the clinical specialization that it had in the past
• “No right of refusal” led to generalized practice.
• Crisis trumps treatment

Design considerations

• Increasing the BH expertise of the workforce
• How can DMH and its contracted programs rebuild clinical capacity?
• What treatment models/strategies should be established/supported?
Short-term Use: “STARR”

What we’ve learned

- Some DMH Areas like STARR
- DMH use overwhelmed by DCF needs

Design considerations

- Creating capacity for Diagnostic Assessment
- Creating capacity for “RR: Rapid Reunification”
- Can short-term use occur within a Group Home setting: benefits and challenges
Short-term Use: Planned Respite

What we’ve learned

• Has not been available at the levels anticipated or needed
• Absent dedicated respite beds, beds are used to meet other (longer-term stay) needs

Design considerations

• How do we secure capacity for Planned Respite
• Can respite use occur within a Group Home setting: benefits and challenges
Closing Remarks

• Debrief of Today’s Meeting
• Outstanding Questions
• Next Meeting:
  – Date: July 12
  – Topic: Clinical Interventions