HCRTP Health Care Reform Tracking Project

PROMISING APPROACHES FOR BEHAVIORAL HEALTH SERVICES TO CHILDREN AND ADOLESCENTS AND THEIR FAMILIES IN MANAGED CARE SYSTEMS

#3: MAKING INTERAGENCY INITIATIVES WORK FOR CHILDREN AND FAMILIES IN THE CHILD WELFARE SYSTEM

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The Health Care Reform Tracking Project (HCRTP)[1]

Since 1995, the Health Care Reform Tracking Project (HCRTP) has been tracking publicly financed managed care initiatives and their impact on children with mental health and substance abuse (i.e. behavioral health) disorders and their families. The HCRTP's Promising Approaches Series highlights strategies, approaches and features within publicly financed managed care systems that hold promise for effective service delivery for children and adolescents with behavioral health treatment needs and their families, particularly for children with serious and complex disorders. The Series draws on the findings of the HCRTP to date, highlighting relevant issues and approaches to addressing them, that have surfaced through the HCRTP's all-state surveys and in-depth impact analyses in a smaller sample of 18 states.[2]

The Promising Approaches Series is comprised of a number of thematic issue papers, each addressing a specific aspect of managed care systems affecting children with behavioral health disorders. The papers are intended as technical assistance resources for states and communities as they refine their managed care systems to better serve children and families. The following topics are being addressed in the first round of papers in the *Promising Approaches Series*:

- managed care design and financing
- services for children with serious and complex behavioral health care needs
- accountability and quality assurance in managed care systems
- the child welfare system perspective
- making interagency initiatives work for children and families in the child welfare system
- clinical decision making mechanisms
- care management.

Methodology of the HCRTP

Many of the strategies and approaches that are described in the *Promising Approaches Series* were identified by key state and local informants who responded to the HCRTP's all-state surveys and who were interviewed during site visits to 18 states for the HCRTP's impact analyses. Additional approaches were identified from other studies and by experts in the field. Once promising approaches and features were identified through these methods, members of the HCRTP team, including researchers, family members and practitioners, engaged in a number of additional methods to gather more information about identified strategies. Site visits were conducted in some cases during which targeted interviews were held with key stakeholders, such as system purchasers and managers, managed care organization representatives, providers, family members and other child-serving agency representatives. In other cases, telephone interviews were held with key state and local officials and family members to learn more about promising strategies. Supporting documentation was gathered and reviewed to supplement the data gathered through site visits and phone interviews.

The *Promising Approaches Series* intentionally avoids using the term, "model approaches". The strategies, approaches and features of managed care systems described in the *Series* are perceived by a diverse cross-section of key stakeholders to support effective service delivery for children with behavioral health disorders and their families; however, the HCRTP has not formally evaluated these approaches. In addition, none of these approaches or strategies is without problems and challenges, and each would require adaptation in new settings to take into account individual state and

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[1] The HCRTP is co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to incorporate a special analysis related to children and families involved in the child welfare system.

[2] The HCRTP is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development. For information about available HCRTP reports, see Appendix A.

local circumstances. Also, a given state or locality described in the *Promising Approaches Series* may be implementing an effective strategy or approach in one part of its managed care system and yet be struggling with other aspects of the system.

The *Series* does not describe the universe of promising approaches that are underway in states and localities related to publicly financed managed care systems affecting children with behavioral health disorders and their families. Rather, it provides a snapshot of promising approaches that have been identified through the HCRTP to date. New, innovative approaches are continually surfacing as the public sector continues to experiment with managed care. While each approach or strategy that is described in the *Promising Approaches Series* is instructive in its own right, there also are important commonalities across these strategies and approaches. Each paper of the Promising Approaches Series focuses on a different aspect of publicly financed managed care systems.

Children and Families Involved in the Child Welfare System

This includes children living in their own homes and receiving services from the child welfare system, as well as children in the foster care system. The "foster care system" refers to children who are in the custody of a county or state child welfare agency or a tribal court and who may live in a foster home, group home, kinship care home, residential treatment center, or other out-of-home placement. It includes children who will return home, as well as those for whom another permanent plan will be made, such as guardianship or adoption. For the purposes of this study, families needing post-adoption services also are included.

The Child Welfare Papers

Since 1996, the HCRTP has included a special focus on the effects of managed care on children and families involved in the child welfare system. This paper, *Making Interagency Initiatives Work for Children and Families in the Child Welfare System*, describes how the child welfare system is participating in collaborative **interagency initiatives** designed to serve children with serious and complex behavioral health disorders and which are using some managed care technologies. A companion paper in the Series focuses on **managed care systems**. Entitled *A View from the Child Welfare System*, it discusses special considerations and describes site examples for meeting the behavioral health needs of children in the child welfare system, and their families.

Children with Serious and Complex Behavioral Health Needs

This includes children with serious emotional and behavioral (mental health and/or substance abuse) disorders who are involved with, or at-risk-for involvement with, multiple systems (e.g. child welfare, mental health, early intervention, special education, and juvenile justice) and represent "high utilizers" of services in terms of the level, amount, and cost of care.

Interagency Initiative

An effort on the part of two or more child and family serving systems to provide services to children with serious and complex behavioral health disorders and their families. The initiative incorporates some managed care technology and intends to integrate a child's care across multiple systems. Children in the child welfare system and their families are included in the target population served. The child welfare system is an active partner in planning, funding, implementation, and evaluation. Resources for the initiative are a shared responsibility across agencies with braided or blended funding strategies in place.

How This Paper Is Organized

Some states and communities have made progress in providing behavioral health services to children and families touched by multiple service systems. The purpose of this paper is to discuss promising approaches and special provisions in successful interagency initiatives that:

- include child welfare systems in planning, funding, implementing, and evaluating the initiative,
- meet the behavioral health needs of children and families in the child welfare system,
- address child welfare system policies, laws, and mandates, and
- share resources and and/or funds between or across child serving systems to serve these children and families.

Making Interagency Initiatives Work for Children and Families in the Child Welfare System

Section I

Highlights the premise of interagency initiatives and the promise that such initiatives have for children and families involved with the child welfare system when child welfare is an active partner in planning, implementation, and evaluation.

Section II

Describes the study methodology, including steps used to identify and select the three interagency initiatives that are featured in this paper:

- ☐ Partnership for Children, New Jersey
- ☐ The Dawn Project, Marion County (Indianapolis), Indian
- ☐ Massachusetts Mental Health Services Program for Youth (MHSPY), Cambridge and Somerville, Massachusetts.

Section III

Highlights similarities, differences, and challenges shared by the three initiatives in accommodating the child welfare system and the needs of children and families served by the system.

Section IV

Offers full descriptions of each of the three interagency initiatives and identifies many strategies used in these sites to include the child welfare system and to meet the behavioral health needs of children and families served by the child welfare system.

Section V

Summarizes how the interagency initiatives described in this study have kept the promise to meet the needs of children and families in the child welfare system, presents advice from study respondents to other states and communities, and offers recommendations for the future.

The Premise and the Promise of Interagency Initiatives

Behavioral Health Needs of Children and Families Involved with the Child Welfare System

Children come to the attention of the child welfare system for many different reasons. Many have experienced abuse or neglect; and a social worker, law enforcement, or the court has determined that they need protection. In other families, parents have turned to the child welfare system as a last resort to gain access to extensive mental health services for their children that they have not been able to get through other child-serving systems. Children in both of these groups tend to be extremely vulnerable and are at high risk for health, mental health, and developmental problems.

For children in foster care, the trauma of separation from their families and the experience of multiple moves within the foster care system itself frequently increase their vulnerability and compound their behavioral health problems. Many parents, who experience the stresses that lead to involvement with the child welfare system, also need mental health services and supports, as well as substance abuse services. Through the federal Child and Family Services Review process, states are expected to provide the services needed to meet the physical health, mental health, and educational needs of children in the child welfare system. They are also charged with helping birth parents develop the capacity to meet the needs of their children.[3] For these reasons, when the child welfare system participates in interagency initiatives to meet the behavioral health needs of children and families, it is very important that these initiatives understand the extent of behavioral health needs of both parents and children and the importance of adequately addressing these needs within the initiative.

The Premise of Interagency Initiatives

Interagency initiatives to serve children with serious and complex behavioral health needs and their families are based on the following premises:

- Children with serious and complex behavioral health needs are already being served by multiple systems.
- Individualized and customized care within an interagency process can be designed with input and agreement from all systems serving the child and family.
- Integrated planning addresses service gaps, avoids duplication and redundancy, and is potentially more cost-effective.
- One integrated system reduces fragmentation and confusion for families seeking services and support.
- Children and families fare better when their care is coordinated and offered to the “whole” child and family.
- By increasing families’ involvement in services design and in determining their own care, services are more meaningful and more suited to family needs
- Shared planning, implementation, and evaluation will lead to services and delivery systems that better meet the needs of children served by the partner agencies and systems.
- Any “untreated” aspect of a child’s or family’s needs costs each service system more.
- Resource sharing – such as pooled, blended or braided funding – provides more flexible opportunities for financing services in general, creating new services, and paying for services that may otherwise be outside of the scope of any one particular service system.

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[3] In March 2000, regulations went into effect for a new approach to federal oversight of state child welfare programs, known as the Child and Family Services Review (CFSR). Overseen by the Children’s Bureau of the Administration for Children and Families, the review process consists of statewide self-assessment as well as an on-site review, conducted by a team of federal, state, and peer reviewers. Information gathered through the review is used to examine the states’ success in meeting the major goals of the child welfare system—child safety, permanency and well-being. When states do not achieve “substantial conformity” with the required outcomes, they develop Program Improvement Plans to describe how they will reach substantial conformity.

- Managed care strategies can be applied to interagency initiatives and support clinical decision-making, access to care, and cost effective service delivery.

The Promise of Interagency Initiatives-Making Interagency Initiatives Work for the Child Welfare System

The hope for interagency initiatives, from the perspective of the child welfare system and the families it serves, is the promise of:

- appropriate and accessible services for children and families with the most complex and challenging needs,
- behavioral health services for the whole family as well as the identified child,
- a commitment to understanding and meeting the special or unique needs of children and families in the child welfare system,
- coordinated and continuous care, and
- access to behavioral health expertise that may be missing in the child welfare system itself.

From a systems perspective, the child welfare system hopes for expanded accountability and cost savings through shared responsibility in serving children and families with these special needs. Ultimately, the child welfare system strives for permanency—safe children, strong parents, caring homes, in the community—with no need for child welfare services.

- ***Commitment***

Interagency initiatives promise a shared commitment to understanding and meeting the needs of all children across service systems. Each agency has a voice in service design, development, and delivery. Agencies also commit resources to support the initiative and achieve full stakeholder investment. The child welfare system has the opportunity to describe the particular needs of the children and families they serve; insert its mandates, policies, and procedures into the mix of working with other child serving systems; and influence service design and delivery.

- ***Access to Services***

Interagency initiatives promise services that are accessible, appropriate, and adequate to serve children with serious and complex behavioral health needs and their families. Through tailored eligibility, streamlined enrollment, clinical decision making, and the use of intentional managed care strategies to maximize resources and support, children with serious and complex behavioral health needs and their families involved with the child welfare system can be accommodated.

- ***Coordinated and Continuous Care —A Plan and a Place for Children***

Interagency initiatives promise integrated service planning and more creative, individualized service plans for children with serious and complex behavioral health needs. They offer formal partnerships and opportunities for cross system communication on many administrative and service levels between systems. For the child welfare system, it is those children who have not benefited from traditional behavioral health services and need so much support who have the most to gain from the interagency, cross-system cooperation and resources.

- ***Whole Families, Stronger Families—Children Back Home and in the Community***

Interagency initiatives promise alternatives to out-of-home placement—by virtue of adequate non-traditional support services and improved child and family functioning. Wraparound support services, built across systems, can link families to community supports, services, and one another so that family functioning can improve and children can return home and to the community. For the child welfare system, this promise can help to address the ultimate goal of safe children in a permanent home with caring adults.

- ***Expanded Accountability***

Interagency initiatives promise a shared, cross-system responsibility for serving and supporting children with complex needs and their families. Each system brings its own expertise and services to offer appropriate behavioral health care, and families have voice as empowered and active partners in charge of their own care. For the child welfare system, this shared accountability eases its sense of sole responsibility for all services to these children and their families.

- ***Cost Savings***

Children with serious and complex behavioral health needs and their families who are involved with the child welfare system are those most at-risk-for involvement with multiple systems (e.g. child welfare, mental health, early intervention, special education, substance abuse, juvenile justice, etc.) and represent "high utilizers" of services in terms of level, amount, and cost of care. They are more likely to receive inpatient services, require therapeutic foster care, and utilize residential services. The child welfare system hopes to see fewer children in residential services (particularly out-of-state placement), lower cost of care, and better care per dollar per child in need.

- ***Permanency***

Ultimately, the child welfare system hopes to find permanent homes and reduce the number of children involved with the system as children and families have appropriate access to behavioral health services, improve and grow stronger, and no longer require supervision, protection from abuse and neglect, or out-of-home placement to receive mental health services.

The Challenge to Interagency Initiatives

The challenge, of course, is to make good on the promise. To fulfill the promise and to create, implement, and sustain interagency initiatives that are effective in all of these ways require significant risk, commitment, creativity, patience, hard work, and proof. Those engaged in interagency initiatives take on the risk of new ways of doing business. We selected three study sites that demonstrate successful strategies for keeping the promise. All three have utilized strategies to accommodate the needs of children with serious and complex behavioral health needs and their families who are involved with the child welfare system. Each initiative is described in Section IV.

Study Methodology

Site Identification

Initial site identification efforts focused on those states or communities where an existing interagency system reform effort, using some managed care techniques, was underway and operating a service system for children with very serious emotional disorders. The special focus for this survey included those sites where the child welfare system is an active partner and where the needs of children in the child welfare system and their families are being addressed. This special focus helped to define the process by which sites were identified and ultimately selected.

Some key sources of information for site selection included:

- ***Health Care Reform Tracking Project (HCRTP)***

Publications of the Health Care Reform Tracking Project (HCRTP), a ten-year review and analysis of state behavioral health managed care reforms, provided baseline information from which a more specialized list of potential sites for this study could be determined. In addition, the HCRTP *1999 Child Welfare Impact Analysis*[4] offered an in-depth look at the information of special significance for children and families in the child welfare system who need behavioral health services. The *1999 Child Welfare Impact Analysis* was limited to eight states and summarized issues important to child welfare stakeholders interested in planning and implementing a behavioral health managed care initiative; described three states' efforts to apply managed care approaches to child welfare funds and services; and recommended a shift in focus from child welfare initiatives to interagency initiatives to consider for this study. In combination, these reports provided a starting point for identifying potential states, counties, and communities.

- ***Child Welfare League of America - CWLA 2000-2001 Management, Finance, and Contracting Survey***

Since 1996, CWLA has conducted four surveys of the child welfare field to identify and report on emerging trends and policies in the management, finance, and contracting of child welfare and related services. In sharing its preliminary state profiles from the 2000-2001 Survey[5], CWLA helped to sort those states where behavioral health initiatives were designed and operated as a child welfare managed care effort and where they were designed and operated within an interagency collaborative with child welfare system involvement.

- ***Health Services Research, Inc. Report***

Health Services Research, Inc. (HSR), with funding from the Federal Maternal and Child Health Bureau, Health Resources and Services Administration, and partners in the National Policy Center for Children with Special Health Care Needs (CSHCN)[6] undertook a study to identify the barriers and strategies for integrating mental health and physical health systems of care for children with special health care needs. In its study, HSR offered a system of care perspective and descriptive information related to those sites offering promising approaches to integrating these two systems. Two of our potential study sites were included in the HSR report findings.

- ***Internet Search***

The Internet and relevant websites provided additional resources for site identification and gathering essential information about specific sites. Funding organizations with interest in this area—Robert Wood Johnson Foundation, Annie E. Casey Foundation, Center for

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[4] McCarthy, J. and Valentine C. (See Appendix A)

[5] The final report of the 2000-2001 Management, Finance and Contracting Survey can be ordered by e-mail at books@cwla.org

[6] Health Services Research, Inc. (www.hsrnet.com) is a public policy research and consulting firm that provides program and technical support to develop and implement innovative and effective strategies that improve the health and social well-being of individuals families and communities. The National Policy Center for CSHCN promotes comprehensive, family-centered systems of care for children with special health care needs and their families. (www.jhsph.edu/centers/cshcn).

Mental Health Services[7], etc.—posted project descriptions, updates, and other reports with information relevant to this study. A number of state, community, and local initiative websites offered a wealth of information about a specific initiative including descriptions, progress reports, evaluation outcome information, as well as other materials for review.

From this search, we identified an initial list of 11 potential sites, including state, county, and locally implemented interagency initiatives and submitted this list to the Health Care Reform Tracking Project partners and collaborators for additional suggestions and input. With their input and suggestions, we expanded the list of potential study sites to 15, clarified the selection criteria, and pursued additional information for each site relevant to this study.

For the 15 initiatives and sites recommended by the HCRTP partners and collaborators, the research team gathered initiative-specific information to better determine the initiative's administrative and finance structures, implementation status, and involvement of the child welfare system. Through this additional research and contacts with key informants, the research team obtained sufficient information to prioritize the sites and apply the selection criteria described in the following section.

Selection Criteria

The criteria for selection of study sites were initially framed by the purpose of this issue paper and later refined through site research and input by the HCRTP partners and collaborators. It was important for this study to include initiatives of various scope (state, county, local, and rural) and those serving culturally diverse populations, not only within each initiative but also across the three selected for the study. In addition, it was important that the selected initiatives be administratively sound and operating with intact partnerships. With these overarching goals in mind, the following criteria were applied to those 15 states, counties, and localities recommended for consideration:

- an interagency collaborative effort using some managed care strategies,
- a focus on behavioral health services for children with serious behavioral disorders (from multiple systems), and their families,
- inclusion of children and families involved with child welfare services
- child welfare system involved as a key partner in planning, implementation, and evaluation
- shared financing strategies across child serving systems, including funding from the child welfare system
- provision of services that meet the needs of children with serious and complex behavioral health needs and their families (high-cost level of care and/or at risk of out-of-home placement)
- demonstrated family involvement and partnership practices
- serving culturally diverse populations (across the three selected sites)
- demonstrating positive outcomes (e.g. improved clinical status; improved family functioning; reduced rate of out-of-home placements, foster care, or residential care) or having an evaluation plan in place.

Selected Sites

Three sites were selected for this study:

- Partnership for Children (New Jersey)
- The Dawn Project, Marion County, (Indianapolis) Indiana

The Robert Wood Johnson Foundation (www.rwjf.org), based in Princeton, NJ is the largest philanthropy devoted exclusively to health and health care in the United States. The Annie E. Casey Foundation (www.aecf.org), based in Baltimore, MD fosters public policies, human service reforms, and community supports to more effectively meet the needs of today's vulnerable children and families. The Center for Mental Health Services, is a component of the federal Substance Abuse and Mental Health Services Administration (www.mentalhealth.org/cmhs).

- Massachusetts Mental Health Services Program for Youth (MHSPY), Cambridge and Somerville, Massachusetts.

Individually, each site meets the selection criteria noted above. Combined, these sites meet the overarching goals of including initiatives of various scope (state, county, and local), serving culturally diverse populations, being administratively sound; and operating with intact partnerships. Two of the sites are well established, having begun in 1997. The third site began implementation in January 2001. (See Section IV for a full description of each site.)

Overview of the Findings—How Interagency Initiatives Meet the Needs of Children and Families in the Child Welfare System

Findings from the study are presented in two parts. Section III synthesizes the information gathered from **all of the three study sites** and looks across sites to observe similarities and differences. Challenges to including and accommodating the child welfare system and the needs of children and families involved with this system also are described.

Findings from the study of **each individual site** are found in Section IV where complete descriptions of each of the three interagency initiatives are provided.

All three initiatives operate with system of care values and CASSP-like principles[8] that are relevant to children and families involved with the child welfare system. This value-based foundation supports the interagency design, guides the approach, and influences the delivery of services in each of the initiatives. Within this system of care framework, there are major similarities across and differences between these initiatives.

Major Similarities

For the purposes of this study, which takes an in-depth look at three initiatives, major similarities include those features or aspects shared by **two or more** of the initiatives in the study sample.

- ***The child welfare system was included as an early and active partner in initiating, planning, and designing the initiative.*** In two of the three initiatives, child welfare stakeholders (state and/or local) contributed to the impetus for the initiative. Concerns about access to adequate behavioral health care, too many children in high-cost residential services, poor coordination of services, and achieving permanency represented the child welfare system's interests in initiating each interagency service approach.

- ***Administrative structures include the child welfare system and family representation.*** Representatives from the child welfare system serve on governing entities, advisory groups, and work groups to ensure that child welfare goals, policies, laws and mandates are considered in the development and implementation of the initiative. Families are also members of these groups; sharing their experience, offering input and advice, and strengthening family partnerships.

- ***Shared resources including funding from the child welfare system are common across all initiatives.*** Pooled, braided, or blended funding strategies across child-serving systems (child welfare, juvenile justice, special education, and mental health) include child welfare dollars. The child welfare system represents a major, and sometimes the largest, contributor of funds in each of the three initiatives. Mechanisms to account for the spending of child welfare funds are in place.

- ***Institutionalized problem solving strategies are in place in the three initiatives; ranging from the state to the local level.*** In addition to the work of the governing bodies (consortium, steering committee, or management team), each initiative includes management meetings at the implementation level where management, supervisory, and front line level stakeholders—including child welfare—can resolve differences and address individual and system level issues. In addition, child welfare liaisons or clinical liaisons to the child welfare system serve to bridge service systems and represent the child welfare system's concerns to and within the initiative.

- ***Clear enrollment criteria across systems and an internal referral process within each system guide referrals and help to ensure services to those children with the greatest need.*** The enrollment criteria are inclusive of children and families involved with the child welfare system; those in, or at-risk of, out-of home placement. Child welfare workers and supervisors work together to identify children and families that meet the enrollment criteria and will

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[8] Stroul, B.A. & Friedman, R. M. (op. cit.)

benefit from the initiative's service design and delivery system. The child welfare system is one of the primary referring systems and the greater portion of children enrolled for services, even those referred by other systems, are involved in some way with the child welfare system.

- ***Uniform screening and assessment instruments are used with all children referred to or enrolled in each initiative.*** These uniform instruments provide a common measure and language for referral selection, service planning, monitoring the process, and assessing outcomes for all systems partners, including the child welfare system. Cross-system referral committees, selection teams, and/or a referral coordinator in each initiative utilize the information to prioritize referrals and influence enrollment. In general, the child welfare system has either had a role in selecting/designing these instruments or has begun to use them in other parts of its service system.

- ***Service planning and service coordination mechanisms commonly take the form of child and family teams that include the child welfare worker.*** For the child welfare worker and the child welfare system, these teams serve as the primary point for communicating the child welfare perspective, addressing protective services concerns, relaying court order information, and incorporating the plan for permanency.

- ***All three initiatives built on existing cross-system partnerships and provider networks already working with children and families involved with the child welfare system.*** By capitalizing on these relationships and services, the initiatives recognized the strengths of the child welfare system in the communities and ensured continuity of working relationships between agencies and continuity of care for children and families.

- ***Shared permanency planning and out-of-home placement responsibilities are present in all three initiatives.*** Permanency planning is an "up front" goal incorporated into the service planning process. The roles and responsibilities of the initiative and the child welfare system in out-of-home placements are clearly defined. In general, the initiative has some responsibility for identifying, coordinating and paying for therapeutic placement (inpatient, residential, therapeutic foster home). The child welfare system is responsible for non-therapeutic placements based on safety or custody issues.

- ***The values and principles of a family-centered, strengths-based approach are common across all three initiatives.*** Having families at the center of care and as equal partners has had a significant impact on the experience of children and families involved with the child welfare system; the child welfare worker's approach to and relationship with families; and the child welfare system itself. In all three initiatives, families report feeling empowered and respected. Child welfare workers report seeing families as partners and experiencing improved (less adversarial) working relationships. Child welfare system leaders describe a philosophical and practice shift toward models of family group conferencing.

- ***Individualized care, traditional services, and non-traditional resources are used to customize care for children and families in all three initiatives.*** The flexibility of non-traditional resources and the wraparound process have been particularly helpful in offering in-home services, linking families to in-community supports, and providing transportation for children and families involved with the child welfare system.

- ***Other family members access care in two ways—directly from the interagency initiative or through other community support services.*** Family members receive direct services if it is in specific support of the intervention of the enrolled child or youth. For many other support services, family members are referred and linked to community services or resources. Family access to care is critical for families involved with the child welfare system (birth, foster, kin, or adoptive) in meeting their goals for the child, reducing risk, moving toward permanency, or achieving family reunification. All three initiatives offer or link families to **family support activities**, including peer support, education, and advocacy activities. Families involved with the child welfare system benefit from sharing experiences, learning from others involved with the child welfare system, and influencing service systems.

- ***The interagency initiative and the child welfare system maintain separate records and utilize primarily traditional methods of formal, signed consent forms to exchange records and reports.*** Two of the initiatives have technology that allows sharing records between the initiative and child welfare through "read only, need to know" access. However, full utilization of this capacity is still under development in each of these initiatives.

- ***All three initiatives have utilized training and technical assistance to convey information about the initiative, support cross-system partnerships, clarify roles and responsibilities and promote effective practices.*** Training topics such as those listed below have been offered in a variety of formats in each initiative:

- values, design and operations of the interagency initiative
- how services can be useful to children and families involved with the child welfare system
- roles and responsibilities of the care coordinators and child welfare workers
- laws, policies, and mandates that impact child welfare services.

- ***Each initiative has an evaluation plan to gather data.*** Each utilizes outcome measures to assess improved functioning for children and families and to guide services design and delivery. All three initiatives measure cost, service, and outcome data relevant to children and families involved with the child welfare system. They have included child welfare representatives in identifying data points, outcome measures, and data reports that would be most meaningful to the child welfare system. Although some of the measures are relevant to SACWIS[9], all three child welfare systems in these initiatives maintain their own database for SACWIS.

Major Differences

For the purposes of this study, which takes an in-depth look at three initiatives, major differences include those features that represent differences between one initiative and the others, or among all three of the initiatives in the study. Within the differences described, the implications most pertinent to the child welfare system are *italicized.*

- ***A striking difference between the initiatives is the scale of implementation.*** Dawn, in Indiana, is county-wide; MHSPY in Massachusetts is community-based; and Partnership in New Jersey is statewide. *While there are many design issues related to this difference, for the child welfare system and the population it serves, the implications focus on: 1) access to care and service continuity for children who may move or be placed outside of a county or community-based initiative's service area, and 2) quality of care for statewide initiatives where consistency of services and service monitoring across different care management organizations may be more of a challenge for these potentially mobile children.*

- ***The developmental paths of these iniatives varied significantly.*** While the impetus for all three initiatives was based on common concerns and generally, the child welfare system was an early and active partner, each initiative's developmental path varied depending on the system that took the lead in the initiative and level of child welfare administration involved. New Jersey's Partnership began as a Governor's Initiative with the Department of Human Services (including child welfare) taking the lead. Dawn began in Marion County as a child welfare and juvenile justice collaboration with state input and designation of the county Mental Health Association taking the lead in the initiative. MHSPY in Massachusetts relied on personal commitment and relationships to get its start, and state leaders charged the Department of Mental Health with lead responsibility in applying for funding. *A top-down or bottom-up beginning and the relationship of the child welfare system to the agency taking lead in the initiative influenced how early and how well an initiative began to address child welfare system concerns.*

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[9] Statewide Automated Child Welfare Information System (SACWIS) is a federally funded, electronic management information system to support the collection, maintenance, integrity checking, and transmission of data specific to state child welfare services. This system supports program administration, coordination of services, and reporting requirements.

- ***While shared resources are common across all initiatives, the funding arrangements—pooled, braided, blended—vary.*** Partnership has carved money out of each contributing agency's budget and dedicated that full amount to the initiative for a single payer system through Medicaid. Dawn partners, including the county child welfare agency, are billed a per child/per month case rate for children they refer. The initiative pays through a single payer system with the County Auditor. MHSPY system partners each negotiated a separate, case rate payment agreement with Medicaid, and the money is used to pay for services without regard to the referral source. *For the child welfare system, the funding arrangements impact budget structure, method of payment, and tracking cost and service data. In addition, there are implications for linking payment to referrals.*

- ***Each of the initiatives utilizes a different type of managed care entity.*** Choices, with Dawn, is a non-profit, care management organization; Neighborhood Health Plan, with MHSPY is a non-profit HMO[10] for Medicaid eligible families; and Value Options, which serves as an ASO[11] with Partnership, is a for-profit commercial behavioral health managed care company. *For the child welfare system, the type of managed care entity can influence funding mechanisms, eligibility criteria for children and families, and decision-making structures. For example: MHSPY utilizes Neighborhood Health Plan. As an HMO, it receives payment for services through Medicaid. To be eligible for MHSPY services, children must be eligible and enrolled in MassHealth (Medicaid).*

- ***Although the intended service populations for all three initiatives are essentially the same, the child welfare system has differentially influenced the child welfare population served.*** Of the three, Dawn focuses primarily on moving children in residential centers back home. In MHSPY, the largest percent of children served are those who are in their own homes with their birth families at the time of the referral (approximately 60%), supporting the child welfare system's view of MHSPY as a "prevention program". Partnership, at its current phase of implementation, provides care management services to children in or "at risk" of out-of-home placement. In the future, when Partnership is at full service capacity, the initiative will serve all children with serious and complex behavioral health needs and their families (as well as those with less acute, intensive needs) throughout the state. The maturity of the initiative, the existing parallel service systems, and the priorities of the local child welfare offices have all influenced who is currently being served. *For the child welfare system these differences imply that the child welfare system has an important role in determining the goals of the initiative, setting priorities within the service population, and maintaining parallel systems of care for those the initiative may not have the capacity to serve.*

- ***Responsibility for managing and funding a child's placement varies across the initiatives.*** When the child welfare system refers a child to Dawn, the initiative accepts responsibility for addressing every need of that child, including taking lead responsibility for arranging and stabilizing placement. Partnership assumes primary responsibility for identifying, coordinating, and funding any treatment or therapeutic placement such as residential, group home, or treatment foster care. MHSPY offers residential services up to 30 days. If a child stays in care more than 30 days, the referring agency becomes responsible for funding the residential placement. *For the child welfare system, these differences impact the costs of out-of-home therapeutic care as well as the responsibility for therapeutic placement services.*

- ***Court involvement in the initiatives varies from one site to the other.*** Dawn has had strong court involvement since its inception and has ongoing court representation on the Consortium and its Executive Committee. MHSPY interacts with the court system on a child-by-child basis and partners with child welfare as a link to the courts. Partnership involves the Administrative Office of the Court on their advisory committee, as part of the Local Implementation Teams, and on a child-by-child basis for children served by the CMO who have court involvement. Partnership is continuing to build working relationships with all

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[10] HMO – Health Maintenance Organization

[11] ASO – Administrative Services Organization

levels of the court system. *For the child welfare system, differences in court involvement in the initiative means more or less court influence on case review and enforcement of ASFA[12] timelines, as well as court orders that include more flexible and unique service recommendations.*

- ***Of the three initiatives, MHSPY is the only one to include comprehensive and integrated primary health care and behavioral health care.*** It is also the only initiative located in a managed care setting and that requires children to enroll in a specific health care plan. MHSPY ensures coordination of primary care for children while they are enrolled, but graduation or disenrollment from MHSPY may require a change in health care provider. Dawn and Partnership refer children to community health care providers who often continue to serve them after they no longer receive services from Dawn or Partnership, but who are not necessarily involved in coordinated service planning. *For children and families involved with the child welfare system, both coordination and continuity of health and behavioral health care are important.*

- ***All three initiatives offer family support activities, however the level of family support activities varies between initiatives.*** In Dawn and Partnership, formal family support organizations are partners in the initiatives. These organizations are funded and have their own administrative structure to provide services. MHSPY's family support activities are coordinated and delivered by MHSPY staff through "in house" activities and linkages with state advocacy groups. *In all cases, family support activities are open to all families, including those involved with the child welfare system. More formal and well-funded family support activities may offer more extensive services, have firmer advocacy network connections, and have a more formal role in influencing child serving systems, including child welfare.*

- ***Training and technical assistance opportunities are present in all three initiatives, however those available in Partnership are more structured and formalized than those in Dawn and MHSPY.*** Partnership has established a training plan and core curriculum for all system partners and for cross-system training. Dawn offers regular training opportunities, but the topic content is less structured and based more on current needs than a structured, curriculum approach. The exception would be its current effort to infuse cultural competence across systems. MHSPY has little funding for training or technical assistance and in general relies on regular, in-house staff development and presentations from invited local partners for training activities. The child welfare system's level of involvement in training associated with each of the initiatives is parallel to these descriptions.

Continuing Challenges

For the purposes of this study, which takes an in-depth look at three initiatives, continuing challenges represent those challenges that **one or more** of the initiatives in the study sample continue to face.

- ***Involving other systems in the initiative, particularly health/public health, substance abuse, and the education system, has been cited as one of the common challenges across the three initiatives.*** These child and family serving systems are important players in the lives of children and families involved with the child welfare system.

- ***Family access to care remains an issue.*** Although these initiatives have flexible funds and can customize care to support families, in general, they focus primarily on the identified child. Family services for individual members most often require referral and/or other community resources. This is especially a concern for the child welfare system where prevention of placement and reunification of parents and children depend upon adequate services for both the children and the parents.

- ***Strategies focused on involving families from the child welfare system continue to be a challenge.*** The family support organizations (FSO's) in two of the

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[12] The Adoption and Safe Families Act (ASFA), passed in 1997, addresses goals and provisions that are intended to promote the safety of children, decrease the time required to achieve permanency, promote adoption and other permanent options, and enhance state capacity and accountability in regards to these concerns. Timelines within these provisions guide service planning, decision-making, judicial hearings, and termination of parental rights.

initiatives very appropriately serve all families involved. They make no distinction between families involved with the child welfare system and other families. However, they have not yet created specific strategies for reaching out to parents involved with child protective services who may be hesitant to seek support from the FSO's on their own.

- ***In two of the initiatives, continuity of care is a concern when payment for services comes from the referring agency and when children move out of the service area.*** In the first example, services may be disrupted when a child is initially referred for services by child welfare, permanency has been established, and the child welfare system's involvement is terminated. In spite of continuing service needs, the child may no longer be eligible for services through the initiative unless another referring service system re-refers the child and assumes payment for services. In the second example, children who may move or be placed outside of a county or community-based initiative's service area may no longer meet residency-related enrollment criteria.

- ***"Re-tooling" traditional service delivery systems and changing the ways providers do business remain a challenge.*** Working as a team in planning and care coordination, seeing families as partners and driving their own care, and shifting to a community-based care perspective represent major shifts for providers who offer more traditional behavioral health services. The provider agencies that serve children and families involved with the child welfare system, such as foster care, residential care, and group home services must also understand their service role in these new approaches to supporting children and families in the community.

- ***Developing service capacity and establishing special expertise continue to be a challenge.*** The initiatives are continuously working to increase service capacity. For children involved with the child welfare system, crisis response and support services, therapeutic foster home and respite care, residential care, post adoption services, and special services such as treatment for sexual abuse victims or sex offenders can be limited resources that require expansion and/or development.

- ***Linking outcomes to child welfare goals requires defining and using child welfare specific measures.*** Tracking progress on these measures specifically for children and families involved with the child welfare system is important for measuring program effectiveness from the child welfare perspective and for planning systems change. Designing systems that can support both the behavioral health and the child welfare systems' needs for information and data linkages remains a challenge.

- ***Keeping up the energy required for systems change and the risk-taking involved in forging new ways of delivering behavioral health services is a challenge for even the most successful initiatives.*** For child welfare services, pacing the work amidst busy schedules, large caseloads, families with complex needs, and tight timelines puts pressure on the system-building process that is essential to successful initiatives.

Description of Three Interagency Initiatives

Three sites are described in this section:

- Partnership for Children, New Jersey
- The Dawn Project, Marion County (Indianapolis), Indiana
- Massachusetts Mental Health Services Program for Youth (MHSPY), Cambridge and Somerville, Massachusetts.

The descriptions of each initiative are organized similarly, beginning with a brief overview of each initiative, a description of the population of children served by the initiative, the administrative structure of the initiative, and information about how the child welfare system in the site is structured. The remaining sections describe approaches used in the initiative to include and accommodate the child welfare system as a key partner in planning, implementation and evaluation. Features depicted in each initiative include:

- Collaboration: Involving the Child Welfare System
- Combining Different Goals, Values and Philosophies
- Accommodating Child Welfare Laws and Policies
- Partnerships with Families
- Funding Strategies
- Access, Screening and Assessment
- Services/Integration and Coordination of Care
- Information Sharing
- Training and Technical Assistance
- Evaluation

Highlights illustrate the child welfare system's perspective of the interagency initiative and specific strategies for meeting the needs of children and families involved with the child welfare system. Finally, each description addresses the impact that the interagency initiative has had on child welfare system practice and how the initiative in each site is moving forward and growing.

As mentioned in the introduction to this paper, the strategies described in this series of approaches are not intended to be "model approaches" that can be transplanted from one community or state to another. For a variety of reasons, what may work in one place may not work at all in another. However, we hope that readers will be able to see within the descriptions certain parts of the approaches that interest them. We also expect that readers will identify aspects of the approach that would need to change in order for it to work in their own locales. For additional information about specific sites, see the contact information that is provided at the end of each site description.

PARTNERSHIP FOR CHILDREN, NEW JERSEY

Partnership for Children[13], the children's system of care initiative in New Jersey, is a statewide behavioral health carve out (currently active in 7 counties), serving all children and adolescents (ages 5 to 21) with emotional and behavioral disturbances who depend on public systems of care, and their families. The population served includes both Medicaid and non Medicaid-eligible children with both acute and extended service needs. The initiative creates a single statewide, integrated system of behavioral health care to replace the previously fragmented system in which each child-serving system (i.e., child welfare, juvenile justice, mental health and Medicaid) provided its own set of behavioral health services. The NJ Department of Human Services is the state purchaser. The initiative uses a statewide administrative services organization and locally based care management organizations to coordinate care.

The goals of the Initiative are to:

- increase funding for children's behavioral health care
- provide a broader array of services
- organize and manage services
- provide care that is based on core values of individualized service planning, family/professional partnership, culturally competent services and a strengths-based approach to care.

Managed care technology includes:

- Contracted Systems Administrator (CSA), a statewide Administrative Services Organization (ASO)-type entity
- Care Management Organizations (CMOs) to provide local, individualized service planning and care coordination
- pooled resources (mental health, child welfare, juvenile justice, Medicaid, and new state funds)
- utilization review.

The initiative began implementation in January 2001 and will rollout by county or groups of counties over a five-year period. The CSA is under contract with full operational status under development.[14]

Population Served

Partnership for Children's intent is to serve all children in New Jersey (ages 5 to 21) who need its services. Ultimately, Partnership will offer three levels of care management:

- CSA care management (care coordination for all levels of need, i.e., joint case reviews, telephone case management for children with the lowest level of need)
- youth case management (children stepping down from more intensive services such as CMO, residential, or crisis support)
- CMO services.

For enrollment in CMO services, each child or youth must meet specific eligibility requirements: any child ages 5 to 21 who has a serious emotional or behavioral disorder; is involved with multiple service systems, and is in (or at-risk-for) out-of-home placement. When statewide implementation is complete, CMOs may

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[13] Formerly known as the New Jersey Children's System of Care Initiative

[14] Pires, S. (2003) *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems—1: Managed care design and financing. Tampa, FL: Research and Training Center for Children's Mental Health.*

serve as many as 4,000 children with complex needs. In addition, Partnership hopes to serve as many as 20,000 at the two lower levels of care, which will also include many children involved with the child welfare system and their families.

As of December 2002, CMOs are serving 878 children and youth. Of this number, 34% were referred by the Division of Youth and Family Services (DYFS). Of all those children being served by CMOs including those referred by DYFS, Mental Health, and Juvenile Justice, 75–80% of these children, at least initially, have some involvement with DYFS. More detailed demographic data information about those children involved with DYFS who are served by the CMOs are not yet available, but are under development.

Partnership for Children Administrative Structure

Partnership for Children is a single, statewide interagency initiative managed by the NJ Department of Human Services (DHS) with the assistance of a statewide ASO-type entity to coordinate, authorize, and track care for all children entering the system. Value Options, a for-profit commercial behavioral health managed care company, has been contracted as the Contracted Systems Administrator (CSA) to serve as the ASO. The CSA is not yet fully operational. Local (one per region) non-profit entities called Care Management Organizations (CMOs) are contracted to provide services to those children and adolescents who have the most intensive, complex service needs and multi-system involvement. Partnership is governed by a three-level, interagency structure that includes:

- ***Executive Oversight Board,*** comprised of the Commissioner, Deputy Commissioner, DHS Division Directors (including the Division for Youth and Family Services (DYFS)), and the individual in charge of Special Initiatives

- ***Partnership Management Team,*** a state-level structure comprised of representatives from the three divisions within DHS (DYFS, Mental Health, and Medicaid), the DHS team leaders from the Local Implementation Teams, and family representation

- ***Local Implementation Teams,*** in each region/county, headed by a team leader who is the local DHS representative and comprised of interagency regional and local managers (DYFS, mental health, county court), system partners (CMOs and Family Support Organizations), and family representation.

Medicaid is the "fiscal engine" for the "pooled" existing behavioral health service dollars from child welfare, juvenile justice, mental health, and Medicaid. Additional new funds are available through approval by the legislature, expansion in Medicaid covered services through the Rehabilitation Services Option, and use of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). The regional CMOs employ Care Managers who coordinate Child and Family Teams and individualized care for children and families. Clinical Supervisors provide supervision and support to the Care Managers. Each community with a CMO also has a Family Support Organization partner that provides advocacy, education, and support services within each CMO's service region. All service providers are contracted by the NJ Department of Human Services to provide behavioral health and social support services. The CMOs use flexible funds to buy individualized services and supports to augment provider capacity.

New Jersey Child Welfare System Structure

New Jersey is a state-supervised, regionally administered, and locally delivered child welfare system. The Division of Youth and Family Services (DYFS) is housed within the Department of Human Services. The central office Deputy Director of Operations provides oversight to four regional offices headed by Regional Assistant Directors. Each regional office has oversight for 5–7 counties and includes a foster care unit that carries out foster care recruitment, training, and facilitating foster care placements. A fifth Regional Director has statewide responsibility for the state's six Adoption Resource Centers (ARC) which coordinate all adoption related activities and services. Under the direction of their regional office, county offices deliver services through district offices (as many as two to three) with service areas determined by population density. In Partnership's design, the county

DYFS office (if only one office), district offices (if multiple offices) and the regional ARC relate directly to their region's CMO.

Collaboration: Involving the Child Welfare System

The catalyst for the creation of Partnership for Children was a Governor's Initiative to design an integrated system of behavioral health care to replace the previously fragmented system. Prior to the initiative, each child-serving system (i.e. child welfare, juvenile, justice, mental health and Medicaid) provided its own set of behavioral health services, in which most resources were consumed by the most restrictive and expensive services (psychiatric hospitalization and residential treatment). In response to the Governor's Initiative, the Commissioner of DHS formed an Executive Oversight Board (EOB) that included the DYFS, DMH, and Medicaid directors (all Divisions of DHS). The responsibility of the EOB was to address the reform objectives to improve access to and availability of services and to reduce categorical funding streams and fragmentation.

The DHS Commissioner, Assistant Commissioners, and Division Directors all took a "let's make this work" approach and made a commitment to creating a new service delivery system. This same group formally adopted system of care values and principles[15] to guide development of the new system. DYFS, a division of DHS, was involved in the initiative from the start with strong support from the Commissioner for child welfare's involvement and systems change.

At the same time, Medicaid, also a division of DHS, was re-writing its state Medicaid plan to include the Rehabilitation Services Option. The resulting Medicaid reform broadened the behavioral health service array and allowed services such as residential treatment and in-home services to be reimbursable by Medicaid. The Medicaid reform was a big impetus for further behavioral health care reform for children and families. In this way, Partnership began and developed "from the top down" within DHS, and over time, included Juvenile Justice as an additional partner. Efforts are under way to include Education, Substance Abuse, and other systems that serve children and families in New Jersey.

The child welfare services agency, DYFS, has been part of the initiative from the beginning as one of the "big three partners" in the Department of Human Services. DYFS is a clear force in the planning, development, implementation, and evaluation of Partnership for Children. DYFS has input at all levels of the initiative including advisory and policy-making roles, service design and delivery responsibilities, and supporting the collaboration from the state to the local level. DYFS has representation on all governing structures and is a main source of funding and referrals for Partnership. Specific strategies for involving and accommodating the child welfare system will be illustrated through this initiative description.

Combining Goals, Values, and Philosophies of Different Systems

The process to combine different goals, values, and philosophies in this multi-level, multi-agency statewide initiative is both simple and complex. Clearly, Partnership's beginning as a Governor's Initiative helped to set the overarching goals for the initiative within DHS. DYFS' role in the inception, design, and implementation has influenced the goals, values, and philosophy of the initiative

■ *Common Goals, Values, and Principles: Let's Make this Work*

DYFS' "let's make this work" approach has helped DYFS—from the state to local levels—support the agreed upon goals, values, and philosophies which are based on system of care concepts. DYFS, at the state level, committed full force to the initiative. County and local offices were somewhat more reserved, even though they felt the goals, values, and philosophies of Partnership for Children initiative were in line with their own—safe children, living in strong families in the community. They were skeptical about the real impact of a new system; how the new system would help children and families, and whether it would help DYFS close cases. The "let's make this work" attitude of

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[15] Stroul, B.A. & Friedman, R. M (1986). A system of care for children and youth with serious emotional disturbances (rev. ed.). Washington, D.C.: National Technical Assistance Center for Children's Mental Health. Georgetown University Child Development Center.

DYFS leadership helped local DYFS offices commit to working with the CMO, tolerate the challenges of a new and developing initiative, and focus on resolving problems. Some early, six-month indicators that the system could make a difference (e.g. access to care for children and families and closed cases with DYFS) held hope over skepticism, and reinforced the commitment to make it work.

■ *Administrative Commitment/Endorsement*

As a top-down initiative, Partnership began with strong administrative commitment and endorsement from the Governor's office to DHS and the divisions, including DYFS. At the local level, District managers and supervisors also expressed their support of the initiative. Local DYFS offices supported the initiative, hoping that children and families with the most complex needs could receive services to meet their needs. Administrative commitment and endorsement have sustained DYFS through the initiative's development, clarification of roles and responsibilities, and the work of creating a new system of care.

■ *Partnership Management and Planning Structures*

The involvement of DYFS in all levels of management and planning for Partnership contributes to inclusion of child welfare system goals and values in the initiative. DYFS participates in all of the entities described below:

■ *Executive Oversight Board* has changed somewhat within the DHS administrative structure since its initial role. However, this group retains policy-making responsibility and ensures "buy-in" from all divisions and departments, including DYFS.

■ *Partnership Management Team*, previously known as the Children's Initiative Management Team, reports to the Project Director, and includes the management staff from Partnership, liaisons from Medicaid, DMHS, and DYFS, and the DHS representatives from the local level. The Management Team is responsible for overall implementation of the initiative. DYFS has had representation on this team from the beginning of the initiative.

■ *State Implementation Advisory Committee*

This 40-person group meets monthly to provide input on the implementation of the initiative and to assist DHS in developing strategies to ensure that the reform's goals will be met. The Committee is chaired by the Deputy Commissioner and includes representation from providers, advocates, families and related government agencies, DYFS, DMHS, Medicaid, Juvenile Justice, Administrative Office of the Court, Division of Addition Services, Department of Education, etc. Workgroups within this Advisory Committee are established to focus on specific issues and activities. Families involved with DYFS are active members of the Advisory Committee and are intentionally part of every work group.

■ *Local Implementation Team*

The local implementation team meets once a month and includes representatives from DYFS, the courts, the Child and Adolescent Resource Team (CART), and from DMHS. The team has two main responsibilities. One is to develop and implement the initiative within the community and the other is to review referrals to the CMO and make enrollment selections. Each DYFS office has one person who represents DYFS on the Selection Team (a subset of the Local Implementation Team).

Having all system partners present helps to identify the most appropriate disposition for each child referred. Initially, virtually all children referred from all of the system partners had some involvement with DYFS. Now, through Partnership, only those children with an abuse or neglect issue will be served by DYFS. If a child is at-risk-of out-of-home placement due solely to behavioral health issues, he/she can be served by the CMO, and DYFS will not be involved.

■ *DYFS Fix-It Meetings*

The DYFS "Fix-It Meetings", between DYFS state and county staff and the CMO at the local level, take place as frequently as weekly and as infrequently as quarterly, depending on the maturity of the initiative in each county. The meetings are led by the county DHS Team Leader, under the guidance of the state-level DHS Operations Manager from Partnership. The meetings are a problem solving strategy to support DYFS system involvement and ensure county-to-county consistency so that services to DYFS children and families can be consistent throughout the state.

DYFS Fix-It Meetings address significant issues such as:

- roles and responsibilities of the DYFS and CMO workers;
- community resources;
- adoption procedures and DYFS roles;
- Adoption and Safe Families Act (ASFA) time lines; and
- permanency.

The meetings have led to outcomes such as:

- a core-training curriculum for DYFS workers on systems of care;
- orientation to Partnership and training about DYFS for CMOs, FSOs[16], and system partners;
- operational protocols.

■ *DYFS Liaison: State and County Levels*

DYFS liaisons at state and county levels have been actively involved in the planning, implementation, and evaluation of the initiative. The liaisons represent the DYFS perspective, provide input and guidance on various workgroups, and act as lead representatives from the child welfare service system. The state level liaison serves on the Partnership Management Team and the State Implementation Advisory. The local level liaison serves on the Local Implementation Team and the DYFS Fix-It meetings. They have played particularly important roles in influencing decision-making and policy development, leading state and local collaboration and partnership efforts, and problem solving within DYFS and across service systems.

■ *Existing System and Agency Collaboration*

Partnership's focus on capitalizing on existing cross-agency, cross-system relationships at the local level is an important factor in its success. Close affiliation of local agencies, where trust already exists, supports the process for sharing its goals, values, and philosophies within the initiative. For example, Partnership first became operational in Burlington County. This county's strong history of successful team efforts with all community agencies—including DYFS—and their experience working together set the stage for the local implementation team model. DYFS' expertise in working with youth with complex needs who are involved across systems, and particularly with juvenile court, boosted CMO referrals for these children in Burlington County as the initiative got its start.

■ *Role Clarification*

Role clarification between the DYFS worker and the CMO Care Manager has occurred through training, problem-solving, and ongoing interaction. Issues of control, as well as roles and responsibilities, had to be addressed. Orientation to the initiative focused on these issues, and for DYFS in particular, the role of the CMO Care Manager, the CMO's responsibility for the Child and Family Team, DYFS participation on the team, roles around follow-up, permanency, placement, and other details related to serving DYFS children and families. The early discussions and problem solving helped guide a training program as well as operational protocols that would assist new counties joining the initiative to make the CMO/DYFS interface go more smoothly.

Accommodating Child Welfare Laws/Policies

The leadership of DHS ensured that child welfare laws and policies were addressed in the design and implementation of the initiative. Many of the strategies included in this description illustrate that fact. A key strategy is highlighted below.

■ *Care Management Operation Manual*

Although Partnership is a young initiative and many policies are still in draft form, Partnership has produced a Care Management Organization Standards of Operation Manual and distributed it to all systems partners (CMOs, DMA, and DYFS managers and staff). The manual delineates minimum standards and

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[16] FSO, Family Support Organization

general operations for the Care Management Organization (CMO). It also helps to clarify roles and responsibilities by describing how the CMO will relate to DHS and to each of the key partners, including DYFS. It assists with decision–making by establishing procedures for integrating clinical and treatment issues with DYFS concerns related to safety, risk, and permanency.

Detailed protocols related to DYFS in the manual include:

- CMO/DYFS Care Management Procedures
    - Selection
    - Enrollment and Assessment
    - Outreach and Engagement
    - Crisis/Interim Service Plan
    - Child and Family Team Organization
    - Comprehensive Individual Service Plan (ISP) Planning
    - Implementation and Coordination
    - ISP Monitoring and Evaluation,
    - ISP Transition Planning
- DYFS Child Placement Review Board
- DYFS Interim Closing
- DYFS Medicaid Termination
- Roles in Placement and Discharge

The manual reflects the goals, values, and philosophies of the initiative and communicates a clear commitment to accommodate the child welfare system and its laws and policies.

Partnerships with Families

From the outset, Partnership made a commitment to involve families at all levels of planning, implementation, and evaluation. Parents plan for both their child and family's services and can participate in services offered by a formal family support organization.

■ *Family Involvement in Planning, Implementation, and Evaluation*

Right from the start DHS invited families to the table. Drawing initially on the New Jersey Parents' Caucus[17], a statewide family advocacy organization, DHS engaged families as active members on the State Implementation Advisory Committee and contracted with this same organization to facilitate the development of family support organizations throughout New Jersey. The continuing role of families is supported by the Family Support Organizations (FSOs) described below. Many of the families had DYFS involvement, either through voluntary placement of their children in residential mental health services through protective services, or as foster or adoptive parents. Under the direction of DHS, the CMOs and the CSA have agreed to recruit family members as staff, establish a family panel to assist with grievances and complaints, include family members in quality management, and request the assistance of the FSO's and or family members in conducting satisfaction surveys.

■ *Family-Centered, Strength-Based Approach*

A core value and principle of care in Partnership is a family-centered, strength-based approach to planning and intervention. Families play a central role in the health and well-being of their children. The family's goals, input, advice, and recommendations are essential to the process of the Child and Family Team and the Individualized Service Plan. The approach builds on family strengths and offers the tools and support each family needs. For families involved with DYFS, this approach empowers them as decision makers in a way that is strikingly different from previous experience where DYFS "told them what to do".

Foster and adoptive families acknowledge that their perspective and concerns are more seriously considered than before Partnership existed, and they "no longer

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[17] New Jersey Parents' Caucus, a coalition of families whose mission is to ensure that every family who has children with special emotional and behavioral needs is given an opportunity to play a strong and active role in the development and delivery of effective and timely services for their children. See their website <www.njparentscaucus.org>.

feel so alone" in caring for children with complex needs. Birth families stated that they feel listened to, respected, and that their "lives may have been different" if this approach and access to care had been available earlier. The CMO includes all family members in its services and makes access to services easier for those who need extra support. Although some families still feel the pressures of family reunification and the Adoption and Safe Families Act (ASFA) timelines, families describe their relationship to DYFS as "less adversarial". They describe the CMO as offering and coordinating individualized services to meet their needs.

▪ *Family Support Organization*

Family Support Organizations are full and equal system partners in Partnership for Children. Each CMO has a Family Support Organization (FSO) partner that provides advocacy, education, and support services to families; ensures family voice and participation in CMO service planning; supports family involvement in planning, implementation, and evaluation; and ensures fidelity to the initiative's principles of family-focused/family driven, child-centered service planning and delivery.

The Family Support Organization works with and on behalf of **all** families caring for children with complex behavioral health needs, many of whom have been involved with DYFS. Upon a child's referral to the CMO, a Family Support Partner[18] accompanies the CMO Care Manager to meet with the family in their home or at a location selected by the family. The Family Support Partner explains his/her role, describes FSO services, and offers a brochure and newsletter. Families choose their level of involvement with the FSO. Families are encouraged to take advantage of support services, become their own advocates, participate in training, and participate on committees and work groups. The FSO and its family members have participated in focus groups, work groups, and training activities specific to families involved with DYFS. They have spoken at DYFS trainings, met with DYFS Regional Directors, and provided input at the service level to sensitize DYFS and the CMO to the experience and needs of children and families involved with child welfare. DYFS values the support services provided by the FSO and sees them as accessible and responsive partners to help families take charge of their child's care. Families involved with DYFS, view the FSO as the "most useful family support service", able to understand their "real life situations", and responsive to families in crisis.

Funding

One of the goals of New Jersey's Partnership for Children is to increase funding for children's behavioral health care. The state has succeeded in doing this through a combination of increased federal Medicaid reimbursement and legislative approval for additional state funding. Existing funds from the divisions of Youth and Family Services (DYFS), Mental Health (DMHS), and Medical Assistance and Health Services (DMAHS, i.e., Medicaid) have been "pooled" to create the funding package for Partnership.

▪ *Pooled Funding*

To pool funds, New Jersey had to carve funds out of existing division budgets and appropriate them to the Medicaid division budget—not an easy task. In 1999, the state identified $167 million that it had been spending on children's mental health through services by examining the expenses of "mental health programs" in the Medicaid, Mental Health, and DYFS systems. With the help of a consultant, the state went program by program to determine which systems were paying for ones included mental health services and which onesdollars should become a part of Partnership. The programs selected and used as funding sources for Partnership are:

- Medicaid (inpatient psychiatric hospitalization and outpatient counseling funds—$24 million)
- Mental Health (psychiatric residential care and residential treatment centers—$26 million)
- DYFS (residential care, group home, and treatment home funds, youth incentives funds, and

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[18] A Family Support Partner is a representative of the Family Support Organization.

psychiatric/psychological/therapeutic intervention funds—$117 million)[19]

This amount, $167 million, became the target for the existing services budget for Partnership. Partnership began FY 2001with an additional $39 million ($10 million in new state funds appropriated by the state legislature and $29 million in new anticipated federal Title XIX (Medicaid) funds. The new Medicaid funds were attributable to residential treatment homes and group homes becoming Title XIX Rehab Option facilities. (See Maximizing Federal Reimbursement below.) The state appropriation allowed Partnership to pay for the Contracted Systems Administrator (CSA), the Care Management Organizations (CMO), the Family Support Organizations (FSO), as well as to serve children not covered by Medicaid. Two accounts were created in the Medicaid agency budget—1) residential treatment, group homes, treatment homes (federally reimbursed by Medicaid and by Title IV-E), and 2) expanded services—covering the CSA, the CMO, FSO, and other in-community children's mental health services.

Among the three agencies, DYFS contributed the most funds; however, it was not reluctant to participate in Partnership. Several factors contributed to this willingness to "buy in".

- From a **program perspective** the CMOs began serving the children in DYFS who were the most difficult to serve. They provided extra services and staff support for these children and their families. Partnership also serves families who, in the past, would have come to DYFS, not because of abuse or neglect issues, but to access treatment services for their children. Because families can now access behavioral health services through the community-based Partnership, they do not have to request them from DYFS.
- From a **fiscal perspective**, there was a spirit of cooperation because the top-level administrators in DHS wanted this to work. A great deal of discussion and negotiation occurred. Partnership was sensitive to the funds that DYFS needed to keep in its budget. DYFS was assured that it would not lose funding by participating in the funding pool. Partnership agreed to hold DYFS harmless for any net federal fund losses. Prior to Partnership, DYFS had a large budget for mental health and residential services. Carving this out of the DYFS budget allows DYFS to focus more on the issues of abuse and neglect, and less directly on providing mental health services.

- ***Maximizing Federal Resources***
- *Medicaid Reform*

At the time of Partnership's development, New Jersey expanded its Medicaid program by conversion from the Medicaid Clinic to the Rehabilitation Services Option. This has broadened the service array and made services such as residential treatment centers, in-home services, and others reimbursable by Medicaid. Partnership also uses the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) to screen children for involvement in Partnership. The use of EPSDT and the Medicaid Rehabilitation Option provides federal participation in services previously funded by state dollars (including DYFS funds).[20]

- *Handling Title IV-E Funds*

Title IV-E funds can be used to cover the room and board portion of treatment services for children who are eligible for Title IV-E through DYFS. Room and board is not an allowable cost under the Medicaid Rehabilitation Services Option. In order to charge IV-E for the room and board portion, the federal Centers for Medicare and Medicaid Services (CMS) approved a median calculation for rehabilitation and room and board costs. In the first year of Partnership, room and board costs were 38% of the cost of service; in another year, room and board costs were 41% of the cost of service. While payments to providers are seamless, the state charges the room and board portion of residential services to Title IV-E, as long as the child is eligible for Title IV-E.

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[19] Note the large amount of dollars that were spent by DYFS (i.e. child welfare and juvenile justice) on mental health services compared to the small amount spent by Medicaid and the Mental Health system. These differences are not uncommon and illustrate the reason that child welfare must be part of any interagency mental health reform initiative.

[20] Pires, S. (op. cit)

When DYFS closes a child's case, but the child remains in residential treatment with Partnership, the state has to pick up the room and board portion that had been covered by Title IV-E. For children referred to Partnership who are not in DYFS custody, there is no federal reimbursement for room and board; it is covered by state general revenue.

Allowable IV-E room and board expenditures are reported to DYFS as an extract file. Providers involved in Partnership have unique Division of Medical Assistance and Health Service (DMAHS) provider numbers. Each division within the Department of Human Services participating in Partnership is sent a copy of the monthly extract file and can retrieve the names of all the children for whom providers have billed. The divisions can aggregate costs for rehab services, for room and board, and for inpatient psychiatric/residential services provided by facilities accredited by JCAHO[21] .

- ***Medicaid as the Fiscal Engine***

Partnership controls how the funds are spent, but all of the funds are appropriated to the state Medicaid agency. Medicaid is the "fiscal engine" for Partnership and disburses funds on behalf of all of the children served. In effect, New Jersey has created a single payer system for children's mental health services, replacing what had been a confusing array of multiple payers.

- ***Child Welfare Providers Become Medicaid Providers***

Child welfare providers, who had previously received DYFS funds to provide services, became Medicaid providers so that they could bill Medicaid for the services that they had been offering to children involved with DYFS. The state provided training to help with their transition and offered them a $6,000 incentive payment to purchase an automated Medicaid billing system. This gives them access to on-line billing, which means they are paid promptly and cash flow problems have been reduced. Becoming a "Medicaid provider" has a positive image in New Jersey and was perceived as a step forward by many of the child welfare providers.

The state also examined the level of service need for children in residential treatment and in group homes to "bring order" to the types of children who were placed in different facilities. Consultants helped develop an assessment instrument that is used to determine individual child level of need. Thus far, this has resulted in two levels of care, thus far. They envision four levels when this effort is complete. The new levels also have resulted in rate increases for many providers; especially those whose rates have been historically low. The state allocated approximately $4 million to stabilize provider rates.

These strategies have enabled DYFS to maintain working relationships with already established providers and allowed continuity of care to children and families already being served by these providers. On the other hand, DYFS is concerned that using the same providers slows the development of "something new and more promising" and risks over-utilization of standard care.

- ***Operating Parallel Systems***

A complicating factor in all of the fiscal procedures that were created is that children are being gradually referred to Partnership. DYFS is operating a parallel system, i.e., making placements for residential care for children who are not yet enrolled in Partnership. Eventually, all of these children will be part of Partnership; but in the meantime, two systems are operating and must be accommodated with appropriate administrative and fiscal procedures.

Access, Screening and Assessment

In its current phase of development, access to Partnership's CMO services is determined by enrollment criteria as well as exclusive referral by child welfare, mental health, and juvenile justice. In addition, enrollment numbers are limited within each county where the CMOs are operational. In full implementation, the number of children who can be served will be greatly expanded.

- ***Roll Out and Implementation Plan***

As a new initiative, and a work in progress, Partnership has developed a five-year roll out and implementation

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[21] JCAHO – Joint Commission on the Accreditation of Healthcare Organizations

plan for its service delivery system. Since implementation in January 2001, Partnership for Children has been implemented in seven counties. The plan is to expand Partnership's CMO services to every county. In those counties where the CMO is operational, each county can refer 10 children per month into the initiative. DYFS, Mental Health, Juvenile Justice, and the Child and Adolescent Resource Team (CART) share these 10 spots, and three referrals are for DYFS children and families. DYFS continues to operate a parallel system through the initiative roll-out so that children who are not yet enrolled in the CMO can continue to receive services. This means that DYFS continues to make placements for those children who require intensive mental health services as well as refer to the CMO. Eventually, all of these children will be part of the initiative. For DYFS, the parallel system provides a way to continue care and offer services to many children across the state; however, during the roll-out phase, it creates confusion and extra work for DYFS workers who must understand and use parallel system procedures for the children in care.

■ *Enrollment Criteria*

Care Management Organization services are available to children, adolescents and young adults (ages 5 to 21 years) who have been determined by DHS (or the CSA when fully operational) to meet any one or any combination of the following eligibility requirements:

- serious emotional or behavioral disturbances resulting in significant functional impairment
- involvement of multiple agencies or systems
- disruption of a current therapeutic placement
- risk of a psychiatric re-hospitalization
- risk of placement outside the home or community, except for foster care placements, if they do not meet any of the previously listed criteria.

Presently, only the referring partners within DHS—DYFS, mental health, and juvenile justice can make referrals to the CMO. These criteria and the current enrollment processes enable DYFS to refer children with the most complex behavioral health needs and their families. If there is some disagreement about the appropriateness of a child for CMO level care, there is an appeal process, but Partnership supports DYFS' having final say, if DYFS believes the more intensive services are necessary. This position demonstrates Partnership's "no reject, no eject policy. In the future, when Partnership is fully operational, other provider agencies and families themselves will be able to make referrals through the CSA.

■ *Presumptive Eligibility for Medicaid*

Children with a serious emotional disorder and at risk or involvement in multiple systems have presumptive eligibility enrollment status in Partnership, regardless of whether or not they are eligible for Medicaid or NJ Family Care[22]. All children (both Medicaid and non-Medicaid eligible children) are issued a "system of care" identifier number that is tracked through the Medicaid agency's management information system. Most children and families involved with DYFS are eligible for the publicly financed system of care; however, for those who are not, presumptive eligibility eases access for all children and families.

■ *Internal Referral Process*

To make referrals to the CMO level of care each referring system uses an internal referral process. For DYFS, the children who are referred are those who have the most complex needs, are causing the most "ruckus" in the local office, or who are in a particularly volatile home or placement situation. The internal referrals go to the casework supervisor or district office manager, are prioritized internally, and then brought forward to the Selection Team (a subset of the Local Implementation Team).

For DYFS, the three monthly referrals from any one county have included one child from the adoption unit (child welfare has guardianship, and the child is in the process of waiting for adoption) and two from other child welfare services (foster care, detention center, ordered from the court to DYFS, child protective services). Once the children are identified for referral, they are brought to the Selection Team for selection and enrollment.

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[22] NJ Family Care is a federal and state funded health insurance program created to help New Jersey's uninsured children have affordable health coverage.

- ***Selection Team***

Currently, each county has a selection team, within the Local Implementation Team, comprised of representatives from DYFS, DMH, Medicaid, and Juvenile Justice, the FSO, the local CMO Director, and local providers. The DHS Team Leader is the convener of the local decision-making teams. Information from the internal referral process described above and the screening and assessment information is brought before the Selection Team. The responsibility of the Selection Team is to decide which children will be accepted into the CMO for that month. DYFS participation on the Selection Team has helped build working relationships with other agencies and across local systems; facilitated communication and linkages with the CMO; helped to coordinate care for those children served by DYFS and other systems; and given local DYFS office a sense of moving forward. Responsibility for the selection and level of care determination will eventually be transferred to the CSA.

- ***Families Access to Services***

Access to care for families (siblings, parents, etc.) will be expanded when Partnership is fully operational with the CSA in place to provide all levels of service. Currently, for a child enrolled in the CMO, any behavioral health issue for a sibling or an involved adult that has an impact on the enrolled child will be facilitated by Partnership. CMOs have flexible funds from which they may draw to pay for these services, but when possible the family member's regular coverage (e.g. Medicaid) is used to cover these costs. For example, if a DYFS worker has a court order for the parent of an enrolled child to have individual therapy, Partnership will find a provider and may or may not be responsible for paying for services—even though the order is to DYFS. In another example, the CMO responded to the whole family's concerns by arranging individual counseling for the mother, mentoring and a fitness program for a sibling, and child care so that the mother can attend meetings related to her son's care.

- ***Uniform Screening and Assessment***

Partnership has selected a series of Information Management and Decision Support Tools (IMDS) to use as uniform screening and assessment instruments. These tools were developed specifically for children referred to Partnership. All system partners, families, providers, and clinicians had input into the development and design of the tools. For example, DYFS recommended adding adoption-specific items, which were incorporated into the final form. All instruments include questions about safety, risk, current living situation, and terms relevant to DYFS. Presently, 750 local DYFS, Mental Health, and Juvenile Justice staff have been trained in the use of the screening and assessment instruments, establishing a common language for decision-making across child welfare, mental health and juvenile justice. Front line workers administer the instruments. Presently, the instruments are being used for the children referred for CMO services and presented to the Local Implementation Team/Selection Team. The assessment instruments include:

- *Initial Assessment,* completed by whoever is making the referral for services (including DYFS workers)

- *Crisis Assessment,* completed by the Children's Mobile Response Services and Stabilization Team when they are involved in crisis intervention

- *Comprehensive Assessment,* completed by the CMO, the residential treatment center, or whoever is responsible for the ongoing work with the child and family. In the future, every child in residential services, entering residential services, or entering foster care will have an assessment and information will go to the CSA to determine level of care for early planning and intervention.

Services/Integration and Coordination of Care

Partnership relies on a team approach for service planning and coordination. The service array includes traditional, non-traditional, and wraparound support services that are customized for individual children and families.

- ***The Child and Family Team***

The Child and Family Team is the main service planning mechanism for those children and families receiving services through the CMO. The team is coordinated by the CMO Care Manager and includes the child; parent, guardian, and other caregiver as appropriate; any other support persons the family requests; a representative from the FSO if desired by the family; a clinical staff person involved in the treatment of the child if desired by the family; and representatives from outside agencies in which the child is involved. The child's DYFS worker is always a member of the team and intimately involved in developing the Individualized Service Plan. These meetings can take place in the home, school, another facility, or the CMO office. The outcome of the team meeting is an Individualized Service Plan to which all parties have had input. Families involved with DYFS report that they feel listened to, "taken seriously", and in charge of working toward their "family vision".

DYFS reports that their participation on the Child and Family team has changed the way DYFS workers see families and the way that families see DYFS. The team approach has contributed to a better working relationship between DYFS and the family and positively influenced a family's progress toward permanency.

- ***Individualized Service Plan***

The Individualized Service Plan (ISP) focuses on more than behavioral health. It focuses on every domain in the child's life, including safety, risk and permanency. While the ISP may not be as detailed on these items as the DYFS service plan, all members of the Child and Family Team know how child protective services and court issues fit into the overall plan for each child and family and what the roles and responsibilities are for DYFS and other team members. Review and update of the ISP occurs every three months and more often if needed.

- ***Service Array***

Partnership offers a broad array of services including traditional clinical services and non-traditional services and supports. The service array includes assessment, acute inpatient hospital services, residential treatment center care, group home care, treatment home/therapeutic foster care, intensive care management, outpatient services, partial care, in-home services, wraparound services and family support, mobile crisis and stabilization services, and transportation. Many of these services were already in place in New Jersey's strong provider community. DYFS is concerned that contracts with and use of customary care providers will slow the expansion of new and more creative services.

New or expanded services that are in place —in-home services (behaviorists), wraparound services and family support (transportation), and mobile crisis and stabilization services—have provided effective supports to children and families involved with DYFS or at risk of out-of-home placement. For example, the Children's Mobile Response and Stabilization Services (CMRSS), is a new, statewide service offered by Partnership. Its intent is to help a child remain in his or her home, rather than being removed due to a behavioral problem/crisis. DYFS workers have found this service invaluable for maintaining youth in their present living arrangements for both foster homes and youth living with family and relatives. The CMRSS has maintained children in their current living arrangements in 95% of the cases in which they have been involved. In many situations this has avoided involvement with DYFS for some families. Intensive in-home services provided by behaviorists have also helped foster and adoptive parents to manage children in the home and to sustain a child's placement.

Information Sharing

Partnership and DYFS maintain their own record systems. Information is exchanged primarily within the service planning process. Partnership is implementing a central administrative record described below.

- ***One Record***

The CSA maintains one record for each child receiving services through the initiative. This record includes the Individual Service Plan generated by the Child and Family Team, as well as administrative, demographic, service delivery data, and contact case notes. DYFS will have "read only" access to these records on a "need to know" basis, and District Office contacts will receive training on the MIS system in the near future. DYFS is just starting its federally funded tracking system, SACWIS[23], which will be managed separately within DYFS; however, the DYFS coordinator for the SACWIS system is meeting with the CSA management information systems director to explore how the two systems may interface. Currently, the primary method for sharing information is the Child and Family Team Meeting and traditional release of information procedures and consent forms.

Training and Technical Assistance

Training and technical assistance is a significant strategy in Partnership for providing orientation to the initiative and building understanding between and across-systems.

- ***Training Services and Core Curriculum***

Partnership has a training design and plan determined and approved by the DHS Partnership Management Team and coordinated by a Training Coordinator. Training topics may be unique to specific system partners, system-wide, or targeted to the interface of two or more systems. The primary system-wide, core training provides an orientation to Partnership and to system of care values, principles, and approach. A wide variety of core operational and other topics focused on communication, confidentiality, and cultural competence are open to all system partners. One training in this group, Cross-System 101, provides basic information about each partnering system, including DYFS, its roles and responsibilities, laws, policies, mandates, and procedures. At the local level, a more focused four-hour training program (DYFS 101) is offered to local community partner CMOs and FSOs. This training has provided greater understanding between the local partners and improved working relationships.

DYFS-only training includes the core topics of the cross system curriculum, and provides one full day on how the DYFS role changes within the system of care. The decision to offer this training to DYFS separately from other systems is based on the significant shift in practice that DYFS caseworkers face in the system of care model. It is also important to note that most trainers for the DYFS 101 training are retired or former DYFS staff members who are well-versed in the content of the training.

- ***Local Training***

Those counties with active CMOs can negotiate training opportunities at the local level. One DYFS office described their CMO partners as very responsive to their requests for additional training on particular topics. The training activities have enhanced their working relationship.

Evaluation/Outcomes

Partnership's evaluation plan is a work in progress with support from the CSA and input from all stakeholders.

- ***Quality Assessment and Performance Improvement Program***

The Quality Assessment and Performance Improvement Program (QAPI) is the responsibility of the CSA, and not yet fully implemented. It will address structural performance in implementing the system of care, as well as service delivery to children and families, and outcomes of care. DYFS is a member of the QAPI committee that is broadly based and looking at quality through the whole system. The committee is currently reviewing more than 80 measures from which it will select what will work best for the state. SACWIS is not part of this effort and will be implemented separately within the DYFS system. However, there are data elements particularly relevant to DYFS children and families, such as crisis management, restrictiveness of living arrangement, placement stability, and reduction in residential treatment. At this point it is difficult to say what will be most meaningful to DYFS, but the mechanisms for DYFS involvement are clearly in place.

Impact on Practice in the Child Welfare System

- ***Re-focus on Protective Services***

In those counties where the initiative and CMO services have been in operation the longest (about one

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[23] Statewide Automated Child Welfare Information System

year), the most significant impact on practice is a reduction in the use of "emergency" foster home placements for children with complex behavioral health needs. The availability of crisis supports, partnership with other systems, and easier access to behavioral health services have allowed DYFS workers to re-focus on protective services and "do what they do best".

- ***Strength-based Approach and Family Group Conferencing***

DYFS is beginning to use Family Group Conferencing[24] within DYFS as a parallel process. For those counties in which the CMO is active and for those DYFS workers who have been part of the Child and Family Team process, Partnership has helped them to use a strengths-based approach with families. The initiative's impact on practice is limited, however, due to the small number of DYFS workers who currently have children enrolled for services with the CMO's.

- ***Placement Responsibility***

Responsibilities related to selecting, making, and coordinating a child's placement in a therapeutic setting are different for children enrolled with a CMO than they are for children who are not involved with a CMO. When a child in DYFS custody who is referred to a CMO needs residential treatment, the care manager from the CMO becomes responsible for identifying and coordinating the placement. As long as the child needs this level of therapeutic placement, the CMO care manager remains responsible. This change in placement responsibility reflects the shifting of costs of therapeutic care, as well as the responsibility for therapeutic placement coordination, from DYFS to the CMO. However, when a child improves and can return to a regular foster home or move to a permanent placement, responsibility for making and coordinating the non-therapeutic placement falls to the DYFS worker.

The implementation of Partnership enables parents to voluntarily seek therapeutic placements for their children without involvement with DYFS. The issues related to assessing parental responsibility for the cost of voluntary placement remains a challenge. Currently, families who become involved with DYFS or the court around voluntary placement of their children are assessed a sliding scale fee based on income through the county adjuster's office. Partnership has not yet created a mechanism for parents, who are not involved with DYFS, to contribute to the cost of their child's care while in therapeutic placement.

Going to Scale

- ***Roll-Out and Parallel Systems***

Since Partnership for Children is a statewide initiative, the concerns about going to scale are somewhat different than initiatives in other states that are only operating initiatives in one county or community. Rolling the initiative out county-by-county and system-by-system has its own challenges. There is a delicate balance between implementing statewide services (like Mobile Response and Stabilization), delivering county specific services (like active CMO services), and continuing a parallel system of services through the traditional model until Partnership is implemented statewide and is at full capacity. This dual system is difficult for DYFS workers. In counties where the CMOs are active, the 10 children per month limit (only three from DYFS), requires that DYFS workers make difficult decisions about whom to refer to which system and then meet administrative requirements for both. In counties where the CMOs are not yet in place, DYFS workers are eager to have CMO services to serve their most challenging children and families.

- ***Burlington Partnership Early Childhood Initiative***

Burlington County, the first county in which Partnership was implemented, is piloting an early intervention initiative and expanding their service population to children ages three to five years. Within Partnership's administrative and fiscal structure, Burlington County will utilize additional Substance

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[24] Family Group Conferencing, also known as family group decision-making, is a practical model that draws together family members supported by professionals and resources to craft a plan to meet child and family needs, especially safety. Developed for use in the child welfare system it is intended to be strengths-based, inclusive of extended family, and guided by respect for and empowerment of the family. Families self-define the support and services that they need.

Abuse and Mental Health Services Administration (SAMHSA) grant funds to mirror Partnership's system of care for these younger children. They will gather data that can influence the statewide reform efforts to include the early childhood population throughout the state. The lead agency for this new initiative is the Division of Mental Health Services and includes all the partners in Partnership for Children (including DYFS) as well as new partners from the early childhood community such as Head Start and day care centers. For DFYS, this initiative expands the population of children involved with the child welfare system and their families who will be served.

Contacts for More Information

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THE DAWN PROJECT, MARION COUNTY, INDIANA

The Dawn Project is a behavioral health carve out serving about 150 children daily, (ages 7 to18 and their families) in Marion County (Indianapolis), Indiana who have serious emotional or behavioral disorders, are involved in multiple systems, and are in or at-risk-for residential placement. About 655 youth and their families have been served since its inception in May 1997. The average length of stay in care is 14 months. The Dawn Project is sustained through financing from several state and county agencies (the state mental health agency, the state special education agency, the county child welfare agency and the juvenile court). Indiana Behavioral Health Choices (Choices), a non-profit care management organization, acts as the managed care entity and receives a per child/per month case rate.

The Dawn Project was created to:

- integrate care for children involved in multiple systems and their families (including the child welfare, mental health, juvenile justice and education systems)
- draw on the strengths of families to reduce long term system dependency and improve outcomes.

Managed care technologies include:

- a case rate of $4,254 per child per month
- Indiana Behavioral Health Choices, a non-profit care management organization
- care management, authorization for services, preauthorized services, utilization review
- an organized provider network
- information management with “real time” data.

The Dawn Project is well established in its service community and the state is considering Dawn Project-like programs in other locations throughout the state[25].

Population Served

For admission into the Dawn Project, each child must meet the same eligibility requirements:

- be between ages 7 and 18
- have a serious emotional or behavioral disorder (DSM IV diagnosis or a special education label)
- involved in multiple service systems, and
- in or at-risk-for, residential placement.

At the end of three years of operation, 47% of the children served by Dawn had been referred through the Marion County Office of Family and Children (MCOFC), and 33 % were referred through Juvenile Court. These trends have generally remained the same over time.

Of the referring and funding partner agencies, MCOFC is the largest referral source, utilizes the most services, and contributes the most funding to the Dawn Project. MCOFC funds those children involved with child welfare, as well as those involved with Juvenile Court. When compared to all children served by Dawn, children referred by MCOFC were more likely to be placed in residential centers (48% MCOFC; 27% all

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[25] Pires, S. (op.cit.)

Dawn) or living in foster homes (21% MCOFC; 10% all Dawn) at the time of enrollment. While enrolled in Dawn, these children involved with the child welfare system also , and incurrringed the highest costs for placement services (77% of all costs). The intent over time is to shift treatment, and thus costs, to more community-based services where children will be living in or outside of the family home.[26]

The Dawn Project Administrative Structure

The Dawn Project is an interagency initiative governed by a cross-system Consortium that includes state and county agencies. Consortium members include the state Division of Mental Health, the state Department of Education/Division of Special Education, the Marion County Office of Family and Children, and Juvenile Probation in Marion County as funding members. Other contributing members include families, youth, the Marion County Mental Health Association, school systems, City County Council, Department of Corrections, the Mayor's Office, service providers, and the family support organization, Families Reaching for Rainbows. The County Auditor serves as the central bank for the project's "braided" state and county funds. Choices employs Service Coordinators who coordinate Child and Family Teams and individualized services for children and families. Choices maintains and utilizes an extensive network of providers; and partners with a family support organization, Families Reaching for Rainbows.

Marion County Child Welfare System Structure

Indiana is a state-supervised, county-administered child welfare system. The Marion County Office of Family and Children (MCOFC) operates under the supervision of the state Family and Social Services Administration (FSSA). Child welfare, mental health, substance abuse and Medicaid services, as well as others, are housed within FSSA. Marion County child welfare workers are state employees and therefore paid by the state, while service dollars for children and families come from the local city/county tax base.

Collaboration: Involving the Child Welfare System

The catalyst for the creation of the Dawn Project was the high cost of out-of-home placements and growing failure to successfully reunify families for those children with complex behavioral health needs who were also involved with juvenile court and the child welfare system.[27] Juvenile Court and the Marion County Office of Family and Children, the Mayor's office and several children's services providers came together to closely examine these concerns. The Child and Adolescent Placement Project (CAPP) was created from this community planning process. The CAPP's role was to create a county-level system of care to serve these children and families, focus on permanency planning for these children, and to reduce costs of care. At the same time, a legislative study by state leaders in education, mental health, and child welfare discovered that access to care for treatment of children with serious emotional disorders was hindered by child serving agencies with separate funding streams and cumbersome administrative structures. With encouragement from the Robert Wood Johnson Foundation and the progress of Marion County agencies working together through CAPP, state mental health officials applied for and received a Mental Health Services Program for Youth (MHSPY) replication grant that began the interagency initiative, the "Indiana Cost Sharing Project"—later renamed, "The Dawn Project".

The county child welfare services agency, Marion County Office of Family and Children, was a founding force and leader in the planning and development of the Dawn Project. As a Consortium member and the largest funding agency, MCOFC has an ongoing role to make referrals, review outcome data, determine

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[26] Rotto, K, (2000). The Dawn Project Brief, Focus Topic: Child Welfare, internal communication.

[27] McIntyre, J., (2002) The Dawn Project - A New Day… A New Beginning: A Brief History and Guide to the Development of a System of Care in Marion County, Indiana (1996-2001). Indiana Behavioral Health Choices and The Dawn Project, Indianapolis, IN.

continuing and new directions for the initiative, and participate in ongoing planning and implementation activities. Specific strategies for involving and accommodating the child welfare system are illustrated throughout this initiative description.

Combining Goals, Values, and Philosophies of Different Systems

Agency relationships are the foundation of the Dawn Project. Building those relationships and combining the goals, values, and philosophies of different child-serving systems occurs through formal and informal structures and processes. Clearly, MCOFC's role in the inception of the initiative maximized the infusion of child welfare goals, values, and philosophy into the design and development of the Dawn Project. Reaching and maintaining a combined "culture" of shared goals, values, and philosophies across partner agencies is an ongoing process for the Dawn Project. Some of the strategies used to incorporate the child welfare system's perspective include the following:

■ *Common Goals/Common Ground*

Reaching a "culture" of shared goals began prior to the creation of Dawn. As the work of MCOFC, Juvenile Court, and the CAPP progressed, they were able to focus on a common goal of more effectively, and less expensively, serving children and adolescents with serious behavioral health concerns. This overarching goal helped all partners embrace the goals, values, and philosophy of the Dawn Project.

■ *The Consortium*

The Consortium meets approximately monthly and offers a formal and ongoing structure for combining goals, values, and philosophies. MCOFC is an active member of the Consortium, as well as the Consortium's Executive Committee, and participates in policy making for Dawn.

■ *Child Welfare Liaison*

A MCOFC administrative staff person serves as the county child welfare office liaison to The Dawn Project. This individual sits on the Consortium and participates in a number of task forces, work groups, and committees described below. Her responsibilities include representing the MCOFC perspective, communicating any information from MCOFC, answering any questions about MCOFC, coordinating internal referrals from MCOFC to the Dawn Project, and facilitating working relationships between MCOFC and the Dawn Project.

■ *Monthly Administrative Meetings and the Referral Committee*

Monthly administrative meetings offer an opportunity for liaison and supervisory staff from each referring agency to share information, solve problems, and review referrals to Dawn. The MCFOC liaison attends these meetings and presents the child welfare system referrals, communicates child welfare system issues, and engages in problem solving

■ *Multi-level Interagency Task Forces, Work Groups, and Committees*

Throughout the initiative's development and when new challenges arise, Dawn utilizes task forces, work groups, and standing committees to address many issues. Current examples include the Training, Education, and Communication Workgroup and the Referral Committee. Child welfare representatives are invited to participate on all of these various working groups. Generally, the child welfare liaison to the Dawn Project or other decision makers participate to represent the child welfare system's perspective and make relevant commitments of time, effort, and resources. In addition to helping to solve problems or address particular issues, the work group format and process help to facilitate cross-system understanding among partner agencies.

■ *Role Clarification*

Role clarification was an essential first step to establishing working relationships between front line staff—MCOFC Family Case Managers and the Dawn Project Service Coordinators. Roles and responsibilities are explicitly stated in the contract between the Dawn Project and MCOFC; however, there are challenges in aligning goals, values, and philosophies. For example, the MCOFC Family Case Manager's priority for permanency may conflict with the Service Coordinator's priority for a particular treatment. Each has to understand the goals, values, and mandates of the other before a compromise plan can be reached. Dawn and MCOFC have reached mutually understood and satisfying working relationships through monthly administrative meetings, problem-solving efforts (survey, focus groups, and feedback mechanisms), and cross system-training. If a compromise cannot be reached, there is a clear grievance policy and administrative process for working toward resolution spelled out in the Team Member Handbook.

- ***Provider Meetings***

Choices has worked hard to engage providers and bring them on-board with Dawn's approach to serving children and families and has focused particularly on those providers who serve children involved with the child welfare system. Initially, key residential care and therapeutic foster care providers met with Choices administrators to learn about Dawn, negotiate ways to work together, and implement changes in serving children and families. Dawn's goals, values, and philosophy represented a "new way of doing business" for these providers. In addition to clarifying their service role in the continuum of care, Dawn outlined the community-based care plan to support children and families and ways to partner with these providers and engage them in the Dawn team process. For example, bringing county-licensed, private treatment foster homes into the team approach presented a particular challenge. These treatment foster families already related to the provider agency, participated in its training, and related to a therapist with the provider agency for support, intervention guidance, and treatment planning. When they began working with Dawn, expectations and communication channels, roles, and responsibilities had to be clarified. The therapeutic foster care agency providers continue to meet regularly, but with less frequency, to deal with issues or problems that arise.

Accommodating Child Welfare Laws/Policies

The following strategies illustrate the ways in which Dawn accommodates child welfare system laws, policies, and mandates.

- ***Administrative Commitment, Investment, and Endorsement***

Administrative understanding and endorsement has helped operationalize and implement polices and procedures that support child welfare system laws and policies. Administratively, Choices has made a commitment to MCOFC as their "customer". Choices has invested time and energy to build relationships with key MCOFC administrators and has utilized the Consortium and other planning structures to learn about child welfare services and mandates. Within Dawn, administrative procedures and front line practices are in place to serve MCOFC children and families in ways that meet the needs of the child and family, as well as the child welfare system. For example, Choices worked with child welfare administrative staff to understand and deliver the specific data necessary for MCOFC to apply for reimbursement through Indiana's Title IV-E Waiver.

- ***Contractual Language and Obligations***

MCOFC maintains a contractual agreement with Choices that reflects the child welfare system. It addresses access to care, placement and permanency planning and outlines Dawn and MCOFC obligations related to referral, enrollment, case reviews, disenrollment, and payment. The contract incorporates ASFA[28] timelines and outlines a process by which MCOFC case reviews will be completed if Dawn indicates a need for longer-term out-of-home placement for treatment purposes than the timelines allow.

- ***Court Involvement***

The Judge for the Marion County Superior Court, Juvenile Division, was a founding member of the initiative. Strong court involvement and the special interest of this county judge has helped to clarify legal issues, procedures, and pressures related to children involved with the child welfare system who receive services through Dawn. A court order is required for a MCOFC child to participate in Dawn services and the

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[28] The Adoption and Safe Families Act

court order initiates the payment. The court's level of involvement is perceived as a benefit. For example, the judge supports the initiative's goals and philosophy and its approach to service delivery. Therefore, the court is willing to craft court orders that support interventions that include natural supports or nontraditional services.

■ *Front Line Practices and Procedures*

Specific front line procedures support child welfare policies. For example, when court reports have to be written by Dawn Service Coordinators, they are written according to child welfare time-lines and format. Case review schedules within Dawn have been set according to best clinical practice, but also consider the mandates of the child welfare system.

Partnerships with Families

Partnerships with families are integral to all aspects of The Dawn Project.

■ *Family Involvement in Planning, Implementation, and Evaluation*

Family partnerships are integral to Dawn's design and service delivery. Family members have been part of Dawn since its inception. They continue as members of the Consortium, workgroups, and training teams at conferences and presentations. Families also have opportunities for input and feedback as partners on the Child and Family Team and in regular meetings with administrative staff of Choices. Dawn also hires family members as Mentors. Early on, Dawn established a family support group, which over time has developed into a family support organization, Families Reaching for Rainbows (Rainbows).

■ *Family-Centered, Strengths-Based Approach*

A cornerstone of Dawn's services is its family-centered approach. The belief that families are resilient, have strengths, and can decide what they need drives Dawn's service planning and coordination process. Some families involved with the child welfare system described feeling listened to and supported. They felt that their input was "taken more seriously" now that they are involved with Dawn. However, other families interviewed were less positive. Foster families, who work for a community-based foster care provider and accept children from Dawn in their homes, complained that the many meetings and appointments involved in the Dawn approach detracted from "normal family life". In addition, working in tandem with Dawn and MCOFC, some foster, and potentially adoptive, families have felt "pressure to adopt" when discussing permanency planning for a child or adolescent.

Strength-based discovery is the core of the Dawn Project philosophy and approach to service delivery. It involves truly listening to families, recognizing them as equal partners, and facilitating individual child and family teams. The strengths discovery process involves drawing on the child's and family's strengths across life domains, and developing a plan for improved outcomes. This "new way" of doing business presented a challenge to MCOFC Family Case Managers and represented a major shift in working with families. However, MCOFC reports that it has made significant changes in the way it works with families. Involvement with Dawn has helped MCOFC begin moving to Family Group Decision Making,[29] even prior to the formal adoption of this approach by the state.

■ *Partner Family Support Organization*

Families Reaching for Rainbows (Rainbows) became the formal family support organization through funding by a Federal Center for Mental Health Services (CMHS) grant received in 2000 and sponsorship by the Marion County Mental Health Association and Choices. Rainbows is charged with providing support, advocacy, and education services to families enrolled in Dawn, as well as families in the general community with mental health concerns. Rainbows' membership is diverse, and includes a significant percentage of foster and adoptive families. In addition to regular meetings and training opportunities, once a month family gatherings at a residential facility provide oppor-

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[29] Family Group Decision Making is a practical model that draws together family members supported by professional and resources to craft a plan to meet child and family needs, especially safety. Developed for use in child welfare, it is intended to be strengths-based, inclusive of extended family, and guided by respect for and empowerment of the family. Families self-define the support and services that they need. Also known as Family Group Conferencing

tunities for families involved with the child welfare system to meet one another. Families involved with the child welfare system described feeling supported by Rainbows in their ability to network, learn from one another, and share experiences. They value the information they receive about the child welfare system, behavioral health services, and training opportunities. They perceive themselves as having potential roles as mentors or advisors to new families entering Dawn because they "know both systems". MCOFC respects and values the support that Rainbows offers to families, but sees Rainbows as a separate organization, with informal connections to MCOFC.

Funding

Dawn has successfully met its initial goal to create the financing strategies and administrative structures necessary for a blended-funding, case rate approach to children's services. Dawn operates on funds from child welfare, juvenile justice, special education, and mental health.

■ *Case Rate and Braided Funding*

The Dawn Project operates on braided dollars. Referring agencies are responsible for paying a monthly case rate for each of the children that they refer. MCOFC pays $4088 per child/per month for children referred by child welfare or juvenile justice. This rate, plus $166 per month contributed by the mental health system, covers all services provided by the Dawn Project to children and families involved with MCOFC. The Department of Education pays the same rate for each child referred. The Department of Mental Health (DMH) does not refer children into Dawn; instead, DMH health pays a much-reduced rate ($166) to support funding for **all** children referred to Dawn. This $166 is part of the total case rate as noted. Of the funding agencies, MCOFC remains the primary source of referrals and thus the main funder of Dawn.

■ *Centralized Bank*

A Memorandum of Understanding established the County Auditor as the central bank. Funds are transferred from each funding agency's budget to the County Auditor electronically. For billing and reconciliation of costs, Dawn submits monthly bills to each funding agency, including referral status and service utilization data. MCOFC and each of the other agencies review the bill and then submit a request to the County Auditor to make payment to Choices.

■ *Medicaid and Rehabilitation Option Dollars*

The majority of children receiving service from Dawn are Medicaid eligible. Medicaid does not cover residential services, a high cost service used by many children involved with child welfare. However, many of the community services used to support children in their return home or to the community, such as outpatient therapy, day treatment, acute hospitalization, and medical care can be billed directly to Medicaid. In addition, Dawn is able to utilize Medicaid Rehabilitation Option dollars to cover salary support for its Service Coordinators. This means that the children referred by MCOFC are receiving additional services without MCOFC having to pay a larger case rate or pay for these services directly.

Access, Screening and Assessment

Access to Dawn services is determined by eligibility and enrollment criteria that include specific descriptors of the eligible youth as well as exclusive access through the three referring agencies: child welfare, juvenile justice, and special education. Referrals are accepted through these agencies that fund out-of-home placement for children in Marion County as an alternative to residential placement, or to facilitate a return home after a placement. 30

■ *Enrollment Criteria*

The enrollment criteria reflect the intent of The Dawn Project's design which is to serve children with emotional and behavioral disabilities, specifically those currently in residential treatment or at risk of out-of-home care—either long-term inpatient psychiatric hospitalization or residential care—and who qualify for or are involved with two or more Consortium agencies. Referrals to The Dawn Project may only be made by juvenile justice (probation), child welfare (MCOFC) and special education—the funding

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[30] McIntyre, J. (op. cit)

partners for the Project. These criteria enable MCOFC to facilitate referrals for their most challenging children and families.

- ***Internal Referral Process***

All referring agencies use a common referral form, but each agency has its own internal referral process for identifying and prioritizing potential children and families who most need and can benefit from services through Dawn. For children and families involved with child welfare services, families first hear about Dawn from their Family Case Manager, who then initiates the referral. MCOFC referrals are made within the context of special team meetings to identify and discuss services for children in or at risk of residential care. At the beginning of the initiative, the Dawn coordinator attended these meetings to help communicate the nature of the Dawn Project, encourage referrals from child welfare, and to assist in identifying appropriate referrals. Presently, the MCOFC liaison facilitates the internal team meeting and any decision to refer a child and family to The Dawn Project. Once the decision to refer is made, the MCOFC liaison to Dawn presents the referral to the Referral Committee at the monthly Administrative Meetings. If the child is accepted into Dawn, Choices determines a start date. Dawn has a "no eject, no reject" policy, and has accepted every referral made to date, including all child welfare referrals. Dawn has the capacity to accommodate additional referrals.

- ***Court Order Requirements***

A court order is required for children who are wards of the court or on probation to receive services through Dawn and for Dawn to receive payment for services from MCOFC. Once a referral is made, Dawn accepts the referral and identifies a start date and MCOFC obtains a court order to authorize care. Court orders are issued either the 1st or the 15th of the month. Dawn may initiate contact with the Family Case Manager and the family just prior to the court order, but cannot formally serve or bill for these services until the court order is in effect.

- ***Uniform Screening and Assessment***

Once a referral to Dawn is complete, the Service Coordinator assigned to the child and family completes a screening and assessment utilizing the Child and Adolescent Functional Assessment Scale (CAFAS)[31] and begin The Strengths-based Discovery Assessment[32], a strengths-based planning process. These instruments were recommended by Choices and approved by the Consortium members, including MCOFC. Screening and assessment information is shared with Family Case Managers through a "staffing process" at the Child and Family Team meeting as well as written in the care plan in narrative form. The CAFAS scores are reported and then interpreted verbally at the Child and Family Team Meeting. The Strengths Discovery Assessment is shared with the Family Case Manager. Aggregate CAFAS scores are shared with the child welfare administrators and Consortium members as one outcome measure and indicator of Dawn's effectiveness and are used for evaluation and planning. MCOFC finds the uniform screening and assessment instruments useful in their contribution to information sharing, evaluation, and planning.

Services/Integration and Coordination of Care

Service delivery and service array have expanded to include traditional and non-traditional partners, providers, and services. A team approach and individualized care based on strengths and guided by the family voice, support integration of services across systems and services that work for families. Dawn relies on the Child and Family Team, a Service Coordination Plan, individualized services and internal administrative structures to coordinate care.

- ***Child and Family Team***

The Child and Family Team is the main service planning mechanism for those children and families

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[31] The CAFAS is a standardized instrument used to assess children's functional level across multiple life domains for children with emotional or behavioral health disorders.

[32] A structured, interactive conversation between children, families, and a "facilitator" (case manager, care coordinator, case worker, etc.) in which a family discovers its strengths, sets goals, determines major needs, and develop strengths-based options for meeting those needs. (John VanDenBerg)

receiving services through Dawn. The Dawn Services Coordinator takes the lead on facilitating a team approach by scheduling the Child and Family Team Meetings and coordinating all services. The team includes MCOFC Family Case Managers as the child welfare services provider, along with family members, natural supports, and other providers and agencies involved with a child and family. Family Case Managers report that this approach facilitates information sharing between Dawn and MCOFC, encourages cross-system planning, and expands intervention options. Role clarification between Dawn and MCOFC has been essential to working as a team. The family-centered, child focused team approach challenged Family Case Managers to share decision-making, and more significantly see parents as partners with equal voice.

■ *Service Coordination Plan and Individualized Services*

A Service Coordination Plan is developed based on the CAFAS, Strengths Discovery Process, and the Child and Family Team meeting. Every Service Coordination Plan contains a clearly defined crisis plan and clearly defined roles for team members, including family members and youth. In addition to addressing safety, every Service Coordination Plan also addresses the issues related to permanency—a plan for placement and/or reunification with family. Individualized services typically include a mix of traditional services and natural and community supports, tailored to build on the child's and family's strengths toward their desired outcome. Through experience with Dawn, MCOFC Case Managers began to think of services for children and families differently, in that traditional services could be combined with, or perhaps replaced by, non-traditional or natural support services with more positive outcomes.

■ *Family Services*

Families have access to services that support the individualized Services Coordination Plan for the child. Dawn reports often spending more time supporting families than providing service to the children. Linking families to community services and teaching them how to access and use services is a large part of the Dawn Service Coordinator's work. Community resources might include neighborhood centers, primary health care, jobs, different living arrangements, etc. Dawn sees these services as part of its advocacy role and building stronger and more resilient families. Birth and foster parents for one child can receive these supports simultaneously and are part of the same Child and Family Team meeting. This is particularly important for addressing the plan for permanency and reunification. For example, if a child is in foster care, Dawn works with the foster family and the birth family around home visits on weekends. While the child welfare Family Case Manager is ultimately responsible for what is required by court order, Dawn provides the supports toward family preservation.

■ *Service Array*

The Dawn Project utilizes over 500 service providers, including clinical treatment services and informal supports. The service array includes nine major categories of services: Behavioral Health[33], Psychiatric Health[34], Placement, Mentoring, Respite Care, Supervision, Care Management and Service Coordination, Discretionary Services[35], and Other Services. While all care is individualized for each child and family, Respite Care and Mentoring Services have been expanded based on the needs of children involved in child welfare. Respite Care was expanded and become a paid service as a result of the needs of children and families involved with the child welfare system. Dawn also supported foster parents to become respite providers for other foster parents. Respite services have helped to prevent foster home and birth home disruptions.

Mentoring has also been a particular support to help individual children negotiate transitions and

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[33] Behavioral Health services include behavior management, crisis intervention, day treatment, evaluation, family assessment and therapy, group and individual therapy, parenting skills, and substance abuse therapy.

[34] Psychiatric Health services include outpatient assessment and medication follow-up/review.

[35] Discretionary Services includes additional support services to families such as housing, security deposit, utilities, supplies, groceries, activities, medical clothing, restitution, damage repair, furnishings and appliances, etc.

movements so common with children involved with child welfare services. Currently, Dawn is exploring new services for children who are sex offenders, a population of children often involved with child welfare. Of additional note, Family Preservation[36] is a specific behavioral health service highlighted in the contractual agreement between MCOFC and Choices for Dawn services. Dawn Services of particular relevance to the child welfare system include:

- Family Preservation
- Foster Home – Non-therapeutic
- Foster Home – Therapeutic
- Group Home Care
- Relative Placement
- Residential Treatment
- Shelter Care (Guardian Home)
- Supported Independent Living
- Crisis Respite
- Planned Respite
- Respite —Residential or Hospital 23 hour.

■ *Placement Responsibility*

When a child is referred to Dawn for services, Dawn then accepts responsibility for addressing every need of that child, including taking the lead in arranging for placement. If the child is already in some type of residential facility, Dawn works to get a child into a home-like setting and develop wraparound supports with a philosophy of "one home, one kid". Dawn sees it as its job to make the placement work. When a child transitions into the new setting, Dawn designs intensive supports to make sure the transition goes well so that the placement is less likely to fail. Over time, responsibility shifts to the caregiver with community supports funding through resources other than Dawn. When services are in place and the child has shown sufficient improvement, Dawn can terminate services. MCOFC can terminate services when there is permanency—guardianship, adoption, or reunification with parents.

If adoption is the plan for the child, Dawn and MCOFC work as partners to identify potential adoptive parents. Potential adoptive parents are brought into the child and Family Team meeting to meet the child and to share information. Once an adoptive home is found, Dawn continues service to transition the child into the home. Once the adoption is complete, MCOFC must close the case and as a result, Dawn services are terminated. Post-adoption support must be arranged as part of the transition plan and come from the community.

Information Sharing

Information sharing related to the services for a child and family involved with the child welfare system takes place primarily within the service coordination process: the Child and Family Team Meeting, telephone and in person discussion, and formal informed consent release and exchange of records. Each agency maintains its own records.

■ *The Clinical Manager (TCM)*

Choices has a management information system called The Clinical Manager, (TCM) that offers a flexible, cost effective, and secure database. It keeps track of assessment information, treatment plans, Child and Family Team meeting minutes, clinical notes and court reports; maintains demographic information; and tracks authorizations, utilization, and billing information. TCM is also used to keep and track case review information.

■ *Co-location of staff and E-mail Communication*

Dawn and MCOFC staffs are located in the same building. They are able to meet informally, building relationships, and sharing information more easily. E-mail, a recent addition to MCOFC's technical resource, has also become a preferred communication mode. Both of these strategies support enhanced communication related to children and families involved with the child welfare system who are also involved with Dawn.

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[36] Family Preservation services are those outcome based, flexible, community-based services provided to families at risk of having a child removed from the home. They may include parent skill training, behavior management, family therapy, and crisis intervention.

Training and Technical Assistance

Training has been essential for sharing the goals, values, and philosophies of the multiple systems and agencies, as well as for understanding child welfare policies, laws, and mandates. In addition, training is a vehicle for change in program quality improvement.

■ *Systems and Technical Assistance Coordinator*

Choices employs a Systems and Technical Assistance Coordinator who among many tasks coordinates all training activities. She has had long-standing relationships with all agencies from the start of the initiative and has a depth of knowledge that helps to facilitate the relationship between Dawn and MCOFC. She has involved MCOFC in identifying training topics most relevant to families and children involved with the child welfare system.

■ *Training*

There are training opportunities for both Dawn and MCOFC at all levels—front-line staff, managers and supervisors, and members of the Consortium.

- Dawn has weekly, mandatory 90-minute meetings set aside for internal continuous improvement or training for their staff. MCOFC utilizes this time about twice a year for training Dawn's front line and supervisory staff on new and updated child welfare policies.
- The monthly Administrative Supervisory Meetings provide an open forum for training and/or problem solving.
- MCOFC has mandated training for two hours, twice a month. Choices has offered training at these sessions.
- The monthly meeting of the Consortium offers a forum for discussion and sometimes formal training. Dawn has taken advantage of this time to bring in a Child and Family Team to help Consortium members better understand the process. Consortium members have attended training events associated with Federal Grant meetings.
- With funding from a federal grant, Dawn hired a local consultant and created a 12—member, cross-system, cultural diversity team. This team has offered 2 hours of consultation to each child serving system, including MCOFC, in order to build cultural competence in the community.

■ *Team Handbook*

The Team Handbook is distributed to everyone on the Child and Family Team. Although Dawn created the handbook, the text was reviewed by MCOFC and the opening page is written by the Executive Council of the Consortium. The Team Handbook helps Family Case Managers and child welfare family members better understand the Dawn program.

Evaluation

The Dawn Project evaluation is guided by the Consortium's local evaluation plan as well as by the requirements of the Center for Mental Health Services grant awarded in 1999. The evaluation plan is supported by continuous improvement and problem-solving mechanisms, the technical capacity to collect and report data, and Dawn's formal research partner, Indiana Consortium for Mental Health Services Research (ICMHSR) at Indiana University.

■ *Defined Outcomes*

The Consortium identified an Outcomes Committee (one of the work groups) to look at outcomes, demographics, and other measures that would help the Consortium decide if the Dawn Project was "working" or "successful". This past year, the Committee revisited the outcomes and created a set of indicators. To ensure their participation, MCOFC reviewed the Committee's work and approved the indicators. The Outcome Measures apply to all children in the Dawn Project and identify indicators of improved child and family functioning. Those most relevant to child welfare's own mandates and outcome reporting requirements focused on "improved records" with the child welfare and the juvenile justice system. Specific indicators were percent of families with no further substantiated incidences of child abuse or neglect which resulted in removal of the child from the home (during involvement and again six and twelve months after disenrollment) and fewer days in out-of-home placement[37].

■ *Quality Monitoring*

Choice's uses satisfaction surveys to help ensure quality and customer satisfaction. Dawn held a focus group and circulated surveys among MCOFC's workers and their supervisors to determine Family Case Manager satisfaction with the Dawn Project. In addition, Quarterly Reviews are required by the Child and Adolescent Project (CAPP) at the Juvenile Court to assess any children enrolled for 15 months or more. Progress toward permanency, details of the child and family situation, and barriers to case closing are examined and discussed by the Choices Service Coordination Team in response to questions by CAPP. The Choices Service Coordination Team includes a supervisor, Dawn Service Coordinators, and their assistant case managers. Others who participate in these quarterly reviews include representatives from MCOFC and Probation, Larue Carter Hospital, the Department of Corrections, and Families Reaching for Rainbows.[38] [39]

■ *Data Reporting and Utilization*

Choices tracks outcome data with the TCM[40] system. Using data generated by TCM, Choices provides service and cost information back to the funding agencies in an annual report. The report includes the number of children served, how much was spent, and what services were utilized across the three referring agencies. Reports of demographic information, as well as placement at referral, and, referral source are distributed at the monthly Consortium meetings. MCOFC finds this information useful for evaluation and planning. MCOFC's perspective is that 80% of children involved with the child welfare system who enter Dawn have successful outcomes. For the other 20%, either decisions have not been made or the Court has remanded the child to the Department of Corrections and Dawn's involvement is terminated.

Impact On Practice in the Child Welfare System

■ *Family-centered Approach*

Dawn's family-centered approach has had a significant impact on the way that MCOFC's Family Case Manager's do business. Family Case Managers who have worked with Dawn describe a "fundamental difference in the way we deal with families." Although they clearly remain an arm of the court and responsible for ensuring child welfare mandates, they have shifted to family-centered work, where parents are partners and working from strengths rather than a deficit model. Based on the experience of the interagency initiative, MCOFC has changed its case planning process to the Family Group Decision Making model prior to its formal adoption by the state. Similarly, the court is also looking at the outcomes of the family conference to make its orders.

■ *A Systems Approach*

MCOFC reports that the experience of being part of the interagency initiative has encouraged them to take a broader systems approach—both to planning and implementation. MCOFC is working toward building better connections with school systems, and the state is initiating cross-system projects in other areas of the state.

■ *Use of Non-traditional Supports*

MCOFC reports that Dawn has expanded MCOFC's ability to access services in new ways. Dawn's use of non-traditional supports has helped Family Case Managers think more creatively and further individualize services for all the families they serve. Family Case Managers with Dawn experience now look beyond the traditional behavioral health services. Ultimately, this new perspective builds more community supports around children and families

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[37] Rotto, K. (Spring/Summer 2002). The Dawn Project: 500 Kids, Five Years, and Still Counting. *Data Matters: An Evaluation Newsletter*, pp. 4–6. National Technical Assistance Center for Children's Mental Health, Washington D.C.

[38] Zimmerman, B. et al., (2001). *Mental and Physical Health: Barriers to and Strategies for Improved Integration*. Washington, D.C: Health Systems Research, Inc.

[39] McIntyre, J. (2000). Dawn Project Update - Dawn Project Accountability: Data Collection and Analysis, Quality Monitoring, Reporting and Evaluation. Retrieved from http://kidwrap.org.

[40] The Clinical Manager

involved with child welfare, can support the goals of child welfare services, and reduce costs.

Going to Scale

- ***Federal SAMHSA CMHS Grant***

In 1999, the federal Center for Mental Health Services awarded Health and Hospital Corporation of Marion County (an Indianapolis government entity), a six-year pilot project to build an integrated system of care for children with serious emotional disturbances and their families. The project's administration was subcontracted to Choices and "added" to Dawn's services, expanding Dawn's approach to a broader population. The project serves youth who are ready to come home from state hospitals; youth who were previously enrolled in the Dawn Project, but placed with the Indiana Department of Corrections; and children who are "at risk" of out-of-home placement but who have not been removed from the home or had any inpatient or residential behavioral health care. These children, who may or may not have child welfare services involvement, are showing positive outcomes. This grant has expanded the access to care for MCOFC children and families; provided access to the family support organization, Families Reaching for Rainbows; and supported a more rigorous evaluation component.

- ***Replications***

In the spring of 2000, the Indiana Division of Mental Health (DMH) and Family and Children funded start-up costs ($50,000 each) for seven new Dawn-like programs at four community sites and three rural sites around the state to replicate the Dawn Project. One year later, this number has expanded to include seven additional communities, some of which are combined counties. Choices/Dawn won DMH grant funding to act as a technical assistance provider to these sites and is facilitating the planning process in each of these communities. The planning process focuses on the unique needs, resources, and potential partnerships for serving the population each community identifies as their focus. Within Choices, the model for Dawn has been applied to operate a similar program for homeless adults who are mentally ill. Choices also has recently been awarded a contract in Hamilton County, Ohio to administer a model similar to Dawn.

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MASSACHUSETTS MHSPY
CAMBRIDGE AND SOMERVILLE, MASSACHUSETTS

The Mental Health Services Program for Youth (MHSPY) in Cambridge and Somerville, Massachusetts, is an integrated physical-behavioral health managed care initiative serving Medicaid-eligible children in the Cambridge and Somerville communities who have persistent symptoms of serious emotional disturbance, risk of out-of-home placement, significantly impaired functioning and multi-agency involvement. Initiated as a one year Robert Wood Johnson Foundation collaboration demonstration grant in 1997, the pilot program was included in the state's Section 1115 Medicaid waiver in July of that year. Presently, the purchasers are several state agencies, including Medicaid, child welfare, mental health, juvenile justice and education. The system has the capacity to serve 100 children (ages 3–18) at any given time, and the average length of stay is 16 months.

The goal of MHSPY is to integrate primary health care, mental health, substance abuse, social support, and non-traditional services for children and adolescents with severe behavioral disorders within an organized system of care.

Managed care technologies include:

- A case rate of $3,283 per child/per month (includes physical and behavioral health care)
- Management by Neighborhood Health Plan, a non-profit health maintenance organization and managed care entity

MHSPY is well established in its two initial service communities and has recently expanded to three additional communities—Malden, Medford, and Everett.[41]

Population Served

For admission to MHSPY, each child must meet the same eligibility requirements:

- be between the ages of 3 to18
- live within the service area
- be eligible for MassHealth/Medicaid managed care program
- be eligible for services from at least one other of the partner or purchasing agencies
- have a score of 40 or higher on the Child and Adolescent Functional Assessment Scale (CAFAS)
- have persistent functional impairment (symptoms for at least six months, expected to persist for at least one year)
- be "at risk of placement outside the home", or be ready to return home from such a placement
- have an adult who can be expected to participate in service planning.

MHSPY provides services to about 100 children and has a short waiting list. Initially, 90% of children referred to MHSPY had some involvement with child welfare services; including those for whom the Department of Social Services (DSS) was not the primary referral source. Presently, this number has shifted to 74%, due to an increase in the number of referrals from other purchasing partner agencies. Over 50 % of the children in MHSPY are involved with three state agencies. Of the referring and funding partner

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[41] Pires, S. (op. cit.)

agencies, DSS remains the largest referral source. Of those referred by DSS, only one percent (1%) are in out-of-home placement. The children referred are primarily those who receive child protective services from DSS in their own homes.

MHSPY Administrative Structure

MHSPY is an interagency initiative administered by Neighborhood Health Plan (NHP), a health plan that primarily serves members of MassHealth, the state's Medicaid managed care program. MHSPY is governed by an interagency Steering Committee that includes senior staff from the central, regional, and area offices of the state Departments of Education, Mental Health, Social Services, Youth Services and Medical Assistance; parents; and senior managers for NHP/MHSPY. Medicaid serves as the central bank for the "blended" state funds from the five stakeholder agencies listed above. Neighborhood Health Plan is a non-profit health maintenance organization and acts as the managed care entity. NHP/MHSPY employs Care Managers who coordinate Child and Family Care Planning Teams and individualized services for children and families; manages the system; and provides directly, or contracts for, medical, behavioral health and social support and wraparound services[42].

Massachusetts Child Welfare System Structure

Massachusetts is a state-supervised, regionally administered, and local area delivered child welfare system. The Department of Social Services (DSS) is one of fifteen agencies housed within the Executive Office of Health and Human Services at the state level. Included among those agencies are the departments of Mental Health, Youth Services, and the Division of Medical Assistance.

Collaboration: Involving the Child Welfare System

The creation of MHSPY was inspired by two individuals concerned about health and behavioral health services for children and families, clinical guidelines, quality care, and the impact of managed care. The two individuals, a child psychiatrist and director of child and adolescent services at Harvard Pilgrim Health Care (HPHC) and the former Commissioner of Social Services in Massachusetts, shared a vision of coordinating care across systems to truly meet the needs of children and families. Together, with strategic support from the Medical Director of HPHC, the state's largest HMO, they began conversations about these issues among the state's Division of Medical Assistance/Medicaid, the Executive Office of Health and Human Services, child serving agencies (mental health, social services, juvenile justice, public health, and mental retardation), the Department of Education, and consumer advocacy groups.

The focus became children and families, enrolled in Medicaid, with severe and persistent mental health needs and for whom access, coordination, and a continuum of care within the current service delivery system was problematic. These children were at-risk-of out-of-home placement. The challenge was to offer coordinated services and integrated medical care delivered in a managed care setting that would be consumer oriented, accountable for outcomes, and maximize funding sources. The Departments of Mental Health took the lead in applying to the Robert Wood Johnson Foundation for initial funding through a planning grant opportunity.

A number of influences led to including the Department of Social Services (and other agencies) in the initiative. These were:

- grant requirements for an integrated and interagency care model
- advocacy by a former DSS Commissioner
- leadership of the Executive Office of Health and Human Services, which includes Mental Health,

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[42] A term commonly used to describe those services identified through the "wraparound process or approach" that uses family strengths, preferences, and cultures to develop individualized plans of care and improve the lives of families with complex needs. Most often, these services are provided in a community setting and include non-traditional forms of support or intervention

Medical Assistance, Social Services, Youth Services, and Public Health.

Initially, a Regional Director for DSS, who had close connections with the former Commissioner of Social Services and leaders in the Department of Mental Health, was "invited to take a look" at the planning grant written by DMH and see how it might reflect or relate to the interests of DSS. The proposed project held great appeal to DSS since it had been experiencing decreased access to mental health services through the mental health system and felt the major responsibility for serving the children with complex needs that the MHSPY project proposed to serve.

Once invited to join the initiative, the Massachusetts Department of Social Services has been an active partner in planning, development, implementation, and evaluation of the MHSPY program. DSS is a champion for the project and has a leadership role as a key stakeholder, holds membership on the Steering Committee (state, regional and area representation), and is a major purchaser of services with the greatest number of referrals to the program. Specific strategies for involving and accommodating the child welfare system are illustrated throughout this initiative description.

Combining Goals, Values, and Philosophies of Different Systems

Although DSS easily agreed with some of the MHSPY's goals, values, and philosophy around integrating care, it had a number of concerns. These concerns stemmed from historical inter-agency experience; risks associated with a new model, and, in particular, blended funding; and different philosophies between the medical model and the social work model of care. For example, previous DSS experience with other systems included dealing with strict eligibility criteria that led to children being shifted between agencies and disagreements about who was responsible and who should pay for services. Also, DSS felt a responsibility to the child and the "whole family" and wanted to refer families for services, in addition to the identified child. DSS felt that the medical model was more individually and clinically focused (DMH) and only allowed for direct services to the identified client (Medicaid and NHP).

A long project development process—17 months—provided time to sort out different agency cultures and align support for MHSPY. High level administrative commitment to the project, trusting personal relationships, the Project Director's understanding of DSS concerns, the work of the Steering Committee, education and training by MHSPY, problem solving efforts at the Area Level Operations Team (ALOT), and relationship building at agency liaison level have all worked toward supporting and reinforcing the goals, values, and philosophy of DSS and MHSPY.

This has been a continuous process supported by various mechanisms to promote collaboration between DSS and the other MHSPY partners. Some of these promising practices include:

- ***Departmental Investment, Endorsement and Commitment***

In spite of a somewhat tenuous beginning, the Department of Social Services continues to have a strong commitment to finding ways to better serve children with complex behavioral health needs and their families in integrated and cost-effective ways. This commitment extends from the highest level in the Commissioner's office to front line staff who have witnessed the positive impact on the children and families they serve. DSS has invested staff time in planning, implementation, and evaluation and reports positive results. DSS has endorsed MHSPY and "championed" the approach to other agencies.

- ***Steering Committee***

Steering Committee membership includes **state level** (Commissioner or Assistant Commissioner) representation from each of the partner agencies. The Steering Committee initially guided the development and implementation of the initiative, and now meets monthly to set overall policy and review the performance of the program. DSS fills two slots on the Committee —one filled by the Assistant Commissioner of DSS and the other with a Regional Director who has been part of the initiative from its start. DSS representatives on the Steering Committee provide the child welfare services perspective and input to influence policy and program development.

- ### *Area Level Operations Team (ALOT)*

The ALOT is a group of **mid-level** representatives from each purchasing agency who review and prioritize referrals to MHSPY, review enrollment, serve as an interagency management and problem-solving resource, and facilitate collaboration between agencies and between members of MHSPY Care Planning Teams. DSS representation on the ALOT team includes an area level Program Manager who interacts with DSS supervisors and front line staff. The DSS Regional Director on the Steering Committee also attends ALOT and facilitates communication between the two entities, providing continuity in combining goals, values, and philosophies. A third DSS voice on the ALOT is that of front line staff members who are part of the MHSPY Care Planning Teams. The ALOT serves as a forum for problem-solving, relationship-building, and review of program elements, progress, and recommendations. MHSPY uses the ALOT meetings as a forum for training and/or sharing evaluation and outcome data as well.

- ### *Agency Liaisons*

Agency liaisons are a third building block in the effort to encourage collaboration. MHSPY Care Managers each serve as liaison to one of the four partner agencies. In this role, they solicit input and feedback about the initiative and consult regarding referrals. In addition, they provide an important connection at the supervisory level between the ALOT and the Care Planning Team which was initially overlooked. From the DSS side, the area program manager is viewed as the DSS liaison to MHSPY and helps to link the two agencies as well as mediate differences. Initially, the DSS liaison encouraged referrals “in-house” by working with the project’s Enrollment Coordinator, sharing information about the program, and relating the potential benefits of the program to DSS mandates, including access to services for some of the most challenging families. These efforts helped to build interest, trust, and belief that MHSPY would be helpful to DSS.

- ### *Staffing and Hiring Practices*

Another mechanism for building alignment is staffing and hiring practices. Specifically, the Enrollment Coordinator and several Care Managers had “cross-over” experience or roles and responsibilities linking DSS and MHSPY. The Enrollment Coordinator in particular played a pivotal role in helping DSS and MHSPY work together. The Enrollment Coordinator is a shared employee of DMA and DSS who has 19 years experience in the local child welfare services office. Her knowledge of DSS values, philosophy, and practices and her understanding of MHSPY serve as a act as a bridge between front-line workers and the MHSPY program. Informal coaching and networking facilitated referrals and enhanced her success in linking families to MHSPY. MHSPY Care Managers with previous experience as DSS workers have reinforced DSS goals and values at MHSPY as well. Concretely, they have brought the DSS curriculum for parent education to MHSPY for implementation. DSS also participates by selectively hiring workers who are more collaborative in spirit and willing to support a team approach to serving children and families.

- ### *Role Clarification*

Clarifying the roles of DSS workers and MHSPY Care Managers is an ongoing process. DSS and MHSPY have come to understand each other’s perspectives and mandates and share belief in the importance of safety for the child. MHSPY Care Managers have expanded their clinical view to include understanding a family’s basic needs and child welfare system’s role in support services. Supervisors from both MHSPY and DSS reinforce the team approach and have a conflict resolution process to resolve problems. If there is a problem that cannot be resolved at the worker level, the two workers meet together with their agency managers and work to reach resolution.

- ### *Existing Child Welfare Service System and Agency Collaborations*

The Cambridge and Somerville Area was a likely choice for the MHSPY initiative because historically the area has engaged in collaborative efforts, for example, a provider network with a self-sustaining interagency group. DSS was part of this networking group that began

10—11 years prior to MHSPY. These well established, continuous over time relationships offered fertile ground for the MHSPY pilot and strengthened the interagency and community-based services approach.

Accommodating Child Welfare Laws and Policies

Many of the preceding strategies also contributed to accommodating child welfare laws and policies. DSS's early involvement, role in governance, and local implementation, as well as problem-solving approaches, all influenced operational processes to meet child welfare's regulations. Of the three initiatives discussed in this paper, MHSPY can more easily adapt to child welfare laws and policies, because the children involved with DSS and served by MHSPY are, by in large, those children who remain in their own home and are "at risk" of out-of-home placement. Therefore, timelines related to permanency do not apply. The following promising strategies illustrate some specific ways that MHSPY and DSS negotiate requirements of the child welfare system.

■ *Care Planning Team Meetings —Safety First*

Monthly Care Planning Team Meetings are the primary vehicle for information exchange and designing individualized child and family services. DSS workers are always a member of the team for children they refer, and are required to attend every meeting. If the child was referred by another purchasing agency and DSS is involved with the child or family, the DSS worker is invited to the meeting with the family's consent. The MHSPY Care Manager, in charge of facilitating the team meeting, is aware of the DSS mandates. Safety concerns are always addressed first, before anything else can be planned. The resulting Crisis/Safety Plan within the Care Plan outlines roles and responsibilities in the event of a crisis, such as circumstances that may disrupt a placement or increase risk of out-of-home care.

■ *Time Limits for Services*

Unlike the other two initiatives, MHSPY works primarily with children who remain in their own homes and are not in the custody of DSS; therefore, ASFA[43] timelines do not play such a significant role. However, DSS is concerned about remaining involved with families for whom safety has been ensured and the risk of out-of-home placement has passed. MHSPY can offer services to a child and family for as long as intervention is needed and as long as the referring agency is involved with the child. DSS on the other hand, may be ready to terminate its services, but feel some pressure to continue its role so that the child can remain enrolled in the MHSPY program. This challenge has prompted MHSPY and the Steering Committee to negotiate time lines, to consider 18 months as a benchmark for service, and to explore ways to maintain services when DSS terminates its involvement.

Partnerships with Families

Family partnerships and family empowerment are firm values of the initiative. In spite of a somewhat tenuous beginning, family involvement has grown and is part of planning, implementation, and evaluation.

■ *Family Involvement in Planning, Implementation, and Evaluation*

Families have been part of each phase of planning, implementation, and evaluation. Initially, involved family members were those parents recruited from the Project Director's medical practice who had been involved with DSS. They spoke about their experiences and the need for appropriate care and services. Formal family representation by trained consumer advocates on the Steering Committee was achieved nine months into project development. MHSPY recruited parents from each of the pilot communities as Parent Partners who provide support services to enrolled families. MHSPY also invites involved parents to become advisors to the project to help further develop the family support program. All parents/caregivers participate in evaluation through the Parent Satisfaction Survey administered by the Enrollment Coordinator.

■ *Family-Centered, Strengths-Based Approach*

MHSPY stresses a family-focused approach, having families at the center of the care planning process, and building on family strengths to improve outcomes and

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[43] The Adoption and Safe Families Act

reduce system dependency. Families are decision-makers in their own care and for that of their child. DSS families describe MHSPY as a "turning point" to reclaim parental power and the courage to change. DSS parents describe experiences with the child welfare system that left them feeling "powerless" and perceived as "a problem". The care planning process encourages parent input and helps parents from DSS feel valued and validated through the strength-based and family-centered approach. As one parent said, "MHSPY allowed me to be a player…, gave me dignity, …my integrity…and they raised me up."

■ *Parent Coordinators*

MHSPY employs two individuals as Parent Coordinators. Both coordinators have been service consumers and bring their own experience to their work with families in MHSPY. They participate in the state's family involvement movement through the Federation of Families and the Parent Advocacy League. They offer peer counseling to new parents in the program and coordinate regular family nights and support activities for families. Families from DSS describe the family support activities as helpful in meeting other parents, having a night out, and sharing ideas. Others thought that more support for new foster parents and more frequent gatherings would be useful.

■ *Parent Partners*

Parent Partners are parent peers, paid hourly by MHSPY, to support parents in the planning process of the Care Planning Team, to help them to identify and set functional goals for themselves and their children, and to work with them toward these goals. Parent Partners are regular members of the Care Planning Teams and have clear responsibilities set forth in the Care Plan. A DSS family expressed great affection and appreciation for their Parent Partner who made weekly visits to the home to help fill out forms, offer support, and "help with whatever comes up."

Funding

MHSPY's funding strategies have three unique features. MHSPY operates within a health maintenance organization, it is the only initiative in this study that integrates physical and behavioral health care in one case rate, and it truly "blends" funds.

■ *Blended Funding*

MHSPY operates with blended dollars from five key stakeholders, the Departments of Social Services, Youth Services, Education, and Mental Health, as well as the Division of Medical Assistance and Medicaid matching funds. Each agency enters into an interagency service agreement with Medicaid as to how much money each will contribute to this program. These rates are based on the original planning discussions with Medicaid about what each agency thought they were spending to serve the identified population when the program began. As a result, the Departments of Education, Mental Health, and Social Services each contributed $250,000 and the Department of Youth Services contributed $64,000 annually for the original service population of 30 children. The Division of Medical Assistance contributed $185,000, which includes a per-member-per month capitation rate of $541, equaling the rate DMA pays managed care plans for children in Rating Category II which includes children eligible for SSI (a cost similar to the population served by MHSPY). Currently, the total dollars have increased to accommodate a larger service population (100 children); however, there has been no increase in each partner's case rate contributions (per child, per month) since MHSPY's inception in 1997.

In the truest sense of blended funding, DSS does not have "slots" or pay a per child/per month rate for children referred by DSS. Rather, the money is blended and used to pay for any child receiving services based on the enrollment criteria and determination by the A LOT. Although the concept of blended funding was a concern initially, and DSS wanted to be sure to "get its share", it soon became evident that this strategy has benefited DSS greatly. Of the children currently enrolled in MHSPY, 74% have DSS involvement. [44]

■ *Case Rate*

Medicaid defined a case rate of $3,283 per month per MHSPY-enrolled child. This payment covers all service provided by MHSPY—including medical, behavioral health, social support and wraparound services. The shares of each agency to this case rate are $842 from

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[44] Zimmerman et al. (op. cit.)

DSS, DMH, and DOE; $216 from DYS; and $541 from DMA. However, the rate does not include residential treatment beyond 30 days. Instead, any residential treatment that exceeds 30 days is the financial responsibility of the referring agency. In this way, DSS and MHSPY are sharing financial risk for children who need more than 30 days of residential treatment. MHSPY pays for the first 30 days and DSS picks up the cost after 30 days. However, MHSPY can continue to provide the additional support services for children in residential treatment and their families for up to 6 months.

■ *Centralized Bank*

Medicaid operates as the central bank for the blended funds. A primary reason for this arrangement is that only Medicaid can pay a Health Maintenance Organization. In addition to negotiating an Interagency Service Agreement with each of the stakeholders as described above, Medicaid also acted as broker to negotiate what payment NHP would accept for MHSPY's package of services. Medicaid's additional role is to pass the partner agencies' financial contributions on to NHP. Each quarter, MHSPY goes through a reconciliation process—tracking for Medicaid the number of children served and a set procedure for categorized expenses such as salary, clinical services, etc. Medicaid's role as purchaser simplifies the purchasing process for DSS.

Access, Screening and Assessment

Access to MHSPY services is determined by eligibility and enrollment criteria as well as through exclusive access by the four referring systems: child welfare, youth services, mental health, and special education. The role of the Enrollment Coordinator is described by DSS as an "unplanned success" and provides an essential link between DSS and MHSPY.

■ *Enrollment Criteria*

The enrollment criteria fit the intent of MHSPY's design, which is to serve children who have who have serious emotional or behavioral disorders, are at-risk-for out-of-home placement, have impaired functioning, and have multi-agency involvement. Referrals to MHSPY may only be made by those participating and paying partners: DSS, DYS, DMH, and DOE[45]. By these criteria, DSS can refer many children; however, the enrollment criteria do not include those children who are in longer term, out-of-home placement or residential services. These children continue to be served through DSS. According to DSS, this is related to three factors: 1) MHSPY is perceived as a more "preventive" program; 2) when a child is in out-of-home placement, it is harder to engage the families and have them enroll in MassHealth/Medicaid (one of the eligibility criteria); and 3) the Steering Committee wanted to ensure that all the purchasing partners could make referrals as opposed to DSS filling the program with children in residential placement.

■ *Internal Referral Process*

When a DSS worker identifies a child and family who may benefit from MHSPY, the worker reviews the request with the DSS area level program manager and completes a Referral/Intake Sheet that includes basic information about the child and family, other agencies involved with the family, the potential benefits of MHSPY to the child and family, and the major strengths that the family brings to the process. This form must be signed and approved by the parent or guardian and the referring party. This information is given to the Enrollment Coordinator during one of her visits to the DSS office to solicit referrals or forwarded to her at the Regional Office The internal referral requirements set the stage for the strengths-based approach in MHSPY and allow for prioritization of referrals with DSS.

■ *Enrollment Coordinator*

By contract, the Enrollment Coordinator may not be an employee of Neighborhood Health Plan and works with all the state agencies referring to MHSPY. The Enrollment Coordinator is a shared employee of Department of Medical Assistance (DMA) and DSS; has 50% responsibility for eligibility determination (MassHealth) and 50% responsibility for DSS information tracking; and is supervised by the DSS Regional Director.

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[45] Department of Youth Services, Department of Mental Health, Department of Education

After receiving a referral form from the DSS area Program Manager and liaison to MHSPY, the Enrollment Coordinator contacts the family and arranges a home visit to explain the program, assess their interest in enrolling their child, and begin the eligibility determination and intake process. As part of the intake process, the coordinator administers the Child and Adolescent Functional Assessment Scale (CAFAS) to determine clinical eligibility; initiates the process for MassHealth/Medicaid enrollment (if necessary); and notifies relevant parties (DMA, agency liaison, and DSS worker) about the enrollment.

The coordinator also participates on the ALOT for referral prioritization and manages the waiting list. As part of the evaluation plan, the coordinator completes the CAFAS interval testing and the Family Satisfaction survey.

DSS sees this position as the key to success for children and families referred by DSS. As described above, the coordinator plays a pivotal role in linking DSS and MHSPY. In addition, the coordinator has vast experience in the DSS system, understands children and families involved with DSS, and provides an "over-time" contact with families through her evaluation role. This takes the burden of the enrollment process off the DSS worker.

■ *Uniform Screening Instruments*

MHSPY utilizes one standardized screening and multiple assessment instruments. The Child and Adolescent Functional Assessment Scale (CAFAS) measures children's functional level across multiple life domains and is used as the uniform screening instrument. The CAFAS was selected initially because it allowed comparison with other programs across the country, due to its broad usage, and because the state DMH uses it to determine eligibility for DMH services. Now DSS uses it in other programs, such as the Child and Adolescent Placement Program (CAPP).

Screening information on MHSPY enrollees is used in enrollment decisions, prioritization of referrals, the strengths—based service planning process, and program evaluation. Information from the initial screening and assessment are shared with DSS at the Care Planning Meeting. The Child Global Assessment Scale (CGAS), a measure of psychiatric functioning, and the Patient Assessment Tool (PAT), which measures children's behavioral health in eight areas, are added instruments used at baseline and used with all children every 6 months as part of the evaluation process.

Services/Integration and Coordination

Of the three initiatives in this study, MHSPY is the only one to offer comprehensive integrated care that includes primary health care, mental health, and substance abuse. MHSPY relies on a team approach for service planning and coordination and uses a structured strength-based planning process to empower families. Services are customized to include traditional and non-traditional services, wraparound supports, and as previously mentioned, primary health care for the identified youth.

■ *Comprehensive Integrated Care*

MHSPY offers integrated physical-behavioral health services within a managed care plan for children and families. MHSPY enrollees must be eligible for MassHealth/Medicaid and participate in the Neighborhood Health Plan (NHP) as part of the enrollment criteria. Once enrolled, they have access to the full provider network of NHP as part of their comprehensive care. DSS values the integrated services, particularly in serving children with special health care needs or medication requirements who also have complex behavioral health concerns. Where appropriate, neurologists, neuropsychologists, testing and /or health promotion programs can become part of the Individualized Care Plan.

■ *Strength-Based Service Planning*

Strength-based discovery is the foundation for MHSPY's approach to service planning and delivery. It involves listening to families, empowering them as equal partners, and facilitating teams of family members, natural supports, and relevant providers and agencies involved with the child and family in the Care Planning Team. The strengths discovery process draws on the child's and family's strengths across life domains, and leads to a plan for improved outcomes.

This new approach to working with families was a challenge to DSS workers who were more accustomed to a structured and directive approach associated with enforcing court orders. DSS has learned to ask the question "What do you need to bring your child home?" and other strategies for engaging families in this new way of doing business. Ultimately, this is one of the MHSPY program features that DSS appreciates most. As a result, DSS has been progressively moving to Family Group Decision Making.

- ***Joint Development of Service Array***

In the planning phases for MHSPY, each partner on the Steering Committee met and listed a menu of services that their agency provided and that they wanted to make sure were included in MHSPY. The lists were reviewed and consolidated by the Steering Committee and helped determine the service package. The resulting array included those services that could be available to families in their homes, at flexible hours, and in non-traditional ways – such as Family Skill Building[46], parent aides, mentors, trackers, etc. In spite of the "culture clash" between the family approach of DSS and Medicaid's focus on the identified child, DSS believes that "all of the MHSPY services" have been designed with children and families from the child welfare system in mind. DSS involvement in the development of the service array, and the initiative's individualized approach to designing an Individual Care Plan support this view.

- ***Service Array***

MHSPY 's service array and benefit package include:

- primary and specialty pediatric services
- inpatient hospitalization
- short-term residential placement, up to 30 days
- therapeutic after-school day treatment
- respite
- crisis intervention
- prescriptions drugs
- substance abuse treatment services (inpatient and outpatient)
- wraparound" services such as recreational activities, music lessons, YMCA membership, summer camp, parent aids, transportation, etc.

As much as possible, these services are made available to families in their homes, at flexible hours, and in non-traditional ways. This flexibility of the benefit package and the way that services can be and are delivered is particularly helpful to those children and families involved with DSS. MHSPY staff flexibility and its ability to find clinicians who can offer specialty care also support the needs of children and families involved in child welfare. Given the opportunity to expand services, DSS expressed interest in increasing respite services so that everyone who cares for children – birth families, foster parents, and residential care programs – could utilize these services.

- ***Care Planning Team***

The Care Planning Team is the primary mechanism for Individual Care Plan development and includes the Care Manager, the DSS worker, family members, other agencies and organizations, and informal supports. The team approach to planning required the DSS workers to "give up power"; share decision making for planning child protection; and learn to sustain their relationship with the family, especially in working with the birth and foster parents on the same team. Role clarification, Care Planning Team experience, and the observation that children and families were benefiting helped DSS accept its role change.

- ***Care Planning Meetings***

Monthly Care Planning Team Meetings are the primary vehicle for information exchange, designing, and coordination of services for each child and family enrolled in MHSPY. Everyone on the Care Planning Team has input into the development of the Individual Care Plan, outlining services and strategies for service coordination. The MHSPY Care Manager has primary

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[46] Solutions for Living's Family Skill Building Program is designed as a time-intensive, home-based, comprehensive array of coordinated services. In this model a therapist and Parent Mentor work together to reinforce family strengths and nurture the development of home and child management skills

responsibility for service coordination. The DSS worker's role is to communicate the child welfare perspective and service plan, address protective services concerns, and relay initial court order information related to supervision or risks associated with out-of-home placement.

- ***Individual Care Plan and Individualized Services***

An Individual Care Plan is developed based on the CAFAS, Strengths Discovery Process, and the Care Planning Meeting. Every Individual Care Plan documents the goals of each family and their monthly progress toward them. In addition to describing the goals, strengths, and barriers, the Plan describes the individualized interventions and those providing them. The MHSPY Care Manager, again, has primary responsibility for service coordination and communicates with the DSS worker regularly through the Care Planning Team Meetings and by phone. Both MHSPY and DSS value individualized services tailored to meet the needs of each child and family. MHSPY has offered new ways of serving children in the community and movement beyond traditional services to include natural supports and more broadly defined interventions.

DSS views the freedom to design creative services, to provide them unencumbered by traditional procedures and structures, and to do a more complete job of meeting the individual concerns of children and families as a boost to the services it provides. DSS workers feel more positive about their work and believe that there is more opportunity to serve children with more complex behaviors.

Information Sharing

MHSPY and DSS maintain their own record systems. Information is exchanged primarily within the care planning process at the Care Planning Meeting. Other opportunities for information exchange include the previously described ALOT meetings and meetings with agency liaisons.

- ***Care Planning Meeting***

The Care Planning Meeting is one of the primary vehicles for sharing information between MHSPY, DSS, other agencies, family members, and other natural supports. DSS workers dictate notes from the Care Planning Meetings into the DSS record. The monthly Care Planning Meetings are supplemented by frequent phone and e-mail contact.

- ***Record Sharing***

MHSPY and DSS maintain their own record systems and do not have automatic or shared access to records. Instead, they rely on traditional consent forms, signed by families at the time of enrollment. The MHSPY Consent and Authorization for Release of Information forms allow release of DSS service plans to MHSPY and authorize the exchange of information to and among the Care Planning Team members for two years.

- ***Co-location of MHSPY and Primary Care***

MHSPY Care Coordinators were, for the MHSPY pilot project, co-located in the same physical space as Harvard Vanguard Medical Associations, the medical group that originally provided all the medical care to MHSPY members when this program was administered by HPHC[47]. Their proximity allowed Care Manager participation in medical visits when appropriate, enhanced communication, included primary care provider participation in Care Planning Team meetings, and permitted sharing physical and electronic access to records. The current challenge is to maintain this integrated care when MHSPY and the health care providers no longer share one location.

Training and Technical Assistance

MHSPY hosted an initial kick-off conference for all vendors, agency representatives, stakeholders, and interested parties to provide information about MHSPY and the Child and Adolescent Services System Program (CASSP) principles upon which the initiative is based. Subsequently, there have been additional training opportunities – some formal and some informal.

- ***Cross-System Training***

Once the initiative was underway, MHSPY used funds to offer follow-up training to reinforce the MHSPY

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[47] Harvard Pilgrim Health Care

approach through more targeted training, including presentations by other interagency efforts in other states that included child welfare as a partner.

- ***Local Level Training***

Early in the project, training at the area level provided information about the project, its approach, potential benefit, and how it would work. Presently, continuous quality improvement discussions take place at the ALOT meetings.

- ***Department Level Training***

Special event training with relevant guest presenters has helped to inform and influence child-serving systems at the state, departmental level. DSS credits the training by out-of-state program representatives from other cross-system initiatives as influencing other state administrators and as instrumental to advancing the MHSPY model. In addition, departmental representatives from the partner agencies, including DSS, participate as co-presenters and conference participants at national events when MHSPY is one of the highlighted programs.

- ***Internal Training***

MHSPY has a monthly, program development day, which is used for outside organizations or agencies, like the Parents Advocacy League, to do training on services or special topics. The DSS Enrollment Coordinator has often attended these trainings.

Evaluation

As a pilot and research based project, MHSPY has an extensive evaluation arm. Data collected internally is analyzed via the Psychiatry Research and Academic Center of Cambridge Health Alliance, with additional analyses performed by MHSPY research staff with NHP. Data collected externally by DMA, is analyzed via DMA's contract with UMASS Medical. MHSPY is actively seeking research funding to perform secondary analyses using reference population data for comparison.

- ***Evaluation Instruments***
- *Satisfaction Surveys*

MHSPY utilizes three satisfaction surveys to gather evaluation data. One is for referring agencies, one is for families, and one is for the youth themselves. For every child involved with DSS who is referred to MHSPY, DSS completes a agency satisfaction survey to rate its overall satisfaction with the program as well as ease of coordination, quality of care for children and families, and the family's ability to keep the child in the home. Families and children are asked to rate items such as how much they felt "listened to", how much "things are better", and their overall satisfaction with the program.

- *Assessment Tools*

As mentioned previously, MHSPY utilizes the Child and Adolescent Functional Assessment Scale (CAFAS), Child Global Assessment Scale (CGAS), and the Patient Assessment Tool (PAT) as assessment tools for evaluation. The medical community selected these instruments in order to measure the effect of the intervention on the child and family's functional status. DSS was active in discussions about what it wanted in terms of data, measures, and outcomes. DSS was interested in four domains: functioning, utilization, cost and satisfaction. DSS wanted to know if children were in foster homes, respite care, hospitalization – services for which they had to pay. MHSPY has developed methods to measure these placements relevant to children and families served by child welfare.

- ***Data Collection***

Data collection begins with the Enrollment Coordinator's visit to the family and the first administration of the CAFAS. The Enrollment Coordinator is also responsible for interval testing every six months, and Satisfaction Surveys at disenrollment. Her experience working with families involved in child welfare services and her neutral role in the MHSPY project contribute to her role in evaluation.

- ***Data Reporting***

MHSPY reports data several ways and at several levels. Data are reported to Medicaid at contract status meetings; to the Steering Committee in annual reviews; and to all the stakeholders every 6 months. MHSPY also publishes a book of results that is distributed to DSS supervisors who then share the information at internal DSS meetings and with workers. It is MHSPY's perception that the data help to hold the ALOT, and perhaps the stakeholders, together because they are interested in the impact. MHSPY's data indicate reduction in the use of residential care and foster care, and an increase in the use of respite care services for children served by the project. Data also have demonstrated improved level of functioning across school and home domains (increasing at intervals over time in the program), high levels of family satisfaction, and cost effectiveness.

- ***Data Use***

Because more than 70% of children enrolled with MHSPY are involved with DSS, MHSPY's outcomes are "DSS driven" by shear volume of referrals. The data are used to demonstrate the impact of the project, but also to build relationships—and reinforce that good interagency relationships and success at working better together lead to better outcomes for children and families. DSS uses the data from this small project to stimulate new projects. It has been used in this way at the Commissioner level and is in large part the basis for some state initiatives.

Impact on Practice in the Child Welfare System

- ***Family-centered, Strength-Based Approach***

DSS describes MHSPY's family-centered, strength-based approach with families as its greatest impact on DSS practice. Seeing family strengths and family members as partners required a shift in role, interaction, and expectations away from a deficit model. This shift has supported DSS in its move to Family Group Conferencing[48] as well as its goal to have the family-centered-strengths-based approach permeate the department within the next five years. DSS has begun this work by articulating six core practice values (child-centered, family-focused, strength-based, community-based, culturally competent/diversity sensitive, and committed to continuous learning).

- ***Team Experience***

DSS workers experience a shared responsibility for services to a child and family, including an understanding that all team members— clinicians, care managers, immediate and extended family members, other agencies, and selected natural supports—are part of the safety plan for the child. With this team approach, the agreed upon and available back-up plans, and the extra supports, DSS workers are more willing to maintain children in their own homes and rely on the team and the additional services to preserve the family.

Going to Scale

- ***Changing the Culture***

Replicating or expanding MHSPY challenges the "culture of collaboration" and requires major changes in values, attitude, trust, and practice. It is key to engage leadership at the higher systems levels to overcome past differences, to change eligibility criteria that limit "ownership" of care to children and families, and to build true collaboration. When the leadership is in agreement, a new way of collaborating can filter throughout each system and "going to scale" is facilitated.

- ***Expansion to New Communities***

In addition to increased service capacity at the original MHSPY site in Cambridge and Somerville, MHSPY now serves 3 additional communities: Malden, Medford, and Everett. DSS is asking for more services and considering new uses for DSS funds that were recently de-categorized by the state legislature. For example, DSS may use its now flexible residential funds to contract directly with MHSPY to assist in locating for children **community** placements that include wraparound services as a diversion program (or alternative) to residential placements.

- ***Maximizing State-Level Resources***

Legislation was recently passed allowing DSS the authority to move money from one category to another. DSS argued that the traditional account structure—line items for adoption, residential care, etc.—meant that dollars drove the services rather than the reverse. Now, for example, DSS can shift dollars from residential settings to community settings. In fact, it is state policy that departments are to move in this

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[48] Family Group Conferencing, also known as Family Group Decision Making

direction. The implications for MHSPY and for DSS are as yet unclear, but could result in more resources and referrals to the program.

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Summary—Keeping the Promise, Advice and Recommendations

Keeping the Promise

In many ways, the initiatives we have studied have kept the promise (defined in Section I) to accommodate the child welfare system and to serve children with complex behavioral health needs and their families.

- ***Commitment***

All three initiatives have demonstrated a **commitment** to the child welfare system and the children and families served by the child welfare system. From the outset, each initiative viewed the child welfare system as a key partner, and created formal structures to ensure that child welfare system mandates, laws, and policies were accommodated. In return, the child welfare system has committed agency resources—in funding, time, and staff activities—to support the development and implementation of the initiative.

- ***Access to Services***

All three initiatives have assured **access to services** for children with complex behavioral health needs and their families served by the child welfare system. However, there is plenty of room to grow, to expand available services, and to serve more children, in more communities.

- ***Coordinated and Continuous Care***

The primary service of each of the initiatives is **care coordination**. Care managers or service coordinators within each initiative have primary responsibility for guiding a team approach to designing, delivering, and ensuring care across service systems and within the community. Clinical decision-making and service tracking methodology support these activities. **Continuous care** remains a challenge when services are predicated on specific enrollment criteria, "step down" services are not as accessible in the community, or when a child and family move from the initiative's service area.

- ***Whole Families, Stronger Families***

All three of the initiatives have taken a philosophical stance and a structured approach to building on the **strengths of families** in service delivery. Traditional clinical services and non-traditional services offered through a wraparound process have been used to support families in the communities and to reunify families and children. Within each initiative, child welfare frontline staff and administrators who are involved in the interagency initiative are adopting this family-centered approach.

- ***Expanded Accountability***

Within these initiatives, the child welfare system is **no longer alone** in providing support, services, and behavioral health care to children with complex behavioral health needs and their families. Other systems are sharing their expertise in planning for cross-system intervention, negotiating their role in delivering care, and sharing responsibility for ensuring child protection, family support, and community resources.

- ***Cost Savings***

Each initiative has funding mechanisms in place for **sharing costs** across child-serving systems. For those initiatives reporting **cost savings**, the cost of care per child for the child welfare system is reduced in that the case rate or contribution paid by the child welfare system is less than full cost for residential care and hospitalization. In addition, the cost of care per child/per month is often less costly than traditional treatment as there is reduced reliance on residential treatment and increased reliance on community-based services. Child welfare systems in these initiatives view their funds as "well spent", in that they have more clear service options, improved access to appropriate care, and shared responsibility. **Cost efficiencies** result from a coordinated team approach, reduced duplication of services, and clear roles and responsibilities. and the overall cost of care within their service system is reduced. The "cost of care" is also reduced for families involved with child welfare services in that they benefit from the improved access to coordinated servicescare, increased family involvement, and intensive customized services.

- ***Permanency***

All three initiatives address permanency as a primary focus in service planning and coordination for children and families involved with the child welfare system. Services and supports are designed to empower and strengthen families and "wrap around" children and families so that children can return to their families or be placed in a permanent home with adequate community resources to sustain the placement and limit disruptions. The proof exists. In these initiatives, child and family functioning has improved, permanent homes have been established, children and youth have "graduated" from intensive services with community supports in place, and the child welfare system has been able to terminate its services.

Advice for Other Communities and States

Respondents offered advice for communities considering an interagency initiative to address services for children with complex behavioral health needs and their families, including how to accommodate the child welfare system and the children and families it serves. Respondents' advice is categorized below from three perspectives—the interagency initiative, the child welfare system, and families.

- ***Interagency Initiative Perspective***

- Include all systems that serve children and families. Engage representatives from different levels of the various systems to learn their perspective, and confirm their commitment to the effort.

- Include service providers (behavioral health, residential, foster care, etc.) from the very beginning. Enroll existing providers to deliver services and ensure continuity of care.

- Take the time to build consensus and a firm foundation of trust, common goals, values, and philosophy.

- After building consensus, identify funding sources and mechanisms before the initiative begins.

- Train everyone across systems and at every level in the goals, values, philosophy and approach. Be clear about roles and responsibilities.

- Understand the child welfare system: what it is, its mandates, its needs as a "customer", and how it works with children and families.

- Build in problem-solving structures and regular communication strategies and use them.

- Start implementation and expect to figure some things out as you go.

- ***Child Welfare System Perspective***

- Include all systems—formal and informal—that touch the lives of children and families. Include natural supports that are most relevant to the children and families in your community culture.

- Engage families as partners and focus on a strengths-based perspective.

- Understand the behavioral health service system, how it works, and how systems can best work together.

- Be clear about how the initiative will make a difference for the child welfare system and the children and families it serves by addressing what is important to this system.

- Organize systems of communication, including liaisons as links between systems and the initiative. Hold regular, formal meetings for problem-solving.

- Build momentum for change by having "champions" within the child welfare system.

- Remain flexible so that change can occur.

- Assure providers and the child welfare system that they all have important roles to play and the initiative will not put them out of business.

- ***Family Perspective***

Ensure a family-centered approach, build partnerships between families and the child welfare system. Plan interventions and family involvement so that they fit within (rather than consume) the family's "family life".

Provide complete information about the initiative to providers (mental health, therapeutic foster care, residential services, etc.) and families. Be clear about everyone's roles and responsibilities.

Recognize the family perspective on permanency and provide support services specific to these decisions — especially to foster and adoptive families.

Hire (initiative) staff that are well trained, understand the child welfare system, and are sensitive to the issues facing children and families involved with child welfare services.

Make services accessible and intervene early to support prevention of out-of-home placement.

Help families play leadership roles, act as advisors, and provide peer support to listen and learn from one another.

Extend access to services so that children and families can continue behavioral health care beyond their involvement with the initiative.

Expand behavioral health services to other communities to avoid disrupted care through a change in placement or a family move.

Expand formal and informal support services by building more community resources and dedicate staff within the initiative to do so.

Recommendations

Recommendations based on the promising approaches noted throughout this paper and on advice from the respondents from each of the initiatives are listed below.

1. Utilize uniform screening and assessment instruments and orient all stakeholders to their use in enrollment, service planning, and evaluation to establish a common language and basis for decision making.

2. Coordinate behavioral health screenings and assessments with child welfare safety assessments. Link outcome measures to child welfare priorities.

3. Establish formal opportunities for system and cross-system training to provide orientation to and reinforce the approach to care, enhance partnerships, ensure quality, and address staff turnover.

4. Within the child and family team approach, expand successful strategies to simultaneously support birth and foster parents for children within the child welfare service system.

5. Expand and extend support services to help prepare potential adoptive families and to help sustain the family after the adoption is complete.

6. Include strong family support services and establish formal linkages with family advocacy organizations.

7. Design intentional outreach strategies to birth parents who are involved with the child protective services system, in order to include them in family support services and activities.

8. Include services to young children (ages birth to six) and/or build strong linkages to existing early intervention behavioral health services for these young children.

9. Emphasize services to those children "at risk" of out-of-home placement as a diversion strategy and early intervention services for children who are new to (or at-risk-for becoming involved with) the child welfare system.

10. Create strategies to assist youth who age-out of the child welfare system and need continuing care in the adult behavioral health system.

APPENDIX A
Reports Published by the Health Care Reform Tracking Project

All reports of the HCRTP are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271:

Stroul, B. A., Pires, S. A., & Armstrong, M. I. (2001). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—2000 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #198)

Pires, S. A., Stroul, B. A., & Armstrong, M. I. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1999 impact analysis*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #183)

Pires, S. A., Armstrong, M. I., & Stroul, B. A. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1997/98 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #175)

Stroul, B. A., Pires, S. A., & Armstrong, M. I. (1998). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1997 impact analysis*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #213)

Pires, S. A., Stroul, B. A., Roebuck, L., Friedman, R. M., & Chambers, K. L. (1996). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1995 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #212)

The following special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University (202) 687-5000:

McCarthy, J., & Valentine, C. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—Child Welfare Impact Analysis—1999*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Schulzinger, R., McCarthy, J., Meyers, J., Irvine, M., and Vincent, P. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—Special Analysis Child Welfare Managed Care Reform Initiatives—the 1997/98 State Survey*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.