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FINAL REPORT

Community-Based Mental Health Services for Children in the Child Welfare System

Volume I
Cross-Site Comparisons and Study Findings

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Macro study team members and authors of this report are William Atkins (Officer-in-Charge), Katie Baer, Lela Noland Baughman, and Coralee Hoffman (Project Manager).

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Executive Summary

I. Overview of Children's Mental Health Needs and Services

- *Danny is 6-years-old and in first grade. He is a constant source of trouble in school--he demonstrates unprovoked physical aggression towards his teachers and classmates and his language is peppered with curses. At home, his father's approach to discipline is to tie him to a chair and hit him with a belt.*

- *14-year-old David is in detention for burglary and assault; this is his fourth time in juvenile court, and he has a long history of physical violence toward his younger sister, behavior problems in school, and truancy. His mother thinks he is mentally ill and wants him evaluated and removed from the home*

- *Thomas, ii-years-old, is often seen on the* street *hustling money for food; he lives in public housing with his mother who is an alcohol and drug user; and has two younger sisters who suffer from fetal alcohol syndrome He has three older brothers; the two oldest are in prison for drug distribution, and the 16-year-old is in a reformatory institution for murder*

- *Shauna, a 6-year-old girl who has been removed from her natural parents because of sexual abuse, is now in her second foster care placement. She is unresponsive and uninvolved with people around her. She demonstrates very little emotional reaction to anything that happens to her--good or bad-and even shows little interest in Christmas-time activities and surprises.*

Children such as Danny, David, Thomas, and Shauna and their families have multiple, complex needs, and often have meager resources with which to meet these needs. They depend on mental health, child welfare, and other service systems to provide myriad kinds of assistance. Too often, those systems are fragmented, hindering access and creating additional stress on children and their families.

The children described above are in the child welfare system. It is unknown how many other children in child welfare are among the estimated 7.5 to 9.5 million children in the United States who need mental health services. However, child welfare, juvenile justice, and mental health providers report that the children they serve share common characteristics: they come from similar circumstances and have comparable childhood experiences. Problems related to these experiences are simply manifested in different ways, and if left unaddressed, can have negative consequences for the child, the family and society as a whole. Such consequences may include difficulty in forming relationships, low self esteem, difficulty in school, delinquency and difficulty in holding a job. These problems could escalate to levels requiring intensive interventions including incarceration or hospitalization.

Definitional issues hamper a neat categorization of children's mental health needs. Approaches to describing children's mental health encompass clinical diagnosis (e.g., a recent Office of Technology Assessment Report adopted the DSM-III-R definition of mental disorder: clinically significant behavioral or psychological syndrome or patterns associated with distress or disability); use of various assessment instruments; and program eligibility guidelines. A widely used framework to identify SED children focuses on two dimensions: severity of social impairment and persistence of the problem.

Despite the lack of a definitive way to categorize children with mental health problems, many communities do have a range of services to help those children and their families. Further, a recent "paradigm shift" in conceptualizing and developing children's mental health services emphasizes a broader range of services, including intermediate care services (therapeutic foster care, intensive in-home care) and family support (crisis intervention, respite care for parents, intensive case management, parenting skills instruction). This wider spectrum of services-which enhances the traditional mental health services such as outpatient psychotherapy, hospitalization, and long-term residential treatment-focuses on adapting services to the needs of the client rather than adjusting the client's need to fit existing services in the system.

Typical of the new emphasis in the field of children's mental health is the concept of a comprehensive system of care developed by Stroul and Freidman, which advocates a full array of services to be provided by various agencies, including child welfare. Categories of mental health care for children include prevention/early intervention, assessment, case management, outpatient treatment, home-based services, day treatment, crisis, and emergency services. This model has been widely used in crafting current legislation to improve children's mental health services at the national level.

The myriad service systems that intervene with children who have emotional disturbances-- and their families-tend to be fragmented and crisis-oriented. Various barriers inhibit a cooperative and holistic approach to working with these children and their families; too often, agencies focus only on the problems they are organized to solve rather than on the array of complex needs brought by their clients.

II. Purpose of this Studv

Contemporary reforms have stimulated state and local efforts to improve coordinated mental health service delivery to children. However, research and program efforts documented in the literature feature issues and accomplishments in serving SED children. The availability and adequacy of mental health services available to children in child welfare, and particularly those who have not yet been designated SED, has not yet been documented. To gain an understanding of these issues, the office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services (DHHS), recently undertook a study to explore approaches to providing needed services to

children in child welfare who are not yet considered SED. Macro International Inc. conducted this study under contract to ASPE.

This study attempted to scrutinize the four major systems that typically have an impact on emotionally disturbed children: child welfare, child mental health, juvenile justice, and schools. Because multiple systems touch the lives of children in the child welfare system who have mental health needs, collaboration among these systems is essential. Through this study ASPE sought to describe the efforts of communities where child-serving agencies have made strides in working together and to identify the issues and barriers these communities face in continuing to work toward improved service delivery. Site visits to selected communities explored three categories of critical factors that can influence development of an integrated approach to child-serving systems: community environmental and contextual issues, system-level factors, and service delivery-level factors. Key questions of concern to the study included the following:

- What characteristics frame the development and implementation of efforts to work together?
- What organizational components and mechanisms promote successful interagency activities?
- What programs and strategies contribute to mental health services for children, especially those who are not SED?
- What are the program, policy, and research implications of the findings from site visit communities?

III. Study Methodology

This project incorporated broad-based input from national experts, published and unpublished reports, and information and insights gathered through site visits. The study had three major phases:

- **Identifying key issues and clarifying the study focus--Because the** issue was complex and cut across many fields, it was important to delineate the crucial issues and direction of the study. A Federal advisory group with representatives from agencies in fields relevant to the study met twice to help guide the project. A panel of experts from outside the government also was convened to contribute their expertise in areas of child welfare, child mental health, special education, and children's advocacy. In addition, telephone interviews with experts at the national and state level elicited perspectives on exemplary community programs. A literature review described current research related to child welfare and children's mental health and helped define the study issues.

- **Developing the study approach-Information** and insights from the first phase helped shape the study approach. First, an analytic framework was developed to guide data collection and analysis. The framework illustrates the general interactions among key factors influencing service delivery approaches and outcomes for children. Next, the study team produced a case study plan to guide the site visit process and ensure that information would be collected in an efficient and consistent manner. An interview guide highlighted questions to elicit information on the environmental/contextual, system-level, and service delivery factors that affected the community's approach to serving children.

  Several criteria guided selection of the site visit locations. Ideally, the communities would have a strong child welfare agency, a collaboration between child welfare and child mental health agencies, and an emphasis on connnunity-based services for children and families. Nine sites met the initial criteria; profiles of these, based on telephone interviews with community experts, helped narrow the list to four localities: Hennepin County, Minnesota (Minneapolis); Jefferson County, Kentucky (Louisville); Scott County, Iowa (Davenport); and Northumberland County, Pennsylvania. Chicago, Illinois, was added to the list of sites to ensure representation from a major urban area with diverse populations and heavy service demands.

- Conducting site visits-Visiting the five sites was the central method of data collection for this study. The purpose of the sites visits was to explore approaches to providing mental health services to children in child welfare, identify and describe factors affecting their approach to services, and discern trends that have implications for future policy and research. Two teams composed of two Macro staff members conducted 4-day site visits to each study locality. Altogether, site visits included discussions with more than 100 individuals representing approximately 46 public and private agencies and organizations, as well as foster parents and children's advocates.

IV. Summary of Major Findings

In examining the systems involved in providing mental health services to children in child welfare among the five communities, certain key themes and patterns emerged.

We have summarized the key findings and aggregated them in the two main issue areas that this study addressed: (1) the kinds of mental health services being provided the children in the child welfare system, with a particular emphasis on children who are not SED, and (2) the extent to which the child welfare and child mental health systems are working together and the extent to which they are collaborating with other child-serving systems.

Findings from these five case studies reflect a range of types and sizes of communities that have what are considered exemplary approaches to serving children and their families.

Mental Health Services for Children in Child Welfare

Status of Services

- The only clear criteria for defining children's mental health needs in sites visited were those developed to identify severely emotionally disturbed children (SED). Although agencies and providers recognize that many children who need mental health services may not fit SED criteria, there is no common way to describe or categorize these needs. For the most part, children who are not clearly SED are recognized as needing mental health services because of behavior or conduct probiems, or because they cannot function in school.

- In almost all sites visited, identifying children's mental health needs and obtaining services is dependent on the child welfare caseworker's training, awareness of resources and concern about observed or reported behaviors or problems.

- Mental health services in all localities include traditional outpatient and inpatient services. However, home- and community-based services are a prominent and growing part of the array of mental health services.

- While a few programs in study areas were developed specifically to serve children in the child welfare system, the majority serve a broader population within which child welfare clients may or may not be a priority. Even where a broad array of programs is in place, children in child welfare may not always benefit due to such constraints as program eligibility criteria, access mechanisms and program capacity.

- Case planning for children who are involved with multiple systems remains, for the most part, fragmented, duplicative or both.

- There was generally no evidence of a system-wide approach to evaluating coordinated provision of mental health services to children in the child welfare system However, individual agencies do track and monitor service delivery measures in many instances.

Approaches to Providing Services

- In some localities, true joint efforts are in place involving multiple agencies and families in service planning; however, most involve independent efforts by each system which may or may not be shared with others.

- Although family involvement and empowerment is recognized as an important value in study areas, there is wide variation in the extent to which families are currently involved in service planning and setting treatment goals. In many places, however, foster parents are being increasingly viewed as extensions of service delivery staff and are involved both in service planning and in working with natural families.

- Generally, case management denotes a "brokering role" in sites visited, i.e., a responsibility to see that children and families obtained access to available resources. However, a more activist concept of case management as a comprehensive process of stimulating development of needed services and helping the family find ways to meet their own needs was also evident.

- Although most needs for additional programs and services identified by respondents were specific to the service delivery system in that locality, three general areas for further program development were cited by several: services for children in the juvenile justice system, improved coordination with the schools, and better ways to address the critical effects of sexual abuse and drug abuse in the lives of most children and families in the child welfare system.

Service Coordination

Status of Coordination

- Very different models for working together have evolved in the localities visited. The extent of coordination is affected by the general climate in the community as well as by the interplay of leadership, communication and problem solving processes, and funding considerations.

- The size, complexity of the systems involved, community values, and operating styles influence the approach to coordination.

- While the strong leadership of an individual leader was noted in one or two of the sites visited, all those who have been successful have supportive leadership in several key agencies who are committed to finding ways to work together.

- Communities varied in the value placed on formal communication and coordinating mechanisms; however, they share an emphasis on mutual problem solving, consensus building among a wide range of community providers, and a recognition of the value of consumer involvement in service planning.

Approaches to Coordination

- Developing community-based mental health services for children requires creative efforts to tap into and mix Federal, state and local dollars from various child serving agencies. A key impetus for developing a broader range of services in the community is concern for the high cost of residential care related to the few children who can be served.

- Coordinating mechanisms exist at both planning and service delivery levels in all study areas visited. For the most part, these represent cooperative efforts through which independent agencies or divisions of an agency share their own plans and

work together to sort out roles, minimize duplication, and improve access to their services. A key impetus for developing a broader range of services in the community is concern for the high cost of residential care related to the few children who can be served.

- Some aspects of the integration process are unique to individual localities. However, there are some common features: shared values, supportive leadership, broad community involvement and consensus-building, stability among service providers, and significant involvement of the courts. In addition, common values and problems, coupled with Federal and state actions, have helped create a climate for better coordination.

- Although the balance varies, coordinating efforts between child-serving systems in localities visited appear to have resulted from converging "top-down" and "bottom-up" efforts.

V. Program, Policy, and Research Findings

A. Introduction

The sites included in this study were selected because of their progressive approaches to improving services to children and families through community-wide service coordination. Their progress in working together may not be typical of communities across the nation. Yet even in these model programs, the need for continuing efforts to develop and fund needed services and to ensure participation and involvement of all relevant child-serving agencies is clear.

The program and policy implications described below delineate more specific aspects of a single overarching observation expressed by national experts and validated by case studies conducted for this study: the current fragmented service system is inadequate to meet the multiple needs of children and families. Ways must be found to provide incentives, reduce institutional and professional barriers and support the development of community-based, child and family centered services for the full range of mental health needs, not just the most severe needs which cannot be ignored. In particular, the needs of children and families in the child welfare system are clear, pressing, and seriously underserved. Child welfare and child mental health specifically, and other systems routinely involved in the lives of child welfare families, must find better ways to assure these needs are met.

B. Program Obsewations and Implications

1. Lack of joint intake, assessment, and case planning **processes** among **child-**serving agencies contribute to fragmentation and duplication of **services** and impede effectiveness in meeting multiple needs.

   Implication: ***Multiple assessment instruments and requirements for program eligibility hinder development of joint procedures and impede systematic assessment of all children and families entering the child welfare system.***

Research and Policy Questions

At what point should children in child welfare be assessed for mental health service needs?

What should assessments encompass-needs and risks? **Families'** needs as well as children's needs?

Who is responsible for assessing children's and families' needs and risks?

Is it possible for one assessment tool to meet the needs of multiple agencies and systems?

Are existing assessment tools suited to this purpose?

Should assessments be conducted without a promise of providing services?

What mechanisms can be used to ensure coordination of assessment tools and procedures across systems?

Implication: *Individual case planning requirements tied to categorical finding streams (e.g., Title IV-E and P.L. 99-457 for Individualized Family Service Plans) inhibit the kind of collaborative service planning necessary to improved services integration*

Research and Policy Questions

What are the existing conflicting mandates in Federal, state, and local case planning requirements?

What mechanisms can be used to coordinate existing Federal, state, and local case planning requirements?

Implication: *Privacy/confidentiality issues need to: be fully explored, with consideration for Federal, state, and local issues and restnctions. A key aspect of this issue is sorting out real versus perceived barriers, while still making sure the rights of clients are protected*

Research and Policy Questions

What are the Federal, state, and local issues related to confidentiality?

To what extent are these real versus perceived?

What mechanisms can be used to overcome confidentiality barriers to coordinating services while ensuring that client's rights to privacy are protected?

2. **Training of professionals providing child welfare and child mental health services has not kept pace with the skills and orientation needed to adequately address mental health needs.**

Implication: ***To address mental health needs of children and families in child welfare, staff in multiple service agencies must have adequate basic preparation and continuing education in undemanding requirements of public service agencies and clients, working with other systems and providers, and understanding children's and families' mental health needs and the range of appropriate and available services.***

Research and Policy Questions

To what extent does basic preparation for social work and mental health professionals meet the demands of practice?

How can schools, professions, and public and private agencies work together to ensure that preparation fits practice needs?

What opportunities are available for continuing education?

What mechanisms can be used to build skills in the areas of coalition building, understanding and working with other professions, and shaping practice to fit into the broader community service system context?

3. **Generally, approaches to improving service coordination and to providing mental health services are not based on proven methods supported by evaluation.**

Implication: ***Wide dissemination of existing evaluation studies and technical assistance, as well as support for additional studies to examine what works in service delivery and coo&nation approaches would help inform and improve system and program level efforts.***

Research and Policy Questions

What are the existing technologies and mechanisms for conducting evaluation at the Federal, state and local levels?

What indicators should be used to measure child and family outcomes?

What indicators should be used to measure system outcomes?

What are the mechanisms for identifying and disseminating existing studies?

What are the incentives for evaluation?

C. Policy Observations and Implications

1. **Children who do not have severe emotional or behavior& problems are not an identified priority population for mental health services.**

   Implication: ***Without incentives to focus on the needs of children who are not at the most severe end of the spectrum of emotional and behavioral problems, the pressing and serious needs of these children and their families will continue to take a back seat to the more acute and obvious needs of those who have SED status.***

Research and Policy Questions

How can Federal and state priorities be expanded to focus more attention on prevention and early intervention services for children with mental health needs who are not severely disturbed?

How can private foundations be encouraged to support demonstration and research efforts for the children with less severe problems?

What other kinds of public and private stimuli are needed to increase awareness of the full range of children's mental health needs and encourage development of a more comprehensive range of programs, including prevention and early intervention services?

2. **Identification of children whose mental health needs are less than severe is inhibited by poor definitions and continued bias toward a "deficit" rather than a "wellness" model of treatment.**

Implication: ***Without improved definitions of children's mental health needs that include environmental and social aspects of healthy adaptation to guide program development, service providers and policymakers are limited in their ability to identify service needs, develop suitable approaches, and assess effectiveness.***

Research and Policy Questions

What is the best approach to defining tbe needs of children whose mental health status does not warrant the designation "severely emotionally disturbed"?

To what extent should the definition include the needs of families and other social and environmental influences which provide the context for children' growth and development?

How can program and policy officials create programs for this population without resorting to categorical eligibility standards that create barriers to coordinated service delivery and subordinate the needs of the child to the administration of tbe system?

3. There is no **designated leadership responsibility for coordinating efforts to address children's mental health needs.**

Implication: *Without clear agency mandates to provide leadership in improving community-wide response to children's mental health needs, improvements will continue to rely on individual combinations of community environment, leadership, and resources.*

Research and Policy Questions

Should a single agency assume the lead for coordinating mental health services for children, including those in the child welfare system?

If responsibility continues to be distributed among several agencies at the state and local level, what strategies can be employed to encourage agencies to accept children's mental needs as integral to their own missions and to develop better working relationships with others?

What strategies should policy makers support to enhance coordinated: service delivery at the local level? At the. state level? At the Federal level?

4. **Absence of a consistent, longer-term source of funding for children's mental health services inhibits long-range planning and development of system-wide activities.**

Implication: *Complex and shifting funding sources will continue to inhibit services integration and the creation* of *lasting improvements in the mental health service delivery system for children and families. Providers are currently deuoting substantial effort to finding and arranging funding.*

Research and Policy Questions

What public and private funding mechanisms could he used to provide a stable source of funding for comprehensive mental health services?

What incentives could be built into existing Federal, state, and local funding sources to increase flexibility in coordinating resources or encourage pooled funding to meet local needs?

D. Summary

Linking children in the child welfare system with needed mental health services may appear to be a logical and straightforward process. In fact, categorical funding, multiple and complex needs of the client population, complexities of the child-serving systems, resource limitations, and definitional issues combine to make this a difficult task. The five sites visited, each with its unique environmental and contextual characteristics and service system configurations, represent different approaches to addressing this issue. Despite the differences, themes, and patterns with implications for future program and policy directions did emerge. These implications can serve as a springboard for further discussions pertaining to future research agendas and additional actions needed to help service systems progress toward integrated and coordinated service provision.

Community-Based Mental Health Services for Children in the Child Welfare Svstem

I. Introduction and Purpose of the Study

Danny, 6 years old and in first grade, is a constant source of trouble in school--he demonstrates unprovoked physical aggression towards his teachers and classmates and often spits and pushes whenever he is thwarted His language is peppered with curses. His teachers think that he must be suffering from attention-deficit disorder. At home, he has the same problems--his mother feels helpless and ineffective in trying to discipline him, and his father's approach is to tie him to a chair and hit him with a belt. His father drinks heavily, but denies that he has a drinking problem, he claims that he needs to drink to relax because of all of the stress caused by Danny's misbehavior. Danny also has an 8 year old sister and a 3 year old brother with Down's Syndrome. Danny's mother comes from a family with a long history of drug and alcohol abuse, although she doesn't have any problems herself. Danny's father comes from an adoptive home which he ran away from as an adolescent and has not contacted since. Danny has recently been brought to the attention of the child welfare agency by the school because of suspected abuse.

The child welfare system is composed of many children like Danny, and many more who face challenges and deprivations that test their physical and emotional well being:

- *14 year old David is in detention for burglary and assault; this is his fourth time in juvenile court, and he has a long history of physical violence toward his younger sister and behavior problems in school and truancy. His mother thinks he is mentally ill and wants him evaluated and removed from the home.*

- *Thomas, 6 years old, is often seen on the street hustling money for food; he lives in public housing with his mother who is an alcohol and drug user; and he has two younger sisters who suffer from fetal alcohol syndrome. He has three older brothers; the two oldest are in prison for drug distribution, and the 16 year old is in a reformatory institution for murder*

- *Shauna, a 6 year old girl who has been removed from her natural parents because of sexual abuse, is now in her second foster care placement. She is unresponsive and uninvolved with people around her. She demonstrates very little emotional reactions to anything that happens to her--good or bad--and even shows little interest in Christmas-time activities and surprises.*

Children such as Danny, David, Thomas, and Shauna and their families have multiple, complex needs, and often have meager resources with which to meet these needs. They depend on mental health, child welfare, and other service systems to provide a myriad of service assistance. Too often, those systems are fragmented, hindering access and creating additional stress on children and their families. What happens when children's problems aren't identified, or if identified, no services exist?

Child welfare, juvenile justice, and mental health providers report that the children they serve are indistinguishable: they come from the same circumstances and childhood experiences. The impact of these experiences is simply manifested in different ways, or if left unaddressed, can have serious consequences for the child, family, and society as a whole. Conduct and behavior problems may accompany difficulties in forming friendships, performing in school, and, later in holding a job. Intensive interventions. may ultimately be needed, including incarceration or hospitalization. Approaches to meeting the myriad needs of children before they reach a level of severity requiring intensive interventions are not yet documented.

To gain an understanding of these issues, the office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services (DHHS), recently undertook a study to explore approaches to providing needed services to children in child welfare who have less than severe mental health problems. Macro International Inc. conducted the study under contract to ASPE. Below, we describe key issue areas of interest to the study, including the risk factors for mental health problems, the importance of early detection and intervention, and the need for service coordination in addressing identified problems. This discussion is followed by a description of the purpose of the study and the five sites visited to gain further insights to these issues at the service delivery level.

A. Risk Factors for Mental Health Problems Among Children in Child Welfare

The primary reasons for which children come into the child welfare system include physical, sexual, and emotional abuse; neglect; and abandonment. These traumatic life experiences are known to have immediate and potentially lifelong negative effects on physical and mental health. In addition to the physical injuries and suffering, there are other consequences of abuse and the lack of consistent, warm, and reassuring responses to a child's physical and emotional needs. For young children, these consequences include failure to thrive, failure to develop secure attachments, feelings of helplessness, and a lack of interest in people and surroundings. These problems, in turn, lead to intellectual deficiencies, social problems, and emotional difficulties among older children.

Families of children in the child welfare system often have a host of interrelated problems and issues-for example, poverty, violence, and teenage parenting. These stressors contribute to poor mental and physical health among children and their parents and are also thought to be causative factors for the abuse and neglect that requires public intervention. Children living in poverty experience well documented negative living conditions: they are typically undernourished, inadequately clothed, and live in substandard housing located in dangerous crime-ridden areas where gang fights and drug dealing are every day occurrences. Teen-age pregnancy and lack of prenatal care are both known to lead to low birthweight babies who may suffer from retardation, developmental delays, and chronic illness. More and more children

coming into the child welfare system are born with in utero exposure to drugs or alcohol, which causes disability, neurological and intellectual impairments, and behavior problems.

Eradicating poverty and its consequences would ameliorate many of the issues faced by child welfare and their families. Efforts to reduce teen pregnancy, drug abuse, unemployment, and homelessness are underway, although, by all accounts, these efforts address only the tip of the iceberg Recognizing the widespread and prevailing nature of these complex problems, it is important to address their impact on children and their families. Left unaddressed, the mental health effects of these conditions have negative consequences for children, their families, and society at large. It is well known that children with a history of family disruption and violence are at increased risk of becoming a victim or perpetrator of violence toward others. Behavior problems at home or at school that are not successfully treated may lead to more severe problems that require more intrusive and intensive levels of care and can result in removing the child from the home, or placing the child in specialized programs or residential care, all of which are expensive and less optimum settings.

B. Importance of Early Intervention in Preventing the Development of Severe Emotional Disturbance

Although experiences that bring children into the child welfare system are known risk factors for mental illness, growing caseloads, and limited resources have engendered a crisis-oriented approach in many child welfare systems. Services are targeted to the most serious and immediate problems. Intervention in less acute situations is often postponed, even though everyone realizes more serious problems are likely to develop as a consequence. Even when caseworkers recognize the need for early intervention and preventive services, many have neither the training nor the skills to determine the problem and obtain appropriate help. Often, mental health resources are limited or difficult to access.

Among mental health providers, reliance on tertiary approaches such as outpatient psychotherapy, hospitalization, and long-term residential treatment continue to inhibit development of needed services. Although more holistic, community-based approaches are advocated by reformers in the field and increasingly evident in communities included in this study, national data suggests that use of residential treatment continues to be high. This is attributed to a tradition of practice in the mental health field, as well as to fiscal incentives which drive the use of hospitalization rather than community-based alternatives. The expenditure of disproportionate amounts of available resources on residential treatment for a small number of seriously disturbed children remains a critical issue.

Most mental health programs and services continue to focus on children who meet program definitions of "severely emotionally disturbed" (SED). While many child welfare clients are eligible for SED services, a great many more would benefit from earlier, less intensive intervention to help negotiate the daily challenges of life and cope with the circumstances which brought them and their families to the attention of the child welfare system. However, attention to and services for children who are not yet designated "severely emotionally disturbed" remain a secondary priority. These children remain underserved, inappropriately served, or receive no services at all.

C. The Need for Coordinated Services Delivery

The delivery of needed mental health services for children in the child welfare system is hampered by a fragmented service system designed around categorical funding streams. Neither system alone has the skills, mandate or financial means to provide the comprehensive array of services needed to help children function well at home, in school and in the community. Professionals in the fields of child welfare and child mental health increasingly understand the value of collaboration.

The case for collaboration is clearly made by Knitzer and Yelton who note that the children and families served by the two systems "are often indistinguishable" and that both systems increasingly see clients with serious behavioral and emotional problems and widespread patterns of violence and family distress. Further, these. systems share complementary (if not identical) policy agendas in serving children in the most home-like, stable and least restrictive environment possible. Both systems also face increasing costs and decreasing availability of appropriate placements. In short, they share a mutual need to save money, increase efficiency, provide an adequate range of services, and avoid the pitfalls of parallel systems.'

In the child mental health arena, major steps have been taken toward the ideal of a coordinated system of care. At the Federal level, the National Institute of Mental Health (NIMH) in 1984 initiated the Child and Adolescent Service System Program (CASSP) to support a more comprehensive, multi-agency approach to addressing the complex needs of children with the most severe emotional disturbances. CASSP has promoted this interagency-system philosophy through grants to states, which were encouraged to develop or expand services for children and adolescents and to bring together disparate agencies to create a more functional integrated system. The relatively small CASSP grants provide funding for planning and coordinating services, but do not fund service delivery. Legislation currently under consideration by Congress would create a new Federal grant program specifically- to fund child-

[1] Knitzer, J. *and S.* Yelton. *1990. Collaborations between child welfare ond mental health: Both systems must exploit the program possibilities.* Public Welfare, Spring. *24-33.*

centered, community-based mental health service demonstrations, consistent with CASSP principles of a coordinated system of care.

Other indications of growing interest in the field of children's mental health include the efforts of private foundations in funding research and demonstration programs (e.g. the Robert Wood Johnson demonstration projects) and the emergence of local coordinated mental health service delivery models (e.g. North Carolina's Willie M. program and California's Ventura County program). However, these mental health efforts share a focus on children with serious emotional, behavioral or mental disorders, and do not specifically target the pressing needs of children served by child welfare.

In the child welfare system, the response to legislative mandates to ensure "reasonable efforts" to keep children safely at home has resulted in a shift toward preventive services and permanency planning. Short-term, home-based, intensive intervention child welfare programs have proliferated, supported by both Federal funds and private foundations (e.g. the Edna McConnell Clark and Annie E. Casey Foundations). While varying in their theoretical base, these home-based programs often involve other agencies, especially mental health and juvenile justice, in service planning and delivery.

However, numerous barriers to better collaboration remain. These include skepticism in child welfare agencies about the capability and experience of professionals in the mental health system to address the complex needs seen daily by child welfare workers. Other barriers include a strong pro-residential bias among legislators and professionals in both systems, difficulty in obtaining reimbursement for nonresidential services, and inflexible, categorical funding streams.

D. Purpose of the Study

Children who enter the child welfare system have faced serious difficulties in their lives, and these experiences are likely to have negative effects on their mental health. Their need for mental health services is clear; however, availability of and access to needed services is not assured. While child welfare reforms have increased the importance of preventive services to assist children and families to stay together, child welfare workers do not have the expertise or the proper orientation to provide a range of mental health services. The mental health system, on the other hand, is a loose alliance of private and public service providers with no historical mandate to serve children or to address family needs. Rather, mental health providers have traditionally focused on the needs of individual adults and on office- and hospital-based therapies.

Contemporary reforms have stimulated state and local efforts to improve coordinated mental health service delivery to children. However, research and program efforts documented in the literature feature issues and accomplishments in serving SED

children The availability of appropriate mental health services for children in the child welfare system, particularly those who have not yet been designated SED, has not yet been documented and thus is a major focus of this study. ASPE sought to identify and study programs in communities that were working together to identify and serve children with less than severe mental health problems. Our charge was to determine how change has developed in localities that have tried to improve service systems, what mechanisms support coordination, and the remaining issues and barriers in working together and improving services.

To guide the development of the study approach, a literature review and extensive discussions with Federal and nonfederal experts in the fields of child mental health, child welfare, mental health law and education helped identify critical factors that can influence the development of an integrated approach. In addition policy analyses, papers were consulted, and inputs from ASPE staff were sought. This process resulted in identification of three general categories of factors, which were explored during site visits: community, environmental, and contextual issues (e.g., values,. philosophy, breadth of involvement, leadership), system-level factors (e.g., coordinating mechanisms, definitions of target populations, funding sources, supply of personnel); and service delivery-level factors (e.g., training, caseloads, kinds of services, links to other systems). In addition, experts stressed the importance of recognizing that systems measures (e.g. improved service integration) should be related to improved outcomes for children and families (e.g. success/continuity in school), A schematic of the interrelationships among these groups of factors, and their ultimate relationship to outcomes for children and families was developed and is displayed in Exhibit 1. The study was not designed to specify or track the effect of any individual factor on a specific outcome, but to help discern their relative roles and general effects on the communities visited. The study methodology is discussed fully in Section IV.

Through site visits to communities with ongoing interagency efforts,. the study sought to answer the following questions:

- What are the characteristics that frame the development and implementation of efforts to work together?
- What are the key organizational components and mechanisms for successful interagency activities?
- What programs and strategies are in place for providing mental health services to children in child welfare, especially children who are not SED?
- What are the program, policy and research implications?

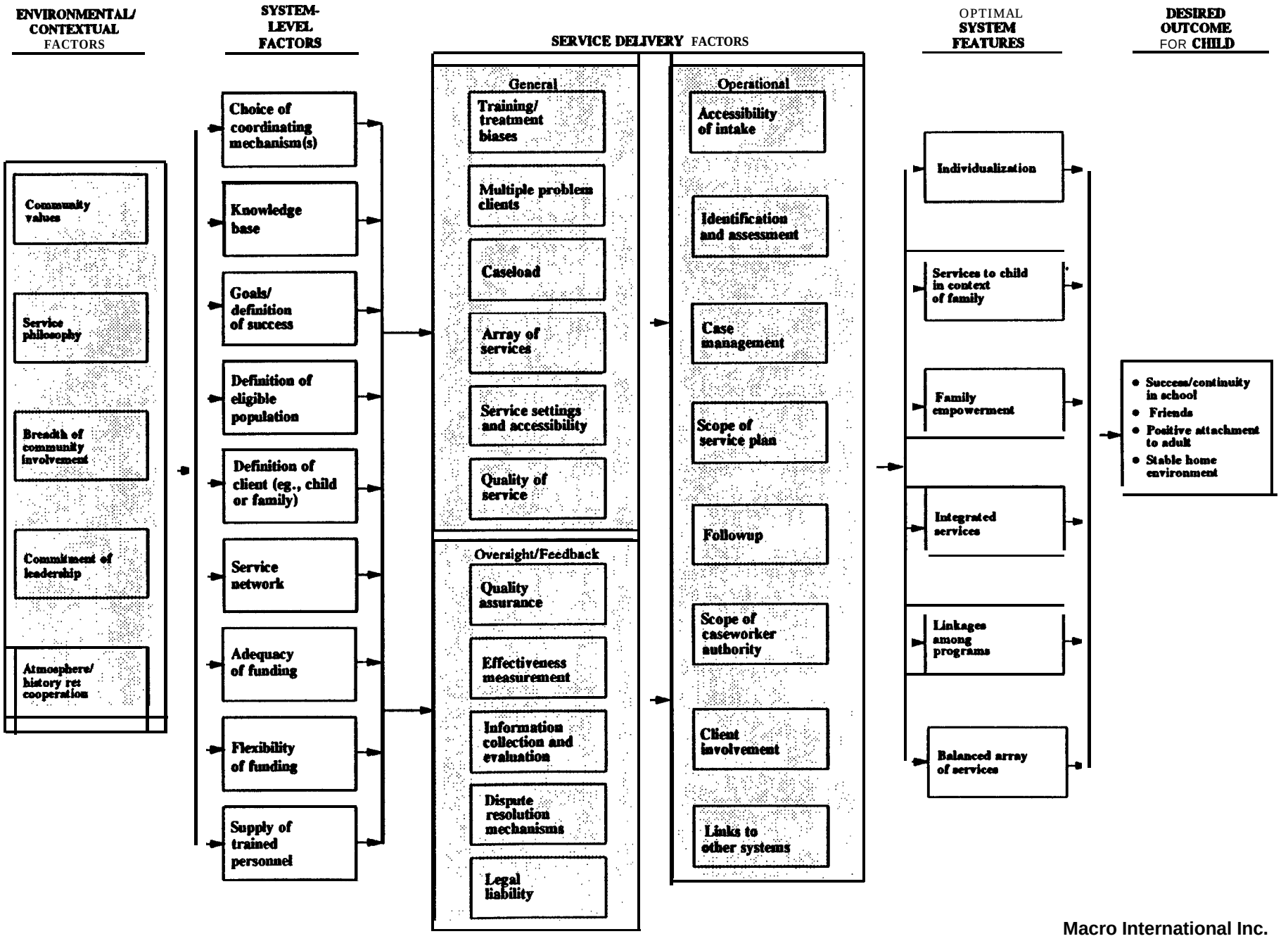
The remainder of this report documents the research that went into developing the study approach and discusses the study findings and implications. Specifically, the report presents:

- an overview of the status of childrens' mental health needs and services as discussed in the literature
- an overview of the multiple child serving systems including child welfare, mental health, juvenile justice, and education
- a description of the study methodology and approach to exploring the study questions
- key findings based on the five site visits in terms of similarities and differences related to two key issues: the types of mental health services being provided to children in child welfare; and, the extent to which child welfare and child mental health are working together and with other key child-serving systems
- program, policy and research implications

Following is a brief overview of the five sites visited for this study.

EXHIBIT 1

ANALYTIC FRAMEWORK: DESIRED OUTCOMES AND FACTORS AFFECTING DESIRED OUTCOMES FOR CHILDREN IN CHILD WELFARE WITH MENTAL HEALTH NEEDS



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E. Study Sites

Three basic criteria, shaped the selection of communities for case study: (1) a strong child welfare role but not necessarily a lead role, (2) a collaboration between child welfare and mental health agencies, and (3) an emphasis on community-based services for children and their families. In addition, various other characteristics were considered, such as the involvement of schools and courts, financing strategies, community size and populations served, and geographic diversity. An effort was made to identify diverse models of collaboration in both rural and urban areas and, in particular, to include the perspective of a major metropolitan area with a varied population and heavy demand for services. Sites selected are involved in active and ongoing efforts to improve the range of community-based services through interagency coordination. The study was designed to explore their experiences to date and the remaining issues in their progress toward improving services. Section IV on study methodology describes the site selection process more fully.

The following communities were selected for case studies:

Northumberland County is a small rural area in central Pennsylvania (population: 100,000). Human services are provided under a single umbrella agency which includes child protection., mental health/mental retardation, and juvenile court services. The consolidation was a county decision, agreed to by the state office. A key feature of the approach in Northumberland County is the "Children's Clinic," a traditional name for an innovative approach to collaborative service planning which involves child welfare, mental health and juvenile justice, as well as families being served.

Scott County is a somewhat larger community in Iowa (population 160,000) which is part of the "Quad Cities" area encompassing Davenport and Bettendorf on the west of the Mississippi River and Moline and Rock Island, Illinois, on the east. Scott county was one of two localities selected by the state to implement a pilot effort to decategorize funding for child welfare services by combining funds from several sources: the executive branch of the Department of Human Resources, the judicial branch and local counties. The program is just beginning its third year, and is characterized by a systematic, centralized planning process which involves a broad base of community agencies.

Jefferson County, is an urban area (population: 950,000) which comprises the largest social services district in the state of Kentucky. The site of district offices, Louisville, has a population of about 670,000 and includes about 40 percent of the state's child protection cases. Child welfare and child mental health services are implemented at the district level, and administered at the state level by different departments within the Kentucky Cabinet for Human Resources. Both agencies have recently benefitted from state legislation supporting family based services and mental health services for SED children. In addition, a progressive family court system has been adopted in

Louisville, and statewide education reform legislation has stimulated the development of family resource centers in local schools.

Hennepin County, Minnesota (population more than l,OOO,OOO) is the largest of the seven counties comprising the Twin Cities metropolitan area and is widely recognized for its tradition of quality public services, generous supply of capable social service providers, and history of leadership and responsiveness to community needs. A specialized family and children's mental health services division has been established within the umbrella of a broad community services agency which also includes child protection and child welfare, as well as other social services. Recent state legislation mandates mental health services for children and families.

Chicago, Illinois provides the perspective of a major city with its complexity of agencies and problems and heavy demand for social services. Child-serving systems operate under separate administrative structures at different levels. Child welfare and mental health are administered by the state, with varying regional structures affecting Chicago and Cook County Services. The Chicago Board of Education is administratively responsible for schools, however individual schools have a high degree of autonomy, as well as local advisory councils. The juvenile courts are part of the Cook County system, which also has its own service delivery structure. Consent decrees issued by the courts, and new leadership in both state child welfare and mental health agencies, have stimulated efforts to improve coordination.

II. Overview of the Status of Childrens' Mental Health Needs and Services

Although estimates vary, most experts concur that between 7.5 million and 9.5 million of the 63 million children in the United States need mental health services for emotional or other problems? At least 3 million of these children are estimated to be"severely" emotionally disturbed (SED). Little is known about the remaining 4.5 million. We do not know how troubled they are nor the extent to which serious emotional difficulty will ultimately develop. The vast majority of these less disturbed children probably are not receiving appropriate services. Fewer than one percent of all American children receive residential or hospital-based mental health services in a year; only about two million total receive any outpatient mental health treatment.

The extent to which these children with mental health needs are represented in the population served by the child welfare system is not known Definitional issues and poor reporting systems cloud an estimate of the extent of the problem However,. practitioners in both child welfare and child mental health report that they see many of the same children and families, who are also often involved with the court system as well. The "door" through which these children and families enter the health and social services system appears largely irrelevant. They are multi-problem families who need intensive and often sustained assistance from multiple agencies. Children and families in the child welfare system are subject to most of the psychological and social stresses and risk factors which have been shown to contribute to childhood behavioral and other mental health disorders.

A. Children's Mental Health Needs

Children's mental health needs cannot be neatly categorized. Mental health is a general term used to refer not only to the absence of mental disorders but also to the ability of an individual child to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional or behavioral dysfunction.

Mental health and mental disorders can be affected by numerous factors ranging from biological and genetic vulnerabilities, acute or chronic physical dysfunction, to environmental conditions and stresses. The causes of mental, emotional, and behavioral disorders in children and youth are not well known. Most professionals in the field would suggest that the disorders are due to a combination of psychological, environmental, and biological factors. Psychological factors include problems with intelligence, reasoning ability, self-esteem, and motivation. Environmental or social factors include peer relations, culture, economics, and family issues. Biological factors include genetic makeup, brain chemistry, serious nutritional deficiencies, and

[2] **U.S. Office of Technology Assessment. 1986.** ***Children's mental health: problems and services-a background paper.*** **OTA-BP-H-33. Washington, D.C.**

substances such as lead. All of these factors can bear some relationship to emotional problems? For children in child welfare, these factors may encompass poor parent-child bonding, family violence, emotional neglect, assaults on self-esteem, sexual abuse, and dysfunctional families. Further, children's emotional health can be affected by system-induced factors such as removing the child from natural parents, multiple out-of-home placements, separation from siblings, labeling, and changing schools.[4,5,6]

Just as the factors that contribute to mental illness are many and varied, the response of an individual child varies greatly. Children's mental health problems exist along a continuum of impairment of social, emotional, behavioral or cognitive functions that may not be easily described using standard diagnostic categories. Inconsistencies in definitions and labels for children who have "diagnosable" disorders have- attracted considerable professional attention. Describing children who are not at the severe end of the spectrum is even more difficult.

In addition, assessment of children's mental health needs must take into account problems that will affect future development as well. Children's mental health advocates emphasize that providers must not rely on an adult-centered view of treatment as a relationship primarily between patient and mental health professionals and must accommodate children's dependence on their families, as well as their stage of social, emotional, and cognitive growth and development.

A number of approaches to defining children's mental health needs may be identified; however, each is specific to the purpose for which it was developed. These purposes range from individualized clinical diagnosis and treatment planning to general assessments of the nature and severity of the problem to guidelines for program planning and eligibility.

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[3] Ibid.

[4] Ad Hoc Study Committee of the Children's Committee of the HRS Diict VI Alcohol, Drug Abuse, and Mental Health Planning Council and the Advisory Board of the District V SEDNET Project. 1990. A *report of the problems in the emergency shelter and foster care system of the HRS District VI.* H&borough County Department of Children's Services, Tampa, FL.

[5] Bumim, IA., S.R. Jackson, D. Schoen, 0. Turner, E. Johnson, and R. Cohen. 1991. The *r.c. case: creating a new system of care for children in the child protection and foster care systems who have or are at risk of developing emotional or behavioral disorders.* Mental Health Law Project, Washington, D.C.

[6] Frank, G. 1980. *Treatment needs of children in foster care. American* Journal of Orthopsychiat. 50(2), April: 256-63.

Clinical Diagnosis

The standard used by mental health professionals for diagnosis and treatment planning is the Diagnostic and Statistical Manual (DSM-III-R). The DSM-III-R include five general categories of disorder: intellectual, developmental, behavioral, emotional-and psychophysiological. Within the context of a recent background paper on children's mental health, the Federal Office of Technology Assessment (OTA) adopted the DSM definition of mental disorder: clinically significant behavioral or psychological syndrome or patterns associated with distress or disability.'

Assessment of the Nature of the Problem

Various instruments have been developed to help professionals identify and describe behavioral and emotional problems. As a way to measure the degree of severity of psychosocial problems in a selected study population, Frank developed aseven-point scale to reflect the range from no problems to the most serious psychosocial problems.8 A number of child behavior checklists and inventories have been. developed within the field of psychology.[9,10] One of the most widely used is the Child Behavior Profile scales developed by Achenbach; his checklist. of items related to behavior and social competence can be used to help characterize groups of disturbed children.[11] Multiple assessment tools used by multiple agencies appear to remain the practice in most places.

Program Planning and Eligibility

Severe emotional disturbance has been defined in different ways for purposes of program planning and determining eligibility for services. For example, CASSP uses a broad definition for designating the SED children it serves. The participants must be under 18 or 21 years of age (depending on jurisdiction); manifest a lack of ability to function in the family, school or community; require services from at least two

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[7] U.S. Office of Technology Assessment, op. cit.

[8] Frank, G. 1980. *Treatment needs* of *children in foster cum. American* Journal of Orthopsychiat, 50(2), April: 256-63.

[9] Achenbach, T.M. 1991. *Behavior checklist.* University Associates in Psychiatry. University of Vermont Department of Psychiatry.

[10] Hoagwood, K. Undated. *Parent checklist of childhood behavior.* National Institute of Mental Health. Division of Applied and Services Research.

[11] Achenbach, T.M., op. cit.

different community agencies; exhibit a mental or diagnosable disorder under the DSM-II-R or other state classification; and, have had the disability for a year or be expected for it to last more than a year.[12] Beyond these requirements, CASSP allows certain flexibility in states' definitions for eligibility.

The Federal Education for All Handicapped Children Act (P.L. 94-142) defines serious emotional disturbance as a condition exhibiting one or more of several characteristics over a long period of time and to a marked degree, which adversely affect educational performance. The characteristics include an inability to learn an inability to maintain peer and teacher relationships, pervasive depression or unhappiness, and a tendency to develop physical symptoms related to personal or school problems.[13]

State agencies concerned with mental health services also define their target population in varied ways; however, in an effort to bring some uniformity to the field, the National Conference of State Legislators (NCSL) recently adopted a definition similar to the CASSP definition: "broadly defined, severe emotional disturbances [that] cause major impairments in functioning for an extended period of time." Characteristics of emotional disturbance include difficulty in carrying out tasks of daily living, extreme vulnerability to stress, increased tendency to use alcohol or other drugs, tendency to "acting out" behavior, lack of ability to develop social networks, and inability to function in school.[14]

In general, existing definitions of children's mental health needs are focused on identifying severely disturbed children. The framework developed by Stroul and Friedman on which the CASSP definition of SED is based does distinguish two dimensions-the severity of social impairment and the persistence of the problems-to suggest a range of children's needs for planning mental health services. The possibilities range from problems of short duration and mild impact on functioning to persistent problems that severely affect functioning, with the CASSP target population defined by the most lasting and severe manifestations. However, no further effort to develop a standardized approach to defining less severe needs for program design and service development were discovered during the course of the study.

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[12] *Stroul,* B. and R. Friedman. 1986. *A system of care for severely emotional& disturbed children & youth.* CASSP Technical Center, Georgetown University Child Development Center. Washington, D.C.

[13] U.S. Office of Technology Assessment, op. cit.

[14] *Craig,* R.T. 1990. *What legislators need to know about children's mental health.* National *Conference* of State Legislators. April, Washington, D.C.

B. Childrens' Mental Health Services

Current approaches to providing children's mental health services reflect what national experts have termed a "paradigm shift" in both concept and implementation. In review of traditional and emerging approaches, Lourie and Katz-Leavy describe men: health services that traditionally included mainly outpatient psychotherapy, hospitalization, and long-term residential treatment. These traditional services were provided by public community mental health centers and state hospitals or obtained from the private sector. "Intermediate care" options (e.g., group homes, therapeutic foster care, and intensive in-home services) were usually funded by other systems such as child welfare and juvenile services and often were considered social services rather than mental health services.[15]

These "intermediate services", as well as other family support services, are now considered part of the mental health continuum of care. Among these services, Knitzer[16] includes crisis intervention, respite care for parents, day treatment, and intensive case management, as well as therapeutic foster care and: group homes. Beyer[17] also includes respite care, as well as parenting skills instruction, chemical dependency treatment, and others in her discussion of mental health services.

A broader range of services is only one feature of the changing approach to meeting children's mental health needs. An extensive review of literature and advocacy group positions by Boyd[18] reflects a strong commitment to providing mental health services through integrated efforts which are community-based and child- and family-centered. The focus is on adapting services to the needs of the client rather than adjusting the client's need to fit what is available in the system

A prominent example of current directions in child mental health is the "system of care" model developed by Stroul and Friedman with CASSP support The model advocates the importance of assuring a full range of services, based on the specific needs of each child and family, and including mental health, social,, educational, health, vocational, recreational, and support services. Within the mental health

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[15] Lourie, IS. and J. Katz-Leavy. 1991. New *directions* for *mental health services for families and children*. *The* Journal of Contemporary Human Services, Rockville, MD.

[16] Knitzer, J. 1989. *Collaborations between child welfare and mental health: emerging patterns and challenges*. *The Changing Services* for Children Project. Bank Street College of Education. May, New York, NY.

[17] Beyer, M. 1991. *Too little, too late. Where do we go from here to achieve reasonable efforts?* Unpublished materials.

[18] Boyd, L.A. 1991. *Integrating systems of care for children and families: an overview of values and characteristics of developing models*. *Florida* Mental Health Institute, University of South Florida. Draft, October *31,* Tampa, FL.

"dimension" of this complete system are an array of services which may be provided by any of several agencies, including child welfare (see below). In addition to providing a comprehensive range of integrated services, this model emphasizes that families and surrogate families should be full participants in all aspects of planning and service delivery.

This concept and the Stroul-Friedman model of a full range of services within the mental health dimension have been widely used in crafting current legislation to improve children's mental health services at the national level and in providing background for state legislators in their efforts to achieve state-level reform. Services included in the "mental health" dimension of the system of care proposed by Stroul and Friedman include the following:

Prevention/Early Intervention - The overall goal of prevention and early intervention is to identify troubled children early, provide appropriate interventions for the child and the family, and prevent residential and/or foster care placements. Problems can be treated more appropriately and effectively if the problems are recognized and the intervention begins early. Early recognition of health and emotional problems in children and the provision of appropriate services can reduce the duration and severity of the problems, as well as the overall prevalence of emotional disturbances in children.

Prevention activities recognized as mental health services may include promoting positive mental health and competencies (e.g., teaching problem-solving skills and strengthening self esteem); increasing self-help groups and support systems; and, modifying the procedures within agencies and systems to improve the experiences and outcomes of children and families.

Early intervention is "almost inevitably" a collaboration between different service systems and agencies. Families beginning to experience difficulty may be identified because of child abuse, physical health problems, developmental delays, learning problems, or others not initially viewed as "mental health."

Assessment-Assessments are probably one of the most adequately funded areas of mental health services, due to a tradition of use within the mental health field. **A** multitude of instruments, tests, and techniques are available for assessing emotionally disturbed children. Some concerns related to assessment include the gap that sometimes occurs between the assessment process and availability of needed services to address individual treatment needs, the time and expense involved in obtaining formal assessments, and the duplication of assessment by different agencies with differing requirements. Stroul and Friedman note the increasing emphasis on the need for a broad approach to assessment that moves beyond interviewing and psychological testing to emphasize the broader environmental, educational, and family contexts for

the problem. They also discuss the role of the growing field of family therapy on the changing role and nature of assessments.

Case Management-Case management is essential to the successful coordination of services for children in the CWS. Case management ensures that children get the most appropriate services they need and that services are coordinated for maximal effectiveness. Case management may include coordinating assessment of a child's (and family's) needs; planning and arranging for services to address those needs; monitoring adequacy and appropriateness of services and ensuring continuity; and, advocating for the child and family, as well as more activist approaches which emphasize "empowerment" of the family to find and make use of available community resources.

Outpatient Treatment-Outpatient services are an important component of 'any system of care for children. Traditional outpatient treatment involves bringing the child and/or family to a mental health center, child guidance clinic, or private practitioner's office for regularly scheduled individual, group, or family therapy sessions. This is generally the first approach to try to assist a child and family through mental health intervention. A variety of therapeutic approaches may be employed, including psychotherapy, behavioral therapy, family therapy, and chemotherapy. Outpatient services may also involve parent training, social skill training, and short-term, problem-oriented counseling.

Home-Based Services-Home-based services are intensive, immediate, family-focused interventions used extensively by child welfare agencies to prevent foster care placement. They often operate as collaborative, interagency programs and are also referred to as family preservation services, though there are a variety of models included in this term. Among the best known is the Homebuilders model, developed in Tacoma, Washington; however, there are other approaches to home-based services that seek to achieve the same goals. Home-based services provide intensive, short-term counseling, therapy, and parent education services to families in their own home settings. Outside resources that can assist the family function better are also incorporated into the service plan. Family preservation services are unique because no diagnosis is required, and there are no restrictions on the type of services provided. A caseworker is assigned to each family, and the treatment varies according to which services are appropriate to the individual family. Typically, family preservation services are crisis-oriented and only last l-3 months with between 5 and 20 hours of intensive, direct in-person contact each week with the families.

Day Treatment-Day treatment programs are the most intensive of the long-term, nonresidential mental health services available to children, and are generally indicated after less intensive programs have been attempted. While this often involves a collaborative relationship between mental health and education agencies, it always requires integrating these services to some extent. Emphasis on educational and

mental health interventions may vary among day treatment programs. Children in day treatment usually remain for at least one school year, spending a minimum of 5 hours a day in the program. Settings may vary among special and regular schools, community mental health centers, hospitals, or other settings. Children in these programs have, for the most part, been identified as seriously emotionally disturbed. Day treatment programs are generally seen as a way to avert the need for residential treatment or as a transitional program to help children who have been in residential treatment to move out of it.

Crisis and Emergency Services-These are a valuable addition to the full range of children's services and may be viewed as a mini-continuum ranging from prevention through crisis stabilization. Practitioners note that many children enter the mental health system during times of crises and that the handling of such episodes may affect the further development of mental health problems. Services range from training for teachers, parents, and children in handling crises and gaining access to services to telephone hotlines and emergency outpatient and inpatient services. Some home-based interventions may also be provided as crisis services.

In addition, a variety of residential services for children with emotional disturbances provide varying degrees of restrictiveness. Among the less restrictive are therapeutic foster care and therapeutic group homes. More restrictive placements include residential treatment centers and hospitals.

Other Services

In addition to these services obtained from the mental health system, children with emotional disturbances require a variety of support services, including self-help and support groups, advocacy, transportation, legal services, and volunteer programs. In addition educational, vocational, and recreational services help to integrate children into community life and reduce isolation and missed opportunities for healthy growth and development.

C. Services Examined in this Study

In exploring the roles and relationships of child welfare and mental health providers for this study, we included the full array of mental health prevention, support, and treatment services described above as potential components of collaborative efforts to meet the mental health needs of troubled children and families, with particular emphasis on those provided in the community.

III. Overview of Multiple Systems Serving Children in Child Welfare

As discussed in preceding sections, children with emotional disturbances have multiple and complex needs. Frequently these children and their families are in contact with child welfare, as well as a variety of other health and social service agencies. Such contacts may provide opportunities to identify children and families in early stages of difficulty; as well as to provide needed prevention, support, and treatment services.

However, for the most part the service delivery system is crisis-oriented and organized into a myriad of discrete programs, each with its own focus, source of funding, guidelines, and eligibility. Lack of communication mechanisms, turf issues and competition for scarce resources, as well as differing traditions and philosophies among varying professional staff, present continuing barriers to better working relationships and promote piecemeal approaches to complex problems. Too often, agencies focus only on the problem they are organized to solve, rather than on the range of additional and associated needs brought by the child and family.

Recognizing that organizational and administrative obstacles play a key role in affecting the approach to providing mental health services to children in the child welfare system, an effort was made in the early stages of study development to identify and include the other major child-serving systems that see these children and their families. Based on literature review and input from Federal and non-Federal experts, the education system and juvenile court activities were included in site visit data collection wherever possible. The role of the courts has gained increasing importance with the advent of "reasonable efforts" legislation in 1980. The interest and involvement of the education sector in improved collaboration is a more recent and still largely developmental component of coordinating efforts, stimulated by concerns about the emotional, social, and environmental factors inhibiting students' ability to learn.

Below, we provide a general overview of the organization and development of the two major systems of interest to this study, child welfare and child mental health systems, as well as of the roles of the education and juvenile justice systems which play such an important part in the lives of these same children. In addition, we provide a brief description of the way each of these systems work in the five study areas visited. The key features of these systems for each study site are displayed in Table III-l.

Table III-1
Key Features of Child-Serving Systems In Study Sites

Stud Sites	Child-Serving Systems			
	Child Welfare	Child Mental Health	Juvenile Court	Education
Northumberland County	County administered under a unified services umbrella agency which also includes mental health, juvenile justice, and drug and alcohol services.	Services obtained primarily through the outpatient arm of the county's mental health program, with Medicaid reimbursement. Counseling and home-based family therapy are key features.	Juvenile court services are part of the county's umbrella department of human services, and led the way in providing mental health and other services prior to the consolidation.	Teachers participate in service planning where indicated for specific children. In addition, the schools use contract services to help identify and support children considered at risk for emotional problems. Planning for increased collaboration around truancy issues is underway.
Scott County	State administered with county service delivery. One of two counties chosen for pilot decategorization of child welfare funding.	Children's mental health services are purchased from private providers or obtained through a traditional outpatient mental health center with Medicaid reimbursement.	The influential Decategorization planning committee includes the chief juvenile court officer. Current and former judges are strong advocates of reduced placements and improved services.	Under Decategorization auspices, schools are launching an effort to improve social and learning capacities and communication among parents, students, community agencies. A new child health decategorization project will involve schools in a key role.
Jefferson County	State-administered child welfare system with county service delivery. Includes both child welfare and juvenile services. State legislated focus on family-based services.	A large and comprehensive community mental health center, as the only Medicaid-approved provider, provides most mental health services to children and families. Limited services are provided by child welfare workers or obtained from specialized private providers.	An innovative Family Court system has been operating for a year integrating all activities involving families under a single court division. An advocate judge has assertively tried to improve collaboration with child welfare and other agencies. Both child welfare and child mental health agencies provide onsite social workers as liaisons to the court.	Statewide education reform has led to collaboration between schools and mental health providers in early intervention and support programs. Coordination between child welfare and education is not yet as well developed.

Table III-1 (2)

Study Sites	Child-Serving Systems			
	Child Welfare	Child Mental Health	Juvenile Court	Education
Hennepin County	County-administered under umbrella of a broader community services agency which also includes mental health. Child welfare is divided into two divisions: child protection and family services. Strong local tax support for services.	A specialized family and children's mental health division provides outpatient services and consults with child welfare workers. In addition, private providers are also used, reimbursed by Medicaid or covered by medical assistance through managed health care. Early intervention services are jointly provided with the schools.	An active juvenile court judge has advocated for and mandated joint case consultation "summits" involving key agencies. Joint psychological assessment procedures are used by mental health and the court.	Early intervention programs for preschool children involve joint planning, funding and service delivery between schools and the family and children's mental health division.
Chicago	State-administered system with county service delivery. Focus is on core child protection services, with some enhanced services.	Primary source of children's mental health services is through contracts with private providers. Effort is underway to expand Medicaid coverage for these services. In addition, a state supported mental health screening and assessment program serves child welfare clients.	A former model of juvenile proceedings, the current juvenile court is widely criticized for its inability to address the severity and volume of problems brought to its attention. The court system as a whole has played a major role in ongoing child welfare reform through consent decrees.	Pilot efforts to develop collaborative programs between child welfare, child mental health and three Cook County schools are expected to be funded in the near future by the state Board of Education.

A. Child Welfare

The term "child welfare system" defies a specific definition because it takes on slightly different configurations and ranges of activities across jurisdictions. Even within jurisdictions, often there is not a coordinated, comprehensive child welfare service system.[19]

Broadly interpreted, the concept of child welfare encompasses social services and income support for children and their families. Over the past several decades it has evolved into a more specific focus on serving children whose parents are absent, are unable to care for them, or provide inadequate care. This is determined by the parent's actions (abuse/neglect, or voluntary relinquishing rights), or by the conditions or actions of the child (e.g., handicapped or behavior problems), with the dual and sometimes conflicting purposes of supporting families who are having problems and ensuring the safety of the child. The core functions comprising the broad concept of child welfare services include:

- Child Protective Services (CPS)--which includes investigation and services to safeguard children who are abused and/or neglected,
- Preventive services-home-based services, for example, family preservation and other family support services, to avoid substitute care.
- Substitute care-temporary out-of-home care including foster care, residential care, and group homes for children who are removed from their homes at the parents' request or because the parents are determined to be incapable of caring for them
- Adoption services-to arrange for permanent placement of children whose natural parent's rights have been legally terminated, with a family who takes over the legal guardianship and custody of the child.

The relative priority and extent of these various services varies depending on the community's philosophy toward child welfare services and resources available to support them.

1. Funding Sources

Child welfare services are funded through a combination of Federal, state, and sometimes county funding.

[19] Kammerman, S.B. and AJ. Kahn. 1989. *Social services for children, youth and families in the United States. The Annie* E. Casey Foundation.

The primary Federal funding sources for child welfare include the following:

- Title IV-B of the Social Security Act, the Child Welfare Services Program, which provides formula grants to the states. States have broad discretion in the use of this money.

- Title IV-E of the Social Security Act, which authorizes open-ended reimbursement to the states on an entitlement basis. These funds are intended to cover a portion of the costs associated with foster care maintenance payments for children who are eligible for Aid for Families with Dependent Children (AFDC), and foster care program administration, staff training, and adoption assistance for children with special needs. Title IV-E children also qualify for Medicaid coverage.

- Title XX of the Social Security Act, which provides coordinated discretionary block grant program funds. These funds are used by some states to fund child welfare.

2. Child Welfare Legisiation

Child welfare service systems as they exist today have been influenced by two key pieces of legislation:

- P.L. 93-247--the Child Abuse Prevention and Treatment Act of 1974, which was in response to the growing recognition of and widespread alarm about undetected physical abuse of children. This law established the National Center for Child Abuse and Neglect and provided funding to the states for training and technical assistance with the stipulation that states have in place mandatory reporting laws and mechanisms for investigating reports. Since the mid seventies child welfare services have been dominated by efforts related to child abuse reporting and prevention. This legislation has been recently amended and reauthorized (P.L. 102-295, May 1992).

- P.L. 96-272--The Adoption Assistance and Child Welfare Act of 1980, which was in response to a series of studies and reports documenting the dire conditions of child welfare which had become characterized by unnecessary out-of-home placements, and children languishing in foster care with no plans or efforts to move them towards permanent home situations. The legislation created Title IV-E and strengthened Title IV-B of the Social Security Act. In addition it provided financial incentives to states to ensure reasonable efforts to avoid removing a child from his/her natural family; case planning; a periodic case review system conducted by

the court system; least restrictive placements; and, efforts to reunify when possible or arrange other permanent placements for children.

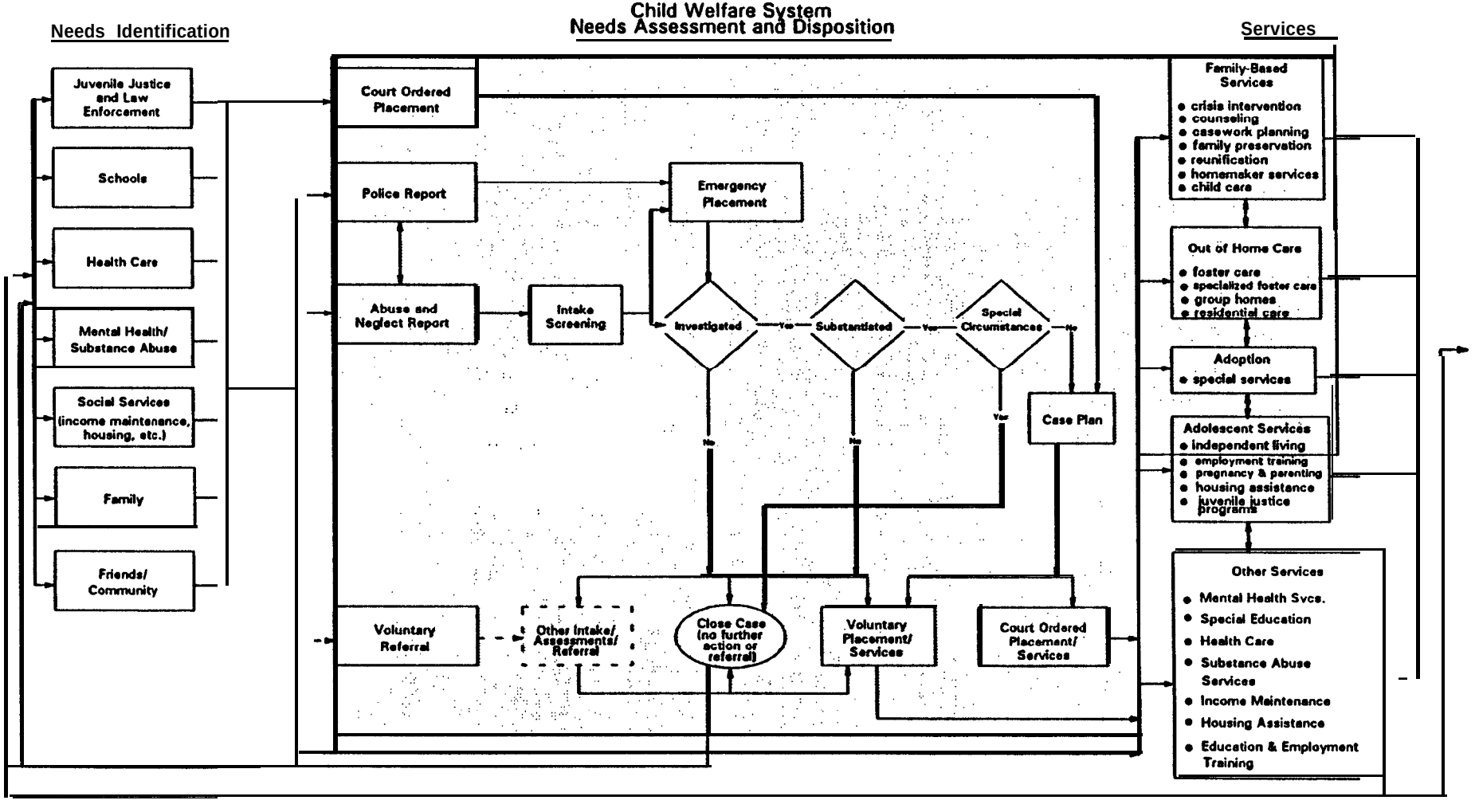
3. Entry into Child Welfare

A theoretical model depicting an idealized flow of children through the child welfare system is represented in Exhibit 2. Typically, children enter the system through a report of suspected abuse or neglect; occasionally other avenues for services are available, either by self-referral, or through programs intended to reach at-risk families. Intake is followed by one or more of several possible activities, depending on the specific situation, including crisis intervention, emergency foster care placement, and investigation.

For cases that are closed (no abuse or neglect was substantiated), most systems take no further action. However, a few systems may have mechanisms for referral to other programs within or outside of their agencies. For cases in which abuse or neglect has been substantiated, referral for ongoing services is made, and it is determined whether the child needs to be removed from the home or will remain at home.

Ongoing services may include a range of options such as home visits, counseling, or intensive home-based services, and may be provided directly by the child welfare agency or through contract with a private agency. Case plating requirements ensure permanency planning provisions and establishment of a case goal, which may include terminating parental rights and referring the child for adoption, moving older children (typically 16 years or older) into independent living programs to help make the transition to self sufficiency, returning the child to the home, or for special circumstances, continued placement in long-term substitute care.

Exhibit 2
Flow of Children Into the Child Welfare System



- - - - - possible link but not typical or well defined

Macro International Inc.

4. Current Status of the System

At the present time, 12 *years* after landmark reforms were initiated by P.L. 96-272, the child welfare system in general is still characterized as one that is in crisis and in need of further reform. P.L 96-272 has been effective in reducing the numbers of children in institutions, shortening the period of time children are in placement, and increasing the numbers of children who are returned to their families or adopted. However, concerns about the effectiveness and quality of services persist, and many still consider the *system* to be in a state of crisis. Although the numbers of children entering foster care decreased during the early 1980's, since the mid 1980's the system has experienced increasing numbers of children in foster care, increasing re-entry rates, and an increase in the number of young children entering the system.

The dire situation in child welfare is attributed in part to the growth in social problems, such as alarming increases in the prevalence of poverty, inadequate housing, unemployment, drug and alcohol use, and AIDS. These conditions constitute risk factors for abuse and neglect and add to the complexity of the problems that must be addressed. In addition, child welfare is a system that suffers from inadequate resources for early intervention/prevention efforts. While Title IV-E, the entitlement portion of child welfare funding, has steadily increased, appropriations for Title IV-B have not kept pace with authorized levels.[20] Title XX funding levels have matched statutory authorization, with the exception of sequestrations; however, the amount available in real dollars has declined.[21] This is particularly notable because Title IV-B is the funding that supports prevention programming targeted to intact families, while Title IV-E supports payments for out of home care. Additional concerns and issues include fragmented services; inadequate Federal oversight; states' failure to comply with Federal legislative intent; escalating administrative expenditures; staffing problems including inadequate qualifications/experience, large caseloads, low salaries, and low job satisfaction; and, foster parent shortages.[22]

This situation of growing caseloads and limited resources has resulted in greater targeting of child welfare services to the most emergent and serious problems. In essence, child welfare has evolved into a child protective services-driven

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[20] Ibid.

[21] U.S. House of Representatives. 1992 *Background material and data on major programs within the jurisdiction of the Committee on Ways and Means: overview of entitlement programs...Green Book* Committee on Ways and Means.

[22] The Crisii in Foster Care: New Directions for the 1990s. 1990. Seminar conducted by the Family Impact Seminar, funded by the E.M. Clark Foundation

system, leaving little time or resources far response to the less serious problems that everyone acknowledges will develop into the more serious problems that bring families into the system

5. Innovations and Pending Legislation

Although overall conditions in child welfare are considered bleak, innovative strategies aimed at prevention have evolved over the years and were spurred on by mandates in P.L. 96-272.

Most notable and widespread of these strategies is the "family preservation" concept which focuses on providing m-home intensive services over a period of about 6 weeks as a means to avoid foster care placement for children. While family preservation is widely regarded as a needed service, it is targeted to very specific populations and the capacity is severely limited by resource constraints. Other specialized services and approaches have also emerged in&ding family reunification programs, some of which are modeled after family preservation, programs targeted to multi-problem children, and others.

At present, there is legislation pending, plus an Administration proposal, which may improve support for family-based, preventive services and enhance child welfare agencies' efforts to develop mechanisms for early intervention and address children's mental health needs before they become severe. The Family Preservation Act (H.R. 3603) would convert Title IV-B into a capped entitlement program and specifically fund family preservation services. The Child Welfare and Preventive Services Act (S.4) would establish a new entitlement within IV-B for innovative services. These services include family support, family preservation, respite care, family reunification, and followup service. The Administration's proposal would allow states to use Title IV-E administration and training funds with no eligibility constraints for services to children and would provide funding for state demonstrations of home-based family interventions and their evaluation.

5. Child Welfare Services in Sites Visited

In spite of the overall impression that child welfare has had to increasingly target services and is in a state of crisis, this condition varies widely across jurisdictions depending on the richness of resources available, and prevailing values and philosophies about social services and public agency responsibility. Kammerman and Kahn describe this variation on a continuum of breadth of services including the following:

- **Core** child protective services-systems that target only the most serious cases and focus on issues of rescuing the child from harm; the emphasis- is on the investigation process and substitute care, with relatively fewer resources allocated to services

- Targeted but enhanced CPS programs-systems that incorporate some specialized help and ongoing services

- Child welfare agencies-systems that offer services to populations beyond just those coming in through CPS and attempt to offer innovative programs for targeted populations

- Enhanced child welfare programs-systems that include child and family services and are integrated with various other child serving systems such as child mental health, status offender and/or delinquency programs, maternal and child health, and adolescent services

- New vision proposals-systems that have enhanced child welfare services but are also working toward placing the child and family service response in a community development context with an **emphasis on community** ownership and responsibility

Depending on the political and public agency administration structure of the state, child welfare systems are either state administered with direct operations at regional/county/local area offices, or county administered with some level of state supervision. The child welfare systems of each of the five sites selected for site visit for this study are briefly summarized below with comparisons to the categories offered by Kammerman and Kahn.

Chicago, Illinois--is a state-administered system delivered at the regional level. The Illinois child welfare system currently focuses on the **core CPS services** with some enhanced services such as family preservation; however, the state is on the verge of change which has been brought about by a comprehensive consent decree that outlines specific activities to take place over the next 3 years.

Hennepin County (Minneapolis), Minnesota-is a county-administered enhanced family and child serving system which is heavily supported by county tax-based dollars in addition to Federal funding. It includes protective services as well as a family services unit that handles at-risk families. A family and children's mental health division, which is relatively new and in the process of forging formal linkages with the child welfare units is under the same umbrella organization.

Jefferson County (Louisville), Kentucky--is a state-administered enhanced family and child serving system with operating offices at the county level. The state has articulated a strong philosophy of family-based services, and the child welfare related services are provided by the Family and Children's Services division which includes juvenile services. Jefferson County has instituted numerous programs targeted to specific populations in an effort to enhance their responsiveness to children's and families' needs.

Scott **County (Davenport), Iowa--is** a state-administered enhanced family- and child-serving system with operational control at the county level. In addition, Scott County was one of two pilot sites in the state (Des Moines was the other) selected for a project to decategorize funding for child welfare services. The project requires close collaboration of child welfare, county, and juvenile court services in developing an overall plan that would use a single child welfare budget to provide a range of services for children in the county. The flexible funding mechanism made it possible to add to traditional child welfare services (child protective services, foster care, etc.) such enhancements as day treatment, respite care, parent-assistance services, family preservation, and a family assistance fund.

Northumberland County (Sunbury), Pennsylvania-is a county-administered system that emphasizes family empowerment and community involvement/ownership. The systems of child welfare (Children and Youth Services), mental health (Mental Health/Mental Retardation), and juvenile justice (Juvenile Court Services) are unified under one Department of Human Services. Through several coordinating mechanisms, including the Children's Clinic, DHS managers identify gaps in the continuum of child-serving programs and plan collaboratively to establish such programs. This site comes closest to being a "new vision" system.

B. Child Mental Health

Among publicly funded human services agencies, mental health has lagged behind in recognizing and addressing the particular needs of children. At the time Jane Knitzer's landmark study of children's mental health services was completed for the Children's Defense Fund (1982), the few Federal dollars targeted to serving children and adolescents had been eliminated under the mental health block grant system. Earlier national efforts to call attention to the problem had emphasized the need for a comprehensive model of coordinated services for mentally ill children. However,

prior legislative efforts on behalf of children's mental health had been both short-lived and poorly funded.[23]

The Knitzer study is generally seen as a turning point in mobilizing growing momentum for change. Congress subsequently allocated $1.5 million for development of an initiative to improve services to seriously emotionally disturbed children, which resulted in creation of the CASSP. Funded and administered by the National Institute of Mental Health (NIMH), the program continues to provide small grants to states to improve multi-agency planning and coordination. Private foundations, notably the Robert Wood Johnson and Annie E. Casey foundations, have also funded research and demonstration programs to examine and test improved methods of delivering social services to children and families.

CASSP activities are acknowledged by both child welfare and child mental health professionals as having played a key role in state-level mental health activities on behalf of children." Legislation currently under consideration by Congress would create a new Federal grant program to specifically fund child-centered, community-based mental health services consistent with CASSP principles.=

1. Children's Mental Health Services

In the ensuing 10 years since the Knitzer report, there has been a growing recognition that children need different kinds of services than adults. The complex biological, psychological, and environmental factors that contribute to emotional and behavioral problems in children are reflected in highly individual responses from the child. In addition, developmental issues and childrens' dependence on their families must be taken into account in any approach to meeting mental health needs. An adult model of treatment based on an individual patient-provider relationship does not account for many of the key considerations in working with children. Contemporary efforts to meet the needs of children and families go beyond traditional hospitalization and office-based therapies, and attempt to intervene in the social system which surrounds and affects the lives of children and families. Newer home-based and family-centered

[23] Knitzer, J. 1982. *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services. Children's* Defense Fund. Washington, D.C.

[24] NAPCWA/SMHRCY Report. 1991. Op cit.

[25] S. 924. to amend the Public Health Service Act to establish a program of categorical grants to the states for comprehensive mental health services for children with serious emotional disturbance. Introduced by Senator Edward Kennedy. April 1991. Similar legislation was introduced in the House by Rep George Miller.

approaches operate more on a "wellness" than a "deficit" model and seek stabilization and improvement rather than cure.

Acceptance of "environmental" approaches has not been easy for mental health professionals or for policymakers comfortable with more traditional treatment modes. Nor do current funding and reimbursement mechanisms easily accommodate community-based alternatives to hospitalization. There remains a large and increasing number of children placed in psychiatric hospitals and residential care at enormous cost.

2. The Mentai Health System

The existing mental health "system," as described by Lourie and Katz-Leavy,[26] is actually composed of four separate sectors which occupy separate service niches and work in complementary ways.

- Public mental health services are provided, for the most part, through community mental health centers and state hospitals. These public services have traditionally emphasized adults and provided few children's services.

- The private, nonprofit sector provides a large proportion of children's services, particularly specialized placements. Child welfare agencies typically contract with these agencies or refer families covered by Medicaid. In addition, services are offered privately to those who can afford them, usually on a sliding scale basis.

- Private, for-profit hospitals provide services to those who are insured, can pay for them or who can obtain public sector funding.

- The private practice sector includes professionals from mental health disciplines (psychiatry, psychology, social work) who offer services to those who can afford them.

Child welfare obtains services from all four sectors, but most notably from private, nonprofit agencies. Services may be supported directly by Federal child welfare funding (e.g. Titles IV-B and IV-E) in combination with state and, in some cases, local tax dollars. A major source of support for mental health services in sites visited is Medicaid.

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[26] Lourie, I.S. and J. Katz-Leavy. 1991. New directions for mental bealtb services for families and children. *The Journal of Contemporary Human Services,* Rockville, MD.

3. Children's Mental Health Services in Sites Visited

The various elements and configuration of the children's mental health system in sites visited are summarized below:

Hennepin County, Minnesota. Two years ago a specialized Family and Children's Mental Health division (FCMH) was created within a broad county social services agency which also includes child welfare and child protective services divisions. A substantial portion of the division's budget comes from local tax dollars, but programs within the division develop and fund services in a variety of ways. A variety of early childhood intervention services, as well as services for school-age SED children., are jointly funded and administered by the county and the school system Medical assistance and Medicaid, supplemented with county funds, private insurers and some fees support direct provision of a wide range of outpatient services. Relationships between FCMH and -the child welfare divisions within the agency are developing; however at present child protection continues to obtain most mental health services throughreferral to private providers reimbursed by Medicaid or to approved HMOs. Family preservation services needed by child protection families are generally. obtained through contracts with private providers. A separate child welfare division (called Family Services) provides family preservation and other home-based services directly to selected families who participate on a "voluntary" basis.

Jefferson County, Kentucky. One of the most comprehensive community mental health centers in the Nation, Seven Counties Services, provides Medicaid reimbursed mental health services to children and families in Louisville and Jefferson County. Although Seven Counties does receive state mental health funds, this is a decreasing portion of its funding. In the area of child and family services, combined state and Federal funds administered by the state mental health agency have supported home-based services for some SED children under the Kentucky Impact program. However, services for most child welfare families referred to Seven Counties are paid for by Medicaid. Seven Counties is the only approved provider of Medicaid services in the area Other insurers, contracts with various agencies (including child welfare) and sliding scale fees make up the rest of its budget. In addition to Seven Counties, the child welfare agency also contracts directly with other private providers for specific services (e.g., sexual abuse expertise) and provides some services directly.

Chicago, Illinois. Mental health services for children in child welfare are provided mainly through contracts with private nonprofit providers. Other publicly funded sources of mental health services include a city-run network of community mental health clinics (which have very limited children's services) and two state-funded acute care hospitals which can also conduct assessments on an outpatient basis. An effort is currently underway to increase the range of

available services by seeking a Medicaid rate structure for mental health services and training providers in obtaining Medicaid reimbursement. A consent decree dating back to the 1970's, involving both the state mental health and child welfare departments, continues to generate activity to decrease the use of and reliance on hospitalization for children with mental health needs. At the state level, a separate office for children and adolescents has been established in the mental health department and a mental health plan for SED children developed which funds a statewide Screening, Assessment, and Support Services (SASS) program delivered through a regional structure. In the northside area of Chicago visited for this study, about half the children and families served by SASS are involved with child protective services. The same mental health center which serves as the regional SASS center also delivers a smaller effort in which mental health and child welfare funding jointly initiated a combined program of office- and home-based services for about 50 families.

Scott County, Iowa. Mental health and other services needed by families in child welfare are generally purchased from private providers or obtained through referral to an approved Medicaid provider. The major public mental health provider in the area is a county-funded community mental health center which provides traditional outpatient therapies for children with a DSM-III-R diagnosis. The center is the sole mental health provider designated by the county for Medicaid reimbursement. Funds from three child-serving agencies are pooled to provide a "decategorized" source of support for providing individualized services, including mental health. Priorities during the 3 years the decategorization program has been underway have included an initial emphasis on establishing a planning process, followed by development of structural components (including a mental health plan).

Northumberland County, Pennsylvania. The Northumberland County Counseling Center, the outpatient mental health arm of the county's Mental Health/Mental Retardation Program, provides therapy for children and their families. The Center receives Medicaid reimbursement at the rate of $25 per hour of therapy. Other programs that involve a therapeutic component are funded in varying ways. For example, Homekeepers, which provides intensive in-home support and counseling for troubled families, initially received funding from a Federal grant; that has since run out, and the state Department of Public Welfare has "backfilled" the funds. Examples of other sources of funding for programs related to mental health needs of children are Federal early intervention for the Parent Center and ADAMHA grants for school-based intervention programs and day programs.

C. Juvenile Justice

The concept of a court devoted to concerns of children originated during a period of rapid social change[27] when child protective services also were established as a public responsibility. The role of the juvenile court has evolved over the years,. embracing a range of proceedings including those related to delinquency, neglect, status offenses, termination of parental rights, adoption, child custody, commitment for a child determined to be mentally retarded or ill, and emancipation.

Typically, children enter the juvenile court system because they have broken the law (delinquent), have committed a status offense (that is, an offense related to their legal "status" as minor, e.g., running away from home, truancy), or are in need of protection because of parental abuse (physical, sexual), neglect, or abandonment. Most juvenile justice referrals are made by the police, although any party who is concerned about a child's welfare or behavior--e.g., social worker, school teacher, parent-may petition to have the child come under the jurisdiction/protection of the court.

When children enter the juvenile justice system, it may be presumed that some have mental or emotional health needs that could be alleviated by appropriate services. The kinds of services likely to be referred for a child in the juvenile court system include general or special counseling (e.g., sexual or physical abuse) for the child and/or family, special home-based programs to preserve the integrity of the biological family, or other programs that focus on children and adolescents at risk If a child is found guilty of breaking the law and is deemed to have emotional problems, the judge has available a range of dispositions, including placing the child in a mental hospital, group home, or long-term residential treatment center. Alternatively, the judge can order an intervention at the child's home. Children who are viewed as violent can be placed in a "secure, locked facility."

The initial view of the juvenile court envisioned the judge as a "gatekeeper" who decided whether to admit "helping professionals" into a family's life.[28] The judge's decision was based on a clinical/medical model, and providers used medical and psychological definitions of a child's needs. Once a judge established a need to intervene, the court stepped out of the picture and left the child's welfare up to the social service system.

Two changes altered that perspective. First, with the emergence of the concept of family rights to privacy, integrity, and due process, the court's role expanded to add

[27] **Fitzgerald, R.W. 1989. *Social services and the law: Conflict and collaboration.* In: Collaboration for competency: examining social work curriculum in the perspective of current practice with children and families. University of Kentucky College of Social Work, OHDS contract #04-CT-029101.**

[28] **Ibid**

an oversight responsibility for the adequacy of services to the child. Further, national legislation (P.L. 96-272) mandated that "reasonable efforts" be made to maintain children in their own biological families. This legislation not only pushed child welfare agencies to adopt a more home-based, family-focused approach, but also increased pressure on courts to review placements, case plans, and mandated services. In effect, this legislation empowered the judiciary to affect the policy and practice of many child welfare agencies.

The reasonable efforts legislation thus thrust the court and welfare systems into a new relationship, one requiring communications and cooperation. Regular meetings between court and agency staff, liaison contacts, and joint training are all ways of fostering this communication.

Despite the important role the court plays in working with a range of troubled youth, the system "often fails to meet the needs of children who are emotionally disturbed," according to one report.[29] Service systems vary in their determination of what constitutes an emotional disturbance, the report states, with the result that "many children do not receive appropriate services until they have severe problems."[30] Another report notes that "there is no clear pattern to how children in the juvenile justice system receive the few services they do get" and no systematic study of the quality of those services?'

Further, the same report notes that there are "no national data on the number of children in the juvenile justice system who have serious emotional or behavioral problems and need mental health services."[32] Two state estimates suggested a range from 30 percent to 58 percent of all adjudicated children had severe emotional problems. Children who receive court-ordered services generally receive them from mental health facilities, juvenile correctional facilities, and through contract providers whose services are purchased by those facilities.

The juvenile court systems (including both judge and probation officers) played important leadership roles in the sites visited for this project.

Jefferson County has adopted a Family Court system that integrates under a single court division all court-related activities involving an individual child and family. The family court concept views the court as an institution that provides a comprehensive

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[29] Craig, R.T. 1990. *What* legislators *need to know about children's mental health.* Washington, DC: National Conference of State Legislatures.

30 Ibid.

[31] Knitzer, J. 1982. Op cit.

[32] Ibid.

array of appropriate services (e.g., legal, social, and psychiatric) for individuals who come under its jurisdiction. The Jefferson County Family Court has actively sought to improve collaboration with child welfare and other agencies through both coercive and cooperative activities. The court has created a cadre of family court liaisons composed of social workers from child welfare and child mental health services who work with families and judges to improve access and assure appropriate disposition.

In contrast, in Chicago efforts are underway to determine how best to reform the current floundering and highly criticized juvenile court, which once held the distinction of being the first in the country to separate juvenile court proceedings from adult proceedings and served as a model for other systems. In addition, the court system has played a major role in making changes in the child welfare system through a consent decree to improve the quality and coordination of services.

In Hennepin County, an active juvenile court judge has both advocated for and mandated joint case consultation "summits" involving key agencies and joint committees to improve case coordination. One result has been a psychological assessment procedure used by the court and children's mental health providers.

The juvenile court system is an integral part of the human services system in Northumberland County, Pennsylvania, and, in fact, is part of the county's umbrella Department of Human Services. The previous director of the agency pioneered many innovative activities when he was the Chief Probation Officer. Prior to the development of an integrated human services system, the juvenile court services were known as the foremost providers of services, including mental health services, for children and adolescents. The juvenile court system still has its separate system of foster care homes, although there is coordination with the main system of human services. The chief probation officer is a regular participant at the weekly Children's Clinic where staffing decisions related to mental health referrals are made. The Juvenile Court also has an active, advocacy-oriented advisory board which has been successful in raising community awareness about issues related to needs of children in the juvenile justice system.

The court is a critical participant in Scott County, Iowa's planning efforts related to decategorization of child welfare funds. The current juvenile court judge is strongly interested in and committed to a family systems approach, and the chief juvenile court officer is a key member of the influential decategorization planning committee. The judge is committed to reducing the number of placements out of the community and is sympathetic to family-centered interventions such as family preservation. The previous juvenile court judge was actively involved in a national campaign to educate court personnel about the "reasonable efforts" legislation.

D. School Systems

The major impetus behind school involvement in child welfare and mental health services has been Federal legislation passed in 1975--P.L. 94-142, the Education for All Handicapped Children Act-which required schools to provide education in the "least restrictive setting" for all children labeled severely emotionally disturbed (SED). The act mandated a broad range of services, including mental health services, for SED children. However, the law was unclear about coverage of children whose emotional problems were considered mild or moderate, and states varied in their interpretation.

Amendments made in 1986 to this legislation (P.L. 99-457) extended benefits to all children with disabilities from the age of 3 years and up, required states to develop early intervention programs for infants and toddlers who are deemed to be developmentally delayed or at risk of such delay, and provided the major impetus for family involvement in educational planning. P.L. 94-142 was reauthorized in 1991 and is now called Individuals with Disabilities Education Act (P.L. 102-119).

Knitzer and Yelton noted the potential importance of this initiative for increasing involvement of child welfare and child mental health sectors with the schools, especially given the importance of the target population (high risk infants and toddlers) to caseloads in both child welfare and child mental health service systems. Currently, however, mental health interventions within schools generally are not widespread or well coordinated with other systems.

Among the localities visited for this study, school systems were less involved in efforts to foster coordination and collaboration with other child-serving agencies. However, involvement by schools in the sites visited did include a range of activities that were at least tangentially related to mental health needs.

Early intervention programs for preschool children in **Hennepin County** involve extensive collaboration between the schools and children's mental health, health, and other agencies. Examples of collaborative endeavors include joint assessment and screening in local health departments, family-focused therapeutic services, respite care, and day treatment.

The involvement of the school system in **Jefferson County** is influenced by educational reform in Kentucky which emphasizes school-based collaboration among community providers for early intervention and support services to children in low-income areas. To date, the child mental health system has been more involved than child welfare providers, at least in Jefferson County, where the site visit took place. Linkages with child protection services in the model school visited there occurs through the efforts of the school social workers. School staff report that families they serve are "afraid of child protection involvement. Staff of child welfare and other child-serving agencies interviewed generally regard the schools as moving toward better working

relationships, but not yet fully on board with others. Jefferson County staff attriiuted reluctance of school personnel to work more closely with child welfare and mental health providers to the school system's concern that involvement in joint assessment and planning activities might translate into increased financial responsibility for services.

In **Chicago,** no collaborations between schools and child welfare or child mental health were reported to be in place. However, the State Board of Education recently awarded grants to three school systems, including Cook County, to develop collaborative approaches with child welfare and child mental health to identify children in need and link them with needed services.

Under the auspices of the child welfare decategorization project in Scott County **Iowa, an** initiative has just been launched in two schools to improve social and learning capacities of youth and to promote communication among parents, students, and community professionals. The pilot project, just underway, is supported by a **Danforth** Foundation grant. Another major effort involving schools was also in the start-up phase at the time of the site visit. A child health decategorization project, supported by the Robert Wood Johnson Foundation, is considered a "mirror" of the child welfare decategorization project. Schools are being seen as a major part of the network, with school-based health clinics part of the plan

The Student Assistance Project (SAP) in **Northumberland County, Pennsylvania,** provides identification, assessment, and support group activity for children considered at risk for emotional problems. Currently, the services are provided by an outside contractor, but the goal is to train school personnel to conduct the SAP activities. School teachers also become involved with the child welfare/child mental health system through participation in the weekly Children's Clinic staffing sessions. If school behavior or truancy are issues, the teacher takes part in the staffing discussion, contributing to the understanding of the child's problems and possible solutions. The county also hopes to increase its collaboration with schools through development of a focused truancy program. The Parent Center is considered a significant way to affect early intervention. Its parent counseling, support groups, and special services aim to enhance parenting skills and empower families to improve their own issues and problems.

IV. Study Methodology

To address the requirements of this study, this project incorporated broad-based input from national Federal and non-Federal experts, published and unpublished reports, and data collection through case studies of five localities. The study approach was developed through an iterative process that included three major phases: identification of key issues and focus for the study through research and expert input, development of the study approach and analytic framework, and conducting site visits.

A. Identifying Key Issues and Focus for the Study

Because of the complexity of the issues surrounding the provision of mental health services to children in child welfare, and the cross cutting nature of the topic, the early activities of the project concentrated on obtaining a broad base of input to help shape the direction of the study and identify key issues to pursue. Input was obtained from a Federal advisory group, a national (non-Federal) group of experts, telephone discussions with additional experts, interviews with service providers, and a focused literature review.

1. Federal Advisory Group

A Federal advisory group was convened to guide all phases of the project. It included representatives from government agencies with jurisdiction over the key service areas of interest--child welfare, mental health, juvenile justice, and education-as well as expertise in integration of services. In addition to staff of the Office of the Assistant Secretary for Planning and Evaluation, the committee included members from the General Accounting Office, Office of Special Education Programs, Office of Juvenile Justice and Delinquency Prevention, the Children's Bureau, the National Institute of Mental Health, and the National Center on Child Abuse and Neglect. A list of Federal advisory group members is attached in Appendix A.

Two meetings of the Federal advisory group were held: first at the outset of the study and again prior to the site visit phase to provide final input to site selection and the case study approach. In addition, the Federal group reviewed and provided input to the final report.

2. National Experts

Between meetings of the Federal advisory group, a panel of non-Federal experts was convened to provide additional insights. This group included persons with

extensive experience in conducting research and studies in the areas of child welfare, children's mental health, and advocacy, as well as representatives from state/county child welfare and child mental health agencies, special education, and a consumer organization. The list of expert panel members is included in Appendix B.

Contributions of the non-Federal expert panel included providing indepth expertise in the issues relating to state and local systems; reviewing and helping refine the study approach; providing input and guidance to site selection criteria and helping identify potential sites for inclusion; and, suggesting additional experts and resource materials.

3. Telephone Discussion with Additional Experts

Subsequent to the meeting with non-Federal experts, telephone discussions were held with a variety of additional persons with national and state perspectives on the issues of concern to this study. The purpose of the interviews was to broaden the base of input to the study, further explore key areas of interest and study questions, and obtain additional suggestions for localities to consider for site visits. A summary of information gleaned from these discussions is attached in Appendix C, and includes a list of the individuals interviewed.

4. Summary of Literature Findings

Published and unpublished literature, documents, and reports related to child mental health and child welfare issues were reviewed to assist in determining the state of current research and defining study issues. Findings were summarized in a report attached as Appendix D.

B. Developing the Study Approach

Inputs from the meetings, interviews, and literature review described above were used to develop site selection criteria, an analytic framework and a case study plan, including a site visit protocol.

1. Analytic Framework

The analytic framework was developed to guide the data collection and analysis phases of the study. The framework illustrates the general interactions among key factors influencing service delivery approaches and outcomes for children

including environmental/contextual factors, system-level factors, and service delivery factors.

In conjunction with the analytic framework, a matrix was developed to translate the causal structure and factors in the framework into a series of research questions. The analytic framework and matrix of research questions are included in Appendix E.

2. Case Study Plan

A case study plan was developed to guide the site visit process and ensure that information would be collected in an efficient and consistent manner. The case study plan is attached in Appendix E and includes a description of the types of person to be interviewed, and the processes used to make initial contact with the sites, schedule interviews and conduct the site visits, as well as the discussion guide used while on site. Types of persons interviewed during the site visits included key persons involved in formulating policy, planning and initiating efforts, administering programs, and providing services.

Discussion topics were developed from the analytic framework and related research questions and were designed to elicit information that would complete our understanding of the environmental/contextual, system-level, and service delivery factors that influence the particular site's approach to providing mental health services to children in child welfare.

3. Site Selection Criteria

Site selection was based on three key criteria as defined in the initial project workscope: 1) a strong child welfare role, but not necessarily a lead role; 2) collaboration among child welfare and mental health agencies; and, 3) an emphasis on community-based services for children and their families.

In addition to these criteria, input from Federal and national experts resulted in developing additional characteristics to consider for the final site selection. These included:

- System context-factors related to general fiscal health, history of collaboration and existence of Federal/foundation initiatives.
- Leadership roles-factors related to level of leadership, systems/agencies responsible.

- Range of systems participating, particularly education and juvenile justice involvement.
- Collaborative program planning and service delivery approaches.
- Financing strategies-pooling funds or other approaches to obtaining needed services.
- A continuum of services-ranging from prevention/early intervention to residential treatment.
- Kinds of populations served-factors related to age-range, severity of needs, reasons for referral.
- Scope of services-targeted to broad or narrow range of eligible populations.
- Jurisdiction of collaboration-state, county, city.
- Geographic location.

From an initial pool of localities suggested by Federal and non-Federal committee members and experts interviewed by telephone, nine sites meeting the primary selection criteria and additional considerations were selected for further research. These included:

- Leon County, Florida
- Coeur D'Alene, Idaho
- Scott County, Iowa
- Jefferson County, Kentucky
- Stark County, Ohio
- Northumberland County, Pennsylvania
- Tennessee (statewide program)
- Vermont (statewide program)
- Hennepin County, Minnesota

Profiles were developed for each of these sites, based on telephone discussions with at least three key persons knowledgeable about the locale and the service approach. Four were selected from this list for case studies.

- Hennepin County, Minnesota
- Jefferson County, Kentucky
- Scott County, Iowa
- Northumberland County, Pennsylvania

Chicago, Illinois was selected as the fifth site, based.on Federal advisory group and ASPE staff recommendations that a large urban area should also be included to gain insights into issues confronting large systems with diverse populations and heavy demand for services.

Together, these sites represent a range of characteristics described above as well as diversity in geographic location and community size. Profiles of all site visit candidates are included in Appendix F.

C. Conducting Site Visits

Visiting the five sites was the central method of data collection for this study. The purpose of the site visits was to explore working approaches to providing mental health services to children in child welfare, identify and describe the particular environmental/contextual, system-level and service delivery factors influencing the approach, and identify common threads and trends across approaches which have implications for future policy and research directions.

Site visits were conducted by two teams composed of two Macro staff over the course of 4 days in each study area. Information was obtained through unstructured interviews, using the discussion guide developed as part of the case study plan, as well as through documented program descriptions, legislation, mission statements, interagency agreements, and data collection and evaluation reports provided by respondents on site. In all, the site visits included discussions with well over 100 individuals, representing approximately 46 public and private agencies and organizations, as well as foster parents and advocates.

Data and information obtained were summarized in a site visit report for each area visited. These reports are included in Volume II of this report.

V. Key Findings from Site Visits

In this section, we discuss similarities and differences among the five localities visited in providing mental health services to children in child welfare. Our findings are drawn from interviews with up to 26 individual providers, administrators, and advocates from a variety of agencies and organizations in each study area. In summarizing findings we address the two main issues that were the focus of this study: 1) the kinds of services being provided to children in child welfare, with particular emphasis on children who are not SED; and, 2) the extent to which child welfare and child mental health are working together and with other key child-serving systems.

Below is a summary of the major findings followed by a discussion of each finding within the two major issue areas. Identification of key issues was guided by the analytic framework which is described in Section IV, study methodology. The framework describes a range of characteristics at the environmental, system and service delivery levels that influence a site's approach to providing services. Discussion points in this chapter reflect the features of developing and maintaining coordinated service delivery that played the most important roles in the sites visited for this project.

A. Summary of Major Findings

Key findings related to the status of mental health services for children in child welfare and the status of service coordination in the five sites visited include the following:

Mental Health Services for Children in Child Welfare

Status of Services

- ***The only clear*** criteria for defining children's mental health needs in sites visited were those developed to identify severely emotionally disturbed children (SED). Although agencies and providers recognize that many children who need mental health services may not fit SED criteria, there is no common way to describe or categorize these needs. For the most part, children who are not clearly SED are recognized as needing mental health services because of behavior or conduct problems, or because they cannot function in school.

- In almost all sites visited, identifying children's mental health needs and obtaining services is dependent on the child welfare caseworker's training, awareness of resources, and concern about observed or reported behaviors or problems.

- Mental health se&es in all localities include traditional outpatient and inpatient services. However, home- and community-based services are a prominent and growing part of the array of mental health services.

- While a few programs in study sites were developed specifically to serve children in the child welfare system, the majority serve a broader population within which child welfare clients may or may not be a priority. Even where a broad array of programs is in place, children in child welfare may not always benefit due to such constraints as program eligibility criteria, access mechanisms and program capacity.

- Case planning for children who are involved with multiple systems remains, for the most part, fragmented, duplicative or both.

- There was generally no evidence of a system-wide approach to evaluating coordinated provision of mental health services to children in the child welfare system. However, individual agencies do track and monitor service delivery measures in many instances.

Approaches to Services

- In some localities, true joint efforts are in place involving multiple agencies and families in service planning; however, most involve independent efforts by each system which may or may not be shared with others.

- Although family involvement and empowerment is recognized as an important value in study areas, there is wide variation in the extent to which families are currently involved in service planning and setting treatment goals. In many places, however, foster parents are being increasingly viewed as extensions of service delivery staff and are involved both in service planning and in working with natural families.

- Generally, case management denotes a "brokering role" in sites visited, i.e., a responsibility to see that children and families obtain access to available resources. However, a more activist concept of case management as a comprehensive process of stimulating development of needed services and helping the family find ways to meet their own needs was also evident.

- Although most needs for additional programs and services identified by respondents were specific to the service delivery system in that locality, three general areas for further program development were cited by several: services for children in the juvenile justice system, improved coordination with the schools, and better ways to address the critical effects of sexual abuse and drug abuse in the lives of most children and families in the child welfare system.

Service Coordination

Status of Coordination

- Very different models for working together have been developed in the localities visited. The extent of coordination is affected by the general climate in the community as well as by the interplay of leadership, communication and problem solving processes, and funding considerations.

- The size, complexity of the systems involved, community values, and operating styles influence the approach to coordination.

- While the strong leadership of an individual leader was noted in one or two of the sites visited, all those who have been successful have supportive leadership in several key agencies who are committed to finding ways to work together.

- Communities varied in the value placed on formal communication and coordinating mechanisms; however, they share an emphasis on mutual problem solving, consensus building among a wide range of community providers, and a recognition of the value of consumer involvement in service planning.

Approaches to Coordination

- Developing community-based mental health services for children requires creative and laborious efforts to tap into and mix Federal, state and local dollars from various child serving agencies. A key impetus for developing a broader range of services in the community is concern for the high cost of residential care related to the few children who can be served.

- Coordinating mechanisms exist at both planning and service delivery levels in all study areas visited. For the most part, these represent cooperative efforts through which independent agencies or divisions of an agency share their own plans and work together to sort out roles, minimize duplication, and improve access to their services.

- Some aspects of the integration process are unique to individual localities. However, there are some common features: shared values, supportive leadership, broad community involvement and consensus-building, stability among service providers, and significant involvement of the courts. In addition, common values and problems, coupled with Federal and state actions, have helped create a climate for better coordination.

- Although the balance varies, coordinating efforts between child-serving systems in localities visited appear to have resulted from converging "top-down" and "bottom-up" efforts.

B. Mental Health Services for Children in Child Welfare

As described earlier in this report, while definitions for severe emotional disabilities have been developed over recent years, mental health problems that are less than severe escape precise definition. Also reflected in the literature and by expert panel members is a recent broadening of the concept and implementation of mental health service delivery from traditional outpatient and inpatient services to include intermediate services such as crisis intervention, respite care for parents, day treatment, intensive case management, therapeutic foster and group care homes as well as a range of other family support services.

During the site visits, we explored how the selected sites approached the issue of defining mental health needs, the types of mental health services that were being provided, the extent to which issues raised by experts and in the literature were reflected in practice and the nature of these issues at the service delivery level.

The approach to defining mental health needs and providing mental health services to children in child welfare was examined by exploring a number of closely interrelated service delivery and system level characteristics and factors, as presented in the analytic framework used to guide this project. Following is a discussion of the factors that emerged as most important in shaping the service approaches in the five sites visited for this study.

The only clear criteria for defining children% mental health needs in sites visited were those developed to identify severely emotionally disturbed children (SED). Although agencies and providers recognize that many children who need mental health services may not fit SED criteria, there is no common way to describe or categorize these needs. For the most part, children who are not clearly SED are recognized as needing mental health services because of behavior or conduct problems, or because they cannot function in school.

In a few instances, children were considered at risk of needing mental health services due to trauma or repeated placements and were provided mental health assessments or supportive services. In Hennepin County, for example, most children in child protective services are assessed by a mental health specialist and service needs are identified. In Jefferson County, child protection caseworkers have initiated a program to help support young children who have experienced multiple placements in developing healthy attachments to caretakers. For the most part, however, emotional or behavioral problems must be clearly evident before action is taken.

1. Children's Mental Health Needs

In almost all sites visited, identifying children's mental health needs and obtaining services is dependent on the child welfare caseworker% training, awareness of resources, and concern about observed or reported behaviors or problems.

Identification and assessment processes are important factors of a systematic approach to providing mental health services to children in child welfare. Some level of informal or formal assessment is necessary to identifying and linking children to needed services. The earlier assessment occurs in the child welfare process, the degree to which assessment becomes routine, and the sensitivity of the assessment instrument or mechanism in detecting problems influence the ability of the system to identify needs and devise an approach to addressing those needs.

None of the systems visited conduct routine psychological assessments; however, in **Hennepin County** assessments end up being requested for almost all of the children. **Jefferson County** is embarking on a pilot project to help caseworkers identify underlying issues that are not always outwardly evident, and is in the early stages of developing an approach to provide multidisciplinary assessment and case consultation for all children in child welfare. The State of **Illinois** also intends to implement an assessment process as required by a recent consent decree-it will be conducted among all children coming into the system and assess medical, psychological, social, and educational needs.

There are several back-up mechanisms for identifying a child's problems when they have gotten to an obvious point. These include assistance from foster parents (many of whom have taken on a paraprofessional role) and identification through other service systems such as the courts and schools. It is not uncommon for the court system to have its own psychological assessment staff and/or providers, as seen in Hennepin County, Jefferson County, and Chicago. In Hennepin County, there have been recent efforts to standardize the assessment instruments and procedures used by mental health and the court. The school system may also conduct assessments; however, several systems indicated that there is a reluctance to do so because if a deficit is identified, then the school system may be mandated to address it under P.L. 99-142 and 99-457, sometimes at a very high cost.

Assessments are not only considered useful for identifying needs, but also are often necessary to establish eligibility for specific services, as described above. Respondents expressed concern about the negative aspects of labeling a child and indicated that often parents resist this.

2. Children's Mental Health Services

Mental health services in all localities include traditional outpatient and inpatient services. However, home- and community-based services are a prominent and growing part of the array of services.

The ability of a service system to address identified mental health needs is in part dependent upon the types of services available. As described earlier, children with mental health problems need a comprehensive array of services which are typically provided by multiple agencies.

Most localities visited emphasized the importance of family preservation efforts, particularly in providing for mental health needs of child welfare families. Availability and accessibility of other home-based and less traditional mental health services varied considerably.

Nowhere were services described as a continuum with varying levels of intensity. Rather, sites have developed a broad and varied range of services, many within the last few years and often in response to specific needs. Only one site (Scott County) uses a systematic, community-wide planning process to determine which services should be in place. Other localities develop services through a variety of formal and informal interactions described in section V.C. below.

Services identified in study areas can be grouped into three broad categories: prevention/early intervention; treatment; and, support services. Each is described below, with examples of services available in each site, the service system under which it is administered, and target populations. The distinction between services in these three broad categories is not always clear, and similar types of services can be categorized in more than one area depending on the specific orientation of the service and the audience to whom it is targeted. For example, services addressing issues of self esteem or parenting skills may be considered early intervention/prevention in some cases, or be included as support services in a broader treatment program (e.g., wraparound).

a. Prevention/Early Intervention

All sites visited included prevention/early intervention activities in their concept of mental health services, and many respondents identified this level of service as most needed. Examples of prevention/early intervention programs observed in each site is summarized in Table V-1. Services included in this category include the following kinds of activities:

Programs to Prevent Problems from Occurring that Would Brine a Child Family to the Attention of the Service System

Examples include broad-based programs geared towards helping children build self-esteem, improve school attendance and achievement; and community-based parenting skills training. Among these kinds of programs identified during the site visits are Hennepin County's multi-agency Truancy Committee, Scott County's Neighborhood Youth Councils, and Jefferson County's Youth Services Centers. Another innovative model is the Parent Center in Northumberland County which focuses on parenting skills and support groups. This program evolved from- one that targeted families whose children were in foster care, to one that targets a much broader population in an effort to address issues before they get to the point when child welfare needs to be involved None of these types of efforts target children in child welfare, or even track the number of children in child welfare served, however, they are considered important in diverting children and families from the system Many of these types of efforts emanate from the educational system, and several are jointly funded and administered by education and mental health and sometimes child welfare.

Programs to Prevent Children/Families with Problems from Getting Worse and/or Going Into a More Restrictive Level of Care

These types of programs include attempts to prevent out-of-home placement or residential placement, and typically include a treatment component aimed at addressing identified problems. Much of the impetus for these types of services is the cost savings incurred by avoiding more restrictive care settings. Examples of these include family preservation programs and other intensive treatment programs similar to family preservation but offering a broader range of services for a longer period of time.

Although family preservation programs were not a focus for this study, they were viewed by providers in sites visited as important mental health components of the service delivery system. In fact, many sites had recently developed variations on the family preservation model to enlarge their range of prevention and treatment options. For example, the Parent Resource Pool in Jefferson County provides in-home services to families who are in crisis or going through post-placement reunification for a period of about 1 year. The focus is on stabilizing the family to avoid removal or to ensure that reunification is a success. Other prevention programs with a strong mental health treatment component include Northumberland County's Homekeepers program which offers intensive in-home services

with a therapy component for a period of 6 months, **Hennepin County's Family-Focused Services** which combine in-home and clinic-based therapies, **Jefferson County's Wraparound and Impact programs** which last in duration up to 1 year and sometimes longer, the **HomeFirst** program in Chicago which also focuses its mental health approach on in-home services, and **Scott County's third level of foster care** which includes a therapeutic component provided by specially trained foster parents. All of these also include a range of support services along with the therapeutic component.

Another innovative effort is the **Jefferson County piiot project** to identify children in foster care who are experiencing **detachment disorders.** Initiated by workers in an ongoing child protection unit, this program includes training for caseworkers to address these problems directly or through consultation or referral to a psychologist, and training for foster parents to help them understand the separation and loss issues that the child is facing. The purpose of the program is to minimize the potential for multiple moves in the foster care system.

Table V-I
Examples of Prevention/Early Intervention
Services Identified in Each Site

	Program	Administering System	Target Population/Eligibility Criteria
Prevention/Early Intervention			
Scott County	Neighborhood Youth Councils--leadership training to promote self-esteem building, positive interactions with peers, school, and families	Jointly by Child Welfare, Mental Health, Juvenile Justice through Decat, with funding from private foundation	AU children in two specific schools--an elementary and adjacent junior hiih school
	Family Resources, Inc.--prevention for kids at risk of joining gangs--broad-based education and linking kids and families to community resources	Grant funding	County-wide, children from 3rd grade through junior high
	Family Preservation	DHS	*All children* at risk of foster care placement will first receive family preservation services
IHennepin County	348-TOTS--early intervention screening and linkages to services	Jointly by Education, Mental Health, and Health	At risk and handicapped children from birth to 3 1/2 years
	Community-based school truancy committee	Private agency, with representation from education, corrections, mental health and child welfare	Targeted to all school-age kids
	Family Preservation	Child Welfare-Family Services	Families at risk of out-of-home placement because of the child's behavior who are motivated to change
	Family Preservation	Child Welfare-CPS, through contract with private providers	Families at imminent risk of having a child removed
	Family focused therapeutic services -- outpatient and home-based	Mental Health	Age birth to five, at high risk of abuse and neglect, not serious enough to warrant day treatment
IVorthumberland County	Parent Center-skill building, parenting workshops, support groups	DHS	Any parents
	CLANCY--GED preparation, pre-employment training, independent living skills	DHS, special programs	Adolescent at risk or referred by court
	CLANCY--student Assistance Program--School- based screening and referral teams; small support groups also offered on-site in schools	DHS	All elementary and high school children (teams based in all schools)

	Program	Administering System	Target Population/Eligibility Criteria
Prevention/Early Intervention			
Jefferson County	Family Resource and Youth Services Centers--school-based program to identify community needs and provide direct family support services as well as referrals	Education	Elementary and middle schools in which 20% or more students are eligible for free school meal program. Operational in 21 of 110 eligible schools in County
	High[5] and Child Development Project--demonstration programs to develop new teaching approaches and increase student and family involvement in the schools	Education--funded by private foundations	Piloted in 3 middle schools and 2 elementary schools
	HELP--family preservation	Jointly between mental health and child welfare	Child welfare-involved families at imminent risk of having children removed from the home
	Parent Resource Pool--in-home services lasting about one year, including training, support group, and recreational and support groups activities	mental health under contract to child welfare	Child-welfare involved families at risk of have chid removed, in crisis, or going through reunification (cannot have sexual abuse or chemical dependency as identified problem)
	Six and Under Program--pilot project to identify and address needs of children experiencing detachment disorders	Child Welfare	Young children in child welfare who have experienced two or more moves within the foster care system
	Informal collaboration with VNA to deflect families from the child welfare system	Child Welfare	Families with drug exposed infants being discharged from the hospital with 9 week VNA supervision
Chicago	**Parent/Child Centers**	**Education**	**Preschool age children**
	Community-based parent skills training and other education efforts	Child Welfare--through grants to CBOs funded by tax check-off and federal funding	At-risk families in the community, defined by grantee
	Counseling services to status offenders for a period of 21 days to avoid adjudication	Juvenile Justice--through contract with private provider	Status offenders identified by police
	Family Preservation	Child Welfare-through contract with private providers	Child-welfare involved families at imminent risk of having a child removed
	HomeFirst -- statewide screening, crisis intervention and intensive in-home service program	Mental Health	Children meeting state SED definition

b. Treatment

Mental health treatment services are based primarily on diagnosed disorders. Examples of treatment programs identified in each site are included in Table V-2.

Treatment services vary in levels of intensity and restrictiveness and may include outpatient counseling, day treatment, foster care, group care, residential care, and inpatient hospitalization. Various treatment approaches used may include individual, family and group counseling, and psychotherapy, behavior modification, and medication. While clinic-based services were seen in all sites, most reported increasing interest and need for home-based services. This was viewed as a departure from traditional mental health services, and was identified as an area where more services, and more accessible services are needed. Examples of these kinds of services are described above under prevention services.

Of particular note is the social systems change approach employed by the **R.E.A.C.H.** program in **Jefferson County,** a contract provider which serves children in child welfare who have run out of placement options. The program is based on a concept of supporting and empowering families (both foster and natural families) to deal with problems through **home-**based behavioral management consultation, respite, and various support services. The focus is *on* "person centered planning" that takes into account the strengths and capacities of the child, flexibility in the roles of the provider staff working with the child and family, integration of formal and informal support systems, and empowering the client, family, and friends to plan and make decisions.

Table V-2
Examples of Treatment
Services identified In Each Site

	Program	Administering System	Target Population/Eligibility Criteria
Treatment			
Scott County	Day treatment--structured therapeutic after-school program including counseling, therapeutic recreation, educational help, behavior management, diet/nutrition, case management	DHS-Child Welfare	Age 12 - 14, at risk of residential placement, difficulties in two of three areas (family, school, community); attending school, have minimal support system and family commitment to program
	Outpatient counseling	County mental health through contract with private provider	DSM-III diagnosis
	The Wittenmyer Campus--secure locked facility for juvenile offenders	Juvenile Court	Juvenile offenders sentenced to incarceration
Hennepin County	Outpatient counseling	Public agency (FCMH) and private mental health providers	FCMH--children/families on medical assistance; private providers--through contract with child welfare, or an HMO designated as medical assistance provider
	Early childhood and school-age day treatment	Mental Health with pooled special education funds	Children meeting state SED criteria and who cannot be served in the schools
Northumberland County	Northumberiand County Counseling Services--outpatient mental health services	DHS, MH/MR	Children/families in need of services
	Homekeepers--intensive in-home family preservation-type services with therapy, 6 months duration	DHS, MH/MR	Families whose services children who are at-risk of placement
	CLANCY--Day Treatment--self esteem, stress management, drug and alcohol education	DHS, special programs	Court-ordered older adolescents with moderate to severe behavioral problems
	CLANCY--Social Rehabilitation--structured activities, social interaction, and help with homework	DHS, special programs	Age 8 - 16, at-risk of out-of-home placement (because of child's behavior)
	Child Residential Rehabilitation Homes--therapeutic foster care homes	DHS MH/MR and CYS	Children released from inpatient mental health services

Table V-2 (2)

	Program	Administering System	Target Population/Eligibility Criteria
Treatment			
leffefson County	Outpatient counseling, including specialized sexual and physical abuse treatment for victims and perpetrators	Mental Health, some through subcontracting arrangements with Child Welfare	Children with DSMIII diagnosis/abused children and perpetrators; Medicaid and other insurance
	Choices Program--intensive services to children in long-term foster care	Child Welfare	Children age 3-17, in foster care, who have severe emotional/behavioral problems with little likelihood of being adopted
	Intensive Services--intensive in-home services to children in foster care to bring resolution to placement decisions	Child Welfare	Multiple problem children who have been in placement for an extended period of time and for whom no definitive permanency plan has been established
	Partnership in parenting -- pilot program to formalize and enhance foster parents and natural parents working together	Child Welfare	Carefully selected foster and natural parents motivated to work together
	Family Treatment Homes--therapeutic foster care homes	Mental Health	Children at risk of residential placement
	Wraparound--intensive clinical, support and case management services provided for at least 8 months and usually longer	Mental Health--under contract to Child Welfare	Child-welfare involved children who are SED and cannot be served in any other setting
	Impact--intensive in-home services--modeled after Wraparound	Mental Health provides services--joint administration at state level (MH, DSS, Medicaid)	Children meeting state SED defmition
	Acute psychiatric services including screening and assessment for inpatient services, in-home crisis intervention for 4-6 weeks, 30 day intensive foster care placement, and discharge planning	Mental Health	Children in need of intensive psychiatric interventions

Table V-2 (3)

	Program	Administering System	Target Population/Eligibility Criteria
Treatment			
Chicago	Outpatient counseling	Mental Health--state-funded and private agencies	Medicaid and other insurance eligible
	Family Services--in-home mental health care patterned after family preservation	Jointly by Mental Health and Child Welfare	Severely disturbed children age 2 to 9
	Day treatment program in Northside	Education and Mental Health	Children who cannot be served in regular classrooms, as determined by the school system
	Inpatient psychiatric hospitals	Mental Health -- public and private	For public hospitals, children screened through SASS programs

c. Support

Support services are designed to meet needs that are indirectly related to identified problems, but considered important in alleviating barriers to the success of prevention or treatment programs and in enhancing healthy adaptation. Examples of support services offered within each site are summarized in Table V-3. Such services can include approaches to developing self esteem., parent skills training, efforts to develop support systems, recreational and socialization activities, respite, child care, and providing for concrete needs such as transportation, food, shelter, and clothing. Taken alone, some of these types of services can also be considered preventive in nature. Coupled with specific treatment modalities, they become important components of a broader treatment program and approach. Most sites incorporated support services as components of specific treatment programs. In contrast, Hennepin County offers respite care and special needs day care as separate services, available to clients in one of several other treatment programs within the umbrella human services agency. In Jefferson County, a program matching adult volunteers to children receiving mental health treatment as a means to help them develop positive adult relationships, provides another example of a separate support service available to children served by several agency units.

Table V-3
Examples of Support
Services Identified in Each Site

	Program	Administering System	Target Population/Eligibility Criteria
Support Services			
Scott County	General--respite care, day care for foster parents, day treatment, family assistance fund	DHS	Families being served by child welfare; foster care families
Hennepin County	Respite care	Mental Health	Families with children with significant developmental delays, serious medical conditions/handicaps, and/or severe emotional/behavioral problems.
	Special needs day care	Mental Health	Families being served by child welfare, mental health or developmental disabilities, for whom child care is included in the case plan as necessary in order for the parent to complete treatment
	General, as part of treatment program, e.g. parent skills training, recreational activities included in Wraparound, Family Focused, and family preservation.	Mental Health and Child Welfare	Families who are being served by a specific program
Northumberland County	General, as part of treatment programs, e.g. self esteem, recreational activities included in Day treatment, family preservation and Homekeepers, Social Rehabilitation programs	DHS	Specific program criteria cited above
Jefferson County	Compeer--volunteer program matching adults with children to provide recreational and social activities	Mental Health	Children in treatment
	General, as part of treatment programs	Mental Health, Child Welfare	Program criteria
Chicago	General, as part of prevention and treatment programs, e.g. **HomeFirst** dollars to cover transportation, rent, utilities, parent skills training; or through private contract providers.	Mental Health, Child Welfare	Individual program criteria

3. Availability of Mental Health Services to Children in Child Welfare

While a few programs in study sites were developed specifically to serve children in the child welfare system, the majority serve a broader population within which child welfare clients may or may not be a priority. Even where a broad array of programs is in place, children in child welfare may not always benefit due to such constraints as program eligibility criteria, access mechanisms and program capacity.

A number of factors combine to determine whether a child in child welfare has access to and will ultimately be able to benefit from the broad array of mental health services available in any specific community. Among these factors, those that were most influential in the five sites visited include program eligibility criteria, mechanisms for accessing specific services and program capacity. Each of these factors are characterized by several interrelated facets, which are further detailed below.

a Program Eligibility

Although programs may include children in child welfare as part of their broad target population, they also have specific program eligibility criteria based on such considerations as

- Identified populations and/or problems, e.g., children age 0 to 5, children in residential care, children involved with the court, children with severe emotional disturbances, sexual abuse, truancy, unnecessary residential placement;
- Funding sources, e.g., Medicaid, specific agency budget items, or grant requirements;
- Treatment modalities to be employed, e.g., family therapy (requiring that the family be present) or in-home services, many of which are predicated on the willingness of the family to be served.

Often the mix of eligibility criteria reflects specific service gaps and the need to determine how best to spend the amount of money available to implement the program.

Population/Problem

While programs such as **Kentucky Impact, Illinois SASS,** and **Hennepin County's Family Focused services are** available to children in child welfare, and provide a broad array of services fit to each child's and family's specific needs, they are all designed to focus on the needs of SED children both within and outside of the child welfare system. Children in child welfare may benefit from these types of services, but they are only available to those children who meet each site's specific definition for SED.

Some programs were developed expressly to serve the child welfare population. For example, the **Jefferson County Wraparound** program is provided by the mental health agency through contract with child welfare. Involvement with child welfare is a key eligibility criteria (and only access to the program) along with other criteria specifying level severity and need for services.

Funding

A key funding issue impacting program eligibility is the categorical nature of many of the funding streams both at the Federal and state levels. Special education funding is targeted to populations meeting certain definitions, as is mental health and many of the social service programs.

In addition, the reliability of funding is a factor in long range planning and service development. While child welfare foster care dollars (through Title IV-E) are entitlement-based (i.e., everyone who is identified in need receives services), other funding streams are not. For example, family preservation services are covered under Title IV-B, which is based on formula grant that is not open-ended. This has been a key concern for prevention programs, which may be addressed by legislation and administration proposals now pending.

Not only are steady funding levels from existing sources difficult to count on, but the ad hoc pooling and joint agreements needed to fund innovative, interagency efforts can vary with community changes.

Insufficient funding is another concern that has led to different responses across the sites visited. It can result in narrowing definitions of eligibility or in turning eligible clients away from services. For example, in **Chicago** severe resource limitations within all child-serving systems has led to efforts to shift multiple problem children from one service system to another in an effort to get someone else to foot the bill for services. In contrast, it can serve as an incentive for the kinds of pooled/joint funding ventures being

put into place. In Iowa, efforts to work with limited resources resulted in a state level effort to decategorize funding streams available to child welfare providers.

Other identified funding and eligibility restrictions centered on a- variety of Medicaid issues. A few respondents expressed concern about families who were not eligible for Medicaid, but who were either uninsured or underinsured, and therefore unable to obtain services. In Hennepin County, many providers expressed concern about limitations placed on treatment modalities and duration by the medical assistance programs. In Jefferson County, where only one mental health provider is approved for Medicaid reimbursement, some respondents felt that options for mental health services were too limited. In Chicago, recent efforts to maximize Medicaid reimbursement have been implemented. The state child welfare, mental health and Medicaid agencies have worked together to develop reimbursement structures under the Medicaid Clinical' Care and Rehabilitative Services Options, and get key private mental health agencies approved as Medicaid providers. This approach is also under consideration in Scott County.

Treatment Modalities/Approaches

Program eligibility was also tied to treatment modalities and approaches. At the core of this issue is the "involuntary" nature of services provided to children and families in the child welfare system. By contrast, mental health practitioners have traditionally served "voluntary" clients, i.e., those motivated and willing to make a change. Child welfare systems are mandated by law to provide services to children for whom abuse and neglect has been substantiated. Many of these services are related to mental health needs. However, there is no similar mandate within the mental health arena. In several of the sites visited, child welfare staff expressed frustration about the inability to get clients into services they felt they needed because they did not meet eligibility criteria

b. Access Mechanisms

Once a child is identified as needing mental health services, the ability to obtain services is contingent on the child welfare system's knowledge of the existence of services and how to access them.Access mechanisms observed in the five sites visited included direct referrals, as well as the use of screening committees that have the ability to route the child to one of many programs either within one system or across systems, In Hennepin

County, the system is moving from an informal referral practice to a more formal and routine referral practice. Caseworkers have been using private providers to conduct mental health assessments and to provide counseling, on an as-needed basis. However, efforts are underway to formalize a consulting relationship between the mental health division staff and child welfare staff which is expected to help caseworkers understand mental health issues and make more informed decisions about treatment plans.

Examples of intra-agency screening committees include:

- **The Jefferson County Family Services Screening Committee,** which determines which of several interagency programs can best serve the child and has space for the child.

- **The Hennepin County Family and Children's Mental Health** unit process to screen all referrals to determine which of several services may be appropriate.

- Case reviews conducted by supervisory staff in child welfare units to monitor the most complicated cases and make service recommendations.

Examples of cross-system screening committees include:

- **The Kentucky Impact Local Interagency Advisory Council** comprised of representatives from education, mental health, child welfare, and other agencies, This group reviews all referrals, determines program eligibility, and makes referral suggestions for those determined ineligible.

- **The Hennepin County 348-TOTS screening** team comprised of staff from mental health, education and health which reviews all referrals, develops caseplans, and coordinates services available across systems for children birth to age 3 1/2.

- **The Northumberland County Children's Clinic,** comprised of representatives from mental health, child welfare, and juvenile justice, which meets on a weekly basis to review the most challenging cases and make service recommendations.

Case management is another key mechanism for coordinating and accessing services, this is discussed in section 4, below.

c. Program Capacity

Another prominent issue identified by ail sites is the issue of capacity. While a child in child welfare may meet program eligibility criteria, and a clear access mechanism may exist, services may have a limited capacity and are therefore not guaranteed. Children are sometimes routed to available programs rather than to appropriate programs as a result. In some cases, children and families simply wait.

4. Case Planning

Case planning for children who are involved with multiple systems remains, for the most part, fragmented, duplicative or both.

Most chiidren who enter the child welfare system come from multi-problem families who are involved with several child-serving systems. When these chiidren need mentai health services, their case planning often is fragmented, duplicative, or both. Each agency may have its own caseworker and case plan.

The consequences for children and their families are all too familiar. They have to deal with an array of caseworkers or specialists, who may or may not agree on treatment goals or approaches; they may faii through the cracks because they don't meet eligibility criteria for available programs or because their complex needs are not viewed holistically in any one place; and, finally, they may find the thicket of providers too bewildering and simply give up on the system.

When families are left out of the process of determining their own service needs, they may become detached from the process or too dependent on providers rather than empowered to become partners in tackling their own problems.

In response to these issues, agencies in the communities visited for this study are generally attempting to overcome traditional turf boundaries and collaborate in providing a range of services, including mental heaith, to children and families they serve.

a. Agency Efforts to Work Together

In some localities, true joint efforts are in place involving multiple agencies and families in service planning; however, most involve independent efforts by each system which may or may not be shared with others.

Generally, approaches seen during site visits can be grouped as collaborative or consultative approaches.

Collaborative Approaches to Case Planning

In this model, case plans are developed jointly by representatives of two or more child-serving agencies, bringing to bear on the case at the outset the knowledge of an array of services and offering the advantage of a certain synergy in thinking together about a client. This model tends to work best, for understandable reasons, when the collaborating parties are programs under one administrative agency or organization.

Examples of collaborative case planning approaches in sites visited include:

- **The Children's Clinic in Northumberland County,** the most powerful example of close collaboration seen during the study. Rather then a physical clinic as the name might imply, the Children's Clinic is a collaborative process of reviewing difficult child welfare cases and agreeing by consensus on the optimal treatment plan. For half a day each week, senior representatives from the major human services organizations-Children and Youth Services, Mental Health, and Juvenile Court Services--meet to review 8 to 10 cases and discuss case planning for them Parents are part of the process (see section b below) and participate in offering their insights about the treatment plan and raising any questions or concerns they have.

- **In Jefferson County, several programs** employ collaborative case planning approaches.

  - Child protection caseworkers convene a treatment team that includes the foster parents, psychologist, and other community-based providers for SED children in the **Choices** program. The teams sets treatment goals for the child and meets every 2 weeks to review progress and adjust plans. Children in the program range from 3 to 17, are in foster placement, and have little likelihood of adoption.

  - The HELP family preservation program, is jointly staffed and administered by child welfare workers and by staff of the mental health center.

  - **The Child Advocacy Center aims** to support children and families during the critical first 6 weeks in which they are in the CPS system. A mental health clinician accompanies the

investigative worker on a first visit and provides assessment and ongoing case management. The program also makes available a community consultation team that includes the CPS worker, law enforcement officer, and mental and physical health consultants.

Consultative Approaches to Case Planning

More common is a consultative approach to case planning which is often specific to individual programs or cases. This model embraces two types of case planning, both of which involve close coordination and consultation rather than joint case planning. In one type, representatives from agencies who have primary responsibility prepare their own case plans but meet on a regular basis to exchange ideas and limit duplication of services. In another type, the case worker who is the primary person assigned to a child's case actively consults with other service providers, sometimes calling them together for a joint planning or troubleshooting session. Examples from the site visits illustrate this approach.

- About half of the 1,400 children served in the **Hennepin County Family and Children's Mental Health (FCMH) clinic are also** served by the county child protection division, and about 10 to 15 percent are served by Family Services (child welfare). If a child is involved with CPS, the FCMH case manager meet regularly with a CPS counterpart to discuss coordination of efforts to assist the child. Because FCMH clients are 'voluntary" and the CPS clients are "involuntary," responsibilities of the respective case workers are determined on a case-by-case basis. Although FCMH and CPS do not have a formalized working relationship, such an agreement is planned.

  When the Family Services unit is involved, case coordination may be easier to accomplish for administrative and philosophical reasons. Both FCMH and Family Services work with clients who come voluntarily. Furthermore, both units are on the same floor of the human services building, so joint intake procedures are being considered.

- Efforts to improve case coordination for drug-exposed **Jefferson County** infants after they are discharged to the community illustrates another approach. In Kentucky, all infants are screened for drugs, and all positive cases are followed by a worker from the **Visiting Nurses Association (VNA)** for 9 weeks. Both the hospital and VNA were contacting CPS about these infants, since drug exposure is

considered a risk factor for child abuse. Duplication of efforts triggered a series of mechanisms to help coordinate these cases, and VNA, the hospital social services staff, and CPS representative now meet regularly to review cases.

- **Court-related consultations in two** of the sites visited also exemplify efforts to assemble key participants in case planning.

  - **In Hennepin County,** the juvenile court judges have instituted a number of reforms to strengthen collaboration among the different child-serving systems that affect children in the juvenile justice system One example is the use of **"summit meetings"** in Hennepin County for the most difficult cases. Representatives from corrections, FCMH, CSD staff who are knowledgeable about community providers, and parents all come together to discuss the case. The goal of these meetings is to enhance the court's ability to more accurately tailor its disposition of the case to the needs of the child.

  - **Team consultation** is a key feature of Juvenile Services in **Jefferson County.** Because the unit is within the Department of Social Services it is somewhat easier to assemble key staff for case review. A weekly screening meeting brings together court staff, supervisors from each Juvenile Services unit team, and a staff member from the joint mental health/child welfare family preservation program. All court cases passed for disposition are reviewed, and the team offers insights and suggestions to the case worker who, in turn, presents recommendations to the judge. At one time, a therapist from the Seven Counties Services, the child mental health provider, participated in these weekly meetings, but budget constraints curtailed this involvement.

Issues in Case Planning

While communities and individual providers vary in their willingness and ability to work together, certain issues affect the development of more coordinated case planning practices:

Perhaps the major resistance to coordinated case planning is the **tendency of organizations to guard their own turf** and exercise control over "their" clients. Sometimes, the resistance comes from the top levels of an organization as directors/managers consider their mandates to protect their turf and assure continued funding. In addition, collaborating agencies may

represent different state agencies, serve different constituencies of children, and have different funding streams, regulations, and eligibility requirements. These barriers are real and can be overcome only by concentrated effort of leaders in the human services and juvenile justice communities.

Even where there is leadership and/or a mandate for coordinated service planning, there may be **opposition from front line workers who resist change in their accustomed ways of working** That may be compounded by the sheer **press of caseloads** that are beyond a reasonable, manageable sire. For instance, DCF S staff in Chicago cited overwhelming caseload size as a disincentive to interacting with colleagues in other agencies or community groups. Caseloads vary through the city, ranging from 45 in the Northside (the area site visited) to 100 in the southside.

Differing philosophical beliefs about treatment and the needs of clients also work against the likelihood of agencies coordinating at a case planning level. Issues of "protecting the child vs. preserving the family" continue to affect both child protection and other child welfare services. Courts are mandated to protect the public safety, as well as the rights of the child and family.

The need to assure **data confidentiality is another** barrier to case coordination in some locations. For example, Minnesota has strict, carefully enforced laws to protect data privacy in all systems: schools, courts, social services. This restrictive environment inhibits sharing of information necessary for coordinated case planning and results in extensive duplication of assessments.

New and/or Planned Changes to Promote Coordinated Case Planning

At several sites, significant changes were in the making

- Scott **County is** poised to launch a comprehensive case management approach that would affect case workers from all public child-serving systems. Extensive planning and training had preceded implementation of this plan to assure "buy-in" from human service staff at all levels. (The planned system is described in more detail below)

- **In Minnesota,** state-level efforts are underway to develop legislation that would ease data sharing barriers among agencies serving children in the welfare and juvenile justice systems.

- **In Hennepin County,** mental health and family services divisions are developing a process for conducting a joint intake procedure and plan to have joint staff within the year. Also, efforts are underway in the early childhood unit to develop a protocol for case plans for the 368-TOTS program that will incorporate case plans from all the systems involved.

- Enhancements of the management information system at **Northumberland County** Department of Human Services soon will enable case workers to call up information on a current client to determine previous experience in the system.

b. The Role of the Family in Service Planning

Although family involvement and empowerment is recognized as an important value in study areas, there is wide variation in the extent to which families are currently involved in service planning and setting treatment goals. In many places, however, foster parents are being increasingly viewed as extensions of service delivery staff and are involved both in case planning and in working with natural families.

A growing trend in provision of mental health services to children in the welfare system is active involvement of the family. Several convictions about the importance of family systems fuel this trend. In this construct, the child is seen within the context of the entire family-whether biological, extended, foster-rather than as an isolated "victim" or "problem." Thus, it follows that the more ways in which the parents can participate actively in a child's "case," the more successful the outcome is likely to be. This theory assumes that all parents have strengths, that the child almost always is best cared for by natural parents, and that active participation of parents empowers them to help seek solutions to their own family problems.

Services for the Family

In family therapy, the child often plays the role of "designated patient," acting out in negative ways in order to call attention to dysfunctional patterns in the family system. So, to "treat" the child means to attend to the whole family with its various needs and problems. This translates into (1) offering family therapy as at least one approach to helping the child and (2) considering an array of services to help the parents cope with **problems related to parenting, life stresses, or other problems such as substance abuse or unemployment.**

Some examples of the latter approach include the programs offered by the Parent Center in Northumberland County. Offerings include intensive skill building, parenting workshops, and support groups. Although the Center is open to any parents, it is often part of the treatment plan for a family with a child in need of mental health services Similarly, the Family Resource Center located in a trailer adjacent to an elementary school in Jefferson County offers a variety of programs including stress management, parenting skills, and home management.

Plan&g with the Family

Beyond being involved in the "treatment" related to a child's problems, the family in some cases participates in determining treatment goals and planning for needed services.

This is a central feature of the Northumberland County approach. Parents are encouraged to attend the case review discussions during the weekly Children's Clinic. Representatives of participating agencies (Children and Youth Services, Juvenile Court Services, Mental Health, the schools) and any other community providers review a family's genogram that graphically delineates family relationships and critical events-such as deaths, divorce, incidents of sexual abuse-that could affect the child. The case worker outlines the key issues, and the parents are asked for their insight, questions, and suggestions. After discussion of 40 to 60 minutes, the assembled groups recommend a treatment, or staffing, plan, and discuss this with the parents. This process provides an opportunity for active input from the family and assures that the recommended treatment is understood and accepted.

Although no other sites had parent involvement as such a central component, other locations did include parents in case plamring in specific programs. Family preservation programs involve parents in regular meetings to review individualized plans and to track progress toward long-range goals. The Jefferson County Choices program for children in foster care brings the child in to "run" the team meeting every other month so he or she can communicate needs and concerns from an empowered position.

Foster parents play a key role in case planning in many places. Not only do they participate in case review with the social worker, in some cases they work with the natural family on parents skills as part of the reunification process. Several sites described foster parents as a. bridge between professional staff and families being served. Increasingly, they are being viewed as paraprofessionals, an extension of staff. This is particularly true for families who receive specialized training to provide therapeutic

foster care. In **Northumberland County,** foster parents are invited to attend any staff training sessions and are often called on to serve as co-therapists for family therapy sessions involving children for whom they provide care. **Jefferson County** plans to begin a program in the summer of 1992 to link foster parents and natural parents in a formalized way for mentoring and support. This **Partnership in Parenting** pilot program will train the child protection workers and foster parents together to reinforce the important role of foster parents.

c. Case Management

Generally, case management denotes a "brokering" role in sites visited, i.e., a responsibility to see that children and families obtain access to available resources. However, a more activist concept of case management as a comprehensive process of stimulating development of needed services in the community and helping the family to find its own ways of meeting its needs was also evident.

Case management is a term that is overutilized and misunderstood. Volumes have been written about the concept, theoretical underpinnings, operational aspects, and benefits. As a "buzzword" of health and human services delivery systems, case management tends to be a term that is defined to fit almost any system. Often, the term "case manager" is used interchangeably with "case worker" to identify a human services professional who is responsible for a "case."

It is beyond the scope of this report to examine the range of meanings ascribed to the term case management or to attempt to categorize the various ways in which programs at the sites visited use the term. For the most part, the term "case management" was used by providers interviewed for this study to describe activities that focused on referring families to community service. The more activist approach to case management is oriented to helping reshape services based on the needs of the client and on working with the client to determine what those needs are. Two notable examples of this approach are described below.

In Jefferson County, the director of the **REACH** program provides training and consultation to child protection caseworkers in ways they can help families organize to handle their own problems, and decrease dependence on the worker. For children who have exhausted available placement options, and for agencies faced with fewer places to "send kids" across the board, it will be more and more necessary to go beyond the brokering role.

Perhaps the most comprehensive approach to case management as an integral part of the child-serving system is the Families Together plan developed by the **Scott County, Iowa,** Decategorization Planning Committee. Though somewhat delayed in implementation, the thoughtful and comprehensive approach used in planning the system is well worth examining.

The planning process itself took well over a year, and involved retreats, community workshops, staff workshops, and staff training to examine options and build a sense of ownership among agencies and workers. The proposed case management system entails a major change in traditional practices in the community. It is based on a conviction that families should be partners in the helping process, that the community is obligated to ensure a broad range of service options, and that the system's role is to empower families and not intervene in their lives any longer than necessary.

For children and families in child welfare, a single designated. case manager will have broad authority to access resources and assume responsibility for the direction of the intervention plan Essential components of the case management process include assessment, plan development and implementation, monitoring and coordination, advocacy, resource development, and evaluation. Central to the case management function is the client-case manager relationship and the participation of the family in decisiomnaking. The desired outcome is the empowerment of families to resolve problems and to access supports as needed.

The intent of the system is to serve all families who receive publicly funded services within the Decategorization Project; families will retain the same case manager even if their needs for varying levels of intensity change over time. The current professional case workers within the Department of Human Services and the Juvenile Court will become case managers under the new system The two separate structural entities will remain, but formal mechanisms will be established to ensure collaboration.

5. Evaluation

There was generally no evidence of a system-wide approach to evaluating coordinated provision of mental health services to children in the child welfare system. However, individual agencies do track and monitor service delivery measures in many instances.

The importance of monitoring and evaluating the effectiveness of system and program efforts is well documented in the literature.[33,34,35,36] Soler points out that "the fact that a system coordinates some services....does not mean that services are better or more helpful to families." Bruner cautions that while outcome-based evaluation methodologies are important to measuring the effects of collaborative efforts, measuring the success of social services is a complex and evolving methodology that has not yet been fully developed. He also stresses the importance of process-based measures. In addition to citing the importance of monitoring and evaluation, Knitzer's 1982 landmark study also raised concerns about the lack of such activities.

These concerns remain today and were mirrored by Federal and national experts providing input to this study. In refining the analytic framework guiding the study, advisory and expert panel members emphasized the importance of recognizing the difference in evaluating systems outcomes, i.e., integrated delivery systems capable of individualizing family and children's services and evaluating child and family outcomes, i.e., stable home environment, success/continuity in school, friendships and positive attachments to adults. Experts consulted in developing this study also acknowledged the lack of agreed-upon measures and methods for evaluation, but felt that general issues related to evaluation approaches should be explored during the site visits.

Accordingly, two aspects of evaluation were explored at a general level to gain insights into the scope and issues of evaluation in existing programs:

- System level evaluation to measure progress or effectiveness in the overall approach to coordinating services; and
- Program level evaluation to measure specific service delivery approaches and their effect on children and families.

[33] Stroul and Friedman. 1986. Op cit.

[34] Knitzer. 1982. Op cit.

[35] Soler. 1990. Op cit.

[36] Bruner, C. 1991. *Thinking collaboratively: Ten questions and answers to help policy makers improve children's services.* Washington, D.C.: Education and Human Services Consortium.

a. System Level **Evaluation**

In sites visited for this project, there was generally no evidence of a system-wide approach to evaluating the coordinated provision of. mental health services to children in the child welfare system Major agencies generally had a clearly defined mission statement and overall. goals. Staff interviewed were able to articulate shared values and operating principles. However, there was little evidence that these had been translated into specific, measurable objectives and time frame for system-wide evaluation purposes. This can be attributed to two key reasons:

- Most of the-approaches explored do not represent a broad system-level integrated process or specific mental health goals for the child welfare population. More typically, they represent a range of innovations on the part of several agencies that have come together to address common and specific needs. These separate programs may be coupled with system-wide initiatives targeted to specific populations (e.g., the **Kentucky Impact** program for SED children). They are often complemented and supported by state-level movement in the same direction. Only in **Northumberland** County was there a specific integrated program established to address child and family mental health needs (the Children's Clinic). The only organized planning process to implement a broadly integrated system was seen in **Scott County.** However the planning process addresses a comprehensive set of needs of child welfare families and is only beginning to identify and focus on mental health concerns.

- There seems to be no clear-felt need to evaluate the overall approach to coordination. Coordination in sites visited appears for the most part to be emerging as a better way to provide servicesin the face of increasing complexity in problems being seen and decreasing resources to address them. Better coordination is also supported by other kinds of Federal and state actions discussed in an earlier **section.**

b. Program Level Evaluation

While evaluation of interagency efforts overall was not evident, individual agencies do track and monitor service delivery measures. In general, broad process measures were tracked, e.g., reduction in institutional' placement, length of foster care stays, or numbers of child abuse reports received and substantiated.

Some of the more comprehensive evaluation plans emanated from SED programs, which have been strongly influenced by CASSP funding and the system of care concept:

- A formative evaluation conducted in early stages of the **Kentucky Impact** program assessed a combination of process and outcome indicators, including restrictiveness and stability in placements, amount of family support, family satisfaction with services, social competence and behavior problems of the child, and adult and child perceptions of progress.

- An evaluation plan for the **Illinois** statewide SASS program includes a number of process measures, for example the number of children receiving case management services, the proportion of admissions to state hospitals receiving SASS screening prior to admission, and the establishment of specific guidelines, workgroups, legislation, and training opportunities.

- **The Northumberland County Children's Clinic** has specified objectives to prevent the out-of-home placement of 20 children in the county by establishing a truancy initiative.

6. Issues and Barriers

The unique combination and interactions of environmental, system, and service delivery factors within a specific locale can create issues and barriers that influence and constrain the approach to service delivery. Issues and barriers among the five sites, as identified and described by the respondents, were of two types, gaps in services or service areas needing further development, and issues related to specific service system characteristics.

a. Areas for Additional Services

Although most needs for additional programs and services identified by respondents were specific to the service delivery system in that locality, three general areas for further program development were cited by several: services for children in the juvenile justice system, improved coordination with the schools, and better ways to address the critical effects of sexual abuse and drug abuse in the lives of most children and families in the child welfare system.

In discussing areas where services needed to be improved or developed, staff interviewed offered a wide range of "wishes" reflecting to a great extent the needs of their communities and their existing services. These ranged from broad service categories (e.g., prevention or treatment services) to indications that particular populations were underserved.

Similarly, among those foster parents and advocates interviewed, areas for improvement generally related to specific issues relevant to the service delivery system in their particular community. For example, in **Hennepin County** one of the foster parents interviewed thought it important to better understand the services offered by the FCMH unit and to be able to access those services more directly for children in her care. She also noted, as did providers interviewed, the difficulty of finding culturally competent therapists and of working with Minnesota's medical assistance system.

However, several areas in need of further program development were identified:

- The difficulty of finding placements and obtaining a whole range of services for juveniles involved with the court system-the nature of the service needs of this population varied somewhat across sites. In **Hennepin County,** the need for "locked beds" for chronic runners was emphasized; most foster care homes and group homes are ill equipped or unwilling to deal with the complexities of this population. In **Jefferson** County, providers indicated that while home-based services are generally designed for younger children, as a service approach it has equal utility for the older juvenile justice population but that few if any such services were available. This is especially critical since there is a dearth of residential placements and foster care homes for this population. In **Chicago,** general concerns were raised about the complexities of the juvenile justice population and the lack of providers able to address these complexities.

- Some difficulty in bringing the schools on board in working with other agencies to identify and address children's needs-although some school initiatives addressing mental health needs were identified, they were often not linked or coordinated with child welfare or mental health system efforts. This was attributed to various reasons across sites. In **Chicago,** respondents attributed the missing link with schools to schools' reluctance to screen and identify children in need of special education because this would ultimately mean that the school system would have to pay for services; in **Scott County,** schools are not currently part of the central planning effort; however, a recent grant award is expected to bring increased

involvement; in **Jefferson County, although the** schools and mental health have forged some relationships around a special state-led initiative, the relationship between child welfare and the schools was not as fully developed.

- The need to address the key underlying issues of drug abuse and sexual abuse which are critical factors in the lives of children and families served by child welfare-Issues related to sexual abuse were a particular concern in **Chicago** where respondents indicated that neither the prevalence of sexual abuse among the service population nor the full extent of the effects on children are fully understood or addressed. In **Hennepin County,** respondents felt that more expertise in issues of sexual abuse among mental health providers was needed. In nearly all of the sites visited, the role of drug use in the lives of families was mentioned as a key concern.

b. Other Issues

Other issues specific to certain aspects or characteristics of the service system were identified in each site. While those identified in this study are unique to the site visited, several may have wider implications for other localities with similar service system conditions or elements. For example, several states now use or are considering a managed health care system approach to providing medical assistance under the Medicaid program. Providers in **Hennepin County, Minnesota** expressed two major concerns related to the state's recently implemented managed health care system: 1) services may be more difficult to access because the priority among managed health care providers is on screening and limiting services. Duration of services is often shorter than the customary treatment plan for such services as substance abuse treatment; and, managed health care providers may be reluctant to refer clients to providers outside their system for specialized expertise or care; and 2) many managed health care providers have a traditionally middle-class orientation with very little expertise in treating clients who bring issues of poverty, cultural diversity, and sexual abuse.

Additional issues and concerns that were expressed by respondents centered around barriers to conducting evaluation. Specific barriers identified included lack of baseline data, lack of agreed upon measures and methods, absence of shared data systems, and difficulty in measuring prevention. In addition, as noted by the national experts involved with the study, there seems little recognition of the need to assess programs in terms

of their impact on the lives of children and their families and lack of widespread knowledge of evaluation technology to do so.

C. Service Coordination

Concern for improved service coordination for children and families can be traced to efforts in the late 19th century, and have received periodic attention every since. While programs were expanded during the 1960's war on poverty, the issue of linking services was not addressed. Intermittent attention was paid to the issue until 1971, when "services integration" was named a Federal priority. The concept focused on improving coordinated delivery of. services, adopting a more holistic approach to children and families, assuring improved allocation of resources based on local needs, and providing a comprehensive range of services at the local level. The importance of integrating services is receiving renewed attention today among child-serving agencies and systems as shrinking resources, mounting caseloads and: increasingly severe problems confront service providers everywhere. However, current concerns are based not only on the pressing institutional need for better resource management, but on a conviction that services must focus on needs and successful outcomes for individual children and families.

In developing the study approach, results of several earlier efforts to identify features of successful service coordination in the community at large, as well as in child-serving systems and service delivery agencies, were incorporated as part of the process of developing an analytic framework to guide on-site data collection. Based on the elements of the framework, a case study plan was prepared itemizing topics to be discussed and kinds of individuals to be interviewed. The following sections discuss the key factors and issues in working together, as well as describe the mechanisms of coordination in sites visited. Although the framework guided data collection,, it was intended to help explore large groups of factors and overall relationships, rather than to specify effects of discrete elements. The discussion that follows reflects the major aspects of coordination as observed in the localities visited for this study.

1. Key Factors Affecting Coordination

Very different models for working together have been developed in the localities visited. The extent of coordination is affected by the general climate in the community as well as by the interplay of leadership, communication and problem solving processes, and funding considerations.

Community climate includes values, philosophies, leadership, and other intangible factors which create the environment in which people and programs can work together to improve the lives of children and families.

- Communications processes address the patterns of interaction across agency lines, as well as among consumers and the community at large. While funding restrictions and limitations are a common problem in all sites visited, localities vary considerably in their approaches to resolving these difficulties to improve service delivery and coordination.

a. Climate of Coordination

The size and complexity of the systems involved, community values, and operating styles influence the approach to coordination.

In selecting study sites, an effort was made to assure that both rural and urban, more homogeneous and more diverse service populations were included. In addition, varying administrative structures were sought: agencies which unify child welfare and child mental health under a single umbrella, as well as areas where each is administered by a separate state or county department. As might be expected, there was substantial variety in the key aspects of community environment seen in sites visited. Below, we briefly describe the key features of each.

Northumberland County, Pennsylvania is a small, rural county where unemployment is high; the mean income low (about $8,000). Human services are provided under a single umbrella agency which includes child protection, mental health/mental retardation and juvenile court services. The consolidation was a county decision, stimulated by the leadership from a single individual and supported by other community providers and policymakers. The state office agreed to the county's experiment with a unified agency. The study team was impressed with the extent to which shared values and commitment to serving families holistically and based on their individual needs permeated the responses of staff at all levels.

Scott County, Iowa is also a rural area; however, the site visit centered on Davenport which is part of cluster of small cities on the Iowa-Illinois state line known as the "Quad Cities" area. Several notable features of the community environment were evident to the site visit team: a tradition of agencies and providers working well together and responding holistically to the needs of children and families, a strong commitment to the importance and value of planning, and a stable community of providers who have built strong relationships over a number of years. Scott County was one of two localities selected by the state to implement a pilot effort to decategorize child welfare funding combining several sources.

Jefferson County, Kentucky is an urban area which comprises the largest social services district in the state, and includes Louisville which houses district offices. Louisville is characterized as having a "small town" atmosphere which provides both advantages and disadvantages in collaborative activities. Individuals in leadership positions have moved up through the ranks of their individual agencies over a period of many years. Turf and jurisdictional issues abound, and it is difficult for anyone who has not grown up and established a placed of trust in the human services network to be effective. However, that same stability has led to relationships of trust and shared visions with strong informal communication loops and problem solving activities on an ongoing basis. Jefferson County is an area in which separate child serving systems work together through the mutual efforts of key staff in multiple agencies and the support of like-minded leadership at the state level. There is a strong, stated value placed on less structured interaction, though staff acknowledge the potential value of more formalized planning and policy development approaches, such as the tiers of interagency councils mandated for the Kentucky Impact program. Typically, formalized programs and structures have grown from reciprocal efforts at the service delivery level to address a particular problem or issue.

Hennepin County, Minnesota is a larger urban area with a long tradition and a strong community commitment to quality public services. The population of the area is relatively stable as is the community of service providers. The county payscale for social workers is competitive, and is actually higher than the private sector. One child welfare administrator noted that somewhat more turnover might be desirable to bring in new ideas and perspectives. An umbrella community services agency administers both broad child welfare programs, and a specialized family and children's mental health service, as well as other social services (e.g., chemical health and developmental disabilities). Attention to children's mental health issues has developed over a decade of community advocacy and consensus-building and as a result of strong individual leadership in the community services agency. Recent state legislation mandating services to children was both a partial result of efforts and a critical influence in overcoming remaining bureaucratic resistance. Interaction among administrators and service providers occurs through both standing and ad hoc groups initiated by various agencies; community input is routinely solicited in assessing problems and recommending approaches.

Chicago, Illinois is a major metropolitan area with multiple agencies and a widely diverse service population. Child-serving systems operate under separate administrative structures at different levels: state, county, city, and neighborhood. Local area providers in any part of the city say they literally

don't know who to involve in coordinating services to their particular communities.

Chicago's child welfare and juvenile justice systems have been besieged by public scrutiny and criticism over the last several years. Two major consent decrees have resulted in a continuing flurry of activity to improve services and relationships among agencies. However, jurisdiction and turf issues remain significant obstacles. Some efforts at the community level to develop information networks were identified during this study, however more systematic coordination continues to be hampered by administrative structures and critically inadequate resources. Scarce resources have been a historical obstacle to working together, and have led to infighting about which agency is responsible for paying for which services.

b. Leadership Support and Commitment

While the strong leadership of an individual lea&r was noted in one or two of the sites visited, all those who have been successful have supportive leadership in several key agencies who are committed to finding ways to work together.

Successful coordination involves all sectors of the service community and staff at all levels. However, leadership and support from key agencies and organizations is critical. In sites visited for this study, leadership was broad-based and often evident at both state and local levels. The influence of a key individual was evident in some places, especially in early stages of program initiation, but we did not note reliance on a "charismatic leader" as critical to sustained coordination in any of the localities visited.

The community services agency in Hennepin County which houses child protection, child welfare, and children's and families mental health services, is headed by an individual with lengthy experience in improving service integration at national and state, as well as the local level, and strong personal commitment to the needs of children and families. In addition, leadership in many other community agencies was engaged in and helped sustain a 10-year process of developing a priority and services for children's and families' mental health.

In Scott County, leadership in the state legislature resulted in the child welfare decategorization initiative being piloted in the county. Among staff interviewed during the site visit, there was general agreement that participants in the project from various agencies represented "strong

leadership" and that the consensus process for decision making in the central planning committee contributes to minimizing any turf issues.

In **Jefferson County,** strong leadership in child welfare, mental health, and the courts is complemented by regular interaction among service delivery workers. Historical leadership from individual judges in encouraging interagency cooperation remains strong in the current family court system which has taken an active, catalytic role in assuring that interaction occurs. As noted above, the basic mode of coordination is through informal networking. State leadership in the social services and mental health departments have also supported innovation and coordination.

In contrast, a single individual in **Northumberland County was** responsible for consolidating juvenile services, child welfare, and mental health under a single agency at the county level. However, a strong cadre of program managers, inculcated in the vision of a client-centered social services system, continues to forge leadership in developing programs; for children and families.

Coordination is not yet well established in **Chicago.** However, new leadership in child welfare and mental health at the state level are working toward better collaboration, both because consent decrees have Ieft little choice and because the individuals now heading these agencies have a personal background and commitment to the needs of children and families.

c. Communication and Problem Solving

Communities varied in the value placed on formal communication and coordinating mechanisms; however, they share an emphasis on mutual problem solving, consensus building among a wide range of community providers and a recognition of the value of consumer involvement in service planning.

A wide variety of committees, teams, and working groups facilitate interaction and communication among participating agencies. Examples are shown in an earlier table. In addition, informal interaction is an important and valued means of communicating with colleagues at both the systems and service delivery levels.

Examples of the ways agencies interact in each site visited are described below.

The Northumberland County Children's Clinic is specifically designed to assure broad based communication and problem solving which includes both key providers and families. There are also weekly managers' meetings among administrators of child welfare, mental health and juvenile services. For families provided therapy, caseworkers and foster parents also often participate. A centralized management information system provides workers with information on caseloads and intensity of services, as well as financial information

In Scott County, multiple committees have been established specifically to involve a broad range of key players at various levels of administration and service, as well as community groups representing the consumer view. Regular meetings and a resolve to "keep people at the table" facilitate consensus building, which is seen as the heart of the process.

The broad-based community consensus- and constituency-building process used to develop family and children's mental health services in **Hennepin County** appears characteristic of the way providers and advocates identify needs and develop approaches to meeting social service needs in general. An ad hoc committee developed to examine truancy issues includes representatives from key service agencies who are organizing community-wide focus groups of consumers and other interested parties, to add to the inputs of professionals and providers.

In Jefferson County informality and spontaneity are highly valued modes of problem solving and generating innovative approaches. Respondents acknowledged the importance of maintaining a balance between formal and informal cooperative mechanisms, between "planful change" and innovative ideas; but strongly advocate for continuing the day-to-day interchange among key service providers that results in "too many creative ideas to be achieved all at once." An interagency assessment team proposed by child protection includes families in developing service plans, as do some other individual programs in child welfare and mental health.

While state-level interaction in **Chicago is occurring** more formally in committees addressing areas mandated by consent decrees, local areas have organized networks of service providers to share problems, issues and ideas in areas such as teenage pregnancy and child and adolescent mental health. Here too, consumers may be involved in service planning in individual programs. For example, older adolescents who come to the city shelter are often asked to participate in determining placement options.

d. Financial Resources and Arrangements

Developing community-based mental health services for children requires creative efforts to tap into and mix Federal, state, and local dollars from various child serving agencies. A key impetus for developing a broader range of services in the community is concern for the high cost of residential care related to the few children who can be served.

The barriers to improved service integration presented by categorical funding streams and program requirements are well documented. The major problems relating to providing mental health services to child welfare families, as identified by Knitzer and Yelton, include the inflexibility of funding criteria and the disproportionate share of available funding which is earmarked for out-of-home placement rather than nonplacement alternatives (both in child welfare and in mental health). The bias toward residential care has been attributed both to unsupported beliefs among policymakers that residential services are more effective and to such realities as the fact that insurance policies tend to cover residential care, rather than in-home alternatives. Medicaid in particular is still used more in most states for inpatient care than for in-home therapy."

Minimizing out-of-home placement, providing services in the most home- and community-like setting possible, and working with the whole family, not just the child, are explicit values and goals in sites visited for this study and are implemented in the array of prevention, support, and treatment services described in Section V.B. An important incentive for increasing the range of community-based services is the belief that this will help decrease the use of more expensive residential placements and result in cost savings, as well as in more appropriate services. In Scott County in particular, the unique Decategorization experiment is designed to support the expansion of the service array through savings realized from decreasing use of residential placements. A first-year effort to provide a secure, locked unit for delinquent youth in the community has achieved documented savings through reduction in out-of-county placements. This is expected to be true, as well, for community-based mental health services as the collaborative use of new therapeutic foster care and day treatment services continue to develop.

Strategies and mechanisms for paying for the range of services, however, vary by community.

[37] Knitzer, J. and S. Yelton, op. cit.

In Chicago, categorical funding and scarce resources remain a major barrier to interagency activities and have generated a tradition of infighting about which agency is responsible for paying for which services. In particular, child welfare feels it should not have to reimburse mental health providers for services to children under state supervision, while mental health providers feel child welfare should pay for their services, just as they do for other services. A current effort is underway by child welfare to obtain a rate structure for mental health services provided to Medicaid eligible families by private agencies. The rate structure has been set and providers are being trained in what is reimbursable and how to obtain reimbursement. This is seen as a major means of increasing the availability of mental health services to child welfare families.

Most mental health services for child welfare families in Jefferson County are provided through referral to a comprehensive community mental health center, which is the only approved provider of services for Medicaid reimbursement. Some contract providers are also used for specialized services such as alcohol and drug abuse treatment, however funds are very limited. In addition, child welfare workers directly provide mental health services through a variety of innovative programs, supported by consultants from both staff and outside agencies.

A variety of funding sources have been tapped to provide mental health services to child welfare families in Hennepin County. Unlike other sites visited, Hennepin County supports a wide range of family and children's mental health services with local tax dollars. FOF early childhood services, local dollars are pooled with education funds to contract with day treatment providers and other services. In addition, Medicaid dollars support services either through direct reimbursement for children in out-of-home placement OF through services of one of three approved HMO's. This "managed care" approach to providing Medicaid services is a source of considerable discussion and concern among providers. Some feel HMO's unjustifiably minimize the benefit and services available to children and families; others suggest HMO's will serve a valuable role in challenging standard, but unproven, treatment assumptions and will result in more efficient service delivery.

The innovative "decategorization" effort in Scott County was established by the state legislature in 1988 in two Iowa counties. By pooling relevant funding resources of the department of human services. and seventh judicial district, along with county dollars, a single child welfare fund was created to address individual service needs without concern for categorical funding restrictions. Funds came from a pool of approximately $25 million which the state originally earmarked for such categorical programs as foster care,

family-centered services, day care, juvenile detention;. state juvenile institutions, state hospital schools, mental health institutes, locally purchased services and juvenile justice services. In addition, funds saved through providing community-based alternatives to residential services were intended to be available for development and improvement. of the service array. This benefit, however, is not assured. Proposals have been introduced to the legislature to return savings to the county rather than to the child welfare pool. The county also has been successful in attracting foundation funding for demonstration projects that benefit children and families. Support from the Robert Wood Johnson and Danforth foundations helps fund child health and school-based initiatives.

In Northumberland County, the primary funding streams for children's services come from state-allocated public welfare funds as well as Medicaid dollars. All publicly funded human services related to children and their families are situated under a single umbrella agency. Through the Children's Clinic these programs share resources, minimizing the concern for whose "turf" is involved and directing attention to the mostappropriate service for the family. Within the agency, programs may "purchase services" from one another (using an official letter of agreement) or may use contract providers. Creative approaches to joint funding of programs are also employed. For example therapeutic foster care is jointly supported using Title IV-E and Medicaid dollars.

2. Coordinating Mechanisms

Coordinating mechanisms exist at both planning and service delivery levels in all study areas visited. For the most part, these represent cooperative efforts through which independent agencies or divisions of an agency share their own plans and work together to sort out roles, minimize duplication, and improve access to their services.

For purposes of this analysis, it has been helpful to use the framework. of the Education and Human Services Consortium, a loosely-knit coalition of 22 national health and human services organizations concerned with interagency efforts to connect children and families with comprehensive services. The coalition characterizes interagency relationships as of two basic kinds?

[38] **Melaville A. and M. Blank. 1991.** ***What it takes: Structuring interagency partnerships to connect children and families with comprehensive services.*** **Washington, D.C. Education and Human Services Consortium.**

- Cooperative service delivery activities include joint efforts to locate individual services in proximity, to accept and make referrals, to share information on plans and goals, perhaps even to train some staff together. However, individual agency goals, plans and funding remain unaltered by the partnership. At the systems level, cooperative ventures may involve jointly assessing problems and developing recommendations. Agencies may cooperate through increasing mutual awareness and advocating for change among participants.

- Collaborative activities, on the other hand, ideally involve common goal-setting and planning, as well as joint resource allocation. At the systems level, participants are authorized to negotiate, alter policy and commit resources to implement joint ventures.

The most common results of cooperative interagency activity are improved access to existing services. Collaborative efforts may be more likely to result in expansion of the service system through creation of new and needed services.

Table V-4 shows examples of the coordinating mechanisms seen in sites visited and categorizes them generally as either cooperative or collaborative in nature. While such distinctions inevitably blur when applied to actual programs and communities, some general patterns of interaction can be identified.

- ***The smaller and more rural areas are those which exhibit higher degrees of working collaboration. In these areas,*** caseloads are smaller, populations less diverse, service delivery providers fewer and leadership more accessible. Both Northumberland and Scott Counties have established community-wide coordinating bodies which bring multiple agencies together for joint planning and which can draw on funding from all participating agencies to provide services. In Northumberland County, the coordinating body also reviews and determines disposition of individual cases.

- ***System level coordination tends to be stimulated by Federal or state level actions.*** CASSP activities were highly influential in development of the Northumberland County Children's Clinic, as well as in the multilevel interagency council structure implementing the Kentucky Impact program for SED children, and in the initiation of the Illinois SASS program. In Scott County, the state legislation created the decategorization pilot. In Hermepin County as well, the children's mental health council is a result of state legislation.

- ***Communities*** *vary in their need for and* ***the value placed on formal coordinating mechanisms.*** *In* Scott County, central&d planning is the cornerstone of the approach. In Jefferson County, on the other hand, respondents emphasized the importance of informal networking among community leaders and problem-oriented teams among services providers in effecting coordination.

Table V-4

Examples of Coordinating Mechanisms

Coordinating Mechanisms	Participants	Cooperative	Collaborative
Jefferson County, Kentucky			
S@em-Level Coordination			
• Kentucky Impact Interagency Advisory **Councils:**			
State **(SIAC):** Consultation, advocacy and lobbying	Social services, education, mental health, the legal system.	X	X
Regional **(RIAC):** Oversight, administration, joint policy and budget **decisions**	Same.	X	X
Local **(LIAC):** Applies eligibili criteria, does case planning and coordination, recommends nee3ed services	Same, plus other key **direct** service providers.	X	
• Jefferson County Child Protection Council: Identifies problems, increases awareness, recommends improvements. Initiated development of the Child Advocacy Center.	Broad representation of about **20** public and private **child-**serving agencies.	X	
• Family Court Committee: Identifies community-wide issues and improves linkages with the court.	Staff of various agencies that work with the court, including child welfare, mental health, education and others.	X	
Service Delivery Coordination			
• Kentucky Impact **LIACs** (See above)	**See** above.		
• DSS Placement **Screening** Committee: Controls access to contracted services and other **specialized** CPS programs.	Supervisors of child **protection** units and selected provider representatives, e.g. **W**raparound coordinator.	X	
• Family Court Liaison Workers: Facilitate court interaction with social services, improve families' access to services.	**Social** workers located at court by child welfare and mental **health.**	X	
• Child Advocacy Center Advisory Group: Coordinates referrals, tracking and follow up and improves service delivery in area of sexual and physical abuse.	Key health, mental health and social services providers.	X	X
• Family Options Interagency Assessment Team (proposed): **Multidisciplinary, multi-agency** effort to assess and develop family service plans for families referred to CPS for investigation.	Proposed to include staff from child welfare, mental health and schools.		X
• HELP Team: Jointly staffed, supervised and administered to provide family preservation services to child welfare families.	Child welfare and mental health workers share planning and service delivery.		X
• Transitions **Linkage** Agreement: Defines roles and relationships between child welfare and the Transitions program for treating physical and sexual abuse.	Child welfare case worker and assigned Transitions therapist/case manager.	X	
• **Byck** Elementary **School** Family Resource Center child study team: consultation to teachers and case planning.	Medical residents,. teachers and school social worker, mental health representatrve. Does not include child welfare.	X	

Coordinating Mechanisms	Participants	Cooperative	Collaborative
Hennepin County, Minnesota:			
System Level Coordination			
• Children's Mental Health Advisory Council: Mandated body to identity community-wide issues and improve coordination among service providers.	Representatives of various health and social services agencies, as well as parents and advocates.	X	
• Children's Mental Health Coordinating Council: Coordinates service delivery.	Various service providers and professionals.	X	
• Minneapolis Early Learning Committee: mandated to coordinate special education services for young children. Identifies problems, improves awareness and recommends approaches.	Representatives from child welfare and mental health, education, public health, plus advocates and other providers.	X	
Service Delivery Coordination			
• 348-TOTS Centralized Intake: Screens referrals, develops service plans, coordinates service delivery for handicapped infants and toddlers.	Workers from child welfare, child mental health, public health and education meet weekly.	x	X
• Early Childhood Providers Council: Shares ideas, discusses issues and coordinates activities.	Child welfare and child mental health staff, plus contract providers and private agencies.	X	
• Court Committees: Subcommittee on Children's Mental Health: examines issues and roles of service providers, makes recommendations to court and agencies.	Child welfare, child mental health, court staff.	X	
• Truancy Committee: Assembled by advocates to identify issues and make recommendations with inputs from the community.	Representatives from child welfare, child mental health, education, corrections and various service providers.	X	
Scott County, Iowa			
System Level Coordination			
• Joint Central Committee: Key policy and decisionmaking body.	Senior administrators from child welfare, the courts, and the health department.		X
• Planning Committee: Develops and coordinates service planning and implementation.	Senior staff from key agencies, plus community providers.		X
• Community Resource Panel: Advises on service development and delivery.	Directors of a wide range of community agencies.	X	X
• Ad hoc task forces and committees: Explore specific issues and recommend approaches.	Front line staff from involved agencies.	X	
Service Delivery Coordination			
• Case Management System (in planning): Case-level coordination of service planning and delivery for all child welfare services, including mental health.	Caseworkers and supervisors from child welfare and juvenile services.	X	

Table V-4 (3)

Coordinating Mechanisms	Participants	Cooperative	Collaborative
Northumberland County, Pennsylvania			
System Level Coordination			
• Unified Services Agency (Department of Human Services): Provides administrative umbrella for planning and service delivery m areas of child welfare, juvenile services, and mental health.	Human Services agency includes child welfare, mental health and juvenile court services (including probation).		X
Service Delivery Coordmatiou			
• Children's Clinic: Case-level service planning, coordination and oversight.	Representatives from child welfare, mental health and juvenile services, other agencies and advocates, as well as famihes and children involved.		X
Chicago, Illinois			
System Level Coordination			
• Residential Services Authority (state level): Identifies problems, recommends service improvements and resolves disputes about placement for SED children and adolescents.	Legislation identifies departments to be represented from state offices of child welfare, education, corrections, alcohol and substance abuse, public health and others.	X	
• Governor's Youth Services Initiative: Regional level resolves disputes between systems regarding services to children in the court system.	Representatives from state offices of child welfare, mental health, corrections, education and the courts.	X	
• Local Advisory Council (for state mental health plan): Identities local area needs and recommends service improvements.	Consumers, providers, and private sector community organizations providing mental health services to children and families.	X	
Service Deliver-v Coordination			
• Child and Adolescent Network (Northside area): Discusses issues and problems, coordinates service provision.	Various local service providers, plus the police department. Occasional participation from mental health, Fardy from child welfare..	X	
• Consortium of Service Providers for teenage mothers (city-wide): Conducts case planning, review and coordmation of Feferrals.	Staff from several agencies providing services to teenage mothers.	X	

3. Key Issues in Working Together

Some aspects of the integration process are unique to individual localities. However, there are some common features: shared values, supportive leadership, broad community involvement and consensus-building, stability among service providers and significant involvement of the courts. In addition, common values and problems, coupled with Federal and state actions, have helped create a climate for better coordination.

Although significant differences in history, tradition, and philosophy have characterized child serving systems examined in this study, contemporary reforms have moved them closer together in important ways. Table V-5 summarizes the shared goals and problems identified in sites visited, along with key Federal actions and state level activities reported by administrators and providers as important influences on their current efforts.

Increased reporting of child abuse and neglect resulted in increasing out-of-home placements in the early 1980s. The high cost of such placement, coupled with "reasonable efforts" requirements legislated in early 1980 pressed both child welfare and mental health systems to look for better ways to support children in their own homes and to provide earlier and more flexible services to prevent development of more serious problems which requires residential treatments. Leadership in both systems began to advocate for more community-based service delivery and for improved coordination. Within the mental health arena, the small CASSP program promoted a model for comprehensive services and strong interagency linkages to serve severely emotionally disturbed children. Within the child welfare arena, complementary innovations such as family preservation and other home-based models were developing. In sites visited for this study, these Federal actions were followed by state and local efforts to improve coordination and service delivery. In many cases, the courts have played a key role, through consent decrees and also through advocate judges who have employed "reasonable efforts" mandates to promote and encourage coordination.

Given these broad incentives, what is it that makes cooperation and collaboration a reality among the disparate localities visited for this study? Some things are clearly unique to the area visited: Hennepin's tradition of progressive social services, Scott County's historical commitment to a holistic approach to service delivery, the unique contributions of individual leadership in unifying child protection and juvenile services. in Northumberland. However, there are some common features which may be identified as well:

- Shared *vision.* This term was used explicitly in Jefferson and Scott Counties, and shared values and common service philosophies were cited in Northumberland County as part of the explanation for ongoing problem

solving and creative programming. In Hennepin County, agency mission statements along with a "strong record of reasonable efforts to maintain children in families" and creation of a categorical public family and children's mental health program attest to common values.

- *Leadership.* Although a single individual leader could be identified as a key factor in initiating coordinating efforts in some places (for example, Northumberland County), continuation and development of interagency activities was attributed to supportive leadership among a broad range of participating agencies.

- Stable community of *providers.* A history and willingness to work together based on longstanding relationships of trust and a strong incentive for mutual problem solving was an important aspect of active coordinating efforts. In Jefferson County, key agency heads have worked together since each was a "line worker" in his or her respective agency. In Hennepin County, community respect for public service and competitive salaries, have contributed to continuity among both administrative and staff workers.

- Broad *community* involvement and *consensus-building.* In Scott County, several planning groups have been specifically designed to involve a broad range of key players at various levels of administration and service delivery. This same is true of the tiered interagency council structure in place for the Kentucky Impact program, buttressed by less formal but regular interactions among caseworkers and agency heads alike. In Hennepin County, the kind of broad-based community consensus building responsible for the development of family and children's mental health services is typical of community processes in identifying and developing approaches to problems. In Chicago, an informal network of child and adolescent service providers shares problems, issues, and ideas.

- *Involvement of the* Courts. While the role and structure of the court system varied in communities visited, there was a consistent pattern of close working relationships evident. The most adversarial situation was seen in Chicago where court involvement is basically a matter of responding to consent decrees. However, in other sites, advocate judges with strong interests in child welfare played key roles in bringing agencies together supporting coordination and improved services.

Although the balance varies, coordinating efforts between child-serving systems in localities visited appear to have resulted from converging "top-down" and "bottom-up" efforts. Federal and state efforts have meshed with local priorities and traditions to create progressive approaches to integration and improved service delivery.

In all of the sites visited coordination efforts were the result of multiple activities emanating from several levels-federal, state, and local. It is the synergy of these activities that has provided the impetus for and created the climate that resulted in coordinated efforts. Some examples of how efforts have converged include:

- **In Hennepin County,** activities among service providers coupled with efforts by County agency administrators spanned a decade of community action to elevate the importance of issues related to children's mental health and overcome barriers within the mid-level bureaucracy. When State action in the form of comprehensive children's mental health legislation finally responded to needs identified at the community level, County efforts were given the support and mandates that made it possible to form the Family and Children's Mental Health Division.

- In **Illinois, the** state mental health agency's efforts to develop a comprehensive approach to serving SED children, coupled with mandates under a consent decree that require child welfare and mental health to work together, represent "top-down" efforts to increase coordination. While much of what is being put into place as a result of these two activities is still in the development stages and has not yet been realized at the local level, a number of community efforts are also underway that may facilitate the implementation of the activities envisioned. For example, The Community Counseling Centers of Chicago was one of the first providers funded under the state mental health plan's Screening, Assessment and Support Services because they already had an infrastructure and service delivery approach that matched the program objectives.

- **In Jefferson County,** innovations at the community level coupled with State-level efforts to incorporate family-based services approaches in all child-serving systems have enabled the proliferation of coordinated activities. In some cases, the origins of state-funded programs can be traced to innovative efforts originating in Jefferson County. Many of the programs and approaches in Jefferson County have been implemented in response to "reasonable efforts" requirements in **P.L.** 96-272, which represents another "top-down" activity emanating from the Federal level.

Table V-5
Incentives for Systems to Work Together

Common Goals/Values	Common Problems	Key Federal Actions	Key State Actions
• **Serving children in the most** home--and community-like setting possible • Working with the whole family, not just the child • Providing services based on the needs of the child and family, rather than the needs of the system • Providing services in the least restrictive, most normative environment possible	• Increasing complexity and severity of problems-in children and families served. • Limited and shrinking resources • Disproportionate expenditures for residential care • Limited placement options	**P.L. 93-247** **Child** Abuse Prevention and Treatment Act of **1974:** mandates reporting of child abuse and **neglect** by multiple agencies and providers. **P.L. 96-272** **Adoption** Assistance and Child Welfare Act of 1980. Mandates "reasonable efforts" to **prevent** placement and work toward **reunification.** P.L. 94-142 (1975) and 1984 Amendments in P.L. 99-457. Education for All Handicapped **Children:** mandates comprehensive, **coordinated,** interagency programs of early intervention services for handicapped infants and toddlers and their families. **Child** and Adolescent Service System Program **(CASSP)** provides grants to states and **localities** to strengthen comprehensive, community-based care, for SED children.	**Illinois:** Consent Decrees mandating improvements in hospitalization decisions and follow-up and improved mental health services for children under state supervision. Iowa: 1988 Decategorixation Legislation authorized pooling of child welfare funding from various sources. Kentucky: 1985 Family Based service legislation (House Bill 2) authorized funding for family-based social services. 1990 SED Plan (House Bill 838) endorsed state funds to improve coordination of community-based services for SED children. 1990 Kentucky Education Reform Act emphasizes collaboration with other community providers; targets low income students. Minnesota: 1989 Comprehensive Children's Mental Health Act mandated specialized mental health services for children/families. Pennsylvania: No statewide mandate. Local initiative: unified services agency.

VI. Program, Policy, and Research Implications

A. Introduction

Localities visited during this study were selected because they offer recognized models of interagency efforts to provide mental health services to children. In each, the child welfare agency is a key participant, though not always the lead organization. Involvement of children's mental health, juvenile justice, and education systems was also examined wherever possible.

Study areas were selected to gain insights into diverse service system configurations and service delivery approaches, as well as to represent a range of geographical areas and rural and urban environments. Each site brings a unique set of environmental and contextual issues that have helped shape its response. However, a number of patterns and themes shared across sites did emerge. This chapter describes these common observations and identifies their implications for future research and policy consideration. Although this study has begun to examine the issues related to meeting the mental health needs of children in child welfare, further efforts will be needed to examine the many aspects of service delivery and coordination identified during the course of this study.

The sites included in this study were selected because of their progressive approaches to improving services to children and families through community-wide service coordination. Their progress in working together may not be typical of communities across the nation. Yet even in these model programs, the need for continuing efforts to develop and fund needed services and to ensure participation and involvement of all relevant child-serving agencies is clear. The program and policy implications described below delineate more specific aspects of a single overarching observation expressed by national experts and validated by case studies conducted for this study: the current fragmented service system is inadequate to meet the multiple needs of children and families. Ways must be found to provide incentives, reduce institutional and professional barriers and support the development of community-based, child and family centered services for the full range of mental health needs, not just the most severe needs which cannot be ignored. In particular, the needs of children and families in the child welfare system are clear, pressing, and seriously underserved. Child welfare and child mental health specifically, and other systems routinely involved in the lives of child welfare families, must find better ways to assure these needs are met,

B. Program Observations and Implications

1. Lack of joint intake, assessment, and case planning processes among child-serving agencies contribute to fragmentation and duplication of services and impede effectiveness in meeting multiple needs.

Since children and families in the welfare system are often involved with other health and social services agencies, mental health assessments, and service planning must be coordinated if duplication is to be minimized and children and families are to receive the help they need.

Some may argue that intake, assessment, and case planning responsibilities belong to the child welfare agency; others that there is critical expertise in other systems and that children's mental health needs warrant a community response. Given current conditions, where these functions reside may be less important than ensuring that they take place and involve all key child-serving systems.

Among sites visited, many examples of coordination were identified; however, most of these were developed around specific populations or problems. More collaborative case planning and service development were evident in several programs emanating from CASSP initiatives, but this did not extend to systematic assessment for all children entering the child welfare system. Even in Northumberland County, which has a strong central planning and joint case management approach, only cases considered most challenging are brought to the table.

Overall, multi-agency assessments using multiple instruments and multi-agency case plans remain the rule. The existence of duplicative and uncoordinated case planning can be attributed in part to Federal program mandates. Title IV-E requires case planning and the Education for All Handicapped Children Act requires that schools develop Individualized Education Plans (IEPs) and, in recent amendments, Individualized Family Service Plans (IFSPs). Efforts among Federal agencies to coordinate mandates and requirements could assist state and local efforts in this area. Emerging technologies may offer additional bridges to help coordinate efforts.

Data privacy issues may or may not pose barriers at the local level, depending on local customs and laws. Neither Scott nor Jefferson Counties reported confidentiality barriers to coordinated case review and planning; however in Hennepin County, strong data privacy traditions and laws were an important issue. Efforts to implement joint assessment and case planning are likely to raise confidentiality concerns, especially if efforts include documented reviews shared across systems or computer tracking and management.

Implication: ***Multiple assessment instruments and requirements for program eligibility hinder development of joint procedures and impede systematic assessment of all children and families entering the child welfare system.***

Research and Policy Questions

At what point should children in child welfare be assessed for mental health service needs?

What should assessments encompass-needs and risks? Families' needs as well as children's needs?

Who is responsible for assessing children's and families' needs and risks?

Is it possible for one assessment tool to meet the needs of multiple agencies and systems?

Are existing assessment tools suited to this purpose?

Should assessments be conducted without a promise of providing services?

What mechanisms can be used to ensure coordination of assessment tools and procedures across systems?

Implication: ***Individual case planning requirements tied to categorical funding streams (e.g., Title IV-E and P.L. 99-457 for Individualized Family Service Plans) inhibit the kind of collaborative service planning necessary to improved services integration.***

Research and Policy Questions

What are the existing conflicting mandates in Federal, state, and local case planning requirements?

What mechanisms can be used to coordinate existing Federal, state, and local case planning requirements?

Implication: ***Privacy/confidentiality issues need to be fully explored, with consideration for Federal, state, and local issues and restrictions. A key aspect of this issue is sorting out real versus perceived barriers, while still making sure the rights of clients are protected***

Research and Policy Questions

What are the Federal, state, and local issues related to confidentiality?

To what extent are these real versus perceived?

What mechanisms can be used to overcome confidentiality barriers to coordinating services while ensuring that client's rights to privacy are protected?

2. Training of professionals providing child welfare and child mental health services has not kept pace with the skills and orientation needed to adequately address mental health needs.

Providers' ability to work with staff in other service systems was raised as an important issue during several site visits.

A key issue involves the basic preparation of service providers to deal with the diversity of clients and complexity of problems seen by health and social service agencies. To work with clients in the public service arena requires addressing issues of poverty, drug use, violence, homelessness, and cultural diversity. Curricula in social work programs, as well as programs in psychology and other human service professions, do not adequately equip students to deal with these issues.

Skills to link and coordinate with other systems, including skills in networking, consensus building, problem solving, and obtaining input from clients and colleagues also need improvement. Service providers must be able to deal with multiple bureaucracies, program eligibility criteria, and application procedures. They must also be able to develop coalitions to effectively address multiple needs together.

An important issue is the tension between child welfare providers and those in other systems, particularly mental health. As an entitlement program, child welfare must serve every child and family meeting case definitions, while mental health can choose which clients to serve and can turn clients away if they are at capacity. Other cross-system issues include lack of understanding about differing

mandates and constraints and differences in terminology, treatment, and service provision approaches. In those programs where joint case planning was implemented, staff emphasized that in addition to better outcomes for the clients, the approach of sitting down at the table together benefits staff. This type of approach provides a forum for enhancing understanding of other professions, recognizing common goals for the families and children being served, and working out differences.

Among mental health providers, and many child welfare providers as well, there continues to be a bias toward hospitalization and traditional office-based therapies. Use of more home- and family-based modalities requires continuing education and re-orientation for many.

Implication: ***To address mental health needs of children and families in child welfare, staff in multiple service agencies must have adequate basic preparation and continuing education in understanding requirements of public service agencies and clients, working with other systems and providers, and understanding children's and families' mental health needs and the range of appropriate and available services.***

Research and Policy Questions

To what extent does basic preparation for social work and mental health professionals meet the demands of practice?

How can schools, professions, and public and private agencies work together to ensure that preparation fits practice needs?

What opportunities are available for continuing education?

What mechanisms can be used to build skills in the areas of coalitio building, understanding and working with other professions, and shapin practice to fit into the broader community service system context?

3. Generally, approaches to improving service coordination and to providing mental health services are not based on proven methods supported by evaluation.

While the value of evaluating system outcomes and child and family outcomes was acknowledged by respondents in all sites visited, efforts to do so were sporadic primarily because of limited resources, lack of time, and no readily available methodology or technology. Much of what has been put into place

The recent surge of interest in system integration and coordination has been accompanied by some efforts to assess impacts, for example the evaluation component of the CASSP program; however, more needs to be done to disseminate the outcomes of these studies. Similarly, localities across the country could benefit from evaluation results from sites which have been able make progress in the field such as those explored in the five communities visited for this study.

Implication: ***Wide dissemination of existing evaluation studies and technical assistance, as well as support for additional studies to examine what works in service delivery and coordination approaches, would help inform and improve system and program level efforts.***

Research and Policy Questions

What are the existing technologies and mechanisms for conducting evaluation at the Federal, state and local levels?

What indicators should be used to measure child and family outcomes?

What indicators should be used to measure system outcomes?

What are the mechanisms for identifying and disseminating existing studies?

What are the incentives for evaluation?

C. Policy Observations and Implications

1. Children who do not have severe emotional or behavioral problems are not an identified priority population for mental health services.

Programs targeted specifically to children's mental health needs are a relatively recent phenomenon. During the last decade, a number of efforts to improve services have been supported by Federal and private foundation funding. However, these efforts focus on children with serious emotional, behavioral, or mental disorders.

In the child welfare system, high caseloads, limited resources, and increasingly complex and serious problems among families served have resulted in greater targeting of services to the most obvious and serious mental health needs.

The study areas visited have developed a variety of interagency coordination mechanisms and service delivery programs to address environmental and social factors that contribute to the development of mental health problems. These approaches have been stimulated and supported, for the most part, by legislative and funding initiatives designed to improve services to severely emotionally disturbed (SED) children. However, agencies generally are flexible in their use of the SED designation in an effort to serve as many children as possible given limited resources. A "trickle down" effect has resulted in some improvements in services for all children with mental health needs, however, this appears to be a byproduct.

Implication: ***Without incentives to focus on the needs of children who are not at the most severe end of the spectrum of emotional and behavioral problems, the pressing and serious needs of these children and their families wilt continue to take a back seat to the more acute and obvious needs of those who have SED status.***

Research and Policy Questions

How can Federal and state priorities be expanded to focus more attention on prevention and early intervention services for children with mental health needs who are not severely disturbed?

How can private foundations be encouraged to support demonstration and research efforts for the children with less severe problems?

What other kinds of public and private stimuli are needed to increase awareness of the full range of children's mental health needs and encourage development of a more comprehensive range of programs, including prevention and early intervention services?

2. **Identification of children whose mental health needs are less than severe is inhibited by poor definitions and continued bias toward a "deficit" rather than a "wellness" model of treatment.**

There is no clear way of defining the needs of children who do not meet the criteria for being designated SED. Children's mental health problems involve a complex mix of biological, environmental, and developmental factors that elicit highly individual responses evident in social, emotional, behavioral, and cognitive functioning at home, at school and in the community.

Development of a set of basic SED parameters was supported by NIMH as part of the initiation of the CASSP program to assist states and communities to

identify the target population for the program. No comparable effort has been identified to define or describe the continuum of less severe difficulties for program development purposes. For the most part, children who are not clearly SED are recognized as needing mental health services because of behavior or conduct problems, or because of difficulties in school. Recognition of the needs of this population depends largely on the training and judgement of individual caseworkers.

While mental health "deficits" are difficult to define, it is widely recognized that most children in the child welfare system are at risk of developing emotional or behavioral problems due to stressors in their lives. These may include poverty, abuse and neglect, substance abuse or other environmental risk factors. Additionally, actions taken by the system to protect children and involving placement may be traumatic, further increasing the need for attention to mental health needs. Being removed from the home can cause feelings of loss and separation, and being moved from one foster care home to another makes it difficult for a child to develop healthy adult relationships and attachments.

Contemporary approaches to meeting children's mental health needs go beyond tertiary treatment modalities and responses to obvious behavioral or emotional problems. They include prevention, early intervention, and support to children and families in dealing with environmental and social risk factors for serious disturbance.

Implication: ***Without improved definitions of children's mental health needs that include environmental and social aspects of healthy adaptation to guide program development, service providers and policymakers ate limited in their ability to identify service needs, develop suitable approaches, and assess effectiveness.***

Research and Policy Questions

What is the best approach to defining the needs of children whose mental health status does not warrant the designation "severely emotionally disturbed"?

To what extent should the definition include the needs of families and other social and environmental influences which provide the context for childrens' growth and development?

How can program and policy officials create programs for this population without resorting to categorical eligibility standards that create barriers to coordinated service delivery and subordinate the needs of the child to the administration of the system?

3. ***There* is no designated leadership responsibility for coordinating efforts to address children's mental health needs.**

In identifying potential study sites, we were struck with the variations in agency roles in the communities recommended for consideration_ Our criteria for site selection included a key role for the child welfare agency, but not necessarily a lead role. In the sites visited, we found two unified services agencies in which child welfare coordinated with other child-serving divisions under a single administrative umbrella, including one with a specific family and children's mental health program providing leadership to coordinated efforts; one where child welfare has played a dominant role, with strong support and involvement of the courts and other agencies; one where a state-funded pilot, program has created an interagency planning entity; and, one where there is no clear lead for widespread coordination.

Coordinating activities have emerged from the interaction of local needs, spurred by court intervention, with Federal and state initiatives to support improvements in coordinated service delivery. CASSP, in particular, has played a significant role in several communities. Very different models for working together have grown in the localities visited.

Implication: ***Without clear agency mandates to provide leadership in improving community-wide response to children's mental health needs, improvements will continue to rely on individual combinations of community environment, leadership, and resources.***

Research and Policy Questions

Should a single agency assume the lead for coordinating mental health services for children, including those in the child welfare system?

If responsibility continues to be distributed among several agencies at the state and local level, what strategies can be employed to encourage agencies to accept children's mental needs as integral to their own missions and to develop better working relationships with others?

What strategies should policy makers support to enhance coordinated service delivery at the local level? At the state level? At the Federal level?

4. **Absence of a consistent, longer-term source of funding for children's mental health services inhibits long-range planning and development of system-wide activities.**

At present, service providers must expend considerable effort to create ways to support and sustain mental health services for children by manipulating categorical funding streams and maximizing ways to access Medicaid. In particular, home- and community-based services must be funded through a mixture of Federal, state, and local dollars from various agencies. Strategies and mechanisms vary in communities visited from the decategorization experiment in Scott County to heavy reliance on Medicaid supplemented by limited child welfare funds.

Severe resource limitations in child welfare agencies generally inhibit support to mental health services, even where there is strong provider and community commitment to its importance. Mental health funding for children's services has been essentially limited to CASSP planning grants, supplemented by some private foundation funding of demonstration efforts. Communities visited are presently mobilizing to maximize their use of Medicaid dollars, to take advantage of potential new sources of support from expanded EPSDT guidelines, and to improve coordinating efforts with the school system to capitalize on Education for All Handicapped Children resources.

Implication: ***Complex and shifting funding sources will continue to inhibit services integration and the creation of lasting improvements in the mental health service delivery system for children and families. Providers are currently devoting substantial effort to finding and arranging funding.***

Research and Policy Questions

What public and private funding mechanisms could be used to provide a stable source of funding for comprehensive mental health services?

What incentives could be built into existing Federal, state, and local funding sources to increase flexibility in coordinating resources or encourage pooled funding to meet local needs?

D. Summary

Linking children in the child welfare system with needed mental health services may appear to be a logical and straightforward process. In fact, categorical funding, multiple and complex needs of the client population, complexities of the child-serving

systems, resource limitations, and definitional issues combine to make this a difficult task. The five sites visited, each with its unique environmental and contextual characteristics and service system configurations, represent different approaches to addressing this issue. Despite the differences, themes, and patterns with implications for future program and policy directions did emerge. These implications can serve as a springboard for further discussions pertaining to future research agendas and additional actions needed to help service systems progress toward integrated and coordinated service provision.

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(2 of 3)

FINAL REPORT

Community-Based Mental Health Services for Children in the Child Welfare System

Volume II
Site Visit Reports

Contract No. HHS-100-91-0016-01

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by:

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Executive Summatv

I. Overview of Children's Mental Health Needs and Services

- *Danny is 6-years-old and in first grade. He is a constant source of trouble in school--he demonstrates unprovoked physical aggression towards his teachers and classmates and his language is peppered with curses. At home, his father's approach to discipline is to tie him to a chair and hit him with a belt.*

- *14-year-old David is in detention for burglary and assault; this is his fourth time in juvenile court, and he has a long history of physical violence toward his younger sister, behavior problems in school, and truancy. His mother thinks he is mentally ill and wants him evaluated and removed from the home.*

- *Thomas, 6-years-old, is often seen on the street hustling money for food; he lives in public housing with his mother who is an alcohol and drug user; and has two younger sisters who suffer from fetal alcohol syndrome. He has three older brothers; the two oldest are in prison for drug distribution, and the 16-year-old is in a reformatory institution for murder*

- *Shauna, a 6-year-old girl who has been removed from her natural parents because of sexual abuse, is now in her second foster care placement. She is unresponsive and uninvolved with people around her. She demonstrates very little emotional reaction to anything that happens to her--good or bad--and even shows little interest in Christmas-time activities and surprises.*

Children such as Danny, David, Thomas, and Shauna and their families have multiple, complex needs, and often have meager resources with which to meet these needs. They depend on mental health, child welfare, and other service systems to provide myriad hinds of assistance. Too often, those systems are fragmented, hindering access and creating additional stress on children and their families.

The children described above are in the child welfare system. It is unknown how many other children in child welfare are among the estimated 7.5 to 9.5 million children in the United States who need mental health services. However, child welfare, juvenile justice, and mental health providers report that the children they serve share common characteristics: they come from similar circumstances and have comparable childhood experiences. Problems related to these experiences are simply manifested in different ways, and if left unaddressed, can have negative consequences for the child, the family and society as a whole. Such consequences may include difficulty in forming relationships, low self esteem, difficulty in school, delinquency and difficulty in holding a job. These problems could escalate to levels requiring intensive interventions including incarceration or hospitalization.

Definitional issues hamper a neat categorization of children's mental health needs. Approaches to describing children's mental health encompass clinical diagnosis (e.g., a recent Office of Technology Assessment Report adopted the DSM-III-R definition of mental disorder: clinically significant behavioral or psychological syndrome or patterns associated with distress or disability); use of various assessment instruments; and program eligibility guidelines. A widely used framework to identify SED children focuses on two dimensions: severity of social impairment and persistence of the problem.

Despite the lack of a definitive way to categorize children with mental health problems, many communities do have a range of services to help those children and their families. Further, a recent "paradigm shift" in conceptualizing and developing children's mental health services emphasizes a broader range of services, including intermediate care services (therapeutic foster care, intensive in-home care) and family support (crisis intervention, respite care for parents, intensive case management, parenting skills instruction). This wider spectrum of s&vices--which enhances the traditional mental health services such as outpatient psychotherapy, hospitalization, and long-term residential treatment-focuses on adapting services to the needs of the client rather than adjusting the client's need to fit existing services in the system.

Typical of the new emphasis in the field of children's mental health is the concept of a comprehensive system of care developed by Stroul and Freidman, which advocates a full array of services to be provided by various agencies, including child welfare. Categories of mental health care for children include prevention/early intervention, assessment, case management, outpatient treatment, home-based services, day treatment, crisis, and emergency services. This model has been widely used in crafting current legislation to improve children's mental health services at the national level.

The myriad service systems that intervene with children who have emotional disturbances--and their families-tend to be fragmented and crisis-oriented. Various barriers inhibit a cooperative and holistic approach to working with these children and their families; too often, agencies focus only on the problems they are organized to solve rather than on the array of complex needs brought by their clients.

II. Purpose of this Study

Contemporary reforms have stimulated state and local efforts to improve coordinated mental health service delivery to children. However, research and program efforts documented in the literature feature issues and accomplishments in serving SED children. The availability and adequacy of mental health services available to children in child welfare, and particularly those who have not yet been designated SED, has not yet been documented. To gain an understanding of these issues, the office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services (DHHS), recently undertook a study to explore approaches to providing needed services to

children in child welfare who are not yet considered SED. Macro International Inc. conducted this study under contract to ASPE.

This study attempted to scrutinize the four major systems that typically have an impact on emotionally disturbed children: child welfare, child mental health, juvenile justice, and schools. Because multiple systems touch the lives of children in the child welfare system who have mental health needs, collaboration among these systems is essential. Through this study ASPE sought to describe the efforts of communities where child-serving agencies have made strides in working together and to identify the issues and barriers these communities face in continuing to work toward improved service delivery. Site visits to selected communities explored three categories of critical factors that can influence development of an integrated approach to child-serving systems: community environmental and contextual issues, system-level factors, and service delivery-level factors. Key questions of concern to the study included the following:

- What characteristics frame the development and implementation of efforts to work together?
- What organizational components and mechanisms promote successful interagency activities?
- What programs and strategies contribute to mental health services for children, especially those who are not SED?
- What are the program, policy, and research implications of the findings from site visit communities?

III. Study Methodology

This project incorporated broad-based input from national experts, published and unpublished reports, and information and insights gathered through site visits. The study had three major phases:

- **Identifying key issues and clarifying the study** focus-Because the issue was complex and cut across many fields, it was important to delineate the crucial issues and direction of the study. A Federal advisory group with representatives from agencies in fields relevant to the study met twice to help guide the project. A panel of experts from outside the government also was convened to contribute their expertise in areas of child welfare, child mental health, special education, and children's advocacy. In addition, telephone interviews with experts at the national and state level elicited perspectives on exemplary community programs. A literature review described current research related to child welfare and children's mental health and helped define the study issues.

- Developing the study approach--Information and insights from the first phase helped shape the study approach. First, an analytic framework was developed to guide data collection and analysis. The framework illustrates the general interactions among key factors influencing service delivery approaches and outcomes for children. Next, the study team produced a case study plan to guide the site visit process and ensure that information would be collected in an efficient and consistent manner. An interview guide highlighted questions to elicit information on the environmental/contextual, system-level, and service delivery factors that affected the community's approach to serving children.

  Several criteria guided selection of the site visit locations. Ideally, the communities would have a strong child welfare agency, a collaboration between child welfare and child mental health agencies, and an emphasis on community-based services for children and families. Nine sites met the initial criteria; profiles of these, based on telephone interviews with community experts, helped narrow the list to four localities: Hennepin County, Minnesota (Minneapolis); Jefferson County, Kentucky (Louisville); Scott County, Iowa (Davenport); and Northumberland County, Pennsylvania. Chicago, Illinois, was added to the list of sites to ensure representation from a major urban area with diverse populations and heavy service demands.

- Conducting site visits--Visiting the five sites was the central method of data collection for this study. The purpose of the sites visits was to explore approaches to providing mental health services to children in child welfare, identify and describe factors affecting their approach to services, and discern trends that have implications for future policy and research. Two teams composed of two Macro staff members conducted 4-day site visits to each study locality. Altogether, site visits included discussions with more than 100 individuals representing approximately 46 public and private agencies and organizations, as well as foster parents and children's advocates.

IV. Summary of Major Findings

In examining the systems involved in providing mental health services to children in child welfare among the five communities, certain key themes and patterns emerged.

We have summarized the key findings and aggregated them in the two main issue areas that this study addressed: (1) the kinds of mental health services being provided the children in the child welfare system, with a particular emphasis on children who are not SED, and (2) the extent to which the child welfare and child mental health systems are working together and the extent to which they are collaborating with other child-serving systems.

Findings from these five case studies reflect a range of types and sizes of communities that have what are considered exemplary approaches to serving children and their families.

Mental Health Services for Children in Child Welfare

Status of Services

- The only clear criteria for defining children's mental health needs in sites visited were those developed to **identify** severely emotionally disturbed children (SED). Although agencies and providers recognize that many children who need mental health services may not fit SED criteria, there is no common way to describe or categorize these needs. For the most part, children who are not clearly SED are recognized as needing mental health services because of behavior or conduct problems, or because they cannot function in school.

- In almost all sites visited, identifying children's mental health needs and obtaining services is dependent on the child welfare caseworker's training, awareness of resources and concern about observed or reported behaviors or problems.

- Mental health services in all localities include traditional outpatient and inpatient services. However, home- and community-based services are a prominent and growing part of the array of mental health services.

- While a few programs in study areas were developed specifically to serve children in the child welfare system, the majority serve a broader population within which child welfare clients may or may not be a priority. Even where a broad array of programs is in place, children in child welfare may not always benefit due to such constraints as program eligibility criteria, access mechanisms and program capacity.

- Case planning for children who are involved with multiple systems remains, for the most part, fragmented, duplicative or both.

- There was generally no evidence of a system-wide approach to evaluating coordinated provision of mental health services to children in the child welfare system. However, individual agencies do track and monitor service delivery measures in many instances.

Approaches to Providing Services

- ***In*** some localities, true joint efforts are in place involving multiple agencies and families in service planning; however, most involve independent efforts by each system which may or may not be shared with others.

- Although family involvement and empowerment is recognized as an important value in study areas, there is wide variation in the extent to which families are currently involved in service planning and setting treatment goals. In many places, however, foster parents are being increasingly viewed as extensions of service delivery staff and are involved both in service planning and in working with natural families.

- Generally, case management denotes a "brokering role" in sites visited, i.e., a responsibility to see that children and families obtained access to available resources. However, a more activist concept of case management as a comprehensive process of stimulating development of needed services and helping the family find ways to meet their own needs was also evident.

- Although most needs for additional programs and services identified by respondents were specific to the service delivery system in that locality, three general areas for further program development were cited by several: services for children in the juvenile justice system, improved coordination with the schools, and better ways to address the critical effects of sexual abuse and drug abuse in the lives of most children and families in the child welfare system.

Service Coordination

Status of Coordination

- Very different models for working together have evolved in the localities visited. The extent of coordination is affected by the general climate in the community as well as by the interplay of leadership, communication and problem solving processes, and funding considerations.

- The size, complexity of the systems involved, community values, and operating styles influence the approach to coordination.

- While the strong leadership of an individual leader was noted in one or two of the sites visited, all those who have been successful have supportive leadership in several key agencies who are committed to finding ways to work together.

- Communities varied in the value placed on formal communication and coordinating mechanisms; however, they share an emphasis on mutual problem solving, consensus building among a wide range of community providers, and a recognition of the value of consumer involvement in service planning.

Approaches to Coordination

- Developing community-based mental health services for children requires creative efforts to tap into and mix Federal, state and local dollars from various child serving agencies. A key impetus for developing a broader range of services in the community is concern for the high cost of residential care related to the few children who can be served.

- Coordinating mechanisms exist at both planning and service delivery levels in all study areas visited. For the most part, these represent cooperative efforts through which independent agencies or divisions of an agency share their own plans and

work together to sort out roles, minimize duplication, and improve access to their services. A key impetus for developing a broader range of services in the community is concern for the high cost of residential care related to the few children who can be served.

- Some aspects of the integration process are unique to individual localities. However, there are some common features: shared values, supportive leadership, broad community involvement and consensus-building, stability among service providers, and significant involvement of the courts. In addition, common values and problems, coupled with Federal and state actions, have helped create a climate for better coordination.

- Although the balance varies, coordinating efforts between child-serving systems in localities visited appear to have resulted from converging "top-down" and "bottom-up" efforts.

V. Program, Policy, and Research Findings

A. Introduction

The sites included in this study were selected because of their progressive approaches to improving services to children and families through community-wide service coordination. Their progress in working together may not be typical of communities across the nation. Yet even in these model programs, the need for continuing efforts to develop and fund needed services and to ensure participation and involvement of all relevant child-serving agencies is clear.

The program and policy implications described below delineate more specific aspects of a single overarching observation expressed by national experts and validated by case studies conducted for this study: the current fragmented service system is inadequate to meet the multiple needs of children and families. Ways must be found to provide incentives, reduce institutional and professional barriers and support the development of community-based, child and family centered services for the full range of mental health needs, not just the most severe needs which cannot be ignored. In particular, the needs of children and families in the child welfare system are clear, pressing, and seriously underserved. Child welfare and child mental health specifically, and other systems routinely involved in the lives of child welfare families, must find better ways to assure these needs are met.

B. Program Observations and Implications

1. **Lack of joint intake, assessment, and case planning processes among child-serving agencies contribute to fragmentation and duplication of services and impede effectiveness in meeting multiple needs.**

   Implication: ***Multiple assessment instruments and requirements for program eligibility hinder development of joint procedures and impede systematic assessment of all children and families entering the child welfare system.***

Research and Policy Questions

At what point should children in child welfare be assessed for mental health service needs?

What should assessments encompass-needs and risks? Families' needs as well as children's needs?

Who is responsible for assessing children's and families' needs and risks?

Is it possible for one assessment tool to meet the needs of multiple agencies and systems?

Are existing assessment tools suited to this purpose?

Should assessments be conducted without a promise of providing services?

What mechanisms can be used to ensure coordination of assessment tools and procedures across systems?

Implication: ***Individual case planning requirements tied to categorical funding streams (e.g., Title N-E and P.L. 99-457 for Individualized Family Service Plans) inhibit the kind of collaborative service planning necessary to improved services integration.***

Research and Policy Questions

What are the existing conflicting mandates in Federal, state, and local case planning requirements?

What mechanisms can be used to coordinate existing Federal, state, and local case planning requirements?

Implication: ***Privacy/confidentiality issues need to be fully explored, with consideration for Federal, state, and local issues and restrictions. A key aspect of this issue is sorting out real versus perceived barriers, while still making sure the rights of clients are protected***

Research and Policy Questions

What are the Federal, state, and local issues related to confidentiality?

To what extent are these real versus perceived?

What mechanisms can be used to overcome confidentiality barriers to coordinating services while ensuring that client's rights to privacy are protected?

2. **Training of professionals providing child welfare and child mental health services has not kept pace with the skills and orientation needed to adequately address mental health needs.**

Implication: ***To address mental health needs of children and families in child welfare, staff in multiple service agencies must have adequate basic preparation and continuing education in understanding requirements of public service agencies and clients, working with other systems and providers, and understanding children's and families' mental health needs and the range of appropriate and available services.***

Research and Policy Questions

To what extent does basic preparation for social work and mental health professionals meet the demands of practice?

How can schools, professions, and public and private agencies work together to ensure that preparation fits practice needs?

What opportunities are available for continuing education?

What mechanisms can be used to build skills in the areas of coalition building, understanding and working with other professions, and shaping practice to fit into the broader community service system context?

3. **Generally, approaches to improving service coordination and to providing mental health services are not based on proven methods supported by evaluation.**

Implication: ***Wide dissemination of existing evaluation studies and technical a&stance, as well as support for additional studies to examine what works in service delivery and coordination approaches would help injonn and improve system and program level effotfs.***

Research and Policy Questions

What are the existing technologies and mechanisms for conducting evaluation at the Federal, state and local levels?

What indicators should be used to measure child and family outcomes?

What indicators should be used to measure system outcomes?

What are the mechanisms for identifying and disseminating existing studies?

What are the incentives for evaluation?

C. Policy Observations and Implications

1. **Children who do not have severe emotional or behavioral problems are not an identified priority population for mental health services.**

   Implication: ***Without incentives to focus on the needs of children who are not at the most severe end of the spectrum of emotional and behavioral problems, the pressing and serious needs of these children and their families will continue to take a back seat to the more acute and obvious needs of those who have SED status.***

Research and Policy Questions

How can Federal and state priorities be expanded to focus more attention on prevention and early intervention services for children with mental health needs who are not severely disturbed?

How can private foundations be encouraged to support demonstration and research efforts for the children with less severe problems?

What other kinds of public and private stimuli are needed to increase awareness of the full range of children's mental health needs and encourage development of a more comprehensive range of programs, including prevention and early intervention services?

2. **Identification of children whose mental health needs are less than severe is inhibited by poor definitions and continued bias toward a "deficit" rather than a "wellness" model of treatment.**

Implication: ***Without improved definitions of children's mental health needs that include environmental and social aspects of healthy adaptation to guide program development, service providers and policymakers ate limited in their ability to identify service needs, develop suitable approaches, and assess effectiveness.***

Research and Policy Questions

What is the best approach to defining the needs of children whose mental health status does not warrant the designation "severely emotionally disturbed"?

To what extent should the definition include the needs of families and other social and environmental influences which provide the context for children' growth and development?

How can program and policy officials create programs for this population without resorting to categorical eligibility standards that create barriers to coordinated service delivery and subordinate the needs of the child to the administration of the system?

3. There is **no designated leadership responsibility for coordinating efforts to address children's mental health needs.**

Implication: ***Without clear agency mandates to provide leadership in improving community-wide response to children3 mental health needs, improvements will continue to rely on individual combinations of community environment, leadership, and resources.***

Research and Policy Questions

Should a single agency assume the lead for coordinating mental health services for children, including those in the child welfare system?

If responsibility continues to be distributed among several agencies at the state and local level, what strategies can be employed to encourage agencies to accept children's mental needs as integral to their own missions and to develop better working relationships with others?

What strategies should policy makers support to enhance coordinated service delivery at the local level? At the state level? At the Federal level?

4. **Absence of a consistent, longer-term source of fundiig for children's mental health services inhibits long-range planning and development of system-wide activities.**

Implication: ***Complex and shifting funding sources will continue to inhibit services integration and the creation of lasting improvements in the mental health service delivery system for children and families. Providers are currently devoting substantial effort to finding and arranging funding.***

Research and Policy Questions

What public and private funding mechanisms could be used to provide a stable source of funding for comprehensive mental health services?

What incentives could be built into existing Federal, state, and local funding sources to increase flexibility in coordinating resources or encourage pooled funding to meet local needs?

D. Summary

Linking children in the child welfare system with needed mental health services may appear to be a logical and straightforward process. In fact, categorical funding, multiple and complex needs of the client population, complexities of the child-serving systems, resource limitations, and definitional issues combine to make this a difficult task. The five sites visited, each with its unique environmental and contextual characteristics and service system configurations, represent different approaches to addressing this issue. Despite the differences, themes, and patterns with implications for future program and policy directions did emerge. These implications can serve as a springboard for further discussions pertaining to future research agendas and additional actions needed to help service systems progress toward integrated and coordinated service provision.

Site Visit Summary
Northumberland County, Pennsylvania

Prepared by:

Macro International Inc.

June 30, 1992

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Northumberland County, Pennsylvania

Northumberland County is a small rural area in central Pennsylvania (population: 100,000). Human services are provided under a single umbrella agency which includes child protection, mental health/mental retardation, juvenile justice, and drug and alcohol services. The consolidation was a county decision, agreed to by the state office. A key feature of the approach to providing children's mental health services in Northumberland County is the "Children 's Clinic," a traditional name for an innovative strategy of collaborative service planning which involves child welfare, mental health and juvenile justice, as well as the families being served

I. introduction

Northtnnberland County, Pennsylvania, has a national reputation for providing excellent human services for children and families. The county has an integrated human services system, with mental health, mental retardation, children and youth services, and juvenile court services under the same umbrella. The county has a strong history of collaboration and cooperation among units in the department and is a model for providing family-centered services, including family therapy, to county residents. The Children's Clinic has attracted national attention as a model for collaborative case planning. In addition, the department itself has drawn notice as a dynamic organization with a management style that fosters professional growth and development. Northumberland County has been the focus of numerous studies and site visits, including one by The Tom Peters Group study on excellence in public service agencies.

The Macro study team visited Northumberland County during the period of March 23-26, 1992. Discussions were held on one or more occasions with the people listed below.

Northumberland County Commissioners
Charles F. Lewis
Samuel S. Deitrick
George Edwards, chief clerk

Northumberland County Department of Human Services
Dr. Calvin Wolfberg, director
Jerome Alex, administrator and financial manager
Cindy Ebright, financial assistant
Debbie McPhail

DHS Children and Youth Services
Jane Keamey, director

CASSP Program/Children's Clinic
Judy Davis, coordinator

Mental Health-mental Retardation
Robert Conklin, director
Ellen Wolf, administrative director, Northumberland County Counseling Services
Judy Wiley, clinical supervisor, Northumberland County Counseling Services

CLANCY
Rick Steele, director

Student Assistant Program/School Services
Terry Brouse

Juvenile Court Services
Charles Chervanik, chief probation officer
Tim Gilliom, foster care coordinator
Jennifer Kirkner, intake officer

Parent Center
Pat Weaver, Liz Mertz

Other Programs/Organizations Reuresented
Pat Mulhell, family preservation
Leslie Ishman, Child Residential Rehabilitation program
Scott Miller
Jeffrey Mensch, special counsel
Rubyanne Burt, chairperson, JCS Advisory Board
Joe Jones, Sunbury Police Department

II. Environmental/Contextual Issues

A. Structure and Philosophy

Northumberland County Human Services has a coordinated and unified system of delivering human services to people in Northumberland County. Several programs are administratively clustered under one umbrella agency-Human Services-with shared system components (administrator, training, management information system [MIS], a weekly meeting of the Children's Clinic (Children's Clinic)). The main programs providing children's services and their relevant offerings are the following:

- Children and Youth Services (CYS)--Service planning, child protective services, foster care, adoptive services, homemaker services,family preservation services,

- Mental Health/Mental Retardation (MH/MR)-Clinical assessment, service planning and casework, Children's Clinic, in-school mental health prevention and intervention services coordinated through the Student Assistance Program, outpatient counseling provided through the Northumberland County Counseling Services, intensive case management services, home-based family therapy services (Homekeepers program), Children's Community Residential Rehabilitation Services (CRR) early intervention services for children with (or at risk for) developmental delays, and summer camp programs.

- Juvenile Court Services (JCS)--Juvenile probation officers (JPO) who provide caseworkers, foster care, CLANCY (umbrella agency embracing day treatment and social rehabilitation program), and truancy.

- Drug and Alcohol

Although each of these four agencies has its unique administrative structure and service focus, it is their collaborative, integrated quality that needs to be emphasized.

They share a common service philosophy, an approach that makes children and families the center of human services efforts. Cooperation and collaboration are essential to this focus; various incentives and shared values contribute to this collaborative approach, and turf battles are rare. Among the tenets that emerged during discussions with a wide range of staff and review of background documents are these:

- The family is the unit of attention and must be supported and empowered in order to best serve the child;

- Children are best parented by their natural parents, and strong efforts to maintain children within the family are a priority for human services;

- Children should be served in the least restrictive environment, and placement in an institution is the very last resort;

- Needed services will be provided to families, without regard to whose "jurisdiction" they fall under (e.g., JCS, CYS,);

- Management of the human services organization should be geared toward serving the clients, not maintaining bureaucracy; and

- Both caseworkers and families, including foster families, are involved in problem solving.

There is a strong commitment to these values, from the County Commissioners down to the individual caseworkers; it is hard to overemphasize the extent to which shared values and commitment to assisting families imbue the entire human services community. As one of the county commissioners said: "We are trying to 're-invent' government. The 'customer' comes first. When we use the term "human services," it's more than just a slogan. We are service-oriented, not bound by bureaucracy. Our job is to see that the programs are staffed and financed-then get out of the way and let people do the job they were hired to do."

Over and over, staff at all levels echoed the belief: "we do whatever it takes to support families." That means that clinical decisions about children and families are driven by need, not funding. Caseworkers on the frontlines know that they are empowered to provide appropriate services without worrying about turf issues or funding_ As one manager said, "When we do a staffing at the Children's Clinic, the- question we ask is: what do the families need? It's then the administration's job to make sure it happens."

Moreover, this overall service philosophy translates into lowering costs through reductions in institutional placement. Combined with other cost-saving, approaches and creative use of shared funding, Northumberland County is able to leverage its budget in creative ways. Jerome J. Alex, administrative officer and finance director put it this way: " The more we expand our human services programs through shared funding, the more fiscally sound we become. This approach benefits not only our agency but the county and its residents in general." That is, the home-based, family-based philosophy and commitment to serving children locally is a fiscally responsible approach.

B. Socioeconomic Context

Northumberland County is a county of about 100,000 people in central Pennsylvania, about 60 miles from the state capital of Harrisburg. Children and adolescents (0 to 18 years) make up about a quarter of the county's population. The overwhelming majority of the county's population is Caucasian; there are few African-Americans, and the Hispanic population only recently has begun to increase. Unemployment is high (about 11 percent), and the mean income is about $8,000; there are "pockets of poverty" within the county. The county is the largest employer, with Weis Markets, a supermarket chain, next. Interviewees characterized the county as "moderate" is many ways. However, Northumberland County has the highest per capita rate of child abuse in the state; the substantiated abuse rate is 30 percent higher than that state average. Of the more than 1500 referrals to CYS, 25 percent are for child protective services.

III. Overview of Service Approach

A. History of Approach

About 6 years ago, all human services were brought under the umbrella of one agency. The impetus for change came about, basically, because things weren't working. Staff turnover was discouragingly high (85 percent for CYS) and the county was at or near the bottom in a number of indicators (e.g., child abuse, sexual abuse, MH/MR services). In the 1970s and early 1980s, the Mental Health Program emphasized adult services, and children were viewed as being the responsibility of other agencies. Mental Health did not develop specific family- or child-based services. As a result, this population was significantly underserved.

Juvenile Court Services had developed a parallel system, primarily because of the widespread perception that MH and CYS weren't doing their job. JCS had its own family therapist, drug and alcohol awareness groups, alternative education program (CLANCY), and foster care program. The tradition of excellence within the court/juvenile probation system is attributed to the leadership of Michael J. Breslin, who was the chief probation officer (CPO) and had developed, with a core staff of highly motivated juvenile probation officer(JPOs), a strong system to support children who were under the jurisdiction of the juvenile court system.

Breslin was asked to take over the Mental Health/Mental Retardation agency in 1984; he agreed on the condition that he would remain as chief probation officer. In 1987, the Department of Human Services was created as an umbrella agency, integrating MH/MR, CYS, D & A, and JCS (see Attachment A for organizational chart). According to current staff, the climate was right for the change-it was a combination of the right policymakers (a committed and knowledgeable group of county commissioners) and the right leader (Breslin)-and the state agreed to the county's experiment with a united agency.

Breslin was "the bridge" that brought disparate agencies together, but he also helped "build the system from the bottom up," from the beginning making sure that "people on the frontline" had ownership of the changes. There was some discomfort with the new ways of doing things, but "people who couldn't live with it left," and staff who remained and those who joined subsequently enthusiastically embrace Breslin's philosophy of client-centered human services.

Early in 1992, Breslin left Northumberland County to accept a position at the state level as executive deputy secretary of the Department of Public Welfare. He was succeeded by Dr. Calvin J. Wolfberg, who had for 4 years been one of the three county commissioners responsible for Northumberland County. He is knowledgeable

about the agency's mission and services and committed to maintaining and strengthening its role in supporting families in the county.

Central to Northumberland County's integrated approach and overall philosophy is the Children's Clinic, a weekly gathering of key representatives of relevant agencies and outside groups to discuss jointly how to staff the most intractable problems faced by children and families served by Northumberland County. (The Clinic is described in greater detail in section B.) The Clinic began in 1985 as a way to "sell" the idea of providing a comprehensive range of children's services, no matter which program or agency took the lead.

The three key aspects of the Clinic in its formative stages, according to Charles Chervanik, who began as a probation officer in 1981 and is now the CJPO:

- the three main agencies (MH/MR, CYS, JCS) began to see the strengths and weaknesses of each others systems and began to break down barriers;
- as the effectiveness of the Clinic grew, other interested groups became involved in the process, e.g., schools, attorney, and, in the late 1980s, parents; and
- the result of continuous working together through the Children's Clinic was the elimination of duplicative services, identification of service gaps, and development of services to fill the gaps. As an example, the social rehabilitation program under CLANCY (see section B for more detail) was created as the social services staff recognized, through the Children's Clinic process, a need for a program to provide younger kids with a program to help them structure after-school times and learn social skills.

"The Children's Clinic began as a response to problems; now it reflects a whole philosophy," said Rick Steele, director of CLANCY. "The process emphasizes strengths, emphasizes what we can do."

B. Description of the Service System

Major service providers for children and families in Northumberland County include the Mental Health/Mental Retardation Program (MH/MR), which includes Northumberland County Counseling Services (NCCS) and the Children's Clinic; Children and Youth Services (CYS); and Juvenile Court Services (JCS) which includes Coordinated Learning Alternatives for Northumberland County Youth (CLANCY). The schools also operate an early intervention program. These components of the human service system and their relevant programs are described below. It is important to understand how each program or service is an integral part of the continuum of

services for children and families. It is equally important to understand how they interrelate and collaborate; that is the focus of section IV.

1. Mental Health/Mental Retardation

Intensive case management is an intense mental health service for high-risk children and adults who have utilized multiple systems and are at risk for frequent hospitalizations. Children must have a serious mental illness or emotional disorder to qualify; if part of the program, the children are seen at least twice a week and often more frequently. The program links clients to community resources and monitors progress to reduce hospitalization and enhance quality of life. Currently, the ICM program serves 25 children, 14 of whom are in CRR, a collaborative effort between CYS and MH to provide mental health therapeutic foster care (see page 11 for more detail).

Northumberland County Counseling Services (NCCS) provides outpatient mental services with 6 therapists. The administrator is Ellen Wolf, who came in 1988 to start the intensive home-based family therapy program (Homekeepers); she subsequently became NCCS director. As part of a state grant to develop such a program, she and other Northumberland County staff created a "multi-financed program model," founded on the conviction that they would do "whatever it takes" to support families. This translates into involvement in a variety of activities, ranging from traditional family therapy to hands-on parenting teaching to providing short-term respite care for parents. The NCCS is unique in being very integrated with other human service programs and staff; a central means of achieving this integration is involving caseworkers as co-therapists and -providing in-house training for caseworker and administrative staff.

Administratively, the dollars for NCCS come from MH/MR, and their services are "purchased" by other Northumberland County agencies such as CYS and JCS. They are licensed as a mental health entity and benefit from numerous funding streams including drug and alcohol funds, developmental disability grants and prevention dollars.

Philosophically, NCCS is committed to a family model of therapy. Judy Wiley, the clinical supervisor who has had extensive training at the Philadelphia Child Guidance Clinic, well-known for its training in the family/systems model of therapy, expressed it this way: "A fundamental belief of this agency is that kids are best parented by their parents. Parents have great strengths-they often don't recognize them. Therapy and caseworkers here act as a team, as helpers to parents, to show them how to improve and increase communication. What we really do in family therapy is act as choreographers [for different members of the family]."

Children's Clinic is perhaps the primary means of effecting a coordinated, focused approach to delivering services to children and families in need. Rather than a specific location or entity, as it name implies, the Children's Clinic is a process of clinical staffing for children and families that centralizes the expertise and resources of several human service programs and agencies and deciding on the best course of action for the respective family/client.

Once a week, representatives from MH/MR, CYS, D & A, Homekeepers, and CSIU sit down around an open-square table and review referrals, which are typically the most challenging cases. All families and children for whom counseling has been recommended go through the Children's Clinic. The caseworker (or other party) responsible for a referred family describes the relevant facts of the presenting case; this summary is supplemented by a family genogram, prepared and circulated at the start of the meeting. Therefore all parties at the table have access to roughly the same information before discussion begins.

In addition to the main Northumberland County representatives in attendance, other relevant staff may sit in on one or more sessions. NCCS therapists and representatives of the Homekeepers staff attend weekly, as does Jeff Mensch, Northumberland County special counsel who serves as guardian ad litem for children. An NCCS psychiatrist attends every other week, and school teachers or system representatives often come if a child's behavior in class and/or truancy is an issue.

Most importantly, the parents are an integral part of the process. As noted in the 1992-93 Northumberland County plan, "the key ingredient in the Children's Clinic is family involvement and participation in service planning." Parents take part in the discussion, volunteer insights, voice concerns, and help contribute to formulating the treatment plan. During the sessions of which they are a part, the parents are treated not as "cases" or "problems," but, with respect, as clients who have much to give to the process. This approach honors the family's values and helps empower them to contribute solutions to their own problems.

Children's Clinic takes about 4 hours every Wednesday afternoon, during which time about eight to nine family treatment plans are discussed. The CASSP Coordinator is responsible for organizing and chairing the Children's Clinic sessions. Beyond serving as an efficient and humane way to determine staffing and treatment plans, the Children's Clinic serves an invaluable role as integrating various human service people and helping forge and reinforce shared values related to children and families. The Children's Clinic is, in effect, a metaphor for the whole approach articulated and lived out by staff of Northumberland County.

Family Preservation Services and Homekeepers are similar programs in that each has as its mission keeping children with their families of origin through providing intensive, home-based services. Family Preservation involves intensive casework in the home, up to three times a week, for a maximum of 3 months, helping link families with community resources. Homekeepers is similar in terms of intensive in-home services, but adds the dimension of therapy provided in the home. The program is seen as the "last resort" before removing children from the home, and its stated goal was to reduce out-of-home placement by 30 percent for its first year of operation **(1988),** with additional reductions in following years. The program also aims to reunite with their families about 30 percent of children who are in placement. "Permanency planning is a major goal of this initiative," according to the Northumberland County plan.

The program's philosophy "assumes that all families in crisis are motivated or can be motivated to make positive changes when counseling goals address their immediate needs and when therapists treat family members with dignity and respect as the family learns better ways of living together."

To receive Homekeepers services, families must be referred through the Children's Clinic process when a consensus of agencies representatives agrees that "the home-based treatment is the treatment modality of choice to empower the family." The designated therapist travels to the family's home within 6 hours of crisis referral and subsequently spends time necessary with the family--anywhere from a minimum of two contacts a week to **24** hours a day. The maximum time a family is involved with the program is 6 months; if the need continues, restaffing must occur through Children's Clinic.

The Homekeepers Program has five areas of concentration:

1. Strengthening family relationships via family therapy, which will increase communication among family members, cultivate and improve family members' self-esteem, and assist and redefine **hierarchial** structure and boundaries of the family unit.

2. Providing immediate, intensive service in clients' homes, including crisis intervention therapy to defuse and stabilize a crisis situation, facilitating the family's use of community resources to meet various needs, and helping the family increasing its life skills and coping mechanisms via family therapy and community **educational** groups.

3. Reduce hospitalization by treating the family on an outpatient basis-or, more precisely, and in-home basis.

4. Reduce by 30 percent foster care placement from families where the child has been abused by providing intensive home-based therapy "to empower the nonoffending parent to realign and maintain the family unit"; to reduce by 30 percent the placement of children from families where parents are identified as "neglectful; reduce by 50 percent the out-of-home placement of "predelinquent and delinquent" children; and reduce by 30 percent the reoccurrence of abuse and neglect.

5. Provide services for the transitional client to ensure successful reunification of the family by identifying children in residential settings who can benefit from reunification and provide intensive home-based services to empower families; identify children in foster care placement and provide intensive home-based services to either enable the natural family reunification or justify termination and subsequent adoption of the children; and provide intensive services for the client when reunited with his or her natural family to help ensure success.

The Parent Center is both a physical space and a program; to help strengthen parents' skills and self-esteem. The space is adjacent to the Human Services office, just off the main street in Sunbury. The center began more than 2 years ago when Fran Vogt, then the CASSP coordinator recognized the need to strengthen parents' abilities to parent. As Pat Weaver, the Parent Center supervisor put it, "The issue was that kids were taken out of their homes to be placed in foster care; after a period, they would return to those same homes where the family structure and environment was virtually unchanged. So, the idea was to help parents with skills. We began by targeting parents with kids in foster care, expanded to parents of kids at-risk, and now are available to any parents." Parents may be referred from any number of agencies or are self-referrals.

The space includes two rooms with coffee and snacks available, telephones accessible, and staff and/or other parents available for structured programs or just talk. Day care and transportation is provided for participants. "It's a 'kitchen table' atmosphere," said Pat. "It's <u>their</u> [the parents'] place."

Regular programs include a Day Program from 11 am to 3 p.m. on weekdays, described as the most intense program with repetition on skill building for parents who are in most need of help. Other activities include parenting workshops, which can focus on the young child, the adolescent, or the disabled child; similar workshops presented at areas schools in the evenings; and parent support groups, which are facilitated by "graduates" of the Parent Center. The overall focus, according to Liz Mertz, early intervention specialist, is "to empower families and help them see that they system really <u>does</u> work for them. It's critical that parents are part of the process, and we try to communicate the message that parents themselves are the best educators."

2. Children & Youth Services

Children and Youth Services (CYS) is the agency that provides child welfare related services. CYS and Juvenile Court Services (JCS) share responsibility for foster care. Each operates a discrete but somewhat overlapping system.

The JCS foster care system is intended for kids-who require intensive interaction with a juvenile probation officer (JPO), and families recruited for these kids are specially selected and trained to work with children under court adjudication. These homes receive separate licensing. This is the only JCS-operated foster care program in the state. The JCS program reflects the overall philosophy of Northumberland County, its goal is to reduce institutionalization and/or out-of-county placement for difficult kids. Currently, 16 kids under adjudication are in foster care homes, of which 6 are licensed by JCS; the balance are CYS homes. One JCS staffperson, Tim Gilliom, is responsible full-time for coordinating their foster care program, and a recently hired assistant will take over responsibility for recruitment.

CYS currently has 38 foster care homes, including 14 that are classified as Child Residential Rehabilitation (CRR) homes. Children diagnosed with a mental health disorder are placed in CRR homes and are cared for by a team consisting of the foster parent, natural parent, CYS caseworker, therapist and mental health intensive case management worker.

All foster care parents must take 12 to 18 hours of initial training, plus at least 6 hours of continuing education each year; CRR families are required to take 1 to 2 hours of continuing education a month, and are paid a $10 incentive for doing so. The per diem for foster care ranges from $12 to $18, with additional funds for medical care and certain special needs; CRR families receive a per diem of $25.

Foster parents are highly respected by professionals at Northumberland County and are, in fact, considered as “extensions of our staff.” They are invited to any human service training and are often asked to serve as co-therapists for children and families with whom they have a relationship. Their association meets monthly, and a CYS representative is available to help address any problems.

CYS recently was awarded a grant to increase recruitment activities for both foster care systems.

3. Juvenile Court Services

Juvenile Court Services (JCS) provides case management, foster care, and specialized programs for children and adolescents who come under adjudication of the juvenile court in Northumberland County. This component of the human services spectrum is important in its own right and also as a model for the orientation and quality of services currently embraced by Northumberland County. As mentioned earlier in this report, Michael Breslin had set a high standard of quality for juvenile services when he was the Chief Juvenile Probation Officer (CJPO). A judge who supported those initiatives and encouraged creativity in programming also contributed to the reputation for excellence in this system Charles Chervanik, the current CPO, said the judge "has been willing to take risks and support creative ideas. Also he and the County Commissioners work well together. Communications are good with other Northumberland County agencies, even though we don't always agree on things." As noted frequently during interviews during this site visit, Mike Breslin was "the bridge" between JCS and other county human service agencies. When he became the county's first human services director, he retained the position of CPO until the winter of 1992 when he left for a new position at the state. This development planted the seeds of collaboration in Northumberland County.

In 1991, JCS intake handled 583 cases. There are 7 staff members: 2 intensive caseworkers (including one who specializes in D & A problems); 1 truancy specialist, 1 field probation officer, 1 intake coordinator, 1 community service coordinator, and 1 foster care coordinator.

The juvenile probation officers (JPOs) have a strong community reputation for "going the extra mile with kids," according to Rubyanne Burt, the chairwoman of the JCS Advisory Board. "They have a real commitment and go above and beyond the call of duty." A member of the Sunbury Police Department concurred, "They always respond to calls about kids, even if it's in the middle of the night. They never turn us down." These accolades reflect the JCS philosophy of "service to customers"; they see as "customers" all the publics they touch-kids, foremost, but also the police, school system, advisory board, community at large.

The JCS program has a good working relationship with the Sunbury Police Department, the jurisdiction with which it interacts most frequently. Tim Gilliam noted that they have come a long way in educating the police about treatment and rehabilitation, partly through providing workshops for police officers. Police and JPOs agree that alcoholism and drugs are a serious problem for adolescents in the county. Tim Gilliom noted a recent trend that they are seeing more violent crimes in general and, in particular, more violence against parents. Furthermore, "Parents are more likely to run to the police for help" when kids

act out, he said. "The usual pattern is that parents provide little structure or limits, then kids grow up, get big, sometimes become abusive, and the parents can't handle them." Other patterns include some problems with runaways in foster care and a trend toward problems involving younger kids--in the 12- to 13-year-old range.

The probation officers try to work with families to help kids, assisting families to access various resources, participate in the Parent Center, and make contact with NCCS. However, they acknowledge that they may tend to focus more attention on the child outside the family context; they emphasize their responsibility in protecting the public.

CLANCY is a division of the Juvenile Court Services that provides a full array of services for youth between the ages of 10 and 18. CLANCY began in 1979 as a program to provide alternative education for kids who were in the juvenile court system and had dropped out of school. Rick Steele, who was the JCS intake worker at the time, is now its director. For the kids he saw, "their educational needs were great, and, therefore, their employment prospects were dim.".

The program grew from a part-time tutoring program to a full-fledged alternative program, one of the first in the state. As the state developed a more complex bureaucracy with regulations requiring supervisors to be certified through the education department, that component was dropped, and CLANCY evolved-in response to gaps in the service system--into a more multi-faceted program serving kids with a broad-range of problems. Its continuum of services currently includes GED preparation, pre-employment training, independent living skills, job search, and two programs that serve high-risk kids and are described in more detail below: day treatment and social rehabilitation. All the programs are housed in a large, airy building, formerly a soft drink bottling company, about a mile away from the Northumberland County offices in downtown Sunbury.

- Day Treatment serves older adolescents who are having "moderate to severe behavioral problems and who are at high risk without the structure provided by day treatment." Participants are adjudicated and court-ordered to the program by the juvenile court judge and are considered the "most difficult delinquents." The intensive curriculum stresses self esteem problem solving, stress management, and drug and alcohol education, through the use of individual and group therapy and a variety of activities focused on rehabilitation. Day treatment operates Monday, with the capability of providing supervised structure from 8:00 am through 10:00 pm.

- Social Rehabilitation provides structured activities, social interaction, and help with homework for younger kids, aged 10 to 14, who are considered at-risk of out-of-home placement without this alternative intervention. Group therapy, community service, and recreational activities are important components of the program. Children are referred through human services case workers, the children's clinic, or schools. Children. often are referred to Social Rehabilitation "for protective reasons.* The program's focus is to provide "structured free time" and help these kids enhance self esteem and build socialization skills.

Rick Steele highlighted the "operating philosophy" of both programs:

- Immediately provide a positive experience for these kids. Typically, they are known as the difficult kids who act out to get attention; they don't know the power of positive attention.

- Don't label kids or let them use labels to justify their poor behavior.

- Establish an environment that is safe, both physically and psychologically.

- Emphasize that the kids have ownership of the program. Get them involved in policy development and designing sanctions for peers (e.g., a peer jury, that help shape appropriate behavior).

4. Schools

Student Assistance Program (SAP) is a school-based, early intervention program to help screen children who are at risk of mental health problems and to provide appropriate referral, programming, and support groups. It operates at both the elementary and high school level. Each school has a SAP team, usually consisting of the supervisor, building administrator, and school staff, such as teachers, counselors, or nurses. These teams help respond to children in their school who appear to need some type of intervention, as indicated by behavior problems, suicidal ideation, or depression.

Once identified as possibly in need of services, children can be referred to mental health, CYS, or other services. Some kids are referred to small groups that meet during the school day. Such groups often focus on common issues or problems (e.g., children at risk because of stressful or difficult family situations and related problems) and some address more generally issues like problem solving, coping skills, self-esteem, and feelings, including anger, loneliness, and desperation). The content is not "canned," but rather, relates to the problems relevant to the particular group. Currently, the county contracts with a private

provider, Synergy Systems Group, Inc., to facilitate the groups, but the goal is to have the school staff trained to do group facilitation.

IV. Svstem Level Issues

A. Coordinating Mechanisms

Northumberland County is notable for a plethora of approaches to coordinating and integrating services. Several have been alluded to already in descriptions of specific service areas, but are worth examining further.

- The administrative structure of Northumberland County itself fosters integration. All publicly funded human services related to children and their families are situated under the umbrella of Northumberland County, with all agencies reporting to one director. There is formal service coordination through the Children's Clinic (see below) and weekly managers' meetings. This weekly meeting was described as being like the Children's Clinic as the managers' level. Ellen Wolf described the interaction: "We do brainstorming, problem solving, deal with funding issues, discuss new opportunities. The approach is to 'break down the walls.' It's exciting to see people come together as a planning team; it's very dynamic. We visualize goals and continue to expand the continuum of care."

- On an informal basis, there is daily interaction among managers and frontline staff. All have offices in the human services building (with the exception of CLANCY, which recently outgrew its basement quarters and moved to another building a mile away), and there is frequent, ongoing contact among key staff. This proximity encourages openness of communication.

- The ongoing blending and sharing of resources is a critical means of integration. Programs don't worry about whose "turf" a particular client is, but rather work together to provide the most appropriate services for a family or child, no matter who the official "provider" is. That sometimes translates into programs' purchasing services from one another (an official letter of agreement is used to authorize such exchange) rather than relying on private providers outside the system. Such "inside contracting" has the advantage of controlling quality and reducing costs.

- A specific type of resource sharing is involving caseworkers in family therapy sessions with their clients. There are multiple advantages to such an approach, according to Judy Wiley. "Caseworkers have a relationship with the family and they have information to share. Having the caseworker involved in some of the sessions also give the message to families that 'we do it differently around her--

we work as a team." It also benefits the caseworkers because they have increased opportunities to be creative, thus helping prevent burnout. As mentioned previously, foster parents also are sometimes involved as co-therapists, helping to empower the families in therapy.

- The Children's Clinic is perhaps the clearest ongoing means of integrating services. As cases are discussed, participants form a consensus about the: most appropriate planning; decisions are made then and there, without requiring time-consuming paperwork or bureaucratic manipulations. All the key players in the system are focused on a common clinical goal for half a day each week; it is clearly the keystone of the system, a reminder of the shared values and mission of the agency. Furthermore, the process enhances all participants' understanding of program services, available resources, and professional staff skills.

- Case management is sometimes shared, sometimes coordinated. Caseworkers from different programs (e.g., CYS and JCS) are sometimes paired. At other times, particularly if a family is referred to home-based services, the- original caseworker may drop out to reduce the number of people in the system that the family has to deal with. Mental health tends to concentrate on more intensive services but still teams in some situations with CYS and JCS. Approval of team formation occurs at the caseworker level, without requiring a supervisor's approval.

- A centralized management information (MIS) system provides common information to all human service staff. Currently, the system provides primarily financial information, such as costs per contract, but also provides informatibn on casework loads, both by number of cases and service intensity.

- A shared pool of funding provides for an all-agency staff development coordinator and a rich array of training opportunities for all staff. Because staff from different programs participate in the same training, they gain a similar perspective on the same topics, e.g., sexual abuse, family therapy, cultural competency. Training is critical not only to build skills but also to inculcate values and stimulate a sense of ownership in the program, according to Rick Steele.

B. Definition of Eligible Population and Clients

Approximately 1,050 children are being served at any given time in the Northumberiand County system, according to the 1992 plan. That figure includes children who are in SED placement at the Intermediate Unit (IU). The breakdown by agency is defined this way:

CYS	550 clients	JCS 150 clients
MH/MR/D & A	300 clients	IU 50 clients

The county also estimate the number of children served by multiple programs in CYS in 1991.

CYS/MH	541 clients	CYS/MH/MR 75 clients
CYS/MR	72 clients	

Staff interviewed during the site visit concurred that most kids are "multi-problem kids--it's the norm." Planning to serve these kids occurs at the Children's Clinic level, when the lead caseworker presents a case. Issues requiring expanded services are addressed in this forum, but "multi-problem families tend to end up in services that serve as a single point of contact, like Family Preservation or Homekeepers."

C. Service Network and Gaps

Northumberland County has created a strong continuum of care for children and families. The need for new or expanded services often becomes apparent in the course of Children's Clinic when a child or family has needs that cannot be addressed by current services. For example, the Children's Clinic process highlighted the need for a structured program of recreation and socialization for younger children similar to CLANCY's day treatment program; thus, the Social Rehabilitation program was proposed, funded, and started.

Currently, the main missing gap in the continuum of services is availability of a specialist in child and adolescent psychiatry. NCCS licensing requires access to psychiatric services for 20 hours a week, a slot filled by a psychiatrist from the nearby Geisinger Medical Center. There is an advantage in this relationship in that the same psychiatrist see hospitalized children when they are inpatients and then can follow them when they return to the community. Geisinger had considered establishing a separate psychiatric unit specifically for children and adolescents, but CYS argued against it on the belief that the existence of such a unit would encourage increased inpatient referrals.

V. Service Delivery Issues

A. Staffing

1. Supply of Trained Personnel

In the mid-1980's, Northumberland County had a discouraging rate of turnover--almost 85 percent in CYS--in part due to low salaries and, in part, to ineffective management. That picture has changed dramatically. Currently, CYS has a

stable employee base, and MH/MR was revitalized when Mike Breslin took over the program. Compensation is better, but still not competitive with other areas in the state. The difference is in the management style, all interviewees concurred. One person explained, "Caseworkers get respect.. Many decisions are made at the caseworker level. And there's opportunity for growth, innovation, and mobility among programs. For example, the new Homekeepers program was created from existing staff. The philosophy is to take people from within the system and teach new skills rather than to overlook them and hire from the outside."

The role of management is seen as fostering a sense of ownership in the agency, to help shape consensus, and to assure inclusiveness of information. The staff is rewarded by expanded roles (e.g., co-therapists, grant writers, community education). Jane Kearney, director of CYS summed up the management style this way: "We provide guidance and room to grow."

The agency's internship program also has strengthened the staff and provided a good source for entry-level case workers. Students are. recruited from area colleges including Penn State and Bloomsburg University, to serve as interns, particularly for the summer camps. They then select the best interns and have been successful to date in attracting some of the best students to entry-level jobs.

2. Training and Treatment Approaches

Staff training, as suggested throughout this report, is a vital component of Northumberland County and another example of its orientation to integration. "We couldn't compete with other places and professions in terms of salary," noted Rick Steele. "So we have made this a good place to work There's lots of empowerment of staff and good training. We looked at management in the same way that we looked at services to clients, and asked: where are the gaps in training? Then we tried to provide them."

Management used discretionary funds from the Human Services Development block grant to the county to fund the staff development specialist and training programs. This flexible funding makes it possible to offer high quality training onsite to many staff members, rather than sending staff away to seminars, with all the attendant costs of travel and lodging. Training is provided on a regular basis on such clinical subjects as child abuse, structured family therapy, and cultural competency. Other areas such as computer training and stress reduction are part of the county's offerings. "Staff development is a great asset," said one interviewee. "It's hard to place a dollar value on it, but we know it reduces turnover and provides employee satisfaction."

B. Caseload Issues

Assuring reasonable caseloads is a priority for Northumberland County. Because caseworkers often get involved in the therapeutic team serving a family, it is important to limit caseloads to reflect this greater degree of service intensity. For example, the case load for foster care caseworkers is 5 families, whereas the state allows a caseload of up to 20. The CPS caseload is 20; it used to be 40.

The county is able to manage lower caseloads because they allocate money saved through reduction of residential placement ($300 a day per client) to increasing case worker staff. The case worker staff has doubled in the past 5 years.

VI. Oversight and Feedback

The principal indicator of success of the Northumberland County approach is the reduction in residential placements. In 1988, three kids were in institutions; this past year, only one child was institutionalized, and that was one 30-day stay in a mental health facility. Another important indicator is the reduction in length of stay for children in foster care. The total number of kids in foster care has remained about stable over the past few years, but the children stay inn foster care placement for a much shorter time.

Other ways in which specific programs or activities are evaluated include the following:

- A parent advisory board for MH/MR interviews parents about their experience in the system.
- Quality assurance/evaluation is built into all contract negotiations.
- The CASSP program conducts a statewide evaluation related of outcomes related to such areas as administration, programming, and cultural awareness.
- A state CYS representative visits once a month to give informal feedback on issues beyond paperwork, e.g., quality of case work.

VII. General Issues

A. Gaps and Barriers Reported by Providers

The three following issues were raised by respondents as service delivery areas needing attention:

- Transportation to services
- A specialist in child and adolescent psychiatry
- Financial constraints

B. Strengths and Innovative Features

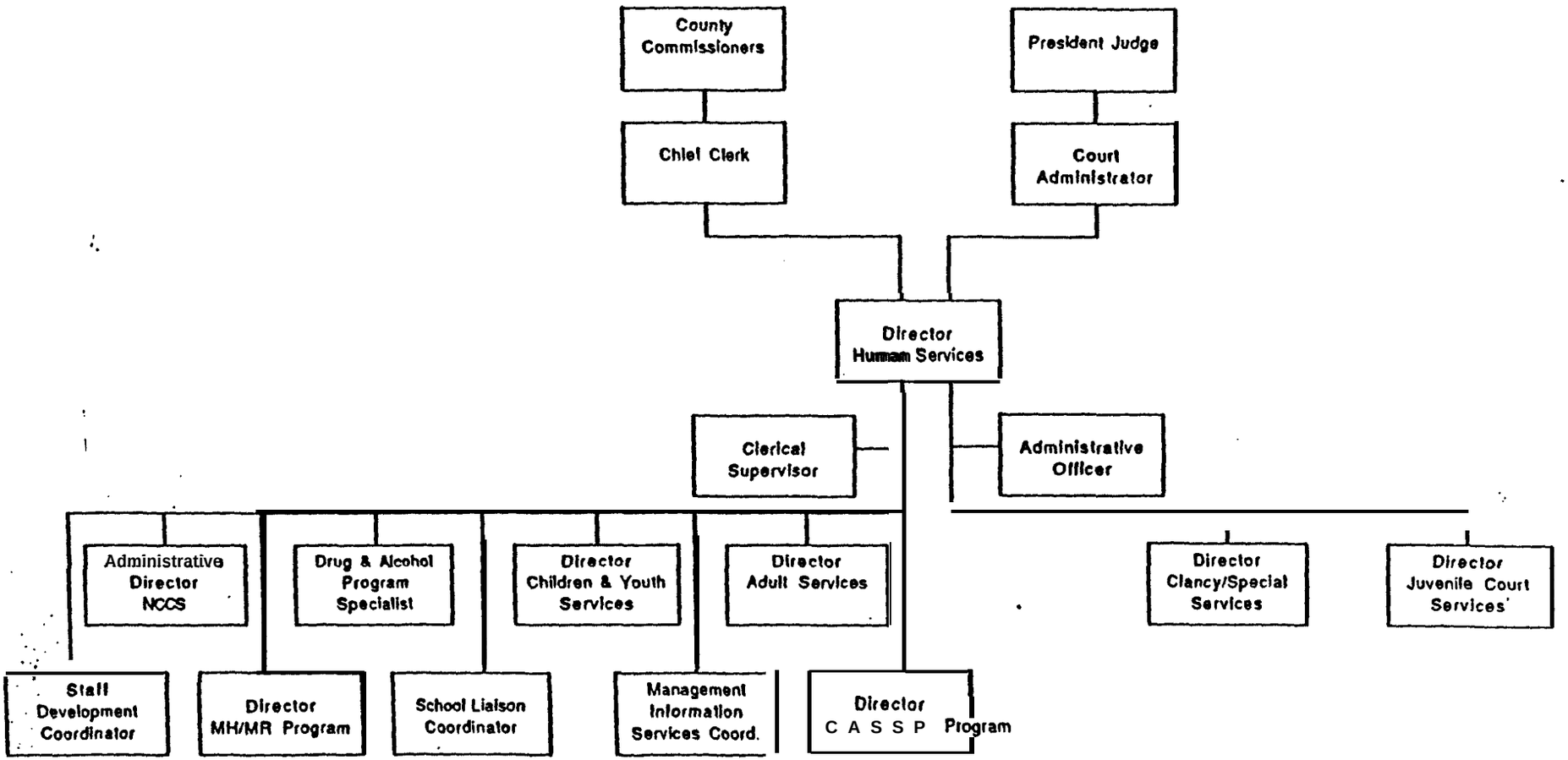
As discussed throughout this report, the primary strength of this site is its integrated approach and the committed, highly qualified staff. The leadership of the previous forged a human services system that has, to a large extent, been institutionalized so that its strengths endure even in his absence. It appears that the values of this agency are so firmly entrenched and the sense of ownership and involvement is so widely shared that it seems likely that the agency will continue its tradition of excellence. The structure that fosters an integrated approach in this system has inherent in it an underlying sense of tension, which can be creative tension. What makes that creativity possible, according to several informants is the attitude of seeing problems as opportunities to learn and grow.

Finally, an aspect of Northumberland County that reflects its overall philosophy is the commitment to involve consumers in planning, service delivery, and evaluation. Several examples illustrate this perspective. Significantly, as mentioned, parents are part of the process in the Children's Clinic; they are viewed respectfully as important partners in deciding on a treatment plan. Parents are central to the Parent Center as staff and group facilitator. Foster parents often can participate as co-therapists with families whose children are in placement or transition, and they actively assist the biological families in parenting skills.

In addition, advisory boards provide guidance to all the Northumberland. County programs. An example of an unusually active board is the group that serves the Juvenile Court. JCS is not mandated to have an advisory board but wanted to do it; theirs was the only one in the state when it started in 1978. The board has a rich tradition of involvement, carrying out community awareness, developing publications, supporting community service projects, and developing scholarship programs for kids and an awards banquet for community service. The board's goal is to serve as a link to the community.

Dr. Wolfberg, director of Northumberland County, has as one of his priorities to increase the involvement of all human service advisory boards by giving them greater leadership and responsibility. 'They are the eyes and ears of the community. They bring the community's view to us and take our message back to the community.

NORTHUMBERLAND COUNTY DEPARTMENT OF HUMAN SERVICES ORGANIZATIONAL CHART



Site Visit Summary
Scott County, Iowa

Prepared by:

Macro International Inc.

June 30, 1992

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Scott County, Iowa

Scott County is a small community in Iowa (population 160,000) which is part of the Quad Cities" area encompassing Davenport and Bettendorf on the west of the Mississippi River and Moline and Rock Island, Illinois, on the east. Scott County was one of two localities selected by the state to implement a pilot effort to decategorize funding for child welfare services by combining funds from several sources: the executive branch of the Department of Human Resources, the judicial branch, and local counties. The program is just beginning its third year, and is characterized by a systematic, centralized planning process which involves a broad base of community agencies.

I. Introduction

Scott County, Iowa, was one of two counties in the state to be selected for a project involving decategorization of funding for human services. A legislative initiative in 1988 enabled the county to pool a certain proportion of its funding normally allocated to categorical programs. The county thus had access to flexible funding, out of which it could develop programs in response to its unique local needs. This flexible funding scenario made it possible for the County to translate its client-directed philosophy into tangible programs and also fostered a way of viewing children's and families' needs from a holistic, rather than a fragmented, perspective. The report from the second year of the project defines it this way: "Decategorization is a system of delivering human services based on client needs rather than a multitude of programs and funding sources with different service definitions and client eligibility."

The underlying assumption of this funding approach is that dollars are saved over the long run because family-focused services tend to reduce institutional and/or foster care placements. As the discussion below suggests, certain impediments to that assumption have emerged. Nonetheless, the entire Decategorization (referred to from here on as Decat) Project has given the county scope to develop and strengthen important services for children and, perhaps equally as valuable, has made possible a centralized planning process involving all the key players in the human services community as well as the public at large.

The Macro site visit team conducted interviews with human services staff and community leaders between February 24-27, 1992. Discussions took place with the following people, identified by agency or organization:

Iowa Department of Human Services (Scott County Office)
Dermis Timmerman, Director

Scott County
Glen Erickson, County Administrator
Mary Dubert, Director, Community Services

Seventh Judicial District of Iowa
John G. Mullen, Juvenile Court Judge
Pat Hendrickson., Chief Juvenile Court Officer

Child Abuse Prevention and Services Council (formerly, Council on Children at Risk)
Roy Harley, Executive Director

Scott County Decategorization Project
Karen A. Spence, Project Director
Lois Wamsholz, Child Welfare Coordinator
Barbara Philabert, Child Health Coordinator

Family Resources, Inc.
Kay Gardner, Vice President
Tom Wilson, Vice President

Vera French Mental Health Center
Chris McCormick-Pries, Associate Director
Annabel Flaherty, Director, adolescent services
Bob Mainey, assistant director for the division of continuing care

Center for Drug and Alcohol Services
Mike Oelrich, Executive Director

Bettendorf School District
Shelly Klaas, Student Services Coordinator

Davenport Community School District
Karen S. Buchanan, Director of Elementary Education
Dorothy Naylor Mark, Principal, Monroe Elementary School

Our main contact for the visit was Dennis Timmerman, who arranged interviews and meetings with a broad range of people involved with child welfare, children's health and mental health, and the schools.

II. Environmental/Contextual Issues

A. Community Setting

Scott County is located on the Mississippi River and is part of the "Quad Cities" area that encompasses Davenport and Bettendorf, Iowa, on the west of the Mississippi, and the cities of Moline and Rock Island, Illinois, on the east: Farming and farm machinery manufacturing have been central to the economy in this area; a decline in the economy due to departure major farm implement manufacturers in the 1980s, when 22,000 jobs in the area were lost, has been partly offset by the recent boom in riverboat gambling, which attracts tourists from around the Midwest. Scott County has a population of about 160,000, and 94 percent of the residents are Caucasian. Davenport is the largest city in the county, the county seat, and site of the county offices of the Iowa DHS.

B. Communitv Values

It is useful to understand the community in which the Decat Project operates. Examining certain underlying themes helps put into context the description and analysis of services that affect children in the welfare system

A Unified Vision of and Approach to Child Welfare and Mental Health Services-Scott County traditionally has considered child welfare and family issues in a holistic way, rather than in the context of fragmented programs. The underlying belief that the system exists to serve the client-rather than the other way around-helps bring together different entities in the community for the good of the client.

Tradition of cooperation and collaboration--Human service agencies in this county historically have worked well together. There appears to be an atmosphere of congeniality and respect. This collaborative climate existed before Decat, although Decat has enhanced it.

Commitment to and continuity of planning--Perhaps the most central theme of Scott County's approach to providing for the health and welfare of children is a strongly held belief in planning, both as a way to shape the service system and as a mechanism to bring together different players in the system on an ongoing basis.

Commitment to building consensus--Related to the commitment to planning is a sense of responsibility among key agency representatives to forging consensus around central issues. Regular meetings and a resolve to "keep people at the table" facilitate consensus building.

Continuity/stability of community in general and human services professionals in particular-Scott County appears to be a relatively stable area, one in which the human service professionals, at least, are not a mobile group. Because many of the key people we talked to had worked together for a number of years, both in **the community** and/or in Des Moines, a strong set of relationships has developed that fosters trust and a shared attitude toward human service and community values.

Breadth of community involvement--A broad range of key players-public agencies, private providers, schools, voluntary agencies, and community groups are involved at different levels of planning and have a commitment to the process of improving. social services to families and children.

III. Overview of Service Approach

A. History of Approach

The concept of decategorization emerged from the Center for the Study of Social Policy and was developed by Susan Yelton, a specialist in child welfare policy. The Center identified states that were most likely to pass legislation to create decategorization. Iowa was one of those states, and Charles Bruner, at that time a state legislator with a strong interest in child welfare issues, worked to facilitate the legislation.

In 1988, the Iowa Legislature passed a law authorizing decategorization of child welfare funds in two pilot counties-Scott and Polk (Des Moines) Counties; decategorization since has spread to three other Iowa counties. The basic concept is to create a single child welfare fund by pooling relevant funding sources rather than relying on narrowly defined line item budgets for specific services. This approach allows local communities greater flexibility in deciding which services are most effective in meeting the needs of clients. Theoretically, decategorization also provides incentives to reduce utilization of more expensive categories of services-for example, institutional placement-because the pooled funds can be reallocated to other, lower cost services, such as family preservation, that also serve clients in a less restrictive manner.

In the case of Scott County, the agencies contributing funding resources to the Decategorization Project were the Iowa Department of Human Services, the Seventh Judicial District, and Scott County.

The mission of decategorization in Scott County, according to project reports, is "to build a child welfare system that is driven by the needs of families and children and that provides services in the most efficient and effective manner." The planning

process that helps shape the system is guided by "a philosophy that providing social service supports to families is the least restrictive intervention into the lives of children and families" and that "prevention-oriented and early intervention services can reduce the need for more costly and restrictive interventions in the future."

According to Scott Count project reports, the key activities that should result from decategorization are the following:

1. Formulation of a local plan based on client needs and the availability of local resources.

2. Development of a service delivery system that

   - is based on goals for the provision of services to best meet client needs;

   - initiates new services and modifies existing services to create a continuum of services from the least structured and least intrusive to the most structured and most intrusive; and

   - creates new service structures and modifies existing structures to provide more efficient and effective access to and utilization of the service delivery system.

3. Funding for new services generated as a result of their anticipated impact on decreasing needs for higher structured and more costly services.

4. Maintenance of fiscal responsibility with less disruption to the service system. Because fiscal management responds to the service system rather than line item funding, adjustments can be based on priorities of the whole system, rather than making mandatory changes in individual services because of funding deficits.

Now in the third of its 3-year funding cycle, the Scott County Decat project can point to significant accomplishments. In the first year, the focus was on overall planning-a process that continues as an integral part of the project today-and developing concrete changes in services so that participants would have a sense of achievement and "buy-in." Initially, they considered creating a case management system as the first step. Realizing the enormity of that task and the upheaval it would cause, they chose instead to establish some concrete services so that they could feel success.

New services implemented in the first year included provision of day care for children in foster care; establishment of a secure, locked residential unit for delinquent youth, thus enabling these youth to receive treatment in their home community and making it easier for families to participate in treatment; establishment of a family assistance fund to help families who need one-time or short-term cash assistance for rent, food,

utilities, or other necessities; and day treatment, a nonresidentid therapeutic program for children and families.

In its second year, the Decat Project focused more on developing structural components, including setting the groundwork, in terms of planning-and training, for a case management system; formulating a comprehensive mental health plan to examine the availability, accessibility, and appropriateness of mental health services to children in the county; and expanding the foster care system to incorporate therapeutic foster care and modify other parts of the system to encourage family preservation and reunification efforts.

The impact of these changes was seen primarily in reduction of out-of-county placement for children at Eldora (the secure residential facility for delinquent youth) and Toldeo (the training school for delinquents and residential treatment for CHINAs). The specific changes related to those institutions between FY 1989 and FY 1991 are the following:

Eldora: 19 percent decrease in admissions
5 percent decrease in bed days
$54,489 savings

Toledo: 40 percent decrease in admissions
59 percent decrease in bed days
$149,790 savings

Clearly, the change in emphasis brought about because of Decat meant that fewer children were institutionalized away from the county, and, because of distance, were often inaccessible to their families. Instead, more children were being served by local programs, e.g., the locked unit or enhanced foster care and/or day treatment programs.

Unfortunately, as the program moved into its third year, an issue arose about savings accrued as a consequence of keeping children in the community. As the progress report from the second year suggested, there is one barrier to continued success of the Decat Project: the ability to access savings resulting from deinstitutionalization. The report noted that legislation "was introduced for the second time during FY 91 to provide for counties to access institutional funds saved, but was vetoed by the governor.

Finally, a word about the planning dimension of the Decat Project. It is difficult to overestimate how vital the planning process is to the Scott County effort. It is both the means by which mission, goals, and priorities evolve and the vehicle for continuing to involve all communities parties in focusing common efforts on strengthening the child welfare system. Planning is described in more detail below.

B. Description of Service System

1. Goals

Goals for the Scott County Decategorization Project include the following:

- Design a coordinated, client-driven system that allows flexibility in accessing appropriate and effective services for family preservation and child protection.
- Develop a social service delivery strategy that provides a continuum of family support services that emphasizes prevention and provides an immediate response to problems presented by families.
- Redesign programs and services with expanded eligibility and service options to maximize the reunification of families in Scott County.
- Create community-based child welfare, juvenile justice, and mental health services for children, youth, and families located in Scott County.
- Promote interagency cooperation, utilize uniform models for family assessment, case planning, case management, and program evaluation.

2. Service System Description

The basic structure of the service delivery system is that the county and juvenile justice system both have case workers who have clients (theoretically, they will be merged under the new case management system). Various services (e.g., foster care, family-centered services such as family preservation) are provided by private providers who contract with DHS. The Decat Project is administered through the Child Abuse Prevention and Services Council (formerly Council on Children at Risk), and its executive director, Roy Harley, plays a key role in facilitating planning meetings. Interagency collaboration is promoted and facilitated through DHS, with Dennis Timmerman serving a central role in coordinating and planning. Specific services provided for children and families are listed below.

a. Family Preservation

A relatively recent policy that evolved out of the Decat process is that no child will be placed in foster care without first having had a family preservation services referral. The case worker's approach is to develop a supportive relationship with the family, to work as a team with the family, as opposed to going in with the message: "If you don't straighten up, your kids will be taken away."

b. Three-Level Foster Care

One of the early projects targeted by Decat planning was refinement of the foster care system to provide a broader range of options for children with varying degrees of need. A three-tier system of foster care was developed, plus a program of emergency care. The assumption was that having a level of intensive foster care services available would help redirect children who might otherwise go to group residential care because of their special needs. The three tiers vary in terms of training requirements, eligibility, and intensity of service.

All family foster care is purchased from community providers. Three main providers contract with DHS for foster care, but collaborate on training, recruitment, and development of common guidelines.

Scott County's system of family foster care reflects a shift from child-focused to family-focused service. This approach recognizes "the inherent rights of the child to services which strive to retain his/her primary relationships" and also "meets the needs of parents and the family as a whole." The new system supports efforts to preserve and reunify families and encourage cooperative relationships among all parties involved in the process.

Biological families help design and implement the treatment plan; the expectation is that, "with support, parents are capable of and. will join in setting the goals and direction on [service] team efforts, to reciprocally share information. .. to engage in self-assessment and growth activities." Foster parents are also a vital part of the treatment process.

c. Day Treatment

A day treatment program was one of the first system gaps identified by the Decat planning process. In the past 3 years, 467 children from Scott

County had been served in residential facilities; other children were placed in institutional settings in other parts of the state. To decrease such utilization, a day treatment program was started to benefit kids who were at risk of such placement by providing them with a structured, therapeutic, after-school program. The main components of the program include counseling, therapeutic recreation, educational help, behavior management, diet and nutrition, and case management. Eligibility for day treatment is limited to kids ages 12 to 14 who are at risk of residential placement; are having difficulties in at least two of the following three areas--family, school, or community; are attending school; and have some kind of minimal support system and family commitment to the program.

Although a young program, its worth is widely touted in the county. Kay Gardner specifically noted that it has "saved" many kids. The day treatment program originally operated under a l-year grant from the Juvenile Justice Advisory Council, but is now funded by DHS.

d. Secure, Locked Facility

The development of a secure, locked facility was another priority for the Decat planning group. There had long been concern about sending juvenile offenders out of the county to the state institution, Eldora, which is a 4-hour drive away from Davenport. Access was difficult for parents, many of them indigent and without transportation, so the kids rarely had visitors during their period of incarceration. Transition back into the community was all the more difficult.

The Wittenmyer campus in Davenport had long housed a residential program for community youth. In 1989, two wings of a building were converted to a secure unit to house delinquent youth. In the process of making the transition, the facility went through a g-month planning process, involving DHS, Vera French, the juvenile court, and other community organizations. The process "paid enormous dividends," according to a staff member, including a feeling of community ownership, a solid reputation with the juvenile court judge, and a greater understanding of the program goals and mission, a knowledge base that will lead to more appropriate referrals, For example, the juvenile court officers (JCO) held a staff meeting at the facility and had' a tour; rapport among the JCOs and the facility staff has strengthened.

3. Roles of Public Entities Involved in Decategorization Efforts

- **Iowa Department of Human Services** is the primary purchaser of services related to child welfare. The Scott County office contracts with a variety of vendors to provide the basic child welfare services and also employs case workers to help coordinate services. Dennis Tiierman plays a central role in the planning committees.

- **Scott County is** the largest payor for mental health services. Unlike DHS, which contracts with an array of providers, the county only contracts with one vendor for mental health services: the Vera French Community Health Center. Services to children through court commitments are provided through the local hospital's psychiatric unit and the State Mental Health Institute.

- **Seventh Judicial District of Iowa,** Juvenile Court plays an important role in planning services for children and adolescents under the Decat Project. The Juvenile Court Judge, John Mullen,is a strong advocate of the Decat process and is personally invested in its goals and mission, e.g., serving kids in their community, treating the entire family when a kid is in trouble.

4. Roles of Private Providers, Voluntary Organizations and Community Groups

- **Child Abuse Prevention and Services Council**

  Formerly called the Council on Children at Risk (the name change was being implemented at the time of our site visit), the Child Abuse Council plays a unique role in the dynamics of child welfare services in the Scott County area. It is the local planning and coordinating body for a wide range of planning, treatment, and prevention services in the Quad Cities area. It is the agency designated to manage Decat Project grant and contract funds and also to serve as employer of the Decat staff. The staff includes a project coordinator, Karen Spence, MSW, JD; a specialist for child welfare, Lois Warnsholz, BS Ed; and a specialist for child health, Barbara Philibert, MN, PhD.

  The Council also is the lead agency for the Robert Wood, Johnson Foundation grant to establish a Child Health Decategorization Project and for the Danforth Foundation school-based early intervention project (see below).

In addition, Roy Harley, the Council's executive director, plays a key role as the facilitator of the weekly Decat planning meetings.

The Child Health Decategorization Project is a "mirror" of the Decat child welfare project and is a joint project of DHS and Scott County. The third partner in this project is the Scott County Department of Health. As with the child welfare decat project, the child health decat project aims to decategorize public funding for child health care services in the county. The overall goal is to "assure continuity and accessibility of health care for children in Scott County." A community planning and implementation process will take place over 3 years.

Among the project's goals are flexible funding, case management, and data collection. Not only can the project improve primary health care for school children, including those in the welfare system, but structural aspects of the grant (case management, flexible funding, evaluation) can benefit the child welfare side of the Decat Project, too.

- **Family Resources, Inc.**

As a not-for-profit provider of social services, Family Resources plays an important role in the community and the child welfare system. They get referrals through the court system and are paid through a direct contract with DHS. They also contract with United Way for certain in-home services. Eligibility for their programs varies, but, in general because funds are tight, they see more families who are in need of services, especially early intervention and preventive services. There are 240 employees including those who provide residential treatment, foster family care, family preservation and family-centered services, adoption (including special needs), post-adoption services, family counseling (both individual and family), and special early intervention programs for kids who are first offenders.

Other programs they offer include a prevention program for kids at risk of joining gangs. This program has two components: (1) identifying potential gang members and working with them and their families, on a voluntary basis, for 30 days, primarily trying to get the kids hooked up with community resources that are alternatives to gangs (e.g., Scouts, neighborhood centers); and (2) broad-based education from 3rd grade through junior high school, working not only with kids but also with neighboring communities around the schools.

Counseling services are approached from a family systems perspective. The Scott County situation mirrors other Iowa communities, in that most

mental health treatment is provided by social service agencies like Family Resources, Inc., according to its vice president, Kay Gardner;

Family Resources is one of three community providers of foster care. They also provide a portion of therapeutic foster care services as well as the foster care coordinator function.

- **Vera French Community Mental Health Center**

A community mental health center that has served the area for almost 45 years, Vera French is the primary provider of outpatient mental health services in the traditional biopsychosocial model. Their programs include crisis intervention; outpatient treatment services, including individual, family, and group therapy; day treatment for adults; residential programs; and a sheltered care program for adults with chronic mental illness.

Last year, more than 600 children were admitted, the main diagnoses being alcohol and drug problems, conduct disorders, anxiety, and depression. All kids are admitted with a DSM-III diagnosis, but most are not in the SED category. About 56 percent of the children are referred by parents, and about 44 percent by schools, family doctors, DHS, or juvenile family court.

Their traditional mental health services are very good, according to Chris McCormick-Pries, associate director and also a key member of the **Decat** planning committee. However, outreach to families on welfare is hampered by fiscal constraints and difficulty in access to the center via public transportation. Currently, their efforts to diversify, beyond their institution focuses on school programs. Ms. McCormick-Pries thinks that the school system is the most effective place to identify and respond to kids who are at risk of developing behavior problem but who are not in serious enough trouble to be picked up by DHS.

- **School Systems**

The **Danforth** Foundation recently awarded a grant to develop a Neighborhood Youth Council Project in collaboration with two adjacent Davenport schools, Smart Junior High School and Monroe Elementary School. The project goal is to "enhance the social and learning capacities of youth in our community by. promoting positive communication and leadership among students, parents, and community professionals.

Neighborhood Youth Councils will serve as a vehicle for leadership training for a select number of children at each school; these- students ideally will then serve as peer leaders and mentors for younger children.

A Project Advisory Team will represent neighborhood parents, different community groups, and professionals from the various social service organizations. A full time social worker hired by the Child Abuse Prevention and Services Council, the lead agency, will coordinate the project. Anticipated outcomes of the project will be to promote the following changes in individual youth: enhance self-esteem, increase positive peer leadership, improve school performance, increase acceptable behavior in school, and the community, and promote positive family interactions.

- **Public Health Department**

  The Scott County Department of Health participates in the RWJ-funded child health decat project.

- **Others**

  The United Way plays a role in planning (a planner, Pam Pippert, is a member of the Planning Committee) and also funds some programs for children.

IV. System-Level Issues

A. Coordinating Mechanisms

- **Planning groups**

  In the beginning, Timmerman and others asked: how can we get people out of their current perspectives of thinking about provision of child welfare services? Their answer was to build change around a "visioning" process. They assembled task forces to focus on children at different stages of development (e.g., from prenatal to 3 years, 4 to 8 years, 9 to 12 years, and 13 and older) and develop consensus around what were key services for kids at these different stages. Groups of about 20 people from the community met for half a day, for 5 weeks. They first developed a vision of all possible services, then discussed barriers, and finally, came up with a realistic plan that included both specific services and structural changes, such as case management. It was this beginning visioning process that shaped the community's design for a continuum of services in child welfare.

Since that initial process, regular planning continues on several levels. The central decisionmaking body is the Joint Central Committee (until 1991 then the Robert Wood Johnson Foundation funded the child health project, it was simply the Central Committee) includes principals involved in the child welfare and child health Decat efforts. It is composed of administrative staff of the Scott County Department of Human Services, Seventh Judicial District Juvenile Office, Scott County Administration, and the Scott County Health Department. The Planning Committee, composed of planners from the key agencies and organizations is known as "the workhorse" of the Decat organization and take the lead role in initiating planning and implementation. As Mary Dubert said, "We come in and take our hats as agency representatives. We share ideas as experts in planning." The significant aspects of this committee include the following:

- Its composition of senior-level staff of participating organization with the authority to move projects along;
- Its commitment-the group has met weekly since 1988 and has taken part in several day-long retreats; and
- The strong continuity (no "drop-outs") and commitment to the work of the Decat project.

Frequently, reference was made to this being a "complex planning structure" and the continuous effect to manage the complexity as opposed to taking the easier route and resulting in a more simplistic process.

At a recent committee meeting, the Decat coordinator for child health noted that the concept for the School Health Initiative, funded by RWJ, (see above) "couldn't have flown without planning committee support and the desire to work together with school, the health department, and the community."

The Community Resource Panel is composed on directors from all the community agencies involved in child welfare. This group meets as needed to provide visions for services and to review the work of the planning committee.

Ad hoc task forces, work groups, or subcommittees that involve front line staff who meet around specific service or system issues. An example is the Mental Health Subcommittee that recently developed a report on the mental health needs of children in the county.

The cumulative effect of all these planning groups, some of whom meet regularly and some of whom meet periodically as the need arises, is to forge a common vision and common conceptual and service approach to child welfare services. Essentially, there is virtually universal "buy-in."

- **Collaborative decisionmaking**

  Not only do the different players participate fully in planning, but they also make decisions by consensus. 'There are no unilateral decision," according to Timmerman. Central Committee decisions are unanimous. A single "no" vote can defeat an issue. 'There's a great deal of trust [among planners in the county]," said Kay Gardner. Pat Hendrickson said, "The close collaboration of agencies here means we have great flexibility. We just don't get bogged down with bureaucratic or turf issues."

  The one-vote veto of the Central Committee can halt a decision, but the situation has never arisen, according to Mary Dubert. "We've never had a situation where conflict couldn't get resolved." She attributes that to close, respectful working relationships and continuing of people involved in human services in the county.

- **Balance of power**

  Several interviewees noted that virtually all the participants in the child welfare system are strong organizations, represented by strong leaders. Consequently, there is no one dominant party that overshadows other entities. Without leadership and a common sense of purpose, however, this situation could devolve into turf wars. That rarely happens in Scott County, at least in part because all the powerful participants are committed to a common vision of the social service system.

- **Incentives for involvement**

  Altruism and professional commitment are important incentives for human service professionals in Scott County. Professionals interviewed during this site visit were genuinely committed to serving people better, earlier, and in their home environment. Having control of funding through Decat means greater opportunity to achieve those philosophical and professional goals. As Roy Harley put it, "People get their needs met. Decat is a way to talk about what's needed-and then, just do it."

  The Decat project also has brought greater opportunities for professional growth through increased training and collegial planning sessions. Throughout the system, there is a sense of empowerment among human service staff, a sense of being able to "make a difference."

  Not least, the Decat Project has attracted additional funding to the community. The recent RWJ grant for child health and the school-based Danforth

Foundation grant are only two examples of grant-funded projects that have benefitted the county and are, in a direct way, related to the community involvement and planning in Decat.

- **Case management**

Case management was identified early on as a desirable structural change in Scott County to empower families and practitioners and to enhance service delivery. In seeking to develop a case management model, the county couldn't find a "perfect" model that fit their situation and realized that case management was "the hardest thing to do." So, they opted instead to establish some concrete services and revisit case management in the second year. In preparation, they went through another round of discussions and planning to create their case management system. Plans to restructure the DHS have put implementation of case management on hold; as of the writing of this site visit report, Decat officials hoped to have the case management system in place by summer. When it is implemented, it will have a significant impact on collaborative activities among agencies.

B. Definition of Eligible Populations and Clients

As Scott County reassessed its approach to child welfare through the visioning process, a consensus emerged around the concept of empowering families as the significant model, moving away from a model of focusing solely on the child. Families are included in planning and counseling.

C. Service Network and Gaps

The service system has been described fully in the section above. The main gaps appear to be implementation of mental health services, e.g., availability of a specialist in child and adolescent psychiatry. There is some hope that mental health services can be expanded under the child health project.

Other gaps or problems in the child-serving system identified by various people interviewed were the following:

- Day treatment for adolescents
- Transportation to get children and families to services

- Better relationships with the medical community; education to help them appreciate alternatives to hospitalization and institutionalization for many kids with conduct disorders.

D. Funding Issues

The concept of decategorization embraces the idea of "funding neutrality," that is, the same amount of money from Federal and state categorical funding streams is provided to counties, but they can use it in more flexible ways. Theoretically, this approach has built into it incentives to reduce spending for such typical "high ticket" items as institutional placement, because the money saved there can be reallocated to other, less restrictive services. However, there are some issues about whether, indeed, the savings will accrue to the county.

Glen Erickson said the Decat probably won't save money, but rather, its benefit is "giving the community the ability to make priorities for the most needy populations. In a cost-cutting environment, it's important to assure that the most needy get served. Decat is a better mechanism for dealing with [state-mandated] cost cuts; we can make across-the-board cuts instead of cutting out particular categorical programs."

V. Service Delivery Issues

A. Staffing

1. Supply of Trained Personnel

There appears to be a sufficient number of trained staff to fill the caseworker positions in the county. Recruitment of qualified foster care families is a challenge that the county is tackling this year.

2. Training Approaches

Scott County appears to be committed to substantive training for line staff in a variety of areas. As an example, during the time of our site visit, a 4-day training session was being conducted for the entire caseworker staff to help them prepare the transition to a case management system. Development of the case management system itself had involved numerous planning retreats and training sessions for senior agency staff and planners.

B. Other Service Delivery Issues

General barriers to the ability of children in Scott County to obtain optimal welfare and health (including mental health) services include the following, as noted in the community description section of the RWJ grant application: "problem areas include access to primary health care for Medicaid patients and/or the differences in payment schedules between private and public insurers, conflicting and competing eligibility for services, lack of communication between the various actors and levels in the system, and children moving in and out of the system without tracking of their needs or the extent to which whose needs are met during interim periods

VI. Oversiaht and Feedback

Most of the interviewees concurred that formal evaluation was one of the weak links in the system It is difficult to measure and document success, in part, because. baseline data are limited. There is no common database among social service providers; information from the state is difficult to access; data are scattered; and a plan has not been integrated nor implemented among the state, county, and providers. An example of specific program outcome evaluation is that Family Resources Inc. was able to document a reduced recidivism rate and reduced number of out-of-home placements linked to, its adolescent program. Also, Decat planners have been able to document overall reductions. in out-of-county institutional placement. The problem, as for many systems, is the difficulty in documenting the impact of preventive services.

Informal or intuitive measures of success relate to improved staff attitudes and enthusiasm.

VII. General Issues

A. Gaps and Barriers Reported by Providers

Among areas identified by respondents as needing further attention were the following:

- Schools not included as a funding partner in Decat
- Limited success in providing mental health care for children (therapy)
- Limited success in implementing important aspect of the mental health plan
- No specialist in child and adolescent psychiatry in the community
- No local availability of residential mental health treatment for children

B. Strengths and Innovative Features

- Planning

  Bringing together all the key players in the system--and keeping them together and focused "on task"--has been a key benefit of the planning process. Planning seems a goal in and of itself. Dennis Timmerman believes that it is critical to "manage the complexity of planning. It is important to work with the complexity and **not** to simplify and thereby risk losing key components." His long-term vision is that services will evolve as the needs emerge. 'There is no end-point. Rather, this is an ongoing process. And process is the key."

  Kay Gardner explained the value of planning this way: "Human service professionals in this community have always talked together and have been amendable to working together. But as a result of Decat, we have had a planning process that has helped us identify our philosophy about families, foster care, adolescents--a whole range of areas. In the process of articulating our philosophy, we have been forming values and building consensus."

- Training

  The many fundamental changes occurring in the Scott County service system are buttressed with training for staff at all levels. For example, the relatively recent shift in emphasis toward family preservation was preceded by extensive training of case workers to assure that staff bought into the fundamental philosophy as well as understood the logistics of a changing service philosophy. Supervisors had been involved in various Decat planning efforts, so they had opportunities to shift attitudes.

- Breadth of community involvement

- Level of commitment of human services professionals to project

  A constant refrain in all interviews for this project was the commitment of human service professionals--in all agencies and organizations and at all levels--to the cause of serving.

C. Level of Consumer Involvement

- Planning

  The public has been involved as representatives of community groups at several different levels of planning. One interviewee said it was important to assure that

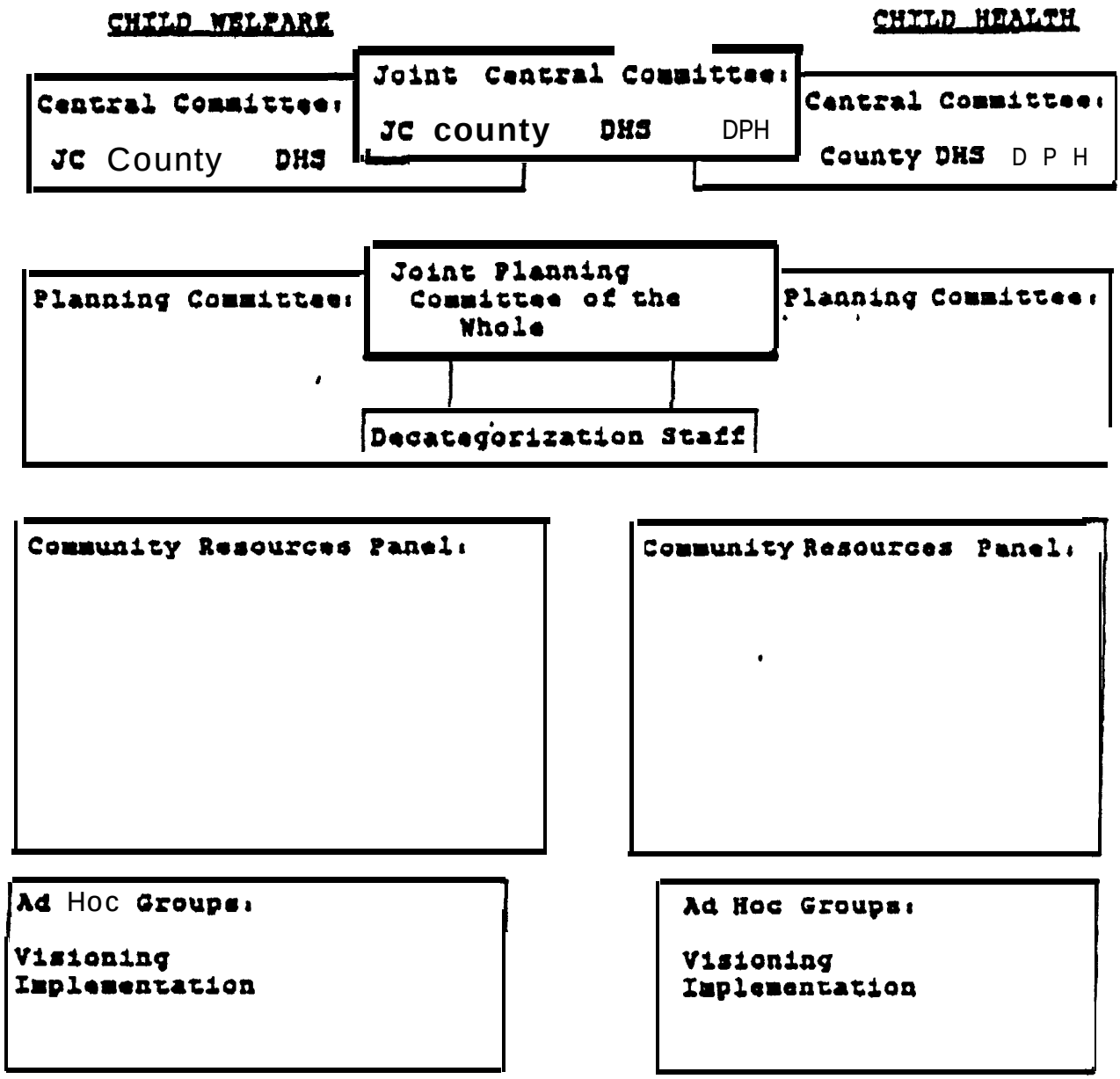
the voices of parents and the public in general get heard and to bring people in on key issues to ask them: What are your needs? What are your barriers to service?

- Client involvement in treatment

  Clients are involved as part of the treatment team for in-house services. Kay Gardner hopes that client feedback can be built into the case management/team process as that gets implemented.

*Attachment A

SCOTT COUNTY DECATEGORIZATION
Figure 1: INTEGRATED ORGANIZATIONAL STRUCTURE



Site Visit Summary
Jefferson County, Kentucky

Prepared by:

Macro International inc.

June 30, 1992

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Jefferson County, is an urban area (population: 950,000) which comprises the largest social services district in the state of Kentucky. District offices are located in Louisville, which has a population of about 670,000 and includes about 40 percent of the state's child protection cases. Child welfare and child mental health services are implemented at the district level, and administered at the state level by different departments within the Kentucky Cabinet for Human Resources. Both agencies have recently benefitted from state legislation supporting family based services and mental health services for severely emotionally disturbed children In addition, a progressive family court system has been adopted in Louisville, and statewide education refom legislation has stimulated the development of family resource centers in local schools. Mental health services are provided primarily by a large comprehensive mental health center which is the only approved Medicaid provider for Jefferson County and the "salt river district" which encompasses the six surrounding urban counties.

I. Introduction

During 1985, the Kentucky legislature appropriated more than $8 million to support family-based services provided through the State Department of Social Services. This action followed a period in the early 1980s when Federal and state funds decreased substantially while child abuse and neglect reports doubled, and was stimulated by findings of a committee appointed by the Governor to assess existing services. The commitment of significant state resources enabled the development of an innovative program oriented to the family as a whole.

The Kentucky Department of Social Services (DSS) is a centrally administered system which incorporates child protective services and juvenile justice within one agency. Service delivery is implemented through *14* districts throughout the state; however contracts with service providers for all districts are administered by the state office. The locality recommended by state DSS staff for site visit for this study was Jefferson County, which comprises the largest social services district in the state. Jefferson County has a population of approximately 950,000. Louisville, the site of the district DSS office has a population of approximately 670,000 and includes about 40 percent of the state's child protection caseload.

One of the most comprehensive community mental health centers in the nation, Seven Counties Services, provides Medicaid reimbursed mental health services to Louisville and Jefferson County. In addition, an innovative Family Court system is linked with mental health and DSS Family Services. Involvement with the school system is developing, but is in earlier stages than relationships among other child serving agencies included in this study.

Jefferson County is known for its innovative programs and has provided models of service which have been adopted for statewide implementation. In addition, Jefferson County offers this study a perspective on ways parallel but equal service systems can work together in an urban setting.

The Macro team visited Louisville March 9-12, 1992. During the site visit discussions were conducted with key administrators and direct services providers within the social services, mental health, court and school systems, as well as with private service providers and child advocates. Individuals interviewed include the following:

Denartment for Social Services. Division of Familv Services
Nancy Rawlings, Director
Bonnie Hommerich, Family Services District Manager
Libby Trager, Assistant District Manager and Supervisor of Child Protective Services
Marsha Roberts-Blethen, Assistant District Manager and Supervisor of Specialized Services
JoAnn Harrison, Assistant District Manager and Supervisor of Support Services
Mike McFall, CPS Intake and Investigation Unit
Pam Reynolds, CPS Ongoing Treatment Unit C
Regina Boyd, CPS Ongoing Treatment Unit C
Pat Blevins, CPS Ongoing Treatment Unit A
Ruth Robins, CPS Ongoing Treatment Unit B
Lee Griffith, CPS Ongoing Treatment Unit B/Medically Fragile Team
James Hildreth, Specialized Services/ Juvenile Services Unit
Natalie Hixson, Specialized Services/Juvenile Services Unit
David Peterson, Specialized Services/ Family Preservation and Permanency Planning Unit

Seven Counties Services. Division of Specialized Child and Familv Services
Emily Hutchinson, Division Director
Matt Veroff, Unit Director/Transitions
Lisanne Giltner, Kentucky Impact, Wraparound Services
Lynn Ward, Parent Resource Center, Compeer and Parent Aid Program
Mike Kramer, Acute Child Psychiatric Service

Jefferson County Family Court
Richard J. FitzGerald, Family Court Judge

Jefferson County Public Schools

Michael Waford, Special Projects
Howard K. Hardin, Educational Assessment
James W. Metcalf, Special Education
Matt Beddingfield, Principal/Byck Elementary School

Jefferson County Child Advocacy Center
Jean Kimberlin, Executive Director

R.E.A.C.H. of Louisville
Robert J. Illback, Executive Director

II. History of the Approach

A. County Efforts

Jefferson County's approach to providing children's mental health services has been evolving over the last 10 years and has been influenced by events and activities at both the county and state levels. At the county level, mental health and child welfare providers began working together in the early 1980s on specific collaborative programs in areas of family preservation, crisis intervention and wraparound services. Mental health providers also began moving toward bringing in parents and families as "therapeutic partners.

During this time, linkages were also initiated between Family Services and the Courts, in response to the permanency planning provisions in P.L. 96-272. A permanency planning committee was established to look at opportunities for multi-agency cooperation, including members from the schools and law enforcement, as well. This group continues to function primarily to provide consultation on the most complicated cases.

These efforts, coupled with historically strong leadership from individual judges in encouraging interagency cooperation, led the court system to reevaluate its role and procedures and to adopt a family court system in place of handling multiple family issues in district courts. The family court concept is based on the importance of an integrated and holistic approach to working with families which can help eliminate duplication of effort, resolve disputes in a timely way, provide access to resources and generally provide an alternative to the adversarial model that prevails in court settings. The Jefferson County Family Court has been in operation for 1 year, and is the only one in the state.

B. State Activities

State-level activities have also had a major impact on the development of Jefferson County services. These include legislative support for a family-based approach to social services described earlier; CASSP planning grants to improve collaborative, community based mental health services to children; and legislative support for

Kentucky Impact, the plan for seriously emotionally disturbed (SED) children. These initiatives provided both validation and concrete funding support to expand and improve local collaborative efforts. In addition, they generated expanded reiationships between the state-level Departments of Social Services and Mental Health, and have had impact on other programs within the Department of Social Services as well as other agencies. The structure of state, regional and local interagency councils developed for the Kentucky Impact program is seen as a potential foundation for improvements in other services as well.

State and county level respondents emphasized the reciprocity betweenthe county and state in influencing approaches. Some of the state-led efforts have been patterned after innovations originating in Jefferson County. For example, Kentucky Impact used concepts from the Jefferson County Wraparound program as a model. Both also acknowledged the importance of maintaining a balance between formal and informal cooperative mechanisms, between "planful" change and innovative ideas. Jefferson County providers strongly value the informal, day-to-day interchange that results in “too many creative ideas” to be achieved all at once. They advocate. for continued ad hoc and informal relationships to continue to stimulate both better services and new approaches.

III. Environmental/Contextual Issues

A. Service Delivery System

Children’s services in Jefferson County are provided by four distinct delivery systems working together at multiple levels, both formally and informally.

Child welfare and mental health services are separately administered and funded by state-level departments within the Kentucky Cabinet for Human. Resources. The Department of Social Services, Division of Family Services, provides child protection, foster care, family preservation and juvenile services. In Jefferson County, the Family Services Division handles about 4,500 cases a month, which involves providing services to more than 10,000 individuals. Approximately 1,100 children are “committed to the Cabinet” at any given time, with approximately 250 of these estimated to be seriously emotionally disturbed. The population served is primarily Caucasian, with African-American cases representing about 20 percent of the total.

Mental health services are provided by Seven Counties Services, a comprehensive mental health center which receives state funding from the Department of Mental Health and Mental Retardation as well as providing services under contract to DSS, schools and other agencies. Seven Counties is the only approved Medicaid provider

of mental health services in Jefferson County and therefore the predominate provider for children in the child welfare system.

Within the last year, Jefferson County has put into place a Juvenile Court System which consolidates all issues involving an individual family under one judge. This is described more fully below.

While Family Services, mental health, and the courts have established some strong working relationships and linkages, staff from the various agencies visited felt that education was not yet fully on board with their efforts. Some programs are in place within the school system, but linkages with other child-serving agencies are not well developed. The school system has focused coordination efforts on the business community through strong linkages with the Private Industry Counsel (PIG)-a far more appealing partnership because of its ability to provide funding support. Respondents felt that inroads to the schools are being made.

Respondents also indicated that private sector commitment and support is lacking; while the local business community has been supportive in the arts, little has been forthcoming for social services.

B. Linkages Among Systems

The development of linkages among the major providers is largely attributed to the shared vision of key leadership in the Jefferson County Family Court, DSS Family Services District Office, and Seven Counties Services. Individuals in leadership positions have moved up through the ranks of their individual agencies over a period of many years. Relationships of trust, along with shared visions, have developed. There has also been movement of key staff between agencies, building bridges of first-hand understanding of issues and constraints among providers. Staff interviewed in all three agencies acknowledge conscious efforts to build communication loops, share in treatment planning and problem solving on a regular basis. They mutually characterize their efforts as imbued with the spirit of collaboration, negotiation and working for children.

Much of what has been put into place in Jefferson County has been a result of ad hoc, informal networking in response to a specific problem or population, or identified service gap. As key leaders in the various child-serving systems have worked together to develop approaches to meeting those needs, they have found that these approaches have utility beyond the initial population or problem of interest and their collaborative efforts have uncovered additional issues and problems to address.

Several efforts which started out as informal linkages have become institutionalized. This is perceived as a mixed blessing. Once a program is formalized, staff feel, it is

easier to obtain state funding and often more clients can be served; however, there is less flexibility in its implementation and the state takes on a watch-dog function.

Even given extended efforts to work together, both administrators and providers recognize that turf and jurisdictional issues abound and that it is difficult for anyone who has not grown up and established a place of trust in the network to have an effect. Louisville was characterized as having a "small town" atmosphere which provides both advantages and disadvantages in developing collaboration. Progress, it is agreed, is only possible because of the commitment and shared visions of key leaders.

IV. Overview of the Service Approach

As noted above, four separate service systems are involved in providing for the mental health needs of children in child welfare in Jefferson County. Mental health services provided by social service and child welfare agencies, as well as the role of the courts, schools and selected private providers and advocates are further described below.

A. DSS Division of Family Services

The Division of Family Services of the Kentucky Department of Social Services has responsibility for child welfare-related services throughout the state. These include child protective services, juvenile services, foster care recruitment and certification, adult/domestic violence services, and family preservation and permanency planning. Administration of contracts with service providers throughout the state is centralized in the state office; however, services are delivered through a system of 14 district offices which have considerable flexibility in developing individual initiatives. Below are described the major program components within the Jefferson County District Family Services office which affect the provision of mental health services to children in child welfare, an organizational chart is included as Attachment A

1. Child Protective Services

Child protective services constitute one of three major operating sections of the Family Services District office. Staff are organized into four units: an intake/investigation unit and three ongoing treatment units. The intake/investigation unit includes 45 investigation workers organized into 7 teams, as well as 7 hotline staff. Approximately 2,200 calls are received each month. About 500 of these result in investigations, of which 60 percent are usually substantiated. About 40 percent of substantiated cases involve sexual abuse.

Once substantiated, an individual case is assigned to one of the three -ongoing treatment units based on geographic location. Ongoing units average about 27 caseworkers organized into teams of 5 or 6 workers. One team in each unit specializes in adolescent cases.

An assessment of mental health needs is conducted by the intake worker in each case. Assistance from staff psychologists in the Support Services section may be sought to help conduct the assessment process. In addition, both intake and ongoing units have a family services treatment specialist who has completed a masters degree and a 2-year training program. The treatment specialist's role is to conduct assessments and provide case consultation, as well as to provide direct services to families. Each unit conducts a weekly clinical case consultation in which the family treatment specialist, and often a staff or consultant psychologist, participate. Inservice training for caseworkers is provided by the family services specialist. For example, a current topic of training is working with families who refuse therapy. In addition a consultant psychologist meets periodically with unit supervisors to help them improve clinical supervision skills and manage difficult situations.

If mental health services are needed, CPS staff may refer to Seven Counties Services (described below) for those who are eligible for Medicaid coverage, as well as to other DSS contract providers, some of whom offer specialized services for such issues as sexual abuse and alcohol and drug abuse. Access to contracted services and to specialized CPS programs described below is determined through an agency-wide screening committee which assesses where the child will be best served and where there are openings.

While traditional psychotherapy and outpatient services are widely available, staff feel a need for more home-based services to help support and stabilize placements, including both respite care and behavioral programs to support parents. Expressive therapy is another service staff consider helpful, but in very short supply.

Within ongoing CPS treatment units, several innovative approaches to addressing a range of children's mental health needs have been initiated. Below are described preventive interventions, as well as programs for children with identified emotional or behavioral problems.

Existing Program:

Crimes Against Children Teams. In 1988, specialized investigative units involving both a CPS worker and a police worker were formed to investigate cases of physical and sexual abuse. CPS/Crimes Against Children Unit contracts with a local private provider with expertise in sexual abuse for 1.5 full time

equivalent (FTE) therapist positions to be available on an emergency basis to meet with the investigative team and the family to provide crisis intervention and to follow the family through the court process.

Collaboration with the Visiting Nurses Association (VNA) is an informal process implemented by the Medically Fragile unit to improve coordination and assist VNA workers who follow up on drug exposed infants when they leave the hospital. In Kentucky, all newborns are screened for drugs. A positive result alone does not warrant a CPS investigation; however, it is well known to be a risk factor for abuse. For all positive drug screen cases, the hospital brings in a VNA worker to follow the case for 9 weeks, which is when a return visit is scheduled for the infant. Because both the hospital and the VNA were routinely contacting CPS about identified infants, the Medically Fragile unit supervisor invited key persons from each of the involved organizations to explore joint approaches to monitoring and assisting the families involved. As a result, several new mechanisms for interaction are now in place. A single point of contact at the VNA has been identified to work with CPS. CPS is routinely copied on all positive results as an early warning mechanism; CPS, VNA and hospital staff meet regularly to review cases and discuss service approaches. CPS staff work with VNA nursing and social services staff (psychologists and social workers) to help them work with families to avoid CPS involvement, and to be more responsive in keeping followup appointments.

The Choice Program is a 2-year old program targeted to SED children, ages 3 to 17, in foster placement who have little likelihood of adoption. Its objective is to help build social skills and minimize the number of moves such children may face. The caseworker convenes a treatment team which includes the foster parents, as well as a psychologist and other community-based providers. The team meets every 2 weeks and sets treatment goals. The caseworker keeps in regular touch with the school, usually monthly, and works with the counselor or teacher. Many Choices children are in ED/BD programs or special schools. Every 2 months the child is brought in to "run" the meeting and to communicate his/her needs. Choices caseworkers carry a smaller caseload (6 to 8 children) and provide services for 18 months.

New and Planned Programs:

The Six and Under Program *is* a new pilot project to identify and address the needs of children who may be experiencing detachment disorders. The idea for the program grew out of concern for young children who have experienced two or more moves within foster care. Its objective is to intervene with a child before placement problems occur and before the child becomes severely emotionally disturbed. A multidisciplinary consultant team assists in assessing the child and family and providing guidance to the caseworker regarding service

needs and treatment approaches. The program is also conducting training with caseworkers to help them learn to identify the more subtle behavioral dues that may indicate a need for more support. An example given was the case of a 5 year old girl who was having some problems with bed wetting, had a "flat affect," and was angry and unengaged during the Christmas season. The consulting team provided guidance to the caseworker on how to talk with the child about her separation from her family and the grief she was feeling, and also provided counseling for the foster family to help them understand her problems and needs. As a related effort, Family Services proposes to gradually increase foster care reimbursement rates for foster parents that keep children longer than a predetermined period of time to provide an incentive for foster parents to work with difficult children.

Partnership in Parenting is a pilot program that is currently in the planning stages and scheduled to begin in late summer of 1992. Its purpose is to formalize the mechanism for foster parents to work with natural parents-an ideal practice that is rarely implemented. Under this pilot program, the foster parent will help the natural parent to identify and meet the child's needs. Staff anticipate use of techniques such as the mentoring approach used in the Seven Counties Compeer program (described below). Natural parents must agree to the service and sign a contract. The program will include a careful selection process for foster parents and extensive training for the CPS case workers, foster parents and natural parents. Caseworkers and foster parents will be trained together to implement the program, and caseworkers will serve both as a resource and an aide to dispute resolution for the foster parent/natural parent team. The program also includes provisions for reimbursing foster parents on an hourly basis for their services, which would be in addition to the base foster care rate.

Family Options is a proposed pilot project to develop an interagency assessment team to become involved with families referred to CPS for investigation. Although a start date has not been set, the plan is to select one intake and two ongoing units for the pilot. The team would include child welfare, mental health and school system staff and would work with the family and assigned workers in conducting family assessments and in developing and reviewing treatment and family service plans. Administrative and supervisory staff from participating systems would provide oversight. The expected benefits of the program include increased ability to keep families together; improved assessment, diagnosis and treatment; more use of family-based, community resources and less of more restrictive treatment; and reduced costs. In addition, the interagency process is expected to contribute to better collaborative relationships among agencies and greater involvement of families, earlier assessment and increased development of innovative service strategies, and expanded use of Medicaid as a financial

resource. See Attachment **B** for a summary description and flow chart of the process.

2. Specialized Services

a. Juvenile Services

Unlike many child welfare systems, Kentucky includes juvenile services under the Department of Social Services umbrella. The Juvenile Services unit falls organizationally within the Specialized Services Section of the Family Services District office, and includes seven teams of five to six caseworkers each. Two of the teams cover all court-involved'cases from the time the petition is filed through adjudication and disposition.. Cases are then assigned to the other teams for ongoing services;. The only part of the process in which juvenile services has no involvement is determination of which cases go to court. Juvenile services workers become involved at the point when a case goes on the court docket.

The age range of children in juvenile services is 11 to 18; the majority are between 14 and 17. Staff report an increase in violent crimes and an increase in younger children coming into the system. The-vast majority of the children in this unit are in need of mental health services.

Service options for the populations served by Juvenile Services include Seven Counties and other private providers for outpatient services, foster care, and a network of group homes and residential facilities which have a total of just over 600 beds. Within DSS, access to residential care is controlled by Children's Residential Services, a DSS unit outside the Family Services Division. Juvenile Services staff report a serious shortage of placement options for the kids served in their unit, particularly status offenders. Even within DSS, there is difficulty finding placement for status offenders. Private facilities tend to "cream" and are not a good- source of services for this population. Staff feel a great need for more family based, **in-home services, more timely access to mental health services and more** appropriate school placements. In addition, more therapeutic foster care is needed, as well as support for foster parents in working with juvenile services kids. **At** present, juvenile services workers note that! services seem to follow available funding and think more secure and consistent funding would greatly help assure more accessible services.

The juvenile services unit holds a weekly screening committee meeting, whose membership includes court staff, supervisors from each unit team,

and a staff member from the joint mental health/child welfare family preservation program. The purpose of these meetings is to review all court cases passed for disposition and provide case planning insights and suggestions to the case worker who in turn presents recommendations to the judge. At one time a Seven Counties therapist also attended these meetings; however, budget cuts curtailed this involvement. Although DSS provides services, generally the Court has control of what is offered. Often, the decision must be based on what resources are available, rather than on the needs of the child.

b. Family Preservation/Permanency Planning

Also located within the Specialized Services Section, this unit is comprised of 5 teams which offer the following services:

- HELP--a family preservation program designed to provide short-term intensive home-based services, modeled after the Homebuilders program. This program is jointly staffed and administered with Seven Counties Services. Supervisors from each agency meet to assign and monitor caseloads.

- Intensive Services--a program targeted to multiple problem children who have been in out-of-home placement for an extended period of time and for whom a definitive plan of action is still unclear. A range of intensive services is provided over a period of 6 months while specific resolution to the case is sought. Services include therapy, in-home aides, respite care, and child care, with the express purpose of coming to a resolution on the case. At the end of 6 months, it is determined whether the child should be reunified with the natural family or whether the process for terminating parental rights should be initiated. Caseloads are kept to 8 to 10 families.

- Adoption-which is handled by two teams that work with children for whom termination of parental rights (TPR) has taken place and failed adoption cases to find adoptive homes. Therapists are routinely involved with the child at the time of placement and to provide post-placement counseling if needed. Staff report that most children are already receiving mental health treatment at the time they are adopted, and these services are kept intact throughout the adoption process and after placement.

- Independent Living/Permanent Substitute Care--a service geared toward adolescents 16 years and older to help them move toward

independent living. This becomes an option at age 18 or can be extended to age 21 if the child desires.

About half the children under the jurisdiction of DSS are served in this unit. The unit supervisor reports that staffing is stable and that those in the unit have worked with individuals and agencies throughout the area over a long period of time and have built strong networks and relationships. This type of networking and developing personal relationships with resources is seen as essential to effective service delivery in Louisville.

Unit staff report a great shortage of family therapists with expertise in adoptive families. The issues of grief and loss which must be addressed are not familiar territory to therapists accustomed to working with natural families. More behavioral therapists, in particular are needed. In addition, more and better training in cultural diversity for both workers and foster parents would be beneficial.

B. Seven Counties Services, Inc.

Seven Counties Services, Inc. is one of 15 state-funded comprehensive care centers whose origins stem from the community mental health concept. Kentucky's approach was to fund private agencies to fill this function. Seven Counties, and the other comprehensive care centers across the state, are the only approved Medicaid providers of mental health services.

Seven Counties is a large private agency responsible for serving Jefferson County and the six surrounding rural counties commonly referred to as the "Salt River District." Its annual budget nears $30 million and supports 600 employees. Roughly 35 percent of the budget is from the state Department of Mental Health; however, this percentage has been decreasing over the last several years. Other funding sources include Medicaid and other third-party payors, contracts with the Department for Social Services, public schools and other providers and a few small grants.

Seven Counties operates four outpatient centers and two centers that provide employee assistance programs (EAPs) and other business-oriented personnel services. The agency serves a cross section of populations focusing on issues of mental health, mental retardation, and chemical dependency. Several years ago the agency defined priority populations as those experiencing domestic/family violence, chemical dependency, and severe emotional disturbance. Policies and funding priorities have been targeted to the needs of these populations.

During the site visit, we focused on the operations of the Centers for Specialized Child and Family Service, a division within Seven Counties that offers a wide array of mental health treatment and intervention programs for children, youth and families. Family/child teams are located at each of the four outpatient centers and provide traditional outpatient mental health services including individual, family and group counseling. Other programs include a variety of intensive, home-based assessment, crisis and treatment services for SED children and their families, and those for whom child abuse or neglect are a focus of treatment. Home-based services are housed at the Center for Community Based Services. In addition, Seven Counties runs a center for treatment of physical and sexual abuse called Transitions, and an acute child psychiatric service. These programs are described in more detail below.

1. Center for Community-Based Services

This center offers a range of programs, including the following:

HELP/Family Preservation Team, a short-term, home-based crisis intervention program modeled after Homebuilders which is jointly staffed with the DSS Division of Family Services. Cases are referred from DSS for family preservation services and jointly staffed. This is more completely discussed in the DSS section above.

The Parent Resource **Pool** is a 5 year old program which is targeted to families in crisis, those at high risk of having a child removed, or those going through reunification. The program is funded through a contract with DSS and involves a high degree of collaboration between the two agencies. The program does not accept families in which sexual abuse is the problem, nor clients who are actively chemically dependent. Services are provided over a period of about 1 year by family aides who carry a caseload of three families. The family aides devote roughly 10 hours per week for each family. In-home and group training are provided, along with recreational and socialization activities in the community. Training focuses on modeling parenting skills and approaches and include specific topics such as impulse control, home management, self-esteem, and relationships with others.

Individualized outcome plans are developed by the family aide with each family specifying what the family wishes to accomplish. Weekly goals are also defined to help track progress towards long range goals. An initial meeting and review meetings every 3 months are held with a treatment team including DSS and Seven Counties workers. These are used for problem solving as well as progress review.

This program serves "voluntary" clients; however, for some families agreeing to services is the only option they have to avoid having the child removed from their care. Families are considered finished with the program when they have achieved their goals, but are encouraged to continue to participate in group activities. The program can serve from 15 to 18 families at a time. There is no waiting list, but referrals are often turned away.

Compeer is a volunteer program that matches adult volunteers with children who are in treatment to provide them the opportunity to develop a positive adult relationship. The volunteers make a commitment to meet with the child for 2 hours per week for a year-long period for recreational activities. Children must be a Seven Counties client to be eligible for the Compeer program. Many are also active with DSS, although eligibility is not restricted, to DSS clients. Volunteers are initially provided 8 hours of training in issues of abuse and neglect, developmental stages in children and communication skills. They are then required to attend ongoing monthly training/support sessions.

Daybreak Family Treatment Homes is a new collaborative project with DSS. Seven Counties will recruit, train and certify their own foster treatment homes which will be reimbursed on a per diem basis through a contract with DSS. The purpose of this program is to expand the availability of treatment foster care as an alternative to residential placement. Planners hope to have 8 foster families recruited by July of 1992. This program will also include specialized 30-day treatment homes in collaboration with the acute care section,

For SED Children:

Wraparound Services are funded by DSS to meet the needs of severely emotionally disturbed children for whom placement and treatment options have been exhausted. Children in the Wraparound program are usually in foster care or are committed to DSS (parental rights have been terminated). Most have experienced multiple placements, and are at risk of hospitalization or of readmission, if discharged. The program started ***5 years*** ago with a small grant to provide treatment planning for children who did not meet eligibility requirements for other programs, and for whom no other options were available. While staff originally envisioned serving children for a period of 9 to 18 months, they are finding that the children in the program tend to stay much longer. In practice, intensive services are generally needed for 8 to 9 months to get past the most acute problems, then can taper off. DSS funded services tend to be clinical in nature, with case management covered under Medicaid. Staff reported the characteristic that distinguished these children from other children experiencing emotional/behavioral problems (including those targeted in the Impact program, described below), is the absence of family support. They described them as children who have been bereft of any type of anchor or consistency in their lives.

Access to wraparound services is through the DSS Family Services placement screening committee, which includes the Wraparound lead service coordinator. Liaison with DSS has been maintained throughout the program. About 10 to 12 children at a time can be served by the program.

Kentucky Impact is a statewide program supported by state and Federal funds to improve the coordination and availability of community-based services for severely emotionally disturbed (SED) children. The program is jointly administered by the three major departments within the Cabinet for Human Resources: Mental Health and Mental Retardation, Social Services and Medicaid Services.

Impact services are modeled on a wraparound concept and include individually tailored Intensive Family-Based Support Services (IFBSS) as well as case management. Children are referred to the program through the schools, DSS or Seven Counties.

Oversight to the Impact program is formally structured at three levels:

- The State Interagency Advisory Council (SIAC) is comprised of representatives from social services, education, mental health and the legal system, and has a consultative, advocacy and lobbying role.

- The Regional Interagency Advisory Councils (RIACs) exist in each of the 15 comprehensive care areas statewide. They include the same type of representation as the SIAC, but from the regional/area office level. The RIACs have responsibility for oversight and administration, budget, policymaking and setting region-specific priorities within the state definition of SED (which is considered very broad). They are also responsible for establishing local councils.

- The Local Interagency Advisory Councils (LIACS) are comprised of key direct service providers and have responsibility for establishing and delivering services. LIACS review all referrals to Impact, prioritize clients for services, make recommendations and monitor individual case planning; and recommend development of needed ancillary services. Service plans are reviewed after 6 months. The LIACs also provide service recommendations for those cases that don't meet eligibility criteria or who are on the waiting list for Impact.

The Salt District Impact program (which serves Jefferson County and 6 surrounding counties) is staffed by 9 service coordinators, each of whom has a caseload of 15. The service coordinators assist the child and family in gaining access to needed services and integrate service plans from key providers (e.g.

DSS and the schools) into an Impact plan which is presented to the LIAC for approval. Service coordinators also serve as liaisons to area LIACs.

IFBSS services are modeled on the wraparound concept and may include crisis intervention and evaluation, as well as respite care, transportation, in-home attendants, and other customized services. Wraparound aides, often graduate students or mental health technicians, are assigned to each family in the Seven Counties Impact program and spend 8 to 15 hours a week with the child.

Of the 8,000 children who are estimated to be SED and in need of Impact or Wraparound services in the Seven Counties area, approximately 140 have been served in the first year of the program. However, staff estimate that the "worst of the worst," i.e. the most difficult cases, were among those served first and that resources may go farther as less difficult cases enter the program.

Staff report that for both Impact and Wraparound programs, their objectives are to keep kids out of residential treatment and to maintain them in their communities, either with natural or foster parents. They report a 96 percent success rate overall. Wraparound staff note that among their clientele of very disturbed children with troubled placement histories and no clear options, four have been adopted or have found permanent substitute care. The program usually serves 8 to 10 at a time and has been in place for 5 years. Together Wraparound and Impact serve about 5 percent of the children involved with DSS.

2. Transitions

The program provides specialized treatment of physical and sexual abuse targeted to both perpetrators and victims, adults and children. The concept for this program grew out of concern about the inconsistent quality and lack of family focus in available treatment for families that had experienced abuse. The program is about 3 years old and provides case management, specialized individual, group and family therapy, support groups, case management and referral services. It is staffed by 16 full-time professionals, including social workers and psychologists, as well as specialists such as art therapists and educational psychologists. At intake, family members are assigned to therapists according to their individual needs; if there is more than one therapist involved, one is assigned case management responsibilities. Where DSS is involved, the therapist brings the DSS caseworker into the first session. Almost all the children seen in the program are involved with DSS. The program director has developed a linkage agreement in collaboration with DSS that describes how Transitions staff and DSS staff will interact. He has also recently initiated a twice monthly meeting with Family Services staff that focuses on ongoing cases

and families that have been referred. The purpose of these meetings is to identify key issues prior to intake and to help sort out roles.

Transitions conducts about 100 intakes per month, and is currently serving about 300 children and their families. Referrals are voluntary, from DSS and from the courts. The length of time a client is in treatment varies; however, all clients are seen for at least 6 months. Adult clients are often in treatment for as long as 2 years, and adolescents average 1 year. The program has a sliding scale fee for services, and bills third-party payers for covered services. Some funding is provided by the Department of Mental Health, but little by DSS. The program is not able to accommodate all referrals immediately, but has set aside some intake hours for crisis situations. Clients may wait 4 to 6 weeks to be seen.

3. Acute Child Psychiatric Services

This is a relatively new unit that began operations 3 years ago under a subcontract with Our Lady of Peace, a local hospital with a state contract to provide 52 inpatient beds for children. The unit started with three staff persons providing screening and assessment services to Our Lady of Peace. At present, the unit has a staff of 19 and includes four components:

- Statewide screening and assessment services to determine and arrange for appropriate inpatient placements.

- Brief family-based intervention and treatment for families in crisis--an intensive service providing consultation and wraparound services for a period of 4 to 6 weeks. In-home services are provided by crisis respite aides who also have access to psychologist consultants. Roughly half of the patient population for this service are self-referrals, and half are referred by DSS.

- Short-term foster care homes. In conjunction with Daybreak, described under community-based services, this unit is developing a program that will provide short-term (30-day) foster care homes to take children and adolescents in need of intensive services. This program is being developed because of the lack of foster homes willing to take this population, and will be complementary to the brief intervention and treatment program.

- Discharge planning for children in residential placement which includes intensive case management that starts as soon as the child is placed. Case managers coordinate all involved parties including the courts, DSS, psychologists, schools, and others as appropriate. A case planning

conference is held to sort out plans for stabilizing the child and to clarify the various providers' roles.

Staff report a shortage of services for chemical dependency which makes it difficult to return children back to the community. Individual therapists have a referral network, but there is a paucity of resources available. In addition, there is a shortage of community-based residential treatment. Most of- the-. children served here cannot live at home; and current foster care resources are not adequate.

C. Family Court System

Two years ago, Jefferson County adopted a family court system. In effect, all family court-related dockets were merged, including divorce, CPS cases, domestic violence, paternity, termination of parental rights, adoptions, and status offenders. Juvenile delinquency cases are still seen in a separate delinquency court; however, if a child who is already involved in family court is charged with a status offense, his/her case remains in family court. The court system was reorganized in this manner to allow the judges to deal with the entire range of needs within a family context and in relation to other issues confronting the family. Six judges share the court caseload, each handling all issues related to a single family. Court staff estimate that of all families seen in family court, 75 percent have CPS involvement.

Each family court judge is assigned a family court support worker whose role is to facilitate court interaction with social services and families and to improve families' access to parallel service systems. The family court liaison staff are comprised of social workers whose positions are provided by DSS (3), Seven Counties (1), and the administrative office of the courts (2). Although each are paid staff of their respective agencies, their offices are located in the family court building and their family court liaison roles constitute full-time responsibilities. This role was initiated, by the court in recognition that judges needed the added information and support necessary to coordinate and facilitate access to services. The support workers accompany the families in court and meet with them afterward to help them understand what happened and what next steps need to be taken. The DSS Family Services Division district manager meets with the liaison team on a regular basis and copies them on relevant communications and materials.

The family court has assembled a committee comprised of staff of various agencies to assist in identifying issues and improving linkages with the court. Several topic-specific subcommittees have been formed, including a dependency subcommittee which is currently exploring issues of access to various child-serving systems and ways to prioritize services.

One family court judge in particular, Judge Richard Fitzgerald, has advocated for improved collaboration and communication among child-serving agencies, particularly DSS. Although the court's role in dealing with DSS is often adversarial, several formal and informal means have been developed to improve working relationships. The court liaison and dependency subcommittee mentioned above are two such mechanisms. In addition, he has instituted a requirement that DSS caseworkers submit affidavits of effort documenting their efforts to obtain needed services. The judge sees this as "empowering" for workers, whose efforts are often unobserved and underestimated, and as "educational" for the court in understanding and identifying systemic problems. Regular, sometimes daily, informal communication occurs between the judge, the DSS Family Services District Manager, and other key providers.

Judge Fitzgerald views the family court role as that of a "change agent" which must insist on, but also support, improvements in the community. In cases where the court has no legal jurisdiction to mandate service coordination, he uses an expansive interpretation of his authority to encourage responsiveness and participation in interagency efforts.

D. School System

The Jefferson County school district serves 93 thousand students, 1,000 of whom have been identified as SED. Although there is no identified system-wide approach to addressing mental health issues, there are several individual programs in place that are related to children's mental health issues. In addition, counseling groups are available through Seven Counties in 40 schools to students and families who are Medicaid-eligible and seek mental health services.

1. Family Resource and Youth Services Centers

This program is a state-funded initiative mandated in Section 18 of the 1990 Kentucky Education Reform Act (ERA). This initiative grew out of concern about the need to address children's physical, mental and social needs in a more holistic way. The program emphasizes collaboration among community-based providers and is targeted to schools in which twenty percent or more of the students are eligible for free school meals (i.e. those serving a large number of low-income students). Family Resource Centers are to serve children up to age 12 (elementary schools) and Youth Services Centers are to serve children age 12 and above (middle schools). Eligible schools are required to conduct a needs assessment, develop clear objectives, and present a proposal that promotes identification and coordination of existing resources and includes ***at least*** the following components:

a. Family Resource Centers

- full-time preschool child care (for 2 and 3 year olds)
- after school care for age 4 to 12 and full-time care during the summer and school breaks
- parenting training for new and expectant parents
- parent and child education (PACE)
- support and training for child day care providers
- direct provision of or referral to health services

b. Youth Services Centers

- referrals to health and social services
- employment counseling, training and placement
- drug and alcohol abuse counseling
- family crisis and mental health counseling

The development of each center must be supported by a community planning process and the establishment of an ongoing advisory group that includes representation from parents, students, teachers, and key community providers from the arenas of health, mental health, justice, state human resources, child day care, private industry, substance abuse treatment, community action agency, and key neighborhood ethnic and minority groups.

The state has determined that over 1,000 schools in Kentucky are eligible for a center and anticipates establishing 125 to 150 centers during the 1991/1992 school year, the first year of a 5-year implementation plan. Of 110 eligible schools in Jefferson County, 18 have Family Resource Centers and 3 have Youth Resource Centers. Establishing plans and obtaining funding from the state for the centers is entirely dependent on individual school's initiatives.

c. Byck Elementary School Family Resource Center

The site visit team visited one of the Family Resource Centers located at Byck Elementary School, a model program built on services in place that predate the state Family Resource Center funding and which attracts visitors from around the country. The program at Byck has been in existence for 6 years, and takes advantage of a variety of funding sources through the continuing efforts of the school's principal, Matt Beddingfield. Although a limited amount of money has been provided by the county

school system, other Federal grants have been obtained and community support and fundraising have played a large role in the schools' ability to continue to develop the program. Support for the family resource center had enabled further expansion for the program.

The school is known as a "cradle school," and emphasizes the empowerment of families and children to solve their own problems. The program grew from concern about the need for remediation as early as first grade and has focused on improving parent skills and involvement, as well as teachers' skills. A weekly child study team meeting, involving medical residents, staff of the family resource center, the school social worker and a Seven Counties counselor, provides an opportunity to discuss individual families and serves as a resource for classroom teachers. The family resource center itself is located in a trailer adjoining the school and offers a variety of programs for parents and preschoolers, including stress management, GED classes and parenting skills. Through community needs assessment, a focus on health services has developed. Nursing students are brought in to teach health education, review immunization records and provide health checks. A health fair for adults was organized, with extensive support from local merchants. Physicians from local universities and practices provide consultation to the child study team. Staff envision facilitating a satellite clinic in the area to provide primary care.

Linkage with CPS occurs through the school social worker around individual cases and is not a specific part of the community involvement process funded under the Family Resource Center program. Byck staff report that families they serve are "afraid" of CPS involvement and feel the CPS approach neutralizes the family, rather than supporting the family empowerment goals of the program. For example, a family which relies on corporal punishment may be better served by a program which supports alternative discipline skills as compared to a threat that the child may be removed. Byck staff report that alcohol use is a significant factor in the community served by the program.

2. The High^5 Program

This middle-school program was developed with a one million dollar grant from the Edna McConnell Clark Foundation through its Program for Disadvantaged Youth, and focuses on three area schools serving the largest proportion of low-income students. The program takes its name from its stated concepts: high content, high expectations, high support, high involvement and high energy. Jefferson County is one of five urban school districts to receive this grant for restructuring educational programs in middle schools.

The purpose of the program is to help teachers develop new approaches to teaching while implementing efforts to increase student and parent involvement in school to ensure better quality education and higher levels of success. The program has included surveys and needs assessments among teachers, students and parents; intensive training among teachers; and working closely with students and parents to be more responsive to their needs and to positively influence attitudes towards school and achievement.

The program is now into its third year and data show significant decreases in the numbers of children who must be retained at the same grade level, slight improvements in achievement, significant improvement in teacher's attitudes, and some improvement in student's attitudes. The program has found that parents are the most difficult population to reach in this effort, and have had little success in impacting their attitudes. All three of the schools targeted in this effort are also participants in the state-funded Youth Services Center program, described above.

3. The Child Development Project

This is one of six elementary school pilot projects being conducted nationwide by the Developmental Studies Center in California. The overall goal of the project is to develop a caring community of learners promoting academic, social, and ethical growth in all students. The program focuses on classroom approaches as well as building bridges between school, home and the community, and has a strong evaluation component. The two pilot schools in Jefferson County are feeder schools to those participating in the High[5] program. Once the pilot has been completed and evaluated, the plan is to implement the program among all eighty-four elementary schools in the district.

E. Other Community Providers

Two additional private providers have been instrumental in developing and implementing key services in the continuum of mental health services available in Louisville:

1. Resources for Education, Adaptation, Change, and Health,, Incorporated (R.E.A.C.H.)

This private agency provides a range of community based and foster care services as well as direct psychological services for children and families with serious emotional and behavioral problems. This program has filled a specific niche in

the continuum of services available to DSS clients, under a subcontract with Seven Counties. REACH provides recruitment, training and support services to specialized foster care homes, with special emphasis on individuals with mental retardation/developmental disabilities and challenging behavior. Most DSS referrals are in a "placement crisis," often coming out of residential care with no clear options.

REACH advocates and employs a social systems approach, rather than a more traditional diagnostic/psychiatric approach. REACH executive director, Dr. Robert Illback, notes that the approach is not "medicalized," but is based on supporting and empowering families to deal with their problems through home-based behavioral management consultation, respite, and various support services. REACH views foster parents as case managers, and views its role as to support them in using their own and community resources. In addition to providing specialized foster homes, REACH provides consultation and training to CPS workers and to CPS supervisors on the placement screening committee to assist in developing staff competency and skill in employing this approach. He notes that there is increasingly "no place to send kids" and that the traditional role of the caseworker as a "broker" of services must give way to a more active role in "making something happen" for the family. However, REACH believes this must be done by empowering family members to act on their own behalf, rather than fostering dependency.

A key precept of the program is "person centered planning" which focuses on the strengths and capacities of the child, flexibility in roles of team members working with the child, integration of formal and informal support systems, and empowering the client, family, and friends to plan and make decisions with professionals and direct service workers.

REACH sees itself as an innovative alternative to the prevailing mode of service in the community, and has found the centralized approach to funding mental health services and selecting DSS providers statewide a significant barrier to the development and growth of such innovative options in individual communities. Dr. Illback advocates more flexibility and more local control over selection of providers. Of the REACH approach, he notes that some impediments to its wider adoption include organizational and bureaucratic issues, staff training and capabilities, and improved teamwork and collaboration among providers. While acknowledging that the REACH approach may entail higher costs than some other kinds of service, Dr. Illback points out that approximately $7 million was spent by the state last year to keep 24 children in long term out-of-state residential treatment.

2. The Child Advocacy Center

The Center evolved from recommendations of a study group commissioned in 1986 by the Jefferson County Child Protection Council, a broad organization of managers of about 20 public and private child-serving agencies. The study group was formed to develop an improved approach to responding to victims of sexual and physical abuse. The Child Advocacy Center was conceived as a way of addressing several key concerns:

- The emergency room response lacked the sensitivities and professional expertise needed to deal with the victims;
- There was much duplication and lack of coordination between CPS, law enforcement, the courts, the treatment community and advocates;
- Case planning efforts were ad hoc, inconsistent and duplicative.

Its primary purpose is to assure that children and families get support needed while long term treatment needs are assessed and arranged. This includes risk assessment and mental health clinical assessment as well as a diagnostic workup. The Center program is targeted to the critical first 6 weeks of each case that comes into the CPS system. The core mental health service involves assigning a mental health clinician to join the investigation team on the first visit to each case. The clinician's role will include mental health assessments (of victim and perpetrator), crisis intervention, and continued support and case management for up to 6 weeks, when longer term arrangements would be in place. Service agreements are being worked out with a variety of local mental health agencies which would assure that children and families coming through the Child Advocacy Center would receive priority treatment. In addition, the Center program will include a community consultation team comprised of a CPS worker, law enforcement officer, prosecutor, mental health consultant, and health care provider to provide input to complex cases, help resolve disputes, and improve coordination among services. The center will also maintain an on-call system of physicians who specialize in child abuse to go to the emergency room when a victim is brought in for examination.

The Center has been in existence since October 1991, but is still developing its funding base and operating procedures. Initial funding has been obtained from DSS and a local corporation, as well as from grants and private donations. Two boards are in place to guide Center operations: A Board of Directors whose function is to involve corporations and civic groups in the work of the Center and to assure adequate funding and an Advisory Group of treatment providers and mental health professionals to guide service delivery. The advisory group

includes working groups in areas of referral, tracking and follow up, evaluation and grant review.

The Center does not want to assume the role of a reporting agency to DSS, but to work with DSS and law enforcement to assure that services are provided. The Center's Executive Director, Jean Kimberlin, notes that CPS staff are overloaded with cases and not trained to perform indepth assessments in cases of abuse with medical needs. However, she notes that individuals in Louisville child-serving agencies, including DSS, have made a real commitment to the Center and to collaboration. This is manifested in leadership within agencies, willingness to take risks and commitment to community partnerships which focus on the best interests of the child.

V. System-Level Issues

A. Coordinating Mechanisms

Respondents indicated that shared concern for children and their families, scarcity of resources as well as mandates for collaboration emanating **from** the state and Federal funding sources, such as Kentucky Impact and **CASSP, are** all factors that have encouraged them to work together. Seven Counties status as the only approved Medicaid provider for mental health services is another factor which supports the need to work closely together.

Coordination of services in Jefferson County has been achieved through a combination of informal networking and formal mechanisms. Among the more formal arrangements identified during the site visit are the following:

- **Contractual agreements,** such as the Wraparound and Parent Resource Pool which were jointly developed and are provided by Seven Counties under contract to Family Services.

- **Advisory and planning groups,** which have tended to form around specific topics--such as the Permanency Planning Committee, the Child Protection Council, and the Regional Interagency Councils (RIACs) for Kentucky Impact-but occasionally have expanded their scope beyond those immediate areas to impact on broader policy and service delivery issues. The RIACs in particular are seen as a resource that may be tapped in the future to address issues beyond SED-its original intent.

- **Staff liaisons,** a role that has been developed within Family Services, Family Court, Seven Counties and the school system. Family Services has designated

family court and school liaisons and Seven Counties has contributed a staff position to the Family Court liaison team. The school system has also assigned court and family services liaison responsibilities to a staff person in its administrative offices. These liaison roles are intended to facilitate communication among the various entities, and help increase the level of understanding about mandates, responsibilities and constraints across systems.

At the planning level, informal networking occurs among agency administrators through ad-hoc meetings and brainstorming sessions. Many of the ideas generated in this manner have been translated into programs and agency roles have then become more formalized. In addition, individual administrators sit on a variety of community planning and policy committees organized around specific issues such as permanency planning and child protection.

At the service delivery level, more formal mechanisms such as contractual agreements and interagency agreements around specific services may be identified, as well as the ubiquitous informal communication among program supervisors and case workers. These informal working relationships around individual cases are also often the origin of more formalized linkages later. For example, the Transitions program for physical and sexual abuse has developed and documented linkage agreements that outline the respective roles of the Family Services worker and the Seven Counties therapist(s) assigned to each case. Another unique arrangement is the joint administration and staffing of the county's family preservation program--H.E.L.P.

Key Jefferson County service system administrators in the mental health and child welfare arenas are now turning their focus to prioritizing services that are needed to enhance their continuum of care, and are considering a more formalized long-range planning effort.

B. Goals/Definitions of Success

The "shared vision" for children referenced repeatedly in interviews with administrative staff of various agencies is not formalized in a community document. However, key programs in each of the systems examined for this study have articulated mission statements which, taken together, reflect a consistent approach and set of values for serving children.

The family-based services approach adopted by the Department of Social Services has been documented in a published mission statement and goals for each element of the program. Primary goals for the program as a whole include strengthening families abilities to protect and care for children and adults; maintain the integrity of families; facilitate family reunification and, when needed, move toward restructuring a new family. In Jefferson County, Family Services and Seven Counties have also developed

program-specific goals and objectives consistent with the family-based services concept. Although there is no community wide effort to evaluate the impact of the continuum of services in place, individual program evaluation plans have been developed.

The SED plan, developed and coordinated jointly by the state Departments of Social Services, Mental Health and Medicaid Services and funded by the Kentucky legislature, resulted in the initiation of the Kentucky Impact program in 1990. The program is based on a commitment to a family-centered approach to care that stresses the importance of building on strengths of families, keeping the child safely in the home and community and working toward reunification when out of home placement is necessary. Services are oriented to reinforcing natural support networks of family, friends and community agencies and interventions are designed to promote normalized experiences, age appropriate activities and mentally healthy environments. A formative evaluation based on early statewide data indicated positive gains in decreasing hospitalization and restrictiveness of placements, as well as improved placement stability, behavior change, social competence and family support.

The Family Court System, adopted over a year ago by Jefferson County, likewise is based on a well-documented concept backed by a national constituency of juvenile and family court judges. In essence, the 'family court model advocates a system that coordinates the various components of the legal process within one court; which takes into account the special needs, feelings and individual rights of the people it serves; which handles multiple problems in an expeditious and humane manner; and provides a comprehensive array of appropriate services within the system.

C. Definition of Eligible Populations and Clients

Although there is a great deal of overlap in the populations served by Family Services and Seven Counties, each system has 'very different eligibility criteria.

As the child welfare agency serving primarily child protection and juvenile justice cases, Family Services describes their population as an "involuntary" population; whereas mental health providers have the option of selecting the populations they will serve. As a result, child welfare is forced to stretch resources to cover all clients needing services, while mental health can limit the numbers served in order to do a better job of serving them well. These differing perspectives on service population are a source of tension; Family Services staff often become frustrated when clients cannot be accepted into needed mental health services because of limited capacity.

Respondents also indicated that the two systems have different perspectives and levels of commitment to the family as a unit. Child welfare providers feel a tremendous pressure to work with the natural family and express a need for more innovative services to empower and support family functioning. These providers feel that mental

health professionals show a tendency to feel that parents are responsible for their children's problems, and to strive for a "norm" of functioning that may not be realistic or appropriate for the families served. Although programs within Seven Counties, especially those in the Center for Community Based Services, stress a home- and community-based approach, traditional outpatient therapy for individuals and groups still comprises a large proportion of mental health services available in the community.

Most of the available mental health programs are targeted to the highest risk and most severely disturbed children; however, respondents indicated that an underlying strategy is to first serve children with the most compelling needs at the severe end and then use the mechanisms and approaches that have been put into place to expand into a broader population.

Specific programs within Family Services' ongoing units are emerging to address earlier issues relating to specific concerns such as attachment disorders and supporting development of better parenting skills. These are described more fully above. Programs in the school system like the Family Resource Centers, while not yet well linked to other agencies, also address preventive issues and improved support to families and have set goals related to family empowerment and avoiding later educational and behavioral difficulties.

D. Funding Issues

Each agency visited uses its own sources of funding to address mental health service needs of the children it serves. While established linkages make it easier to move children back and forth than might be possible otherwise, and to assure that full advantage is taken of those services which exist, there does not appear to be any pooling of funds by agencies at the local level. Children are still routed, for the most part, to the service for which they can qualify. Once admitted, individualized service plans are often developed. This is most often a Seven Counties program, since most children in child welfare use Medicaid.

An exception to this general pattern appears to be the joint staffing and operation of the HELP family preservation program, which is delivered by social workers from Family Services and Seven Counties. Referrals come through DSS, which has mandated responsibility for the program, but service delivery is a truly collaborative activity.

At the state level, coordination has been mandated in administering funds provided by Kentucky Impact legislation. However, in Jefferson County Impact services are provided by Seven Counties. Many Impact services are supported by Medicaid.

around specific programs has helped staff from both systems better understand the others' mandates and constraints. Because Louisville is a "small town," there is also a tendency for staff to move from one arena to another, which also helps bridge the two systems, for example, the director of the Center for Specialized Children and Family Services used to work in CPS and a psychologist from the Family Services unit recently took a position with Seven Counties.

The REACH program's approach to family-based services represents a significant departure from traditional mental health services. The emphasis is on providing in-home services that focus on family support and empowerment--case workers help parents learn behavior management and how to work with other conimunity systems to obtain what they need for their child and family. In the program's work with children in foster placement, the foster parent is viewed as a case manager and is encouraged to help the child build support systems through pursuing friendships, and using existing community resources such as churches, neighborhood groups, and YWCAs to promote a sense of belonging.

Ongoing staff training is emphasized within Family Services. Numerous ongoing training opportunities for staff are provided based on departmental priorities and staff needs. A recent topic, presented by the director of the REACH program is working with clients who resist interventions. Focus of the session is on helping case workers move beyond the more passive stance of linking clients with existing services, towards a "systems change" orientation in which they take an active role in identifying the system issues and making sure that something happens to address these.

Through activities put into place to implement the Impact program, informal training has been conducted in the schools which, respondents feel, has helped the school personnel better understand the child protective worker's role and has helped improve relations between the two entities.

B. Case planning and Approaches to Meeting Multiple Needs

Children are likely to have a separate case plan or treatment plan developed by each system with which they are involved. Family Services workers develop case plans for all DSS-involved children, Individualized Education Plans (IEP) are developed for children in special education programs, and treatment plans are developed by mental health providers. Case plans and treatment plans developed by Family Services and Seven Counties are informally coordinated among workers when the child is involved in specific programs that have established patterns of interaction such as the Wraparound program and the Parent Resource Pool program. Transitions has also developed procedures for sharing information. The Family Court Liaisons also serve

Family Services funding sources for direct provision of mental health services include some state DSS funding and Title IV-E funding which may be used to obtain specific services from private providers or support in-house programs such as Choices.

Those interviewed felt that, while limited, local funding was more secure than state-level funding. More funding for intensive services under Kentucky Impact were specified as a concern. Seven Counties staff reported that this year's IFBSS budget has been spent, leaving only some case management services still available.

Family Services staff also expressed a concern about the seeming hesitancy at the state level to fully access Title IV-E and felt that growing resource needs will force the state to either tap their own tax base, or better maximize Federal funding. With increasing emphasis on states' responsibilities to provide more comprehensive services for children identified through the EPSDT program, there will be increased demands on the Medicaid system.

VI. Service Delivery Issues

A. Staffing Issues

1. Supply of Trained Personnel

It was widely felt that social services staff coming into DSS are ill-equipped by basic preparation to deal with the complexities of the populations and issues facing public human service agencies. Mental health professionals expressed a similar concern about professionals in their field and report that new staff do not have the clinical depth needed to serve their client population. The relatively low state salary structure also puts Family Services at a disadvantage when recruiting for new staff, and limits their ability to hire staff with the requisite expertise and experience.

2. Treatment Approaches and Training

While service providers in Louisville emphasize family-based approaches to treatment, subtle differences still exist between mental health and child welfare. Related to the differing definitions of target population described above, the child welfare system's mandate to serve all clients who are identified as needing services forces them to develop approaches that will allow them to balance staff and services whereas other child serving systems are able to define a focus for their services. Respondents feel that the collaboration that has taken place

to coordinate information among the various case workers and providers involved with the child.

The RIAC and LIAC structure for the Impact program has created a formal mechanism for collecting and coordinating multiple case plans. Key providers are brought to the table and work together to coordinate their services plans. In order for case information to be freely shared, clients sign an information release and LIAC members are required to sign a confidentiality statement.

C. Caseload Issues

Within Family Services caseload size varies with the level of complexity of the cases. Typical CPS caseloads are 20 to 25 children and their families. If cases are considered only moderate in complexity, caseloads may be higher. Caseloads for the specialized programs are much lower--6 to 8 children (and their families) for both the Choices and the HELP teams. Caseloads for the Seven Counties specialized programs are also kept small.

CPS staff feel that case workers could be trained to take on more of the assessment and intervention for children who are not severely emotionally/behaviorally disturbed with appropriate training, but their caseload sizes prohibits this.

VII. Oversight and Feedback

Program outcomes and measures have been defined for the specialized Seven Counties and Family Services programs. Measures used include the number of children remaining with their natural families; number of children reunified with natural families; number of children for whom hospitalization has been prevented; recidivism; child behavioral measures (using Ackenback and the Louisville Behavioral Checklist); and parent/client satisfaction measures. These are tracked and used internally by the respective agencies for reporting and planning purposes.

The state has also implemented a comprehensive evaluation plan for the Impact program. An early formative evaluation, conducted by the REACH executive director, examined several variables including restrictiveness of living situations, placement stability, amount of family support, family satisfaction with support, child social competence, child behavior problems and adult and child perceptions of progress. Findings were reported as “highly promising” with early evidence showing consistent positive gains relative to program goals in a number of key areas. Among the areas cited as needing further attention by program managers were areas of services coordination, development of natural supports and in-home clinical interventions.

VIII. General Issues

A. Gaps and Barriers

A summary and review of key service needs and barriers to continued progress. cited by respondents are provided below:

- Fewer services are available for adolescents than for young children. Foster care homes have a history of limited success with adolescents, either because of difficulty in coping with behavior problems, or because the kids run away. Residential care is often inappropriate and when it is needed there are usually long waiting lists. Staff indicated a need for more in-home services, and pointed out that most if not all programs available now are geared- toward young children.

  Juvenile Services staff, in particular, report a serious shortage of options, particularly for status offenders. Private residential facilities are generally reluctant to accept these children; there is little therapeutic foster care available. Staff report a great need for more family based, in-home services, more timely access to mental health services and more appropriate **school** placements.

- Staff working with adoption cases find there is a great shortage of family therapists with expertise in working with adoptive families. The issues of grief and loss which must be addressed are not familiar territory to therapists accustomed to working with natural families. In particular, more behavioral therapists are needed.

- Crisis intervention staff report a shortage of services for chemical dependency which makes it difficult to keep children in and return them to the community. Individual therapists develop personal networks, but there is a paucity of resources available.

- Centralized administration of contract service providers by the state may inhibit quality control and development of needed services at the local level. The regional DSS offices have limited authority over providers since all contracts are set-up and monitored at the central office level. There is very little accountability imposed on private providers.

- The existence of a single approved Medicaid provider for mental health services, Seven Counties, may have limited development of a broader array of services.

- There is a shortage of available workers with adequate training and skills to provide more holistic, family-based services. In particular? poor training and high

turnover rates are a problem among child protection staff. Effective collaboration is not only dependent on leadership with shared goals and visions, it is also a human resource issue. There is a need for staff with specialized skills and the commitment and stamina to carry out the programs.

- Although a wide variety of services are available in the community, there are few intermediate or low-intensity level services available to assist children and families being discharged from the very intensive services provided by such programs as the Parent Resource Pool or the Impact Program.

B. Strengths and Innovative Features

Jefferson County represents a service area in which several child serving systems operate in tandem through the shared vision and mutual respect of key staff in multiple agencies and support from like-minded leadership in the state social services department. Staff interviewed characterize their relationships as working together in a spirit of collaboration, negotiation and working for children. Mission statements and program objectives are documented, but the impetus for movement toward integrating services comes less from formalized committees and agreements than from mutual trust and patience in working out problems and acceptable arrangements.

Some formalized processes do exist at various service levels and are described in earlier sections. Examples include the court liaison staff provided by Family Services and Seven Counties; the Regional Interagency Councils developed to help implement the Kentucky Impact program; interagency agreements between the Transitions program and other providers; and contractual agreements between service providers. Typically, however, these more formal structures have usually grown from informal efforts to address a particular issue or problem. The tiered interagency council structure mandated by the Impact legislation seems the closest thing to a formalized process for overall planning and policy development which currently exists. Staff acknowledge that this may be a potential model for working together around other issues; but caution that there must be continued opportunity for less structured interaction if innovation is to continue.

The basic mode of coordination, however, is through informal networking. This occurs at all levels: among caseworkers about specific service plans, among Family Services and Seven Counties administrators about program planning and implementation, and among leadership of all agencies included in this study around identifying needs and developing approaches to improving the overall service delivery system.

Attachment A

DEPARTMENT FOR SOCIAL SERVICES

JEFFERSON COUNTY DISTRICT

BONNIE BONNEICH
FAMILY SERVICES DISTRICT MANAGER

Renee Close - Adm. Secretary
Gloria Whetstone - Office Coordinator
Marilyn Kirkendall - Secretary Chief

Staff Assistant - Kathleen Gunderson
Receptionist - Melissa Roberts
Clerical Support - Brenda Forrest
FAMILY COURT SUPPORT WORKERS - 3
FAMILY COURT SECRETARY - 1
PARALEGAL - 3
CLERK CHIEF - 1

SUPPORT SERVICES SECTION
JOHN BARNISON/APSDM
BARBARA CAPPS/SECTION SECRETARY

FINANCE & BOOKKEEPING - 3

TRANSPORTATION.....1 - FSDS
..... 1 - SECRETARY
.*....a.....1 - JTC *
.....1 - JTAP
. ..*.**....*.1 - JTSA

5 - CHILDREN'S BENEFITS
3 - PSYCHOLOGISTS

6 - WORD PROCESSING
1 - TRAINING

1 - FOSTER CARE SPECIALIST
1 - INDEPENDENT LIVING

4 - GRANTS
2 - CRISIS IN SCHOOLS

CHILD PROTECTIVE SERVICES SECTION
LINDA TRAGER/APSDM
MARY SUE CARLE/SECTION SECRETARY
1 CPS PROTECTION SPECIALIST
2 COURT LIAISONS
1 - PSWC

CPS INTAKE & INVESTIGATION UNIT
MIKE MCFALL/PSPS
6 TEAMS

CPS ONGOING TREATMENT UNIT A
MARTHA CASTER/PSPS
5 TEAMS

CPS ONGOING TREATMENT UNIT B
ELEANOR RUTH ROBERS/PSPS
5 TEAMS

CPS ONGOING TREATMENT UNIT C
PAMELA REYNOLDS/PSPS
5 TEAMS

SPECIALIZED SERVICES SECTION
MARSHA ROBERTS-SLATTERY/APSDM
RITA BILES/SECTION SECRETARY
1 ADMINISTRATIVE ASSISTANT
1 - PSAS

JUVENILE SERVICES UNIT
JAMES BILLDERTE/PSPS
5 TEAMS

RECRUITMENT & CERTIFICATION UNIT
SYLVIA BERRY/PSPS
5 TEAMS

ADULT SERVICES/SPECIAL SERVICES UNIT
LINDA MURRAY/PSPS
7 TEAMS

FAMILY PRESERVATION/PERMANENCY PLANNING UNIT

DAVID PETERSON/PSPS
5 TEAMS

Family Options
A Jefferson County Family Health Care Initiative

Summary Description

Attached is a proposal from the Jefferson County Department for Social Services for a family assessment center, Family Options. Family Options will focus on reducing the costs of services to protective services (abused, neglected, dependent children and families) by reducing the fragmentation that currently plagues our service delivery system, by providing comprehensive family assessments that are linked to practical, outcome oriented treatment plans and by stressing costs and quality controls based on managed care principles.

To accomplish these things, Family Options will focus on:

- development of collaborative relationships with service providers
- empowerment of families and children
- use of non-traditional treatment modalities to reach families who don't respond to traditional approaches
- outreach to families
- expanded use of Medicaid as a financial resource.

Expected benefits of this program are as follows:

- increased ability to maintain families together
- improved assessment, diagnosis, and treatment
- decreased use of inappropriately restrictive treatment (including psychiatric hospitalization)
- increased use of family-based community resources
- reduced cost of services.

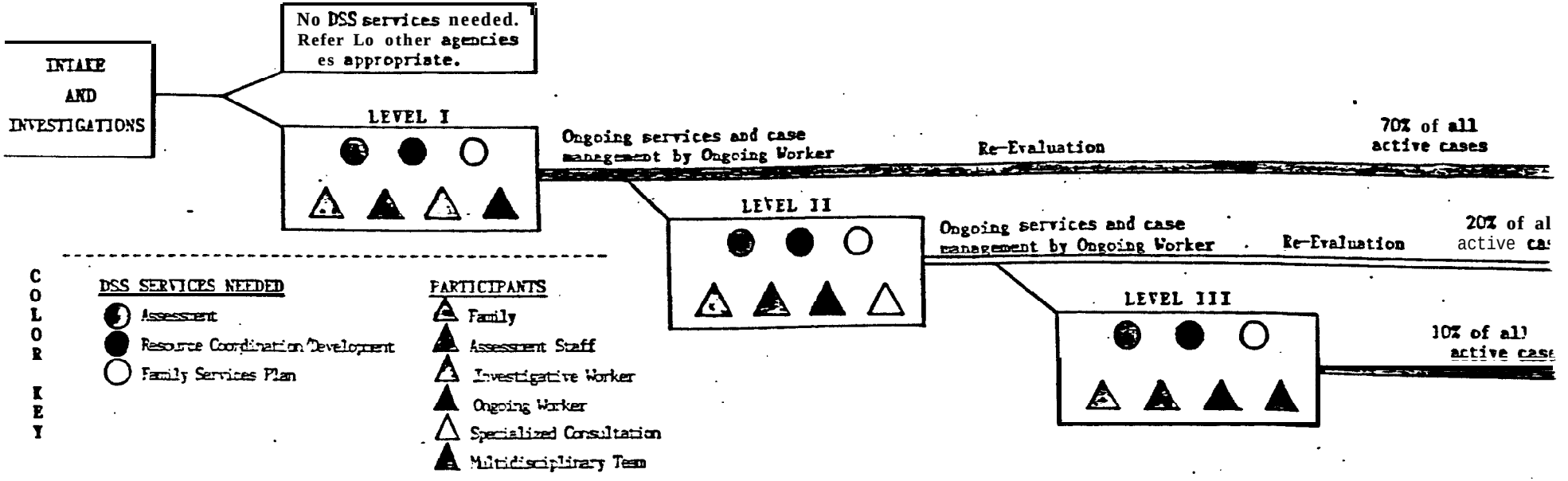
Participant Agencies

Jefferson County Department for Social Services
Jefferson County Health Department
Jefferson County Public Schools
Seven Counties Services, Inc.

FAMILY OPTIONS: AN INNOVATIVE INTERAGENCY RESPONSE FOR HIGH RISK FAMILIES

GOALS:

- Provide family-based assessments
- Provide outcome-driven treatment plans
- Provide services Eased on a family empowerment partnership model
- Preserve the integrity of the family while minimizing the need for out-of-home care and ensuring the safety. of the child
- Provide an integrated interagency response to DSS's most vulnerable families through training and joint consultation



INVESTIGATIONS

- DSS handles 80% CPS investigations locally.
- About 15-20 cases are at risk of removal from home: identified project staff refer these to Family Options Assessment staff.
- Each month 70-100 cases are open for ongoing services.

WILY OPTIONS ASSESSMENT STAFF

- Consult with DSS supervisors & staff on treatment planning and review.
- Conduct family assessments to identify needs, strengths, sources of support, treatment goals, and mosaic of needed services and special evaluations.
- Family Services Plan development with family and identified project staff.

SPECIALIZED EVALUATIONS

- Assessment staff accesses appropriate evaluations: neurological, psychological, behavioral, medical, developmental, educational, substance abuse, etc.
- Collaboration of family and worker on plan development.

MULTIDISCIPLINARY TEAM

- Reviews cases; assists in development and ongoing review of family services plan.
- Assists in development of resources.
- Acts as interagency liaison.

Site Visit Summary
Hennepin County, Minnesota

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Macro International Inc.

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Hennepin County, *Minnesota (population of more than 1,000,000) is the largest of the seven counties comprising the Twin Cities metropolitan area which is widely recognized for its tradition of quality public services, generous supply of capable social service providers, and history of leadership and responsiveness to community needs. A specialized family and children's mental health services division has been established within the umbrella of a broad community services agency which also includes child protection and child welfare, as well as other social services. Recent state legislation mandates mental health services for children and families. Early intervention services for preschool children are jointly provided by mental health and the schools, and the juvenile court has been active in promoting joint case planning and assessment procedures across systems.*

I. Introduction

Hennepin County is generally recognized as a locality with a tradition of quality public services, a generous supply of trained and capable social services providers, and a history of community leadership and responsiveness to community needs. In their study of social service agencies throughout the country, Kamerman and Kahn described the Hermepin County approach as an "enhanced child welfare delivery system" which offers much more than child protective services. The system is state-supervised and county administered. At the county level a Community Services Department within the Bureau of Social Services encompasses child protection, **family** services (formerly called child welfare), family and children's mental health (as well as separate mental health services for adults), developmental disabilities and chemical health, as well as services for the disabled and for seniors. A community resources division recruits and monitors foster and day care, emergency shelters and other special services.

Inclusion of Hermepin County among sites selected for this study contributes insight into a progressive and comprehensive approach to defining and meeting the needs of children in child welfare in an urban area with a population exceeding one million.

The Macro site visit team visited Minneapolis, Minnesota, (where **Hennepin** County offices are located) during the period of February 3 - 6, 1992. During the site visit we conducted discussions with key administrators within the county Community Services Department including the department director and directors of the children's mental health and child welfare related divisions within that department. In addition we held discussions with representatives of the court and school systems, advocates and providers from community agencies. Those interviewed include the following:

Hennepin County Community Services Department
Michael Weber, Director, Community Services Department
David Sanders, Manager, Family and Children's Mental Health Program
Dale Gartzke, FCMH Psychologist
Mike Sancilio, FCMH Psychologist
Kay Pitkin, FCMH psychologist
Darlene Sholtis, FCMH psychologist
Carol Miller, Manager, Early Childhood Services Unit
Jill Alverson, Manager, Service Delivery Contracts
Carol Ogren, Manager, Family Services Division
Karen Wahlund, Child Protection Division
Laura Linn's Child Protection Unit
Ummil-Kher Shabazz, Foster Parent
Connie Kirby, Foster Parent
Anita Davis, Supervisor, Unit of Licensing Social Workers

Hennepin County School System
Janet Proehl, Special Education Department, Minneapolis Public Schools

Hennepin County Juvenile Court
Judge Isabel Gomez, Presiding Juvenile Court Judge

Washburn Child Guidance Center
Carol Kaste, Director of Early Childhood programs
Dana Fox, Director of Outpatient, Day Treatment and Family Community Support

Family and Children's Services
Patti Larson, Attorney and Advocate

Early Childhood Providers Council Meeting
Miscellaneous community agency representatives

II. History of the Approach

Hennepin County's approach to providing mental health services to children has been evolving and was influenced by activities dating back to 1978. Prior to 1978, welfare and social services were combined in one agency and mental health, mental retardation, and chemical dependency (MHMRCD) were in a separate agency. The two agencies were very different in organizational style and operations. Welfare was an older, more established organization that had become very insular and "bureaucratic" in its mode of operating. MHMRCD was a newer organization and tended to be less traditional. At that time there was a strong rivalry between the two agencies, and very little impetus or interest in collaboration. Child welfare had its own psychologist consultant, and MHMRCD would not

serve "involuntary" clients. Moreover, within mental health, the focus was on adult mental health needs and very little attention or services were directed at the needs of children.

At the top agency levels, however, there was a growing recognition that the client populations served by the two agencies overlapped and an identified need to increase collaboration. A new department director was brought in to oversee a major reorganization which brought the two agencies together under a single department, the Community Services Department (CSD). Initially, although combined under a single administrative structure, the two groups still existed as separate divisions within CSD and resisted interaction and coordination of roles. Several events that took place in the early 80's precipitated a change in these relationships:

- In 1981, one of the department psychologists refused to testify in a Child Protection case because of client privacy. Eventually, the psychologist was subpoenaed. This situation brought to the forefront the need for policies that would ensure coordination and cooperation.

- In 1982, the McKnight Foundation (a local organization) announced that it wanted to do something for the community that would result in a major public policy change, and made a number of grants available. Mental health was one area of focus. CSD's mental health division developed a plan which focused on chronically ill adults, and circulated the plan among community advocacy groups and providers (as required by the Foundation). A clear message from the community was that the department's plan did not adequately address the needs of diverse ethnic groups. nor the needs of children.

- In 1984, in recognition of the need to better address issues surrounding sexual abuse, the department brought in an evaluation team from California to examine their approach. At that time, mental health services for children were provided through purchase of services from private providers. The evaluation study showed that almost all Child Protection referrals went to only 7 providers in the community. The initial concern was that special arrangements or "payoffs" were creating this situation; however, a closer examination of the situation revealed that there were very few private providers willing to take Child Protection children as clients, and few were experienced in dealing with sexual abuse issues.

These events prompted department leadership to advocate for a specialized program for children's mental health. However, the concept was met with opposition within the department staff. Underlying their response was a strong commitment to and historical pattern of working with adults, a resistance to someone from the "outside" telling them what to do, and the perception that confidential files would become available to anyone in Child Protection.

In 1985 a community task force was developed to examine the issues. The task force was comprised of CSD staff and representatives from a variety of community agencies, and spent about 6 months examining children's mental health needs and priorities. Department organizational issues were deliberately omitted from the task force agenda. Task force findings emphasized the need for a specialized program for children, expressed concern about the overuse of institutionalization and foster care, and identified the need for more outpatient care. Again these findings were representative of the concerns shared by leadership within CSD and the community, but were not widely accepted among mental health staff.

Around the same time, state-level interest in mental health issues and the need for reforms was building. The work of a special commission assembled by the governor stimulated passage of state mental health legislation in 1987; however, its focus was on adult issues. Later that year, state task forces were formed to draft legislation specific to children's mental health needs. Statewide hearings held to elicit the input of parents, resulting in identification of two key problems: 1) there was little consistency across providers-often parents had to take their children to several different providers before a diagnosis could be made; 2) there was no information transfer across providers and systems--at every point in the process, and with every contact made, parents had to repeat their story. The findings from these hearings culminated in the Minnesota Comprehensive Children's Mental Health Act (CCMHA) of 1989, which mandated specialized mental health services for children and families.

By 1989, a decade of community consensus-building coupled with statewide legislation made the movement toward specialized children's mental health services an accomplished fact. CSD leadership began the process of moving children's mental health services out of the existing mental health division and establishing a separate unit, the Family and Children's Mental Health division (FCMH), within CSD.

A children's mental health advisory council was established in the county, which includes parents as well as providers and advocates, along with a coordinating council for service providers and systems professionals. These bodies have initiated joint annual meetings and each has appointed a liaison to the other. Both meet monthly. The coordinating council is working on developing a formal interagency agreement for various county and other agencies.

III. Environmental/Contextual Issues

The Minneapolis area is characterized by a relatively stable population whose origin is largely Minnesotan or from other nearby mid-western states. Respondents describe the community as one that places a strong value on good and responsive government and has high expectations for social services to support the needy members of their community.

These values have enabled the county government to count on a strong tax-base to help support the broad array of social services that have been put into place there:

Efforts to enhance the approach to providing mental health services to children., and to establish stronger linkages between mental health and child welfare, have been supported by a broad base of involvement and commitment at the top level of. public agency administration-including the governor's office, the mayor's office, the chief judge, the chief of police, CSD, and education-as well as among private agencies and community providers.

While resistance of agency line staff did slow the momentum for change; sustained efforts by the community at large have prevailed. In order to bring about change, community leaders have been faced with addressing underlying philosophical differences in the approach to providing services, a history of antagonistic relationships, and fears of losing control over patient/client populations.

More comprehensive and focused services for children and families have been possible because of a tradition of broad-based community action and the leadership- and shared vision of public and private administrators. In particular, the Director of the Community Services Division has brought lengthy personal experience with the demands of improving integrated service delivery at national, state and county levels, as well as strong personal commitment to the needs of children and families. Mechanisms for coordination and interaction tend to be somewhat formal, involving committees and task groups composed of various community groups. However, the area is characterized by an openness to all levels of community input and a system of regular communication among advocates, agencies, providers and consumers.

IV. Overview of the Service Approach

Hennepin County has put into place a number of initiatives that address children's mental health needs ranging from early intervention to crisis intervention. Children in the child welfare system are not the only target population for these services, although they are a significant portion of those served, and often a priority population for service, Most of these efforts are under the direction of the Family and Children's Mental Health (FCMH) program within the Community Services Department (CSD). CSD is an umbrella agency which includes in addition to FCMH, adult mental health, developmental disabilities; chemical health; child protection; family services; services to seniors and services to the disabled. See Attachment A for the organizational chart. The site visit focused on operations of FCMH and the child protection and' family services divisions (the two "child welfare" components of CSD) and their linkages with FCMH in providing children's mental health services.

Other key players involved in providing and/or linking children to mental health services in Hennepin County include education, the juvenile court and an advocacy group. An overview of each of their roles is presented below.

A. Hennepin County Community Services Department

1. Family and Children's Mental Health (FCMH)

The expansion of FCMH from a unit within the mental health division to a division in its own right resulted in a doubling of staff size and greatly expanded the range of available services. FCMH has four operational units: early childhood services, a family and children's mental health center, family and children's case management, and family/ community support services.

Early Childhood Services. This unit focuses on high risk and handicapped preschoolers (up to age 6) and their families. Services available include the following:

- Early childhood day treatment-intervention and treatment for children displaying emotional disturbance and/or severe behavioral difficulties. Special education funds for early intervention are pooled with county FCMH funds to contract for needed services with two private providers. FCMH screens for entry, and administers the funds. In addition, medical assistance and sliding scale fees are used to help cover costs. The target population is children who cannot be served by public preschool special education programs because of their emotional/behavioral problems. Services include therapeutic preschool, individual/family counseling and therapy, adjunctive therapies (e.g., speech, occupational, etc.), and parenting education. Approximately 60 percent of the children served in these programs have had past or current involvement with Child Protection.

- Family focused therapeutic services-home-based, center-based, or a combination of both types of services to assist families improve their functioning level. The target population is children birth to age five and their families whose problems are not severe enough to warrant a day treatment program, but for whom some help is needed in improving parenting skills and parent-child interactions. A specific target population is families who are at high risk of abuse or neglect. Approximately 70 to 80 percent of the families served in this program have had past or current involvement with Child Protection For the most part these are single parent households, about 95 percent of whom receive AFDC support. In addition, alcohol and cocaine use are a significant problem.

FCMH uses county funds to contract with **eight** private providers, who supplement costs with their own fund-raising activities. Together, contract providers have a total capacity to serve about 300 to 350 children. The programs are multidisciplinary in approach, involving social work, early childhood education, nursing staff, and are based on individualized, flexible, client-centered service plans. Although home-based services are offered, these programs are not patterned after the homebuilders family preservation model. Most families served are in the program for at least 1 year, and may be involved in any combination of services including regular therapy sessions, home visits, parenting education, support groups, and developmental stimulation and preschool activities for the child.

- Respite care-center-based or in-home part-day respite services for families with children who have significant developmental delays, serious medical conditions or handicaps, and/or severe emotional or behavioral difficulties. FCMH contracts with two private providers for these services. The program is supported by parent fees and county funding Referrals come from screening teams in five school areas.

- Special needs day care-intended to meet the special needs of the family as part of a Child Protection, Family Services,. or Developmental Disabilities division case plan For the child to be eligible for day care, it must be considered necessary for the parent to attend therapy sessions or to complete treatment, and be included in the case plan. FCMH contracts with numerous mainstream day care providers (centers and family day care homes) for these services, some of which may also have specialized services (e.g., speech therapy, parenting groups, lower staff-to-child ratios).

Family and Children's Mental Health Center. FCMH operates a mental health clinic for children of all ages and their families which provides a full range of outpatient mental health services from assessments to therapeutic interventions. Staffing includes psychiatrists, social workers and psychologists. The clinic maintains a waiting list; however, priority populations for immediate assignment include any department referrals (primarily through Child Protection and Family Services) and court-ordered referrals. Eligible populations for service include individuals or families on medical assistance, as well as those not covered by private insurance or medical assistance. The center serves approximately **1,400 clients per year; 50 percent are also served** by Child Protection and 10 to 15 percent are also served by Family Services.

Several child protection field units have been assigned a consulting FCMH psychologist to help with assessments and smooth the working relationships.

Family and Children's Case Management. State law mandates that any child meeting state criteria for severe emotional disturbance must receive mental health case management services. Children served under Child Protection, Family Services or Developmental Disabilities identified as needing intensive mental health services are referred to the FCMH case management team who conducts a screening/assessment to determine eligibility. All children in residential care are automatically eligible for services.

When a child is also involved with Child Protection, managers from the two units meet regularly to discuss coordination. Responsibilities of the respective caseworkers are sorted out on an individual case basis.

Both FCMH and family services work primarily with "voluntary" clients and intake for the two divisions is on the same floor. A joint intake procedure is currently under consideration. At present, a single case manager is assigned to each child and family through consultation between the two divisions. Attachment C presents a flow chart of the referral process for children recommended for residential treatment. FCMH anticipates that this process will be a model for all referrals.

Family/Community Support Services. Services under this unit are focused on school-age children and their families and include day treatment, less intensive support services, and crisis intervention.

- Several day treatment programs are available through contract providers. For the most part, these are available to children meeting state SED criteria. In addition, children are sent by the courts. Children accepted into the program must have a long term problem which cannot be handled in the public schools or may be involved with the courts. Both FCMH and the schools screen for eligibility for SED children. Programs are funded through a variety of special education and county funds, as well as through private insurers, medical assistance, foundations and client fees.

- Wraparound services are provided to families whose needs do not warrant the intensity of day treatment, or those who may be on the waiting list for day treatment. Many children in the program have case managers. Services are provided after school and range from individual counseling to recreational activities to advocacy. The in-home component of the program may range from 1 day per week **4** days per week depending on the need. The duration of **services** is open ended and may be 3 months or longer. FCMH contracts with two private providers and works closely with the schools in identifying children for this program and supporting the program's costs. Services are written into the child's individualized education plan (IEP), and can be reimbursed 50 percent as a "related

service" through state special education funding. The county views its share of the cost of these services as a wise investment in forestalling more intensive and costly day treatment which would be required at a later date.

2. Child Protection

The child protection division includes 17 units; five for conducting intake and 12 ongoing units. Each unit includes about eight social workers and a supervisor, for a total of about 130 child protection workers. Reports of abuse and neglect are handled in the intake units by telephone screeners. If it is determined that the reported case constitutes maltreatment as defined by state law, the case is referred to the intake supervisor who assigns an intake worker. The intake worker investigates the allegations of abuse and if it is determined that maltreatment occurred, then the case is referred to one of the ongoing service units and a case plan is developed.

During 1991, approximately 2,750 calls were received by child protection telephone screeners. Of these almost 500 were assigned for assessment; about 150 were substantiated as involving maltreatment. Approximately 30 percent of cases referred to ongoing services are estimated to be reopenings, i.e., have been open cases within the past 7 years.

Although not a requirement for developing a case plan, psychological assessments are provided for most children over the age of five. These are generally sought because evaluations by caseworkers do not have sufficient credibility with the court, and because an assessment is usually necessary for entry into available services. Even so, there is a wide variation in the ability of workers to understand and effectively use psychological assessment in case planning.

Key triggers for assessments/evaluations tend to be the child's behavior and sexual abuse. At present, child protection uses private contract providers to conduct a large proportion of psychological assessments and to provide treatment. Often, providers are selected by geographic location and familiarity of the individual case worker, as well as whether the provider can and will testify in court. However FCMH services are being used increasingly. Staff report they are "very hopeful" that FCMH can help provide missing quality control over mental health services and increase the availability of good services. In particular, child protection views FCMH as a resource to help interpret and use psychological assessments. At present, child protection workers do not have a formalized working relationship with FCMH, but both units are working on this.

Although a broad range of mental health services is currently available to child protection workers through private providers, reimbursement of services through medical assistance is a significant issue. If a child is in out-of-home placement (about 60 percent of those in child protection) any needed services can be funded through medical assistance (Medicaid). However, if a child remains at home, it is necessary to use a designated HMO in the state's managed health care system. The priority among HMO providers, as seen by child protection workers, is generally screening out and limiting services rather than assuring that needed services are accessible.

For home-based services, child protection generally contracts directly with its own providers. Even though the Family Services division provides family preservation and other home-based services, child protection workers report it is extremely difficult to get family services to accept child protection cases. This is due, in part, to the difference in clientele: child protection families are involved "involuntarily" while family services requires "voluntary" participation by parents to be eligible for the program.

Among the gaps in service identified by child protection are family treatment for sexual abuse and services for children who are sent by the courts. The latter is a particularly acute problem. Many of the children seen in court have such severe behavior problems that foster homes and shelters cannot be found to take them. These children are physically or sexually aggressive, fire starters, and others. In addition, many are "runners" and will not stay in any place long enough to get help.

3. Family Services

Services provided by this division include adolescent parent services, adoption services, family support services, home team services, reunification/permanency services, and special services for refugee families and families with hearing impaired members.

This summary will focus on the home team services unit, which is the largest section within this division and has the most, relevance to this study. The home team unit provides home-based services using the family preservation/homebuilders model to families who voluntarily seek services.

The nature of the population served and the services provided have taken shape since 1984 when a new division director was appointed. Prior to 1984, the unit was referred to as "Child Welfare". However, the new director felt that there was no clear distinction between child welfare and child protection, and has moved toward specifying a clear role and target population. The reorganization

that occurred in 1984 involved cutting the division's caseload by 25 to 30 percent, and establishing priorities for those to be served and the types- of services to be offered. At present, services are provided to families for whom out-of-home placement would occur (because of the behavior of the child rather than for reasons of abuse by the parent) if an intervention was not provided. Families receiving home team services do so voluntarily, and the motivation of families to make a change is a key factor in determining who will be served.

Referrals come from the schools and from mental health professionals who think a family may be at risk of an out-of-home placement. There are three adolescent units and one unit for children under twelve, for which there is always a waiting list. Approximately 1,500 families a year are served with both "concrete" and therapeutic services. Family services staff are committed to the approach and cite savings of more than a million dollars: in residential placements during the first year of operations.

As noted, differences in basic eligibility criteria for services and operating style have made referrals between child protection and the home team infrequent. However, family services and FCMH staff share common criteria (both serve primarily "voluntary" clients), as well as former staff. Many FCMH case management staff came from family services originally. In addition, the FCMH manager joins regular family services staff meetings once a month to keep abreast of issues and activities.

B. Education

The Hennepin county school system encompasses 14 school districts, 13 of which are suburban Prior to 1986, special education was available to handicapped children age four and older. Since then, state legislation (in response to P.L. 99-457, Part H) has expanded these services to include children from birth through age three.

The Minneapolis Public School Special Education Department has the lead. role in a collaborative effort among CSD, Education and the Health Department to provide centralized intake and linkages to services for at-risk and handicapped children from birth to age 3 1/2 years. This program-348-TOTS-is located within the health department and is collaboratively funded by the three agencies. It is staffed by a team of four interagency facilitators who meet on a weekly basis to screen referrals, develop service plans, and coordinate the provision of services. See Attachment B for a flow chart of the major components and processes of this program.

The 348-TOTS program is an outgrowth of the efforts of the Minneapolis Early Learning Committee which began in 1983 as an informal group of public and private service providers concerned about the issues and needs related to early childhood

programs and services. In 1986, in anticipation of state legislation mandating services for handicapped 3 year olds, the committee organized annual community meetings and developed a collaborative interagency model. The committee became the official local early intervention committee mandated by state law in 1987, and was well positioned to respond to the 1988 state law mandating special education services for young children.

C. Juvenile Court

The juvenile court is comprised of two full-time judges, two part-time judges and five referees. The judges are appointed and serve rotating 3-year terms. The juvenile court serves two primary populations--juveniles (age 10 and older) entering through the corrections system (status offenders or delinquents), and children in need of protection or services (CHIPS).

Mental health evaluations are routinely conducted by court psychologists for children who enter the system for reasons of delinquency. The results of the evaluations, along with the results of a field study (child/family history), are used to help determine the case disposition.

Historically, the court system has operated in a closed and isolated fashion, rarely collaborating with other service systems. Recent changes in this orientation, however, have been instituted through the efforts of one of the full-time judges, Judge Isabel Gomez, who is now in her second year of the 3-year rotation. Specific observations that led Judge Gomez to explore changes include the following:

- As a result of mental health assessments ordered by the court, treatment is often part of the dispositional hearing and is seen as a punishment. Treatment options then become part of the negotiation process, and in the end the negotiated settlement does not always match the child's needs. This may occur either because the preferred treatment is not available and the court is still faced with "doing something" with the child, or because a "less punitive" alternative was negotiated by the attorney.

- The average age of children placed in residential treatment settings is 15 years. Half have been placed in therapeutic settings at least once before and most of these placements were the result of a court order.

- The court has often found it difficult to determine the child's needs because of the multiplicity of psychological assessment approaches and differing results.

- Many of the children seen in court have been in contact with child protection earlier.

The judge noted that in 15 years on the bench, only three cases involving death or harm to another involved individuals who did not have a history of child abuse. Further, statistics in the state show a striking increase in younger children in very major offense areas: arson, aggravated assault, criminal sexual conduct and homicide. Children under 13 commit more than half the sex offenses seen in court.

In trying to convert delinquent cases to child protection cases, the change in focus from child (the court's focus) to family (child protection's focus) is a significant issue. Placing a child under the jurisdiction of child protection provides leverage with the parents that the courts do not have when only the child's misconduct is being addressed However, because child protection focuses on the parents, the system may often harm the child. This may be especially so in cases where parents are chemically dependent, mentally ill or developmentally disabled.

In some cases, the courts have contracted directly with residential treatment facilities. However, if better relationships with child protection can be developed, children and families would have better access to home based services and the court would have more leverage with parents as well. Among the existing barriers to improved collaboration are the following:

- The county does not want more delinquent cases converted to child protection cases because of the difficulty of these cases and the demanding increased caseload they represent.

- There are large, and historically very significant, data privacy barriers in Minnesota in all systems: schools, courts, police. A court order was required for family services and the court to exchange records. Data privacy laws are very restrictive and carefully enforced. One result is "rampant" duplication of assessments.

- Funding and turf issues remain. The agency that has the funding contracts for the service.

In response to these concerns, a number of steps have been undertaken to strengthen collaboration among the various systems and establish a standard for ensuring that their actions do not harm the child. In particular, Judge Gomez sees a need to shift from short term placements to long term solutions. Current efforts include the following:

- Summit meetings are held for the most serious cases, including representatives from corrections, FCMH, parents, and CSD community resources (staff knowledgeable about all contracted providers available under CSD). These

meetings enhance the court's ability to ensure that the disposition better matches the child's needs.

- A court children's mental health subcommittee was established to examine issues around standardizing psychological assessments, determine who should be assessed and which system should conduct the assessment. While the standardized assessment procedure has been agreed upon by the court and FCMH, other issues are still being addressed. In addition, the courts are moving to conduct mental health assessments for all juvenile justice cases (not just delinquency cases).

- Efforts are under way at the state level to develop legislation that clearly identifies who must share records. This is envisioned as a means to overcome some of the confidentiality barriers being used as roadblocks to coordination. One model being explored is a similar effort in Oklahoma.

- A pilot project has been started with the Native American community to put together an action plan on how to get parents involved. This is seen by the court as a means to address its limitations in areas of cultural differences.

Court staff are concerned that the enhanced role that the court is adopting may be perceived by child protection and FCMH line staff as encroaching on their territory or responsibilities, with underlying fears that their recommendations will no longer be considered. Efforts to maintain open communication are seen as a way to help allay these concerns.

D. Child Advocacy

Family and Children's Services is a private provider that contracts with the county to provide services. In addition it has an active advocacy unit that is responsible for monitoring legislation and obtaining community input on key issues, as well as participating in developing procedures and agreements. Subject areas covered by each of the three advocates on staff include children's mental health; child abuse prevention and early intervention; and housing/homelessness and hunger. Key areas of interest are identified by routine surveys, focus groups and informational interviews held with community providers and clients.

A recent focus of the children's mental health advocacy unit has been on the issue of school truancy. Truancy is viewed as a symptom of underlying problems and represents a means to identify and address difficulties before they become more severe. Last year, approximately 1,500 citations of truancy were filed by the Minneapolis school system. Although state law allows a child to be absent only seven times without an excuse, and often the school will try to contact the family at that

point, it is not uncommon for the schools to wait until a child has been absent for as long as a month before filing a citation with the court. The court has not placed a priority on dealing with truancy citations, so often no action is taken. This situation is further complicated for children with unexcused absences who are under age 10. The court's stance is that these children are not truant because the absences are not of their own volition. It is possible for the courts to file petitions of educational neglect against the parents, but the court is unlikely to take such actions because of relatively low priority and lack of resources.

To respond to these concerns, a truancy committee was formed including representatives from education, corrections, CSD and providers. Initially, mental health issues were thought to underlie the truancy problem. However, with input from a wide range of community providers and agencies with first hand experience, it was determined that there were other issues of equal or greater influence. These include such problems as the lack of culturally appropriate teachers and curriculum; poor teacher-student relationships; and barriers related to school policies (e.g., early starting hours which prevented some families from getting children to school on time). The next step will be to elicit input from parents and children through focus groups which are planned to take place in the spring of 1992.

In the meantime, steps are being taken to bring cases of truancy into the court under CHIPS status rather than as a status offense. This would allow the courts to identify underlying problems within the context of the family, and gain access to the parents as a way to leverage their role and involvement in determining what actions will be taken.

The approach to identifying and responding to the issue of truancy typifies Hennepin County's approach of involving a broad base of community providers and agencies in identifying a problem and determining mutually acceptable approaches to addressing it.

V. System-Level Issues

A. Coordinating Mechanisms

Children's mental health services are coordinated with child welfare and child protection within CSD, as well as with efforts of other community agencies through both formal and informal mechanisms.

Within CSD, a number of coordinating activities are in place. FCMH was established to centralize children's mental health services and to enable the county to address children's issues as separate and distinct from adult mental health issues. The

division's role in coordinating access to services and in providing services is still evolving, Some specific efforts to build linkages within CSD include:

- Four units within the Child Protection division have been assigned a consultant psychologist from the FCMH outpatient clinic on a trial basis to help build working relationships between children's mental health and child protection. FCMH consultants attend the monthly unit meetings and are available on an as-needed basis for case consultation. In 1992, Child Protection consultation with FCMH psychologists will be mandated within the department.

- FCMH and the Family Services division are working together to improve and coordinate intake procedures. Staff of the two divisions met last year to review all incoming telephone calls and to assess their appropriateness to the division receiving them. They found that most FCMH calls belonged with mental health, and that many of the Family Services calls would benefit from a referral to FCMH. Family Services intake and FCMH are located on the same floor which facilitates coordination, in addition they are now developing a process for conducting joint intake and have included joint staff in the 1992 budget. The director of FCMH regularly attends the Family Services monthly meetings to maintain linkages between the two divisions.

There are also a number of mechanisms in place to facilitate coordination with various groups outside of CSD:

At the Department level

- A CSD representative participates in the Minneapolis Early Learning Committee, which includes representation from education, public health, advocates and other providers as well.

- The legislatively mandated Children's Mental Health Advisory Council includes a CSD representative, as well as parents and members of other community agencies.

At the FCMH division level

- FCMH case workers are assigned to the 348-TOTS central intake team for the collaborative early childhood program;

- Two psychologists from the FCMH outpatient clinic provide onsite consultation to two different school districts. Their roles are loosely defined and can be shaped to meet the particular needs of the school. Specific activities have included case consultation with school social worker(s) and teaching staff of the

EBD (emotionally/behaviorally disturbed) program, leading support groups, and individual/family counseling;

- The FCMH Early Childhood unit hosts and provides staff support to the Early Childhood Providers Council, a group comprised of private agencies and contract providers who meet monthly to share ideas, discuss issues and coordinate activities;

- FCMH participated in recent efforts to develop joint assessment procedures with the juvenile court, and participates in a joint screening committee including the court, FCMH and Child Protection;

- FCMH staff participate in the legislatively mandated county coordinating council for children's mental health, designed to function as a service delivery complement to the policy and planning activities of the Advisory Council. The coordinating council is comprised of local service system professionals. A current activity involves developing a protocol for interagency agreements. Both advisory and coordinating councils meet monthly, and each has a liaison representative to the other. A joint meeting is held on an annual basis.

In addition, DCS and FCMH staff are involved in a variety of ad hoc consultations and working groups with other community providers around specific issues. For example, FCMH staff are involved in the truancy committee convened by the advocacy unit at Family and Children's Services (a private agency).

B. Goals/Definitions of Success

The concepts of community based and family centered services are central to both the overall stated mission of the Department (attached) and the children's mental health program implemented through FCMH and other Department divisions.

A 1991 report on children's mental health reform in Minnesota, prepared by investigators at the University of Kansas Beach Center, found that strong state legislative support for a community based philosophy has been actively incorporated into Hennepin County programs and activities. The study cites elements of the Hennepin County's own mental health plan as well as noting its strong record of "reasonable efforts" to maintain children in families under permanency planning efforts and its intention (at that time) to create a children's mental unit. Major factors identified in the study as contributing to the county's strong commitment include dedication of top-level administrators, active family advocacy groups and county taxes that enable provision of services beyond those funded by the state.

The lengthy process of developing community consensus and building a broad-based constituency for children's mental health reform, including parents and advocates, was described earlier in the section on history of the program. This operating style continues to be evident in the implementation of CSD/FCMH programs and in the problem identification and problem solving processes used by community agencies visited for this study.

C. Definition of Eligible Population and Client

FCMH serves children of all ages; however, eligibility criteria for various programs vary. For the most part, services are targeted to children meeting the state definition of SED (attached), or at risk of SED. Among divisions within CSD, there is some disagreement about how inclusive this definition is. FCMH staff view the criteria for service as very broad, and consider it fairly easy for children with mental health needs to gain access to their programs. Outside of FCMH, some respondents hold the perception that only the most severe cases are eligible for services. FCMH is working on building linkages with other divisions within CSD and hopes to clarify their role and eligibility criteria.

While the child is considered the client for FCMH services, most of the programs that have been put into place during FCMH's 2 years of operation have components that address the child's needs within the context of the family and attempt to deal with family functioning issues. This is consistent with both the Department mission statement and with county mental health and child welfare reform initiatives.

Differing definitions of "client" and "eligible population" were a source of earlier tensions between mental health and child protection staff. Two key distinctions were identified:

- Clients served by the mental health division are primarily voluntary clients although children sent by the courts and wards of the state are also served. Clients served by child protection are primarily involuntary. This results in differing relationships with clients and families. Historically, mental health providers have served primarily those who seek services.

- The child is the focus of traditional mental health services, while for child protection the family (and often the parent) is the focus. Two key roles of child protection are to protect the child from abuse and neglect and work toward providing the child with a permanent home-preferably with the child's natural parent(s). Concerns about serving the child vs. maintaining the family were seen as issues in working together.

Key respondents feel that some of these tensions between FCMH and Child Protection are waning, and that an understanding between the two divisions is building While the issue of "voluntary vs. involuntary" clients also exists between the Family Services division and the Child Protection division, FCMH and Family Services have more overlap in the types of populations served and in their definitions of client.

Differing definitions of client and service orientation also cross other service systems. When children are brought in under the juvenile justice system, the focus is on the child's behavior. In these cases, the courts have no authority to address the underlying problems of the child and family that lead to the behavior that brought the child into the system. One response to this has been efforts by the court to convert juvenile justice cases to CHIPS cases by bringing them in under the child protection- system, allowing the courts more leverage in dealing with parents. A danger in this approach may be a reversal in emphasis from child to family, rather than the more comprehensive effort intended. This has been of particular concern where parents are chemically dependent, mentally ill or developmentally disabled. In these cases, staff may tend to focus on getting help for the parents (who are often considered "blameless" because of their condition) and feel that treatment will. fix the family's problems.

CSD is not always supportive of the court's efforts to convert delinquency cases to CHIPS cases because of the added responsibility and complexity of issues and severity of problems these children pose. Funding is not the issue, because all out-of-home placements are paid for by CSD regardless of whether they are juvenile- justice or CHIPS cases.

D. Funding Issues

The projected 1992 budget for FCMH services is just over $14 million, with a projected full-time staff of 45. About three-quarters of the division's funding comes from county tax dollars, 12.6 percent from the state (induding a block grant and the family community support services grant), 10.3 percent from a federal block grant, and 2.4 percent from insurance, client fees and other sources.

The majority of the county share of funding goes toward contracted services. CSD pays for all out-of-home care whether accessed by CSD divisions or juvenile justice. Client services provided under FCMH are covered by a combination of private insurance, medical assistance, sliding-scale client fees, and county funding as the payer of last resort.

Two years ago the state medical assistance program (Medicaid) went to a managed health care system. Under this system, persons eligible for medical assistance must obtain health care from one of three health maintenance organizations (HMOs), one

of which is operated by the county. Two populations exempted from this requirement are children in foster care and SSI recipients. Both of these populations are covered under general medical assistance and are not required to use the HMOs. Mental health services are covered under the HMOs; however, a number of issues were raised by respondents about the extent and appropriateness of mental health care available to CSD clients.

- The HMOs won't always cover the recommended services; they have an incentive to screen out services to limit costs which sometimes means they won't cover ongoing therapy. In addition, when the HMO does not offer the needed service, or have the appropriate professionals on staff, they are reluctant to contract out for the services.

- An interrelated problem is that often the HMO's limit the length of time a service or therapy is covered--for example, the chemical dependency programs base their service approach on a 6-month plan of care, but the HMO's will only cover 3 months of care.

- HMO's will only cover services requested by the clients (or parents), they will not cover court ordered services or services recommended by child protection.

- Service providers report that HMO staff are not well equipped to deal with cultural diversity and with the multiple problems typical of this client population.

In general, respondents feel that the County run HMO has been more responsive to these issues and there are fewer complaints about their coverage and services. The County has put a trouble shooter in place to address issues and problems that arise, and several respondents indicated that the situation is improving.

One perspective is that the HMOs will serve a valuable role in challenging unproven treatment assumptions. Often the length of time a service is offered may be a matter of tradition rather than a tested and proven practice. If providers can document the effectiveness of their approach than they are likely to be able to get it covered, otherwise, in some instances the shorter length of treatment may be all that is necessary.

VI. Service Delivery Issues

A. Staffing Issues

1. Supply of Trained Personnel

The administrators of the various divisions within CSD indicated that well trained social work staff are available and most of their social worker positions are filled by masters level personnel. The County pay scale is competitive and in fact is generally higher than the private sector; however private sector providers typically have smaller caseloads. Schools offer the highest pay scale for social workers, along with a 9-month work year. Private providers are concerned that with level funding, or potentially decreased funding, they will lose staff to the schools and will not be able to keep good staff.

CSD has experienced a great deal of stability in staffing, in fact, some child protection administrators indicated that somewhat more turnover in staff would be desirable because new staff bring in new ideas and perspectives. Of the line staff in the Child Protection unit with whom we met, several had been with the department for 5 or more years.

Some concern was expressed about the dearth of private mental health providers familiar with and capable of dealing with the multiple and complex need of children in child welfare, as well as those who are willing to take medical assistance payments. Several respondents indicated that often the type of assessment conducted and the resulting diagnosis differed depending on the provider. As described earlier in this report, many respondents also expressed concern about the lack of culturally appropriate and sensitive mental health providers in the HMO system.

2. Treatment Approaches and Training

Respondents at all levels spoke of issues related to the different perspectives held by mental health and child welfare-related staff. As mentioned earlier, a key issue in improving mental health service delivery for children was the differing definitions of "client" and issues surrounding approaches *to* serving voluntary populations versus involuntary populations. Interviewees also spoke of differences in terminology, rules, and structure. Some examples of these issues articulated by respondents include:

- The use of highly technical clinical terminology that is not always understood by the caseworkers.

- The longstanding professional standards of upholding client privacy among mental health providers versus the need to share information with child protection workers and the courts to ensure that client's needs for services are met.

Although all CSD staff go through orientation, and FCMH staff participate in this training as well as training for foster parents, many of these perceptions and issues have persisted. FCMH and Child Protection staff felt that various consultant relationships among divisions are helping to resolve remaining differences. FCMH staff indicated that during their first several meetings with the child protection unit workers, much of the focus was on clarifying roles, terminology and processes for referral. Now the meetings focus more on case consultation and working together to address specific client's needs. Respondents also felt that a side benefit of the county's Child Mental Health Advisory Committee is the contribution of shared knowledge and perspectives across professions and systems.

It is clear that some of the long-term foster parents have taken on a para-professional role, and through experience have become skilled at recognizing the need for mental health services among the children under their care and at finding ways to access the system to obtain services. One foster parent indicated that she was provided very little training in this respect, but had learned much in her years with the system. This parent stressed her own view of her role as an advocate for the child, to help assure that child protection workers did not submerge or ignore the needs of the child in their efforts to maintain the family.

B. Case Planning and Approaches to Meeting Multiple Needs

Children with multiple service needs are likely to have multiple case plans depending upon the systems with which they have come into contact. If a child is under child protection supervision the caseworker prepares a case plan. If the child has come into contact with the courts there will be a court-prepared case plan. And if the child is in need of special education services, an educational plan (IEP) is developed. Providers and staff within CSD recognize this as a problem; however, to some extent legislative mandates have created this situation.

An ambitious effort is underway in the FCMH's early childhood unit to develop a protocol for case plans for the 368-TOTS program that will follow Federal guidelines for the Individualized Family Service Plan (IFSP), and that will incorporate case plans from the various systems involved.

FCMH is currently working out procedures with Child Protection and Family Services for transferring case planning responsibility when a child is determined eligible for

receiving FCMH case management services, to avoid duplication of efforts within CSD.

The issue of confidentiality has been identified as a barrier to coordinating services and case plans across systems; however, some respondents feel that often these are artificial barriers which mask staff resistance. As discussed earlier, one of the juvenile court judges is currently working on legislation that will clearly identify who must share information, with provisions to ensure data privacy.

C. Caseload Issues

The average caseload for child protection workers is around 20 children; however, since they deal with the family, the number of individuals is higher. Workers report that their caseload size and the complexity of problems typical of the families in their caseload limits their ability to address all issues that a child and family may bring, and forces them to focus only on the most serious issues. Mental health assessments and services are sought only when a child's behavior indicates this need, or if the child has been sexually abused. If a child in foster care or receiving in-home services does not outwardly exhibit behavioral problems, then services are unlikely to be pursued. As one case worker put it "trying to link kids who may just be in need of self-esteem building would be icing on the cake," and went on to say that the more severe cases take up too much of her time to be able to fit these issues into her case plan

Family Services workers case loads average about nine families. With reorientation to intensive in-home family preservation services, the current division director moved to decrease caseload size. The differences in caseload size is a source of tension among child protection workers, who feel that their caseloads are far more complex than families who seek services voluntarily.

The FCMH case loads for SED case managers are typically 12 to 15 children. An individual therapist may see 75 children (and their families) in a year. FCMH staff feel that caseload size for their services and those provided by contract are reasonable and do not unduly affect case workers ability to provide services.

VII. Oversight and Feedback

Although there is no systematic department-wide effort currently in place to evaluate the approach to consolidating and enhancing children's mental health services, a number of outcome and process measures are monitored by different programs. Some examples are described below:

- The FCMH Early 'Childhood Unit is tracking who is coming into their system, why they are in need of services and where they are referred. Staff report that the incidence of abuse and neglect among the populations they serve is going down, and are currently in the process of determining additional means of measuring the impact of their services.

  In the family-focused unit of the early childhood program, staff plan to use indicators developed by the Child Welfare League of America (CWLA) for intake and discharge points, and will follow up with families at a predetermined time interval (e.g., 6 months to a year) after discharge.

  For the early childhood day treatment program, staff are tracking the age at which clients come into the service and the age at which needs are being identified.

  For early childhood programs as a whole, existing data indicate that problems are being identified and dealt with at earlier ages than before. Staff note it is now unusual for a child with emotional or behavioral difficulties to reach age four without having been identified earlier. Further, out of home placements are dropping, indicating that early intervention may be helping keep children out of later placements.

- Family Services tracks the rate of cases that need to be re-opened (20 percent, which is considered acceptable because families are encouraged to come back if in need) and the number of children that end up in foster care placement (8 to 10 percent).

VIII. General Issues

A. Gaps and Barriers

A summary and review of key service needs and barriers to continued progress cited by respondents are provided below:

- The Minnesota medical assistance system (reimbursement through the Medicaid program) is a source of concern among many staff interviewed for this study. Medical assistance must be obtained through use of an approved Health Maintenance Organization if a child remains with his or her family. As seen by child protection workers and foster parents, the HMO priority is on screening and limiting services, rather than making access easier. In addition, HMO providers generally have little expertise in child sexual abuse and related issues, or with the cultural diversity and multiple problems characteristic of families served by the Department. An alternate view held by some respondents is that the HMOs will serve a valuable role in challenging standard, but unproven, treatment assumptions and will result in more efficient delivery of services.

- Concerns about the lack of cultural competence are also expressed about private providers in general. The pool of available mental health providers is seen as "too middle class" and as often having expectations for families which are unrealistic and based on creating "optimal" conditions, rather than helping kids and families cope with the realities of their lives.

- There are large, and historically very significant, data privacy barriers in Minnesota in all systems: schools, courts, social services. Data privacy laws are very restrictive and carefully enforced. This results, among other things, in extensive duplication of assessments. Sharing information among caseworkers in different systems is difficult and rare; a court order was recently required to allow family services and the courts to exchange records.

- Differing definitions of clients and criteria for service continue to slow cooperative activities among mental health, child protection and family preservation workers. The perception of "voluntary vs. involuntary" participation of families is a key difference, as is the continuing issue of "protecting the child" vs. "preserving the family." Operationally, child protection workers. have larger and more difficult caseloads than either mental health or family preservation staff, without the benefit of agreement by families to participate.

- Children over the age of 10, who are seen by the courts, are a population in dire need of services. Various program staff noted that chronic "runners" are especially difficult to serve. "Locked beds" (not children's prisons) are badly needed. Adolescent girls are another population specifically identified as needing services which are largely unavailable.

- A related issue is the reluctance of Child Protection to accept responsibility for delinquency cases due to the difficulty of these cases and the demanding increase in caseload they represent. Placing a child with child protection is seen by the courts as a way to access a wider range of services, including home-based services, as well as providing the court with more leverage over parents.

- Early intervention and transition programs for school-age children are an important missing piece. Collaboration between children's mental health and the school system have resulted in a number of programs and services for children birth through age five. However, little is available once a child enters elementary school.

- Due to legislated program requirements and data privacy concerns, children with multiple service needs are likely to have multiple case plans depending on the systems with which they have had contact.

B. Strengths and Innovative Features

As noted in the introductory section of this report, Hennepin County is recognized for its progressive and comprehensive approach to providing social services to children and families. Kamerman and Kahn note that Hennepin has "clearly resisted a national trend in which the need to develop an effective response to abuse/neglect led to a taking over of child welfare by a constricted CPSP Child protection, family services (i.e., additional child welfare services including family preservation) and mental health services specifically for children and families co-exist as separate divisions within one county department and are actively developing consultative and more formal referral arrangements among them.

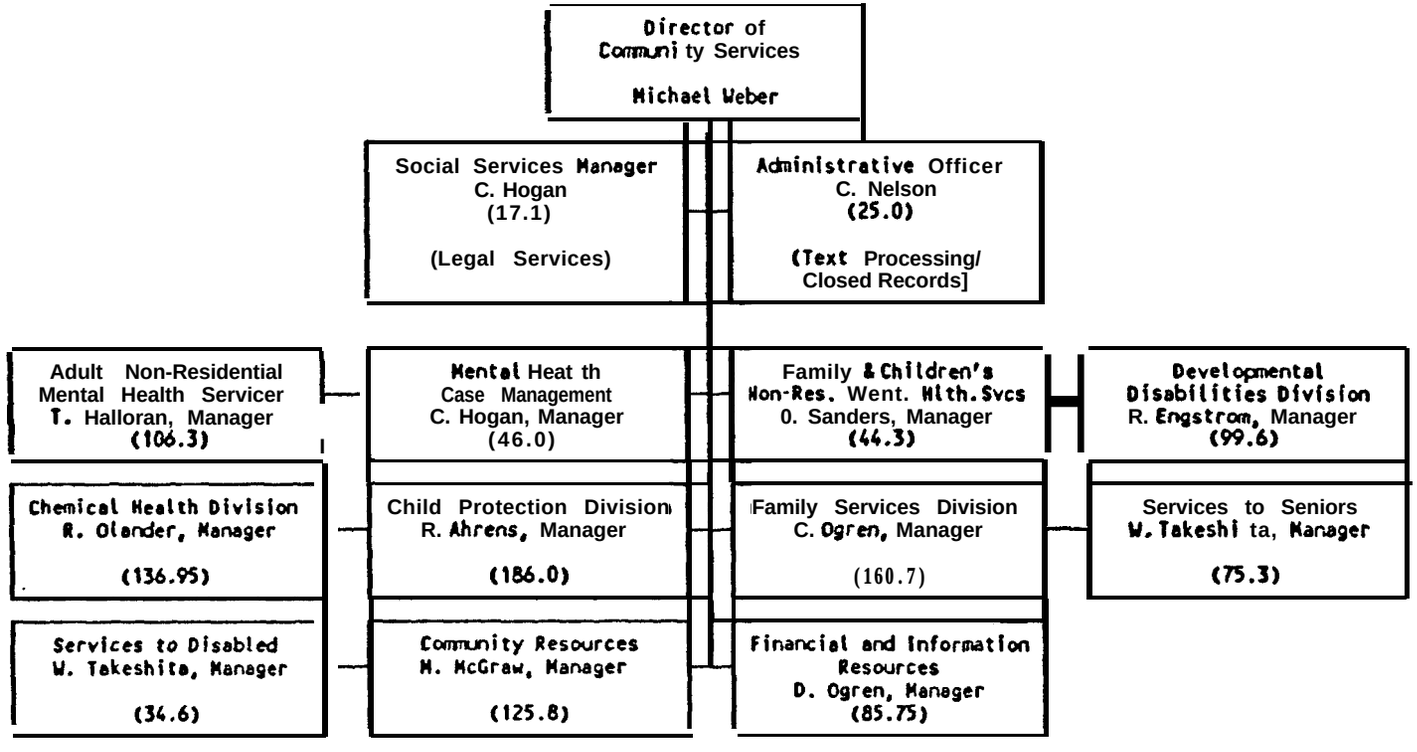
Of particular note is the recent institution of a "categorical" family and children's mental health division (FCMH), separate from general mental health services provided by another division which addresses adult needs. FCMH division provides a focus for services and a resource for other divisions; however, children in Hermepin County can receive mental health services through child protection and family services as well.

The community at large has a tradition of broad-based consensus building in identifying and developing approaches to community problems which actively seeks to involve both provider and consumers in the process. Formal and informal coordinating mechanisms are evident across a variety of agencies and programs. Linkages between social services and the school system are particularly strong in the area of early childhood intervention and services. Joint efforts with the courts to improve procedures (i.e., joint assessments) as well as address larger problems (i.e. summit meetings around specific cases) are under way.

Attachment A

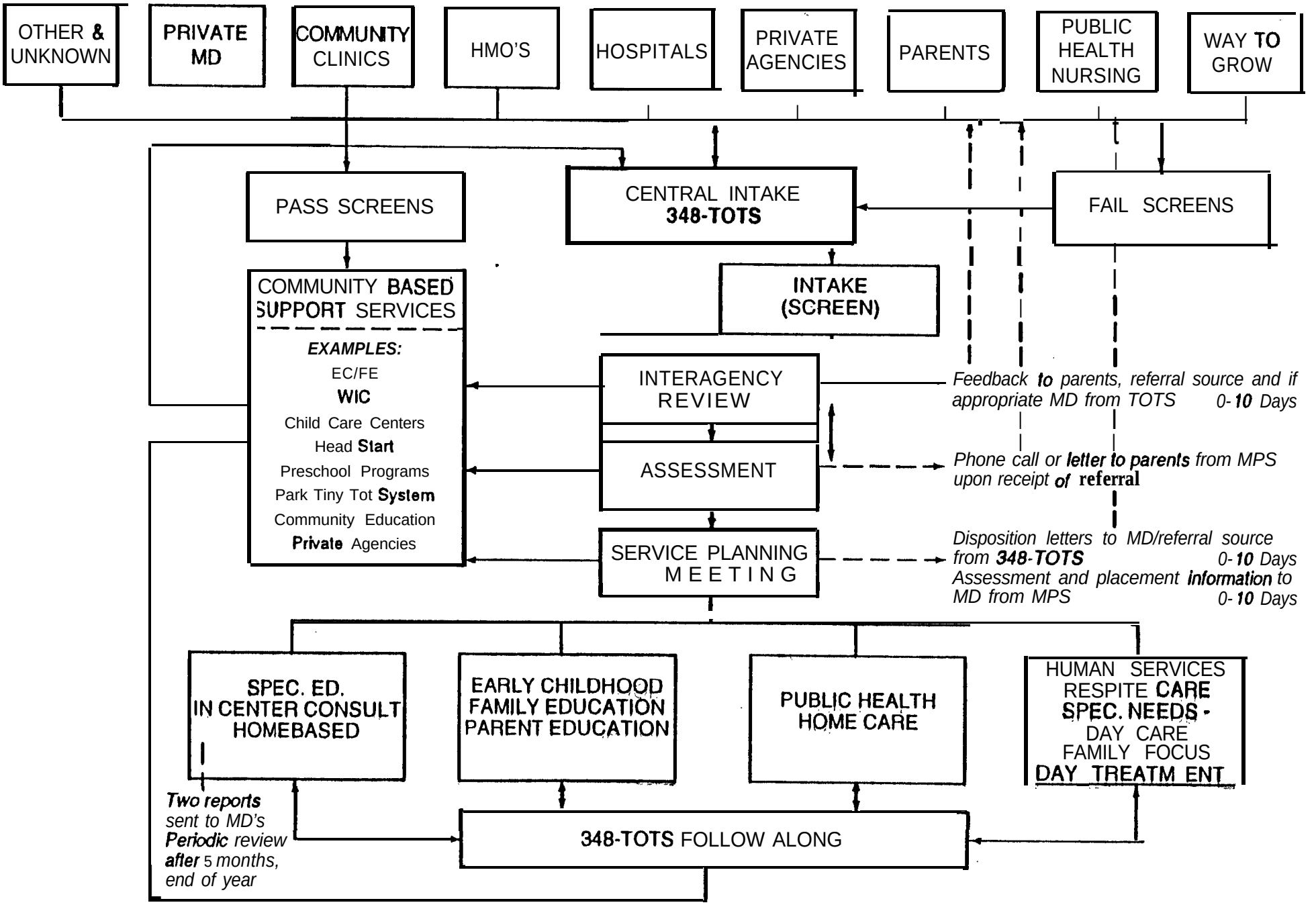
Camni ty Services Department
Overvieu
4/6/91PCN Report

CS Staffing Total: 1,144.7
This Page: 1.0

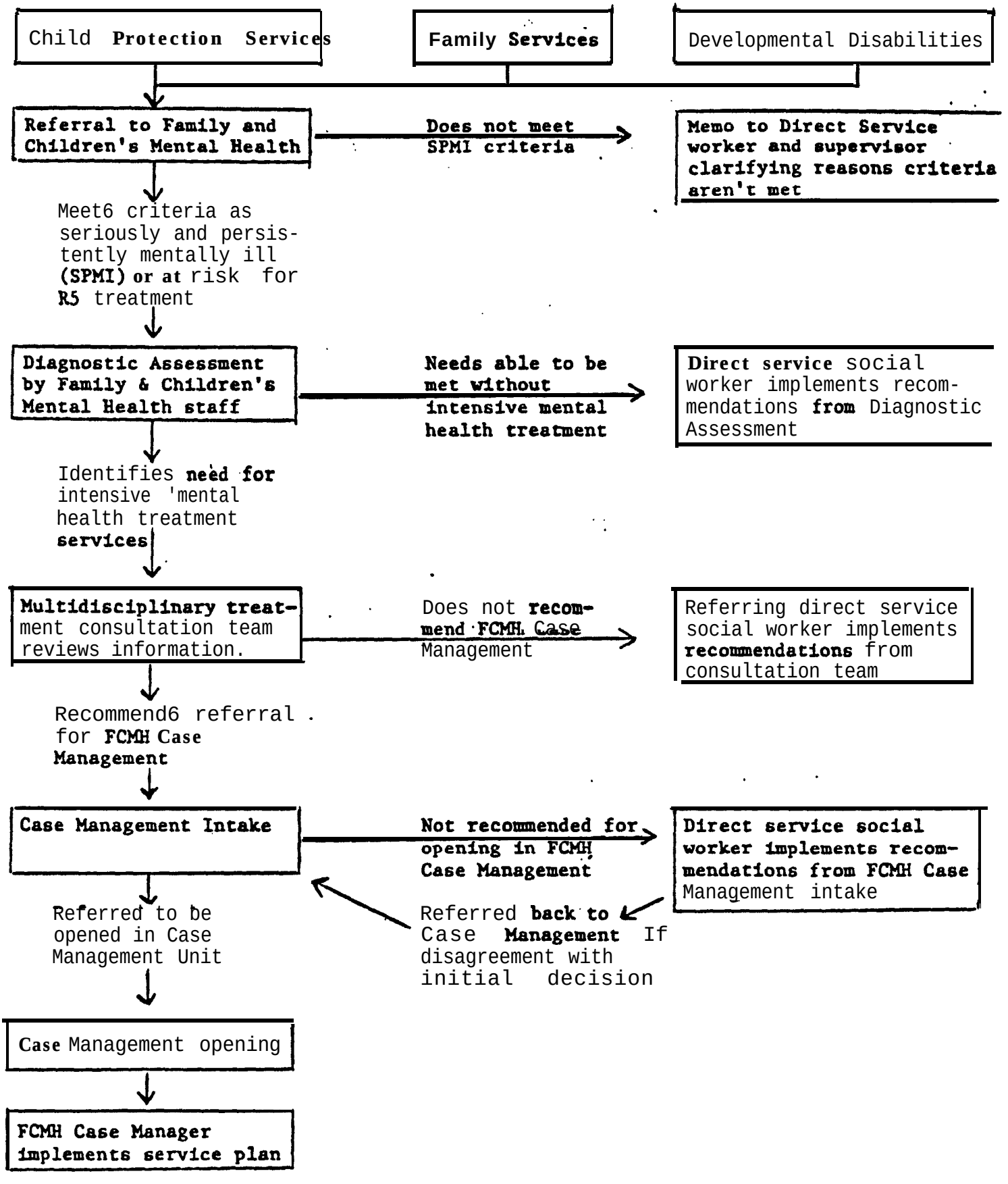


Attachment B

Minneapolis Early Intervention System
For High Risk/Handicapped 0 to 3 Year Old Children
(all time units are school days)



REFERRAL PROCESS
COMMUNITY SERVICES DEPARTMENTS REFERRALS FOR CHILDREN RECOMMENDED FOR RESIDENTIAL TREATMENT



Referring social worker6 are an integral part of our decision making process and are welcome as full participants at each step.

Site Visit Summary
Chicago, Illinois

Prepared by:

Macro International Inc.

June 30, 1992

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Chicago, Illinois provides the perspective of a major city with its complexity of agencies, economic problems and heavy demand for social services. Child-serving systems operate under separate administrative structures at different levels. Child welfare and mental health are administered by the state, with varying regional structures affecting Chicago and Cook County Services. The Chicago Board of Education is administratively responsible for schools, however individual schools have a high degree of autonomy, as well as local advisory councils. The juvenile courts are pan of the Cook County system, which also has its own service delivery structure. Consent decrees issued by the courts, and new leadership in both state child welfare and mental health agencies, have stimulated efforts to improve coordination

I. Introduction

Illinois' child welfare and juvenile justice systems have been besieged by public scrutiny and criticism over the last several years. It is well known that the child welfare system is overwhelmed and underfunded which has led to a poorly operating system accused of being unable to provide for the children under its supervision the very thing for which they have been removed from their homes-a safe, nurturing environment. Events revealing the system's inadequacies have culminated in a far-reaching consent decree that addresses all aspects of the child welfare system. Similarly, the Cook County juvenile court system--which holds the distinction of being the first in the Nation to recognize the need to separate juveniles from adults in handling law enforcement and protection issues and was once touted as an exemplary model to follow--is now widely criticized and has become less and less capable of handling the ever-growing caseloads. A recently initiated project sponsored by the MacArthur Foundation and the Northwestern University School of Law has the ambitious goal of developing and implementing a plan to transform the floundering Juvenile Court of Cook County into an effective center for the legal representation of children and a model of juvenile justice for the Nation. Overlaid on this environment of two intertwined systems in a state of crisis and change, are efforts at the state level to improve relations between child welfare and mental health and put into place a more comprehensive system of care for the severely emotionally disturbed (SED) population, as well as efforts at community level to carve out roles and responsibilities among private service providers and caseworkers in the child welfare system.

In Illinois, child welfare is centralized at the state level in the Department of Children and Family Services (DCFS), and administered regionally. State DCFS offices are located in Springfield. The regional office in Chicago has responsibility for Cook County, and currently provides supervision for nearly 25,000 children, which represents about 60 percent of the total number of children under DCFS supervision statewide, and a doubling of

caseload in the last 3 years. The ethnic composition of Chicago's child welfare caseload is overwhelmingly African-American (82 percent) as compared to only 11 percent Caucasian and 5 percent Hispanic.

Chicago was selected for site visit to bring to the study the perspective of a very large urban area. It represents a system in a state of flux and in the early stages of development vis-a-vis addressing the mental health needs of children in the child welfare system. Chicago highlights the particular barriers to coordination that are present in any large urban area, especially one that is highly segmented and territorial in nature. Because of the size of Chicago and the vast number of service providers, and because service approaches take on different characteristics in different sections of the city, we focused our site visit on the service system in place in the northside area of the city. While we obtained general information on state-level factors and the county-level service system configuration and issues, we concentrated on these aspects as they related to operations of key providers in the northside area.

The Macro site visit team visited Chicago April 13 - 15, 1992. During the site visit we conducted discussions with key administrators within the DCFS Cook County offices and DMHDD offices, a supervisor in the probation section of the juvenile court responsible for the northside area of the city, and key private providers serving the northside area of the city. In addition, interviews were conducted with department directors at the state administrative offices in Springfield Illinois around the same time period by another team member. Those interviewed included:

Department of Children and Family Services
Sue Suter, Director
Jeff Buhrmann, Administrator of the Office of Interagency Coordination
Glynne Gervais, Resources Administrator, Cook County Operations
Jack Targonski, Contracts/Grants, Cook County Operations
Jennie Perkins, Assistant Regional Administrator of the West Region
Carlton Williams, Regional Administrator of the North Region

Department of Mental Health and Developmental Disabilities
Jess McDonald, Director
Lorene Cameron, Bureau of Child and Adolescent Support Services

Juvenile Court of Cook County
Walter Bradford, Juvenile Court Probation Department

Community Counseling Centers of Chicago
Anthony Kopera, Executive Director
Joanne May, Associate Director
Viviane Ploper, Acting Program Director, Child and Family Counseling Center

Chet Edwards, HomeFirst Unit Manager
Evaristo Ruiz, Supervisor, HomeFirst II

Columbus/Maryville Shelter
Sister Honora McNichols, Program Director

Doyle Center
Cliff Kaspar, Director

Pathways Schools and Treatment Center
Paul Deutch, Director

Hull House Headstart Center
Elyne Handler, Director
Linda Johnson, Assistant to the Director

Chicago Department of Human Services, Division of Children and Youth
Norman Galloway, Northside Coordinator of Onsite Services for Headstart Children

II. History of the Approach to Providing Children's Mental Health Services

The ability to link children in child welfare with mental health services in Cook County is strongly influenced by state-level issues and developments. Historically children's mental health services at the state level have had little priority and have taken a backseat to adult mental health services. Limited resources coupled with funding restrictions that earmark facilities and services to adults have left children's services with a very small portion of the budget. As a result DCFS has been used as a "back door" to children's mental health services. In the absence of services and with no other options available, some families relinquished custody of their children because they no longer felt able to handle them. Once under state supervision, DCFS was responsible for accessing mental health services for these children. Several events taking place over the last 15 years have led to an increased focus on children's mental health issues:

- DMI-IDD and DCFS were both part of a consent decree dating back to the 1970's that addressed the population of children who have been hospitalized and processes to ensure that they are served in the least restrictive setting. The decree focuses on approaches to keep children out of hospital settings if possible, and for those who are hospitalized, processes for discharge planning. The decree outlines the roles of child welfare and mental health, and has gone through several revisions over the years.

- In 1985 the Residential Services Authority (RSA) was created to identify problems, make recommendations about programs and services for severely emotionally disturbed students, and develop a dispute resolution process to be followed when there

is disagreement about the need for residential placement or who is responsible for funding the placement. Participants include representatives from the Attorney General's Office, Governor's Purchased Care Review Board, Governor appointees, Elementary and Secondary Education Committees of the State Legislature, Department of Alcoholism and Substance Abuse (DASA), DCFS, Department of Corrections, DMHDD, Department of Public Aid, DPH, Department of Rehabilitative Services, and State Board of Education.

- In 1987 the office for Children and Adolescents was established as a division within DMHDD in response to provider pressure and the growing recognition that greater priority needed to be placed on children's mental health and that the issues for this population are different than those for the adult population. Prior to this, children's mental health issues were handled by the Institute for Juvenile Research.

- In 1989 DMHDD submitted a mental health plan for children and adolescents outlining the state's approach to addressing the mental health needs of children and adolescents with severe emotional disturbances. This plan grew out of a comprehensive study conducted by the Chapin Hall Center for Children at the University of Chicago, commissioned by the Governor and inspired by the state's failed attempt to obtain Robert Wood Johnson funding. These activities formed the basis of the state Screening, Assessment, and Support Services (SASS) program.

- A more recent consent decree-B.H. versus Suter-addresses the state's responsibility for all children under DCFS supervision, and represents the most instrumental event promulgating the change in focus. It represents the culmination of several years of criticism of the DCFS system which is widely reputed to be underfunded and overwhelmed. This decree has mandated an extensive planning process with input from a plethora of action groups and implementation teams to address the full range of issues including mental health services.

Currently there is no systematic approach to reaching children with less than severe problems nor to targeting children in the child welfare system; however, the B.H. consent decree and recent efforts to broaden the definition of SED carry the potential of expanding the range of children served.

III. Environmental/Contextual Issues

The Chicago community is characterized by 'distinct neighborhood areas each with boundaries that are widely recognized and distinct personalities related to the ethnic groups that comprise its population and the economic condition of the area. The great disparity in the availability of resources and the levels of need across neighborhoods has impacted the service system's ability to provide services and make needed linkages. The south and west areas of the city are characterized as the most impoverished with the fewest available

resources. The north area by comparison is considered "resource rich," and although it encompasses a very poor area of the city with one of the largest public housing projects in the country-Cabrini Green-it also includes a recently gentrified area inhabited by a largely young urban professional population. The child welfare population in the North Region is 54 percent African-American, 16 percent Hispanic, and 26 percent Caucasian. In contrast, the South Region has a caseload that is 94 percent African-American.

Similarly, the key child serving systems in Chicago have a **strong sense** of "turf." Each has a very specific and fairly narrow definition of target population, and each has a clear sense of geographic boundaries of their service area-none of which exactly coincide.For example, DCFS is a centralized system with four regional offices; however, **contracts** with service providers (which represents a substantial portion of services) are for county-wide services. Many of the key private providers are very large organizations that do not think in terms of community/neighborhood services. Key mental health providers delineate their target population according to the old Federal community mental health planning areas, which is somewhat complicated by the delineation of SASS program responsibilities. which divide responsibility for metropolitan Chicago in half-north and south. State DCFS and DMHDD officials are in the process of looking at how boundaries within each system can be readjusted to coincide.

Scarce resources have exacerbated relations among state agencies, and have led to infighting about which agency is responsible for paying for which services. In addition, the more complicated cases are often shifted from one system to another in an effort to get someone else to take fiscal responsibility. Many of the formal coordination mechanisms have been put in place to respond to these issues.

Children's mental health has only recently received prioritization at the state cabinet level, which can be attributed in large part to the B.H. consent decree. In addition, respondents feel that perspectives brought by the new leadership appointed to the key child-serving agencies have greatly benefitted the redirection. The new director of DMHDD served as director of DCFS for a short time prior to his appointment, where he initiated activities to help resolve the class action suit that led to the consent decree, and instituted efforts to maximize Medicaid dollars for mental health services. The DCFS director was previously in the public aid department. These two directors are reported to have a strong working relationship, and have made efforts to increase collaboration between the two systems. Although collaboration is felt to be strong at the state level, this is not a shared perception at the community level among providers, where collaboration is felt to have a long way to go.

IV. Overview of the Service Approach

A. Child Welfare

1. Department of Children and Family Services

The Cook County division of DCFS has four regions with responsibility for serving specific geographic areas of the county. Initial screening of calls to the abuse and neglect hotline is a centralized function, cases that move on to the investigation stage are referred to the appropriate regional office based on geographic proximity.

The range of ongoing DCFS services includes in-home family preservation services; substitute care including regular foster care, kinship foster care, therapeutic foster care homes and residential care (treatment oriented institutions and group homes). About 20,000 children under DCFS supervision are in substitute care placements, which represents 80 percent of the total caseload. Of these, more than 6,000 are in regular foster care, over 11,000 are in relative foster care placements, and another 2,500 children are in group homes or institutions.

Additional services such as mental health counseling can also be arranged by the child's DCFS caseworker, or by a contracted private provider either through referral to another provider or to a service under the provider's umbrella organization.

Linkages to mental health providers occur when the assigned caseworker has concerns about the child's behavior. Psychological assessments are not routinely conducted, however, a comprehensive evaluation will be required in the future as part of the consent decree. This evaluation will include an educational assessment, a medical assessment, and a mental health assessment. Primary sources of mental health services include a city-run network of community mental health clinics, two state funded acute care hospitals which also can conduct assessments on an outpatient basis, and private providers either by referral or more formally through contractual arrangements.

Specific programs and activities relevant to DCFS's role in providing or linking to mental health services are described below.

Foster Home Disruption Prevention Program. A program that is currently being developed which will provide emergency response services to foster homes as a

means to deflect a crisis situation and help preserve the foster care placement. This program is administered out of the Bureau of Youth Services.

Medicaid Clinic and Rehabilitation Option Certification Process. An effort underway to obtain a rate structure for mental health services provided to Medicaid eligible DCFS supervised clients by private agencies under contract to DCFS. This process was initiated as a means to maximize Federal dollars for Medicaid covered services. The rate structure has been set and DCFS is in the process of training providers so they will know what services are reimbursable and how to obtain reimbursement.

Early Intervention/Prevention. DCFS has two very small programs focusing on early intervention services. One involves grants to community-based organizations to implement programs that assist families through education with the purpose of deflecting them from the Child Protective Services (CPS) system. These grants are funded by money raised through an income tax check-off option. A second program that provides community-based grants for community education and services to strengthen parenting skills is funded through Federal child abuse prevention funding.

In addition, the DCFS state office is in the early stages of implementing a targeted case management system for children with multiple disabilities and parenting and pregnant teens.

2. Private Providers

DCFS also uses contracted private providers for service delivery, including case management and other more specific services, and is moving toward more privatization of services. Private providers are considered the first choice in providing services, if there is no availability, the case is assigned to a DCFS caseworker. All of the in-home family preservation and group/institutional care is contracted out to private providers, about 60 percent of the regular foster care and just under half of the relative foster care placements are provided under contract.

During the site visit we visited the Columbus-Maqville Shelter, a private provider in the northside under contract to DCFS to provide emergency placement services. The shelter serves a city-wide population and can accommodate up to 120 children from birth to age 20. Children come to the shelter primarily through the CPS investigation process or because of a disrupted foster care placement. A DCFS Emergency Services Center worker is placed on-site at the shelter to conduct intake which consists of verifying that the child is involved with DCFS and no other placement resources are available. The

shelter is intended to serve as a temporary placement lasting 3 to 5 days while DCFS workers find an appropriate longer term placement. In reality, the average length of stay ranges from 1 day to 3 months, and occasionally a child has stayed as long as 1 year. The longer-stay children are typically older children whose behavior makes it difficult to find longer term placements in foster or group homes. The shelter has developed a special arrangement with the local public school which includes the provision of 6 teachers assigned to the shelter to conduct onsite classrooms based on capsule curricula with program oversight provided by the local school principal.

Shelter staff report that all children brought to the shelter have mental health service needs. The shelter has money in the DCFS contract to cover such services as crisis intervention, clinical monitoring of children on psychotropic medication, and consultation with staff through subcontract arrangements with a private agency focusing on services for sexually and physically abused children and a local mental health hospital. The shelter also uses SASS services for crisis intervention. No ongoing counseling is provided or sought because children are not in the shelter long enough to make this a useful service; however, staff run a "Choices" program geared toward youth three times per week. The focus of the program is to conduct group discussions around issues of chemical abuse, sex, and gangs. DCFS also contracts with Maryville Academy (the Columbus shelter administrating agency) to provide residential care; pre- and after-care for youth who are either in need of residential treatment but for whom no vacancy exists, or for youth who have completed residential care and require followup services; a teen pregnancy program; and a program for maternal substance abusers and their children which is jointly funded by DASA and DCFS.

B. Mental Health

As mentioned earlier, during the site visit we concentrated on exploring issues and services available on the northside of Chicago. Three key private providers in this area were visited: Community Counseling Centers of Chicago, Doyle Center, and Pathways. Each is described in more detail below.

1. Community Counseling Centers of Chicago (CCCC)

CCCC (formerly Edgewater-Uptown Community Mental Health Center) is a private mental health provider serving the northside of Chicago. It provides adult and children's mental health services. The center first started providing children's mental health services in 1972 with 4 family therapists. In 1985 the Family Support Program was funded (a joint venture between DCFS and DMHDD) and in 1990 the programming was expanded to include the SASS

program. Child and adolescent services are now provided by the Child and Family Counseling Center which includes three components:

- Children and Family Learning Center-provides individual and family therapy, psychiatric evaluations and psychological assessments. There are currently 95 ongoing clients. A recent focus has been on developing support groups for adolescents and expanding skills training. for parents.

- Family Support Program-initiated with joint funding from DCFS and DMHDD, this program was created to provide early intervention services to families with children age 2 to 9 who were at risk of being excluded from their home or community. Presently funded only by DMHDD, the focus is currently on providing parent support groups, play/art therapy for the children, and family interaction therapy. The program provides a combination of office-based support groups and education sessions and in-home family sessions. DCFS is not the only referral source; however the majority of clients served are involved with DCFS. The. program is currently serving 50 families.

- **HomeFirst.** One of 23 state-funded Screening, Assessment and Support Services (SASS) programs designed to serve primarily the SED population. The state SASS project is implemented within 6 regions, each of which is assigned responsibility for several out of a total of 78 mental health planning areas statewide. The Chicago area is divided into two regions for implementation of the SASS program, 5-A and 5-B. CCCC, through its HomeFirst program, is the SASS provider for 5-A which covers the entire north area of the city.

  SASS services differ somewhat across providers. The CCCC was one of the first providers funded because of its ability to build on a base of already existing services. HomeFirst services are provided out of two offices, one located in the northside, the second located in the westside. Services include screening and assessment to determine whether a child should be hospitalized, crisis intervention, and intensive ongoing in-home services for 90 days to stabilize the family. In-home services include individual and/or family therapy, homemaker services, and respite care. Caseworkers conduct home visits to each family two to five times per week. In addition the program also has a pool of money set aside as "wraparound" funding to cover such needs as clothing, emergency food assistance, rent/utility assistance, beds, and registration for after-school care programs and summer camps. This pool of money is also available to other agencies upon request. The other 10 child and adolescent mental health providers in the region tend to rely on CCCC only for crisis intervention and retain the role of providing ongoing services. The CCCC

Homefirst program has served children who don't necessarily meet the state's SED definition because they have had the capacity to do so. However, they are seeing more severity among the children they are screening and predict that they will soon no longer be able to accommodate the less severe referrals.

The two HomeFirst offices conduct about 25 assessments per month each, of these approximately 50 to 60 percent are provided intensive in-home services.

Overall, CCCC estimates that 50 percent of its caseload are families who are involved with DCFS.

2. Doyle Center

Doyle Center is a private children's mental health services agency located on Loyola University's Lakeshore campus. It is one of 11 DMHDD-funded child and adolescent agencies in the north Chicago area. Referral sources include schools (accounting for 95 percent); physicians; and self-referral. Services focus on family functioning rather than on the individual child's diagnosis and are based on an intensive 3-hour diagnostic session including all family members. Participation of all family members is a prerequisite for receiving services which includes outpatient services, day school, neuropsychological services, and research. Treatment includes counseling for the parents and children together and separately and support groups. The program has recently added a focus on the family's functioning within the community in its treatment approach. Seventy-five percent of the agency's budget is supported by the University as a training source for its students, other funding sources include DMHDD, Medicaid reimbursement, and client fees which account for less than 5 percent of the funding sources. The center currently serves 175 families, of which less than 10 percent are involved with DCFS. This low percentage is attributed to the fact that the Center is not a DCFS contract provider. As a child and adolescent agency, the center has access to the CCCC HomeFirst program, and tends to use it primarily for crisis intervention during nonoffice hours and funding for concrete services such as transportation.

The executive director of Doyle Center serves as co-chair of the northside Child and Adolescent Network.

3. Pathways School and Treatment Center

The Pathways School and Treatment Center is a therapeutic day treatment program for children ages 5 to 14 with severe emotional and/or behavioral disorders. Eligibility for services is contingent on the school system's determination that the child cannot be served in a regular public school classroom. The majority of the program's $550,000 budget comes from state special education dollars, but also includes $50,000 from DMHDD. In addition to treatment staff, Pathways has social work staff who are assigned caseloads of 12 to 14 families. Their role is to provide overall treatment coordination and help link families to other services such as public aide. Social work staff will arrange a "staffing" when needed which may include other service providers and DCFS workers if the family is under DCFS supervision. The program currently serves 32 children. Roughly 60 percent of Pathway's clients are- on public aid, and 20 to 25 percent have past or current involvement with DCFS.

Although the Pathways program has found itself providing more m-home work in recent years, it does not expect this to be a priority or focus. The Center director has been active in the mental health field for 20 years, and is one of the founders and current co-chairs of the northside child and adolescent network. At one time, the Center was funded to provide drug treatment programming in area schools which included a half-day program for students and teacher consultation. The Center director indicated that the program was becoming effective in prodding system change, but was abruptly stopped because of lack of funding.

C. Education

Although Chicago has a Board of Education, local schools have a great deal of autonomy and each is provided oversight by a locally elected school council comprised of parents, community representatives, teachers and the principal. The primary role of the council is to establish policies and develop plans for improving the school. No specific school-based programs were identified to visit in the Chicago area; however, respondents briefly described two education-led initiatives which were indirectly related to this study's focus.

- The Department of Education operates Parent/Child Centers geared toward preschool age children with funding under P.L. 94-142; however, respondents report that this program is very inconsistently run within Cook County.

- The State Board of Education has recently provided grants to three school systems statewide to implement a pilot project to identify children with mental health needs and link them with needed services using a collaborative approach

among DCFS, schools and mental health. Cook County is an awardee of this pilot effort and has developed a project called 'Project Partners." This project involves subcontracts with private providers to provide the identified assessment and direct services; however, respondents report that the school system is slow in getting the project underway and are skeptical about its ability to provide the financial support necessary since the level of state funding is relatively small,

In addition, individual schools have implemented various innovations, one example described during the site visit was a school that operates on a flexible schedule that runs year-round to accommodate working students and teen parents. Several of the northside mental health providers provide services on-site in the local schools, an arrangement that is worked out on a school-by-school basis.

D. Juvenile Justice

The Juvenile Court is a division of the Circuit Court of Cook County. The Circuit Court Chief Judge appoints the Presiding Judge over Juvenile Court as well as the other judges which now number between 15 and 20. The Probation Services Department is the largest of six departments within the Juvenile Court, and is organized into six divisions: Chicago North, Chicago South, Suburban, Dependent/Neglect, Specialized Services, and Complaint Screening/Adjudication. The other five departments include Legal Services, Clinical Services, Statistics, Budget and Accounts, and Personnel and Training.

Types of cases handled by the Juvenile Court include:

- Delinquency
- Minors Requiring Authoritative Intervention (MRAIs)(i.e. status offenders)
- Drug addiction
- Abuse
- Neglect
- Dependency

In 1990 the court handled 24,868 complaints, delinquency cases accounted for the majority of cases seen (73 percent) followed by abuse, neglect and dependency cases (28 percent).

Referrals to the court are processed by the Complaint Screening/Adjudication Division, if it is determined that a petition will be filed, the case moves through the preliminary, adjudicatory and dispositional hearing processes. Probation officers are assigned according to geographic area and type of case. Among services available to the child throughout these steps include psychological assessments and services provided directly by staff in the Clinical Services Department and referral to treatment

programs offered by DMHDD or private providers. Also during this process, the assigned probation officer conducts a social investigation report and prepares a recommendation for disposition. Services can be ordered as part of the adjudication hearing without going to a dispositional hearing at the agreement of all involved parties, depending on the individual judge's determination.

The court has instituted several diversion programs designed to address issues and help children avoid the court process if at all possible. One of these targets MRAI cases and involves a 21 day "cooling off' period during which a contract provider conducts counseling with the child and family. The child is referred to the program directly by the police department and after the 21 day period it is determined whether the case will proceed to adjudication or if identified issues have been adequately addressed. Another diversion program involves placing the child under a 6 month supervision period with a probation officer or a private agency. Again, at the end of the 6 month period, it is determined whether the court proceedings need to continue, or if the case can be dismissed.

The Juvenile Court interacts with DCFS primarily around MRAI, abuse, neglect and dependency cases. For those MRAI cases that are not diverted from the court process, once adjudication takes place, referral to DCFS is one dispositional option. This disposition decision is not always welcomed by DCFS because of their overwhelming caseloads and the special issues that these children bring. For abused and neglected children, the most typical dispositions are out-of-home placement under supervision by DCFS or continued in-home placement with court-ordered supervision by DCFS and services provided by social service agencies. Once DCFS becomes involved, the probation officers are removed from the case.

Other disposition options, depending on the type of case, can include commitment to the Department of Corrections (DOC) Juvenile Division; probation, which involves supervision by the Probation Services Department for a specified period'. of time; conditional discharge; out-of-home placement with providers under contract to the Juvenile Court, or a DMHDD facility; referral to a DMHDD drug treatment program; detention; or emancipation for children age 16 and older. In cases where there is disagreement about which system should serve the child, the Governor's Youth Services Initiative is brought in to make a determination. This group is comprised of representatives from DCFS, DMHDD, Juvenile Court, DOC and the Board of Education.

Many of the probation officers have training, in family counseling, and when a child is placed under their supervision they try to work with the child and the family. They are also asked to make recommendations to the judge based on a social history that they prepare, as to whether the child should receive a psychological evaluation and dispositional options that would best serve the child.

As with the child welfare system, the Juvenile Court has struggled with ever-growing caseloads and abounding criticism about its inadequacy in handling cases. Efforts are currently underway to examine how to improve the current system.

V. System Level Issues

A. Coordinating Mechanisms

The B.H. consent decree is the driving force behind the coordinating mechanisms being put into place to increase the availability of mental health services to children in child welfare, and has spurred the coordination among DCFS and DMHDD and other human services agencies that is beginning to take place at the state level primarily around the SASS program and its efforts to serve the SED population. The state mental health plan for child and adolescent services outlines various coordination activities and plans, and a number of task forces and coordinating groups have been established. However, the extent to which SASS programs at the local level are coordinating with other providers and agencies varies. SASS staff at Community Counseling Centers of Chicago indicated that the state plan requires that they collaborate with child welfare and to that end they have attempted to meet with area office staff in the northside and westside offices to ensure that referrals are taking place. Staff report varying success with these efforts and find that often direct line workers are not familiar with SASS services and don't know to refer their clients to CCCC. CCCC has had better success in working with other community-based providers, and has reached out to other state-funded child and adolescent mental health providers in their role as the SASS provider. In addition, staff from the various program components of CCCC provide onsite services and consultation to 22 Head Start Centers in the northside area.

The earlier consent decree requiring DMHDD and DCFS to work together to conduct discharge planning for children who are hospitalized, the joint funding of the Family Support Program and the Partners initiative currently being developed under the leadership of the board of education represent additional mechanisms to ensure coordination among child-serving systems. However, these are narrowly defined efforts all of which target the SED population.

The Governor's Youth Services Initiative, described above, is another coordination mechanism of sorts. It was put into place to ensure services for adolescents who are falling through the cracks. A group composed of representatives from DCFS, DMHDD, Juvenile Court, the Board of Education, and the Department of Corrections was established to review cases for which there is disagreement about which service system should be taking responsibility for the child.

Although few formal mechanisms are currently in place to enhance coordination around the needs of the broader population of children with mental health problems, state officials within DMHDD and DCFS feel that SASS efforts will pave the way for coordination and collaboration among the key child serving systems to provide the broader array of services, and recent changes to the SED definition will broaden the number of children that can be served. Respondents indicate such efforts have been more successful outside of the Chicago area and don't vary so widely across neighborhoods as seen in Chicago. This was attributed to two interrelated reasons: 1) communities outside of Chicago are dealing with much smaller numbers of people in need of services; and 2) the power structure is smaller and more compact with fewer players.

At the local level, coordination-where it exists--tends to be more informal. Several such examples were identified during the site visit:

- The Child and Adolescent Network is comprised of mental health and social services providers in the northside area, and has been meeting for over 20 years. Members meet monthly to discuss general issues and approaches to coordinating service provision for children and adolescents. Each year the group determines an agenda of key issues they plan to address and individuals sign up to work on topic-specific committees. This forum helps local providers build: working relationships and coordinate efforts. Representation is also elicited from the police department, department of mental health and DCFS; however, the group has found it difficult to get ongoing representation from DCFS, and DMHDD participation is inconsistent.

- Youth Services Networks which exist in some parts of the city. This concept grew out of efforts of the City in 1986 to hold an annual Youth Conference as a means for providers and agencies to come together to discuss issues. Networks of key public and private service providers were set up to provide input to the annual conference. Some of these networks have continued and meet monthly to share information and strengthen relationships and linkages. The annual conference also continues to take place. The Youth Services Network in the northside area has not continued, one respondent speculated that because the key providers are well known to each other and because probation officers in particular have developed strong linkages at the direct line level and know which services to access, they no longer perceived the need for monthly meetings.

- A consortium of seven city-wide agencies that provide services targeted to teenage mothers was established and is hosted by the Maryville Academy. The consortium meets on-a monthly basis to review individual cases for the purpose of identifying appropriate and available referrals and to give programs the opportunity to obtain background information on future referrals.

The informality of these types of networks is considered a strength in that it allows providers to tailor their services for their client populations; however, it was pointed out that a large portion of the population in need of services is not receiving any services at all. More formalized community-level planning mechanisms with direct reporting responsibilities to (and clout with) state agencies are needed.

B. Goals/Definitions of Success

The Illinois State Mental Health Plan for Child and Adolescent Services articulated a basic philosophy and direction and specific goals and objectives to support these in 1989. Progress toward project goals and objectives is documented in an annual report. DCFS also has a documented mission and values statement which was prompted by the new director and recently adopted (see Attachment A). While each of these two systems is guided by its respective philosophy and mission, and both incorporate the concept of family-based services, there was no evidence that any efforts had been made between the two agencies to articulate shared missions or goals.

C. Definition of Eligible Population and Client

Resource constraints and tradition has led the child welfare and child mental health systems to carefully monitor who they will serve. Each is concerned about using their limited budgets to serve a population that they consider the responsibility of another system. The SASS program is designed to serve the SED population based on the state definition which, until recently, was patterned after the CASSP definition and required that a child be 17 years old or younger, have a DSM-III-R diagnosis (with specific V-code exclusions), experience significant limitations in capacity to live in a family or family equivalent and additional limitations in the areas of self-care, language, learning and social interaction. In addition, the functional disability must be of l-year duration or at substantial risk of lasting more than 1 year, and it must be considered likely that more than one child-serving system is needed to provide the required array of services. The new definition will be broadened to include V-codes (functional impairments).

SASS staff are careful to delineate their role vis a vis the DCFS caseworker role. They view themselves as the mental health providers and will also provide case management when no other system is involved. For children under DCFS supervision, they feel strongly that the case management role belongs with DCFS and find that they often must clarify this perspective with DCFS workers. There is a sense that the reluctance of DCFS staff to work with SASS is related to DCFS's concern that additional problems and issues among the children they serve will be identified but not meet the SASS eligibility criteria and thus ultimately give them more work to do within an already overwhelming caseload. This reluctance is also attributed to

caseworker frustration caused by failed attempts to engage mental health agencies to accept DCFS wards for services.

The school system has also been cautious about its role in identifying children in need of mental health services. The Board of Education has been unable to respond with the desired expediency to DCFS wards who require Individualized Educational Plan (IEP) referrals or placement in therapeutic school settings. School system staff are reported to be very careful about what is included in the IEP because once a problem is documented, the school system will have to pay for the necessary services, as a result many of these special needs minors are "handed-off to the DCFS system

D. Funding Issues

Illinois is in a severe recession; however, the B.H. consent decree will bring an infusion of close to $60 million over a 3-year period to DCFS to enable the agency to implement its mandates, and SASS funding has remained in tact in the face of reductions in other departmental programs Limited resources was a prevailing concern among all of the respondents with whom we spoke. As discussed earlier, lack of funding has served as an incentive for agencies to have narrowly defined target populations and search for avenues for shifting clients to other systems so that services are paid for out of another budget. In addition to the expanded DCFS budget, respondents indicate that the Medicaid Clinic and Rehabilitation Option Certification project will provide some relief to this situation. Rules have been promulgated and providers are being trained. Once this effort is fully implemented, mental health providers will be able to access payment for services provided to DCFS children.

VI. Service Delivery Issues

A. Staffing Issues

1. Supply of Trained Personnel

DCFS has had difficulty recruiting and retaining qualified staff. DCFS has particular problems retaining staff in the regional offices located in the poorest areas of the city. The problem here is cyclical-staff openings result in higher caseloads for the casework staff which in turn leads to burnout and transfers to other area offices or to private agencies.

In contrast, mental health providers in the North area of the city report great success in recruiting qualified staff. The Chicago area is rich in college and

university institutions, many of which have developed formalized internship training relationships with area providers. CCCC has a strong focus on family therapy and is a well known training opportunity in this area among the psychology and social work programs.

2. Training and Treatment Approaches

Differences in treatment approaches among mental health providers has created some barriers to program linkages. Early in the implementation of the SASS program in the northside, there was some concern among other mental health providers that the CCCC Homefirst program would take away from their client base; however, providers have found the SASS crisis intervention services to be complementary to their services. An issue that persists is the state requirement that SASS conduct an assessment of every child who is recommended for residential care in a state funded facility. Agency mental health staff often object to this procedure because they feel that their credibility as a clinician is at question. However, SASS staff also feel that many clinicians are not aware of the benefits and success rates of intensive in-home services since it is a relatively new and nontraditional approach in the mental health arena, and their assessment and recommendation for in-home services will help educate clinicians about this approach.

B. Case Planning and Approaches to Meeting the Multiple Needs of Clients and Family

Case plans are done independently by each service system with whom the child comes into contact.

CCCC's approach is to invite the DCFS caseworkers to at least one meeting with the referred family to provide input to the treatment plan. The delineation of roles and case management responsibilities takes place on a case-by-case basis and the ease with which this happens is dependent on the individual caseworkers and private providers involved. CCCC and other providers expressed a general concern about the inexperience and seemingly inadequate preparation among DCFS workers; however, pointed out that only the negative experiences are brought to their attention, and recognized that DCFS caseworkers have an overwhelming caseload size.

Caseplans for children in the child welfare system ideally address the service needs of children and their parents; however, DCFS workers reportedly tend to focus on the parent's needs while private providers focus on the needs of the child.

Since CCCC's focus is on family therapy, their approach attempts to address the needs of the family unit. While the child may be the focus initially, often the parent becomes the client as well.

C. Caseload Issues

Caseload size is a pervasive issue within DCFS. Caseloads vary across the four regional offices in relation to the complexity of the populations they tend to serve. The northside office caseloads average 40 to 45, while the southside has approached 100. Caseload size is a serious problem for DCFS and a clear detriment to caseworkers' abilities to ensure that services are provided. As mentioned above in the section discussing definitions of client population, the large caseloads can act as a disincentive to interact with other systems if it means additional work and ultimate responsibility on the part of the overloaded caseworker. Staff report that the B.H. consent decree has outlined a systematic process to decrease caseload size over time.

SASS staff carry between 4 to 9 ongoing cases, and also conduct several assessments per month. Other CCCC program caseload sizes for children and adolescent se&es range from 15 to 22.

VII. Oversight and Feedback

DMHDD, in its state mental health plan, has developed measurable objectives and has put into place a process for tracking and reporting progress towards these objectives on a state-wide basis. Measures are largely process oriented and include such indicators as the number of children receiving SASS case management services; the proportion of admissions to state-funded hospitals receiving SASS screening prior to admission; and the establishment of specific guidelines, workgroups, legislation and training opportunities.

CCCC does not currently have an evaluation component to their programs; however, felt that it would be useful to track outcomes.

VIII. General Issues

A. Gaps and Barriers Identified by Respondents

Respondents spoke in general terms about the huge pockets of poverty and neglect in Chicago that is multigenerational in nature, and the lack of resources available to address these basic issues. The key child serving systems-child welfare, juvenile justice and education--have all been caught "off guard" by the numbers of children coming

into the system because of substance abuse among their parents as well as their own addiction. In addition, respondents identified several key service gaps and issues and barriers to coordination and service provision. These are briefly summarized below.

- Sexual abuse is seen as a key underlying issue that is not being adequately addressed. Most children seen in the mental health system have experienced sexual abuse and much of their behaviors are attributed to acting out the violence that they experienced at a younger age. Respondents identified the need for better screening to ascertain if sexual abuse has occurred and mechanisms to ensure that treatment is routinely provided for every child who is identified as a sexual abuse victim.

- There is a need for closer relationships among public service agencies focused on establishing clear linkages and working together to serve children. Although respondents identified a need for more resources, several respondents felt that a lot more could be done on behalf of children, even in the absence of increased funding, with better linkages.

- Services for multiple problem minors are particularly difficult to find; this population brings such complex issues as chronic running, attention deficit disorders, developmental delays, suicidal tendencies, behavior disorders and others.

- More services targeted to teenage mothers, and to address drug use with a focus on preventing these populations from coming to the attention of the mental health or child welfare systems. Some respondents feel that the responsibility for these types of services belongs with community-based agencies.

- Access to residential care is very difficult, and is sometimes restricted by insurance coverage, for example, HMO's will only cover 5 days in some cases which is not long enough.

- There are few providers able to accommodate children with a dual diagnosis of behavior disorders and developmental delays; typically treatment approaches are geared toward only one of these problems.

- There is a need for a mechanism to conduct mental health assessments for all children in DCFS and provisions for prevention services. Mental health staff indicated that among those children being screened for SED-related services, the level of severity seems to be getting worse and could be addressed with earlier prevention services.

- Each child serving system has its own mental health system-child welfare has its private providers; juvenile justice has its separate pool of providers; and the health system has yet another pool of mental health resources.

B. Strengths and Innovative Features

Chicago is on the brink of several changes in its child-serving system approaches. Although state directors could point to strong collaborative relationships and mechanisms, much of what was observed during the site visit indicated that many of these efforts had not yet been felt at the community level, although movement toward developing better coordination and collaboration was evident. Key indicators of change include events that mandate it-for example the B.H. consent decree which has far reaching implications for comprehensive change-as well as efforts at the state leadership level to at least improve communication between child welfare and mental health. The recent elevation of the priority placed on children's mental health, efforts to maximize Medicaid coverage for mental health services, and the state SASS program for SED children and its recent broadening of the definition of children who can be served are also indicators of progress. Similarly, the State Board of Education is reported to have more progressive administrative staff and has also demonstrated some interest in and movement towards coordinating efforts with other systems.

Informal networking at the community level has created pockets of coordinated services such as efforts observed in the northside area of the city. Respondents cautioned, however, that the northside cannot be considered representative of the city as a whole since it is considered relatively better off than other areas of the city. Providers in the northside agree that the northside probably offers the most comprehensive array of mental health services in the city; however, point out that the resources fall short of the level of need.

Mission Statement

Illinois Department of Children and Family Services

Adopted April, 1991

The Illinois Department of Children and Family Services, in partnership with others, will provide services to children snd families to protect and advocate on behalf of children and youth who are, or who are at risk of, being abused, neglected or removed from their families.

Values

DCFS Staff and Foster Parents believe:

- That children have a right to a safe, secure, permanent living arrangement, preferably with their own family.
- That we should act quickly, competently and professionally to protect children, prevent harm and advocate for their well being.
- That children and families are served best in homelike settings in their own community.
- That we should recognize the humanity and importance of each individual, and treat them honestly, with fairness, dignity, compassion and cultural competence.
- That we should foster a stable, supportive workplace which will allow each employee to grow, develop and participate in the fulfillment of the DCFS mission.
- That we are accountable for the work we do, and thus, must effectively and efficiently utilize all available resources to carry out the mission of the Department.

We believe in acting on these values in our relationships with each other, with the community we work in and with the children and families we serve.

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(3 of 3)

FINAL REPORT

Community-Based Mental Health Services for Children in the Child Welfare System

Volume III
Appendices

Contract No. HHS-100-91-0016-01

Submitted to:

Assistant Secretary for Planning and Evaluation
Department of Health and Human Services

by:

Macro International Inc.

June 30, 1992

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Appendix A

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Appendix B

Panel of Experts

Panel of Experts
Study of Community-Based Mental Health Services for Children in Child Welfare

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Appendix C

Summary of Interviews with National and State Level Experts

Study of Community-Based Mental Health Services for Children in Child Welfare

Summary of interviews with National and State Level Experts

Submitted to:

Assistant Secretary for Planning and Evaluation
Department of Health and Human Services

by:

Macro International Inc.

December 11, 1991

Summary of Interviews with National and State Level Experts

Telephone interviews were conducted with selected national and state level experts knowledgeable about the issues of providing mental health services to children in the child welfare system. Experts were identified by the Federal advisory committee, the expert panel members and ASPE staff. The purpose of the interviews was to broaden the base of input to the study, to further explore key areas of interest and study questions, and obtain additional suggestions of sites to be considered for the case-study phase of the project Prior to the interview, respondents were sent a brief overview of the study and a list of the key points to be covered in the telephone conversations, this document is attached.

Persons interviewed include:

- Marty Beyer-Independent Consultant
- Charles Bnmer--Executive Director, Child and Family Policy Center, Iowa
- Robert Friedman-Florida Mental Health Institute
- Barbara Friesen-Portland State University, Research and Training Center
- Jerome Hanley-Director, Division of Children, Adolescents and Their Families--South Carolina Department of Mental Health
- Ira Lourie--Consultant, Human Service Collaborative
- Gary Melton-Vice Chair, U.S. Advisory Board of Child Abuse and Neglect
- Carol Williams-Center for the Study of Social Policy
- Susan Yelton-Research and Training Center for Children's Mental Health

Additional persons scheduled to be interviewed, but who were not available prior to December 10, 1991 include: Mark Soler, Youth Law Center; Bob Goerge, Research Fellow, Schapin Hall Center for Children; Jim Comer, Researcher at Yale University; and David Wolff, recommended by Gary Melton for his research in child abuse interventions. Mary Lee Allen, with the Children's Defense Fund was also on the original list of persons to be interviewed, but has been unavailable for interview by telephone.

Following is a summary of the key points made by the expert consultants under each of the discussion categories.

I. Key Issues in Providing Mental Health Services to Chiidren in the Child Welfare System

The key issues related to providing mental health services to the population of interest to this study identified by the experts interviewed fall into five general categories: the range of mental health needs and services, how problems/needs are identified, special populations of interest, service/system characteristics, and staff training. Each is further described below.

A. Range of Mental Health Needs and Services

Virtually all of the respondents emphasized the need to look at the full range of mental health needs among children and not to focus on only those with severe problems. Two of the experts felt that the distinction of severe/nonsevere was not useful, the key issue is that most of the children in the child welfare system are not receiving appropriate mental health services. One person suggested that most children in this system would fit the CASSP definition.

One respondent suggested that "mental health" is an adult concept reflecting the view of health versus illness. The central focus or concern for children should be on developmental needs since they are continuing to develop and change, recognizing that some children do in fact have "mental illness." Developmental progress is a critical underlying aspect of children's emotional and mental status.

Respondents emphasized the need to take a broad view of "mental health services," and go beyond traditionally defined services. It was suggested that the less severe population is in need of systematic interventions, not just formal mental health services. Experts suggested that the continuum of services needs to include both formal and informal services as well as those that don't typically fall under the mental health system. Examples that were mentioned include: substance abuse services, family support services, respite care, and day care services The importance of responding to other needs such as housing, economic independence or vocational assistance was also emphasized since these issues have implications for the child's/family's mental health and can influence efforts to address mental health problems.

It was also suggested that the potential providers of mental health services have an equally broad view and may include child welfare workers, teachers, juvenile justice workers, health care workers, mothers, and friends. One person pointed out that interaction between a child welfare worker (for example the protective services worker) provides an opportunity for that person to provide a dimension of mental health care. The extent to which this actually happens varies. Another expressed distress that "states remove children from the home but in fact do a far worse job at parenting than the family from whom the child was removed" and went on to emphasize that one aspect of addressing children's needs is assisting parents in assuming their roles.

Respondents reiterated the need for the broad continuum of services to be family-based, community-based, need-based, flexible 'and integrated

B. How Mental Health Problems and Service Needs are identified

Respondents expressed support for the importance of early identification and intervention, but indicated that the child welfare system is not set up to identify children's mental health needs. If the child enters the system because of behavior problems then problems are more likely to be identified; however, the most typical course is residential care. Children who enter the system for other reasons (e.g., abuse/neglect), which represents a larger proportion of the population in child welfare, do not have their mental health needs identified or addressed.

The points at which children's mental health needs may be recognized can be anywhere along the continuum of child welfare services and workers who come into contact with the child, but. depends on the workers' capabilities and whether the worker recognizes the mental health nature of the need.

Several experts felt that all children in child welfare need some level of mental health services (defined broadly), and several expressed concern that inadequate attention is given the issue of system-induced problems. It should be assumed that children need help in dealing with separation, foster care placement, etc.

The responsibilities of the child welfare agency include protecting children; addressing separation/attachment issues of the child; and providing comprehensive assessments, case management and planning. However, the reality is that because most systems are in crisis the emphasis is on protecting children. As one respondent described the situation: "child welfare systems are beleaguered and in crisis, they have neither the skills, resources or leisure to do early detection/intervention."

C. System/Service Characteristics

Several of the respondents pointed to the different goals, values and characteristics of the child welfare and mental health systems as issues that influence responses to meeting the needs of the population of interest to this study. Key characteristics and issues that were raised include:

- limited mental health capacity in most states
- mental health generally continues to use an individual treatment model, however, parents are also part of the child welfare system
- child welfare is truly a public system that serves children who meet specific criteria, mental health has no mandate to serve children
- for child abuse and neglect, the focus has been on investigation, not treatment (which is partially due to the lack of involvement from the research oriented agencies of the Federal government, e.g., ADAMHA)

Several respondents emphasized the need for the two systems to continue to work together (and cited the national level efforts between SMRCY and NAPCWA). One spoke of the need to bring the two systems and services together, while still maintaining separate identities, and suggested that there has been an artificial distinction between the child welfare and mental health roles and that they need to be working together to serve families. Another emphasized the need for more consultation between the two systems and suggested that joint committees could be involved in assessment processes and developing treatment strategies.

D. Special Populations of Interest

Two populations that are especially in need of services were identified: preschool-age children and families with post-adoption problems. However, it was recognized that the post-adoption population is so specialized it may not fall under the purview of this study.

Issues and concerns raised in relation to the preschool population include:

- lack of daycare services (especially therapeutic daycare) and related family support
- many problems can be/are identified during the preschool period, but children don't end up getting services until they are older

E. Staff Training

The lack of adequately trained staff was a key concern raised by several of the experts interviewed. Several aspects related to staff training, skills and support needs were raised:

- The need for general training and support for staff across systems (e.g., teachers, child welfare workers)
- the lack of mental health training in schools of social work
- the failure of schools of social work to prepare students to work in the public sector and with "nontraditional" populations (i.e., poor and of color)
- perceived roles and skills (related to mental health and therapeutic interventions) of child welfare workers

- an anti-family bias in the training and orientation of child welfare professionals (the focus is on protecting the child from the family rather than working with the family)

il. Programs Addressing Key Issues Raised

Several respondents stressed that site selection should not be contingent on child welfare being the locus of services or even have the lead role in developing/implementing the services. Many felt that it was unlikely that child welfare systems are providing the full constellation of services. Other systems from which these services may originate include mental health, juvenile justice, education and health. Some felt that family preservation-type programs, to the extent that they are broad in scope, should be looked at as models that can be replicated for a variety of populations and earlier in the continuum of need. It was also suggested that some SED-serving programs provide good models and are beginning to broaden their population, and that school-based early intervention may also be a model to explore.

It was suggested that when we examine services and approaches within the sites, it is important to explore the range of services available among each of the four phases in child welfare-at-home protective services, out-of-home placement, reunification, alternative permanent placement-since they may be very different for each.

Key features or characteristics programs are likely to share include the following:

- Have an emphasis on engaging the family
- Tendency to stay away from labeling
- Have roots in the family preservation concept
- Have a single point of access
- Services are delivered in the home or in community settings (e.g. community mental health centers, schools)
- Address the full range of family needs and are individualized
- Have a case management/monitoring component
- Have an evaluation component

Suggestions for specific sites have been summarized into a separate document.

III. Effectiveness Measures

Respondents indicated that this is an area that is not well developed and attributed this to two interrelated reasons: effectiveness is not well defined, and there is very little research that shows what works.

On a general level, it was suggested that programs need to be able to answer some basic questions: 1) were out-of-home placements averted; 2) has the program improved outcomes for children and families; 3) is the family now able to deal with the situation that initially brought it to the attention of the system; 4) would the family feel comfortable coming back for services if they were needed again? To answer these questions programs would need to be collecting individualized data on how services are impacting the lives of their clients.

Specific effectiveness measures identified included 1) taking a comprehensive look at effectiveness consisting of client oriented outcomes, e.g., the child's behavior, family adaptability, family satisfaction, and problem solving skills, and 2) program/process measures, for example cost effectiveness or how well the program works with other programs.

Several respondents indicated that measures are available and referred to the many tools used to measure child development and the Moses and Magure text (as well as others) on measures. However, it was felt that the broader measures of family functioning are less well developed and rely more on anecdotal information.

While it was suggested that most programs are likely to have some data on the impact on families they serve, it was also felt that many programs do not measure effectiveness. This is because, at best, programs must often settle for a minimally adequate child development environment and programs may not be able say that their clients meet some of the desired outcomes.

IV. Who Should Intervene

Most of the respondents indicated that "who" intervenes (child welfare worker, mental health professional, teacher, etc.), is less important than making sure that intervention occurs, it that it is conducted by someone who is well trained, able to establish trust and build on family strengths, and it adequately addresses the family's needs in a culturally appropriate manner. One respondent felt that child welfare is probably not the appropriate intervenor or system in which to locate services (it doesn't have the expertise or resources), and suggested that the schools represent a better locus. However, she emphasized the importance of a strong child welfare component.

Experts emphasized the importance of a multidisciplinary, integrated approach delivered at the community level with local planning and prioritization of services.

V. Questions This Study Should Answer

The range of questions and issues that experts felt this study should explore include:

- Explore the need to develop student's and worker's competencies as well as provide adequate preparation and encouragement to work in the public sector
- Examine the issues around categorical funding and approaches to bringing together child welfare and mental health
- Examine the amorphous issue of national will and commitment (as two separate issues), which is felt to be lacking
- Explore families' perspectives and issues of cultural competence as a key underlying issue
- Look at the interface between Head Start and child welfare
- Examine issues related to circumstances where systems have required parents to transfer custody of their children to the state for the sole purpose of obtaining necessary services at public expense
- Examine what programs learned in their efforts and what mistakes were made
- Focus on obstacles (we already know what needs to be done, look at why it isn't)
- Better define and describe the population, all we know now is that 5 percent of the estimated 12 percent of children with mental health needs have severe problems. We know nothing about the other 7 percent.
- How are system-induced problems being addressed (and eliminated)?
- How is funding being spent?
- Identify strategies for improving outcomes for children, creating a more effective focus on this population, for community and state integration of services and funding.
- Is there potential to develop common ways of assessing children's needs in terms of a shared view/process across agencies?
- What are the core elements each system/agency would bring?

- Is there a body of knowledge available to guide the choice of therapeutic treatment choices?

- Identify ways to strengthen child welfare system.

VI. Suggestions for Additional Materials and Resources

Additional resources identified by the experts include:

- Elizabeth Schorr -- "Within Our Reach"
- Doug Nelson -- Casey Foundation
- Bill Arroyo -- psychiatrist at University of Southern California Medical Center in Los Angeles, works with low income and minority populations (especially Latino) and studies children's responses to traumatic experiences (213) 226-5302.
- David Wolff -- research on treatment issues for abuse and neglect, at the- University of Western Ontario
- Jim Gabarino/Robert Halpem -- Erickson Institute in Chicago, looking at how to help families not yet in the system but on the margin settlement house-type approaches
- Ira Schwartz -- University of Michigan School of Social Work, focuses on children moving across systems, has done some work on the explosion of the private mental health industry and home-based juvenile justice services
- Brian Wilcox -- American Psychological Association, involved in the Association's mental health, juvenile justice and abuse and neglect coalitions
- Center for Social Policy -- many white papers on related topics
- APWA report "National Commission on Child Welfare and Family Preservation: Committment to Change"

Study of Community-Based Mental Health Services for Children in the Child Welfare System-Telephone Interview Overview and Discussion Points

I. Overview

The Office of the Assistant Secretary for Plarming and Evaluation (ASPE), Department of Health and Human Services (DHHS) is conducting a study to examine approaches to meeting mental health needs of children in the child welfare system. Recent Federal and state efforts have begun to address the needs of children with serious emotional, behavioral or mental disorders (e.g. the National Institute of Mental Health funded Child and Adolescent Service System Program, North Carolina's Willie M. program, and California's Ventura County model), and there have been some efforts to identify programs and document innovative approaches to serving this population. However, very little has been done to identify programs and document approaches to serving the nonseverely emotionally disturbed population.

The focus of the ASPE study is on the nonseverely emotionally disturbed population of children in the child welfare system. An issue with which we have grappled since the onset of the study is how to define the population of interest. As children's mental health problems cannot be neatly categorized and there are no widely agreed-upon labels other than "severely emotionally disturbed" (SED), we have resorted to defining our population of interest by description. By "mental health problems" we are referring to the full continuum of impairment of social, emotional, behavioral or cognitive functions, regardless of duration. This would include any child that has undergone a traumatic experience, which probably includes virtually every child in the child welfare system. An underlying premise of the study is that any child who has undergone a traumatic experience has some level of need for mental health services. We are defining "mental health services" in the broadest sense--that is any effort to identify and explore with the child and family the traumatic events that have been experienced, the consequences of those events, and approaches to easing the impact on the child and family. This would include all levels of intervention ranging from family support services and short-term counseling to formal psychological assessments and intensive therapies.

The goals of the ASPE study are to:

- Conduct five case studies of localities that are providing mental health services to children in the child welfare system;

- Identify and describe the key strategies and approaches to successfully delivering services to this population;

- Describe the key characteristics of the child welfare system that facilitate or hinder provision of mental health services; and

- Identify policies issues and areas for further research.

ASPE has contracted with Macro International Inc. to conduct this study. Preliminary activities of the study included a literature review, obtaining input from a panel of Federal-level officials, and convening a panel of non-Federal experts. To broaden the base of input to the study we are now conducting telephone interviews with additional experts.

II. Discussion Points

Key points that we would like to cover with you during the telephone discussion include:

1. What are the most important issues in providing "mental health" services to nonseverely emotionally disturbed children in the child welfare system?

2. What kinds of programs are addressing these needs?

   - Where are they located?
   - What is the lead agency (or "system")?
   - What kinds of things are they doing?
   - Who is the contact person?

3. How might the effectiveness of programs and efforts be examined?

   - Are there measure of effectiveness?
   - What is the state of knowledge in the field about which services are effective in helping these children?

4. Who do you see as the appropriate "intervener" in helping the children of concern to this study7

5. What kinds of questions do you think this study should try to answer?

6. Do you have any suggestions about materials we should get or other individuals we should talk with about these issues?

Appendix D

Summary of Literature Findings

Study of Community-Based Mental Health Services for Children in Chiid Welfare

Summary of Literature Findings

Submitted to:

Assistant Secretary for Planning. and Evaluation
Department of Health and' Human Services

by:

Macro International Inc.

December 11, 1991

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Summary of Literature Findings

I. Introduction

A. Overview

Over the past decade, concern has escalated about children with mental health problems, and there has been a growing recognition that children in the child welfare service system compose a critical aspect of this problem. These children have multiple, complex needs, and they and their families often have meager resources with which to meet these needs. They depend on mental health, child welfare, and other service systems to provide myriad service assistance. Too often, those systems are fragmented, hindering access and creating additional stress on children and their families. In recent years, a number of initiatives at state and Federal levels have attempted to bolster coordination of human services to better serve children and adolescents with mental health needs.

B. Scope of the Problem

Although estimates vary, most experts concur that between 7.5 million and 9.5 million of the 63 million children in the United States need mental health services for emotional or other problems.@ At least 3 million of these children are estimated to be "seriously" or "severely" emotionally disturbed (SED). Little is known about the remaining 4.5 million except that they presumably are less seriously disturbed or are at risk of developing emotional problems. Definitional issues and poor reporting systems cloud an estimate of the exact prevalence of the problem; section II will examine these issues in more detail.

It is estimated that the vast majority of children with mental health problems may not be receiving appropriate services. Less than 1 percent of America's children (approximately 100,000) receive residential treatment or hospital-based mental health services in a year. Approximately 2 million receive outpatient mental health treatment.[22] Among the critical issues related to children with mental health problems is that disproportionate amounts of available resources are expended on a small number of children in need of services, mainly to support residential care. A large number of children, usually the less severely disturbed children, remain underserved, inappropriately served, or receive no mental health services at all.

A number of studies and reports responded to this dire situation, culminating in Jane Knitzer's 1982 landmark study for the Children's Defense Fund of mentally ill youth "unclaimed" by the governmental and community agencies that are responsible for providing urgently needed services. These reports helped galvanize efforts to focus resources and improve mental health services for children.

At the Federal level, the National Institute of Mental Health (NIMH) in 1984 began the Child Adolescent Services System Program (CASSP) with the understand@ that the current service system was fragmented and that children with the most severe needs often were served by single-focus agencies when a multiple-agency, comprehensive approach was indicated.[19] CASSP promoted this interagency-system philosophy through grants to states, which were encouraged to create or expand services for children and adolescents and to bring together disparate agencies that serve these children in an effort to create a more functional integrated system. Most recently, the focus has shifted to building systems of care at the community level following these CASSP ideals. The relatively small CASSP grants provide funding for planning and coordinating services, but do not fund service delivery.

Other indications of growing interest in the field of children's mental health include the efforts of private foundations in funding research and demonstration programs. The Annie E. Casey Foundation funds large studies in the field of children's mental health, and recently funded Kamerman and Kahn's two year study[14] of alternative state and county approaches to delivering social services to children, youth, and their families. The Robert Wood Johnson. Foundation supports a $20 million project to fund 12 states to improve the programming. and delivery of children's mental health services. However, again these efforts focus on the severely emotionally disturbed child.[10]

The most recent literature suggests that risk factors for children likely to enter the child welfare system (CWS) are similar to, if not the same as, risk factors for mental health problems. These include substance abuse, teenage parenting, poverty, homelessness, child abuse and neglect, and sexual abuse. Children in the child welfare system come from society's most challenged families. The families whose children enter the child welfare system need intensive and often sustained assistance from the public sector and are a significant factor in state and Federal budget considerations.

The particular significance of the mental health needs of children served by child welfare has been recognized in the Nation's plan for health objectives for the next decade, Healthy People 2000. A major objective is to "increase to at least 30 the number of states in which at least 50 percent of children identified as neglected or physically or sexually abused receive physical and mental evaluation with appropriate followup as a means of breaking the intergenerational cycle of abuse."[26]

C. Purpose of this Background Paper

This report will summa&e findings from articles, unpublished reports, and documents related to coordination of care for children in child'welfare with mental health problems. The paper will support development of a study of approaches to providing mental health services to emotionally troubled children in the child welfare system, with a particular focus on mental health services for children who (a) are less than "severely" emotionally troubled and (b) who are at risk of developing mental health problems. It should be noted that the

study's emphasis on less severely disturbed children reflects an acknowledged need among researchers and Federal policy and program officials to assess the status of services for a population of children known to be seriously underserved, but does not suggest that children with severe problems are necessarily adequately served. Because the aspect of mental health services for nonserved children has been largely unexamined to date, references were scant. However, much of the literature on severely disturbed children is applicable for this discussion.

il. Causes and Definitional Issues

Mental health and- mental disorders can be affected by numerous factors ranging from biological and genetic vulnerabilities, acute or chronic physical dysfunction, to environmental conditions and stresses. The causes of mental, emotional, and behavioral disorders in children and youth are not well known. Most professionals in the field would suggest that the disorders are due to a combination of biological, psychological and environmental factors.[26] Biological factors include genetic makeup, brain chemistry, serious nutritional deficiencies, and substances such as lead. Psychological factors include problems with intelligence, reasoning ability, self-esteem, and motivation. Environmental or social factors include peer relations, culture, economics, and family issues. All of these factors can bear some relationship to emotional problems.[25] Further, children's emotional health can be affected by system-induced factors such as removing the child from natural parents, multiple out-of-home placements, separation from siblings, labeling, and changing schools.[3,7,11]

Just as the factors that contribute to mental illness are many and varied, the response of an individual child varies greatly. Consequently, children's mental health problems and needs are difficult to categorize. They exist along a continuum of impairment of social, emotional, behavioral or cognitive functions that may not be easily described using standard diagnostic categories. Inconsistencies in definitions and labels for children who have "diagnosable" disorders have attracted considerable professional attention. Describing children who are not at the severe end of the spectrum is even more difficult.

In addition, a perspective on children's mental health must not rely on the adult-centered view of treatment as a relationship primarily between patient and mental health professionals and must accommodate the "children's overwhelming dependence on their families."[2] Professionals who assess the extent of children's mental health problems, must take into account problems that will affect their future development as well as their current state. Achenbach maintains that an understanding of developmental issues for children should be part of any study of psychopathology of children and would involve "delineating the specific ways in which disorders disrupt the typical course of cognitive, emotional, behavioral, and social development and how the outcomes of various disorders affect long-term adaptation."[2]

A number- of approaches to defining children's mental health needs may be identified; however, each is specific to the purpose for which it was developed. These purposes range from individualized clinical diagnosis and treatment planning to general assessments of the nature and severity of the problem to guidelines for program eligibility.

A. Clinical Diagnosis

The standard used by mental health professionals for diagnosis and treatment planning is the Diagnostic and Statistical Manual (DSM-III-R). The DSM-III-R include five general categories of disorder: intellectual, developmental, behavioral, emotional, and psychophysiological. Within the context of a recent background paper on children's mental health, the Federai Office of Technology Assessment (OTA) adopted the DSM definition of mental disorder: clinically significant behavioral or psychological syndrome or patterns associated with distress or disability.[25]

B. Assessment of the Nature of the Problem

Various instruments have been developed to help professionals identify and describe behavior and emotional problems. As a way to measure the degree of severity of psychosocial. problems in a selected study population, Frank developed a seven-point scale to reflect the range from no problems to the most serious psychosocial problems.[11] A number of child behavior checklists and inventories have been developed within the field of psychology.[1,13] One of the most widely used is the Child Behavior Profile scales developed by Achenbach; his checklist of items related to behavior and social competence can be used to help characterize groups of disturbed children.[1]

Yet another approach is the Stroul and Friedman framework that distinguishes dimensions of need without relying on diagnostic detail. The framework incorporates two dimensions--the severity of social impairment and the persistence of the problems-to suggest a range of children's needs for mental health services. The possibilities range from problems of short duration and mild impact on functioning (category 1) to persistent problems that severely affect functioning (category 4).[24]

Known environmental "risk factors" and stressors that influence clinical assessments performed by trained professionals affect the vast majority of children served by the child welfare system-poverty, minority ethnic status, abuse and neglect, teenage parents and substance abuse. Typically, only those children exhibiting the most severe problems are referred for formal assessment. Many of these environmental risk factors trigger a variety of responses such as anger, anxiety, depression, or learning difficulties. These responses are not severe enough to warrant formalized psychological assessment, diagnosis, and treatment, but nevertheless constitute disabilities that negatively affect the child's ability to function and should be properly addressed.

C. Program Eligibility

Severe emotional disturbance has been defined in different ways by professionals who serve this target population of children. For example, CASSP uses a broad definition for designating the SED children it serves. The participants must be under 18 or 21 years of age (depending on jurisdiction); manifest a lack of ability to function in the family, school or community; require services from at least two different community agencies; exhibit a mental or diagnosable disorder under the DSM-II-R or other state classification; and have had the disability for a year or be expected for it to last more than a year.[24] Beyond these requirements, CASSP allows certain flexibility in states' definitions for eligibility.

The Federal Education for All Handicapped Children Act (P.L. 94-142) defines serious emotional disturbance as a condition exhibiting one or more of several characteristics over a long period of time and to a marked degree, which adversely affect educational performance. The characteristics include an inability to learn, an inability to maintain peer and teacher relationships, pervasive depression or unhappiness, and a tendency to develop physical symptoms related to personal or school problems?

State agencies concerned with mental health needs of children also define their target population in varied ways; however, in an effort to bring some uniformity to the field, the National Conference of State Legislators (NSCL) recently adopted a definition similar to the CASSP definition: "broadly defined, severe emotional disturbances [that] cause major impairments in functioning for an extended period of time." Characteristics of emotional disturbance include difficulty in carrying out tasks of daily living, extreme vulnerability to stress, increased tendency to use alcohol or other drugs, tendency to "acting out" behavior, lack of ability to develop social networks, and inability to function in school.[9]

Children with mental health problems that do not qualify as SED are even more difficult to identify. Mental health is a general term used to refer not only to the absence of mental disorders but also to the ability of an individual to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional, or behavioral dysfunction. Because of the challenges faced by children served by the child welfare system, it is safe to assume that they are at risk of, or, at some level, experience dysfunction and therefore need services.

111. Chiidren's Mental Health Services

A. Mental Health Services

The scope and nature of mental health services for children and families have undergone significant change in the last decade. In a review of traditional and emerging approaches, Lourie and Katz-Leavy describe mental health services that traditionally included mainly outpatient psychotherapy, hospitalization, and long-term residential treatment. These traditional services were provided by public community mental health centers and state hospitals or obtained from the private sector. "Intermediate care" options (e.g., group homes, therapeutic foster care, and intensive in-home services) were usually funded by other systems such as child welfare and juvenile services and often were considered social services rather than mental health services.[19]

These intermediate services, as well as other family support services, are now considered part of the "mental health" continuum of care. Among these services, Knitzer[16] includes crisis intervention, respite care for parents, day treatment and intensive case management, as well as therapeutic foster care and group homes. Beyer[5] also includes respite care, as well as parenting skills instruction, chemical dependency treatment, and others in her discussion of mental health services.

A broader range of services is only one feature of the changing approach to meeting children's mental health needs. An extensive review of literature and advocacy group positions by Boyd[6] reflects a strong commitment to providing mental health services through integrated efforts which are community-based and child- and family-centered. The focus is on adapting services to the needs of the client rather than adjusting the client's need to fit what is available in the system

A prominent example of current directions in child mental health is the "system of care" model developed by Stroul and Friedman, with CASSP support. The model advocates the importance of assuring a fullrange of services, based on the specific needs of each child and family, and including mental health, social, educational, health, vocational, recreational, and support services. Within the mental health "dimension" of this complete system are an array of services which may be provided by any of several agencies, including child welfare (see below). In addition to providing a comprehensive range of integrated services, this model emphasizes that families and surrogate families should be full participants in all aspects of planning and service delivery.

This concept and the Stroul-Friedman model of a full range of services within the mental health dimension have been widely used in crafting current legislation to improve children's mental health services at the national level[8] and in providing background for state legislators in their efforts to achieve state-level reform.[24] Services included in the "mental

health" dimension of the system of care proposed by Stroul and Friedman include the following:

Prevention/Early Intervention - The overall goal of prevention and early intervention is to identify troubled children early, provide appropriate interventions for the child and the family, and prevent residential and/or foster care placements. Problems can be treated more appropriately and effectively if the problems are recognized and the intervention begins early. Early recognition of health and emotional problems in children and the provision of appropriate services can reduce the duration and severity of the problems, as well as the overall prevalence of emotional disturbances in children.

Prevention activities recognized as mental health services may include promoting positive mental health and competencies (e.g., teaching problem-solving skills and strengthening self esteem); increasing self-help groups and support systems; and modifying the procedures within agencies and systems to improve the experiences and outcomes of children and families.

Early intervention is "almost inevitably" a collaboration between different service systems and agencies. Families beginning to experience'difficulty may be identified because of child abuse, physical health problems, developmental delays, learning problems, or others not initially viewed as "mental health."

Assessment-Assessments are probably one of the most adequately funded areas of mental health services, due to a and tradition of use within the mental health field. A multitude of instruments, tests, and techniques are available for assessing emotionally disturbed children. Some concerns related to assessment include the gap that sometimes occurs between the assessment process and availability of needed services to address individual treatment needs, the time and expense involved in obtaining formal assessments, and the duplication of assessment by different agencies with differing requirements. Stroul and Friedman note the increasing emphasis on the need for a broad approach to assessment that moves beyond interviewing and psychological testing to emphasize the broader environmental, educational, and family contexts for the problem. They also discuss the role of the growing field of family therapy on the changing role and nature of assessments.

Case Management-Case management is essential to the successful coordination of services for children in the CWS. Case management ensures that children get the most appropriate services they need and that services are coordinated for maximal effectiveness. Case management may include coordinating assessment of a child's (and family's) needs; planning and arranging for services to address those needs; monitoring adequacy and appropriateness of services and ensuring continuity; and advocating for the child and family.

Outpatient Treatment-Outpatient services are an important component of any system of care for children. Traditional outpatient treatment involves bringing the child and/or family to a mental health center, child guidance clinic, or private practitioner's office for regularly

scheduled individual, group, or family therapy sessions. This is generally the first approach to try to assist a child and family through mental health intervention. A variety of therapeutic approaches may be employed, including psychotherapy, behavioral therapy, family therapy, and chemotherapy. Outpatient services may also involve parent training, social skill training, and short-term, problem-oriented counseling.

Home-Based - Services-Home-based services are intensive, immediate, family-focused interventions used extensively by child welfare agencies to prevent foster care placement. They often operate as collaborative, interagency programs and are also referred to as family preservation services. Among the best known examples is the Homebuilders model, developed in Tacoma, Washington; however, there are other models of home-based services that seek to achieve the same goals. Home-based services provide intensive, short-term counseling, therapy, and parent education services to families in their own home settings. Outside resources that can assist the family function better are also incorporated into the service plan. Family preservation services are unique because no diagnosis is required, and there are no restrictions on the type of services provided. A caseworker is assigned to each family, and the treatment varies according to which services are appropriate to the individual family. Typically, family preservation services are crisis-oriented and only last 1-3 months with between 5 and 20 hours of intensive, direct in-person contact each. week with the families.

Day Treatment--Day treatment programs are the most intensive of the long-term, nonresidential mental health services available to children, and are generally indicated after less intensive programs have been attempted. While this often involves a collaborative relationship between mental health and education agencies, it always requires integrating these services to some extent. Emphasis on educational and mental health interventions may vary among day treatment programs. Children in day treatment usually remain for at least one school year, spending a minimum of 5 hours a day in the program. Settings may vary among special and regular schools, community mental health centers, hospitals, or other settings. Children in these programs have, for the most part, been identified as seriously emotionally disturbed. Day treatment programs are generally seen as a way to avert the need for residential treatment or as a transitional program to help children who have been in residential treatment to move out of it.

Crisis and Emergency Services-These are a valuable addition to the full range of children's services and may be viewed as a mini-continuum ranging from prevention through crisis stabilization. Practitioners note that many children enter the mental health system during times of crises and that the handling of such episodes may affect the further development of mental health problems. Services range from training for teachers, parents, and children in handling crises and gaining access to services to telephone hotlines and emergency outpatient and inpatient services. Some home-based interventions may also be provided as crisis services.

In addition, a variety of services for children with emotional disturbances provide varying degrees of restrictiveness. Among the less restrictive are therapeutic foster care and therapeutic group homes.

Therapeutic Foster Care-This service involves placing a child with foster parents who have been recruited and trained to work with emotionally disturbed children. These placements generally have low numbers of children in the home, special stipends for the foster parents, and a support system; however, the level of training and the amount of the stipend vary by program. These are typically the least expensive of the residential treatment options. Portions of costs are provided by child welfare, with specialized services often paid separately by mental health or other agencies. Programs are operated by a variety of agencies, including mental health centers, residential treatment centers, local foster care programs, and other family service agencies.

Therapeutic Group Care-Like residential treatment centers, therapeutic group homes provide a round the clock therapeutic environment serving small groups of children with an array of interventions. The approach to treatment generally derives from social work or social-psychological origins, as compared with the medically oriented program in most residential treatment centers (RTCs). Therapeutic approaches vary widely and may include combinations of individual psychotherapy, group therapy, and behavior modification, with an increase in family therapy. Vocational training, particularly for adolescents, may also be included, along with recreational activities. Many of these group care programs originated with the child welfare system.

Residential Treatment Centers (RTCs)-These are expensive and generally restrictive mental health services, providing around-the-clock treatment and care to children, primarily under l&years-old, with serious emotional or mental disorders. Children usually stay in these settings anywhere from several months to several years. In contrast to group care programs, RTCs tend to offer a stronger medical orientation. Treatment approaches may include individual, group, and family therapy, behavior modification, recreational therapy, and special education. Often an RTC will operate its own school. RTCs are often chosen to address not only children's treatment needs, but also their need for a place to live. Out-of-state placement of children in RTCs is an important concern for proponents of community-based care, as well as for those concerned about the high cost of residential treatment. Treatment far from home is seen as disorienting and disruptive for the child, as well as creating problems in maintaining contacts with family and other key persons and agencies in the community, and in making the eventual transition out of residential care. Stroul and Friedman report estimates that a significant percentage of children in residential services are misplaced and note that experience with home-based intervention and day treatment supports this assessment.

Inpatient Hospitalization-This is typically the most expensive, restrictive service with the highest percentage of medical staff involvement. It is generally used in three basic ways: for short term treatment and crisis stabilization in cases of acute distress, for comprehensive

evaluation (generally 30 days or less), or for long-term treatment when there are no alternatives or when short-term placements become longer-term.

Some other residential services include therapeutic camps which provide family therapy and special education in a wilderness setting, and independent living services which offer vocational training, work experience, and skills of daily living, to help children make the transition from home or residential programs.

B. Other Services

In addition to mental health services, children with emotional disturbances require a variety of support services that are described briefly below.

Social Services-Social services support the child and the family in many areas. These services include protective services to prevent abuse and neglect, caretaker services to provide supervision when necessary, shelter services to provide temporary placement, foster care, residential treatment centers, and adoption. Child welfare is the major agency providing these services.

Educational Services-Educational services provide children who are emotionally disturbed with programs and services to help them learn. Examples of these services include educational assessment and planning, individualized assistance to maintain children in regular classrooms, special schools that provide full-day educational programs, on-site mental health services linked to in-home services for families, and full-time residential schools.

Health Services-Health services detect and treat health disturbances that may be caused by underlying mental health disturbances. These services include health education, prevention, screening and assessment, and primary acute and long-term care.

Vocational Services-Vocational services are often overlooked, despite the vital role employment can play in integrating children with disabilities into community life. These services include career education, vocational assessment, work experiences with job coaches, job finding, placement and retention services, and supported employment.

Recreational Services--Recreational services are important to emotionally disturbed children because they are often isolated from peers. Missed opportunities for growth and development can often compound emotional disturbances. These services include Big Brother/Big Sister programs, after-school programs, and summer camps.

Support Services-Support services are various services provided to children and families that can make the difference in effectiveness of care. These services include self-help and support groups, advocacy, transportation, legal services, and volunteer programs.

IV. Systems of Care

A. Child Welfare

Child welfare encompasses two broad programs-child protective services and foster care placement. These two major Federal programs are authorized by the Social Security Act: Title IV-B Child Welfare Services Program and the Title IV-E Foster Care and Adoption Assistance Program. Title IV-B provides grants to states for a broad range of child welfare services, including protective services and foster care placement prevention services, and Title IV-E provides funding for foster care maintenance payments.,

Child welfare services can be conceived on a continuum. The typical point of entry into the child welfare system is when there is a suspicion of abuse or neglect. At that time, the child welfare system goes into a needs assessment and identification phase which may result in no action or a case plan. The case plan can call for home-based services in an effort to prevent foster care placement, or voluntary or court-ordered placement, which is followed by a permanency plan. By law, every effort should be made to return the child to the biological family, In cases where this is not possible, a plan is developed for another type of permanent placement.

Theoretically, the child welfare continuum includes a broad range of services such as family support programs, prevention and treatment services for abused and neglected children, and family preservation and reunification services. In reality, much of the child welfare system focuses on "rescue and place" operations that offer temporary refuge for neglected children, but do little to help rebuild troubled families. *In* large part, this is due to the ever-growing incidence of child maltreatment.

In 1989 there were 2.4 million reports of child abuse and neglect, a 259 percent increase in reporting between 1976 and 1989.[21] Such large increases in child abuse and neglect have resulted in an overburdening of the child welfare system. Staff shortages and high caseloads mean that resources are so focused on investigating these abuse and neglect reports that caseworkers can intervene only with children most in danger. This situation is exacerbated by an increasingly litigious environment where liability concerns may overshadow child welfare practice.

A related problem is that the population who receives services through the child welfare system has narrowed recently. An estimated 5 percent of the severe abuse cases served by the child protective system drives the entire system.[14] The majority of children who need child welfare services, i.e., children who are characterized as long-term chronic neglect cases, but are not deemed to be in acute danger, cannot obtain services because the system's emphasis and professional efforts center on the extreme cases. Staff are so overburdened

with the task of removing the child in immediate danger that they do not have time to handle or address the needs of the other cases.

As discussed in a previous section, many, if not all, of the children and families who cycle through the child welfare system are in need of mental health services. Opportunities for assessment and referral to mental health services exist at every point on the child welfare continuum but the child welfare system does not have an organized pattern of moving children with mental health problems through the system Instead, children are moved among service settings based on their behavior and availability of services. The case planning stage represents the most likely point at which children's mental health service needs can be addressed. However, many children who have come into contact with the child welfare system and are likely to have mental health service needs have dropped out of the child welfare system prior to this point. Unfortunately, many of these children may recycle back into the child welfare system again, as recidivism becomes an increasing problem.

The child welfare caseworker could be the link between the child welfare system and the mental health system. Caseworkers should be knowledgeable about child development, family systems, dysfunctional behavior, clinical assessment, and many other related subjects to make effective decisions. However, low minimal qualifications for child welfare positions, high caseloads and worker turnover mitigate against this ideal.

While a masters-prepared social worker would have had courses in these subjects, a national survey showed that only 13 percent of the child welfare staff had an MSW and only 28 percent had even a BSW.[18] Poor working conditions and low pay contribute to the consistently low number of trained social work staff. Child welfare programs that call for professionals trained in mental health techniques, such as family preservation. and family reunification programs, do exist but are sparsely funded. Increases in these types of programs could help strengthen the link between the child welfare and mental health service systems.

B. Mental Health

As described by Lourie and Katz-Leavy,[19] the mental health "system" is actually comprised of four separate sectors: the public sector, the private non-profit sector, the private for-profit sector and the private practitioner sector.

- The public sector provides therapeutic services directly through cormmmity mental health centers and state hospital programs. Other public agencies, primarily schools, social service and juvenile justice purchase mental health services from the other sectors. Child welfare, in particular, typically obtains mental health services from all four sectors, with "a pronounced emphasis on the private non-profit sector."

Of the major human services agencies, mental health has traditionally had the weakest mandate to serve children. Public agencies have been responsible only for children and adolescents "who were a danger to self and others" and only as long as the danger persisted.

- **The private nonprofit sector** includes a variety of service agencies that account for a large proportion of specialized in-home and group-living services, as well as providing traditional outpatient services. The public sector, especially child welfare, obtains these services through contracts and fee-for service arrangements (e.g., Medicaid). In addition services are privately offered to those who can afford them, usually on a sliding scale basis.

- **The private** for-profit **sector** includes many hospitals which provide **services** to those who can pay for them individually, through insurance, or through public sector funding.

- **The private-practice sector** includes professionals from mental health disciplines (psychiatry, psychology, social work, etc.) who offer services individually to those who can afford them

Lourie and Katz-Lcavy note that the sectors work well together, especially the public and the private, nonprofit sectors, but best serve children with simple needs who fit services provided by available agencies. Needs which cut across agencies or which require services not provided by existing agencies are those most difficult to address in the current system.

However, emerging models of mental health services, described in earlier sections, emphasize provision of a comprehensive array of services, based on the individual needs of the child and family, delivered in the community, and integrated with other child and family serving agencies.

For the most part, these model systems of care have been developed around the needs of children categorized as "severely emotionally disturbed" (SED). Friedman, Burns and Behar note that in the prevention/early intervention area, the focus has been more on the identification of risk factors and the development of specific intervention models than on the establishment of overall approaches. They note the need to pull together available research and take advantage of field experience to identify or develop models for care for children not severely disturbed.[12]

C. Other Public Systems Providing Mental Health Services

Children with emotional disturbances may be in contact with public systems other than child welfare and mental health. These systems include criminal justice, health care services, education, and social services. Children can also be involved in vocational rehabilitation, substance abuse, foster care, and special education. Children, especially those who are not

severely emotionally disturbed would benefit if professionals in these service systems were trained to identify children who need mental health services, provide **interventions, and offer** programs to meet mental health needs. However, most systems are designed and funded to provide specific services, and mental health interventions are not usually part of their service plan

Educational System-The Federal Education for All Handicapped Children Act; P.L. 94-142 mandates an appropriate education for all children who are severely emotionally disturbed. The state usually describes a child who is at least 2 years behind academically as emotionally handicapped.[9] These services should be provided in the least restrictive setting possible, and include mental health services so the child can benefit from the educational system. **It has** been estimated that **4** million students received mental health services under P.L. 94-142 in 1984.[25]

Mental health problems are likely to be recognized in the school setting because they usually interfere with the educational progress of the child. Children cannot receive an adequate education until their mental health needs are met.[9] This philosophy also applies to the less severely disturbed child. Unfortunately, this law only applies to the "severely emotionally disturbed."

Some schools **have** their own mental health professionals to provide these services, while others refer these children outside the school for services. Typically, when the services are provided by the school they are not well integrated and coordinated with other necessary services and often only provide educational services and not the mental health components most needed by the child.

Juvenile Justice System-Children who enter the juvenile justice system because of breaking a law generally are taken to an intake unit for evaluation and referral. It is assumed that each offender has a behavior problem, although their problems usually are not viewed as a consequence of mental illness.

If the child is convicted of the crime, the court can order the child into a residential facility or order other services such as community-based services. The children who are acquitted are the real victims, because they are released without any treatment, and their emotional problems are not dealt with at all. Even if therapy is recommended for these children, they must obtain it through private sources because the juvenile justice system does not provide mental health therapy. Private funding often is an option and consequently, the result is that these children do not receive services until their problems are severe and more difficult and costly to treat.

Health System-Primary care physicians have an opportunity to notice mental health problems when they see children for physical complaints or regular visits. The impact could be significant, according to one source: "Approximately 11 to 12 percent of pediatrician and family practitioner office visits are by children with psychological disorders.* However,

some studies note differences among primary care physicians in their ability to recognize mental health problems in children. This variation concerns mental health professionals. Physicians too often do not recognize, diagnose, or treat mental illness largely because they pay too little attention to personal, psychological, and social factors affecting a patient's health.[25]

If the child is under the care of a mental health professional at the time he or she sees a primary care physician, treatment approaches may be uncoordinated and may be contradictory.[25] Some physicians refer children with mental health problems to a mental health professional, whereas others try to treat these children themselves.

Some have recommended enhancing primary care providers' skills in recognizing and treating children's mental health problems since they are likely to be the first professionals to recognize the problems. The primary care office is an ideal setting to provide preventive care and early intervention for children's mental health. These preventive efforts are mostly limited to health maintenance organizations that commonly refer mental health problems or try to provide an appropriate intervention.

V. Funding Issues

The ability of child-serving systems to provide the broad range of mental health services described in previous sections is complicated by an uncoordinated and complex array of Federal, state, and local funding streams. Most available funding does not specifically target mental health services for children or even children, but has eligibility criteria under which some of the identified children's mental health service needs may be covered or indirectly addressed. In addition, most funding that can be used for services to this population is focused on inpatient care, has limited eligibility and benefits,@) and is sometimes the cause of delays in the provision of care because of disputes and confusion about which funding source applies when more than one can pay for a particular service.[15]

States have the central role in providing and financing children's mental health services. This is consistent with the pattern of state responsibility for most child-serving systems including child welfare, education, and juvenile justice. Many states use matching formulas to distribute mental health funds to counties.[9] Federal support for mental health services, coordination, and research comes from a number of different sources. Exhibit A provides a summary of the most common sources of Federal funding along with their limitations for serving children with mental health service needs.

Private sector support for mental health services is also available to a very limited extent. Insurance programs cover some of the costs of mental health services; however, coverage usually includes only inpatient treatment, and such services as day treatment, intensive home-based services or crisis intervention services are not usually reimbursable.*

Exhibit A
Key Federal Programs that Affect the Provision of Mental Health Services for Children

Federal Program	Program Characteristics
Medicaid	• state administered, Federally matched health insurance for low income families • financial and categorical eligibility criteria and reimbursable services vary from state to state • optional services for children with emotional disturbances that can be covered under medicaid include case management, personal care services, rehabilitation services, clinic services, and early and periodic screening, diagnosis, and treatment (EPSDT) services, however, many states do not offer optional services
Medicare	• Federally sponsored health insurance program for persons over age 65, persons receiving social security disability payments for 2 years, and persons with end-stage renal disease • covers only a small proportion of children with mental health needs, i.e. disabled and dependents of deceased, retired, or disabled social security beneficiaries • diagnosis-related group (DRG) prospective payment system • influences medical care reimbursement nationwide-some states adopted medicare reimbursement rules for medicaid • inability of DRG for childhood mental disorders to account for length of stay variations and severity lead to inadequate cost coverage, some cases being denied services, doesn't adequately cover the range of treatment needs
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	• health insurance program dedicated to serving military dependents and retirees, administered by the U.S. Department of Defense • known as one of the most generous third-party payers of mental health care • to control costs, has recently limited payments for hospital care and residential treatment centers for children
Education for All Handicapped Children Act (PL 94-142) and Amendments (PL 99-457)	• mandates that children who are physically and emotionally handicapped be provided free, appropriate education and "related services" • amendments mandate services to 3- to 5-year-old handicapped children • amendments created voluntary program for handicapped and at-risk children from bii to age 3 including financial assistance to establish statewide, comprehensive, coordinated programs of early intervention services; facilitate coordination of Federal, state and local resources and enhance states' capacities to provide services • Federal government provides small amount of grant money to states to assist with implementation • services available to mentally disturbed children vary widely by state • disagreement about whether mental health services are included under "related services" • disagreement about which system should pay for mental health interventions (if included)-school, welfare, health care or mental health

Federal Program	Program Characteristics
Title IV-B of the Social Security Act	• provides child welfare services, including family counseling, crisis intervention, and emergency caretaker services in the home • matching funds allocated to states according to formula
Title IV-E of the Social Security Act	• authorizes open-ended Federal reimbursement to states for foster care maintenance payments, adoption assistance for AFDC-eligible children, including special needs children, and administrative and training activities related to the program implementation • Federal match • eligibility based on AFDC program eligibility
Supplemental Security Income (SSI)	• provides monthly payments to children who are blind or disabled and whose family income and resources are below specified levels • supplemental programs are allowed, but vary across states
Alcohol, Drug Abuse and Mental Health Block Grant (ADM block grant)	• provides funds to states for community mental health services • inpatient care is not allowed • states required to set aside 10 percent for children and underserved (amounts to less than $20 million nationwide and not all for children) • mental health portion of block grant has decreased
Child and Adolescent Service System Program (CASSP)	• administered by NIMH • provides funding to states and local areas to coordinate and integrate children's mental health services for seriously troubled children • emphasis on community-based systems of care • funding is not provided for treatment services

- In addition, NIMH is the major source of training and research support in the mental health area, and other Federal programs provide funds that may be used to support delivery of mental health treatment (e.g.,. Maternal and Child Health Block grant), or directly or indirectly affect services or relate to children's basic health, nutrition, and cost-of-living needs such as Title XX Social Services Block grant, Child Abuse Prevention and Treatment Act programs, Food Stamp Program, WIC, and AFDC, to name a few.

Source: Children's Mental Health: Problems and Service, Office of Technology Assessment, December 1986; Craig, RT What Legislators Need to Know About Children's Mental Health, National Conference of State Legislatures, April 1990.

Foundations are another source of private sector support. For example, the Edna McConnell Clark and Annie E. Casey Foundations have provided significant support to family preservation programs, and the Robert Wood Johnson Foundation funds the Mental Health Services Program for Youth, a $20.4 million, 12-state program designed to improve mental health services for seriously mentally ill children and youth. Numerous other foundation-initiated demonstrations which directly or indirectly address children's mental health needs may also exist at the state and local level in selected communities,

Many states have developed innovative strategies to finance child mental health services in the face of continuing budget cuts and resource constraints. Some of these approaches, as described in the OTA report,[25] include the following:

- - **Phasing down institutions.** Efforts to close institutional settings such as inpatient units and juvenile justice institutions and shift the savings to create other community and home-based alternatives.

- **Blending interagency budgets.** Combining Federal and state resources dedicated. to children within mental health, education, juvenile justice, and child welfare into a singe budget.

- **Expanding Medicaid initiatives.** For example, expanding home- and community-based services under existing optional provisions; seeking waivers through the home- and community-based services program; implementing optional case management services; increasing community mental health center reimbursement rates to leverage Federal funds better; using mental health authority resources as state matching funds; covering inpatient services-for individuals under age 21; adopting the special education system option to bill for health-related services; and using the EPSDT services.

- **Developing fiscal incentives between state and local entities.** For example, cost-sharing arrangements for hospitalization usage beyond a targeted amount and single points of program authority for hospital and community funds with county boards responsible for developing and administering a range of community services.

- **Expanding private insurance.** Negotiating with private insurers to increase range of services, broaden coverage for community services, develop captation-type arrangements to allow a broader range of services in anticipation that inpatient utilization will decrease, and mandating coverage of mental health services.

- **Developing a third-party billing plan.** Ensure that the education department recovers some of the cost of supplying "related health services" (under Education for all Handicapped Children Act) for those who have health insurance or are eligible for Medicaid.

- **Establishing trust funds.** For example the Self-Sufficiency Trust (SST) which provides a mechanism for families of children with handicaps to contribute money to their children without jeopardizing eligibility for public programs.

- **Earmarking revenues.** Designating specific taxes and fees for particular programs.

- **Providing family support dollars.** For example, cash assistance programs which provide dollar resources directly to families who select and pay for needed services.

- **Reusing surplus state hospital property.** Many of the empty state psychiatric hospital buildings and land could be a source of funds or benefits, for example selling, renting or leasing buildings to new users.

VI. Collaborative Efforts to Improve Mental Health Services for Children

A. Need for Collaboration

Fragmentation of services is one of the most frustrating aspects of providing mental health care for children and adolescents. Two authorities[19] recently assailed the "patchwork system" prevalent in most places: a system in which "multiple agencies have partial mandates to serve some of the children and no single agency has the scope and authority to assure that all the needs of children are addressed."[19] Given the array of diverse settings in which children's mental health problems are treated and prevention is attempted, it is "not surprising that fragmentation of services is often reported," according to the 1986 OTA report.[25] Such a system may be adequate for simple problems, but will be ineffective for children and families with complex problems and needs whose resolution cuts across agency boundaries.

A number of issues are forging a sense of urgency to the challenge of knitting together components of mental health services for children and adolescents, and, increasingly, professionals and policymakers are calling for translation of the rhetoric of collaboration into action. The growing need for services and static or shrinking resources are major incentives fueling collaborative efforts. For example, more children and families with multiple needs are being seen by both the child welfare and child mental health agencies--and single-focus agencies aren't capable of adequately serving these children.[4,17] Knitzer and Yelton (1991) note that the populations served by the child welfare system and mental health system are "often indistinguishable,"[17] with both agencies seeing children with serious behavioral and emotional problems and families that have patterns of violence and dysfunction.[17] The increasing number of families in poverty and the expanding realm of social problems like homelessness and crack use also put pressure on agencies to collaborate and thus conserve resources.

Common policy concerns also stimulate agencies to collaborate for the greater benefit of children and adolescents. For example, a goal for many agencies in recent years has been to serve children in "the most home- and community-like setting possible."[17] The recent trend toward favoring family preservation-bringing together resources form several agencies to work with families in their home settings--has served as a catalyst for cross-system collaboration

B. Efforts to Encourage Collaboration

During the past decade, a number of promising attempts to foster collaboration have occurred in the public sector (Federal, state, and local level) and in the private, nonprofit sector.

At the Federal level, the Child and Adolescent Service System Program (CASSP), referred to earlier in this report, has had a major impact on fostering collaborative efforts to improve child mental health services. Its goal is to "improve the way in which children and adolescents with severe emotional disturbances and their families [are] offered multi-agency services."[19] An underlying assumption of the legislation was that such collaborative activity would occur first at the state level and later at the community level, and states were expected to develop a strategic plan for creating an interagency process. Some of the strategies include "convening interagency groups, developing regional/local interagency or case management structures, training... and [encouraging] family participation."[19]

Legislation currently under consideration by Congress would create a new Federal grant program specifically to fund child-centered, community-based mental health services consistent with the CASSP system of care.@)

Other recent Federal legislation that promoted collaboration in the field is the State Comprehensive Mental Health Services Act of 1986 (PL 99-660) which encouraged states to develop a continuum of services and coordination among agencies. Although the legislation focused on community-based care and case management for chronically mentally ill people and not exclusively children, the legislation clearly has implications for children's mental health services. The law recently was amended to require states to "submit and interagency children's mental health plan," a mandate that surely will involve child welfare agencies as active partners in state planning for mental health services.[17]

Further, recent changes in two aspects of the Medicaid program have the potential of fostering better collaboration among agencies involved in children's mental health. States have the option of incorporating case management in delivering services to children, and the Early Periodic Screening, Diagnosis, and Treatment Program will require developmental and mental health screening for all Medicaid-eligible children, even those in foster care.[17]

Numerous states and local communities identified by Knitzer and Yelton have initiated innovative approaches to fostering collaboration. A few examples will suggest the range of possibilities. In Kentucky, collaborative efforts have enabled community mental health centers to develop and deliver a range of home-based programs. In Tennessee, three state-level agencies concerned with children's health pooled their resources to fund eight family preservation projects. Similarly, in Contra Costa, California, four public systems-child welfare, probation, mental health, and special education-coordinated their efforts and pooled resources to enhance family preservation initiatives in the community.Collaboration was advanced in New York City by means of a common assessment instrument used for families referred for family preservation services.

Successful collaboration and integration of services are easier to support in theory than to achieve in practice. Logistical and political barriers may be difficult to overcome. However, several researchers have identified components of successful systems of integrated care.

For example, Boyd[6] describes strategies of integrated programs for children and families, based on a review of various research and programs as follows:

- Establishment of clear goals and a well-defined target population for the provision of services
- An emphasis on working with the entire family, rather than just the identified at-risk child
- Development of a broad array of services to meet the different needs of the target population
- Reliance on case management that includes active brokering for services and advocacy for the child and family
- The importance of leadership in initiating, developing and implementing the coordination program

Characteristics of an integrated systems further identified by Soler and Shauffer[23] include the following:

- accessibility of services
- availability of flexible and reliable funding
- elimination of categorical funding requirements, confidentiality strictures, and other statutory and regulatory barriers to coordination
- development of processes for facilitation communication among agencies
- existence of a mechanism for resolving interagency disputes
- involvement of the private sector
- need for enhanced or modified training and other staff supports
- facilitation of information collection, management, and retrieval

- development of meaningful outcome measures
- capacity for innovation

Although activity at various levels and in various sectors suggests a positive trend toward collaborative efforts in the cause of serving children's mental health needs, complete implementation of this approach is-not assured. For example, Knitzer and Yelton identified four barriers to provision of intensive, nonresidential care for troubled children and their families; among these was the organizational culture barrier that works against successful collaboration between the two central systems serving children. "Child welfare agencies are often highly skeptical of the mental health systems' capabilities," assuming that mental health professionals do not understand the child welfare system or appreciate its challenges.[17]

The authors maintain nonetheless, that "opportunities must be created for both policymakers and workers to talk to each other, to build a common language, and a common philosophy.""') They identify three critical ingredient for successful collaboration: leadership, shared goals, and a realistic sense of time. They also propose a variety of formal and informal strategies to promote successful interagency collaboration and conclude: on a positive note: "... there may soon be a broad consensus on the importance of cross-system endeavors to make to most of the ever-shrinking pool of human service dollars."[17]

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Appendix E

Analytic Framework and Case Study Plan

Analytic Framework and Case Study Plan

Study of Community-Based Mental Health Services for Children in the Child Welfare System

Submitted to:

Assistant Secretary for Planning and Evaluation

by:

Macro International Inc.

December 19, 1991

Study of Community-Based Mental Health Services for Children in the Child Welfare System

The attached schematic is a visual representation of the analytic framework which will guide the development of the data collection and analysis phases of the study. The framework displays the critical factors which can influence the development of an integrated approach to meeting the mental health needs of children in the child welfare system. [1] As shown in the framework, key factors can be grouped into three general categories:

- Environmental/contextual factors
- System-level factors (including general, oversight and operational clusters)
- Service delivery-level factors.

These groups are displayed in a hierarchical structure which illustrates the general interactions among broad community and system-level factors, and how these interactions influence service delivery factors, which in turn shape program features and outcomes for the child. Each group of factors influences and in turn is influenced by the others. The schematic is not intended to track the effect of any individual factor on a specific outcome. In particular, the contextual factors and the groups of service delivery factors are seen as clusters which have an aggregate effect; therefore are shown as shaded blocs.

The table following the analytic framework translates the causal structure and the factors into a series of research questions. Again, these are loosely grouped into environmental/contextual questions, system-level questions and service delivery-level questions. The organization of the table follows the order of groups and factors in the analytical framework.

The research questions in turn have guided the development of the discussion guides to be used during the site visit phase of the study. The attached case study plan includes the discussion guide to be used on site and defines our approach to collecting data from selected localities.

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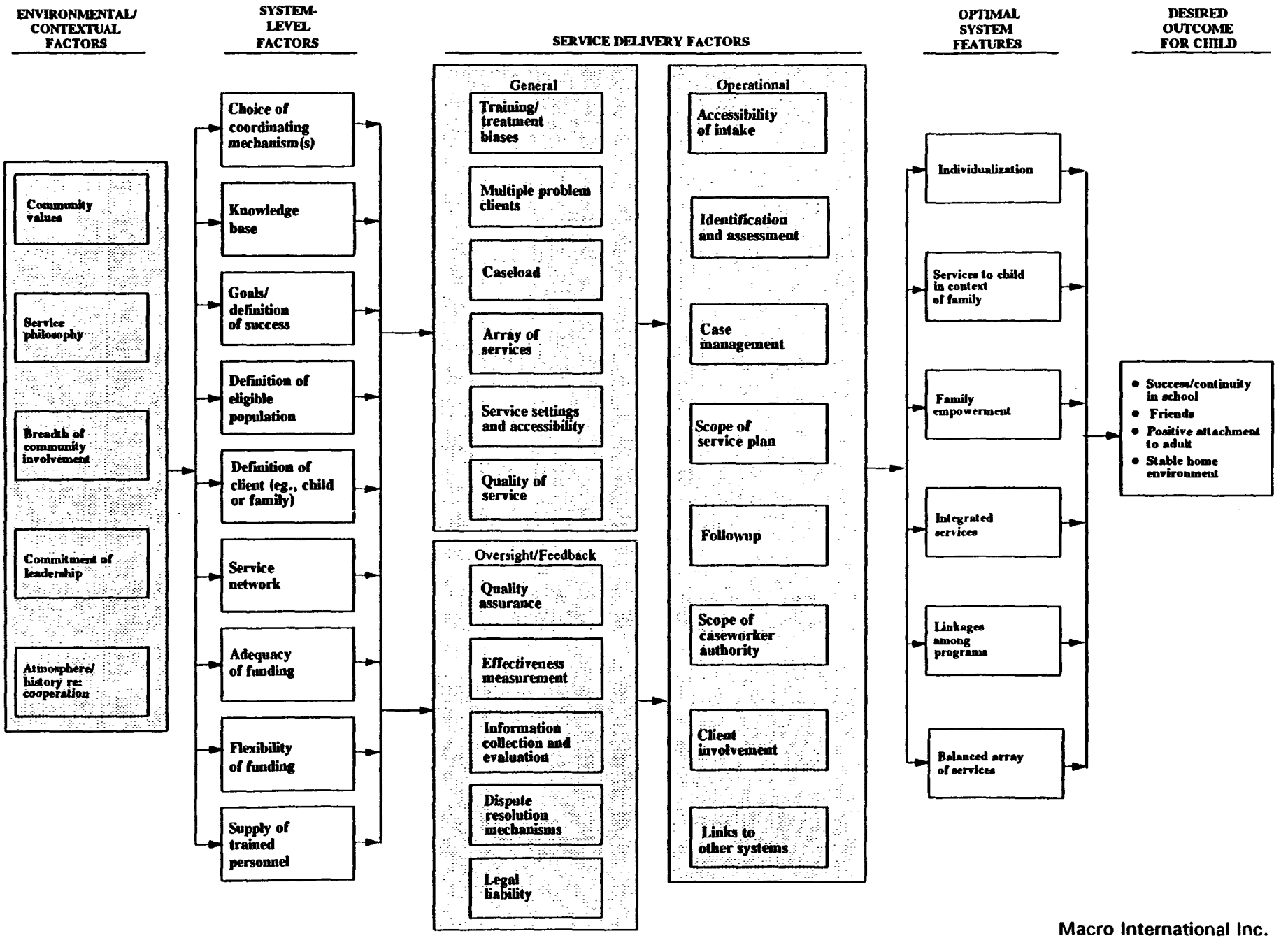
[1] **Factors identified in the analytic framework were identified through extensive discussions with Federal and nonfederal experts in the fields of child mental health, child welfare, mental health law, and education. In addition, policy analyses papers and inputs from staff of the Office of the Assistant Secretary For Planning and Evaluation were incorporated. Literature on collaborative programs used to identify key features included the following:**

Soler, M. and C. Shauffer. 1990. Fiiting fragmentation: coordination of services for children and families. Nebraska Law Review 69(2): 278-297.

Boyd, LA. 1991. Integrating systems of care for children and families: an overview of values and characteristics of developing models. Florida Mental Health Institute, University of South Florida. Draft. Tampa, FL.

ANALYTIC FRAMEWORK: DESIRED OUTCOMES AND FACTORS AFFECTING DESIRED OUTCOMES FOR CHILDREN IN CHILD WELFARE WITH MENTAL HEALTH NEEDS



Macro International Inc.

Study Aims, Factors, and Related Research Questions

Study Aim	Factors Affecting Coordination	Selected Research Questions
Identify the ENVIRONMENTAL AND CONTEXTUAL FACTORS which frame the development and implementation of successful strategies to address the mental health needs of children in the child welfare system.	Community values	What was the impetus for change? How widespread was the felt need for change? Was need felt at the community and system level as well as at the service delivery and client level? What was the political climate for change?
	Service philosophy	What is the overarching service philosophy of the agencies involved in the collaboration? Is the project consistent with this philosophy, inconsistent, or does it represent a new attempt to change philosophy?
	Breadth of community involvement	Which entities and agencies are involved in the collaboration? Is it one agency's "baby" or are others willing partners? Are major interest groups such as advocacy groups, philanthropic organizations, and unions involved?
	Commitment of leadership	Was the impetus for change felt at the top levels of the organization? Does the top leadership understand the intent and importance of the efforts? Is the top leadership willing to help "grease the wheels" within the bureaucracy?
	Atmosphere/history of cooperation	Have the agencies and entities involved collaborated before? Can their historical relationship be characterized as cooperative or adversarial?
Identify the necessary components and mechanisms, the facilitators and barriers, and the most successful strategies at the SYSTEMS LEVEL for addressing the mental health needs of children in the child welfare system.	Choice of coordinating mechanism(s)	What mechanism was used to develop coordination? Was an interagency agreement used? What is the content and scope? Who was involved in development of egreement? What were the incentives to initiate collaboration? What is the scope of collaboration--goal setting, planning, needs assessment? Who "runs" the coordinated effort at the system level? What mechanisms ensure participation of all agencies? What are the incentives to maintain collaboration?
	Knowledge base	To what extent do staff believe that available treatment services are based on research and demonstrated efficacy?
	Goals/definition of success	What does success mean? Were there differences in how each party defined success? How were differences resolved?

Study Aim	Factors Affecting Coordination	Selected Research Questions
	Definition of eligible population	How has target population been defined? How broad is range of child welfare cases addressed? How broad is range of mental health needs addressed? Were differences in target population of collaborating systems found? How were these resolved?
	Definition of client	Who is the focus of the services--the child, the family? Was this a shift for either agency? How was it resolved?
	Service network	What types of providers are in the service network for each agency? How closely do the networks resemble each other'! Do services duplicate or supplement each other?
	Adequacy of funding	How adequate is the funding relative to the need for services? How are the coordinated services funded? Were new funding sources employed? Were existing funds pooled? Is funding soft or hard money?
	Flexibility of funding	How are the coordinated services funded? What obstacles were encountered in funding services? Were new funding sources employed? Were existing funds pooled? Is funding soft or hard money? How were categorical funding problems surmounted? Which services receive the bulk of the funding? What are the incentives or disincentives to use certain services?
	Supply of trained personnel	How adequate is the supply of personnel with the training required to serve the clients participating in the collaboration?
Identify the necessary components and mechanisms, the facilitators and barriers, and the most successful strategies at the SERVICE DELIVERY LEVEL for addressing the mental health needs of children in the child welfare system.	Professional training and resulting treatment biases	What are the professional backgrounds of the staff? Have the collaborating agencies traditionally regarded each other's approaches with skepticism?
	Multiple problem clients	How and by whom is planning done? How are multiple case plans avoided or integrated for the child? For multi-problem families, how are plans of family members integrated?

Study Aim	Factors Affecting Coordination	Selected Research Questions
	Size of caseload	What are typical case ratios? What are the consequences of high caseloads--focus on crisis only, narrow definition of responsibility etc?
	Array of services	What is the array of available services? What are the major service gaps? What is the relationship to referral resources? Are agreements formal or informal? Are spaces guaranteed or do clients wait for openings?
	Service settings and accessibility	Where are services provided? How accessible to the client in terms of location or hours? Are each agencies' services provided in different locations? Can the service provision be consolidated?
	Quality of services	How is quality defined? Do services measure up to defmition? Do services meet state and Federal legal requirements; applicable professional standards?
	Quality assurance	What mechanisms are in place to assure quality of services? Are case plans reviewed? What is the process for this? Who reviews case plans? How are results of quality assurance integrated into service planning?
	Effectiveness measurement	What are the primary indicators of effective and satisfactory services? Are they formally stated or agreed upon? To what extent are these measured? Do measures include both systems measures and client measures?
	Information collection and evaluation	What type of information is collected? Program level? Client level? How often is the information collected? Who is involved in collecting/sharing data? What are the confidentiality issues and barriers and bow were they overcome? Are the information systems for the entities involved shared? The reporting formats?
	Dispute resolution mechanisms	What types of disputes arise between system? How are disagreements resolved? Between providers? How are these resolved? How are disagreements between clients and providers or the service system handled? Do resolution mechanisms include due process, notice of complaints, a neutral decision-maker, and a record of the decision?

Study Aim	Factors Affecting Coordination	Selected Research Questions
	Legal liability	What legal issues constrain staff's involvement in innovative practices? How do they differ across systems?
	Accessibility of intake	Is intake physically accessible; i.e., brought to the clients or conducted in a location that can be reached by public transportation? Are hours broad enough to accommodate working parents? Is the intake environment comfortable--i.e., clean, hospitable? Are clients treated with respect?
	Identification and assessment	How are clients with mental health needs identified? How are barriers related to categorical eligibility overcome? What prompts assessment--crisis, referral, periodic needs assessment? How is a multi-agency perspective incorporated?
	Case management	Who does case management? How is a multi-disciplinary perspective incorporated into case planning and management processes?
	Scope of service plan	Who does case planning? When is the case plan initiated?
	Followup	When does a child or family stop being a client?
	Scope of caseworker(s) authority	Are the responsibilities of caseworkers narrow or broad? How many different caseworkers might a client have? How much do responsibilities of caseworkers overlap? Have changes been made in the scope of authority of the case manager--i.e. more control of resources for service provision or referral?
	Client involvement	Are families involved in case planning and treatment? What mechanisms are used to involve families? What is the quality of the relationship between families and caseworkers?
	Links to other systems	(How) are school and criminal justice system involved in service provision, goal setting, and case planning and management for child welfare clients with mental health problems? What are the incentives for systems to collaborate?

Case Study Plan

Study of Community-Based Mental Health Services for Children in the Child Welfare System

Submitted to:

Assistant Secretary for Planning and Evaluation

by:

Macro International Inc.

December 19, 1991

Study of Community-Based Mental Health Services for Children in the Child, Welfare System

I. Introduction

Identifying the appropriate respondents, planning, and clear delineation of information to be explored are key aspects necessary to conduct successful site visits. An orderly process in conjunction with well-trained staff and detailed discussion points and probes will help ensure effective and efficient field work.

The purpose of this case study plan is to describe the steps and activities that will be undertaken to conduct the site visits, present a detailed description of the topics to be discussed on site, and describe how the information obtained during the site visits will be summarized. Setting forth the activities will ensure that site visit staff approach the site visits and discussions in a consistent manner and obtain the same level and detail of information.

For purposes of this study, site is defined as a state, county or local jurisdiction that has implemented efforts to meet the needs of children with mental health problems in the child welfare system. Such efforts can involve unified service systems, collaborative relationships among child serving agencies, and a variety of innovative funding and service delivery approaches. Exploration of such efforts will include discussions with key persons involved in planning and implementing the efforts as well as program level staff involved in delivering services that emanate from these efforts.

Background information on each site selected for visitation was collected through telephone interviews with key persons involved in the effort during the site selection phase of the project. This information will be reviewed and incorporated into the process of arranging the site visits and the discussions held on site by the individual site visitors assigned to each of the sites.

Each site visit will be 3 to 4 days in duration and will be conducted by a team of two site visitors.

The plan includes a discussion of the following:

- Types of persons to be interviewed
- Initial contact with sites and identifying relevant persons to be interviewed
- Scheduling interviews
- Conducting the site visits
- Summarizing information obtained during the site visits

II. Types of Persons to be Interviewed

To obtain a complete understanding of the efforts to address the mental health needs of children in the child welfare system in any given locality, a range of persons will need to be interviewed. These include key leaders and decisionmakers, persons involved in planning and initiating the efforts, and those involved in administering and providing services. In addition, at the program level, key persons in the service/referral network will be contacted. Attachment A lists the range of candidates who may be interviewed for a particular site as well as their potential organizational affiliations and roles. Roles of these candidates may overlap, and only a few selected persons may be relevant for any given program being studied. The next section discusses how individuals to be interviewed in each site will be identified.

III. Contacting Sites, Identifying Relevant Persons to be interviewed, and Scheduling Interviews

For each of the five sites to be visited, some of the key persons to be interviewed were contacted during the site selection phase of the project During this telephone conversation, an initial list of potential contacts was elicited. Site visit staff will review this list and identify any key roles or organizational representations that may appear to be missing (using the list of types of persons presented in Attachment A). As the first step in setting up the site visits, we will recontact the persons who were initially called during the site selection phase, inform them that their site was selected for visit, and review once again the list of persons to be contacted and probe for suggestions for any of the roles/representations that seem to be missing. We will also explore convenient dates and times for site visit.

Once the initial contact persons have been scheduled for interview, we will proceed to contact other persons identified, and schedule their interviews. With each of these persons, we will explore suggestions for additional people to contact, in the event any were missed by our initial contacts. We will also request them to prepare a package of any written documents available that describe their service effort, and document utilization or outcome data, and any other materials they feel may be relevant, for the site visitors to receive while on site. If the proposed dates for site visit are impossible for any of the persons identified, we will explore with them suggestions for a substitute or as an alternative, arrange a telephone interview at their convenience.

Letters confirming the interview dates and times, reiterating the purpose of the interviews, and describing the types of written materials that we would like to receive while on site will be sent to all contacts.

IV. Conducting Site Visits

Site visits will be conducted by teams of two Macro staff. All discussions will be guided by the discussion topics outlined in Attachment B. Topics and questions flow from the study's analytic framework and are organized into three broad areas: 1) environmental/contextual factors; 2) system-level factors; and 3) service delivery factors. Within the category of service delivery factors, we will examine general issues, oversight and feedback issues, and operational factors.

The information obtained during the site selection phase of the project will provide site visitors with a solid baseline of information from which to begin their discussions. The discussion guide is written to reflect this general understanding of the nature of the effort to be examined, and is designed to delve into the specific characteristics of the effort. Many of the sub-topics and areas of exploration cross over two or more of the broad categories described above. This allows us to explore the issues from the genera3 perspective of the environment or context of the service system, from the perspective of the service systems in place and the from the perspective of the specific service delivery factors. All of these perspectives interact and impact on optimal program features and desired outcomes. Clearly, not all questions will be asked of each individual with whom we meet. Each conversation will focus only on those topics related to the individual's organizational affiliation, role and area of expertise.

The following characterizes the type of person with whom we will explore issues in each category of questions:

- Environmental/contextual factors-all respondents.
- System-Level Factors-key persons identified as formulating policy, planning and initiating efforts. In addition, program administrators will be asked questions related to funding and personnel.
- Service Delivery Factors--key persons involved in administering programs, providing services, and in the service delivery network

However, it is likely that key respondents identified will have a broad range of involvement and responsibilities and many will be asked questions that cross topics and categories. For example, a key contact within a state child welfare agency may be directly responsible for a program that provides services, and also have an. overview/leadership role and so would be asked about the general supply of trained personnel (question II. H.) as well as the more specific questions about the number, and roles of service delivery staff (question III. A).

Prior to the site visits, site visit staff will meet as a team to review the discussion guide and become familiar with all topics to be explored. Prior to each scheduled interview, the site

visit team assigned to each site will review the discussion guide in relation to. the individual's self-described role to determine which topics will be the focus of the discussion. In this manner the discussion guide is individualized for each interview.

V. Summarizing Site visits

Upon completion of each site visit, a debriefing will be held among site visit staff. The debriefing will include a discussion of findings and issues encountered. In this way, information gleaned from each site visit will serve to inform subsequent site visits.

In addition, each site visit will be summarized into a standardized report format. The outline for the site visit reports is included in Attachment C. As the site visit reports are written, staff may identify issues needing further clarification At this point, we will recontact persons interviewed as needed. In addition, the draft reports will be sent to selected respondents in each site to review for accuracy.

Attachment A

Types of Persons to be Interviewed

Attachment A
Types of Persons to be Interviewed

1. Key persons involved in formulating policy, planning, and initiating efforts:

   - State/local legislators
   - State/local agency staff (e.g., child welfare, mental health, education, juvenile justice)
   - Advocacy groups
   - Court Judges
   - Public and private program directors
   - Demonstration/Federally funded initiative project directors
   - Task forces and review committees

2. Key persons involved in administering programs

   - Public and private program directors
   - Demonstration/Federally funded initiative project directors
   - Line supervisors

3. Key persons involved in providing services

   - Public and private program directors
   - Line supervisors
   - Field staff (e.g., case planners, case managers, case workers)
   - Paraprofessionals (e.g., lay/peer workers, volunteers, foster parents)

4. Key persons in service/referral networks (including sources of referral to program providing the service of interest to this study, as well as sources to whom the program refers).

   - Public/private programs (program directors and/or field staff)
   - Individual consultants

Attachment B

Site Visit Discussion Guide

Attachment B
Sii Visit Discussion Guide

I. Environmental/Contextual Factors

A. Community Values

1. What was the impetus for change?

2. How widespread was the felt need for change?

- Community/system level
- Service delivery level
- Client level

3. What was the political climate for change?

B. Service Philosophy

1. What is the overarching service philosophy of agencies involved in the collaboration?

2. Is the collaborative effort consistent with existing philosophies or does it represent a change in philosophies?

C. Breadth of community involvement

1. Which agencies/entitites are involved in the collaboration?

- Public agencies
- Private agencies
- Advocacy groups
- Philanthropic organizations
- Volunteer sector/religious groups

2. What are their roles and level of involvement?

- Who has the lead role?
- Are all agencies involved willing partners?

D. Commitment of leadership

1. Was the impetus for change felt at the top levels of the organization?

   - Does the top leadership understand the intent and importance of the efforts?
   - Is the top leadership willing to address bureacratic issues impacting the efforts?

2. What state/local legislation or initiatives influence services in general and the specific approach?

3. Have there been, or are there any impending consent decrees?

4. How committed are government sector and other key players?

5. What is the state/local funding climate?

E. Atmosphere/history in relation to cooperation

1. Is there a precendent for cooperation/collaboration?

   - Have the agencies involved collaborated before?
   - Is their historical relationship characterized as cooperative or adversarial?

2. What are the factors that facilitate or hinder collaboration/ cooperation?

II. System Level Factors

A. Coordinating Mechanism(s)

1. What mechanism was used to develop coordination?

   - Pooled funding
   - Agency/service system reorganization
   - Case management
   - Joint intake/assessment

2. Was an interagency agreement used?

   - Content and scope of agreement
   - Organizations/persons involved in its development

3. What were the incentives to initiate coordination/collaboration?

4. What is the scope of collaboration?

   - Goal setting
   - Planning
   - Shared services

B. Knowledge Base

1. What leads you to believe that your approach will result in the desired goals/outcome?

2. Is the approach/service based on research and demonstrated efficacy?

C. Goals/Definitions of Success

1. What goals are you trying to achieve?

   - Are they formally stated/agreed upon?

2. How are you attempting to document and measure your progress in achieving these goals?

3. Were/are there differences in how the various agencies/staff involved describe their goals?

4. How were differences resolved?

D. Definitions of Eligible Population and Client

1. What is your target population?

   - Age

- Level of mental health needs (i.e. at-risk, Iow severity, high severity)
- Proportion of children served who are in child welfare
- Range of. child welfare cases being addressed (e.g. in supervised homes; in foster care or other out-of-home care; reunified with family; in other permanent placement alternatives)
- Other eligibility criteria

2. Who is the focus of services?

   - Child
   - Natural parents
   - Foster parents
   - Other family members

3. Were there difference in target populations and definitions of client between agencies/programs involved?

4. How were these resolved?

E. Service Network

1. What types of services are available through each of the systems involved?

2. Is there a duplication of services?

3. What are the service gaps?

F. Adequacy of Funding

1. At what level is the program funded (total budget)?

2. What are the funding sources?

   - Proportions of each
   - Any new funding sources employed?
   - Were existing funds pooled?
   - How “soft” is the funding?

3. Is funding adequate relative to the need?

G. Flexibility of Funding

1. What obstacles were encountered in funding services?;
2. How were categorical funding problems surmounted?
3. Which services receive what proportion of funding?
4. What are the incentives or disincentives to use certain services?

H. Supply of Trained Personnel

1. Is the service adequately staffed?
2. Are staff with the training required (i.e. appropriate skill level and cultural competence) available?
3. What are the staffing issues and barriers?

III. Service Delivery Factors-General

A. Professional training and resulting treatment biases

1. What are the professional backgrounds of staff?
2. Is there skepticism between the different professions or agencies regarding treatment approaches?
3. To what extent are there turf issues?

B. Multiple problem clients

1. What are the range of problems that clients are experiencing?
2. Who does case planning to make sure these problems are addressed?
   - Are there multiple case plans?
   - How are these avoided or integrated?

2 What is entailed in doing the case plans?

- How are the multiple problems of a child addressed?
- What problems does the case plan attempt to address, which are considered beyond the scope of the case plan?
- How are plans for family members integrated?

C. Caseload

1. What are the typical case to staff ratios?

- Ideal versus actual
- Do they vary by population served?

2 What are the consequences of high caseloads?

- Narrow definitions of responsibility
- Focus on crisis situations

3. To what extent has caseload hindered the original intent of the program?

D. Array of services

1. What is the array of services made available by this effort?

2 How are they made available?

- By contract
- By referral

3. What is the relationship of the program to referral sources?

- Degree of formality of the arrangement
- Is there a financial responsibility

4. Are services guaranteed?

- Space available/Waiting lists?
- "Entitlement" basis?

5. What are the service gaps?

E. Service settings and accessibility

1. Where are services provided?

- Geographic proximity of various services
- Physical location
- Agency/organizational auspices

2. What hours are services available?

3. How can clients get there?

- Accessibility to public transportation
- Special transportation provisions

4. What are the barriers to access?

F. Quality of services

1. How is quality defined?

2. Do services measure up to definition?

3. Do services meet state and federal legal requirements? Applicable professional standards?

IV. Service Delivery Factors-Oversight/Feedback

A. Quality assurance

1. What mechanisms are in place to assure quality of services?

2. Are case plans reviewed?

- What is the process for this?
- Who reviews case plans?

3. **How are** results of quality assurance integrated into service planning?

B. Effectiveness measures

1. What are the primary indicators of effectiveness/satisfactory services?

   - Are they formally stated/agreed upon?

2. To what extent are these measured?

   - Do they include system measures and client measures?

C. Information collection and evaluation

1. What type of information is collected?

   - Program level
   - Client level

2. How is the information used?

   - Case planning
   - Program evaluation

3. What data collection mechanisms are used?

   - Computerized
   - Periodicity

4. Who is involved in collecting/sharing data?

   - Shared information systems
   - Shared reporting formats

5. What are the confidentiality issues/barriers and how were they overcome?

D. Dispute resolution mechanism

1. How are disagreements between systems/providers handled?

2. How are disagreements between client and provider handled?

E. Legal liability

1. What are the legal liability issues for staff?

   - How do these differ across systems?

2. To what extent do they constrain services/innovative practices?

V. Service Delivery Factors-Operational

A. Accessibility of intake

1. Where is intake conducted?

   - Is it brought to clients, or in a location accessible by public transportation?

2. Are hours broad enough to accomodate varying schedules (e.g. working parents)?

3. What is the environment like?

B. Identification and assessment

1. At what points in the child welfare "process" are mental health needs identified?

   - At the reporting stage.
   - At intake
   - While supervised in-home
   - In out-of-home placements
   - During reunification
   - Points in between, or other

2. **What** prompts assessment?

   - Intake **only**
   - Crisis/child's behavior
   - Referral
   - Periodic needs assessments

3. What procedure is used to assess mental health needs?

   - Assessment tools
   - At-risk categories
   - Professional **judgement/contract** with mental health specialists

4. **Who** conducts the assessment?

   - Intake worker
   - Multidisciplinary team
   - Mental health specialist

5. How is referral for assessment handled?

   - How is information shared?

6. &e/were there- barriers related to categorical eligibility for assessment?

   - How were these overcome
   - How do they impact on the ability to assess and identify children for services?

C. Case Management

1. How is case management defined?

2. **Who** does the case management?

3. How are the responsibilities/multi-agency perspectives incorporated into the case management process?

D. Scope of service plan

1. What is included in the service plan (e.g. health needs, education, housing, economic assistance, etc)?

2. What issues/services are considered outside the purview of the service plan?

3. How are the broader family issues/needs addressed?

E. Followup

1. How long are clients followed?

2. What do followup services entail?

3. When does the child (and family) stop being a client?

F. Scope of caseworker authority

1. What roles do staff in each of the involved systems/agencies play?

   - Scope of authority/responsibility
   - How clearly is this delineated?
   - How is this determined?

2. To what extent do roles overlap?

   - How is this resolved?

G. Client involvement

1. Are families involved in developing their case plans?

2. To what extent are services mandatory?

3. What mechanisms are used to involve families?

4. What is the quality of the relationship between staff and clients?

H. **Links** to other system

1. What other systems are involved in service provision?

2. What is the level of involvement?

   - Goal setting
   - Planning
   - Referral

3. What are the incentives for involvement?

Appendix F

Site Profiles

I. Interviewed for this Profile

Beth Stroul
Management and Training Innovations

Jerry Torano
SED-NET

II. Description of Efforts

In Florida, the SED-NET (the multi-agency service network for severely emotionally disturbed students) was created in response to frustration- about the out-of-home placement costs and process. In 1982, the legislation mandated that child welfare, mental health, and special education together focus on the problems of and services to seriously emotionally disturbed (SED) children. They created two county-based demonstration projects, requiring merely that the county set up an interagency steering council, and giving the counties funds for a small staff to this council. The experiment was successful in that the children seemed better served, and shortly thereafter the program became statewide. Implementation was uneven, but in many counties (and especially the rural ones), the case managers who staffed the steering committee and assumed responsibility for the target children were able to generate local services (e.g., respite care) and to. smooth over crises. Currently SED-NET is implemented throughout Florida.

Many agencies are part of Florida's collaborative effort including HRS, the Alcohol Drug Abuse and Mental Health Agency, Administration for Children Youth, and Family (CYF) including child welfare, child protective services, and foster care; vocational rehabilitation developmental services; local school districts; and the juvenile justice system

The SED-NET program recommended for a site visit was the program in the "Big Bend" district, an eight-county area centered in Leon County and including the following counties: Madison, Jefferson, and Taylor (to the east of Leon), Gadsen and Liberty (to the west of Leon), and Franklin and Gulf (coastal counties).

David Fairbanks is program project manager for the Leon County SED-NET program which is a joint mental health-education effort with child welfare. involvement.

Leon County has a population of approximately 195,000 including a large African-American population with pervasive poverty. Two universities and the state government are also located in this area which creates a "large-city environment."

SED-NET services are provided throughout the Big Bend region; however, the concentration of the services (and needs) are in Leon County.

The Community Mental Health Center is the central source of an array of services including outpatient therapy, day treatment (in conjunction with the schools), home-based services (not just family preservation), crisis intervention, therapeutic foster care and a community psychiatric hospital

Recently, with the use of dollars obtained from cost-savings from shortened residential stays, the SED-NET has purchased community-based and home-based services from private providers.

III. Collaboration

Coordination occurs at both system and case planning levels through multi-agency committees and councils. The first level of coordination is to build a "system- of care" through a variety of community and home-based services. The system of care provides a range of services from home-based treatment to residential placements. The network emphasizes the use of community and home-based services because they. are most beneficial to the child and family, and they are more cost effective.

The SED-NET program has an Interagency Advisory Council, composed of all agencies participating in the SED-NET, which develops an annual service plan, discusses future efforts of the network, and continues to work together to provide effective services to children and families in Leon County. There are multi-agency contracts and cost. sharing mechanisms for all agencies involved in the network.

Florida's mental health service system for children has had an interagency staffing mechanism for many years to review and make recommendations on residential treatment options. Now, a similar mechanism focuses on nonresidential service planning. First introduced in FY 1987-1988, Family Service Planning Teams (FSPTs--the second level of coordination) have been fully implemented in six service districts and were implemented in the remaining five districts in the spring of 1990. The FSPTs use community-based, nonresidential resources to maintain the child in the least restrictive environment and to enhance the ability and likelihood of family participation.

FSPTs focus on the child with a case-based level of community services. Community interagency groups meet to discuss individual cases to plan treatment options which will be the most efficient and effective way to get a child back into the home. This method has proved successful: kids have been brought back into the home sooner, with a large cost savings to the community. These additional cost-savings funds have been used to purchase home-based services from the private sector. At FSPT meetings, a central case manager is

assigned to each case to coordinate appropriate services for the child and the family. These FSPTs use "wraparound" dollars (i.e., flexible funding) to assist families.

Regional planning teams coordinate service delivery and case management.

Another current project that has evolved from SED-NET and from a new 1990 law that requires full-service schools for all children at high risk of emotional disturbance and other effects of poverty (not just SED) is "KID-NET' (not the real name, the program does not have an official name yet). This project is also being funded by the Department of Education. Both David Fairbanks and Mr. Torano are working on this project. In addition, there are efforts in the works to implement an interagency Email to facilitate coordination among agencies.

Joint intake has been part of the school system for several years. Primary health care provided in elementary, middle, and high schools serves as a point of identifying children with specific needs. Otherwise intake and assessments are performed by the individual agencies participating in SED-NET.

IV. Funding

SED NET is funded by a grant from the Federal Department of Education which is given through the State Department of Education. The majority of services are paid for by HRS.

V. Services

Assessment-all agencies participating in SED-NET have eligibility criteria that must be met to obtain funding. Therefore, many assessments may be performed on a child by various agencies. SED-NET hopes the joint data collection and the interagency Email will alleviate this costly duplication of services.

Case Management-is a strong component of services delivered through various providers. Case management is emphasized because Medicaid requires targeted case management in Florida. Each agency may have a case manager; however, when the child is referred to SED-NET, a coordinating case manager is identified. This could be the same person as the case manager from the referring agency, if he or she is the most appropriate one to handle the treatment plan for that child.

Day Treatment-Florida has recently implemented a day treatment program in the schools. This program is particularly targeted to the poor populations, and provides integrated education and mental health services. It is operational in eight districts.

VI. Children Being Served

The majority of children served through SED-NET are from poor African-American families, although the two coastal communities are mostly Caucasian families living in poverty. Although SED-NET has seen all age ranges in their program, most are between the ages of 12 and 14. Poor populations are overrepresented in the caseload numbers in SED-NET. (Mr. Torano thought these estimates were similar throughout the country.) The majority have severe emotional or behavioral problems and are referred from CYF (particularly foster care). Mr. Torano thinks that the program only serves a minority of the population needing services.

VII. Most Notabie Features

Interagency case conferences (FSPTs meetings) and the development of a System of Care are the most important aspects of the SED-NET program. The ability to shorten residential stays is beneficial to the child (faster and more efficient rehabilitation) and the community (reduced costs).

VIII. Additional Contacts

John Bryant
Alcohol, Drug Abuse and Mental Health

Larry Pentacutta
CYF

DC. Additional Contacts for Site Visit

Jane Smith
Subdistrict administrator for HRS

Beverly Bland
Leon Education Department

The other seven counties participating in SED-NET (particularly in schools and education).

I. Interviewed for this Profile

Wes Engle
Coordinator for Children's Mental Health
Bureau of Family Services
Division of Family and Children's Services
Idaho Department of Health and Welfare

Dennis Coe (Social Worker Specialist/Senior)
Asst. to Program Manager, Region I
Also Regional Quality Assurance

Kent Henderson
Chief, Bureau of Family Services
Division of Family and Children's Services

Debbie Scudder
Region I Program Manager

II. Description of Efforts

In April 1989, responsibility for children's mental health was placed within the Division of Family and Children's Services (FACS), along with child welfare, child protective services, and juvenile justice. Integration of family and children's services within one division was intended to provide a single entry point into needed services for children and families, regardless of their source of referral. The Division resides within the Idaho Department of Health and Welfare.

A new position, Coordinator for Children's Mental Health, was created within the state structure as part of the change to an integrated services model. Previously, there was no comparable role. Adult mental health concerns are the purview of a different division.

The integration initiative was a result of several converging forces: interest and concern within the state office that children's mental health needs were not well addressed in existing programs, some stimulation provided by CASSP funding to examine this issue, and strong leadership from the Department director, who comes from a child mental health background. The integrated services division was a result of recommendations of a study group put together by the state to examine options.

III. Agencies Involved

Services are delivered through a strong regional structure (seven regions) of family service centers. The regions determine in large measure what program priorities and services will be provided. Coeur D' Alene is the regional headquarters for Region I in the northern. part of the state. Region I has taken the lead in developing an integrated, family-centered approach to providing services, due in part to the capability and interests of the staff there. Region I is a rural area, with a total of about 100,000 in population within an area approximately the size of Vermont. The region even resembles the shape of Vermont--turned upside down. Coeur D' Alene has a population of 35,000. Other towns in the region average about 2,000 population.

IV. Collaboration

Within a unified services setting, collaboration occurs within the office. Staff fill several roles, depending on whether they are dealing with child protection, juvenile justice, etc. There are not separate staff or separate tracks. FACS gets many referrals from schools in the area, but no single person could be identified to give the "education" perspective.

Staff experience is that the same children come to FACS-sometimes through the juvenile justice route, sometimes through protective services, sometimes from mental health. But basically, the same children have multiple problems. Philosophically, the agency is less concerned which "door" they enter and more concerned about which services they need. This is notably true in Region I.

A hallmark of the Region I program is a continuous "treatment team" approach, with mental health professionals included in the team. Staff include master's level social workers with strong family therapy backgrounds. Certified family therapists generally lead the. treatment teams. There is a shortage of psychologists available, but a family-oriented psychiatrist is available through contract for specific services.

V. Funding

Funding is pooled at the state level, but separate "audit trails" are maintained for reporting purposes to various Federal sources. Services were integrated to allow providers to consider the needs of individual children and families, rather than the categories of funding into which their need for services might be fitted. Programs are staffed from "blended" funds. Funding sources are not a major consideration in service planning Every effort is made to keep service delivery "transparent" for clients and the community and to disentangle needs from available resources from the client's and even the provider's point of view.

State officials feel the fiscal picture is "okay, pretty good" and no major cuts are looming in the future; still, resources are scarce and staff are constantly faced with decisions about which clients can be served. About 15 percent of FACS budget comes from state dollars, with the balance from various Federal funding streams. These include Titles IV B and E, the social services block grant, and Title XX block money.

VI. Services

The intake worker (either a bachelor's or master's level social worker) determines the needs of the child and family at intake. This involves a thorough family history. The intake worker may refer a child to local mental health providers if necessary. However, generally a child and family are assigned to a "treatment team" within the center. The treatment team both provides services directly and serves in a case management role where additional services are needed.

There are four or five certified family therapists on FACS staff in Region I. These specialists may be brought in to assist in assessment if needed. Generally, they lead the treatment teams in working with children and families in an ongoing way. Assessment instruments used by the team include the Achenbach child behavior scales for parents and teachers, as well as family assessment tools. There are also psychiatric services, with strong family therapy orientation, available through a contract arrangement with practitioners in nearby Spokane.

The Region essentially operates on an outpatient therapy model. Sessions are conducted at the Family Service Center and may involve both natural and foster parents along with the children. For "juvenile justice" children, there may be additional services, including supervision and youth companions or "trackers." The trackers help the children with transportation, remind them about therapy sessions, and generally provide support to a variety of activities. Most children who get this service are "acting out." The service is paid for through juvenile justice funding.

A CASSP demonstration grant picks up costs for specialized foster homes. These are reimbursed at two to three times the "normal" rate for foster care. Training and support services are provided by the CASSP program to foster parents. For children NOT in foster care, CASSP provides "wrap-around" dollars and respite care for parents. Effects of using "treatment families" (i.e., therapeutic foster care) and respite services on placement in residential treatment services will be assessed in comparison with another region (Region III) where these interventions are not being tried.

Region I generally has very low out-of-home placement, and FACS is committed to maintaining and increasing that pattern. Placing a child in a residential treatment center for mental health problems means sending the child to a facility that is a 9 to 12 hour drive for parents.

FACS provides funding for day treatment. This is a joint program with two school districts and a residential care provider. It is needed for children who are closer to the "severe" end of the spectrum of emotional disturbance and is an alternative to the child's being kicked out of school.

VII. Children Being Served

The population of children served in Region I is approximately 95 percent Caucasian. There is a small proportion of Native American clients and a small proportion of African-American clients as well. FACS caseloads are difficult to determine, since the approach involves working with natural and extended, as well as foster, families. The Region I program manager estimates there about 100 families in Coeur D' Alene and another 100 in the outlying areas.

It is difficult for service delivery staff to articulate "eligibility" criteria, given a pooled funding approach; and staff are reluctant to express any general boundaries. Service providers note it is a continuing source of discussion, mainly centering on "who we can afford to serve."

State-level staff see FACS as mainly a "deep end" agency, because the client population of FACS has progressed to serious problems before ever coming in the door. However, the Region I program is seen as a comprehensive approach to supporting mental health and other needs of children and families, based on a family-focused assessment and service planning process. The Region I program manager notes that all the children and families in child welfare have problems-conduct, affective, reactions to traumatic experiences. Very few of these children have truly severe psychiatric disabilities such as schizophrenia.

VIII. Most Notable Features

Key features of the Region I program include a strong family focus, a distinct team-oriented service concept, and fully integrated services.

IX. Additional Contacts

Kent Patterson-Administrator of the state Division of Family and Children's Services

Other Region I Staff-Rob Gregory, Patty Fraser, Roy Moe

Joanne Wilson-Curtis, Special Education Director, Post Falls

Scott County Department of Human Resources

I. Interviewed for this Profile

Dennis Timmerman
Director
Scott County Department of Human Resources
Scott County, Iowa

Chris McCormick-Pries
Associate Director
Vera French Community Mental Health Center

II. Description of Efforts

Through legislation, Iowa initiated a program tying funding to the needs of the child welfare client rather than to program categories. A single child welfare budget replaced a system of providing different services under multiple, separate funding categories. The legislation called for the decategorization of funds from the executive branch of the Department of Human Resources (DHR), judicial branch, and local counties to focus on child welfare. This concept was based on "funding neutrality" with the premise that with no additional funds and a decrease in high-cost, high-structure services, a continuum of care could be established for children and their families. Underlying this concept was the goal of serving children and families in their communities, in the least-restrictive, most home-like setting.

Funds for child welfare-related services in these three departments were allocated to a pool, resulting in:

1) elimination of line-item restrictions including rigid eligibility criteria; and
2) involvement of local communities in planning for child welfare services based on their unique needs and attributes.

Two pilot counties were designated, Scott and Polk, and a 3-year project was developed. Since that time, three additional counties have been added, and there is now legislation enabling any county to go in this direction.

The remainder of this profile describes the Scott County project.

III. Planning Process

A complex planning structure undergirds the planning process. They have continued to keep the process complicated so that none of the components would be lost during implementation. At the heart of this process are several committees:

Central Committee. These are the decisionmakers. The committee is made up of representatives from DHR, the county, and judicial. It includes a judge and chief juvenile court officer, the county child welfare department director and the district director, among others. (Note: Child Welfare and Mental Health are under the DHR. Juvenile Justice is not.)

Planning Committee. These are community planners recognized for their planning capabilities in the human services field. Eight of the 13 people are outside of the 3 agencies and include representatives from United Way, local college, local mental health director, and so forth, They are the "keepers of the planning process."

Administrative Committee. This is made up of representatives from the community child welfare agencies. They review all proposed changes and help develop new ideas

Scott County took a "comprehensive visioning approach" to the decategorization project. They set up a series of task forces and included everyone who would be in the system, including providers and clients, and then went through a nominal group process to identify things that could be done and developed a list of goals.

Three-year plans were developed to identify areas of potential cost savings so that new services could be started. These new services have included programs such as:

- day care foster programs
- family-assisted funding
- three-tiered approach to foster care
- secure lock-up for juveniles
- additional funding for in-home services
- day treatment program
- therapeutic foster care for younger children

One of the unique things that came out of the process was a model of interagency contracting. For example, a settlement house provides space for a day treatment center while a family counseling agency provides counseling services.

IV. Case Management

In February, Scott County will initiate a case management system to cross the child welfare and juvenile justice departments. One case manager will be assigned to a family, no matter where they enter the system. If the family has a dual diagnosis, i.e., issues that relate to both systems, then a primary case manager is assigned who has a consultant from the other system. Integration will take place at the supervisory level. The case manager will deliver some services but most of the intensive services will be delivered by other providers while monitored by the case manager.

Each case manager will have a caseload of 25 families. Each family is assigned a risk classification so. that the caseloads can be allocated by risk status and no case manager will be overwhelmed by an overly high-risk caseload.

V. Mental Health

A mental health study committee developed a community plan with seven recommendations. Underlying the recommendations were core values and guiding principles adopted from Stroul and Friedman. The recommendations were developed using a three-pronged strategy:

- Gathered information through review of several cases
- Read pertinent materials and drew heavily on Stroul and Friedman model
- Gathered information on all applications over past 2 years to mental health and substance abuse programs

Three issues formed the backdrop to the recommendations:

- Children are classified by the system they access-in fact, they meet the definition of multiple programs or systems;
- The entire population of troubled children and families are potentially in need of **all services** represented on the task force; and
- There are a rapidly increasing number of children younger than 12 years of age entering the system.

The study committee wanted to decrease the use of institutions for treatment of the adolescent and young client. The plan also called for a residential treatment center, family-centered services, respite services, and a mobile crisis response team. Specific recommendations include the following:

1. Consider soliciting an education representative for the decat planning committee
2. Take leadership in forming an administrative-level community task force to enhance collaboration between CW, MH, and JJ
3. Develop a case review team to offer consultative services to physicians and court when child is admitted to hospital
4. Develop a comprehensive, coordinated data collection system
5. Consider mental health system issues in planning for case management
6. Examine interagency and intersystem issues relevant to confidentiality
7. Participate in attracting a child psychiatrist to community

The plan has not been implemented of yet. It has been difficult in a funding neutral environment to target funds used at institutions (because they are a complex mix) and redirect them back into the community. Recommendations 3 and 5 are underway.

VI. Children Being Sewed

The lack of continuity in the definition of mental health has made it difficult to determine the eligible population. In the past there was an effort to identify all SED children but that was not successful. The definition included every child in the child welfare system because they used the Stroul and Friedman definition.

VII. Other

Scott County has just been approved for a $2.8 million grant for substance abuse programming. They are going to establish another locked facility for kids with dual diagnoses of substance abuse and juvenile delinquency. Again, they will have an interagency contractual arrangement-the substance abuse agency will provide counseling and a child welfare agency will provide residential treatment with a cross-section of professionals to conduct diagnosis and evaluation.

The Robert Wood Johnson Foundation (RWJ) asked the county to develop a decategorization proposal for child health after they saw the child welfare project It is now being funded by RWJ and will interface with the child welfare project. It is here that the mental health component can take real shape.

VIII. Additional Contacts

Shelley Klaus
Bettendorf School District
(3 19) 359-3681

Judge J.G. Mullen
(319) 32643611

Dennis Timmerman was very positive about the possibility of a site visit to Scott County.

I. Interviewed for this Profile

Nancy Rawlings, Director
Division of Family Services
Kentucky Department for Social Services

Note: The director was not available for interview until the afternoon of 12/19 and preferred not to provide additional names in advance of her own interview. Additional suggestions from her include the Jefferson County program manager, who she feels can refer us to individuals in the courts and the mental health center for additional information.

II. Description of Efforts

During 1985, the Kentucky legislature appropriated more than $8 million to support family-based services. This action followed a period in the early 1980s when Federal and state funds decreased substantially while child abuse and neglect reports doubled, and was stimulated by findings of a committee appointed by the Governor to assess existing services. This commitment of significant state resources enabled the development of an innovative family-based services program, implemented through the Department for Social Services. Services are oriented to the family as a whole, rather than an individual within the family who is exhibiting unacceptable behavior. A review of programs in other states led Kentucky officials to conclude that it was necessary to develop a unique system to accomplish state goals; one which would use direct service employees as service providers to deliver family centered services. As the system has evolved, contracts are used to supplement service delivery and provide some services the Department does not deliver directly.

The Department's stated mission is to assist families to maintain or regain family autonomy while at the same time assuring protection of individuals. A variety of interventions and techniques are used in adult cases and in the context of family-based services, with emphasis on 'building competencies of an individual and appropriate family members, while mobilizing community resources to empower the family to enhance self-determination and self-sufficiency."

Kentucky views the out-of-home placement rate as a key measure of success of the family-based services program. While other states have seen an increase in these placements with resulting financial stress, Kentucky has stabilized the out-of-home population in relation to continuing increase of referrals related to child abuse, sexual abuse, and neglect.

Among the interrelated programs which comprise the statewide Kentucky model are the following:

A Family Preservation Program involving intensive services over a 4 to 6 week period with families who have one or more children at imminent risk of removal from their homes. The primary emphasis is on teaching/empowering skills to family members so families learn to function on their own

The Preventative Assistance Program which seeks to alleviate emergency financial problems of families in crisis to prevent removal of children and/or the elderly and to aid in returning children to their natural homes when finances are the major barrier. The program is also designed to assist at-risk adults needing immediate protective services intervention. State funds are available up to $500 in financial assistance per household during the fiscal year.

Intensive Family-Based Support Services initiated and tailored to specific needs by a Family Services Worker. The worker deveiops an individualized plan and remains involve as the case manager, monitoring case progress. A wide range of services are included: comprehensive medical, psychological, social and educational assessment; discharge planning, when appropriate; planned support services to assist with routine day-today activities crucial to stabilizing the child in the family unit; family intervention services, including behavioral and family counseling; respite care to allow biological or foster parents relief for a designated period; in-home/foster home paraprofessional attendants to provide direct in-home services; alternate living units; and other services such as educational consultation and support, crisis intervention, skill development, or others identified in the treatment plan.

Kentucky Impact, targeted to SED children and supported by a specific $20 million appropriation from the legislature. Services include respite care, early childhood support, therapeutic after-school programs, day treatment support services, special parents and remedial care, residential care for psychiatric needs, community-based aftercare services, clinical support staff, intensive in-home services, and private child care for multiple problem children.

Family Resource/Youth Services Centers an education reform effort developed as a responsibility of local schools in which at least 20 percent of the student body is eligible for free school meals. The centers develop linkages among child serving-agencies in the community to assist and support children in achieving educational goals.

In addition, family-sensitive residential treatment, child care services, and post-legal adoption services are included in the full array of family based services.

III. Agencies Involved

The Kentucky Department of Social Services (DSS) is a centrally administered system which incorporates child protective services and juvenile justice within one agency. Service delivery is implemented at the district level.

The locality recommended for site visit for this study is Jefferson County, specifically Louisville. Jefferson County has its own district-the largest in the state. DSS maintains 31 contracts with a variety of other agencies for services. The major mental health agency is the 7-Counties Mental Health Center. However, the mental health center does not have a child mental health program. The courts are also actively involved in collaborative activities with DSS and mental health.

Jefferson County has a population of approximately 950,000. Louisville has a population of 600,000 and considers itself an urban area.

It may also be useful to spend some time in Lexington (an hour or so away) visiting the family service center there. The Lexington family service center is funded by an RWJ grant and was recently visited by Jane Baird from ASPE. Its focus is early intervention with "Level 1" kids. The program is further described below.

IV. Services

In Jefferson County, children in levels one to three are being served with collaborative family preservation efforts and other family-based services for multi-problem, dual-diagnosed children. There is an excellent statewide SED program, Kentucky Impact, which may be examined more closely in Louisville and which has a "spill over" effect on services for all children with mental health problems.

Other specific aspects of the Jefferson county program include:

- A "Child Advocacy Center," recently funded with state dollars, which involves bringing together specialists from social services, law enforcement, medical and mental health services in a single "child friendly" location to help children who are believed to be victims of sexual or serious physical abuse. The Center grew out of interagency agreements and the Jefferson County Criminal Justice/Social Service/Child Abuse Consultation Team that has been meeting regularly over the past several years.

- R.E.A.C.H. of Louisville (Resources for Education, Adaptation, Change and Health), which provides short-term behavioral assessment and intervention planning and direct psychological services to "dual diagnosed" children and adolescents, i.e. those with mental retardation and behavior/conduct disorder. The program addresses conduct disorders, learning disabilities, attention deficit disorders, mental retardation, autism, and pervasive developmental disorders. Services include family-based behavioral intervention, in-home attendant care, respite care, staff training, educational consultation, crisis intervention, service coordination, social and recreational opportunities, and social skills training.

- A "Help Team" which includes mental health, social service and court workers which maintains low caseloads (10 or less) to work with special needs families on a more extended basis than can be accomplished by the Family Preservation program.

- A collaborative arrangement with the family court (a new entity in the last year combining district and circuit court functions) in which social services and mental health workers are on site to help assess and support families. The program seeks to "head off more severe problems" by making services available at the point of contact with the court system

- A new initiative is moving out of the design phase and will be implemented beginning the first of the year to provide multidisciplinary assessment, diagnosis and evaluation for emotionally disturbed children in foster care or at risk of out-of-home placement. The program involves collaboration between the University of Louisville College of Medicine and Department of Psychiatry.

Note: Brief descriptions of Jefferson County activities will be forthcoming from staff of the county program within a week or so.

In Lexington, the Family Care Center is a comprehensive facility which includes child care, adult education, and health care for families which are at-risk or include a teen parent_ The program is operated by the Lexington-Fayette Urban County Government, funded by local government, the school system and the state, as well as Medicaid and various grants. Teen parents who do not have a diploma or a GED are eligible, with priority given to AFDC recipients. Although the Center has provided child care and social services since 1972, the Parent Eduction and Health Care program were started in 1989.

V. Children Being Served

Jefferson County DSS handles approximately 4,500 cases a month. Approximately 10,800 individuals are receiving service at any given time. There are 1,119 children "under commitment" to the state. An estimated 300 new intakes for child protective services occur each month, of which about half are substantiated. The population served is primarily Caucasian and African American (about 18 percent of the total).

VI. Additional Contacts

Bonnie Hommerich, Jefferson County District Manager

Individuals from the 7-Counties Mental Health Center and the Courts, to be identified by Bonnie Hommerich.

Stark County-Ohio

I. Interviewed for this Profile

Beth Dague
Coordinator, Stark County Interagency Children's Cluster
Stark County Mental Health Board

Rick DeHeer
Court Administrator, Stark County Courts

John McCall
Program Administrator, Stark County Department of Human Services

II. Description of Efforts

The Stark County Interagency Children's Cluster (Cluster) was initiated by an executive order in 1984. Currently the Cluster is legislatively mandated through the "Cluster Legislation," which requires interagency collaboration throughout the county in order to provide more efficient and effective services to Stark County's children. The Stark County Interagency Children's Cluster is composed of the following agencies: Child Welfare, Mental Retardation and Developmental Disabilities (MRDD), the Mental Health Board, the Child and Adolescent Service Center (the children's mental health agency), the Department of Human Services, the Alcohol and Drug Addiction Services Board, the Canton School System, Canton Health Department, Stark County Family Courts and the local Stark County School System. Cluster participants are bound by a legal contract.

A small grant by the Children's Service Bureau of the Ohio Department of Mental Health provided four, 2-day creative planning sessions for all participants in the Cluster. In these planning sessions, a vision statement was developed and the participants agreed on the driving principles of the system This process is ongoing, and the Cluster meets every year to revise the goals, priorities, and strategies of the system.

III. Leadership

Cluster leadership is provided by a rotating chairmanship (a 6 month position) that is shared by all participants in the Cluster. The current director is John McCall who also is the Program Administrator for the Stark County Department of Human Services. Ms. Dague felt that this rotating leadership has been one of the more positive factors that has helped the county get where they are **today. Rick DeHeer also served a term as chair** of the Cluster. Both McCall and DeHeer stated that they enjoy working with the cluster, and that the chair position was not too difficult.

IV. Size

Stark County is considered an urban area with 375,000 to 400,000 residents. There are 88 counties in Ohio, and Stark is the seventh largest county in the state. Seventy percent of the population is Medicaid-eligible, and the majority of the community can be considered "blue-collar workers." Three cities are located in Stark County-Canton (the largest of the three cities), Massillon, and Alliance. Unfortunately, the city of Canton is severely depressed, and the Cluster has faced some recent fiscal problems.

V. Services

The Cluster is a county effort with services provided throughout the county with multiple locations in some cases. Children are eligible for Cluster services if they have multi-agency needs. They can be identified by any participating agency in the Cluster. Once identified, the child is assigned a case manager who will assist in locating and coordinating appropriate services.

Social services and income maintenance are both housed. in the Stark County Department of Human Services (SCDHS). Social services provided under this umbrella agency include all children's services such as child welfare and child protective services. Not all counties in Ohio have this combined department.

Mr. McCall recognizes that children in the child welfare system have multiplemental health needs, however, SCDHS does not routinely provide mental health services. They usually refer most mental health needs to public mental health (private, not-for-profit) agencies, private providers (who accept Medicaid), and contractors. The SCDHS has a contracting psychologist once a week who works closely with the social workers to determine the appropriate level of mental health needs for specific cases. The county is currently shifting children's mental health services from the more traditional placement services to community-based services, especially for the less severely emotionally disturbed children. These services will be provided in community centers and/or the schools.

The court's participation in the Cluster revolves around the legal decisions that get children into various systems. All child welfare hearings are conducted by the court, and most mental health services are provided through referral to outside agencies. The courts have the standard services (e.g., probation, detention) and Stark County has implemented an in-home detention program that has proved to be very successful. In this program support workers provide intensive family-based services in the home.

VI. Collaboration

The planning and development process of the Cluster is divided into a two-tiered interagency structure. Each tier has a diverse membership, representing all participating

agencies in the Cluster. The Administrative Cluster, composed of all Cluster agency heads, makes decisions about funding concerns, in addition to solving other differences that may arise. The Administrative Cluster also serves as a catalyst for special projects and programs. (For example, the Administrative Cluster is currently trying to implement cross-system-training for professionals and joint intake and assessment plans for the Cluster.) The Accord (A Creative Community Options Review Decision), the second tier, is composed of various managers, service providers, and community members that handle issues at the "system-level" of the cluster. The Accord membership is multi-agency and involves those who have direct involvement with the children.

All Cluster cases begin at the Accord with the identification of a case manager for each Cluster case. If services are not available, the lead case manager calls a Creative Community Options (CCO) meeting, which involves service providers and clients (the child and their family) to develop service plans and treatment options. These meetings are usually called by the system representative who currently holds the lead case management responsibility and always involves the child and family in the planning process. The purpose of these CCO meetings is to creatively examine what might work for the child and family in developing treatment strategies that cover the range of needed services. CCO meetings are not used to discuss the issue of funding responsibility or to blame parents. It is strongly felt that such negative discussions prevent creative solutions to problems.

The Accord also serves as problem solver and reviewer for the CCO meetings. If problems arise, referral is made back to the Accord. If consensus is reached, the lead case manager will assist in the referral process to the various agencies. If no consensus can be reached (after review by the Accord) on services and/or resources, a referral is made to the Administrative Cluster.

All three interviewees described their future plans for a joint intake process and assessment activities. This is a goal that the Administrative Cluster has discussed, however, no action has been taken to implement the process. Mr. McCall noted that the Cluster has been happy with the multi-agency assessments and that the agencies also feel comfortable with the current process. The Cluster "trusts" the individual agency assessments, and the Accord works out any unexpected difficulties.

All three interviewees also described the Cluster's recent joint data collection effort. They have their first two months of data about the number of children served in each agency, the current status of the children, how many are in foster care, therapeutic foster care, home-based treatment, and cost information All agencies in the Cluster have a joint data collection form. Ms. Dague noted that they "were not where they wanted to be" in terms of joint data collection efforts.

VII. Funding

Services are funded through a blended pool of funding which is used to pay for Cluster services. The services provided are described in the next section. The following core agencies contribute funding to the Cluster, a total amount of $350,000:

The Stark County Department of Human Services	(49 percent)
The Stark County Mental Health Board	(30 percent)
The Stark County Board of Mental Retardation and Developmental Disabilities	(20 percent)
The Alcohol and Drug Addiction Services Board of Stark County	(1 percent)

Other member agencies participating in the Cluster may consider contribution on a case-by-case basis, considering the child's need and the services provided by that agency. These member agencies include, but are not limited to, local and city school districts in Stark County, health departments in Stark County, and the Family Court and Job Training Partnership. Mr. McCall, Chair of the Cluster, has been in the process of trying to get more agencies/systems to contribute funding to the Cluster. He also stated, "even if the Cluster runs out of money...one way or another, the child will get services."

A child's lead case manager will pursue all appropriate sources of funds for the case, including, parental support, insurance, Medicaid, Social Security and SSI. Costs recovered from any one or more sources will be reimbursed to all contributing agencies, whether core Agencies or noncore Agencies, relative to their contribution.

VIII. Services

Prevention/Early Intervention-Currently the Cluster is trying to expand the target population definition to include less severely disturbed children. They are in the process of discussing a restructuring of mental health services and child protective services to initiate early intervention programs, particularly in the schools. The Cluster has also approached two private foundations in the area to help create a public/private partnership to expand the target population to reach at-risk children earlier.

The SCDHS is not directly mandated to provide prevention/early intervention efforts. However, a large majority of their efforts are utilized to educate other systems about (1) the importance of early referrals, (2) funding opportunities to provide prevention efforts, and (3) educating community groups and schools about the benefits of recognizing risks and early referrals.

The courts provide prevention/early intervention services largely through an educational program in the schools for grades 3 through 5-a basic "how to stay out of trouble" program.

Assessment-The Cluster does not have a single point of entry. Any system involved in the partnership can refer into the Cluster, performing its own assessment. However, the Cluster wants to develop a more consolidated assessment effort: joint intake and assessment is a goal. The Cluster recently wrote a grant to develop multi-system training for case managers. The grant was approved but not funded. The Cluster has continued with efforts to educate and train case managers in the similarities and differences among the various systems in the Cluster and is in the process of establishing various protocols for assessments in each system.

SCDHS focuses on the protection of children and the preservation of families. All clients referred are assessed for risk of abuse and/or neglect.

The courts provide assessment mainly through psychologists and other methods if required (i.e., medical need). Court staff are responsible for gathering social data.

Case management--Each system has case managers. The Cluster wants to provide cross-system training for each system's case managers.

The Accord appoints a lead case manager to coordinate all services needed for each child referred into the Cluster. Often, SCDHS workers are legally responsible for the child and therefore are designated as case manager.

Case management has been part of Child Protective Services (CPS) for years. In essence, the CPS system provides two case managers for each case: (1) an intake coordinator who assesses the risk for abuse/neglect and (2) a social worker who is responsible for the coordinating services.

In the court system, the intake officer serves as the case manager and makes decisions, referrals, and followup visits. Intake officers are educated about the agencies and resources available throughout the community. A child referred to the Cluster from the court might be assigned to another case manager at that point.

Outpatient Treatment-is provided by the Child and Adolescent Service Center located in six sites throughout the county. The Child and Adolescent Service Center focused on SED children in the past; however, they plan to expand to include all children at risk of emotional, behavioral, or mental health problems. The center provides extensive mental health services and serves as the comprehensive mental health agency for Stark County. This is a large agency with a budget of $2.1 million.

Home-Based Services-are also provided through the Child and Adolescent Service Center. The courts provide a unique In-Home Detention Program for delinquents (have committed a crime) and unruly children (have not committed a crime). A case worker provides intensive home therapy for the child and the family. This program has reduced by 90 percent the number of unruly children that the courts previously had to detain for 24 hours.

Day Treatment-is provided by the Shipley Day Treatment Center, which has joint funding from mental health, education., and child welfare. The program serves children with severe behavior problems and handicaps.

T.I.E.S., (Therapeutic In Home Emergency Services)-the Child and Advocacy Program, is also supported through joint funding, but primarily mental health dollars. This program is for sex victims, sex abusers, those at risk for sexual abuse, and others at risk of removal from home. The underlying principle of T.I.E.S. is that children with mental health problems are best served while remaining with their families whenever possible. Crisis intervention techniques and a family system framework with structural family therapy techniques are utilized.

T.I.E.S. therapists, in addition to providing home-based crisis intervention and family therapy, teach daily living skills, coordinate community resources, and provide concrete services. During the second phase of ongoing therapy, treatment goals include resolving areas of family dysfunction that contributed to the threat of the child's removal from home. To be eligible, a family must have a child under 18 who is severely emotionally disturbed and in imminent danger of being placed out of the home. Clients receive 11 hours of therapy each week for a 6-week period. That first intensive home-based phase is followed by an ongoing phase of weekly office-based therapy during which deeper issues related to the family's functioning can be addressed

Foster Care, Special Foster Care, Intensive Home-Based Care and Residential Treatment--are also provided through the Cluster for children in Stark County.

The courts have a residential treatment center where juveniles from several counties live, receive counseling, and education

IX. Children Being Served

A. Beth Dague gave the following estimates of demographic information for Cluster clients:

- 888 children in custody
- 2,257 children not in protective custody
- 1,648 families in services
- 29 to 33 percent of the population served are minorities
- Half the population served have learning problems that need intervention.

Severity of emotional disturbance: 70 percent SED
30 percent not SED; however, this proportion is expanding

The largest populations served by the Cluster are neglected children (47.3 percent of the population served), physically abused children (28.4 percent), and sexually abused children (17 percent).

Only 50 percent of the population in child welfare receive mental health or Cluster services, and only about 50 percent of the non-SED children are served through the Cluster.

B. John McCall gave the following demographic information for children's services in 1990:

Total number of abuse/neglect reports	3,600
Ages O-5	1,512 (42 percent)
Minority population Stark County	9 percent
Percentage of minority children placed	22 percent

C. Rick DeHeer gave the following estimates of the population seen in Stark County Courts:

- 18-20 percent minority youth
- 50-60 percent are from "broken homes"
- 14-16 year-olds most common
- 20 percent SED

The majority of the population seen in the courts are not SED children, but it is common to see school-based problems and learning disabilities. The majority of children in child welfare are victims of emotional and/or physical abuse and neglect.

X. Most Notable Features

Ms. Dague noted that one of the most notable features of the Cluster program was the blended funded approach which in turn leads to blended programs. In addition, the Cluster's efforts to move beyond the severely emotionally disturbed child to the at-risk population are commendable. Their program also shares a strong sense of unity.

Mr. McCall thought that the Cluster was notable because it inspires such collaboration among community systems to work together towards common goals. For the SCDHS, the goals and mission are simple, protecting children and preserving families, but it is unusual and unique to have several agencies share the responsibility to achieve this goal.

Mr. DeHeer acknowledged that the ability of all agencies involved in the Cluster to ignore the turf issues, in order to discuss and improve the services for the children of the county was the most notable feature. "If we can do this, we can accomplish almost anything." In

addition, the Cluster has not received any additional funding to accomplish this task-this is "unique."

XI. Additional Contacts

Mike Johnson, Executive Director of Child and Adolescent Services
John McCall
Rick DeHeer, Family Court Administrator
Les Able (Beth Dague's Boss)

XII. Additional Contacts for Site Visit

Bonnie Pitzer-Accord member
Christiana Young-Creative Planner and Chair of the Florida Board of Research and Training Center
Joe James (or his designee)-superintendent of the MRDD
Cleo Lucas-City Schools
Ron West or Dick Anderson-County Schools
Robert Patterson-Health Department
Dr. John Thomas-Accord member
Thelma Cost-Accord member

Tennessee Department of Finance, Assessment and Care Coordination Team Program

I. Interviewed for this Profiie

Susan Robinson, National Conference of State Legislatures
Charles Wilson, Director of Child Welfare Services
Jeffery Roberts, Director of Department of Finance and Administration

II. Description of Efforts

Tennessee is in the process of putting into place a statewide assessment, intake and management system for all children taken into state custody as well as for those who are at imminent risk of being removed from their homes. The system involves multidisciplinary case planning teams located in community health agencies across the state. Teams have the responsibility to assess children's needs, prepare case plans addressing needs and provide case management services.

The approach grew out of recognition that the lines of responsibility are blurred among several state child-serving departments-human services, youth development, mental health, and special education-and the need to address the escalating costs of children's services and maximize Federal sources of funding.

Several historical developments led to the current initiative:

- In 1985 Interdepartmental Case Assessment and Management (ICAM) teams were established to report to the judge responsible for making custody decisions. Teams were comprised of representatives from youth development education, human services and mental health, but were charged with this function in addition to full-time responsibilities to their respective departments so they did not have a lot of time to focus on the issues.

- In 1987 the legislature developed a select joint committee on children and youth which included representatives from the Senate and House. The committee's mission was to develop a state policy. They held hearings to look at the problems and issues. Information collected showed a 28 percent-plus increase in out-of-home care per year.

- The concept of an assessment, intake, management system (AIMS) grew out of the ICAM studies and experience. This included teams located in 12 counties to conduct assessments for children in out-of-home care, Problems with this approach included: (1) staff limitations allowed for initial assessment only, and did not include case management; (2) teams had no authority to ensure that

services were delivered; (3) the teams operated under the direction of child welfare which left the potential for departmental bias.

- The Department of Finance and Administration, because of concerns. about appropriateness of care and increasing costs, took the initiative to study children in state custody (a multidisciplinary team reviewed a sample of case records). The study showed that 40 percent of children in care were not receiving appropriate services in spite of the increased amount of money spent. This department then took the lead in developing a Children's Plan The current ACCT approach comes out of this plan and is based on lessons learned from earlier efforts.

ACCT will be piloted in two CHA regions beginning in January 1992--upper east Tennessee and north of Nashville-and will be implemented in all 12 CHA regions statewide by July 1992. Each of the two pilot areas currently has about 750 children in out-of-home placement per year. Statewide, this number is about 8,900.

III. Agencies Involved

The effort is a state-led effort which will be administered at the regional level. Departments involved in the effort include human services, mental health, youth development, education, and health. The Department of Finance and Administration is the lead agency, and the Department of Health has jurisdiction over thecommunity health centers (CHAs) in which the ACCT programs will be located. It was felt that the teams should be outside of the jurisdiction of any of the program agencies to avoid departmental biases. The CHAs were developed 3 years ago. They exercise a fair amount of autonomy because they are administered by local boards, appointed by the governor. The teams will report to the executive director of the CHA.

IV. Collaboration

These agencies have all been involved in the planning and development of the approach. Services under each of the departments will in effect be treated as referral sources by the ACCTs.

V. Fundina

Funding for children's services within each of the involved departments is pooled into one budget administered by the Department of Finance and Administration. Eligibility workers will be assigned to identify funding sources for which each child is eligible as the

child enters the system In this way, the state will be able to increase its effectiveness in accessing relevant Federal funding.

In addition, the state has made changes in the mechanisms used by state agencies in contracting with private providers. In the past, each state agency had its own contracting mechanisms, which meant that often the same private providers were used by several state agencies, but under separate contracts and rate structures. It also meant that different state agencies often were competing for the same services. There is now a single state contract system that will make all contracts, rate structures, and avenues of access uniform.

VI. Services

The ACCTs will be responsible for the first 15 days of care once a child is placed into state custody. During this time period the teams will conduct an assessment using a standardized assessment tool, convene a "staffing" comprised of custodian, natural parents, schools and others who may be involved with the child/family. This will result in a care plan that will determine the type of placement and other services. Services under the case plan span the full range from counseling to residential treatment centers.

Child Protection Services (CPS) and other collaborating agencies will be treated as referral sources. The ACCTs are also given responsibility for ensuring that the case plan is implemented. This authority is backed by an ability to arrange for services on a fee-for-service basis. The case planning function is also supported by a computerized monitoring system, "qualifax," which will give staff the capability to match children's profiles with agencies that provide services and to monitor services being provided.

In tandem with the expanded assessment and services for children in state custody, the statewide family preservation program (Home Ties-modeled after homebuilders) is also being expanded from 11 programs statewide to 26 programs by July 1992.

In addition, new components to existing services are being added through an RFP process. Currently underway are plans to expand the number of therapeutic foster care beds (adding 180), treatment slots for adolescent sex offenders, emergency shelter beds, and programs to serve children with dual diagnoses.

Additional efforts underway include expanding Medicaid coverage for targeted case management services for mental health and utilizing components of EPSDT under medicaid.

VII. Children Being Sewed

The focus is on children in state custody and at imminent risk of state custody. Once the system goes statewide, all children under this category will be served. The Department of Human Services currently has 8,900 children in state custody, and roughly half are adolescents. (This profile differs somewhat from most other systems.) Of children currently in child welfare, 73 percent are Caucasian, 23 percent are African-American, and the remainder are "other" and more than half qualify for title IV-E. Tennessee also has an unusually large proportion of cases in state custody that did not come in under CPS.

VIII. Most Notable Features

Unique aspects of the program include leadership from the Department of Finance and Administration, which is removed from the potential service biases of the program agencies involved; the expanded authority of the assessment teams to include purchase of care; and the approach of starting with new cases coming under state custody and then moving to provide assessments for all children already in state custody.

IX. Additional Contacts

Mental Health (CASSP)--Charlotte Bryson, (615) 741-0651

Department of Health-Kim Skinner, (615) 741-7308
(was director of AIMS)

Assistant Commissioner overseeing CHA's--Dr. Wendy Long (615) 741-7308

Human Services Commissioner-Bob Grunow, (615) 741-3241
Deputy Commissioner-Ed Lake (same number as above)

Youth Development--Cordell Short (615) 741-7232

Education-Joseph Fisher (615) 741-2851

Finance and Administration-Jeff Roberts and Paul VanderMeer (615) 741-4806

Comment: If we were to site visit, to gain a good understanding of how the approach works in practice, the earliest advisable time to come would be May (and even then there will still be many issues to iron out). To gain a good understanding of the design and process, we could go as early as January.

Vermont Department of Mental Health and Mental Retardation: Therapeutic Foster Care Program

I. Interviewed for this Profile

Sherry Schoenberg
Program Development Coordinator
Child Adolescent Unit
Department of Mental Health and Mental Retardation
Agency of Human Services

Steve Dale
Department of Social and Rehabilitative Services
Agency of Human Services

II. Description of Efforts

The Agency of Human Services is an umbrella agency that encompasses most human service functions. The child welfare system (CWS) is contained within the Department of Social and Rehabilitative Services; mental health within the Department of Mental Health and Mental Retardation.

Vermont was a CASSP state and currently has an RWJ grant. Both of these efforts spawned early attention to collaboration within the Agency of Human Services and between its component departments and other agencies such as education.

Efforts in Vermont have been directed at SED kids, but the state intentionally has a very broad definition of SED. The statutory definition encompasses the vast majority of adolescents in need of mental health services and includes those in special education as well as those not in special education. The state has aggressively tried to maximize Federal Medicaid (MA) dollars; since MA payment for treatment is limited to defined categories of children, the' broad definition permits wider use of MA funds.

Vermont has several collaborative initiatives of interest underway; this interview focused on therapeutic foster care and one of the channels into the foster care program--a system of interagency assessment boards. Besides being prodded by the CASSP process, Vermont moved to a collaborative model because of concern about the number of children being sent out of state for residential treatment, the high cost of treating them out of state, and the lack of community alternatives when they returned to their home communities.

Through the CASSP process starting in 1985, the Departments of Social and Rehabilitative Services (SRS), Mental Health, and Special Education began a major effort to identify children and adolescents in need of specialized services. They formed an interagency team

at both the state and local levels and developed a System of Care Plan. Each year that plan has to be reviewed and updated. Under the plan, they have developed:

- intensive family-based services in every region
- significantly expanded residential programs
- respite services
- intensive case managers
- special education programs
- significantly expanded therapeutic foster care programs

The Vermont System of Care Plan is a model with 64 components (we have received a copy of this) to serve children and families. The focus is intensive family-based services; however, we specifically pursued the TFC program because it came closest to the project's main goal.

Fiscally, Vermont faces a large budget deficit, and the services will be level-funded next year.

III. Services

Prior to 1985, there were two therapeutic foster care (TFC) programs in the state. These were serving kids from throughout the state and were accepting CWS and non-CWS kids. The state is divided into 12 catchment areas; the programs were replicated in other catchment areas. Currently, there are 6 programs serving 10 of the 12 catchment areas.

Children in custody are the primary audience for the program, in part because funds for other children have dried up. However, referrals are accepted from anyone for any child. The Vermont child welfare population is made up of children without any parental control (CHINS), delinquents, and those who have experienced abuse or neglect. The TFC population reflects these categories. About 95% of the children in TFC have been abused and most of that has consisted of sexual abuse.

One key source of referrals into TFC is through the local interagency team. These teams in each catchment area have representatives from special education (one of' the special education coordinators from a local school district), CWS (the local director of CW), mental health (the children's program coordinator for the local community mental health center), and a parent. of a child being served. The existence, composition, and duties of this team are mandated by law. Their focus is children who need a collaborative effort to develop a stable service plan. The typical client is a CWS child who has fallen out of many foster care placements and is at risk for residential treatment out of state. When the local team cannot come up with a feasible service plan or resolve decisions over services, the case is referred to a state interagency board which has more flexibility over funding and policy.

The therapeutic foster care program is run as a collaboration of the CWS and MH systems. At the service delivery level, the typical program is run by a community mental health center (CMHC) which has a contract with CWS to supply a certain number of beds. The CMHC bills CWS for the foster care cost, and bills MA for the treatment cost. The CMHC recruits the foster parents and coordinates the' support services necessary to the program.

The typical program staffing consists of case managers, a program administrator, and a clinical coordinator. These are CMHC employees. The foster parents are contractors of the CMHC. In one program, operated by the Easter Seal Society, the recruits are current foster parents who are being trained to better handle the foster children they have or to take on more challenging foster children.

Children usually are referred to the program by the CWS which identifies children who have fallen out of multiple placements. The most disturbed children are almost always placed in TFC; however, there are many children with less severe symptoms that could also benefit from TFC. In Vermont, there are about 950 children in placement and about 100+ of those children are in TFC situations.

IV. Funding

By defining SED broadly, Vermont is able to maximize MA funding for therapeutic foster care. The CMHC coordinates the billing; it bills CWS for the beds and MA for the treatment costs. CWS funds its payment for beds out of Title IV-E.

V. Additional People to Interview

Steve Dale: He is familiar with the foster care system and therapeutic foster care system from the perspective of the Department of Social and Rehabilitative Services, the other partner in the foster care collaboration. (Interview conducted January 3).

Therapeutic Foster Care Program Providers:

Maureen Dwyer
(802) 4792502
Washington Co.

Jeanne Fiorito
(802) 775-2386
Rutland County

Hennepin County Department of Community Services: Family and Children's Mental Health Program

I. Interviewed for this Profile

Mike Weber, Director
Hennepin County Department of Community Services

Dave Sanders, Director
Family and Children's Mental Health Program
Hennepin County Department of Community Services

Carol Miller, Director
Early Childhood Services Unit
Family and Children's Mental Health Program
Hennepin County Department of Community Services

II. Description of Effort

Hennepin County Department of Community Services (DCS) is an umbrella agency that encompasses income maintenance, health, some housing, child protection, family support, and mental health among its many components. Theoretically, issues of collaboration among key agencies are made somewhat easier because the reporting authority is held in common; however, staff indicate that the various divisions of the DCS are just as likely to have differences of terminology and philosophy as if they were separate agencies. Collaborative efforts abound, but these result from consistent efforts on all sides to make the efforts work

Hennepin County has several collaborative initiatives of interest underway, all of which fall under the umbrella of the Family and Children's Mental Health (FCMH) program. This Program was initiated about one year ago to integrate the various efforts directed at children's mental health and to counteract the bias of the existing MH system towards adult MH. The county believes that MH services for children need to look different than services for adults, and, in particular, need to be more closely tied to the other systems serving children. The FCMH Program brought together several early intervention, assessment, and other efforts that were previously spread throughout the components of the DCS. The key issue was how will kids be treated in the MH system The problems had been:

- MH had lots of data privacy rules and was reluctant to give information to CWS
- MH workers wouldn't leave the office, did little outreach
- MH defined the client as an individual, and families were considered five different clients even if seen together.

While Hennepin County was well on its way toward a collaborative and interagency planning model for MH and other services during the 1980s, their efforts were prodded by several state mandates and initiatives. The state's 1989 Comprehensive Children's Mental Health Act mandated a range of services and a model of interagency and family-centered services planning. Similarly, the efforts in early childhood services can be traced to state: initiatives in 1984 and 1986, which resulted, at the state level, in interagency agreements to do coordinated planning for children 0 to 3 years-old. In special education., Federal requirements for an Individual Family Services Plan (IFSP) helped move Hennepin to formalize relationships it had already established informally.

The orientation towards comprehensive, interagency planning permeates all services to children, not just child welfare or MH services. Consequently, while it is hard to find collaborations directed just at the link between CWS and MH, CWS children are the beneficiaries of the wider efforts that try to integrate assessments and service planning for a broad array of educational, developmental, health, and mental health problems. In general, the FCMH Program services do not exclusively serve child welfare clients, but child welfare is one of the key audiences in all cases. Moreover, child welfare status accords priority for services, and about half of the clients in the various component programs of the FCMH Program have a child welfare connection.

Fiscally, Hennepin County is in good shape; it is one of only 14 counties in the U.S with a AAA credit rating. The state faces a large deficit ($300 million for biennium), but compared with other states is probably not in bad shape.

Demographically, the children using these collaborative services are poorer, do worse in school, and are more likely to be persons of color than the population in general. CWS kids are not the majority of those served, but are increasing, as a proportion. Staff indicate that these programs could be filled with CWS clients, but the county chooses to keep the clientele more mixed.

III. Services

The key initiatives encompassed by the FCMH Program include the following:

A. Outpatient Services

The FCMH Program operates a suburban and city outpatient clinic with a staff of 20 clinicians providing early intervention, evaluation, and assessment. Access, on paper, is by internal, external, or self-referral. These services are directed at children who are SED, persistently mentally ill (a state term), or at-risk of being SED. Although

these clinics are a program in their own right, the existence of these services also provides an infrastructure for other department efforts.

For example, the outpatient clinic staff also are in the school system under a collaborative arrangement with school systems and city health departments in Hennepin County. Some of these collaborations include the following

- An expansion of the Early Childhood Service Unit program to include children in grades K-3
- Assigning MH clinicians to the staff of a school-based high school health clinic run by the city health department
- Day treatment programs in the school setting funded by state special education money, health money, and community services

More importantly for this study, selected outpatient clinicians have also been assigned on an experimental basis as consultants to child welfare workers to provide guidance, services, and quality assurance for children identified by the social workers as having mental health problems. Outpatient services through the FCMH program are key source of services for these children. This experimental collaboration will be mandated for all CWS social workers in January. This collaboration is described in more detail in the next section.

B. Early Childhood Services Unit

Although the umbrella program is called the Family and Children's Mental Health Program, it consolidated many disparate systems serving children, not just mental health. No unit within the program typifies this approach more than the Early Childhood Services Unit. This unit is an internal consolidation of early intervention, assessment, and service planning functions. Most relevant to this study is an interagency collaborative effort of public health, DCS, and special education to assess and assist preschool children with developmental issues including mental health and behavior problems. The core services are based in the local schools and include a collaborative interdisciplinary assessment and service planning process. About half the clientele for this program have a child welfare system association.

While clients previously might access these services in a piecemeal fashion or access only some of the services they were entitled to, the Early Childhood Unit is intended to ensure that all agencies view the child's and family's needs simultaneously and that a feasible service plan is developed with input from the family and all agencies.

Referral can be internal, external, or self-referral. The collaborative effort maintains an intake phone line, and initial assessments are done within a few days.Assessments

and referrals can be the result of any number of causes-suspicion of abuse, developmental delay, behavior problems, suspicion of special education need, multiple health problems. The participating agencies jointly fund a pool of intake workers who perform the initial assessment including a family and developmental history. They bring results to an interagency screening board, which is also co-funded. Once the client's needs are identified, the board outlines some options that might fill the need; the appropriate agencies on the board assume responsibility for making their piece of the puzzle work At a second meeting, a service plan is developed based on the additional research of each agency, the family's eligibility for various programs, and the family's desires. The service plan packages any number of assorted services depending upon these needs and eligibilities. This process takes about 6 weeks. The result usually is a complex service plan which draws on the services of all of the agencies in the collaboration.

C. Case Management Services

This is a high-priority initiative of the department to help reduce the number of residential treatment placements. Case management services are provided to any child in residential treatment or defined, per state law, as persistently mentally ill. Where the child is already part of another system such as developmental disabilities or CWS, the case is jointly managed; otherwise, the case manager from the FCMH Program does the case management.

Of particular relevance to this study is one new initiative aimed at SED and at-risk kids. The project will develop a series of four to five foster homes for these children. Crisis staff and clinicians will be assigned to each home to work in the home with the foster child, foster parent, and the natural parent. This is designed as interim care for children with MH needs. While the model is close to a family preservation model, the intent is to serve the mental health needs of the child.

D. Crisis Outreach

The Program has crisis teams of 6 staff (psychologists, nurses, and psychiatric social workers) who provide services in-home to families with an SED or at-risk child Again while the model resembles family preservation approaches, the focus is mental health needs of the child.

IV. Collaboration

While these services are open to children from many different systems, child welfare children are a key audience. In general, child welfare status does not significantly change the process of accessing services except that the foster parent and the social worker are additional players in the process. However, child welfare status does accord priority for services which is important since there is a waiting list for many of the services. Child welfare also affords financial options that other children many not have. Title IV funds are used for foster children who are eligible for AFDC; more importantly, foster children are exempted from the county's requirement that all Medicaid clients be enrolled in an HMO. For mental health services, this provides flexibility in providers that is not available to HMO clients who may be limited to a list of HMO-approved providers.

One key relationship between CWS and MH is the soon-to-be mandated consultation process for child welfare children in need of mental health services. The fear has been that social workers tend to view therapy as monolithic/homogeneous. Little thought is given to the purpose or type of therapy. Some almost go to the yellow pages to select a therapist. As a result, there is concern that only peripheral issues are addressed. Once the mandate is in effect, DCS will mandate that social workers use the FCMH program for CWS clients with mental health problems. The FCMH staff will probe more for reasons for therapy, can provide services directly or help direct the worker to outside providers, and can control quality assurance by giving a seal of approval to certain providers. For example, they are currently working with a day treatment program to develop a specialized program for victims of physical or sexual abuse.

Some workers will like the extra help, others will resent it; however, community services won't pay for MH services in a service plan unless the worker goes through this system. One "carrot" is the availability of direct services through the FCMH outpatient clinics when the client can't find services in the community.

For voluntary services (e.g., homebuilders), the link between FCMH and CWS is even more explicit. Before the FCMH program, separate intakes were done for CWS and MH. Now, the agencies are on the same floor; when a family or client can benefit from the program, intakes are done together for those using the program voluntary. In 1992, a single worker will perform the intake for both agencies.

However, referral of CWS children to mental health services is still the result of social worker initiative; that is, routine assessment of CWS cases is not done by the FCMH program unless the social worker, the parent, or the foster parent raises the issue.

V. Funding

Social services in Minnesota are officially state-funded but administered through the county. However, there has been a shift over the decade in the ratio of state/local funds. It was 66 percent state, but is now 66 percent property tax.

For the collaborative efforts, the funding is pulled from assorted sources available to each agency. The service plans derived as part of the interagency assessment process may involve state special education funds, MA, Title IV, or special appropriations of each agency. Because DCS money is two-thirds property tax, there is more flexibility than if it used only categorical state or Federal money.

VI. Additional Contacts

For the tri-agency assessment team:

- Jan Proehl for education
- Betty Flanagan for public health

Additional contacts if Hennepin were chosen for a site visit:

- Tri-agency staff people
- Agencies working in the schools
  - School-age day treatment
  - Preschool day treatment
  - Specialized program for victims of sexual and physical violence
  - Program with residential treatment center.
- Child protection and family service people
- Juvenile judge: FCMH people have a good relationship with judge [has kept system from being driven by the courts]

Edgewater-Uptown
Community Mental Health Center-Chicago

I. Interviewed for this Profile

Anthony Kopera, Ph.D., Executive Director
Edgewater-Uptown CMHC
4740 North Clark Street
Chicago, Illinois 60640
(3 12)769-0205

Ms. Joanne May, Associate Director of Outpatient Services
Edgewater-Uptown CMHC
(312)769-0205

Anthony Jenkins, Deputy Director
Illinois Department of Children & Family Services
(618)583-2136

Mr. Jeff Buhrmann
Illinois Department of Children & Family Services
(217)785-1495

Mary Lou Hicks, Bureau Chief of Children & Adolescent Services
Illinois Department of Mental Health & Developmental Disabilities
(217)785-7226

Bob Goerge, Ph.D., Resident Fellow
Chapin Hall Center for Children
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(312)753-5900

II. Description of Effort

Edgewater-Uptown Community Mental Health Center (CMHC) has had a traditional child/adolescent outpatient program funded by the Illinois Department of Mental Health and Developmental Disabilities (DMHDD) for the past (20) twenty years. This program, based on a family model, uses family therapy as a primary approach. The program is currently Medicaid Certified and serves a diversified low income multicultural population.

In 1984 CMHC entered into a joint agreement with DMHDD (Department of Mental Health and Developmental Disabilities) and DCFS (Department of Children and Family Services) to develop a Family Support Program for highly at risk families and individuals.

This early intervention outreach program accepts referrals **primarily** from DCFS and provides in-home assessments and services. The program offers a full range of services including parenting education and management services, kids groups and even assists kids with their homework if necessary.

In 1990 the Edgewater-Uptown CMHC began working with the DMHDD to develop the SASS (Screening, Assessment and Support Services) initiative. The Edgewater-Uptown CMHC calls their SASS program **"HomeFirst."** This is a 24 hour, 7 day a week, service to the northern half of the City of Chicago. They serve a service area larger than their regular area and provide emergency services to anyone at risk of hospitalization or extrusion from their family. They, under the SASS initiative, work collaboratively with other providers and respond with anything from rent assistance, foster care, links to other agencies, homemaker services, respite care and respite workers, etc. They primarily respond to requests from DCFS and in that role receive referrals of less severe (SED) kids.

The primary objective of SASS on a statewide basis is to establish a community-based service system which focuses on the development of a screening and assessment capability, as well as intensive home-based services and crisis intervention for families with children and adolescents who have severe emotional disturbances. Additionally, the program allows for the provision of a range of support services, including respite care and **case management** services, to help maintain a child at home in the community and avoid psychiatric hospitalization or other out-of home placement.

The screening, assessment and support provision is available in the child's normal. settings; i.e., home, school and community. The assessment intervention is conducted at the location of the child or adolescent; i.e., school, home, community agency or program, etc. The program involves the family in the assessment and evaluation process. Referrals come from schools, child welfare agencies, DMHDD facilities, courts, hospitals, families, the police and other community agencies. Pre-admission screening of children and adolescents for psychiatric hospitalization to a DMHDD facility (Chicago Reed) of a private facility is provided by the community-based SASS program **24** hours a day.

The Edgewater-Uptown CMHC also has a contract with the Chicago Department of Human Services to provide on-site services to the Head Start programs in 30 schools. Through this effort they identify families and individual children in need of services and assist them in identifying and accessing services as needed.

III. Children Being Sewed

The Edgewater-Uptown CMHC **serves** a multicultural, low income **population.** Their focus is on families with children and adolescents, age 17 and younger, with severe emotional disturbances and who are at risk of extrusion from their families. **"Families"** refers to

families of origin or foster families, A child with a severe emotional disturbance (SED) is one who, on the basis of a psychosis or other emotional/behavioral disorder, suffers from severe disability, which requires sustained treatment interventions for a year or more, and which generally requires attention from two or more agencies or professionals.

The Edgewater-Uptown program is also, on increasing occasion, providing respite and homemaker services in homes where one or both of the parents are dying of AIDS or are substance abusers.

In addition they administer the Interagency Care Grants (ICG's) for 156 kids, many of whom are placed out of state.

Representatives of the Department of Children and Family Services, although they see themselves as attempting to implement CASSP project components, indicate that the CASSP definition of the target population is too restrictive. They are attempting to work out a more liberal definition which will be more inclusive of kids able to make use of counseling and mental health services. Their efforts are now very much driven by the "BH vs Director Suter" consent decree which calls for a comprehensive assessment and an aftercare continuum of care for all children under the care of the Department.

IV. Services

The key categories of services provided by Edgewater-Uptown include the following:

- Screening and Assessment
- Crisis Intervention
- Home-Based Services
- Respite Care Services
- Case Management Services

IV. Additional Contacts

Mr. Jess McDonald, Executive Director, IACMHA
110 West Lawrence
Springfield, Illinois
(800)777-4983

Mr. McDonald, presently the Executive Director of the State Community Mental Health Agency advocacy association was a member of former Governor James Thompson's program staff and spent many years working on the issues of service delivery to children in all of the human service systems.

Mr. Carlton Williams, Administrator North Cook County Region
Illinois Department of Children & Family Services
(312)282-9470

Mr. Joe Loftus, Consultant to DCFS
(312)764-6297

Additional Information for Consideration

Mr. Buhrmann indicates that if Macro and ASPE wish to study the Illinois child welfare system, it would be appropriate to address a letter to Director Sue Suter expressing our interest, outlining our study and requesting her support.

Ms. Joanne May, Edgewater-Uptown CMHC, indicates an interest in a site visit but suggests that we avoid scheduling the visit for the first week of April (April 6-8th), because these are the Spring Legislative Conference dates for IADDA & IACMHA (the state advocacy associations for substance abuse and community mental health) in Springfield.