New York State Conference of

Local Mental Hygiene Directors, Inc.

Integrated Systems of Care for Children's Mental Health: A Technical Assistance Resource Book

Prepared by:

Meridian Consulting Services Inc.

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The Resource Book was developed by Meridian Consulting Services, Inc., a consulting firm based in Albany, New York. Meridian helps state and local governments and not-for-profit agencies redesign their organizational structures and delivery systems to maximize resources and provide high quality services to children and their families. Meridian specializes in working with stakeholders to develop visions for change, outcome-focused planning processes, and integrated funding and service delivery approaches.

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Core Elements of an Integrated System of Care for Children and Families with Complex Needs

Introduction

In communities across New York State, there are children with severe emotional and behavioral problems and their families whose service needs are very complex. While many of these children and families are well known to county departments, providers, and schools, communities are confounded in their attempts to serve them. The coordination, flexibility, and creativity that is essential to helping families of children with serious emotional disturbances is difficult to achieve in the current service structure. The existing system is fragmented, with rigid program requirements established through narrow categorical funding streams and bureaucracies designed to address a single problem or need. One major result is an over reliance on residential services, with too many children being served away from their homes, schools, and communities. A deep-seated frustration with the current system of care is the driving force behind a call for better ways to serve children with emotional and behavioral problems and their families.

In response, the New York State Conference of Local Mental Hygiene Directors, Inc., has taken a proactive role to improve service delivery for children with serious emotional disturbances and their families. As part of its Technical Assistance Project, the Conference selected Meridian Consulting Services, Inc. to review county models of integrated systems of care and provide New York State's County Directors with information on best practices needed to advance system improvements. This document, *Integrated Systems of Care for Children's Mental Health: A Technical Assistance Resource Book*, is the outcome of Meridian's work.

This *Resource Book* includes a description of core elements of an integrated system of care; (pages); profiles of seven state and national models (sections 2-8); family perspectives about these models (section 9); and, an assessment tool to help communities take stock and make improvements in their approaches to serving children and families with complex needs (section 10).

Meridian's Process

Meridian's model selection and research to identify core elements were guided by a Steering Committee, composed of: staff from the Conference of Local Mental Hygiene Directors; Phil Endress, Oneida County Mental Health Commissioner; Dr. David Gottesman, former Albany County Mental Health Commissioner and Medical Director for Kids Oneida; Joan Valery, Families United Network; and Agnes Rivera, Mental Health Association of New York City. To identify national sites, Meridian interviewed experts in children's mental health for suggested models. Experts included: Beth Stroul and Ira Lourie, MD, two well known

authors in this field; Barbara Huff, Executive Director of the Federation for Children's Mental Health; and Pat Sokol, former Director of the Robert Wood Johnson Foundation's Mental Health Services Program for Youth Initiative. New York State models were identified with the aid of the Steering Committee and with input from staff at the New York State Office of Mental Health involved with the implementation of the Coordinated Children's Services Initiative (CCSI).

As a result of these contacts, Meridian selected the following models for review:

County	Model	Population
Chautauqua County, New York	Coordinated Children's Services Initiative	142,000
Milwaukee County, Wisconsin	Wraparound Milwaukee	1,100,000
Oneida County, New York	Kids Oneida	231,000
Sonoma County, California	Youth and Family Services Partnership	450,000
Southern Consortium for Children/ Lawrence County, Ohio	Integrated Services for Youth	62,000
Stark County, Ohio	Stark County Family Council	367,000
Westchester County, New York	Community Networks	898,000

Profiles of the seven models were prepared by Meridian, based on in-depth phone interviews with two to three key individuals at each site, including county mental health directors, program coordinators, and fiscal managers. Each model profile was reviewed by the site for accuracy. For each site, Meridian also interviewed a family representative to obtain their perspectives on the strengths and challenges of the model. Information gained through the model research process was then synthesized by Meridian into a set of core elements to serve as a template for an effective integrated service delivery model.

Description of Core Elements

Meridian has identified nine core elements of an integrated service delivery system that any community should be working towards, regardless of whether the community is large, small, rural or urban. These core elements stand on their own but are clearly interconnected:

❶ Clearly Defined Target Population
❷ Shared Vision and Principles
❸ Strong Leadership
❹ Broad-based Oversight Body
❺ Effective Structure for Care Coordination
❻ Strength-Based Child and Family Teams
❼ Flexible Funding to Support Individualized Care Plans
❽ Meaningful Family Involvement
❾ Ongoing Evaluation

As shown in the following graphic, these core elements cluster into three categories: those that must be implemented at the systems level, those that are central to service delivery, and those that are cross-cutting and must be implemented at both the systems and service delivery levels. To build an effective system of care, the system level core elements need to be firmly in place before developing the service delivery components. The cross-cutting core elements of family involvement and evaluation must also be incorporated in the initial phase and kept in the forefront throughout all steps of the system reform.

❶ Clearly Defined Target Population

As with any new program or reform effort, achieving clarity about who the initiative is intended to serve is an essential first step. Identifying the target population is a prerequisite for all program planning, including the identification of the service systems and key stakeholders that should be involved, and the potential funding streams that can be used to support the new model. The selection of a target population is usually shaped by the experience of managers in local child-serving systems who collectively define a group of children that are very challenging or costly to serve. The target population is sometimes driven by a state initiative that either mandates local action or provides funding as an incentive to improve services for a particular population.

Based on the model research, the target population for integrated systems of care initiatives fall into one of two categories: 1) children with serious emotional disturbances and their families; and 2) children needing assistance from multiple service systems and their families. The second is a broader target population that incorporates many children with serious emotional disturbances. The target populations for the seven models are summarized below:

County	Children Needing Assistance from Multiple Systems and Their Families	County	Children with Serious Emotional Disturbances and Their Families
Chautauqua County	Child involved in: a) multiple service systems without improvement or b) served in one service system for a considerable period of time without significant improvement.	Milwaukee County	Youth who have a mental health diagnosis and are identified by the child welfare department or juvenile court as 1) needing an out of home residential placement, or 2) able to return to the community from a residential placement if Wraparound Services are available.
Stark County	All families voluntarily seeking services and all children who are abused, neglected, unruly or delinquent between the ages of birth through 21. System of care efforts focus specifically on children and their families whose needs can not adequately be met by a single service system.	Oneida County	Child deemed at imminent risk of out of home placement in a residential facility or psychiatric impatient facility and having a DSM-IV diagnosis.
Sonoma County	Youth who are involved with or need services from more than one service system. A child and his/her family may also be referred if the child is at risk of a higher level of service or exacerbated emotional problems.	Southern Consortium for Children - Lawrence County	Youth with severe emotional disturbances who are at risk of out of home placement in the child welfare system or in a juvenile corrections facility as well as those who are returning from such placements.
Westchester County	Child that a) any community service provider is facing difficulties serving or b) that needs the assistance of more than one service system in addition to education.		

How a community defines its target population has implications for funding. Communities that exclusively serve children with mental health diagnoses are able access Medicaid for their integrated systems of care initiatives. The three counties that target children with mental health diagnoses -- Milwaukee, Oneida, and Lawrence -- are using Medicaid as a major source of support. They either have established or are moving toward a managed care approach that uses Medicaid to support care coordination and traditional and non-traditional mental health services. On the other hand, those communities that broadly target children who need services from multiple systems may gain buy-in and support from a greater number of potential funders if the effort is not seen as a "mental health" initiative. This has clearly been the case in Stark County, where a pool of flexible funds combining resources from six child serving systems has been established.

Frequently, a community's criteria of who will be served changes over time. For example, Chautauqua County has broadened the criteria for its Coordinated Children's Services Initiative to focus on serving children at an earlier point on the continuum. Rather than restricting services to children at imminent risk of placement, the County now targets children who are not making significant improvements in a single system or need assistance from multiple service systems. In Lawrence County, key stakeholders made a strategic decision to initially focus on bringing children who were placed out of county in residential settings back home. Immediate cost-savings provided momentum for expanding the target population to include children at risk of out-of-home placement.

The model research revealed that, regardless of targeting approach, all of the initiatives served predominantly children and youth with serious emotional disturbances and their families. Diagnoses prevalent among children and youth served through all of the models include conduct disorder, oppositional defiance disorder, attention deficit hyperactivity disorder, depressive disorder and bipolar disorder.

❷ Shared Vision and Principles

Once the target population is established, stakeholders must achieve consensus about the desired directions for a new service delivery approach. When stakeholders take the time to collectively articulate their vision and guiding principles for a new model, community buy-in and ownership in the change process are enhanced. The vision and principles can serve as a beacon, to ensure that implementation is on course and consistent with the stated needs and aspirations of the community.

A community's vision and principles must be embraced at all levels, from top leadership to frontline workers. Concerted staff training and development efforts are needed to communicate and reinforce the vision and principles and ensure that practice is in alignment with these values.

Each of the models reviewed for this project have adopted a core set of principles to guide their integrated service delivery approach for children and families. While the wording of these principles vary across sites, there is also substantial commonality in their themes. These themes include:

- involving families in the design, delivery and evaluation of services;

- using culturally competent, individualized, strength-based approaches;
- maximizing use of natural family and community supports; and
- serving children in the least restrictive, most normalizing environment.

All of the sites referenced the principles of the federal Child and Adolescent Service System Program (CASSP) as influential in the development of their own community value statements. These principles are presented below:

CASSP Values and Principles for the System of Care

Core Values

1. The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community based, with the locus of services as well as the management and decision making responsibility resting at the community level.

3. The system of care should be culturally competent, with agencies, programs, and services which are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families with children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.

5. Children with emotional disturbances should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing, and coordinating services.

6. Children with emotional disturbances should be provided case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Children with emotional disturbances should be ensured smooth transition to the adult service system as they reach maturity.

9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.

10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

❸ Strong Leadership

Strong leadership is essential to move a vision from concept to reality. Shifting from a categorical system to a family-centered, integrated model requires major restructuring in how services are currently organized, funded, and delivered. Change is difficult and always meets some resistance, particularly when it involves major shifts in authority, staff roles, distribution of resources, and frontline practice. Leadership is required to move a reform agenda forward, keep the focus on the agreed upon vision and principles, and make the case for change to key decision makers at the state and county levels. Leadership may be transitioned from one individual or group to another as the initiative moves from design to the actual implementation phases.

While state or federal funding or mandates can serve as a catalyst for developing an integrated service delivery model, the leadership for effective change must come from the community. A leader can be an elected official, county administrator, family advocate, a service provider, or a group or coalition. In the initiatives we reviewed, leadership came from commissioners or mid-level managers working for county government. In nearly all of the initiatives, these leaders came from the ranks of commissioners or mid-level managers within the county mental health departments.

❹ Broad-based Oversight Body

Any initiative designed to provide a more integrated system of care for hard to serve youth and their families must have an active oversight body. The policy making body must be empowered by its member organizations with the mission and authority to provide direction for making broad system level changes. The organizational structure for this body can be a formally constituted public body with written by-laws, as was established in Stark County, Ohio (Family Council) and Sonoma County, California (Youth and Family Services Partnership). Or a community may establish a less formal structure, similar to the CCSI Tier II Committees in New York State and the Partnership in Milwaukee, Wisconsin.

Whether it's a formally constituted entity or a less formal standing committee, the oversight body must have a clear mission to develop a comprehensive, coordinated, and interagency system of care for children, youth, and their families. It must also have representation from a diverse group of community stakeholders, including leadership from county mental health, child welfare, juvenile justice, and health systems, schools, parent representatives, key provider organizations, and other community stakeholders. Members must be of sufficient level within their organizations to make commitments to policy and service delivery changes that will support a more integrated system of care. In the words of Les Abel, Director of the Stark County Community Mental Health Board, representatives must be able to "put a deal on the table."

Minimally, a community's oversight body should assume the following roles and responsibilities:

- promoting system level changes that are necessary to advance a new model of care;

- identifying and addressing service gaps;
- determining the best structure for ensuring care coordination for their community;
- establishing a pool of flexible resources to support non-traditional services; and
- assessing the impact of the initiative at both client and system levels through evaluation.

❺ Effective Structure for Care Coordination

Beyond this broad oversight body, counties must establish an ongoing structure that is responsible for care coordination. This entity is essential because children and families have needs that cross systems, often leading to confusion as to which agency should assume lead case management responsibility. Our review suggests that model counties have taken one of two directions when forming this coordination entity.

One major pathway is for a county to vest the responsibility for ensuring care coordination in a single public or private agency. Oneida County, NY, Chautauqua County, NY, Lawrence County, OH, and Stark County, OH have all taken this approach. In the first three counties, a non-profit agency has assumed primary responsibility for coordinating care for the target population. Care coordinators on staff at the non-profit agencies serve as single points of contact for families. The care coordinators are held accountable for ensuring that quality service plans are developed and that services are delivered that meet the child and family's individualized needs. In a variation on this theme, the Stark County Family Council is a public entity that has a coordinator on staff who is responsible for arranging child and family team meetings (see below) and ensuring that an ongoing care coordinator is identified for each family among the team members**.**

Several of the models have chosen a second pathway. These communities delegate the responsibility for care coordination to a standing committee that is typically composed of mid-level managers from each of the involved systems, parent representatives, and community stakeholders. These standing committees meet at least monthly to review individual cases, identify potential services and supports that might be helpful, and assign a care coordinator for the child and family. The standing committees often take on additional responsibilities, depending on the design and development of the individual initiative. For example, in Milwaukee, Wisconsin, the Wraparound Review and Intake Team assesses the circumstances of each referral and enrolls eligible youth in Wraparound Milwaukee. In Sonoma County, the Mid-Level Council serves as the gatekeeper for intensive residential services that have mental health components.

Regardless of the pathway, a county's care coordination structures and the oversight body must be closely linked. This interconnection is vital to inform policy makers about the strengths and weaknesses in the system and the need for improvements. To accomplish this linkage, a care coordination structure may have one or more representatives on the oversight body or be established as a sub-committee of the oversight body, as was done by Sonoma County.

❻ Strength-based Child and Family Teams

Helping Networks. Support Circles. Creative Community Options Meetings. While known by different names, the child and family team is an essential ingredient of an integrated delivery system. Through the team process, the child and his/her family are fully involved in assessing strengths and needs, identifying their goals, developing a service plan, and evaluating progress on a regular basis. To be effective, child and family teams must include family members, involved professionals and providers, parent advocates, and other community helpers and informal supports. Team meetings need to be facilitated by individuals that have been trained in strength-based assessment and treatment planning processes.

The child and family team process is a centerpiece of all the models we reviewed. Across the board, they are seen as the vehicle to put into practice the commitment to working in partnership with families and to providing individualized services tailored to the unique needs and strengths of families. Team meetings are either facilitated by a neutral person or the individual assigned as the care coordinator. Parent advocates play a critical role in the child and family team process, serving as a resource and support to the family before, during, and after team meetings.

The chart below highlights the various ways in which the model counties have structured their child and family teams.

County	Composition	Facilitation	On-going Coordination
Chautauqua	Standing Tier I plus additional members of helping network identified by family	Neutral Facilitator	CCSI Case Manager
Milwaukee	Membership changes based on family situation, needs, preferences	Care Coordinator	Care Coordinator
Oneida	Membership changes based on family situation, needs, preferences	Kids Oneida Service Coordinator	Kids Oneida Service Coordinator
SCC-Lawrence	Membership changes based on family situation, needs, preferences	Integrated Services for Youth Resource Coordinator	Integrated Services for Youth Resource Coordinator
Sonoma	Membership changes based on family situation, needs, preferences	Determined by the Wraparound Team	Determined by the Wraparound Team
Stark	Membership changes based on family situation, needs, preferences	Neutral Facilitator	Identified at Creative Community Options Meeting
Westchester	Standing Community Network (Tier 1 Committee); Support Circle formed of professionals, friends, and relatives to help family move plan forward	Network Facilitator	Identified at Community Network Meeting

Because the child and family teams are the closest to actual service delivery, there must be a mechanism for ongoing communication between the teams and the care coordinating structure and oversight body. This linkage enables staff working directly with families to provide continuous feedback to mid-level and senior managers about what works well, service gaps, and needed improvements.

❼ Flexible Funding to Support Individualized Care Plans

Throughout the nation, much of the categorical funding for community mental health services has been channeled to clinically oriented mental health services, such as crisis services, day treatment, and group and individual clinic treatment. While these services are important, families with children who have serious emotional disturbances often need non-traditional supports and services, such as mentoring, respite, in-home therapeutic services, and community supervision. Families also need help in supporting their child's involvement in typical youth development activities (e.g. camp scholarships and club memberships) or in obtaining critical services and items (e.g. transportation, appliances, prescriptions). Flexible funding can be the key to ensuring that the needs of families, rather than funding requirements, are driving service development and availability. Flexible funding enables a system to tailor services to the particular needs of a family and promotes the concept that the service system will do "whatever it takes" to keep a child with serious emotional disturbances in the most normalizing, least restrictive setting possible.

One approach to flexible funding is to develop and implement a capitation funding methodology. Under the capitation approach, a managed care entity receives a fixed monthly rate for each youth under its responsibility. The managed care entity, through its provider network, can use the funding to support whatever services will most effectively address the goals identified in the service plan. This provides enormous flexibility, because any service or item -- traditional, non-traditional, or a combination -- can be authorized. With this flexibility comes an assumption of some risk by the managed care entity. The entity is responsible for paying for more costly residential or inpatient care if the child's situation deteriorates. A distinct advantage of a capitated funding approach is that it can effect major changes in the service delivery system. Because it is consumer driven, it can foster changes in the provider mix and in the availability of non-traditional services.

The model that has been most successful in developing a capitation approach is Wraparound Milwaukee. Under this initiative, the County's Division of Mental Health Services operates as the managed care entity and receives a monthly capitation rate of $4,800 ($3,300 from child welfare and $1,500 from Medicaid) for each youth enrolled in the initiative. The Division is responsible for supporting all community and crisis services as well as inpatient care. Any savings incurred by the Division can be used to fill gaps in the community service system. Wraparound Milwaukee has been very successful in expanding the continuum of available services to families of children with serious emotional disturbances. Over 60 different services are provided by the Wrapround services network, which includes over 170 agencies. The most frequently provided services include care coordination, in-home treatment by a variety of specialists, and discretionary funding for individualized items and supports.

Another approach to establishing flexible funding is to create a separate flexible funding pool from multiple funding streams. The pool of resources can be made available for services not supported through categorical funding streams. This approach was taken by Stark County. Stark County has created a pooled fund ($524,500 in 1999) that combines resources from multiple systems: the Department of Human Services, Mental Health Board, Mental Retardation and Developmental Disabilities Board, Alcohol and Drug Addiction Services Board, Family Court and several school districts. Pooled funds are used to pay for services such as: respite; one on one support for youth at school, camp, or recreation programs to assist with behavior management; camp scholarships; or adaptive equipment. Pooled funds are also used to pay for residential treatment or high level therapeutic foster home services in the child welfare system for families that need to access these services but want to maintain custody of their children.

A third approach is to earmark funds from single funding streams as flexible funding for wraparound or non-traditional services. Chautauqua County uses Mental Health reinvestment funds to establish a $15,000 wraparound pool and Westchester County dedicates funds from multiple funding streams without merging them into a single pool. Both these counties have significantly expanded the availability of respite, mentoring, and other non-traditional services.

❽ Meaningful Family Involvement

Nationally, there is a growing recognition that family involvement improves the quality, responsiveness, and cultural relevance of policies, programs, and services. Through their involvement, family members gain increased skills and confidence, are empowered to be active partners in change processes, and make systems more accountable to families. In developing integrated systems of care, counties must open up their processes and put the customer in the forefront.

The reviewed models involve families at three critical levels: policy, service delivery, and advocacy. Across all of the sites, parents are represented on the oversight body that sets policy and direction for the initiative. For example, in Stark County, six parents sit on the Board of Trustees of the Family Council as full voting members. Some of the models even involved families during the initial policy development for the initiatives. In designing Kids Oneida, for example, Oneida County formed a parent participation work group that outlined the primary concerns of parents, their recommended changes, and their suggested strategies for eliciting and securing on-going parent involvement in the new system of care.

At the service delivery level, family members are central participants in the child and family team, with each member identifying strengths and service needs and actively participating in the establishment of a plan of care. Unlike traditional approaches, where providers often see themselves as “experts” responsible for “fixing” a family’s problems, all of the models empower families to make decisions about what will work best for them. In Wraparound Milwaukee, family empowerment is uniquely linked to service delivery. In this initiative, long term service contracts with providers have been eliminated. Family satisfaction is given high priority by requiring family members to authorize or re-authorize services on a monthly basis. In Kids Oneida, Chautauqua County’s Coordinated Children’s Services Initiative, and Wraparound Milwaukee, parent satisfaction with the service system is routinely evaluated through surveys.

Family advocacy has played a strong role in strengthening family involvement in all of the models of integrated care. A number of the initiatives have supported the development and involvement of parent advocacy organizations in their community. Other initiatives have take the approach of employing family advocates to work directly with the family during service planning and delivery. Regardless of how family advocacy is arranged, advocates give families the information, support, and courage needed to become more effective advocates for themselves. They guide families though service planning and delivery processes, help them understand their rights and responsibilities, and link them to family support groups. Family advocates are also used to train providers in family-centered practice techniques.

❾ Ongoing Evaluation

If a new initiative hopes to catch hold as a viable alternative to the conventional method of delivering services, it must incorporate evaluation strategies that enable clear documentation of results. Many integrated system of care models begin as demonstration sites and are under careful scrutiny by their funders and other interested communities. In establishing an evaluation strategy, the oversight body must first identify the desired outcomes of the initiative and the markers of success. Once this evaluation framework is established, more specific questions need to be addressed, including what measurement tools will be used, who will collect data and how frequently, and how the data will be summarized and distributed.

The reviewed initiatives have focused their evaluations on four major areas:

- ***child and family functioning.*** Measures of child and family functioning are used to assess changes over time in a child and family's behavior and their ability to function in every day activities. They are typically administered at intake, at set intervals during a child and family's involvement with a system of care initiative, and at discharge. Instruments that are being used by models to assess child and family functioning include CAFAS, the Child Behavioral Checklist, and the Ohio Scales.

- ***out-of-home placement rates.*** All of the models embrace the philosophy that children are best served in their own homes and communities. As such, one indicator used by most of the initiatives is reductions in both the number and length of stay in of out of home placements for the children that they serve. Initiatives plot residential placement data over time to demonstrate trends. This data can be used to impute the costs that have been avoided because of reduced out-of-home placements.

- ***cost.*** One of the motivating forces for establishing an integrated delivery system is often concerns about the rising cost of residential care. New models are built on the assumption that given the flexibility and an expanded service continuum, children can be served with the same or less resources in their home or community settings. By gathering average cost data for children and families served, the models have been able to demonstrate the cost-effectiveness of their approaches.

- ***family satisfaction.*** Because of the customer focus of these integrated delivery models, family satisfaction is also an important measure. Several models employ surveys to assess both child and parent satisfaction with services they receive, the manner in which they receive them, and the child and family team meeting process.

These nine core elements represent the essential ingredients of an integrated system of care for children and families with complex needs. All nine of the elements must be in place for the system of care to be effective. However, as demonstrated by the descriptions of the seven profiled initiatives in the following sections, there is no one best way. Each model has implemented the core elements in a different fashion, building on Federal and State initiatives and community strengths. The assessment tool contained in this notebook will help New York State counties examine their strengths and building blocks for local implementation of each of the core elements, taking into consideration their experience with Coordinated Children's Services Initiative, Mental Health/Juvenile Justice initiatives, PINS Adjustment Services, Home and Community Based Waivers, Task Force on School-Community Collaboration projects, or other related initiatives. As a whole, it is hoped that this *Resource Book* will be used as a springboard for local reflection and action to build a more seamless, integrated system of care for children and families.

Coordinated Children's Services Initiative
Chautauqua County, New York

A. Context

- Chautauqua County is the western-most county in New York State. With a population of approximately 142,000, Chautauqua County has two urban centers at each end of the County. The more densely populated southern section is dominated by Jamestown, a city with a population of about 25,000. The north is more rural and contains the two small cities of Dunkirk and Fredonia.

- Chautauqua's population is approximately 96% Caucasian, 2% African American, and 2% other.

Distinguishing Features

- **S** Consolidation of CCSI administrative and coordination responsibility in a single not-for-profit agency, Family Services of Jamestown.

- **S** Enhancement of Coordinated Children Services Initiative (CCSI) through use of State Office of Mental Health Reinvestment Funds for mentoring, respite, and wraparound services.

- **S** Strong family support through use of parent advocates at the family and policy level.

B. Impetus for Change

- Statewide funding for Coordinated Children's Services Initiative (CCSI) was a major catalyst for Chautauqua's development of a more integrated system for children services. The County recognized that CCSI presented an opportunity to better coordinate services for high need children in all service systems. In 1997, the County contracted with Family Services of Jamestown to fund a full time CCSI Coordinator, case management services, and parent advocacy and support. That same year, New York State's Office of Mental Health reinvestment funds were made available to Family Services of Jamestown from the County to augment CCSI services with respite, mentoring and wrapround services to better meet the needs of hard to serve children and their families.

C. Vision and Principles

- The vision of Chautauqua County CCSI is to be the most competent, responsive, and accessible family centered providers of professional counseling, educational, and supportive services in the communities of the southern tier.

- The guiding values include:

  - family empowerment;
  - placement in the least restrictive environment;
  - individualized care;
  - family systems approaches;
  - strength-based assessments;
  - respect for the inherent dignity of all persons;

- recognition of the importance of the family in all its changing forms;
- customer friendliness;
- commitment to the communities served, including learning from them; and
- well being and growth of employees, including recognition of their contributions.

D. Population Served

- Initially, the County's CCSI eligibility criteria required that a child be at risk of out of home placement in order to get CCSI services. The criteria was expanded in 1997 to enable the County to provide earlier intervention. Currently, children and their families are eligible for CCSI services if the child has been involved in: a) multiple service systems without improvement, or b) served in one service system for a considerable period of time without significant improvement.

- CCSI serves approximately 100 children and youth and their families per year, with an average daily caseload of about 50.

- Consistent with the strength-based philosophy adopted by Chautauqua County CCSI and Family Services of Jamestown, there is no requirement that children served through CCSI have a mental health diagnosis. However, the Director of Family Services of Jamestown believes that most children served have the following problems: conduct disorders, oppositional defiance disorders, and ADHD.

- The youth served are predominantly male, approximately 80 percent of which are Caucasian and 20 percent minorities. The most common presenting problems include violent behavior in the home or school, sexual offenders, victims of sexual abuse, and truancy.

E. Oversight and Coordination Structures

- In 1998, as part of a major reorganization, Chautauqua County organized its departments into five basic functional areas: Human Services, Administrative Services, Planning and Economic Development, Public Facilities, and Intermunicipal Services. The Human Services group contains the County Departments of Public Health, Mental Health, Probation, Social Services, Aging, Youth Department, Planning Department, Veterans Affairs and the County Nursing Home. The County Executive appointed a Leader from the Human Services group to serve on the Executive Cabinet, charged with meeting regularly to jointly address County goals. This reorganization facilitated coordination of many cross system efforts by the human service agencies, including the coordination of services to hard to serve children through CCSI.

- The County's CCSI Tier II Committee serves as the policy making body for efforts to coordinate services to hard to serve children and their families. Membership on the Tier II Committee include representatives from the Department of Social Services, Probation Department, Department of Mental Health, United Way, BOCES, Dunkirk and Jamestown School Districts, and Family Services of Jamestown, and several parent representatives.

- Administrative responsibility for coordinating CCSI and providing related services is vested with the Family Services of Jamestown. The County contracts with Family Services of Jamestown to provide a full time CCSI Coordinator and five associated services: CCSI case management, pre-school coordinated children services, parent advocacy and support, respite, and mentoring.

- At the family level, coordination is accomplished through Child and Family Teams (CCSI Tier I) which are responsible for developing and monitoring the service plan.

F. Client Flow

- Any agency or organization on the Tier II Committee can make a referral for CCSI services. The majority of referrals come from the Probation Department and the school systems.

- Upon referral, the CCSI Primary Parent Advocate assesses the case and contacts the family by phone to ensure that the parent is still interested in participating in CCSI. The Primary Parent Advocate then sets up the initial interview and assigns a parent advocate located in the family's area of the County to conduct the interview and work with the family.

- The parent advocate meets with the family to explain the process and identify individuals in the community that family members believe would be helpful. This "helping network" is most often composed of school officials, professionals, and provider staff, but on occasion include extended family members, clergy, and other members of the community.

- Within a couple of weeks, the Child and Family Team (CCSI Tier I) is convened. In addition to family members, the Team is composed of the parent advocate, school officials, professionals, provider staff, and members of the helping network identified by the family. The Team meetings are facilitated by a neutral facilitator, typically a community volunteer or County agency staff person not involved with the case but trained in facilitation and the delivery of strength based services. During the Team meeting, family strengths, supports and needed services are identified and a plan of service is established.

- Services are initiated and provided until goals are meet and the family can transition to less intensive services and natural supports. The average length of service through CCSI is approximately one year.

G. Flexible Funding

- For 1999, Family Services of Jamestown was provided $15,000 of reinvestment funds as flexible resources for wraparound services. These funds are being used for expenses that cannot be supported through traditional categorical sources and include such items as utility bills, child care, weekend respite for family members, and transportation.

H. Family Involvement

- CCSI, housed at Family Services of Jamestown, has a full time Primary Parent Advocate and contracts with approximately 12 parent advocates in the community to help families as they participate in the CCSI process. A parent advocate meets with every parent prior to the Child and Family Team meeting to provide support, identify family strengths and needs, and select a helping network. Most of these advocates have been involved in the service systems as foster parents or parents with difficult to serve or special needs children. The Primary Parent Advocate also participates in CCSI Tier II meetings to discuss systemwide service planning for hard to service children and their families.

- The County has established two parent support groups, one in the north and one in the south. At these meetings, parents share information, concerns, problems, and successes and provide each other with encouragement and advice.

I. Services

- Most frequently provided community services include care coordination, mentoring, discretionary/flex funding for various supports, in-home treatment by a variety of specialists, and mental health outpatient services.

J. Impact

- Data is not yet available on the impact of this initiative. The CCSI Tier II group has established a task force on outcomes to identify the impact of CCSI on families with hard to serve children. An initial satisfaction survey conducted six months ago indicated that approximately 80 percent of families served during a one week period felt that the Child and Family Team process was very helpful to their family. A more comprehensive satisfaction survey instrument is being developed and will be used to obtain a better understanding of how families feel about CCSI.

K. Lessons Learned

- Setting up a system of coordinated care is time intensive and complex, particularly when attempting to bring service providers together. But in the long run, the organized team approach should prove to be less time intensive and produce more efficient outcomes. Scheduling and organizing key team players to meet the needs of the family is critical.

- Looking at the family as having strengths and capabilities is radical thinking. At times, providers still want to be the “fixers” instead of partners working toward an established goal with the family. A change in role means a change in attitude toward the client and their special needs.

- Participation by all County providers (especially Tier I and Tier II) is essential for maintaining and monitoring the process. The process has helped providers more clearly understand their respective roles in a family's life. When there is provider cooperation in a team, things happen with greater continuity.

L. Contacts

County Mental Health Director
William Serafin
Commissioner
Chautauqua County Department of Mental Health
Phone: (716) 753-4319
E-mail: SerafinW@co.chautauqua.ny.us

Program and Fiscal
Chuck Weis
Executive Director
Family Services of Jamestown
Phone: (716) 488-1971

Family Representative
Rebecca Hodgson
Primary Parent Advocate
Coordinated Children's Services Initiative
Phone: (716) 488-2280

Wraparound Milwaukee
Milwaukee County, Wisconsin

A. Context

- Milwaukee County is dominated by one major city, Milwaukee, with the remainder of the County composed of suburban areas.

- Milwaukee County has a population of about 1.1 million, approximately 20% of which are minorities.

- The City of Milwaukee has a population of about 600,000, approximately 40% of which are minorities.

B. Impetus for Change

- The major incentive for establishing Wraparound Milwaukee was the growing cost of inpatient and residential care. The initiative also was prompted, in part, by the availability of federal grant funds in 1994 from the Federal Center for Mental Health Services to support demonstration sites of integrated systems of care.

Distinguishing Features

- **S** Publicly operated managed care system, operated and coordinated through the Milwaukee County Department of Human Services' Mental Health Division - Child and Adolescent Services Branch. Eleven lead agencies in the community provide care coordination under Wraparound Milwaukee through contracts with the Mental Health Division.

- **S** Capitation rate established and received from the child welfare system and Medicaid augmented by block grant funds from juvenile justice and mental health. Funds are pooled and treated non-categorically, i.e., they are intermingled and can be used for any service or administrative component.

- **S** Profits are reinvested to increase the capacity of existing community services or develop new community services.

- **S** Family satisfaction given high priority by requiring family reauthorization of services on a monthly basis.

C. Vision and Principles

- The mission of Wraparound Milwaukee is to provide cost effective, comprehensive and individualized care to children with complex needs and their families in Milwaukee County. Wraparound Milwaukee is designed as a unique type of health maintenance organization that promotes collaboration among child welfare, juvenile justice, mental health, and education in the treatment of children with serious emotional, mental health and behavioral challenges. Its goals are to:

  - minimize out-of-home placements;
  - support families to function as autonomously as possible;
  - build on family strengths;
  - help families access an array of services and supports;
  - coordinate care;
  - develop service capacity in the community; and
  - deliver services in a cost effective manner.

- Wraparound Milwaukee's guiding principles include:

  - building on strengths to meet needs;
  - developing one plan for each family;
  - establishing the best fit with culture and family preferences;
  - fostering community based responsiveness;
  - increasing parent choice and parent independence; and
  - caring for children in the context of families.

D. Population Served

- In operation since 1995, Wraparound Milwaukee targets youth who have a mental health diagnosis and are identified by the Child Welfare Department or Juvenile Court as 1) needing an out of home residential placement, or 2) able to return to the community from a residential placement if Wraparound services are made available. A youth must be referred through the court system in order to access Wraparound Milwaukee services. Approximately 60 percent of youth served by Wraparound Milwaukee are involved in juvenile offenses. Approximately 40 percent are involved in substantiated child abuse and neglect cases and are at risk of out of home placement.

- The estimated daily census for 1999 for this program is 620 youth. Approximately 60% of the youth served are minorities and 71% are males. Approximately 80% are Medicaid eligible.

- The top diagnoses of youth enrolled in Wraparound Milwaukee: conduct disorder/oppositional disorder (38%); ADHD (23%); and depressive disorder (22%).

- The top four primary issues of the youth at enrollment: behavior or emotional problems affecting functioning in the school or community (40%); severe aggressiveness (34%); drug or alcohol abuse (25%); and runaway behavior (23%).

- While the age of youth served range from 6 to 18, approximately 71 percent of youth served are from ages 13 through 16.

E. Oversight and Coordination Structures

- The Partnership Council is charged with planning for joint funding and ensuring that the planning and delivery of services is coordinated. The Partnership Council includes 25 members representing judges, district attorneys, probation, child welfare, public health, mental health, schools, care coordinators, supervisors, family members, and others, as needed.

- At the family level, coordination is accomplished through Child and Family Teams which are responsible for developing and monitoring the service plan.

F. Client Flow

- An enrollment worker from the County Mental Health Division's Child and Adolescent Services Branch meets with the child and family in the youth's home or detention center to conduct an initial screening and assess strengths, resources, and immediate issues. The plan is sent to the court and the Wraparound Review and Intake Team and a care coordinator is assigned from one of eleven community agencies.

- The Wraparound Review and Intake Team (WRIT), composed of representatives from County mental health, public schools, child welfare, probation, and a family support organization, reviews the preliminary plan. The WRIT team also authorizes enrollment in Wraparound.

- Within a week, the care coordinator meets with the child and family to establish a rapport, hear the family's story, discover strengths, determine immediate needs and establish a crisis safety plan. The care coordinator conveys to the family the wraparound philosophy of providing whatever items or services are necessary to enable the child to reside in the least restrictive care setting.

- Within the first month, the care coordinator works with the child and family to establish the Child and Family Team, typically including all family members, natural supports, mental health workers, teachers and other school personnel. Probation is included when the child is involved in a juvenile court case.

- The Team works with the family to conduct a broad based assessment of strengths and needs, particularly in the areas of safety, legal, psychological, educational/vocational, living arrangements, medical, cultural/spiritual, social and recreational. A service plan is prepared, including short term and long term goals and the services needed by the family to achieve the agreed upon goals.

- A service plan is disseminated to Team members and signed off by the family.

- Service Authorization Requests (SARs) are generated from the plan authorizing payments to providers in the Wraparound Milwaukee network. The family, along with the Child and Family Team, authorizes services by signing off on the SAR. Aside from a check for extreme outliers, the only SAR request that needs prior approval other than from the family and team are requests for inpatient and residential treatment.

- The care coordinator must submit a new SAR, approved by the family, every month. The service plan must be reviewed by the Child and Family Team at least every 90 days.

- A family is discharged from Wraparound Milwaukee when the service plan goals are met and they can transition to other less intensive services and/or more natural supports. Average length of stay is 14.8 months.

G. Flexible Funding

- Wraparound Milwaukee's 1999 annual budget is $26 million with funding as follows: 53% from child welfare and juvenile justice, 31% from Medicaid, and 16% from SSI, grants, and other sources.

- Wraparound receives a monthly capitation amount of $3,300 from child welfare and $1,500 from Medicaid for a total of $4,800 per month per child served to support both community services and needed crisis and inpatient care. The per capita amount for Medicaid was actuarially determined by a firm hired by HCFA to identify the cost of services used by a cohort of 200 youth with serious emotional disturbances who are in residential care. Wraparound Milwaukee's Medicaid capitation rate is equal to 95% of the cost identified in this study. Juvenile justice and mental health provide lump sum amounts annually for the program.

- The average monthly cost for a youth served by Wraparound is $3,300 versus average monthly cost of residential care of $5,000 and in-patient care of $15,000.

- Funds are pooled and non-categorical. No final reconciliation is required by HCFA against actual Medicaid costs. Savings by Wraparound Milwaukee can be used to expand services in the community and serve more youth.

H. Family Involvement

- Working with the Child and Family Team, the family determines needed services and signs off on the plan. The family signs off on service authorizations on a monthly basis, giving family satisfaction a high priority.

- The County Family Advocate and Families United Milwaukee serve on the Partnership Council and other workgroups, conduct training for care coordinators, and contact families to offer support and advocacy. The family may request that a family advocate serve on the Child and Family Team.

I. Services

- Over 60 different services are provided by the Wraparound service network, composed of over 170 agencies.

- Most frequently provided community services include care coordination, mentoring, discretionary/flex funding for various supports, in-home treatment by a variety of specialists, and outpatient services.

- The Mobile Urgent Treatment Team, operated by the County, is responsible for finding

clinically appropriate alternatives to hospitalization and residential treatment for children in crisis situations. Review by the Mobile Urgent Treatment Team is required before any residential and in-patient services are authorized.

J. Impact

- Reduction in residential placement - 60 percent drop from 1996 to 1999.
- Reductions in psychiatric inpatient hospitalizations - average length of stay reduced from over 15 days to 6.2 days over an 18 month period.
- $4.2 million reduction in Medicaid expenditures for psychiatric inpatient care for children.
- Significant improvement in clinical and functional outcomes as indicated by three nationally recognized instruments (CAFAS, YSR, CBCL). For example, for children enrolled in Wraparound Milwaukee, average CAFAS scores dropped by more than 20 points from intake to discharge.

K. Lessons Learned

- Residential providers will work with you to revamp the service system if they are involved in the process and are assured that they can fiscally benefit from the development of new services. Purchasing care coordination from the residential providers was a major step in getting them to buy into the effort to reduce residential placement and develop alternative community services.
- Targeting a population that is certain to go into residential care if Wraparound services were not provided was essential to convincing the funding agencies to support the program since these agencies had nothing to lose fiscally. If they did not fund Wraparound Milwaukee for these youth, they clearly would have spent the funds on expensive residential care.

L. Contacts

County Mental Health Director
Kathy Eilers
Director
Milwaukee County Mental Health Division
Milwaukee County Department of Human Services
Phone: (414) 257-5202

Program
Bruce Kamradt
DirectorChild and Adolescent Mental Health Services
Milwaukee County Mental Health Division
Milwaukee County Department of Human Services
Phone: (414) 257-7639
E-mail: bkamrad@wrap.org

Fiscal
Bill Herd
Fiscal Coordinator
Child and Adolescent Mental Health Services
Milwaukee County Mental Health Division
Milwaukee County Department of Human Services
Phone: (414) 257-5385

Family Representative
Margaret Jefferson
Families United of Milwaukee
Phone: (414) 257-6857

Kids Oneida
Oneida County, New York

A. Context

- Oneida County has a total population of 231,000; approximately 48,000 residents are between the ages of 6 and 18.
- Utica (population of 68,000) and Rome (population of 44,000) are the two main cities in Oneida County. These cities are surrounded by smaller towns and rural areas.
- 96% of Oneida County's residents are Caucasian. The minority breakdown is 3% African American and 1% Hispanic. There is a growing population of Vietnamese and Bosnian immigrants.

Distinguishing Features

- **S** Managed care model for providing integrated services and supports to children and adolescents with serious emotional disturbances and their families.
- **S** Initiated in August 1998 as a three year special demonstration project.
- **S** Operated by Integrated Community Alternative Network, Inc, a not-for-profit entity, licensed as an outpatient clinic under Article 31 of the Mental Hygiene Law.
- **S** Per child per month rate of $3,739, including a bundled case payment fee from Medicaid ($1,189) and a case payment using local prevention block grant funding ($2,550).

B. Impetus for Change

- Kids Oneida was initiated as a new financing and service delivery strategy aimed at keeping children and adolescents with serious emotional disturbances at home, in school, and in the community.
- Foundation funding was a major catalyst for development. Oneida County, through New York State's Research Foundation for Mental Hygiene, received a replication grant as part of the Robert Wood Johnson Foundation's Mental Health Service Program for Youth (MHSPY). Oneida County was selected because of its demonstrated commitment to coordinated planning and care and the readiness to proceed with the MHSPY model.
- Leadership from Oneida County Commissioners of the Departments of Mental Health and Social Services and the County Executive was key; as was the County's partnership with New York State government agencies. The Governor's personal involvement and support was required to resolve an impasse over Medicaid funding for Kids Oneida.

C. Vision and Principles

- Mission:

Kids Oneida believes it is their mission to give priority to those individuals and families with high needs and limited resources so they may live in ways that are productive, healthy, meaningful, and satisfying to them..

- Goal:

  The goal of Kids Oneida is to divert and reduce the number of children in Oneida County with serious emotional, behavioral, and mental health disturbances from out-of-home placements and/or to shorten the time that children remain in such placements. Kids Oneida will accomplish this through the use of intensive, flexible, accessible community-based services based on the wraparound system of treatment and support services which are designed to meet the individualized needs of children and their families.

- Fundamental Principles:

  - Kids Oneida is a value-based integrated system of care for families and children that takes into account outcomes, family empowerment, and cost.
  - Kids Oneida is in the business of purchasing service outcomes rather than the services themselves.
  - Kids Oneida is committed to full family involvement in the design, delivery, and receipt of services.

D. Population Served

- Target population is defined by the following four criteria:

  - resident of Oneida County;
  - under the age of eighteen;
  - deemed at imminent risk of placement in a residential facility or psychiatric inpatient facility by the Oneida County Committee on Appropriate Placement or the Oneida County Department of Social Services Placement Committee; and
  - a DSM IV mental health diagnosis.

- KIDS Oneida began serving children in January 1998, however, it wasn't until August 1998 that it received its outpatient mental health clinic designation. Kids Oneida has the capacity to serve 120 children and adolescents at any point in time, both Medicaid and non-Medicaid recipients.

- From August 1, 1998 through April 30, 1999, Kids Oneida served a total of 65 children with the following profile:

  - 63 % Male; 37 % Female
  - 48 % Medicaid eligible; 52 % Non-Medicaid eligible
  - 79 % Caucasian; 18 % African American; and 3 % Hispanic
  - Top five DSM-IV diagnoses at enrollment: ADHD, conduct disorder, oppositional defiance disorder, depressive disorder, and bipolar disorder

E. Oversight and Coordination Structures

- **Integrated Community Alternatives Network**. Kids Oneida is operated by Integrated Community Alternatives Network (ICAN), Inc, a not-for-profit care management entity and outpatient clinic licensed under Article 31 of the Mental Hygiene Law. As a not-for-profit agency, ICAN is governed by a Board of Directors. In addition to several community professionals, the current Board includes the Deputy Commissioner for Social Services, a parent advocate, and a parent whose child is participating in Kids Oneida.

- **Child and Family Teams.** At the child and family level, coordination is accomplished by the Child and Family Team. The Child and Family Team includes the child, parent(s) or guardian(s), individuals identified by the family as being helpful in developing and carrying out their plan of care, the Kids Oneida Service Coordinator, and community service agencies.

F. Client Flow

- A child is referred from Oneida County's Placement Committee (a committee which reviews the cases of children in foster care for whom more restrictive settings are being recommended) or Committee on Appropriate Placement (a committee which makes recommendations to Family Court regarding the placement of PINS and JD children for which preventive services have not worked). All referrals must be approved by the County Department of Social Services prior to enrollment in Kids Oneida.

- A Kids Oneida Service Coordinator is assigned to work with the child and family. Within 30 days from admission into the program, the Service Coordinator is responsible for working with the family to develop an initial 30 day plan of care. If needed, however, services can be put in place immediately to respond to emergency situations.

- As a first step in the process of developing the plan of care, the Service Coordinator meets with the child and family to discuss the child's and family's strengths, assess the child's functioning, and determine what types of supports and services would be helpful and who could best provide these supports and services. The Service Coordinator also provides an overview of the Child and Family Team process.

- Based on the information provided by the family, the Service Coordinator makes decisions about which service providers to involve as part of the Child and Family Team and schedules a team meeting.

- At the first Child and Family Team meeting, the family and Service Coordinator discusses the child and family's needs and strengths and the Team develops an initial 30 day plan of care. At the end of the meeting, all Team members sign off on the plan.

- Each plan of care is forwarded to the Kids Oneida's Medical Director for review, consultation, and authorizations necessary for Medicaid payment.

- The Service Coordinator authorizes payment for services in accordance with the plan of care and the child and family begin receiving services.

F

- The Service Coordinator stays in close contact with the family and meets at least monthly to determine if services need to be continued or discontinued for the upcoming month. Every three months, the child's plan of care is formally updated. If there are major changes, a Child and Family Team meeting is held.

- A child is discharged from Kids Oneida when the Child and Family Team feels that he or she has substantially met his or her goals. Formal discharge criteria include: the child is no longer at imminent risk of an out-of-home placement; the parent or guardian requests that the child be removed from the program; or the child moves out of Oneida County. Average length of participation is approximately 14-16 months from the time of enrollment.

G. Flexible Funding

- Kids Oneida receives a per child per month payment of $3,739 ($1,189 is a bundled case payment fee from Medicaid and $2,550 is a case payment from Oneida County Department of Social Service using local prevention block grant funding). When a child receives out-of-home services in the child welfare system, Federal Title IV - A/E are drawn down and less Oneida County DSS block grant funds are expended.

- Kids Oneida assumes the risk for providing all mental health services using this monthly rate except for psychiatric hospitalization and Residential Treatment Facility care. Kids Oneida is responsible for paying the care costs of up to 6 months of out of home services within the child welfare system, until the child's status within the child welfare system shifts from "preventive" to "placement".

- Kids Oneida is reimbursed by Medicaid based on the number of Medicaid recipients enrolled in Kids Oneida during a given month who subsequently meet the minimum service standards, i.e. 6 face to face contacts in that month (three of which can be collateral contacts).

- During its first nine months of operation, the average per child per month cost for services was $2,794.

H. Family Involvement

- Parents were involved in the initial design phase of Kids Oneida. A parent participation work group outlined the primary concerns of parents regarding the current system of service delivery and recommended changes; provided regular feedback to other work groups; and developed strategies for eliciting and securing parent involvement in the new system of care.

- Parents have a role in setting policy for Kids Oneida through their participation on the Board of Directors. The current Board includes one parent whose child is participating in Kids Oneida and a parent advocate.

- The family is present at all Child and Family Team meetings. The plan of care developed by the Team is family-driven, based on the family's goals, strengths and resources.

- Kids Oneida routinely evaluates youth and family satisfaction, and family empowerment, and solicits the youth and parent's feedback on the effectiveness of the Child and Family Team process. Kids Oneida has paid parent advocates to administer the satisfaction and empowerment surveys and to provide feedback to Kids Oneida staff to ensure that families concerns are being heard.

- Kids Oneida will be expanding its parent advocacy services. The plan is for every family participating in Kids Oneida to be offered a parent advocate to assist them throughout the process, including participation at Child and Family Team meetings. The parent advocates will also conduct family strength assessments and administer the satisfaction and empowerment surveys.

I. Services

- Kids Oneida has an open network of organizations and individuals that provide an array of over 40 traditional and non-traditional services to children and adolescents enrolled in the project and their families. The only service provided by Kids Oneida itself is case management through its Service Coordinators.

- The most frequently used community services include: in-home treatment, intensive supervision, community supervision, mentoring, supported work environments, and respite.

J. Impact

- While no aggregate data is currently available, Kids Oneida's evaluation strategy includes a focus on the following dimensions:

  - **outcome tracking**: attainment of goals in plan of care; level of functioning/impairment (using Child and Adolescent Functional Assessment Scale: behavioral outcomes; need for inpatient admission and/or residential placement.
  - **youth satisfaction**: youth enrolled complete written evaluations of the Kids Oneida Child and Family Team meetings, the individual plans of care, and services received.
  - **parent satisfaction**: parents complete written evaluations of the Child and Family Team process/functioning, the individual plan of care, and services received.
  - **provider satisfaction**: providers (including members of the Child and Family Team) complete written evaluations of the child and family team process/functioning and the individual plans of care.

- **provider performance**: Kids Oneida tracks each providers' performance on each service in the plan of care.
- **use of services:** Kids Oneida tracks and generates monthly reports on authorization and utilization of each service for each enrollee.

K. Lessons Learned

- It is important to take the time to clearly delineate the roles and responsibilities of the new care management entity, county departments, and providers early on to avoid confusion.

- While top level leadership is essential, equally important is buy-in and support from mid-level management and frontline staff. Processes that allow "everyone to be heard" in the design stage smooth the path toward implementation.

- County service integration initiatives need to be supported by state level changes. Duplicative regulatory paperwork requirements (e.g., OMH Plan of Care and DSS Uniform Case Record) can be overwhelming and contribute to staff burnout.

- In building a network of service providers, training is critical to help providers "think outside the box" and understand the role of non-traditional services. Having a solid provider network in place at the outset is essential. Otherwise, service coordinators run the risk of providing direct services themselves with no reimbursement for this function.

L. Contacts

County Mental Health Director
Phillip Endress
Commissioner
Oneida County Department of Mental Health
Phone: (315) 798-5903
E-mail: pendr83485@aol.com

Program and Fiscal
Renee Rich
Chief Operating Officer
Integrated Community Alternatives Network, Inc.
Phone: (315) 792-9039
E-mail: rcn@dreamscape.com

Janice Schwartz
Network Director
Integrated Community Alternatives Network, Inc.
Phone: (315) 792-9039
E-mail: janices@dreamscape.com

Family Representative
Contact Janice Schwartz for connections to a family member involved in Kids Oneida or a parent advocate.

Youth and Family Services Partnership
Sonoma County, California

A. Context

- Sonoma County has a population of 450,000 with several small to medium sized cities and stretches of rural areas.

- Approximately 72% of the population is Caucasian and 28% is made up of minorities. The largest minority population is Hispanic, approximately 18 % of the population. About 5% is African-American and 4% Native American. There is also a growing Asian population.

Distinguishing Features

- **S** Sonoma County's Youth & Family Services Partnership is a formally constituted public body composed of parent groups, county agencies, and other county stakeholders responsible for broad cross-systems planning and coordination for hard to serve youth. A sub-committee of the Partnership, the Case Management Council, is responsible for cross system collaboration for youth who are being served by or need services from multiple service systems. A family from any service system may be referred to the Case Management Council.

- **S** Sonoma County's Division of Mental Health established strong family involvement through the establishment of five family support programs throughout the County and the hiring of a Family Advocate and members of seven families to work along with direct service workers.

B. Impetus

- Planning for a more integrated system for youth with serious emotional disturbances occurred in the late 80's and early 90's, but these efforts took on new life when the County received a Federal Center for Mental Health Services grant in 1994. The grant served as the catalyst for the development of child and family teams by the mental health system to provide individualized service planning for children with serious emotional disturbances and their families. It also stimulated interagency efforts to improve cross systems coordination for serving children and families. In 1998, these interagency efforts were formalized through the creation of the Youth and Family Services Partnership.

C. Vision and Principles

- The Vision Statement:

  Every person in the community is responsible to ensure that all at-risk children have the opportunity to reach their potential.

- Driving Principles:

  - **S** Working collaboratively, in partnership with families and the community, to identify and meet the needs of all at-risk children;
  - **S** Creating an integrated, culturally-competent system of services and support which will foster health, independence, and competence of children and families in Sonoma County;
  - **S** Building cross-agency relationships which support creative and flexible access to

resources;
- **S** Building on the strengths of families and the community to maximize resources; and
- **S** Improving access to information through community education.

D. Population Served

- The Youth and Family Services Partnership's Case Management Council serves youth who are involved with or need services from more than one service system. In addition, a child and his/her family may be referred to the Council if the child is at risk of a higher level of service or exacerbated emotional problems.

- The Partnership reviews three to six cases every month, or approximately 50 unduplicated cases per year. Approximately 80 percent of the cases reviewed involve male youth.

- Over half of the cases are brought to the Partnership by the Division of Mental Health. The remaining case are presented by Social Services, Probation, and the schools. Regardless of the system that brings a case forward, the most prevalent reason why a case is brought to the Partnership is that the involved youth has a serious behavioral or emotional problem.

- The age range of youth served through the Partnership is age 11 through age 17.

E. Oversight and Coordination Structures

- The Partnership meets monthly and is responsible for developing a comprehensive, coordinated interagency system for children, youth, and families, ensuring input from families receiving services, monitoring the Partnership's progress in achieving results, evaluating the interagency system, filling in service gaps, and designing new approaches to achieve better results. Members of the Partnership include the juvenile court judge, parents from family advocacy and support groups, school district superintendents, and senior representatives from county health, human services, education, special education, probation, and the non-profit agencies.

- The responsibilities of the Partnership are carried out with the help of two standing committees.
  - **S** The Mid-Level Management Council is composed of the mid-level managers from the county's health and human service agencies, the county probation department, and the Superintendent of County Schools. This body is responsible for problem solving, information sharing, and improving understanding between the schools and other service systems.

  - **S** The Case Management Council, with representatives from the health and human service agencies and the schools, is responsible for cross system collaboration for hard to serve youth or youth at risk of a higher level of care or in need of services from multiple service systems. The Case Management Council meets at least monthly and is specifically charged with reviewing cases and coordinating services for youth at risk of incarceration, exacerbated emotional problems or placement in the highest level of residential care

(which is required to include mental health services). No placement can be made into this high level of residential care without approval of the Case Management Council.

- On a family level, the Sonoma County Division of Mental Health provides wraparound teams for children with serious emotional disturbances and their families if one is requested by the family or determined necessary based upon the Division's assessment of the case. The formation of a wraparound team may also be recommended by the Case Management Council. The wraparound team, composed of involved professionals from different systems, and, sometimes, extended family members and other natural supports, meets with the family to discuss how to best build on the strengths of the family and provide supports and services.

F. Client Flow

- Any professional in any system may present a family's situation to the Case Management Council, a standing committee of the Partnership.

- Since a case may be presented to the Case Management Council by any of the service systems, the client flow prior to that point will be different, depending on the initial point of intake. Described below is the client flow for those children and families entering through the mental health system:

  - Families of children with serious emotional disturbances entering the mental health system are initially assigned a clinician from one of four geographically assigned service teams in the Division of Mental Health to serve as the care coordinator. The clinician calls the family within 2 or 3 days of initial contact or referral, discusses the family's needs, and sets up a face-to-face meeting.

  - The clinician and family jointly assess strengths and needs and develop a preliminary plan of services. If needed, a crisis plan is also developed.

  - The mental health service team reviews the assessment and develops a plan of service. The plan of service is signed off by the family, and if the child is over 12, by the youth. The service team determines the necessity of establishing a wraparound team, composed of involved professionals, family members, and occasionally, extended family members and other natural supports. A family can obtain a wraparound team upon request at any point in the process.

  - The plan of service is reviewed after the first six months, and again after the first year of service by the family, clinician, and service team. The plan is then reviewed on an annual basis by all parties to determine if functioning of the child and family has improved, if the supports are adequate, and if additional or fewer services are required.

- At any point in the process, the mental health system can make a referral to the Case Management Council for review and coordination. The Case Management Council's review can result in a number of solutions for coordinating services. These include: assigning clear responsibility for the case, establishing a mental health wraparound team, joint funding of service or expense item, or creating a new, unique service.

G. Flexible Funding

- Approximately $180,000 of state funds are allocated for respite and other supports, services, or items not available through categorical funding. Use of these flexible funds are proposed by the clinicians involved with each family and approved by the Division of Mental Health's service team.

H. Family Involvement

- The County helped establish five support groups. The support groups enable parents of children suffering from a mental illness or emotional disturbance to share information, concerns, problems, and successes and provide each other with encouragement and advice.

- In September of 1995, a parent was hired to serve as a Family Advocate. This Advocate coordinates the development of the parent support system, acts as a liaison between families and the mental health system, coordinates the development of parent participation in the treatment of children, and provides a family perspective in policy development. The Family Advocate also participates on the Case Management Council.

- In June of 1998, seven parents were hired into temporary items as Family Partners and dispersed throughout the mental health system, including assignment with the Division of Mental Health's geographic service teams and the county operated day treatment program. Their responsibilities varied, but included outreach to other families, advocacy, mentoring, data collection, bi-lingual assistance, support group and wraparound facilitation, developing a library for parents, providing transportation to support groups, and attending staff meetings to provide a family perspective. Because of recent funding cutbacks and union rules that require that temporary positions be eliminated first, these items have been terminated. While the philosophy and actions of the county service staff remain family focused, the elimination of the parent positions has seriously cut back on the ability of the county to provide peer to peer services to the families.

- Family members are serving on the Mental Health Board and other policy making committees within the Division of Mental Health. Parents have also been attending training sessions and conferences to gain exposure to best practice strategies for addressing their children's needs.

I. Services

- The Partnership does not provide services directly but relies on the resources of its member agencies to fund services or expense items deemed necessary by the Case Management Council. One of the available resources is the pool of flexible mental health funds, identified above.

- The Division of Mental Health directly provides case coordination services, day treatment, and clinic and crisis services. The In-Home Crisis Team serves as the gatekeeper of inpatient services, i.e., all youth must be evaluated before being admitted to inpatient care. The Crisis

Team also provides follow-up services for up to two months of a crisis episode. Other services are purchased on a fee for service basis.

- The services most frequently purchased using the mental health flexible funds are respite services, behavioral assessment, behavioral intervention, and instruction in behavioral management in the home or classroom. Other items are camp scholarships, memberships in community organizations and clubs, clothes, and transportation.

J. Impact

- The impact of the Partnership is limited since it was only established in 1998. However, the wraparound teams, flexible funding, support of non-traditional services, and other integration efforts begun in 1994 have yielded some dramatic results, including:

  - Reduction in residential placements - Over a 50 percent drop from fiscal year 1995 to fiscal year 1999. A reduction in placements made per year from 60 to 14 over the same period. Most reductions in placements have occurred in the mental health and education systems. Child welfare and probation placements have risen slightly in recent years.

  - Significant improvement in clinical and functional outcomes, as measured by CAFAS. Average CAFAS scores dropped by more than 16 points from intake to discharge.

  - High client satisfaction with services, as indicated by a 1998 survey using the CSQ-8 questionnaire (developed by Cliff Attkisson of the Children's Service Research Group in conjunction with the University of California at San Francisco). Client satisfaction averaged 3.0 to 3.5 on a 4 point scale with 1 representing strong dissatisfaction and 4 indicating strong satisfaction.

K. Lessons Learned

- Some dependency was created by the wraparound funding. It became easier to just approve wraparound funds for new services than to build on the strengths of the family by using natural supports or finding existing community services.

- Initially, solutions were not always developed that were relevant to the cultures being served. Problems must be addressed in a way that makes sense to those being served so that they will continue to use the problem solving mechanisms and techniques after involvement with the service system.

- Positions created for consumers to work within the system should be established as permanent positions to give them some seniority and status during cutbacks. Otherwise, positions may be first to go because of union requirements.

L. Contacts

County Mental Health Director
Cathy Geary
Sonoma County Department of Health
Division of Mental Health
Phone: (707) 565-4705

Program
Mary Jo Burns
Sonoma County Department of Health
Division of Mental Health
Phone: (707) 565-5148
E-mail:mburns@sonoma-county.org

Fiscal
Donna Thorp
Sonoma County Department of Health
Division of Mental Health
Phone: (707) 565-4705

Family Representative
Kathryn Cowdry
Phone: (707) 528-7223

Integrated Services for Youth
Lawrence County, Ohio
Southern Consortium for Children

A. Context

Distinguishing Features

- Rural model targeting children with serious emotional disturbances involved with the child welfare and juvenile court systems.
- Operated by Integrated Service Systems, Inc., a non-profit entity that is certified by the State of Ohio as a mental health provider.
- Serves Lawrence County and is expanding into additional rural counties throughout southeastern Ohio.
- Measures clinical outcomes with a new instrument -- the Ohio Scales -- developed in partnership with Ohio University.

- Integrated Services for Youth (ISY) is an initiative developed under the auspices of the Southern Consortium for Children.

- The Southern Consortium for Children (SCC) involves ten economically depressed rural Appalachian counties in southeastern Ohio. In addition to its role in the initial design of ISY, SCC has several ongoing responsibilities:

  - *Inpatient and Outpatient Psychiatric Utilization*. SCC contracts with board certified child psychiatrists and brokers outpatient services with four mental health agencies across the 10 counties. SCC is the gatekeeper for any child or adolescent needing psychiatric hospitalization, holding contracts with seven regional inpatient treatment facilities.

  - *Runaway and Homeless Youth*. SCC oversees Time Out, a host home network to provide short term emergency shelter for homeless and runaway youth throughout the region, and Teenline, the Southeastern Ohio Runaway Information Line.

  - *Southern Ohio Advance Practice Nurse/Telemedicine Program*. SCC is expanding access to psychiatric care for children and their families by linking advance practice nurses specializing in mental health in the region with child psychiatrists via video-conferencing.

- ISY has been operational in Lawrence County since August 1996 and is now expanding to serve children in other rural counties in southeastern Ohio.

- This summary focuses on ISY's experience in Lawrence County. Lawrence County has a population of approximately 62,000; 97% of which are Caucasian, 2.5 % are African American, and less than .5 % are Native American, Asian, and Hispanic combined.

B. Impetus for Change

- ISY was established to develop a delivery structure to better respond to the needs of children and adolescents with serious emotional disturbances involved in multiple systems and to end the "it's your kid" phenomena where no one system took responsibility for serving a child with multiple needs. Local efforts have been shaped by state directions, including Ohio's Interagency Cluster and Family and Children's First Initiatives, two sequential efforts aimed at developing unified and comprehensive systems of support for children and families. The design and initial implementation of the ISY model in Lawrence County was supported through federal funding as part of the Southern Consortium for Children's grant with the Center for Mental Health Services.

C. Vision and Principles

- Mission Statement:

  To provide an array of services that supports the integration of health and human services across systems. To foster services that are family centered, community based, and culturally competent.

- ISY adheres to both managed service and system of care philosophy and principles*:*

  Managed Service Philosophy and Principles require that services:
  - **S** are family-centered and tailored to meet practical needs
  - **S** build on strengths
  - **S** are based on psychosocial necessity and "best practices"
  - **S** are least restrictive, goal oriented, and solution-focused
  - **S** are time limited or time sensitive
  - **S** evaluate for medication needs early
  - **S** evaluate for substance abuse and treats appropriately
  - **S** include vigorous discharge plans

  System of Care Philosophy and Principles:R
  - **S** The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
  - **S** The system of care should be community-based, with the locus of services as well as management and decision making responsibility resting at the community level.
  - **S** The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

D. Population Served

- During its first year of operation, ISY strategically targeted a discrete group of 20 children who were in residential placements outside of Lawrence County, with the specific goal of

bringing these children home with the necessary community supports and services. ISY has since broadened its target population to include youth with severe emotional disturbances who are at risk of out of home placement in the child welfare system, in a juvenile corrections facility, or returning from placement.

- During the most recent annual period, October 1998-September 1999, ISY served 150 youth and maintained an average daily census of 50. The profile of youth served is as follows:
  - ***age:*** ranging between 10-18 years of age, with an average of 14
  - ***race/ethnicity:*** majority Caucasian, with 5%-10% minorities
  - ***sex:*** 1/3 female; 2/3 male
  - ***top diagnoses:***
    - 55%-60% externalizing diagnoses (conduct disorders, oppositional defiance disorder, and ADHD)
    - 20% internalizing diagnoses (depression, anxiety disorders)
    - 15%-20% sex offending charges
  - ***Medicaid eligibility:*** majority of youth were Medicaid eligible

- In addition, ISY has a respite service that is accessible to any family facing difficulties and needing temporary relief. Approximately 200 episodes of respite services were authorized through ISY in the last year.

E. Oversight and Coordination Structures

- ***Integrated Services for Youth Steering Committee***. Lawrence County's Family and Children First Council, a broad-based interagency planning body, has established an Integrated Services for Youth Steering Committee. This Steering Committee currently includes representation from the juvenile court, child welfare services, and mental health/alcohol and drug addiction board. The Steering Committee, which meets quarterly, guides ISY's policy and program development and oversees implementation.

- ***Integrated Service Systems, Inc***. Integrated Services for Youth is one of two divisions of Integrated Service Systems, Inc., a non profit corporation that develops, manages, and provides services and support for individuals and families who at-risk for significant long term involvement across public sector systems. As a non-profit entity, Integrated Service Systems is governed by a Board of Directors, with bylaws that stipulate family representation on the Board. Integrated Service Systems is certified by the State of Ohio as a mental health provider of outpatient therapy, diagnostic assessment, and community support (i.e case management) services.

- ***Child and Family Teams***. As described in the client flow section below, ISY forms a Child and Family Team for each youth with level III needs. These Teams are facilitated by ISY's resource coordinator and include the child, family members, representatives from all relevant agencies, and community members who are important to the family. The Team's purpose is to develop, implement, and make necessary refinements to a child and family's individualized service plan.

F. Client Flow

- Children and adolescents are referred to ISY for two distinct services: multi-systemic therapy and resource coordination.

1) Multi-systemic Therapy

- The court is ISY's referral source for multi-systemic therapy (MST), an intensive and well-validated family preservation treatment model developed by Scott W. Henggler Ph.D., Director of the Family Services Research Center at the Medical University of South Carolina. One group of court referrals are felony offenders who would otherwise be sent to a juvenile corrections facility. The other group of referrals are youth at imminent risk of placement in the child welfare system.

- Multi-systemic therapy is provided directly by ISY staff. Services are directed toward the psychological, social, educational, and material needs that face families in which a child is in imminent danger of out-of-home placements. MST therapists maintain a small caseload (1:4-6), have daily contact with youth and their families and are available 24 hours/7 days/week, and provide treatment in the field (e.g. home, school, neighborhood and community) rather than office settings.

- Average length of treatment in the multi-systemic therapy program is 4-6 months. After treatment, youth are typically referred to a mental health provider in the community or to ISY's resource coordination staff.

2) Resource Coordination

- Children with serious emotional disturbances and their families may be referred to ISY's central intake through any of the public entities or from other sources. The primary referrals are the courts and the child welfare system.

- ISY's resource coordinators conduct an initial assessment to determine the appropriate level of service need.

Level I	Level II	Level III
No system involvement Stable placement Brief Duration of Problems Easily identified needs Brief Intervention	System involvement Stable or tenuous placement Moderate duration of problems Uncomplicated needs Standard services	Multiple system involvement At risk for out-of-county placement Persistent difficulties Complex needs Need wrap-around flexibility

- For youth with level III needs, the resource coordinator organizes a Child and Family Team meeting which includes the child, family members, representatives from all relevant agencies, and community members who are important to the family (e.g. pastor, doctor, relatives). At the initial Team meeting, an initial service plan is developed.

- After approving the initial plan, the resource coordinator works with the Child and Family team to obtain services included in the plan through existing licensed or credentialed service providers. The resource coordinator provides case management services and may also provide some direct services, such as diagnostic assessments, and outpatient therapy.

- The Child and Family Team meets at a minimum of every 90 days to review and update the service plan.

- For youth with level I and II needs, ISY does not establish a Child and Family Team. Instead, the resource coordinator works with the family to develop and implement a service plan. As above, the resource coordinator functions as a case manager and may also directly provide assessment and therapy services.

G. Flexible Funding

- ISY manages a flexible funding pool in addition to maintaining discrete budgets for respite and family support services. During the period of September 1998 - October 1999, approximately $8,600 was budgeted as follows: flexible funding - $1,700; respite - $5,200; family support services - $1,700. ISY's source of funding for these services was the Family Stability Incentive Fund (funding provided by the State after a county demonstrates reductions in out-of-home placements). ISY expects to see an increase in resources for flexible funding, respite, and family support services in the coming year.

- ISY's resource coordinators are the gatekeepers to the flexible funding pool. The use of this funding has been highly individualized, ranging from purchasing alarm clocks and medications to YMCA memberships.

H. Family Involvement

- For youth enrolled in ISY's MST program, parents are highly involved in the intervention. MST therapists include parents in all decisions and work with them to establish weekly, attainable goals so that parents experience success.

- Family involvement is key for youth served through ISY's resource coordination function. For children with level III needs, the family or parent surrogate is involved in all Child and Family team meetings. For children with level I or II needs, the family or parent surrogate is included in all treatment planning carried out by the resource coordinator.

- Integrated Service System's bylaws require family representation on the Board. While there is a clear commitment to family involvement at this policy level, the agency has experienced some difficulty in recruiting families to the Board and there is currently no family representation. One of the barriers has been the distance between the program site and the administrative office where Board meetings are held. This distance, about 1 ½ hours travel time, has presented a challenge for families with experience with ISY to participate on the Board.

- With Center for Mental Health Services funding, Dream Catchers was established to serve as the Southeastern Ohio Chapter of the Federation of Families for Children's Mental Health. Dream Catchers was created to provide advocacy for parents and emotionally challenged children; support groups for parents and children; and information regarding mental health issues. A representative from Dream Catchers served on ISY's Steering Committee and each family of a child with level III needs was assigned a family advocate to assist them throughout the process. Securing ongoing funding has been a struggle and Dream Catchers has been forced to cease operations. It is everyone's hope that this organization will be revived.

I. Services

- ISY staff directly provide multi-systemic therapy and resource coordination. Resource coordinators provide case management and may also provide diagnostic assessments and outpatient therapy. Sources of support for these direct services include Medicaid, the Family Stability Incentive Fund, and funding from the juvenile court.

- The resource coordinator has the ability to authorize three services that are under the auspices of ISY: respite, family support, and flexible funding. ISY manages the flexible funding pool for wraparound services and holds contracts for respite and family support services with community providers. ISY has developed an extensive respite care capacity, including in-home and out-of-home services. Family support services are provided by specially recruited, trained, and supervised paraprofessional staff, and include assistance with activities of daily living, behavior management, and crisis stabilization support.

- For children with level III needs, initial service plans typically include respite and on-call case management to help stabilize the family. Once stabilized, plans typically include psychiatric and case management services. Respite, flexible funds, and family support services are accessed to meet individualized needs identified by the Child and Family Team.

J. Impact

- ISY's data reflects its experience during the first six months of operation. During this time, the ISY resource coordinators functioned solely as case managers and did not provide any direct services themselves. Data indicate the following positive outcomes:

  - reductions in out-of-county placements;
  - less restrictive placements; and
  - improvements in CAFAS scores.

- ISY is now using the Ohio Scales to measure clinical outcomes. Developed in partnership with Benjamin Ogles, Ph.D. from the Department of Psychology at Ohio University, the Ohio Scales were designed as practical and scientifically sound measures (e.g. easily administered, scored, and interpreted). The Ohio Scales focuses on four content areas: problem severity, functioning, hopefulness, and satisfaction with mental health services. The

instrument includes three parallel forms for completion by the youth's parents (or primary caretaker), the youth (age 12 and older) and the youth's agency worker/case manager. Data from psychometric studies to date suggest that the Ohio Scales are reliable, valid, and sensitive to change. The State of Ohio is in the process of adopting the Ohio Scales as a tool to measure clinical outcomes.

K. Lessons Learned

- Don't wait for a miraculous state level system reform to move forward with system integration for children and adolescents. If it makes sense for all stakeholders, there will be local support.

- ISY's initial focus on bringing children in out-of-county residential placements back home was an effective strategy. Immediate cost-savings were demonstrated which provided momentum for the initiative.

- Multi-county administration of an initiative like ISY is possible but requires a commitment to build relationships on a county by county basis and tailor the specifics of implementation to each local community. ISY envisions that as it expands to additional counties, payroll, billing, and some quality assurance functions will occur centrally, while all service delivery responsibilities will be localized and guided by separate steering committees.

- Successfully transitioning a model from grant to ongoing funding is challenging and may alter program directions. While not part of the original plans, ISY's resource coordinators have taken on direct service functions that generate additional Medicaid revenue to support operations.

L. Contacts

County Mental Health Director
Steven Trout
Executive Director
Southern Consortium for Children
Phone: (740) 593-8293
E-mail: Steve_Trout@scc.ccmail.compuserve.com

Program and Fiscal
Kevin Gillespie
Executive Director
Integrated Support Services, Inc.
Phone: (740) 594-6807
E-mail: kgillespie@integratedservice.org

David Nelson
Site Manager/Resource Coordinator
Integrated Services for Youth
Phone: (740) 532-1613
E-mail: ISYETC@bright.net

Family Representative
Karen Howells
Phone: (740) 532-1613

Stark County Family Council
Stark County, Ohio

A. Context

- Stark County is the seventh largest county in Ohio with a total population of 367,000.

- Stark County has three major cities: Canton, Massillon, and Alliance. Canton is the urban hub and approximately half of the county's population resides in the Canton/North Canton area. The remainder of the County is characterized as suburban or rural.

- 92% of Stark County's residents are Caucasian. The minority population is located in the urban hubs. The minority breakdown is 7% African American and less than 1% of each of the following: Asian, Hispanic, and Native American.

Distinguishing Features

- **S** Cross-system integration model with a 15 year history of serving children and families whose needs cannot adequately be met by a single service system.

- **S** Operated by the Stark County Family Council, an independent entity within county government, that serves as a coordinating hub for system of care activities.

- **S** Flexible funding achieved through a pooled fund involving resources from six systems, totaling $525,000 for 1999.

- **S** Any individual or organization may become a voting member of the Family Council, facilitating broad community involvement.

B. Impetus for Change

- Stark County recognized that cross-system responses were needed to improve the quality, cost-effectiveness, and outcomes of services for children with multiple needs and multiple system involvement. System of care development has been evolving over the past 15 years, spurred by a family court judge who convened the heads of the child-serving agencies in 1983 to strengthen relationships among the systems. Local efforts have been shaped by state directions, including Ohio's Interagency Cluster and Ohio's Family and Children's First initiatives, two sequential efforts aimed at developing unified and comprehensive systems of support for children and families. Federal grant funding from the Center for Mental Health Services provided Stark County with resources to enhance its cross-system capacity.

C. Vision and Principles

- Vision Statement:

  The Stark County Family Council will endeavor to encourage and nurture the development of a unified service system that collaborates with families and pools resources to meet the individual needs of children and their families. This collaboration will strengthen and empower all participants to meet the physical, emotional, intellectual, and social needs of families and children, helping all to build on their strengths.

- Driving Principles:

  - Empower families to identify their priorities, concerns and needs.
  - Ensure family-centered, culturally sensitive, individualized services and supports.
  - Develop programs that wrap services around the family's needs and work to provide whatever services are needed.
  - Ensure availability of service coordination using a non-categorical approach.
  - Affirm that the community is a part of the solution.
  - Reaffirm that everyone has the right to life, liberty, and the pursuit of happiness.
  - Affirm that all families are partners in the defining of the issues as well as the planning of solutions.
  - Meet the needs of families by utilizing the least restrictive community-based services and supports.
  - Develop community awareness of the various systems that provide services and supports to families.
  - Focus on prevention and the family's strengths, priorities, and concerns.
  - Accept every family with a "no eject, no reject" services and supports policy.

D. Population Served

- Stark County's initial target population for system of care activities was youth with multiple needs and with multi-agency involvement. In 1994, as a result of the County's participation in the Ohio Family and Children's First Initiative, the target population expanded to all families voluntarily seeking service and all children who are abused, neglected, unruly or delinquent between the ages of birth through 21.

- In 1998, the Family Council coordinated Creative Community Options (CCO) meetings for 108 children. These children were referred to the Family Council directly by families and staff from all child serving systems, including education, courts, mental health, mental retardation, substance abuse, and child welfare.

- Approximately 75% of the children that came forward through the CCO process had a mental health diagnosis. The profile of the 108 children served in 1998 was as follows:

  - ***age***: age range of those served was 4-21, with a clear majority being 10-17 and average age of 14
  - **sex:** 1/3 female; 2/3 male
  - **diagnoses:** (duplicated counts since many of the children had multiple diagnoses):
    - 25% behavior disorders (e.g. oppositional defiance disorders, conduct disorders)
    - 17% ADHD
    - 15% anxiety/depression
    - 15% co-existing substance abuse issues
    - 7% sex offending charges
    - 7% post traumatic stress disorders
    - 3% thought disorders

- 3% pervasive developmental disorders (e.g. autism, Aspergers)
- 3% Tourettes Disorder

- Twelve of the 108 children accessed pooled funding to support their service plan through the ACCORD (see below).

E. Oversight and Coordination Structures

- The Stark County Family Council is an independent entity within county government that plans for and coordinates services for all of the families in the community. The Family Council is working toward creating a full continuum of family support, prevention, intervention, and treatment services that are infused with the system-of-care principles. Within this broad charge, the Council has responsibility for coordinating efforts for hard to serve children, the focus of this summary. Oversight and coordinating structures are as follows:

  - *The Family Council Board of Trustees* – The governance of the Family Council is vested in a Board of Trustees that is responsible for system development, resource development, redirection of resources, and policy impact. Membership on the Board includes the county directors of all of the child-serving systems, parents, and at large community members elected from the general membership. The Executive Director of the Stark Family Council is directly responsible to the Board of Trustees

  - *Family Council General Membership* – As the collaborative body for Stark County, the Family Council is committed to inclusive opportunities for all members of the community. As a result, the Board of Trustees has created an open process for any individual or organization to become a member of the Council. There are currently over 150 members of the Council.

  - A Creative Community Options Review Decision (ACCORD) – The ACCORD is a mid-level management group that includes supervisory staff from the child serving systems, providers, schools, and parent coordinators. The ACCORD reviews Creative Community Options (CCO) decisions and authorizes expenditures from the pooled fund; serves as a consultative group for local providers seeking to develop creative service responses for specific children and families; and helps to identify and respond to service gaps and cross system issues.

  - *Creative Community Options* (CCO) – Developed by the Family Council, CCO is a multiple systems strength-based assessment and treatment planning process for children and their families. Through the CCO process, direct service providers and families come together to address the needs of a single child and family. Membership changes based on who is most attached to the child or family and the family's preferences.

F. Client Flow

- Any professional in any system or a family may contact the Stark County Family Council and request a Creative Community Options (CCO) meeting for a child and family that needs a more creative and flexible service package. About 80% of referrals come from providers and 20% come from families.

- The Family Council's CCO coordinator works with the case manager and family to identify who should be part of the child and family's team and participate at the CCO meeting.

- Through the Council's contract with FACES, Stark County's family support organization, a family advocate is assigned to the family to be a resource before and after a CCO team meeting and to provide follow-up assistance.

- Typically, within two weeks of receiving the referral, a CCO meeting is held where a strength-based, wraparound approach to service planning occurs. The CCO is facilitated by a neutral person whose system is not involved with the child or family. (The Council has trained a small cadre of staff within the existing systems to facilitate CCO meetings and contends that neutral facilitation is essential). At the CCO meeting, the team members develop and sign off on the service plan. In addition, a follow-up meeting is scheduled to review the plan within 30 - 60 days.

- Children may be referred to the ACCORD, a mid-level management group, if they meet the following criteria: 1) two or more systems involved; 2) a CCO has occurred; and 3) the CCO has recommended a service plan that requires fiscal assistance above and beyond what can be paid by the family, insurance, or the existing systems.

- The ACCORD meets twice a month and family members may attend the meeting during the time of their family's presentation. As the gatekeeper and manager of the pooled fund, the ACCORD authorizes the expenditure of flexible funds. For children needing residential placement, the ACCORD authorizes and monitors lengths of stay.

- The family advocate stays involved until the family feels stabilized and confident that the service plan is working.

- In addition to the flow specific to the CCO and ACCORD process, a family can call the Family Council for any type of assistance. In these instances, the family is connected with a parent coordinator on staff at the Family Council who helps the family access needed services. If the family feels that the service(s) are not meeting their needs, a CCO meeting may be requested and the flow proceeds as outlined above.

G. Flexible Funding

- Since 1992, the Family Council has established a pooled fund to pay for services for multi-need youth. This pool blends resources from multiple systems: the Department of Human

Services, Mental Health Board, Mental Retardation and Developmental Disabilities Board, Alcohol and Drug Addiction Services Board, Family Court, and several school districts. Only local dollars are included in the pooled fund.

- The first funding pool was established after each of the systems reviewed their case loads for children involved with two or more systems and then transferred a portion of these cases and associated resources to the Family Council for the ACCORD to manage.

- The total amount of the pooled fund and contributions of each of the systems for the years 1998 and 1999 are as follows:

System	1998	1999
Department of Human Services	$10,000	$50,000
Mental Health Board	200,000	300,000
Mental Retardation/ Developmental Disabilities Board	140,000	140,000
Alcohol and Drug Addiction Services Board	10,000	15,000
Family Court	10,000	10,000
Canton City Schools	13,000	13,000
Fairless Local Schools	2,500	2,500
Total	$384,500	$524,500

- The pooled fund is used as the last dollar in funding service plans. In 1998, there were 48 children that were authorized by the ACCORD to receive services paid for through the pooled fund. Twelve of these children accessed pooled funding for the first time in 1998. The pooled fund paid for 67% of the total cost of services for these children, after drawing down other resources from SSI, Title IV-E/B, and parent contributions.

H. Family Involvement

- Six parents sit on the Board of Trustees as full voting members.

- On staff at the Stark County Family Council are two parent coordinators that serve as advocates and service plan facilitators. These parent coordinators are also members of the ACCORD.

- CCO meetings always include families and families may also attend ACCORD meetings.

- The Family Council contracts with FACES (Family Advocacy + Community Education = Support) for flexible services such as family advocacy, respite care, and other supportive services.

I. Services

- Ohio law prohibits County Mental Health Boards, which serve as the local mental health authority, from providing direct services but allows for the provision of services through contracts with local provider organizations.

- Up until January 1999, the Family Council's pooled funding was used solely to pay for residential care or long term respite situations. In the majority of instances, pooled funding has been used to access residential treatment or high level therapeutic foster home services in the child welfare system for families that want to maintain custody of their children yet access these services. In most cases, child welfare requirements mandate that families relinquish custody to obtain residential services.

- Since January 1999, the Pooled Funds Group has authorized the use of pooled funding to pay for support services. The support services most frequently paid for through the pooled fund to date are weekend respite and tagalong services (one on one support for a youth at school, summer camp, recreation program to assist with behavior management). Other support services include after-school programming, community center memberships, summer camps, and adaptive equipment.

- 10% of pooled funds are used to support the administrative costs of the Family Council. In addition, pooled funds have also been used to support special projects, e.g. start-up of an alternative education program.

J. Impact

- Reduced total out of home placements across all systems by 34% during the period of 1/96-6/99.

- Decreased length of stay for children served through the CCO and ACCORD from an average of 2.8 years for youth entering residential services in 1992 to .8 years in 1996 and .3 year in 1998. In addition, increased parent involvement and maintained children in the custody of their parents.

- Demonstrated the cost-effectiveness of home based services using the wraparound approach. Using aggregated three year data, Stark County has shown that the average per diem costs of home based services is $30-$150 compared to residential costs of $52-$389.

K. Lessons Learned

- Children and families need to be the rallying point — not children with serious emotional disturbances. Targeting children and families involved with multiple systems creates greater opportunity for sustainability and buy-in because the effort won't be seen as a "mental health" initiative.

- The operational responsibility for implementing a cross-system approach can not rest on any one system. Stark County's experience is that cross-system collaboration is best achieved through an independent entity. It is also Stark's experience that the appointment of a seasoned individual skilled in interagency work to lead the new organization is key to success.

- Families are central and need to be involved at all levels.

- Active and on-going involvement of the directors of the child-serving systems — those able to "put a deal on the table" — has been essential to forging new approaches to funding and service delivery. A critical mass of leadership is needed to initiate the process with a clear strategy to build support and buy-in among all major stakeholders.

L. Contacts

County Mental Health Director
Les Abel
Director, Stark County Community Mental Health Board
Phone: (330) 455-6644
E-mail: lesa@starkmhb.org

Program
Carol Lichtenwalter
Executive Director
Stark County Family Council
Phone: (330) 455-1225
E-mail: carol@starkfamilycouncil.org

Rick Shepler
CCO Coordinator
Stark County Family Council
Phone: (330) 455-1225
E-mail: ricks@starkfamilycouncil.org

Fiscal
Susan Hays
Benefits Coordinator
Stark County Family Council
Phone: (330) 455-1225
E-mail: shays@starkfamilycouncil.org

Family Representative
Jan Smith
Executive Director
FACES
Phone: (330) 455-2520

Community Networks
Westchester County, New York

A. Context

- Westchester County has a population of about 898,000 individuals. The County contains 6 cities, extensive suburban areas, and some rural sections in the north.

- Approximately 80% of Westchester's population is Caucasian, 15% African American and 5% Asian. Hispanics, who make up approximately 12% of Westchester's population, are also included in the Caucasian and African American percentages.

B. Impetus for Change

- Westchester County's reform effort was initiated to improve the delivery of services to children and reduce out of home placements. The New York State's Coordinated Children's Service Initiative (CCSI) grant served as a catalyst for improving coordination of services for families with children who have serious emotional disturbances.

Distinguishing Features

- **S** A community based cross-system case conferencing model to address the needs of the most difficult cases within the family and youth services system.

- **S** Initiated in the city of Mount Vernon in 1979, the model has been expanded to nine other communities in Westchester. Over the last eight years, Community Network activities have been enhanced through the infusion of strength-based, family centered approaches.

- **S** Strong family and youth involvement and support at multiple levels is provided through 1) Family Ties - a parent support organization and 2) the Youth Forum - a peer run support service for older adolescents and young adults who have experience in mental health services, special education, and residential placement.

C. Vision and Principles

The guiding values and principles of Westchester's Networks are:

- Parent/families are full participants in the Network process;
- Each participant and agency is a valued member;
- It is expected that the integrity and boundaries of each agency will be understood and respected, not changed;
- It is better to include, not exclude, a "difficult" worker or "problematic" agency. There will undoubtedly come a time when you will have to work together. Use Network to positively influence this relationship;
- Network members and their guests are always bound by the laws of confidentiality;
- Networks must consistently reach out to include the services and agencies that work in their community;
- Network planning is based on an assessment of each family's strengths; and

- Network promotes “unconditional care” by service providers for all clients.

D. Population Served

- The goal of the Community Networks is to identify and coordinate care for cases that meet two criteria: 1) a community service provider is facing difficulties serving the child and family, and 2) the child needs the assistance of more than one service system in addition to education.

- During 1998, there were nine Community Networks in place, serving 176 families. Approximately 70% of those served were male and 30% female. Approximately 65% are Medicaid recipients, 32% have private insurance, and 3% have no insurance. Approximately 65% of youth served are age 12 through 15.

- The percentage of referrals by referring agency are as follows:

-- mental health	35%
-- education	15%
-- social services	13%
-- psychiatric hospital	10%
-- Family Ties	8%
-- probation	7%
-- child care agencies	5%
-- community agencies, clinics, private physicians, or others	7%

- Of those served, 55% were African American, 26% Caucasian, 15% Hispanic, and 4% other.

- Recent and current problems of children and youth referred to the Networks (1997-98 data) include school failure and truancy (93%), alcohol and drug abuse (20%), dangerous to others (19%), runaway (14%), out of home placement (13%), criminal activity (12%), sexually aggressive behavior (12%), sexual abuse victim (12%), and fire setting (12%).

- The most predominant diagnoses of youth served through the Community Networks include ADHD, conduct disorder, and bi-polar disorder.

E. Oversight and Coordination Structures

- Coordination of children’s services are provided through two main entities within the geographic areas served by Community Networks:

  - *The Community Networks* - At the family level, a Community Network serves as the vehicle for coordinating cases for those families who the community finds difficult to serve and are in need of services from multiple systems. Currently, Westchester has Community Networks in the areas of Mount Vernon, Yonkers, Peekskill, Ossining,

New Rochelle, Bedford, Port Chester, Lakeland School District, and central Westchester. Community Network meetings are also held at the Westchester Medical Center for families throughout the County. In addition to family members, the Network meetings typically include front-line workers and supervisors from police, juvenile justice, health, mental health, education, social service agencies, family support groups, providers, and other local agencies. The meetings serve as the Tier 1 meeting for CCSI.

- Local Planning Councils - Many of the municipalities served by Community Networks also have Local Planning Councils, which are responsible for system planning and development and coordination of resources for children and family services. Membership on the Local Planning Councils includes municipal officials, board of education members, and administrators or directors from family support groups, police, juvenile justice, health, mental health, education, and social service providers, and other community agencies.

- Countywide coordination is provided through the following entities:

  - The Coordinated Children's Services Advisory Council - This body consists of county level planning and decision makers for each service system. Serving as the Tier 2 entity for CCSI, the Advisory Council identifies systems issues, designs system improvements, and strengthens community services so that Westchester County is less reliant on out of home placements.

  - Single Point of Entry Committee - Chaired by the County Department of Social Services, this committee serves as the gatekeeper for residential placement. The group, consisting of mid-level managers from the County Departments of Social Services, Mental Health, and Probation, identifies all children and adolescents at a very high level of risk of residential placement and develops community options to avert their placement, with an emphasis on non-traditional approaches. When placement is unavoidable, the group determines the most appropriate, least restrictive and shortest treatment that is clinically appropriate, with cross system support to facilitate return to the home community as soon as possible.

  - Community Mental Health Intake Committee - Coordination of services within the mental health system for hard to serve individuals is provided by the Community Mental Health Intake Committee. The Intake Committee is made up of representatives of programs that provide case management services and certain intensive children services, including community residential services, family preservation, therapeutic foster care, respite, Family Ties, and the Youth Forum. The Committee reviews data from a universal referral form, developed by the County Department of Community Mental Health to obtain a standard set of information on each family, and matches programs and care coordination with the needs of the child and family. Children with serious emotional disturbances are eligible for one of the 150 case management slots established through the various case management programs (e.g., Children's Intensive Case Management, and Home and Community Based Waiver) and the flexible funds

associated with these programs. The Community Mental Health Intake Committee also participates in and coordinates its activities with those of each of the Community Networks.

F. Client Flow

- Network meetings are conducted at least monthly but as frequently as weekly, depending on the caseload of the Community Network. A representative from any of the systems providing services to children and youth can make a referral for consideration at a Community Network meeting.

- A parent who is a member of the grassroots parent support organization - Family Ties - meets with the family prior to the Community Network meeting to explain the process and lend support. This Family Ties member also attends the Community Network meeting to provide assistance. Other resource people, such as service provider staff, family members, or other community members, may be asked in advance to attend the meeting and help in the process.

- Parents are encouraged to attend the Community Network meetings as full partners in the case planning/coordination process in recognition of their continuous roles as ultimate case managers for their children.

- At the Network meeting, the Network facilitator conducts a strength-based assessment noting family strengths, assets, issues, and concerns. The family and Network members jointly develop a coordinated case plan for each child and family based on the family's strengths and assets. The Network then reaches a consensus on which agency should take responsibility for case coordination.

- A support circle is formed of professionals, relatives, and friends identified by the parent as most needed by him or her to move the Network plan forward. The support circle continues to meet, or communicate by telephone, on a regular basis to assist the family.

- Four to six weeks after initial presentation, a case is reviewed by the Network for progress and potential problems.

G. Flexible Funding

- Although a flexible funding pool has not yet been established, approximately $200,000 of flexible funds are available annually as components of the County's various case management programs. The County has increased the amount of flexible funding by adding it to each County agency's request for expanded or new programs over the last several years. In this manner, the County received flexible funding to support programs funded by the State Department of Social Services, Office of Probation, and Department of Education. Westchester County is planning to use a grant recently received from the Center for Mental Health Services to expand both case management and flexible funding. This resource is critically important to appropriately serve children with serious emotional disabilities in a strength-based, family centered system of care.

H. Family Involvement

- Family Ties, a family support and advocacy organization, is actively involved in the development, implementation, and on-going operation of the Community Networks. As core members of each Community Network, Family Ties family members give a "parent to parent" orientation on the Network process in a family friendly and culturally relevant manner. They also provide assistance and support to parents during and immediately after Network meetings and, frequently, during service delivery. Family Ties staff and volunteer parents are actively involved in other planning and review activities of the County, including the County Integrated Services Planning group, the County Mental Health Community Services Board, and Coordinated Children's Services Advisory Council, which helps formulate policies effecting services to children with emotional disabilities.

- The Youth Forum, Peer Support and Leadership Program (The Youth Forum) is a nationally recognized peer run support service for older adolescents and young adults who have had a wide range of experiences in special education settings, residential placements and mental health services. Youth Forum members often participate in Community Network meetings when there is an older adolescent or young adult who is the focus of planning. Youth Forum members also attend and contribute to local, county, and state level planning groups and advisory councils.

I. Services

- The services most frequently being provided to children and/or their families prior to the initial Community Network meeting include:

mental health clinic	58%
mandated preventive services (DSS)	26%
mental health case management	18%
psychiatric hospitalization	18%
probation	16%
child protective service	16%
family support	15%
alcohol/drug treatment	13%

- The services or items most frequently purchased through flexible funding are non-traditional services, such as camper scholarships, respite services, mentoring, and club memberships.

- Westchester County has used the state's reinvestment funds to expand non-traditional services for children with serious emotional disabilities and their families. Approximately $1.3 million of reinvestment funds have been used between 1994 and 1998 to expand family support, respite, and mobile case management teams.

J. Impact

- In 1993, there were 220 admissions to County Department of Social Services residential facilities. By 1997, the number of annual admissions to DSS residential care was reduced to 86 children.

- Between 1993 and 1997, the County avoided placements of 174 children into DSS residential care, at a cost savings of close to $12 million. Placements of juvenile delinquents decreased from a high of 44 in 1995 down to 22 in 1997 for a total cost savings of $1.9 million. Mental health placements in Residential Treatment Facilities have remained flat at an average of 15 placements per year. The reduction in overall residential placements can be attributed, in part, to the efforts of the Community Networks, the Single Point of Entry Committee, and Westchester's Mental Health/Juvenile Justice Project, established in 1995 to provide integrated mental health, probation, and substance abuse services to the juvenile delinquency population in one of three family court jurisdictions in the County.

K. Lesson Learned

- The strength-based approach to serving families provides a clear and common language that is understandable across systems and to the family. This approach is an extremely valuable way of engaging families and solving problems.

- Using support circles, consisting of people that the family has identified as being supportive to them, helps to facilitate a creative process that enhances coordination of services and accountability. The County has learned that families and communities begin to work better and address their own issues when allowed to do so from within. By starting out with a Community Network approach and modeling this approach for each family, the families become empowered to identify their own network of natural supports which will sustain them long after the service providers leave.

- It is essential that agency administrators develop and promote flexible services that can best meet families' needs rather than fit them into a restrictive categorical services system. Belief in an individualized, strength-based system that is flexible is needed at all levels - clinical and executive leadership, supervisors, middle management, treatment supervisors, and frontline workers. This principle must be publicly endorsed and reinforced by county government's mental health leadership.

L. Contacts

County Mental Health Director
Steven J. Friedman
Commissioner
Westchester County Department of Community Mental Health
Phone: (914) 285-5236
E-mail: sjf3@co.westchester.ny.us

Program
Myra Alfreds
Director, Children's Mental Health Services
Westchester County Department of Community Mental Health
Phone: (914) 285-5250
E-mail: mw4@co.westchester.ny.us

Fiscal
Thomas Neufeld
Director of Administration
Westchester County Department of Community Mental Health
Phone: (914) 285-5224

Family Representative
Karen Fredericks
Director
Family Ties
Phone: (914) 285-5238

Coordinated Children's Services Initiative
Chautauqua County, New York

Perspectives from
Rebecca Hodgson
Primary Parent Advocate

Strengths

- A major strength of Chautauqua County's Coordinated Children's Services Initiative (CCSI) is that it is responsive to family need. One mechanism for ensuring that family needs are primary is the family visit by a parent advocate prior to the child and family team meeting. This visit by the family advocate prepares the family for interaction with the team and helps to identify family strengths ahead of time.

- Having a core team composed of the Primary Parent Advocate, the lead facilitator, and the service coordinator located in the same office facilitates coordination and makes troubleshooting easier.

- Chautauqua County's CCSI has excellent follow-up to make sure that goals included in a service plan are achieved. Each team member and, sometimes, a family member, gets a specific assignment. Team meetings are held frequently (every two weeks to every other month) to ensure that the assignments are being carried out.

Challenges

- One of the challenges is to make sure that all team members are taking their responsibility seriously and carrying out their assigned responsibilities.

- Turf issues can still be a problem among the different systems, particularly when accessing funding from a categorical funding stream.

Advice

- Match families with advocates so that they are compatible. For example, a family with a teen who has a behavior problem should not be assigned an advocate who is too young (not enough of an authority figure) or too old (possibly have difficulties relating with the teen).

- Ensure that advocates handling complex cases know the requirements of all of the systems. Cross training is essential.

Wraparound Milwaukee
Milwaukee County, Wisconsin

Perspectives from
Margaret Jefferson, Executive Director
Families United of Milwaukee

Strengths

- Wraparound Milwaukee is family centered, with the focus on the strengths of families, not weaknesses. Workers are not patronizing and families' opinions are valued. "Parents feel like MVPs when involved."

- There is excellent collaboration in the community - reaching out to the judges, county agencies, and the provider network. All segments are working together to meet the families' needs.

- Wraparound is delivered in a culturally competent manner. Services are accessible to the people that are served and efforts are made to keep people in the areas where they live. Families have the opportunity to make choices about their lifestyles. This has resulted in a positive attitude toward Wraparound, with 85% of families indicating in a survey that they are satisfied with Wraparound services.

Challenges

- More education and training is needed. Many staff have come out of colleges with "book" learning without really understanding how to deal with people or deliver services in a family friendly manner. We should start educating staff on the principles and methods of Wraparound in college.

- While Wraparound Milwaukee is supportive of the family advocacy organization, more funding is needed for family support and advocacy work.

- More parent involvement is needed in systems planning -- not just in planning for Wraparound, but in the development of other service systems (schools, juvenile justice, health, etc.).

Advice

- Keep the mission in the forefront. Make sure that the design and practice of your system is consistent with its principles.

- Put training and education of staff in place early in the development of the new system. Involve family members as key players in this training.

- Foster good communication and collaboration. This is particularly critical between the family advocacy organization and the director of the initiative.

Kids Oneida
Oneida County, New York

Perspectives from a
Parent of Child Served Through Kids Oneida

Strengths

- Kids Oneida's service coordinator was excellent, helping to "tie the pieces together for the family."

- The service coordinator provided a lot of helpful suggestions so that family members would be able to handle situations on their own, after Kids Oneida was no longer involved.

- The approach of bringing services to the home was seen as valuable and effective. Having the service coordinator and mentor make home visits helped them to better "see issues from our family's point of view."

Challenges

- While the family was comfortable with the decision to discharge their child from Kids Oneida, they would have liked their mentor to continue for a longer period of time. This raises questions about the sudden loss of all services once a child is discharged from the program and whether some transitional services are needed.

Advice

- Develop prevention services in addition to more intensive interventions like Kids Oneida. While there is a clear role for programs like Kids Oneida to serve children with serious emotional disturbances and their families, communities need to place greater emphasis on prevention. Work with the schools to identify children needing supports and services earlier, before crisis situations occur.

Youth and Family Services Partnership
Sonoma County, California

Perspectives from
Kathryn Cowdry
Parent and Family Advocate

Strengths

- The In-Home Crisis Team is a major strength of Sonoma's system of care. The Crisis Team was a "life-saver" because it was able to help stabilize my child and link my family to services.

- The availability of family advocates is also wonderful. While services often focus only on the needs of the child, the family advocate addresses the needs of the whole family. In particular, my family advocate helped me obtain respite and other services that I needed.

- The wraparound teams are excellent. The approach provides a sense of hope because the team members focus on families' strengths, listen to family members, and respect their opinions.

Challenges

- One of the challenges is determining when a family is ready to be discharged from the integrated service system and who makes this determination.

- Wraparound funds are sometimes over-relied upon when other community supports can be used. Another challenge is to allocate wraparound funds equitably to avoid the situation where some families use a disproportionate share of these resources.

Advice

- Create a system of care that is family friendly. Concentrate on family strengths, not weaknesses, and do not blame the family.

- Fully integrate family advocates into the system. Family advocates must be chosen carefully for their understanding and willingness to work with families. It is most helpful to have family advocates who have been through a 12 step self help program since so many of the families have a least one member who is involved in drug or alcohol abuse.

- Incorporate family therapy as a major component of the continuum of available services since family dynamics is such an important part of dealing with the behavior of hard to serve children.

Integrated Services for Youth
Lawrence County, Ohio

Perspectives from
Karen Howells
Grandparent of Two Children with Behavioral Problems and
Former Family Advocate

Strengths

- Integrated Services for Youth (ISY) is making great strides in increasing awareness of children's mental health issues in the community. ISY is helping families and schools to better understand and respond to children with emotional and behavioral problems.

- ISY is committed to family empowerment. Families feel like they "have a say" in their care plans and are learning to take charge of their own lives.

Challenges

- One of the major challenges for ISY is the mind set and lifestyles of many of the Appalachian families it serves. Many family members think that "things are never going to get better" and have a poor sense of self esteem.

- Securing funding to revive Dream Catchers, the Southeastern Ohio Chapter of the Federation of Families for Children's Mental Health, is another challenge. When grant funding ended, Dream Catchers was forced to cease operations. Family advocates are critically important, helping families to fully understand and navigate the process.

Advice

- Listen to families, without being judgemental. A parent caring for a child with emotional or behavioral difficulties faces enormous stress every day. Try to walk in their shoes.

- Involve families in policy level discussions. Their input is beneficial because they make sure that policy directions are grounded in the real life experiences of families.

Stark County Family Council
Stark County, Ohio

Perspectives from
Jan Smith, Executive Director
FACES (Family Advocacy + Community Education = Support)

Strengths

- Several essential concepts have been fully integrated into Stark County's Creative Community Options (CCO) process: bringing a family as a unit to the table, encouraging the family to also invite other individuals who are their natural supports to CCO meetings, and building on family strengths when developing care plans.

- There has been tremendous buy-in to the CCO process. While there was some initial hesitance, providers now see CCOs as a successful approach to frontline case management.

- CCOs provide the forum for providers to work together with the family to develop a coordinated care plan. Families feel a greater sense of partnership with providers and benefit from everyone being on the "same page" regarding the service plan, roles, and expectations. The CCO process is also time efficient, replacing the need for families to fit multiple meetings with individual systems into their hectic work/family schedules.

Challenges

- As the CCO process has gained acceptance, some of the systems have initiated the process internally in their systems. While this is positive, the systems are replicating the CCO approach without an important element: the use of neutral facilitators that are trained in the strength based assessment and treatment planning process. This direction is seen as problematic because trained, impartial facilitators are seen as skilled at tempering the attitude among some professionals that they know what is right for the family.

Advice

- Plan for and fund a model that is implemented across systems. To ensure consistency, consider contracting with one organization to either facilitate care planning meetings or to train individuals with a uniform strength-based approach to assessment and treatment planning.

- Don't link parent advocacy to one system. To make the case for cross system support, parent advocacy organizations need to collect data that profiles the characteristics of the families they serve.

- Create a sense of convenience for families. Meeting locations and times need to work for families.

- Build opportunities for parent advocates to meet on a regular basis for on going training and peer-to-peer sharing and learning.

Community Networks
Westchester County, New York

Perspectives from
Karen Fredricks, Director
Family Ties

Strengths

- A major strength is the community focus of Networks, whereby the whole community takes responsibility for hard to serve children and their families. All of the systems are at the table together. Families do not receive mixed messages from the different systems.

- The family is listened to and empowered through this model. Also, services are delivered in a culturally competent manner, respectful of the families' backgrounds and interests.

- Families come out of the Community Network process with not only a plan, but also on-going support in the form of the support circle. This continuous support is extremely helpful to the family.

Challenges

- One challenge is for Community Network members to understand the differences in the requirements and restrictions of the various systems. We must keep "turf" issues out of the picture, so that everyone remains committed to a solution.

- Another challenge is make sure that flexible dollars aren't used for a quick fix, but as part of a broad, long term solution that takes advantage of existing natural supports and services.

- It is sometimes difficult to keep members of support circles involved so that the circles are effective. Staff can be overwhelmed by the workload or the significance of the problems faced by the families. The need to train new and existing staff in approaches that are supportive and empowering of families is another challenge.

Advice

- Look at some of the existing models that work before developing your own system. You may learn something from this.

- Ensure that leadership and vision are in place before you start.

- Commit to and integrate the principles of family support into all aspects of the design and delivery of services. Family advocates should be part of a family support organization or at least affiliated with the state and national organizations so that they are supported.

Taking Stock and Moving Forward:
A Self-Assessment Tool to Guide System Integration for Children and Families with Complex Needs *

Purpose:

This tool was designed by Meridian Consulting Services for the New York State Conference of Local Mental Hygiene Directors to stimulate local reflection and discussion about the current status of delivering integrated services to children and families with complex needs and to help establish priorities for implementation.

Suggested Process for Administering the Self Assessment Tool:

- Identify community stakeholders who should be involved in developing a more integrated system of care for children and families with complex needs. Include representatives from county government and not-for profit agencies in the mental health, child welfare, juvenile justice, and health systems and stakeholders from schools, family court, and family support and advocacy organizations.

- Send out the assessment tool with a cover letter that expresses your interest in obtaining feedback from the community about the current status of system integration for children and families. You may also want to include a copy of *Core Elements of an Integrated System of Care for Children and Families with Complex Needs* from the Conference of Local Mental Hygiene Directors' Technical Assistance Resource Book.

- Compile and analyze the ratings for each core element and implementation step (Section I of tool), taking note of the scores which indicate a great discrepancy in the viewpoints of stakeholders.

- Compile and analyze the priorities identified by stakeholders (Section II of tool) to determine whether there is any consistency in direction. For each priority identified, also summarize the actions suggested to further implementation.

- Hold a meeting of community stakeholders to review the results of the self-assessment tool and to develop a consensus on a plan of action for creating a more integrated system of care for children and families with complex needs.

* Note: This tool will be pilot tested and may be modified as a result of this process. Please contact Meridian Consulting Services, Inc. (518-869-6198) or the New York State Conference of Local Mental Hygiene Directors, Inc. (518-462-9422) for the latest version.

Taking Stock and Moving Forward:
A Self-Assessment Tool to Guide System Integration for Children and Families with Complex Needs
Version 1 - 2/00

Section I: Assessment of the Degree of Implementation of Core Elements

A series of implementation steps have been identified for each of the nine core elements of an integrated system of care. The core elements are grouped into three categories: systems level; service delivery level, and cross-cutting (relevant for both systems and service delivery levels). Using the rating scale identified at the bottom of each page, indicate your opinion about the extent to which each element has been implemented in your community.

Core Elements and Implementation Steps	Degree of Implementation
A. <u>Systems Level</u>	
1. Clearly Defined Target Population	
a. A diverse group of stakeholders has been involved in defining the target population for the integrated system of care, including representatives from county government, schools, provider agencies, and family advocacy organizations.	1 2 3 4 DK
b An agreement has been reached about who the integrated system of care will serve, e. g., children with serious emotional disturbances and their families, children needing assistance from multiple service systems and their families, children at risk of out of home placement and their families, or some combination of the above.	1 2 3 4 DK
c. Data is available to estimate the number of children and families that fall within the target population and the current cost of services to these individuals.	1 2 3 4 DK
2. Shared Vision and Principles	
a. Key stakeholders from county government, schools, providers agencies, and family advocacy organizations have achieved a consensus and developed a written statement describing their vision and guiding principles for a new service delivery approach.	1 2 3 4 DK
d. The vision and principles reflect the spirit of the values and principles adopted by the Federal Child and Adolescent Service System Program (CASSP).	1 2 3 4 DK
e. Strategies have been implemented to ensure that the vision and guiding principles are infused into the ongoing operations of public and private sector provider agencies.	1 2 3 4 DK

Degree of Implementation Rating Scale: 1 = does not exist, 2 = in process of development, 3 = in place but needs improvement, 4 = in place and effective, DK = don't know

Core Elements and Implementation Steps	Degree of Implementation
3. Strong Leadership	
a. A clearly identified leader or group of leaders in the community has assumed responsibility for advancing an integrated system of care.	1 2 3 4 DK
b. The leader or group of leaders has the authority to effect change at the county level.	1 2 3 4 DK
c. The leader or group of leaders are well respected by community stakeholders.	1 2 3 4 DK
d. The leader or group of leaders has the ability to effectively advocate for changes needed at the state level to support the implementation of the integrated system of care.	1 2 3 4 DK
4. Broad-based Oversight Body	
a. A broad-based oversight body has been established with diverse community representation, including leadership from county mental health, child welfare, juvenile justice, and health systems, schools, parent representatives, provider agencies, and other community stakeholders.	1 2 3 4 DK
d. Representatives on the oversight body are at a sufficient level within their organizations to make commitments to policy and service delivery changes.	1 2 3 4 DK
e. The oversight body has a written statement describing its mission and responsibilities for advancing the new model of care.	1 2 3 4 DK
B. <u>Service Delivery Level</u>	
5. Effective Structure for Care Coordination	
a. A structure has been established for assigning a primary care coordinator to each child and family served by the integrated system of care, either through an independent lead agency or a multi-agency team process.	1 2 3 4 DK
f. The primary care coordinator's roles and responsibilities have been clearly delineated and are routinely conveyed to family members and provider staff.	1 2 3 4 DK
c. Information about the care coordination structure (i.e. mission, responsibilities, contact information) has been widely disseminated to potential referral sources in the community.	1 2 3 4 DK
d. There are regular opportunities for the care coordination structure to provide feedback to the oversight body regarding the strengths and weaknesses of the system and needed improvements.	1 2 3 4 DK

Degree of Implementation Rating Scale: 1 = does not exist, 2 = in process of development, 3 = in place but needs improvement, 4 = in place and effective, DK = don't know

Core Elements and Implementation Steps	Degree of Implementation
6. Strength-based Child and Family Teams	
a. Child and family teams, that include family members, involved professionals and providers, parent advocates, and other informal supports, are formed for each child and family served by the initiative.	1 2 3 4 DK
d. Through the team process, the child and his/her family are included as full partners in assessing their strengths and needs, identifying their goals, developing a service plan, and evaluating progress on a regular basis.	1 2 3 4 DK
e. Facilitators of child and family team meetings are trained in strength-based assessment and treatment planning processes.	1 2 3 4 DK
f. Agency staff providing services as part of the initiative are trained in cultural competent, individualized, and strength-based approaches to service planning and delivery.	1 2 3 4 DK
g. The child and family team ensures a smooth transition to other community services when a child is disenrolled from the initiative.	1 2 3 4 DK
h. Feedback loops are established so that the experience of child and family teams (e.g. what works well, service gaps, and needed improvements) is regularly communicated to both the care coordination structure and the oversight body.	1 2 3 4 DK
7. Flexible Funding to Support Individualized Care Plans	
a. The oversight body and the care coordination structure have identified the non-traditional services that are currently not available but could improve outcomes for children and families, such as respite, mentoring, and in-home treatment services.	1 2 3 4 DK
b. The oversight body has reviewed options (e.g. capitation, multi-agency pooled fund, or single agency flexible fund) and selected an approach to establish flexible funding to support non-traditional services.	1 2 3 4 DK
c. The funding streams to be used for flexible funding have been identified and all approvals at the state and county levels have been obtained.	1 2 3 4 DK
d. Clear processes have been established for care coordinators to access flexible funding.	1 2 3 4 DK
e. The use of flexible funds is routinely reviewed to ensure that funds are used efficiently and effectively and do not supplant the use of natural and informal community supports.	1 2 3 4 DK

Degree of Implementation Rating Scale: 1 = does not exist, 2 = in process of development, 3 = in place but needs improvement, 4 = in place and effective, DK = don't know

Core Elements and Implementation Steps	Degree of Implementation
C. <u>Cross-Cutting</u>	
8. Meaningful Family Involvement	
a. Family representatives are full and active members of the oversight body.	1 2 3 4 DK
d. Family members are viewed by professionals as partners on the child and family team and the team actively empowers families to make decisions about what works best for them.	1 2 3 4 DK
e. The plan of care developed by the child and family team is family-driven, based on the family's goals, strengths, and resources.	1 2 3 4 DK
f. Families are routinely provided the opportunity to express their opinions about services and the child and family team process.	1 2 3 4 DK
g. Family advocacy services are available to advocate for families and provide them with information and support.	1 2 3 4 DK
9. Ongoing Evaluation	
a. The oversight body has determined the desired outcomes for the initiative and markers for success (e.g. changes in child and family functioning, out-of-home placement rates, service utilization, cost, and family satisfaction).	1 2 3 4 DK
b. A process has been established to ensure that data on selected markers are collected and analyzed.	1 2 3 4 DK
c. Evaluation data is used to demonstrate the impact of the initiative.	1 2 3 4 DK
d. Evaluation data is used to make positive changes in the design and delivery of services.	1 2 3 4 DK

Degree of Implementation Rating Scale: 1 = does not exist, 2 = in process of development, 3 = in place but needs improvement, 4 = in place and effective, DK = don't know

Section II. Priority Implementation Steps

Identify the number and letter of the core element and implementation step corresponding to your top five priorities for action. For example, you would write 9 (d) if you believe that evaluation data is not being used to make positive changes in the design and delivery of services and that this is a priority. For each of your priorities, also identify any suggestions you have to initiate or further advance implementation.

Priority Implementation Steps	Suggested Actions for Improvement
1.	
2.	
3.	
4.	
5.	