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

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

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

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

Major Similarities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Major Differences

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

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

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

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

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

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

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

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

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

[10] HMO – Health Maintenance Organization

[11] ASO – Administrative Services Organization

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

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

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

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

Continuing Challenges

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

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

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

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

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

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

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

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

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

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

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