Building Systems of Care

A Primer for Child Welfare

BY Sheila A. Pires

IN PARTNERSHIP WITH Katherine J. Lazear and Lisa Conlan

FOR
National Technical Assistance Center for Children's Mental Health
Center for Child and Human Development
Georgetown University

IN PARTNERSHIP WITH
National Child Welfare Resource Center for Organizational Improvement
Muskie School of Public Service
University of Southern Maine

SUPPORTED BY
Children's Bureau
Administration for Children and Families
U.S. Department of Health and Human Services

AND

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Center for Mental Health Services
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Introduction

MODULE 1
Introduction and Overview

MODULE 2
Context: System Building Definitions,
History, Values, Principles and Characteristics

MODULE 3
Process and Structure in System Building

MODULE 4
Cross-Cutting, Non-Negotiable Characteristics

MODULE 1 Introduction and Overview

Background and Purpose

Increasingly, a system of care approach[1] is being adopted by national leaders in child welfare and by States and communities as a means to produce better outcomes for children, youth and families[2] involved, or at risk for involvement, in the child welfare system. *Building Systems of Care: A Primer for Child Welfare* is a companion document to *Primer Hands On—Child Welfare*[3], a web-based training resource for system builders who are concerned about children, youth and families involved, or at risk for involvement, with the child welfare system. *Both documents are intended to strengthen the capacity of system builders to operate strategically in the work of building systems of care*.[4]

Systems of care, which focus on *systemic change*, are a fundamentally different approach from usual practice in child welfare. At the heart of systems of care in child welfare is a belief that to achieve good outcomes—such as those articulated in the Child and Family Services Review (CFSR) process—the child welfare system cannot do it alone. Systems of care require:

- leadership by the child welfare system to build strategic alliances and engage critical partners, including: families and youth themselves; other systems that serve children, youth and families; natural helping networks in communities; providers; and other stakeholders
- thinking strategically about the pros and cons of different structures and practice models
- being strategic about the collaborative process to implement these changes.

The *Primer* is designed to assist with these tasks.

Target Audience

The target audience for *Building Systems of Care: A Primer for Child Welfare* is system builders who can provide leadership in building systems of care for children,

[1]System of care approach is fully described in Module 2, p. 3.

[2]"Families" includes all types of families: birth, adoptive, foster, kinship, guardian and other arrangements that children, youth and families themselves identify as "family".

[3]Available at http://www.muskie.usm.maine.edu/helpkids/systemofcare.htm.

[4]Both the training resource and this *Primer* are based on the organizing framework and strategic approach to building systems of care that is described in Pires, S., *Building Systems of Care: A Primer*. 2002. National Technical Assistance Center for Children's Mental Health. Georgetown University. Washington, D.C. http://gucchd.georgetown.edu/object_view.html?objectID=2500.

youth and families involved, or at risk for involvement, in the child welfare system. This includes all key stakeholders at national, State, Tribal, local, and neighborhood levels—families, youth, providers, natural helpers, frontline staff, supervisors, county managers and State administrators, judges, court appointed special advocates, guardians ad litem, law enforcement personnel, policy makers, researchers and evaluators, technical assistance providers, advocates and others.

A Strategic Framework—Organization of the Primer

Building systems of care is inherently a strategic process. Strategic planning is defined by Webster's Dictionary as *"the science and art of mobilizing **all** forces—political, economic, financial, psychological—to obtain goals and objectives"*. This terminology comes out of warfare! It assumes that there is clarity about goals and objectives. Creating that clarity and mobilizing "all forces" are key roles that system builders play. This document provides a strategic framework to support system builders in these roles by:

- reviewing the history, values, principles and operational characteristics of systems of care and how these are applied in child welfare
- describing and providing examples of effective system-building processes
- exploring many of the key functions that require structure in systems of care
- discussing examples of various structural arrangements that promote improved outcomes for children, youth and families involved, or at risk for involvement, in the child welfare system.

Additional Resources

The National Child Welfare Resource Center for Organizational Improvement (NRCOI) has developed technical assistance materials to support States and communities in implementing CFSR process expectations and Program Improvement Plans (PIP). These materials[5] address elements of strategic planning, which the Center defines as:

- a continual process for improving organizational performance by developing strategies to produce results
- focusing on what the agency wants to accomplish (outcomes) and on how to move the agency towards these larger goals
- engaging all stakeholders
- communicating the agency's mission and goals to the public.

Another resource that reinforces a strategic framework for building systems of care in child welfare is *Improving Child Welfare Outcomes Through Systems of Care: Building the Infrastructure—A Guide for Communities*, developed by the National Systems of Care Technical Assistance and Evaluation Center at Caliber/ICF.[6]

[5]Available at http://muskie.usm.maine.edu/helpkids/cfsrta.htm

[6]Available at http://www.childwelfare.gov/systemwide/service/soc

MODULE 2

Context: System Building Definitions, History, Values, Principles, and Characteristics

Definitions

Definition of System of Care

Stakeholders involved in building systems of care for children, youth and families involved, or at risk for involvement, with the child welfare system are not operating in a vacuum. There is a considerable and rich history to systems of care. The concept of systems of care originated over 20 years ago and was applied initially to children and youth with serious emotional disorders (SED) and their families, including children with SED involved in the child welfare system. *It has evolved over time as a concept that can be applied to any designated population of children, youth and families that requires an array of services and supports from multiple entities, including any or all populations of children, youth and families involved, or at risk for involvement, in the child welfare system.*

We define a system of care as: "a broad, flexible array of effective services and supports for a defined population(s) that is organized into a coordinated network; integrates services/supports planning, service coordination and management across multiple levels; is culturally and linguistically competent; builds meaningful partnerships with families and youth at service delivery, management and policy levels; and has supportive management and policy infrastructure."

Administration for Children and Families (ACF) System of Care Sites

In recent years, most of the major federal agencies serving children and adolescents have funded system of care demonstrations for designated populations, including the Administration for Children and Families (ACF), which has funded nine system of care demonstrations. The ACF system of care grant sites include: Contra Costa County, CA; State of Kansas; Bedford-Stuyvesant, Brooklyn, NY; Jefferson County, CO; Clark County, NV; State of North Carolina; State of Oregon; State of Pennsylvania; and Tribal Sites in North Dakota.

History

System of Care History

A retrospective review of national system of care (SOC) activity begins with the original Child and Adolescent Service System Program (CASSP), which launched the SOC concept, as well as early national foundation-sponsored system of care demonstrations. These included the Robert Wood Johnson Foundation's Mental Health Services Program for Youth (MHSPY), which introduced the use of managed care technologies to systems of care and the concept of one accountable care management entity, and the Annie E. Casey Foundation's Urban Mental Health Initiative, which took the SOC concept to a neighborhood level.

National SOC grant initiatives include over 100 SOC grant communities funded by the federal Center for Mental Health Services, virtually all of which include populations of children involved, or at risk for involvement, with child welfare. Several focus predominantly on the child welfare population, e.g., Los Angeles County, the State of Maine, and Multnomah County, Oregon. Current SOC activities also include those sponsored by the Center for Substance Abuse Treatment and those sponsored by ACF already mentioned. System of care principles and goals also are evident in grant activities of the federal Centers on Medicare and Medicaid Services (CMS); e.g., the CMS demonstration grants that allow use of 1915(c) Home and Community-Based waivers to create home and community-based alternatives to residential treatment. System of care principles are embedded in the report of the *President's New Freedom Commission on Mental Health*[7] and in the federal Substance Abuse and Mental Health Services Administration's "transformation" grants to states. *Most importantly for child welfare, the SOC concept also resonates with the principles and goals underlying the CFSR process and with recent foundation-sponsored child welfare initiatives, such as the Edna McConnell Clark Foundation's Community Partnerships for Protecting Children Initiative*.

Child Welfare System of Care Activities

Examples of system of care activities recently sponsored by national leadership in child welfare include: the nine ACF grant sites; technical assistance for systems of care in child welfare provided through the National Systems of Care Technical Assistance and Evaluation Center at Caliber/ICF; the ACF Region III Policy Academy sponsored by ACF and the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with the National Technical Assistance Center for Children's Mental Health at Georgetown University and the National Child Welfare Resource Center for Organizational Improvement at the University of Southern Maine; the *Primer Hands On—Child Welfare* web-based training resource; and this document.

In 2008, ACF released a program announcement to establish two National Child Welfare Workforce Initiatives: a National Child Welfare Workforce Institute, and four Child Welfare Comprehensive Workforce Grants. These initiatives are guided by a system

[7]Available at: http://www.mentalhealthcommission.gov/reports/reports.htm

of care approach to child welfare and informed by the CFSRs. By doing this, ACF intends to drive systemic change while subscribing to the system of care framework and to the CFSR guiding principles.

Avoiding "Categorical Systems of Care"

The commonality of a system of care focus across major federal programs is encouraging, but there is a danger now that States and localities may build "categorical systems of care", depending on which federal or foundation initiative is leading the way. *One of the major opportunities that a SOC approach provides is to bring together related reform efforts and reduce a "siloed" approach to serving children, youth, and families.*

EXAMPLE

Alamance County, North Carolina is an example of a county that has multiple children's reforms underway supported by multiple planning and governance bodies. It has formed an overarching Children's Executive Oversight Committee, comprised of the leaders of these multiple initiatives to ensure synergy and coordination across the reforms. **(www.alamance-nc.com/Alamance-NC)**

Values

Organizing Framework Supported by Core Values

The system of care concept provides an organizing framework, a philosophy and a values base for systemic change, which can be applied to any population that requires services and supports across multiple providers or systems.

System of care *core values* that developed over 20 years ago include the following:

- **Child/Youth-Centered and Family-Focused**
- **Community-Based**
- **Culturally and Linguistically Competent**

These core values developed, initially, out of a children's mental health movement at a time when many mental health systems were adult-focused and hospital-based. Hence, values of "child and youth centered and family focused" were in direct response to concerns that children were being treated as "little adults" and not within the context of their families. The value of "community-based" was in direct response to the lack of home and community services for children and families and the bias at the time to hospitalize children with serious disorders. The value of "cultural and linguistic competence" was in response to concerns over the disparity in access to services experienced by racially and ethnically diverse children and families and their disproportional representation in restrictive services. These core values have evolved in meaning over time as multiple systems serving children, youth and families have embraced a system of care approach.

FULL RANGE OF SYSTEM OF CARE VALUES AND PRINCIPLES

- Comprehensive array of services and supports
- Individualized services and supports guided by an individualized service/support plan
- Least restrictive, most appropriate environment
- Families, surrogate families and youth as full participants in all aspects of the planning and delivery of services and supports
- Integrated services and supports across systems and providers
- Services/supports coordination and management accountability across multiple systems
- Early identification and intervention;
- Smooth transitions
- Rights protected and effective advocacy efforts promoted
- Non-discrimination
- Provision of services that are responsive to cultural and linguistic differences and special needs

Adapted from Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with serious emotional disturbances* (Rev. ed.). Washington, D.C.: Georgetown University, National Technical Assistance Center for Children's Mental Health.

Synergy with Values of Family Support and Youth Development Movements

System of care values and principles are very similar to the principles and values that grew out of the family support movement in child welfare, as well as youth development principles that emerged initially in youth employment and youth work. System of care is now being used as an organizing framework for many different populations of children, youth and families.

EXAMPLE

In **Milwaukee, Wisconsin**, *Wraparound Milwaukee*, which began to use a system of care approach for children involved in child welfare who were in, or at risk for, residential treatment, is now applying a system of care approach to divert youth from detention and for adult family members with substance abuse challenges who are involved in child welfare. **(www.milwaukeecounty.org)**

Synergy with Child Welfare CFSR Principles

System of care values also resonate closely with the child welfare principles that underpin the CFSR process, including:

- **Family-Centered Practice**
- **Community-Based Services**
- **Strengthening the Capacity of Families**
- **Individualizing Services**

More information about the principles embedded in CFSR can be found at: www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm

EXAMPLES

Alabama is an example of one of the first States to undertake reform of its child welfare system utilizing system of care principles and values, adding to them and adapting them for the child welfare system, and anticipating by several years CFSR principles in the process.

For more information read: **Making Child Welfare Work: How the R.C. Lawsuit Forged New Partnerships To Protect Children and Sustain Families*, Judge David L. Bazelon Center for Mental Health Law, Washington DC, May 1998. **www.bazelon.org**.

Nevada, **Kansas**, **North Carolina**, **Oregon**, and **North Dakota** are examples of state child welfare systems that more recently adopted system of care values and principles to guide their Program Improvement Plan (PIP) activities.

Characteristics

SOC Operational Characteristics

From a philosophy/values standpoint, there is far more synergy today among all of the systems that serve children, youth and families than there was twenty years ago when the system of care movement began. There is greater understanding and more examples of how to apply a system of care approach to different populations of children, youth and families (and not just for children with serious emotional challenges as was the case 20 years ago when the movement began). There also is more shared understanding today across systems about the operational characteristics of systems of care.

OPERATIONAL CHARACTERISTICS OF SYSTEMS OF CARE

- Collaboration across agencies
- Partnerships with families and youth, including with family and youth-run organizations
- Cultural and linguistic competence
- Blended, braided or coordinated funding
- Shared governance (and liability) across systems and with families
- Shared outcomes across systems
- Organized pathway to services and supports
- Staff, supervisors, providers, and families trained and mentored in a common practice model based on system of care values
- Interagency child and family service planning and monitoring teams
- Single plan of services and supports
- One accountable service manager
- Cross-agency service coordination
- Individualized services and supports "wrapped" around children, youth and families
- Home and community-based alternatives
- Broad, flexible array of services and supports
- Integration of formal services and natural supports and linkage to community resources
- Integration of evidence-based and promising practices
- Data-driven systems supported by cross-system management information systems and focused on continuous quality improvement

Consistency with CFSR Systemic Factors

A number of SOC operational characteristics are reflected in the systemic factors that are reviewed as part of CFSR, which are related to a State's capacity to achieve CFSR outcomes.

CFSR SYSTEMIC FACTORS

- **Statewide information system** (having access to "real time" information to inform decision making at policy and service levels)
- **Case review system** (having a process in place to ensure development, in partnership with families, of timely and appropriate plans for services and supports and review of plans as needed to ensure appropriateness and effectiveness of supports)
- **Quality assurance system** (using information to improve quality on a systematic basis)
- **Staff and provider training** (capacity building in new practice models and system goals)
- **Service array and resource development** (having access to a broad and diverse array of services and supports through partnerships and collaborative financing)
- **Agency responsiveness to the community** (ensuring involvement of the community, drawing in community resources, and being responsive to unique community needs)
- **Foster and adoptive licensing, recruitment, and retention** (with appropriate supports for foster and adoptive families to enhance recruitment and retention efforts)

Resonance Between SOC and CFSR Outcomes

Over time, the system of care movement has become very outcomes-oriented. Systems of care focus on outcomes both at the *child/family level*, e.g., clinical and functional outcomes and family/youth satisfaction and their experience with the system; and on outcomes at a *systems level*, e.g., reduced use of out-of-home placements and family stability. Because systems of care include children and families involved in child welfare systems, they pay attention to safety outcomes, quality of living arrangements, and overall well-being. Outcomes that are important to child welfare systems, such as reduction in the incidence of repeat maltreatment or foster care re-entries, permanency and stability are also important to systems of care.

Similarly, the CFSR process is inherently outcomes-focused. It is concerned ultimately with whether safety, permanency and well-being outcomes are achieved on behalf of a defined population of children and families, i.e., those in, or at risk for involvement in, the child welfare system.

The CFSR Child and Family Outcomes resonate with a system of care approach and include:

- **Safety Outcome 1**—Children are, first and foremost, protected from abuse and neglect.
  (Systems of care are fundamentally concerned about safety and address safety issues through child and family team processes, building safety plans into services and supports plans.)

- **Safety Outcome 2**—Children are safely maintained in their homes whenever possible and appropriate.
  (Systems of care seek to prevent out-of-home placements and strengthen the capacity of families to keep families together.)

- **Permanency Outcome 1**—Children have permanency and stability in their living situations.
  (Systems of care seek to minimize disruptions in children's lives and promote continuity of services and supports and smooth transitions.)

- **Permanency Outcome 2**—The continuity of family relationships and connections is preserved for children.
  (This is a core value of systems of care.)

- **Well-Being Outcome 1**—Families have enhanced capacity to care for their children's needs.
  (Systems of care seek to strengthen the resiliency of both families and youth and enhance natural helping networks to strengthen families' capacities.)

- **Well-Being Outcome 2**—Children receive appropriate services to meet their educational needs.
  (Systems of care focus on the strengths and needs of children and families across life domains, including education.)

- **Well-Being Outcome 3**—Children receive adequate services to meet their physical and mental health needs.
  (Systems of care take a holistic approach and have as a core tenet the importance of a broad, flexible array of services and supports to meet the needs of children, youth and families.)

Systems of Care as a "Differential Response System" for Child Welfare

As one considers many of the issues that have been identified through the CFSR process, one can begin to conceptualize use of a SOC approach as a "differential response system", in effect, for child welfare's work with families. Major concerns identified through the CFSR include:

- **Safety**
  – Inconsistent services to protect children at home
  – Inconsistent monitoring of families
  – Insufficient risk or safety assessment

- **Permanency**
  – Inconsistent concurrent planning efforts
  – Adoption studies, court proceedings take too long

- **Well-Being**
  - Inconsistent match of services to needs
  - Lack of support services to foster and relative caregivers
  - Parents not involved in case planning
  - Lack of health and mental health assessments

Systems of care provide a framework for a differential response to address these issues, including a framework for:

- Engagement of families and youth
- Cross-training around a common family-centered practice model
- Collaboration with other systems and programs, such as substance abuse and mental health, domestic violence, housing, etc.
- Expansion in the availability of services and supports through partnerships and collaborative financing approaches
- Comprehensive child and family assessments, including risk and safety and strengths and needs
- Data-driven policy and service delivery
- Quality improvement informed by data.

The CFSR process has led to identification of "State successes" in implementing Program Improvement Plans (PIP). These successes include:

STATE PIP SUCCESSES

- Changing the culture of agencies
- Aligning child welfare, juvenile justice and mental health through communications, shared values, and common practice
- Improving collaboration with community partners
- Using best practices
- Reorganizing child welfare as a "learning organization" through a Continuous Quality Improvement structure
- Using data to inform decision-making and improve quality.

These are the same strategies and desired outcomes seen in systems of care. Indeed, many of the States that have successfully implemented their PIP have adopted a system of care approach to do so.

EXAMPLE

Oregon is an example of a State that utilized a system of care approach in response to a child welfare-related lawsuit. Oregon connected its system of care strategies to the CFSR and its PIP, in particular incorporating the SOC and CFSR principle of family-centered, comprehensive assessment throughout the entire period of a child and family's involvement in child welfare to prevent repeat maltreatment, promote permanency, and ensure well-being through the provision of needed services and supports. **(www.oregon.gov/dhs/children/welfare/systemofcare)**

Systems Problems

The concept of systems of care developed and has taken root over time as an approach to address long-standing problems with traditional systems, many of which persist today.

ENTRENCHED SYSTEMS PROBLEMS
• Lack of home and community-based services and supports for children and youth, and for their families • Patterns of how children, youth and families use services and supports (e.g., a relatively small percentage of children and families with the most serious and complex needs use a very large percentage of the service dollars because they are placed for too long, or repeatedly, in restrictive levels of care, or because financing streams may create incentives for placement) • High costs associated with these patterns of utilization • Administrative inefficiencies when multiple systems serving children and families create parallel delivery systems serving many of the same children and families • Knowledge, attitudes and skills of key stakeholders (e.g., staff, supervisors, providers, clinicians, families who do not embrace or know how to implement family-driven, youth-guided, culturally and linguistically competent, strengths-based and individualized services and supports) • A history of poor outcomes • Rigid financing structures • Deficit models with limited types of interventions that do not lend themselves to a strengths-based, individualized approach.

These types of system problems translate, in child welfare, to a range of issues that have led to increasing interest in a system of care approach. These include such issues as:

- lack of services and supports for parents, particularly for those with challenges such as mental health or substance abuse problems
- lack of services and supports for youth transitioning from foster care
- lack of prevention and outreach to high-risk populations because the bulk of resources are tied up in out-of-home placement costs
- a recognition that the farther a child is removed from family, the poorer the outcomes and the higher the costs.

A system of care approach recognizes that the child welfare system alone cannot be expected to address successfully these and other cross-system issues; they are the responsibility of multiple systems and of the larger community.

Fractured Accountability

A fundamental challenge to multiple system involvement in the lives of children and families is that—**No one system controls everything, and every system controls something**.

Systems of care represent a way to address this basic challenge of multiple system involvement in the lives of families and fractured accountability. This is particularly true for children and families involved in child welfare. Better outcomes are more likely to be achieved through effective collaboration.

SOC Connected to Larger System Reform Movement

The system of care movement is part of a larger systems reform agenda in child, youth and family services, which has multiple characteristics, including movement:

FROM:	TO:
fragmented service delivery	coordinated service delivery
categorical funding and programs	blended resources
limited services	a comprehensive services/supports array
reactive, crisis-oriented systems	focus on prevention/early intervention
focus on out-of-home placements	individualized services and supports in least restrictive, normalized environments
children out-of-home	children within families
centralized authority	community-based, local ownership
creation of system dependency	creation of self help.

Need for Frontline Practice Change

Systems reform involves both systems-level and frontline practice change. Shifts required at a practice level include movement from:

- control by professionals to partnerships with families and youth
- only professional services to a partnership between professional services and natural helpers and supports
- multiple case managers to one accountable service manager
- multiple service plans to a single plan for a child and family
- family blaming to family partnerships
- a deficits to a strengths-based approach
- a mono cultural to a culturally and linguistically competent approach.

FRONTLINE PRACTICE SHIFT

Given power imbalance →	Acknowledgment of power imbalance with family and that their fears and concerns are real
"I'm in charge" attitude →	Positive engagement
Controlling →	Collaborative
Law enforcement approach →	Helping/Social worker approach
Multiple case managers →	One service manager
Multiple service plans for child →	Single plan for child and family
Family blaming →	Family partnerships
Deficit-based →	Strengths focused
Mono cultural →	Sensitivity to culture/linguistics and family ritual

Understanding How Families Become Involved with Systems of Care

It is important for all system partners to understand how families representing the child welfare population may become involved with the system of care. The majority of families who become involved with the system of care due to their involvement with the child welfare system do so involuntarily. Based on safety concerns, families may have been investigated, and abuse and neglect may have been founded. Parents may be seeking additional services and supports for themselves to prevent their children from going into placement, to strengthen their parenting skills, and to preserve their families. They may be dealing with their own childhood traumatic experiences, cognitive impairments, mental health and/or substance abuse issues, lack of access to housing and other basic needs, as well as family violence issues. When children or youth display harmful or delinquent behaviors, some families become involved with child welfare in an attempt to access services needed to meet their child's serious behavioral health challenges.

From a frontline practice standpoint, understanding a particular family's reasons for being involved with child welfare and the system of care, and understanding the strengths and challenges within the family, is a critical first step in partnering with families and moving toward a family-centered approach. A better understanding of and partnership with families also can help develop prevention strategies to keep families from becoming involved, or from deeper involvement, or repeat involvement with child welfare.

Family-Centered Practice Approach

The implementation of family-centered practice is an expectation in child welfare practice, just as it is in systems of care. The National Resource Center for Family Centered Practice and Permanency Planning reports four essential components of family-centered practice.

ESSENTIAL COMPONENTS OF FAMILY-CENTERED PRACTICE

1. The family unit is the focus of attention. This helps to ensure the safety and well-being of all the family members.
2. Strengthening the capacity of families to function effectively is emphasized. The primary purpose of family-centered practice is to strengthen the family's potential for carrying out their responsibilities.
3. Families are linked with more comprehensive, diverse, and community-based networks of supports and services. Family-centered interventions assist in mobilizing resources to maximize communication, shared planning, and collaboration among the several community and/or neighborhood providers that are directly involved with the family.
4. Families are engaged in designing all aspects of the policies, services, and program evaluation.

(www.hunter.cuny.edu/socwork/nrcfcpp)

To successfully implement family-centered practices, learning new approaches for family and youth engagement is critical.

Shift in Roles and Expectations of Families and Youth

Systems change not only involves changes in the way that staff and providers interact with families and youth, but changes as well in the roles and expectations of families and youth themselves.

SHIFTS IN ROLES AND EXPECTATIONS OF FAMILIES AND YOUTH

From being:

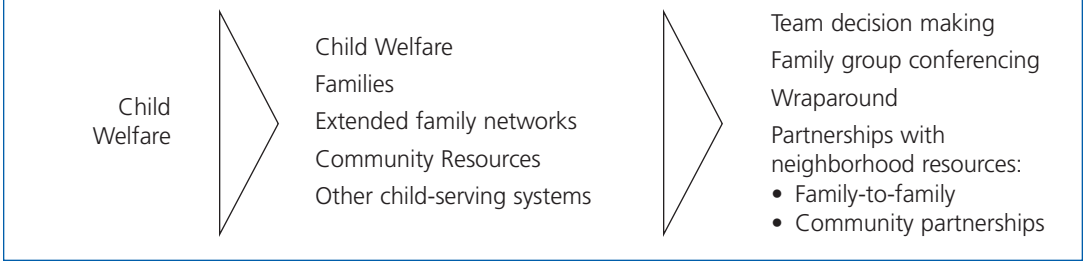
1. A recipient of service plan information and service requirements TO participating in service planning TO being a service planning team leader
2. An unheard voice in program evaluation TO participating in evaluation TO being a partner in developing and conducting program evaluations
3. A recipient of services and supports TO partnering in planning and developing services/supports TO being a service/supports provider
4. Uninvited to training activities TO participating in training TO partnering in developing training and being trainers
5. Angry and resistant to what may feel like coercion TO self advocacy and peer support TO systems-level advocacy and expanded capacity to provide peer support.

Just as staff and providers need training and support to make the shifts called for in a system of care practice model, so, too, do family and youth partners.

Shift in Child Welfare Decision Making Practice

Partnering with families involved in child welfare, many of whom are involved involuntarily, entails a fundamental shift both in the perspective of families and of child welfare systems. Judgments about children's safety within families still fundamentally have to be made. However, a system of care approach moves child welfare from unilateral decision-making about children and families to one of partnering with youth and families, extended family networks, community resources and other systems that serve children, youth and families to ensure the safety and well-being of children and support for families. At a practice level, this is reflected in such approaches as Team Decision Making, Family Group Conferencing, and Wraparound, as well as by partnerships with neighborhood collaboratives through "Family-to-Family" and "Community Partnership" initiatives, which we will talk about in more detail later.

PARTNERSHIP WITH FAMILIES IN CHILD WELFARE: FUNDAMENTAL SHIFTS IN DECISION-MAKING PRACTICE



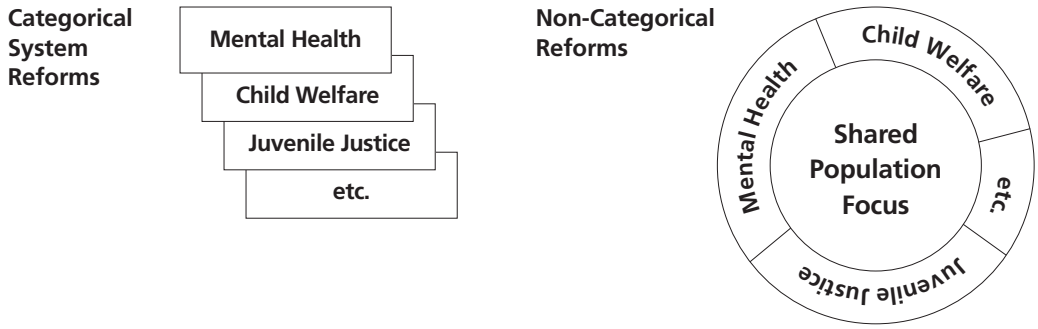
Change at Multiple Levels

As noted earlier, systems reform entails changes at multiple levels and with multiple stakeholders. These levels include: the **policy level**, where changes need to be made in such areas as financing, regulatory policy, rate-setting, etc.; the **management level**, where changes are needed in such areas as information management, quality improvement, training, and system organization; the **frontline practice level**, where changes are needed in assessment, services and supports planning, service coordination, etc.; and the **community level**, where changes are required to partner with families, youth, and natural helping networks and to achieve community support.

Non-Categorical vs. Categorical System Reform

Systems of care are fundamentally non-categorical reform initiatives, unlike categorical reforms in child and family services where individual systems engage in efforts to reform their own systems, such as de-institutionalization in mental health, child welfare reforms that seek to prevent or reduce lengths of stay in foster care, school-based inclusion reforms in special education, and alternatives to incarceration in juvenile justice. As a non-categorical reform, a system of care reform takes a **population focus**. This means it focuses on a population or populations of children and families who cross, or at risk of crossing, all or many of these systems and engages all systems in a reform agenda.

CATEGORICAL VS. NON-CATEGORICAL SYSTEM REFORMS



A Population Focus

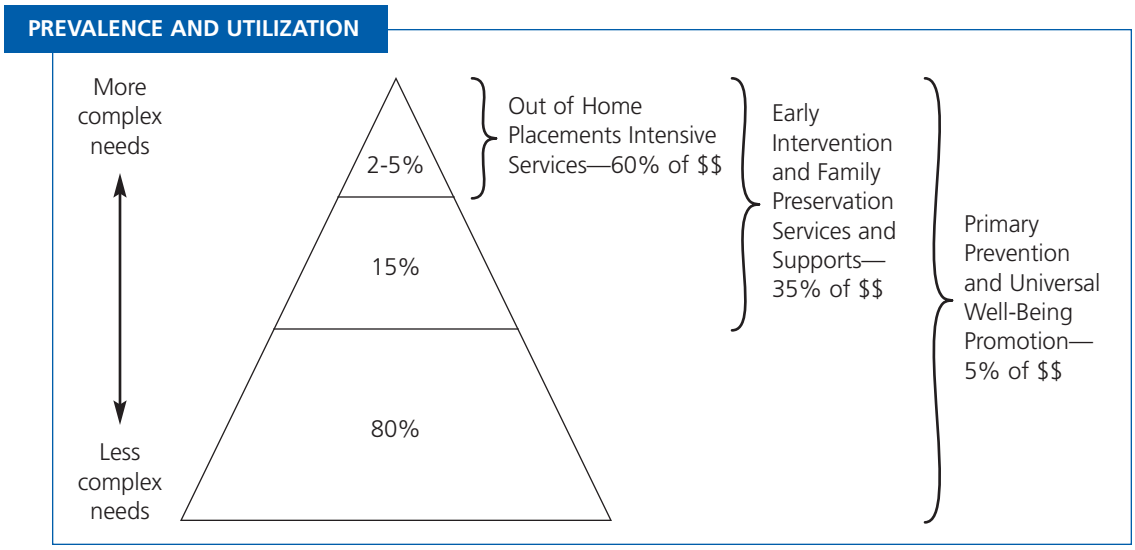
An essential early focus of system builders needs to be on understanding the populations of children, youth and families that are involved, or are at risk for involvement, in the child welfare system and determining target populations for the developing system of care. Population issues for the child welfare system include whether the focus is on the total population of children or subsets. Several ways of thinking about subsets is by:

- **Demographics**, e.g., Infants and toddlers? Transition-age youth? Racially and ethnically diverse children over-represented in child welfare?
- **Intensity of system involvement**, e.g., out-of-home placement; length of stay in foster care; multi-system involvement; number of placements; repeat maltreatment

- **At risk characteristics**, e.g., children with birth families at risk of child welfare involvement; children in permanent placements at risk for disruption; families in which methamphetamine abuse is occurring; teen mothers under severe stress, etc.
- **Level of clinical/functional impairment**, e.g., children with serious emotional disorders; children with serious physical health conditions; children with developmental disabilities; children with co-occurring disorders, such as mental health and developmental challenges.

Prevalence and Utilization

Understanding prevalence of problems and current utilization—that is, the way that children and families use services and supports—also is essential. Visually, think of a triangle representing prevalence and utilization among all children and families in a given State, Tribe, or community for problems that may lead to involvement with public systems.



At the top of the triangle is the relatively small percentage of children and families with serious and complex problems who may be using a large percentage of the dollars, including many of the children and families involved in child welfare. These include, for example, children in out-of-home placements. In the middle of the triangle are various at risk populations of children and families who need services and supports, but where there may be few resources available (because a large percentage of the dollars are going to the top of the triangle). This includes many families at risk for child welfare involvement. At the bottom of the triangle are most children and families, who do not need specialized services and supports but where primary prevention is imperative. In most States, however, very few resources are available for prevention (because the dollars are being spent on the rest of the triangle).

A Population-Driven Systems Approach

The strengths and needs of the populations must drive the types of services, supports and strategies that will be required in the system of care, the financing streams that need to be accessed, the stakeholders that need to be involved, etc. For example, if the system is focusing initially on *infants and young children and their families*, it must partner with early intervention programs, Head Start and child care, and primary care practices become even more critical. If it is focusing on *transition-age youth*, another set of players, funding streams, services, supports and community resources come into play. For example, in a system of care approach to a population subset of transition-age youth who are aging out of the child welfare system, it is important to recognize that this population is not only involved in child welfare but also may be involved with juvenile justice, mental health and substance abuse, special education, etc. They will require supports from many systems, such as vocational rehabilitation, public assistance, housing, employment services, etc.

EXAMPLE: TRANSITION-AGE YOUTH

What **outcomes** do we want to see for this population?
E.g., connection to caring adults, employment, education, independence

What will our **system** look like for this population?

Policy Level

What systems need to be involved? *E.g., housing, vocational rehabilitation, employment services, mental health, substance abuse, Medicaid, schools, community colleges/universities, physical health, juvenile justice, child welfare*

What dollars/resources do these systems control?

Management Level

How do we create a locus of system management accountability for this population? *E.g., in-house, lead community agency*

Frontline Practice Level

Are there evidence-based/promising approaches targeted to this population? *E.g., family finding*

What training do we need to provide, and for whom, to create desired attitudes, knowledge, skills about this population?

What providers know this population best in our community? *E.g., culturally diverse providers*

Community Level

What are the partnerships we need to build with youth and families?

How can natural helpers in the community play a role?

How do we create larger community buy-in?

What can we put in place to provide opportunities for youth to contribute and feel a part of the larger community?

State Commitment and Local Ownership

System of care reforms entail State, Tribal and local partnerships. States must be committed to reform because so much of the needed financing is controlled at State levels, along with critical policy and regulatory responsibilities. Local ownership is essential to reflect community strengths, needs, values, and day-to-day realities in order to make the system of care relevant to the community. In some States, child welfare is a State-supervised system, in which State-level stakeholders must figure out how to generate community-level involvement and buy-in. In other states, child welfare is a locally-run system in which local stakeholders must determine how to create State-level buy-in. In still other States, child welfare is a hybrid with both the State and localities playing major policy and funding roles. In States where child welfare has been privatized, private providers are playing key roles that, historically, were played by state or local agencies. Tribal authorities also play key roles, with a right to intervene in situations involving children enrolled as Tribal members.

Definition of Evidence-Based and Promising Practices

Systems of care have been influenced over the past decade by the movement toward evidence-based and effective practices in child and family services—and vice versa.

EVIDENCE-BASED PRACTICES AND PROMISING APPROACHES

Evidence-Based Practices
Show evidence of effectiveness through carefully controlled scientific studies, including randomized clinical trials

Practice-Based Evidence/Promising Approaches
Show evidence of effectiveness through experience of key stakeholders (e.g., families, youth, providers, administrators) and outcomes data

Examples of Evidence-Based and Promising Practices

Examples of evidence-based practices include Multi-Dimensional Treatment Foster Care (MDFT) and Multisystemic Therapy (MST) and promising approaches including such examples as Family Group Decision Making, Wraparound, and Mobile Response and Stabilization Services. The Kaufman Foundation, in collaboration with the National Child Traumatic Stress Network, recently published a report on evidence-based practices for children involved in child welfare who have been exposed to trauma. These include a number of cognitive behavioral therapy approaches, as well as Parent-Child Interaction Therapy. (Available at: www.kauffmanfoundation.org)

EXAMPLE

Several States also are systematically trying to identify and implement effective practices for children involved in child welfare, such as **California's** *Evidence-Based Clearinghouse for Child Welfare*. **(www.cachildwelfareclearinghouse.org)**

Comparative Evidence

Research conducted by Barbara Burns and Kimberly Hoagwood examined evidence-based practices for children with serious behavioral health disorders, including children and youth involved in child welfare, whose prevalence for behavioral health problems is very high. They concluded that there was most evidence for the following services:

- intensive case management
- in-home services
- treatment foster care.

They found less evidence, *because so little research has been done*, for:

- crisis services
- respite
- mentoring
- family education and support.

To reiterate, there was little evidence because so little research has been done—this is an important caveat because families often identify these services as the most "missing" and most needed within the service array.

Burns and Hoagwood found the least evidence, *and lots of research*, for the services we tend to use the most for children with serious problems:

- inpatient hospitalization
- residential treatment and group homes.[8]

Shared Characteristics of Evidence-Based and Promising Practices

Burns and Hoagwood identified shared characteristics of evidence-based and promising practices.

SHARED CHARACTERISTICS OF EVIDENCE-BASED AND PROMISING PRACTICES
• function as service components within systems of care • are provided in the community • utilize natural supports and partner with families, with training and supervision provided by those with formal training • operate under the auspices of all systems serving children and families • are studied in the field with "real world" children and families • are less expensive than institutional care, such as residential treatment and hospitals, when a continuum is in place

[8]Burns & Hoagwood. 2002. *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. Oxford University Press.

Returning to Values

This Module began with a discussion of values because that is where system of care work begins. Shared system of care values are what guide a system building process. The child welfare system itself has a culture, based on certain values, as do other systems serving children, youth and families. The courts, providers, community representatives, families and youth themselves also have distinct cultures. Achieving consensus on values across diverse stakeholder groups is a first step in system building.

The goal of the exercise below is for system builders to understand that, while there are no right or wrong "answers", the positions stated in this exercise are examples of those that will crop up in system building. They are issues that need to be discussed openly and with agreed upon definitions.

We all come to this work with values that we have integrated into our lives from our own culture, family, work environment, sub-groups, etc. These values are tested over time and shaped as system building proceeds. System builders need to create an environment in which it is safe for stakeholders to express their values. System builders need to provide leadership in developing sufficient common ground for system building to advance. The most successful and sustaining system building efforts have been those that establish their values early, use them to guide their decisions, and revisit them often.

EXERCISE 1: ASSUMPTIONS AND VALUES

A system of care approach begins with shared values and principles. The various stakeholders involved come with their own established values that are not necessarily shared at first. This Exercise provides stakeholders an opportunity to express the degree to which they hold certain values related to building systems of care and to explore with others the similarities and differences in their perceptions. The Exercise may provide a starting point for the process of building consensus on a set of shared values to guide system building.

Instructions: Circle the degree to which you agree with the following statements:

1. With limited resources, we need to focus on implementing evidence-based (i.e., scientifically supported) practices in child welfare.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
2. We need to focus on implementing services and supports that families feel are effective, whether or not they are evidence-based.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
3. Certain populations of children and youth, for example, those with sexual offenses and with fire-starting behaviors, need to be treated in residential facilities, rather than in home settings, both for their own protection and that of others.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
4. Privatization and use of managed care technologies can help us to manage limited dollars more effectively and flexibly and achieve better cost and quality outcomes	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
5. Privatization and use of managed care technologies will dilute the ability of the child welfare system to be accountable for the safety and well-being of children	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
6. We need to have everybody at the table to be effective in building a system of care for children and families involved or at risk for involvement in child welfare.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
7. We can be effective with a small number of key people at the table.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
8. The child welfare system should control its own treatment dollars, for example, for behavioral health services, rather than having to try to get what it needs from other systems.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
9. With limited resources, we need to focus on children and families with the most serious problems.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
10. We need to focus on prevention and early intervention before problems become severe.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE

MODULE 3

Process and Structure in System Building

The Role of Process and Structure in System Building

System building involves both process, i.e., how system builders conduct themselves, and **structure**, i.e., what gets built and how. *Process* fundamentally has to do with who is involved in system building; the rights, roles and responsibilities various stakeholders are assigned or assume; and how stakeholders communicate, negotiate, and collaborate with one another. *Process* also has to do with being strategic (or failing to be). *Structure* refers to the organization of functions within systems of care, such as how policy, management, and service decisions are made, how care is managed, how services are financed, and the like. Both process and structure play critical roles in system building. Ineffective system building processes can derail efforts to put needed structures in place or to reform existing structures. By the same token, certain functions within systems of care must be structured (or re-structured); the system building effort cannot concern itself only with process, or it will fail.

Definition of Structure

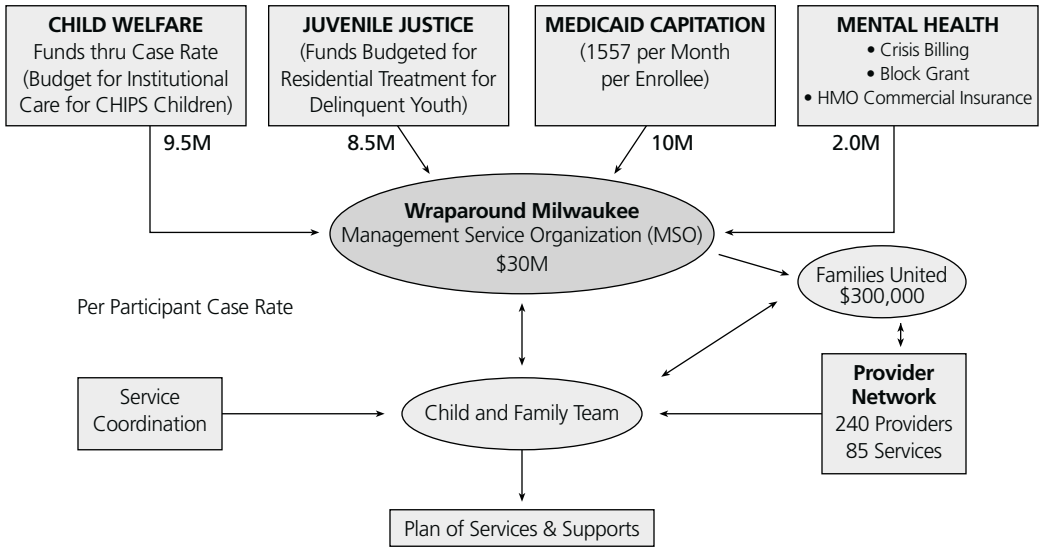
Structure can be defined as "something arranged in a definite pattern of organization". The types of structures that are created (or left standing) reflect and influence values, have very much to do with how power and responsibility are distributed, will affect how stakeholders experience the system of care, and will affect outcomes.

Example of Structure's Impact

For example, let us say that an important goal of the system of care is a single plan of services and supports for children and families involved in child welfare who are also involved with other systems, such as mental health, education, juvenile justice and Medicaid. Typically, each system structures its own services/supports planning process—e.g., child welfare uses family group decision making, mental health uses a wraparound approach, education uses its child study team, juvenile justice uses an assessment center, and Medicaid uses a managed care plan. Even if most stakeholders agree to the principle of one plan of services and supports, the multiple structures for the same function (i.e., services/supports planning) will make it frustrating to achieve that goal, and stakeholders, such as families, will likely feel overwhelmed. Restructuring is needed. The example below of Milwaukee, Wisconsin's **Wraparound Milwaukee** illustrates how

restructuring a scenario such as this can help to support achievement of the goal of a single plan of services and supports.

EXAMPLE



In this case, one entity—Wraparound Milwaukee—serves as the locus of accountability for the development of one plan of services and supports covering all needed services and placements for populations of children, youth and families involved in multiple systems. Child welfare, juvenile justice, education and mental health partner as needed on child and family teams with families and youth to develop one services/supports plan for a given family, and the child and family team recommendations count as "medical necessity" for purposes of accessing Medicaid. The one plan developed by the team also informs court actions for court-involved children and families. **(www.milwaukeecounty.org)**

Important Points about Structure

Several points about structure in systems of care must be made. Specifically, certain functions must be structured and not left to happenstance. For example, if quality improvement is not structured, it is unlikely to occur. Structures need to be evaluated and modified, if necessary, over time. System builders may have to create new structures and demolish old ones, or keep or modify existing ones. The analysis of what structures to keep, modify or destroy is a *strategic* one. It needs to take into account what system builders are trying to achieve, as well as the difficulty involved in creating a new structure or getting rid of an existing one. Considering structural change is a strategic process in which all system builders need to have voice. There are no perfect or "correct" structures, but there are pros and cons to structures that make one more desirable than another. The relative pros and cons will vary in communities, as well as the capacity to undertake structural changes.

EXAMPLE

For example, a rural community decided to structure a Targeted Case Management system incorporating Master's level care managers, based on the belief that Medicaid would require this type of structure. It was impossible for the community to recruit a sufficient number of Master's level care managers, and this critical element of the system of care floundered as a result. The community had to re-structure Targeted Case Management to allow for paraprofessionals (including family members) to be care managers and to have them work under the supervision of licensed staff, which satisfied Medicaid requirements.

Functions Requiring Structure in Systems of Care

There are certain functions that require structure in systems of care, that is, they need to be organized in a defined arrangement and not left to happenstance. Many functions require structure at both State and local levels. The list of functions that follows provides a good starting point that system builders can add to and adapt, based on their own experiences.

SYSTEM OF CARE FUNCTIONS REQUIRING STRUCTURE

- Planning
- Governance
- System Management
- Service and Supports Array
- Evidence-Based and Promising Practices
- Outreach and Engagement
- System Entry/Access
- Screening, Assessment, and Evaluation
- Decision Making and Oversight at the Service Delivery Level
  - Services and Supports Planning
  - Services and Supports Authorization
  - Service Monitoring and Review
- Service Coordination
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management
- Family Involvement, Support, and Development at all Levels
- Youth Involvement, Support, and Development
- Human Resources Development/Staffing
- Staff Involvement/Support/Development
- Orientation, Training of Key Stakeholders
- External and Internal Communication
- Provider Network
- Protecting Privacy
- Ensuring Rights
- Transportation
- Financing
- Purchasing/Contracting
- Provider Payment Rates
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management
- Quality Improvement
- Evaluation
- Systems Exit
- Technical Assistance and Consultation
- Cultural and Linguistic Competence

Though daunting, this list is also no doubt incomplete. The reality is that most of these functions already are structured, but they may not be structured in ways that will support attainment of system of care goals. Determining which to tackle over what time period, and how to approach structuring various functions, is part of the strategic decision making process involved in system building.

Core Elements of System Building Process

The core elements of an effective system building process can be clustered under two broad headings:

- **Leadership and constituency building**
- **A strategic orientation**

The Importance of Leadership and Constituency Building

Typically, effective system building processes have a *core leadership group* representing key stakeholders. The group may change over time, but there is consistently a core group of leaders driving the process. *Leadership capacity development across stakeholder groups* also is critical, that is, identifying and building family and youth leaders, judges who will play leadership roles, county managers and state administrators, supervisors, providers, line staff, service coordinators, researchers, evaluators, policy makers, legislators, etc. Such leadership capacity development is essential to the growth of systems of care.

Effective processes also incorporate *effective collaboration* across systems that serve children, youth and families and with families, youth, providers and other key stakeholders. There are many formal systems important to children and families involved in child welfare or at risk for involvement, not just the child welfare system itself and the courts. For example, Medicaid, mental health and substance abuse, housing, domestic violence, child support enforcement, Temporary Assistance to Needy Families (TANF), Early Intervention (Part C) programs, education, Supplemental Security Income (SSI), vocational rehabilitation and employment—to name a few. Strategically engaging these systems is a fundamental responsibility of system builders taking the lead on behalf of populations involved or at risk for involvement in child welfare.

Effective planning processes build *meaningful partnerships with families and youth* and are *culturally and linguistically competent*. They also *connect to neighborhood resources and natural helpers*, drawing them into the process. Effective processes include both a *"bottom up and top down" approach*. They build in *communication mechanisms* so that stakeholders know what is going on, and rumors and misinformation can be minimized. Effective processes also build in *mechanisms for conflict resolution, mediation and team-building*, and seek ways of minimizing nay saying and negative attitudes.

The Importance of Being Strategic

The essential process elements can be described as: a strategic mindset; a shared vision based on common values; a clear population focus; shared outcomes; community mapping—understanding strengths and needs; understanding the various roles played by systems serving children, youth and families and how they can be changed; understanding major financing streams across systems and how they can be mobilized; connecting related reforms; having clear goals, objectives and benchmarks; being opportunistic; building in opportunity for reflection; and allowing adequate time for systems change.

Effective strategists look for ways to create *structural change objectives*. Other types of objectives may be worthwhile, but structural change increases the likelihood that change will be sustained. For example, an objective to create a newsletter for families (a non-structural change objective) may be worthwhile, but it does not fundamentally change a system in the way that an objective to require family involvement on service planning teams and on governance bodies would. Similarly, a one-time allocation of monies to create new services may be worthwhile, but it does not have as enduring an impact as changing the structure of a State's Medicaid plan to incorporate a range of home and community-based services and supports.

Components of Effective Leadership

Leadership and a *strategic orientation* are intertwined because effective leaders are strategic, and operating strategically requires leadership on many different fronts at both State and local levels and across stakeholder groups. Components of effective leadership are illustrated by the five "Cs"—constituency (i.e. representativeness), credibility, capacity, commitment, and consistency.

THE 5Cs OF CORE LEADERSHIP

Constituency (representativeness)
Credibility
Capacity
Commitment
Consistency

Leadership Styles

There are many types of leadership styles—charismatic, facilitative, managerial—and all are needed in system building at various stages. Part of the strategic thinking that system builders need to undertake is to understand the types of leadership needed at different stages, particularly in the context of the leadership that is prevailing, which may or may not be what is needed. For example, initially, the charismatic, visionary leadership style often dominates to launch or reinvigorate a system building effort. In a developing system, the facilitative leadership approach of "giving away power", of empowering others to share leadership responsibilities, may prevail. In a maturing system, strong managerial leadership may be needed. Successful system builders pay attention to the types of leadership styles that are needed at different developmental stages.

Elements of Partnership

Collaboration is at the heart of system building. Children and families who are involved, or at risk for involvement, in child welfare depend on multiple agencies, providers, community supports, funders, and their own internal resources and family connections. Effective collaboration does not simply occur because stakeholders are well-meaning. It requires time and attention to: relationship-building; team building; communication; negotiation; conflict resolution; leadership development; mutual respect; skill building; and information sharing.

The first hurdle in a collaborative process is getting stakeholders to actually commit to collaboration. The second is for stakeholders to agree on *a set of principles to guide their collaboration*. Such principles include:

- building trust to work as a team
- agreeing on values that partners will honor
- agreeing on goals and concrete objectives
- developing a common language so that there is not confusion about important terms, such as family-centered practice or cultural and linguistic competence
- respecting the knowledge and experience partners bring, including that of families and youth
- assuming the best intentions of all partners
- recognizing strengths and limitations partners have
- honoring all voices by being respectful
- sharing decision making, risk taking and accountability.[9]

These are not simply "nice words". They can actually draw out the best in system building partners if they are adhered to in practice.

[9]Stark, D. (1999). *Collaboration basics: Strategies from six communities engaged in collaborative efforts among families, child welfare, and children's mental health*. Washington, D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Challenges to and Strategies for Collaboration

There are obviously numerous challenges to collaboration, but there also are "barrier busters" developed by system builders over time to address these challenges. Time invested in team building, conflict resolution, information sharing, and putting effective communication structures in place is time well spent. On the other hand, collaboration for the sake of collaboration is ultimately destructive as stakeholders lose interest in the process. Collaboration needs to have a purpose and concrete objectives, which change over time as objectives are achieved or new circumstances arise. *Part of being strategic is to understand how to use collaborative processes to drive toward concrete systems change*.

CHALLENGES TO COLLABORATION AND "BARRIER BUSTERS"

CHALLENGE	BARRIER BUSTERS
Language differences: Mental health jargon vs. court jargon	• Cross training • Share each other's turf • Share literature
Role definition: "Who's in charge?" Mandated services vs. requested services	• Family driven/accountability • Team development training • Job shadowing • Communication channels • Share myths and realities
Information sharing among systems	• Set up a common data base • Share organizational charts/phone lists • Share paperwork • Promote flexibility in schedules to support attendance in meetings
Addressing issues of child and community safety	• Document safety plans • Develop protocol for high-risk kids • Demonstrate adherence to court orders • Maintain communication with District Attorneys • Myths of "bricks and mortar"
Maintaining investment from stakeholders	• Invest in relationships with partners in collaboration • Share literature and workshops • Track and provide meaningful outcomes
Sharing value base	• Infuse values into all meetings, training, and workshops • Share documentation and include parents in as many meetings as possible • Strength-based cross training • Develop QA measures based on values

Adapted from Wraparound Milwaukee. (1998). *Challenges to collaboration/"barrier busters."* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.

Catalysts for Reform

Often, system building leaders use catalysts or trigger mechanisms to start or jump-start a system building process, either one that needs to be launched or an existing one that has stalled. There are various types of "trigger mechanisms" that can be employed, such as: legislative mandates (new or existing); study findings; class action suits; charismatic leaders, outside funding sources such as a federal grant; funding changes such as budget shortfalls or new revenue streams; local scandals or even tragedies; and coverage of successes. *A major catalyst in child welfare is findings from the Child and Family Services Reviews (CFSR) and Program Improvement Plans (PIPs).*

Managing Complex Change

Strategic system building has to do with managing complex change. This template illustrates elements that will create change and factors that may impede change. For example, if system partners seem confused, perhaps the vision is not clear. If staff or providers are anxious, perhaps they have not been provided the training that would give them the skills to do what is being asked.

BUILDING LOCAL SYSTEMS OF CARE: STRATEGICALLY MANAGING COMPLEX CHANGE

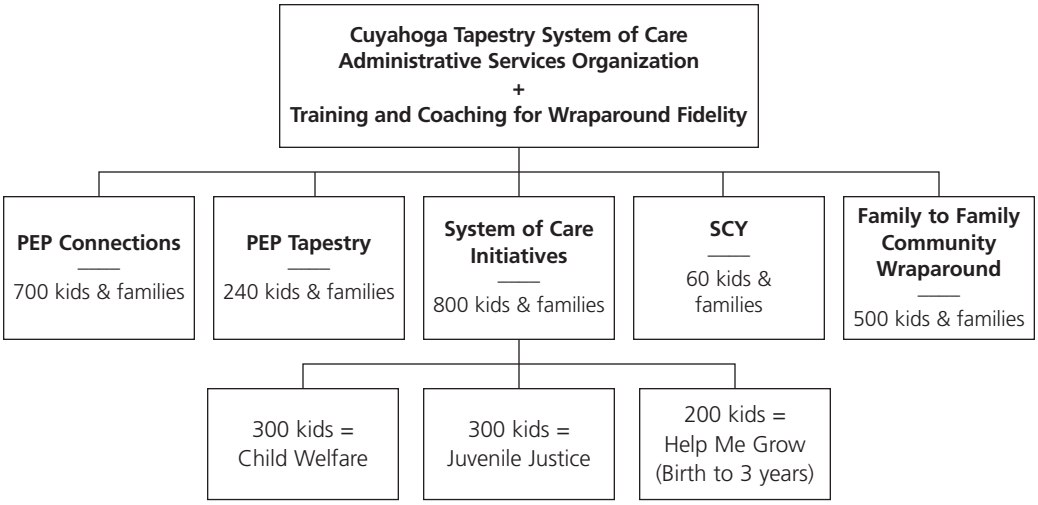
Vision	+	Skills	+	Incentives	+	Resources	+	Action Plan	=	**CHANGE**
		Skills	+	Incentives	+	Resources	+	Action Plan	=	**CONFUSION**
Vision	+			Incentives	+	Resources	+	Action Plan	=	**ANXIETY**
Vision	+	Skills	+			Resources	+	Action Plan	=	**RESISTANCE**
Vision	+	Skills	+	Incentives	+			Action Plan	=	**FRUSTRATION**
Vision	+	Skills	+	Incentives	+	Resources			=	**TREADMILL**

Adapted form T. Knosler (1991). TASH Presentations. Washington, D.C.

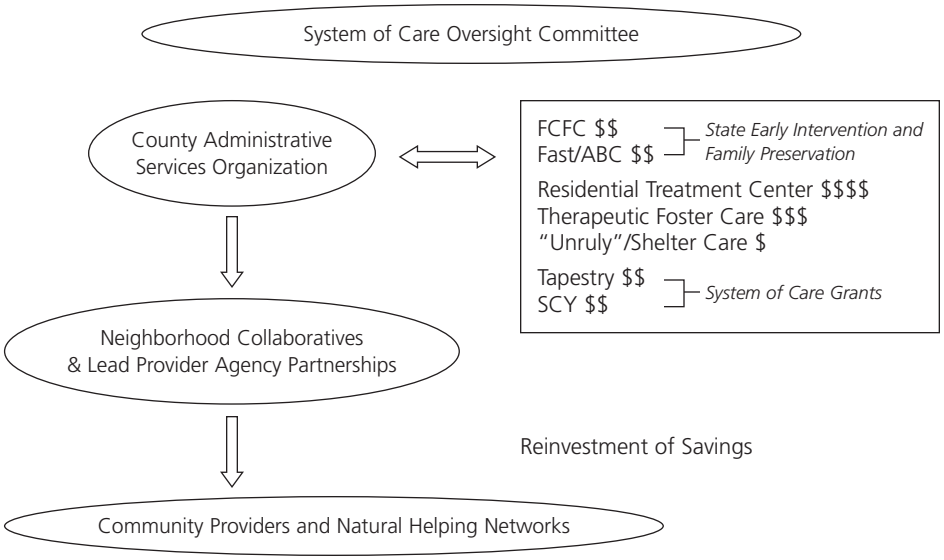
Effective strategists are continually scanning the environment looking for opportunities on which to build. Being strategic is both a science and an art, and the list of potential strategic alliances and opportunities is constrained only by limited vision, creativity or capacity to think strategically.

EXAMPLES

Cuyahoga County, Ohio (Cleveland) is an example of a system building process supported by a core leadership group operating strategically, which is leading to key structural changes on behalf of children involved or at risk for involvement in child welfare. The Cuyahoga County reform is bringing together related reform initiatives into one system of care approach. The Family-to-Family Neighborhood Collaboratives from the child welfare system and mental health provider agencies have combined efforts in Cuyahoga County's system of care. **(www.cuyahogatapestry.org)**



At a frontline practice level, **Cuyahoga County, Ohio** is utilizing high fidelity wraparound as a common practice approach and bringing together Family-to-Family community wraparound and clinical care coordinators in co-located neighborhood collaborative settings. At a system management level, the County is creating an "administrative services organization", which is called a System of Care Office, to manage multiple braided funding streams. At a policy-making or governance level, there is a multi-stakeholder system of care oversight body. **(www.cuyahogatapestry.org)**



MODULE 4

Cross-Cutting, Non-Negotiable Characteristics: Family/Youth Partnership and Cultural/Linguistic Competence

Non-Negotiable Characteristics of Systems of Care

To be effective, system building processes and structures need to support the ability to operate in cross-cultural situations and to partner effectively with families and youth. *Family and youth partnership* and *cultural and linguistic competence* are not "stand-alone" characteristics, but are woven throughout the fabric of system of care processes and structures (as is the characteristic of cross-agency collaboration and state/local/Tribal partnership noted earlier). The principles of family and youth partnership and cultural and linguistic competence also are embedded in the CFSR process and are essential to achieving CFSR (i.e., child welfare) outcomes. Family and youth partnership and attention to diversity, along with a cross-agency perspective and state, local and tribal partnership, are non-negotiable characteristics of effective system building processes and structures.

Building Systems of Care: A Primer for Child Welfare integrates concepts and examples of family and youth partnership and cultural competence throughout, rather than having just a "stand alone" section on these intrinsic characteristics of effective systems of care. Module 4 is included to provide an important context setting piece about these essential characteristics:

- **Family and Youth Partnership**
- **Cultural and Linguistic Competence**

EXERCISE 2: ATTITUDES ABOUT FAMILIES, YOUTH AND CULTURE

Exercise 2 reflects certain beliefs about the role of families, youth, and culture in system building that may help to stimulate an open discussion among stakeholders about what can be sensitive topics. The Exercise supports stakeholders to spend time, preferably in facilitated discussion with one another, exploring differences and similarities in perceptions. System building leaders need to spend time listening, rather than immediately responding to what is said. This is an important discussion and may set the tone for the system building process regarding families, youth, and culture.

Instructions: Circle the degree to which you agree with the following statements:

1. Cultural competence means paying attention primarily to the cultures of racial and ethnic minority families.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
2. Cultural competence means paying attention to the cultures of all families.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
3. Our goal should be to match providers and families that share the same racial and ethnic backgrounds.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
4. Families know what is best for their children and should drive decision-making about service delivery.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
5. Families should be partners in service decision-making, with a role equal to but not more important than that of child welfare staff.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
6. It is very difficult, if not impossible, to implement a family-driven approach with families who are involuntarily involved in child welfare.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
7. Family members should not be employed by the system because it compromises their autonomy to advocate on behalf of other families.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
8. Family organizations can be both service providers with contracts with the system and still play an organizing, education and advocacy role to build a family movement.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
9. Youth should be partners in all system of care activities, including planning, implementing and evaluating services and supports.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE
10. Youth-guided organizations should be separate entities from family organizations.	STRONGLY DISAGREE	DISAGREE SOMEWHAT	NEITHER AGREE NOR DISAGREE	AGREE SOMEWHAT	STRONGLY AGREE

Family and Youth Partnership

Defining Family and Youth

It is important to define who represents family and youth when building systems of care that support the child welfare population. There are parents and guardians who are at risk and are working with the system of care in meeting their child and family needs to preserve their family. There are many grandparents who have assumed parental responsibility for their grandchildren when the parent is absent. It is important to learn more about kin or extended relatives, including non-custodial or non-resident fathers, who may become involved not only in the child and family's life to promote change, but have valuable information to share in system reform efforts. Foster parents and adoptive parents, who are raising children on a day-to-day basis, have valuable information and experiences that can support outcomes at a child/family level and further system development. Youth, who are currently involved or have been involved with child welfare and the interacting child and family service agencies, are most powerful when engaged to be involved at all levels of system reform.

A system of care approach, as well as CFSR principles, requires child welfare and its system partners to change the approach to engaging and working with families and surrogate families to one that is strengths-based, seeks to build resiliency, and approaches families with respect and empathy, even in the most troubling situations. This requires new types of engagement and partnership strategies. For example, non-custodial or non-resident fathers may be a resource, but at least half the time, the child welfare system does not try to find them, according to research by the Urban Institute. This is changing through partnerships with other systems, such as adult corrections, child support enforcement, and substance abuse agencies.

The **Pennsylvania** Department of Corrections, for example, launched a "Long Distance Dads" initiative to promote fatherhood and empower fathers, through training and support, to become involved in the lives of their children. CFSR encourages child welfare systems to partner with substance abuse and domestic violence programs, among others, to work with fathers who have substance abuse problems and in families where domestic violence is an issue. National policy confirms the importance of reaching out to and involving fathers. The Adoptions and Safe Families Act, for example, clarified that child welfare systems are not only allowed but encouraged to use the Federal Parent Locator Service (as well as State locator services) to try to find non-custodial fathers. The Federal Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been funding research with a focus on fathers, with a particular look at non-custodial fathers and child welfare. (For more information on the ASPE-funded work, including the Urban Institute studies cited earlier, contact: www.aspe.hhs.gov/hsp/06/cw-involve-dads/index.htm.)

Child welfare systems also have become more open to involving various family and surrogate family members simultaneously—for example, working with both birth and foster families to determine what is best, which can help to promote permanency outcomes. From a system of care standpoint, the important principle (found as well in CFSR) is that families and youth are more likely to build internal and external supports

and experience positive outcomes if they are listened to, respected and engaged as partners; in addition, their experiences with systems gives them unique and valuable perspectives on how to improve systems at a policy and management level as well.

How Systems of Care Are Structuring Family/Youth Involvement at All Levels

A system of care approach holds that it is essential that families and youth have the opportunity and support to partner at all levels of the system—from entry into the system of care where individual and family needs are first starting to be met, to working with service providers and system managers to implement system of care activities, to being part of the oversight and policy structures that define and shape the system of care. Effective systems of care structure family and youth partnerships at policy, management, and service delivery levels. This includes, for example, at a policy level, families having representation on governance structures; at a management level, families being part of quality improvement processes or families being utilized as trainers; and at a service delivery level, families not only being partners on service planning teams for their own children, or for children in their care, but having roles as service/support managers, peer mentors, or system navigators for other families based on their past experiences and knowledge of their system involvement.

HOW SYSTEMS OF CARE ARE STRUCTURING FAMILY INVOLVEMENT AT VARIOUS LEVELS OF THE SYSTEM

LEVEL	STRUCTURE
Policy	As voting members on governing bodies; as members of teams to write/review Request For Proposals (RFPs) and contracts; as members of system design workgroups and advisory boards; raising public awareness
Management	As administrators; part of quality improvement processes; as evaluators of system performance; as trainers in training activities; as advisors in selecting personnel
Services	As members of team for own children; service providers, such as family support workers, respite providers, service/support managers, peer mentors, system navigators

Over a decade ago, the American Humane Association (AHA), in collaboration with many national organizations concerned about children and families in child welfare, hosted the first roundtable on child welfare and managed care and developed a set of "ethical standards" that embrace the concept of family partnership. The AHA principle states,

> *"Families should have a meaningful role at both the case level—in assessing, planning and evaluating their own needs and services—and the systems level—in setting eligibility criteria, determining service offerings, selecting managed care intermediaries and providers, etc. This will require training and ongoing support for families."*

The issue of *training and support*—for child welfare workers, supervisors, other system partners, and families themselves—cannot be overstated. Family and youth partnership is a fundamental practice shift, which requires capacity-building to change attitudes (of child welfare, other systems partners, and of families themselves), build knowledge about how to partner, and teach and coach partnering skills.

Applicability of a Family-Driven Approach to Court-Involved Families

A still timely resource on family-driven care in the child welfare arena is *Partnering with Families to Reform Services: Managed Care in the Child Welfare System: A primer on family-driven managed service systems* by Madeleine Kimmich and Tracey Feild and published by the American Humane Association (AHA) in 1999. It addresses the concern about whether a family-driven approach applies to court-involved families—

> *"It is important to address the issue of court involvement, which makes services involuntary for many families and thus affects their desire—and legal ability—to choose services. There is more danger of under-service (in child welfare services) than in other systems…because child welfare clients are unlikely to advocate on their own behalf for services. Families may be fully capable, physically and mentally, to make good choices about what services and what particular providers could be of most assistance to them, but because of court involvement, these families may not be permitted to exercise any choices. The challenge for family-driven…service models is to bring judicial stakeholders into the discussion of how much choice a particular family should have, given the circumstances of the court's involvement."*
>
> Kimmich, M., & Feild, T. (1999). *Partnering with families to reform services: Managed care in the child welfare system*. Denver, CO: American Humane Association.

EXAMPLE

In Milwaukee, Wisconsin, in a system of care such as **Wraparound Milwaukee**, most of the families involved are court-involved, and Milwaukee's judges predominantly concur with the decisions made through the child and family team process, in which families participate as critical partners. **(www.milwaukeecounty.org)**

Addressing Families' Capacity and Willingness to Partner

The American Humane Association (AHA) report also addresses concerns that families may lack the capacity to partner—

> *"Critics argue that family-driven systems have greater potential than traditional approaches for exploitation or ill-informed decision making by families. While it is true that some families may be limited in their ability to manage their own resources, the difficulty some may have in making decisions is no justification for circumscribing the decision-making authority*

of all participants. Indeed, there will be some families who, because of legal involvement and safety issues, will not have the option of controlling service decisions. However, many families are quite capable of making (or learning to make) key decisions concerning their lives, and systems must be structured to promote and to support such capability from the start." (Kimmich, M. & Feild, T. 1999)

It is important to acknowledge the concerns that may arise about partnering with families and youth—such as families lacking expertise about policy issues or youth and families having too many personal crises to be reliable—and strategize ways to address these issues, such as training, orientation, and coaching (for families/youth and staff), connecting families and youth to family/youth organizations for supports, or putting "buddy" systems in place when crises arise.

By the same token, it is important for system partners to acknowledge that families and youth may have experienced a system "culture" in child welfare that fostered feelings of fear, anxiety, hopelessness, and powerlessness. As a result, families and youth may feel anger, shame, and distrust, making them reluctant to partner. Again, system builders need to work in partnership to develop strategies to address these issues, such as supporting the organization of parents who have been involved in child welfare, training and capacity building to change the practice culture in child welfare, etc.

A very basic way to support families is to provide them with information, including information about the child welfare system itself. A resource for helping child welfare systems to change practice and families to have greater voice in child welfare deliberations is: *A Family's Guide to the Child Welfare System*, available from the Georgetown University National Technical Assistance Center for Children's Mental Health at: www.gucchd.georgetown.edu/programs/ta_center.

EXAMPLES

Jefferson County, Colorado provides an example of a child welfare system that partners with families to implement a system of care. It utilizes parent partners, who are trained and supported by a parent partner coordinator, to help other families involved in the system. The parent partners are parents who have had experience with the child welfare system. **(www.co.jefferson.co.us/care/care_T189_R2.htm)**

The **Rhode Island Parent Support Network (PSN)** developed a self-assessment tool for system builders, called *Family Coalition for Family Support & Involvement & Family-Centered Practice: How are we doing?* The tool incorporates a family-centered rating scale that supports families, policy makers, administrators, and service providers to examine how family-centered their programs, supports or services really are. This assists system builders to identify strengths and areas that need improvement. These key areas include: focus on the strengths of the child and family; support relationship building and community membership; foster mutual trust and respect between families and program staff and/or administration; promote family choice and control; offer families good information and access to information; and include families in policy decisions and program planning. **(www.psnri.org)**

Definition of Youth-Guided

Systems of care increasingly have embraced the concept of a youth-guided system, which is defined as encompassing the principles described below.

PRINCIPLES OF A YOUTH-GUIDED SYSTEM

- Youth have rights
- Youth are utilized as resources
- Youth have an equal voice and are engaged in developing and sustaining the policies and systems that serve and support them
- Youth are active partners in creating their individual support plans
- Youth have access to information that is pertinent
- Youth are valued as experts in system transformation
- Youths' strengths and interests are focused on and utilized
- Adults and youth respect and value youth culture and all forms of diversity
- Youth are supported in a way that is developmentally targeted to their individual needs

YouthMove, 2006, Technical Assistance Partnership, American Institutes for Research, Washington, D.C.

Roles for Youth

It is important to have youth who are currently involved with the child welfare system, or have been involved in the past, take on key roles to support continued system of care development, implementation and evaluation. There are many different roles for youth in systems of care.

ROLES FOR YOUTH: INFUSING YOUTH VOICE IN ALL LEVELS

- Engage youth in the CFSR process
- Include youth on Program Improvement Plan workgroups
- Create youth advisory boards
- Develop youth-run organizations
- Train and utilize youth as peer mentors
- Involve youth as educators/trainers/evaluators

Adapted from Materese, M., Technical Assistance Partnership & National Child Welfare Resource Center for Youth Development

Barriers to Youth Partnership

As the list below shows, both adults and youth perceive barriers to youth participation. Some of the barriers, such as lack of time and money, are noted by both adults and youth, but there are also some differences in perception of barriers. While both groups identify racism as a barrier, youth also identify sexism, homophobia, ageism or adultism and stereotyping by appearance as barriers. Adults identify as an issue that adults are not empowered to partner with youth, while youth identify the related issue of lack of support from adults. Initiating and continuing a dialogue with youth is a first step in all parties thinking strategically about how to break down barriers.

BARRIERS TO YOUTH PARTNERSHIP

As Identified by Adults
- Time
- Funding
- Staffing
- Access to youth
- Lack of training (in how to work with youth)
- Politics
- Parents
- Adult staff not empowered
- Program evaluation requirements
- Weak leadership
- Racism

As Identified by Youths
- Ageism/Adultism
- Money
- Racism, sexism, homophobia
- Stereotyping by appearance
- Time
- Transportation
- Language
- Lack of access to information
- Lack of access to opportunities
- Lack of support from adults
- Few role models
- Lack of motivation

Politz, B. (1996). *Barriers to youth participation*. Washington, DC: Academy for Educational Development. The Center for Youth Development.

Family & Youth Networks of Support and Advocacy

Family and youth support and advocacy networks, both formal and informal, support involvement, partnership and system reform efforts and fill the following roles:

- working with families (birth, foster, adoptive, and kinship/relative) or youth to provide support to one another by sharing information
- holding support groups
- providing training
- mentoring and delivering family and youth support services
- creating opportunities for social interaction
- guiding system reform efforts.

The Role of Family-Directed Associations and Organizations

Organizing family and youth networks through the work of a family- or youth-directed organization is a key strategy in systems of care to support family and youth involvement. Strategies include both partnering with existing family and youth associations/organizations and supporting the development of new ones where none exists. These associations or organizations can start as informal networks of support as stated earlier and grow over time.

Some of the considerations in *establishing a new family- or youth-directed organization* include:

- identifying and supporting birth family and youth leaders in the community
- providing adequate funding
- delineating relationships

- letting families and youth decide the mission, goals, structure and activities of the new organization
- partnering with families and youth in strategic planning for sustainability.

Key elements in *contracting with existing family organizations* include ensuring that the organization has the following:

- representation from the culturally and linguistically diverse families currently involved in the child welfare system
- strong ties to the community and linkages with other family groups both locally and nationally
- clear expectations of what is required
- performance criteria and evaluation procedures
- fair compensation for the work to be performed.

A family or youth organization can help to ensure a higher level of accountability from the system of care than individuals working on their own might be able to create, to ensure that families and youth receive the necessary services and supports and that they are involved in meaningful ways as system partners.

ROLE OF FAMILY- AND YOUTH-DIRECTED ASSOCIATIONS AND ORGANIZATIONS

- Mobilize family and youth voice
- Provide a structure for implementing family and youth partnership with the system of care
- Engage and support families, youth, and family members who may feel disenfranchised from or distrustful of child welfare and other systems (e.g., birth parents whose children have been removed; fathers; racially/ethnically diverse families; LGBTQ youth or caregivers)
- Create ties to the larger community and other family and youth organizations (e.g., Federation of Families for Children's Mental Health, Foster Parents Association, Adoptive Resource Center, Parents Anonymous, and/or Grandparents Resource Center)

Through its capacity to develop family or youth leadership and mobilize a family and youth "voice", an organization can strengthen the strategic approach to family and youth partnership-building within the system of care. Family organizations also can play an effective role in organizing and providing support for families and family members who may feel distrustful of or disenfranchised from the child welfare system (and other systems) because of their experiences—for example, birth families whose children have been removed, fathers who may feel "cut out of the picture", racially and ethnically diverse families or lesbian, gay, bisexual, transgendered or questioning (LGBTQ) youth or caregivers. Family organizations can create a safe space for these families and family members to air concerns and support them to become involved in systems change.

EXAMPLES

Missouri is one example of a State whose child welfare system has created a Youth Advisory Board, which has produced, among other accomplishments, a video describing youths' experience in foster care, which is used during foster and adoptive pre-service training. **(www.dss.mo.gov/cd/chafee/syab/index.htm)**

Texas is an example of a State that is organizing regional advisory groups comprised of birth parents who have been involved in child welfare. **(http://www.dfps.state.tx.us/about/renewal/cps)**

Cultural and Linguistic Competence

Why Culture Matters

Recognizing that different terminology may be used across stakeholders, as well as across the country, we define culture as a broad concept that reflects an integrated pattern of a wide range of beliefs, practices and attitudes that make up an individual. Culture matters because culture affects:

- attitudes and beliefs about services
- parenting and child rearing
- expression of symptoms
- coping strategies
- help-seeking behaviors as well as helping behaviors
- utilization of services and social supports
- including kinship support
- appropriateness of services and supports.

Cultural Competence Realities

There are a number of basic realities as to why system builders need to develop multicultural knowledge and skills, including:

- to respond to demographic changes in the U.S.
- to eliminate disparities and disproportionality
- to improve the quality and relevance of services and supports
- to meet legislative, regulatory and accreditation mandates
- to decrease the likelihood of class action suits
- especially important to child welfare stakeholders, to meet CFSR outcomes.

Given the extent to which racially and ethnically diverse children and families are over-represented in child welfare systems, and findings from the CFSRs that outcomes tend to be poorer for these children and families, arguably, it would seem impossible to achieve CFSR outcomes in many areas without paying attention to cultural and linguistic competence.

Disparities and Disproportionality in Child Welfare

In 2005, the Congressional Research Service (CRS) explored the issue of disproportionate representation in child welfare. They found that African American and Native American children are significantly overrepresented in the child welfare system compared to their representation in the overall child population, while Asian and, to a lesser extent, white, children are underrepresented. While Hispanic/Latino children seem to be neither under- nor over-represented in child welfare looking at national data, this can shift dramatically by locality.

DISPROPORTIONALITY IN CHILD WELFARE

"…all states have a disproportionate representation of African American children in foster care. As of 2000, the child welfare system in 16 states had extreme rates of disproportionality that were more than three and one-half times the proportion of children in color in the state's total child population."

Robert B. Hill, Overrepresentation of Children of Color in Foster Care in 2000—Revised Working Paper, March 2005.

"In states where there is a large population of Native Americans, this group can constitute between 15% and 65% of the children in foster care."

Casey Family Programs, Framework for Change (April 2005).

"Hispanic/Latino children may be significantly over-represented based on locality (e.g., Santa Clara County, CA: Latino children represent 30% of child population, but 52% of child welfare cases)."

Congressional Research Service. August 2005. Race/Ethnicity and Child Welfare.

With respect to disparities, numerous studies, as well as the U.S. Surgeon General's report in 2001, have documented that racial and ethnic minority children tend to have less access to services, receive a poorer quality of services, and are more likely to be placed into care. Also, the first round of CFSRs shows that white children achieve permanency outcomes at a higher rate than children of color.[10] Research also shows that disparity includes not only children, but families. For example, African American families are investigated for child abuse and neglect twice as often as Caucasian families.

Theories About Disproportionality in Child Welfare

A key aspect of a culturally competent approach is to understand the racial and ethnic disparities and disproportionality issues in one's particular child welfare system. A system may also experience geographic disparities and disproportionality with, for example, rural areas being under- or over-represented in the system. The CRS report identified a number of reasons for disproportionate representation. Theories advanced by researchers in the field, include:

- children of color are more likely to be in poor or in single-parent homes—both of which are risk factors for maltreatment

[10]Adapted from Congressional Research Service. August 2005. Race/Ethnicity and Child Welfare.

- more likely to come into contact with social service or other workers who notice and report child maltreatment
- more likely to be reported and less likely to be reunified due to biased decision making
- children of color have less access to services that prevent placement and hasten permanency.

The CRS report also described the perspectives of child welfare administrators, supervisors and workers as to why there is racial and ethnic disproportionality. Child welfare stakeholders pose the following reasons:

- poverty and related issues, such as homelessness
- lack of community resources to address a range of issues, such as substance abuse and domestic violence
- greater visibility of minority families for reporting of child maltreatment
- a lack of experience with other cultures and lack of familiarity regarding what constitutes abusive behavior across these cultures
- media pressure to remove children.

Each of these potential reasons lends itself to particular collaborative strategies for change. For example, combining resources across systems and partnering with natural helping networks might help to make more services and supports available. Training and coaching across systems and partnering with families and youth might help to reduce biased decision making. Social marketing strategies might help to alleviate media pressure to remove children. The point is that cultural and linguistic competence, like all aspects of system-building, must be approached strategically.

Examples of Partnerships to Address Disproportionality

Texas, **Iowa**, and **South Dakota** are examples of States whose child welfare systems are partnering with community stakeholders to address issues of racial and ethnic disparities and disproportionality.

Important to trauma-informed work is having Tribal governments as full partners with State child welfare agencies, both to share responsibility for native children, youth and families and to fully comply with the Indian Child Welfare Act. The CFSR Comprehensive Training and Technical Assistance Package has a focus area on State-Tribal partnerships. For more information, go to **www.nrcoi.org** or **www.nicwa.org**.

EXAMPLES

Iowa has launched the *Children of Color Project*, addressing the disproportionality of African American and Native American children in their child welfare system. The project links families and children to neighborhood organizations that offer a range of culturally appropriate services and also assists the State child welfare agency to be more culturally sensitive and responsive in interactions with minority families. **(http://216.38.216.37/adoptusa/diligent.html)**

In **Woodbury County (Sioux City), Iowa** the 2000 Census shows the Native American population to be .05%, yet 2.2% of the child welfare population is Native American. Most children are removed from their homes due to poverty-related conditions, substance abuse and domestic violence. In 2003, the Iowa Legislature enacted the Iowa Indian Child Welfare Act (IICWA) requiring the implementation of the Children of Color Project in Sioux City. Now called the Minority Youth and Family Initiative, the project is part of the Department of Human Services' (DHS) Child Welfare Redesign Initiative. The key strategies are:

- Create a process whereby relatives are identified earlier and are approved as placement options;
- Review the Interstate Child Placement Compact (ICPC) to increase border state placements in tribes that cross state lines;
- Recruit and retain Native American foster homes; and
- Use Family Team Meetings as the primary service delivery process.

In addition, in 2005 DHS restructured to create a specialized unit to provide services to Native American children and their families. The unit has two Native American staff members who serve as liaisons to the Native American community. You can obtain more information at **http://www.legis.state.ia.us/Legislation.html** or Sioux City Family Resource Center (Sioux City, IA) or *Places to Watch: Promising Practices to Address Racial Disproportionality in Child Welfare*, a report from the Center for Community Partnerships in Child Welfare of the Center for the Study of Social Policy.

Texas is partnering with Casey Family Programs to address both disproportionality and disparities in access to needed services by African American children and families and has created Community Advisory Committees on Disproportionality. For more information, contact: **http://www.dfps.state.tx.us/about/renewal/cps.**

South Dakota's Collaborative Circle for the Well-Being of South Dakota's Native Children was established because Native American children were so disproportionally represented in South Dakota's child welfare system. Four key stakeholders came together in 2005 and committed themselves to partnering to reduce the number of Native children in child welfare and to achieve better outcomes for Native children and families. The four partners are (1) the nine Sioux Tribes; (2) the State Division of Child Protection Services; (3) birth parents, family caregivers, and youth; (4) and the provider community. Together, they created the Collaborative Circle, and since its creation, there has been a 10 percent reduction in Native disproportionality in child welfare. For more information, contact: **http://dss.sd.gov/cps/icwa/index.asp**.

Positive Outcomes From Addressing Disproportionality

Positive outcomes can emerge as more communities address the issues of disproportionality and disparity through a systemic reform approach.

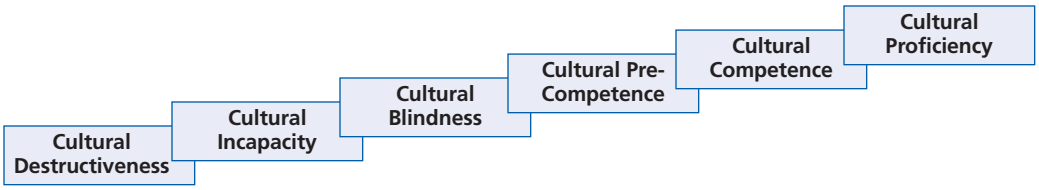
EXAMPLES

In **Wake County, North Carolina**, African American children make up 25% of the child population but are 60% of the child welfare population. In the past 5 years, Wake County has implemented several strategies to reduce racial disparity and improve child welfare outcomes. The County's initiatives included A Family-to-Family Initiative, the implementation of a Racial Disparities Workgroup, a Believe in the Children Campaign, a Child Welfare Faith Based Partnership, and the establishment of a small fund to help kinship caregivers purchase legal services to establish custody. The County has reported that the percentage of African American children entering foster care in Wake County and the overall percentage of Wake County's African American foster children have both decreased. For more information, contact: **http://www.casey.org/resources/publications/placestowatch.html.**

Cultural Competence Continuum

Some years ago, Terry Cross of the National Indian Child Welfare Association and colleagues identified a "cultural competence continuum", which still has relevance. The continuum moves from cultural destructiveness to cultural incapacity to cultural blindness to cultural pre-competence to cultural competence to cultural proficiency. This construct provides one useful tool for assessing the cultural strengths and weaknesses of the system of care.

CULTURAL COMPETENCE CONTINUUM



Cultural competence is a developmental process that evolves over an extended period. Individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (NCCC adapted from Cross et al., 1989)

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Toward a culturally competent system of care Vol. 1*.

Organizational Cultural Competence

Systems of care fundamentally are concerned about organizational cultural competence. The following criteria are useful to identify culturally competent organizations; they are adapted from the monograph cited above, *Toward a Culturally Competent System of Care*, by Terry Cross of the National Indian Child Welfare Association, and colleagues:

> *"Cultural competence requires that organizations:*
>
> - *Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally*
> - *Have the capacity to value diversity, conduct self assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve*
> - *Incorporate the above in all aspects of policy making, administration, practice, and service delivery, and involve systematically consumers, key stakeholders, and communities."*

Using these and similar parameters, system builders can assess the cultural competence of their systems and develop strategies to address areas needing improvement.

Definition of Linguistic Competence

The U.S. has become not only increasingly multicultural but also multi-linguistic. The National Center for Cultural Competence at Georgetown University offers this definition of linguistic competence:

> *"Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competence requires organizational and provider capacity to respond effectively to the health (and well-being) literacy needs of populations served. The organization must have policy, structures, practices, procedures and dedicated resources to support his capacity."*

Cultural Competence Core Elements

Leaders in the area of cultural and linguistic competence also have identified core elements of a culturally competent system of care. These elements provide a framework for system builders to gauge the cultural and linguistic competence of their systems and strategize action steps for improvement.

CORE ELEMENTS OF A CULTURALLY AND LINGUISTICALLY COMPETENT SYSTEM OF CARE

- Commitment from top leadership
- Organizational self-assessment
- Needs assessment and data collection relevant to diverse constituencies
- Identification and involvement of key diverse persons
- Mission statements, definitions, policies and procedures reflecting the value of cultural and linguistic competence
- A strategic plan for cultural competence
- Recruitment and retention of diverse staff
- Training and skill development in cultural competence
- Certification, licensing and contract standards
- Targeted service delivery strategies
- Internal capacity to monitor the cultural competence implementation process
- Evaluation and research activities that provide ongoing feedback about progress, needs, modifications, and next steps
- Commitment of agency resources (human and financial) to cultural competence quality improvement

Isaacs, M., Benjamin, M., et al. (1989-1998). *Toward a culturally competent system of care* (Vols 1-3). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Additional Resources on Cultural and Linguistic Competence

The National Center for Cultural Competence at the Georgetown University Center for Child and Human Development (http://www11.georgetown.edu/research/gucchd/nccc/index.html) maintains many online resources and tools addressing the foundations of cultural and linguistic competence, including, among other resources:

- conceptual frameworks/models, guiding values and principles
- definitions of cultural and linguistic competence and family-centered care
- policies to advance and sustain cultural and linguistic competence
- tools and processes for self-assessment.

The NCCC also has a searchable database listing a wide range of resources on cultural and linguistic competence.

Remaining Sections of Primer

The remaining sections of *Building Systems of Care: A Primer for Child Welfare* explore many of the functions that require structure in systems of care, beginning with planning.

Key Functions that Require Structure in Systems of Care

MODULE 5
Planning
Governance
System Management

MODULE 6
Outreach and Engagement
Organized Pathways to Services/Supports
Screening, Assessment, Evaluation, and Service Planning

MODULE 7
Service Array
Financing

MODULE 8
Provider Network
Natural Supports
Purchasing and Contracting

MODULE 9
Service Coordination and Care Management
Utilization and Quality Management

MODULE 10
Other Important System of Care Functions

MODULE 5 Planning, Governance, System Management

FUNCTION Planning

Issues for Structuring Planning

Because building systems of care is a dynamic process occurring in an ever-changing environment, "planning" is an ongoing function that requires structure. Typically, building systems of care involves structuring planning by launching or reinvigorating a planning process (or bringing related planning efforts together). The planning process itself needs to be structured; it cannot be left to happenstance. In time, the planning process must lead to a clear system design, and the process will then become a planning and implementation oversight process. Planning, in effect, does not really end; it is part of a cycle in a Continuous Quality Improvement framework, which includes: planning, implementing, evaluating, changing as needed (which usually involves additional planning).

There are a number of structural issues that need to be considered related to structuring (or re-structuring) the planning process, such as: who is taking leadership; how will the process be staffed; when and where will meetings be held; how will stakeholders be involved; how will diverse and disenfranchised stakeholders be reached and involved; what structures are needed to involve families and youth; will the process use committees, workgroups, focus groups; how will communication and information dissemination be structured; and how will the system building process link to related reform initiatives.

Stages of Planning

One way to think about planning is in stages having to do with articulating and implementing a "theory" or theories about systems change. A "theory of change" assumes that "if certain things change, certain outcomes will be achieved". The theory of change methodology tests these assumptions by implementing them (or trying to) and revising them as needed based on an evaluation of whether they are working to achieve intended outcomes. Researchers have articulated various stages of planning to support a theory of change.

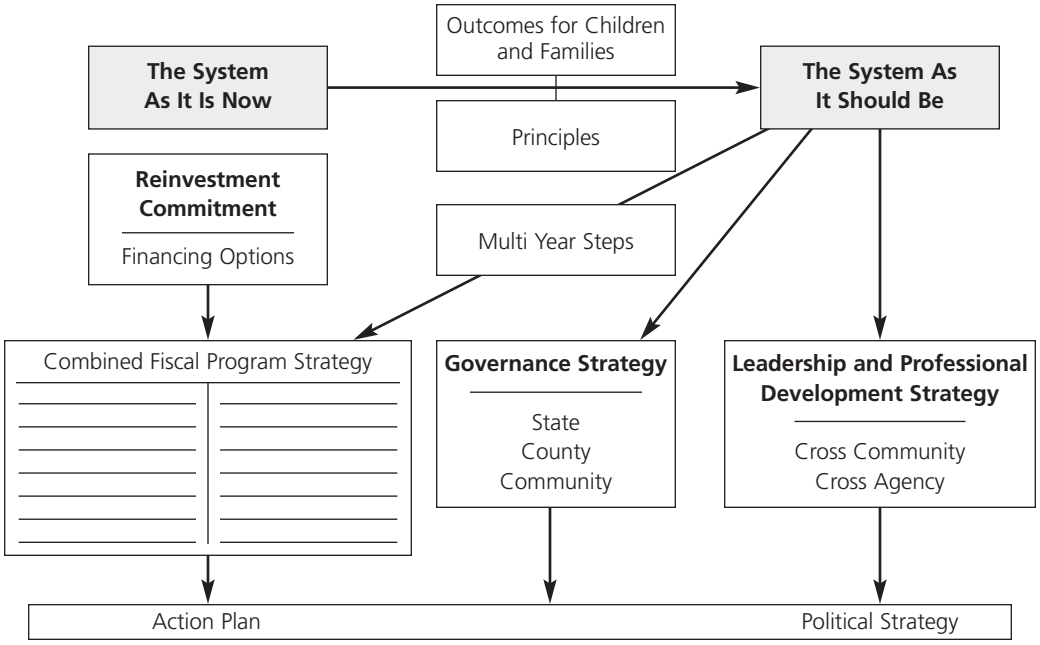
STAGES OF PLANNING FOR SYSTEMS OF CARE

STAGE 1: Form workgroup
STAGE 2: Articulate mission
STAGE 3: Identify goals and guiding principles
STAGE 4: Develop the population context
STAGE 5: Map resources and assets
STAGE 6: Assess system of flow
STAGE 7: identify outcomes and measurement parameters
STAGE 8: Define strategies
STAGE 9: Create and fine-tune the framework
STAGE 10: Elicit feedback
STAGE 11: Use framework to inform, plan evaluation, and technical assistance
STAGE 12: Use framework to track progress and revise theory of change

Hernandez, M., & Hodges, S. (2003). *Crafting logic models for systems of care: Ideas in action*. Tampa, FL: University of South Florida.

In addition to conceptualizing planning in stages related to a theory of change, creating a graphic representation of a planning process for child and family service system reform also can be an effective tool in planning. This graphic of steps to take in a planning process was developed by Mark Friedman for the Center for the Study of Social Policy.

A PLANNING PROCESS FOR FAMILY AND CHILDREN'S SERVICE REFORM



Friedman, M. (1994). Washington, D.C.: Center for the Study of Social Policy.

Elements of Effective Planning Processes

A number of elements of effective planning processes have been identified over the years in system of care efforts.

ELEMENTS OF EFFECTIVE PLANNING PROCESSES

- They are staffed
- They involve key stakeholders
- They involve families and youth early in the process and in ways that are meaningful
- They ensure meaningful representation of culturally diverse constituencies
- They develop and maintain a cross-agency focus
- They build on and incorporate related reform agendas
- They continually seek ways to build constituencies, interest and investment
- They pay attention to sustainability and growth of planned system changes from day one.

Strategies for Involving Families and Youth in Planning

The family preservation literature in child welfare, now over a decade old, describes a number of still very relevant strategies that can be adapted for involving families and youth in planning processes.

STRATEGIES FOR INVOLVING FAMILIES AND YOUTH IN PLANNING

- Provide information about planning meetings to family organizations, agencies providing family preservation or family reunification services, and community organizations, such as Boys and Girls Clubs
- Provide special orientation and training and meet with families and youth prior to meetings
- Contract with community based youth and family-run organizations to develop and support family and youth involvement
- Ask agencies that work with families and youth to recommend families and youth for planning bodies
- Pay stipends, arrange for child care and transportation and have food at meetings
- Hold planning meetings at various times, for example, in the evenings, on weekends, and after school
- Hold meetings at diverse locations, such as at schools or recreation centers
- Use a variety of methods to elicit the views of families and youth, such as focus groups and surveys
- Work with family and youth support groups to tap into informal networks
- Work with a variety of programs, such as home visiting programs, health clinics, Head Start programs, schools, Big Brother/Big Sisters, etc. to reach out to families and youth
- Conduct sessions for all planning group members with trained facilitators to explore attitudes about race, culture and attitudes about families and youth
- Publicly acknowledge the contributions and strengths of families and youth

Adapted from: Emig, C., Farrow, F,. & Allen, M. (1994). *A guide for planning: Making strategic use of the family preservation and support services program*. Washington, D.C.: Center for the Study of Social Policy & Children's Defense Fund.

Culturally Competent Planning Processes

Because of issues of disparities and disproportionality, particular attention needs to be paid in the planning process to cultural and linguistic competence. Numerous examples of strategies in planning for cultural competence have been described.

STRATEGIES IN PLANNING FOR CULTURAL COMPETENCE

- Conduct periodic assessments of the cultural and linguistic competence of existing systems serving children and families in or at risk for involvement in the child welfare system
- Build support for the changes in knowledge, skills and attitudes needed for the system to be culturally and linguistically competent
- Identify, acknowledge, engage and partner with formal and informal leadership in culturally diverse communities
- Identify resources and leadership capacity to enhance cultural and linguistic competence for the planning process
- Articulate values and set goals with respect to cultural and linguistic competence
- Plan action steps in partnership with families, youth and culturally diverse communities
- Determine best strategies for formally sanctioning and mandating, if necessary, the incorporation of cultural knowledge into policy making, system management and frontline practice

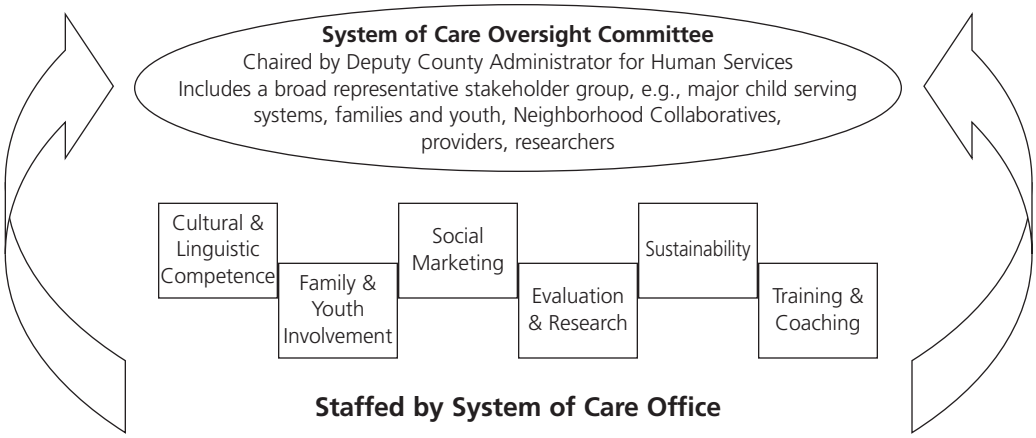
Adapted from Cross, T., Bazron, B., Dennis, K., & Issacs, M. (1989). *Toward a Culturally Competent System of Care* Vol. 1. National Center on Cultural Competence, Georgetown University.

Families, youth and culturally diverse constituencies are critical to the planning process. The planning structure needs to create a safe environment where these key stakeholders can share their points of view without fear of retribution. Often, effective planning structures utilize family leaders or youth to co-facilitate or co-lead the planning process and provide ongoing support to families and youth during planning meetings. Effective family, youth and cultural leaders can help to set the tone with all stakeholders to raise the level of sensitivity to issues of family and youth partnership and cultural/linguistic diversity. Family organizations may play a key role in reaching out to families from diverse communities to be involved in planning and other system of care functions. The system's capacity to provide basic support to families and youth, such as transportation, childcare, stipends, and food, has a major bearing on success in partnering with families and youth.

EXAMPLE

We return to **Cuyahoga County, Ohio (Cleveland)** for an example of a structured planning process. There is a System of Care (SOC) Oversight Committee, chaired by the Deputy County Administrator for Human Services, which includes a Broad Representative stakeholder group, e.g., the major child-serving systems, families and youth representing Family-to-Family Neighborhood Collaboratives, providers, university partners, etc.The SOC Oversight Committee has six overarching SOC subcommittees, including: cultural and linguistic competence, evaluation and research, family and youth involvement, social marketing, sustainability, training and coaching. This structure for planning and implementation oversight brings together several related reform initiatives into one coordinated planning and implementation approach. It is staffed by a "system of care office" that reports to the Deputy County Administrator. **(www.cuyahogatapestry.org)**

Cuyahoga County Planning Process Structure



Questions for System Builders to Consider

1. How is our **planning** process structured?
2. What are the strengths and shortcomings in our current planning structure?
3. How does our planning structure incorporate partnership with families/youth and other systems, and what makes the structure culturally competent?
4. What strategies can we implement to improve our planning process structure?
5. What are the pros and cons of these strategies?
6. *Has our planning process led to consensus on the target population and on a design for the system of care guided by a consensus on values and a practice model?*

FUNCTION Governance

Definition of Governance

Governance—policy level decision making and oversight—should not be confused with system management. These are two distinct functions. *Governance* has to do with policymaking and oversight and is defined as *"decision making at a policy level that has legitimacy, authority and accountability"*. *System management* has to do with *day-to-day operational decision-making*. In some communities, the same entities may be involved in both governance and system management, but in many communities, the players are different—and in either event, these are two separate functions. This is an important distinction to make as some entities may be appropriate for one function but not the other, and if the two functions are confused, the roles of potential stakeholders cannot be clarified. For example, a lead agency may be an appropriate entity to carry out the function of system management, but the agency's management cannot serve as the governance—i.e., policy making—structure for the system of care because system of care governance, by definition, must involve other systems and families and youth. A State-level interagency body can be an appropriate structure for a governance entity, but it cannot serve as a management entity if it lacks the technical and staffing capabilities.

Key Issues for Governing Entities

There are several key issues for governing bodies to address, as described below.

KEY ISSUES FOR GOVERNING ENTITIES
• Has authority to govern • Is clear about what is being governed • Is representative • Has the capacity to govern • Has the credibility to govern • Assumes shared liability among partners for identified populations

The issue of *shared liability* is especially important for systems, such as child welfare, that have legal mandates to serve children. If the system of care governance structure does not assume shared liability to meet these legal responsibilities, system builders are creating a situation of "double jeopardy" for partner agencies that have legal mandates and that have committed resources to the system of care. The principle of unconditional care, which is vital to the integrity of the system of care, begins with the governance body's embracing the concept of shared liability. Without it, governance structures leave themselves "outs" that are inherently suspect to partners with legal mandates and to families tired of having to navigate multiple systems.

Families and youth and culturally diverse constituencies need to be represented on governing bodies. Some governance structures that are particularly effective involve families and youth with at least 51% representation. They also involve families or youth as co-leaders of governance processes. System of care policies are more likely to be embraced by the families and youth who are being served if there is high-level commitment to their representation on policy-making bodies. Some systems of care contract with family organizations to reach out to families and diverse communities to ensure full representation in governance functions. Some governance structures may include key family or youth members who represent larger constituencies, such as the head of the statewide family network, foster family association, organizations of current and former foster youth and other youth forum representatives. A similar strategy can be employed to ensure representation from culturally and linguistically diverse communities, who may be over-represented in child welfare and other public systems, by reaching out to the leaders in those communities to be involved in governance. Individuals representing specific populations on governance structures must have credibility with those populations for the governing body to be sanctioned by the community and garner grass roots support.

Types of Governance Structures

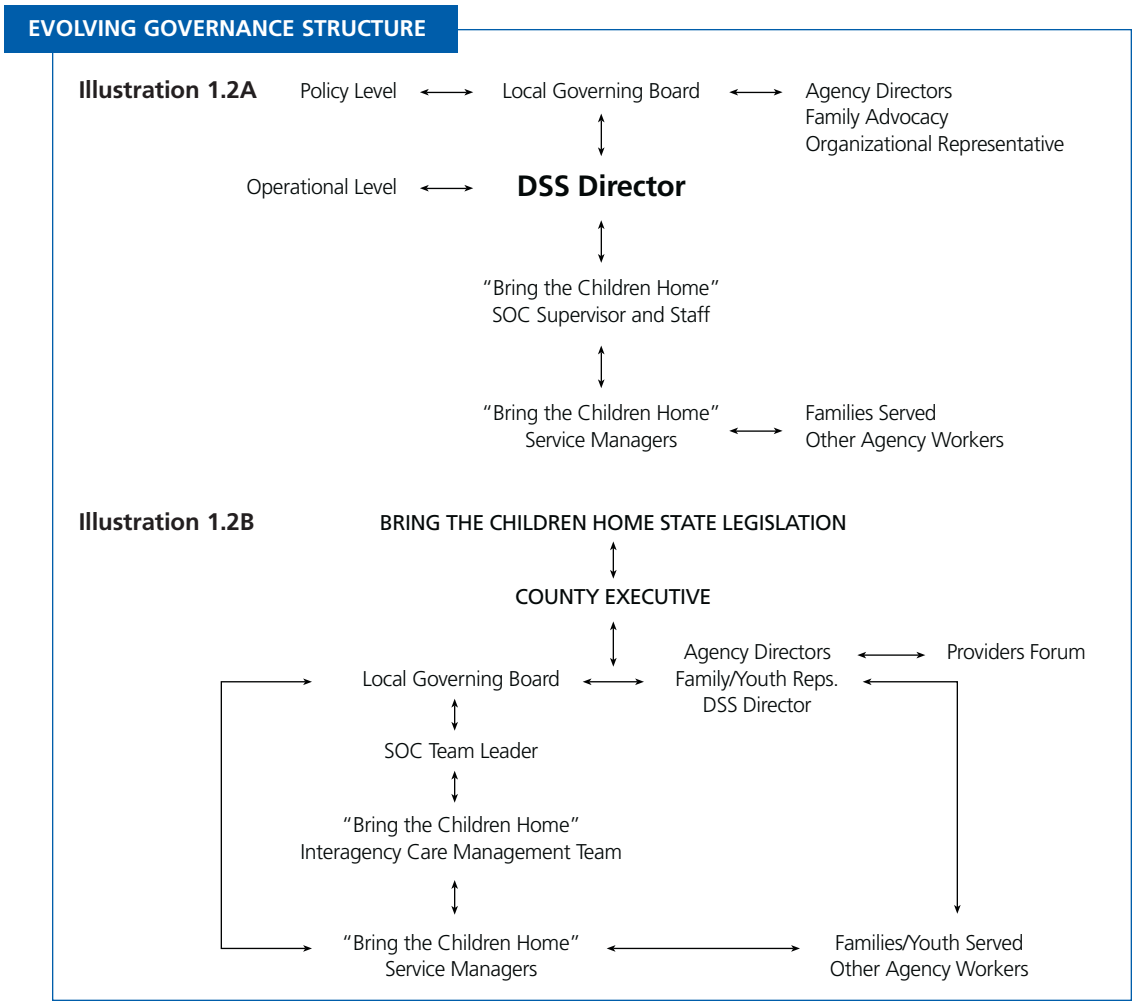
The key issues described above for governing bodies must be settled first before determining the *type* of governance structure. There are several different types of governance structures, such as State/local interagency bodies, quasi-governmental entities, and nonprofit boards. The type of structure and membership on it also is inherently driven by the population focus. For example, if the focus is on the 0-3 population that is in, or at risk for involvement in, child welfare, there may be an existing Early Intervention governance structure in the State or community. It might make more sense to undertake reform efforts under the auspices of this body, with appropriate changes as necessary in its policy focus and membership, rather than to create yet another governance body. Also, the membership of a governance structure focusing on the 0-3 population will look different from one focusing on, say, transition-age youth.

EXAMPLE

In **Cuyahoga County**, the governance structure is the SOC *Oversight Committee*, which has a very broad representation because it is focusing on many different high risk populations of children and families involved, or at risk for involvement, in child welfare. **(www.cuyahogatapestry.org)**

Example of an Evolving Governance Structure

Governance structures typically evolve over time as they wrestle with and resolve the key issues described above, as illustrated by the following example of a county-level governance entity.



Illustrations 1.2A and 1.2B describe the evolving governance structure in a county in which the State enacted legislation requiring counties to reduce the number of children in out-of-home placements. This county lodged its system of care initiative to meet this goal in a lead agency—the child welfare agency (DSS), although it is envisioned as an interagency reform. In Illustration 1.2A, it is not clear from whom the governing body derives its authority. It also is unclear what the governing body oversees since it appears as if DSS actually is in charge. (Indeed, when asked to whom the system of care director reports and who is accountable for expenditures, both the DSS Director and board members responded, "To me/us".) While the board includes representation from a statewide family organization, it does not include representation from families and youth

actually served by the system. Providers seem to have no voice in this structure. The structure seems to suggest that service coordinators "belong to" DSS. There are no feedback loops between the board and staff and families. Those closest to the ground, who often know the most about what is happening—i.e., service coordinators, families and youth—seemed to be most removed from the board. It does not appear as if the board shares liability for outcomes; it would appear as if DSS is solely liable.

Over time, this governing body re-structured, as shown in Illustration 1.2B. The County Executive drew up an Executive Order to give the board its authority and cited the State legislation. The DSS Director's role became the same as that of other board members. The system of care director reports to the board and meets with the board monthly. Families and youth served by the system are represented on the board. The board created a Providers Forum to elicit quarterly input from providers. The board set up feedback loops; service coordinators and families and youth served by the system but not actually serving on the board meet quarterly with the board. The Executive Order and the board's by-laws make it clear that the board is sharing liability for outcomes.

Questions for System Builders to Consider

1. What is the **governance** structure for our system of care?
2. What are its strengths and shortcomings?
3. How does our governance structure incorporate partnership with families/youth, and what makes the structure culturally competent?
4. What strategies can we implement to strengthen the governance structure?
5. What are the pros and cons of these strategies?
6. *Does our governance entity have the authority, capacity and credibility to govern effectively and has it assumed shared liability for the identified population(s)?*

FUNCTION System Management

Key Issues for System Management Structures

System management has to do with *day-to-day operational decision-making*. There are a number of key issues that must be addressed for system management entities, as described below.

KEY ISSUES FOR SYSTEM MANAGEMENT STRUCTURES
• Is the reporting relationship to the governance structure clear? • Are expectations and outcomes to be achieved clear? • Does the system management entity have sufficient technical and staff capacity? • Does the system management entity have credibility with key stakeholders?

Types of System Management Structures

There are many different types of system management structures in systems of care, such as nonprofit lead agencies, for profit managed care organizations, and government entities. There is no one right or wrong type of structure, but system builders need to weigh strategically the pros and cons of different structures to determine what is the best fit for their particular system of care.

EXAMPLE

Sarasota County, Florida provides an example of a coalition management structure, in which multiple child welfare providers joined forces with community organizations, families and youth to create the *Sarasota County Coalition for Families and Children*, which serves as the locus of management accountability under contract to the child welfare system to manage service provision, care management and outcomes for all children in the County needing protective services, foster care and adoption services.
(http://www.dcf.state.fl.us/publications/docs/bpreport/3body1.pdf)

Locus of Management Accountability for Target Population

An important concept in systems of care is the creation of a *locus of management accountability* for the population(s) that are the focus of the system of care. As already discussed under governance, accountability and liability at a policy level need to be shared. However, if system management is spread across many systems, it is unlikely the system will be well managed, even with shared governance. Indeed, that is basically the structure we have had historically, with multiple systems managing different pieces of the system for the same families. A system of care approach seeks to create one locus of service management accountability that is managing as many relevant pieces of the system as is possible and is deliberately coordinating around the pieces that need to remain with any given system. For example, **Wraparound Milwaukee** manages virtually everything related to children in child welfare in or at risk for residential treatment, including placements, behavioral health services, and basic supports for families, like transportation; for the pieces it does not manage directly, including physical health care and treatment services for adult family members, it intentionally seeks to coordinate with those systems.

EXAMPLES

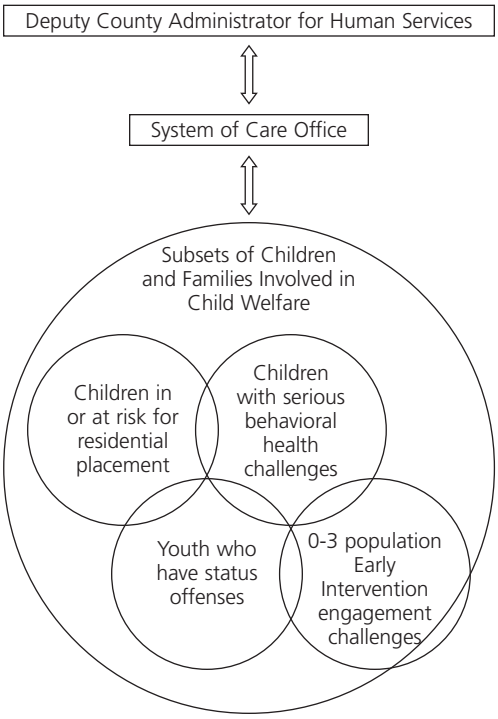
In **Sarasota County, Florida**, the Sarasota County Coalition serves as the locus of management accountability for County children and families who are in or at risk for child welfare involvement. **(http://www.dcf.state.fl.us/publications/docs/bpreport/3body1.pdf)**

In **Milwaukee County, Wisconsin** the Division of Child Mental Health Services serves as the locus of management accountability for subsets of children and families involved in child welfare, including those with serious behavioral health disorders and children in or at risk for residential placement, and it has proposed assuming management responsibility, in partnership with a Health Maintenance Organization, for all behavioral and physical health care for children in child welfare. **(www.milwaukeecounty.org)**

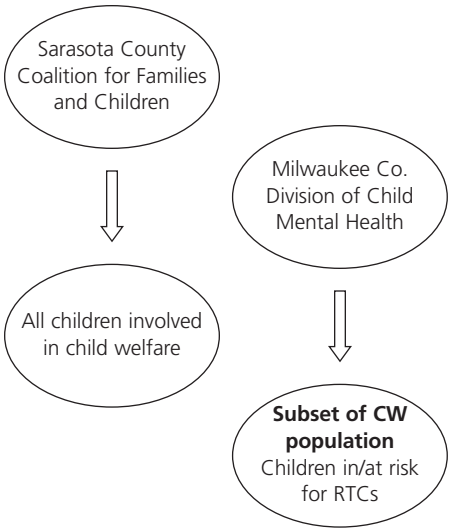
In **Cuyahoga County, Ohio**, the new System of Care Office reporting to the Deputy County Administrator for Human Services will serve as the locus of management accountability for subsets of children and families involved in child welfare, including children in or at risk for residential placement, youth who have status offenses, children with serious behavioral health problems, and a subset of the 0-3 population whose families the Early Intervention Program is having difficulty engaging. **(www.cuyahogatapestry.org)**

Examples of Management Accountability

Cuyahoga County Management Structure



Sarasota Co. and Milwaukee Co. Management Structures

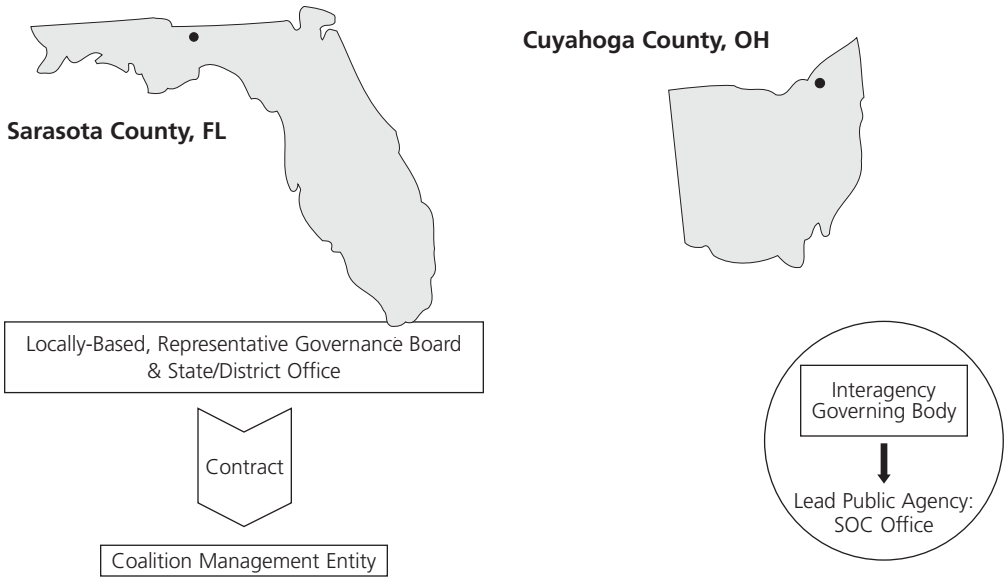


MODULE 5

Relationship Between Governance and System Management Structures

There needs to be a clear relationship between governance and management structures. The following illustrations provide two different examples: one in which system management is purchased via contract with a coalition management entity (Sarasota Co.) and one in which system management is lodged within a lead public agency (Cuyahoga Co.).

EXAMPLES OF RELATIONSHIPS BETWEEN GOVERNANCE AND MANAGEMENT STRUCTURES

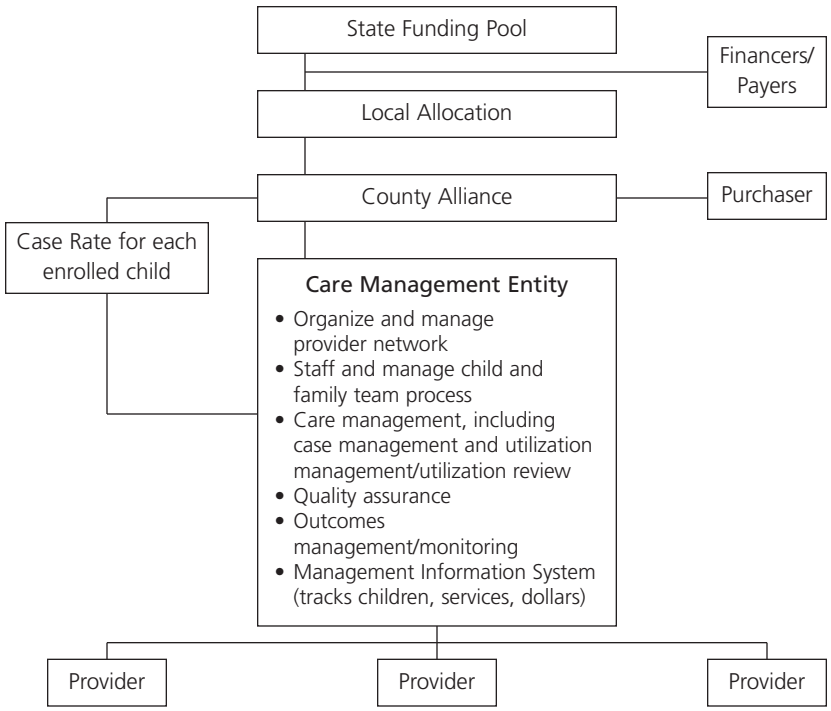


EXAMPLE

Sarasota County has a locally-based, representative governance board and State/district oversight and a coalition system management structure. **Cuyahoga County** has an interagency, cross-stakeholder body as the governing entity and a lead public agency performing system management functions.

The next illustration shows a management structure in which State and local dollars are contracted to a service management entity, such as **Maryland** is planning in order to re-direct dollars from out-of-home placements in residential facilities to home and community-based services and supports and service management.

EXAMPLE OF GOVERNANCE/MANAGEMENT STRUCTURE



There is no one right or wrong governance or system management structure, as long as the structure takes into account the key issues for governance and system management entities. However, there are pros and cons to every structure, which will vary in every State and community. For example, creation of a new nonprofit, 501 (c) 3 entity in the management role may be perceived in some communities as "creation of just another nonprofit that will compete for funds". In other communities, this may be perceived as the optimal route because there is no existing entity—nonprofit, for profit or governmental—that has the capacity or credibility to assume the management role. Similarly, a for-profit company may have the technical capability to be the system manager, but may lack credibility with key stakeholders.

The essential point is that system builders must think strategically about the pros and cons of different governance and management structures. They may not be able to put in place the optimal structures for their particular communities due to political, technical, economic, or other reasons; however, by thinking strategically, system builders can plan for shortcomings, as well as for future optimization strategies.

Involving Families and Youth in System Management

Examples of how system management structures can involve families and youth and diverse constituencies include their providing input/evaluation regarding:

- key management positions
- the quality of services and the overall functioning of the system of care
- resource allocation decisions
- service planning and implementation
- policies and procedures
- grievance and resolution procedures.

Families and youth may be involved in advisory capacities, in management oversight, such as quality improvement (QI) processes, and in management operations, such as reviewing bid proposals and personnel selection.

Culturally Competent System Management Structures

System management structures may become more culturally and linguistically competent through such strategies as:

- implementing policies to hire from racially/ethnically, socio-economically diverse communities
- incorporating quality improvement measures that reflect the issues facing diverse communities
- undertaking concerted outreach to and relationship-building with diverse communities and other "minority populations"
- conducting cultural "self-assessments" to ensure that management operations are culturally competent.

Questions for System Builders to Consider

1. What is our system management structure?
2. What are its strengths and shortcomings?
3. How does the system management structure incorporate partnership with families and youth and what makes the structure culturally competent?
4. What strategies can we implement to strengthen the system management structure?
5. What are the pros and cons of these strategies?
6. *Does our system management structure have the capacity to manage effectively?*

MODULE 6

Outreach and Engagement; Organized Pathways to Services/ Supports; Screening, Assessment, Evaluation, and Service Planning

FUNCTION

Outreach and Engagement

Overview

System builders need to think strategically about the question, "Who is it we are trying to reach?" This question encompasses a number of outreach and engagement issues, including: How are we going to structure outreach activities to the population(s) of focus? How are we going to reach out to culturally diverse communities and partner with these communities and with parents and youth in outreach efforts? How are we going to engage needed system partners? For example, if a targeted concern is overrepresentation of African American children and families involved or at risk for involvement in child welfare, strategies need to be developed to reach out to and engage the African American community itself, as well as those who make decisions about referring children to child welfare. If the population of focus is youth in transition, strategies are needed to reach out to and engage the youth themselves, as well as resources in the community, such as community colleges and housing agencies.

Roles for Families and Youth in Outreach and Engagement

Families and youth are critical partners in helping to develop plans for effective outreach. They are effective spokespersons to share information with other families and youth and advocate for their involvement in system building.

POTENTIAL ROLES FOR FAMILIES & YOUTH IN OUTREACH AND ENGAGEMENT ACTIVITIES

- Family and youth peer helpers can be present and available to families at strategic points in the system, such as child protective services offices, family court, health clinics, etc.
- Families and youth can help build formal and informal environments of trust, such as focus groups, education forums, social events, and support groups
- Family and youth run organizations can be contracted with to provide outreach and engagement and to help systems understand population needs and diverse cultures
- Systems can support families and youth themselves to share information, such as phone trees, chat rooms, etc.
- Systems and families and youth can co-sponsor conferences and design workshops to create bridges of trust between systems and communities

Culturally Competent Community Engagement

Many families and youth, and especially those from diverse cultures, will not comply with mandated service requirements, initiate service involvement, or remain in services if the pathway to services is inaccessible or insensitive to family and cultural issues. Principles of culturally competent community engagement include:

- working with natural, informal supports and helping networks within culturally diverse communities
- the concept of communities determining their own strengths and needs
- partnership in decision-making; meaningful benefit from collaboration
- reciprocal transfer of knowledge and skills among partners.

Examples of Culturally Competent Outreach and Engagement

Following are examples of culturally and linguistically competent outreach and engagement strategies.

EXAMPLES

An example of culturally competent community outreach and engagement strategies is evident at the Everglades Health Center in **Dade County, Florida** and includes: signs in several languages; literacy programs; audio cassettes in multiple languages; and, use of mini soap operas on the radio on critical community issues, such as substance abuse and domestic violence, with follow-up from health care outreach workers. **(www.gucchd.georgetown.edu/nccc)**

Another example of culturally competent community outreach and engagement strategies is evident at the Hmong Resource Center in **St. Paul, Minnesota**. The Center was established to serve as a community resource offering information about the Hmong people and their culture and provides workshops and educational presentations to the Hmong as well as to the wider community. **(www.cssp.org)**

The Abriendo Puertas Family Center in East Little Havana, **Miami, Florida** implemented a number of strategies to engage community members and families and children in need of services and supports. Strategies included: a Family Council; a governing board with 51% resident membership; family members and natural helpers partnering with formal service providers and child welfare workers in a team approach to reaching and serving families; implementation of a barter program (Time Dollar Bank) to track volunteer hours given in exchange for services received; use of a neighborhood-based Family Resource Center as a hub for services and supports and community enrichment activities; and extensive collaboration among providers, including co-locating various services and supports. **(www.abriendopuertas.org)**

Caseworkers' Role in Outreach and Engagement: Home Visits

Front line workers' contacts with families, such as caseworker visits, provide an opportunity for outreach and engagement. During these relationship-building times, caseworkers spend time with the family and observe them in their homes and in other settings, also providing a community framework for children—that of protection and

support—when families are struggling to care for their children. In a report available from the National Conference of State Legislatures (**www.ncsl.org/programs/cyf/caseworkervisits.htm**), it is reported that a fundamental shift in perspective on the part of child welfare workers—from only looking at the family's performance to include reviewing the caseworker and agency's performance—promotes a continuous quality improvement loop and is more effective at engaging families. Such a framework shifts a worker from looking only at the family's performance (e.g., did the parent attend substance abuse services) to examining the system's performance as well (e.g., were services available). These visits may also serve to educate extended family, friends, and neighbors about child welfare.

Oregon's System of Care identified characteristics needed by a caseworker to successfully engage a family. These characteristics include:

- Understands and agrees with the principle of appreciating strengths and the culture of children, youth and their families;
- Understands the concepts of using the child's safety, attachment and other needs to engage a family;
- Appreciates a family's expertise on their child's needs;
- Finds common ground;
- Gives the family the opportunity to tell their story;
- Is empathetic while being honest and straightforward, while communicating unmet safety and attachment issues;
- Is creative and can think beyond traditional services;
- Is comfortable taking risks and working with traditional and non-traditional providers to begin providing different services;
- Is confident and persistent;
- Has a positive and goal oriented philosophy;
- Is solution-based rather than seeing problems as barriers that cannot be overcome.

(**www.oregon.gov/dhs/children/welfare/systemofcare**)

Questions for System Builders to Consider

1. How have we structured **outreach and engagement**?
2. How do we incorporate partnerships with families and youth?
3. How are we engaging ethnically and racially diverse partners and families, youth and natural helpers that may be isolated in rural communities or in inner cities?
4. What strategies can we implement to improve our outreach and engagement strategies?
5. What are the pros and cons of these strategies?

FUNCTION Organized Pathways to Services/Supports

Organizing a Pathway to Services/Supports

No matter how families become involved in child welfare, involuntarily through the courts or voluntarily, they need a manageable way to access services and supports. This is called an *organized pathway to services and supports*. Families under enormous stress, with complex issues going on, are unlikely to meet service requirements or have their service needs met if the pathways to services are confusing or difficult to manage.

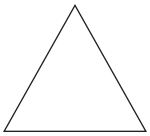
Creating an organized pathway to services and supports for families involved in child welfare and those at risk is an essential component of system building. It is needed to rationalize an otherwise fragmented service system for families. While the court is the pathway for many families into the child welfare system, there still needs to be an organized pathway for families once involved in the system—or at risk for involvement—to access needed services and supports. This is true as well for foster, adoptive, guardian, and kinship families. For example, one family involved in the child welfare system may need multiple services. The parent or caregiver may be required to obtain substance abuse treatment services, the identified child may need both a health and behavioral health screen and linkage to needed services, and other siblings may need some type of support. How accessible these services are and the extent to which they are coordinated (for example, appointments do not conflict) will have a major bearing on whether families meet and take advantage of service requirements.

An organized pathway to services and supports does not necessarily mean there is only one place to go to access services and supports. System builders must make strategic decisions about whether to create multiple entry points or a single access point, and there are pros and cons to each. One entry point may be less confusing and give the system greater control, but it may be inaccessible for some families. Multiple entry points may be more accessible to more families but give the system less control over quality. In either event, a virtual "single" system needs to be created through integrated information management and communication mechanisms.

ORGANIZED PATHWAY TO SERVICES AND SUPPORTS

While the court is the pathway for many families into the child welfare system, there still needs to be an organized pathway for families once involved in the system—or at risk for involvement—to access needed services and supports.

Multiple Entry Points	One Access Point
+more accessible	+less confusing
-loss of entry control	+more entry control
-loss of quality control	-inaccessible
+	-
-	-



Can create virtual single pathway through integrated MIS

MODULE 6

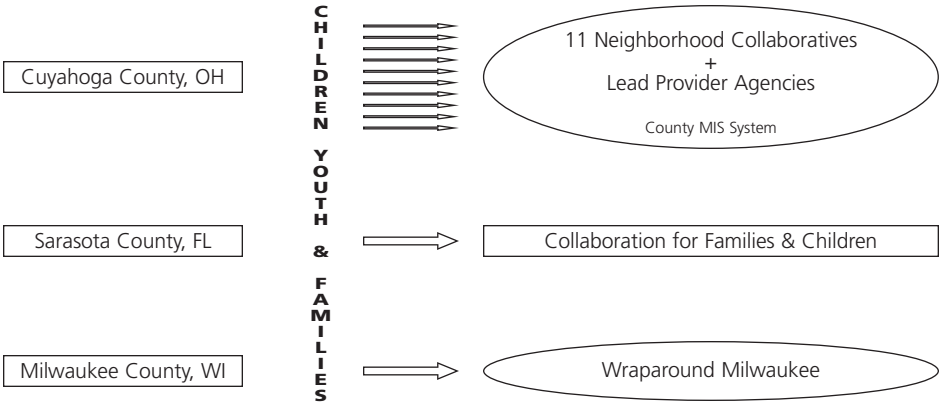
EXAMPLES

In **Cuyahoga County, Ohio** there are 11 Neighborhood Collaboratives, which serve as identifiable pathways to services and supports for families at risk for involvement in child welfare. The County is partnering these Neighborhood Collaboratives with lead provider agencies to extend the pathway to families already involved in the system, indeed in multiple systems, who need intensive services and supports and service management. Through the County's MIS system, system managers will be able to track activity at all entry points, and system managers can ensure that the same family-centered practice model, supported by training and coaching, is utilized at all sites. This is an organized pathway with multiple entry points. **(www.fcfc.cuyahogacounty.us/services.htm)**

In **Milwaukee County, Wisconsin, Wraparound Milwaukee** serves as the single organized pathway to services and supports for all children and families referred by the court for intensive services and supports, who, in the past would have been placed in residential treatment. **(http://www.milwaukeecounty.org/wraparoundmilwaukee7851.htm)**

In **Sarasota County, Florida**, the Collaboration for Families and Children serves as the single organized pathway to services and supports for all children referred by child protective service investigators, including both children and families at risk and in placement. **(http://aspe.hhs.gov/hsp/CW-financing03/ch1.htm)**

Pathways to Services and Supports for Families at Risk for Involvement in Child Welfare



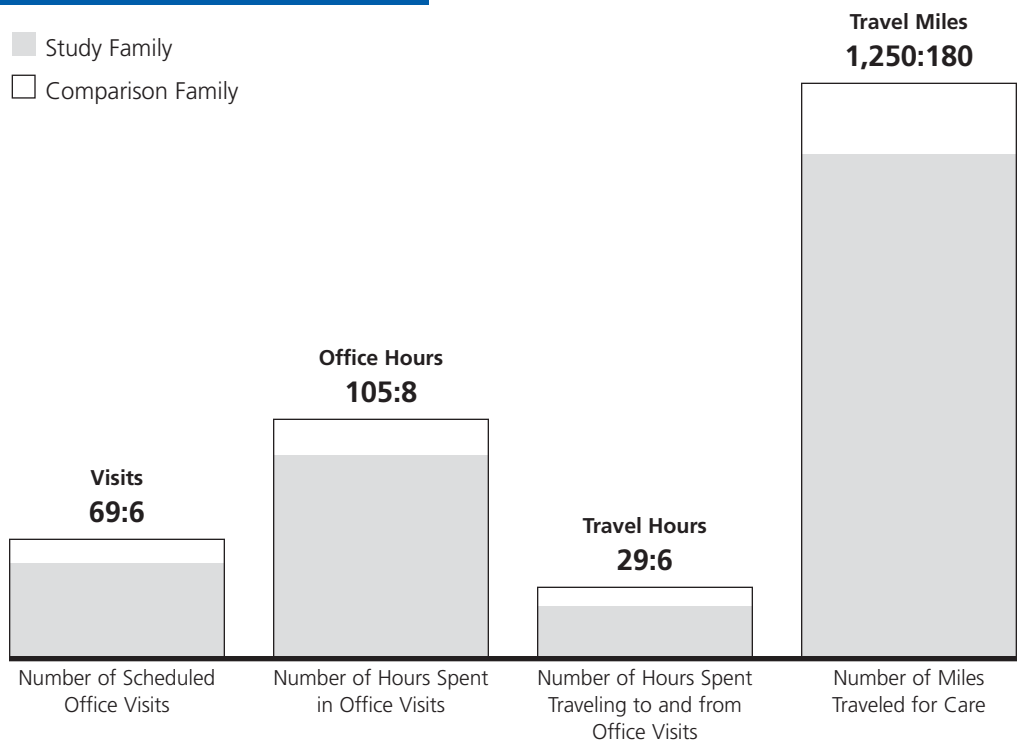
Burden on Families

Navigating traditional pathways to services and supports that are disconnected and fragmented is time-consuming and stressful for families who have complex needs to try to obtain services and supports. In the child welfare system, workers often go to the families, making home visits. However, most families also have to obtain other services and supports, often as part of their service plan or as a court requirement. This might include substance abuse treatment, anger management classes, parenting classes, family therapy, mental health services for their children, etc. The burden placed on families of navigating the system and getting to multiple providers can be exhausting and stressful.

The illustration below shows the results of a study in Florida that examined the amount of time spent by families with a child with serious emotional problems to access

services compared to a family without a child with serious behavioral health needs. At the time of this study, the family (the mother, father, and three children) were living together and not involved with child welfare. However, the mother reported that she feared losing her children to "the system" as she was beginning divorce proceedings and was afraid she would be "living out of her car in the not so far off future." Also, imagine the number of additional hours the family would have spent with a caseworker if the family were involved with child welfare. *Understanding the burden on families of trying to access services and supports when there is no organized pathway, and developing strategies to make the pathway less stressful, is a critical step for system builders.*

TIME AND TRAVEL (TEN MONTH PERIOD)



Lazear, K. (2003). Family Experience of the Mental Health System. Research and Training Center for Children's Mental Health, Tampa, FL.

Family-Centered System Entry

An important part of structuring the pathway to services/supports has to do with how families and youth and culturally diverse constituencies will be received when they enter the system, the types of forms they must complete, whether entry is culturally and linguistically competent, and whether there are partnership roles for families, youth or natural helpers in system access. Some child welfare systems are hiring parent partners to support families when they enter the child welfare system.

EXAMPLE

Maryland is an example of a state that is engaged in a reform initiative spearheaded by the Governor's Office on Children to create "single points of access" in localities for families in need of services and supports that are also embedded in a system of care practice model (i.e., strengths-based, family-centered, individualized, culturally competent, cross-agency). Many of the Maryland counties are developing structures which connect families to family or system navigators. **(www.goc.state.md.us)**

An excellent resource for families encountering the child welfare system is *A Family's Guide to the Child Welfare System*, developed by five national organizations and written in partnership with families. The *Guide* provides a comprehensive introduction to the various aspects of the child welfare system, concrete information and practical tips for families, and stories of real families' experiences. It is an example of a written resource that can be shared with families at system entry to help ease their involvement with the system. (**http://gucchd.georgetown.edu/object_view.html?objectID=2590**)

Questions for System Builders to Consider

1. How have we structured an **organized pathway to services and supports**?
2. What are the strengths and shortcomings in our current structures?
3. How do our pathway(s) to services/supports incorporate partnership with families and youth, and what makes the structures culturally competent?
4. What strategies can we implement to improve our pathway(s) to services and supports?
5. What are the pros and cons of these strategies?

FUNCTIONS Screening, Assessment, Evaluation and Service Planning

Overview

Screening, assessment, evaluation, and service planning are distinct functions, which may be carried out by different entities, but they need to be linked in a continuous process and by a common practice model reflecting system of care values. All of them need to embody the characteristics of being individualized, coordinated across child-serving systems, culturally and linguistically competent, strengths-based and carried out in partnership with families and youth, not "done to them".

Generic Definitions of Screening, Assessment, Evaluation and Service Planning

These functions are defined as follows:

- **Screening:** first step triage, identifies children and families at high risk and links them to appropriate assessments
- **Assessment:** is based on data from multiple sources; is comprehensive; identifies strengths, resources and needs; leads to and informs service planning
- **Evaluation:** is discipline-specific, e.g., a neurological exam; is a closer, more intensive study of a particular or suspected issue; provides data to the assessment process
- **Service planning:** is an individualized, collaborative decision making process for determining services and supports, placements, timeframes and goals. It draws upon screening, assessment and evaluation data and utilizes a child and family team approach (e.g., wraparound, family group decision making)

Screening, Assessment, Evaluation and Service Planning in a Child Welfare Context

Screening and assessment in child welfare typically begins with a safety and risk assessment before it moves to a more comprehensive assessment and service planning process. Timing is often an issue in that assessments may have to be done quickly to ensure a child's safety. When a child welfare system uses a system of care approach, safety and risk assessments are informed by family-centered values (strengths-based, culturally competent, etc.) and must lead to comprehensive family assessments.

SCREENING AND ASSESSMENT IN CHILD WELFARE

Question #1: Does the family need child welfare services?
Screen #1: *Does preliminary information suggest that a child has a been a victim of, or is at risk for, child abuse and/or neglect?*

Assessment and Plan #1: *Safety/Strengths, Is the child at imminent risk of harm and if so what needs to be in place to ensure safety (e.g., services, placement).*

Assessment and Plan #2: *Risk assessment/strengths assessment—identifies concerns about future risk and family's strengths to mitigate these.*

Question #2: What/which services would help the family?
Assessment: *Based on data from multiple sources; Comprehensive; Identify strengths, resources, needs; Leads to services/supports planning.*

A comprehensive family assessment is usually undertaken when it is determined that the child welfare agency is responsible for serving the family. In the first round of the CFSRs, no State was found that had a successful child welfare comprehensive family assessment. Assessments tended to be superficial, did not successfully identify the underlying causes that were bringing the child and family into the child welfare system and, hence, did not lead to an effective service plan. The Federal Children's Bureau commissioned the development of *Guidelines for Comprehensive Family Assessments*, which was disseminated to all States. The Guidelines can be found at the National Resource Center for Family-Centered Practice and Permanency Planning at **www.nrcfcppp.org**. The Children's Bureau report stated that a "*comprehensive family assessment…begins with the first contact with a family and continues until the case is closed; must be completed in partnership with families and in collaboration with other community partners; is a process, not the completion of a tool. Simply completing a form will not capture all that is needed for comprehensive assessment.*"

It is also important that immediately after entering the system, children be assessed for the existence of trauma-related symptoms and specific interventions that would be most beneficial. A number of systems, such as **Maine's** child welfare system, are introducing the concept of *trauma-informed practice* into their systems of care. (www.thriveinitiative.org)

Child Welfare Case Worker's Role in Assessment and Service Planning

The Child and Family Services Reviews highlight the important role that case workers play in assessment and service planning and the impact of their role in influencing whether children are protected, families receive the supports they need, and whether families are engaged to play a role in planning for their futures.

IMPORTANCE OF CASEWORKER'S ROLE IN ASSESSMENT AND SERVICE PLANNING: CFSR FINDINGS—HOME VISITS

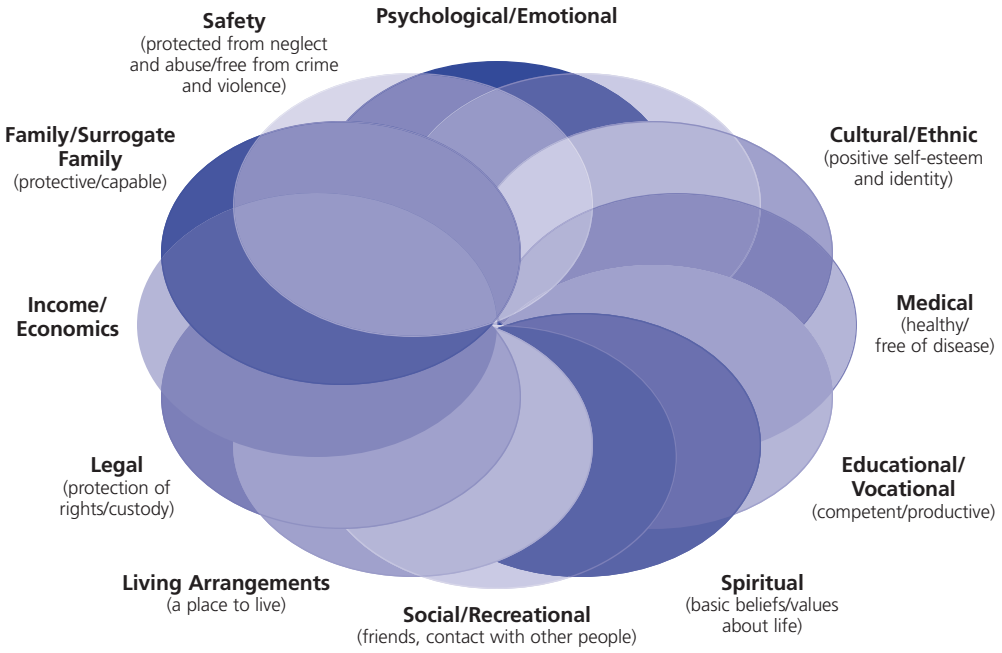
- When state child welfare agencies do well on the caseworker visits, they are…
  - Better positioned to assess children's risk of harm and need for alternative permanency options
  - Better able to identify and provide needed services
  - Better able to engage children and parents in planning for their future.
- Concerns include…
  - Insufficient face-to-face contacts with children or parents to address their safety and well-being
  - An inconsistent focus on issues regarding case plans and goals during visits.

Child and Family Services Review (2001-2004).

Comprehensive, Strengths-Based Principles

System of care principles require that assessment and service planning be comprehensive and strengths-based, looking across "life domains." These domains include: psychological/emotional; safety (protected from neglect and abuse; free from crime and violence); family/surrogate family (protective and capable); income/economics; legal (protection of rights; custody); spiritual (basic beliefs and values about life); living arrangements (a place to live); social/recreational (friends; positive contact with other people); medical (healthy and free of disease); educational/vocational (competent/productive); and, cultural/ethnic (positive self-esteem and identity).

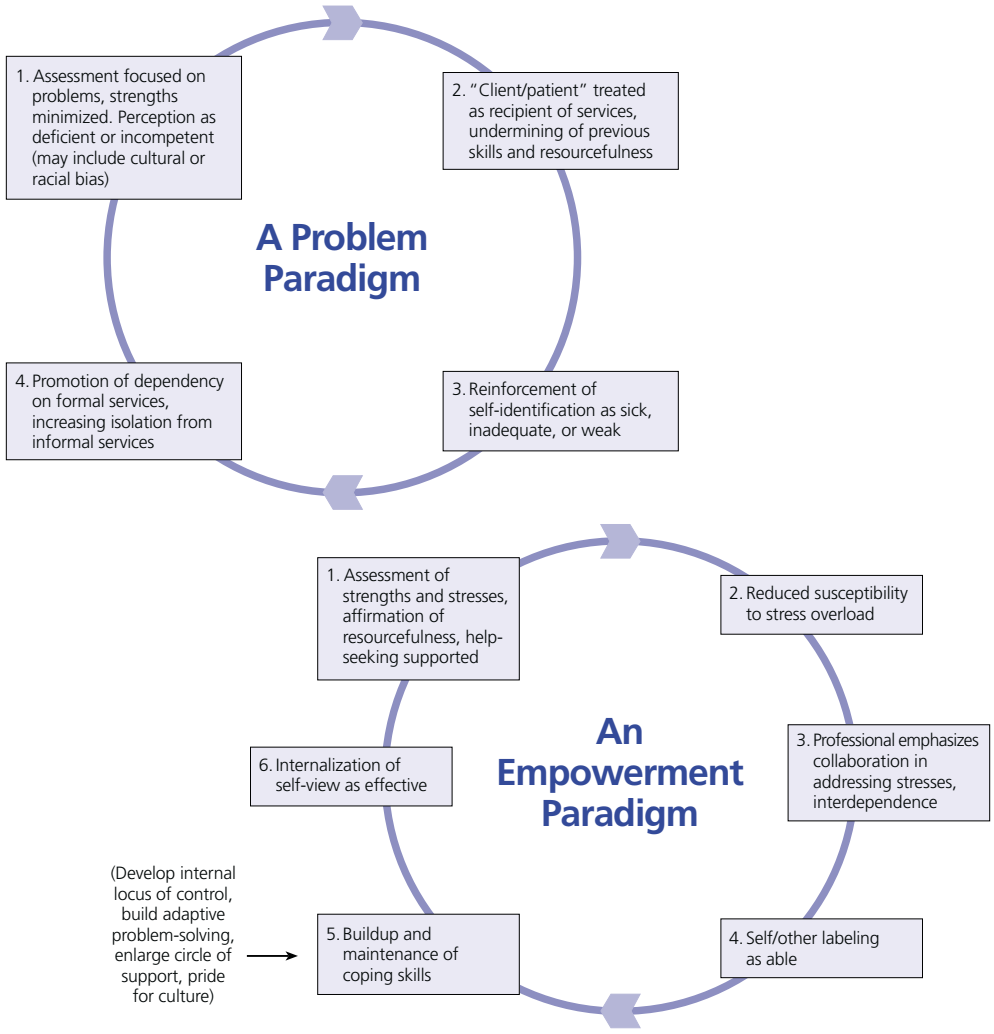
LIFE DOMAINS



Adapted from Dennis, K., VanDenBerg, J., & Burchard, J. (1990). *Life domain areas*. Chicago: Kaleidoscope.

System of care principles also require moving away from a "problem paradigm to an empowerment paradigm" approach in screening, assessment and evaluation processes. The Child and Family Services Reviews also stress the importance of building resiliency in families.

PROBLEM ORIENTED TO STRENGTHS-BASED APPROACH



Models developed by Ted Bowman, Associate Director, Community Care Resources, A Program of the Wilder Foundation, St. Paul, MN. In *Guide to developing neighborhood family centers.* (1993).Cleveland, OH: Federation for Community Planning.

EXAMPLE

Mississippi Division of Children and Family Services provides a Family Centered Strengths and Risk Assessment Guidebook to guide caseworkers in their initial assessment conversation with families, youth and children in ways that focus on family strengths and successes and seek to employ principles of family-centered practice in planning services and supports from the entire system of care that can help parents improve their ability to care for their children. **(www.hunter.cuny.edu/socwork/nrcfcpp/info_services/assessment)**

Comprehensive, Strengths-Based Approaches in Child Welfare

Both a wraparound approach to service planning and various types of family group conferencing or team-decision making approaches are used in child welfare and other systems serving children, youth and families. From a values standpoint, they are very similar. Burns and Hoagwood describe *Wraparound* as *"…a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes."* The National Child Welfare Resource Center for Family-Centered Practice describes *Family Group Decision Making* as *"…a non-adversarial process in which families, in partnership with child welfare and other community resources, develop plans and make decisions to address issues of safety, permanence and well-being…Reflecting the principles of family-centered practice, FGDM is strengths-oriented, culturally adapted, and community-based."* Individual states and communities may have their own definitions as well. The point is that there is commonality in the values base that informs these practices and, therefore, opportunity to coordinate across systems on a common practice approach.

Essential Elements of Wraparound, Family Group Conferencing and Related Approaches

The **Arizona** Department of Health Services conducted an analysis of similarities among various individualized, strengths-based, culturally competent service planning approaches, including family group decision making, wraparound, and person-centered planning, and concluded that they were "not that different". (See: Rider, F. 2005, A Comparison of Six Practice Models, AZ Department of Health Services, **www.azdhs.gov/bhs**)

ESSENTIAL ELEMENTS OF WRAPAROUND, FAMILY GROUP CONFERENCING AND RELATED APPROACHES

- Family and youth voice and choice
- Team-driven (i.e., not single agency or single provider driven)
- Community-based
- Individualized
- Strengths-based and focused across life domains
- Culturally competent
- Flexible approaches, flexible funding
- Informal family and community supports
- Unconditional commitment (or persistence)
- Interagency, community-based collaboration
- Outcome-based

Goldman, S. & Faw, L. (1991). *Three wraparound models as promising approaches*. In B.J. Burns & S.K. Goldman (Eds.). *Promising practices in wraparound for children with severe emotional disturbance and their families. Systems of care: Promising practices in children's mental health* (1998 series). 4. Washington, D.C.: American Institutes for Research and the National Wraparound Initiative (2005).

Examples of Wraparound Approaches in Child Welfare

A number of states and counties are utilizing a wraparound approach to service planning for children and families involved in or at risk for involvement in child welfare, such as Milwaukee Wraparound, Cuyahoga County, the Dawn Project, the Sacred Child Project in South Dakota and a number of states, such as Alabama, Nevada, North Dakota, and Kansas.

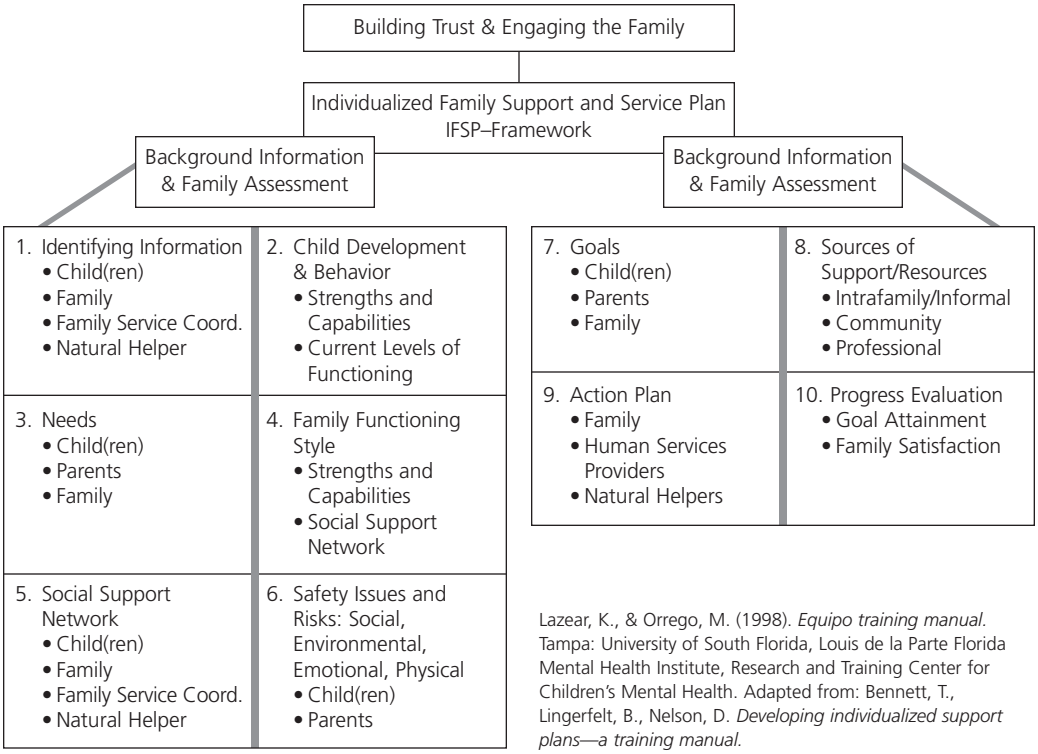
EXAMPLE

Kansas is an example of a state child welfare system that is using both family group decision making and wraparound in its system of care. Wraparound is conceptualized in Kansas as being tied to intensive service management and utilized for children and families with the most intensive service needs, while family meetings are used throughout the child welfare system for all families coming into contact with the system. A family may experience both family group conferencing and wraparound in the Kansas system, depending on the family's strengths and needs. Both come under what Kansas calls "family-centered practice within a family-centered system of care". **(www.srskansas.org/CFS/FCSOC/whatissoc.htm)**

An Individualized Approach to Services/Supports Planning

The following is an illustration of one individualized approach to service/supports planning. This graphic points out the importance of both safety and crisis plans and trust and relationship building within comprehensive service plans.

EXAMPLE OF DEVELOPING A COMPREHENSIVE PLAN IFSP FRAMEWORK



Lazear, K., & Orrego, M. (1998). *Equipo training manual.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Adapted from: Bennett, T., Lingerfelt, B., Nelson, D. *Developing individualized support plans—a training manual.*

MODULE 6

Characteristics of a Well-Documented Services/Supports Plan

Components of an individualized services and supports plan include:

- Strengths and culture discovery
- Crisis/safety plan
- Vision (family's, youth's, system partners')
- Family narrative
- Needs statement
- Strategies (who, what, when, how) based on strengths (including transition out of formal services
- Tells the family and youth story in a way you would want your own story told
- Is written from a strengths perspective
- Uses family- and youth-friendly language
- Reflects what was actually said in the service planning meeting
- Is specific and concise
- Addresses mandates while staying family-focused

(Adapted from Meyers, MJ. Wraparound Milwaukee, Milwaukee County Behavioral Health Division, Child and Adolescent Services Branch)

The Team Approach

Family-centered practice requires a team approach, both with families and other system partners. Being part of a team means:

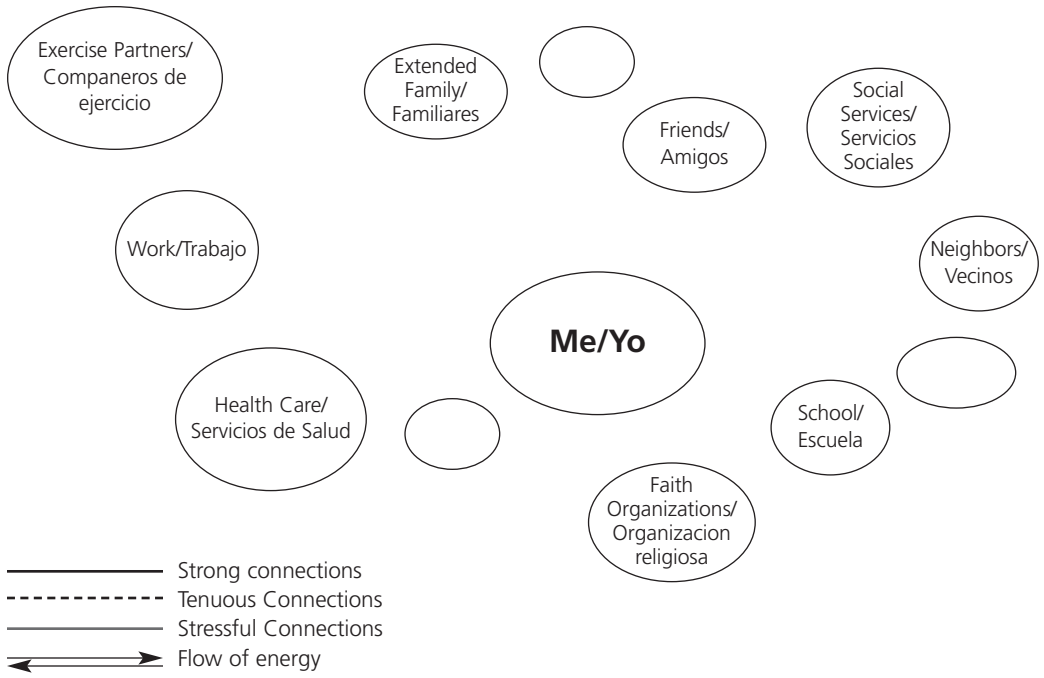
- appreciating strengths and cultures of families
- being creative and thinking beyond traditional services
- listening
- being honest and empathetic
- being comfortable taking risks and working with traditional and non-traditional providers
- being confident and persistent
- having a positive and goal-oriented philosophy
- finding solutions, rather than seeing problems as barriers that cannot be overcome.

It also means working with families to create choice and explore possibilities and not simply tell families what to do. Working in a team requires training, coaching and practice. The diverse perspectives brought to the team by the different formal and informal service and support providers can lead to holistic, comprehensive and family-driven service and support plans. It is important to clearly acknowledge the roles and expectations of each team member, as illustrated in **Oregon's** *Manual for System of Care* from which this material is drawn.

Family Partnerships and Cultural Competence in Screening, Assessment, Evaluation and Service Planning

Screening, assessment, evaluation and service planning functions are among the most critical for partnering with families and youth as resources and for cultural proficiency. There are many examples of structures that incorporate family partnerships in screening, assessment and service planning. For example, families may be involved, often on a paid basis, in providing peer support to families involved in service planning processes. Parents and youth may play a role in the screening process as system "navigators" and to help put families at ease. Some screening and assessment processes link families to family organizations for peer support. Family and youth representatives on screening teams bring a unique perspective. Often, systems of care report higher levels of family engagement and satisfaction when a family peer support worker is available to families through the initial screening, assessment, and service planning processes, and when families can connect through these processes to a larger family organization. Often, family members hired by systems of care, by working inside the system, can help to change the overall culture of the system.

ECO-MAPPING



Orrego, M. E., & Lazear, K. J. EQUIPO: University of South Florida, Tampa, FL. Adapted from Markiewicz, J. Eco-Map.

MODULE 6

Screening, assessing, evaluating, and individualized service planning require a comprehensive base of information regarding cultural background and history. Those who conduct screening, assessment, evaluation, and service planning functions play critical roles in ensuring a culturally sensitive system. They need to be self-reflective and sensitive to their own cultural norms and practices and how these may influence their cultural competence as screeners, assessors, evaluators, and service planners. Service planners may choose to develop an eco-map as a tool to assist with the screening, assessment, evaluation and service planning processes. The eco-map supports a systems approach, family centered practice, and development of a culturally appropriate and reflective service plan. In the eco-map diagram above, for example, the strength of the connections between the family and others are entered as service planners work with family members on the eco-map.

Accurate and Accessible Information for Families

A Family's Guide to the Child Welfare System is an example of accurate and accessible information focused on the issues families care about most. The *Guide* was developed through a representative workgroup, which included: birth, foster, and adoptive parents; child welfare administrators and direct service workers; providers; lawyers; national organizations; mental health workers; national child welfare clearinghouses; federal agencies; researchers; and advocates from across the country. The *Guide*, designed to follow a family's path through the child welfare system from first contact, can be a valuable resource for outreach and engagement activities with the community and other stakeholders and system partners. (Available at: (**http://gucchd.georgetown.edu/object_view.html?objectID=2590**)

When a Parent Has a Mental Illness

Providing family-centered care is essential when addressing the needs of families in which a parent has a serious mental illness. This is a population that is particularly vulnerable to losing custody of their children. As a result of possible loss of custody and issues related to stigma, some parents may not seek needed services and supports, thus diminishing their ability to parent effectively. (For more information on this issue, see: **www.nmha.org**; also, "Caregiver Depression, Mental Health Service Use and Child Outcomes", Burns, B., Mustillo, S., Farmer, E., McCrae, J., Kolko, D., Libby, A., Webb, M.B. 2007.)

The Center for Mental Health Services Research at the University of Massachusetts Medical School, in partnership with consumers, published a report identifying critical issues for parents with serious mental illness. These issues include:

- Recognize the strengths of parents;
- Identify the specific service needs of parents;
- Battle the stigma of mental illness;
- Attend to custody and visitation issues;
- Attend to termination of parental rights issues;
- Attend to the legal issues of parents;

- Provide supports for children of parents with mental illness;
- Educate professionals to the needs of parents;
- Identify/provide peer support for parents;
- Coordinate services for parents;
- Provide family-centered care;
- Multiple systems must work together.

(Adapted from Nicholson, J., Biebel, K., Hinden, B., Henry, A., and Stier, L. (2001). *Critical issues for parents with mental illness and their families*. Department of Psychiatry, University of Massachusetts Medical School, and *Strengthening Family Fact Sheet*, National Mental Health Association (now Mental Health America, Alexandria, VA)

Families with Repeat Involvement with Child Welfare Systems

Some families may have repeat involvement with child welfare agencies, cycling in and out. There may be many reasons for these "recurrences." It may have to do with family structure such as unemployment. Child characteristics suggest that younger children, children with a disability or serious behavior problems, and European American children, as compared to African American children, are more likely to experience repeat reports of maltreatment (see Drake, Johnson-Reid, Way & Chung, 2003). Social and economic context, such as pronounced and persistent poverty, also may play a role. Families who frequently encounter the child welfare system are also likely to have problems with substance abuse, domestic violence, and mental illness. The Center for Community Partnerships in Child Welfare of the Center for the Study of Social Policy has identified steps to respond more effectively to the issue of repeated involvement. These steps include:

- Develop a better understanding of the phenomenon;
- Make needed change in management, staffing, and training in the child welfare agency and in the court;
- Assess and enhance the services and supports needed to address families holistically, recognizing and responding to the multiplicity and complexity of family needs;
- Listen to the voices of families and youth;
- Heighten attention to the impact of trauma on children and youth to meet children's physical, cognitive, emotional, social, and behavioral needs;
- Build stronger community responses;
- Use local, county, and state resources more cohesively and effectively.

EXAMPLE

Pennsylvania's Allegheny County Department of Human Services is an example of a system that redesigned its human services as a cross-systems approach to meet families' needs holistically, particularly families with repeat involvement. Recognizing that at any given time, nearly 70% of individuals served by the Department receive services from more than one program office, teams were created to look comprehensively at the whole family and emphasize prevention and in home, community-based services. **(www..county.allegheny.pa.us/dhs.CSYST/index.htm)**

Use of Common Screening and Assessment Tools

Some systems of care utilize common screening and assessment tools, or service decision-making tools, to support a common practice approach. For example, **New Jersey** is training workers, providers and family members across systems in the use of the Child and Adolescent Needs and Strengths (CANS) tools for use by those engaged in screening and triage, such as their mobile response and stabilization teams, and service planning, such as their care management organizations. If the tools used are strengths-based and support communication and decision-making across stakeholder groups, as the CANS does, they can be helpful in supporting a consistent practice approach, such as wraparound or team decision making, document service planning decisions for judges and others, and allow a state or county to collect state or county wide service outcome data. However, if the tools are deficit-based or used rigidly by service planners, they can frustrate an individualized approach to care. (For more information about the CANS, see: www.buddinpraedfoundation.org)

Role of CASA Volunteers, Guardians Ad Litem and Judges in Service Decision Making

One of the problems for child welfare systems is that assessment and service planning often "takes on a life of its own", driven by court decisions, often informed by child advocates, such as guardians *ad litem* and court appointed special advocates (CASAs), who, while well-intentioned, may not be intimately involved in understanding or promoting a reformed practice model. Judges also often make their decisions based on assessments conducted by independent clinical consultants, who also may not be trained in or committed to a reformed practice model. Recent research conducted by Washington University in St. Louis on how child welfare consumers reach mental health services, for example, found that the system is driven by judges, guardians *ad litem*, CASAs, and assessments performed by outside clinical consultants. They found that what is not driving the system are: child welfare professionals, families' needs, and evidence of what works in child welfare. They also found, as a result, that "treatment for child welfare consumers lacks individualized plans or services." Interestingly, another recent study, conducted by Caliber Associates, found that investigations by CASA volunteers were associated with higher rates of removal from parents, less kinship care and less reunification with parents. These findings point to the critical importance of system builders' involving CASA volunteers, guardians *ad litem*, and independent clinical consultants in change processes. (See: Washington University Center for Mental Health Services Research Grant. 2005, and Caliber Associates. 2004).

Role of Supervision and Coaching

Supervisors play an active role as practice change agents, and thus must be provided opportunities and be required to participate in workshops/trainings, etc. that reflect new approaches and/or philosophies. Supervisors are the link between administration and frontline staff. They can use their knowledge and understanding of agency data to

provide frontline practice change supervision and proactively direct the achievement of outcomes. Supervisors also play a critical role in selecting the best candidates, e.g., those skilled in system of care practices, for agency vacancies.

SUPERVISING STRENGTHS/NEEDS BASED PRACTICE

- Experienced supervisors comment that supervising strengths/need based practice requires a different, disciplined approach to coaching workers.
- The goal is deepening the worker's empathy for the child, youth, family and foster family.
- It takes time to reflect with workers on their cases and coach them on engaging families more effectively.
- Appreciate workers' strengths at developing collaborative relationships with families.
- Help workers have the patience to help families over time to get a better understanding of their child's needs and to see how they can build on their strengths.
- Encourage workers to help families design interventions that are most likely to meet needs, rather than being limited to programs that already exist.

Adapted from Englander, B. *Oregon Manual for System of Care*.

How systems of care structure screening, assessment, evaluation and service planning functions will vary, and there are no "correct" structures, as long as the structures support the principles and goals of systems of care. The challenge for system builders is to think strategically about the pros and cons of various structures and which will best help them achieve their goals.

Questions for System Builders to Consider

1. How have we structured **screening, assessment, and service planning functions**?
2. What are the strengths and shortcomings of our current structures?
3. How do our structures for screening, assessment, evaluation, and service planning incorporate partnership with families and youth, and what makes the structures culturally competent?
4. What strategies can we implement to strengthen the screening, assessment, evaluation, and service planning structure(s)?
5. What are the pros and cons of these strategies?

MODULE 7 Service Array and Financing

FUNCTION Service Array

Overview

System builders need to determine the types of services and supports that will be available, taking into account system of care principles, such as the importance of a broad, flexible array of services and supports and inclusion of both natural supports and formal services. The array needs to encompass services and supports for parents as well as children and youth. Analysis and mapping of the services and supports available and needed is, by necessity, a collaborative process across agencies and community stakeholders because no one system controls all of the resources needed. Medicaid, for example, is a key entity in covering health and behavioral health services for children and families involved, or at risk for involvement, in child welfare and needs to be at the table. Medicaid officials may refer to "benefit design", rather than services/supports array. "Benefit design" is a term borrowed from insurance practice and managed care and pertains to the types of services and supports that are allowable within systems of care and under which conditions.

Importance of Medicaid and Managed Care for Child Welfare

Medicaid is the primary source for health and behavioral health care for children in child welfare. It is imperative that Medicaid be a collaborative partner in system building efforts. As Medicaid dollars (and, increasingly, child welfare treatment dollars) have moved into Medicaid managed care arrangements, child welfare stakeholders and their system building partners also must become very familiar with the Medicaid managed care systems in their states and communities.

STATE COVERAGE OF CHILD WELFARE POPULATION IN MEDICAID MANAGED CARE

26 states include the child welfare population in Medicaid managed care—

- 22 with mandatory enrollment
- 4 with voluntary enrollment

Source: Health Care Reform Tracking Project 2003 State Survey.

Over half the states include the child welfare population in their Medicaid managed care arrangements. Child welfare stakeholders need to ensure that Medicaid benefit designs and managed care arrangements take into account the unique needs of children and families involved in child welfare and that managed care organizations are partners in system building efforts.

CHILDREN IN CHILD WELFARE IN MEDICAID MANAGED CARE

53%-72% of foster care population is enrolled in Medicaid managed care—

HMO Enrollment:		245,313
BHO Enrollment:	+	174,584
Total Enrollment:		419,897

Source: CMS/MSIS State Summary Data, FY 2003.

Partnerships with State Medicaid agencies and Medicaid managed care organizations are critical. Partnerships may be needed both with managed care organizations managing physical and oral health care, as well as with behavioral health organizations managing behavioral health care, depending on the state or community. Understanding how Medicaid managed care is organized in one's state and community is part of the strategic scan that system builders need to conduct.

Array of Services and Supports—NRCOI Framework

The National Child Welfare Resource Center for Organizational Improvement (NRCOI) has developed a collaborative, strategic, population-focused process, guided by a set of tools, to help system builders specifically assess and enhance the array of services and supports needed in a system of care for children and families involved or at risk for involvement in child welfare. It creates a systematic process for system builders, provides a set of tools, and is nested within the Child and Family Services Review's seven outcome areas.

The NRCOI framework can be used for several purposes, including:

- to create a services directory
- to prepare for CFSR and the Statewide Assessment, and to develop areas of the PIP related to the service array
- to meet CAPTA requirements to conduct an annual inventory of services
- to help define the services and supports needed for the system of care when the target populations have been defined
- to identify gaps and strategies to improve the service array
- to support better collaboration among providers and with community collaboratives.

More information about the NRCOI process is available at **http://muskie.usm.maine.edu/helpkids/servicearray.htm**. The NRCOI provides training and technical assistance in the process of using these tools and is available to work with agencies to customize and adapt the tools to their own individual situations.

EXAMPLES

Several states and localities are using the **NRCOI** framework and set of tools, with **Nebraska** having already applied it in a 14-county area and **Pulaski County, Virginia**, using it to assess service array issues and strategies for a rural community. **(See: www.nrcoi.org)**

Example of a Broad Array of Services and Supports in a System of Care

The **Dawn Project** in **Marion County, Indiana**, utilizes a very broad array of services and supports. The system of care operates with a locus of management accountability for children in or at risk for involvement in child welfare, among others, who have serious behavioral health problems and their families. This service array spans a broad, flexible array of both formal services and informal supports and is made possible through collaborative funding across major systems serving children, youth and families. Note that the array covers services and supports both to children and families, including basic supports like transportation, food, and help with utility bills, as well as formal services to parents, such as parent skills training, as well as services and supports to children. **(www.choicesteam.org)**

Dawn Services and Supports

Behavioral Health
- Behavior management
- Crisis intervention
- Day Treatment
- Evaluation
- Family assessment
- Family preservation
- Family therapy
- Individual therapy
- Parenting/family skills training
- Substance abuse therapy, individual and group
- Special therapy

Placement
- Acute hospitalization
- Foster care
- Therapeutic foster care
- Group home care
- Relative placement
- Residential treatment
- Shelter care
- Crisis residential
- Supported independent living

Psychiatric
- Assessment
- Medication follow-up/psychiatric review
- Nursing services

Mentor
- Community case management/case aide
- Clinical mentor
- Educational mentor
- Life coach/independent living skills mentor
- Parent and family mentor
- Recreational/social mentor
- Supported work environment
- Tutor
- Community supervision

Respite
- Crisis respite
- Planned respite
- Residential respite

Service Coordination
- Case management
- Service coordination
- Intensive case management

Other
- Camp
- Team meeting
- Consultation with other professionals
- Guardian ad litem
- Transportation
- Interpretive services

Discretionary
- Activities
- Automobile repair
- Childcare/supervision
- Clothing
- Educational expenses
- Furnishings/appliances
- Housing (rent, security deposits)
- Medical
- Monitoring equipment
- Paid roommate
- Supplies/groceries
- Utilities
- Incentive money

Evidence-Based and Effective Practices

Children's services—in child welfare, mental health and substance abuse, juvenile justice, education, early intervention and other arenas—have benefited in the past decade from a growing research base, including research on *evidence-based practices*, that is, practices that show evidence of effectiveness through carefully controlled, randomized clinical trials. The field also is benefiting from a growing literature about promising

approaches, which have not yet had the benefit of scientific research but which, experientially, are demonstrating effective outcomes. This is sometimes referred to as *practice-based evidence*. The National Association of Public Child Welfare Administrators (NAPCWA) published a *Guide for Child Welfare Administrators on Evidence-Based Practice*, which discusses both evidence-based and promising practices and includes a list of other relevant websites on this topic. The NAPCWA Guide can be found at: www. aphsa.org.

Examples of Evidence-Based Practices for Families and Children Involved in Child Welfare

The California Evidence-Based Clearinghouse (**www.cachildwelfareclearinghouse.org**) has identified numerous examples of evidence-based practices related to CFSR outcomes. They include:

- **Programs Addressing Safety**
  - Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)
  - AMEND, Inc. (Abusive Men Exploring New Directions)
  - Child Parent Psychotherapy for Family Violence (CPP-FV)—Domestic Violence Rated
  - Child Parent Psychotherapy for Family Violence (CPP-FV)—Trauma Treatment Rated
  - Domestic Abuse Intervention Project (DAIP)
  - Intensive Reunification Program (IRP) Motivational Interviewing (MI)
  - Nurturing Parenting Programs
  - Nurturing Program for Families in Substance Abuse Treatment and Recovery
  - Parent-Child Interaction Therapy (PCIT)
  - Project Connect
  - Project SafeCare
  - Project SUPPORT
  - Self-Motivation Group (SM Group)
  - Shared Family Care (SFC)
  - Supported Housing Program (SHP)
  - The Community Advocacy Project
  - Triple P—Positive Parenting Program

- **Programs Addressing Permanency**
  - HOMEBUILDERS
  - Intensive Reunification Program (IRP)
  - Project CONNECT
  - Shared Family Care (SFC)

- **Programs Addressing Well-Being**
  - 1-2-3 Magic: Effective Discipline for Children 2-12
  - Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)
  - Alcoholics Anonymous (A.A.)

- AMEND, Inc. (Abusive Men Exploring New Directions)
- Child Parent Psychotherapy for Family Violence (CPP-FV)—Domestic Violence Rated
- Child Parent Psychotherapy for Family Violence (CPP-FV)—Trauma Treatment Rated
- Community Reinforcement + Vouchers Approach (CRA + Vouchers)
- Community Reinforcement Approach
- Domestic Abuse Intervention Project (DAIP)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Intensive Reunification Program (IRP)Motivational Interviewing (MI)
- Nurturing Parenting Programs
- Nurturing Program for Families in Substance Abuse Treatment and Recovery
- Parent-Child Interaction Therapy (PCIT)
- Parenting Wisely
- Project CONNECT
- Project SUPPORT
- Self-Motivation Group (SM Group)
- Shared Family Care (SFC)
- STEP: Systematic Training for Effective Parenting
- Supported Housing Program (SHP)
- The Community Advocacy Project
- The Incredible Years
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Triple P—Positive Parenting Program

In addition to evidence-based practices identified by the California Evidence-Based Clearinghouse, other examples of evidence-based practices that have had the benefit of research dollars include those for children involved, or at risk for involvement, in the child welfare system exposed to trauma. These services were identified by the National Child Traumatic Stress Network and included in a report issued by the Kauffman Foundation **www.kauffmanfoundation.org**:

- Trauma-Focused Cognitive Behavioral Therapy
- Abuse-Focused Cognitive Behavioral Therapy
- Parent-Child Interaction Therapy.

Others have been identified through the federal Substance Abuse and Mental Health Services Administration (**www.samhsa.gov**), including:

- Functional Family Therapy
- Matrix Model for methamphetamine abuse
- Multisystemic Therapy
- Multidimensional Foster Care
- Intensive Care Management.

Examples of services that are promising and show evidence of effectiveness based on the experience of families, providers and administrators, and outcome data include:

- family group conferencing
- team decision making
- the wraparound process
- intensive home-based services
- respite services
- mobile response and stabilization services
- independent living skills and supports
- family/youth peer mentors.

Examples of Non-Evidence Based Practices

Services that do not tend to show up in the evidence-based practice literature as having sustainable outcomes for children, although they may be standard practice, include: residential treatment, group homes, traditional office-based "talk" therapy, and day treatment. These often are the services used most frequently for children with the most serious needs, and some carry very high costs.

EXAMPLE

Hawaii provides us with an example of efforts to identify both effective practices for children presenting with specific problems—for example, cognitive behavior therapy for children with anxiety—as well as practices that carry documented risks, such as group therapy for youth with delinquent behaviors. **(http://www.hawaii.gov/health/mentalhealth/camhd)**

Examples of Hawaii's List of Evidence Based Practices

PROBLEM AREA	BEST SUPPORT	GOOD SUPPORT	MODERATE SUPPORT
Anxious or Avoidant Behaviors	Cognitive Behavior Therapy (CBT); Exposure Modeling	CBT with Parents; Group CBT: CBT for Child and Parent; Educational Support	None
Depressive or Withdrawn Behaviors	CBT	CBT with Parents; Inter-Personal Tx. (Manualized); Relaxation	None
Disruptive and Oppositional Behaviors	Parent and Teacher Training; Parent Child Interaction Therapy	Anger Coping Therapy; Assertiveness Training; Problem Solving Skills Training; Rational Emotive Therapy; AC-SIT, PATHS & FAST Track Programs	Social Relations Training; Project Achieve
KNOWN RISKS: Group Therapy			
Juvenile Sex Offenders	None	None	Multisystemic Therapy
Delinquency and Willful Misconduct Behavior	None	Multisystemic Therapy; Functional Family Therapy	Multi-Dimensional Treatment Foster Care; Wraparound Foster Care
KNOWN RISKS: Group Therapy			
Substance Use	CBT	Behavior Therapy; Purdue Brief Family Therapy	None
KNOWN RISKS: Group Therapy			

HA Dept. of Health, Child & Adolescent Division (2005). Available from: http://www.hawaii.gov/health/mentalhealth/camhd

MODULE 7

Challenges to and Strategies for Implementing Evidence-Based Practices

Implementation of evidence-based and promising practices requires a commitment of resources to create a supportive infrastructure that, for example, will provide:

- training
- consultation
- coaching
- provider capacity development
- fidelity monitoring
- outcomes tracking
- policy and financing changes.

Several strategies for addressing these challenges, which mirror system of care approaches, include: adopting a population focus across systems and identifying incentives to the various systems for collaborating. Examples of types of incentives for the various systems that need to be engaged in this effort include:

- Medicaid—slowing the rate of growth in inpatient, emergency room, psychiatric residential treatment, and pharmacy costs
- child welfare—meeting ASFA outcomes and PIP objectives, such as reducing out of home placements and lengths of stay
- juvenile justice—creating alternatives to detention
- mental health—creating a more effective delivery system
- education—reducing special education expenditures.

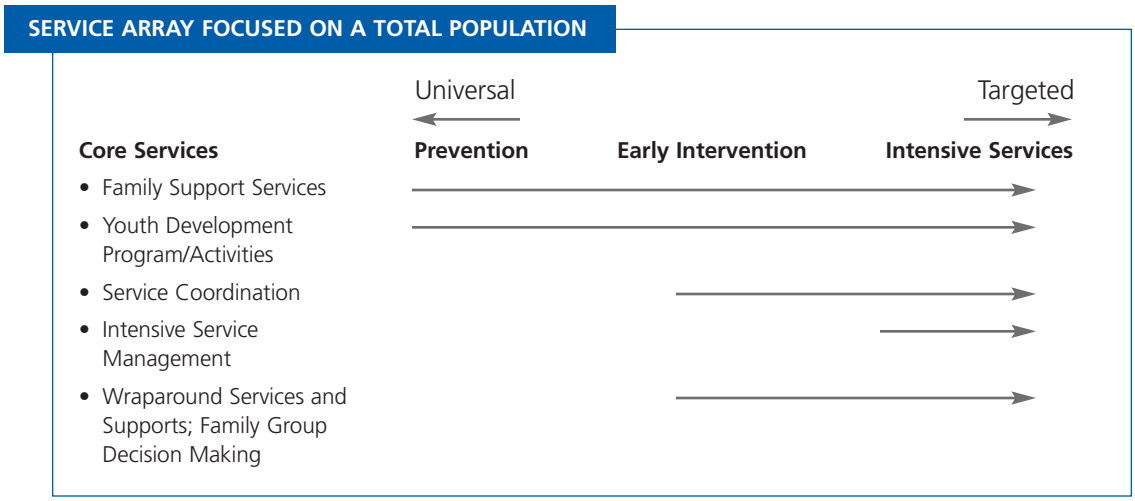
EXAMPLE

Contra Costa County, CA provides an example of cross-system partnerships to implement evidence-based practices for children in child welfare and juvenile justice systems, including Multidimensional Treatment Foster Care, for example. A Federal grant from the National Institute of Mental Health to the California Institute of Mental Health paid for training; AFDC-FC (child welfare) funds pay for room and board; Medicaid (Medi-Cal in California) covers clinical costs, and juvenile justice general revenue pays for children who are non-Medicaid eligible. **(http://www.cchealth.org/services/mental_health/youth_families.php)**

Universal Versus Targeted Services

Particularly if a system of care is focusing on a total population of children and families (e.g., all children and families in a county; all Medicaid-eligible children; or all children and families in, or at risk for involvement with, the child welfare system in a given community), it needs to encompass both universal (those services geared to all children and families, including prevention and early intervention services) and targeted services and supports (those services geared to children and families identified with, or at

risk for, serious problems, including early intervention and treatment services). The following graphic illustrates this point by showing examples of a service array spanning universal through targeted interventions focused on a "total population".



Culturally Competent, Family/Youth-Driven Service Array

Families/youth and culturally diverse constituencies need to be involved in the design of the service array, and the services and supports need to reflect the priorities of these key stakeholders. The availability of appropriate services and supports will send a powerful message about values and goals. If it is a narrow, inflexible array and fails to include non-traditional supports, families, youth and culturally diverse constituencies are likely to question the sincerity of system builders. Some tenets of culturally competent service design and practice include:

- identifying and understanding the needs and help-seeking behaviors of culturally and linguistically diverse families and youth
- embracing the principles of equal access and non-discrimination
- implementing services and supports that are tailored or matched to the unique needs of culturally diverse families and youth
- incorporating family and youth choice
- recognizing that well-being crosses life domains.

Role of Family-Run Organizations

Youth and family or youth directed organizations play an important and culturally competent role in the delivery of services as providers, trainers, evaluators, outreach workers, etc. Families and youth are taking on paid and stipend positions as support group facilitators, family interviewers, and mentors. Foster parents and birth parents are learning new shared parenting practices. Family members who have been successfully re-unified with their children are mentoring and supporting other families entering the

system of care for child welfare needs. Family leaders and youth who have aged out of the system are becoming service coordinators and service providers and carry a deep sensitivity to supporting families and youth in need. Youth who have had experience in foster and group homes are participating in licensing visits to group care facilities and are serving on national initiatives to improve practices in residential treatment facilities.

FAMILIES AND YOUTH PROVIDE VALUABLE SERVICES AND SUPPORTS

As technical assistance providers and consultants

- Training
- Evaluation
- Research
- Support
- Outreach

As direct service providers

- Foster Parents
- Mentors
- Service Coordinators
- Family Educators
- Specific Program Managers (respite, etc)

EXAMPLE

In **Rhode Island**, the Parent Support Network has hired a family mentor who works specifically with families involved with child welfare to mentor them through the service planning process, and provide ongoing emotional support, empowerment and education. The person in this position works very closely with child welfare family service workers and individuals in charge of placement. The family mentor also encourages families who have successfully preserved and reunified their family to become more involved in participating in quality assurance, mentoring or other roles like hers. **(www.psnri.org)**

Family/Youth Role in Evidence-Based Practice Development

Families and youth also play a role in the development and dissemination of evidence-based practices. There are various ways in which families and youth can partner in these efforts, including: advocating for ethical, culturally sensitive research; participating in the development and analysis of research to support evidence-based practices (EBPs); assisting in data collection to support EBPs; and, educating families and youth about EBPs.

Strategies to Increase Array of Services and Supports

Virtually every community lacks a sufficient array of services and supports. This is particularly critical with respect to home and community-based services. States and communities are implementing a variety of strategies to increase the service array.

STRATEGIES FOR INCREASING HOME AND COMMUNITY-BASED SERVICE CAPACITY

- Support family and youth movements so that families and youth can organize to advocate for services
- Engage natural helpers and culturally diverse communities to identify and utilize informal supports
- Implement a meaningful Rehabilitation Services Option under Medicaid (as, for example, Arizona has done)
- Collapse out-of-home and community-based budget structures so that savings in reduced out-of-home placements can be used to expand community services (as, for example, Massachusetts is doing)
- Re-direct dollars from "deep end" spending, such as on out-of-home placements, to community services
- Implement flexible rate structures, such as case rates (as Wraparound Milwaukee is doing)
- Implement capacity-building grants for providers
- Implement performance-based contracts
- Develop practice guidelines that support home and community-based service decision-making
- Orient and train key stakeholders, such as judges, CASA volunteers, providers to the effectiveness of home and community based services
- Implement quality and utilization management practice that reinforce use of home and community based services
- Apply for federal system of care demonstration grants
- Collect data on outcomes, family and youth satisfaction and on cost/benefit of home and community based services
- Educate key policymakers, such as Governor's office staff and legislators

With the research supporting home and community-based services and system of care principles, arguments can be advanced regarding the need to change financing policies, such as Medicaid, provider contracts and incentives, and training agendas for staff and other stakeholders.

Questions for System Builders to Consider

1. How have we structured the **array of services and supports** (or benefit design)?
2. What are the strengths and shortcomings in our current array of services and supports?
3. How does our service array incorporate partnership with families and youth, and what makes the structure culturally competent?
4. What strategies can we implement to improve our benefit structure/service array?
5. What are the pros and cons of these strategies?

FUNCTION Financing

Overview

The following graphic depicts examples of funding for children and families in the public sector. These funding streams tend to operate categorically and are protected by different interest groups. The traditional rigidity and lack of coordination among these funding streams pose daunting challenges to families, providers, and administrators alike. The more that system builders understand these funding streams—how they might be utilized and their constraints—the more likely they can develop less categorical, more integrated financing approaches.

EXAMPLES OF SOURCES OF FUNDING FOR CHILDREN/YOUTH

Medicaid
- Medicaid In-Patient
- Medicaid Outpatient
- Medicaid Rehabilitation Services Option
- Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management
- Medicaid Waivers
- TEFRA Option

Substance Abuse
- SA General Revenue
- SA Medicaid Match
- SA Block Grant

Mental Health
- MH General Revenue
- MH Medicaid Match
- MH Block Grant

Child Welfare
- CW General Revenue
- CW Medicaid Match
- IV-E (Foster Care and Adoption Assistance)
- IV-B (Child Welfare Services)
- Family Preservation/Family Support

Juvenile Justice
- JJ General Revenue
- JJ Medicaid Match
- JJ Federal Grants

Education
- ED General Revenue
- ED Medicaid Match
- Student Services

Other
- TANF
- Children's Medical Services/Title V—Maternal and Child Health
- Mental Retardation/ Developmental Disabilities
- Title XXI—State Children's Health Insurance Program (SCHIP)
- Vocational Rehabilitation
- Supplemental Security Income (SSI)
- Local Funds

Major Child Welfare Funding Streams: Advantages and Disadvantages

The major funding streams that are typically used for children and families in or at risk for involvement in child welfare include: Child Welfare Services-Title IV-B of the Social Security Act (SSA) (capped, flexible, small); Foster Care and Adoption Assistance-Title IV-E of the SSA (uncapped but restricted); the Social Services Block Grant (flexible but capped and increasingly limited); Temporary Assistance to Needy Families (TANF) (important source of emergency funds for families but capped); Medicaid-Title IX of the SSA (critical source of medical and behavioral health funds for children but depends on state plan and under increasing scrutiny by Federal Medicaid agency); and state and local general revenue.

Each of these financing streams has its particular advantages and drawbacks. For example, while IV-B funds are flexible and include family preservation and support dollars, IV-B is a capped allocation from the federal government to states and represents a relatively small percentage of available dollars. While IV-E funds are uncapped entitlement dollars, they can be used only for room and board costs for eligible children in out-of-home placements and certain administrative and training costs. One of the attractions of the federal IV-E waiver program (now ended) was that it allowed states and localities to "blend" IV-B and IV-E dollars to allow for more flexibility and potential revenue for home and community based services and supports; in return, cost neutrality had to be shown, which represented a risk to states if they could not redirect (reduce) out of home expenditures. Medicaid is an important source of revenue for health and behavioral health services for children in or at risk for child welfare involvement, but Medicaid agencies are concerned about increasing costs and assuming too much responsibility for "high-cost" populations. In addition, adult family members may not be eligible for Medicaid.

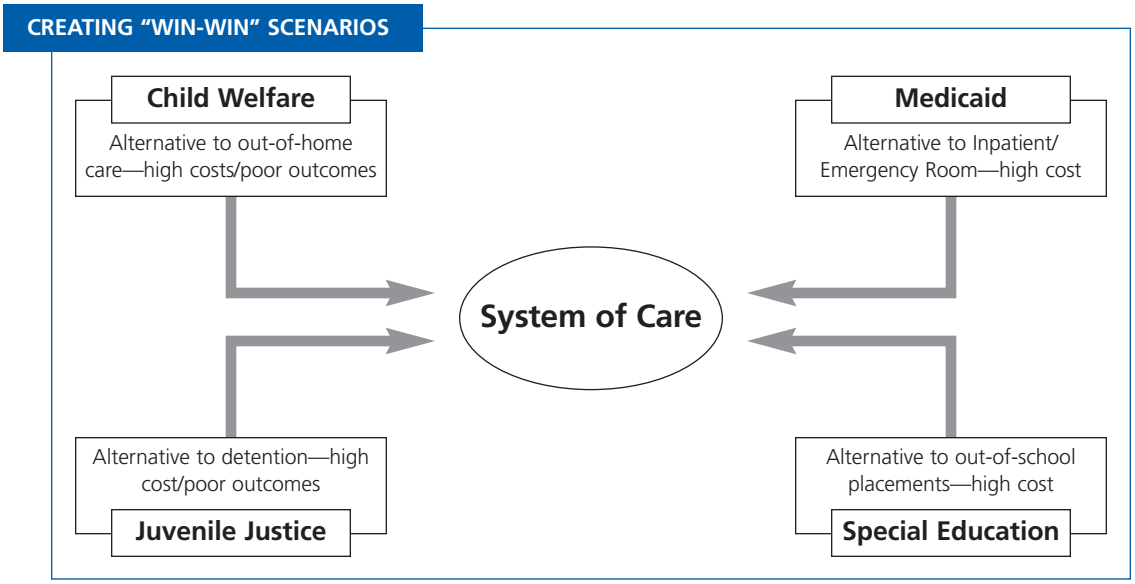
ADVANTAGES AND DRAWBACKS OF SPECIFIC CHILD WELFARE FINANCING STREAMS

TYPE	ADVANTAGES	DRAWBACKS
IV-B	Flexible, includes family preservation and support $$	Capped allocation from federal government to states and represents a relatively small percentage of available $$
IV-E	Uncapped entitlement $$	Can be used only for room/board costs for eligible children in out-of-home placements and certain administrative and training costs
Medicaid	Important source of revenue for health and behavioral health services for children in or at risk for child welfare involvement	Medicaid agencies are concerned about increasing costs and assuming too much responsibility for "high-cost" populations; Adult family members may not be eligible
TANF	Important source of emergency funds for families	Capped
SS Block Grant	Flexible	Capped and shrinking

Creating "Win-Win" Financing Scenarios

Part of the strategic challenge for system builders is to understand these funding streams, who controls them, what they are buying, and what other systems' issues are. Another aspect of the strategic challenge is to understand how to use these various funding streams to support systems of care and then to convince various interest groups that use of these funds within the system of care can be a "win-win" situation.

For example, *child welfare directors* might be convinced that use of child welfare general revenues to support alternatives to residential treatment through the system of care makes more sense than their continuing to spend large amounts on residential treatment with little evidence of efficacy. *State Medicaid directors* might be convinced that the home and community-based supports available through the system of care—made possible by implementing an effective Rehabilitation Services Option in Medicaid—will help to reduce expenditures on hospital, psychiatric residential treatment, and emergency room admissions, lengths of stay or recidivism rates, or on psychotropic medications. Similarly, the system of care may provide a viable alternative to incarceration for juveniles involved in the delinquency system and thus be attractive to *juvenile justice stakeholders*. *School officials* could utilize the home and community-based services and supports as alternatives to removing children from regular classrooms and increasing special education costs. This strategic analysis will vary from one community to another. The more system builders know about the various funding streams and who controls them, the more comprehensive can their analysis and financing strategies be.



Thinking of Financing Across Systems

One of the factors that make financing systems of care challenging is that system builders are thinking of benefits *across* child-serving systems, whereas (unless they are part of the system building effort) other systems are thinking about the benefits to their own system. For example, state Medicaid directors may not be so interested in reducing expenditures on residential placements if Medicaid plays no role in funding residential care. Medicaid directors may become interested, however, if there is a groundswell of support for using Medicaid to pay for psychiatric residential treatment.

While system builders must think strategically about what will appeal to each interest group and agency director that controls a funding stream, they must also think

strategically about how to approach legislators and governors' executive staff, who should be more concerned about spending and outcomes across systems than individual agency directors may be.

Financing Strategies and Structures

There are various types of financing strategies and structures used in systems of care, but they all begin with the basic principle that the system design itself needs to drive the financing strategies and structures, not the other way around. (This also means that system builders have developed the system design, and it is clear to stakeholders.) For the Annie E. Casey Foundation, Mark Friedman identified a number of key financing strategies critical to systems of care, including:

- **Redeployment of existing dollars:** In most states and communities, there are very few new dollars for services to children and families, which means that to finance new types of services, dollars must be re-directed from areas that are producing high costs or poor outcomes, such as out-of-home placements.
- **Refinancing to maximize federal match dollars:** This includes maximizing Medicaid dollars by expanding services covered under Medicaid or increasing the enrollment of eligible children and maximizing Title IV-E by ensuring effective draw-down of federal dollars for all IV-E eligible children and for the various activities that are allowable under IV-E, such as case management and training.
- **Raising new revenue:** This includes various efforts to generate new funds, such as advocacy with state legislatures and taxpayer referenda that create special tax revenue for children's services—for example, Proposition 63 in California, which creates an additional tax on the incomes of those earning more than $1 million a year, with the revenue earmarked for mental health services for adults and children.
- **Creation of new structures**, such as pooled, braided, and blended funding and collapsing out of home and community service budget line items so that "savings" in out-of-home spending can be used for home and community services. Strategically, system builders need to obtain assurances from policy makers that "savings" generated by reducing out of home placements (or lengths of stay or out-of-school day placements) will revert back to the system of care and not be used for other purposes, such as state deficit reduction or the building of highways.

FINANCING STRATEGIES TO SUPPORT IMPROVED OUTCOMES FOR CHILDREN, YOUTH AND FAMILIES

FIRST PRINCIPLE: System Design Drives Financing

REDEPLOYMENT

Using the money we already have

The cost of doing nothing

Shifting funds from treatment to prevention

Moving across fiscal years

RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN

Donations

Special taxes and taxing districts for children

Fees and third party collections including child support

Trust funds

REFINANCING

Generating new money by increasing federal claims

The commitment to reinvest funds for families and children

Foster Care and Adoption Assistance (Title IV-E)

Medicaid (Title XIX)

FINANCING STRUCTURES THAT SUPPORT GOALS

Seamless services: Financial claiming invisible to families

Funding pools: breaking the lock of agency ownership of funds

Flexible Dollars: Removing the barriers to meeting the unique needs of families

Incentives: Rewarding good practice

Friedman, M. (1995). *Financing strategies to support improved outcomes for children*. Washington, D.C.: Center for the Study of Social Policy.

Examples of Financing Strategies

Following are a number of examples illustrating the strategies described above.

EXAMPLES

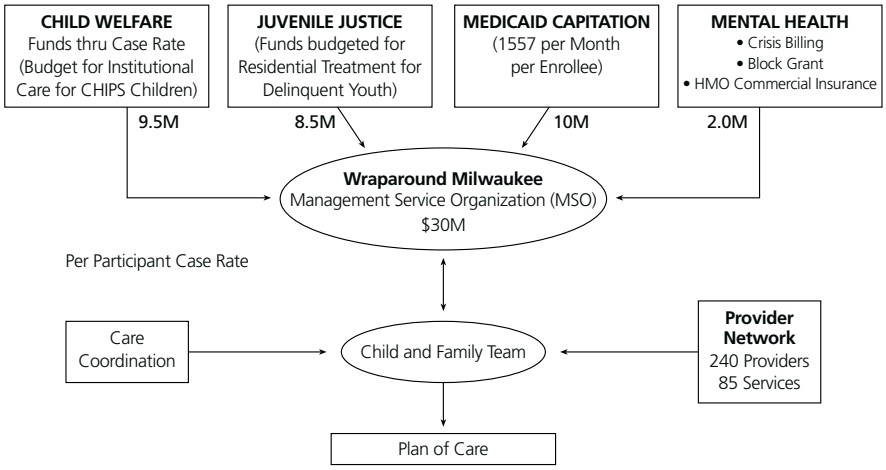
El Paso County, Colorado integrated child welfare and cash assistance programs to better utilize Temporary Assistance to Needy Families (TANF) as a primary prevention program for families involved and at risk for involvement in child welfare. For example, the county combined Title IV-B family preservation services with TANF-funded services such as substance abuse counseling and domestic violence prevention. The county also used TANF to augment supports to grandparents raising children.

The **North Carolina** State System of Care Collaborative has **pooled dollars** to support training across systems in a family-centered practice model, develop curricula, and build and maintain a website for communication across stakeholders. They also combined funding from their system of care grant with county mental health funding to finance family advocate positions. **(www.dhhs.state.nc.us/dss/systemofcare/soc.htm)**

EXAMPLES

In **Milwaukee, Wisconsin**, Wraparound Milwaukee is one example of a system of care using **blended funding** and **redirecting spending** on residential treatment from child welfare to community services and supports. Milwaukee estimated that, without having re-designed its system and re-directed dollars, child welfare spending on residential treatment would have increased from $18m in 1996 to $43 m today; instead, Milwaukee is spending less on residential treatment today than in 1996 and serving more children. To prevent disruptions in placements of children in foster care, **Milwaukee** also used combined funding to finance a Mobile Urgent Treatment Team (MUTT), which can work with children and families in any setting and over a flexible 30-day time period. The child welfare system provided general revenue funds, which Wraparound Milwaukee can **maximize** by billing **Medicaid** for Medicaid-eligible children. For example, child welfare provided $450,000 in funding; Wraparound Milwaukee is able to generate another $200,000 in Federal Medicaid match, creating a $650,000 mobile crisis capacity for children and families in child welfare. Use of MUTT has reduced the placement disruption rate in child welfare from 65% to 38%. **(www.milwaukeecounty.org)**

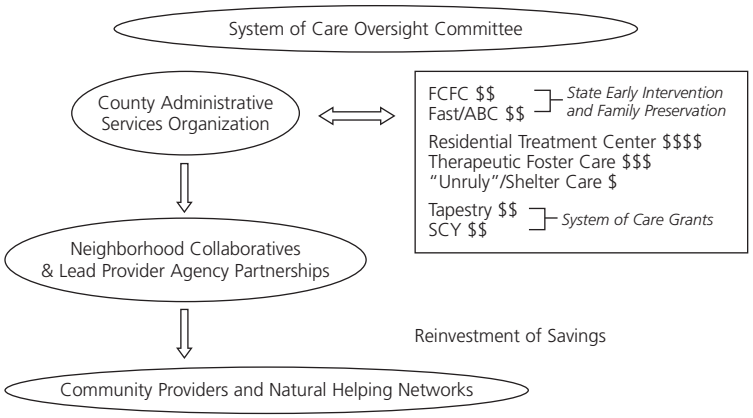
What Are the Pooled Funds?



Wraparound Milwaukee. (2002). *What are pooled funds?* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Branch.

Cuyahoga County provides an example of a system of care using **braided or "virtually blended" dollars** from child welfare and other systems on behalf of several different populations of children, youth and families involved, or at risk for involvement, in child welfare and other systems. **(www.cuyahogatapestry.org)**

Financing—Cuyahoga County (Cleveland)

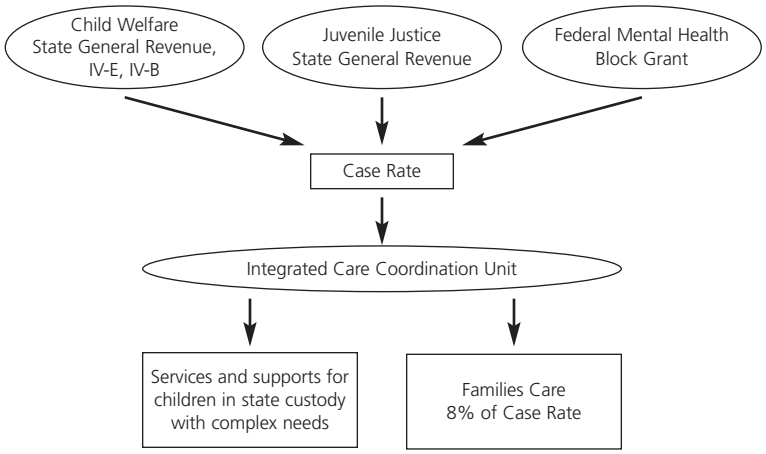


MODULE 7

EXAMPLES

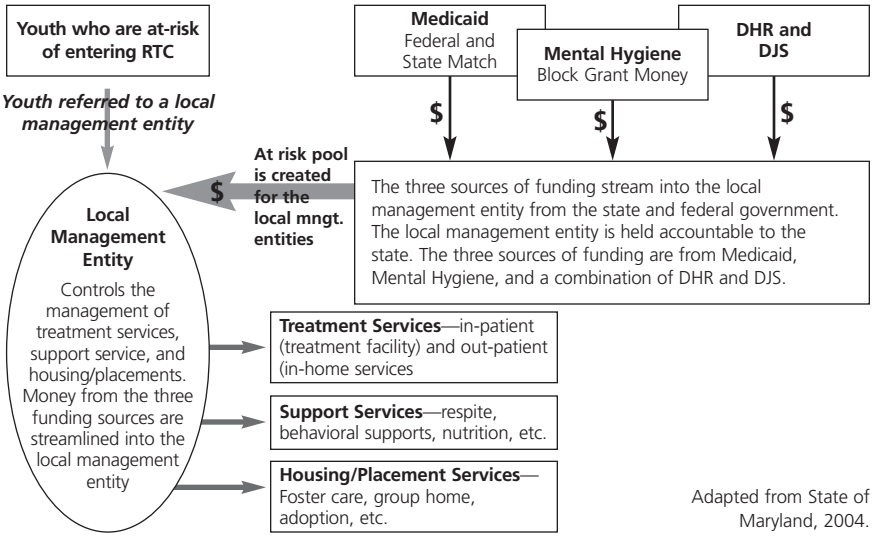
In **Central Nebraska**, the Integrated Care Coordination Unit is another example of **pooled funds** to reduce out-of-home placements and re-direct spending to provide care coordination and home and community-based services and supports for children in state custody with complex needs. This approach has led to a reduction in the percentage of children living in group or residential care (from 35.8% to 5.4%), a 2.3% reduction in children "stuck" in hospital care, and an increase in the percentage of children living in the community (from 41.4% to 87.1% reunited with family, living with relatives, in family foster care, or in independent living. Eight percent of the case rate funding is used to support programs and services offered by the region's family organization, Families Care. **(www.regionsix.com/iccu.htm)**

Example: Pooled Funds for Nebraska's Integrated Care Coordination Units



Maryland is an example of a state initiative to **re-direct** Medicaid dollars from residential treatment to local management entities. Maryland is planning to redirect Medicaid dollars spent on residential treatment to local management entities, using a 1915 (b) Medicaid managed care waiver for Medicaid-eligible children and a 1915 (c) Home and Community Based Waiver to cover non Medicaid-eligible children and families. (The 1915 (c) waiver is through the Center for Medicare and Medicaid Services federal demonstration grant program to allow use of home and community based waivers for psychiatric residential treatment.) **(www.goc.state.md.us)**

Example of Redirecting Funds



Adapted from State of Maryland, 2004.

MODULE 7

A longer range strategy is a taxpayer referendum to earmark tax dollars, through, for example, allocating a percentage of sales, property or income taxes to children's services.

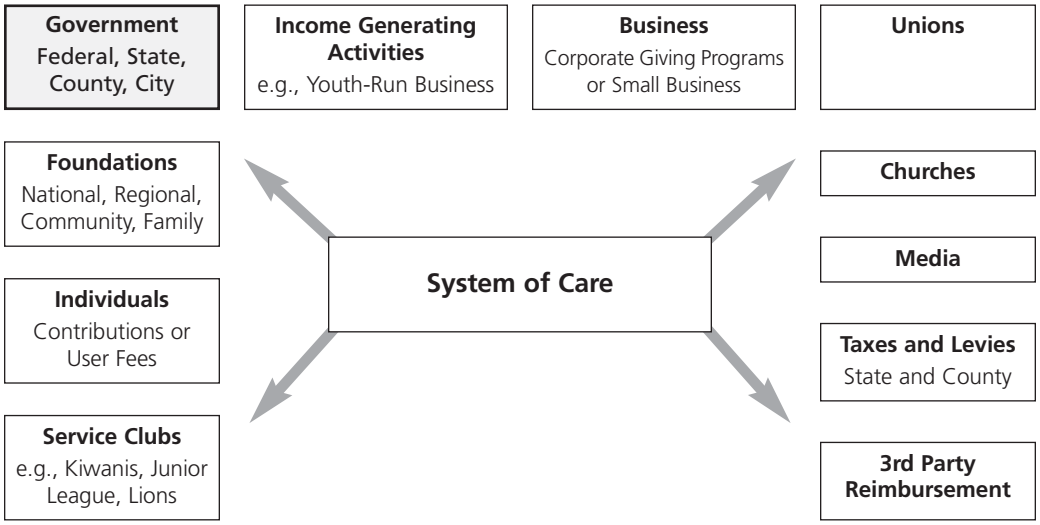
EXAMPLE

The Children's Trust Fund in **Miami, Dade County, Florida**, created through a taxpayer referendum, generates over $30 million a year in funding for early intervention. **Spokane County, Washington**, through a taxpayer referendum, is levying a 0.1% sales tax to generate over $6 million new, flexible dollars for mental health services (adult and child). **(www.thechildrenstrust.org)**

Comprehensive Strategy

Part of a comprehensive financing strategy is to draw on multiple funding sources. While government funding streams are the largest, other sources of funds—i.e., foundations, businesses, donations, etc.—are also important. They are often sources of flexible dollars and lead to broader community buy-in for the system building effort.

WHERE TO LOOK FOR MONEY AND OTHER TYPES OF SUPPORT



Pires, S. (1994). *Where to look for money and other types of support.* Washington, DC: Human Service Collaborative.

The following is a graphic depiction from federal system of care sites regarding the diversity of funding support being tapped in these sites.

DIVERSITY OF FEDERAL GRANT SITE FUNDING

SOURCE	SYSTEM	DESCRIPTION
State	Mental Health	General fund, Medicaid (including FFS/managed care/waivers), federal mental health block grant, redirected institutional funds and funds allocated as a result of court decrees.
	Child Welfare	Title-IVB (family preservation),Title IV-B foster care services, Title IV-E (adoption assistance, training, administration) and technical assistance and in-kind staff resources
	Juvenile Justice	Federal formula grant funds to state for juvenile justice prevention, state juvenile justice appropriations, and juvenile courts
	Education	Special education, general education, training, technical assistance, and in-kind staff resources
	Governor's Office/Children	Special children's initiatives, often interagency blended funding
	Social Services	Title XX funds and realigned welfare funds (TANF)
	Bureau of Children w/ Special Needs	Title V federal funds and state resources
	Health Department	State funds
	Public Universities	In-kind support, partner in activities
	Department of Children	In states where child mental health services are the responsibility of child agency, not mental health, sources of funds similar to above
	Vocational Rehabilitation	Federal and state-supported employment funds
	Housing	Various sources
Local	County, City, or Local Township	General fund
	Juvenile Justice	Locally controlled funds
	Education	Court, probation department, and community corrections
	County	May levy tax for specific purpose (mental health)
	Food Programs	In-kind donations of time and food
	Health	Local health authority—controlled resources
	Public Universities/Comm. Colleges	
	Substance Abuse	In-kind support
Private	Third Party Reimbursement	Private insurance and family fees
	Local Businesses	Donations and in-kind support
	Foundations	R. W. J., Casey, Soros Foundations, various local foundations
	Charitable	Lutheran Social Services, Catholic Charities, faith organizations, homeless programs, and food programs (in-kind)
	Family Organizations	In-kind support

Koyanagi, C., & Feres-Merchant, D. (2000). For the long haul: Maintaining systems of care beyond the federal investment. *Systems of care: Promising practices in children's mental health, 3*. Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practice.

Diversified Funding Sources and Approaches for Family Organizations

Financing for family and youth-run organizations needs to be treated as a "cost of doing business" in systems of care. The Rhode Island Parent Support Network (PSN) provides one example of a family-run organization that is drawing financing from multiple State agencies serving children and families, diversifying its funding base and supporting a number of programs that are directed and implemented by families and youth to support systemic change. PSN started as a small project out of the RI Mental Health Association in 1986 and then became an independent 501(c)3 nonprofit by 1993 with the support of a Federal statewide family network grant.

PSN learned early that key to building its funding base was the ability to build relationships across State systems serving children, youth and families. PSN worked creatively to utilize funding sources in the State to implement family and youth directed programs and activities. For example, a major need identified by families and youth was to have a peer who could provide support at an individualized child, youth and family level to help youth and families work with education, behavioral health, child welfare, juvenile justice, and other systems to receive necessary services and supports and preserve the family. PSN has been able to utilize child welfare Title IV-B funding, state appropriations allocated to the Department of Children, Youth and Families, Department of Education discretionary funds, and private foundations to support its peer mentor program. The peer mentor program provides: ongoing information and referral with a toll-free helpline; support for families involved in child welfare; support through the wraparound and education planning processes; ongoing education and individualized advocacy training; and family and youth directed support groups.

In addition, PSN has been able to develop new positions, programs and approaches with federal grant dollars that, for the most part, have been sustained with State appropriation funds based on producing successful outcomes for children, youth and families. This has included: the development of the "Youth Speaking Out" youth group; a family and youth leadership program; available participant supports for families and youth to participate on policy boards and trainings; implementation of ongoing focus groups; and, conducting public awareness activities.

In building a diversified funding base, PSN has learned that it is important to have a sound administrative infrastructure that includes: management leadership; supervision; administrative support; fiscal and management information system and technology; and staff capacity needed to support the ability to take on new funding opportunities and programs.

EXAMPLE: DIVERSIFIED FUNDING SOURCES AND APPROACHES AT THE PARENT SUPPORT NETWORK, RI

CHILD WELFARE IVB FUNDS	STATE APPROPRIATION FUNDS FOR BEHAVIORAL HEALTH	DEPARTMENT OF EDUCATION DISCRETIONARY FUNDS	FEDERAL GRANT AND PRIVATE DONATIONS

Administrative Infrastructure (4.0 FTE)
Executive Director, Assistant Director, Administrative Assistant, and Data and Technology Specialist

Peer Mentor Program (3.25 FTE)	Family and Youth Leadership Program (2.50 FTE)
Information and Referral	System Reform Training and Technical Assistance
Child and Family Teams	Placement on Policy Boards
Education Planning	Focus Groups
Support Groups/youth Speaking Out	Social Marketing/Presentations
Training	

Conlan, L. (2007). Parent Support Network of Rhode Island and Primary Funding Sources.

Medicaid Strategies

Medicaid is a critical financing stream for children and families in the child welfare system. Medicaid provides a number of options that states can use to fund appropriate health and behavioral health services for children involved or at risk for involvement in child welfare and, sometimes, for family members, depending on eligibility and benefit design. There are pros and cons associated with these options, which need to be analyzed as part of a strategic financing approach to systems of care. The options discussed here include:

- Rehabilitation Services Option
- Managed Care 1115 and 1915 (b) demonstrations and waivers
- Home and community-based waivers (1915 c)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management
- Administrative Case Management
- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
- Medicaid as part of a blended or braided funding strategy.

The **Rehabilitation Services Option** allows flexibility to cover a broad array of home and community services. Many states use the Rehab Option, but covered services vary from state to state. System builders need to ensure that the Rehab Option, in addition to covering an appropriate array of services and supports for children, youth and their families, includes definitions of covered services that are tailored for child and youth populations, and are not just "adult-focused".

Managed care 1115 and 1915(b) demonstrations and waivers also allow flexibility to cover a broad array of services and supports. However, the Federal waiver process can be challenging, and managed care needs to be implemented carefully, with customized approaches for children and families in and at risk for involvement in child welfare, such as risk-adjusted rates and coverage of appropriate services.

EXAMPLE

New Mexico and **Arizona** are examples of states using managed care waivers that include evidence-based and effective services for the child welfare population, such as Multisystemic Therapy and family support services. To guard against under-service, **Arizona** also incorporates a risk-adjusted rate (i.e., a higher payment) into its managed care system for children involved in child welfare, recognizing their higher service utilization needs. The Arizona managed care system also has built an urgent response system for children coming into care in child welfare. **(www.azdhs/bhs.gov)**

Home and community-based waivers (1915 c) allow flexibility to cover populations, as well as types of services, not covered in a state's Medicaid plan; however, they can be used only for those who would otherwise be in an institutional (i.e. hospital) level of care, not currently including residential treatment facilities; however, the Federal Medicaid agency is funding demonstrations of home and community-based waivers as alternatives to psychiatric residential treatment facilities This is an opportunity for some states to utilize Medicaid to fund more community supports for children in child welfare and other populations;

EXAMPLE

A number of states, such as **New Jersey** and **Minnesota**, have HCBS waivers for children with chronic physical or developmental disabilities; a smaller number, such as **Kansas**, **New York**, **Vermont**, **Indiana**, **Michigan** have HCBS waivers for youth with serious emotional disorders. **Wisconsin's** HCBS waiver covers primarily children with autism. Ten states have Centers for Medicare and Medicaid "PRTF" demonstration grants, which are testing home and community based waivers for psychiatric residential treatment facility (PRTF) alternatives; these include: **Arkansas**, **Florida**, **Georgia**, **Indiana**, **Kansas**, **Maryland**, **Mississippi**, **Montana**, **South Carolina**, and **Virginia**.

The **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** program is the broadest entitlement to services for children and youth, ages 0-21. EPSDT requires periodic screens and provision of medically necessary services, even if those services are not included in a state's Medicaid plan; however, in practice, EPSDT is implemented primarily with respect to physical health issues (even though Federal law requires inclusion of behavioral health screens and services if needed). Because of the broad nature of EPSDT, cost concerns are an issue, requiring effective utilization management. EPSDT, however, is a very appropriate vehicle for screening children involved or at risk for involvement in child welfare and linking them to appropriate physical and mental health services, and the courts have recognized this.

EXAMPLE

Examples of states and localities in which the courts have ruled in favor of plaintiffs bringing EPSDT lawsuits, including for children in child welfare, are **Massachusetts**, **California**, and **Pennsylvania**.

Targeted case management (TCM) can be targeted to high need populations, such as children in child welfare; however, TCM is not sufficient without other services being available. Also, the Federal Medicaid agency is scrutinizing targeted case management for children in child welfare to ensure that it is not being used in lieu of child welfare case management (i.e., as a cost shift to Medicaid).

EXAMPLE

Vermont and **New York** are two examples of states that utilize targeted case management.

Administrative case management can be used to help families access and coordinate services, but it is not sufficient without other services being available.

EXAMPLE

New Jersey is an example of a state that is using administrative case management dollars to fund some of the activities of family-run organizations, including linking families in child welfare to appropriate entitlements.

The **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** provision allows states the option of serving in the community children and youth with physical, developmental and behavioral health disabilities who can meet Supplemental Security Income (SSI) disability criteria. Families whose income levels exceed those of Medicaid eligibility may apply. TEFRA does not expand the array of services, and many youth with serious behavioral health disorders have difficulty meeting the SSI disability criteria. Because TEFRA cannot be capped, some states fear the cost implications of serving a large number of children and have excluded children with mental disorders by the way they define a medical institution or levels of care. However, even with these constraints, TEFRA is an important vehicle for covering children whose families might otherwise have to relinquish custody to child welfare to access health or mental health care. TEFRA is sometimes called the "Katie Beckett Option" after the child whose situation inspired it.

EXAMPLE

Minnesota and **Wisconsin** are examples of states that have the TEFRA option.

When Medicaid is **part of a blended or braided funding strategy**, it allows for the most flexible provision of an integrated array of services and supports, but involves significant restructuring of financing and accountability mechanisms (and must still ensure an "auditable" trail for Medicaid purposes).

EXAMPLE

In **Milwaukee**, **Wisconsin**, Milwaukee Wraparound is an example of a blended funding approach using Medicaid dollars.

EXAMPLES OF MEDICAID OPTIONS STATES USE TO COVER EVIDENCE-BASED AND PROMISING COMMUNITY-BASED SERVICES

MEDICAID OPTION	ADVANTAGES	ISSUES	EXAMPLE
Rehabilitation Services Option	• Flexibility to cover a broad array of services and supports provided in different settings (e.g., home, school)	• Service definitions often adult-oriented • Provider-service mismatch	• OH—developing new service definitions and case rates for intensive home-based services and Multisystemic Therapy
Managed Care Demos and Waivers—1115 and 1915 (b)	• Accountability and management of cost through risk structuring/sharing • Flexibility to cover wide range of services and populations	• Managed care not without risks/challenges • Federal waiver process can be challenging • Cost neutrality issues	• NM—covering Multisystemic Therapy • AZ—covering family support and urgent response for child welfare
Home and Community-Based Waivers—1915 (c)	• Flexibility, broader coverage, waiver of income limits and comparability	• Alternative to hospital-level of care but PRTF (i.e., residential tx.) may be issue • Cost and management concerns/limited to small number	• KS, NY, VT, IN, WI, MI—have HCBS Waivers • AK, FL, GA, IN, KN, MD, MS, MT, SC, VA—have community psychiatric residential treatment facilities demonstration grant
Early and Periodic Screening, Diagnosis and Treatment—EPSDT	• Broadest entitlement • Supports holistic assessments and services • No waiver or state plan amendment requirements	• Management mechanism critical because of cost concerns • Oriented more to physical health in practice	• RH • PA
Targeted Case Management	• Can be targeted to high need populations, such as child welfare • Supports small case load focus (e.g., 1-10)	• Not sufficient without other services • Federal attention	• VT • NY
Administrative Case Management	• Ability to cover basic case management services to support enrollment access	• Not sufficient without other services	• NJ—covering some activities of family-run organizations
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	• Avenue to eligibility to community-based services for children who meet SSI disability criteria—allows disregard of family income	• SSI criteria not easy to meet for children with SED • Does not expand types of covered services • Cost issues, so generally small program	• MN • WI
Medicaid as Part of a Blended or Braided Funding Approach (without a waiver)	• Holistic, integrated (across systems) financing, supports broad array of services, natural supports and individualized care	• Involves significant restructuring	• Milwaukee Wraparound • DAWN Project • Massachusetts Mental Health Services Program for Youth • New Jersey Partnership

Need for Cross-System Financing Strategy

The "bottom line" is that states are cobbling together a variety of options to cover and contain home and community-based services under Medicaid and that an overarching strategic financing plan, which crosses systems serving children and families and involves child welfare stakeholders, often is missing. Development of a strategic financing plan needs to be a key priority of system builders once they have reached consensus on a system design.

First Steps in a Strategic Financing Approach

There are two basic questions that must be answered first in a strategic financing approach—*financing for whom and financing for what?* Answering these questions requires stakeholders to address a number of issues, including: identifying the population(s) of focus; agreeing on underlying values and intended outcomes; identifying needed services and supports and the practice model; identifying how services will be organized (e.g., how will families access them, how will children be screened, assessed and linked to services and supports, etc.); identifying the infrastructure to support the delivery system (e.g., system management; training and capacity building; family and youth partnership); costing out the system of care.

FIRST STEPS

If you have answered the questions:

Financing for Whom?
Financing for What?

- Identified your population(s) of focus
- Agreed on underlying values and intended outcomes
- Identified services and practice model to achieve outcomes
- Identified how services/supports will be organized (so that all key stakeholders can draw the system design)
- Identified the administrative/system infrastructure needed to support the delivery system
- Costed out your system of care

Then You Are Ready To Talk About Financing!

Resources related to strategic financing for systems of care include:

- *A Self-Assessment and Planning Guide: Developing a Comprehensive Financing Plan* (**http://rtckids.fmhi.usf.edu/study03.cfm**)
- *Improving Child Welfare Outcomes through Systems of Care: Building the Infrastructure A Guide for Communities*, Appendix J (**www.childwelfare.gov/systemwide/service/soc/build/soctoolkit.cfm**)

Steps in a Strategic Financing Analysis

Once system builders are clear about what they want to finance and on behalf of which population(s), they can undertake a strategic financing analysis.

STEPS IN STRATEGIC FINANCING ANALYSIS

- Map the state and local agencies that spend dollars on the identified population(s), how much they are spending and on what
- Identify resources that are untapped, such as Medicaid dollars (for example, if the child welfare system is spending 100% general revenue to buy services that could be paid for by Medicaid
- Identify utilization and expenditure patterns associated with high costs or poor outcomes (for example, large expenditures on out-of-home placements or on psychiatric and psychological evaluations that do not lead to individualized, strengths-based, solution-focused interventions)
- Identify disparities and disproportionality in access to services and supports (for example, racially and ethnically diverse children and families involved in child welfare and overrepresented in out-of-home placements)
- Identify funding structures that will best support goals (such as blended funding)
- Identify short and long term financing strategies, such as re-directing spending from out-of-home placements to community-based care or garnering support for a taxpayer referendum to generate new dollars for early intervention for children and families at risk of child welfare involvement.

Tools to Support Families and Staff

A *program budget*, as opposed to a line item budget, gives a much clearer picture of what a system of care is actually doing, and thus is a good strategic tool for system builders to use with stakeholders—to educate, plan, and strategize. It can help to de-mystify cost and financing issues.

The following illustration describes a program budget for a neighborhood system of care, in which a Family Resource Center served as a hub for services and supports to neighborhood families, including those in or at risk for involvement in child welfare. In this program budget, line item costs—personnel, equipment, etc.—are cross-walked to program categories, such as family services and neighborhood governance. This makes it clearer to stakeholders for what activities dollars are being spent and whether expenditures reflect the values and goals of the system of care. So, for example, a good percentage of the dollars here are being spent on services to families and on family leadership—both of which are indeed priorities.

PROGRAM EXPENDITURE BUDGET FOR A NEIGHBORHOOD-BASED SYSTEM OF CARE

Cost Categories	Proposed Total Costs	Neighborhood Governance	Family Leadership	Family Service/ Support	Removal of Barriers	Community Organizing	School Linkage	Tracking and Evaluation	Volunteers	Partnership Building	Exec. Direct. & Support
Salaries	446,000	21,000	29,000	190,000	21,000	26,000	35,000	15,000	30,000	18,000	63,000
Fringe	133,000	6,300	8,700	57,000	6,300	7,800	10,500	3,900	9,000	5,400	18,900
Building Occupancy	93,600	8,700	12,300	36,800	2,400	4,300	4,000	2,500	4,300	2,500	15,800
Professional Services	109,000	17,600	22,100	32,400	3,600	2,700	2,700	18,600	2,700	2,900	3,700
Travel	43,700	12,300	5,300	10,300	9,000	1,200	3,000	500	500	500	1,600
Equipment	6,000	600	600	600	600	600	600	600	600	600	600
Food Services	25,000	0	4,000	1,000	18,000	0	1,000	0	1,000	0	0
Subcontracted	89,000	0	0	89,000	0	0	0	0	0	0	0
Insurance	13,500	2,700	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Operating Supplies & Expenses	21,500	1,800	700	8,600	200	1,300	2,100	500	1,500	4,100	4,100
Other (Parent stipends, transportation, child care)	84,000	0	40,000	9,000	35,000	0	0	0	0	0	0
Equip. Lease	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Property	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
GRAND TOTAL	1,115,100	80,000	125,900	459,900	84,300	51,100	64,100	45,800	55,300	36,800	113,900

Below, the second half of this table shows, not expenditures by program category, but revenue by category. This gives stakeholders a picture of which program areas may be too dependent on one funding source; in this example, the school linkages program is almost entirely dependent on one grant source. If that source were to disappear, school

PROGRAM REVENUE BUDGET FOR A NEIGHBORHOOD-BASED SYSTEM OF CARE

Revenue Totals Across Sources	Proposed Total Costs	Neighborhood Governance	Family Leadership	Family Service & Support	Removal of Barriers	Community Organizing	School Linkage	Tracking and Evaluation	Volunteers	Partnership Building	Exec. Direct. & Support
	REVENUE ALLOCATION BY PROGRAM										
Foundation	217,100	40,000	30,000	25,000	28,300	24,000	0	22,800	12,000	15,000	20,000
State-MH&SA	258,800	2,500	28,400	157,900	3,000	20,000	0	5,000	12,000	5,000	25,000
County–CWS	124,900	20,000	30,000	30,000	10,000	5,000	0	3,000	12,000	2,000	12,900
Dept. of Ed.	70,100	2,500	1,600	0	0	0	60,000	0	0	0	6,000
Family Preservation Grant	373,400	5,000	20,000	230,000	35,000	0	0	12,000	18,000	14,000	39,400
In-Kind	29,300	0	10,000	10,000	5,000	1,00	0	0	800	0	2,500
Donations	21,300	5,000	900	5,000	1,000	100	2,100	3,000	500	800	5,000
Other Grants	20,200	5,000	900	5,000	1,000	100	2,100	3,000	0	0	3,100
GRAND TOTAL	1,115,100	80,000	125,900	459,900	84,300	51,100	64,100	45,800	55,300	36,800	113,900

linkages would be likely to disappear as well. A program budget can help stakeholders think strategically about tying financing strategies to their priorities.

Families, youth and culturally diverse constituencies need to be active and informed partners in the development of financing strategies. The more these key stakeholders know about funding streams and the politics around them, the more effective they can be in advocating for needed changes. More importantly, funding priorities and the strategies to support them should be driven by the strengths and needs of those most affected by them. Financing viewed through a multicultural lens may lead system builders to strategies "outside the box". For example, a strategy being used by some Family Resource Centers is built around the concept of "reciprocity", where there is no monetary fee for services, yet all participants "contract" for services by agreeing to provide volunteer hours through a "Time Dollar Bank" to support the agency.

EXAMPLE

Oregon's System of Care has developed a Cost Center and Object Code Matrix, an accessible chart for field staff on "how to pay" for services. The Matrix provides a list of Child/Family Related Expenditures: such as Goods (clothing, food, etc.); Home Related Services (client home repairs, housing, etc); Legal Services (guardianship/custody/adoption); Transportation (out of state and instate, gas vouchers, per diem, etc.); Education (classes, school supplies); Social/Treatment Services (counseling, mentoring, day care, etc.); and, Medical/Health (psychological evaluations, drug testing, etc.). The Matrix then provides guidance on "how to fund the service array", relying on family or relative resources first. Funding sources include such sources as: non-profit community resources, Oregon Health Plan, county mental health, central adoptions funds, Foster Care Prevention funds, IV-E Waiver, flex funds, etc. Lastly, the Matrix provides guidance on "how to process" the payment from the quickest (i.e., expense voucher) to the most restrictive (i.e., contract) methods. **(www.oregon.gov/dhs/children/welfare/systemofcare)**

Questions for System Builders to Consider

1. Are we clear about what we want to finance and for whom?
2. Have we undertaken a strategic financing analysis?
3. How have we structured financing?
4. What are the strengths and shortcomings of our current financing structures and strategies?
5. How do our financing structures and strategies incorporate partnership with families and youth, and what makes them culturally competent?
6. What strategies can we implement to strengthen the financing for our system of care?
7. What are the pros and cons of these strategies?

MODULE 8

Provider Network; Natural Supports; Purchasing & Contracting

FUNCTION Provider Networks

Provider Network Options

"Provider network" has to do with *who* will provide the needed services and supports in the system of care. Will some services/supports be provided by in-house staff? Will some or all be contracted? To one main provider? To multiple providers? How will informal providers and parents and youth be included as providers?

There are many ways of structuring the provider network, such as allowing any "willing provider" to provide services and supports within the system of care as long as the provider meets the system's standards and criteria, or designating a qualified provider pool, or creating a selective network for fixed service amounts through contracting arrangements. There are pros and cons to all of these arrangements. For example, on the positive side, a selective network may allow for greater quality control over the network; however, it may disenfranchise some providers who do not get selected, and it may reduce the choice of providers available to families. On the positive side, an "any willing provider" pool may give families considerable choice, but it may be difficult for the system of care to exercise sufficient quality control over providers. A "qualified provider pool", from which families and service planners may draw, provides flexibility and choice, but it may create management difficulties for some providers who do not get "chosen" frequently enough and face revenue losses, or for providers who are chosen too frequently and cannot sustain the volume. System builders need to engage in a strategic analysis of which provider network structures make sense for their particular circumstances.

PROS AND CONS OF VARIOUS PROVIDER NETWORK ARRANGEMENTS

Selective Network (contracts)
- Allows for greater quality control over the network
- May disenfranchise some providers who do not get selected
- May reduce the choice of providers available to families

"Any Willing Provider" Pool (meets standards)
- May give families considerable choice of providers
- May be difficult for the system of care to exercise sufficient quality control over providers

Qualified Provider Pool (designated)
- May give families and service planners considerable choice of providers
- May be difficult for some providers to manage too much or too little service volume

Characteristics of Effective Provider Networks

Whatever provider structure is employed, it needs to be guided by some common principles.

CHARACTERISTICS OF EFFECTIVE PROVIDER NETWORKS

- Are responsive to the populations using the network
- Include both formal service providers and natural helpers, traditional and non traditional services and supports
- Are committed to evidence-based practices and other promising approaches
- Include culturally and linguistically diverse providers
- Include families and youth in provider roles
- Are flexible and accountable.

Elements of Trauma-Informed Provider Networks

Many children in the child welfare system are exposed to multiple or complex traumas, such as abuse, neglect, and domestic violence. Children are often further traumatized by their involvement in the child-serving systems (i.e., child welfare, mental health, juvenile justice, etc.), through insensitive interviews, repeated changes in treatment providers or placement, court testimony, and removal from home and loved ones. The National Child Traumatic Stress Network has begun to address this issue and recently identified eight essential elements of trauma-informed child welfare practice.

ESSENTIAL ELEMENTS OF TRAUMA-INFORMED CHILD WELFARE PRACTICE AND PROVIDER NETWORK

- Maximize the child's sense of safety.
- Connect children and youth with providers who can assist them in reducing overwhelming emotions.
- Connect children with providers who can help them integrate traumatic experiences and gain mastery over their experiences.
- Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma.
- Provide support and guidance to the child's family.
- Ensure that caseworkers manage their own professional and personal stress.

Focal Point: Traumatic Stress/Child Welfare. Winter 2007. Research and Training Center on Family Support and Children's Mental Health, Portland, OR.

This list can be used to begin a discussion among system builders about the capacity of the provider network (including both in-house staff and contracted providers) in their respective communities to practice trauma-informed service provision. Achieving these essential elements requires work at the individual family, child and youth level, the direct service (front-line practice) level, and the system level.

Examples of Incentives to Providers to Change Practice

System builders seek ways of creating incentives for providers to change practice. Provider payment rates obviously have a major bearing on the interest and quality of providers. System builders may not control the rate structure for all providers, however. For example, Medicaid providers will be in the network, and their rates may be controlled by the state Medicaid agency, not by child welfare. In this case, system builders need to strategize how to provide other incentives to providers, such as allowing them greater flexibility and control, offering training and staff development, providing back up support when especially difficult administrative or service challenges arise, providing more timely reimbursements, providing them with capacity development grants, and the like. System builders need to consider the issue of provider rates across systems because differences in rates among key child-serving systems for the same services aggravates the problem of fragmentation in children's services as providers abandon one system to obtain more decent rates from another.

FUNCTION Natural Supports

Importance of Natural Helpers

Natural helpers and social supports may be family members, youth, representatives from culturally diverse neighborhoods, and others who can provide a more "normalized" and enduring form of support to families and youth than can formal services. Natural helping networks may include groups such as faith-based organizations, neighborhood watch groups, or informal social groups such as a neighborhood scrap booking club. A major concept underlying "Family-to-Family" initiatives in child welfare is the importance of natural supports for families at risk.

Roles for Natural Helpers

Examples of what natural helpers can provide include: skill building (for example, a grandmother teaching a younger woman about child care); emotional support; resource acquisition (for example, providing information about how to obtain housing or food assistance or linking families to support organizations); and concrete help, such as transportation. Natural helping networks and social supports may also provide a potential "pool" of foster or adoptive parents or help to identify individuals who may be interested in fulfilling these roles.

Child Welfare Initiatives to Build Natural Supports

Increasingly, children's systems, including child welfare, are recognizing the importance of including natural helpers in provider networks. The following national reform initiatives in child welfare seek to build natural supports for children and families in or at risk for involvement in child welfare.

Family-to-Family (F2F) Neighborhood Collaboratives—Neighborhood resources are mobilized to support families at risk for involvement in child welfare.

EXAMPLE

Cuyahoga County (Cleveland), Ohio is one of the older examples of F2F, with 11 Neighborhood Collaboratives throughout Cleveland. **(www.ehsd.org/child000.html)**

Community Partnerships for Protecting Children (CPPC) focus on changing child protective services through family-centered practice supported by neighborhood networks.

EXAMPLE

Cedar Rapids, **Jacksonville**, **Louisville** and **St. Louis** all are employing CPPC strategies, such as locating CPS workers in neighborhoods and enlisting neighborhood partners to provide supports to at risk families, such as new mothers. **(www.emcf.org/programs/children)**

Family Finding uses Internet search engines to locate extended family members for children and youth in care.

EXAMPLE

Family Finding is being used in **Washington State** and in **Santa Clara County, CA**, among others.

OTHER EXAMPLES OF INITIATIVES TO BUILD NATURAL SUPPORTS

Mecklenburg County, North Carolina is an example of a child welfare system of care initiative that is structuring formal partnerships between child welfare staff that are geographically assigned to specific communities and family partner neighborhood agencies in order to implement best practice strategies of Multiple Response System and Family-to-Family, move the system toward a family-centered approach, and improve system performance as measured by CFSR. **(www.charmeck.org/Departments/MeckCARES/Contacts.htm)**

In **Pinellas County, Florida**, the Sheriff's Office has reached out to neighborhood churches and other faith-based entities to partner with child protective service investigators to wrap supports around families first encountering the child welfare system.

In **San Antonio, Texas**, the Community Partnerships in Child Welfare was established to involve the community in developing a network of support for at-risk families, changing the culture, policies and practices of the child welfare agency to be more family-centered and building a stronger base of community leaders. The Partnership also encourages strong ties between families and their support systems, including both formal and informal helpers.

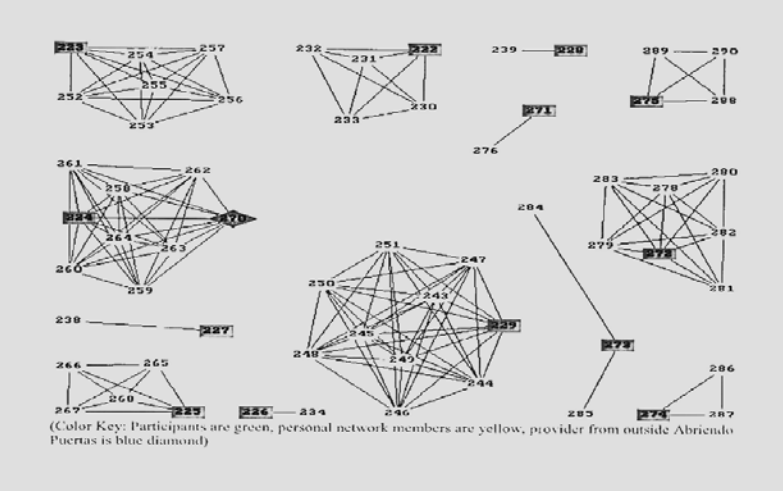
In **East Little Havana, Miami, Florida**, the Abriendo Puertas Family Center implemented a training *initiative—EQUIPO*—to develop partnerships between the formal service providers and informal providers or natural helpers. **(www.abriendopuertas.org)**

One of the most important and now recognized roles of the natural helper is that of "connector", helping to connect families to basic supports and resources, formal services, and informal support systems, as illustrated by the example of the Abriendo Puertas Family Center's "*Equipo* Network" in the following illustrations. *Equipo*, which means "team", was an initiative that trained natural helpers in a community, as well as formal service providers, to work in partnership to engage families at risk and implement family-centered practices. The illustrations below are from an evaluation of Equipo in the year before and year after its implementation.

The first graphic illustrates the connections that recently arrived immigrant families had to natural and formal helpers prior to development of the *Equipo* natural helpers initiative; the second depicts connections after the development and implementation of the natural helper network.

The pre-*Equipo* network shown below is composed of 13 sets of largely disconnected families in the year prior to implementation of *Equipo*. The green blocks represent 13 families; the blue triangles represent formal providers; the yellow blocks represent natural supports (e.g., neighbors, faith-based organizations, extended family.) As can be seen, many of these families were very isolated even from natural helpers, and most had no connections to formal providers.

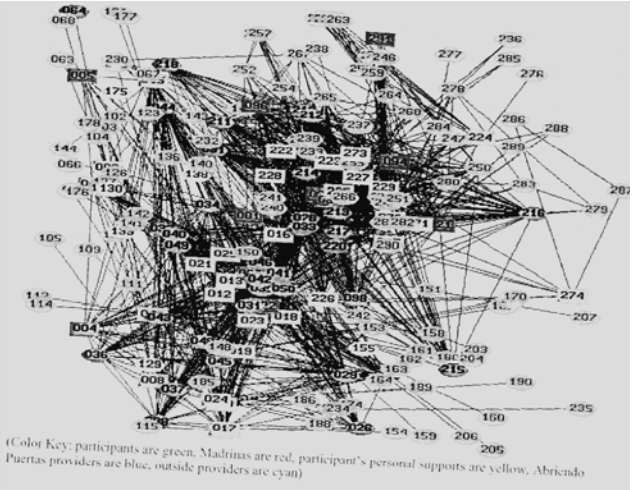
PRE-EQUIPO NETWORK



Guiterrez-Mayka, M., & Wolfe, A. (2001). EQUIPO Neighborhood Family Team: Final Evaluation Report.

The following slide illustrates the connections for these 13 families one year after implementation of *Equipo*. In the post *Equipo* network, there are many more relationships, so the network has a much higher density. There are no more clusters isolated from all the others. This decrease in isolation led to greater access to services. Decrease in isolation and improved access to services are also key variables in prevention of child abuse and neglect.

POST-EQUIPO NETWORK



Guiterrez-Mayka, M., & Wolfe, A. (2001). EQUIPO Neighborhood Family Team: Final Evaluation Report.

Families and Youth as Providers

Families and youth can play an important role as providers if they are supported by systems that recognize their role as providers.

ROLES THAT FAMILIES AND YOUTH ARE UNIQUELY POSITIONED TO PLAY

- Active outreach in the community
- First to connect with family or youth upon intake
- Respect for family's and youth's experience
- Reflective of the families and youth to be served culturally, linguistically, and socio-economically
- Support for family and youth to have active voice and choice
- Work collaboratively to connect families and youth to one another as a network of support
- Work within or in partnership with family organizations (training, system reform)
- Building of trust & bridging relationships between families and youth and formal systems
- Co-location to create a family-driven working environment and culture

Family organizations, state and county government, and local community provider agencies are hiring family members who have had experience with child welfare and other child and family service agencies to be on the front line. This has helped to establish trust, diversify the work force, and increase family and youth engagement in the delivery of services and supports. It is important, though, that as these new positions are created, there are clear job descriptions, supervision models, and training.

Specific roles for families and youth as providers include: providing basic information to families about how various systems operate, such as child welfare, the courts, special education, etc.; orienting families to service planning processes, such as Family Group

Decision-making or Wraparound and helping them think through strengths and needs; helping families locate resources; helping families navigate systems, etc. Families and youth also may provide specific services, such as respite and mentoring.

Infrastructure to Support Families and Youth as Providers

It is not sufficient simply for systems of care to hire parents and youth; the system itself needs to be structured in ways that embrace family and youth partnership. For example, families will feel isolated if they are the lone family member working in the system and are not connected to a larger family movement. Families and youth need clear job descriptions and fair compensation. Agency policies may need to be changed to support more flexible working arrangements (which should then be changed for all employees, not just for family members and youth; otherwise, a two-tiered system is created.) Systems of care can model partnerships, such as co-supervision and joint training.

For additional information on involving families and youth in systems of care, see the *CFSR Training and Technical Assistance Package*, Focus Area IV C, Engaging Birth Parents, Family Caregivers and Youth, on the website of the National Child Welfare Resource Center for Organizational Improvement,
http://muskie.usm.maine.edu/helpkids/cfsrta.htm

FUNCTION Purchasing and Contracting

Purchasing/Contracting Structures

Once system builders determine the array of services and supports that is needed, as well as the types of providers (and/or in-house staff), then they must decide which purchasing or contracting options to use. There are a number of different purchasing or contracting structures for services and supports, and pros and cons associated with all of them. Some of them include the following:

- **Pre-approved provider lists**, such as qualified provider panels, which create flexibility for the system of care and choice for families but can disadvantage small providers who are not guaranteed a set volume of services or dollar amount in this arrangement; also, this arrangement could overburden some providers who get used a lot;
- **Risk-based contracts**, which create flexibility for providers and potentially for families but create a potential as well for under-service or for over-payment for services;
- **Fixed price or fixed service contracts**, which create predictability and stability for providers but families then have to "fit" what has been "fixed".

Performance-based bonuses or penalties could be built into any of these approaches. In addition, one could combine various options—for example, creating qualified provider panels and having a fixed price contract in place as well with a given provider to help support their capacity to participate on the panel.

EXAMPLE

A southern state replaced a contracting structure in which each system serving children, youth and families issued its own Request for Proposal, leading to separate contracts, with a structure that puts approved, qualified providers on a "provider list". Agencies purchase services from providers on the list at rates not to exceed Medicaid rates. Providers in this arrangement have no guarantees as to a specific number of units of service or amount. On the other hand, they do not have to grapple with multiple contracting arrangements and differential rates across systems.

Capitation and Case Rates

Child and family services, including child welfare systems and systems of care, increasingly are using managed care purchasing strategies. These strategies introduce the notion of financial "risk" into purchasing structures. Medicaid managed care systems often use *capitation*, while child welfare systems and systems of care often use *case rates*, if they are using risk-based purchasing strategies. The differences between capitation and case rates can be explained as follows:

- **Capitation** arrangements pay managed care entities or providers or lead agencies a fixed amount per *eligible* user of services, that is, for every child/family that is enrolled in services, regardless of whether the child/family actually uses services.
- **Case rates** pay a fixed rate per *actual* user of services, based typically on the service recipient's meeting a certain service or diagnostic profile. In a capitated arrangement, a potential incentive is to prevent eligible users from becoming actual users. This can be accomplished through positive steps, such as prevention activities, or through negative steps, such as constraining access to services. In a case rate arrangement, there is no such incentive, although case rates do create an incentive, like capitation, to control the type and amount of services provided. This can be positive, for example, reducing use of out-of-home placements, or it can be negative if it leads to under-service.

CAPITATION AND CASE RATE DISTINCTIONS

CAPITATION: Pays Managed Care Organizations (MCOs) or providers a fixed rate per *eligible* user

Incentive:
#1: Prevent eligible users from becoming actual users (e.g., make it difficult to access services; engage in prevention)
#2: Control the type and volume of services used

CASE RATE: Pays Managed Care Organizations (MCOs) or providers a fixed rate per *actual* user

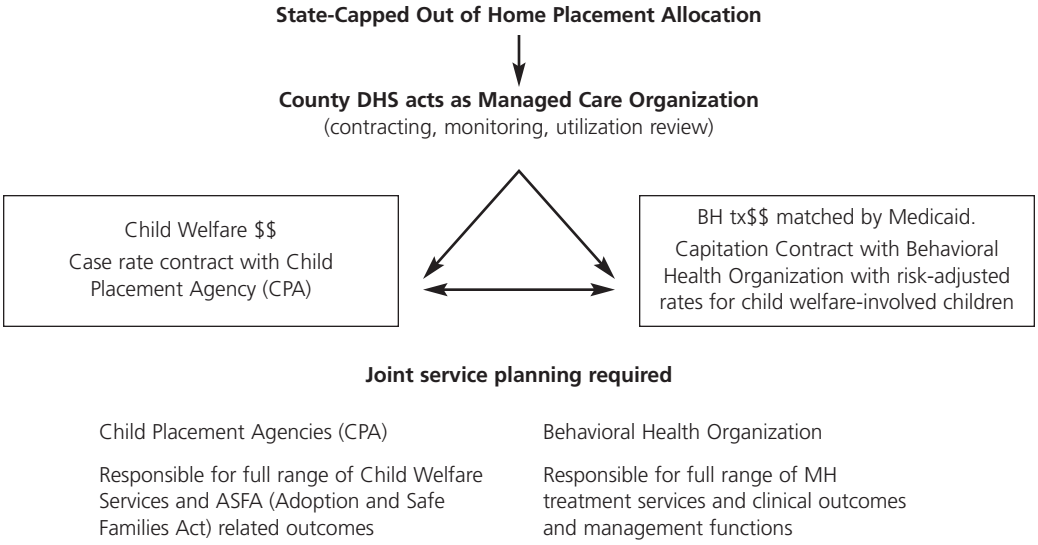
Incentive:
#1: Control the type and volume of services used (e.g., reduce inappropriate use of out-of-home placements)

Case rates, rather than capitation, seem to be more appropriate for systems of care serving children, youth and families with serious and complex issues, such as families involved in child welfare systems. Because these children and families need to use services, it does not make sense to try to prevent them from using services (an incentive in capitated arrangements), but it is appropriate to try to manage the types and cost of service to prevent over-utilization of restrictive settings and expensive services, such as out-of-home placements. A number of states, when they privatized their child welfare systems, combined out-of-home and family preservation and support dollars in a case rate arrangement and paid the case rate to lead non-profit agencies. The case rate gives the lead agency flexibility to provide different types of services and supports as needed in exchange for assuming a level of financial risk (i.e., all services have to be provided within the amount of the case rate or the provider loses money) and for meeting outcomes, such as reduced use of out-of-home placements and increased permanency. Outcomes monitoring is essential to ensure that the provider is not providing a low level of services in order to save money.

Example of System Using Capitation and Case Rate

The following illustration provides an example of the El Paso, County, CO system serving children and families in child welfare that is using both capitation and case rates—capitation on the Medicaid managed care side and case rates on the child welfare side.

RISK-BASED CONTRACTING ARRANGEMENT



Pires, S. (1999). *El Paso county, colorado risk based contracting arrangement*. Washington, DC: HSC.

MODULE 8

Progression of Risk

From a financial standpoint, all purchasing/contracting structures carry some degree of risk for systems of care as purchasers, as well as for providers or lead agencies. The following graphic, borrowed from work done by Tony Broskowski for the Annie E. Casey Foundation, illustrates the progression of risks to systems of care as purchasers, compared to providers/lead agencies, based on the type of purchasing/contracting structure. It illustrates how risks to each operate in inverse proportion to one another. For example, the risk to the system of care as purchaser is highest in a grant structure because the system of care has little leverage over the provider once the grant has been made, but a grant carries the lowest risk to the provider/lead agency. Capitation, on the other hand, carries a low financial risk for the system of care as purchaser (because expenditures are capped) but a high risk for the provider/lead agency, which has to manage the dollars and achieve outcomes within the "cap" (or lose money if expenditures exceed the cap). Not surprisingly, case rates tend to cluster in an area where the "risk" is more balanced between purchaser and provider.

PROGRESSION OF FINANCIAL RISK BY CONTRACTING ARRANGEMENT

RISK TO SYSTEM OF CARE	RISK TO PROVIDER	TYPE OF CONTRACTING ARRANGEMENT
HIGHEST RISK	LOWEST RISK	• Grant
⇧	⇩	• Fee-for-Service
		• Case Rate
LOWEST RISK	HIGHEST RISK	• Capitation

Adapted from Broskowski, A. (1996). *Progression of provider's risks*. In Managed care: Challenges for children and family services. Baltimore, MD: Annie E. Casey Foundation.

Purchasing Quality Care

Because contracting is a powerful tool for achieving (or hindering) system of care goals, system builders need to be strategic in determining what mechanisms to employ. Families and culturally diverse constituencies need to be involved in decision-making about contracting structures because they are directly affected by them. Contracting structures have a bearing on such factors as whether families will have choice of providers, whether there will be incentives for providers to under-serve, whether there will be performance incentives to provide quality home and community-based care, and the like.

In addition, sponsoring or funding agencies that award contracts should have requirements concerning practice standards and training and staff preparation to address diverse needs and provide culturally competent services and supports. In systems of care, system builders are moving from a mentality of "funding programs" to "purchasing quality care" and need to think about the purchasing/contracting strategies that will best support their goals.

Move from a mentality of "funding programs" to one of "purchasing quality care"

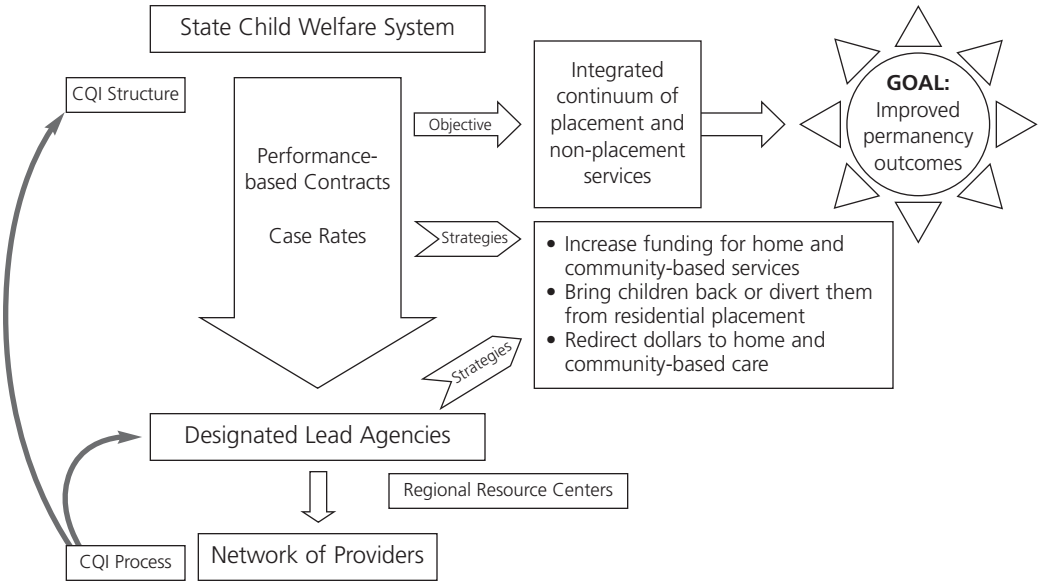
What do you want to buy that will really make a difference for your identified population(s)?

How do you want to use your dollars to promote practice change?

EXAMPLE OF PURCHASING STRATEGY TIED TO REFORM GOALS

Massachusetts provides one example of a state child welfare system that has changed its purchasing strategy to support system goals. The agency utilizes performance-based contracts with designated lead agencies on a case rate basis to create an integrated continuum of placement and non-placement services. The goal is to improve permanency outcomes by increasing the funding for home and community-based services, bringing children back or diverting them from residential placements, and re-directing dollars to home and community-based services/supports. Lead agencies, supported by regional resource centers, manage a network of providers using measurable performance standards in a Continuous Quality Improvement (CQI) process linked to the state child welfare system's own CQI structures.

Massachusetts Purchasing Strategy to Support System Goals

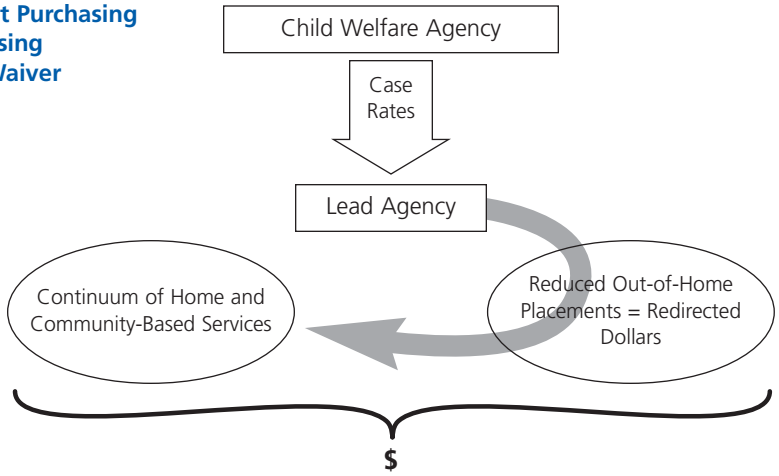


MODULE 8

EXAMPLE OF PURCHASING STRATEGY TIED TO REFORM GOALS

Connecticut is another state that changed its purchasing strategy, using a Title IV-E waiver. The child welfare agency provided case rates to lead service agencies to provide a continuum of home and community based services, re-directing dollars from out-of home placements. Evaluation of the waiver found that lengths of stay in restrictive placements were reduced, children returned to in-home placements sooner, use of care management, crisis stabilization and family support services increased, the well-being of children improved, and costs were lower.

Connecticut Purchasing Strategy Using Title IV-E Waiver



FINDINGS FROM EVALUATION OF WAIVER

- Lengths of stay in restrictive placements reduced
- Children returned to in-home placements sooner
- Use of care management, crisis stabilization and family support services increased
- Well-being of children improved
- Costs were lower

Adapted from Holden, W., et al. *Outcomes of a randomized trial of continuum of care services for children in a child welfare system*. ORC MACRO.

Questions for System Builders to Consider

1. How is the provider network, including natural supports, structured in our system of care?
2. What are the strengths and shortcomings in our current structure(s)?
3. How does our provider network incorporate partnership with families and youth, and what makes the network culturally competent?
4. What strategies can we implement to improve the provider network structure, including natural supports?
5. What are the pros and cons of these strategies?
6. What is our contracting/purchasing structure(s)? What are the strengths and shortcomings of our current contracting structure?
7. What strategies can we implement to strengthen the contracting structure(s)? What are the pros and cons of these strategies?

MODULE 9

Service Coordination and Care Management; Utilization and Quality Management

FUNCTION Service Coordination and Care Management

Service Coordination Versus Care Management

Children and families in or at risk for involvement in child welfare often have multiple issues and stressors in their lives and involvement with multiple agencies. They may need and want support to manage and coordinate their involvement with many systems and providers. Some families may need just a basic level of support in managing and coordinating service requirements, which may be court-ordered or other types of needed services; other families may require far more intensive service coordination or "care management" support. System builders need to define what they, collectively, mean by service coordination or care management before they can implement effective service coordination/care management structures, and this will be driven by the characteristics and needs of the defined target population(s).

We make a distinction between **service coordination** and **care management**. *Service coordination* is defined as assisting families with basic to intermediate needs to coordinate services, where the service coordinator has other responsibilities or is responsible for relatively large numbers of families—for example, a child welfare worker with fairly large caseloads may be providing service coordination along with other responsibilities. In contrast, the role of a *care manager* as used here is that of working with only a few families (for example, on a 1:10 ratio), who have multiple, complex needs, where the care manager is closely involved with the family and youth and with the array of providers and natural helping networks to ensure that the family can access

DEFINITION OF TERMS

Service Coordinator
Assists families with basic to intermediate needs to coordinate services and supports, usually has other responsibilities and/or is assisting large numbers of families.

Care Manager
Primary job is to be the accountable care manager for families with serious and complex needs; works with small number of families (e.g., 8-10), has authority to convene child/family team as needed and often has control over resources.

needed services and that the services and supports continue to be helpful. The care manager often controls flexible resources and has the authority to convene child and family teams. The care manager also is available to the family on a 24 hour/7 day a week basis and is not performing other functions, except that of care manager.

EXAMPLE

Nebraska has developed Integrated Care Coordination Units in which care managers work with only 10 families each and utilize informal supports as well as formal services, an approach that is decreasing the time it takes to meet the permanency goals of children with multiple and serious issues. **(www.regionsix.com/iccu.htm)**

Example of Care Management: Nebraska Integrated Care Coordination Units

We intentionally do not use the term, "case management". Many families, youth and other stakeholders find the term, "case management" off-putting since no one likes to be thought of as a "case". Thus, we use the term, "care management", but others also use the term, "care coordination".

Care Management Principles

There is no one "correct" care management or service coordination structure, but there are principles that need to underpin these structures.

CARE MANAGEMENT PRINCIPLES

- Support one plan of services/supports, even when multiple agencies and systems are involved
- Support the goals of continuity and coordination of services/supports over time and across systems
- Encompass families and youth as partners in managing services/supports
- Utilize a strengths-based focus that incorporates use of natural helpers and social support networks on which families rely and cultural and linguistic competence.

Importance of Structuring Care Management

If care management is not deliberately structured across systems for children and families involved in multiple systems but left to each agency to design its own, regardless of whether the system of care has a goal of "one plan of services/supports", the result is likely to be multiple plans and multiple service coordinators—with no one accountable "care manager" as the term is being used here. The graphic below illustrates this point, showing multiple systems involved in developing plans of services/supports with no one accountable care manager.

MULTIPLE CARE MANAGEMENT STRUCTURES NO ONE ACCOUNTABLE STRUCTURE

Intended Goal: One plan of services/supports; one care manager

Child Welfare
- Family Group Decision Making
- CW Case Worker

Kinship Care | Subsidized Adoption | Permanent Foster Care | Tutoring Parent Support, etc.

Mental Health
- Individualized Wraparound Approach
- Care Manager

Crisis Services | Treatment Foster Care | In-Home Services

Juvenile Justice
- Screening & Assessment
- Probation Officer

Community Services

Children in out-of-home placements

Education
- Child Study Team
- Teacher

Alternative School | EH Classroom Related Services

MCO
- Prior Authorization
- Clinical Coordinator

Out-patient Services | Primary Care | Medical Management

Results: Multiple plans of services/supports; multiple service coordinators

A Continuum of Service Coordination/Care Management

Depending on the population focus, a system of care may incorporate both service coordination and a care management structure. For example, it may have an intensive care management structure for children and families with serious, complex problems and more of a service coordination structure for children and families using fewer services or services intermittently.

SERVICE COORDINATION/CARE MANAGEMENT CONTINUUM

Children & families needing only brief short-term services and supports	Children & families needing intermediate level of services and supports	Children & families needing intensive and extended level of services and supports
No formal service coordination	*Service Coordination* *Larger staff:family ratios*	*Intensive care management* *Very small staff:family ratios*

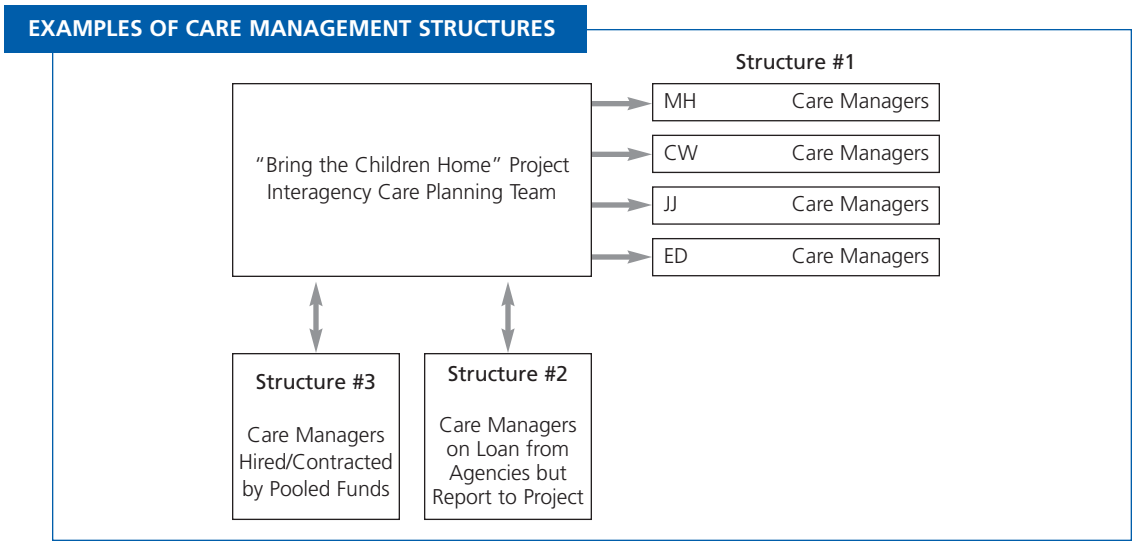
MODULE 9

Types of Care Managers

Systems of care utilize many different types of individuals in care management structures, including family members, those with professional social work or other clinical training, and paraprofessionals.

Pros and Cons of Different Structures

The following graphic can be used to illustrate the pros and cons of different care management structures.



This illustration shows three structures: one in which care managers remain in their home agencies, such as child welfare and mental health; one in which care managers are detailed from the home agency to the system of care; and one in which the care managers are hired directly by the system of care. There are pros and cons to each of these. For example, care managers staying in their home agencies might find it difficult to implement a new practice model if their surrounding agency culture is very different; on the other hand, they might become catalysts for change within their home agencies. Care managers on detail to the system of care may be more likely to implement the new practice model, but they also might feel like they are serving two masters. Newly hired care managers can be hand-selected by the system of care for their adherence to the practice model, but their positions could be vulnerable if their role is not embraced by the other agencies. There is no one perfect structure, but system builders need to think strategically about the structures that best fit their particular communities.

Questions for System Builders to Consider

1. How is service coordination and care management structured in our system of care?
2. How does our structure support the principle of "one plan of services and supports and one care coordinator" for families involved in multiple systems?

FUNCTION Utilization Management

Utilization Management

Utilization management (UM) has to do with the system of care's paying attention to how services are being used by children and families, both at an individual level and at a system's level, how much service is being used, what services are being used, the cost of those services, the effect those services are having on those using them in areas such as achieving permanency and increased safety, and whether children and families are satisfied with what they are using and experience the system as empowering. UM's areas of concern are essential to address from both a quality and a cost standpoint. At a systems level, UM data can guide quality improvement. Monitoring and review of service provision at the level of individual children and families, i.e. managing utilization, ensures that: children do not remain "stuck" in placements; families do not have to continue using services that are no longer appropriate or helpful; and costs do not escalate. Family representatives are key partners in this review process to ensure that family and youth views are part of the service decision making and quality review process.

Historically, utilization management may not be a concept frequently employed in child welfare systems; however, it pertains directly to achievement of CFSR outcomes. If systems do not know who is using services at any given time, or over the course of time, how much the service is costing and what effects or results it creates, the system will not know if it is achieving outcomes such as increasing permanency, reducing out-of-home placements, or improving functional outcomes in families and children.

EXAMPLES OF CARE MANAGEMENT STRUCTURES

- Who is using services and supports?
- What services/supports are being used?
- How much service is being used?
- What is the cost of the services/supports being used?
- What effect are the services having on those using them? (i.e., Achieving permanency? Increased safety? Are clinical/functional outcomes improving? Are families and youth experiencing the system as empowering?)

Principles for Utilization Management

There are different ways to structure UM. For example, a system of care may do its own in-house UM, or it may contract with an external entity, such as a managed care organization, a provider agency, or a family or neighborhood organization, to handle some or all UM functions. The pros and cons to these different structures have to do

with technical capacity, values, readiness, interest, etc. However UM is structured, it needs to be informed by certain *key principles*:

- it must be understood as an important function by all stakeholders, such as child welfare workers, providers, families, and managers
- it must focus on both the cost and quality of services and supports
- it need to be tied to the quality improvement structure
- it needs to address/integrate CFSR and PIP objectives.

Aligning UM Interests and Responsibilities

Utilization management may be structured as a shared responsibility among care managers, child and family teams that conduct service/support planning, providers, families, and system managers. Service/support planners, for example, may build "trigger dates or events" into service/support plans to ensure timely review. Care managers or providers may be charged with reporting back on some regular basis to service/support planning teams. Families and youth, as active partners, often know when a service has outlasted its usefulness or it is time for a change. Finally, monitoring and review functions can be structured to ensure that the family and youth voice is heard on a regular basis.

Utilization management structures need to respect the circumstances and cultural diversity within families. When service/support plans are not authorized and service barriers and gaps arise as a result, or when children are stuck in inappropriate placements, monitoring and review structures need to ensure appropriate changes in service authorization and service provision procedures. To be culturally competent, UM structures need to pay particular attention to service utilization among diverse children and families to ensure that there is not a perpetuation of either the under-service (i.e., lack of access to supportive services) or over-service in restrictive services, such as residential treatment or other out-of-home placements, that has characterized traditional service delivery to diverse populations. This may require a change in the way service data are collected and analyzed and outreach to diverse populations regarding service utilization issues.

EXAMPLE

Pennsylvania's managed care system, for example, has an "Early Warning System" that, among other things, flags disparities and disproportionality in use of behavioral health services by racially and ethnically diverse members.

FUNCTION Quality Management

Quality Management (Continuous Quality Improvement)

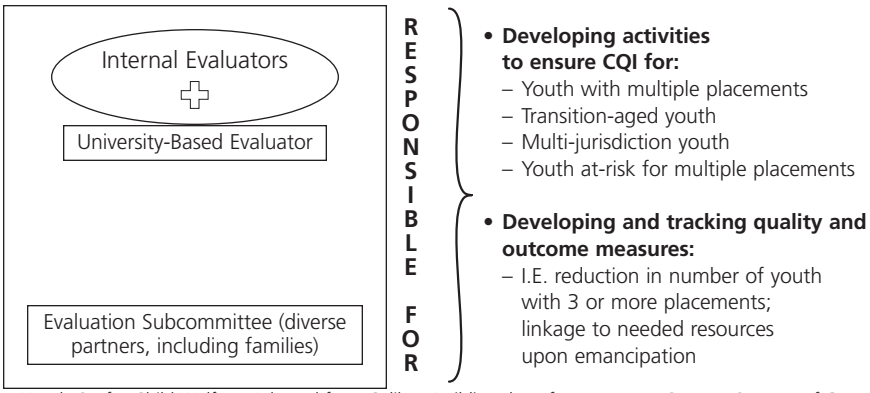
Quality management has to do with putting structures in place that are capable of telling system builders and other key stakeholders whether what is being done is making any difference for the better in the lives of the children and families being served, the taxpayers who support the system, and for the community in which the system operates. It is especially critical to partner with families and culturally diverse constituencies in the design and implementation of Continuous Quality Improvement (CQI) structures because definitions and perceptions about "quality" vary, and these stakeholders are directly impacted by the system's expectations about quality service provision. Also, it is important to understand families' experiences, not only as ultimate outcome issues, but as quality of life issues; family and youth voice is critical to this understanding and, therefore, to any CQI activity. CQI structures and methods in systems of care include both quantitative and qualitative data collection and entail a participatory evaluation framework.

EXAMPLES

The **Massachusetts** child welfare system CQI structure uses both qualitative data—e.g., foster parent satisfaction survey—and quantitative data—e.g., Family-Centered Behavior Scale and Child and Adolescent Needs and Strengths (CANS) assessment tools. These data can lead to a better understanding of what is actually occurring in the system and to more effective implementation strategies to improve the system.

Contra Costa County, California, a child welfare system of care grantee, is an example of a jurisdiction that has developed structures for utilizing data to drive quality. It formed an in-house team of "internal evaluators", contracted with an external, university-based evaluator, and created an evaluation subcommittee representing diverse stakeholder partners, including families. These entities are responsible for developing activities to ensure CQI with respect to their identified target populations, which include youth with multiple placements, transition-aged youth, multi-jurisdictional youth, and youth at risk for multiple placements. The CQI partnership has developed and is tracking quality and outcome measures specific to these populations, such as reduction in the number of youth with three or more placements and linkage of youth to needed resources upon emancipation.

Example: Utilizing Data to Drive Quality Contra Costa County's CQI Structure



Pires, S. (2006). Primer Hands On for Child Welfare. Adapted from Caliber, *Building the Infrastructure to Support Systems of Care*.

MODULE 9

Confidentiality and Rights Protection

Both the privacy and rights of families and youth involved in the system of care need to be safeguarded. Confidentiality need not become a deterrent to service coordination and collaboration, but it needs to be addressed by system builders, and structures put in place to maintain confidentiality. This becomes even more important in light of the stigma associated with child welfare involvement. Similarly, system builders need to address the rights (and responsibilities) of families and youth and put structures in place to allow for fair and timely attention to grievances. *Confidentiality and rights protection needs to be seen strategically as part of a system's quality improvement process*. It is important that these rights be effectively communicated to all families, which necessitates culturally competent communication vehicles.

CQI systems are strengthened by the involvement of stakeholders affected by or involved in child welfare, such as families and providers.

EXAMPLE

The **Missouri** child welfare system involves community partners in conducting Quality Assurance Practice Development Reviews, which mirror the CFSR reviews. **(www.dss.mo.gov/cd)**

Purposes of UM and Evaluation Data

Effective systems of care use UM and other types of evaluation data for many reasons, including: planning and decision support; changing practice, supporting a continuous quality improvement (CQI) structure, for cost monitoring, and for media and marketing results to legislators, the community and others. Data, of course, also are critical to inform CFSR reviews and PIPs. The CFSR Comprehensive Training and Technical Assistance Package Focus Area V—Using Information and Data in Planning and Measuring Progress—includes a section on "Using Reports as Tools" and identifies various types of reports and the information each may convey. It is available on the website of the National Child Welfare Resource Center for Organizational Improvement (http://muskie.usm.maine.edu/helpkids/CFSRPackage/Area5-Synopsis.doc).

PURPOSES OF UM AND EVALUATION DATA

- Planning and decision support (day-to-day and retrospectively)
- Quality improvement
- Cost monitoring
- Research
- Marketing and media
- Accountability
- Changing casework practice

EXAMPLE OF USE OF DATA FOR CONTINUOUS QUALITY IMPROVEMENT

Michigan requires its local community mental health authorities to use the Child and Adolescent Functional Assessment Scale (CAFAS), including for children in child welfare, and uses data from the CAFAS to inform quality improvement and use of evidence-based and effective practices (e.g., Cognitive Behavior Therapy for depression).

Example: Statewide Quality Improvement Initiative

Michigan: Use data on child/family outcomes (CAFAS) to:

- Focus on quality statewide and by site
- Identify effective local programs and practices
- Identify types of youth served and practices associated with good outcomes (and practices associated with bad outcomes)
- Inform use of evidence based practices (e.g., Cognitive Behavior (CBT) for depression)
- Support providers with training by data
- Inform performance-based contracting

QI Initiative designed and implemented as a partnership among State, University and Family Organization

Hodges. K., & J. Wotring. 2005. State of Michigan.

Examples of Outcomes Measures Related to CFSR

The Oregon system of care approach was a voluntary settlement agreement to a law suit that kept child welfare out of court, but included close monitoring and involvement from the plaintiff attorneys. According to Beth Englander, who was the first multi-field administrator and then the system of care manager, a major reason for the success of the implementation of the system of care in the pilot district was developing buy-in from the community throughout the process. The pilot district also implemented a system of care at the same time it was selected as a demonstration site for Oregon's IV-E Waiver, which created financial flexibility. The state eventually implemented systems of care statewide, reaching about 75% of the state's foster care caseload, connecting the system of care to Oregon's initial CFSR and the PIP. The PIP was heavily built around system of care values, principles and operating characteristics for the well-being objectives and a good portion of the permanency actions and benchmarks. (www.oregon.gov/dhs/children/welfare/systemofcare)

PROPOSED OUTCOMES MEASUREMENTS OF SUCCESS FOR A SYSTEM OF CARE IN OREGON

1. The array of services available to children and families will increase and there will be evidence in case records that the community is collaborating to provide wraparound services.
2. The number of parents actively involved in planning for reunification or preservation of their families will increase. (i.e., the number of Family Meetings will increase; more voluntary agreements; earlier compliance; increase in staff and partners trained to facilitate Family Meetings; parents will be able to articulate their child's needs and understand how to meet those needs; increase in direct family contact; when a child is re-abused or at risk of re-abuse, parents will be able to recognize the need for assistance and make a voluntary request for services)
3. There will be an increase of foster care beds in targeted recruitment areas of minority and medically fragile providers.
4. Every child entering foster care will have a full physical and mental health assessment by two weeks time in placement.
5. Case records will clearly document practice change that supports identified child needs (i.e., children will make fewer moves in care; the Service Plan clearly reflects children's needs and is based on sound assessment practices.
6. Reasonable efforts will always be made to prevent placements in foster care and attachment will always be considered as a factor in placement (i.e., law enforcement will place children in care after hours with consultation from SCF; children will be placed with kinship providers unless safety is n issue; children will be placed in their neighborhood or origin, or the SOC plan will address a desired permanency outcome for transient children and their parents that establishes a stable environment; length of stay in care will reduce; length of time to the initial visit will decrease considerably; school age children will remain in their current school)
7. The focus of visitation practice will continue to shift toward a fully therapeutic model and there will be an increase in the number/types of tools used to promote visitation.
8. Every case worker will have cases meeting SOC criteria designated as such.
9. There will be fewer Termination of Parental Rights (TPRs) and more relinquishments, when the presumed alternate plan is adoption and must be implemented.
10. Foster Parent will be involved with case planning.
11. Children will be placed in compliance with the agreement.

Englander, B. System of Care, Oregon.

EXAMPLE

Central Nebraska (a 22-county region) provides another example of a system of care approach to achieve CFSR-related outcomes. Through its *Integrated Care Coordination Units*, which developed through a system of care approach involving child welfare, mental health, juvenile justice, Medicaid and the family organization, outcomes achieved included the following:

Integrated Care Coordination Unit

- At enrollment, 35.8% of children served were living in group or residential care; at disenrollment, 5.4% were in group or residential care
- At enrollment, 2.3% of children were living in psychiatric hospitals; at disenrollment, no children were hospitalized
- At enrollment, 7% of youth served were in juvenile detention or correctional facilities; at disenrollment, no youth were in these facilities
- At enrollment, 41.4% of children were living in the community (at home - 4.4%; with a relative - 1.5%; in foster care - 35.5%); at disenrollment, 87.1% were living in the community (at home - 53.5%; with a relative - 7.6%; in foster care - 14.5%; independent living - 11.5%).
- Improvement in Child and Adolescent Functional Assessment Scale scores
- Generation of $900,000 in cost savings (by reducing cost per child served)

Early Integrated Care Coordination Unit

- Prevention of placement in state custody for 88.1% of children referred.

EXAMPLE

Wraparound Milwaukee reports and collects outcome data related to children involved in child welfare as well as the experience of families. They then use these results to track progress, inform CQI internally, and inform legislators and others.

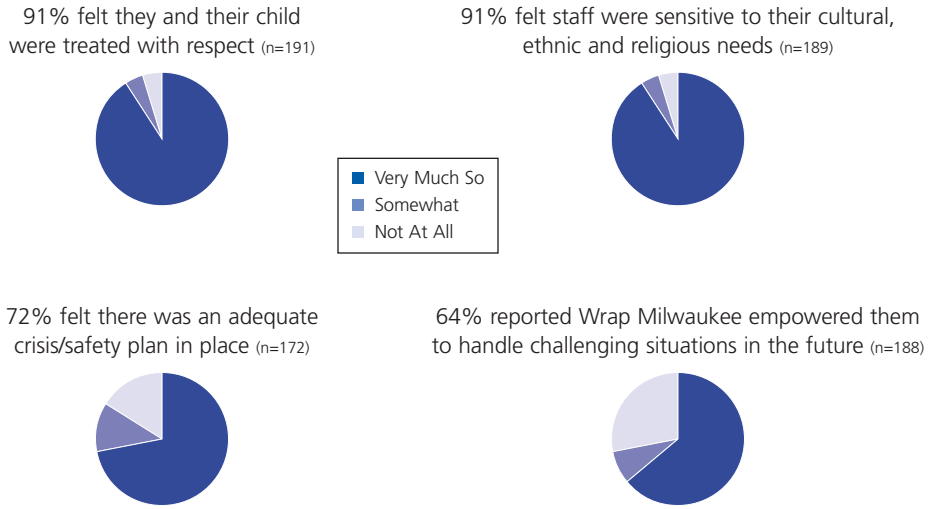
Example: Outcomes for Wraparound Milwaukee

- Reduction in placement disruption rate from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily RTC population from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days less than 200 days per year
- Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)

Wraparound Milwaukee. 2004. Milwaukee, WI.

Example: Family/Caregiver Experience Wraparound Milwaukee

*Nearly half had previous CPS referral



Questions for System Builders to Consider

1. What is our utilization management structure?
2. How does it link cost and quality concerns?
3. How is utilization management linked to continuous quality improvement?
4. How do our UM and CQI structures promote alignment of interests across systems and stakeholders?
5. How are families and youth involved in our UM and CQI structures?

MODULE 10

Other Important System of Care Functions and Wrap Up—Common System of Care Elements

Building Systems of Care: A Primer for Child Welfare has covered many of the functions that require structure in systems of care. Several more functions that have not been addressed fully and individually in the previous pages are discussed here in Module 10. These include:

- Human Resource Development
- External and Internal Communication
- Information Management
- Technical Assistance and Consultation

FUNCTION Human Resource Development

Overview

Human resource development (HRD) focuses on a number of elements to ensure adequate numbers of appropriately trained personnel—both in-house and within provider and other stakeholder communities—with the skills, knowledge, and attitudes to work effectively in systems of care. HRD functions require strategic planning and are tied to quality improvement goals.

HUMAN RESOURCE DEVELOPMENT FUNCTIONS

- Assessment of workshops requirements (i.e., what skills are needed, what types of staff/providers, how many staff/providers) in the context of systems change
- Recruitment, retention, staff distribution
- Education and training (pre-service and in-service)
- Standards and licensure

Culturally Competent, Family/Youth-Driven HRD Strategies

Families, youth, and culturally diverse populations need to be involved in the development of human resource development strategies. They are themselves potential resources in staffing arrangements and are directly affected by HRD decisions. Systems of

care use a variety of strategies to involve families and diverse communities in human resource development functions.

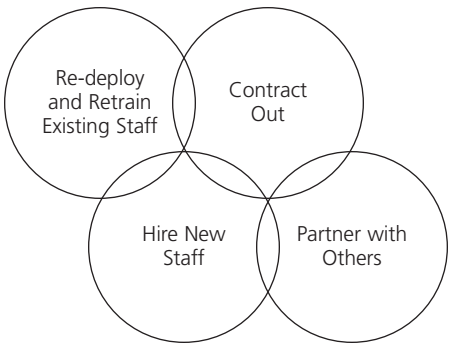
STRATEGIES TO INVOLVE FAMILIES, YOUTH AND DIVERSE COMMUNITIES IN HRD FUNCTIONS

- Involvement in assessing workforce requirements
- Helping to develop requirements for job announcements and having input on hiring decisions
- Hiring family members and youth in paid staff roles
- Engaging leaders from culturally diverse communities to assist in recruitment
- Partnering with Historic Black and Hispanic colleges and other institutions both for recruitment and to train existing and prospective staff in cultural competence
- Utilizing families and culturally diverse constituencies to develop questions in interview protocols that reflect cultural awareness

Staffing Systems of Care

There are many different ways of "staffing" systems of care, including redeploying existing staff, contracting out, hiring new staff, and partnering with others for staff capacity. There are pros and cons to all of these arrangements. For example, hiring all new staff or contracting out provides flexibility in choosing staff, but it may disenfranchise staff in traditional agencies whose support is also needed. System builders also have to consider the types of staff needed, such as formally trained staff, paraprofessionals, culturally diverse staff, natural helpers, and family members and youth in staff roles. These decisions have issues attached to them, such as salary equity issues and the kind of training that is needed. The strategic analysis regarding staffing must also take into account the availability of staff and the compatibility of staffing decisions with staffing requirements of accrediting organizations, funders such as Medicaid, and licensing bodies. Recruitment and retention of staff in child welfare systems is typically a major challenge, and the system of care must develop strategies to ensure a sufficient staff capacity so that staff are not overwhelmed and families under-supported.

STAFFING SYSTEMS OF CARE



EXAMPLE

For example, some jurisdictions, such as the **District of Columbia**, offer student loan repayment as an incentive to social workers to join the child welfare system.

A Cross-System Training Focus

Besides figuring out how to staff system of care functions, system builders need to strategize regarding the kinds of staff, provider and other stakeholder development to implement. They also need to think about what staff support, training, and supervisory structures to implement. For example, staff working in dangerous neighborhoods need back-up supports, such as "buddy systems". Workers need to be able to turn to well trained and supportive supervisors for guidance, brainstorming, and encouragement.

Few system builders or those providing services within systems of care come to the task with all the requisite skills, knowledge, and attitudes. Training structures that are ongoing, tied to system of care principles and goals, and inclusive of key stakeholders are needed. System builders need to be strategic about how to build on and adapt existing training structures, such as those supported by Title IV-E (child welfare) dollars, since dollars for training are often scarce.

In traditional systems, each agency tends to develop its own training and staff development agenda, using its own training resources. *Systems of care try to develop strategic training and human resource development activities across child-serving systems*. A more traditional approach is when systems, programs and practice operate in isolation, creating separate training agendas and utilizing an "expert model" only. Systems of care take a more unified approach where state systems pool training efforts, and families, youth and the community are integral participants in all aspects of training.

A DEVELOPMENTAL TRAINING CURRICULUM

	TRADITIONAL	MODIFIED	INTEGRATED	UNIFIED
SYSTEM	State systems develop training along specialty guideline—Promotion of stronger specialty focus	State systems independently adopt similar philosophy, promoting Collaboration	State systems begin sharing training calendars Promotion of cross-training; joint funding	State systems pool training staff, merge training events
PROGRAM	Community agencies and universities operate in isolation Disciplines train in isolation from one another Instruction in didactic, "expert" No support for cross-training	Community agencies and Universities begin joint research and evaluation Pre-service training remains separate from the field	Community agencies and universities begin to integrate field staff/families into pre-service training Student field placements cross-agency boundaries Cross-agency training gains support	Community agencies and universities collaborate with larger community, e.g., families as co-instructors; curricula reflect practice goals Training geared to system goals
PRACTICE	Participation in professional conferences on individual basis within agency boundaries Services are provided within agency boundaries	Staff receive training that promotes collaboration but receive it within agency boundaries Specialty focus predominant Services remain within agency boundaries	Service teaming is promoted through cross-agency training	Service teams with full family inclusion are the norm Redefined specialty practice roles develop to support professional identity while promoting collaboration

Meyers, J., Kaufman, M., & Goldman, S. (1991). *Training strategies for serving children with serious emotional disturbances and their families in a system of care. Promising practices in children's mental health*. 5. Washington, D.C.: American Institutes for Research.

EXAMPLES

Clark County, Nevada and **St. Mary's County, Maryland** are two examples of local jurisdictions that are implementing cross-stakeholder, cross-system training in a system of care practice model. They are training, for example, CPS investigators and permanency staff, mental health clinicians, juvenile probation staff, provider agencies, and families in a strengths-based, culturally competent, individualized, child and family team approach.

North Carolina, which has a child welfare system of care grant, provides a State example through its formation of a System of Care Child and Family Team Curriculum and Training Workgroup. This workgroup is composed of a cross-section of state and local agencies, several university partners, and family partners. The goal of a cross-agency/stakeholder training agenda is to develop a consistent practice model in implementing a system of care approach. The NC State Collaborative (made up of representatives from all of the major systems serving children, youth and families, community-based organizations, non-profits, university partners, and family members) worked together to obtain additional grant funding from the NC Crime Commission to conduct trainings on system of care principles and the Child and Family team approach. Trainings were conducted by a parent/youth/professional team. They also have pooled resources to develop a cross-agency child and family team curriculum, funding family members to participate on the curriculum development team. They also are pooling funds to train child and family team facilitators. **(www.dhhs.state.nc.us/dss/systemofcare/soc.htm)**

Questions for System Builders to Consider

1. Have we undertaken an HRD assessment and developed strategies to ensure that we have an adequate number of personnel (in house and contracted) with the right skills, knowledge and attitudes to function effectively in a system of care?
2. How do we involve families and youth in our HRD strategies?
3. How are our HRD strategies culturally and linguistically competent?

FUNCTION External and Internal Communication

Overview

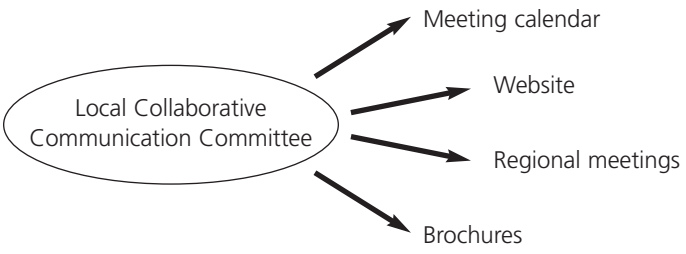
External communication includes structures to inform those outside the system of care, such as legislators and the media, about system of care goals, achievements, and challenges. Effective communication, which is a strategic tool, can be key to sustaining and growing the system of care; on the other hand, it can also lead to greater demands from families, legislators and others on the system than it can handle. External communication must take into consideration the intended audience and the desired outcome of the communication. Social marketing and the media are discussed more fully below.

Internal communication structures are critical to ensure an ongoing information exchange across stakeholders within the system of care so that misinformation, rumors, and gossip do not sabotage the system.

EXAMPLE

North Carolina, through its child welfare system of care grant, created a Local Collaborative Communication Committee, representing the cross-agency and family stakeholders involved in the system, to plan a variety of ways to ensure communication, such as a website, regional meetings, brochures, a meeting calendar, etc. The State Collaborative pooled resources to finance development of the website, and one of the non-profit agencies participating on the Collaborative serves as fiscal agent for the website.

Communication Mechanisms in the North Carolina System of Care



MODULE 10

Social Marketing, Media and Public Relations

An important system function, which should be part of every system of care's strategic planning process, is social marketing. A social marketing campaign is run when you are trying to change behavior of a large number of people usually over a long period of time. When system builders for the **Kansas** Family Centered Systems of Care decided they wanted to make long term changes in the culture of child welfare in Kansas, they embarked on a marketing strategy, stating that their purpose was *"to create massive and unprecedented community support and involvement on their [children's] behalf."*

EXAMPLES

The **Kansas** *Family Centered System of Care* embarked on a social marketing campaign *"to make long term changes in the culture of Child Welfare in Kansas...seeking to infuse this philosophy along with its 6 principles into the everyday policies and practice process that is utilized in partnering with families and children."* For more information go to **www.ctb.ku.edu**.

One of the goals of **Oregon's** *System of Care* Goals and Performance Measures was *"Public Pride—The public knows about and takes pride in Oregon's record of child safety and permanency."* Goals and Performance Guidelines included actions to be taken by system of care communities and specific performance measures. For more information, go to: **www.oregon.gov/dhs/children/welfare/systemofcare**.

Illinois' *Don't Write Me Off: Foster Kids Are Our Kids* campaign conducted a seminar with top social marketing experts. The seminar was geared for *Don't Write Me Off* Ambassadors, Foster Home Recruiters, Communications and/or Development Directors and Executive Directors. It included detailed information about media opportunities for Illinois child welfare agencies and the placements of billboard, transit and other advertisements of the Don't Write Me Off Campaign throughout the state. For more information contact Barb Oldani at **bmo@cca-il.org**.

While many consider the media something to be avoided, it can be a powerful ally if approached strategically. Any contact with the media, whether proactive or reactive, needs to be strategic. The media are often responding to child abuse and neglect cases and looking for "child welfare stories." Media outlets need quick and useful references, including web-sites, advocacy organizations, and "media-friendly" experts for background and contextual information. Who better to oblige them and meet their needs than a representative from the system of care community, who is prepared to give thoughtful, honest answers? Nedra Kline Weinreich crafted the following media-related questions for the National Clearinghouse on Child Abuse and Neglect Information. By carefully considering answers to these questions, system builders can build strategies for working with media professionals to get system of care messages out to the people systems wish to reach.

DEVELOPING A MEDIA STRATEGY

1. Why do you want the media attention?
2. What is your "news?"
3. What types of media coverage do you want?
4. Whom will you contact in the media?
5. How will you contact the media?
6. What do you have to offer?
7. How will you respond when the media call you?
8. Which media strategy can your available resources support?
9. What other sources of free publicity are available in your community?
10. How will you know if you've been effective?

Questions for System Builders to Consider

1. What structures have we put in place for internal communication among the many stakeholders involved in system building?
2. What are our external communication structures and strategies, for example, for dealing with the media, for getting outcomes data to legislators?

FUNCTION Information Management

Overview

Systems of care are best supported by management information systems (MIS) that provide "real time" data to support decision-making and accountability. Data are needed to guide child and family teams and care managers, to track service utilization, to measure and assess the quality and cost of care, and to communicate information to key audiences, such as legislators and family members. Strategic decisions have to be made as to how much energy to devote to changing larger MIS systems or to developing customized ones, and there are pros and cons to these decisions.

How MIS systems are structured can make people's jobs more difficult or easier. Everyone has heard stories of staff that keep a "shadow" paper file because the MIS system does not make sense to them, or they view it as unreliable.

FUNCTIONS NEEDING MIS SUPPORT

- **Tracking:** Who is providing what to whom at what cost? Where are children in placement? What Federal, State or court timelines need to be met? Etc.
- **Measuring and Assessing:** What effect is what we are doing having—on children, on youth, on families, on providers, on workers, on other systems, on taxpayers?
- **Communicating:** Packaging and providing information to different audiences (e.g., to providers, legislators, families and youth, care managers, supervisors, the general public, etc.)

Most systems of care have to navigate existing MIS systems, for example, those in child welfare, Medicaid, mental health, and often systems at both State and local levels. A goal of systems of care is to create integrated or at least compatible MIS systems across child-serving systems serving the same population(s). That is often an enormous and time-consuming process. Some systems of care, particularly those focusing on smaller subsets of children, have elected to develop or purchase a more customized MIS system and link it to the existing MIS systems.

EXAMPLE

Wraparound Milwaukee developed its own web-based MIS system to provide real-time data to child and family teams, care managers, providers and administrators. The same system that captures child and family plans of care and services and supports provided also allows providers to bill on-line (reducing reimbursement time to 5 days), and it captures data for QI and outcomes monitoring. **Cuyahoga County, OH** is purchasing Wraparound Milwaukee's MIS system, called *Synthesis*, to support its own developing system of care. *Synthesis* is capable of interfacing with the child welfare's system's MIS and can extract needed data for Medicaid reporting purposes.

Questions for System Builders to Consider

1. Do we have MIS systems in place to track, measure, assess and communicate our activities?
2. Do our MIS systems provide key stakeholders (such as child and family teams and care managers, with real-time data to inform decision-making?

FUNCTION Technical Assistance and Consultation

Overview

System builders need to be strategic in how they utilize consultants and technical assistance providers, recognizing that there are various types of technical assistance, such as local, national, technical skill-building, advice, facilitation, coaching, peer mentoring, etc. Strategies for using various types of technical assistance and training resources need to be tied to the goals and concrete objectives of system builders. There needs to be a coordinated technical assistance and consultation approach, not one in which various consultants and trainers are operating independently without understanding the broader strategy.

There is, of course, a certain blurring among the types of support described above. System builders need to think strategically about how to use these various types of support and how they want to draw on national, local and/or peer resources.

TECHNICAL ASSISTANCE TAXONOMY

- **Technical Assistance:** provision of specialized, practical knowledge on a particular aspect of system building, for example, maximizing Federal revenue
- **Consultation:** providing advice and opinions
- **Coaching or Mentoring:** acting as a "trusted guide", providing direction, prompting, instruction and support
- **Facilitation:** providing support to a system building process to make the process run more smoothly
- **Persuasion:** acting as a "provocateur" or "national expert" when systems are stuck or when local system builders cannot carry the message themselves (sometimes simply because it is difficult to be "a prophet in your own land")
- **Training:** teaching and skill building
- **Peer Support:** support provided by someone who has had similar experience

Questions for System Builders to Consider

1. How are we building technical assistance and consultation into our system?
2. How is technical assistance and consultation coordinated across the various parts of our system to maximize its impact?

Wrap Up—Common Elements of Systems of Care

The purpose of *Building Systems of Care: A Primer for Child Welfare* is not to describe everything there is to know about every function or process variable in building systems of care. While a number of critical functions and process elements have been addressed in the monograph, the purpose is to provide a strategic framework for the development of systems of care and describe the common characteristics of systems of care, with particular attention to children, youth and families in, or at risk of involvement in, child welfare. The following list re-caps these common elements.

COMMON ELEMENTS OF RE-STRUCTURED SYSTEMS OF CARE

- They are values-based systems that incorporate the concept of partnering with families and youth
- Population(s) of focus are identified, and who controls funds and resources for the population(s) is determined. These entities are engaged as partners
- A locus of accountability (often with some element of shared risk) is created for children and families that cross multiple systems and services and have intensive service needs
- The pathway to services and supports is clear to families and other system stakeholders
- The system incorporates a practice model that is strengths-based, individualized, family and youth-guided, and culturally/linguistically competent
- The system includes mechanisms for service coordination and intensive care management
- Flexible and coordinated financing and purchasing arrangements are utilized, such as case rates, qualified provider panels
- The system often combines funding from multiple funders (e.g., Medicaid, child welfare, mental health, juvenile justice, education)
- The system includes a broad provider network that understands the target population. The network includes formal services, informal supports, and evidence-based and promising practices
- The system uses real-time data to guide service planning, utilization and quality management
- The system tracks meaningful outcomes at a child/family level and at a systems level, including outcomes related to CFSR/PIP
- The system pays attention to utilization and quality management
- The system utilizes mobile crisis response systems to prevent placement disruptions and use of restrictive levels of care, such as hospitalization
- Efforts are made to educate, engage, and get buy-in from judges, guardians ad litem, CASA volunteers and those performing assessments for the court
- The system engages residential treatment providers to "re-engineer" their services to provide a continuum of home and community based services and partner with families and other stakeholders
- There is shared governance and liability across stakeholders for the identified population(s)
- Training and technical assistance are priorities and are used strategically to support system builders.

"The world that we have made as a result of the level of thinking we have done thus far creates problems that we cannot solve at the same level at which we created them." —A. EINSTEIN

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Resources

Acronyms

Glossary

Web Links

RESOURCES

Acronyms

ACF	Administration for Children and Families
ADH	Administrative Disqualification Hearings
AECF	Annie E. Casey Foundation
AHA	American Humane Association
ASO	Administrative Services Organization
BH	Behavioral Health
BHO	Behavioral Health Organization
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CAPTA	Child Abuse Prevention and Treatment Act
CASA	Court Appointed Special Advocate
CASSP	Child and Adolescent Service System Program
CBT	Cognitive Behavior Therapy
CFSR	Child and Family Services Review
CME	Care Management Entity
CMHS	Center on Mental Health Services
CMS	Centers on Medicare and Medicaid Services
CPA	Child Placement Agency
CPPC	Community Partnerships for Protecting Children
CPS	Child Protective Services
CQI	Continuous Quality Improvement
CRS	Congressional Research Service
CW	Child Welfare
DHHS	Department of Health and Human Services
DHS	Department of Human Services
DSS	Department of Social Services
EBP	Evidence-Based Practice
ED	Education
EPSDT	Medicaid Early Periodic Screening, Diagnosis and Treatment Program
F2F	Family-To-Family
FCFC	Family & Children First Council
FFS	Fee-For-Service

FGDM	Family Group Decision Making
FSPT	Family Service Planning Teams
GAL	Guardian Ad Litem
GUCCHD	Georgetown University Center for Child and Human Development
HCBS	Home and Community Based Services
HRD	Human Resource Development
IFSP	Individual Family Service Plan
IP/ER	In-Patient/Emergency Room
JJ	Juvenile Justice
MCO	Managed Care Organization
MDTFC	Multi-Dimensional Treatment Foster Care
MH	Mental Health
MHSPY	Robert Wood Johnson Foundation's Mental Health Services Program for Youth
MIS	Management Information System
MRS	Multiple Response System
MSO	Management Service Organization
MST	Multisystemic Therapy
NRCOI	National Child Welfare Resource Center for Organizational Improvement
PCIT	Parent-Child Interaction Therapy
PEP	Positive Education Program
PIP	Program Improvement Plan
QA	Quality Assurance
QI	Quality Improvement
RFP	Request for Proposals
RTC	Residential Treatment Center
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SCY	Strengthening Communities—Youth
SED	Serious Emotional Disorder
SOC	System of Care
SSA	Social Security Act
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
UM	Utilization Management
UR	Utilization Review

RESOURCES

Glossary

assessment—comprehensive analysis of data gathered from multiple sources that identifies strengths, resources and needs; leads to and informs service planning

Abuse Focused Cognitive Behavioral Therapy—example of an evidence-based therapy for use with children involved, or at risk for involvement, in the child welfare system; developed to resolve posttraumatic stress disorder and depressive and anxiety symptoms, as well as to address underlying distortions about self-blame, safety, the trustworthiness of others and the world; the treatment also fits sexual abuse and other traumatic experiences into a broader context of children's lives so that their primary identity is not that of a victim

action plan—an objective or goal to be reached by a desired end point in development; it is usually endeavored to be reached in a defined time by setting deadlines

benefit design—term borrowed from managed care pertaining to the types of services and supports that are allowable within systems of care (or insurance coverage) and under which conditions

bottom-up approach—individual of a system is recognized first and then linked together with other individuals to form a larger subsystem which is linked together with other subsystems until larger networks formed; also referred to as a "seed" model

capitation rate—a fixed amount per eligible user of services paid to managed care entities, providers, or lead agencies

case rates—a fixed rate per actual user of services, based typically on the service recipient's meeting a certain service or diagnostic profile

categorical—a specifically defined division within a classification system

communication mechanism—a method used for the exchanging of ideas, thoughts, opinions, and feelings so that stakeholders know what is going on, and rumors and misinformation can be minimized

community level—partnerships with families, youth, and natural helping networks to achieve community support

Community Partnerships for Protecting Children—an initiative of the Edna McConnell Clark Foundation that focuses on changing child protective services through family-centered practice supported by neighborhood networks

conflict resolution—the process of attempting to dissolve a dispute; usually occurs through listening to and trying to meet each side's needs so both sides are satisfied with results

constituency building—the gathering of individuals, stakeholders, or organizations which are bound by shared structures, goals or loyalty

core value—constant, fundamental beliefs that construct the values by which one lives his/her life

cultural competence—the capacity to value diversity, conduct self assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge and adapt to diversity and the cultural contexts of the communities served; having a defined set of values and principles and demonstrating behaviors, attitudes, policies and structures that enable one to work effectively cross-culturally

culture—a broad concept that reflects an integrated pattern of a wide range of beliefs, practices and attitudes that make up an individual

day treatment—type of program used in treatment of mental illness and substance abuse; may include special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy; typically lasts at least 4 hours a day; day treatment programs work in conjunction with mental health, recreation, and education organizations

deficit-based—an orientation to the lack or impairment of a functional capacity

didactic—designed or intended to teach or instruct

disenfranchised—disadvantaged, underprivileged, lacking in necessities, advantage, and/or opportunity; especially of economic or social necessities

disproportionality—the state of not corresponding in size or degree or extent; an absence of proper proportion

early intervention programs—a preventive treatment for children of school age or younger and their families, who are discovered to have, or be at risk of developing, a handicapping condition or other special need that may affect their development; also, programs that seek to identify any populations at risk and provide supports before problems become serious or crises arise

eco-map—a tool to assist screening, assessment, evaluation and service planning processes; supports a systems approach, family-centered practice and development of a culturally appropriate and reflective plan of services and supports

empowerment paradigm—stresses empowerment as the method to solving problems (especially poverty), and expanding opportunities, allows fundamental changes to take place

ethical standards—moral and value reasoning with which an organization, person, or professional operates

evaluation—closer, more intensive study of a particular or suspected issue; provides data to the assessment process; discipline-specific.

evidence-based—shown effectiveness through carefully controlled, random clinical trials

expert model—reliance on expert opinion to determine appropriate provision of services and supports

Family Finding—use of Internet search engines to locate extended family members for children and youth in foster care

Family Group Conferencing—a decision-making process involving families, public agencies and community participants that is structured so that families involved in child welfare can exercise a meaningful voice over their affairs; facilitated by a trained, "independent" coordinator

Family Group Decision Making (FGDM)—"a non-adversarial process in which families, in partnership with child welfare and other community resources, develop plans and make decisions to address issues of safety, permanence and well-being…reflecting the principles of family-centered practice, FGDM is strengths-oriented, culturally adapted, and community-based." (National Resource Center on Organizational Improvement)

family/youth peer mentors—relationship development between two individuals who have shared life experiences to increase social skills and confidence

family-driven—families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, State, Tribe and nation that includes: choosing supports, services and providers; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; and determining the effectiveness of all efforts to promote the well-being of children and youth

fee-for-service—a payment mechanism in which providers receive a fee for each service actually provided, such as an in-home visit or counseling session

frontline practice level—the level at which health and human services workers actually interact with children, youth and families in directly providing services and supports

Functional Family Therapy—an evidence-based and systematic family-based model for working with at risk adolescents and their families

geographic disparities—the state of being unequal or different based on where one lives

governance—decision making and oversight at a policy level that has legitimacy, authority and accountability

group home—a dwelling which has been adapted to house a number of un-related persons who share a common characteristic

Head Start—the federal program that promotes the economic and social well-being of families and children from three to five years of age

independent living skills and supports—help provided to youth in transition and young adults designed to increase self-reliance and self-confidence and build skills to function on one's own

in-kind support—assistance or aid given with commodities or work, but not with money

intensive care management—working with only a few families who have children with multiple, complex needs, where the care manager is closely involved with the family and youth and with the array of providers and natural helping networks to ensure provision of the appropriate services and supports; the care manager often controls flexible resources and has the authority to convene child and family teams

intensive home-based service—clinical services and supports provided in the home often with the intent to prevent removal of a child from the home

life domains—spheres of activity that constitute an individual's perceptions of quality of life; examples include: physical functioning, spirituality, occupational/role functioning, future orientation, social functioning, sexuality/intimacy, emotional functioning, health concerns, family well-being and financial satisfaction

linguistic competence—the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities

locus of management accountability—the concept of lodging responsibility with one entity for populations of children, youth and families that are involved in multiple entities

Master's Level Care Managers—those managers who have received a Master's level degree

mediation—an attempt to bring about a peaceful settlement or compromise between disputants through the objective intervention of a neutral party

Mobile Response and Stabilization Services—aimed at expeditiously ensuring the safety of child, youth, and adults and their family/care-givers that are facing a crisis situation in order to prevent the disruption of current living arrangements

Multidimensional Treatment Foster Care (MDTFC)—serves as an alternative to residential treatment and to deter subsequent incarceration among a high risk population; the goal of MDTFC is to provide at-risk youth with the skills, resources, supervision and structure necessary to reduce delinquency or other behavioral problems in place of more pro-social and adaptive behaviors; the program relies on the involvement of trained foster families, therapists, and case managers to provide youth with the skills and structure to modify behavior; the ultimate goal of MDTFC is to return youth to their biological or adoptive families, who are also involved throughout the process.

Multisystemic Therapy—an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in youth

natural helpers—may be family members, youth, representatives from culturally diverse neighborhoods, and others who can provide a more "normalized" and enduring form of support to families and youth than can formal services; examples of what natural helpers can provide include: skill building, emotional support; resource acquisition and concrete help.

non-categorical—an approach that cannot be categorized into a specific division

Parent-Child Interaction Therapy (PCIT)—an empirically-supported treatment for young children with behavioral challenges that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns

political strategy—a manner of positioning one's goals so as to attain and/or retain one's standing

population focus—centers on a population or populations of children and families who cross or at risk of crossing all or many systems and engages all systems in a reform agenda

practice-based evidence—an approach which has not yet had the benefit of scientific research but which experientially has demonstrated effective outcomes

residential treatment—a structured out-of-home placement utilized for treating an individual's behavioral/emotional problems by providing 24-hour care with counseling, therapy and trained staff

respite services—service which enables caregivers to take needed breaks from caregiving while knowing their loved one is being cared for

screening—identifies individuals at high risk and links them to appropriate assessments

self-assessment—process in which the respondent determines his or her level of knowledge and skills, strengths and needs

service coordination—the assisting of families with basic to intermediate needs to coordinate services, where the service coordinator has other responsibilities or is responsible for a relatively large number of families

service planning—an individualized, collaborative decision-making process for determining services and supports, timeframes and goals, drawing on screening, assessment and evaluation data

siloed approach—a methodology that cannot easily integrate with any other because of multiple versions of the same data which violate the idea of a single version of the truth

stakeholder—a person or organization with a legitimate interest in a given situation, action or enterprise

strategic mindset—a shared vision based on common values, shared outcomes, community mapping, understanding strengths and needs and the various roles played by child-serving systems and how they can be changed, the major financing streams across systems and how they can be mobilized, and connecting related reforms

strategic orientation—a focus on the "big picture," an attention to defining the future direction of an enterprise, and in using this definition, to direct and guide the efforts of all in the enterprise

structure—something arranged in a definite pattern of organization

system management—has to do with day-to-day decision making within an organization

system reform—a type of alteration that takes a population focus—focuses on a population or populations of children and families who cross or at risk of crossing all or many systems and engages all systems in a reform agenda

systems of care (SOC)—a broad, flexible array of services and supports for a defined population(s) that is organized into a coordinated network, integrates service planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management and policy levels, and has supportive management and policy infrastructure

talk therapy—also referred to as psychotherapy as a general term for a way of treating mental and emotional disorders by talking about one's condition with a mental health professional; typically conducted in an office setting

targeted services—service aimed at a particular group of individuals

team-driven—not single agency or single provider driven

Time Dollar Bank—a strategy built on the concept of reciprocity, where there is no monetary fee-for-services, yet all participants "pay" for services by agreeing to provide volunteer hours to support the agency

top-down approach—a system theory with which an overview of a system or an organization is first formulated, specifying but not detailing any first-level subsystems; a scheme imposed from the top

Trauma-Focused Cognitive Behavioral Therapy—a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy; addresses the unique biopsychosocial needs of children with post traumatic stress disorder and other problems related to traumatic life experiences

triage—a system for allocating scarce resources; it provides the maximum resources to individuals of highest priority, and few or no resources to individuals of lowest priority; derived from practices used to prevent medical systems from being overwhelmed when there are many sick or injured.

universal services—geared to all children and includes prevention and early intervention services

utilization management (UM)—has to do with the system of care's paying attention to how services are being used by children and families, both at an individual level and at a system's level, how much service is being used, what services are being used, the cost of those services, the effect those services are having on those using them, and whether children and families are satisfied with what they are using

wraparound approach—a process for planning and implementing services and supports that is based upon individualized, strength-based, needs-driven planning and service delivery

youth-guided—encompasses the principles of: youth have rights; youth are utilized as resources; youth have an equal voice and are engaged in developing and sustaining the policies and systems that serve and support them; youth are active partners in creating their individual support plans; youth have access to information that is pertinent; youth are valued as experts in system transformation; youths' strengths and interests are focused on and utilized; adults and youth respect and value youth culture and all forms of diversity; and youth are supported in a way that is developmentally targeted to their individual needs

RESOURCES

Web Links and Descriptions

Abriendo Puertas, Inc
www.abriendopuertas.org
Provides human services in a linguistically and culturally competent manner to children and families in the Little Havana Community of the City of Miami, Florida in hope for a better quality of life

American Humane Association
www.americanhumane.org
Through consultation, training, research and evaluation, advocacy and information dissemination, supports the development and implementation of effective community, State, Tribal, and national systems to protect children from abuse and neglect and strengthen families

Annie E. Casey Foundation
www.aecf.org
Builds better futures for disadvantaged children and their families in the United States by fostering public policies, human service reforms and community supports that more effectively meet the needs of today's vulnerable children and families

Arizona Department of Human Services-Behavioral Health Services
www.azdhs/bhs.gov
Supports and monitors a statewide system for the delivery of comprehensive community-based behavioral health services for all of Arizona's children and adolescents

Bring the Kids Home Project—Alaska
www.hss.state.ak.us/dbh/resources/initiatives/kids_home.htm
Focus is to return children being served in out-of state facilities back to in-state residential or community-based care.

California Evidence-Based Clearinghouse for Child Welfare
www.cachildwelfareclearinghouse.org
Serves as an online connection for child welfare professionals, public and private organizations, academics and others who are committed to serve children and families by providing up-to-date information on evidence based child welfare practices

Casey Family Programs
www.casey.org
Provides and improves-and ultimately prevents the need for-foster care by providing direct services and promoting advances in child welfare practice and policy

Center for Child and Family Policy, Duke University
www.childandfamilypolicy.duke.edu
Assists the State Division of Social Services in evaluating the development of Systems of Care in three North Carolina Counties: Alamance, Bladen, and Mecklenburg.

Children's Bureau
www.acf.hhs.gov/programs/cb/index.htm
Seeks to provide for the safety, permanency and well being of children through leadership, support for necessary services and productive partnerships with States, Tribes and communities.

Children's Executive Oversight Committee—Alamance, North Carolina
www.alamance-nc.com/Alamance-NC
Oversees system reform initiatives for children, youth and families

The Children's Trust
http://thechildrenstrust.org
Funds programs that offer the highest possible quality services, with the goals of implementing best practices and improving the lives of children and families in the Miami/Dade County community

Colorado Systems of Care Collaborative
www.cosystemofcare.org
Provides state of the art information and strategies to communities and policy makers so that children and their families receive seamless, effective services

Community Partnerships for Protecting Children—IOWA Department of Human Services
www.dhs.state.ia.us/cppc/family_team/index.html
Focuses on changing child protective services through family-centered practice supported by neighborhood networks

The Congressional Research Service
www.loc.gov/crsinfo/whatscrs.html
The public policy research arm of the United States Congress; as a legislative branch agency within the Library of Congress, CRS works exclusively and directly for Members of Congress, their Committees and staff on a confidential, nonpartisan basis

Contra Costa County California—Employment and Human Services
www.ehsd.org/child000.html
Protect children from abuse and neglect by working with families to ensure the safety of their children and assisting children and families to reach their full potential; work in collaboration with the community toward healthy independence for families and their children

Cuyahoga County, Ohio—Systems of Care Initiative
www.fcfc.cuyahogacounty.us/services.htm
A collaborative system for addressing the needs of multi-need, multi-system children, youth, and families

Cuyahoga County, Ohio (Cleveland) Tapestry System of Care
www.cuyahogatapestry.org/media/news.htm
Takes a family-centered, team approach to serving children who have serious emotional needs that require many sources of support that cannot be met by traditional services

The Dawn Project
www.choicesteam.org/page/program/alias/dawn&article=311&prog=311
Helps Marion County, IN youth with serious emotional disturbances and their families by developing integrated care plans designed to improve each family's unique situation

Edna McConnell Clark Foundation's Community Partnerships for Protecting Children
www.emcf.org/programs/children
Seeks to enhance the ability of communities to protect children from abuse and neglect by engaging a broad range of stakeholders, including government agencies, nonprofit groups and local residents, in assuming responsibility for child safety

Family Voices
www.familyvoices.org
A national grassroots network of families and friends that advocates for health care services that are family-centered, community-based, comprehensive, coordinated and culturally competent for all children and youth with special health care needs; promotes the inclusion of all families as decision makers at all levels of health care; and supports essential partnerships between families and professionals

Federation of Families for Children's Mental Health
www.ffcmh.org
A national family-run organization dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life by providing leadership on developing and sustaining a nationwide network of family-run organizations and aiding policy-makers, agencies and providers to become more effective in delivering services and supports that foster healthy emotional development for all children

Georgetown University Center for Child and Human Development
http://gucchd.georgetown.edu
Directly serves vulnerable children and their families, as well as influences local, State, national and international programs and policy to improve the quality of life for all children and youth, especially those with, or at risk for, special needs and their families

Georgia Connection Partnership
www.gafcp.org/index.html
Assists communities in addressing the serious challenges facing Georgia's children and families and also serves as a resource to state agencies across Georgia that work to improve the conditions of children and families

Greene County Pennsylvania, Department of Human Services Child and Adolescent Service System Program
www.co.greene.pa.us/secured/gc/depts/hs/mhs/cassp.htm

A comprehensive system of care for children and adolescents with severe emotional disturbance; ensures that services for children and adolescents with or at risk of severe emotional disturbance are planned collaboratively with the family and all the agencies that are involved in the child's or adolescent's life

Integrated Care Coordination Units—Nebraska
www.regionsix.com/iccu.htm

A collaboration between Region 6 Healthcare, Nebraska Department of Health and Human services, and Nebraska Family Support Network serving state ward youth and their families through family advocacy, protection and safety, and case management in a team-based approach for out-of-home state ward children and their families

Invest in Children—Cuyahoga County Early Childhood Initiative—Ohio
www.investinchildren.cuyahogacounty.us
www.cuyahogacounty.us

Seeks to eliminate service gaps and barriers for families with children from birth to age five by improving service coordination and interagency communication; focuses on three program areas: effective parenting, child-care and health care; and collaborates county-wide among public, private and non-profit groups

Jefferson County, Colorado—System of Care
www.co.jefferson.co.us/care/care_T189_R2.htm

Promotes the welfare of children and families through the development of sustainable partnerships that provide integrated, quality services that are individualized, strength-based, family centered and culturally sensitive

LINK Families
New York Citizens' Coalition for Children Inc. Program Initiative
www.nysccc.org/linkfamily/Realities/sharedparent.htm

A new approach for family foster care, in which birth families work as teammates with foster families and caseworkers in caring for children

Maryland's Governor's Office for Children
www.goc.state.md.us

Coordinates child and family-oriented care within the State's Child-Serving Agencies by emphasizing prevention, early intervention and community-based services for all children and families; leads the development of a three-year plan establishing goals and strategies for delivery of integrated services to children and families. GOC will work to promote the well-being of children by collaborating with Local Management Boards, expanding SCYFIS (State Children Youth and Families Information System), and developing and implementing Integrated Systems of Care.

Missouri State Youth Advisory Board
www.dss.mo.gov/cd/chafee/syab/index.htm

Each member of the SYAB is an outstanding youth in foster care that represents other youth in his/her area of the state. Each SYAB member is responsible for providing Children's Services policy and procedural input to Children's Division administrative staff/Juvenile Court. The SYAB decides what goals and activities they want to pursue for upcoming meetings and carry those out accordingly. The SYAB also works as a network by bringing back important information to the Area Youth Advisory Board (AYAB), which, in turn, takes information back to Independent Living Program Specialists and youth in the Independent Living Program classes.

Mobile Response and Stabilization Services—State of New Jersey Department of Children and Families
www.state.nj.us/dcf/behavioral/links/mobile.html

Provides time limited, intensive, preventive service that include behavioral and rehabilitative interventions designed specifically to diffuse, mitigate and resolve an immediate crisis to prevent disruption of children and youth's current living arrangement

National Center for Cultural Competence at Georgetown University
www11.georgetown.edu/research/gucchd/nccc

Provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy

National Child Traumatic Stress Network
www.nctsnet.org

Works with the Substance Abuse and Mental Health Services Administration to develop and maintain the Network structure, provide technical assistance to grantees within the Network, oversee resource development and dissemination, and coordinate national education and training efforts to raise the standard of care and increase access to services for traumatized children and their families across the United States.

National Child Welfare Resource Center for Organizational Improvement
www.nrcoi.org

One of seven national resource centers (NRCs) funded by the Children's Bureau (CB), U.S. Department of Health and Human Services. The Center supports organizations committed to the welfare of children, youth and families through training, technical assistance, research and evaluation by providing free, on-site training and technical assistance (T/TA) to State and Tribal child welfare agencies.

National Technical Assistance Center for Children's Mental Health at Georgetown University
http://gucchd.georgetown.edu/programs/ta_center

Dedicated to helping States, Tribes, territories, and communities to transform their mental health systems through innovative and collaborative solutions that improve the social, emotional, and behavioral well-being of infants, children, adolescents and families.

National Technical Assistance and Evaluation Center for Systems of Care Resources at Caliber/ICF
www.childwelfare.gov/systemwide/service/soc/communicate/initiative/ntaec.cfm
Provides programmatic and evaluation technical assistance to recipients of cooperative agreements from the Improving Child Welfare Outcomes Through Systems of Care demonstration initiative, funded through the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Pennsylvania Child and Adolescent Service System Program
www.dpw.state.pa.us/child/behavhealthservchildren/003670138.htm
By collaborating with child's or adolescent's family, the mental health system, the school and other agencies, helps children and adolescents with emotional disturbances gain access to needed services.

Prairie Band Potawatomi Nation & Social Services Indian Child Welfare Department
www.pbpindiantribe.com/PBPN_SS/wraparound/wraparound.html
The goal of the wraparound project is to implement, through training, the wraparound process throughout the Social Service department and Prairie Band Potawatomi Nation, and all others interested in providing wraparound services to the PBP families.

President's New Freedom Mental Health Commission
www.mentalhealthcommission.gov/index.html
Established by President George W. Bush in April 2002 as part of his commitment to eliminate inequality for Americans with disabilities

Research and Training Center for Children's Mental Health, Tampa FL
http://rtckids.fmhi.usf.edu/rtcconference
Works to strengthen the empirical foundation for effective systems of care and improve services for children with serious emotional or behavioral disorders and their families

Rhode Island Department of Children Youth and Families
www.dcyf.ri.gov/programs.php?progmsg=101
Child and Adolescent Services Program (CASSP) is a locally based, family driven and culturally competent system of mental health care for children with serious emotional disorders and their families. Provides family service coordination and wraparound supports to children and youth with SED disturbances who are at risk for placement outside of their homes and communities, as well as assists in returning children and youth from restrictive placements to their communities

Robert Wood Johnson Foundation's Mental Health Services Program for Youth (MHSPY)
www.rwjf.org/files/publications/books/1999/chapter_09.html
The Nation's largest philanthropy devoted to improving health and health care; supports training, education, research and projects that demonstrate effective ways to deliver health services, especially for the most vulnerable among us.

Sacred Child Project
http://cecp.air.org/teams/prospectors/sacred_child_project.asp
The Sacred Child Project is a reservation-based system of care approach for children and families with complex needs

Statewide Family Networks Technical Assistance Center
www.tacenter.net/index.cfm
An online network that creates support, information and education networks for families of children with serious emotional and behavior problems. Each of the family networks is unique in its approach of providing opportunities for families, service providers and systems of care to work on family partnership efforts

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov
Works to improve the quality and availability of substance abuse prevention, alcohol and drug addiction treatment, and mental health services

Systems of Care
www.systemsofcare.samhsa.gov
A website devoted to providing systems of care, partnerships, and collaboration information about the mental health of children, youth and families

www.childwelfare.gov/systemwide/service/soc
A section of the Child Welfare Information Gateway that provides resources on systems of care related to children and families involved with the child welfare system

Technical Assistance Partnership for Child and Family Mental Health at American Institutes for Research
www.tapartnership.org
Provides technical assistance to system of care communities funded by the Comprehensive *Community Mental Health Services for Children and Their Families Program*, funded through the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Texas Community Advisory Committees on Disproportionality
www.dfps.state.tx.us/About/Renewal/CPS/disproportionality.asp
In conjunction with the Texas Department of Family and Protective Services, committees deal with disparity in child welfare and the issues associated with it

Views on Foster Care in North Carolina
http://ssw.unc.edu/fcrp/fp/fp_vol7no2/reform.htm
Multiple Response System (MRS) of North Carolina's child welfare system

Wraparound Milwaukee
www.milwaukeecounty.org
Wraparound Milwaukee, a managed care program operated by the Milwaukee County Behavioral Health Division, designed to provide comprehensive, individualized and cost effective care to children with complex mental health and emotional needs