
Reforming the Delivery of Children's Services:

A STUDY OF THE IMPLEMENTATION AND EFFECTS OF THE NEW YORK STATE COORDINATED CHILDREN'S SERVICE INITIATIVE

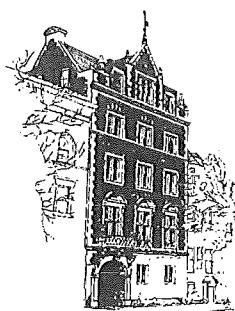
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EXECUTIVE SUMMARY

The Coordinated Children's Service Initiative (CCSI) is a multi-agency effort to reduce out-of-home placements of children with emotional disabilities by creating locally coordinated systems of care. CCSI was conceived and planned by a team of State administrators and local providers convened by the State Office of Mental Health in the early 1990s. Since 1993, the State has funded county CCSI programs in three phases, supporting a total of 33 counties.

CCSI was based on the belief that there has been an over-reliance on out-of-home residential placements, the most restrictive and expensive form of treatment. Instead, CCSI was designed to promote community-based alternatives that support the care of children in family and family-like settings.

To accomplish this, CCSI promotes core principles designed to address the fragmented, categorical, and inflexible nature of the children's service system. These core principles include:

- ❖ *Cooperative interagency planning and integrated service delivery:* Coordinated services maximize community resources, reduce waste and inefficiency, and address the complex needs of clients in the most comprehensive manner.
- ❖ *Individualized care approach:* Service plans are developed around individual client needs, rather than form-fitting clients into existing categorical programs.
- ❖ *Strength-based approach:* This approach emphasizes empowerment of clients by making them full participants in service planning and delivery and focusing on strengths rather than pathology.

This study describes CCSI's implementation and examines its effectiveness. We used a combination of qualitative and quantitative methods. In the qualitative component we conducted on-site structured interviews with participants in the eight Phase 1 counties: Broome, Chemung, Monroe, Rockland, Schenectady, Suffolk, Ulster, and Westchester. In the quantitative component we analyzed placement data from the child welfare, education, juvenile justice, and mental health residential placement systems. We compared CCSI counties with non-CCSI counties and examined changes in placements over time, changes in placements by service system, and the potential cost savings of averted placements.

After completing the analysis, the picture that emerges is not one of a single, stable model that is equally effective across all counties. Rather, CCSI was quite different from county to county and changed over time. This variation makes sense, given CCSI's flexibility, but it also means that a great deal of its effectiveness is

based on the commitment each county had to the program. In general, most interviewees felt that CCSI's activities helped children and saved money, and the qualitative study did not find evidence to the contrary. Many counties have continued CCSI or similar programs, leading one to feel that the local agencies believe that coordination is a valuable effort and one worth investing their own resources to pursue.

CCSI and Its Implementation

In 1993, New York State issued a Request for Proposals (RFP) to counties eligible to participate in CCSI. According to the RFP, the purpose of CCSI was to "create or enhance a local system of care which integrates the efforts of all involved systems to provide more flexible services to children and families and to reduce residential placements." Counties accepted in Phase I of CCSI received state grants totaling \$700,000.

The RFP specified how CCSI should be structured on the local level by creating two levels of interagency committees, identified as Tier 1 and Tier 2. Tier 1s were responsible for identifying and coordinating community-based services that would meet the needs of children and their families while avoiding out-of-home placement where possible. Tier 1s were comprised of parents, workers from child-serving agencies, and family advocates. Tier 2s, on the other hand, were more involved with policy-making and administrative activities. They were responsible for identifying barriers to interagency coordination and local service provision, proposing solutions for improved coordination, and overseeing the CCSI effort. Tier 2s were comprised of family advocates and upper-level administrators from the children's service system.

These county-level coordinating teams would then coordinate with Tier 3, a team of parent representatives and officials from state child-serving agencies. Tier 3's composition varied over time, but it usually included the Office of Mental Health, the Department of Social Services, the State Education Department, and several other agencies. Tier 3 was responsible for eliminating state-level barriers to coordinated local service delivery.

No simple description of CCSI's implementation would be accurate. Different counties implemented CCSI differently, sometimes a county's implementation changed over time, and sometimes CCSI overlapped with similar collaborative efforts that preceded it or operated concurrently. To illustrate the range of CCSI programs, we describe four broad models. The models do not match any single county's CCSI program, but counties typically tended toward one model or another.

- ❖ **The Case Management Model:** Focused on the interaction between the client and the case-worker, with the goal of empowering families and developing individualized service plans.
- ❖ **The Training Model:** Promotes the CCSI philosophy among all children's service systems primarily through worker training.
- ❖ **The Flexible Funding Model:** Focused on the flexible funding elements of CCSI, providing funds to families for needed goods and services without regard to categorical funding limitations.
- ❖ **The Centralized Structured Model:** Emphasizes structural reform, with a well-defined case conferencing committee, an explicit referral process, and a strong county-level policy-making group.

How Well Does CCSI Serve Children and Families?

Does CCSI Serve the Right Children?

In most counties CCSI targeted children who: (1) were at risk of placement, (2) had multiple service needs, and (3) had an emotional disability. Some interviewees felt that three populations continue to be underserved:

- ❖ Children diagnosed with a developmental disability or substance disorder *in addition to* a designated mental illness. In these cases, specialists from different systems often disagree over which system should be responsible for the child. Meanwhile, the child's needs are unmet.
- ❖ Children who commit minor offenses when they age out of the Persons in Need of Supervision (PINS) system at 16 years. Counties argued that there are not sufficient services available for these children.
- ❖ Other children with special needs such as youthful sexual offenders and fire setters. Providers said there are not enough programs willing or able to work with the growing number of these children.

Does the CCSI Structure Foster Effective Coordination?

Many counties struggled to determine appropriate membership for Tiers 1 and 2. Overall, CCSI seemed to work best when Tier 1 included families, front-line workers, parent advocates, and informal supports. Tier 2 generally was most effective when it included local agency administrators with authority to make decisions for their agencies. Many counties found that although neither Tier 1 nor Tier 2 included supervisory staff, these staff were needed to support worker efforts and to serve as liaisons between the front line and the administrators. Some counties therefore created alternative structures – “Tier 1.5” – which included supervisory staff.

Communication between the county level and state level was weak. Interviewees attributed this partly to the uncoordinated regional structure among the State agencies and their regional staff who varied in terms of their level of knowledge of CCSI and their willingness to work with counties.

Difficulties in Coordination

Many interviewees said a major problem is that the education system is not involved in interagency processes. Some said that schools inappropriately recommend residential placements without consulting other children's services. Others argued that schools are reluctant to provide needed community-based educational services because fiscal incentives favor placement: If schools recommend residential placement, the other systems and state aid will cover most costs, whereas if the child remains in the community the local school district will face increased costs. Some interviewees felt it was difficult to involve the education system because the school system is organized differently than other children's service agencies. Schools, by contrast, claimed that by the time a child with special needs comes to the attention of the other systems, the education system has already served the child for a long time, exhausting their resources on a wide variety of programs in a number of different settings.

Interviewees also thought the program could be improved in other ways:

- ❖ Some mental health workers said it was difficult to obtain reimbursement for Tier 3 meetings and other activities outside the office, and to gain approval for services for all family members, rather than just the targeted child.
- ❖ Social service administrators feel victimized because they wind up responsible for children who are refused services by other systems.
- ❖ Some interviewees expressed frustration over lack of coordination between CCSI and new interagency collaboratives being promoted by State agencies.

Views on Other Elements of CCSI

- ❖ Most service providers were extremely grateful for flexible funds and believed that they helped prevent out-of-home placements. They usually used flexible funds for five major services: (1) respite care, (2) recreational services, (3) youth employment opportunities, (4) concrete services (for basic needs such as food, clothing, and shelter), and (5) mental health services.
- ❖ Family advocates were represented on all three tiers of CCSI and assumed a variety of family-support roles. Agency staff and family advocates generally had good relationships, but some family advocates felt that Tier 2 members could be patronizing and condescending, and some providers believed that family advocates could be adversarial and harm the process.
- ❖ Some counties have used CCSI to develop effective discharge plans and to coordinate aftercare services to ensure a successful transition back to the community. Many respondents believe that CCSI has shortened stays in care, and prevented returns to placement.

Does CCSI Improve Outcomes?

Interviewees generally were positive about CCSI. They believed that CCSI: (1) averts residential placements, (2) improves relationships among children's service systems, (3) identifies and provides needed community-based services, (4) improves the way families are served, and (5) improves worker morale.

Do the quantitative data support these opinions? Between CCSI's inception in 1993 and 1997, placement rates in Phase 1 counties declined steadily, while placements in the rest of the state (non-CSPI) rose. Phase 2 counties showed relatively minor changes. While it is tempting to think that placement declines in Phase 1 counties are attributable to CCSI, we don't have enough information to conclude that. It simply was not possible to isolate the effects of CCSI from other factors that affect children's placement rates. But the data on their face are consistent with the belief of many CCSI participants that the elements of CCSI – however defined and designed – contribute to lower rates of placement.

Recommendations

Based on our analysis of the CCSI program, we offer the following recommendations.¹ We have divided them into three groups: recommendations directly related to the structure of CCSI, recommendations for counties, and recommendations for the state.

¹ This is a partial list of recommendations. The main report contains the full list.

CCSI Reforms

- ❖ Counties should consider applying the CCSI model to all children with multiple needs who are at risk of out-of-home placement, regardless of diagnosis or condition.
- ❖ CCSI structures should be used for discharge planning and coordinating aftercare services for children returning to the community.

County Level Reforms

- ❖ The education system should become more involved with other providers, and should be involved earlier in the process, in an effort to find ways to meet children's needs before they are at imminent risk of placement.
- ❖ All school personnel should be trained in system delivery reform principles used in other children's service systems, such as family empowerment building, strength-based assessments, and family systems approaches.
- ❖ County agencies should develop contracts with residential facilities that require strong connections with community-based providers to ensure that children have a seamless transition back to their communities.

State Level Policy Changes

- ❖ State agencies should consider expanding flexible funding mechanisms to include additional programs and activities in the counties.
- ❖ The state's child-serving agencies divide the state into regions in different and inconsistent ways, making coordination difficult. The State should consider reconfiguring the regional territories of child-serving agencies to make them more consistent.
- ❖ Each agency should examine age requirements for services within the context of other systems. The state should attempt to develop alternative juvenile justice programs that provide services to youth under 21 years who are ineligible for PINS services.
- ❖ The State Offices of Mental Health and Mental Retardation and Developmental Disabilities should form a task force to study the issue of serving children with dual diagnoses.
- ❖ Many local providers are overwhelmed by the number of new collaborative initiatives being created on the state and county levels. The state should identify the best collaborative models, promote linkages, and eliminate duplication.
- ❖ The state should work with localities to develop a unified information system to track residential placements, number of days in care, and community-based service provision.

1

INTRODUCTION

"The weaknesses of the current social service system have been broadly noted and identified: fractured, categorical programming, duplicative casework, uncoordinated service delivery that is often confusing to families and working at cross purposes, narrow specialization of provider skills, inflexible processes and organizational structures, the lack of client involvement or participation in service plans, lost referrals, duplicative, incongruent, and cumbersome paperwork and eligibility processes, and the lack of prevention and early intervention services." (O'Looney, 1994)

Defining the Problem

The New York State Coordinated Children's Service Initiative (CCSI) is part of a growing movement in the reform of human services sweeping this country. This movement has been driven by an overall dissatisfaction in the way services are organized and provided, and the resultant outcomes that they have produced. The inadequacies of children's services can be best conceptualized by examining two areas: the **structure of systems** and the **process of service delivery**.

Structural Issues

The human service system has been criticized for being overly fragmented, categorical, inefficient, duplicative, and crisis-oriented. (Konrad, 1996; Illback, 1995; Saxe, 1988). It is common for children and families to receive services from multiple agencies simultaneously, and for these services to overlap or conflict. The systems work in isolation and place competing demands on their clients. Each service system has its own eligibility requirements, case managers, physical locations, programmatic policies, administrative bureaucracies, databases, confidentiality systems, state and federal parent agencies, professional associations, and funding sources, often originating in discrete federal and state statutes (Sailor and Skrtic, 1996).

Delivery Issues

The other area of emphasis in the reform of children's services focuses on the process of service delivery. Providers have been criticized for being inflexible and largely non-responsive to the needs of children and families. Specifically, the service providers have been charged with taking the following approaches:

- ❖ Functioning under a rigidly hierarchical arrangement where all the decision-making power rests in the hands of the professional with little or no authority granted to the client.
- ❖ Adopting treatment approaches that remove the child from his/her home, school, and community. Historically, there has been an over-reliance on out-of-home residential placement, the most restrictive and expensive form of treatment.
- ❖ Determining services according to what agencies offer and what is available at a particular moment in time, rather than by the pressing needs of the family. That is, families are made to fit into the structure of the service system, whether it addresses their needs or not.
- ❖ Compartmentalizing needs into rigid categories while ignoring interrelated causes, effects, and solutions. Service systems and providers have overlooked the interconnection of the client to their support systems. Often it is the individual, rather than the family that is viewed as the unit of service.
- ❖ Focusing on identifying individual problems and deficits while ignoring family strengths and resources.

Moving to a More Rational System

With the desire to better meet the needs of children and their families, and to expend resources in a more efficient manner, alternatives to traditional service models have been developed. There are a number of examples within the mental health, child welfare, health care, and educational systems. Although known by different names, authorized under different legislation, and targeting different populations, the basic framing elements remain consistent across disciplines.² These reforms address the criticisms previously noted related to systemic issues and delivery issues.

Reforms to Promote Systemic Change

Over the past few decades the idea of cooperative planning and integrated service delivery has been promoted, especially for children and families with complex service needs. Coordination has been advocated for a variety of reasons. For one, it increases the ability to address the needs of multi-service clients in a more comprehensive manner. Each service system can contribute specialized expertise and services, and can bring into focus different perspectives and concerns. Coordination also decreases duplication of services, reduces waste and inefficiency, and lessens competing demands on families. And joint planning and service delivery enhances accountability, for systems are no longer acting in isolation.

Within the children's service system, the cooperating agencies include child welfare, mental health, juvenile justice, and education. While these agencies are typically recognized as the primary "players," other systems of care have also been identified including substance abuse services, services for developmentally delayed populations, and health care services. Components of system integration models can include single point of entry referrals, common screening and assessment procedures, streamlined application and intake processes, common consent and application forms, co-location of staff, joint and cross training of staff, shared information, pooled funds, joint programming, and shared management information systems.

2 On the federal level, a few of the most influential initiatives have included the Child and Adolescent Service System Program (CASSP) of 1983; Individuals with Disabilities Education Act (IDEA) of 1990; and the National Agenda to Improve Results for Children and Youth with Serious Emotional Disturbance of 1994 (Shrag, 1996).

Reforms to Promote Effective Service Delivery

A number of reforms in the area of service delivery have been promoted (Osher and Hanley, 1995; Illback and Nelson, 1995; VanDenBerg and Grealish, 1996). These reforms include the following:

- ❖ *Family Empowerment:* Decision-making authority concerning the scope and intensity of services has transferred from the agency and worker levels directly to the recipients. The movement is from a strictly hierarchical relationship between the professional and family toward a partnership. Families are full participants in all aspects of the planning and delivery of services. All individuals are made to feel that their perspectives are respected and their participation is constructive and influential. By involving families in case planning, families are more likely to “buy into” the service plan and take on increased responsibility. When possible, the desire is to develop the capacities of families to become strong enough on their own, so that they no longer need to depend on the service delivery system to meet their needs.
- ❖ *Placement in the Least Restricted Environment:* It is now acknowledged that the greatest benefits can be achieved by providing children with services within the most normative and stable environment that is clinically appropriate. The family is viewed as the most desirable setting in which to rear children.
- ❖ *Individualized Care Approach:* With an individualized care approach, service plans are developed around child and family needs, rather than form-fitting children and families into existing categorical programs. The specialized needs of the child and family dictate the types and mix of services provided. Services are continually adjusted to meet the changing needs of the family.
- ❖ *Family Systems Approach:* There is a philosophical reorientation in human services that regards the family, not the individual, as the unit of service. The individuals’ behavior is best understood as affected by the structure, barriers, and influences of the community and culture. This ecological theoretical orientation suggests that if services are to be effective, attention must be paid to interrelated causes, effects, and solutions.
- ❖ *Strength-Based Assessments:* Service providers are now adopting the perspective that more effective service delivery can result from assessing the client’s psychological competence and available resources rather than focusing exclusively on dysfunction and pathology. Strengths are assessed as a means of guiding formal and informal interventions that utilize personal resources and increase the motivation of the child and the family.

These new directions in the structure and delivery of human services laid the foundation for the establishment of New York’s Coordinated Children’s Service Initiative.

Background to the Coordinated Children’s Service Initiative

The impetus for developing CCSI originated with the New York State Office of Mental Health, which had been seeking to improve locally based service delivery and to decrease reliance on out-of-home residential placement for children with serious emotional disturbances. In the early 1990s the State Office of Mental Health developed a multi-year plan that incorporated principles based on the federal initiative, the Child and Adolescent Service System Program (CASSP) of 1983, and was built on the belief that a family or family-like setting was the most desirable setting to rear children.

Recognizing the need to work across systems, the State Office of Mental Health convened a group of other state agencies representing the Department of Social Services, Office of Probation and Correctional

Alternatives, the State Education Department, the Division for Youth, and the Council of Children and Families.³ These agencies were also seeking ways to reduce the number of children inappropriately placed in residential settings and to promote community-based alternatives. The child-serving agencies were also alarmed by the large number of children who were being placed in residential settings outside of New York State.

The State group invited county agency representatives who had been involved in local cross-system efforts to participate in the state-level discussions. The State group continued to meet regularly and designed the model that evolved into the Children's Coordinated Service Initiative. A Request for Proposals was prepared in early 1993 offering support for "local efforts to coordinate community-based services across systems that would result in a reduction of residential placement of children with serious emotional disturbances." The RFP was sent to twenty-one counties and New York City based upon the high rate and volume of residential placements made in the mental health, social services, education, and juvenile justice systems.⁴ A total of \$700,000 was made available from funds identified by the State Office of Mental Health and the State Education Department to support eight counties and a site in New York City.

Applicants were required to submit proposals that were developed collaboratively by representatives of all child-serving agencies – Mental Health, Social Services, schools/BOCES, Youth Bureau, and Probation – to avoid duplication and to ensure the best use of new and existing resources. As displayed in Exhibit 1, funds were provided to a geographically diverse group of counties across the State. The funds were administered through county agencies – usually mental health or social services.

Exhibit 1
First Year CCSI Counties and Lead Agencies

County	Lead Agency
Broome	County Youth Bureau
Chemung	County Department of Community Mental Health
Monroe	County Department of Community Services
Rockland	County Department of Social Services
Schenectady	County Office of Community Services
Suffolk	County Department of Social Services
Ulster	County Department of Social Services
Westchester	County Department of Community Mental Health

3 The Department of Social Services and the Division for Youth no longer exist. All of the Division for Youth and the services parts of the Department of Social Services are now housed within the Office of Children and Family Services.

4 Counties with a placement rate at or above .2% of the total youth population, or with residential placements totaling 100 or more, as of December 1992, were invited to apply.

Description of the Evaluation

This study was carried out by the Center for Human Services Research of Rockefeller College and the Center for the Study of the States of the Rockefeller Institute of Government. The study was designed to describe the implementation and assess the effectiveness of CCSI. To get a complete understanding of the program, the research team used a multifaceted approach that involved a combination of both qualitative and quantitative methods.

The Qualitative Component

The qualitative component consisted of conducting a series of on-site structured interviews with participants in Phase 1 sites, the eight original counties that were supported in the first year of CCSI implementation. These counties are Broome, Chemung, Monroe, Rockland, Schenectady, Suffolk, Ulster, and Westchester.⁵ We did not include New York City in our analysis because of inherent differences between the New York City site and the other Phase 1 counties.

The analysis was limited to year one counties for several reasons. The first consideration was to conduct an intensive, high quality analysis with a limited amount of time and resources. Second, the selection of year one counties allowed us to examine sites where CCSI had been in place for the longest period of time, and after early implementation issues had been resolved. Year one counties also provided a representative sample of the different regions of the state and different sizes and types of counties.

To collect qualitative data, researchers spent about two days at each of the Phase 1 sites and conducted over 60 interviews with administrative and line staff representatives from mental health, juvenile justice, social services, and the education system. In addition, State-level administrators involved in the development and implementation of CCSI were also interviewed.

The interviews were conducted using standardized topic guides that covered a wide range of topics including how CCSI was planned, the underlying program goals and philosophy, who is served, what services are provided, how services are delivered, administrative issues, and program benefits.

The researchers also conducted a review of available records and documents from the sites and the state agencies including quarterly reports, project proposals, meeting minutes, and other documents that provided a description of the structure and processes of the program.

Limitations of the Qualitative Study

While the research team worked diligently to collect reliable and valid data, there were several methodological issues that need to be considered.

For one, the individuals who were interviewed were not totally representative of the entire stakeholder group at each site. Because of its collaborative nature, CCSI involves an enormous number of individuals. Time and resource constraints precluded interviewing all those involved with CCSI at each site. Moreover, some key stakeholders were simply unavailable at the time of the scheduled site visit, and some could not be

⁵ CCSI was funded in three phases. Phase 1 counties were initially funded in 1993. Phase 2 consisted of an additional nine counties that received funding beginning in 1994. Phase 3 consisted of another 15 counties that were initially supported with small grants in 1995.

"fit in" during the two-day allotment per site visit. Although the research team developed some criteria for interviewee selection, we depended on, to a great extent, the judgment of the local CCSI Coordinators to choose the major stakeholders in each community, which biased the selection process.

For the reasons cited above, parents and children were particularly underrepresented in the interview process. We believe that a much more comprehensive picture of CCSI would have emerged by gathering information from the perspective of parents and children who were the recipients of services.

In addition, we had limited opportunity to "watch CCSI in action." We observed only a few actual case conferences and interagency policy meetings at a limited number of sites.

The Quantitative Component

In the quantitative component of this study we analyzed existing data on New York State's residential placements from 1993 through 1997 – covering the pre-CCSI period through the most recent available year. The available data include the number of children in each of the state's residential systems⁶ as of September 30 of each year by county, the total number of children (ages 0-21) in each county, and the per-diem cost of each placement system. The data do not distinguish between children served by CCSI and children served by other programs. Furthermore, the data only count children who have been placed in a residential facility – they do not count children served by CCSI, or by other programs, who are not placed in a residential facility.

The Council on Children and Families gathered data on the number of children by system from each of the placing agencies, and on the per-diem cost of the systems.⁷ The placements by system were quite difficult for the Council to obtain, as it took considerable effort to ensure that the number of children in each system were counted on a reasonably consistent basis, with little or no double-counting of children who had been involved in more than one system. This database is still new and evolving, and as new quarters are added it should become a very useful data source. The Department of Social Services provided the annual estimates of the number of children in each county, which it in turn had obtained from Woods & Poole, a well-known market research and demographic data firm.

We performed several rounds of quality control checks on the data, looking for consistency with other data on New York's counties such as the 1990 census, and looking for unusual changes over time and unusual differences across counties that might be attributable to keypunch errors or other problems. As a result, we are confident that the data provide a substantially accurate picture of placements and placement rates in New York counties.

These data allow us to describe changes in residential placements over time in CCSI counties and non-CCSI counties. They also allow us to estimate savings to government that would result if a child were averted from placement. They do not, however, allow us to estimate the extent to which CCSI may have averted children from placement, or the amount of money that may have been saved in aggregate. The Data Limitations section describes these issues in greater detail.

6 These systems are: Child Welfare (Social Services), Juvenile Justice (Division for Youth), Education, and Mental Health.

7 The specific agencies providing data were: the Office of Children and Family Services (since this is comprised of the old Department of Social Services and Division for Youth, it provided data on both Child Welfare and Juvenile Justice), the Department of Education, and the Office of Mental Health.

Limitations of Quantitative Study

It is not possible to draw conclusions from available data about the extent to which CCSI may have averted placements in the state's residential system. That would require data isolating the effects of CCSI from other factors affecting child placements. With appropriate data, there are two approaches that might be useful.

First, if children within a county were assigned randomly either to CCSI or to the usual method of serving children, then in theory the children in the two groups would be subject to the same influences except for the mode of treatment: they would be subject to the same economic conditions, level of enthusiasm in the county, and so on. With a large enough sample, and after controlling for any known differences between the two groups, we might reasonably conclude that a difference in placement rates was attributable to CCSI.

This kind of controlled experiment is rare in government. One of many reasons this is not done frequently is that it is difficult, and potentially expensive, to run two parallel treatment systems. Furthermore, as is often true of programs like this, by design there was nothing random about who is assigned to the program. CCSI counties go out of their way to ensure that children served by CCSI are different from other children – they tend to be at greatest risk of placement, and with greater needs and known problems than other children. Even if this group were then split, there would most likely be self-selection both by savvier families and by those distributing staff between the programs.

A second-best approach would be to compare residential placements in CCSI counties with placements in non-CSPI counties, and with placements in CCSI counties before CCSI went into effect, controlling for known differences in economic conditions and other factors affecting placements. Even this approach is not possible with available data for many reasons, including the following:

- ❖ As this report makes clear, there is no simple defining line between CCSI programs and other methods of serving children. Many counties had some sort of collaborative or holistic process in place before CCSI so that there is no easy break between the old method and the new. Likewise, non-CSPI counties may currently be using collaborative or holistic methods of some sort, and we do not know the extent to which their systems differ from those in CCSI counties.
- ❖ Ideally, CCSI counties would be as much like non-CSPI counties as possible, but for the fact that they operate CCSI. In fact, CCSI counties were generally chosen because they had high placement rates, or large numbers of children in placement – they were not like other counties, by design.
- ❖ A more detailed study could have been done if we had had time-series data, preferably quarterly, on the number of children served by CCSI in each county, the number served by other methods, the number of CCSI children placed in residential facilities, the number of other children placed in residential facilities, and measures of demographic and economic conditions. Annual data are available on the number of children in residential placement in each county, and on the total number of children, but data are not available on the number of children served, or on the number served by CCSI. CCSI counties were required to file quarterly reports until recently, but the reporting requirements appear to have been interpreted differently in different counties, and differently in individual counties over time. While the reports may have provided useful information on the design and conduct of CCSI, they did not provide reliable quantitative data.
- ❖ External changes undoubtedly have affected the residential placement system in ways that are difficult to analyze: counties have begun to implement welfare reform in the last two years, and the state has converted foster care funding to a block grant.

- ❖ We would like it if CCSI served a relatively large portion of children in CCSI counties, so that we might be able to draw conclusions about the impact of CCSI on overall placements, but that does not appear to be the case. In fact, the available evidence suggests that CCSI is a small component of the overall system in CCSI counties.
- ❖ Finally, the fact that CCSI was often quite different in nature from one county to another makes it difficult to assess its impact in aggregate on those counties.

With the available data, we are able to describe changes in residential placements in CCSI counties and in other counties. This description provides a useful context for understanding CCSI, but it does not allow us to draw conclusions about the effect of CCSI on placements. The analysis is exploratory and raises questions about why some counties, and some systems, have reduced placements while others have not – questions that state and local officials may wish to investigate further.

Overview of the Report

This report begins with a general description of the program model and goals in Chapter 2. This is followed by a more detailed specification of various CCSI program elements in Chapter 3. Chapter 4 explores the relationship among service systems. This is followed by Chapter 5 where we present an analysis of placement data comparing CCSI with non-CSPI counties, changes in placements over time, changes in placements by system, and the potential cost savings from averted placements. We then discuss some of the reported effects of CCSI and make a series of recommendations relating specifically to CCSI programs and more generally to the broader scope of children's services systems.

The qualitative study presents major trends that were noted among most of the counties; the few references made to individual sites are used to provide an illustration of actual implementation. For the most part, the findings that are presented were reported at more than one site, unless otherwise noted.

In several places throughout this document we quoted the remarks made by the interviewees. The researchers want to ensure readers that we spent considerable time in selecting statements that we felt best articulated commonly held beliefs. The remarks are used for illustrative purposes only. While the validity of each statement has not been verified, we did not select any statement that we felt was incorrect.

This report presents both model practices as well as obstacles to implementation. We hope that disseminating these findings will assist program developers in planning and delivering similar initiatives, enable service providers to improve service delivery, and enlighten policy makers in making informed decisions.

2

PROGRAM MODEL

"Human services integration initiatives are, by their nature, complex approaches to service provision. They consist of multiple partners, operate along numerous dimensions, and at various levels of intensity, and encompass a variety of components, structures, and designs. Like other multifaceted human services programs, and even more so than traditional categorical programs, they present particular challenges to evaluators." (Konrad, 1996)

Program Design

Goals and Objectives

As stated in the year one Request for Proposals, the purpose of CCSI was to "create or enhance a local system of care which integrates the efforts of all involved systems to provide more flexible services to children and families and to reduce residential placements." Six outcomes were specified:

1. Decreased residential placements in the mental health, social services, education, and juvenile justice systems. This includes preventing or returning children from in-state and out-of-state residential placements.
2. A reduced number of care days for children who are placed residentially.
3. Increased access to and availability of integrated, community-based services.
4. An enhanced local decision-making capacity to make better and shared decisions regarding services to children with emotional disabilities and their families.
5. The creation of mechanisms that increase the ability of local agencies and schools to earlier identify high-risk children and families and/or better prepare for the return of children from residential placement to the community.
6. The formation of a more flexible funding mechanism that encourages and supports the development of community-based services to children with emotional disabilities and their families.

Exhibit 2

Coordinated Children's Service Initiative Purpose

The purpose of the Coordinated Children's Service Initiative (CCSI) is to ensure that families are supported in staying together and that children remain at home and in their community through improving the quality of decision making for children with emotional and behavior disturbances through State and local interagency partnerships.

PRINCIPLES

To have a shared commitment to serve children with emotional and behavioral disturbances, with the goal of supporting families' efforts to stay together.

To share resources among child-serving systems that meet the needs of the child and family.

To increase each child serving systems accountability to each other.

To increase family involvement in service delivery decision making, to base those decisions on the family's strengths and to meet identified family needs.

To utilize an individualized care model of service planning and delivery, which focuses upon "one child at a time."

To provide services and supports while maintaining a holistic view of the child and family.

To provide services and supports that will prevent residential placements and to reduce the number of existing placements, through periodic reviews that ensure the shortest appropriate length of stay and that services and program options are employed to enhance family, school and community readjustment.

To provide services and supports that are culturally competent and build on the unique strengths of the State's culturally diverse populations.

To enable workers to deliver services in a manner that encourages innovation and creativity.

To develop State and local partnerships through more effective collaboration and the removal of barriers which impede interagency service delivery.

To have active parent participation at all levels of developing the CCSI.

Source: Tier 3 CCSI Purpose and Principles

Exhibit 3

Excerpts from the RFP

Tier 1 should consist of a local, multidisciplinary team (or teams) of professionals responsible for identifying children most at risk of residential placement, providing comprehensive assessments of these youth and their families, and developing and monitoring an individualized service plan for the entire family which includes service referrals to all appropriate agencies. Preference will be given to counties that assign a single case manager to the family who would be responsible for coordinating services to ensure that the family receives the kinds of services they need.

Members of Tier 1 should include, but not be limited to, the parent of the child being case conferenced and supervisory level staff from the involved local agencies and schools/BOCES. Staff assigned to this group should have the ability to make agency decisions and commitments regarding service planning and delivery. Additionally, counties are encouraged to develop linkages with specialized public and voluntary service providers to ensure that a broad range of community-based resources are available to these high risk children and families.

Tier 2 should consist of local agency administrators and school/BOCES officials who would be responsible for activities such as resolving case specific conflicts, identifying existing, community-based services and supports for children and families, identifying state and local barriers to inter-agency collaboration and service delivery, and proposing solutions for improved coordination. Members of this group should have the authority and power to make local systems-level changes. Representatives of Tier 2 should include a parent of a child with emotional disabilities, the commissioners and directors of the involved local agencies, a BOCES/district superintendent and other appropriate persons identified by the county. It is anticipated that this group would work closely with the Tier 1 group to identify problems relating to the provision of integrated services.

In addition to promoting local coordinated services, the plan embraced many of the major human system reform principles discussed earlier – increased family empowerment, individualized service planning, family systems approaches, placement in the least restricted environment, and strength-based approaches (see Exhibit 2).

Program Structure

The RFP specified the structural arrangement of CCSI and created two levels of local authority identified as Tier 1 and Tier 2. Both tiers were to be comprised of multi-disciplinary teams of professionals from child-serving agencies, as well as parents of a child with emotional disabilities. As expressed in Exhibit 3, Tier 1 included service-delivery staff whose role was to develop and monitor service plans and Tier 2 included administrative-level staff whose role was to establish local policy and direction. In addition, a state-level entity was created – Tier 3 – which was “responsible for the review and implementation of systems-level changes in state policies, financing and regulations that pose barriers to coordinated service delivery, as identified by the local Tier 2 groups.” Presently, Tier 3 is comprised of two parent representatives, and its member agencies are the Office of Mental Health, Office of Children and Family Services, State Education Department, Division of Probation and Correctional Alternatives, Office of Alcoholism and Substance

Abuse Services, the Council on Children and Families, and the Office of Mental Retardation and Developmental Disabilities.

The RFP also adapted the idea of flexible funds from the Office of Mental Health Intensive Case Management Program, to give counties the ability to expend funds for family services and supports without regard to categorical funding limitations.

Program Funding

The Phase 1 counties received start-up funding in 1993 to test the viability of CCSI concepts and practices. These localities continued to receive funding for the 1994-1995 and 1995-1996 funding years. The Phase 1 counties were also eligible for small transitional funds (up to \$10,000) in the 1996-1997 funding years to support program continuation efforts or expansion of CCSI in their community. In 1994, nine additional counties were funded, and in 1995 fifteen counties were supported to develop local CCSI initiatives (see Exhibit 4)

Exhibit 4 CCSI Funding Cycles	
Phase 1 Counties	Broome, Chemung, Monroe, Rockland, Schenectady, Suffolk, Ulster, Westchester, New York City
Phase 2 Counties	Columbia, Erie, Fulton, Greene, Jefferson, Oneida, Onondaga, Orange, Rensselaer
Phase 3 Counties	Allegany, Cayuga, Chautauqua, Dutchess, Essex, Herkimer, Madison, Montgomery, Oswego, Putnam, St. Lawrence, Sullivan, Tomkins, Wayne, Yates

Program Implementation

On one level, CCSI is a very well-defined program. It encompasses macro-level systems change by co-ordinating child-serving systems within counties and within the state. Three levels of coordination were specified—Tier 1, responsible for case conferencing; Tier 2, responsible for county policy and oversight; and Tier 3, responsible for state-level coordination and reform. On a more micro-level, CCSI is also characterized by reforming service delivery approaches to increase family empowerment, recognize strengths, develop individualized service plans, and place children in the least restrictive environment.

However, as the CCSI study progressed, and as additional site visits were conducted, we found that it was increasingly difficult to characterize CCSI simply by what was written on paper. As argued by Richard Nathan in his book *Turning Promises Into Performance*, there is a “shadow land” between policy development and program implementation. The way CCSI was designed on a state level, and how it was implemented on a county level varied immensely. In this section we will focus on the institutional realities of transforming CCSI from a conceptual framework into an actual program.

Providing a clear description of CCSI is difficult for several reasons. For one, there was tremendous variability in the way CCSI was implemented among the eight counties. Which systems were involved, who

was targeted for the intervention, and how services were planned and delivered varied immensely across the eight Phase 1 counties. From one site to another CCSI took on very different forms.

Secondly, CCSI meant different things to different people. Collaborative programs by their very nature involve the perspectives of many different stakeholders and participants. Within sites, the CCSI picture that emerged varied by stakeholder group membership.

Thirdly, individual counties changed the way they implemented CCSI over time. Often this was due to the changes in county leadership over the course of implementation. Different administrations provided more or less support to CCSI. And the players in the “CCSI game” changed with new county leadership. In addition, state financial support terminated after a few years. This caused many counties to reflect on how they would continue the initiative and in what form.

Finally, there were many pre-existing and co-existing collaborative initiatives operating within counties at the same time. They often overlapped with CCSI and were hard to distinguish from CCSI.

We found the most effective way to characterize CCSI without detailing the diversity of implementation among the eight counties, and the variations that occurred over time, was to use the conceptual tool of “ideal types.” The ideal type, an analytic construct to describe phenomena, was originally developed by the sociologist Max Weber. An ideal type never corresponds directly to concrete reality. It is constructed out of certain elements of reality and forms the basis to portray similarities and differences in concrete cases (Coser, 1977). Accordingly, each of the CCSI “ideal types” presented below do not fully describe any one program, but instead depict the nature of implementation among the eight counties and over time.

CCSI as a Case Management Program

This ideal type was focused on reforming the process of service delivery. The initiative primarily took place in the interaction between the client and the caseworker. The intent was to develop a partnership between the family and the worker to create an individualized service plan grounded in a strength-based assessment. The emphasis of the case management approach was to empower families and develop more appropriate case plans. There was less emphasis on addressing broader systemic issues to reform fragmented, categorical service structures.

The CCSI Training Model

This “ideal type” was designed to promote the CCSI philosophy among all the county child service systems through cross-system training. Workers were trained in the interagency case conferencing process and in service delivery reforms. There was little emphasis on a centralized CCSI organization. With this type of approach there may not be a systematic client referral process to a CCSI program. Instead, the trained worker might convene a cooperative case-planning meeting when a client with multiple service needs was identified through his/her regular caseload. This makes it very difficult to identify exactly who was a CCSI client.

The CCSI Centralized Structural Program

In comparison to the decentralized model, this approach has a well-defined organizational structure. At one extreme, the most structured Tier 1 case conference committee is comprised of a standing group of children’s services workers and family advocates who meet with families on a scheduled basis to develop individualized service plans. In more flexible models the membership might change based upon the family’s

desire and situation. In any case, the CCSI Coordinator usually attends all meetings and often facilitates the group. There is a well-defined referral process to CCSI. The structural approach also has a strong Tier 2 county-level policy-setting body that is informed by the Tier 1 case conferencing group. This approach seemed to come closest to achieving all the goals of CCSI – promoting interagency cooperation, developing community-based alternatives, and performing model casework practice.

The Flexible Funding Model

To certain service providers, CCSI offered a way to obtain access to special funds to provide families with needed goods and services that could not be supported through categorical funding streams. These funds could be used for nontraditional purposes that could have an impact on averting residential placement. Sometimes a Tier 1 case conference would be convened simply to meet the requirement needed to qualify for flexible dollars. These meetings were often viewed as an unnecessary annoyance, and would seem to conflict with the program's intent to streamline service delivery. While this model probably had some influence on maintaining the child in the community, there was less emphasis on reforming systems and service practices.

3

SERVICE PROVISION

Recruitment Process and Targeting Issues

Who Was Served?

In general, there was consensus among the eight counties of the appropriate target population for CCSI. Most counties required, at a minimum, three criteria:

- ❖ **The child was at risk of residential placement.** For some counties, the requirement was at *imminent* risk of residential placement; for other counties, it was simply at any risk of future placement.
- ❖ **The child was involved with multiple systems or had cross-system needs.** If a child could benefit from a single service, s/he was considered inappropriate for CCSI. In some cases evidence needed to be presented that alternative services had failed.
- ❖ **The child had an emotional disability.** This was defined differently across the counties. Some counties had very loosely defined criteria of what constitutes an emotional disability. And in other cases this was clinically defined, and required a psychiatric diagnosis that is recognized by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised, or DSM-III-R.

Furthermore, other eligibility criteria were adopted. Some Coordinators indicated that services were limited to families who could demonstrate a willingness to work with CCSI to avert out-of-home placement. In addition to averting residential placement, CCSI was also considered for discharge planning for children who were coming out of placement or to reduce the number of days in care. Finally, some sites had a designated number of CCSI slots. Families might not be served, or might be put on a waiting list, if the site had a full caseload.

Hard-to-Serve Populations

There are children who are under-served by existing systems because they fail to meet rigidly defined eligibility criteria. CCSI was designed to provide unconditional care – no youngster or family would be found ineligible or terminated due to challenging or disturbed behaviors. However, those involved with CCSI

found it difficult to meet the needs of children who fall outside of the “system boxes.” The sites reported critical systemic issues in serving the following populations.

Children with Dual Diagnoses

Children and adolescents with a diagnosis of developmental disability or substance disorder (alcohol or drug), in addition to a designated mental illness diagnosis, are considered to have a dual diagnosis. While there are some guidelines regarding which agency is primarily responsible to serve the dually diagnosed child, there are disagreements when it comes to the actual delivery of services.⁸ Specialists in each system often claim that the primary diagnosis is with the other system. According to one provider, these children are “passed around in a game of systems football.”

Aging Out Population

Across systems, there are different age requirements regarding youth eligibility for services and parental rights and responsibilities. For example, CCSI is designed to serve youth between the ages of 5 and 21 years. Within the State’s mental health system, children and adolescents are defined as persons younger than age 18. And the juvenile justice system restricts eligibility for PINS (Persons in Need of Supervision) programs to youth younger than age 16.

Counties argued that there is a lack of available services for children who commit minor offenses when they age out of the PINS system at 16 years but whose parents are still responsible for their actions. It was pointed out that there are contradictions between the Family Court Act and the Education Law. The Education Law states that youth must attend school until the end of the school year when they turn 16, but Family Court Act restricts filing PINS up to, but not through, 16. This leaves the school districts and probation officers with a period of time when there is very little that can be done.

Other Special Needs Populations

Two populations of children who had committed specific offenses were identified in several counties – youthful sexual offenders and fire setters. Providers noted that there is a lack of programs within the state that are willing to, or have the capacity to, work with these children with these presenting issues.

Tier 1 – The Case Conferencing Process

Tier 1 Members

The Request for Proposals in Phase 1 for CCSI solicitations stated that the Tier 1 body should to be comprised of a multi-disciplinary committee of parents and supervisory-level staff who have the ability to make agency commitments about service planning and delivery. While most sites had a fairly well-conceptualized Tier 1 structure, some of the CCSI counties struggled with developing committees composed of the pre-

8 Persons with developmental disabilities are the primary responsibility of the Office of Mental Retardation and Developmental Disabilities (OMRDD); persons with substance abuse disorders are the primary responsibility of the Office of Alcoholism and Substance Abuse Services (OASAS); and persons with DSM-III-R diagnoses other than developmental disability or substance abuse disorder are the primary responsibility of the Office of Mental Health (OMH).

scribed membership. Specifically, it was argued that a standing committee of supervisors conflicted with many of the CCSI principles.

A committee of system supervisors is inconsistent with the ideals of family empowerment and individualized services. These principles suggest that Tier 1 needs to be form-fitted to every individual family and that the family should have an active role in choosing who is (and is not) "at the table." Over time, workers increasingly saw the value of involving the family's informal support system – relatives, neighbors, religious advisors, etc. It is also critical that front-line staff who provide services and manage cases are part of the service-planning team. Case managers who were not part of the Tier 1 team reported more antagonism when they tried to work with other service systems.

Many Tier 1s evolved over time – they initially included supervisory level staff and later included only front-line staff and informal supports. However, it was recognized that some level of supervisory involvement is critical in the CCSI process, although not necessarily at the Tier 1 table. Consequently, some of the counties created alternative structures comprised of supervisors.

Supervisory involvement is necessary for several reasons. Front-line workers need supervisors who encourage and support their efforts to case conference. As one interviewee noted, "Sometimes DSS caseworkers wanted to convene case conferences, but their Supervisors didn't know what they were talking about." There needs to be a level of staff to serve as liaisons between the front line and higher level administrative staff. As one provider argued, "Members of Tier 1 are too intimidated to go to Tier 2; there's a chain of command that they are used to following."

In one county, the CCSI workers abandoned the idea of case conferencing in favor of a family empowerment approach. While the latter approach was devoted to enhancing the family's capacity to deal with issues on their own, it does little to promote cooperative planning and interagency service delivery. There was noticeably more antagonism among systems at this site. A family empowerment approach does not need to preclude a cooperative, interagency model. Unfortunately, when a new idea is promoted in the human services, some providers have a tendency to give up on formerly effective, yet currently unpopular program models.

The Conferencing Process

While there was variability among the sites, there was some consensus about the ideal components of the case conferencing process. Through the ideas expressed in the field, as well as by our own observations, the research team developed the following list of important elements comprising the model case conference. Not all of these approaches were necessarily followed by all CCSI programs. However, there was general agreement that they represent best practice.

- ❖ The case conferencing process should be fairly standardized and begin with assessing family strengths and identifying the resources that families already possess.
 - ❖ An attempt should be made to satisfy a concrete need that the family has identified early in the intervention. Families often identify that their most pressing issues involve basic needs relating to food, clothing, and shelter.⁹ Families are more likely to "buy into" the plan when they see that a pressing need that they have identified is being met.
-

9 There is some evidence that a family's perception of needs often differs from service providers. According to a study by the Urban Strategies Council (1992), families were more often concerned about meeting basic needs, while service providers tended to focus on longer term priorities like job training, education, or family counseling.

- ❖ Case conferences should promote family empowerment. The family determines who should attend (and not attend) the meeting, the family identifies the most pressing issues that should be given priority, and the family works in partnership with providers to establish goals and create the service plan. Providers should seek to develop a family's capacity to solve problems so that they are less dependent on service systems.
 - ❖ Family advocates should be equal partners of Tier 1s, contributing another perspective to the group, and supporting families by empathizing with their needs and concerns.
 - ❖ An individualized service plan should be developed so that services meet the needs of families, rather than forcing families to fit into the available services.¹⁰
 - ❖ A case manager should be identified from the group who will oversee the implementation of the plan. This can be the referring worker, a parent advocate, someone who just emerges from the group, or the CCSI Coordinator. In some counties, funds were committed for CCSI-specific case managers. Sites reported that it was preferable to have case management functions handled by someone other than CCSI Coordinators, so that the Coordinators could devote their time to other responsibilities such as fostering collaboration and resolving system issues.
 - ❖ While there is a case manager who is assigned to oversee the implementation of the service plan, tasks to be carried through should be shared by all members at the table including the family. Attempts are made to have all systems offer something to the mix. By involving a greater number of workers across several systems there is access to a broader range of resources. This also lessens the work burden on any one worker or one system.
 - ❖ Periodic follow-up meetings should be scheduled at the first case conference. This ensures that the plan is being carried through and is being adapted as different issues arise and additional needs are identified.
 - ❖ At all times the safety of the child must be addressed. When a program focuses on averting out-of-home residential placement, there is some potential that the child's safety in the home could be endangered. This was never the case with CCSI. Everyone the research team interviewed believed that decisions resulting from CCSI meetings never placed the child's safety in jeopardy. At some Tier 1 meetings protective services were contacted when it was determined that child safety might be an issue.
 - ❖ It is critical to have case conferences convened by someone who is well-trained in group facilitation skills. In many cases, the CCSI Coordinator led case conferencing meetings. Interviewees noted that case conferences could be disastrous if not convened by a skilled facilitator.¹¹ Front line staff need training so that they buy into and understand the value of case conferencing, and are empowered and capable of organizing and facilitating meetings.
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10 One CCSI Coordinator offered an example of an individualized care approach that gave this somewhat abstract concept more meaning. A parent wanted to acquire de-escalation skills to work with her child. While the parent desired hands-on training in her home, there was no available program service that provided that specific service. However, the county identified a program that did this training for respite workers and arranged through flexible funds to have a trainer go to the parent's home.

11 One interviewee stated: "In the beginning, some meetings were horrible, there was no control. We needed training on how to run meetings, and who facilitates. The kids ranted and raved, families cried, we were all thrown together. Often the core members disagreed and would fight in the middle of the meeting. The families sat there and watched like it was a tennis match. The group needed more work than the kids did.... You can't throw people together and come out with a treatment plan. You need preparation and training."

- ❖ All stakeholders need to expect that the benefits of collaborating will outweigh the costs, such as loss of decision-making autonomy and increased time commitment.

Tier 2 – The County-Level Policy-Setting Committees

Tier 2 Membership and Role

The Phase 1 RFP stated that Tier 2 should consist of “a parent of a child with emotional disabilities, the commissioners and directors of the involved local agencies, a BOCES/district superintendent and other appropriate persons identified by the county.” For the most part, Tier 2 membership consisted of those individuals “second in command” at the child-serving agencies. A few commissioners were involved, but they generally sent their designees. There was only one county where it was considered a problem that the DSS Commissioner was not on the committee, because his designee did not have the authority to make decisions.

In addition to the major systems, Tier 2s commonly included representatives from youth bureaus, non-profit agencies (e.g., Catholic Charities, Berkshire Farms), hospitals, and residential facilities. Most groups had at least one parent advocate on the committee. One county had a county attorney. Members from education generally included BOCES staff; a few Tier 2s had principals.

The Tier 2 role varied across counties and over time – including cross-system information sharing, policy making, system coordination, and system conflict resolution.

A number of accomplishments from Tier 2s were noted:

- ❖ Development of a universal consent form that was used across all child-serving systems
- ❖ Increased ability of the CCSI Coordinator to cut through bureaucratic red tape and gain access to needed services for CCSI cases. For example, one Coordinator reported that he contacted a Tier 2 representative who helped him gain access to a crisis center; another was able to get an emergency social services placement for a case that had not been opened.
- ❖ Identification of new programs based on issues brought to Tier 2. For example, one Tier 2 developed a single-point-of-entry committee that reviewed placement recommendations across all children’s services systems.
- ❖ Coordination of all flexible dollars entering the community.

Tier 2 Issues

Tier 2 members raised several issues. It was not uncommon for Tier 2 members to express uncertainty about their role on the committee. This was primarily voiced by individuals who did not have decision-making authority for their agencies.

The major communication barrier was not among the Tier 2 members but between the structural levels of Tiers 1 and 2. Typically, the CCSI Coordinator raised issues at Tier 2 meetings that had been identified by Tier 1s. However, communication back to Tier 1 members was weak. Tier 1s were convened to discuss cases, and there simply was no mechanism to report back about Tier 2. One county had a CCSI newsletter which facilitated communication between the tiers.

Some Tier 2 members believed that the Tier 2 body was unnecessary because they were already involved with other interagency committees. Some counties did not organize a Tier 2 if another interagency committee seemed to meet the purpose; and some counties disbanded their Tier 2 if the group was duplicative of other county structures, a rational response to an initiative established in part to eliminate overlapping services. The issue of overlapping interagency structures will be discussed in more detail in chapter four.

Family Advocates

During the 1980s, several key documents and federal activities called for the involvement of families in systems of care for children with emotional disturbances. These initiatives culminated in the formation of a national family-driven organization – the Federation of Families for Children's Mental Health. The Federation, in conjunction with grants provided by the federal Center for Mental Health Services, supported community-based efforts to increase family involvement in children's mental health services. In New York State, the family advocacy organization is known as Families Together.

The family advocacy movement has played an important role in the development of CCSI. Family advocates are represented on all levels – Tier 1, Tier 2, and Tier 3. Family advocates assumed various roles in CCSI across the eight sites including:

- ❖ Helping families navigate systems to obtain needed services and resources.
- ❖ Supporting families during case conferences.
- ❖ Assisting in the development and implementation of the service plan, providing case management, and performing follow-up services.

Generally, service providers expressed a deep appreciation for the contributions made by family advocates and recognized that advocate involvement was a vital component in their attempts to adequately serve families. A parent's first-hand experience in raising an emotionally disturbed child contributes a critical perspective. They are personally familiar with the hardships and difficulties experienced by other parents raising a child with complex needs and can empathize in a way that others can not. One family advocate stated, "Many of the parents have become isolated. People pull away from parents with children with serious emotional disabilities."

Some family advocates expressed mixed feelings about their role. In some cases family advocates and systems people developed very close relationships and valued and respected each other. However, some advocates felt undermined. According to one:

"It is hard for me to sit on Tier 1 because I'm the only parent. Sometimes they will agree with me, and sometimes they won't. They have a tendency to blame parents, to fall back on that. It's scary for parents to come to the meeting. Everyone there has power over them and what happens to their child."

It was apparent that this parent never really felt like an equal partner in the Tier 1 group. Some family advocates felt that certain members of Tier 2 were patronizing and condescending.

And from the other side, certain providers believed there were some family advocates who adopted an adversarial role and had a negative influence on the process. According to one:

"There is animosity between parents and the program. There have been hand-to-hand battles. The parents didn't understand the system and its parameters within the county.... They had a problem with separating being a parent from a parent representative. They tend to 'bring their baggage with them' and the parent advocate shouldn't have a child in the system."

Some family advocates were provided stipends for attending meetings and to cover the expenses of transportation and babysitting. Some family advocates are regular employees of community organizations. These individuals seemed to be less adversarial than volunteer family advocates. One could argue that this is a result of being "co-opted" by the system; and others might argue that this is the result of an increased understanding of the limitations imposed by bureaucracies. There may be some uneasiness about hiring family advocates because they are chosen on the basis of a personal experience, which can be interpreted as contradicting more meritocratic employment practices.

Flexible Funds

CCSI had a flexible funding mechanism that enabled providers to purchase goods and services to meet the individualized needs of children and families, but were not allowable under traditional, categorical funding streams. Most service providers were extremely grateful to have access to flexible funds and believed that the funds contributed toward preventing out-of-home placements. Flexible funds, according to the providers, are "small amounts of money that go a long way."

Providers found that the goods and services purchased through flexible funds helped establish trust with families. Providers were able to offer support for those priority needs identified by families, without regard to the limitations imposed by categorical programs. What is most enlightening about flexible funds is that it provides a glimpse of what the community is lacking and what families need.

Flexible funds tended to support five major services:

- ❖ *Respite Care Services.* Raising a seriously emotionally disturbed child can be very stressful. Respite care services offer parents temporary relief, reduce their levels of stress, and thereby contribute toward averting out-of-home placement. Respite care services included planned respite when child care was needed for such occasions as school vacations, and emergency respite when an unpredicted crisis arose within the family.

There was also a category of "respite type" services that was provided in the home. This type of respite often consisted of a youth "companion" (also referred to as a Big Brother or youth support worker) who performed other functions in addition to providing relief to parents. These workers developed a special therapeutic relationship with the child and were able to offer needed support. They were also role models for parents, informing them of alternative ways to deal with and work with the child. Some workers were responsible for ensuring that the child attended school each day, or serving as a one-on-one aide in the classroom.

- ❖ *Recreational Services.* It was commonly reported that there is a lack of community recreational opportunities for seriously emotionally disturbed children. Traditional programs often reject the special needs children. This population requires programs that are supervised by recreational therapists and other trained staff. When these programs do exist within a county, transportation is often unavailable.

Flexible funds support such recreational opportunities as camp experiences, karate lessons, Y memberships, and dance lessons.

- ❖ *Youth Employment Opportunities.* Several sites provided successful employment opportunities for youth and used flexible funds to support expenses for transportation, job coaches, and youth stipends.
- ❖ *Concrete Services.* Many families had basic needs relating to food, clothing, and shelter. Flexible funds supported transportation needs, clothing for children, household goods, and utility bills.
- ❖ *Mental Health Services.* The Medicaid-supported mental health services often are limited and do not provide all the therapeutic care that clients need. Flexible funds were used to increase the intensity and duration of counseling and other mental health services.

Issues Relating to Flexible Funds

There were a few issues concerning flexible funds. Some workers associated CCSI exclusively with flexible dollars, leading to a potential misuse of funds. That is, some community-based providers convened Tier 1 meetings, primarily to fulfill a requirement to access the funds. In some cases this led to individuals “going through the motions” of conducting a Tier 1 meeting rather than developing a meaningful service plan. When used in this way, a few providers indicated that they perceived of Tier 1s as an unnecessary annoyance involving extra paperwork, when they simply wanted to obtain a simple service or resource for a family. This is a complex issue, however, since in most cases it appeared that the funds were used to cover the costs of a needed service that contributed to averting placement.

Simple administrative mechanisms need to be established to facilitate the use of flexible funds. Complicated bureaucratic sign-off procedures simply defeat the intent of having flexible funds.

CCSI and Aftercare

Most children who are placed in residential facilities eventually go home. However, reintegration in their communities and homes is often troublesome. In some places, the CCSI initiative has been used to develop effective discharge plans and to coordinate aftercare services to ensure a successful transition back to the community. Many believe that CCSI has shortened stays in care, and prevented returns to placement.

A few successful examples were given where the CCSI mechanism was used for discharge planning and aftercare services:

- ❖ Several counties convene Tier 1s to develop plans for a child returning to their home community following placement in a Residential Treatment Facility (RTF) or in a hospital.
- ❖ One county social services department mandates that agencies with DSS residential contracts use Tier 1 to work on transitioning the child to the community.
- ❖ One CCSI county recently received a federal grant to support discharge planning and aftercare services. They are using their Tier 2 to serve as the discharge committee and are hiring a discharge planner who will also work on three months of aftercare.

CCSI seems to be a “natural” for aftercare. A child leaving a residential facility probably has cross-agency needs and requires system coordination efforts.

4

RELATIONSHIPS AMONG SERVICE SYSTEMS

"Although new service delivery policy frameworks are being developed to respond to the gaps and overlaps created by the specialization and categorization of children's services, actual changes in school practices are rare.... Policy frameworks have not been able to penetrate the organizational structures of schools enough to create the conditions for effective collaboration. The norms of educational professionals do not include a service reform mentality. They say that educational professionals have "repair shop" mentality while collaboration and service integration initiatives need to be child focused, family centered and consumer guided. They indicate that educational policy makers have focused on categorical thinking rather than these more relational processes." (Mawhinney and Smrekar, 1996)

Overview

It was generally agreed that CCSI led to improved communications and understanding among child-serving agencies and systems. It was also reported that CCSI had resulted in cross-system efforts that went beyond CCSI-related activities. Prior to CCSI, if agencies worked together it was idiosyncratic, through the initiative of individual workers. CCSI institutionalized cross-agency efforts. The sites rarely reported obstacles relating to information sharing or confidentiality concerns.

This chapter will focus on the relationships among systems involved in CCSI and in meeting the community-based service needs of the targeted population.

The Educational System Involvement

There is always some difficulty in analyzing implementation findings from a multi-site initiative. The researcher is seeking to identify commonalities among places that have a unique history, political orientation, geographical location, and organizational culture. Therefore, when a finding is uncovered that is passionately reported and consistently expressed among all the sites, it requires close examination. The nature of the involvement of the education system in local interagency efforts is such a finding. *Every* county indicated that there were significant challenges concerning education's commitment to CCSI principles and education's active participation in CCSI structures. This is a critical issue since education is the only system that is legally obligated to provide services to all children in the community.

Education's Response to Meeting the Needs of Children

There were two related issues concerning the educational system's response to children with special needs: inappropriate recommendations for residential placement, and reluctance to provide needed community-based services.

It was reported that Committees on Special Education (CSE) make decisions in isolation. In comparison with other child-serving systems, placement decisions made by CSEs were never brought before Tier 1s or a county review committee, where one exists. The perception of the other children's service systems is that the education system recommends residential placement as the first option rather than attempting to provide services within the community.

Some claimed that schools have a narrow perspective of children and a low level of tolerance for children with special needs leading to an overreliance on residential treatment. Furthermore, some argued that once a child was placed by the education system, there was a tendency for him/her to remain in placement longer than children who were placed by other systems.

And others believe that the educational system was reluctant to provide children with needed community-based services. For example, in one county, workers hypothesized that four-year-olds were being declassified by the education system when they are about to enter kindergarten, so that education could avoid paying for services.

It was further reported that children "get lost in the system." Children experience extensive delays waiting for school placements when returning home from residences. They also experience delays waiting for residential placement. Such children are given a mere two hours of home instruction a day, which is very inconvenient for families. It was also noted that the CSEs will not convene to create an educational plan until the child has returned home from a residence, which results in unnecessary delays in educational program enrollment.

While there are regulations to protect children, it is argued that schools are violating children's rights. The other systems, especially social services and the juvenile justice system, view themselves as much more conscious of due process and regulations. This situation has become so exaggerated that some counties have hired a designated staff person who is responsible for becoming an expert on educational law, regulations and entitlements, to advocate for families and ensure that children are getting due process.

Toward an Understanding of the Educational System

The constraints experienced by the educational system are both self-imposed and imposed by the structure.

Traditionally, education has not sought solutions from other systems. The service delivery reforms that have developed in other children's service systems have not infiltrated the education system. Education is accused of not adopting strength-based approaches or a family-systems model. In one county, education was the only children's service that was not represented on the Single Point of Entry Committee, which reviews all recommendations for residential placements.

There appears to be a financial disincentive for providing community-based educational services and an incentive for recommending residential placements because the other children's systems, along with state aid, cover most of the costs. As one provider saw it:

"Once the child is labeled, education will aggressively work toward placement. Day treatment is more costly to the educational system than residential placement where the costs are picked up by other systems."

And one Tier 2 member remarked,

"If the Superintendent got a \$1million bill for residential tuition costs on his desk today, he'd be calling me tomorrow and asking me what can we do? Make them pay, and they'll start paying attention."

The first step toward creating a cooperative system is to recognize that schools simply cannot be treated as an equal partner because of structural and regulatory factors. Education is a radically different system from the other child-serving systems.

The organizational arrangements of schools make it very difficult to involve them in a locally inspired county-level program. There is no central coordinating body for schools and there is no one person who represents the schools on a county level. This makes it very complicated to arrange referrals. The counties contain many different school districts that function fairly autonomously. For example, Schenectady County has 7 school districts, Monroe County has 18, Broome County has 19, Westchester County has 46, and Suffolk County has 71. The authority of the Superintendent over the schools varies among the districts. In some districts it is the principal who has the authority to make the decisions for his/her individual building. On the county level, the schools are not under the direction of the county executive. And on the state level, the Commissioner of Education is the only agency commissioner who is not selected by the Governor.

It is also difficult for school staff to leave the building during the day to attend case conference meetings. This has led to their gross underrepresentation on Tier 1s and 2s.

It is very important to consider the outside pressures that are put on the schools. All members of the community do not support school-based efforts to serve children with special needs. There is pressure from "regular education" parents who are concerned that their own child's education may be jeopardized by efforts to serve special needs children in integrated settings. There are now higher educational standards and a zero tolerance for violence. There is also some community pressure to rely on punitive approaches (e.g., suspensions) rather than more service-oriented approaches.

Education is the only child service system that is legally obligated to serve all children in the community. Schools claim that by the time the child with special needs comes to the attention of the other systems, the education system has already served the child for a long period of time, exhausting their resources on a wide variety of programs in a number of different settings. As a Tier 2 member explained:

"With some children, they have involved the school psychiatrist, the guidance staff, and the social worker, and have used detention and suspension. These kids drain their resources. They have already dealt with the child when he becomes a new case to the county."

Educational Efforts to Serve Special Needs Children

While there were reports of the lack of appropriate school-based approaches to serve children, there were reports of some noteworthy attempts where schools were involved in cross-agency efforts to avert residential placements and provide community-based care.

In some places, it was found easier to involve education personnel if case conferences were convened in the schools. In one county, a City School District worker was supported by and co-located within the county

department of social services. She was responsible for establishing educational plans for children who were leaving residential care. Another county has a mental health liaison stationed at several schools who assists staff in dealing with children who have mental health issues. And it was mentioned that there are efforts to bring services into the school, such as health centers, youth emergency services, PINS prevention workers, and mobile crisis team for children with serious emotional disturbances.

It was suggested that there is a need for additional teacher training in such topics as mental health conditions, adolescent issues, and approaches to work with special needs children. There is a need to expand special programs such as day treatment programs and more alternative options within the community on the full continuum of services.

And others claim that by the time the child becomes known to a Committee on Special Education it is too late to effectively serve the child in the community. There is a need to intervene earlier, before a child is at imminent risk of placement. In one county, caseworkers went into elementary schools as part of a PINS diversion effort, even though PINS are not usually filed until the child reaches late middle school or high school. In earlier grades, they target issues such as truancy, which may be an early indication of later difficulties. One provider noted:

“We need to start services in schools before the child comes to the attention of the service system. You need a Junior High School principal or attendance officer who sees a kid with a problem, instead of filing a petition, to understand his mental health needs, education needs, juvenile justice needs – and assist with accessing helping resources, with parents involved and everyone sitting around the table.”

And finally, some claim that New York State needs to mandate that schools become more involved with CCSI and other cross-agency efforts and to make community-based care a priority.

Other Child-Serving Systems

In general, there was uneven involvement of the different agencies across counties. This section will present a few observations that were made about the primary child services systems.

Juvenile Justice

The participation of county probation programs varied from site to site. In general, probation was more active in places where CCSI evolved from PINS diversion efforts.

As would be expected, other systems perceived that probation workers take a more punitive approach, are more control oriented, and more often recommend placement.

In one county, probation workers were co-located with social service workers. Both agencies felt they benefited from the different perspectives introduced by each agency. They reported:

“Probation’s mission is to protect the community from the child; social services is to protect the child from members of the community. We both gain insights from each other.”

A few places tried to increase the involvement of Family Court judges by soliciting their membership on CCSI committees or inviting them to CCSI meetings. One county has regularly scheduled quarterly meetings with Family Court judges to review new service programs and discuss service delivery issues. One site

coordinator reported that the Family Court judge might decide to delay placement when the CCSI Case Manager was involved with the family. And one county attorney reported making more informed decisions based on increased knowledge about community-based services through her CCSI involvement:

“[Before CCSI] when we used to go to court and argue for a position, we had no idea of how it would take place. We didn’t have an accurate picture of the services that were available. And I had no idea that there were as many services in the community as well as the limitations of service providers.”

A few counties reported that within the last year the family court system has taken a more punitive approach toward dealing with juvenile offenders and more often recommend out-of-home care.

Mental Health

Some providers reported that the local mental health programs were fragmented and isolated – they are supported under different funding streams, operate fairly autonomously, and the staff do not know each other.

Providers argued that Medicaid funding imposed limitations on appropriate service provision. Reimbursable services are office-based and for this reason some mental health providers were reluctant to attend Tier 1 case conferences because it was not a billable service.¹² Some reported that mental health providers were child-focused rather than family-focused. A county Mental Health Intensive Case Manager was told in a State and County review not to continue services for the siblings and parents of the child targeted for services. While the Mental Health system promotes the rhetoric of a family-based approach, funding does not back it. It was also reported that Medicaid imposed inappropriate time limits on services.

One provider indicated that the State Mental Health regulations were overly rigid for three case management programs operated by her agency. She explained that the regulations stipulated that each program had to provide a fixed number of hours of case management per week. If she wanted to decrease the number of hours for a particular case, the child had to be transferred to another program with another worker, undermining the time it takes to establish the client-worker relationship.

Inappropriate placements occur because of a lack of beds in residential treatment facilities (RTFs). The placement costs are often incurred by social services, rather than mental health, and the child is not served properly. The lack of residential treatment facilities sometimes results in out-of-state placements. There is also a lack of mental health facilities for younger children with significant mental health issues.

Most agreed it was a huge mistake not including developmental disability agencies in the initial design of CCSI, especially because of the issue of adequately serving dually diagnosed children.

Social Services

There were two issues that were raised concerning social services. One issue involved the process of service delivery, and the other was related to interagency system concerns.

12 One county brought this issue to the attention of Tier 3, who clarified that case conferences could be a billable service. Other counties, however, are still under the impression that they are not a billable service.

Some observed that child welfare workers have difficulty in accepting the idea of family empowerment. They hypothesized that this was the result of the child protection orientation of workers and their role in assuming child custody.

In addition, social service administrators feel victimized because they wind up responsible for children who are refused services by other systems. They explained that in the mental health and developmental disability systems, there is no right to treatment – service delivery is capacity-driven, not needs driven. When there are no available beds in Residential Treatment Facilities, children are put on waiting lists. The children, however, still require services and oftentimes become the responsibility of the child welfare system, which is mandated to provide services, while mental health is not. Social service administrators also raised issues regarding education system placements. They objected to having to pay for a large portion of the costs for placements that are determined by Committees on Special Education, when they do not have a voice in the placement decision.

Tier 3 and the County/State Relationship

Tier 3 is the State-level tier of CCSI. It is comprised of two parents and the executive staff representatives of the member agencies: Office of Mental Health, Office of Children and Family Services, State Education Department, Division of Probation and Correctional Alternatives, Office of Alcoholism and Substance Abuse Services, the Council on Children and Families, and the Office of Mental Retardation and Developmental Disabilities. Tier 3 is responsible for addressing major policy, regulatory, or legislative areas that have been identified as barriers to the local implementation of CCSI. Staff representatives of the Tier 3 agencies also form a work group that conducts the day-to-day functions necessary to administer the program.

Vertical communication – the communication between the counties and the State policymakers – was weak. Several explanations were provided.

Most counties admitted that they simply did not bring many issues to the attention of Tier 3 because they found it easier to resolve things locally. Others said that they thought the lack of dependence on the state was good, because it forced the counties to work on their own to deal with the issues. And in general, some of the issues were simply too overwhelming for the Tier 3 group to address. The issue of categorical funding, for example, goes beyond the scope of a Tier 3.

However, many interviewees reported that Tier 3 was helpful when they did request assistance and the issues were explicitly defined. One provider reported that the Office of Mental Health approved the Tier 1 case conference as a billable service. Tier 3 also helped expedite the placement process for a child awaiting placement.

There were also CCSI regional teams comprised of regional staff from the member agencies. The teams were responsible for providing local staff with ongoing assistance and training and were considered the primary conduit of information and recommendations between the local CCSI programs and Tier 3. For the most part, the local sites had limited contact with the regional teams and generally found them to offer little help. The failure to establish a strong regional link partially explains why the counties did not utilize Tier 3.

Part of the difficulty in developing the regional linkage can be explained by the uncoordinated regional structure that exists among the State agencies. One Coordinator pointed out that there is no consistency in the way regions are established by the different state agencies. In Western New York, for example, education's regional office is located in Batavia, the social services regional office is located in Rochester, and the two

were simply not accessible as a group. Also, levels of knowledge about CCSI, and the willingness to work with the counties, varied among the regional staff.

Overlapping Initiatives

There are other initiatives in the counties that are similar to CCSI in terms of:

- ❖ goals – to avert placement
- ❖ structure – comprised of multidisciplinary teams
- ❖ processes – involved in case conferencing and case management services
- ❖ targeting – to serve similar populations

On the one hand, preexisting collaborative arrangements made it was easier to plan CCSI because the different agencies were already meeting and coordinating approaches. On the other hand, pre-existing collaboratives could cause confusion in implementing CCSI. Specifically, it resulted in some uncertainty about how these preexisting structures would fit into the new model.

There is also a trend, on both the state and local levels, to create additional interagency coordinating bodies. An incredible number of locally inspired and state-supported collaborative efforts were mentioned.¹³ Sometimes CCSI was successfully integrated with other collaborative structures. And other times, the different collaborative groups continued to meet separately, resulting in a lot of meetings that dealt with common clients and overlapping issues. This sometimes occurred when the other groups did not exactly meet the CCSI membership requirements, and so the counties thought they were required to organize a different but overlapping group.

One coordinator felt that the development of new coordinating bodies and programs was a “step backward.” While these efforts have been initiated to resolve local service gaps, there needs to be some coordination among the coordinators to eliminate duplicating, overlapping structures, the original intent behind developing all the interagency efforts. Additional study needs to be devoted to what is presently working, where there is duplication, and how efforts can best be coordinated.

13 Some local initiatives that resemble CCSI included the following:

Suffolk’s Interagency Committee on Children’s Issues, predating CCSI by two years and resembling a Tier 2 structure; Monroe’s Kids, which reviews all out-of-state placement; Monroe’s Cross System Committee, which looks at all coordinating bodies; and Monroe’s Children’s Referral Committee, which performs intakes for four mental health programs; Rockland’s JD/PINS Placement Workgroup, which meets regularly to reduce placements and to reduce length of stay in care; and Ulster’s Weekly Review Committee, which reviews placements and includes all child-serving systems, except education.

Some State initiatives include: Partners for Children, the Task Force on School Community Collaboration, Family Resolutions Program, Mental Health/Juvenile Justice Program, PINS Diversion Programs (Diagnostic Assessment Teams, Institutional Review Teams), Juvenile Intensive Supervision Program, Home and Community Based Waiver Service, and the Integrated County Planning Initiative.

5

OUTCOMES

Reported Effects from Interviews

There is no doubt that each of the eight Phase 1 counties was successful in designing and implementing CCSI programs. While the counties varied substantially in terms of how the model was developed and carried out, the basic objectives of CCSI were met by creating interagency structures and reformulating the way services are delivered to clients.

Attributing the changes that occurred in the counties to CCSI, however, is problematic. While individuals reported that CCSI had an effect on rates of placement and the delivery of services, without a carefully designed experimental study it is impossible to know if these effects were due to CCSI as opposed to the other programs and initiatives operating in the counties. The fact that most of the counties have provided local funds to sustain CCSI efforts after state support terminated provides some evidence that at least in the eyes of the localities, CCSI produces some positive change.

While there were many co-existing interagency programs, there were also preexisting initiatives that also add to the confusion regarding the extent of the influence of CCSI. In one county where there was a long history of interagency cooperation prior to CCSI, the providers felt that gaining State backing made a crucial difference in their efforts to advance coordinated planning and service delivery. According to the provider:

“Although the structure was there before CCSI, the fact that the State formulated this design, and gave it a structure – this all gave it credibility and support that was needed. It is not just a county thing. It’s more important and fits into the planning of the State. It added a whole new dimension. It’s hard on the local level to do something. To the County executives and commissioners, they now see it’s important because others see it as important. If it’s just local, it doesn’t allow other county departments to jump in; they need the word from their state departments.”

There were five main effects attributed to CCSI: averting residential placements, improving relationships among children’s services systems, identifying and providing needed community-based services, changing the way families are served, and improving worker morale.

Averting Residential Placements

Most people felt that CCSI had a positive effect on averting out-of-home placements and shortening length of stay in care. There were a few counties that performed formal evaluations. However, the methodology was not rigorous, and claims of averting placement were probably overstated. In general, it was argued that CCSI created a “deinstitutionalized” mentality. There is a clear orientation toward thinking about what can be done to serve children locally and avoid out-of-home placement.

Improving Relationships Among Children's Services Systems

CCSI improved communications and understanding among children's service agencies. The different systems reported increased knowledge regarding what resources are available, who to call, and where to make referrals. The increased coordination was related to non-CCSI activities as well. Some of the cooperative activities mentioned included participating on another agency's interview committee (e.g., mental health and juvenile justice), co-location of workers (e.g., probation and social services), and joint funding for case management positions (e.g., youth bureau and mental health).

Identifying and Providing Needed Community-Based Services

Interviewees reported that CCSI led to increased identification and provision of needed services. This occurred as a result of collaborative meetings of Tiers 1 and 2 and sometimes led to joint funding, especially in the area of respite care services and case management.

Changing the Way Families Are Served

According to those interviewed for the study, CCSI institutionalized new approaches in human service delivery—individualized service planning that is strength-based and involves the active participation of families. These approaches have been integrated into “non-CCSI” activities.

Improving Worker Morale

Although this was not an intended benefit of CCSI, interviewees said the initiative led to improving worker morale because CCSI allows everyone to “share the load.” Workers reported that case conferences provided them with relief since they can get additional support to work with very challenging cases. As one worker confessed:

“It's very draining and upsetting and you feel you're not getting anywhere when the issues are extremely complex. We have a forum to bring families and issues back. You feel validated. Workers feel isolated and burnt out. Going into bad neighborhoods. We get replenished by the others.”

By dividing labor and sharing difficult cases, worker stress is alleviated, and motivation and energy to cope with challenging cases is increased. CCSI may have an effect on reducing staff turnover, which is viewed as a major problem in human services.

Quantitative Results

As noted above, many of the participants in the CCSI program, at all levels, believe that the program has had the effect of reducing residential placements. This section of the study is devoted to discussion of what the data show about overall trends in placement. While, as stated above, there are many limitations to this part of the study, given the nature of the program and the nature of the data that have been collected, a lot can still be learned about the context of CCSI from an analysis of the data that are available.

Snapshot of the Residential Placement System

As of September 30, 1997, approximately 12.3 thousand children were in residential facilities within New York State's residential placement system. This system consists of placements from Child Welfare (Social Services), Juvenile Justice (Division for Youth), Education, and Mental Health. It is dominated by Social Services placements, which account for approximately two-thirds of the total as shown below. New York City accounts for roughly 56 percent of the placements in the state.

Children in Residential Facilities, by System
September 30, 1997

	<i>Number</i>	<i>Percent</i>
Child Welfare (Social Services)	8,147	66.1%
Division for Youth	2,006	16.3%
Education	1,653	13.4%
Mental Health	516	4.2%

The NYS Department of Social Services (now the Office of Children and Family Services, and referred to in the table above as "Child Welfare") supervised an extensive network of foster care services for children. While DSS licensed these facilities and provided the regulatory framework for the provision of foster care services, the placement and supervision of children in foster care were the responsibility of the county social services district. Local social services have different levels of care within their system ranging from kinship foster care to institutional placement. The data gathered for this study were compiled from placements in four levels of care within the DSS system: Institution, Group Residence, Group Home, and Agency Operated Boarding Home. An institution is a facility for 25 or more children. Group residences are facilities for 13 to 25 children, operated by authorized agency. A group home is a family-type home for 7 to 12 children, operated by an authorized agency. An agency operated boarding home is an operated home for not more than six children.

The NYS Division for Youth (now also a part of the Office of Children and Family Services, and referred to above as "Juvenile Justice") was responsible for the prevention of delinquency, and the care, treatment, and rehabilitation of juvenile offenders, juvenile delinquents, persons in need of supervision, and other trouble-prone youth. The Division for Youth provided a wide range of residential programs that served court-adjudicated youth. These residential programs vary in the degree of security provided and the level of community involvement afforded the youth in care. The Division also contracted with private care agencies for residential services and monitors local secure and non-secure juvenile detention facilities. The placements in this study under the Division for Youth were their state-operated facilities. Placements in private agencies were included in the DSS data.

The New York State Education Department (referred to above as "Education") requires local school districts to offer children with handicapping conditions an appropriate education in the least restrictive setting. Although most children with special educational needs are educated in public or private day programs, some children who are educationally handicapped require a residential placement for educational reasons. The placements included in this study are made into DSS licensed institutions with on-grounds schools.

The NYS Office of Mental Health (referred to above as "Mental Health") is responsible for providing service to emotionally disturbed children. This is carried out through programs that are state operated as well as programs that are privately operated but licensed by OMH. Residential Treatment Facilities provide severely emotionally disturbed young people, ages 5-21, with highly specialized care and treatment programs away from a hospital setting. Placements within the Office of Mental Health licensed Residential Treatment Facilities are the only OMH placements included in this analysis.

This assessment covers data received from September 1993 to September 1997 in which the current Office and Children and Family Services was operating as two separate agencies, the New York State Division for Youth and the New York State Department of Social Services. The recent merger of the Division for Youth and the family and children services division of the former Department of Social Services created the current Office of Children and Family Services.

CCSI Counties Versus Non-CCSI Counties

CCSI counties differ from non-CCSI counties in a number of ways. First, as noted above, CCSI counties were chosen partly because they had high placement rates — the number of children in residential facilities per 1,000 children — or large numbers of children in placement. The table below shows placement rates and numbers of placements, as of September 30, 1993 (before CCSI was in full force), in CCSI counties and non-CCSI counties.

CCSI and Non-CCSI Counties, 1993

	<i># of Counties</i>	<i>Placement Rate</i>	<i># of Placements</i>	<i>Share of Total</i>
Phase 1 (1993 CCSI)	8	2.51	2,117	18%
Phase 2 (1994 CCSI)	9	2.01	1,323	11%
New York City (not CCSI)	1	3.03	6,377	54%
Rest of State	40	1.15	1,931	16%
 NYS Total	 58	 1.60	 11,748	 100%

NOTE: Placement rate are # of children in placement per 1,000 aged 21 or younger.
Unweighted means of counties in each group.

The mean placement rate in the Phase 1 counties was more than double the rate in non-CCSI counties outside New York City, and the mean in Phase 2 counties was much larger than the rest of the state. CCSI counties also tended to have large numbers of children in placement, with the eight Phase 1 counties having more placements than the 40 rest-of-state counties. Finally, as is true with many demographic and economic measures, New York City is unlike most of the rest of the state. It has higher placement rates and many more children placed.

Although Phase 1 counties generally had higher placement rates than the rest of the state, there was considerable variation within the group. Suffolk county, for example, had one of the lowest placement rates in the state, ranking 48th out of 58 with a 1993 placement rate of only 0.77 per thousand children. It was included in Phase 1 partly because even with its low placement rate it had a large number of children in placement due to its sheer size. Schenectady county, also in Phase 1, had a 1993 placement rate of 4.47 per thousand – 40 percent higher than Albany county (not in CCSI), which had the next-highest placement rate in the state.

The distribution of children by type of facility differs somewhat between CCSI and non-CCSI counties. Phase 1 CCSI counties tend to have a greater share of children in the Social Services system than do non-CCSI counties outside of New York City, and fewer children in Education and Youth systems. The table below shows the distribution of placements by CCSI status and type of system in 1993.

Residential Placements by CCSI/Non-CCSI Status, 1993
Each System as Share of Total

	<i>Social Services</i>	<i>Youth</i>	<i>Education</i>	<i>Mental Health</i>	<i>Total</i>
Phase 1 (1993 CCSI)	64%	12%	20%	4%	100%
Phase 2 (1994 CCSI)	67%	17%	13%	3%	100%
New York City (not CCSI)	69%	21%	7%	3%	100%
Rest of State	54%	15%	26%	5%	100%
NYS Total	65%	18%	13%	4%	100%

Changes in Placements Over Time

From September 1993 through September, 1997, residential placements in Phase 1 CCSI counties fell while placements in the rest of the state rose, as the table below shows.

Changes in Residential Placements, 1993 to 1997

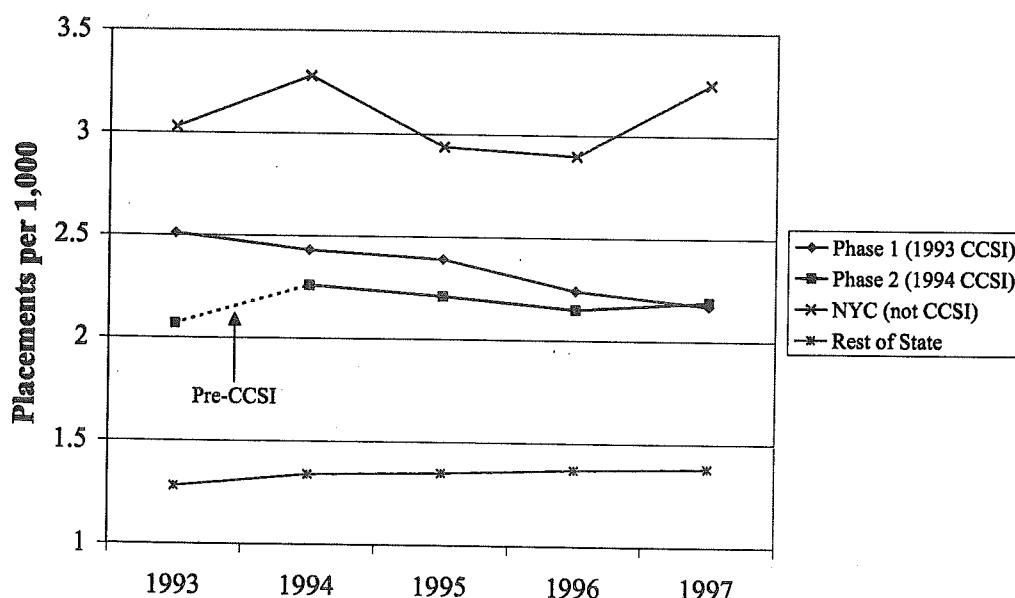
	<i>1993</i>	<i>1997</i>	<i>Change</i>	<i>Percentage Change</i>
Phase 1 (1993 CCSI)	2,117	1,941	-176	-8.3%
Phase 2 (1994 CCSI)	1,323	1,452	129	9.8%
(Phase 2, 1994-1997)	1,408	1,452	44	3.1%
New York City (not CCSI)	6,377	6,835	458	7.2%
Rest of State	1,931	2,094	163	8.4%
NYS Total	11,748	12,322	574	4.9%

NOTE: Represents placements in 1994.

Changes in Placement Rates

When we adjust for growth in the population of children by computing placement rates, the difference between Phase 1 and other counties is more pronounced. Figure 1 shows mean placement rates for Phase 1, Phase 2, New York City, and the rest of the state, for September 30 of each year from 1993 through 1997.¹⁴ Placement rates in Phase 1 counties declined steadily throughout the period, falling nearly 14 percent from 1993 to 1997. Phase 2 counties showed relatively minor changes in placements, New York City oscillated, reflecting large changes in its Social Services placements, while the rest of the state had an 8% increase in placements. The subsequent table shows the placement rates underlying Figure 1.

Figure 1
Placement Rates (Unweighted Mean)



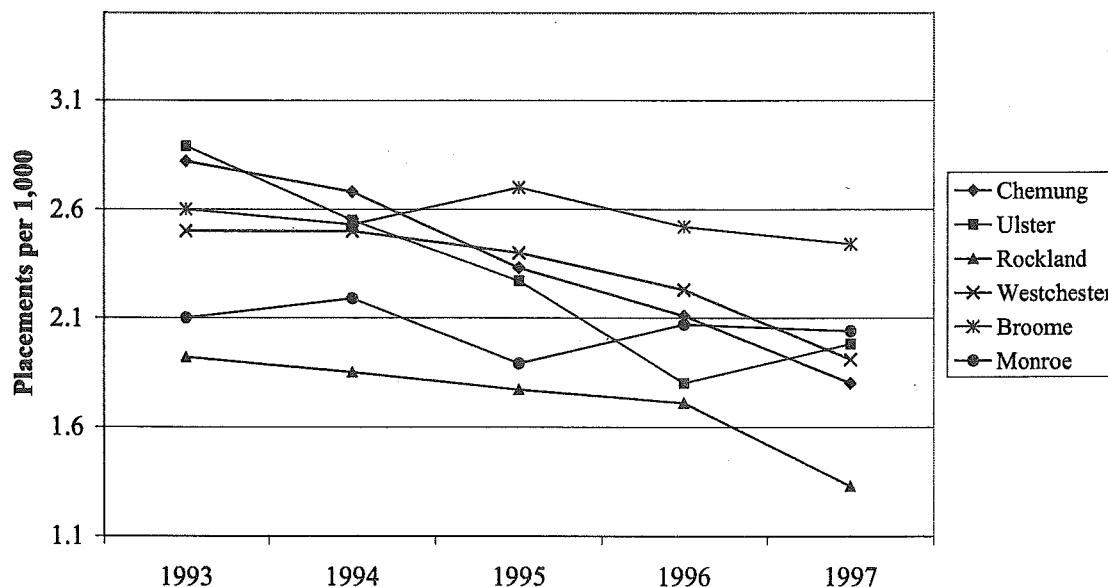
**Average Placement Rates by Year
(Unweighted Means)**

	1993	1994	1995	1996	1997	1993 to 1997 % Change
Phase 1 (1993 CCSI)	2.51	2.43	2.39	2.24	2.17	-13.5%
Phase 2 (1994 CCSI)	2.07	2.26	2.21	2.15	2.19	5.8%
New York City (not CCSI)	3.03	3.28	2.94	2.90	3.25	7.3%
Rest of State	1.28	1.34	1.35	1.37	1.38	7.8%

¹⁴ Unless otherwise noted, placement rates for county groups are *unweighted*, meaning that each county is as important as any other, regardless of size. We do this because for most purposes in this report we want to think of each county as potentially providing information that is as important as other counties.

Six of the eight Phase 1 counties shared in the declines. Schenectady, the county with the highest 1993 placement rate in the state, and Suffolk, with one of the lower placement rates, were the only two counties in Phase 1 to see placement rates increase. Figure 2 shows placement rates in the Phase 1 counties, excluding Schenectady and Suffolk so that the graph can be presented on the same scale as Figure 1. The subsequent table shows the placement rates by county underlying this graph, and shows the excluded counties as well.

Figure 2
Placement Rates, Phase 1
Excluding Schenectady, Suffolk



**Average Placement Rates by Year
 (Unweighted Means)**

	1993	1994	1995	1996	1997	1993 to 1997 % Change
Chemung	2.82	2.68	2.33	2.11	1.80	-36.2%
Ulster	2.89	2.55	2.27	1.80	1.98	-31.5%
Rockland	1.92	1.85	1.77	1.71	1.33	-30.7%
Westchester	2.50	2.50	2.40	2.23	1.91	-23.6%
Broome	2.60	2.53	2.70	2.52	2.44	-6.2%
Monroe	2.10	2.19	1.89	2.07	2.04	-2.9%
Schenectady	4.47	4.31	4.97	4.56	4.87	8.9%
Suffolk	0.77	0.83	0.80	0.90	1.00	29.9%

The decrease for some counties over this period is marked, and would appear quite significant. However, whether these changes are due to CCSI or to some other factor is, as will be discussed more thoroughly below, an open question. For instance, Chemung County, which had the steepest drop in placements, did not have a typical CCSI program at first. Instead, it used its CCSI funding to operate a youth employment program and to provide other programs with flexible funds (although this changed later). And Ulster County, which spent most of its CCSI funding on training, served only eight CCSI children in 1997. However the 31.5% drop seen in that county would have required the non-placement of 45 children. Even within counties that had very highly developed CCSI programs, such as Westchester, Broome, and Monroe, it is hard to draw a direct connection, as CCSI might not have been the only integrated wrap-around style program in existence.

Although Suffolk County had a large increase in its placement rate over the period, it still has the lowest placement rate among Phase 1 counties, remaining 25 percent below Rockland's rate, and ranked 48th in the state out of 58. Throughout the state, counties with large percentage increases in placement rates generally had very low rates in 1993 (an increase of one child per thousand has a much larger impact, in percentage terms, in a low-rate county than a high-rate county). Schenectady, on the other hand, started with the highest placement rate by far of any county in New York, and increased further still.

Changes in Placements by System

Changes in placements were naturally dominated by Social Services, as it is the largest component of the residential placement system. As the table below shows, in all groups changes in Social Services placements accounted for the majority of the total change. Phase 1 counties were the only group that saw declines in this category between 1993 and 1997. All areas of the state outside New York City also saw declines in Youth placements. Education placements increased by 81 (19%) in Phase 1 counties even as they declined in most of the state outside of New York City. The increase in Mental Health placements was quite large in percentage terms in most of the state (11% in Phase 1 counties, 105% in Phase 2 counties, and 7% in the rest of the state outside New York City) but Mental Health was only 4 percent of the system in 1993 and a relatively small number of placements – or even data errors – could cause large percentage changes.

Change in Placement by Type of System, 1993 to 1997

	<i>Social Services</i>	<i>Youth</i>	<i>Education</i>	<i>Mental Health</i>	<i>Total</i>
Phase 1 (1993 CCSI)	-241	-26	81	10	-176
Phase 2 (1994 CCSI)	147	-62	1	43	129
(Phase 2, 1994-1997)	78	-54	7	13	44
New York City (not CCSI)	385	33	32	8	458
Rest of State	216	-21	-38	6	163
NYS Total	507	-76	76	67	574

Most Phase 1 counties followed the general Phase 1 pattern of declines in Social Services and Youth. As the table below shows, the large increase in Schenectady county placements was driven entirely by Social Services increases that more than offset a large decline in Youth placements. Suffolk, on the other hand, had increases across the board, including an extremely large increase in Education placements of 54 children

(37%), that accounted for two-thirds of all Education placements in Phase 1. In fact, Suffolk added more children to its Education placement system than did New York City over this period despite the fact that New York City is much larger. Suffolk's Education placements rose substantially in each year over the 1993 to 1997 period.

Change in Placement by Type of System, Phase 1 Counties, 1993 to 1997

	<i>Social Services</i>	<i>Youth</i>	<i>Education</i>	<i>Mental Health</i>	<i>Total</i>
Westchester	-141	-12	12	1	-140
Rockland	-47	—	-2	-2	-51
Ulster	-63	3	11	4	-45
Chemung	-27	-5	6	-3	-29
Broome	-4	-11	3	—	-12
Monroe	-32	19	-3	5	-11
Schenectady	42	-25	—	1	18
Suffolk	31	5	54	4	94
 Phase 1 Total	 -241	 -26	 81	 10	 -176

While it is interesting to examine the individual components of the residential placement system, it is important to remember that it is a system. If a child is in need of placement and room is not available in one component of the system, in some cases another may serve as a second-best alternative – components may be partial substitutes for each other at times.

Conclusions About CCSI and Residential Placements

It is tempting to think that the tendency for placement declines in Phase 1 counties is attributable to CCSI, but clearly we don't have enough information to conclude that. For example:

- ❖ We do not know what was happening to placements before 1993, as sufficient data are not available; perhaps the decline in CCSI counties is simply the continuation of a longer-term trend.
- ❖ Or perhaps the decline reflects changes in economic circumstances or other factors affecting likelihood of placement. Again, relatively little data are available to answer this question.
- ❖ The conversion of foster care to block grants may have affected residential placements in ways that are difficult to understand.
- ❖ If CCSI is behind the declines in Phase 1, why don't we see declines of similar magnitude in Phase 2? Five of Phase 2's nine counties had declines between 1994 and 1997, but four had increases. (One of these increases, however, was in Erie county, which did not implement CCSI in 1994.)
- ❖ Finally, as we noted earlier, CCSI appears to serve a very small portion of children at risk of placement, and so it seems unlikely that CCSI alone could lead to large changes in the entire placement system. (It is possible, of course, that counties used CCSI as an opportunity to re-

structure their larger service delivery systems, and CCSI might have served as the impetus for broader change.)⁸

In any event, the data do not appear to contradict the belief of many CCSI participants that the elements of CCSI – however defined and designed – contribute to lower rates of placement.

Potential Cost Savings from Averted Placements

Many CCSI officials believe that the CCSI approach can reduce both the rate of placement, and lengths of stay for those who are placed. Unfortunately, for reasons given earlier, we cannot know whether CCSI has in fact reduced placements. We also cannot know the full costs of CCSI. These costs clearly go well beyond the \$700,000 initial appropriation for the Phase 1 counties. The CCSI approach requires considerable effort on the part of state administrators and local officials. It requires more meetings, and greater effort to work with families and children. The degree of effort, and how it differs from the pre-CCSI effort, varies from county to county and in general is not measurable although local officials are able to give illustrations of the effort involved.

Nonetheless, placing children in residential settings is expensive and so the potential savings are large. Depending on the type of setting a child is placed in, and its location, the cost at current rates typically ranges from about \$168 per day in a Social Services setting to \$357 per day in a Mental Health institution. Residential settings in upstate New York tend to be moderately less expensive than in downstate, but the difference usually is not significant.

The table below shows the average daily cost of placement in recent years by component of the residential placement system, and for the system as a whole. These are based on average daily rates provided by the Council on Children and Families, by type of institution and location (upstate or downstate), weighted to reflect the number of children in each type of setting and location. The column labeled "Social Services and Education" includes children placed in foster care settings whether placed there through a social services agency or through a Committee on Special Education. The rate is weighted to reflect the fact that some children are placed in institutional settings that require additional tuition payments, and others are placed in settings that allow them to attend local schools.

Average Daily Cost of Placement

	<i>Social Services and Education</i>	<i>Youth</i>	<i>Mental Health</i>	<i>System Average</i>
1993-94	155	196	329	169
1994-95	162	204	342	176
1995-96	157	209	334	174
1996-97	161	239	351	183
1997-98	168	239	357	187

The average cost across all settings currently is about \$187 per day – or more than \$68,000 for a 365-day year. The costs exceed \$60,000 annually even for the least expensive settings, and for the relatively few children placed in mental health institutions, they can exceed \$130,000 annually.

Not all of these costs are paid by the state and county governments, and not all would be saved by these governments if a placement is averted. Federal, state, and local governments share in these costs, depending

Outcomes

on where a child is placed, and under what program. The table below illustrates typical financial sharing arrangements.

Typical Federal/State/Local Cost Sharing During CCSI Years *			
	<i>Federal</i>	<i>State</i>	<i>Local</i>
Federally Eligible: DSS – Title IV-E Foster Care	50%	25%	25% (County) *
Not Federally Eligible: DSS – Child Welfare		50%	50% (County) *
Juvenile Justice (DFY)	50% **	50% **	
Mental Health	50%	50%	
SED: Institution		50% of residential costs	50% County pays residential costs; School district pays tuition from state grant

* During CCSI, these programs were categorical grants from the state to the counties. This is no longer the case. They have now been block granted. As a result, counties now bear a larger share of costs at the margin for additional children placed. Among other things, this increases the incentive for counties to reduce costs.
** Slight variation

Because the federal government shares in the costs of Title IV-E foster care placements and mental health placements, it would share in some of the gains from placements averted.

For CCSI to achieve savings at least equal to the \$700,000 in grants by the State for Phase 1, it would have had to avert placements of more than 10 children for at least one year, assuming the children would have been placed in the various residential settings in the same proportion as existing placements. This requires about a one-half percent reduction in total placements in these counties. CCSI would have to avert further placements still to recoup the costs of state and local implementation of CCSI.

Unfortunately, as noted earlier, the data needed to know whether CCSI has averted placements simply are not available.

6

RECOMMENDATIONS

This section will present a series of recommendations based upon the experiences of the individuals who were interviewed as well as our own observations. The recommendations are made on three levels. We initially focus on specific reforms to CCSI that address the areas of client targeting, service provision, worker training, and program administration. This is followed by broader-based recommendations relating to county interagency efforts and service delivery reform. We conclude our recommendations by suggesting reforms to State-level policy.

General Reforms to CCSI

It is difficult to formulate general recommendations for an initiative that by its very nature is individually tailored and flexible to accommodate local conditions and structures. However, there were a number of best practices that were either implemented or advocated by the different sites that we will present here.

CCSI Targeting

CCSI was initially designed to serve children with serious emotional disturbances. A compelling case could be made to apply the CCSI model to serve all children with multiple needs who are at risk of out-of-home placement, regardless of their diagnoses or conditions. The shortcomings of children's services do not exclusively affect children with serious emotional disabilities. Therefore we recommend that consideration be given to expanding the CCSI initiative to serve all children with complex needs.

CCSI Coordinator Position

CCSI programs seemed to be administered most effectively when managed by a full-time Coordinator who is devoted to enhancing interagency efforts and service delivery reforms. Some CCSI Coordinators had their time divided between CCSI and other county initiatives. A few CCSI Coordinators were responsible for providing case management services in addition to overseeing the CCSI initiative. We recommend that CCSI sites consider supporting a full-time position that is devoted exclusively to system coordination and system conflict resolution.

CCSI Structure

Some counties expressed confusion concerning membership on the case conferencing process (Tier 1) and membership for the county policy-making committee (Tier 2). We recommend that CCSI programs involve three levels, not two levels, of local coordinating committees: (1) a group comprised of parents and front-line workers who case conference and develop individualized service plans; (2) a group comprised of parents and supervisory-level staff who serve as liaisons between the front-line and administrative leaders, train workers, and resolve lower-level system issues; and (3) a group comprised of parents and senior-level administrators who serve as liaisons between the County and the State and work on major county regulations and policies that impede coordinated service delivery.

CCSI and Aftercare

Many families experience difficulty when their child returns home following a placement in a residential facility. In some places, CCSI structures have been effectively used to develop discharge plans and to coordinate aftercare services that ensure a successful reintegration into the community. We recommend that the CCSI initiative be used in the process of developing discharge plans and coordinating aftercare services for children returning to the community from residential care facilities. Furthermore, county agencies should consider including CCSI in contracts with residential agencies.

CCSI Training

Case conferences need to be convened by someone who is well trained in group facilitation skills. Interviewees noted that case conferences could be disastrous if convened by an unskilled facilitator. Workers felt that they were not sufficiently trained to run a case conference. We therefore recommend that hands-on interagency training be delivered to all front-line staff that provides a step-by-step guide on how to run case conferences, includes videotapes of actual case conferences, and offers opportunities for role-playing for participants.

County System Reforms

CCSI can only partially contribute to averting out-of-home care. No matter how well interagency mechanisms are developed, or how far-reaching innovative service delivery reforms are adopted, if there are not sufficient resources devoted to appropriate community-level services averting residential placement becomes increasingly difficult. There is still a need to devote additional resources for the development of community-based services.

While we do not have the complete answers regarding the array and mix of services that are needed, we offer the following recommendations:

Aftercare

As already noted, there needs to be a closer connection between residential facilities and local providers. To ensure a seamless transition back to the community, we recommend that county agencies develop contracts with residential facilities that require strong connections with community care providers. Community providers should be collaborating with residences before the child leaves care. Furthermore, residences need to work with the whole family while the child is in placement.

Community-Based Services

Many providers found that respite care services offer parents temporary relief that reduces their levels of stress and thereby contribute to averting placement of their child. A few providers also found that structured youth employment opportunities offered enriched experiences for youth with emotional disturbances. And finally, it was noted that there is a lack of recreational services designed specifically for children with emotional disabilities. We recommend that consideration be given to supporting innovative local approaches in the areas of respite care, youth employment, and recreational services designed for children with emotional disturbances.

Co-locating Services

Often, co-location is cited as an important ingredient to collaboration. However, there were only a few isolated cases where this occurred. Where services were co-located, interagency collaboration was quite successful. We recommend that additional consideration be given to co-locating services when possible.

Education System

There were a number of issues that were raised concerning the education system's commitment to CCSI principles and active participation in CCSI structures. It is recommended that teacher training be coordinated to further develop the adoption of system delivery reform principles in the education system that have been integrated in other children's service systems. This includes training in the areas of family empowerment building, strength-based assessments, and family systems approaches. It was also reported that additional teacher training was needed in the areas of mental health conditions, adolescent issues, and approaches to work with special needs children.

When implemented, school-based services that incorporate other providers were particularly successful. Such approaches have included locating a school district worker at a county social service office to develop educational plans for children leaving residential care, establishing a mental health liaison position in the schools to assist staff in dealing with children who are not "formally identified" but have special needs, and providing PINS prevention services in the early grades. It is recommended that the education system continue to work with other providers to support innovative approaches to interagency service provision to meet the needs of children before they become at imminent risk of placement.

There is a perception that Committees on Special Education (CSEs) make decisions in isolation. It is recommended that CSEs develop mechanisms that would open up their processes to include other children's service systems. This would assist the schools in identifying local resources that might avert placement and better serve troubled children and their families.

Single-Point-of-Entry Committees

The counties that have established Single-Point-of-Entry Committees among the county children's service system have experienced success to averting residential placement and providing families with needed community-based services. We recommend that all counties consider establishing placement review committees comprised of county service agencies.

State Level Policy Changes

State Agency Regional Offices

Some providers experienced difficulty in accessing the State because of the uncoordinated regional structure that exists among the State agencies. There is no consistency in the way regions are defined by the different state agencies and arranging meetings of regional staff representing different agencies is extremely difficult. Interagency initiatives would be enhanced with a coordinated regional structure. It is recommended that the regional structures of State agencies be reformulated so there are geographically defined regions that are consistent from agency to agency. Co-locating different agencies on a regional level should be considered.

Other Collaborative Initiatives

There appears to be a trend on both the state and local levels for the creation of new interagency, coordinating bodies that in many cases stand alone as pilot projects. Many local providers find the number of collaborative initiatives and structures overwhelming and counterproductive. It is recommended that additional study be devoted to understanding what collaborative initiatives are working, where there is duplication, and how efforts can best be linked.

Meeting the Needs of Underserved Populations

Children with a dual diagnosis (i.e., have a developmental disability or substance disorder in addition to a designated mental illness diagnosis) have difficulty receiving services. Oftentimes, specialists in each system claim that the primary diagnosis is with the other system while the child's needs are unmet. It is recommended that the State Offices of Mental Health and Mental Retardation and Developmental Disabilities form a task force to study the issue of serving children with dual diagnoses.

Across the various child-serving agencies there are different age requirements regarding youth eligibility for services. We recommend that the age requirements be viewed by each agency within the context of other systems. Particular emphasis should be given to exploring contradictions between the Family Court Act and the Education Law. Additional study needs to be devoted to developing alternative juvenile justice programs that provide services to youth under 21 years who are ineligible for PINS services.

Management Information Systems

The counties reported difficulty in tracking residential placements. There is a need for an integrated management system that tracks placements in all children's service systems. We recommend that the State work with localities to develop a unified data information system to track residential placements, number of days in care, and community-based service provision.

In general, evaluation of similar programs could be greatly improved if the state were to establish a more comprehensive approach to data management. Two specific areas of basic data that would have been helpful to have for this study would have been easy access to non-duplicative placement data by system, and the count of participants in CCSI.

Policy Review

Policies need to support the rhetoric behind the CCSI principles. All agencies should reexamine policies and funding mechanisms that do not support family system approaches and other guiding principles of service delivery reform. Regulations need to be clarified by the Office of Mental Health regarding reimbursement of interagency activities that are not office-based. When placement in the most appropriate setting is unavailable, parents should not need to lose custody to access needed services for their children. Additional study needs to be devoted to developing a diversity of treatment settings to properly serve children within the community.

Flexible Funds

Most service providers were extremely grateful to have access to flexible funds and believed that the small amount of allotted funds brought enormous benefits for families and contributed toward preventing out-of-home placements. In many cases, flexible funds were able to fill the gap between what families need and what their communities lack. We recommend that state agencies strongly consider expanding the use of flexible funding mechanisms for additional programs and activities in the counties.

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