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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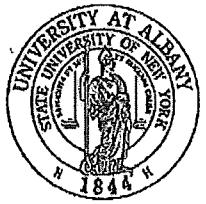

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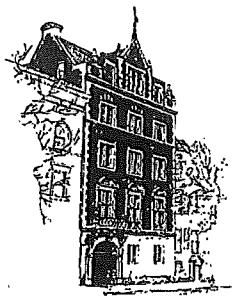

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EXECUTIVE SUMMARY

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 resposible 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 caseworker, 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-CCSI) 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.

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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.