# Mix and Match

## Using Federal Programs to Support Interagency Systems of Care for Children with Mental Health Care Needs

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### INTRODUCTION

The importance of cross-system collaborations to address the needs of children with mental or emotional disorders who receive services from various child-serving agencies—most commonly, mental health and substance abuse, child welfare, education and juvenile justice—is increasingly recognized. Over the past decade, the federal government has provided resources to encourage states to develop interagency systems of care to meet these children's needs. As states develop such collaborations, they need to draw on various federal funding programs while also using their own resources to support the comprehensive array of services necessary to meet the needs of children with serious mental and emotional disorders.

All states have now developed some level of cross-system collaboration. However, these collaborations vary widely in extent and effectiveness. Many states have had considerable difficulty bringing systems of care to scale in the state. Local systems have often floundered once their special funding from foundations or government sources has ended.

Yet the need for such interagency collaborations is great. The way resources for children's mental health services are distributed, organized and funded often makes little sense. Most funds are still directed to the most restrictive forms of care in response to escalating crises—crises that could have been avoided, had adequate resources been available to serve these children in the community. Families face significant gaps in services due to funding constraints. Some are assigned several case managers (one from each system), and the goals of different agencies often conflict. In extreme cases, families are forced to give up custody to the child welfare system in order to obtain care for their child.

Clearly, much more can be done to increase coordination and expand families' access to needed services. Federal programs can be improved to assist states, and the Bazelon Center has made recommendations to this effect.[1] However, states and localities can also use existing federal programs in a coordinated manner to finance the widest possible array of services for children of all ages and income groups. This issue brief is produced to help them do so.

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The brief was written by Chris Koyanagi, Ron Boudreaux and Elizabeth Lind, and edited and designed by Lee Carty and Christopher Burley. Its development, production and distribution were funded by the William T. Grant Foundation, with additional support provided through the Bazelon Center's general program by the John D. and Catherine T. MacArthur Foundation, the Evenor Armington Fund and the Public Welfare Foundation.

The Bazelon Center is the leading national legal advocate for adults and children with mental disabilities. The staff uses a coordinated approach of litigation, policy analysis, coalition-building, public information and technical support for local advocates to end the segregation of children and adults with mental disabilities and assure them of the opportunity to access needed services and supports.

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The information presented here comes from officials in states with a history of interagency collaboration—in particular, from individuals representing state mental health, child welfare, juvenile justice, education and Medicaid agencies, along with families and national experts, who met in the Fall of 2002. The group discussed how states and communities can create sustainable statewide systems of care and how they can use existing federal programs to fund them. This report is based both on their recommendations and on a separate set of conversations with officials in 10 other states, held prior to the meeting.

#### FEDERAL PROGRAMS FOR CHILD MENTAL HEALTH SERVICES

Financing an interagency system of care requires that state and local officials make effective use of all relevant resources. Much of the funding for services to children with mental and emotional disorders comes from the federal government. Unfortunately, these monies come from numerous complex programs. These programs are hard to understand individually and even harder to understand as parts of a comprehensive revenue stream for state and local systems of care.

The rules for the various federal programs are designed to ensure accountability. These programs target resources to address specific needs of children and achieve specific federal policy objectives. However, participants stressed that both the number of federal programs that fund services for children and the fact that federal dollars flow through several separate federal agencies create significant difficulties for state and local officials who are designing comprehensive interagency systems of care to meet the range of needs that children with serious mental and emotional disorders have.[2]

Those interviewed were most frustrated by the fact that individual children may be eligible for some federal programs, but not others. This creates gaps in funding for the continuum of needed services. Families may have limited choices and experience delays in accessing appropriate services because their children fall between the cracks of federal programs. In the worst situations, children are provided the services that can be funded rather than the services that could best meet their needs. At a minimum, disjointed funding streams force families to go from place to place to seek care and undermine efforts to provide continuity in services. Inconsistent accounting standards, including different data-collection and reporting requirements, can further frustrate state and local efforts to provide a coordinated system of care.

While these are all significant obstacles, states contacted for this study have found ways to address many of them and to use federal funds effectively and in a coordinated manner. These states have achieved more success in this than many other state and local officials realize. Their combined experiences are reflected in the recommendations that follow.

## PRINCIPLES FOR A SUCCESSFUL FUNDING STRATEGY

A study of the Robert Wood Johnson project that led the way in demonstrating the effectiveness of interagency systems of care found that successful systems use resources from various sources, often in ways that less successful collaborations do not. Successful systems integrate resources behind a common plan for each child and family, to which all the collaborating agencies are committed. Rather than tightly controlling expenditures through overly restrictive regulations and burdensome cost-accounting at the provider level, these systems have set up an extensive provider network, which operates in a flexible manner, focuses on performance and outcomes, and makes continuous efforts to improve the quality of services. Flexibility is supported either by blending various funding streams and/or by braiding major program funding or by doing some of both (see box on page 4 for discussion of these mechanisms). Under this approach, each family has one care plan that is coordinated through a single accountable entity but funded with resources from various programs.[3]

To ensure a successful funding strategy, those interviewed suggested that state and local planners need to:

◆ have a clear vision of what they are trying to finance;

◆ engage in collaborative planning across agencies and with families;

◆ understand resource options. Planners must determine in what way federal funds can be used, under what timetable, how and by whom, and what are reporting requirements. In doing this, it is important to avoid a rigid and conservative interpretation of federal rules, particularly Medicaid;

◆ create a funding strategy that merges and takes maximum advantage of different funding sources—federal and other—so that child and family needs drive agency decisions on which services to provide;

◆ focus on outcomes but recognize the need for accountability – in particular, cost-accounting must be rigorous to demonstrate how program requirements are being met. It is necessary to track, document and account for funds as well as demonstrate outcomes;

◆ engage families in the service and provider monitoring process;

◆ possess a data infrastructure that can provide the essential information needed to ensure accountability; and

◆ provide training and cross-training of staff.

## BLENDING OR BRAIDING FEDERAL FUNDS

Blending or braiding federal funds allows decisions on services to be made with the family and by those working most closely with the family. Both strategies offer local flexibility and allow providers to focus on outcomes. However, this flexibility must be accompanied by accurate measurement of outcomes.

Those interviewed stressed that systems of care must track, document and account for the funds they spend, whether using a blended or a braided funding approach. To collect the information needed to demonstrate effective outcomes for children served and accountability to taxpayers, systems of care must coordinate monitoring across agencies and strive to demonstrate total costs and benefits across systems.

Blended funding—even on a small scale – has advantages over braiding of funds because it offers significant flexibility for state and local agencies and reduces the work required for reporting and accountability measures. Blended funding can allow systems to fund activities that are not reimbursable through specific categorical programs. In so doing, blended funds can help plug funding gaps in the services continuum. This is particularly true when blended funding includes flexible dollars such as those available through a state's general fund.

Braiding, on the other hand, allows resources to be tracked more closely for the purpose of accounting to federal program administrators. It thus recognizes the categorical nature of existing programs and avoids some of the conflicts that can arise in blended funding pools.

Blending funds is often more politically difficult than the newer approach of braiding because agencies lose control; the ability to track funds to the service-delivery point may also be lost. Those interviewed pointed out that agencies are often reluctant to contribute to a blended pool or, if they do, contribute only small sums, which they generally expect will be used to pay for activities that cannot be billed to a specific funding source. Braided funding approaches tap into the larger funding sources in a manner that allows both for accountability and local flexibility in meeting individual children's needs.

Implementing a braided funding approach involves significant attention to administrative issues, according to those interviewed. It requires that states or communities ensure that there is a single point of responsibility for assessing services and the funding stream that can pay for them. Large provider agencies may be able to handle the fiscal accounting of braided funding themselves, but small providers cannot. To implement a braided funding approach, states may wish to make available to smaller providers a skilled fiscal agent who is responsible to all agencies participating in the braided funding approach. This agent would address the various requirements of funding programs, such as different funding cycles, different payment arrangements (prospective, retrospective) and different reporting requirements. This approach would provide a single point of accountability for funders, but would also require its own administrative funds. Braided funding can be a cost-accounting challenge, but it can be done and ultimately is an important strategy for making the best use of the significant federal resources available for children's services.

We use woven funding. Financing streams in the state are mapped out. (State *mental health official)*

**BLENDED AND BRAIDED FUNDING ARRANGEMENTS**

Blended funding pools have been used for many years, while the concept of braiding funding is a more recent approach. Both approaches combine funds from different federal agencies or programs into a single funding stream so they are indistinguishable at the point of service delivery.

Blended funding: Funds are combined into a single pool from which they can be allocated to providers.

Braided funding: Funds from various sources are used to pay for a service package for an individual child, but tracking and accountability for each pot of money is maintained at the administrative level. The funds remain in separate strands but are joined or "braided" for the individual child and family.

To local providers of care and for families, blended and braided funding streams should look the same. However, braiding avoids some potential difficulties with blended funding pools in that it recognizes the categorical nature of how we fund services in this country.

## USING FEDERAL FUNDS EFFECTIVELY: ENTITLEMENTS AND PERMANENT AUTHORITIES

Whichever system of merging funds is adopted, it is important to understand fully the rules that govern the financing of services through federal programs and use them in the most advantageous ways. The interviewees urged system planners, when designing a sustainable funding strategy, to consider different ways of using two categiories of federal programs:

- ongoing funding streams such as block grants or entitlement programs that provide resources year after year in a reliable fashion, and
- discretionary grants, which are time-limited and often require state or local matching funds.

No state or local system of care can be sustained effectively without ongoing financial support from both state/local and federal sources using reliable funding streams. This means that the first and most important step for planners is to review federal programs that provide ongoing support without arbitrary federal time limits. Such programs exist to fund the activities of all core child-serving agencies. For example:

- Medicaid supports all agencies—mental health, child welfare, education and juvenile justice.
- Programs under the Individuals with Disabilities Education Act, the Elementary and Secondary Education Act and Vocational Education Act are available to school systems.
- Department of Justice Juvenile Justice and Delinquency Prevention Act programs can support a wide array of activities.
- Title IV-B and Title IV-E of the Social Security Act provide resources to child welfare systems.
- The mental health, substance abuse and Maternal and Child Health block grants fund specific services through three state agencies.
- Temporary Assistance for Needy Families (TANF) pays for services for low-income families.
- The Social Services block grant (Title XX) funds a range of services for many children.

The matrix on pages 8-9 offers an overview of the services and other activities that can be funded through these and other major federal entitlement or block grant programs. All programs in this matrix provide ongoing resources without arbitrary time-limits, although the level of funding available may vary, depending on federal appropriations and the state and local resources available to provide a match.

The matrix is intended as a guide to specific opportunities for funding services and activities with these federal programs. Each program has its own restrictions on eligibility and on what can be funded, but it is impossible to show

### EXAMPLES OF BLENDED AND BRAIDED FUNDING

Wraparound Milwaukee, Wisconsin is a county-based managed care program operating with a blended funding pool. Medicaid, child welfare, juvenile justice and mental health agencies all contribute resources. Medicaid pays on a capitated basis, the other agencies pay case rates. Thus each agency knows the cost of services to children it refers to the system.

Vermont has operated a braided funding system for the past 15 years, using child welfare, juvenile justice, mental health and special education funds to develop innovative community-based treatment plans for children, adolescents and their families with the most intensive and complex needs. For the past 10 years, mental health, juvenile justice and child welfare have blended funds to operate a comprehensive immediate- response system in each of the 12 regions of the state.

Michigan, in 17 counties, uses a case-rate and wraparound approach to blend funding from mental health, juvenile justice, child welfare and education to serve children with serious mental or emotional disorders. Funding is separately tracked for accounting purposes, but at the child-family level the source of appears to be a single pool.

(continued on the next page)

**EXAMPLES (continued)**

New Jersey, in a new statewide initiative, combines blending and braiding approaches. The payment source for a specific service is unknown to providers and families, who see only a flexible pot of funds available for the child's services. The state contracts with an administrative services organization to address payment issues and to support individualized service planning at the local level. The ASO identifies the payment source for each identified service or support for the child and family. This is facilitated through the creation of a single electronic record. Funds for the initiative (Medicaid and non-Medicaid funds) are held by the state Medicaid agency and the Medicaid agency handles all reimbursement through its existing financial management system.

The Dawn Project in Indiana has braided funds from mental health, special education, child welfare and juvenile court to create a case rate paid per member per month to be used flexibly by providers in the system to finance an individualized and comprehensive plan of care for each child and family. Agencies contribute to the case rate based on established eligibility criteria. The project uses clinical-management software which can integrate clinical and fiscal data. These data are used to handle cost approval and analysis and claims adjudication.

such level of detail in a chart. For example, Medicaid is shown as funding both therapeutic foster care and supported housing. However, Medicaid will fund only some of these activities' costs (those related to services) and not others (such as rent or reimbursement to a foster family). Title IV-E funds certain expenses, but only when children are in foster care and only if costs are built into the foster care rate. Each program in the matrix, similarly, has limitations. Table 1, on pages 24-25, presents a few of the most important caveats regarding these programs.

Interviewees strongly recommend that to use these programs effectively, states and, to a lesser degree, localities should charge individual staff with the task of becoming experts on federal rules. Without a full understanding of federal program rules and what can be done with particular federal funds, significant opportunities to support the system of care with federal resources may be lost. Given the complexity of many federal programs, this is most effectively done by a team consisting of staff from all relevant agencies. The matrix identifies the potential of the various funding streams and can facilitate such work.

The first several lines of the matrix identify key aspects of eligibility rules, and can help planners identify whether:

◆ the program is means-tested, meaning that program eligibility is tied to family income and/or resources;

◆ only children and youth of a certain age range are eligible. Programs where no such limit is indicated may nonetheless define the end of childhood differently, such as at age 18, 20 or 21;

◆ children must have a certain level of impairment or disability before they can qualify for the program; or

◆ other eligibility criteria exist, such as being in foster care.

This allows system planners to see how certain children may qualify for some services through one program and other services through another. It thus shows planners which services are not adequately supported by federal sources and where alternative funding approaches will be needed.

The matrix also shows the services and activities that can be funded for eligible individuals under each of the listed federal programs. These are grouped into:

◆ screening and assessment;

◆ services for children and families (medical and clinical services are shown first, followed by rehabilitation and support services); and

◆ infrastructure funding (training, transportation, etc.).

Because this matrix is for use by interagency systems of care serving children whose mental health care needs have already been identified, it does not include the preventive programs that have a broad population-based public health approach.[4]

The matrix is based on federal rules governing the use of funds and on state efforts to fund specific mental health services or activities through the programs.

With respect to Medicaid, services checked include those incorporated in a number of states' definitions of rehabilitation services, even though, because of Medicaid's reliance on state flexibility, there may be no federal rules defining these services.

To replicate this matrix at the state level—to show what is now funded through these various federal sources—key information is needed on who is eligible, who can provide services, how funds must be accounted for, and what are the administrative requirements. Administrative requirements include the rules on reimbursement (prospective and retrospective), reporting requirements and more. It is also important to identify the state and local agencies that can draw down funds from the various federal programs.

**Action step:** The interviewees suggested that states set up a review process to consider the services they wish to fund and the eligibility status of the group of children they intend to serve, and to identify existing budget assets. The matrix can then be used to identify gaps in their current use of potential federal funding sources.

Interviewees suggested that one way to gather information is to send a questionnaire to agency personnel and to families, asking what works well in the current system of mental health service delivery and what does not. This can help identify services that require expansion and those viewed by key players in the system as not helpful.

Once the funding for various services and activities is mapped, it is then possible to engage in a meaningful process to identify opportunities in the major federal programs by matching the funding stream to the programmatic goals of the system of care. It is also important to consider how programs can work together to fund particular services. For example, Title IV-E can fund room and board for therapeutic foster care while Medicaid can fund training and services for the therapeutic foster family.

Such a comparison can also help states develop a strategy to divert residential-service spending to community care. Over the years, a number of states have found this an important tool for improving systems. Recently, New Jersey, as part of its statewide child services reform, was able to leverage federal funds for residential services that had been 100-percent state-funded. This enabled dollars previously used for long-term residential care to serve as the state Medicaid match in order to extend the array of services provided through local community-care organizations. As a result, children and families have access to a more diverse array of appropriate, individualized community-based services.

Part of this process should be the identification and removal of state and local barriers to tapping into federal resources in appropriate ways. The end result should be a coherent set of policies that allows programs to work together as much as is feasible under federal law. In some cases, this may require changing state rules and regulations or even state statutes.

You need the skill to identify rules you can change. Then change those rules you can through legislation, policy bulletins or whatever. It's a skill to identify what you can change and what would be wasted energy. (State mental health official)

# Matrix of Federal Entitlement and Block Grant Programs to Support Systems of Care for Children with Serious Mental and Emotional Disorders

| | Title IV-E Foster Care | Title IV-E Training | Title IV-E Administration | Title IV-B/ Promoting Safe & Stable Families Prog. | IDEA, Part B | IDEA, Part C | IDEA Pre-School Grants | Sliver Grants | Vocational Rehabilitation, State Grants | ESEA, Title I used for special education students | Community Development Block Grants | Section 8 Housing | Juvenile Justice & Delinquency Prevent. Form. Grant | Delinquency Prevention Block Grant (Part C) | Medicaid: Clinic Services | Medicaid: Rehabilitation Services | Medicaid: EPSDT Administration | Medicaid: Targeted Case Management | Medicaid: Psychiatric hospital services for children | Medicaid: Home & community-based waiver | Medicaid: Other* | S-CHIP | Community mental health block grant | Substance abuse block grant | Maternal and Child Health Block Grant | Social Services Block Grant | TANF | Child Care Block Grant |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ELIGIBILITY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Income | X | X | X | | | | | | | X | | X | | | X | X | X | X | X | X | X | X | | | | | X | X |
| Severity of child disorder | | | | X | X | X | X | X | X | | | | | | | | | | | | | | X | | | | | X |
| Age | X | X | X | X | | | | X | | | | | | | | | | | | | | | | | | | | |
| Other factors | X | X | X | | | | | | | | | | | | | | | | | | | | | | | | X | |
| **SERVICES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Screening | X | | X | X | X | X | X | X | | | | | X | X | X | X | | | X | | X | X | X | | X | X | X | |
| Assessment/evaluation/diagnosis | X | | X | X | X | X | X | X | | | | | X | X | X | X | | | X | | X | X | X | | X | X | X | |
| Anticipatory guidance | | | | X | | | | | | | | | X | X | X | X | | | X | X | X | X | X | | X | X | X | |
| Individual, group and family therapy | | | | X | X | X | X | X | | | | | X | X | X | X | | | X | X | X | X | X | | X | X | X | |
| Crisis intervention | | | | X | X | X | X | X | | | | | X | X | X | X | | | X | X | X | X | X | | X | X | X | |
| Mobile crisis services | | | | X | | | | | | | | | X | X | X | X | | | X | X | | X | X | | X | X | | |
| Medication management | | | | X | | | | | | | | | X | X | X | X | | | X | X | X | X | X | | X | | | |
| Prescription medications | | | | | | | | | | | | | X | X | | | | | | | X | | X | | X | | | |
| Substance abuse outpatient treatment | | | | X | X | X | | X | | | | | X | X | X | X | | | | X | X | X | | X | X | X | X | |
| Parental education on child disorder | | | | X | X | X | | X | | | | | X | X | X | X | | | X | X | X | X | X | | X | X | X | X |
| Home visits for new borns | | | X | X | | X | | X | | | | | X | X | X | X | | | | X | X | X | X | | X | X | X | |
| Family services for 0-6 | | | | X | | X | | X | | | | | X | X | | | | | | | | | X | | X | X | X | |
| Intensive in-home services | | | | X | | X | | | | | | | X | X | | X | | | | X | | X | X | | X | X | X | |
| School-based day treatment | | | | X | X | | X | X | | | | | X | X | X | X | | | | X | | X | X | | | | | |
| School-based mental health services | | | | X | X | | X | X | | | | | X | X | X | X | | | | X | | X | X | | | | | |
| Other day treatment | | | | X | X | | X | X | | | | | X | X | X | X | | | | X | | X | X | | X | X | X | |
| Behavioral aide | X | | | X | X | X | X | X | | | | | X | X | | X | | | | X | | X | X | | X | X | X | |
| Social skills daily living skills training | X | | | X | X | X | X | X | | | | | X | X | | X | | | | X | | X | X | | X | X | X | |
| Therapeutic nurseries/preschools | | | | X | | X | X | X | | | | | | | | X | | | | X | | X | X | | X | X | X | |
| After-school programs | X | | | X | X | X | X | X | | | | | X | X | | X | | | | X | | X | X | | X | X | X | X |
| Summer day programs | X | | | X | X | X | X | X | | | | | X | X | | X | | | | X | | X | X | | X | X | X | X |
| Parent hotlines | | | | X | | X | | X | | | | | X | X | | X | | | | X | | X | X | | X | X | X | |
| Therapeutic recreation | | | | X | X | X | X | X | | | | | X | X | | X | | | | X | | | X | | X | X | X | |
| Service team meetings | X | | X | X | X | X | X | X | | | | | X | X | | | | | | | | | X | | X | X | X | |

# Matrix of Federal Entitlement and Block Grant Programs to Support Systems of Care for Children with Serious Mental and Emotional Disorders (continued)

| | Title IV-E Foster Care | Title IV-E Training | Title IV-E Administration | Title IV-B/ Promoting Safe & Stable Families Prog. | IDEA, Part B | IDEA, Part C | IDEA Pre-School Grants | Sliver Grants | Vocational Rehabilitation, State Grants | ESEA, Title I used for special education students | Community Development Block Grants | Section 8 Housing | Juvenile Justice & Delinquency Prevent. Form. Grant | Delinquency Prevention Block Grant (Part C) | Medicaid: Clinic Services | Medicaid: Rehabilitation Services | Medicaid: EPSDT Administration | Medicaid: Targeted Case Management | Medicaid: Psychiatric hospital services for children | Medicaid: Home & community-based waiver | Medicaid: Other* | S-CHIP | Community mental health block grant | Substance abuse block grant | Maternal and Child Health Block Grant | Social Services Block Grant | TANF | Child Care Block Grant |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wraparound facilitation | X | | X | X | X | X | X | X | | | | | X | X | | X | | | | | | | X | | X | X | X | |
| Case management | X | | X | X | X | X | X | X | | | | | X | X | X | X | | X | | X | | X | X | | X | X | X | |
| Intensive case management/ACT | | | X | X | | | | | | | | | X | X | | X | | X | | X | | | X | | X | X | X | |
| Supported employment (adolescents) | | | | X | X | | | X | X | | | | X | X | | | | | | | | | X | | X | X | X | |
| Supported education (adolescents) | X | | | X | X | | | X | X | | | | X | X | | | | | | | | | X | | X | X | X | |
| Supported housing (adolescents) | X | | | X | | | | | | | X | X | X | X | | | | | | | | | X | | X | X | X | |
| Education and consultation | | | | | X | X | X | X | | | | | X | X | | X | | | | | | | X | | X | X | X | X |
| Respite services | X | | | X | | X | | | | | | | X | X | | | | | | | | | X | X | X | X | X | X |
| Parent-to-parent support groups | X | | | X | X | X | X | X | | | | | X | X | | | | | | | | | X | X | X | X | X | |
| Engaging natural supports | X | | X | X | | | | | | | | | X | X | | X | | | | X | | X | X | | X | X | X | |
| Transportation | X | | | X | X | X | | X | | | | | X | X | | | | | | | X | | | | X | X | X | |
| Inpatient psychiatric hospitalization | | | | | | | | | | | | | | | | | | | X | | | | | | | | | |
| Residential treatment center services** | X | | | X | X | | | X | | | | | | | | | | | X | | | | | X | | | | |
| Crisis residential services** | X | | | X | | | | | | | | | | | | X | | | X | | | | | X | X | | | |
| Group homes** | X | | | X | | | | | | | X | X | | | | X | | | | | | | X | X | X | | | |
| Therapeutic foster care** | X | | | X | | | | | | | | | | | | X | | | | | | | X | X | X | X | | |
| Purchase of goods/opportunities for child | X | | | | X | X | | X | | | | | X | X | | | | | | | | | | | X | | X | |
| Recruitment of personnel | X | | X | X | X | X | X | X | | | | | X | X | | | | | | | | | | | X | X | | |
| Pre-service training | X | X | X | X | X | X | | X | | | | | | | | | | | | | | | | | X | X | | |
| Multi-discipline & cross-discipline in-service train | X | X | | X | X | X | X | X | | | | | X | X | | | | | | | | | | | X | X | X | |
| Resources for family organization | | | | X | | | | | | | | | X | X | | | | | | | | | | | X | | | |
| Resources for family partic. in policy & program | X | | X | X | | | | | | | | | X | X | | | | | | | | | X | X | X | | | |
| Advocacy services | | | X | X | | | X | | | | | | X | X | | | | | | | | | | | X | | X | |
| Mediation of disputes | | | | X | X | X | X | X | | | | | X | X | | | | | | | | | | | X | | X | |
| Technical assistance to providers | X | | X | X | | | X | X | | | | | X | X | | | | | | | X | | X | X | X | | | |
| Management information system | X | X | X | X | | | X | X | | | | | X | X | | | | | | | X | | X | X | X | | X | |
| Provider netw orking | X | | | X | X | X | | X | | | | | X | X | | | | | | | | | X | X | X | | X | |
| Systems collaboration (agency level) | X | | X | X | X | | | X | | | | | X | X | | | | | | | X | | X | X | X | | X | |

*Medicaid: Other category includes physician, home health, transportation, administration

** Under Title IV-E, only room, board, and care can be covered; under Medicaid, only services can be covered

Those interviewed stressed that, while addressing all state-created barriers at once may not be manageable, states should begin this process by dealing with the most problematic constraints.

It is important to drop rules when they are out-of-date. (State mental health official)

Interviewees stressed that the process of removing program barriers and simplifying rules should not diminish accountability. Instead, the aim is to create flexibility and improve continuity of funding for systems of care. Systems of care should adopt appropriate performance measures to measure their outcomes.

**How States Use Federal Entitlement and Block Grant Funds**

Without exception, interviewees had found Medicaid to be the backbone of their funding strategies. Although federal Medicaid law allows states to fund a wide range of services, the interviewees knew that in many states either the state Medicaid agency or the federal regional office resists efforts to take full advantage of federal options. But not all states are so reluctant. New Jersey's representatives described a strategy where several state officials—including those from the state Medicaid agency—went to the federal regional office to explain their plan for funding community mental health services for children, showing how it would make services more accessible and improve child outcomes. Federal approval of most of the state's Medicaid proposals followed.

A second significant yet often underutilized federal entitlement for children with mental and emotional disorders is the Individuals with Disabilities Education Act (IDEA). The IDEA funds services for children of all income groups and is thus a critical adjunct to Medicaid funding. In Vermont, negotiations with the education system have led to school systems' contributing to the state Medicaid match in order to support more than 300 school-based clinicians. Mental health centers provide significant backup once children are identified under the IDEA.

Child welfare resources are typically used to fund room-and-board costs for children in care (Title IV-E) or to support adoption and reunification. Federal funds for prevention of out-of-home placements (Title IV-B) are much scarcer, but the rules are very flexible as to the range of services that can be funded and more flexible than Title IV-E regarding the low-income children who can be targeted.

Juvenile justice funds flow in large formula-grant programs to states, which must funnel most of them to localities. As the matrix shows, very few restrictions are placed on the use of these funds for children with mental or emotional disorders. However, mental health and other eligible activities often compete for these funds locally. Ultimately, juvenile justice typically provides fewer dollars to a system of care than mental health, child welfare or Medicaid, but these funds can be used for activities other federal sources will not support.

**Discretionary Programs Plug the Gaps**

Interviewees reported using a number of federal categorical programs for children's services to strategically supplement funds from entitlements and block grants. They suggest that states review the most relevant categorical programs to determine whether these dollars can fill gaps in funding of a particular system of care, provide start-up money for new services, underwrite infrastructure, support training or retraining, or finance strategy-planning processes.

Major discretionary programs authorized through each of the four core child-serving federal systems (mental health and substance abuse, child welfare, education and juvenile justice) are shown in Table 2 on pages 26-28. This is not a definitive list, but a listing of programs considered most relevant and useful by the officials who participated in the Bazelon Center study. Most of these programs are funded by the Department of Health and Human Services—particularly the Substance Abuse and Mental Health Services Administration—but the Departments of Education and Justice are also important sources to which state and local systems can look for discretionary funds.

Because it is important not to rely too heavily on discretionary programs that will inevitably end within a prescribed number of years, one strategy, according to those interviewed, is to use such programs to initiate the most critical services missing in the current system. In some cases, a federal entitlement program may pay for the service once it is in place, but it will not pay development costs. In other cases, once demonstrated effective, such services may be more readily funded through state or local sources. In adopting this approach, it is important to develop a strategy for how a reliable funding stream will eventually pay for the services or activity once discretionary funds are terminated

Other activities that can often be best funded through federal discretionary programs are time-limited, such as planning, technical assistance, training or building data infrastructure.

Such time-limited activities can also be funded with private resources, such as grants by national and local foundations, corporations and community organizations. The interviewees pointed out that, while private grants or contributions provide lower funding levels than most government sources, they can be extremely flexible and therefore valuable to system planners.

Those interviewed saw many opportunities for states and localities to use federal programs to fund an expansive array of services for children with mental disorders who receive services through various child-serving systems. However, these funds will be more efficiently used if the core child-serving agencies collaborate around both service delivery and funding issues. The remainder of this report reflects the perspectives of these officials with respect to forging meaningful and long-lasting cross-agency collaborations better to meet children's mental health care needs.

## COLLABORATIONS FOR INTERAGENCY SYSTEMS OF CARE

Those interviewed for this study have had considerable success in forging interagency collaborations and they offered tips and suggestions for colleagues who are struggling to find the resources and political will in their states to establish collaborations that promote effective systems of care. Although the interviewees did not feel that a single model for establishing a system of care could be uniformly applied in all cases, they believe their experiences can guide others seeking to develop such systems.

Several excellent publications also discuss in detail how systems of care can be organized (see resources section on pages 22-23). *Building Systems of Care: A Primer,* by the Human Services Collaborative for the Georgetown University National Technical Assistance Center for Children's Mental Health, is particularly informative.

### Who Collaborates?

Leadership has been a key factor in every collaboration that has achieved long-term viability and success in improving child outcomes.

All of the agencies are jointly committed to the best care for each child... commitment of the agencies at middle management (responsible bureaucrats near the top of each of the child agencies) is what worked in our state. (State juvenile justice official)

Finding and supporting people who will play these leadership roles is not always easy. Participants at the meeting identified three key barriers that must be overcome:

- Leadership in an agency may be turf-oriented and self-protective.
- The system could be about to lose critical leadership or leadership combinations.
- Personnel shortages may limit the time that can be devoted to the required meeting/planning for system change or individual child/family planning.

To overcome these barriers, commitment from a high level of government has generally been necessary. The officials interviewed for this study stressed that top leaders must either buy into the concept or, at a minimum, support the collaboration's broad goals and empower agency personnel to collaborate in new and effective ways.

Some states establish separate committees, task forces or a children's cabinet to bring about high-level collaboration. Other states have less formal, but nonetheless effective, strategies.

Find champions to carry the message and exemplify it. (State juvenile justice official)

Leaders must remain engaged. In the experience of those interviewed, the greatest success was achieved when high-level leadership stayed informed on

progress and had regular contact with those who were designing and implementing the system of care. At the same time, leaders must allow agency personnel the flexibility to think creatively and "out-of-the-box" in order to develop new ways of doing business.

The interviewees also stressed the importance of identifying individuals who can act as effective leaders within each agency (such as the state mental health authority's children's staff or the child welfare staff responsible for foster care), in family groups and in the stakeholder community. These individuals must do the actual work of collaboration on a month-by-month basis. In a few states, leaders at this level have achieved long-lasting and effective collaboration despite minimal involvement of higher-level leadership.

You need people who have informal leadership, not necessarily formal leadership, to be engaged—people who are on your wavelength. (State mental health official)

While the exact structure varies to suit state dynamics, generally a core leadership group has formed in all successful states to sustain the collaboration through changes in political leadership. Another large, inclusive group often exists as well, to keep everyone informed and to collect feedback from a broad group of stakeholders.

You can't be dependent on one person. It must be a culture of collaboration. (State child welfare official)

Collaborative relationships are built on trust among people who have shared ideas of system needs. According to the officials interviewed for this study, one way to assess who will be a strong partner is to look for willingness to make compromises when necessary. Rigid thinking will undermine collaborative efforts. People in the collaboration should be accessible to their colleagues and be ready to give up some control in order to further the collaboration.

The skills you need to look for (in agency personnel) are facilitation skills, not diagnostic skills. (State mental health official)

Those interviewed felt strongly that family members need to be brought into such collaborations at the earliest possible stage, to work alongside agency personnel and help guide the collaboration so that outcomes are acceptable to families. This is unlikely unless public agencies provide resources for family members to participate, such as payment for their time and reimbursement for travel or other related costs and child care.

What works is having families as allies...this enhances the vision that kids belong in communities and reduces turf issues. (State child welfare official)

All parties must make a real commitment, not just give lip-service to collaboration. The group needs to be action-oriented to avoid promoting reforms that

will exist only on paper. Participants pointed out that each participating agency must be willing to commit to the collaboration in a meaningful way so as to purchase results.

The ingredients that make the system work are leadership and money as an incentive. If you play (collaborate) you get the money/resources to have your children served; if you don't, you don't. (State mental health official)

**Action step**: Establish a common mission and vision. Mental health systems commonly develop mission statements using the principles of the Child and Adolescent Service System Program (CASSP), on page 29. However, it is important to build a mission statement across agencies. This mission statement may need to be broader in some respects or narrower in others. Most state interagency mission statements incorporate many of the basic values of CASSP, but do not adopt the principles in their entirety.

**First Steps to Take**

Leaders must subscribe to the same important values. In particular, they must agree that children's and families' needs must be prioritized and must always override agency issues and staff needs.

What brings people together is a shared commitment to do the right thing. (State juvenile justice official)

This philosophy should be clarified in a collaborative process and be in writing.

An important aspect of the mission, and one that should be dealt with by the highest level of leadership, is the definition of children to be served. Is it all children, all children with mental health care needs, children of all ages, children with serious mental or emotional disorders? Decisions on system-building vary greatly depending on this choice. Regardless of this decision, leaders must also focus on how the most complex cases will be resolved without disputes, because a failure to deal with the most difficult cases will undermine agencies' commitments to work together in the future.

We have state review teams for very complex children. The directors of all agencies come together to deal with these children's issues. (State juvenile justice official)

**Action step:** As a group, establish a change-management plan, with a long-range view of perhaps five to 10 years to implement reforms. Such long-range change-management plans should take into account the potential impact of a change in political leadership.

Collaborators need to be clear not only on their mission and purpose but how they will accomplish their goals and the timeline for making the various changes needed. It is unreasonable to expect quick results.

To build long-lasting collaborations, the proposed system must both address children's and families' needs and serve each agency's goals. Participants believed that no single solution could guide collaborators, but that it is possible in each case to determine how the system of care will help agencies stay true to their basic mission. For example, many agency goals can be satisfied in a system of care whose articulated objectives include preventing children's involvement with juvenile justice, helping children behave appropriately in school or improving their academic performance, and keeping children safe either in their own home or in an alternative placement when necessary.

**Action step**: Prepare a marketing plan as part of the group collaborative process to address the issues for various stakeholders: agencies, families and policymakers.

Experience has shown participants that systems of care can readily be marketed to all agencies—and to legislators or senior policy officials who oversee such agencies—by showing how the collaboration will satisfy each agency's existing goals and improve outcomes. They stress that successful collaborations

do not result from mental health agencies' dictating to other child-serving systems what must be done by the group, but from mental health agencies' learning what other agencies require better to serve children with mental health care needs in their systems.

What's clear from this is that the system's objections to change were taken seriously and dealt with effectively from the beginning, so they were invested in the process. (State child welfare official)

Child welfare has been relieved of the sole responsibility for deep end kids' mental health issues. (State child welfare official)

**Getting Down to Business**

The process must begin with individuals' spending time to learn about each of the other systems—their language and goals, the data they collect and the products they want. This enables the group to acknowledge and respect the differences between agencies and to identify commonalities.

**Action step:** Engage in a process to identify what is working and what is not. This will identify gaps, overlaps, conflicts and poor outcomes to be avoided in the future.

The group should share detailed information about each agency, including budget information. Planning groups should be mixed, with policy experts, administrators and direct-care staff.

Frequent contact and a willingness to respond to problems of colleagues can facilitate this process. In time, informants had found, the group will begin to share power and control as well as the burden of running overextended systems with too few resources. All agencies may not be prepared to "play" and the collaboration must be prepared to proceed.

**Action step**: Determine where funds currently exist in the system, then identify how some of these dollars might be redirected to more effective strategies.

Our primary systems are mental health, child welfare and Medicaid. Juvenile justice is a partner, but no funds yet. Education is involved to a lesser degree and substance abuse has a long way to go. (State mental health official)

Policy changes should allow for some top-down reform, such as a state's setting broad policy reform goals, designing new initiatives and providing funding, infrastructure and training. But they also should allow for bottom-up reform through local design and built-in flexibility at the local level, within the framework established by the state.

Particularly successful strategies to foster closer working relationships between mental health and other agencies are:

**Action step**: Create and implement a plan that addresses the need for integrated cross-agency financing, clinical practice and training of staff.

- Mental health staff volunteer to work on other agency committees—for example, to help write state regulations on IDEA regarding mental health issues.
- Mental health line staff are outplaced into other child-serving agencies.
- Cross-agency job shadowing is arranged for those working in all the collaborating agencies.

**Action step**: Early in the collaboration process, create a plan for how to obtain useful data and a plan for developing the necessary data infrastructure so that cross-system data can be compiled and analyzed.

Mental health staff are co-located in [the] child welfare agency to resolve issues quickly. We co-fund certain services and share supervisory responsibility and jointly certify wraparound coordinators. (State child welfare official)

Collecting good data is critical for monitoring, evaluating and demonstrating success. Interviewees urged collaborations to address data-system issues early in the reform process. Unless it is clear what is happening to children and families from the outset, the effect of the collaboration will be difficult to determine. Without evidence that collaboration makes a real difference, resistance to change and other obstacles may soon overwhelm reform efforts. Collaborators must continue to evaluate the outcomes achieved by the system of care and must constantly work to improve its responsiveness and effectiveness.

We use Medicaid MIS now for some non-Medicaid services so we can identify all the funds for the child in one place. (State mental health official)

**Action step**: Recruit diverse professionals and para-professionals for service delivery, engage and support families of color, assure that cultural competence is a value included in all agencies' programming and maintained through the use of cultural competence consultants for planning and training.

Data should focus on outcomes and speak for itself. That is, collaborations should avoid over-interpretation. Data might include:

- drop outs/school discipline incidents;
- child welfare residential-placement rates;
- use of inpatient psychiatric hospitals or residential treatment centers (RTCs);
- family views on services;
- number of children in juvenile justice because mental health services are inaccessible elsewhere.

As system reform is designed, it is critical to address the broad range of issues raised by the families who are to benefit from the provision of more effective services for their child. Each reform will need to infuse cultural competence throughout its systems of care.

#### Barriers to be Overcome

Long-standing suspicions, misunderstandings and different views of children and families in different systems can work against collaboration. Participants reported that the organizational culture in some agencies can also work against collaboration. They point out that these barriers should be recognized, so they can be addressed and agencies can remain focused on the child and family.

Different values, beliefs, funding, "blaming and shaming" need to be dealt with early in the collaboration process and gotten out of the way. (State child welfare official).

Teachers are invested in the status quo. A system of cross-agency staff training has been used to assist in implementing the [new] system. (State special education official.)

#### Keeping Collaborations Going

In addition to having formal processes for discussing key issues, participants reported, collaborations are often most successful when people get to know each

other in less formal ways. Deliberate plans to get together outside meetings—over lunch, for example—enhance the sense that all are engaged in a common task and walk the same path. This can help a group overcome the inevitable and difficult clashes of agency needs. Accordingly, said the officials interviewed, a sense of shared ownership, shared burden and shared leadership must exist within the group.

In spite of legislation and policy, we were able to build strong relationships based on trust. (State education official)

Consultants can be helpful in developing and implementing these steps, according to participants. Outside experts can create trust when, as often happens, people within the state know each other too well and are unable to hear new ideas from their in-state colleagues. To get the most value from such outside consultants, it is best to work with only one or two individuals over time, so that the consultant becomes familiar with state-specific issues and problems.

An ongoing training program for administrators and direct staff is necessary to ensure success and maintain collaboration at both state and local levels. Cross-training is the most effective approach. Training must be ongoing, due to staff turnover and because the pressures of everyday work can overwhelm staff. If that happens, collaborative work, despite its long-term payoff, will be dropped.

We have had wraparound training universally. Even correctional officers in the juvenile justice institution have received wraparound training (State juvenile justice official)

Two trainers train staff from mental health, child welfare, juvenile justice and education with families for a week. (State mental health official)

Family engagement at the implementation stage is key, according to the officials interviewed. Family engagement can help maintain constant pressure for real improvement. It can also help motivate policymakers and legislators to support a process that may not immediately demonstrate its efficacy.

As time passes, participants warned, it is easy to allow day-to-day pressures to reduce the time spent continuing to build and nurture the collaboration process and the essential relationships. Strong collaborations are built on frequent contact and must involve individuals who are willing to spend time going beyond their normal responsibilities.

**Managing Change in Difficult Times**

Managing change is the difficult task facing a collaborative effort at systems reform. Those interviewed stressed that it is critically important to be strategic about what can be changed, and not to overreach in the early stages of reform. This is an evolutionary process and there will inevitably be stages to the relationships between agencies.

Interviewees reported that they had faced and overcome several challenges

to successful interagency system-of-care reforms, including:

◆ resource issues—a continuing and sometimes overwhelming barrier;

◆ changes in leadership, particularly at the highest levels;

◆ lack of advocacy and support from child agencies, families or various other child advocates in the state; and

◆ already overworked staff's becoming overwhelmed.

Those interviewed also highlighted four specific resource issues of concern:

◆ To be successful, systems of care must be able to serve all children who qualify, regardless of the funding source. Currently, mental health and, increasingly, other state systems focus almost exclusively on Medicaid-eligible children.

◆ Short-range cost concerns too often drive state and local rulemaking. This creates difficulties for the system of care and hampers long-range improvements in outcomes for children and families.

◆ Reformers are constantly threatened by potential funding cuts—a problem that is particularly acute as this study goes to print.

◆ Different values between the systems about what should be funded can lead to cost-shifting and blaming.

Less money can cause more gate guarding and people retrenching. (State child welfare official)

Participants reported that funding constraints are often created by one system or another either out of ignorance of a particular program's spending rules or out of a desire to limit spending in a particular agency's budget. For example, there is great confusion over the use of Medicaid funds and some state officials may erroneously believe that federal rules prohibit certain types of spending. Those interviewed urged efforts to overcome bureaucratic resistance to examining all funding streams and devising ways to use existing funds appropriately in a collaborative manner to achieve the same goals and outcomes for children.

Escalating costs can result in cost-monitoring and cost-containment measures. When this is a motive and drives rulemaking, the less the system is oriented to child services and therefore the less effective it is. (State education official)

On the other hand, some interviewees pointed out that budget crises have often driven successful reforms and that the lack of resources can help advance reforms. Resource shortages force officials to think out of the box and devise more cost-efficient ways of using limited funds. Interagency systems of care are efficient and, if appropriately designed and implemented, can reduce wasted expenditures and improve child outcomes, resulting in significant future savings for many state systems. In times of fiscal crises, policymakers are often open to such new ideas.

Economic downturn is an asset in that it forces more efficiency and effectiveness in planning and execution. In our state it caused entities to come together and blend whatever they had to contribute. (State juvenile justice official)

A strategy that might be used in difficult fiscal times would be for agencies to join together on major initiatives, such as applications for a federal waiver. An application in one system (Medicaid or child welfare) could involve partner agencies who would make policy changes in their own systems to support the waiver. In this way, the waiver can be designed to support the interagency system-of-care goals and objectives, and working together strengthens the collaboration as well as the system of care.

Besides the obvious opportunities presented by demonstrating successful outcomes, positive resource benefits can result for every agency once a system of care begins to show results. Individual agency budgets may be increased as policymakers see the success of this approach. Data sharing and improved data infrastructure can produce information to help policymakers view the total costs of serving children. Cost-savings can then be appropriately considered to include savings in various other state systems.

When state administrations change and new high-level leadership takes over, the value, goals and objectives and system-of-care outcomes must be explained all over again. This can be done successfully, but must be a focus for those engaged in the reform initiative; collaborators cannot assume that new leadership will buy into the principles underlying reform.

A split among agency-level participants over key issues, such as reform goals, is a constant threat to collaborative efforts and can reduce agencies' commitment to the process. The officials interviewed for this study repeatedly emphasized that these reforms are constant and evolving processes and that collaborators need to remain focused on how each agency can gain from the collaboration and to work at building relationships within the collaboration.

Finding time for sustained collaboration can be difficult. The commitment to carve out the hours necessary for interagency discussions and new planning can become burdensome.

Many states have developed successful local collaborations in some areas of the state, but have had great difficulty in stimulating similar reforms in others. An examination of why these areas are doing so much better in collaboration can be useful. For example, is it due to better collaborative structures, personnel or other factors? Other strategies might include states' supporting local collaborations by forging common approaches to children's and families' needs. For example, state-level collaborations can design core competencies across child-serving systems. They can arrange a common schedule for training (and retraining) to reorient direct-care staff to a systems-of-care approach. States can also assist local system-of-care sites by providing technical assistance directly and furnishing flexible funds that can be used locally for planning or training.

Another threat identified by the group is lack of advocacy to create pressure for a single agenda. This, it was observed, has undermined many reforms. Lack of advocacy also affects the ability of reformers to sell their approach to the

state's political leadership. If families are fully involved and committed to the system-of-care reforms, they must also recognize their important role as advocates and spend time and resources to learn how to present a case to policymakers. To do so, families and advocates need access to key information and data and should be fully engaged in a meaningful, ongoing way in the design and implementation of reform.

Those interviewed pointed out that working first to solve a specific problem or to provide useful, timely information to others can be helpful in creating a sense early on of the successes that can come from collaboration.

## CONCLUSION

Above all, said participants, all state and local officials engaged in designing and implementing interagency systems of care for children who need mental health services must be willing to be flexible, to work at these issues over a considerable period of time, to be critical of their own agency's role and policies, and to engage and work with families and youth in design, implementation and oversight of the system. According to officials interviewed for this study, successful programs:

◆ ensure that the child's needs drive program and funding, not the other way around;
◆ make certain that each child and family has a single service plan;
◆ blend and/or braid funding;
◆ use significant federal resources in a manner that supports the system's goals;
◆ create new services to ensure that all essential child and family needs can be met;
◆ establish a range of performance measures and standards that make systems focus on outcomes;
◆ engage in continuous quality improvement;
◆ keep senior policymakers informed and engaged to enable the successful adoption of sustainable reforms around the state.

Those who are engaged in these processes report substantial rewards.

It has been the most exciting thing I have ever worked on. (State child welfare official)

## NOTES

1. Bazelon Center for Mental Health Law (2003). *The Federal Government and Interagency Systems of Care for Children with Serious Mental Disorders: Help or Hindrance?* Washington, DC: Bazelon Center for Mental Health Law.

2. For more information on federal rules that pose a barrier to state and local officials designing systems of care for children who need mental health services, as well as proposals for changes to those rules, see *The Federal Government and Interagency Systems of Care for Children with Serious Mental Disorders: Help or Hindrance?* (2003). Washington, DC: Bazelon Center for Mental Health Law.

3. Cole, Robert F., Poe, Stephanie, L. (1993). *Partnerships for Care: Systems of care for Children with Serious Emotional Disturbances and their Families, the Mental Health Services Program for Youth*. Washington, DC: Washington Business Group on Health.

4. Wischman, Amy, Kates, Donald and Kaufmann, Roxane (March 2001) *Funding Early Childhood Mental Health Services and Supports* (EI07) National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). Workbook for states, communities and programs to navigate federal programs and tax provisions providing benefit to children and families. Based on a meeting of stakeholders and experts. Provides: a blank matrix that can be used to consolidate the services and funding source inventories into a single, two-dimensional depiction; Tables listing services and financing resources; and a description of funding sources outlining eligibility criteria, services and activities covered, provider qualifications, and any special features or unique issues to consider.

## FURTHER READINGS

### Building Systems of Care

Pires, Sheila A., *Building Systems of Care: A Primer*. (Spring, 2002). Washington, DC: Human Service Collaborative for (and available from) the National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000).

Child, Adolescent and Family Branch, Center for Mental Health Services, *Systems of Care: Promising Practices in Children's Mental Health Series* (1999, 2000 and 2001). CMHS Child, Adolescent and Family Branch, Substance Abuse and Mental health services Administration, U.S. Department of Health and Human Services. (301/433-1333).

Cole, Robert F., Poe, Stephanie, L. (1993) *Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and their Families, The Mental Health Services Program for Youth*. Washington DC: Washington Business Group on Health.

### Medicaid

Bazelon Center for Mental Health Law (1999). *Making Sense of Medicaid*. Washington DC: Bazelon Center for Mental Health Law.

Pires, Sheila A., (2002). Health Care Reform Tracking Project: Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems—Managed Care Design and Financing. Tampa, FL: Research & Training Center for Children's Mental Health, Dept. of Child & Family Studies, Florida Mental Health Institute, University of South Florida. (FMHI Publication #211-1)

### Child Welfare

Hepburn, Kathy & McCarthy, Jan, (2003). Health Care Reform Tracking Project: Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems–Making Interagency Initiatives Work for Children & Families in the Child Welfare System. Washington, DC: Georgetown University Center for Child and Human Development. Available at: gucdc.georgetown.edu.

*Meeting the Health Care Needs of Children in the Foster Care System* (2002) National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). Summary of a three-year study to identify and describe promising approaches for meeting the physical, mental, emotional, developmental and dental health care needs of children in the foster care system.

Stark, Deborah (September, 1999). *Collaboration Basics: Strategies from Six Communities Engaged in Collaborative Efforts Among Families, Child Welfare and Children's Mental Health* CW05 National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). Describes practical strategies for mental health and child welfare systems to work together with families on issues that require the attention and commitment of families and both systems. This document provides a summary of lessons learned from three national organizations representing child welfare, mental health, and families. Reviews successes and struggles of six state and community sites, lists principles to guide collaboration, elements of effective collaboration, and gives a checklist to guide the collaborative process.

Meyers, Judith, McCarthy, Jan and Vivian Jackson, (May 1999) *The Adoption and Safe Families Act: Exploring the Opportunity for Collaboration between Child Mental Health and Child Welfare Systems*

(CW03). National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). A resource technical assistance guide tool for child welfare and children's mental health systems about the Adoption and Safe Families Act exploring creative ways for child welfare and children's mental health systems to work together.

#### Education

Wischman, Amy, Kates, Donald and Kaufmann, Roxane (March 2001) *Funding Early Childhood Mental Health Services and Supports* (EI07) National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). Workbook for states, communities and programs to navigate federal programs and tax provisions providing benefit to children and families. Based on a meeting of stakeholders and experts. Provides: a blank matrix that can be used to consolidate the services and funding source inventories into a single, two-dimensional depiction; Tables listing services and financing resources; and a description of funding sources outlining eligibility criteria, services and activities covered, provider qualifications, and any special features or unique issues to consider.

Feinberg Edward and Fenichel, Emily (September 1996). Who *Will Hear My Cry? Developing a System of Care to Meet the Mental Health Needs of Infants, Toddlers, Preschoolers and Their Families*. (EI04) National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). Describes an invitational meeting where states, communities, and national experts shared promising policies and strategies for developing an early childhood system of care that meets the social/ emotional needs of young children and their families. Defines mental health needs of infants, toddlers, preschoolers and their families; looks at the key components of a system of care to meet the needs of young children; and addresses barriers to system development and strategies for change.

#### Family Partnerships

Adams, Jane, Biss, Charles, Burrell Mohammad, Valerie, Meyers, Judith & Slaton, Elaine (September 1998). *Learning From Colleagues: Family/ Professional Partnerships: Moving Forward Together A product of the Peer Technical Assistance Network*. National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). (FAM03) A monograph reflecting dialogue between professionals and family advocates on issues of power, empowerment, interdependence, mutuality, and reciprocity. Presents research and commentary on issues related to a systems approach to family/ professional partnership.

Tannen, Naomi, *Families at the Center of the Development of a System of Care* FAM02 (April 1996). National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). Describes Families First initiative in Essex County, New York, a service system designed and implemented by families for families. Provides a philosophical framework, principles, strategies, and materials for developing a family-driven service system.

#### Human Resources

Pires, Sheila A., (April, 1995). *Resources for Staffing Systems of Care for Children with Emotional Disorders and their Families*. National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center (202/687-5000). Manual to help identify strategies and resources for recruiting, retaining, training and developing a workforce to deliver community-based, family-focused services to children and their families within the context of an interagency system of care.

**TABLE 1: PURPOSES OF AND CONSTRAINTS IN MAJOR FEDERAL PROGRAMS**

| Program | Purposes | Limitations |
|---|---|---|
| Title IV-E | Title IV-E Foster Care and Adoption Assistance Program supports the maintenance and associated administrative child welfare functions for children in foster care (first column in the matrix). Title IV-E administrative and training funds can be used to supplement these funds as well as for additional specific purposes (second and third columns in the matrix). A separate fixed annual appropriation provides additional funds for independent living services (not separately listed in the matrix). | Children must meet certain low-income guidelines to benefit from Title IV-E. For costs to be funded through Title IV-E those activities must be included in the foster care rate. Title IV-E can support a family organization or family participation in policy and program, but only when the families are designated as volunteers supporting the appropriate department's foster care or protective services program. Finally, use of training funds in university settings is limited to those who work, or agree to work in the future, in a public or private non-profit agency. |
| Title IV-B and Promoting Safe and Stable Families Program | Child welfare systems can use Title IV-B funds for children and families where problems may result in neglect, abuse, exploitation or delinquency of children. There are two pots of funds under Title IV-B, the standard IV-B program which can support both families in care and families at risk and the Promoting Safe and Stable Families Program (formerly the Family Preservation Act) targeted specifically to keeping children with families, reunifying children with their families and providing adoption promotion and support services. | Most Title IV-B spending must be allocated to services that prevent child welfare placement. Title IV-B appropriations are significantly lower than Title IV-E. |
| IDEA | Children from all income levels are eligible for special education and related services under IDEA. Under federal law, if a service in a child's IDEA special education plan (IEP) is covered by Medicaid, Medicaid pays first. | To qualify, children must meet the education system's criteria as a child with a disability (usually children with mental disorders qualify as a child with emotional disturbance, other health impairments or learning disabilities). |
| Medicaid | Medicaid eligibility for children is primarily based on family income, and income levels vary by state as states have the option to raise the basic federally-mandated income level (federal poverty level). Children may also qualify due to the severity of their disorder, but in this case must also come from low-income families. | Only through certain optional eligibility categories (such as a home- and community-based waiver or the TEFRA option[1]) can children from some higher income families qualify. Medicaid pays for health-related services; it will not pay the non-service costs of certain mental health programs, such as housing costs, job training or academic teaching. |
| State Child Health Insurance Program (S-CHIP) | S-CHIP benefits vary by state. Some states provide these children with Medicaid coverage, some with a Medicaid-like benefit and others with a benefit modeled on private insurance plans. | States using the option to provide S-CHIP children with a benefit modeled on private insurance have placed significant restrictions on the amount of service covered (day and visit limits) and on the type of services paid for (rehabilitation and other intensive community services are rarely covered). |

1. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, which created this eligibility option. TEFRA replaced a previous authority for state waivers that had provided a similar eligibility expansion. The TEFRA option is sometimes known as the Katie Becket option after the child whose plight came to the attention of Ronald Reagan, who then proposed the waiver.

**TABLE 1 (continued)**

| Program | Purposes | Limitations |
|---|---|---|
| Maternal & Child Health Block Grant (Title V) | These funds support a wide array of family-centered, community-based services as well as training, family-to-family support and other activities. Funds can be used for direct services, enabling services, population-based services or infrastructure building. The matrix presents the broad array of services that states are permitted to cover. | States have the flexibility to determine children who will qualify as well as services and activities to be funded. Many states specifically exclude mental health as a covered service under the Maternal and Child Health program. These funds may not support inpatient or residential care. If a service is covered by Medicaid or the State Child Health Insurance Program, those programs must pay and Title V funds may not be used. |
| Social Services Block Grant | Services are provided to low-income individuals and families and children and adults who have been abused or neglected and other vulnerable populations. | There is considerable variation in states' use of these funds for mental health services. These funds rarely support a service entirely but are used to supplement other resources. |
| TANF | TANF is a capped block grant with no required state match, although there are maintenance-of-effort requirements. Services can be funded for needy families with children and can include services for family reunification, parenting education, in-home services and crisis intervention. Children removed from home and placed with a relative are also eligible for a range of services. | Medical services are not covered. States can transfer some funds from TANF to their social services block grant. |

**TABLE 2: DISCRETIONARY FEDERAL PROGRAMS SUPPORTING SERVICES AND ACTIVITIES OF INTERAGENCY SYSTEMS OF CARE FIR CHILDREN WITH MENTAL HEALTH NEEDSACTIVITIE**

| Administering Agency | Program | Eligible Applicants | Description |
|---|---|---|---|
| **DEPARTMENT of HEALTH and HUMAN SERVICES** | | | |
| Substance Abuse and Mental Health Services Administration www.samhsa.gov | Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances and Their Families | States, county or local governments, Indian Tribal governments | Six-year grants to provide community-based system of care for children with a serious emotional disturbance and their families. Ensures that services are provided collaboratively across child-serving systems. |
| Substance Abuse and Mental Health Services Administration www.samhsa.gov | Starting Early Starting Smart | Public and private nonprofit organizations | Grants provide integrated behavioral health services for very young children and their families and inform practitioners and policymakers of successful interventions. |
| Substance Abuse and Mental Health Services Administration www.samhsa.gov | Youth Violence Prevention Grants | Public and private nonprofit organizations | Two-year grants for collaborations of community organizations and constituencies to foster prevention of youth violence, substance abuse, delinquency, suicide or other mental health problems through a public health approach. |
| Substance Abuse and Mental Health Services Administration www.samhsa.gov | State Training and Evaluation of Evidence-Based Practices | State mental health authorities and tribal organizations | Grants to conduct evidence-based practices training and evaluation programs. |
| Substance Abuse and Mental Health Services Administration www.samhsa.gov | Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems | Public and private nonprofit entities | Provides funds to assist communities in strengthening their drug and alcohol abuse identification, referral and treatment systems for youth. |
| Substance Abuse and Mental Health Services Administration www.samhsa.gov | Statewide Family Network Grants | Statewide focused, family-controlled private nonprofit entities composed primarily of family members | Supports coalitions of family members, policymakers and service providers to strengthen families' capacity to influence services provided to them and to their children |
| Administration on Children and Families www.acf.hhs.gov | Head Start | Local governments, federally recognized Indian tribes or nonprofit agencies | Funds comprehensive health, educational, nutritional, child care and social services primarily to economically disadvantaged preschool children. |
| Administration on Children and Families www.acf.hhs.gov | Early Head Start | Local governments, federally recognized Indian tribes or nonprofit agencies | Funds family-centered services for low-income families with very young children to promote child development. |

| Administering Agency | Program | Eligible Applicants | Description |
|---|---|---|---|
| Administration on Children and Families www.acf.hhs.gov | Adoption Opportunities Program | Public and private nonprofit agencies | helps find permanent families for children who would benefit by adoption. |
| Administration on Children and Families www.acf.hhs.gov | Child Welfare Training Program | Nonprofit institutions of higher learning | Provides funds to upgrade the skills and qualifications of child welfare workers. |
| Administration on Children and Families www.acf.hhs.gov | Child Abuse Prevention and Treatment Act Research and Demonstration Projects | State and local agencies and organizations | Funds research on causes, prevention and treatment of child abuse and neglect, demonstration programs to identify means of preventing maltreat-ment and treating troubled families. |
| Administration on Children and Families www.acf.hhs.gov | Child Abuse and Neglect Discretionary Activities | Public agencies, nonprofit organizations and universities | Funds activities to prevent, assess, identify, and treat child abuse and neglect through research, information and dissemination. |
| Administration on Children and Families www.acf.hhs.gov | Transitional Living for Homeless Youth | States, localities, Indian organizations, and private entities | Grants for transitional living projects, and to promote self-sufficiency and avoid long-term dependency |
| Administration on Children and Families www.acf.hhs.gov | Runaway and Homeless Youth (Basic Center Program) | States, localities, Indian tribes and private entities | Assists community programs that address immediate needs of runaway youth and their families. |
| Health Resources and Services Administration www.hrsa.gov | Maternal and Child Health Federal Consolidated Projects (SPRANS) | Nonprofit institutions of higher learning or public or private nonprofit organizations | Carries out special maternal and child health projects of regional and national significance and projects to conduct training and research. |
| Health Resources and Services Administration www.hrsa.gov | Healthy Start Initiative | State or local health departments or other publicly supported organizations | Targets communities with high infant-mortality rates to support efforts to improve access to, utilization of and full participation in comprehensive maternity and infant care services. |
| Health Resources and Services Administration www.hrsa.gov | Healthy Schools, Healthy Communities | Public and private entities, including community- and faith-based organizations | Increases access to primary and preventive health care for underserved children, adolescents and their families. |
| **DEPARTMENT of JUSTICE** | | | |
| Office of Juvenile Justice and Delinquency Prevention www.ojjdp.hcjrs.org | Drug Prevention Program | Public and private organizations, states and local units of government | Seeks to reduce drug use through multiple approaches for young adolescents, e.g., life-skills training, education and motivation for a healthy lifestyle, fostering interpersonal and decision-making skills. |
| Office of Juvenile Justice and Delinquency Prevention www.ojjdp.hcjrs.org | Drug-Free Communities Support Program | Anti-drug coalitions | Supports community coalitions to help reduce substance abuse among children and at-risk youth, and to reduce substance abuse among adults. |

**TABLE 2 (continued)**

| Administering Agency | Program | Eligible Applicants | Description |
|---|---|---|---|
| Office of Justice Programs www.ojp.usdoj.gov | Youth Offender Initiative Reentry Grant | State, local and tribal units of government and nonprofit organizations | Enhances community safety by helping young offenders to reintegrate into the community. |
| Office of Justice Programs www.ojp.usdoj.gov | Safe Start Initiative | States, localities and tribal governments applying on behalf of a collaborative group of public or private agencies or organizations | Creates comprehensive community service- delivery systems by expanding partnerships and improving access to services for young children at high risk of exposure to violence and their families. |
| Office of Justice Programs www.ojp.usdoj.gov | Crime Victim Assistance Grants | Native American tribes and tribal organizations, states, eligible victim service agencies and private nonprofit agencies | Supports training and technical assistance to crime victim-assistance programs, funds demonstration projects and support services provided to victims of federal crimes assistance programs. |
| **DEPARTMENT of EDUCATION** | | | |
| Office of Safe and Drug-Free Schools www.ed.gov/offices/OSDFS | Safe Schools/Healthy Students | Local educational agencies | Provides comprehensive educational, mental health, social service, law enforcement and, as appropriate, juvenile justice system services to students, schools and communities |
| Office of Safe and Drug-Free Schools www.ed.gov/offices/OSDFS | Elementary and Secondary School Counseling Grants | Local educational agencies | Enables local educational agencies to establish or expand elementary and secondary school counseling programs |
| Office of Safe and Drug-Free Schools www.ed.gov/offices/OSDFS | Alternative Strategies to Reduce Student Suspensions and Expulsions Grants | Individuals, nonprofit organizations and public and private nonprofit organizations | Funds projects to enhance, implement and evaluate strategies to reduce suspensions and expulsions and ensure continued educational progress through challenging coursework for students who are suspended or expelled |
| Office of Elementary and Secondary Education www.ed.gov/offices/OESE | Even Start | State educational agencies, with various local sub-grantees | Funds to integrate early childhood education, adult literacy and parenting education in family literacy program |
| Office of Special Education and Rehabilitative Services www.ed.gov/offices/OSERS | State Program Improvement Grants Program | State education agencies | Funds to reform and improve systems for providing educational, early intervention and transitional services to children with disabilities |
| Office of Special Education and Rehabilitative Services www.ed.gov/offices/OSERS | Special Education-Personnel Preparation to Improve Services and Results for Children with Disabilities | Institutions of higher education | Funds to help address state-identified needs for qualified personnel in special education, related services, early intervention and regular education, to work with children with disabilities. |

**PRINCIPLES FOR A SYSTEM OF CARE FOR CHILD AND ADOLESCENT SERVICES**
**Developed by the Child and Adolescent Service System Program (CASSP)**

**Core Values**

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

**Principles**

◆ Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
◆ Children with emotional disturbances should receive individualized services in accordance with the unique needs and potential of each child and guided by an individualized service plan.
◆ Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
◆ The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
◆ Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
◆ Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that the children can move through the system of services in accordance with their changing needs.
◆ Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
◆ Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
◆ The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
◆ Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics and services should be sensitive and responsive to cultural differences and special needs.

## SELECTED BAZELON CENTER PUBLICATIONS ON PROGRAMS AND SERVICES FOR CHILDREN WITH MENTAL OR EMOTIONAL DISORDERS

May be purchased on the Bazelon Center's website, www.bazelon.org. Some are available to print or download from the site (linked from the page on children's issues). To order by mail, email pubs@bazelon.org or call 202-467-5730 ext. 110 for information.

**Suspending Disbelief—Moving Beyond Punishment to Promote Effective Interventions for Children with Mental or Emotional Disorders**
Examines provisions of the Individuals with Disabilities Education Act (IDEA) targeting services and supports for students with emotional or behavioral problems; compares the mandate with its implementation, as shown by administrative and judicial decisions. Includes discussion of research supporting positive interventions. May 2003, 28 pages.

**Failing to Qualify—The First Step to Failure in School**
Issue brief discusses federal policy changes needed to encourage earlier and more accurate identification of children with mental or emotional disorders under the IDEA. January 2003, 21 pages.

**Help or Hindrance?—The Federal Government and Interagency Systems of Care for Children with Serious Mental Disorders**
Issue brief examines how federal programs and their rules have contributed to the fragmentation of services for children and explores ways to harmonize some of the differences to foster coordination of the services and supports needed by children and their families. February 2003, 15 pages.

**Avoiding Cruel Choices—A Guide for Policymakers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment**
Describes the TEFRA option and the home- and community-based services waiver—two Medicaid provisions that states can use to fill the gap in private insurance coverage that forces families to relinquish custody of their children to get them access to mental health services and supports through Medicaid. November 2002, 28 pages.

**Merging System of Care Principles with Civil Rights Law—Olmstead Planning for Children with Serious Emotional Disturbance**
Questions, answers and recommendations for state policymakers and advocates involved in implementing the Olmstead mandate of integrated services and developing a comprehensive plan for children that is responsive to their civil and human rights. November 2001, 20 pages.

**Covering Intensive Community-Based Child Mental Health Services Under Medicaid**
A set of issue briefs explaining Medicaid definitions of key rehabilitation services for children with serious mental or emotional disorders. July 2001, folder with six 4-page briefs and introduction.

**Making Sense of Medicaid for Children with Serious Emotional Disturbance**
A review of how states provide access to the most effective community-based services for children on Medicaid who need mental health care. September 1999, 89 pages.

**Where to Turn—Confusion in Medicaid Policies on Screening Children for Mental Health Needs**
Report on states' ineffective use of EPSDT to identify children who need mental health services, with recommended state policy changes and advocacy approaches to help families secure appropriate assessments for their children. September 1999, 18 pages.