COORDINATED CHILDREN'S SERVICES INITIATIVE (CCSI) IN NEW YORK STATE: IMPLEMENTATION STATUS AND FUTURE DIRECTIONS

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October, 2001; Final Revisions August 2002
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Prepared for:
Coordinated Children's Services Initiative

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CCSI IMPLEMENTATION STATUS AND FUTURE DIRECTIONS

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SUMMARY

Created at the state level in 1993, the New York State **Coordinated Children's Services Initiative (CCSI)** is a multi-agency effort designed to reduce institutional and congregate care placements among children and youth with various types of emotional and behavioral disturbances. To help accomplish that goal, and as a goal in its own right, CCSI was also designed to create coordinated systems of care for children and families at the county level, based on a number of core principles, the purpose of which was to strengthen families and the services available to them.

Although CCSIs are now in place in more than 40 counties throughout New York, until now no comprehensive statewide assessment has been undertaken of the status of implementation of the Initiative across all CCSI counties. This study by CGR (the Center for Governmental Research Inc.) provided a statewide assessment of the status and impact of CCSI and the 41 sites in operation in 2000.

The results of CGR's assessment of the status of CCSI show that the Coordinated Children's Services Initiative cannot be described as a single, consistent approach common to all counties. It is indeed less a program than it is a philosophy or process. CCSI has clearly allowed counties the flexibility to respond to the issues surrounding out-of-home placements in ways that are suitable for them, rather than through a single "cookie cutter" approach.

Referrals to CCSIs across the state increased by 70% between 1998 and 2000. About half of all referrals involve children

between the ages of 11 and 15, but the biggest increase over that period was referrals involving children 6 through 10 (up 129%).

The CCSIs have generally been quite successful in the development of local structures of decision-making groups that support the principles of CCSI. In most CCSI counties, the Initiative has helped strengthen interagency coordination, use of strength-based individualized care approaches, family involvement at all levels of decision-making, and use of flexible funds to support individual service needs.

Evidence from CCSI sites suggests that the numbers of CCSI children and youth identified as at risk of placement increased dramatically, by more than 150%, between 1998 and 2000. But during those same years, proportions of those at-risk youth who were actually placed declined significantly, suggesting that CCSI has helped prevent placements that otherwise would have occurred among children and adolescents who were part of CCSI services. Data are less clear about whether the systems-change role of CCSI has led to reductions in *total* placements at an overall countywide level, including among those not served directly by CCSI. Available data suggest that CCSI efforts have contributed to some lowering of overall placement rates, compared to what they would have been without CCSIs in place, but CGR is not able from existing data to conclude definitively that reductions in placements can be attributed primarily to CCSI efforts. More consistent tracking of placement data over time among both CCSI and non-CCSI participants, including data on length of stay in placement facilities, is necessary before definitive conclusions can be drawn about the systemwide impact of CCSIs on placement reduction.

The report concludes that CCSI is a viable model that should be continued and strengthened. The report makes a number of recommendations designed to strengthen the vital partnership between New York State and the counties. Recommendations are made to both the state and CCSI counties regarding specific contributions and actions needed from each of the partners if the CCSI model is to build on past successes and continue to be viable in the future.

TABLE OF CONTENTS

ACKNOWLEDGMENTS

CGR acknowledges and thanks the New York State Coordinated Children's Services Initiative (CCSI) Tier III Team and the Tier III Work Group for their leadership in undertaking this assessment of the statewide implementation status of CCSI. We appreciate their understanding of the need for and value of such a statewide assessment, and recognize their responsiveness in addressing many of the issues raised in this report, even as the report drafts were being reviewed prior to release of this final report.

Within the Tier III structure, we particularly thank Families Together in NYS, and its Executive Director, Paige Macdonald, for their oversight of the project and for acting as the contract agent with CGR. We also thank Chris Cargain of the Council of Children and Families, who served throughout the project as liaison to CGR on behalf of Tier III, and who was instrumental in obtaining various data and background materials requested during the study.

We are especially grateful to the many county CCSI Coordinators who completed the extensive survey on which most of this assessment was based, and who provided considerable additional information as requested. Several Coordinators also met with CGR staff and/or spoke extensively by phone to clarify and help us understand the particular issues they were dealing with in their respective counties. The study could not have been completed without their cooperation.

Staff Team

Major roles in all aspects of this study were played by Kimberly Hood and James Fatula. Each was involved in the design of the survey instrument, each was involved in various analytical tasks, and each wrote sections of the report and contributed substantively to the development of the study's final conclusions and recommendations. In addition, Sarah Boyce helped conceptualize the initial study design, and Jaclyn Boushie helped with data entry and analysis tasks.

PART ONE: THE CONTEXT

Created at the state level in 1993, the New York State **Coordinated Children's Services Initiative (CCSI)** is a multi-agency effort designed to reduce institutional and congregate care placements among children and youth with various types of emotional and behavioral disturbances. To help accomplish that goal, and as a goal in its own right, CCSI was also designed to create coordinated systems of care for children and families at the county level, based on a number of core principles. These coordinated systems of care were intended to strengthen families and the services available to them.

Although CCSIs are now in place in more than 40 counties throughout New York, until now no comprehensive statewide assessment has been undertaken of the status of implementation of the Initiative across all CCSI counties. In 2000, the Tier III State agencies overseeing the Initiative contracted with CGR (the Center for Governmental Research Inc.) to undertake such a statewide assessment of the status and impact of CCSI. The contract was monitored on behalf of Tier III by Families Together in NYS, Inc., which is represented on the Tier III Work Group.

A valuable study of the implementation of CCSI was completed in 1998,[1] but its primary focus was limited to the eight initial Phase 1 CCSI counties. The current CGR study was designed to build on that research effort, to extend the assessment to address additional issues, and to focus on the full range of counties that had implemented some version of CCSI by the year 2000.

This report was initially completed in October 2001. The Tier III State agencies spent several months reviewing the initial draft, and provided written and verbal comments and suggestions to CGR in April 2002. This final report reflects changes made in response to those suggestions.

[1] See The Nelson A. Rockefeller Institute of Government, *Reforming the Delivery of Children's Services: A Study of the Implementation and Effects of the New York State Coordinated Children's Services Initiative,* December 1998.

This report presents the results and implications of this assessment. It is divided into three parts:

- The three chapters of Part One provide an introduction and background to the current research, outline the methodology and approaches used to carry out the study, and describe CCSI in more detail, along with the process and phases by which CCSI has been implemented in counties across the state.
- The chapters in Part Two of the report present detailed findings and analyses of the current status of the various CCSI programs and counties, and indicate how the various county initiatives have evolved over time since their inception.
- Part Three's concluding chapters focus on CGR's observations and conclusions concerning the implications of the findings, and a series of recommendations are presented for consideration by state and local officials concerning the future of CCSI.

1. BACKGROUND AND INTRODUCTION

In communities throughout the country, and across New York, dissatisfaction and frustration with the delivery of services to children with serious emotional and behavioral disturbances, and to their families, is leading to human services reform. States and localities have begun to take action to respond to fragmented services, to "top down" service plans driven more by needs and desires of agencies rather than by the needs and resources of families, to rigid program requirements and categorical funding streams that limit flexibility in service delivery, and to too much reliance on placements in residential facilities.

Focus and Nature of CCSI

In New York State, one of the most pervasive responses was the creation in 1993 of the multi-agency Coordinated Children's Services Initiative (CCSI). This state-level Initiative was created to help local communities develop and maintain alternative structures, processes, and service delivery systems devised to provide children at risk of placement, and their families, with individualized community-based services designed to meet their needs without removing the child from the home.

The Initiative is based on the assumption that historically too much emphasis has been placed on out-of-home residential placements as solutions to problems within families, and that children, families and taxpayers would all benefit from increased emphasis on alternative approaches that focus on integrated, more holistic care for children in community-based, family-oriented settings. Such alternative approaches are designed to break down as much as possible the fragmented, categorical nature of many of the traditional children's and family services, and to replace those services with more systemic, coordinated, strengths-based approaches.

Between 1993 and 2000, more than 40 counties of all types throughout all regions of New York became designated as "CCSI counties." But despite the common nomenclature, there is no single "CCSI approach" common to all counties. There is

considerable variation in the ways in which the core CCSI principles have been implemented, given differences in local circumstances, resources, leadership, and political support. Even the Requests for Proposals issued by the State for different phases of CCSI implementation have emphasized different features of the Initiative, helping to further assure differences across sites. One of the reasons for undertaking this study was to determine what aspects of CCSI seem most determinative of successful implementation and of positive impact on the lives of children and families.

CCSI's Core Principles

Indeed, it is not always appropriate to even consider a county CCSI to be a formal "program." It is probably more appropriate to consider CCSI a "philosophy," or a means of doing business in new ways, rather than considering it as a program or service *per se*. It may take on the form of a formal "program" in some counties, but generally it is better described as a "process." What is supposed to be consistent across CCSI counties, at least conceptually, is a set of core principles which help support the goals of reducing the number of children requiring institutional or congregate care placement. The CCSI process incorporates such core principles as:

- interagency coordination,
- integrated service delivery,
- use of wraparound/flexible funds,
- individualized services targeted to the unique needs of each individual and family,
- focus on strengths-based approaches to service planning (i.e., the belief that all individuals and families have resources and assets that can be used to resolve problems), and
- the inclusion of families in all levels of decisions that affect what happens to them.

One of the tasks of this assessment study was to determine the extent to which such core principles are actually in place in all CCSI counties, and how important they appear to be.

Focus of This Assessment of CCSI

A number of the issues addressed in this assessment were initially raised in the 1998 study of the initial CCSI implementation.[2] That report provided a number of observations about how CCSI was implemented in the eight Phase 1 counties, including the types of models that the initial counties adopted, service provision and case conferencing issues, who was targeted for services by the initial programs, governance issues, structural and coordination issues, extent and nature of family involvement, cross-systems relationships, and initial conclusions about the outcomes and impacts resulting from CCSI. The current assessment revisits and updates many of the same issues, and addresses additional issues that have emerged over time. This study is particularly able to update and expand on the 1998 findings in several important ways, including:

- the ability to add a longitudinal perspective to the Phase 1 CCSIs, by incorporating knowledge about an additional three years of evolution in those counties;
- assessing the implementation of three other phases of CCSI counties, including CCSIs initiated as recently as 1999 and 2000;
- incorporating expanded quantification of information about the current status of CCSI counties, including more extensive information about CCSI funding, numbers of people served by CCSI, and CCSI impact on residential placements averted; and
- revisiting observations and specific recommendations made in the 1998 report to determine whether changes have occurred regarding those issues and the extent to which progress has or has not been made toward implementation of those recommendations in the intervening years.

[2] See Rockefeller Institute of Government, *Reforming the Delivery of Children's Services, op cit.*

2. METHODOLOGY

Intent and Core Issues Raised

Our overall intent in this statewide CCSI assessment was to develop a point-in-time "snapshot" of what exists in the 41 CCSI counties that had been in operation in 2000, as well as to develop more of a "movie" of how the various county initiatives have evolved over time since their inception. We sought to document the extent to which changes have occurred in the initiatives, the reasons for any changes, and the impact those changes have had on the ability of the counties to accomplish their initial objectives, as well as documenting any changes in the objectives themselves over the life of the initiatives.

Our data-gathering efforts yielded detailed comprehensive information about existing CCSIs. We characterized what is currently in place in the various counties (and any changes over time) in terms of such classifications as: core models or categories of types of programs; types of administrative and governance structures; levels and types of involvement of families and agency staff; and levels and types of involvement of key county policymakers and decision-makers. We examined the different approaches and models in terms not only of what seems to be working well administratively and in terms of meeting CCSI goals, but also in terms of what approaches seem to be having difficulties for various reasons. In the latter cases, we attempted to determine the reasons for the problems, and what might be done in the future to correct them.

This report provides an overall statewide CCSI profile of what exists and the impact of CCSI across the state, as well as focusing on the various county-specific variations, their implications and the impact of those variations (both pro and con) on the intended CCSI goals. The assessment produced information about why changes have been implemented in some counties—and what impact those changes had—and about how counties and their CCSIs can learn from the experiences of other counties. Although experiences of individual counties are cited in broad terms, they are referenced in a way that cannot be attributed to a specific county, as CCSIs were promised that information would not be quoted or attributed back to a program or county, and that

"detailed information about individual programs will not be included in the report."

Survey

Most of the information was gathered from a comprehensive 23-page, 98-question "CCSI Coordinator Survey" (copy included in the appendix). Although longer and more extensive than ideal, the long survey was necessary to obtain all the information desired by the Tier III state leadership team that provided oversight for this project. The Tier III team, as well as several CCSI Coordinators from counties of various types and sizes, pretested the survey instrument and decided that the questions were clear, that the information being requested was reasonable, and that it was feasible for Coordinators to complete the surveys within a reasonable period of time.

The survey proved to be feasible to complete, but it took many Coordinators or other staff longer to finish than originally anticipated, especially for Coordinators who had not been part of CCSI from the beginning. As a result of the extensive nature of the survey, several time extensions were granted to enable CCSI staff to complete the surveys and have them included in the analyses. Several surveys were several months late in their submission, but the Tier III team agreed to the extensions in order to assure the most complete responses possible.

Survey Response Rate

Ultimately, out of the 41 counties with CCSIs in operation or startup in 2000, we mailed to 40 (one was not yet in operation when the survey was mailed). Of those, 26 returned completed surveys in time for inclusion in the analysis. Since two of those counties operate a combined CCSI (Warren and Washington), we processed 25 completed surveys. Thus 63% of the CCSI sites were included in the detailed analyses described in the subsequent chapters. (Some limited information was also available and presented for all 41 counties, even though not all completed the surveys). A 63% response rate (actually 65% of those actually mailed) is considered excellent for such a survey. Moreover, the completed surveys reflected representative responses from all phases of CCSI implementation, as well as being representative of both large and small counties and of predominantly rural, suburban and urban counties. Thus we are confident that the findings from the surveys are representative of all CCSI counties,

and that it is possible to generalize the findings reported in subsequent chapters to the full range of CCSIs throughout the state.

78% of the counties ultimately responded to the survey; thus findings accurately reflect the status of CCSIs in 2000.

That conclusion is buttressed by the fact that we actually received an even higher response rate than 63% of the counties. Even after the lengthy extension for survey submission, six additional surveys arrived at CGR, as recently as a week before completion of the draft of this report. Although by agreement with Tier III leadership, we could not include those six counties in our analyses, we were able to read through those surveys, and can report that the basic findings and trends represented in those six counties are generally consistent with those reflected in the surveys we analyzed in depth. Therefore, our final actual response rate, with those six surveys included, was 78%. Thus, given that the responses from the six late surveys were typically consistent with those in the analyzed surveys, there is even further reason to conclude that the findings in this report do accurately reflect the status of CCSIs around the state, for CCSIs in operation as of 2000.

Other Data Sources

To supplement the extensive survey findings, CGR also reviewed various historical state documents such as CCSI descriptions and RFPs; reviewed documents such as original CCSI proposals and annual and quarterly reports; interviewed CCSI Tier II representatives in selected counties; conducted field visits in four counties; and conducted detailed analyses of trends in institutional and congregate care placement data from 1993 through 2000 in both CCSI and non-CCSI counties, focusing in particular on placement rates prior to and since the implementation of CCSI in the aggregate and in specific groupings of counties. These trends focused on placement data from four State of New York residential placement systems: Child Welfare, Juvenile Justice, Mental Health, and Education. We examined the trends both in the aggregate and for each of the individual systems over time.

Further comments about the methodology, and any caveats that may be necessary in interpreting specific data, are presented in the context of the discussions of data which follow.

3. STRUCTURE AND EVOLUTION OF CCSI

The initial impetus behind the creation of what became CCSI originated with the NYS Office of Mental Health, which in the early 1990s was seeking to improve the delivery of services at the local level and at the same time to decrease reliance on out-of-home residential placements for children and youth with serious emotional disturbances. Recognizing that solutions would need to involve multiple service delivery systems, OMH convened representatives from a number of state agencies which developed the CCSI concept and issued the first CCSI Request for Proposals (RFPs) in 1993. In response, eight counties plus New York City became the initial Phase 1 CCSI sites. Phase 2, 3 and 4 RFPs followed in 1994, 1996 and 1998, respectively, resulting in a total of 41 CCSI locations (40 counties plus NYC) in operation by 2000.

Consistencies Across CCSIs

As indicated in Chapter 1, there is no single CCSI approach common to all local communities. But there are themes, goals, target groups, core principles, and structures that appear to have remained consistent across the different RFPs and across the different approaches implemented in the various CCSI counties.

Core Principles

As noted above, the core principles, which appear to exist to some extent at least in virtually all CCSIs (as shown in more detail in Part Two of this report), revolve around such concepts and service delivery approaches as interagency coordination, integrated service delivery, use of wraparound/flexible funds, individualized services targeted to the unique needs of each individual and family, focus on strengths-based approaches to service planning, and the inclusion of families in all levels of decision-making that affect what happens to them.

Goals and Outcomes

Two major stated goals or outcomes have remained consistent across the RFPs: (1) developing an infrastructure to provide coordinated community-based services and supports to children with emotional/behavioral disabilities and their families, and (2) preventing/reducing residential placements among these children.

Target Population

Similarly, the stated target populations of the CCSIs have remained basically the same, though with some nuances and flexibility within the core definitions. The consistent definition of the CCSI target population in various RFPs has been children and youth with emotional disabilities between the ages of 5 and 21 "as defined by the social services, education, mental health and juvenile justice systems, and who are at risk of residential placement." (This definition includes children already in residential facilities who are returning back to the community.) *Typically the targeted children are viewed as having serious emotional disabilities, as defined by their respective service systems, and as having service needs "that cross agency boundaries" and can't be adequately met by a single agency.* Further definitions of "sub-populations" are typically provided for each of the four defined service systems.

In addition to these core definitions of the target population, the Phase 4 RFP appeared to broaden the focus for new CCSI counties to include additional children outside the identified groups who may be at risk of placement: "…we will welcome efforts by the local collaboratives…to prevent the need for *any* residential placement." (emphasis added) Furthermore, the Phase 3 RFP specifically noted that within counties funded under that CCSI round of reduced funding (see below), "children will not need to be labeled, diagnosed or classified seriously emotionally disturbed by any one system" to gain access to the CCSI and its services.

Tier Structure

Also consistent across the evolution of CCSI counties has been the three-tier structure for addressing individual and systems issues. *Tier I* is viewed as the level at which decisions are made about individual cases at the local level. It typically consists of a multi-disciplinary team (or teams) of professionals from various provider agencies and systems, along with the affected child and family and/or their representatives, as well as other parent representatives. The Tier I teams convene for the purpose of determining strengths and needs of the child and family, and of building upon their strengths to develop appropriate individualized community-based services designed to maintain the child in his/her natural environments. Tier I is also responsible for monitoring progress against the service plans which are developed.

Also at the county level, *Tier II* should consist of local service system leaders (e.g., agency administrators, department heads and school/BOCES officials) and at least one parent of a child with emotional disabilities. This group is responsible for resolving cross-systems problems and facilitating solutions and coordination of services across systems. It is responsible for identifying local barriers to coordination and service delivery, and for developing local strategies and practices to remove such barriers. It also identifies policy and regulatory issues and barriers that may need to be addressed at the state level, and refers such issues to Tier III. The *Tier III* state leadership team is composed of decision-makers from the seven child-serving systems that collectively are responsible for the oversight of CCSI, as well as family representatives.

CCSI's Sponsoring State Agencies

As noted, the Tier III membership includes the seven New York State agencies that collaboratively oversee the CCSI efforts across the state. These agencies include the Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Children and Family Services, Office of Mental Health, Office of Alcoholism and Substance Abuse, Office of Mental Retardation and Developmental Disabilities, and the State Education Department. In addition, two family representatives are integral parts of the Tier III team and thus are a key part of the CCSI oversight process.

Changes in Focus Over Time

The chapters in Part Two of this report go into more detail concerning how CCSIs have developed and evolved over time. While many of the changes are a function of local circumstances, there are some overall changes—some obvious and some more subtle—that have been made at the state level since 1993 that have helped shape the ways in which CCSIs evolved at the local level. Some of the more important of those are summarized briefly in this section.

Eligible Counties

CCSI was initially targeted to specific counties, based on their rates and volume of residential placements across the various systems during the previous year. The Phase 1 RFP was sent to the 21 counties with the highest rates of placement (proportions of the youth population of the county who were in a residential

placement facility) and/or a large total number of placements, regardless of proportions.

Subsequent to the initial limitations on applicants for CCSI funding, more universal invitations to submit proposals appear to have been in effect for the Phase 2 and 3 RFPs. However, the Phase 4 RFP was again limited to a select, small number of counties who had not yet received CCSI funding, but which continued to have what state officials considered to be unacceptably high congregate residential placement levels across the mental health, child welfare/social services, juvenile justice and education systems.

Anticipated Outcomes

The State's clearly-defined anticipated outcomes—as specified in the Phase 1, 2 and 4 RFPs—focused primarily on the reduction in residential placements, with what appears to be a clear, but secondary focus on process. The first two of six anticipated outcomes identify (1) "decreased residential placements" in the four systems, including both prevention and also returns of children from placements, and (2) reduced numbers of days in care for those children who are placed. The other four outcomes refer to such improved systems and process issues as: increasing access to and availability of integrated, community-based services; enhanced local decision-making capacity; better identification of children and families at high risk of placement; and the formation of a more flexible funding mechanism to support the development of community-based services.

The state's anticipated CCSI outcomes primarily focused on decreased placements and reduced days in care. Improved processes and systems change were also anticipated.

By contrast, the Phase 3 RFP, which generated the largest number (15) of new CCSI counties of any of the RFPs, had somewhat different emphases. While clearly continuing to emphasize the goal of decreased residential placements, *more emphasis was placed on processes and changes in the county infrastructure.* Outcomes emphasized such things as "institutionalized permanent systems change" to improve the process of making and sharing decisions about how services are provided to children with emotional disabilities and their families. More emphasis was placed on the provision of services "based on the children's and family's expressed needs," and on the expansion of the "concept of parent-professional partnerships" in all aspects of the service planning and delivery.

Available Funds

As shown in more detail below, funds available for new CCSI sites were generally sufficient to enable a range of services and staffing to be implemented. However, in Phase 3, the CCSI funds available per site were significantly reduced. The RFP indicated that $25,000 would be available for single-year awards. In reality, the actual amounts awarded were $20,000 per county, based on county size and placement rates. The counties also received a second year of funding at $10,000 each. The practical effect was that for the largest "entering class" of CCSI counties, which amounted to more than a third of all CCSI counties through 2000, there was virtually no money to provide dedicated CCSI staff, unless other sources of supplemental funds were also available. As CCSI Tier III officials explain, this represented a conscious decision to provide reduced per-county resources, but to spend those resources across a greater number of sites. Officials indicate that this decision to reach out to more counties and to provide fewer funds per county was influenced by the fact that some Phase 3 counties already had a CCSI-type process in place and had lower placement rates than those of Phase 1 and 2 counties.

Focus on Flexible Funds and Parent Involvement

From the beginning, the state was concerned about, and RFPs emphasized, the importance of two particular dimensions: *parent involvement in the CCSI process, and flexible funding to enhance available services for families.* However, the Phase 3 RFP was unique among the first four CCSI RFPs in its almost exclusive emphasis on both of these dimensions. The RFP was clear in establishing the state's expectations as to how the funds were to be used. The funds were clearly to be used only for flexible funding, and for stipends to reimburse parent participants for Tier I and Tier II training, travel and related activities. The RFP specifically noted that the funds were not to be used for staff hiring or equipment.

Strengthening Tier I and Tier II

From the beginning, the state had a clear interest in making sure that each CCSI county had strong functioning Tier I and II teams as part of the CCSI infrastructure. Strengthening that Tier I and II infrastructure became even more important to the state over time, as suggested by the wording of both the Phase 3 and 4 RFPs. The emphasis appeared to differ somewhat between the two RFPs, with exclusive focus placed in Phase 3 on strengthening the parent component of the teams, whereas in Phase 4 attention

appeared to return more explicitly to strengthening the staffing of the CCSI initiatives.

Focus on Tracking Results

In the Phase 1, 2 and 4 RFPs, counties were clearly expected to provide estimates in their proposals of the numbers of people to be served by the CCSI project, along with estimates of the expected reductions, as a result of CCSI efforts, in the numbers of children and youth who would be placed in residential care. Consistent with that requirement for setting specific measurable targets, CCSI also required Phase 1, 2 and 4 counties to provide quarterly reports that asked for detailed information on the numbers and ages of children and youth served and the extent to which they were placed in various types of residential care.

By contrast, the Phase 3 counties—given the different Phase 3 resources, expectations and systems/infrastructure goals—were asked for no such estimates of numbers of children to be served or of estimated reductions in placements. They were required to provide some reports of numbers of children served and numbers placed, but the quarterly data requested were less detailed than what was required of the CCSI counties in the other phases. The reduced expectations in terms of holding Phase 3 counties accountable for meeting measurable goals were a reflection of the fact that fewer CCSI resources were available to them, and that restrictions were placed on what could be done with those resources. The implications of those decisions are addressed in subsequent discussions in Part Two of this report.

CCSI Funding by Phase and Year

The detailed table at the end of this chapter shows the pattern of CCSI funds allocated by year to each of the 41 CCSI locations in operation as of 2000. The table reflects only those funds considered to be CCSI allocations, according to data supplied to CGR by Tier III officials. Not included in these totals are substantial amounts of Mental Health Community Reinvestment funds, or of various other sources of state and local funding which many CCSIs have parlayed into more significant budgets than those reflected here. More details on such sources of funds are provided in Part Two of the report for the counties from which we received completed surveys.

More than $7 million in designated CCSI funds were allocated to counties between 1993 and 2000.

The summary table below indicates how the funds were allocated by phase by year.[3] Even without including the various supplemental sources of funds, the state's investment in CCSI counties has been substantial over the years. Between 1993 and 2000, well over $7 million in CCSI funds were allocated to the counties from such state sources as OMH general funds, OMH Community Mental Health Block Grant funds, State Education IDEA funds, OCFS general funds, and OCFS Title IV-B funds. Almost three-quarters (74%) of those funds were allocated in the four years between 1994 and 1997—$5,259,793. About 60% of the funds were allocated in the three peak Phase 1 and Phase 2 years from 1994 through 1996—a total of $4,299,761.

CCSI Phase	1993	1994	1995	1996	1997	1998	1999	2000	Total
Phase 1 (N=8)	$245,000	$780,167	$662,912	$503,803	$174,574	$18,796	$43,116	$48,000	**$2,476,368**
Phase 2 (N=9)	NA	$137,500	$757,500	$798,360	$458,653	$142,000	$50,900	$70,800	**$2,415,713**
Phase 3 (N=15)	NA	NA	NA	NA	$300,000	$150,000	$160,800	$111,000	**$721,800**
Phase 4 (N= 4)	$27,476	$507,524	$152,000	NA	$26,800	$150,000	$243,200	$390,000	**$1,497,000**
Other (N=5)	NA	NA	NA	NA	NA	NA	NA	$30,000	**$30,000**
Total (N=41)	**$272,476**	**$1,425,191**	**$1,572,412**	**$1,302,163**	**$960,027**	**$460,796**	**$498,016**	**$649,800**	**$7,140,881**

[3] Note that "Other" counties refer to those that are considered CCSI counties even though they have received no designated CCSI funds other than limited training funds, or they may include some early Phase 5 counties. Also note that Phase 4 shows allocations prior to the beginning of the implementation of Phase 4 in 1999. This is because New York City initially received funds as a Phase 1 county, before withdrawing and subsequently reapplying under Phase 4. All of its funding is shown under Phase 4.

Clearly, Phase 1 and 2 counties have received the bulk of the CCSI allocations, with each receiving slightly more than a third of the $7.1 million total. And, if the New York City allocations from 1993 through 1995 were attributed to Phase 1 rather than lumped with their second round of funds in Phase 4, the Phase 1 allocations would increase to 44% of the total. Without including New York, Phase 1 counties received an average allocation of more than $97,500 in 1994 and almost $83,000 in 1995. Phase 2 counties received an average of more than $84,000 in 1995 and more than $88,500 in 1996.

Phase 1 and 2 counties have received most of the CCSI allocations; Phase 3 has received the least, by Tier III design.

By contrast, Phase 3 counties each received $20,000 in their first year (1997) and half that the following year. By conscious decisions of Tier III officials, more than 35% of all CCSI counties were funded in Phase 3, but only about 10% of the total CCSI allocations have been spent on Phase 3 counties. Average grants increased again for the few Phase 4 counties.

County	Phase	Year	Population - 2000 Census		CCSI Funding (Excluding OMH CR Funding)								Total
			All Ages	<21	1993	1994	1995	1996	1997	1998	1999	2000	
Broome	I	1993	200,536	57,615	$32,500	$97,500	$85,944	$52,986	$20,000	$1,000	$0	$1,000	$290,930
Chemung	I	1993	91,070	26,003	$22,500	$71,791	$77,500	$60,743	$20,000	$1,000	$0	$1,000	$254,534
Monroe	I	1993	735,343	220,999	$37,500	$118,750	$106,268	$71,478	$20,000	$4,000	$0	$1,000	$358,996
Rockland	I	1993	286,753	90,518	$17,500	$62,500	$61,700	$59,918	$18,204	$2,796	$19,116	$11,000	$252,734
Schenectady	I	1993	146,555	41,126	$27,500	$86,571	$75,000	$59,265	$10,000	$1,000	$0	$1,000	$260,336
Suffolk	I	1993	1,419,369	418,389	$37,500	$118,750	$93,750	$47,000	$20,000	$4,000	$12,000	$11,000	$344,000
Ulster	I	1993	177,749	48,862	$32,500	$100,000	$72,500	$42,500	$46,370	$1,000	$0	$11,000	$305,870
Westchester	I	1993	923,459	259,517	$37,500	$124,305	$90,250	$109,913	$20,000	$4,000	$12,000	$11,000	$408,968
Columbia	II	1994	63,094	17,134		$18,750	$88,750	$71,900	$32,500	$31,000	$0	$11,000	$253,900
Erie	II	1994	950,265	268,324		$25,000	$112,500	$89,337	$99,213	$11,000	$8,900	$18,400	$364,350
Fulton	II	1994	55,073	15,580		$18,750	$88,750	$75,249	$86,940	$11,000	$6,000	$18,000	$304,689
Greene	II	1995	48,195	13,469		$0	$37,500	$60,780	$35,000	$11,000	$0	$1,000	$145,280
Jefferson	II	1994	111,738	35,099		$18,750	$88,750	$122,473	$32,500	$11,000	$0	$1,000	$274,473
Oneida	II	1994	235,469	65,922		$18,750	$88,750	$130,011	$32,500	$21,000	$0	$1,000	$292,011
Onondaga	II	1995	458,336	138,933			$75,000	$75,000	$75,000	$21,000	$18,000	$8,500	$272,500
Orange	II	1994	341,367	133,558		$18,750	$88,750	$106,110	$32,500	$4,000	$6,000	$10,900	$267,010
Rensselaer	II	1994	152,538	44,776		$18,750	$88,750	$67,500	$32,500	$21,000	$12,000	$1,000	$241,500
Allegany	III	1997	49,927	16,776					$20,000	$10,000	$13,000	$1,000	$44,000
Cayuga	III	1997	81,963	23,781					$20,000	$10,000	$1,000	$1,000	$32,000
Chautauqua	III	1997	139,750	41,651					$20,000	$10,000	$19,000	$11,000	$60,000
Dutchess	III	1997	280,150	83,780					$20,000	$10,000	$47,000	$40,000	$117,000
Essex	III	1997	38,851	9,954					$20,000	$10,000	$12,800	$18,000	$60,800
Herkimer	III	1997	64,427	18,464					$20,000	$10,000	$1,000	$1,000	$32,000
Madison	III	1997	69,441	22,350					$20,000	$10,000	$13,000	$1,000	$44,000
Montgomery	III	1997	49,708	13,765					$20,000	$10,000	$11,000	$1,000	$42,000
Oswego	III	1997	122,377	39,262					$20,000	$10,000	$13,000	$1,000	$44,000
Putnam	III	1997	95,745	28,029					$20,000	$10,000	$13,000	$11,000	$54,000
St. Lawrence	III	1997	111,931	34,322					$20,000	$10,000	$1,000	$1,000	$32,000
Sullivan	III	1997	73,966	21,108					$20,000	$10,000	$1,000	$11,000	$42,000
Tompkins	III	1997	96,501	32,036					$20,000	$10,000	$1,000	$11,000	$42,000

Wayne	III	1997	93,765	28,800					$20,000	$10,000	$1,000	$1,000	$32,000
Yates	III	1997	24,621	7,877					$20,000	$10,000	$13,000	$1,000	$44,000
Albany	IV	1999	294,565	87,712							$60,000	$60,000	$120,000
Nassau	IV	1999	1,334,544	372,777							$60,000	$60,000	$120,000
NYC	IV	1993	8,008,278	2,264,245	$27,476	$507,524	$152,000	$0.00	$26,800	$150,000	$123,200	$225,000	$1,212,000
Niagara	IV	2000	219,846	63,340								$45,000	$45,000
Franklin	IV+	2000	51,134	13,833								$18,500	$18,500
Lewis	IV+	2000	26,944	8,488								$1,000	$1,000
Warren	IV+	2000	63,303	17,550								$1,000	$1,000
Washington	IV+	2000	61,042	17,416								$1,000	$1,000
Wyoming	IV+	2000	43,424	11,995								$8,500	$8,500
Total					**$272,476**	**$1,425,191**	**$1,572,412**	**$1,302,163**	**$960,027**	**$460,796**	**$498,016**	**$649,800**	**$7,140,881**

PART TWO: ANALYSIS AND FINDINGS

Part Two of the report presents the detailed findings from the study. Most of the analyses are presented in the form of tables, graphs and narrative discussion based on results from the 25 completed surveys (63% of the total CCSI counties) which were submitted in time to be included in the report. Also included are detailed analyses of placement data. Other observations and findings are also interwoven within the discussion, based on CGR's review of initial CCSI proposals, a review of six surveys submitted too late to be included in the detailed statistical analyses of survey data, discussions with county officials, and field visits. Each chapter that follows is organized around a specific topic or theme. Following the presentation of the findings for each topic, that chapter concludes with a set of summary observations and conclusions that attempt to interrelate the various findings pertinent to the chapter.

Chapter 4, the first chapter of Part Two, summarizes information obtained from the initial CCSI proposals concerning what they initially proposed to do, and how they proposed to organize to accomplish their tasks. Following that discussion, the remaining chapters in Part Two describe the current status of the CCSIs, and how they have evolved over time. Where relevant, findings in those chapters are compared to the findings from the original proposals in Chapter 4, to determine the extent to which the CCSIs have or have not adhered to the initial proposals, and to assess where possible the nature of and reasons for any changes that have occurred.

Since most of the analyses presented in the following chapters pertain to the CCSI sites from which we received completed surveys, it is useful to indicate which counties are included in the detailed analyses, and how representative they are of all 41 CCSI counties (representing 40 actual CCSI sites, since Warren and Washington are a combined site). The detailed table on pages 21-22 presents all CCSI counties in operation in 2000, by phase and their startup year, along with their 2000 population, based on the

2000 Census. The table also shows which of those counties completed surveys in time for inclusion in the detailed statistical analyses reported in the Part Two chapters, and which returned surveys too late for inclusion in the detailed analyses (although those surveys were reviewed by CGR staff, and any pertinent observations were incorporated into the findings presented below). In general, the patterns reflected in the six late surveys did not differ in significant ways from those in the other 25 completed CCSI surveys.

Survey counties were representative of all CCSI counties.

As indicated in the summary table below, all phases of the CCSI implementation were well represented by completed surveys, thus leading us to conclude that the findings presented in the subsequent chapters are representative of all CCSI counties, and that the findings can be generalized to all CCSI sites throughout the state. This conclusion is further supported by the fact that, as indicated in the more detailed table on the next page, the few counties in each phase from which we received no surveys at all were similar in size (and, though not shown in the table, in urban/suburban/rural composition) to other counties for which we did receive completed surveys. Thus there is no reason to believe that there are any significant gaps in the types of counties included in the analyses.

CCSI Phase (and Number of Sites)	Surveys Completed; Results Analyzed	Surveys Received Late and Reviewed; Not Analyzed	Total Surveys Received
Phase 1 (N=8)	7	0	**7 (87.5%)**
Phase 2 (N=9)	4	2	**6 (66.7%)**
Phase 3 (N=15)	9	2	**11 (73.3%)**
Phase 4 (N=4)	1	2	**3 (75.0%)**
Other (N=4)	4	0	**4 (100%)**
Total (N=40)	**25 (62.5%)**	**6 (15.0%)**	**31 (77.5%)**

CCSI Counties, Phase, Population, and Survey Status

	County	Phase	Year	2000 County Population	
				All Ages	<21
*	Broome	1	1993	200,536	57,615
*	Chemung	1	1993	91,070	26,003
*	Monroe	1	1993	735,343	220,999
*	Rockland	1	1993	286,753	90,518
	Schenectady	1	1993	146,555	41,126
*	Suffolk	1	1993	1,419,369	418,389
*	Ulster	1	1993	177,749	48,862
*	Westchester	1	1993	923,459	259,517
	Columbia	2	1994	63,094	17,134
*	Erie	2	1994	950,265	268,324
*	Fulton	2	1994	55,073	15,580
**	Greene	2	1995	48,195	13,469
	Jefferson	2	1994	111,738	35,099
**	Oneida	2	1994	235,469	65,922
*	Onondaga	2	1995	458,336	138,933
	Orange	2	1994	341,367	133,558
*	Rensselear	2	1994	152,538	44,776
	Allegany	3	1997	49,927	16,776
*	Cayuga	3	1997	81,963	23,781
	Chautauqua	3	1997	139,750	41,651
*	Dutchess	3	1997	280,150	83,780
*	Essex	3	1997	38,851	9,954
**	Herkimer	3	1997	64,427	18,464
	Madison	3	1997	69,441	22,350
*	Montgomery	3	1997	49,708	13,765
*	Oswego	3	1997	122,377	39,262
**	Putnam	3	1997	95,745	28,029
*	St. Lawrence	3	1997	111,931	34,322
*	Sullivan	3	1997	73,966	21,108
*	Tompkins	3	1997	96,501	32,036
	Wayne	3	1997	93,765	28,800
*	Yates	3	1997	24,621	7,877
**	Albany	4	1999	294,565	87,712

	Nassau	4	1999	1,334,544	372,777
*	NYC	4	1993	8,008,278	2,264,245
**	Niagara	4	2000	219,846	63,340
*	Franklin	O	2000	51,134	13,833
*	Lewis	O	2000	26,944	8,488
*	Warren	O	2000	63,303	17,550
*	Washington	O	2000	61,042	17,416
*	Wyoming	O	2000	43,424	11,995

Note:

O (Other) = CCSI counties not associated with a particular phase. Only in limited operation in 2000. Note that Warren and Washington counties are a combined CCSI site.

* = Completed CCSI survey included in report's detailed analyses.

** = Received survey too late to be included in detailed analyses; surveys reviewed by CGR staff.

4. THE BASELINE: WHAT THE CCSIS INITIALLY PROPOSED TO DO

In order to assess the initial intentions of the CCSI counties, and to be able to compare the initial plans with what actually happened as CCSIs were implemented over time, we reviewed and summarized the initial CCSI proposals as submitted (and in some cases resubmitted and revised) by the counties. Of the 25 CCSI sites for which the detailed statistical analyses of the surveys were completed, we had access to 21 of the initial proposals. What was specifically proposed in those documents is the basis for the discussion which follows in this chapter.

Identification of Barriers

When submitting their initial CCSI proposals, counties were asked to indicate the barriers they were facing, particularly those imposed by state agencies, regulations and practices. Responses were consistent, regardless of the size or type of county, and regardless of when they became CCSI counties.

At the time counties submitted their proposals, the most-frequently-cited barriers to being able to provide needed services to children and families included:

- restricted funding and categorical funding barriers that limit the ability to pool resources to meet needs;
- related eligibility restrictions and criteria that limit those who can be served to only those with specific criteria or disabilities;
- fragmentation of services that prevent the ability to address needs of children and families on a holistic basis;
- the lack of a single assessment tool or uniform service plans that cut across agencies and systems;
- insufficient services and service gaps, particularly related to older adolescents aging out of services at age 18 or so; and
- too many regulations and too much paperwork that interfere with service provision.

Description of Problem/Need for CCSI

With those barriers as the backdrop, counties submitting applications for CCSI funds were asked to define the specific needs or problems they were attempting to address through the implementation of their initiatives. The initial proposals reflected a distinct change over time in how they described those needs or problems.

The Phases 1 and 2 proposals, for the most part, emphasized high rates of out-of-home placements and the concern that their counties were placing too much emphasis on placements as a solution for child and family problems. Nearly all the Phase 1 and 2 proposals made some reference to the need to bring placements under control. This seems logical, given that that was the clear primary focus of the Phase 1 and 2 RFPs, and that many of those counties were singled out to receive the RFP in the first place because of high rates or volumes of placements. In addition, a few of the proposals also mentioned the need to improve the delivery of youth and family services, and to coordinate those services more effectively across systems. A handful of the Phase 1 and 2 proposals referenced the need to get parents (and in one case, schools) more actively and effectively involved in the process of making decisions about service delivery and developing service plans for individual families.

By contrast, the proposals received by the state from Phase 3 and 4 counties rarely mentioned placements when describing the precipitating needs. The primary focus in those proposals clearly shifted to the need to get parents and families more involved in the process of making decisions that affect their lives, and to give them more of the tools needed to strengthen families and help build their capacities to deal with their own issues, as well as to help them be more prominently involved and effective as advocates for systems change. This is clearly in contrast to the "sporadic" role that too often characterized the circumstances prior to the time of the CCSI application. The importance of changing systems, filling service gaps and developing better cross-systems partnerships, and of involving parents in those partnerships, was emphasized in one way or another in most of the Phase 3 and 4 needs statements.

One quarter of the proposals were at best vague about the needs that motivated them to submit the proposal.

Given that the RFPs had particular goals, from the state perspective, and that counties were apparently eager to tap CCSI resources and to at least attempt to make some constructive

changes in their counties, it is interesting to note that fully one quarter of the proposals across all phases were at best vague about the needs that motivated them to submit the proposal, and at least two funded proposals made no reference at all to the underlying needs or problems.

Stated Goals/Expected Benefits

The pattern concerning the statement of goals was somewhat similar to the definition of needs and problems. Phase 1 and 2 proposals each stated clear goals of reduced placements, and in every case, a specific measurable goal was delineated. In some cases, the specific placement reduction goal was stated in a revised proposal or followup correspondence, but it is clear that the state was pushing counties at that point to be precise in stating goals to which the counties could be held accountable. Most of the Phase 1 and 2 proposals also referenced less precise goals related to improving the community-based services available to families and strengthening cross-systems collaboration, strengthening flexible funding and, in a few cases, making parents more active and effective participants in the decision-making process. But the clear distinguishing feature of the goals statements in Phase 1 and 2 proposals was that all had specific and measurable placement-reduction goals explicitly stated.

Proposals for Phases 1 and 2 had explicit measurable goals; subsequent proposals were less precise in stating specific measurable goals in their proposals.

In stark contrast—given the different expectations of, and resources provided to, the Phase 3 counties in particular—three of the 11 Phase 3 and 4 proposals were vague in their goal statements, four made no explicit reference to any placement-reduction goals, and only one county proposed to reduce placements by specific measurable amounts. To the extent that goals were stated clearly, they focused on expanding parental roles, training and other supports; expanding cross-systems collaboration; and expanding strengths-based services for children and parents. These goals and directions were clearly viewed as important by the counties, and they were consistent with the statements of needs and problems. Nonetheless, it seems clear from the proposals that, as part of the process of qualifying for CCSI funds, counties in the later phases of CCSI were for whatever reasons typically less precise in stating specific measurable goals than were the earlier counties.

The proposals of most CCSI counties in all phases focused on both systems change and individual services and case conferencing.

The proposals sometimes provided information concerning whether the CCSIs viewed themselves as focusing primarily on individual services and case conferencing, or acting primarily as a systems change agent. In general, nearly all the proposals, regardless of which Phase, described themselves as attempting to do at least some of both. Some were not as explicit as others in addressing those issues, but in most cases the proposals referenced these dual objectives.

Target Population/ Numbers Served

The patterns of specificity noted above between the first two phases and the subsequent phases of CCSI funding were even more prevalent and obvious when examining what the proposals said about their target populations, and how many children and families they promised to serve in their first year of operations.

The Phase 1 and 2 counties typically indicated that they would target services to children and youth (and their families) between the ages of 5 and 21, with serious emotional disabilities, and deemed to be at risk (often immediate risk) of placement. The age focus occasionally varied a bit within that broad range, and some counties indicated that they would also consider some children/ youth who were not specifically identified as SED, but generally the profile of target populations was as stated, with the additional criterion in several cases of people needing, or already using, multiple agencies or service systems. Several counties also targeted, in part, children already in a placement setting, and two others targeted specific geographic areas within their counties.

Phase 1 and 2 counties typically specified how many children/ families they would serve in their first year, ranging from as few as 14 or 15 to as many as 110, with most CCSIs targeting between 20 and 35.[4] However, even among the Phase 1 and 2 counties, three of the proposals did not specify how many were to be served in the first year, and there is no indication from the files made available to CGR that the state required such information to be submitted before agreeing to fund the initiatives.

Many funded proposals did not provide information on target population or numbers to be served.

Furthermore, *only one* of the 11 Phase 3 and 4 proposals CGR reviewed specified numbers of children or families to be served,

[4] Actual numbers served by the CCSIs will be addressed later in a subsequent chapter.

and only about half provided any information concerning the anticipated target population. This is partly an understandable function of the fact that Phase 3 counties were focused more on parent empowerment and use of flexible funding, which are less amenable to delineation of numbers served. Nonetheless, it is reasonable to assume that there should have been some intentionality concerning to whom the flexible funds were to be directed, and how many children and families the applicants hoped to reach. There was little evidence of such thinking included in the proposals, and little indication that the state required such information to be provided as a condition of funding. To the extent that target populations were specified, they were usually somewhat vaguely defined as "SED children," with little further specificity. Occasionally, reference was made to helping to prevent placement, or to working with families for whom current service interventions were not working, but generally little detail was provided concerning groups being targeted with Phase 3 and 4 CCSI funds.

Lead Agency

Most of the CCSIs began under public auspices, with county departments identified as the lead agencies. Eight of the 10 Phase 1 and 2 counties for whom we had access to the initial proposals were established as public CCSI entities. Phase 3 and 4 counties were less likely to be established as public agencies, with five of 11 created with non-profit lead agency status. In several of the non-profit lead agencies, a county department was the initial applicant, but indicated from the beginning that it would contract with a specified non-profit service provider to act as the lead agency. More than half of the public lead agencies were Mental Health/ Community Services departments, with the remaining counties led by DSS or Youth Services/Youth Bureau departments. Two of those public lead agencies subsequently shifted to non-profit lead agency status, as will be discussed in more detail in the next chapter.

Building on Existing Networks

Nearly all the counties had some type of interagency network in place at some level prior to the formal initiation of CCSI. In most cases, such networks became the basis for CCSI's Tier I and/or II teams. In several counties, what existed was some type of assessment team or teams that met to discuss and/or case conference specific children and families. Some had formal

institutional review teams that met to discuss alternatives to placement for children and youth at high risk of being placed in an institutional setting. In other cases, what was in place was some type of systems change or policy-level group that met to address cross-systems issues. In a handful of the counties, a Tier I building block was in place, but without a corresponding Tier II-level team, and CCSI was to be used to add such a Tier II team to the existing structure.

In nearly all the proposals, what was added or strengthened as a result of, or in conjunction with, the CCSI process, was a more significant role of parents, at both the Tier I and II levels. In some cases, this meant adding parents to existing teams, and in others it meant giving them added training, stipends or other types of support to make it easier and more feasible for them to have the skills and time to play a true partnership role along with agencies in the various Tier level teams and processes.

CCSIs typically had interagency networks in place to build on by strengthening parent roles, expanding school involvement, adding staff, or flexible funds.

About a quarter of the counties said in their proposals that they would build on the existing structures by adding school representatives and/or working more closely with such representatives to make sure that they played more active leadership/partnership roles in the future on the various Tier level teams. A few counties said they would build on existing efforts by adding CCSI staff/coordinators to enable the Tier teams to have the resources needed to make them more effective, and to assure that needed coordination, communications, training and logistical support occurred. About a third of the counties said that the key to making the successful transition from the existing networks to CCSI infrastructure effective would be the addition of flexible funds to provide the needed supports to help flesh out family service plans.

Use of Flexible Funds

Across all phases of CCSI counties, virtually every proposal built in the use of flexible funding to supplement traditional service provision, and to enable resources that might not otherwise be available to be used to fund such things as respite care, child care, transportation, training costs, stipends for parents, and the like.

In nearly every proposal, specific funds were designated as some variation of "wraparound funds" or "flexible service funding." These funds could be used to purchase such services as respite

care, recreation services, food, or any type of service or amenity viewed as complementing a service treatment plan for a child or family, but which might not otherwise be available without such funds. In each case, several thousand dollars were usually earmarked for such purposes, ranging in the proposals from as little as $2,500 to as much as about $60,000 in one county in CCSI funds (these CCSI wraparound funds were often supplemented by other sources of funding, as indicated in a subsequent chapter in the more detailed analysis of overall CCSI budgets). About a third of the initial proposals designated wraparound funds of $10,000 or less, about a third indicated amounts of between $11,000 and $25,000, with the final third setting aside amounts in excess of $25,000 for such purposes.

All but three or four counties also indicated in their proposals the intent to allocate money for stipends for parents. Such funds were to be used to pay parents primarily for participation in various Tier I and II-related activities and meetings. Usually a few thousand dollars were allocated for such purposes, with parents typically paid $8 to $10 an hour, or as much as $35 for a meeting and/or $75 for a full day's activities.

Nearly all counties proposed use of several thousand dollars in flexible funds for supplemental services, parent stipends and/or training.

In addition, most of the counties specified additional flexible funds to be used for training purposes. All but two or three of the proposals specifically allocated funds for such purposes. In most cases, the funds were to be used to help train parents for expanded roles in Tier I and/or II teams, though in some cases funds were also set aside for training of CCSI coordinators and CCSI and/or other agency staff in various techniques designed to make various processes operate more effectively in the interests of children and parents. Typically counties allocated amounts of $2,000 to $5,000 for training purposes.

Initial CCSI Budgets

The original CCSI proposals spelled out in some detail how the specific CCSI funds they were requesting were to be allocated. Most also indicated some sense of in-kind contributions that were being made to supplement the CCSI funds. Many of the proposals were less precise in indicating the extent to which, if at all, funds from other sources were also being used to flesh out a full CCSI program budget.

As indicated in the table on pages 17 and 18 at the end of Part One of this report, most of the CCSI allocations for the first full year of Phase 1 and 2 counties ranged between $75,000 and $100,000 per county (with lower amounts having been allocated in most cases for a preceding startup year). As emphasized in a subsequent chapter on CCSI finances, nearly all CCSI counties ultimately developed additional sources of funds to sustain their efforts in later years. But for the most part, it appears from data made available to CGR as if the initial year or two of the Phase 1 and 2 CCSI efforts were funded almost entirely by the CCSI allocations alone, supplemented by some in-kind contributions from county agencies. Most of those in-kind contributions covered such things as space/leasing costs and equipment, time contributed by staff at Tier I and II meetings, and some administrative/coordination staff support in a few counties.

In all but one of the Phase 1 and 2 counties for which we had access to initial proposals, a CCSI staff person was hired directly or by contract with a portion of the funds. Of the $725,000 in first-year CCSI allocations referenced in those proposals, about 47% of the funds were allocated to staff salaries and benefits, and another 39% were specified as wraparound/flexible service funds. Although most of the Phase 1 and 2 counties indicated funds for training and parent stipends, only about 4% of the initial CCSI allocations in those counties were allocated for those purposes. The remaining 10% were allocated for various administrative and miscellaneous expenses, plus employment opportunities in one county.

Much of the initial CCSI grant funds for Phase 1 and 2 counties was for staff; no Phase 3 CCSI funds were allocated for staffing. Some used other funding sources to hire staff.

Among Phase 3 counties, as indicated in the table on pages 17-18, CCSI allocations were limited to $20,000 in the first year and $10,000 in the second. Although the proposals were not always clear concerning whether other sources of funds were also used to supplement CCSI dollars in the first year of operation, there were indications in about half of the available proposals that additional funds had been allocated to the CCSI effort—to fund CCSI staff, for the most part. In fact, since the Phase 3 RFP specifically prohibited the use of CCSI funds to hire staff, the only way any support staff could be hired was through the use of supplemental sources of funds. In some counties, staff support was provided by in-kind contributions from county departments, though that

typically was limited to administrative support, rather than full-time oversight or program direction. As discussed in a later chapter, some of the CCSI counties have been limited in what they could do regarding staff resource capability as a result of funding limitations.

Of the CCSI funds allocated to Phase 3 counties in the first year, about 44% were used for wraparound/flexible services. About 29% of the funds were allocated for training of various types, often for parents, and another 12% were set aside for stipends specifically targeted to parents. The remainder of the funds were allocated to travel, and other miscellaneous expenses. (The proposals for the two Phase 4 counties did not provide clear indications of how all their CCSI funds would be allocated.)

Relatively small proportions of first-year CCSI funds were allocated for training or parent stipends.

It is worth noting that, despite the importance placed in most of the CCSI RFPs and proposals on training and stipends for parents, relatively little money was actually allocated to those purposes. In the proposals available to CGR, across all phases, of the first-year CCSI funds whose uses we could clearly identify (about $865,000), only a little over $34,000 were allocated to parent stipends (4%), and about $53,000 were allocated for training purposes (6%).

Summary Observations and Implications

The above findings and discussions suggest the following observations and implications, which will be discussed further and related to specific recommendations in Part Three of the report:

- A number of significant barriers to improved service delivery to children and families were identified in the proposal process. To what extent those issues have been addressed subsequent to the initial proposals will be addressed in more detail in the chapters that follow.

- In too many counties, the initial proposals' statements of needs for CCSI, and stated goals and expected benefits, were vague and not sufficiently measurable, thereby making it difficult to hold counties accountable for their CCSI performance against stated, measurable goals, and making it difficult for the counties themselves to monitor their accomplishments against stated goals and to take needed corrective actions.

- Funding of CCSIs—whether from explicit CCSI funds or other funding sources—does not always appear to have been made contingent upon meeting, *or even clearly documenting,* performance against measurable goals.

- Many CCSI initial proposals were also somewhat vague in defining their primary target populations, and in specifying the expected numbers of children and families to be served. Initial approval of proposals did not seem to be contingent upon such specificity, and our data indicated that many counties have not needed to be more specific in updating target groups and numbers served (or performance goals) in subsequent years.

- CCSIs have rarely if ever needed to be built completely from scratch, as some level of building blocks/foundations were in place pre-CCSI in virtually all counties. CCSIs have helped strengthen the foundation by adding dedicated staff in some cases; strengthening the involvement, roles, training and support of parents in the decision-making processes; expanding the explicit role of schools in the process of making decisions about children and families; and making resources more available to families through the use of flexible funding.

- Despite the expansion of flexible funds for the purposes of training and parent stipends, relatively small proportions of CCSI funds were allocated to those purposes in the initial proposals.

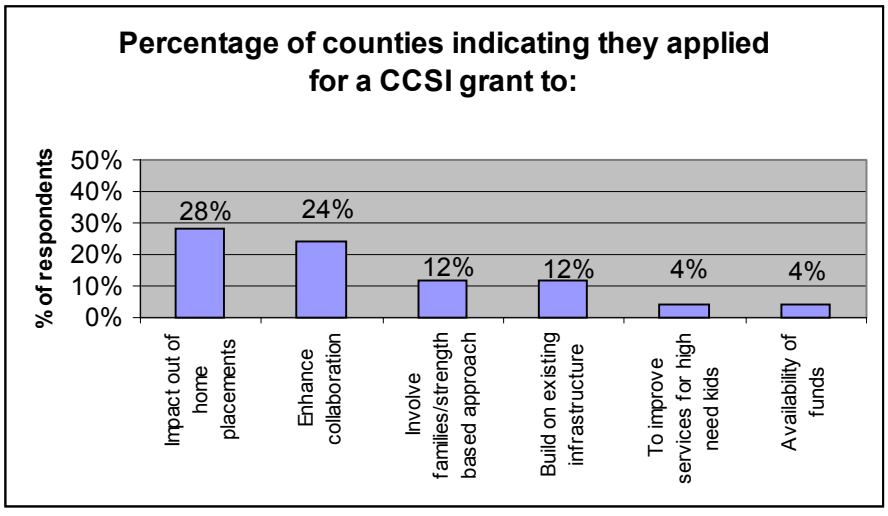
5. BACKGROUND AND CCSI ADMINISTRATION

As the transition from Chapter 4's discussion of what the CCSI counties initially proposed to do, to the detailed analyses of what they are now—and of how they have evolved from the proposal stage to their current operations—this chapter summarizes the administrative structure of the CCSI operations. It describes the current lead agency status and staffing patterns of each of the 25 CCSIs from which we received completed surveys, and how the lead agency and staffing profiles have evolved since the initial CCSI proposals were developed. This chapter also indicates the kinds of startup problems reported by the various counties, along with the levels of technical assistance needed and received from the state prior to and since CCSI implementation.

Before addressing these administrative/infrastructure issues, it is worth noting what the CCSIs indicated, in their survey responses, were their primary reasons for applying for CCSI funds.

Reasons for Applying for CCSI Grant

More than half (13) of the CCSIs said that their county originally decided to apply for a CCSI grant either to impact out-of-home placements, or to enhance collaboration. Other reasons for applying for CCSI funding included efforts to better involve families in strengthening services and to build on existing efforts. As noted in Chapter 4, Phase 1 and 2 counties were more likely than other CCSI sites to focus on placement reduction as their reason for applying.



Lead Agency and CCSI Implementation

The table on pages 21 and 22 showed all the 41 funded CCSI counties, along with an indication of which of those counties were included in the core survey analyses. Those 25 CCSI sites are listed in the table on the next page, along with the phase in which they were funded, their first year of operation, and the current lead agency (government or non-profit).

As indicated in that table, 12 of the 25 CCSI sites in our analyses (48%) began operations between 1993 and 1995, with the others beginning since 1997. Our sample proportions are almost identical to the proportion of *all* funded CCSI sites (45% began between 1993 and 1995), as shown in the table on page 21. Roughly half of the sites began to serve children and families in their first year, with the other half delaying the start of direct services until some point in their second year of operation.

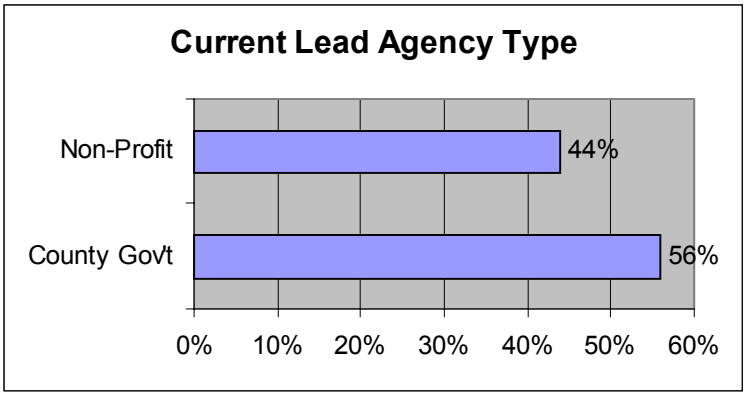
14 of 25 current lead agencies are part of county government, mostly Mental Health departments. Phase 1 and 2 counties were most likely to have county government lead agencies; most non-profit lead agencies are in Phase 3 or later sites.

The lead agency for 14 (56%) of the CCSI sites is part of county government, while 11 (44%) are non-profit agencies. Ten of the 14 government lead agencies are in the Mental Health/Community Services Department, and two each are in the Youth Bureau and Department of Social Services. The government lead agencies were split evenly between those that were Phase 1 or 2 CCSIs and those that were funded in subsequent phases. By contrast, seven of the 11 non-profit lead agencies are in sites that began in Phase 3 or later. Looked at from a different perspective, the 14 Phase 3 and subsequent sites were evenly split between government and non-profit sites, and the lead agency in seven of the 11 Phase 1 and 2 CCSIs were government agencies.

The lead agency in four of the sites changed since the initiatives began. Two of those four began as non-profit lead agencies, and simply shifted to a different non-profit agency over time. The other two began as public/government lead agencies and converted over time to non-profits. One of them started as a DSS lead agency, and the other began in a Youth Bureau. Thus, when initially created, 16 of the 25 CCSIs (64%) were located within county government, including 10 in Mental Health/Community Services units, three in Youth Bureaus, and three in Departments of Social Services. Nine of the 11 Phase 1 and 2 counties initially started with government lead agencies, compared to the seven of 11 that exist now.

Counties Included in Analyses

County	Phase Funded	1st Year of Operation	Lead Agency
Broome	I	1993	Non-Profit
Chemung	I	1993	Government
Monroe	I	1993	Government
Rockland	I	1993	Non-Profit
Suffolk	I	1993	Government
Ulster	I	1993	Government
Westchester	I	1993	Government
Erie	II	1994	Government
Fulton	II	1994	Non-Profit
Onondaga	II	1995	Government
Rensselaer	II	1994	Non-Profit
Cayuga	III	1997	Non-Profit
Dutchess	III	1997	Non-Profit
Essex	III	1997	Non-Profit
Montgomery	III	1997	Non-Profit
Oswego	III	1997	Government
St. Lawrence	III	1997	Government
Sullivan	III	1997	Government
Tompkins	III	1997	Government
Yates	III	1997	Government
New York City	IV	1993	Non-Profit
Lewis	IV+	2000	Government
Franklin	IV+	2000	Non-Profit
Warren/ Washington	IV+	2000	Non-Profit
Wyoming	IV+	2000	Government



In that context, it is worth noting that even though there were initially 16 governmental lead agencies and are now 14, four other counties which are reflected among the 11 non-profit lead agencies may be viewed, according to their coordinators, as also having a close, contractual relationship with their county government. In each of those four, the initial proposal to the state reflected language indicating that the formal applicant for CCSI funding was the local government—in each case the Mental Health/ Community Services department—but that the clear intent from the beginning was for the lead agency responsibilities to be contracted out to a non-profit service provider. In each case, the non-profit agency was the one completing the CCSI survey. Thus a governmental agency formally operates 14 of the 25 CCSIs that we analyzed in depth, but local government also has at least a contractual oversight role in four other sites. In 14 of that total of 18 CCSIs with at least some level of local government oversight, the Mental Health/Community Services department is the designated oversight unit.

Four non-profit lead agencies operate under contract with a local government agency. Thus county government has an oversight role in 18 (72%) of the surveyed CCSIs.

Lead Agency Type: County Government

Of the 14 CCSIs with a county government lead agency, 13 said that being part of county government has had a positive effect on their CCSI. One CCSI said it has had no direct positive effect.

Advantages of being part of county government

Most (12) of the CCSIs with a governmental entity serving as the lead agency said that the advantages of being part of county government included some combination of the following: it allowed increased participation and/or increased effectiveness, such as the involvement of other county departments, and their close cooperation and collaboration; the support of the county

Many advantages were cited for having CCSIs be part of county government.

legislature and county administrator/executive; and increased access to county departments. Other noted advantages included bringing other players to the table, and that it is non-threatening. CCSI coordinators cited the following as more specific examples of positive effects/benefits associated with a governmental lead agency:

- "helps us with the Department of Social Services, its workers and its policies;"
- "encourages the participation of county agencies;"
- "administration is very supportive of CCSI;"
- "helps lend credibility to planning efforts;"
- "gives CCSI more visibility;"
- "helps to get all the players to the table;"
- "best place to effect change; access to policymakers across systems is better;"
- "inclusion in county planning process re children's services;"
- "enables obtaining support and commitment from all child-serving county departments;"
- "gives it more effectiveness to drive the system;"
- "has been critical in impacting systems change with the county and state agencies;"
- "allows greater impact on the child-serving system, and infusing CCSI principles on a broad level."

Disadvantages of being part of county government

Nine CCSIs mentioned some disadvantage to being part of county government. Disadvantages mentioned included:

- "'bureaucratic limitations' related to authorizing flexible funds, adding new positions, or providing direct service;"
- "the CCSI can be perceived to be a 'program' of a county department, as opposed to a cross-cutting initiative;"

- "as part of county government, it can be perceived as less 'grass roots';"
- "larger departments may dominate."

Lead Agency Type: Nonprofit Organization

When asked how the non-profit lead agency designation affected the success of the CCSI, nine CCSIs reported that they felt that being outside of county government allowed for increased collaboration/integration, and/or an enhanced ability to address system barriers; and two CCSIs simply said that it allowed for overall better success.

Advantages of being outside of county government

Eleven CCSIs identified advantages associated with a lead agency located outside of county government. The main advantages identified were greater flexibility and greater independence (in particular, no need for action by a county legislature for every personnel action). Two CCSIs said that being outside of county government makes the CCSI neutral, not "county owned." One respondent said that being outside county government was helpful because it enabled it to avoid any stigma for its families working with DSS, and that it actually broadened the number of agencies with a stake in the success of CCSI.

Disadvantages of being outside of county government

Five CCSIs identified disadvantages to being outside of county government. Three said this resulted in less access to funding for their CCSI. The other two identified lack of county buy-in or control as the disadvantage.

Determining Lead Agency Designation

As noted above, the lead agency in 14 sites was a county government department (most often the Department of Mental Health/Community Services), and non-profit agencies are the lead in the other 11. The following is a summary of the comments given regarding how lead agency designation was determined:

Lead Agency: Department of Mental Health/Community Services

- "Already operated most of the county's mental health (MH) programs, and had already established an interagency committee for high-risk youth;"
- "Decision among County Government Community Services, Board and Director of Community Services;"
- "Deputy County Executive and Mental Health Director agreed;"
- "Main sources of funds are reinvestment funds from MH;"

- "LGU (Local Government Unit role of Mental Health Department) is looked at as a coordinator…more neutral entity;"
- "MH Dept had the commitment and the interest;"
- "Department of Community Services was selected by the County Manager, based on the skills of staff in the lead agency;"
- "Funded through reinvestment, was a way to begin without startup money from the state;"
- "Community Services wanted to have direct oversight;"
- "Funding linkage from NYS Office of Mental Health to County MH;"
- "Had a strong history and active leadership in developing a community system of care."

Lead Agency: Department of Social Services

- "DSS is the last stop for placement, therefore they have more at stake and less to lose compared to other agencies;"
- "DSS was a leader in county collaboration and encouraged the implementation of CCSI."

Lead Agency: Department of Youth Services/Youth Bureau

- "Youth and Probation were the only departments with staff devoted to developing an initiative; Probation would do a juvenile justice initiative, Youth Services would do CCSI."

Lead Agency: Local Non-Profit

- "Consensus among original county stakeholders (county had history of contracting out services, rather than expanding county government);"
- "Other county departments had previously served as the lead agency, but with limited referrals; it was determined that a not-for-profit with a long history in the county would be a good source;"
- "The non-profit agency 'volunteered' among the large group of interested parties;"
- "Non-profit agency was asked to do it;"
- "The county's Director of Community Services selected the organization via an RFP process;"

- "Wanted an agency not connected to the county's infrastructure, a private not-for-profit already providing community services (respite, and crisis respite) and able to take on CCSI;"
- "The non-profit agency was viewed as an agency which had been consumer friendly and innovative in program development;"
- "The position was assigned to the non-profit agency;"
- "The non-profit agency was chosen by community leaders to be the designated agency;"
- "The non-profit agency took the initiative to be lead agency, and county agencies were not interested;"
- "Tier II based the decision on the non-profit agency's experiences with families and youth, as well as the fact that the non-county lead would make funding concerns easier to handle."

CCSI Coordinator and Staff Roles

The level of CCSI staffing, the role of the CCSI coordinator position, and the experience of the coordinators vary considerably across the various sites. Most (60%) of the CCSI coordinators responding to the survey became coordinators since 1997. Eight (32%) became coordinators between 1993 and 1996, and one has been a coordinator pre-CCSI official funding (since 1990). One response was missing.

CCSI Coordinator FTE

Over half of the CCSIs (14) have a full-time coordinator. Another six (24%) have a coordinator at 50-60% FTE. Three (12%) have coordinators at 30% or less of a full-time position. One site said it did not have a coordinator.

% FTE	# Respondents	% Respondents
0	1	4%
.1	1	4%
.3	2	8%
.5	4	16%
.6	2	8%
1.0	14	56%
Missing	1	4%

40% of CCSI sites do not have full-time CCSI coordinators, including most CCSIs started in 1997 (Phase 3) or later.

As noted earlier in Chapter 4, the CCSIs funded since 1997 (Phase 3 and later) were less likely initially to hire staff. Although ultimately nearly all CCSIs have employed at least some staff support, the initial distinctions between the early-phase CCSIs and those funded later have continued as they pertains to the ability to maintain a full-time CCSI coordinator: The coordinator in nine of the 11 Phase 1 and 2 counties provides 100% focus on CCSI, compared to only five full-time coordinators in the 14 CCSI sites first funded in Phase 3 and later. Although the 14 government lead agency counties are split evenly between full-time and part-time coordinators, six of the seven government sites funded in Phase 1 and 2 have full-time positions, and the exact reverse is the case in Phases 3 and beyond, as six of those seven have part-time coordinators. Among non-profit lead agencies, seven of 11 have full-time coordinators, including three of the four funded in Phases 1 and 2.

Respondents who indicated that the CCSI coordinator position was part-time were asked how the rest of the coordinator's time is spent. Of the county part-time coordinators, most said that the rest of their time is spent on other county work, and all but one of the part-time coordinators in non-profit agencies said that they spend the remainder of their time on other activities for their organization. It is assumed that the handful of part-time coordinators who did not account for all their time may simply have a part-time position, all of which is devoted to CCSI activities.

Other CCSI Staff

The 25 CCSI survey respondents support a total of 131 paid positions (including the coordinators). As shown in the table on the next page, two counties indicated that they had no paid staff. About one third of the CCSIs employ three or fewer staff. The highest number of staff employed by a single CCSI is 23 (20 of which are part-time). Overall, nearly three quarters of the paid positions are part-time, and the remaining 34 positions were listed as full-time CCSI employees. While exact staff titles vary by CCSI, the following roles/positions are examples of those identified by respondents: Coordinator/Administrator/Manager/Monitor; Family Advocate; Meeting Coordinator; Training Coordinator; Referral Coordinator; Parent Advocates and Coordinators.

Most CCSI staff are part-time. Phase 1 and 2 sites typically have more CCSI staff, and more full-time staff, than do more-recently-funded sites.

Consistent with the above discussion, the number of CCSI staff varies by funding phase. The average number of staff per CCSI site is more than 8 in Phase 1 counties, about 6 in Phase 2, 4 in Phase 3, and 2 in subsequent phases. Nearly all Phase 1 and 2 sites have at least one full-time staff, compared to full-time staff in only six of the 14 counties funded from Phase 3 on. Sites with a non-profit lead agency have slightly larger staffs, on average--about six per site in non-profit agencies compared with about five in those headed by a governmental agency, and slightly more full-time staff in the non-profit counties.

Total Number of CCSI Staff		
# CCSI Staff	% Counties	Cumulative %
0	8%	8%
1	12%	20%
2	8%	28%
3	8%	36%
4	20%	56%
5	12%	68%
6	4%	72%
7	12%	84%
10	8%	92%
13	4%	96%
23	4%	100%

CCSI Implementation Problems

Sixteen (64%) of the 25 CCSIs said they had experienced implementation problems. Specific problems that were mentioned included:

- "Started the project with other than CCSI dollars; recognized the need for a paid coordinator early on; had CCSI staffing needs;"
- "Lack of real support and buy-in from other agencies—people were too busy;"
- "Increased demand with little structure or staff support;"
- "Insufficient start up funds;"
- "Insufficient time to do outreach to the community;"
- "The coordinator position experienced turnover;"

- "Getting providers to the table;"
- "Difficulty in obtaining ongoing participation from agencies and schools for Tier I;"
- "Initial collaboration; getting turf issues resolved;"
- "Breaking down initial barriers to sharing information and creating solutions;"
- "Finding the right coordinator, getting different systems to agree to project goals and making the goals a priority;"
- "CCSI staffing needs and developing Tier I;"
- "Difficulty in creating and operationalizing Tier structure;"
- "Difficulty in setting up wraparound funds;"
- "Lack of leadership at higher levels;"
- "No more than the usual start-up delays."

Technical Assistance Needed and Provided

Given various implementation problems, the CCSI coordinators were asked what kinds of technical assistance they needed at various points, and how they assessed the level of assistance they actually received.

Assistance Needed at Startup

Respondents were asked *What kinds of Technical Assistance, if any, did your CCSI need during the start up period after CCSI implementation funds were received?* They noted the following, including a number of comments assessing the value of the assistance received:

- "Conferences;"
- "Had few funds ($1000), so training needs were few;"
- "Little contact with Tier III except occasional memos;"
- "Helpful—CCSI coordinator was invited to participate in CCSI coordinator meetings;"
- "Wasn't involved in initial start up;"
- "Most helpful—Tier III provided training during start up period; didn't find technical assistance useful and didn't fully understand their function;"

- "All questions were answered;"
- "We were all figuring it out from scratch (state and counties);"
- "Provided with ICP training;"
- "Had a fair amount of support that met our needs;"
- "Needed help with Tier structure and function; differences between running CCSI as a program vs. a way to address how systems work with families and each other;"
- "NYSOMH provided strong leadership, supervision, and technical assistance with our effort to establish a Tier I Family Network;"
- "CCSI conferences were helpful, but it was hard getting people outside our agency to attend;"
- "The Tier III representative and workgroup leader always responded to the county's questions and concerns; County felt intense support from the state."

Several counties cited considerable evidence of startup support from state agencies and Tier III representatives.

Assistance Needed Since Implementation

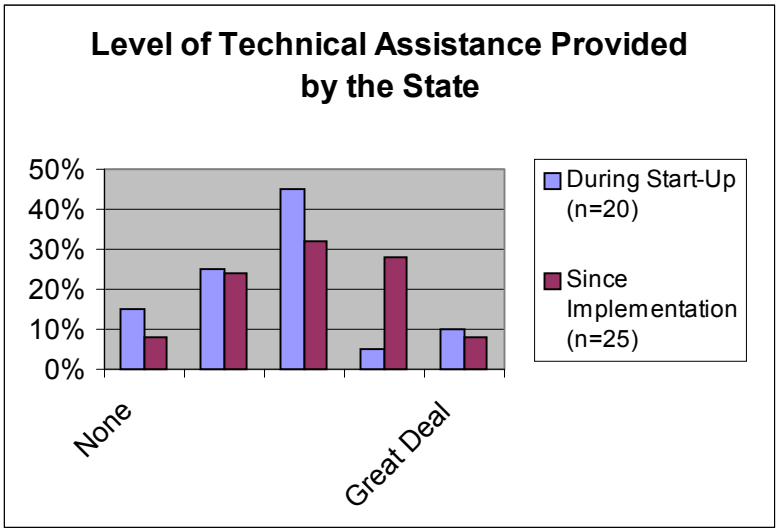
CCSIs were also asked *What kinds of TA, if any, has your CCSI needed since implementation?* Nine respondents provided the following, again interspersing needs with comments about assistance actually received:

- "Annual conferences, spinoff grants;"
- "Assistance at Tier II level in coordinating planning with out-of-county psychiatric centers, RTFs, etc.;"
- "Attended many conferences;"
- "Was visited by Tier III rep; OMH staff attend Tier II meetings; training event scholarships given;"
- "Conferences;"
- "Counties need to figure out design and implementation; state can only make sure the principles are well-integrated;"
- "County researched other sites throughout the country who had embarked on their system redesign (Wraparound Milwaukee, Alaska Youth Initiative, Vermont);"

- "Improved communication between county and state agencies, helping with strategies for getting buy-in from different systems;"
- "In the last 2-3 years, getting CCSI coordinators together; sharing information, trainings (Wraparound), spin-off grant proposals."

Level of Technical Assistance Provided by the State

The level of technical assistance provided by the state increased after startup. Using a 5-point rating scale, ranging from "None" (no assistance provided) to "A Great Deal" of assistance, the coordinators provided the following assessment of assistance provided during startup and since implementation:



County CCSIs are more likely to have received technical assistance from the state since implementation than during startup, but 1/3 reported receiving little or no assistance at any stage.

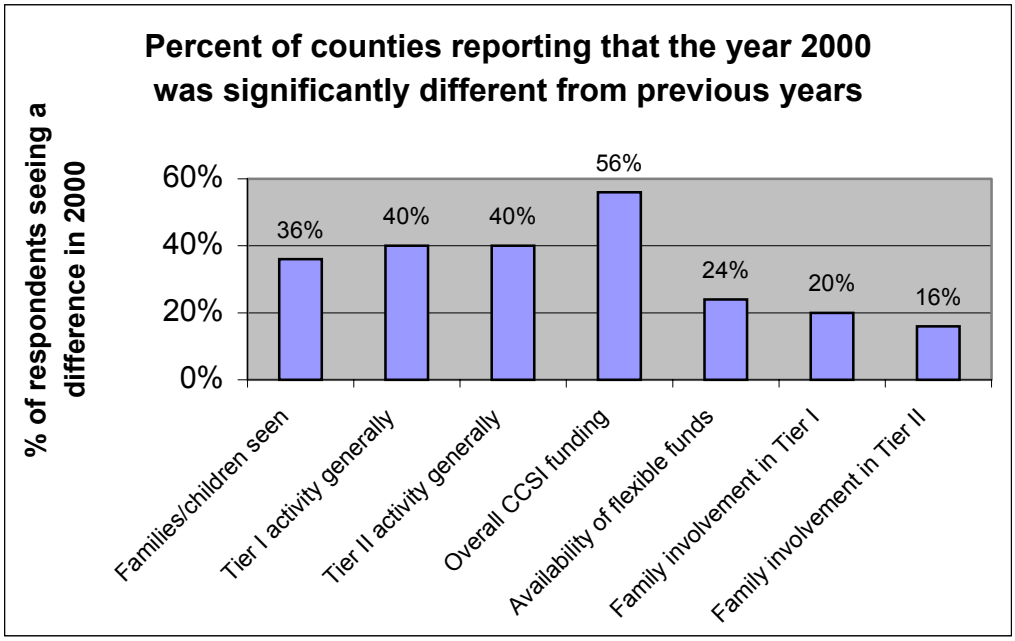
Forty percent of the CCSIs indicated that they received very little or no assistance during startup, and 32% also said they received little or no assistance since implementation. On the other hand, 36% of the sites indicated that they had received a fair amount or a great deal of assistance since implementation (compared to only 15% of the sites saying they received that much assistance during the startup stages of their initiatives).

How Was 2000 Significantly Different from Previous Years?

CCSI counties were asked if a variety of aspects of the CCSI experience had been significantly different in 2000 than in previous years. The responses suggest that there is considerable movement and change from year to year within the CCSIs, as a number of the sites reported significant changes in the past year. Changes in overall CCSI funding was the major difference (mostly

Counties reported considerable change from year to year in their CCSIs, especially in funding and Tier I and II activities.

increases), with 14 counties (56%) reporting a significant difference, followed by differences in Tier I and Tier II activities, with 10 counties noting significant differences from previous years in each of those activities. More than a third of the sites also reported increases in the numbers of children and families seen by the CCSI program. Smaller numbers of sites also noted increases in the amounts of available flexible funds, and increased family involvement in Tiers I and II. Several of these issues will be addressed in more detail in subsequent chapters.



Changes Needed in How CCSI is Administered

When asked if any changes are needed in the way in which CCSI is administered in their county, nearly a third (8) of the CCSIs said that more funding and resources were needed to expand the program. Three CCSIs said that more parent involvement was needed. Six CCSIs indicated that they didn't think any changes were needed. A variety of "other" changes were mentioned by eight of the CCSIs, including:

- "There is a need to share responsibility beyond the coordinator to service providers, as the demand for the program is high. Education, training and policy/procedural changes are planned."
- "Better Tier I activity in selected school districts."

- "CCSI is viewed as a program. Buy-in from different systems is uneven. Many still view the initiative as one department's program rather than a countywide initiative."
- "Need to fully implement the 'strength based model.'"
- "Tier I re-formation: the need for greater autonomy by participants in order to provide services in a more timely manner."
- "We need more cross system (county and school) involvement. If other agencies received funding to support their involvement that might act as an incentive."
- "More top down communication of the executive level of support and commitment."
- "More direct link with County Executive's office."

Summary Observations and Implications

The above findings and discussions suggest the following observations and implications, which will be discussed further and related to specific recommendations in Part Three of the report:

- The role of, and key buy-in from, the public sector/local government in the CCSI process can make a number of things happen that might not happen otherwise. Local governmental lead agencies can be pivotal in helping assure access to services, support and active participation of key providers across systems, assuring the credibility of the process, and providing needed resources to assure that desirable action occurs, both at the individual and systems levels. On the other hand, there are downsides to government's role as lead agency, mostly related to various bureaucratic delays and barriers, as well as personnel policies. Non-profit lead agencies can in some cases operate more effectively to get around such barriers. But even in those cases, support of local government is still viewed as being key to CCSI success. It may be that more counties should consider the blending of both approaches that seems to have worked well in some counties, whereby a non-profit agency operates as the official lead agency, but under contract with an oversight governmental agency. Such an approach can work effectively if careful contractual expectations are established, and the agency is clearly held accountable for meeting specified goals by the governmental contracting entity.

- Support from top levels of county and agency officials is viewed as being key to CCSI success, including especially the support of the County Executive or County Manager and other top elected officials.

- Active involvement of top level school officials is also important, and the effectiveness of the CCSI appears to be diminished without the active support and involvement at both policy and individual service planning levels of key school officials.

- Forty percent of the CCSIs have no full-time coordinator. The CCSIs initially funded under Phases 1 and 2—even though the substantial funding they received initially from CCSI has for the most part been replaced by other funding sources—continue as a whole to have more staff and full-time coordinators than do the CCSIs that were implemented in later phases. The lower levels of staff support and coordinator time in many of the CCSI counties funded in Phase 3 and thereafter clearly place limits on what some of the CCSIs are able to do.

- Several of the sites experienced a variety of startup problems related to such things as insufficient funds and staff, lack of top level county support, difficulties in getting buy-in and support from key community agencies and county departments, having time to do the needed outreach to community leaders and the heads of such key agencies, difficulties in getting Tier I and II operating effectively, etc. In several instances, counties reported that they needed more help in obtaining outside training, technical assistance and advice from state and possibly local officials in other counties concerning how to best address such issues. In several cases, training and support for CCSI activities may need to be made more visible and tangible in the future by trainers or Tier III officials working directly not just with local coordinators, but also reaching out directly to other key local officials to assure their support and understanding of the key CCSI principles and goals.

- Technical assistance that counties have obtained from the state has often been well received, but counties report that such assistance has not always been available as often or in as timely a fashion as would have been useful. In particular, technical assistance has been insufficient to meet the perceived needs of CCSI counties during the startup stages. Future consideration should be given to

ways of providing incentives for key local officials and staff from key systems critical to CCSI success, to assure that they will be participants in training and other important activities designed to elicit their full cooperation and support in all aspects of the CCSI effort.

- CCSIs have been constantly evolving, with frequent changes in their processes, funding and sources of funding, parental involvement, Tier I and II functioning, etc. It is important that processes be in place at both local and state levels to monitor such changes, and to assure that the CCSIs remain on target to meet defined goals as the changes occur. Few CCSIs report having such formal monitoring/evaluation processes in operation—and the state, despite significant Tier III support and leadership, does not appear to have in place a comprehensive monitoring/assessment/ evaluation mechanism to effectively track how well sites, individually and in the aggregate, are doing on an ongoing basis against a variety of goals and process improvement measures.

- CCSIs themselves report that they are reasonably satisfied with their progress and implementation, though many are concerned that they have insufficient staffing and financial resources to fully accomplish what they want to do.

6. CCSI BUDGETS AND FUNDING SOURCES

Listed below are the 25 CCSI sites included in the survey analyses. For each site, the total CCSI budget for 2000 is listed, along with the % FTE for the coordinator and the number of paid staff. [5] These data reflect total budget figures, and not just the CCSI portion.

	Total Budget 2000	% FTE CCSI Coordinator	# of Paid Staff
A	103,983	100	23
B	34,800	100	6
C		30	7
D	160,500	100	3
E	133,749	100	5
F	68,000	100	7
G	43,500	50	1
H	159,070	100	4
I	10,000	N/A	0
J	88,000	100	1
K	75,500	50	4
L	123,200	100	4
M	106,871	100	10
N	25,000	30	2
O	120,000	50	4
P	101,114	100	7
Q	59,000	100	3
R	135,000	100	13
S	46,614	60	2
T	19,500	0	0
U	11,000	100	5
V	45,804	60	1
W		100	4
X	36,215	50	5
Y	7,846	10	10

[5]In order to protect the anonymity of information provided in the surveys, as promised, we assigned letters to the counties, so the range of information can be shown without identifying specific sites. They are not presented in the same order as in earlier tables. Note: we believe CCSI site U's budget is incomplete.

Although useful for overview and trending purposes, the budget and funding information presented in this chapter should be reviewed with some degree of caution. CGR is confident that the information is useful in providing a broad overview perspective on the scope of the CCSI efforts and the role of various funding sources in covering the CCSI costs. However, *the information should not be viewed as providing precise, completely accurate data* about the various CCSI sites. For example, several of those completing the information acknowledged that some of the data as originally presented in the surveys were not always internally consistent. Furthermore, in about half the counties, the designated state CCSI grant allocations presented in the survey for a given year did not always agree with the allocations figures provided by Tier III. Usually the differences were not major, but in some cases they were significant.[6] Some CCSIs were able to provide only partial data in some years for certain funding sources. The fact that many of the current CCSI coordinators were not the same ones who were present at the beginning meant that historical perspectives and accuracy were not always the norm.

Nonetheless, CGR is convinced that the information as presented is sufficiently accurate and consistent to be useful for broad analysis and trending purposes, and to provide a sense of the overall budgets of the CCSI sites, as well as to provide indicators of the importance of different sources of funds at different times in the lives of the CCSI initiatives. CGR was able to make a number of corrections and updates of the originally-submitted information, so that the data are now much more consistent and accurate than in their original form. Thus, although it is important and appropriate to point out the problems, so the reader can exercise appropriate cautions in interpreting the data, it is also important and fair to say that the vast majority of the information as originally presented is sufficiently accurate, and has been subjected to enough consistency checks, for CGR to be comfortable presenting it. Thus, we believe that, caveats notwithstanding, what follows provides a useful overview

[6]In response to one question, one county indicated that it last received CCSI funding in 1994, four counties said they received their last CCSI funding in 1996, another in 1998, and one in 1999. In fact, all seven had received CCSI funds, according to Tier III records (albeit small amounts in most cases), in 2000. Clearly there is considerable confusion concerning the sources of funding for the CCSIs.

perspective on the CCSI funding patterns over the past three years.

Size of CCSI Site Budgets

More than $1.7 million was spent in 2000 to operate 22 sample CCSI sites. The budget for nine of those sites was less than $50,000, and was more than $100,000 in another nine.

According to the CCSI coordinators in the survey sites, more than $1.7 million was spent to operate the 22 CCSIs for which we had useable budget data for 2000—an average of $79,740 per site. The table below summarizes the size of the CCSI site budgets as presented in the surveys, for the 2000 budget year (including all sources of funds). The data are grouped by the phases in which the CCSIs were funded. Of the 22 sites for which we received complete budget information for 2000, the total budget for CCSI operations was less than $50,000 in nine of the sites (41%), including four in which the annual budget was $25,000 or less. An identical number of sites (nine) had CCSI budgets exceeding $100,000, with another four ranging between $50,000 and $100,000.

Size of Annual Budget	# of Phase 1 & 2 Counties	# of Phase 3 & Later Counties	Total # of Counties
Less than $50,000	0	9	9
$50,000 - $100,000	1	3	4
More than $100,000	7	2	9
Total	8	14	22

Budget Size by Type of County

Most of the larger CCSIs were funded in Phase 1 or 2; all of the smallest CCSIs were funded in Phase 3 or later—all but one with only part-time staff.

As shown in the table, all nine of the smallest CCSI efforts, from a budget perspective, were initially funded in 1997 or later (Phase 3 or later). At the other end of the spectrum, seven of the nine largest programs in our survey sample were among the programs funded in Phase 1 or 2. Looked at another way, seven of the eight Phase 1 and 2 programs have annual budgets of $100,000 or more—indicating that they have been able to come up with additional sources of funding to replace the original designated CCSI funding—while only two of the 14 sites funded since then have budgets that large, and nine of those 14 more-recently-funded sites have budgets of less than $50,000.

It is also interesting to note that six of the nine least costly CCSI counties are operated under a government lead agency, while identical proportions, six of the nine largest initiatives, are

operated by non-profit lead agencies. Publicly-operated CCSIs are at each budget extreme: all four of the Phase 1 government sites are funded at the level of $75,000 or more, but all seven government CCSIs funded in Phase 3 or later have budgets below $75,000, with six of those below $50,000.

Staffing Implications

The staffing implications of these budget amounts are clear. Eight of the nine smallest CCSIs (budgets of less than $50,000) have only part-time coordinators, while eight of the nine $100,000-plus operations have full-time coordinators (most have other full-time staff as well), as do three of the four sites with budgets between $50,000 and $100,000.

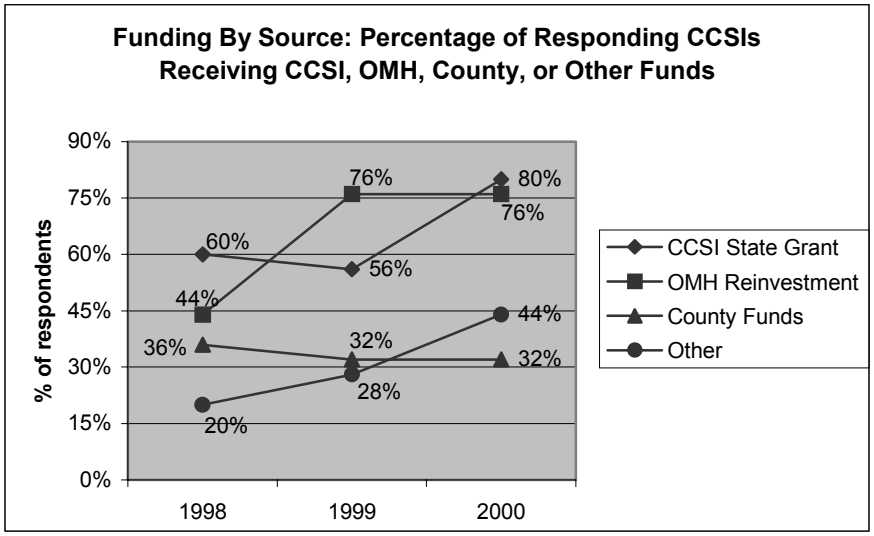
Amounts and Sources of CCSI Funding

Funding for CCSIs comes from a variety of sources. With advice from Tier III members, CGR categorized three broad primary sources of funds in the CCSI survey: CCSI state grants, OMH Community Reinvestment funds, and funds from the local counties. We also included a fourth category of "other" funding. The graph on the next page indicates the proportions of CCSI counties in the survey which received the various types of funds in each of the last three years (1998 – 2000). Clearly there has been considerable variation between funding categories from year to year.

The vast majority of sites in 2000 received both designated CCSI grant funds and Community Reinvestment funds, while only a third received county financial support.

As recently as 1998, fewer than half of the CCSI sites in the sample reported receiving Community Reinvestment (CR) funds. But in each of the next two years, that proportion had increased to about three-quarters of all sites. During the first two of those three years, only about 60% of the CCSI sites reported receiving designated state CCSI grant funds. These *reported* numbers are likely to be smaller than reality, as Tier III allocation reports suggest that some of the counties overlooked some of the *actual* allocations made by the state under CCSI budget lines. An influx of additional CCSI funds in 2000 brought the reported proportion of sites receiving designated CCSI funds to 80%. Many of those counties, however, were receiving only small amounts of CCSI funds limited to $1,000 training grants and/or $10,000 "spin-off grants." Even this 80% figure is probably low compared to reality, as virtually all CCSI counties in 2000 received at least a $1,000 training grant. It is of further interest to note that, even though there was at least an implied assumption that over time, counties

would pick up more of the costs of operating the CCSIs, for the last three years only about a third of the counties are reported to have put their own funds into CCSI operations.



Growth in CCSI Funding

To put the graph proportions in further perspective, it is important to determine the value of the amounts actually received from the various funding sources represented in the graph. The table below indicates for the most recent three budget years the total and average budget amounts for the 22 sites for which such information was available, broken down by the funding sources.

Funding for surveyed CCSI sites increased by 49% between 1998 and 2000, and total CCSI budgets increased in 77% of the sites during that time.

Overall during the past three years, the average CCSI operation grew by 49%, from an average per site of $53,398 in 1998 to an average of $79,740 in 2000, with a total of more than $1,750,000 spent on 22 CCSI sites that year (almost $580,000 more spent on those CCSI sites than in 1998). In a few of those counties, CGR believes that the actual expenditures may have been even greater than what was shown in the surveys, so these figures may represent conservative estimates of the total value of the initiatives. Whether or not that is true, it is clear that funding for these CCSI sites has increased substantially since 1998. Looked at by individual county, at least 17 of the 22 counties (77% of the counties) with full budget information for the three years increased their budgets and funding between 1998 and 2000. Most of the

others maintained their budgets at about the same level over those years (or had just begun to receive funding in 2000).

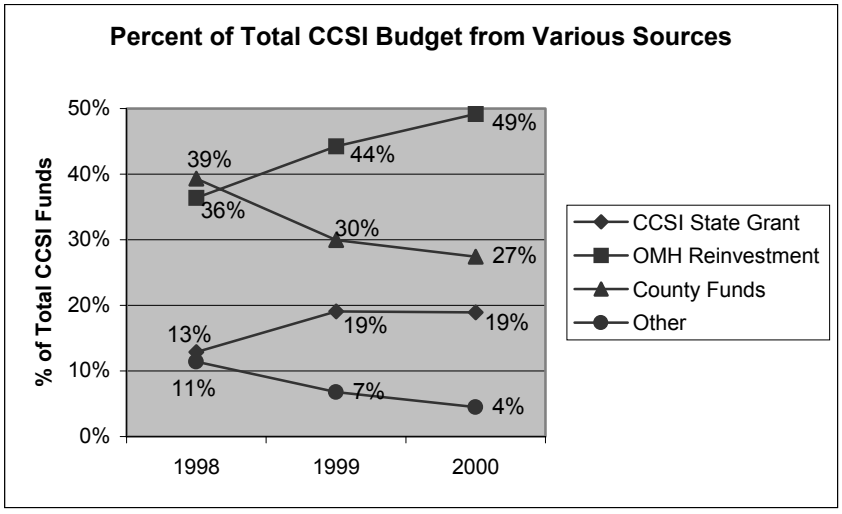
	Year 2000		Year 1999		Year 1998	
Funding Source	**Total Funding Amount**	**Average Funding Level**	**Total Funding Amount**	**Average Funding Level**	**Total Funding Amount**	**Average Funding Level**
CCSI	$332,500	$15,113	$293,590	$13,345	$151,020	$6,864
OMH	$862,189	$39,190	$681,681	$30,986	$427,707	$19,441
County	$480,969	$21,862	$461,252	$20,966	$461,813	$20,991
Other	$78,619	$3,573	$104,585	$4,754	$134,225	$6,101
Total	$1,754,277	$79,740	$1,541,108	$70,050	$1,174,765	$53,398

Amounts of Funding by Source

As shown in the table, much of the increases in funding for CCSIs is the direct result of expanded Community Reinvestment funding. As recently as 1998, CR funds were the second largest source of funding for the CCSIs, with an average of less than $20,000 spent per site. By 2000, however, CR funds had doubled, and had become by far the biggest source of support for CCSI counties—accounting for more than $862,000 in the survey counties, an average of more than $39,000 per site. During those same years, direct county support grew only slightly in amounts, from an average of less than $21,000 per county to less than $22,000 per site. In the process, county support dropped from the leading funder of CCSIs to a distant second place. Between 1998 and 2000, designated CCSI grant funds more than doubled, from an average of less than $7,000 per site to more than $15,000 each, but those specified CCSI funds remained a distant third category in the order of funds allocated to CCSI operations.

Since 1998, CR funds have become by far the largest source of support for CCSI operations, accounting for almost half the total budgets. Direct CCSI funds, while increasing, account for only 19% of total budgets, while county funds declined to 27% of total operations.

The graph below reflects the changes over time in the proportions of the total budgets for these 22 sites which come from the various major funding sources. Even though nearly all CCSI sites received designated CCSI funds, those funds accounted for only 19% of the total operational budgets for those 22 sites in 2000. The Community Reinvestment share increased between 1998 and 2000 from 36% to just under half of the total budgets. Meanwhile, the total county funding, which has remained relatively flat during that time, while total CCSI budgets increased, declined from about 39% of the total budgets in 1998 to 27% in 2000.



Amounts of Funding by Phase

Most CCSI sites have been able to find sufficient alternative sources of funds to continue and expand their efforts, even as initial designated CCSI funds are reduced.

As indicated in the table below, the CCSI sites funded in the early phases of the initiative continue to be the largest programs, in terms of average budgets per site. Initial Phase 1 counties have expanded from an average budget of about $70,000 in 1998 to more than $86,000 in 2000. The Phase 2 counties in the sample increased to an average per-site budget of more than $140,000 in 2000. Although Phase 3 counties still have the lowest average budgets, they have increased from just under $42,000 in 1998 to about $57,000 in 2000. That average is just under the average annual budget of the counties which have started since Phase 3, and actually would exceed the average of those most recent counties if New York City were removed from the equation (that would drop the 2000 average of those sites from about $62,000 to just under $42,000). Thus the Phase 3 counties have been able to build on the initial small CCSI grants to find larger amounts of replacement funds to continue and expand their initiatives.

	Year 2000		Year 1999		Year 1998	
	Total Budget	Program Average	Total Budget	Program Average	Total Budget	Program Average
Phase 1	$430,351	$86,070	$399,307	$79,861	$350,440	$70,088
Phase 2	$562,096	$140,524	$482,570	$120,643	$352,642	$117,547
Phase 3	$513,111	$57,012	$412,358	$45,818	$376,725	$41,858
Phase 4+	$248,719	$62,180	$246,873	$61,718	$94,958	$23,739
Total	$1,754,277	$79,740	$1,541,108	$70,050	$1,174,765	$53,398

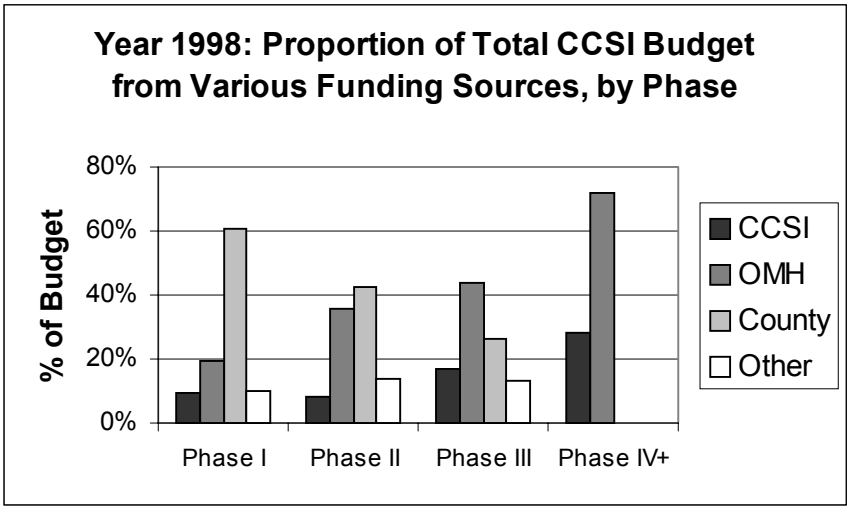
Funding by Phase and Source of Funds

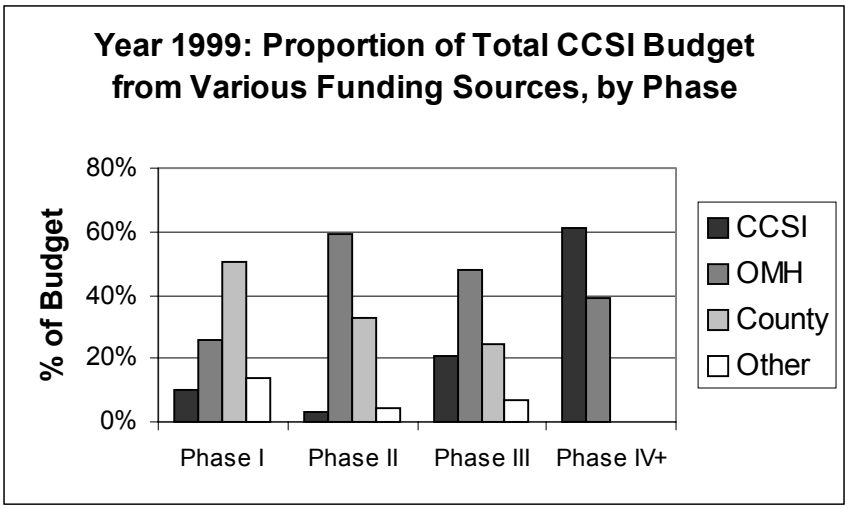
The three graphs which follow show the differences in the shares of the contributions to the total CCSI budgets of the various funding sources for the survey counties in the various CCSI funding phases, for each of the years from 1998 to 2000. For the older CCSI counties *funded in Phases 1 and 2*, the following patterns have evolved:

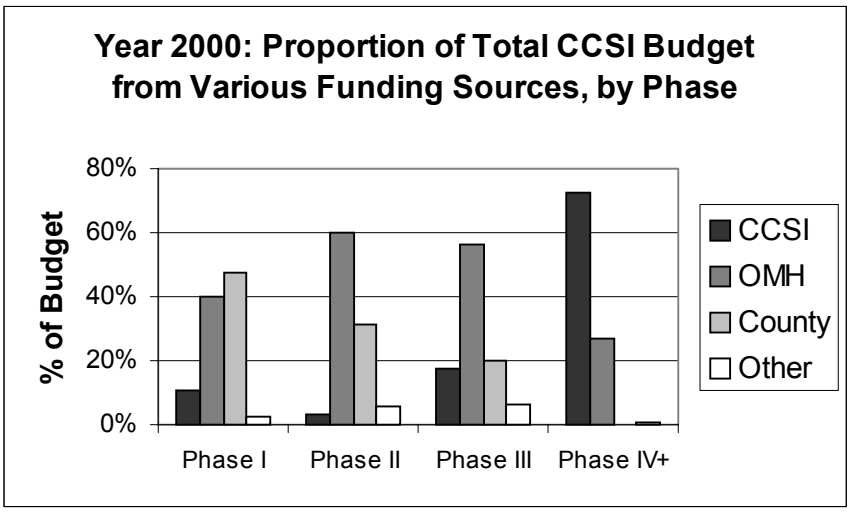
- CCSI grant shares of the operational budgets have remained around 10% (even less in Phase 2 counties);
- County shares of the budgets, though declining, have remained higher than for other phases (especially in Phase 1 counties); while
- OMH Community Reinvestment funds by 2000 had almost reached the county shares in Phase 1 counties and significantly surpassed the county shares for Phase 2 CCSIs. Fully 60% of the costs of the Phase 2 sites in 1999 and 2000 were covered by CR funds.

CR funds play key funding roles in all phases of CCSIs. Designated CCSI grant shares are small in Phases 1 and 2, but predominant in newer CCSI operations, and County funds play significant (though declining) roles only in older sites.

In *subsequent funding phases* of the initiative (since Phase 2), county shares have been much lower (non-existent for the most recent phases after Phase 3). CCSI grant funds remain around 20% of the costs of Phase 3 counties, while CR funds have gradually increased to almost 60% of the total costs. Only in the CCSIs which have begun since Phase 3 are designated CCSI state grant funds predominant, with almost 75% of the costs of these newer county initiatives covered by such funds in 2000—thus far, in an almost exclusive funding partnership with CR funds, and no county funding role to date.





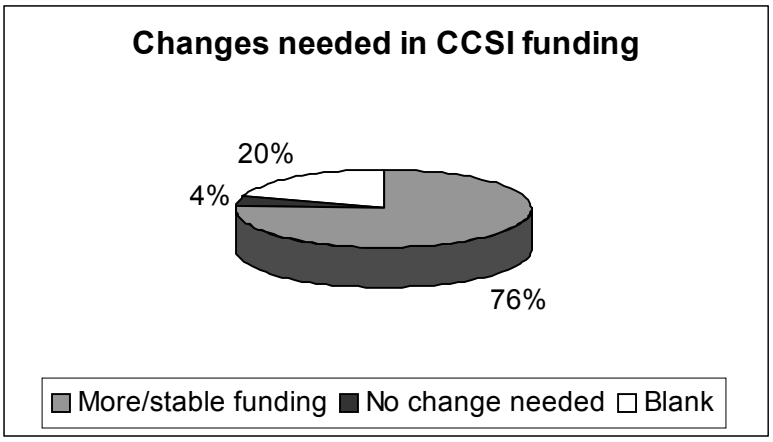


Changes Needed in Funding of CCSI

Nineteen CCSIs (76%) said that more and stable funding for CCSI was needed, either from the state and/or from other systems or departments within the counties. Overwhelmingly, the primary concern was over the amount and stability/permanency of funding for CCSI. One survey respondent said that their CCSI was not allowed to use funding to hire a coordinator.

Most CCSI sites expressed concerns about the future stability of their various funding sources.

Only one CCSI said no change in funding was needed. Five CCSIs did not respond to this question.



CCSI coordinators made a number of specific comments about changes needed in future funding, including:

- "The state needs to assign county funding for CCSI to a special category outside of child spending caps. This needs to be done to improve reimbursement levels for the program."
- "The CCSI funding amount of $25,000 for our county is not sufficient to cover the cost of coordination. The coordination is now used to implement single point of accountability, and the infrastructure funding associated with the new substitute helps, but it is not covering the total cost of full-time coordination."
- "It'd be great to have more CCSI funding on an ongoing basis."
- "Other systems need to buy-in with financial support."
- "Additional consistent dollars have to flow to CCSI to assist in all facets of delivering services to families. Funding should be based on numbers served."
- "A yearly allocation would help each county to define and accomplish activities directed to CCSI outcomes. The team conferencing in the county is widely used."
- "We were never allowed to use the money to hire a coordinator."
- "Each local system should fund and have buy-in to CCSI."
- "We can fund CCSI with MH Reinvestment, but we cannot fund the at-home and school-based crisis services which the most

difficult children need. Until there is a much stronger financial support for community mental heath, CCSI is limited."

- "A permanent state funding structure should be initiated."
- "Blended funding at the state and local levels best supports the philosophy and mission of CCSI. Ownership by one system can dilute the intent of cross system collaboration and system reform."
- "Reinvestment funds need to be available at the 1st of each year."
- "More wraparound funds are needed for dealing with contingencies that occur."
- "There is too much reliance on Community Reinvestment funds. Would like to see community funding from other county departments – DSS, Probation, etc."
- "We need some COLAs as expenses go up."
- "We would like different agencies on the county level to commit funds to CCSI yearly. This would increase our funding and support 'buy-in'."
- "Contributions are needed from County DSS, Probation and Youth Bureau."
- "Need a dependable funding stream, as applying for grants is time consuming."
- "Need strong state level commitment to CCSI (all state agencies), and greater consistency of Tier III members."

Summary Observations and Implications

The above findings and discussions suggest the following observations and implications, which will be discussed further and related to specific recommendations in Part Three of the report:

- The surveys received by CGR indicate that there are some inconsistencies and misunderstandings concerning budget and funding data across many of the CCSI sites. This at least suggests the possibility that better financial controls need to be put in place to track and monitor the fiscal conditions of individual CCSI sites, as well as at the aggregate state level.

- Counties are clearly calling for expanded and more stable funding for CCSIs in the future. It would make sense to tie such requests for future funds to the need for better financial controls, and for improved monitoring and documentation of the performance of CCSIs against measurable goals and objectives—and to make future funding more contingent upon the implementation of such improved monitoring approaches, at both local and state levels.

- CCSIs funded in the early years of the initiative have continued to do well in maintaining significant funding levels and staffing, including full-time coordinators and other staff. However, although more-recently-funded CCSIs are catching up in overall funding levels, they continue to lag behind the earlier programs—with clear implications for what appear to be insufficient staffing levels in several of the "younger" programs, even acknowledging the fact that they are, for the most part, smaller counties.

- Funding allocations overall have steadily increased in recent years for most CCSI sites, but there is a sense that much of this may not be permanent; sites are concerned that they need to be spending too much time thinking about funding, since there are few if any "permanent" or even relatively stable sources of CCSI funding upon which county CCSIs can depend for ongoing future support.

- Relatively small amounts of county funds are currently being used to support the CCSI efforts, with only about a third of the survey sites and about 27% of the CCSI budgets in those sites funded by dollars allocated by the counties. It is true that the older CCSI sites have developed and maintained higher levels of local support than the newer locations, which is appropriate, but even those levels are declining—and the sense remains overall, including comments expressed by many of the local sites themselves, that county governments in general (and/or other sources of funding at the local levels) should be contributing more direct financial support to the CCSI efforts, particularly to the extent that localities can document savings as a result of reduced placements.

- The absence of stable sources of funding makes it particularly hard for CCSIs to commit to long-range planning or setting new directions or establishing new initiatives. It limits the ability to undertake initiatives beyond a year at a time. It further limits the

ability to expand as needed, without assurances of resources being in place in the future to support any such expanded efforts.

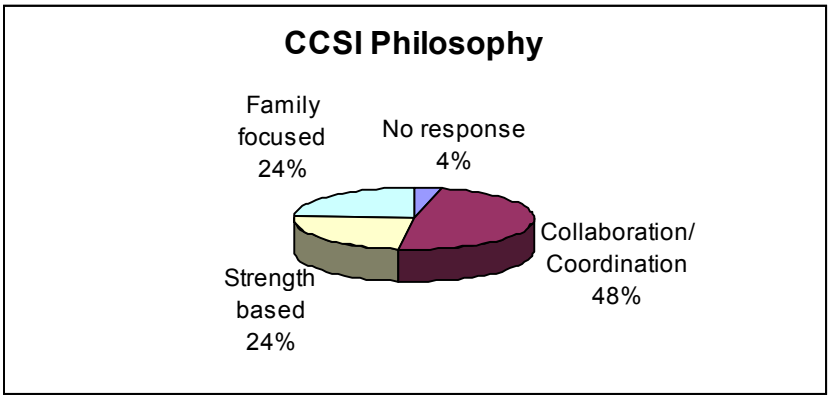
- A concern remains that despite the CCSI focus on blended funding, actual allocations of funds can still be too associated with a single system of services, thereby diluting the growth and impact of cross-systems approaches. Consistent cross-systems sources of funds are desirable for the future, at both local and state levels.

7. CCSI Focus and Tier Infrastructure

This chapter focuses attention on the philosophy and basic infrastructure of the CCSIs, as reflected primarily in the reported workings, structure, composition, approaches and impact of the various Tier groups/teams at both the local and state levels.

CCSI Philosophy

Almost half of the CCSIs identified their philosophy as one of "collaboration" or "coordination." Another quarter each identified their philosophy as either "strength-based" or "family-focused."



Most CCSIs said the primary focus of CCSI in their county is both reducing out-of-home placements for at-risk children, and interagency collaboration/systems change.

Twenty (80%) of the survey respondents said the primary focus of CCSI in their county is *both* reducing out-of-home placements for at-risk children, and interagency collaboration/systems change. Two CCSIs each indicated that their primary focus is one or the other. Five counties also indicated an additional primary focus, such as: school-based early intervention for at-risk kids; parent participation/training/Parent Partners; and special education, mental health, children and family services, child welfare, juvenile justice, and health sectors. These "target groups" are probably not inconsistent with the general category of children at risk of out-of-home placement.

Changing CCSI's Primary Focus

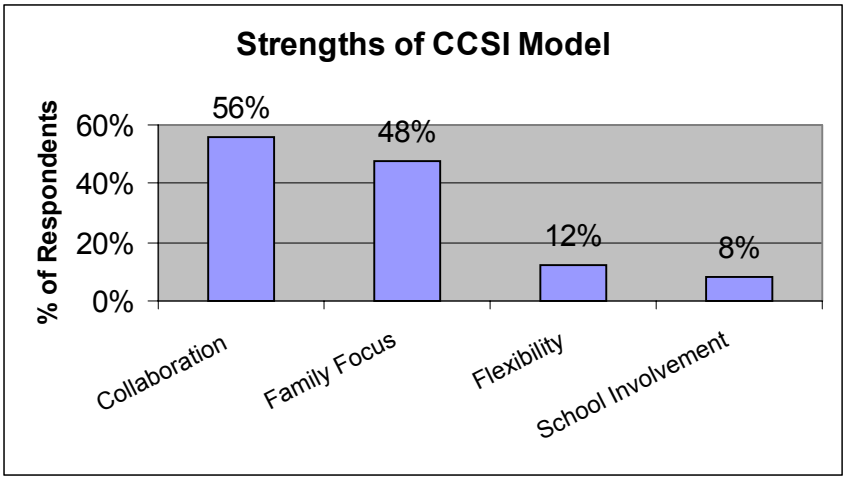
Eighteen (72%) of the CCSIs indicated that their primary focus had *not* changed from what was stated in the original proposal. Five (20%) said it had changed. Two counties did not respond.

When asked *how* their focus had changed, counties responded with the following:

- "There was an existing committee that received youth at-risk for placement."
- "Individual agencies use family conferencing as an accepted practice because they don't have a coordinator."
- "CCSI was instrumental in an evolving process and helped bring stronger inter-agency commitment."
- "Original purpose—role of case managers; CCSI has evolved into a process that brings the larger community together to serve families."
- "Increasing focus on systems advocacy and strengthening the voice of the Tier II workgroup around system issues."

Perceived CCSI Strengths

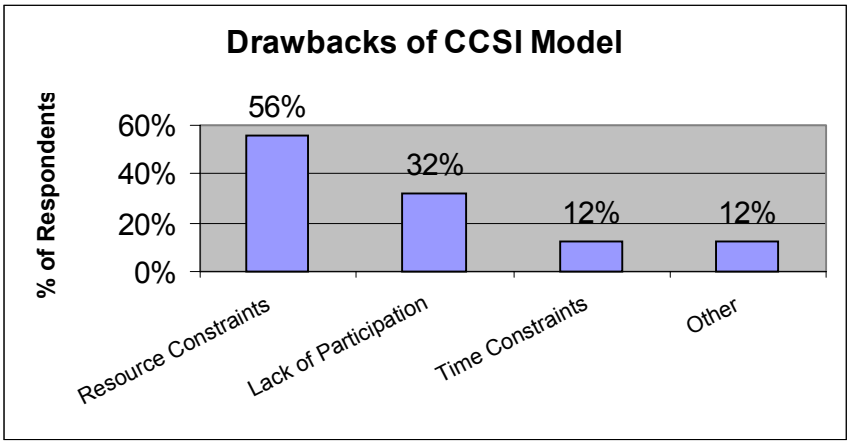
Over half (56%) of the survey respondents cited "collaboration" or "cooperation" as a strength of their CCSI model, and nearly half (48%) identified "family focus" as a strength. Three CCSIs (12%) identified flexibility, and two identified school involvement as strengths. It is interesting to note that in such an open-ended question, no CCSI explicitly mentioned placement reduction as one of the primary strengths of their model.



*Note: some counties identified more than one strength.

Perceived CCSI Weaknesses

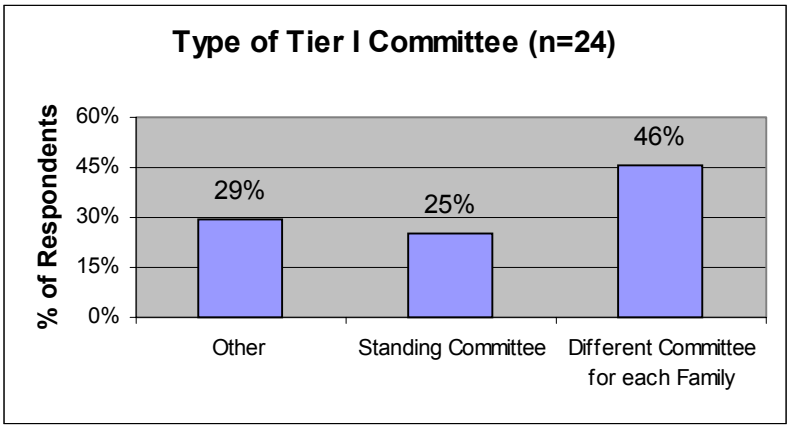
More than half of the CCSIs (56%) identified resource or funding constraints as a drawback or limitation. One third of the respondents identified lack of participation or involvement by various players as a drawback. Three CCSIs identified "time constraints."



* Note: some counties identified more than one drawback.

Tier I Service Approach

The following sections focus on the Tier I committee structure and processes. Nearly half of the counties (n=11) have a different committee for each family. A quarter of the programs (n=6) use a standing committee for Tier I. An additional seven CCSIs (29%) use another arrangement, including a mixture of these approaches.

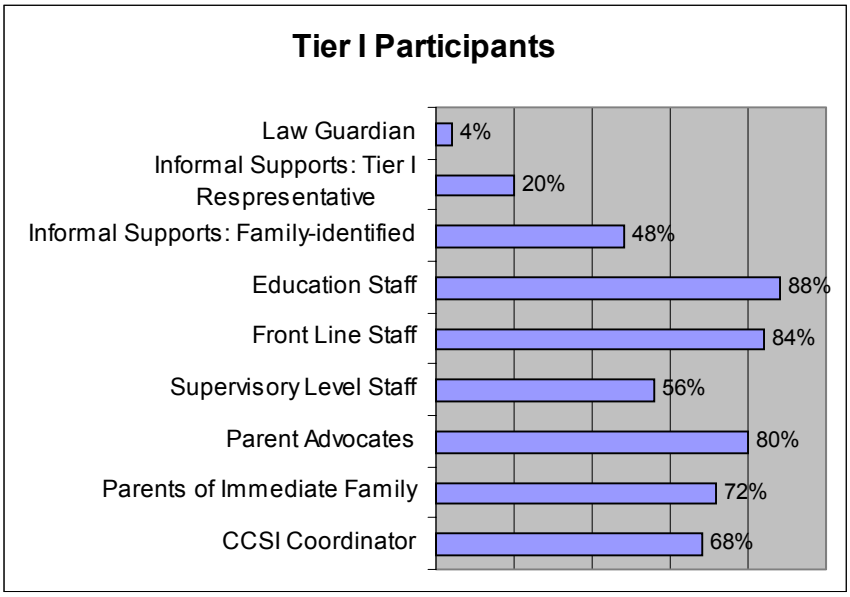


Participation in Tier I

The smallest number of Tier I participants reported in any county was five. Fourteen of the counties (56%) typically have between five and ten individuals participating in Tier I activities, 24% usually have between 11 and 15 participants, and two counties

(8%) typically have 16-20. Three counties did not provide any information on Tier I participants.

The following graph indicates the extent to which various potential Tier I participants are involved in various CCSIs. The proportions indicate the percentage of counties in which each of the listed participants "generally participate in Tier I" efforts.



Despite substantial parent involvement in Tier I, in about a fifth to a quarter of the counties, neither parents nor parent representatives were generally participants in the Tier I process. CCSI coordinators are not typically involved in 1/3 of the county Tier I meetings.

Several aspects of the participation rates are of particular interest. Despite the fact that the education community was frequently criticized in several of the counties for not being sufficiently involved in the CCSI process, they were listed as being involved in more counties than were any of the other typical Tier I participants. Consistent with the objectives of many of the CCSI efforts, the vast majority of the counties indicated that parents of the immediate family and parent advocates were typically involved in Tier I activities. On the other hand, the data imply that, despite the stated importance of parent involvement, *in about a fifth to a quarter of the counties, neither parents nor parent representatives generally were participants in the Tier I process*, perhaps suggesting that considerable work remains to be done in some counties to get parents to the table in effective functioning roles. And the ability to recruit and train parents, and help make them comfortable in that role, is probably not enhanced by the fact that the CCSI Coordinator is

not typically a participant at Tier I meetings in one-third of the CCSI counties.

Education community representatives are often highly involved in Tier I efforts; however, they receive lower effectiveness ratings than other participants.

When asked to rate the effectiveness of the Tier I participants listed above on a scale of 1-5, where "1" means "not at all effective" and "5" is "very effective," on average, respondents perceived all participants except education staff to be effective/highly effective, with an average rating between 4 and 5. Despite the fact that the education staff were said to be generally involved, they were, on average, perceived to be slightly less effective than other participants, receiving a slightly lower average rating of 3.8.

The Education Community and Tier I

CCSIs were asked more specifically about the involvement of the "education community" in Tier I. There was significant variability among their responses. A summary of their comments follows:

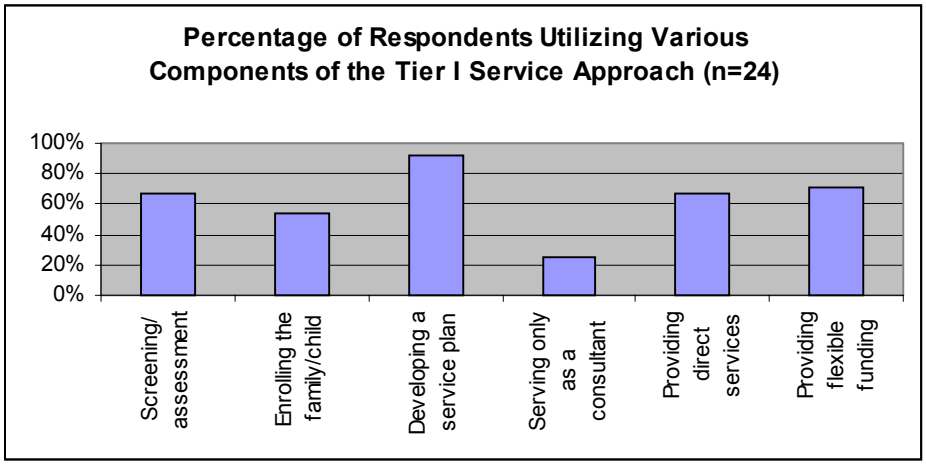
- "Five of 10 community networks are hosted by school districts; approximately 20% of the families who attended the networks in 2000 were invited by a school representative;"
- "There are many school districts in our county; most of the time we struggle to get participation;"
- "A social worker from one school district and a guidance counselor from a different district participate as part of the standing Tier I committee;"
- "Involved in a Tier I workgroup—contact by referral;"
- "School staff relating to identified family are always invited to a Tier I meeting;"
- "Always have education system at Tier I because it's a system that is an integrated part of the family system;"
- "School personnel are asked to attend as appropriate, but they are not on the standing committee;"
- "CSE coordinator, and a social worker participate from local schools;"

- "Depends on the case; frequently school personnel attend the 1st meeting, then they become less involved;"
- "Each school district has separate Tier I;"
- "Tier I identifies at least one Board of Education representative to sit on our standing committee; Tier I also invites specific education staff who are currently involved with individual children to each network;"
- "Individual teachers, guidance counselors and support staff are invited; Tier I has two school social workers on its standing teams;"
- "Schools are involved with Tier I meetings if family requests and/or agrees to school's participation;"
- "Person familiar/active with child attends meetings;"
- "School representatives are on Tier I and Tier II, but the education system has the most difficulty freeing up the appropriate individual for meetings;"
- "Representatives from various school districts participate in Tier I meetings;"
- "School districts actively participate if the child is in school;"
- "School personnel make up about one half of the members of Tier I committees;"
- "School psychologist or school CSE chair attends meetings;"
- "Schools are more active but find it difficult to be lead workers; they are uncomfortable dealing with all families, so this year we are focusing on training;"
- "Teachers and a student coordinator often attend meetings;"
- "They are part of the Tier I Family Team;"
- "The education community is very involved on the front line of promoting our services."

Components of the Tier I Service Approaches

Most of the CCSI sites indicate that they are activists in working with individual children and families. About 20% of the sites indicated that they "serve only as a consultant." The rest appear

to offer more "hands on" approaches: Two thirds (n =16) of the CCSIs do screening/assessment, 22 (92%) develop a service plan, two-thirds provide direct service, 54% enroll the child/family in their CCSI, and 71% indicated that they provide flexible funding. However, in response to a different question asked elsewhere in the survey, 92% indicated that they use flexible funding for CCSI families. Based on project goals and budgeted funds, it seems likely that the higher proportion is the more realistic one in this case.



*Note: Most Tier I approaches involve multiple components; counties were asked to "check all that apply."

Impact of Health Insurance Coverage on CCSI

CCSIs were asked about the impact of health insurance (e.g., Medicaid, and Medicaid reimbursements; HMOs; Child Health Plus coverage limitations) on the ability to serve families/children referred to CCSI, and the responses were evenly divided. Half of the 24 responding CCSIs indicated an impact, ranging from inconvenience to an extremely significant impact on the ability to access needed services.

The other 12 CCSIs said health insurance coverage issues had no impact on their CCSI, explaining that "CCSI is a process, not a program," "there is no direct impact on CCSI, though it directly affects the services that are set forth by some agencies," and "CCSI accepts all children regardless of health insurance coverage."

Discharge Planning

Fifteen CCSIs (60%) said they provide discharge planning/ aftercare services for children placed in facilities, and nine (36%) said they did not. One did not address the issue. Those sites which are involved mentioned the following examples of the roles they do or plan to play:

- "CCSI will be part of discharge if the facility refers the family first;"
- "We are working on this;"
- "We are asking that all children be referred to CCSI to develop aftercare services;"
- "Tier II committee/SPOA is in charge of looking for appropriate discharge plans;"
- "Not necessarily, only if asked for;"
- "This will be part of our SPOA plan;"
- "Waiver program provides those services;"
- "We respond to requests for intervention;"
- "Not formally, though infrequently this can occur at the time of referral;"
- "CCSI is involved in discharge planning for kids placed in RTFs;"
- "Tier I meets to plan transition from residential facilities/hospitals;"
- "Staff will meet regularly with facilitator and will assist/coordinate services for the child's return to community;"
- "Conduct Tier I meeting to develop plan when a child is being discharged from residential facility or hospitalization;"
- "County created a Single Point of Return committee (SPOR). One primary objective is to ensure that each child returning from care receives an individualized care plan;"
- "Work specifically with kids in CCSI, if placed; at time of discharge, work with transition plan and provide care;"

- "It's available, but hasn't been used for aftercare; the county is currently looking at the aftercare issue;"
- "To a limited extent: have accepted some referrals of children currently in foster care, hospitalization, residential placement."

Among the smaller number of reasons CCSIs gave for not being involved in discharge planning:

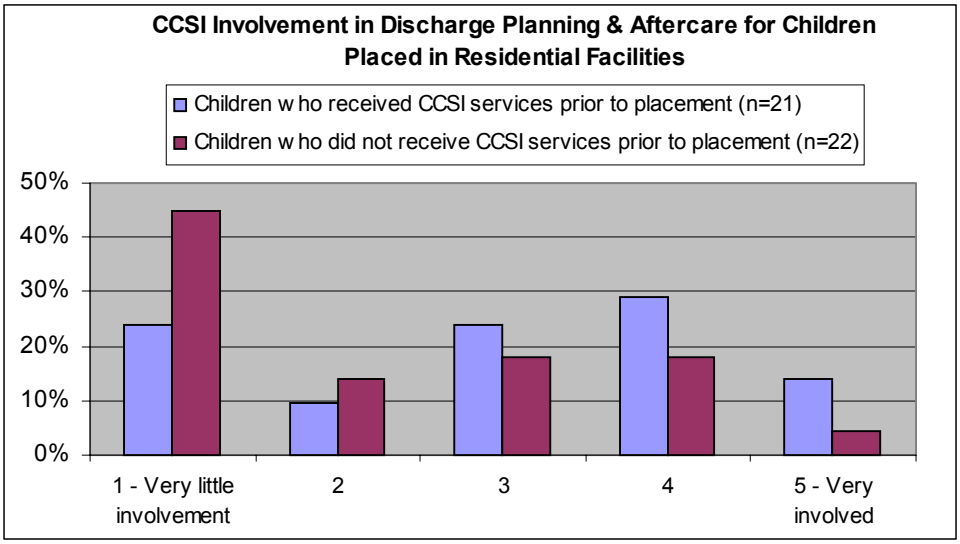
- CCSI's limited involvement in aftercare services;
- Involved only if the facility refers to them at the time of discharge.

A few CCSIs said they are working on getting involved in aftercare services, and that it will be part of their Single Point of Access/Accountability (SPOA).

Extent of involvement in discharge/aftercare services

3/5 of CCSIs provide discharge planning/ aftercare services for children, although the level of involvement is often limited. CCSIs are far less involved with aftercare if they have not worked with a child pre-placement.

As shown in the graph below, the level of involvement of CCSIs regarding discharge planning and the provision of aftercare differs for those children who received CCSI services prior to placement, compared with those who had not received CCSI services before being placed. CCSIs were considerably less likely to be involved in discharge planning and/or aftercare when they have not worked previously with a child than when CCSI services have been provided prior to the placement. Conversely, where services had previously been provided, a higher proportion of CCSIs had provided at least some discharge planning/aftercare, including more than 40% of the counties which had been heavily involved (a rating of 4 or 5 on the 5-point involvement scale).



Potential for future expanded discharge/aftercare involvement

Of the nine CCSIs not currently involved in providing some types of discharge planning or aftercare services, seven said they would want to be involved in these activities at some point in the future, under the right set of circumstances. But it is clear at this time that many of the CCSIs believe that their resources only allow them to provide concentrated discharge/aftercare services to those children and families with whom they already have a service relationship.

CCSI Data Collection

A subsequent chapter summarizes data which CCSIs reported on whom they have served, referral sources, numbers of placements, etc. Prior to that discussion of actual data, however, it is appropriate, in the context of discussing the infrastructure of the CCSI operations, to focus on the extent to which CCSIs maintain data for management and evaluation purposes. Eighteen (72%) of the CCSIs said they collect at least some information regularly. The information can range from keeping a roster, to, in one case, very detailed information on children/families served. Examples of data collected by at least a few CCSIs include the following: referral source; age; school district; gender; general family demographics; monthly data on new referrals; follow-up of family/child plan; implementation of referrals for services and success of plan; number of face-to-face contacts; collateral contacts; phone contacts; number of discharges; numbers at risk of placement; number of children placed; and estimates of dollars saved through averted placements. Individual CCSIs maintain varying combinations of such data.

There is considerable variability in the amount and nature of information maintained and monitored by CCSIs. Few CCSIs maintain a formal management information system.

While there is a great deal of variability in what is collected among CCSIs, what is collected is not standardized across sites, and is also fairly elementary. This is reflected in the fact that only four (16%) of the CCSIs report that they currently have a data system/MIS for CCSI. When asked to consider what data or management information system they would find helpful to improve the effectiveness of CCSI, respondents indicated the following:

- "If the state directed each county to collect the same data and recommended a management information system that could

provide the sheets to do so, we would not struggle on what is essential to collect."

- "We need a tool to collect and store all data as required by the state Tier III (e.g., the types of information you requested in this survey)."
- "A data collection system which includes stats on families including demographics, family plans completed, stats about the child, outcome results."
- "Monthly statistics specific to neighborhoods, town and city, outcomes."
- "A basic release form consistent with databases across all sites in the state."
- "Creating and maintaining a database is labor intensive. It is a time/resource issue for the coordinator."
- "A local area network for CCSI staff to manage a project database; internet access for development of CCSI website and for use as a search engine to research resources."
- "Follow-up system review of length of stay in community for those youth that have received CCSI services."
- "A comprehensive MIS system would be helpful. The idea of one case record (computerized) that families could have and share with other service providers rather than duplicate the information."

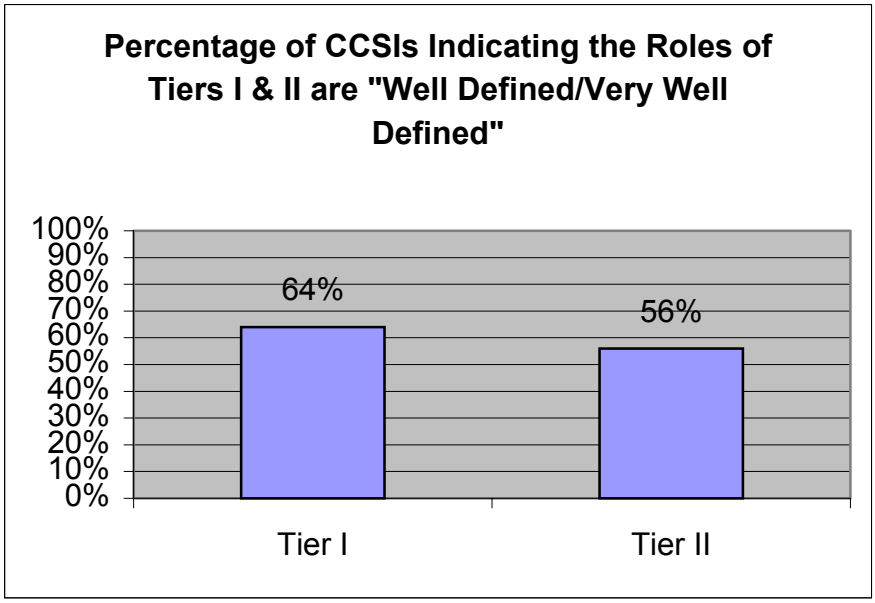
Rated Effectiveness of Tier I

Tier I was typically rated as effective.

When asked to rate the effectiveness of Tier I in achieving CCSI goals, 62% of the CCSIs rated Tier I as above average or better in its effectiveness, while 38% of the respondents indicated average effectiveness. No CCSI reported that Tier I was not effective in achieving CCSI goals.

Defined Role of Tier I

When asked how well defined they thought the role of Tier I was, 16 CCSIs (64%) thought the role of Tier I was well or very well defined; another 20% thought it was adequately defined. Three of the sites (13%) thought the role of Tier I was not well defined.



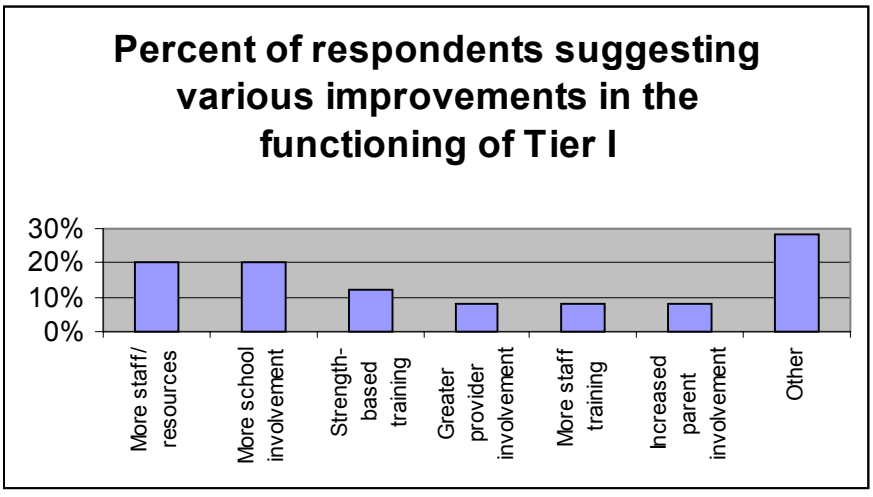
CCSIs were somewhat more inclined to perceive that the role of Tier I is well defined, compared to the role of Tier II (see below).

Tier I Accomplishments

Almost three quarters (18) of the CCSIs said that their main accomplishment involved family empowerment and/or helping families overall, and 60% said that enhanced collaboration and communication was their main accomplishment. Ten CCSIs identified *both* of these areas as their main Tier I accomplishment.

Improving the Functioning of Tier I

Twenty-one CCSIs had suggestions for improving the functioning of Tier I. The most common responses (5 each) mentioned either the need for more staffing and resources, or greater involvement from the schools/educators.



*Note: counties may have provided more than one suggestion.

"Other" responses include:

- "Putting protocols/procedures in a usable format."
- "Computer-related needs: Need consultation regarding setting up databases; computer training; development of effective data collection and recording."
- "Earlier intervention in the CCSI process."
- "Stronger mission—structure—definition of role of members who are able to make decisions. Systems for information to get down to online staff regarding services, support, and family needs."
- "Expanding interventions used at Tier I meetings and increasing the number of facilitators of Tier I meetings."
- "Tier I lead workers need to have time to devote to the high levels of service a CCSI case demands. A trained unbiased facilitator would be very helpful in creating an initial plan. A mechanism is needed for Tier I to give feedback to Tier II."

Tier II Issues

The following sections focus on the Tier II structure, roles and accomplishments, as reported by the CCSI Coordinators.

Tier II Participants

As indicated in the table below, in about two-thirds of the CCSIs, between 6 and 20 individuals, agencies and/or other parties were currently participating in Tier II at the time of the survey completion. The 21 counties responding indicated a total of 510 individuals and agencies were participating at some level in Tier II.

Number of Individuals/Agencies Currently Participating in Tier II	Number	Percent
0	1	4%
1-5	0	0%
6-10	4	16%
11-15	6	24%
16-20	7	28%
21-25	0	0%
26-30	1	4%
40	1	4%
200	1	4%
Missing/blank	4	16%

Of those involved at some level, it appears that most actually attend Tier II meetings. As indicated below, in two-thirds of the counties, the attendance at the most recent Tier II meeting was also between 6 and 20 individuals and agency representatives, with almost half the counties reporting between 11 and 15 attendees. Most of the CCSIs indicated that the most recent meeting attendance was typical.

Number of Tier II Participants Attending Most Recent Tier II Meeting	Number	Percent
0	0	0%
1-5	2	8%
6-10	3	12%
11-15	12	48%
16-20	2	8%
21-25	1	4%
26-30	1	4%
31+	1	4%
Missing/blank	3	12%

Participants' Level of Involvement in Tier II

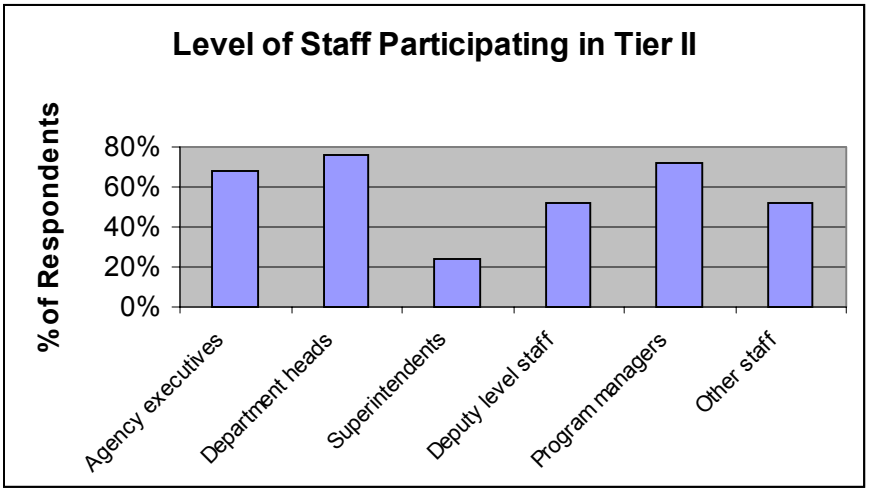
The table on the next page indicates the proportion of counties in which various types of participants are reportedly involved at an "above average" level or are "very involved" (involved at either of the two highest levels on a 5-level involvement scale).

Those with the highest levels of involvement in most CCSI sites include various county government offices—Mental Health, Social Services, Probation—and various providers of children and family services. Various other county and state offices are less heavily involved. Despite the major focus on greater involvement of family members in both Tier I and II processes, family members are reportedly heavily involved in only about two-thirds of the CCSI sites. Also, school officials are reported to be heavily involved in Tier II in only 40% of the counties.

Many county agencies and department heads are heavily involved in most Tier II efforts. However, schools and superintendents are typically not heavily involved.

Percentage of Counties Indicating Various Participants Are "Involved/Very Involved" in Tier II	
Participant	**Percent of Counties**
County Office of Mental Health	88%
State Office of Mental Health	40%
Office of Mental Retardation & DD	20%
Office of Alcohol & Substance Abuse	24%
County Dept. of Social Services	84%
Probation	84%
Schools	40%
Youth Bureau	56%
County Health Department	24%
Health care providers	8%
Children/family services providers	80%
Family members	64%
Family Court	20%
Local police	4%
Faith Community	0%
Business Community	0%
United Way	0%

In general, Tier II appears to attract high-level participation, with department heads and agency executives involved in most counties (76% and 68% of the CCSI sites, respectively). Program managers and deputy level staff also attend relatively frequently. Less encouraging is the fact that superintendents are represented in any significant way in Tier II in only about one-quarter of the counties.



Changes in Tier II Composition

Sixty percent of the CCSIs experienced changes in the composition of their Tier II over time. About two thirds of the counties experiencing such changes reported an *increase* in the number of agencies on Tier II, while a third reported a decrease in agency participation. In addition, 40% of the CCSIs reported that time devoted to Tier II by agency representatives has increased over time, while 36% reported no change, and 16% thought Tier II representatives now spend less time on their Tier II activities than in the past (one county did not respond). The main reason given for increased time related to the number of "subcommittees" or workgroups that CCSIs had formed to address a number of issues (e.g., sexual offenders; training; SPOA; other problems). The main reason for decreased time was related to poor attendance at meetings.

Formality of Tier II Mission and Roles

Fifteen (60%) of the CCSIs said their Tier II had a written job description; seven (28%) did not. Fourteen (56%) of the CCSIs responded that the role of Tier II was well or very well defined (compared to 64% of the CCSI sites that said Tier I was that well defined). The other ten CCSIs who responded believed that the role is adequately defined.

Frequency of Tier II Meetings

In 16 (64%) of the CCSIs, Tier II meets monthly, two meet bi-weekly, and one quarterly. The rest meet at different times (e.g., every other month or weekly). One CCSI said its Tier II is not currently meeting.

The CCSI Coordinator, Tier II, and Communications

The CCSI Coordinator's role with respect to Tier II varies from county to county. Coordinators may do one or more of the following: set the Tier II agenda, chair their Tier II, attend Tier II meetings and/or be a Tier II member, and facilitate or coordinate meetings. The Coordinator is also viewed in most counties as playing a key role in maintaining communications between Tier I and Tier II. Tier I chairs are regularly invited to attend Tier II meetings.

Twenty-two (88%) of the CCSIs said that they kept minutes of Tier II meetings. Twenty-one CCSIs distribute the minutes to all Tier II participants, and eight distribute the minutes to individuals other than Tier II members—such as Tier III representatives,

superintendents, and other concerned community agencies; 14 CCSIs do not distribute the minutes to others.

Tier II and County Government

Eight CCSIs indicated they have a strong/close relationship with county government, five indicated they have no relationship, and nine counties provided other descriptions of their relationships with county government. Comments from the individual counties are provided below.

Strong/close relationship with county government

- "The Coordinator is a department head in county government and meets regularly with county officials. They are very supportive of this initiative's focus and plan."
- "The members of Tier II participate on multiple decision-making committees and collaborations throughout the county. Tier II successfully secured funding for CCSI positions, increased funding to community services and grasped the philosophy of the strength-based approach. DSS is training key staff."
- "County Mental Health was the originating sponsor. Representatives and/or Department Heads of Health/Human Services, MH, Youth Bureau are regular participants. County provides the funding through MH and HHS. Tier II communicates with the county legislature through the MH and HHS Departments and directly to the legislative committee."
- "Tier II is now the Integrated Service Council; the chair reports back to the Cabinet of the county."
- "CCSI is an integral part of the Community Services Board operation and the activities of CCSI are communicated monthly to the CSB."
- "System issues that negatively impact service delivery are identified at Tier II meetings. These issues can be brought to our Oversight Committee which is attended by department heads and key system representatives, who can suggest means of addressing Tier II recommendations."
- "Tier II members typically report to County Department Heads and Commissioners. The Commissioners report to the County Manager and Legislature."

- "The County Executive sends a deputy county executive to the executive committee. Tier II originally was part of the PINS/JD planning team under the Youth Bureau. County executive said the same people would be designated to CCSI."

Other ways in which Tier II fits within the county's decision-making structure

- "The Tier II committee and process offer an opportunity to trouble-shoot systems issues, and provide better services and shared accountability. Tier II's roles impact services delivered and children's need for out-of-home community placement."
- "Tier II identifies gaps in services and suggestions for needed services. It also identifies programs and services that need improvements."
- "Family services Task Force was convened by the Human Services Commission. Supervisors group convened by parent coordinator and DCS."
- "Tier II operates separate from county government, although three county department directors are members (DSS Commissioner, Director of Community Services, and Director of Probation)."
- "Issues presented by CCSI get included in the on-going decision-making processes within and among county agencies. It's impacted issues re: cross-agency collaboration and strategies for reducing placements."
- "We like to think we act in a political vacuum."

Educational community involvement with Tier II

The most common way that the "education community" is involved at the Tier II level is through BOCES involvement (10 of the 25 CCSIs said this). Five (20%) said they involved school superintendents at this level, and 36% involve other school personnel.

Changes in Tier II Functions Over Time

Fourteen (56%) of the CCSIs said that Tier II functions had changed significantly since CCSI started, and ten said it had not. Changes cited include the following:

- "The Executive Committee was formed to facilitate decision-making."

- "Tier II has become more system-focused; meets more frequently and has embraced the philosophy of CCSI more than at the start."
- "Once funding decreased, we were unable to have a Coordinator who carried a caseload."
- "Tier II function has expanded and has become governing body for federal SAMHSA grant, MH/JJ, special projects, and other committees."
- "Initially, Tier II was primarily involved with cross-system education via presentations by each system representative; now that members are more informed, more focus is placed on cross system obstacles to service delivery."
- "Group expanded to more decision makers in the county; added parents who are less adversarial/more plentiful."
- "Original Tier II disbanded—duplication of functions already in place."
- "Attendance fell off—not clear about mission."
- "Changing from information sharing to action-specific cases; more Tier II representatives and funding."
- "Tier II as SPOA is now responsible for intensive service oversight and referral."
- "Better understanding of roles and services, though some are not attending."
- "Look at what the county is doing to prevent/reduce placement, share resources, look at how to reach families."
- "Tier II has displayed increased flexibility, enhanced communication and collaboration; there's a closeness to accomplish shared goals."
- "Originally specifically related only to hard-to-place kids, now plan for the entire community."

Systems Issues Addressed by Tier II

The most common systems issues addressed by Tier II concerned communication/decision-making/systems issues/turf issues; 15

(60%) of the CCSIs said such systems issues were addressed by Tier II. These systems issues involved matters such as:

- Communication between schools/agencies, and sharing of resources;
- Improved communications between Social Services and Community Services and schools;
- Conflicting decision-making criteria;
- Systems issues, such as conflicting admission/discharge mandates and barriers with the systems—DSS, schools, MH and Probation;
- Lack of coordination between juvenile justice and MH;
- Improved collaboration and working together;
- How to establish and maintain integrated systems of care; and
- "Turf issues" generally.

Funding/shared resources issues and helping to access needed services (e.g., transportation, case management, community based services) had been addressed at the Tier II level in about a quarter of the counties. A fifth of the counties said their Tier II process had addressed educational/school issues. Several counties said that confidentiality issues and the ability to share information with other providers were also raised.

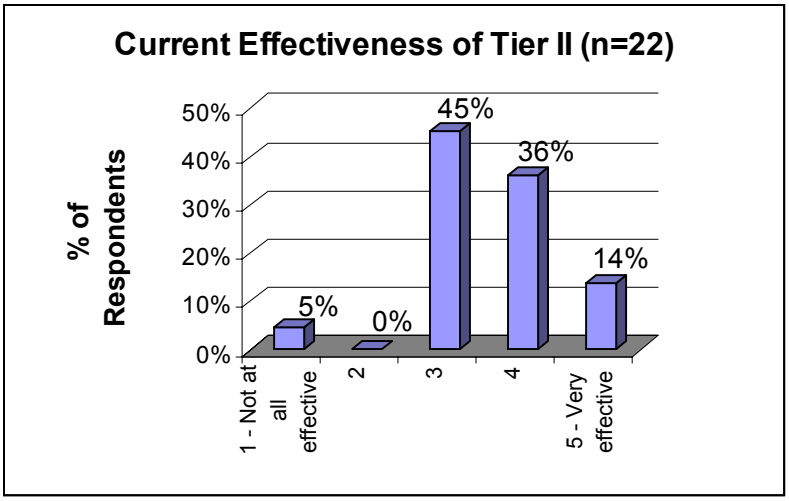
Percentage of CCSIs indicating the following issues have been addressed at their Tier II	
Communication/Decision making/Systems issues/Turf	60%
Funding/Shared resources	24%
Accessing needed services	24%
Educational/School issues	20%
Parent involvement	8%

* Counties may have identified more than one issue.

Rated Effectiveness of Tier II

Of the 22 responses, on a scale of 1-5, where "1" meant "not at all effective," and "5" meant very effective, 10 CCSIs rated the current effectiveness of their Tier II as a "3," eight as a "4" and three as a "5". One CCSI rated their Tier II as a "1."

Most CCSIs said Tier II has been reasonably effective.



Fifteen (60%) of the CCSIs said they do not have a way to measure the effectiveness of Tier II, although a few said they are looking into or will develop such measures. Three responses were blank. The remaining seven responses included the following "measures":

- "Are systems fluid? Are all aware of Tier II and roles? Do we have an effective way to address barriers?"
- "County is currently involved in a federal evaluation under federal SAMHSA grant."
- "Informally via attendance at meetings and dialogue between agencies."
- "Keep placement numbers and monthly minutes; Tier II is currently completing a self-assessment tool."
- "Quality of the minutes."
- "Success in getting planning grant funds; diverting kids from inpatient placements; numbers served."
- "Surveys to families and referring workers."
- "Verbal reports, attendance at Tier II meetings, referrals, and new services developed."

Main Obstacles to Tier II

The major obstacles to Tier II success include level of involvement/ commitment, problems with effective decision-making, and unclear Tier II role.

CCSIs identified a number of obstacles to the effective functioning of Tier II. One third (8) of the CCSIs identified problems with participant involvement/commitment as the most prevalent obstacle. Other frequently mentioned obstacles included problems with effective decision-making and lack of clarity about the Tier II role (each mentioned by four CCSIs), and the amounts of time involved in meetings (mentioned by three). Actual responses from coordinators included:

- "The numbers of children to discuss has led to long meetings."
- "None that are significant, other than periodic minimal involvement of one school district."
- "Finding appropriate training opportunities."
- "Not having high county decision makers at the table on a regular basis who decide on county department policy and funding."
- "Cooperation of families."
- "Finding common ground. Finding time to organize meetings."
- "Adequate funding and conflicting state policies."
- "The loss of impact during the month as each agency head returns to their respective agency to report needs. Would like to make more decisions at the table."
- "Change over from Tier II to ISC lost track of role/mission for a little while. School involvement - superintendent. Change of Tier II coordinator."
- "Very large in scope, less operational focus."
- "In a large county the Tier II ends up being supervisors – the buy-in and participation of top level system administration is an issue."
- "Each partner in Tier II operates under different funding requirements, regulations and statutes which make it very difficult to collaborate and difficult even to be sure what is legal."
- "We are in the process of redefining role of Tier II to enhance participation in the goals of CCSI."

- "Consistent system representation to maintain continuity of Tier II work is needed. Dissemination of Tier II information to respective system staff following meetings may not be occurring. Key systems, such as OMRDD and Housing are not represented."
- "Limited participants from all the child serving agencies/programs."
- "Time; having people available for a meeting, monthly."
- "Lack of mission, goal directed meetings, clarification of roles."
- "Having a clear direction."
- "We are starting to talk more directly about how we can all support and embrace CCSI. Folks on Tier II are still trying to understand CCSI. There is not a lot of commitment from the various agencies, poor follow through and virtually no work is done between meetings by Tier II members."
- "Multiple collaborative projects in community; full commitment to project's goals by all systems."
- "Based upon history that each Tier II member has, there are different levels of knowledge and perspective on CCSI and unifying these differences is a challenge. Too limited dialogue with Tier III."
- "Our biggest challenge in a large county has been involving all the school districts in Tier II."

Main Accomplishments of Tier II

Sixty percent (15) of CCSIs said that enhanced collaboration and communication was the main accomplishment of Tier II. Also mentioned were the development of local funding commitments, educating systems regarding strength-based work, systems wide analysis of services for families with children at risk of placement and individual case intervention.

Improving the Functioning of Tier II

Twenty-eight percent of the survey respondents thought that the functioning of Tier II could be improved through broader participation, and an identical 28% felt that their Tier II could be better organized and more focused. Other comments included the following:

- "State agencies other than OMH must communicate to their local counterparts that CCSI is important and what can legally be done in a collaboration."
- "More communication with Tier III."
- "Local training regarding strength-based model and collaboration."
- "Need a budget, and more policymaking power, as well as support from County Legislature."
- "More dedicated time to issues by Tier II members."

Tier III Issues

Tier III is responsible for addressing major policy, regulatory or legislative issues that have been identified as barriers to the local implementation of CCSI. Its role is to reduce barriers, help promote a more streamlined delivery system to children and families, and help CCSI counties reduce the number of out-of-home placements. Local CCSIs were asked their perspectives on Tier III and the extent to which their CCSIs have received ongoing support from state level officials.

Issues Referred to Tier III

Twenty CCSIs said they had referred issues to Tier III. A third of the CCSIs have requested assistance with training needs. Twenty percent of the CCSIs had requested assistance with various funding issues, whether for internal CCSI needs or for "external" needs such as additional services (e.g., case management slots). A variety of other issues mentioned by respondents are listed below:

- "Difficulty around placement mandates (hospital discharge prior to readiness of alternative placement)."
- "Lack of transportation."
- "Confidentiality."
- "Requested a special education representative to speak concerning whose responsibility it is for payment of children placed."
- "Conflicting state department regulations that hinder collaboration."

- "If county saves money by reducing number of placements, the county should be rewarded."
- "Tier structure and function; philosophy issues; coordination issues."
- "Youth in need of higher placements."
- "Classification on release; managed care issues surrounding SIA and therapy."

Responsiveness of Tier III

Counties were also asked how Tier III responded to their issues. Responses were fairly evenly divided. Seven counties found the Tier III response to their inquiries to be responsive or helpful, and another seven found their interaction with Tier III to be minimally helpful, if not inadequate. "Helpful" actions included sending an appropriate form regarding confidentiality, sending a representative to the county to answer questions, and receiving grant funding.

Tier III: Accomplishments

The major accomplishments of Tier III, as viewed by about one third of all respondents, include Tier III's assistance with funding and other resources (32% of the counties), as well as the training/ conferences and technical assistance provided by Tier III (36%). Additionally, one third of the counties mentioned either general support for CCSI, or enhancing collaboration among counties as strengths of Tier III. One CCSI noted: "Tier III has found a good balance for the most part in pushing the initiative and its principles, while recognizing that each county needs to individualize its operations of it."

Tier III: Obstacles

Counties noted the following obstacles to the effective functioning of Tier III:

- "Lack of effective commitment/collaboration;"
- "Lack of communication;"
- "Turnover of staff at the state level;"
- "In the beginning Tier III had difficulty understanding their role;"
- "Change in Tier III membership/change in players, limited visitation;"

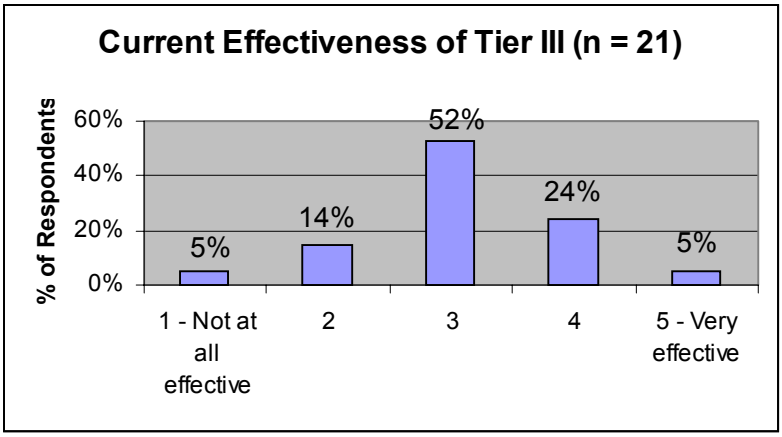
- "Inability to eliminate barriers among agencies—e.g., single planning document;"
- "Categorical funding."

One CCSI noted: "Tier III membership does not reach out enough to make significant changes in our system. They have not established funding streams to support integrative systems. There is a need to create a 'Tier 4' level to effectively create change. There have been no efforts to support legislative change or effective advocacy to support a legislative agenda."

Overall Perceived Tier III Effectiveness

Tier III is generally rated as moderately effective by the CCSIs. Main pluses include funding and training/technical assistance, with drawbacks including communications and the continuing inability to eliminate categorical funding and funding stream barriers across agencies.

On a 1 – 5 scale from "not at all effective" to "very effective," the graph below indicates that the majority rated Tier III as moderately effective, with almost 30% rating their value as better than average. On the other hand, almost a fifth of all CCSI counties surveyed rated Tier III below average in terms of effectiveness.



Improving Tier III

CCSIs felt that the functioning of Tier III would be improved through more communication and support for the CCSIs, including removing barriers at the state level. Over half (13) of the CCSIs felt that the functioning of Tier III could be improved with more communication with and from Tier III. Other suggestions for improvements included:

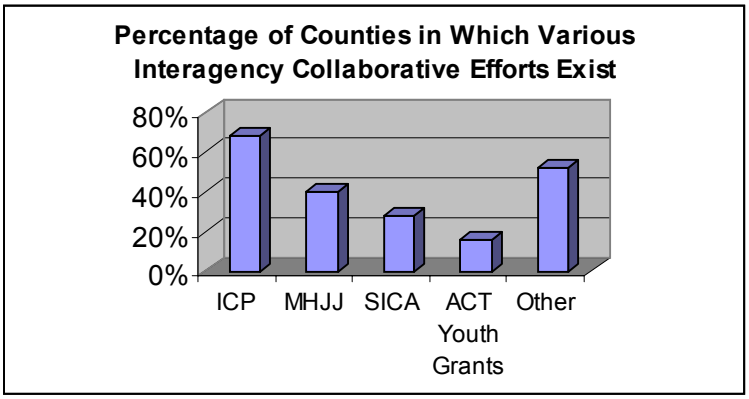
- "Work seriously to eliminate categorical funding and regulations which prevent a seamless service system;"

- "More support from Tier III's respective agencies in time and dollars;"
- "It is vital that knowledgeable and articulate family representatives be identified to participate fully in Tier III;"
- "Tier III should respond in writing in a timely way to all system issues identified to them by Tier II;"
- "Tier III should have more authority within their own systems and legislative process."

Since this project began, Tier III took the important step of hiring a statewide CCSI Coordinator to strengthen communications between Tier III and the local sites. Tier III has also assigned representatives to specific counties to assist with barrier resolution and issues affecting program implementation, continuation and expansion.

Interagency Coordination

CCSIs often operate in the context of other interagency collaborative efforts in their counties. They were asked what other such efforts currently exist in their counties, and the relationship between them and the CCSI effort. As indicated in the graph, a number of other such collaborative efforts exist in most of the CCSI counties, with ICP (Integrated County Planning) being the most prevalent.



Relationship Between CCSIs and Other Collaboratives

Fourteen counties noted a fairly significant CCSI involvement in these various interagency efforts, and often a significant overlap in membership among these efforts. Seven counties described a relatively minimal overlap between CCSI and the other interagency efforts.

Other interagency collaboratives were generally viewed as complementary to CCSI efforts.

Fifty-six percent of the CCSI counties felt that the relationship between the Integrated County Planning process and CCSI was complementary. Only one county felt ICP and CCSI were working at cross-purposes. About one-third of the counties described the Mental Health/Juvenile Justice collaboration and CCSI as complementary efforts, and a single county felt the two initiatives were working at cross-purposes. The State Incentive Cooperative Agreement (SICA) was seen as complementary to CCSI by 20% of the counties, and 12% view the ACT for Youth Grants as complementary. Most of the other counties expressed no opinion about these other entities. There was little indication that the various collaborative efforts were working at cross-purposes or were being duplicative.

Measurement of Interagency Coordination

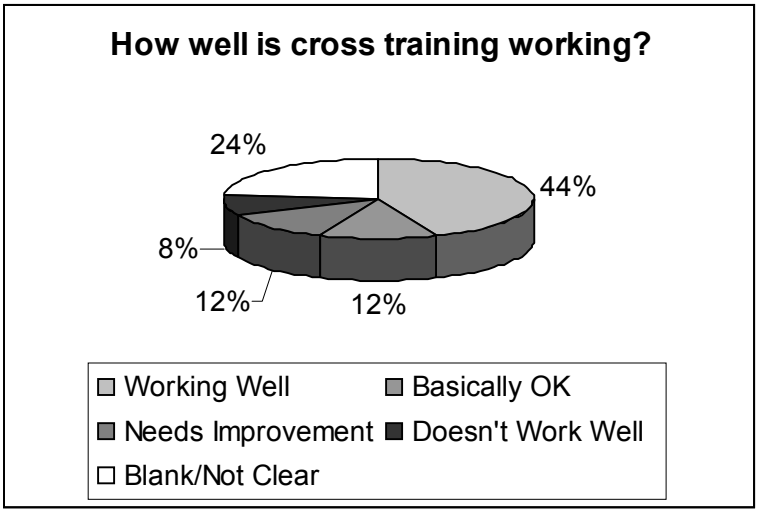
Twenty (80%) of the CCSIs said they did *not* measure interagency coordination, and four (16%) said they did—one is involved in a federal evaluation under a SAMHSA grant; one by development of individual service plans with various providers working with the family; one through system changes monitored monthly; and one on a "subjective" basis.

Tier II Support of Interagency Coordination

When asked *In what ways does Tier II support or not support interagency coordination,* more than half (11) of the CCSIs responding said that Tier II was generally supportive of interagency coordination. The others indicated that this support was evidenced though staff support or attendance at meetings. Only one CCSI specifically indicated that their county's Tier II was not supportive.

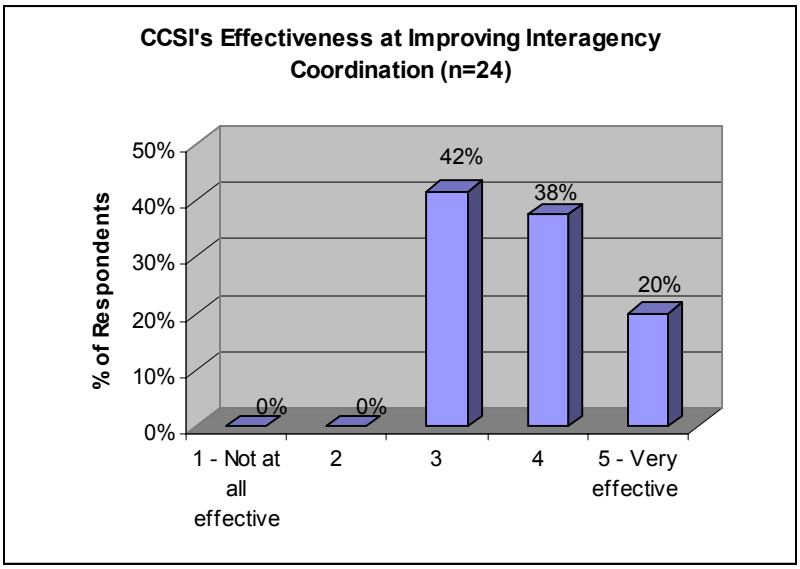
Cross Training of Staff

CCSIs were asked the extent to which cross-training exists as a result of CCSI, and how well any cross-training is working. As indicated in the graph below, almost half (44%) indicated that such training is working well, and another 12% said it is working "basically OK." Another fifth of the counties raised questions about its effectiveness and value (12% said the training needs improvement, and 8% said it is not working very well). A quarter of the counties did not respond to the question, or gave ambiguous responses.



Improving Interagency Coordination

All 24 CCSIs who answered this question rated the overall effectiveness of their CCSI in improving "interagency coordination" as at least moderately effective, with 14 of those (58%) rating that effectiveness as "quite" or "very" effective. There was one missing response.



Summary Observations and Implications

The above findings and discussions suggest the following observations and implications, which will be discussed further and related to specific recommendations in Part Three of the report:

- In many of the CCSI counties, considerable work is needed to bring local schools into the process as effective partners. Often the schools are at the table as partners at the Tier I level, but they

are typically not rated among the most effective participants. At the Tier II level, superintendents of school districts are typically not part of the process, and schools are among the least involved institutions in the Tier II process.

- Despite the CCSI focus on bringing parents into both Tier I and Tier II in more meaningful, fully-involved roles, the involvement of parents and parent advocates is not extensive in between a fifth and a quarter of the counties at the Tier I level; and in more than a third of the counties at the Tier II level, family members are not heavily involved.

- There is a reported shortage of effective discharge planning and aftercare services within CCSIs in a number of counties, particularly for those children and their families who were not served by the CCSI prior to placement. CCSI sites tend to place little emphasis on addressing aftercare issues for those being returned to the community from placement, unless there had been previous CCSI involvement with the family. In most cases, this appears to be a question of not having the resources to expand their focus to individuals and families not previously involved with CCSI. There is a willingness to consider expansion of aftercare services to help reduce length of stay for those placed without a prior CCSI affiliation, but the question of providing sufficient resources to help CCSIs take on this issue would need to be addressed.

- Few county CCSIs have effective data collection and monitoring systems in place, and there appears to be little emphasis on maintaining information systems to help effectively manage the programs or to help monitor how well the CCSIs are doing in meeting goals and performance standards. What data are maintained are typically not used systematically for management or evaluation purposes, at either the local or state levels. The counties place little emphasis on such issues, and there appears to be little guidance from the state regarding what is needed, what should be collected, how it should be used by either county or state level officials to assess program effectiveness or impact, or how it could be used as an effective management tool.

- State and local officials should be carefully considering ways CCSIs can begin to more effectively assess their performance and

track outcomes, and ways in which the state itself can use data more effectively to monitor aggregate impact across the state and across different types of programs in the future. Increasing emphasis should be placed on holding CCSIs accountable for their performance against stated goals, and for documenting performance on a regular basis. The state should be prepared to help counties in such efforts, by providing training and assistance in setting up consistent management information systems across counties.

- Accomplishments attributed to both Tiers I and II in the CCSI counties tended to focus on systems issues, introduction of family empowerment and strength-based resources, and enhanced communications and collaborative efforts, all of which are important and have significant value. But rarely did counties consider among their stated accomplishments progress against the goal of the reduction of out-of-home placements. It is not clear whether this was because they do not consider that they have made significant progress in addressing this goal, or whether they do not consider that goal to be as important as the systems change and service enhancement goals, regardless of whether or not those worthy accomplishments help lead to placement reductions.

- Counties indicated that they see little evidence that the funding restrictions and regulations of the various statewide systems are being affected in significant ways as a result of the CCSI efforts. The counties reported little evidence of significant reductions in red tape or of an increased ability to blend funding across systems, other than through the funds specifically designated for flexible funding services at the local level.

- County officials suggest that there is the need for better communications, despite the efforts of the Tier III group at the state level, between county officials and their counterparts in their oversight state agencies.

- Many counties argued strongly for the need for more action at the Tier III level, and for that body to play a more aggressive change agent role, and to be given more authority to act as needed.

8. CCSI Implementation of Core Principles

Early in Part One of the report, and in various places throughout the rest of the document, reference has been made to key core principles that are believed to characterize CCSI counties. Among these principles are the use of strength-based individualized approaches to service delivery to children and families, increased family involvement and empowerment, and use of wraparound, flexible funds to address service needs as they arise. This chapter addresses the extent to which the sample CCSI counties report that they have implemented those core principles, and with what impact.

Use of Strength-Based Individualized Care Approaches

All 25 CCSIs said they use strength-based care approaches, but to varying extents, as evidenced by these comments:

- "Approach once used by the CCSI Coordinator in handling high risk cases is now utilized across systems/agencies."
- "Assess family/youth strengths at time of referral; identify strengths in Tier I process."
- "CCSI completes a strength-based assessment with family prior to Tier I Family/Team meeting; at meeting, identify strengths, needs."
- "Use at child and family meetings."
- "County trains and uses Family Development Training and Credentialing Approach."
- "Create individualized "child and family team"/identify school and home coordinator for each team."
- "Desperately trying to use the concept."
- "Develop plan using families' strengths and needs during Tier I."
- "Family Network model based on a strength-based, individualized care approach (families very satisfied)."
- "Family advocates assist families in identifying their strengths and advocate across systems."

All CCSIs say they use individualized strength-based approaches to varying extents.

- "Generate service plan (generated at specific individual meetings with family) that parents and professionals contribute to/follow."
- "Individual Care Model, Person-centered Planning, Solution-founded therapy, FDC."
- "It's the core value which drives our entire system of care design at all levels."
- "Meet with parent and family, discuss, find supports and involve, work with family."
- "Provide training and support resources to promote strength-based services."
- "Strength-based assessment tools; utilization of parent advocate; separate individualized planning meetings, etc."
- "Team approach with the family designating the members."
- "Tier I Support Plan is based on the families' strengths."
- "Tier I meeting identifies strengths, interests and activities having success with; training on county level in development."
- "Use FDC (Cornell University) Model; all staff hold the FDS credential."

Evidence of Strength-Based Approach

Nearly three quarters (18) of the CCSIs report that the strength-based approach is generally used within the child caring systems in their counties. Training is generally offered at least once a year. Respondents offered the following examples of the role CSSI has played in implementing such approaches:

- "Team meetings with parent involvement are encouraged throughout the service community."
- "CCSI has been asked to provide strengths-based training to other county systems."
- "It is the core value that drives our entire system of care and design at all levels."
- "Much more animated discussion between agency/department staff, real interest in learning and using techniques."

- "CCSI has had a noticeable effect in enhancing the use of an individualized care approach. Most agencies train staff in this way and utilize flexible funds."
- "Strengths of families are documented within a service plan which all Tier I members sign off on. CCSI has had much influence on spreading the work about a strength-based approach."

Other respondents offered the following explanations as to why the strength-based approach was less widely used in their county:

- "We don't have the power to implement this approach elsewhere."
- "It is used in mental health only."
- "Depends upon which service agency is providing services. Training is very specific to each agency and there is not enough training going on."
- "Agencies claim to use strength-based but they don't understand the strength-based process."
- "Lots of talk—little implementation."

Training in Strength-Based Approaches

The amount, level, and breadth of training in strength-based approaches vary significantly across CCSIs, from: very sporadically, to as needed, to very consistently.

Family Development Credentialing (FDC) is most commonly mentioned as the training vehicle.

Often, the CCSI coordinator serves as the cross-systems trainer; other times, the community college provides the training. Occasionally, staff from a county department (e.g., DSS) provide the training.

Half the CCSIs engage in consistent strength-based training; others have more sporadic or non-existent training.

Half of the CCSIs are engaged in fairly consistent training efforts (at least annually, on a regular basis). Over a third of the CCSIs are engaged in fairly sporadic training efforts.

Strength-Based Service Plans

Twenty-two CCSIs (88%) said that their *CCSI service plans* reflect a strength-based individualized care approach; none said no, and three CCSIs did not respond. Fourteen CCSIs (56%) said that the *agency service plans* reflect a strength-based individualized care

approach. Four CCSIs (16%) said it did not. Seven responses were missing.

Measuring the Impact of Strength-Based Approaches

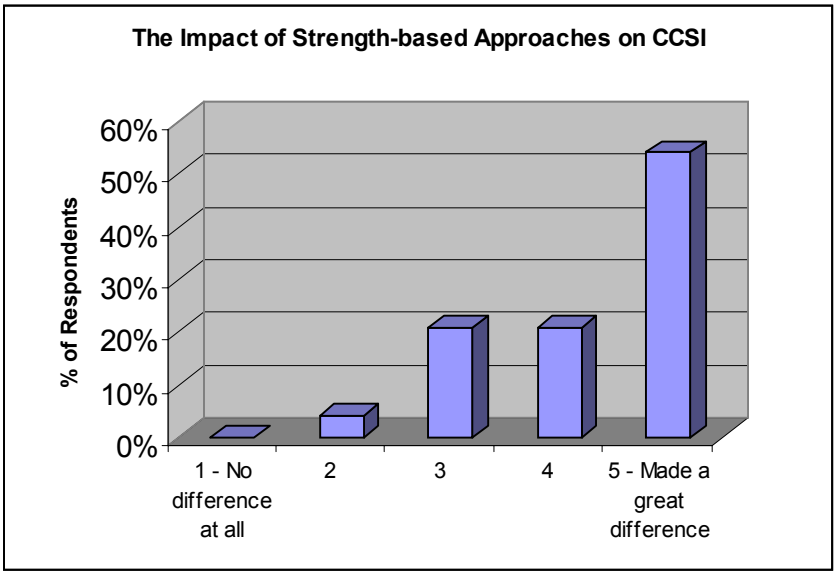
Six CCSIs said that the single most important indicator of the use or impact of strength-based individualized care approaches is the success of the family/child plan. Other measures include the enthusiasm of the Tier Is and subcommittees, case management meetings with staff, high number of referrals received, outcomes of interventions, systems changes, family satisfaction rates, and placement rates. Eight CCSIs (32%) said they have no measures of the impact of strength-based approaches.

Over half (14) of the CCSIs said there was evidence that the use of strength-based individualized care approaches has made a difference, e.g., in reducing out-of-home placements. A third of the CCSIs (8) responded "no" to this question.

However, in *explaining* what the evidence is, only six (24%) of the CCSIs said they could cite evidence that the use of strength-based individualized care approaches has made a difference in reducing out-of-home placements. Four CCSIs said the increased parent/ family involvement shows that difference. Eleven (44%) CCSIs said they did not have the evidence that strength-based approaches make a difference. Five CCSIs did not respond to this question.

In terms of how much perceived difference strength-based individualized care approaches have made in the success of CCSI, on a scale of 1 - 5, where "1" meant "made no difference at all," and "5" meant "made a great deal of difference," over half (13) rated the difference as "5," five each rated the difference as either "3" or "4", and one CCSI rated the difference as "2." Thus the perception at least is that strength-based approaches have had a significant positive impact on CCSI success, though any specific impact on reducing placements is less clear.

Most CCSIs perceive that strength-based individualized care approaches have made a significant difference in the success of CCSIs, though few could cite specific evidence of the impact on reducing placements.



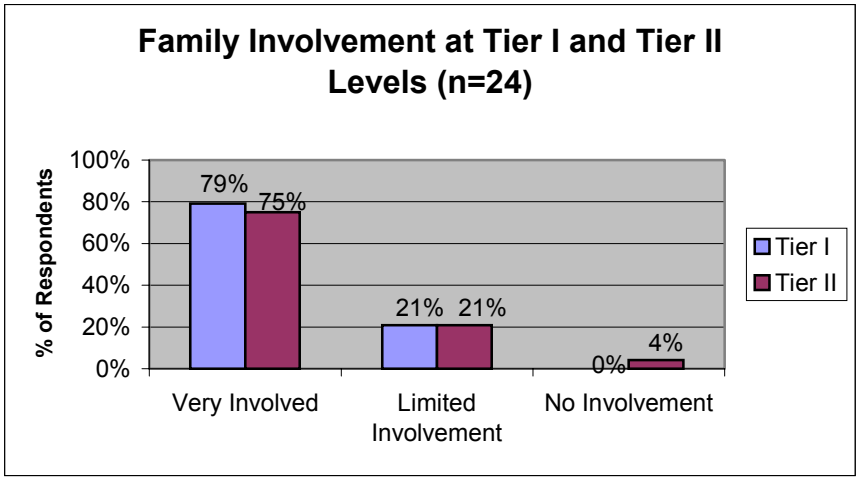
Improving Strength-Based Approaches

Seven (28%) CCSIs said that continued or expanded use of strength-based approaches would improve the effectiveness of their CCSI. Eight (32%) said that more or expanded use of training in strength-based approaches would be valuable. Specific suggestions included:

- "Have all intake forms and service plans be essentially the same, using a consistent format."
- "Stronger, improved outcome measurement tools; county buy-in."
- "Stronger connections to Tier III when all other avenues have been exhausted in an individualized care plan."
- "More family-centered approach; families reaching out to help others; increased confidence on the part of agency staff to trust parents."
- "Facilitator-led initial wraparound."

Family Involvement

About three quarters of the CCSIs characterized the involvement of families at both Tier I and Tier II levels as "very involved." Another 20 percent (five CCSIs) had some involvement and believed it could be improved.



Most CCSIs have family representatives at both Tier I and II levels, and most are very involved.

As shown in the table below, most CCSIs have between one and five family representatives on both Tier I and Tier II teams. The number in Tier I is variable in about a fifth of the sites. There are no representatives in Tier I in two counties, and none in Tier II in three of the CCSIs.

Number of family representatives:	Tier I (n=23)	Tier II (n=22)
0	9%	14%
1-5	61%	73%
6-10	4%	9%
11-15	4%	0%
16-20	0%	5%
Variable	22%	0%

Changes in Family Representation at the Tier I Level

Thirteen (52%) of the CCSIs said that family representation at the Tier I level had not changed over time, and 11 (44%) said that it had. Changes cited included increases or decreases in the *number* of family representatives, as well as changes in the *roles/involvement* of those representatives, as evidenced by the following comments:

- "Families have more positive influence."
- "Parent representatives have become more consistently available."
- "More family representatives have participated over time."
- "Experienced turnover in parent/family representatives."

- "No parent partners since 1998—no funding to cover their expenses."
- "Increased family involvement."
- "Difficult to maintain parents on Tier I—scheduling is difficult; parent commitment is a problem."

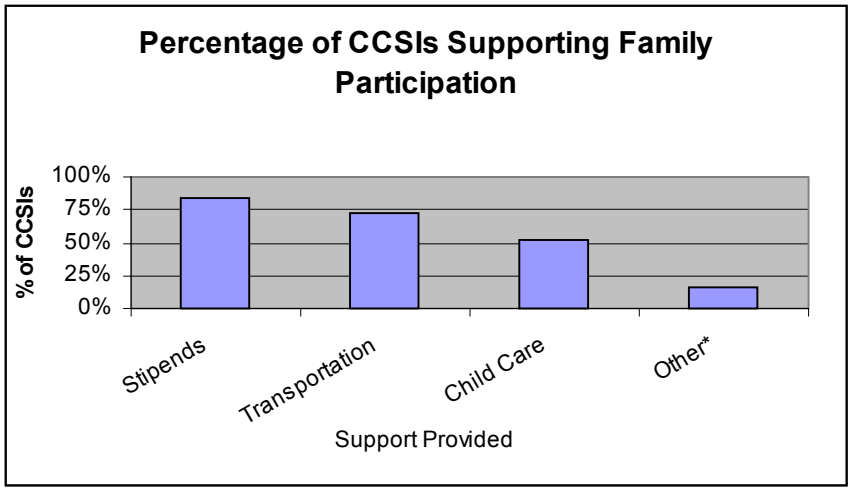
Changes in Family Representation at the Tier II level

Twelve (48%) of the CCSIs said that family representation at the Tier II level had not changed over time, and 12 said that it had. Changes mentioned about family Tier II involvement included:

- "The addition of a new parent."
- "Increased family representation; greater parent involvement."
- "Alternating parent representatives."
- "Acquired a per diem parent advocate."
- "Recruiting for family representatives."
- "Two parent advocates regularly attend Tier II meetings."
- "Experienced turnover in parent/family representatives."
- "Very limited involvement of family representatives."

Supports for Parent Participation

As shown in the graph, counties provide support for family participation in a number of ways. Around 75% of the CCSIs provide stipends and help with transportation costs, and about half provide childcare support.



*Other includes: strong encouragement and training.

Recruiting Parent/Family Participants

Nearly half (12) of the CCSIs expressed at least some difficulty in recruiting parent/family participants for Tier I and/or Tier II. Only nine CCSIs said they were having no such difficulty. Four CCSIs did not respond to this question.

CCSIs frequently have had problems in recruiting and retaining parent participants.

Difficulties mentioned included:

- "Time of meetings, feeling of powerlessness in being part of professional group."
- "Availability of parents due to work demands."
- "Much difficulty in finding advocates that can devote the time to work with these challenging families."
- "Families don't have time for long and complex meetings on a subject which they can't understand."
- "Funding, lack of motivation, commitment, and value."
- "Getting interested parents; commitment of time due to their own family needs; money for reimbursement."
- "Generally it has been hard recruiting advocates due to type of position; hard to advocate and work cooperatively with others."
- "Parents do not seem particularly invested. Scheduling is difficult. Other agencies resist/have difficulty identifying parents to be involved in these efforts."
- "Recruiting parent partners has been difficult as many of the parents do not feel they have the time or ability to handle the jobs—also schedules are different."

Most responses generally did not distinguish between Tier I and Tier II recruitment issues.

Counties were also asked to describe the ways in which they dealt with any difficulties in recruiting parent/family participants:

- "Calling parents ahead of meeting to explain the program and sending written information."
- "More training."
- "Recruitment efforts, word of mouth, with CCSI families."

- "Support, educate service providers.:
- "Working with non-profit parent agency."
- "Keep trying to educate them."
- "Having Parent Partners, not professionals, make initial contact with parents."
- "Attempt to expand budget, advertise, mailings, public speaking."
- "Advertising through newsletter, schools, word of mouth; being as creative as possible."
- "Contract with a nonprofit agency."
- "Paying stipends helps."
- "Part-time parent partners with flexible schedules."

Encouraging Parent Participation in Tier I

Sixteen CCSIs said they had done something to encourage more active parent participation in the Tier I process, and five CCSIs said they had not done anything. There were four blank responses. Responses mentioned:

- "Calling parents ahead of meeting explaining program and sending written information."
- "Send out information, written letters, phoned to follow up."
- "Having Parent Partners engage with parents on the phone before formal referral into CCSI."
- "Attempt to expand budget, advertise, mailings, public speaking."
- "Call parent and explain process of CCSI."
- "Transport parents to individualized planning meetings; meetings have been coordinated at times relevant to their availability, and childcare had been provided."
- "Proposals for full-time parent positions."

Encouraging Parent Participation in Tier II

Twelve CCSIs mentioned some things they had done to encourage more active parent participation in the Tier II process and/or expressed concern about the need to do so. Two said they had done nothing. Eleven CCSIs did not respond to this question.

- "Included the Mental Health Association in its Tier II group because MHA hired a parent who also serves as an advocate."
- "Recruitment; child care and transportation stipend."
- "Hired a full-time parent advocate—pay parent to be in all systems."
- "A Tier I advocate is paid to be there."
- "Work with Parent Advocates."
- "Agency staff discuss it with families."
- "We have been inviting parents who have had involvement with CCSI, Waiver, and ICM."
- "Stipends, childcare, and transportation are available."

Employment of Family Members

The table below shows the number of full- and part-time parent employees, by non-contract and contract basis, employed by Tiers I and II. In every instance, half to three quarters of the CCSIs indicated that no family members were employed.

	Tier I				Tier II			
	Non-contract employees		Contract employees		Non-contract employees		Contract employees	
	Total # Employed	N	Total # Employed	N	Total # Employed	N	Total # Employed	N
Full Time Staff	5	21	7	21	3	19	2	19
Part Time Staff	1	21	20	22	10	19	16	21

Paid employment has a significant impact on the involvement of family members in CCSI, but none are employed in half to ¾ of the CCSI counties.

Family members employed by Tier I or Tier II are likely to work for non-profit agencies or the county.

Nearly two thirds (16) of the CCSIs said that employment had a positive impact on the involvement of family members in CCSI, and three CCSIs said it had no impact. Six CCSIs did not respond to this question.

Positive impacts mentioned include:

- "Parents who are paid come to meetings."

- "A full-time Family Support worker enables the person to attend to the process responsibilities as well as actively participate on other coalitions/committees in the county."
- "Employed parent partners are more consistently available on a scheduled basis."
- "Very helpful to have paid full-time parent advocate; it levels out the playing field."
- "Flexibility is the key. Some want a FT job, others want to help and get paid, but can only realistically devote several hours per week."
- "It is sometimes critical in reaching parents."
- "With part-time status there is a built-in flexibility. This allows Parent Partners to take care of their children with SED in a crisis."
- "The fact that parent advocates are employed by our systems allows them to join CCSI efforts during their working hours—as do all participants."
- "The advocates are very committed to CCSI and the principles. Their employment is essential. Their time is no less valuable than anyone else's."
- "The CCSI parent advocate has stated that being a paid employee adds credibility and a sense of professionalism to the role."
- "Full-time contract is very critical to maintain family involvement."
- "A part-time position without benefits makes it hard for parents to devote enough time to CCSI."

Training Available to Family Members

All CCSIs provide some form of training for <u>paid</u> Tier I and II family members, and most offer training for <u>unpaid</u> family participants in Tier I and II activities.

Of 22 CCSIs responding to the question *What type of training is available to family members who are <u>paid</u> staff (Tier I and Tier II)?*, all said they use some form of training, conferences and/or in-service. There was no consistent pattern for the kind or amount of training used or made available. Family Development Credentialing was explicitly mentioned by five of the CCSIs.

Fifteen CCSIs mentioned the following forms of training that are available to <u>unpaid</u> family members participating in Tier I and II:

- "Mental health conferences, schools, stress reduction."
- "Various training opportunities."
- "Families receive newsletters on community resources and upcoming conferences with the understanding that if they are interested, CCSI uses wraparound for conference fees, travel, child care, etc."
- "Some workshops are available to family members."
- "CCSI conferences."
- "Offered trainings to parents and have applied for scholarships and provided transportation to their trainings."
- "Parent support group questions all participants about what they would like to be trained on and speakers come to the support groups."
- "Educational advocacy, psychotropic medications, system information."

Information about how often such training was given was generally not mentioned.

Active Involvement of Families

Twenty-one (84%) of the CCSIs said that their family representation at the Tier I level was at least "active;" 16 (64%) said it was "very active." Only one said it was not active at all.

Nineteen (76%) of the CCSIs said that their family representation at the Tier II level was at least "active;" 12 (48%) said it was "very active." Only two (8%) said it was not active at all.

Perceived Impact of Family Involvement

Most counties said family involvement made a difference in the success of CCSI at Tier I and II levels, especially Tier I.

Twenty-two (88%) of the CCSIs said that family involvement made at least some difference in the success of CCSI at the Tier I level; 16 (64%) said that it made a great deal of difference. None said it made no difference, and only two said it had made only a little difference.

Nineteen (76%) of the CCSIs said that family involvement made at least some difference in the success of CCSI at the Tier II level; 10 (40%) said that it made a great deal of difference. One said it made no difference at all, and four said it made only a little difference at the Tier II level.

Use of Flexible Funds to Support Individual Service Needs

Twenty-three (92%) of the CCSIs said that flexible funds were available for those families involved in CCSI. One said that no funds were available, and one did not respond to this question. The most frequently-noted source of flexible funds was OMH (including Community Reinvestment dollars); other sources included local youth bureaus, local DSS agencies, state CCSI, and training grants. Nineteen counties indicated the amount of flexible funding they received in 2000; the total was $286,956 (an average of $15,102 per county). As shown in the table below, the amount of funding varied significantly from county to county.

Flexible Funding Amounts in 2000	
Amount	**% of Counties (n=19)**
$1 - $5,000	37%
$5,001 - $10,000	16%
$10,001 - $15,000	11%
$15,001 - $20,000	21%
$30,000 - $40,000	11%
$65,000	5%

Not only does the amount of funding vary from CCSI to CCSI, but so also does the number of families using those funds. Of the 15 counties which provided specific numbers, two used flexible funds with 10 or fewer families; in nine of the counties, more than 30 families benefited from the use of flexible funds.

In most CCSIs, well over half of the families served received flexible funding to meet various needs.

More than 60% of 21 CCSI sites responding indicated that well over half of the families they serve have received CCSI flexible funding, including one-third of the counties in which most (80% or more of the families) benefited from such funds. Two counties reporting using flexible funding for all families served. On the other hand, about 20% of the CCSIs use flexible funding for less than half of the families they serve. Four CCSIs did not answer this question.

Range of Spending for Flexible Funding

The smallest dollar amount spent on flexible funding for a single family/child in 2000 ranged from $3.25 in one CCSI, to $100, which two CCSIs said they spent as their smallest dollar amount. The average "smallest amount" spent by the 16 CCSIs that

answered this question was $25.33. Fifteen counties provided examples of how the smallest dollar amount of flexible funding was used:

- "4H camp expense;"
- "Alarms for the house;"
- "To clean a trumpet;"
- "Family needs;"
- "Food;"
- "For child to go on field trip;"
- "Gas card used to visit hospitalized child out of town;"
- "Ice cream treat during outing with workers;"
- "Laundromat money;"
- "Movie tickets and bus passes;"
- "Prescription;"
- "Snack for a child;"
- "Taxi costs to attend Family Support meeting;"
- "Transportation."

The largest dollar amount spent on one child/family in 2000 ranged from $50 for one CCSI, to $15,000 for one CCSI. The average "largest dollar" amount (excluding the $15,000) spent on one family/child was $740.

Accessing Flexible Funds

Twenty-one (84%) of the CCSIs said they had a procedure to access flexible funds. More than three quarters of the CCSIs can access flexible funds immediately—within a day or so. Four (16%) can do so within a week.

The counties were asked to rank various services in terms of how often flexible funds were used for the particular service. The table below shows that flexible funds were most frequently used for recreational activities. While 24% of the counties reported frequently using flexible funding for respite services, as many reported never using funds for that service.

Flexible funds are used most often for recreational activities, and are also used for transportation and respite care, among many other uses.

All CCSIs reported using flexible funds for transportation at least occasionally. Flexible funds were also used for "urgent" household expenses such as clothing, lessons, furniture, groceries, and educational needs. Most of the time, flexible funds are used for one-time-only expenses, as opposed to "ongoing" expenses.

Utilization of Flexible Funds in 2000						
	Percentage of Counties					
Service:	1 (Not used at all)	2	3	4	5 (Used quite frequently)	Missing/ Blank
Respite	24%	12%	16%	4%	24%	20%
Mentor	24%	8%	28%	8%	8%	24%
Transportation	0%	12%	32%	20%	12%	24%
Recreational activities	4%	4%	20%	28%	32%	12%
"Urgent" household expenses	4%	8%	24%	28%	16%	20%
Co-pay for therapy	24%	36%	8%	0%	0%	32%

Blending of Funding Streams

Respondents were asked on a scale of 1 - 5, where "1" equals "not at all," and "5" means "very much so," to what extent their CCSI was allowed to blend certain existing funding streams into a single fund which could be used to pay for services and supports to certain children and their families. Of the 20 responses, 11 said that they were able to blend funding to some extent, with five CCSIs indicating they were very much able to do so. Four were able to do so in a very limited way. Five CCSIs said they were not at all able to do so. Comments included:

Counties have had mixed success in blending funds across systems.

- "This remains one of our biggest challenges."
- "We are making slow yet steady progress with this."

- "Same restrictions as MHC funding was burdensome, but overall no problems."
- "We have worked with ICMs and DSS to blend funds for additional community supports for our families."
- "We blend CCSI, Youth Bureau, private funds and reinvestment dollars."
- "We have only one funding stream."
- "We have blended MH reinvestment and Youth Service local county dollars to create our CCSI which funds advocates, coordinator and wraparound funds."
- "Other funding streams are never available."
- "We rely totally on reinvestment dollars."
- "Within our agencies we had different funding sources: reinvestment, spin off grants and United Way which we blend. They are all 'envisioned' as 'flexible.' We do not blend interagency."
- "Our county's flexible funds are not 'blended funding.' To date it includes SAMHSA federal grant funds. Several of our programs in our system of care have received "blended funds" from various county agencies (Youth Bureau, Mental Health and Title XX)."

Changes Needed in Flexible Funding

Eleven (44%) CCSIs said that changes are needed on the issue of flexible funds, and 12 CCSIs said no changes were needed. Two CCSIs did not respond to this question. Changes needed, according to the CCSIs, include:

- "State level agencies should include flexible funds in all future initiatives and programs."
- "Increased flexible funding is a key component to family success."
- "Unsure—our flexible funds are local monies."
- "Ability to access funds through a county procedure."
- "More agencies pooling funds; some agencies find other ways of paying."

- "More available funding sources needed."
- "More funds made available."
- "Less rigidity."
- "Funding from other agencies would help."
- "Would like to see blended funding from different systems."
- "More systems contribute (i.e., DSS, JJ) and centralize the management of the funds; develop and purchase non-traditional services such as mentoring."
- "Would benefit from state training for their systems."

Perceived Value of Flexible Funds

All but one of the 24 responding CCSIs said that flexible funding was either quite or very valuable (4 or 5 on a 5-point rating scale) to the effectiveness of CCSI. One said it was not very valuable.

Nearly all counties said flexible funding was instrumental in accessing services, breaking down funding barriers, and in contributing to the effectiveness of CCSIs.

Seventeen out of 23 CCSIs responding (74%) said that flexible funding was either quite or very valuable in helping break down funding barriers. Two said it was not very valuable, and one said it was not valuable at all in that regard.

Twenty-one (88%) out of 24 CCSIs responding said that flexible funding was either "quite" or "very" valuable in enabling families/ children to access services not otherwise available to them. One said it was not at all valuable in that respect.

Overall Perceived CCSI Impact

Twenty-one of 24 survey respondents rated their CCSI as either "quite" or "very" successful. Three rated their initiative as moderately successful (a rating of 3 out of 5), and one county did not respond to that question.

CCSIs believe they have been successful overall. Tier I interagency cooperation and use of strength-based approaches were most consistently reported as contributing to CCSI success.

The CCSIs were asked to rate various aspects of the CCSI experience in terms of their contributions to the success of their overall operation. As shown in the table on the next page, Tier I interagency coordination received the most frequently positive responses in terms of major responsibility for the success of CCSI. It is the only item or operating principle in the list that had no below-average responses from any county. Use of strength-based approaches also was considered to be a major contributor to CCSI success, but two counties felt that they had little to do with how successful CCSIs were. Also viewed as contributing to CCSI

success, though to somewhat lesser degrees, are Tier II interagency cooperation, significant family involvement in the decision-making process, use of flexible funds, and resources (funding and staffing) available to the CCSI.

County government funding support, and perceived support from Tier II and III, were viewed as having little to do with CCSI success.

Not surprisingly, given that there is relatively little of it in most CCSIs, local funding support from county government was viewed as having little to do with CCSI success. Perhaps a bit more surprising is the small amount of perceived positive impact associated with either Tier II or Tier III "support" on the success of county CCSIs. None of these three factors received a single positive vote of contribution to CCSI success.

Percentage of respondents indicating the degree to which various features contribute the success of CCSI in their county

	1 (Not Responsible	2	3	4	5 (Very Responsible
Interagency coordination (Tier I)	0%	0%	12%	20%	56%
Interagency coordination (Tier II)	4%	0%	20%	32%	40%
Use of strength-based care approaches	4%	4%	20%	12%	56%
Family involvmeent at all levels of decision making	0%	8%	20%	24%	40%
Use of flexible funds to support individual service needs	4%	4%	20%	24%	44%
CCSI budget/resource/staffing levels	4%	12%	12%	24%	36%
County government support	20%	76%	0%	0%	0%
Tier II support	24%	72%	0%	0%	0%
Tier III support	16%	80%	0%	0%	0%

Improving CCSI

One-third of the counties felt their CCSI could be improved if it had more resources; a third cited increased/more effective family involvement as a means to improve; a quarter of the counties identified increased use of strength-based approaches as a means of improvement; and 20% saw Tier III support as in need of improvement. Tier II improvement was also cited by 20%, and others noted improvements necessary in the following areas: in the way that CCSI is defined; increased county support; interagency coordination; and flexible funds. One CCSI said "all" of the characteristics listed needed improvement in that county.

Conflicts Experienced

Seven CCSIs said that turf issues were a key conflict for their CCSI. Another six identified obtaining or keeping county buy-in

as a key conflict. Funding was mentioned by five CCSIs, and four mentioned getting family involvement as a key conflict. Seven CCSIs said they experienced no significant conflicts. One mentioned that there have not been conflicts *per se*, more like apathy. "Turf" issues mentioned include:

- "Treatment and referral sources."
- "All working together and sharing information/communication—took a few years. At times service providers feel they cannot take on any more work and feel that interagency work is more work.".
- "Turf and participation—time and trust."
- "Professionals not trusting parent partners, parent partners not trusting professionals."
- "Territory—who is in charge of a case and how to deal with families who refer themselves vs. an agency referral."
- "Agencies need to work together to develop services to keep an identified child in the community. Agency willingness to take on a severe case is key. Using Tier I as a referral source."

Impediments to a Successful CCSI

Just over a quarter of the CCSIs said that lack of agency buy-in was a main impediment to a successful CCSI, and another 20% identified turf and collaboration issues as an impediment. Other impediments included: not having enough strength-based available community resources for SED children; old style case management by agency staff; lack of willingness to blend funds; reactivity of professional community to "the parent voice;" parent partners who have not been trained; perceived need for "well-groomed" parents; lack of structure; "too many chiefs not enough Indians;" parent partners trying to "fix" the situation; Tier III support does not necessarily trickle down to Tier II; school issues continue to be a concern; and people are very threatened by parent involvement.

Summary Observations and Implications

The above findings and discussions suggest the following observations and implications, which will be discussed further and related to specific recommendations in Part Three of the report.

- The strength-based approach is widely used by CCSIs, but some counties report lagging compared with what is desired. In several counties, there have been insufficient resources to train staff and parents and other community resources, and to implement the concepts as widely as desirable. It is also not clear that there is a consistent understanding of the strength-based process and concepts across the CCSIs, though there is general agreement that the idea is a good one for a community to implement.

- There is a strong perception that strength-based individualized services have a positive impact on placement reduction, but the evidence is mostly anecdotal thus far, as there are few good measures in place concerning how to determine the impact of strength-based approaches. The state Tier III group should consider working with counties to develop such measures.

- Family member CCSI involvement reaches significant levels in most counties, but it is clear that some counties have considerable work to do in recruiting, training, and making the best use of parents.

- It is difficult for many CCSIs to recruit and incorporate parents into the Tier I and II process, working closely with professionals in those capacities. Many CCSIs need to find more ways to make both the parents and professionals more comfortable working together in those situations, and more mutually respectful of each other. Specialized training may be needed for both groups to help make the working relationships more viable and productive in the future.

- Counties ideally need to find ways to pay parents as parent partners or parent advocates, so they can afford to be more consistently involved in the Tier I and II processes, and so they can have more of a professional/peer stature with other professionals at the table. Most CCSI counties are not now able or willing to hire parent staff, even on a part-time basis. It is important to consider making sure that funds are available to make this more universally possible, if the desired goals of parent involvement, empowerment and legitimacy are to become more a reality in the future.

- CCSIs are still finding that it is difficult to blend funds, other than the use of designated wraparound flexible funds. Such funds are

keys to success in many cases in working with families, but they are often insufficient to fully meet the needs, and the flexible funds available to CCSIs do not necessarily equal blended cross-systems funds. The latter remains necessary if true cross-systems service delivery is to become possible across the board.

- County government support for CCSIs, and help from the local Tier II and the state's Tier III are viewed by the CCSIs as being relatively irrelevant to the success of the CCSI operations. This suggests a need for each to re-think what it can do to become more relevant, and more supportive of the CCSI mission in various counties.

This Summary section of CGR observations and implications has been used as the concluding section of most of the preceding chapters in the report. However, in this chapter we make an exception. The observations, conclusions and advice of the CCSI Coordinators, which CGR requested and which were provided quite eloquently, serve as a far more effective conclusion to this chapter, so we close with their words.

Coordinator Perspectives

Coordinators were asked *What are the main things you have learned since becoming the Coordinator that would be helpful for other CCSIs?* We decided that, rather than summarize the responses, we would let the Coordinators speak for themselves, in the hope that their words may prove valuable and offer helpful advice to other counties and to state officials:

- "I think every county configures differently so it's hard to say. Our CCSI works because 1) the members of Tier II are committed to families; and 2) a not-for-profit agency is doing the coordinating."
- "My attempt to restructure—instituting change and helping everyone to be comfortable with that—seems to be the task at hand."
- "Communication!"

- "Training staff throughout the county needs to be a continual effort. When parents feel empowered, the whole scenario changes for the child and family."
- "Go to schools. All children are in schools and if you are truly non-adversarial, it will be received and appreciated by all."
- "It takes at least a ½-time staff person, which we do not have."
- "Parent partnering is very effective in building trust with families and empowering them. Families are more able to trust systems and engage as a team member."
- "Takes time for philosophy to become livable. Takes time for people to share resources and turf. Shared money by all who are involved keeps investment there."
- "Perseverance is key. Look for support in the short run and long run. Both planning and operations are important. Parents are equal partners. Keep looking for ways to improve your CCSI."
- "Individualized strategies – every county is different. These are critical decisions about program vs. philosophy that can only be addressed based on where each county is at."
- "The children's service system is insanely complicated. Needs continuous/ongoing redefinition. Identification of appropriate pathway/intervention … to child/family needs."
- "Parents truly are the experts, and if we listen and give them a voice, they become empowered and active members of a team. Professionals and parents judge parents. How much more I have to learn."
- "I have learned that CCSI is a powerful opportunity for service providers to address both micro and macro issues concurrently. The development of collaborative linkages, the use of mediation skills in Network meetings, the consumer empowerment movement, and the strength-based, individualized care approach are all wonderful elements of CCSI. It is a privilege to be part of such an enlightened project."
- "Make sure that you have a broad representation of staff at the Tier II level. Make sure that the area schools are involved with the CCSI process. Make sure the referred families feel that their voice

counts. Always look for the strengths and positive things in their lives and that the family can see those things also."

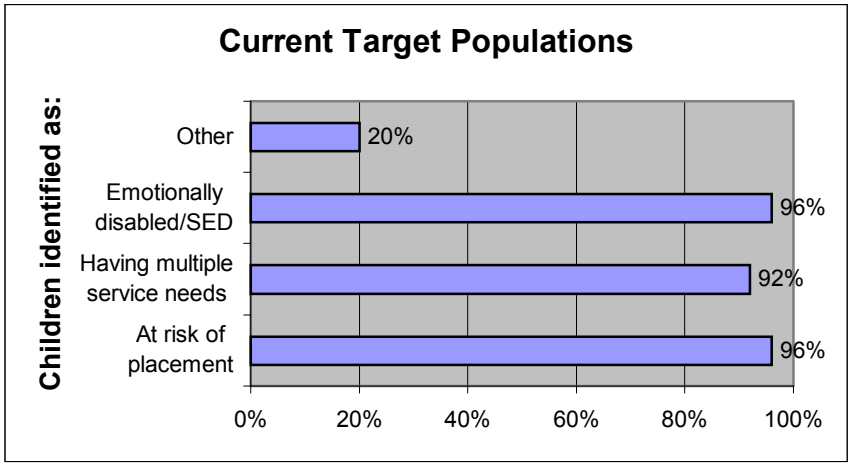
- "Don't rush into the process. Make sure everyone is on board. Get people trained, go to conferences. Learn from others how things were done and how they can be adapted to your own county."
- "1. Stay neutral during meetings. 2. Be assertive. 3. Encourage parental support."
- "Importance of having a clear mission of both Tiers I and II. Ability to monitor and measure the effectiveness of the program. Ability to meet regularly with other counties. Commitment by county in providing community-based services to children with an ongoing review of community needs and gaps. Alternatives to assist with funding."
- "Listen to families and follow through with assisting them with what they feel they need. Go slowly, softly and be kind. Include all of the members of the Tier I Family Team."
- "Take things slowly. This is a process not a program. It would be helpful if there were people from multiple agencies responsible for coordinating the efforts. Get training in from other places."
- "Few kids would need to be placed in institutions if there were comprehensive community-based services that used wraparound approaches. Need a FT Coordinator – be careful about becoming a program if you want to impact systems change."
- "Parent partners are essential to success. County support (Commissioner level) is vital."
- "Efforts MUST be supported at every level (community, families, government, state) and be guided by the CASSP principles at all times and stages of the evolution process. It is essential that all new funding and program initiatives be connected in some way to support efforts and develop a true system of care which supports families and the service community. SUSTAINABILITY is another important concept. CASSP principles should drive the system regardless of funding – and all new programs should be built on the CASSP values and commitment."

9. CCSI Target Population, Numbers Served, and Placements

Reference has been made elsewhere in this report to concerns about the accuracy and reliability of data about the CCSIs. With data caveats in mind, it is nonetheless useful to pull together in this one chapter what the surveys and other supporting documentation told us about the numbers of people and families served by the CCSI operations, what we know about their characteristics, and what happened to them while in, or subsequent to being served by, CCSI. Even with data limitations, we are confident that the data provide, for the 25 sites included in our detailed survey, a snapshot of statistical indicators that is useful for describing the profile of those the CCSI programs have served, and of what has happened to them, over the past three years.

CCSI Target Population

The vast majority of CCSIs target children who meet *all* of the following core CCSI criteria: they are at risk of placement, they have multiple service needs, and they have an emotional disability.



Virtually all CCSIs target children with serious emotional disabilities, who have multiple service needs, and who are deemed at risk of placement. Several sites indicated that the complexity of needs has increased over time.

Twenty-two (88%) of the counties have written criteria that identify the target population for CCSI. Seven counties indicated that the target population for CCSI had changed over time, though typically in ways that are basically consistent with their initial proposals. Several of the sites indicated that the target populations

have become somewhat more dysfunctional, with more complex needs, over time.

Referral Sources

The table on the next page indicates in the aggregate, across all 25 survey sites, the numbers and sources of referrals to CCSI between 1998 and 2000. In just the two years between 1998 and 2000, the number of referrals in these counties increased by 70%, from 875 to 1486. Average referrals per county over those years increased from about 44 to 65. A small portion of the increased number of referrals—about 100 in 2000—was the result of three new programs starting that year. But even if those programs are eliminated from the comparison, the growth for the CCSIs that were in existence for all three years was 58%, thereby suggesting that the CCSI sites are reaching increasing numbers of people over time.

Referrals to CCSIs increased by 70% from 1998 – 2000, to an average of 65 per CCSI site.

Over the three years, the primary source of referrals to CCSIs across the counties has been a variety of children and family service providers, mostly from the private, non-profit sector. Schools and mental health agencies have been the next largest referral sources over the three years, followed by Social Services departments, Probation, and families.

The majority of referrals have consistently come from three primary sources: a variety of children and family non-profit providers, schools, and mental health agencies. Very few referrals have come from several logical potential referral sources.

By contrast, very few referrals to CCSI have come from such potential referral sources as Family Court, MRDD, Alcohol and Substance Abuse Services, and Health Departments and other health care providers.

Referral Source	1998			1999			2000		
	Number of Referrals	% of Total Referrals	Average Referrals Per County	Number of Referrals	% of Total Referrals	Average Referrals Per County	Number of Referrals	% of Total Referrals	Average Referrals Per County
Families	71	8.1%	5.9	148	12.2%	7.8	128	8.6%	6.7
School	99	11.3%	6.6	190	15.6%	10.0	281	18.9%	14.1
Social Services	79	9.0%	5.6	125	10.3%	6.3	144	9.7%	6.5
Mental Health	130	14.9%	8.7	235	19.3%	11.8	262	17.6%	12.0
Probation	63	7.2%	5.3	71	5.8%	4.4	126	8.5%	7.0
Family Court	13	1.5%	1.2	12	1.0%	1.0	4	0.3%	0.3
MRDD	0	0.0%	0.0	4	0.3%	0.4	5	0.3%	0.4
Alcohol/Substance Abuse Services	6	0.7%	0.7	4	0.3%	0.4	5	0.3%	0.4
Health Department	10	1.1%	1.1	3	0.2%	0.3	5	0.3%	0.4
Other health care	12	1.4%	1.3	24	2.0%	2.0	47	3.2%	3.6
Family/Children Service Providers	336	38.4%	24.0	309	25.4%	18.2	365	24.6%	19.2
Other	56	6.4%	6.2	93	7.6%	8.5	114	7.7%	9.5
Total	875	100.0%	43.8	1218	100.0%	55.4	1486	100.0%	64.6

From 1998 – 2000, school referrals tripled, mental health referrals doubled, while referrals from traditional children and family service providers leveled off.

Referrals from all of the major referral sources grew substantially between 1998 and 2000, except for the largest source—the traditional children and family service providers. The numbers of referrals from those sources actually declined from 1998 to 1999, before increasing somewhat in 2000. But over those three years, that combined source of referrals dropped from 38% of all the referrals made to the CCSIs in our sample counties in 1998 to about 25% in 2000. Meanwhile, school referrals almost tripled, and in 2000 made up almost a fifth of all referrals to the CCSIs. Mental health referrals doubled during this period.

Thirteen (52%) of the CCSIs said that the overall primary characteristics of families referred to CCSI since it began operation had not changed, and 11 (44%) said they had changed. The most common reasons for the changes were that children were more at risk and had more complex needs, and that children were being referred at a younger age.

Age of Children at Referral

As seen in the table below, for those sites which provided data on age of children, the largest concentration of referrals to CCSIs has been among children and youth between the ages of 11 and 15, an age group which each year has accounted for about half of all

referrals. The largest proportionate increase during that period was among young children between the ages of 6 and 10. That group grew by 129% from 1998 – 2000, increasing from about 30% of all referrals in 1998 to 33% by 2000.

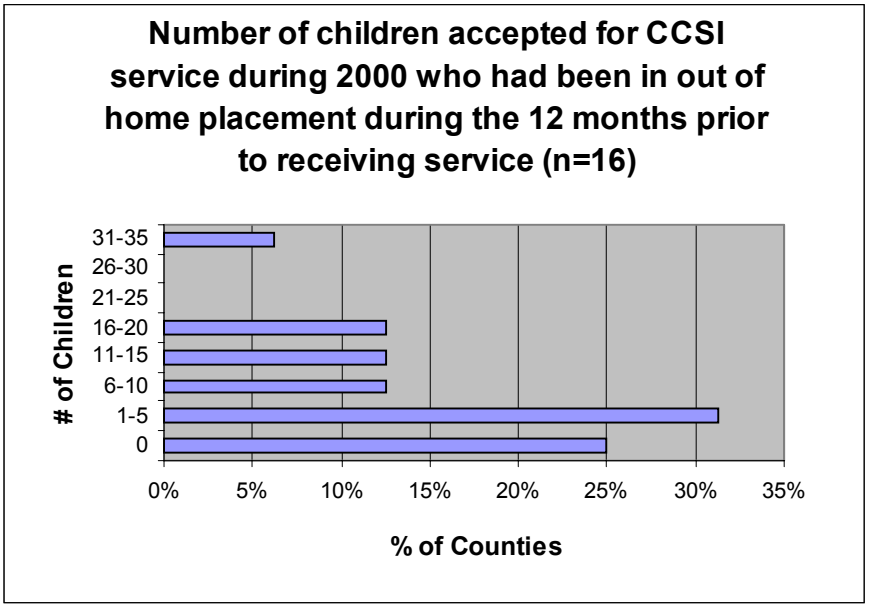
	1998		1999		2000	
Age	Total Number of Children	Number of Respondents	Total Number of Children	Number of Respondents	Total Number of Children	Number of Respondents
<6	40	12	45	18	61	20
6-10	194	13	283	18	444	20
11-15	316	13	499	18	662	20
16+	99	13	145	18	173	19

About half of all referrals to CCSI are between 11 and 15, but the biggest increase from 1998 – 2000 was among those 6 – 10.

Thirteen (52%) of the CCSIs indicated that there had been significant changes in the ages of children referred to their program since they began operation. The most common explanation given for the significant change was that younger children were being referred—seven CCSIs reported that change. Another three CCSIs said that more high school adolescents were being referred.

Children Previously Placed

The graph below indicates the number of children accepted for CCSI service during 2000 who had been in out-of-home placement during the 12 months prior to receiving services:



Most CCSIs accepted few post-placement children for services who had not previously been served by the CCSI.

More than half of the CCSI counties accepted no more than five previously-placed children, including 25% who accepted none. This would seem to be in keeping with the earlier discussion about the fact that relatively few CCSI programs provide discharge planning and aftercare support for children whom they have not previously served.

CCSI Waiting Lists

Seventeen (68%) of the CCSIs said there was typically no waiting list of families awaiting CCSI service, while seven (28%) said they did have one. Five CCSIs indicated the number of families on their waiting lists: three had waiting lists where the number of families was 8 – 13; one had 32 families on the waiting list; and one had a waiting list of 50 families.

Numbers Served and Placed

The table below shows the growth between 1998 and 2000 in the total numbers of children and families served by the CCSIs, increases in the numbers of new children and families served each year (new entrants to the program in those years), increases in the numbers of children at risk of placement, and the growth in the numbers of children actually placed.

Total (All Phases)	1998			1999			2000		
	Total Number	County Average	N	Total Number	County Average	N	Total Number	County Average	N
Familes Served	1,061	56	19	1,231	59	21	1,566	71	22
Children Served	1,244	65	19	1,494	71	21	1,971	90	22
New Families Served	639	36	18	819	39	21	1,109	50	22
New Children	820	46	18	1,118	53	21	1,404	64	22
Children At Risk of Placement	371	26	14	677	38	18	941	47	20
Children Placed	91	6	14	100	6	18	114	6	20

Changes by Year

Children and families served by CCSIs significantly increased between 1998 and 2000.

The numbers of families and children served by CCSIs (including carryovers from the previous year) increased by 48% and 58%, respectively, between 1998 and 2000. The rate of growth was even greater in the numbers of families and children *new* to the programs each year (growths of more than 70% in each category, to 1,109 new families and 1,404 new children in 2000). Those growth rates in new program participants were similar to the rate of increase in referrals to the programs, as noted above. Some of the growth was due to new programs being started, but they also reflected increases in numbers of people being served from year to

year within the same CCSI sites. Average numbers per county have increased each year as well.

Proportions of CCSI children and youth identified as at risk of placement increased dramatically between 1998 and 2000. Actual placements grew at a much lower rate, suggesting that CCSI may have helped prevent placements for some of the at-risk children.

As an indication of the view of many of the CCSIs that the programs are seeing more difficult cases, the data indicate that children deemed to be at risk of placement have become an increasingly high proportion of the children served each year (from 30% of the children served in 1998 to 48% in 2000). CCSI children at risk of placement increased by 154% in those two years (from 371 to 941). During the same period, children *actually placed* also increased (from 91 to 114), but at a much smaller rate of growth (+25%) than the at-risk growth rate. This suggests that alternative services available through CCSI may have helped prevent placements that might otherwise have been expected for some of the at-risk children. Indeed, *the proportion of children placed (as a percentage of the at-risk totals) was much lower in 2000 (12.1%) than it was in 1998 (24.5%)*, as indicated in the table on the next page.

Changes by Phase

Phase 1 CCSIs serve the largest number of at-risk youth, but have the lowest placement rates. The most recent CCSIs serve the fewest people, with the highest placement rates.

The table below presents similar data to that presented above, for 2000 only, but organizes it by counties by funding phase. Shown this way, the data indicate that the largest programs, in terms of numbers served, were the Phase 1 counties. The more recent CCSIs, funded in Phase 4 or later, are serving only a fraction of the number of children and families as the earlier sites, which is not surprising given their startup status and the fact that they tend to be smaller counties in the more recent funding cycles. But what is of greater interest is the fact that in the Phase 1 and 2 counties, which were initially among the counties with especially high placement rates, the proportions of at-risk children served by CCSIs who were placed are substantially lower than the placement rates for the more-recently-funded sites.

Year 2000	Phase I			Phase II			Phase III			Phase IV+		
	Total #	County Average	N	Total #	County Average	N	Total #	County Average	N	Total #	County Average	N
Families Served	576	**115**	5	236	**59**	4	647	**72**	9	107	**27**	4
Children Served	787	**157**	5	258	**65**	4	782	**87**	9	144	**36**	4
New Families Served	564	**94**	6	157	**39**	4	324	**36**	9	64	**21**	3
New Children Served	732	**122**	6	191	**48**	4	394	**44**	9	87	**29**	3
Children At Risk of Placement	411	**82**	5	175	**44**	4	252	**32**	8	103	**34**	3
Children Placed	24	**5**	5	15	**4**	4	46	**6**	8	29	**10**	3

Placement rates for Phase 1 and 2 CCSI counties were significantly lower in 2000 than in 1998, compared with consistently much higher rates for more-recently-funded CCSIs.

The data presented below suggest dramatic changes from 1998 - 2000 in placement rates in the different CCSI implementation phases. The changes are almost suspiciously dramatic (and are influenced by significant shifts in individual counties), but even if there are questions about the data, they are consistent enough across counties to suggest strongly that CCSI placement rates declined dramatically between 1998 and 2000 in Phase 1 and (to a lesser extent) Phase 2 sites—and that Phase 1 and 2 sites have put into place practices that seem to be having an impact in reducing placements from what they might otherwise have been, *at least for those they serve.*[7] By contrast, the CCSIs funded in more recent years—which, as noted above, have typically had fewer resources and have therefore presumably been able as a rule to offer less comprehensive alternative services—have not as yet been nearly as able to stem the tide of placements among at-risk children.

Percentage of At Risk Children Served by CCSI Who Were Placed in Residential Care (by Phase)			
	1998	**1999**	**2000**
Phase I	30.7%	11.8%	5.8%
Phase II	10.8%	11.7%	8.6%
Phase III	18.7%	20.3%	18.3%
Phase IV+	NA*	12.7%	28.2%
Total	24.5%	14.8%	12.1%

* Note: Data not presented, since only one county in 1998.

Possible Reasons for Changes

Some of the CCSIs which experienced significant changes in numbers of at-risk children and in rates of placement offered some possible explanations, including:

- One county indicated that several Family Court judges had placed children in secure facilities without giving CCSI a chance to work with them;
- One county received a federal SAMHSA grant which allowed it to expand service capacity;

[7] A reminder that these data apply only to those children and youth actually served by the CCSIs. For a discussion of the impact on placements systemwide, for all children and youth, whether served by CCSI or not, see Chapter 10.

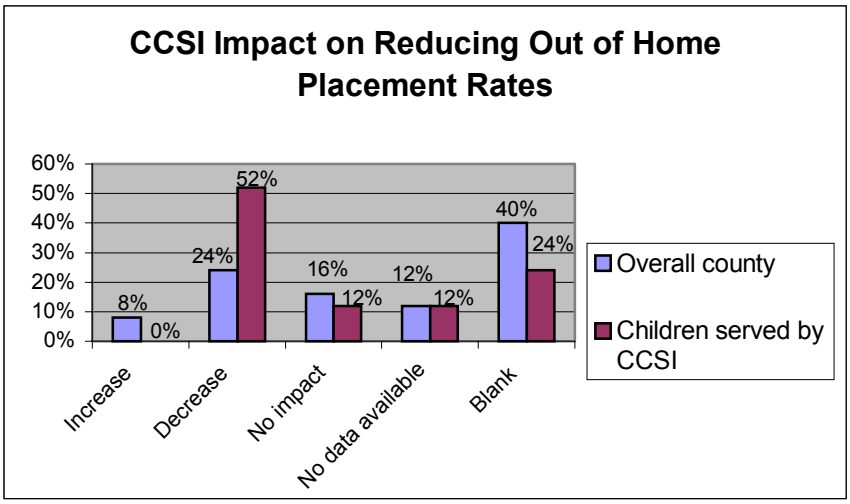
- One mentioned more accurate monitoring of statistics on families who refused or were unreachable and did not participate in CCSI; the referral process was streamlined;
- One works with the family while the child is in placement to make the return home with support a speedier process;
- Project has become more focused on children deemed certain to be placed without significant intervention;
- Some families carry over from one year to the next;
- The information was not tracked; information was extracted from the review of annual reports.

Perceived Impact on Placements

Most CCSIs believe they have helped reduce placement rates among youth they've directly served. However, substantial proportions were unable to comment and/or had no data on the impact of their CCSIs on placement rates.

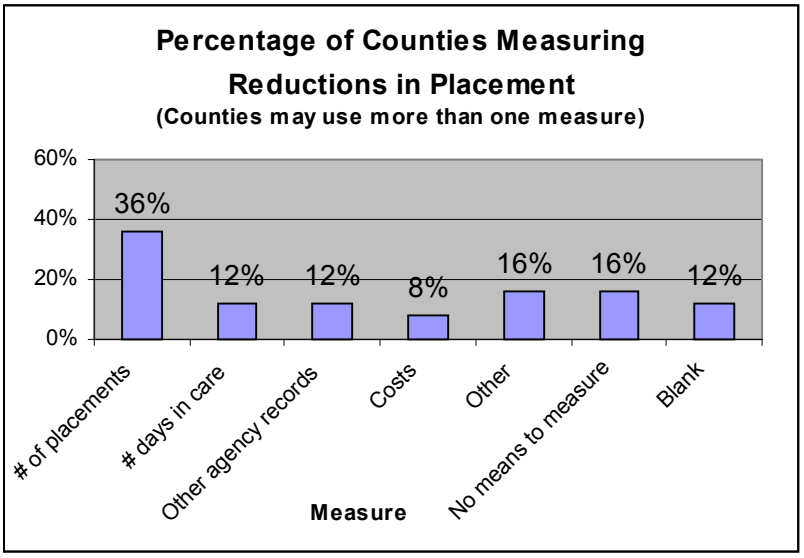
CCSIs were asked: W*hat impact has CCSI had on reducing the overall county out-of-home placement rate, and on the placement rate of children served by CCSI?* More than half (52%) indicated that they'd observed a reduction in placements among children served by their CCSI (perhaps a conservative estimate, given the above data), and 24% indicated that their CCSI had helped reduce the overall county placement rate. Another 24% said the CCSI had had no impact on the countywide rate, or that the rate had increased.

Perhaps just as significant as their perceptions is the fact that more than half of the respondents did not comment, or said no data were available, related to overall county placement rates. Furthermore, more than a third of the CCSIs (36%) weren't able to comment and/or had no data on the impact on placement rates even of the children they had directly served.



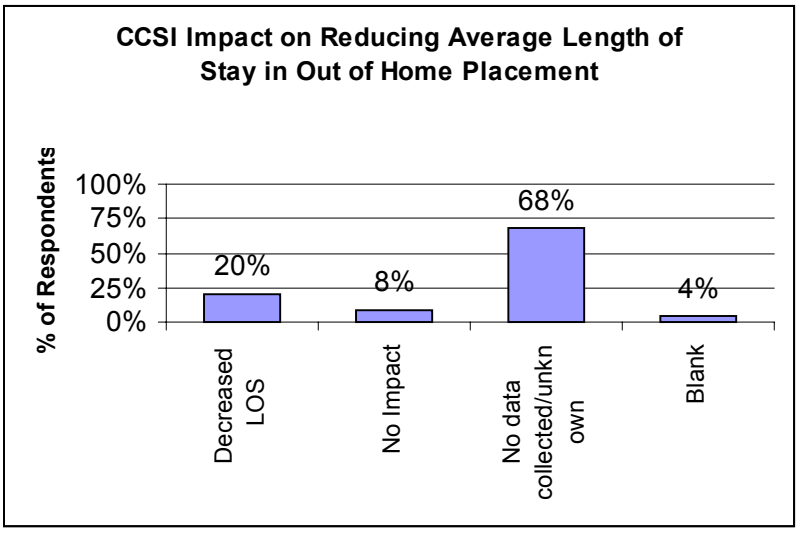
Measuring Reductions in Placement

Just over a third (9) of the CCSIs said they measured "reduction in placements" by the actual number of placements. Three said they used number of days in care or in placement as the measurement. Four CCSIs said they had nothing in place for this kind of measurement, and three did not respond to this question.



About 2/3 of the CCSIs had no way to measure their impact on length of stay in placement settings.

When asked to comment on CCSI's impact on reducing the average length of stay in out-of-home placements, more than two thirds of the CCSIs (17) said they did not collect data on, or were unable to measure the impact of CCSI on, the length of stay in placement for those served by CCSI. Five CCSIs (20%) said that their CCSI had an impact on the length of stay for children served by them. Two said there was no impact on length of stay.



When asked about annual savings resulting from reductions in institutional placements, ten CCSIs were able to provide a dollar estimate of annual savings associated with keeping children out of institutional placement. Savings estimates ranged from $40,000 to $75,000+ per child, with six counties in the $60,000 - $74,999 range. A few counties estimated actual annual savings, ranging from about $450,000 to as much as $2.9 million a year. However, there is no way to independently verify the numbers and assumptions underlying those figures. Half (12) of the CCSIs either did not know or did not answer this question. One respondent said, "this is not our focus."

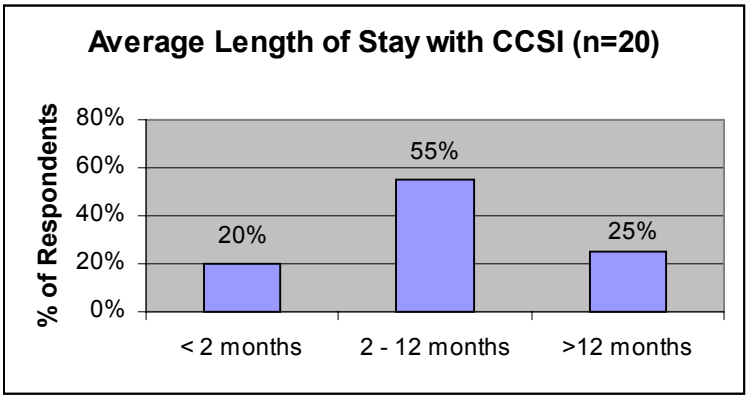
Average Length of Time within CCSI

The average length of time a person receives services from a CCSI is less than a year, with six to nine months typical.

Most of the CCSIs provide services for children and families for a year or less, as shown below. In a fifth of the CCSIs, children remain in the program for an average of less than two months, but more typical is six to nine months. About a quarter of the programs have average program stays of more than a year.

Eleven counties (52% of those responding) said that since their CCSI began, they have seen *no* change in the "average length of time in program" among the families they serve. Ten (48%) counties said that the length of time within the program *had* changed, and cited the following as contributing factors:

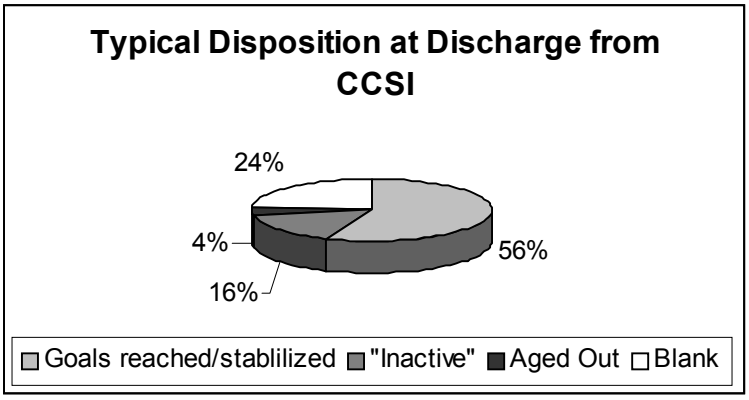
- "The process evolved from a single meeting to longer-term involvement (involvement as long as multiple services are needed and in place);"
- "As we have developed and grown, families, schools, and community agencies refer to us more frequently, and families tend to stay with us for a longer period of time;"
- "At this time, CCSI generally does not serve in the capacity of case manager;"
- "CCSI process has changed;"
- "Degree of need for collaboration determines length of stay;"
- "Families remain more connected due to newsletter, educational advocacy, care coordination; the county has showed increased dedication to the process. Families stay in contact longer than Tier II had envisioned;"
- "It has shortened as we've improved access to flexible services that meet the needs of our families;"
- "More meetings are needed with the higher risk kids;"
- "Families have greater needs;"
- "Only serving families for one year;"
- "Pick families up earlier with younger children;"
- "We have worked to shorten the length of follow-up."



Disposition at Discharge

Over half (14) of the CCSIs said that children/families are "discharged" from their CCSI when goals have been reached and

service is no longer needed, when the child/family is stabilized, and/or when the service plan is working. "Not discharged" can also mean being placed on an "inactive" list.



Summary Observations and Implications

The above findings and discussions suggest the following observations and implications, which will be discussed further and related to specific recommendations in Part Three of the report:

- The target population of CCSIs has remained constant over time—SED, multiple service needs, and at risk of placement—though several sites report that target populations of children and families have become more dysfunctional over time, with more complex needs to be addressed.

- The numbers of referrals to CCSIs have increased substantially over time, suggesting that sites are more visible and/or more aggressive in reaching more at-risk youth in their respective communities. Referrals have increased particularly from schools and mental health agencies. Although remaining the largest sources of referrals, traditional children and family service providers (typically non-profit agencies) have referred a smaller proportion of children in 2000 than they did two years earlier, perhaps suggesting the need to re-educate providers in those agencies. In addition, significant opportunities exist to expand outreach/recruitment efforts to such potential resources as Family Court, alcohol/substance abuse providers, MRDD providers, Health Departments and other health care providers that so far have made very few referrals to CCSIs throughout the state.

- Although about half of all CCSI referrals from 1998 to 2000 were in the 11-15 age group, the biggest proportionate increases during those years were in the 6 – 10 age range. The number of younger children referred to CCSIs increased by 129% in just two years. More emphasis may be needed to assure that appropriate community-based services exist in sufficient numbers to meet the needs of younger children in their respective communities.

- Data indicate that there is a need for increased emphasis on—and increased resources devoted to—aftercare services to help reduce lengths of stays in placement facilities.

- As the numbers served by CCSIs have increased significantly in just the past three years, the numbers and proportions of children identified as at risk of placement have increased at an even faster rate. However, the proportion of those at-risk children and youth actually placed out-of-home has declined substantially during the same period of time, suggesting that the CCSI approach and alternative services available through CCSI may be helping to prevent placements.

- The CCSIs serving the smallest number of children/youth, and typically with the smallest number of staff and resources—for the most part the newest CCSIs—also typically have the highest placement rates. They may just need more time to settle into their routines and ways of doing business within their respective communities, but they may also need more staff resources and increased community-based services—and more training and technical assistance from state Tier III agencies—to have the type of impact the older and larger CCSIs appear to be having.

- Substantial proportions of CCSIs remain unable to determine what impact they are having on reducing placement rates or average length of stay in their counties, or even among those children/ youth they serve directly. CCSIs must increasingly be able to document the impact they are having, and the state should work with the counties to develop the capability of measuring impact—and then should hold the counties accountable for reducing placements and lengths of stay while placed. Many, and perhaps most, of the CCSIs appear to be having such impact, but better data are needed to make such pronouncements more definitively in the future.

- The average amount of time children spend in CCSIs is less than a year in most sites, and is typically between six and nine months. However, in a quarter of the CCSI counties, the average program stay is more than a year. CCSI sites report that no data are available within counties or at the state level to document what effect if any the amount of time spent in CCSIs has on subsequent placement reduction and/or reduction in the length of time a person spends in placement. Such data should be maintained, monitored and analyzed in the future to help determine if specific types of services, and how long they are offered, has any determinative effect on placement reduction and/or on other outcomes.

10. Analysis of Countywide Placement Data

Chapter 9 presented data from the survey of CCSI sites indicating that they are serving significantly more children and youth each year, and that the numbers of those children who were at risk of placement increased from 1998 – 2000. The CCSI site-specific data also indicated that the total number of those youth who were actually placed increased at a much slower rate than the rate of increase in number of at-risk youth—and that the overall proportion of all at-risk youth served by CCSIs who were placed outside the home had been reduced by about half during that time. Those data are encouraging and suggest that the CCSIs and the alternative services they help make available may be helping to prevent placements, at least among those directly served by the more established CCSIs.

This chapter broadens the placement discussion to examine *overall countywide placement rates across all placement systems, regardless of whether the youth were served directly through the CCSI process or not.* Such analyses help assess whether the overall systems change goals of CCSIs—the strengthening of the infrastructure and integration of services to children and families across service delivery systems—have resulted in placement reductions for *all* children and youth within a county, whether or not they came through the CCSI system. If CCSIs have been successful in implementing core CCSI principles and strengthening the overall approaches used in delivering services to children and youth and their families across their respective communities, it could be hypothesized that overall placement rates throughout CCSI counties should be lower than what those rates would have been in the absence of CCSI's efforts—and that those placement reductions would occur across the board, even for those youth not directly served by a CCSI program.

Analytical Approach

In order to test such hypotheses and assess the overall placement impact of CCSIs, CGR obtained data from New York State on the numbers of placements by system (DSS/Child Welfare, Division for Youth/Juvenile Justice, Office of Mental Health, and State

Education Department), by county, from 1993 - 1999. These placement data provide a "snapshot," based on the number of children/youth in placement as of September of each year through 1998, and as of December for 1999. For most of the four systems, data were also available for 2000, but since 2000 data were not uniformly available for all systems, the analyses were limited to the 1993 – 1999 years.

CGR also obtained census data by county for 1993 - 1999 that shows the estimated number of persons under age 21 by county for each of these years. Using those population data, placement rates per 1,000 children/youth age 0 - 20 were calculated for each county, for each placement system, and for the total of all four systems. The detailed data tables are included in the Appendix, with summary tables presented throughout this chapter

To put the data that follow in context, it should be noted that out-of-home placements in New York State disproportionately involve children and youth living in New York City. While 40% of all state residents under the age of 21 live in New York City, 55% of the placements involve NYC youth. By contrast, about 35% of the population age 20 and younger live in the 17 Phase 1 and 2 CCSI counties, which accounted for only 28% of total placements in the state in 1999. Phases 3 and 4 counties (exclusive of NYC) accounted for 19% of the youth population, vs. 13% of the placements.

In the following discussion and tables, out-of-home placement totals and rates for the different CCSI phases are compared for the years 1993 (the earliest year for which placement data were available for each county), 1996 and 1999 (the most recent year for which there is complete available data for all four reporting placement systems: DSS/CW, DFY/JJ, OMH, and SED). These three points in time were chosen because nearly all Phase 1 and 2 CCSIs became operational in 1993 and 1994, and the Phase 3 and 4 CCSIs became operational in 1997 and later, thus allowing for observations about pre- and post-CCSI changes that occurred between 1993 and 1999, and 1996 and 1999. It should be noted that references to Phase 4 counties in these analyses exclude New York City, which is broken out separately in all subsequent analyses because of its disproportionate effect on the data.

CCSI Impact on Placements

The following summary table shows the *total number of children in congregate care placement for all four systems combined* in 1993, 1996, and in 1999, and the percentage change for various groupings of counties:

Total Congregate Care Placements					
	1993	1996	1999	Percent Change 93--99	Percent Change 96-99
Phases I and II	3,440	3,480	3,477	1.1%	-0.1%
Phases III and IV	1,498	1,567	1,688	12.7%	7.7%
Rest of State (w/o NYC)	433	462	489	12.9%	5.8%
New York City	6,377	6,091	6,948	9.0%	14.1%
NYS Total	11,748	11,600	12,602	7.3%	8.6%

Note: For this and subsequent tables, Phase 3 and 4 counties are exclusive of NYC.

CGR also compared *rates of placements* standardized for population. The following table shows the total number of children/youth in placement (across all four systems) per 1,000 population under age 21.[8]

Rates of Congregate Care Placement per 1,000 Children under Age 21					
	1993	1996	1999	% Change 93--99	% Change 96-99
Phases I and II	1.90	1.91	1.95	2.5%	1.7%
Phases III and IV	1.52	1.58	1.73	13.6%	9.7%
Rest of State (w/o NYC)	1.28	1.36	1.48	14.9%	7.9%
New York City	3.14	2.94	3.36	6.8%	14.3%
NYS Total	2.27	2.22	2.44	7.3%	9.9%

* Percent change is based on calculations from Appendix Tables

As indicated in the tables, the numbers and rates of placement in CCSI Phase 1 and 2 counties remained relatively stable between 1993 and 1999, in contrast to the other groups of counties, which showed substantial increases in both numbers and rates of placement during those years. For example, in two-thirds of the non-CCSI counties, placement rates increased during those years.

[8] The complete tables showing the number of placements by county, for each year between 1993 and 1999, and the rates of placement for those years, are provided in the Appendix.

Phase 1 and 2 CCSIs have helped to stabilize the numbers and rates of placement during years when increased placements were the norm in most of the counties in the rest of the state.

The Phase 1 and 2 counties started in 1993 with the highest placement rates of all the groups of counties (not including NYC), which is consistent with the fact that the only counties eligible for the initial rounds of funding were those with the highest numbers or rates of placements. They continued to have the highest rates in 1999, but the composite Phase 1 and 2 rate had increased only marginally since 1993, compared to the rates in Phase 3 and 4 counties, NYC, and the remaining non-CCSI counties in the rest of the state—all of which had increased substantially in the intervening years. Thus, although CCSIs in the Phase 1 and 2 counties cannot be said to have caused substantial reductions in aggregate numbers of placements in their counties, it seems fair to conclude that they have helped to stabilize the numbers and rates of placements during years when increased placements were the norm in most of the counties in the rest of the state.

The positive impact of Phase 1 and 2 CCSIs in their counties' overall placement rates, compared to other counties, is consistent with the reported impact on placements for those children *directly served by the CCSIs*, as discussed in Chapter 9. The apparent reduction in rates of placement among increasing numbers of at-risk-of-placement children and youth served by CCSIs in those counties appears to have prevented what otherwise would have been significant increases in their *countywide* placement rates reflected in the two tables above.

By contrast, the placement record for CCSI Phase 3 and 4 counties is decidedly less positive in the aggregate. Placement totals and rates both increased over time, and even though the rates of growth were lower from 1996 through 1999 than from 1993 through 1999—suggesting some impact associated with the introduction of the initiatives in those latter years—the reality is that their placement totals and rates increased more rapidly between 1996 and 1999 than in the non-CCSI counties, in the aggregate. On the other hand, as indicated in a section below, there are some more encouraging signs when these data are examined county by county.

It should also be noted that, despite the re-instatement of New York City as a Phase 4 CCSI county, the placement rates in NYC were dramatically higher in 1999 than they had been in 1996.

However, to be fair, the new CCSI effort in NYC had not been in effect long enough to have had any impact on overall placement rates by 1999.

The next two sections focus in more detail on the differential impact on out-of-home placements of CCSIs in Phase 1 and 2 counties, vs. the impact in Phase 3 and 4 sites.

Impact on Phase 1 and 2 Counties

As indicated above, Phase 1 and 2 counties clearly showed more favorable changes in the overall number of placements than the rest of the groups in the state: a 1.1% increase in the number of those in placement from 1993 to 1999, compared to a 12.7% increase in placements for the Phase 3 and 4 counties, and a 12.9% increase for the rest of the state excluding New York City. Between 1996 and 1999, the Phase 1 and 2 counties actually experienced a *decline* of 0.1% in the number of placements, compared to an increase of 7.7% for the Phase 3 and 4 counties for this period, and an increase of 5.8% for the rest of the state excluding New York City.

A more accurate measure of what happened to placements is to use *rates* of placement, standardized for population, as shown in the above tables. When standardized for population (rates of placement per 1,000 population under age 21), the rate of placement (for all four systems) for Phase 1 and 2 counties increased 2.5% from 1993 to 1999, and 1.7% from 1996 to 1999—compared to much higher increases for all other groups of counties during those years.

Phase 1 and 2 counties have clearly, in the aggregate, stabilized placement rates compared to the rest of the state. However, the effect was not uniform, as eight of the 17 Phase 1 and 2 counties actually increased placements since 1993.

However, the overall favorable effect was not uniform across the Phase 1 and 2 counties. In both 1993 – 1999 and 1996 – 1999 comparisons, nine of the 17 Phase 1 and 2 counties accounted for the decrease in placements for that period. The other eight Phase 1 and 2 counties actually experienced an overall 19.7% increase in the number of children/youth placed between 1993 and 1999**.** By way of comparison, nine of the 23 Phase 3 and 4 counties (excluding New York City) experienced a decline in the number of placements between 1993 and 1999, and 13 experienced an increase (one remained unchanged). For the rest of the state for this period, excluding New York City, only five of 17 non-CCSI counties experienced a decline in the number of placements. New

York City experienced a 9% increase in its placements between 1993 and 1999.

As suggested above, Phase 1 and 2 counties had a total rate of placement for all four systems (1.90 per 1,000 children and youth under 21) that was 25% higher in 1993 than the rate for the Phase 3 and 4 counties in that year (1.52), and 48% higher than the rest of the counties, excluding New York City (1.28). By 1999, the total placement rate for Phase 1 and 2 counties (1.95) had increased slightly, but at a lower rate of increase than in the other counties. For example, by 1999, the Phase 1 and 2 1.95 rate of placements per 1,000 had decreased to 13% higher than the rate for the Phase 3 and 4 counties (1.73), and 32% higher than the rest of the counties, excluding New York City (1.48). So, while not conclusive, there are strong suggestions that CCSI has played an instrumental role in narrowing the gap in the *rates* of placement for Phase 1 and 2 counties, relative to other counties in the state.

Impact on Phase 3 and 4 Counties

While the evidence for the impact of CCSI on Phase 3 and 4 counties is not as manifest, there are suggestions that CCSI has made at least some marginal impact on those counties, given their shorter experience with CCSI, and given that these counties already had lower rates of placement than Phase 1 and 2 counties in 1993 and 1996.

In the aggregate, the Phase 3 and 4 counties showed a 7.7% increase in the total number of placements from 1996 – 1999, compared to a decrease of 0.1% for the Phase 1 and 2 counties for that period, and a 5.8% increase for the rest of the state excluding New York City. Their rate of placement increased by 9.7%, from 1.58 per 1,000 children/youth under age 21 in 1996, to 1.73 in 1999. The rest of the state excluding New York City increased 7.9% from 1996 to 1999, from a rate per 1,000 of 1.36 to 1.48.

But there is evidence to suggest some impact from initiating CCSI in these counties. Thirteen of the 23 Phase 3 and 4 counties showed reductions in placements and rates of placements from 1996 – 1999, compared to only 6 of the 17 non-CCSI counties. Moreover, three of the 23 counties disproportionately account for the relative increase in placements and rate of placement for the Phase 3 and 4 counties during this period; the remaining 20 Phase 3 and 4 sites actually showed an overall cumulative *reduction* in

placements of 6.6% from 1996 – 1999. Finally, eight of the Phase 3 and 4 counties showed increased numbers of placements from 1993 to 1996 (i.e., pre-CCSI), and then dramatically reversed those numbers, showing often-substantial reductions in placements in the period following the introduction of CCSI.

Despite aggregate and program-specific data that suggest that Phase 3 and 4 CCSIs have had relatively little impact on placement rates, countywide placement rates suggest that CCSIs may have had some positive impact in a number of counties, though more research is needed to determine the causes of placement reductions.

Overall, then, there are some reasons to believe that CCSI may have had some favorable impact on overall county placement rates, even in Phase 3 and 4 counties during their relatively brief history. This is particularly intriguing since the data in Chapter 9 indicate that most Phase 3 and 4 counties have not been particularly successful in reducing placements even for those they have served directly. It may be that at least some of the Phase 3 and 4 efforts have been able to have some overall impact by helping to change systems, even if not impacting as effectively on their own directly-served youth. Or, it is possible that the countywide placement reductions in some of these counties may have had little or nothing to do with CCSI efforts. Regardless, it is likely that any impact in Phase 3 and 4 counties may be able to be expanded if more resources are directed in the future to those typically-understaffed CCSI sites.

This is another example of why an ongoing effort is needed in each CCSI county to track program impacts on placement rates over time and against services provided, both for those served directly by the program and for those in the countywide placement system who are not served directly by CCSI.

Impact by Placement System

While to this point we have focused on the impact of CCSI on the total number and rates of placements for the four systems combined (DSS/CW, DFY/JJ, OMH, and SED), there is a great deal of variation in the impacts across the various systems, as described below and indicated in the tables on the next page.

DSS/CW Congregate Care Placements					
	1993	1996	1999	% Change 93--99	% Change 96-99
Phases I and II	2,232	2,154	2,270	1.7%	5.4%
Phases III and IV	779	856	1,077	38.3%	25.8%
Rest of State (w/o NYC)	255	273	353	38.4%	29.3%
New York City	4,374	4,178	4,838	10.6%	15.8%
NYS Total	7,640	7,461	8,538	11.8%	14.4%

DFY/JJ Congregate Care Placements					
	1993	1996	1999	% Change 93--99	% Change 96-99
Phases I and II	471	429	516	9.6%	20.3%
Phases III and IV	239	236	245	2.5%	3.8%
Rest of State (w/o NYC)	55	65	55	0.0%	-15.4%
New York City	1,317	1,231	1,416	7.5%	15.0%
NYS Total	2,082	1,961	2,232	7.2%	13.8%

OMH Congregate Care Placements					
	1993	1996	1999	% Change 93--99	% Change 96-99
Phases I and II	136	192	176	29.4%	-8.3%
Phases III and IV	71	70	75	5.6%	7.1%
Rest of State (w/o NYC)	21	34	36	71.4%	5.9%
New York City	221	208	228	3.2%	9.6%
NYS Total	449	504	515	14.7%	2.2%

SED Congregate Care Placements					
	1993	1996	1999	% Change 93--99	% Change 96-99
Phases I and II	601	705	515	-14.3%	-27.0%
Phases III and IV	409	405	291	-28.9%	-28.1%
Rest of State (w/o NYC)	102	90	45	-55.9%	-50.0%
New York City	465	474	466	0.2%	-1.7%
NYS Total	1,577	1,674	1,317	-16.5%	-21.3%

Child Welfare Placements

DSS/Child Welfare placements typically account for from one half to two-thirds of all congregate care placements across counties, ranging from 23% to 100% for individual counties during 1993 – 1999. In *absolute numbers*, the Phase 1 and 2 counties experienced by far the greatest impact on Child Welfare placements relative to the other counties. Child Welfare placements increased 1.7% between 1993 and 1999 for Phase 1 and 2 counties, from 2,232

placements in 1993 to 2,270 in 1999. In comparison to this small increase, there were large double-digit increases in numbers of Child Welfare placements in all other groups of counties examined during those years. For example, DSS/CW placements for Phase 3 and 4 counties increased 38% from 1993 to 1999, from 779 in 1993 to 1,077 in 1999, and placements increased 38% for the 17 non-CCSI counties in the rest of the state excluding New York City, from 255 in 1993 to 353 placements in 1999. New York City placements increased by 11% during those years.

Phase 1 and 2 CCSI counties have consistently been most likely to hold the line in limiting Child Welfare placement increases, compared to double-digit increases in placements in all the other groups of counties in the state.

Between 1996 and 1999, the patterns were similar, with Phase 1 and 2 counties showing much smaller rates of increases compared with other counties—though the differences between Phase 1 and 2 sites and other counties had begun to narrow somewhat since 1993. Clearly, however, Phase 1 and 2 counties have consistently been most likely to hold the line in limiting Child Welfare placement increases, compared to all the other groups of counties in the state. As noted above, all the other groups show large double-digit increases from 1996 through 1999, compared to the 5% increase in placements for Phase 1 and 2 counties. As an example, there were reductions in DSS/CW placements from 1996 to 1999 in only four of the 17 non-CCSI counties.

State Education Placements

Placements initiated through the State Education system account for about 12% to 15% of all congregate care placements in the state (except in NYC, where only about 8% are State Education placements; excluding NYC, the proportions in other counties average just over 20% a year). State Education placements in general have declined substantially across the state since 1993, and that is true in more than two-thirds of all counties, regardless of whether CCSI sites or not. New York City is the only major category in which there has been little change between 1993 and 1999. There have been substantial numerical reductions in placements in CCSI counties in all phases (between 1996 and 1999, reductions from 705 to 515 in Phase 1 and 2 counties, and from 405 to 291 in Phase 3 and 4 sites), but those reductions cannot be attributed to the unique impact of CCSI, as the greatest *proportionate* reductions (50% from 1996 – 1999) have actually occurred in the 17 *non-CCSI counties*, although the actual numbers are small in those mostly small, predominantly rural counties.

There have been substantial reductions in the numbers of State Education placements in CCSI counties, but proportionate reductions were even greater in non-CCSI counties.

Mental Health Placements

Mental Health system placements only account for about 3% – 7% of total placements, although the percentage varies by county. To the extent that CCSI has had any significant impact on the reduction of placements in OMH facilities, it appears to have happened primarily among Phase 1 and 2 counties, since 1996. Following a big increase in numbers of Mental Health placements in those counties between 1993 and 1996, MH placements declined by 8% between 1996 and 1999, while the numbers of such placements were increasing for all the other groups of counties for this time period. Mental Health placements declined in 11 of the 17 Phase 1 and 2 counties since 1996, with no change in a 12th county.

MH placements in Phase 1 and 2 counties declined by 8% between 1996 and 1999, while such placements increased for all other groups of counties.

Juvenile Justice Placements

Division for Youth/Juvenile Justice placements account for about 13% – 20% on average of all placements, ranging from 0% to 33% across individual counties. CCSI appears to have had little or no impact on reduction of juvenile justice placements, especially in the mostly larger Phase 1 and 2 counties. There has been little change since 1993 in numbers of juvenile justice placements within Phase 3 and 4 counties. In Phase 1 and 2 counties, following a decline between 1993 and 1996, the number of juvenile justice placements increased by 20% between 1996 and 1999 (from 429 placements to 516). During that period of time, the only group of counties showing significant reductions in juvenile justice placements were the non-CCSI counties, with a 15% reduction from 65 to 55 placements. This may be an area where CCSIs need to be conscious of making increased efforts to seek referrals in order to have greater impact in the future.

CCSI appears to have had little or no impact on reduction of juvenile justice placements, especially in the mostly larger Phase 1 and 2 counties, where placements have increased 20% since 1996.

Caveats

The preceding data and observations about impact need to be interpreted with some caution:

- CGR was not able to obtain information on placement system capacity, i.e., the total number of "congregate care beds" available for the state, and whether there was any change in this capacity over time. Placements and rates of placement can be affected by the availability of congregate care beds for placement.
- We also do not know the extent to which all counties have been successful in developing or expanding community-based services during this time period for "hard to serve" children. The

availability and effectiveness of such services would presumably have an impact on out-of-home placements.

- CGR does not have objective evidence of the extent to which all CCSI counties actually targeted "hard to serve" children/youth, i.e., those at highest risk of placement. CCSI sites indicated the numbers of children and youth identified by counties as being at risk, but CGR has no way to independently verify the data.

- The favorable impact of reductions in placements and in rates of placement for Phase 1 and 2 counties may also reflect in part the fact that they have higher rates of placement than most other counties, and therefore perhaps more opportunities or more latitude to affect placements compared to the other counties with lower rates of placement.

- It is not known whether, for whatever reasons, there is some "target" or desirable rate of placement in each county, below which it becomes especially difficult to influence further reductions. The fact is that, even though Phase 1 and 2 counties showed favorable impacts on the numbers of children/youth placed, and in the rates of placement, by 1999 their total rate of placement of 1.95 per 1,000 children under 21 remained 13% higher than the total rate of placement for the Phase 3 and 4 counties, and 32% higher than the total rate of placement for the rest of the state (non-CCSI counties) excluding New York City. This was during a period in which the total rates of placement were increasing more rapidly for the non-Phase 1 and 2 counties.

- Finally, these are fairly short periods of time for comparison, and many of the CCSIs experienced (and continue to experience) significant "start-up" challenges. It is not clear when the effects of CCSI efforts should show up in countywide placement rates. There is no way to know definitively what would have been the numbers and rates of placement in the absence of CCSIs. Nonetheless, despite the above caveats, *it seems reasonable to conclude that CCSI may have at least helped contribute to the modest impact on placement rates suggested above.*

Savings

Has CCSI saved the state and its counties money? Some of the county CCSIs reported savings, but the realistic simple answer to

this question is, it is not possible to know for sure, for a number of reasons.

It is known that at least $7.1 million in CCSI-specific grants were spent on CCSI operations between 1993 and 2000. However, statewide data were not available to CGR concerning the total additional funding from other sources such as Community Reinvestment and local county contributions. Survey data indicate that at least an additional $3.75 million in such funds were spent between 1998 and 2000 in just the sample survey counties. A simple cost-benefit analysis would need to show that the total amount of money saved in placement costs through CCSI interventions had exceeded the total cost of funding CCSI from 1993 – 1999. But no such total cost figures are available.

A cost-benefit analysis would need to show that the total amount of money saved in placement costs through CCSI interventions had exceeded total costs of funding CCSI and alternative services. But no such total cost figures are available.

Moreover, since children/youth diverted from placement would surely be using community-based services for at least some period of time, some assumptions would need to be made about the cost of those services, based on the amount and length of time each child was receiving service. In short, it is certainly not the case that the amount saved for a child diverted from congregate care placement is a simple sum of the average cost per day/year for that congregate care placement avoided, as some counties have calculated. Those figures, even if accurate, must be compared with actual costs of CCSI plus alternative services to have meaning.

Furthermore, while there are some indications that CCSI has impacted the number and rate of congregate care placements, it is not possible to quantify the impact of CCSI with the available data. The data on the number of placements averted directly due to CCSI are incomplete. There are no objective, independent data available on whether children referred to and served by CCSI were in fact at risk of placement, although presumably most were. But perhaps the biggest gap in data, from the perspective of calculating savings resulting from placement reductions, is the absence of data concerning how long on average children/youth placed in each of the systems stay in congregate care placement. Without such length-of-stay data, it is impossible to calculate cost savings in a reliable fashion. CGR attempted to obtain such information at several points during the study, but was unsuccessful. Finally,

information was not available from the counties on other variables that may have impacted numbers and rates of placements, but which would not be directly attributable to CCSI: e.g., the introduction or expansion of various community-based services.

This combined lack or incompleteness of information again argues for the routine collection, analysis, and publication of relevant comprehensive data for CCSI regarding placement rates, length of stay, and data on both for both CCSI and non-CCSI children and adolescents. In addition, data are needed on the total costs of CCSI and any related community-based services used with CCSI youth. Absent this information, the question of costs savings attributable to CCSI will remain an unanswered one. Such information must be collected consistently by counties and aggregated at the state level.

Summary Observations and Implications

The above findings and discussions suggest the following observations and implications, which will be discussed further and related to specific recommendations in Part Three of the report:

- Overall, there is substantial evidence that CCSI has had some impact, on balance, in preventing placements among at-risk youth. Data from CCSIs presented in the previous chapter on placements averted among children served directly by CCSI programs seems to be fairly consistent with countywide placement data in indicating that Phase 1 and 2 CCSI counties have helped to stabilize the numbers and rates of placements during years when increased placements were the norm in other counties.

- Even among Phase 3 and 4 counties, despite their limited resources and staff (compared to Phase 1 and 2 counties), there is evidence that overall placement rates have declined in many of those counties, though more research is needed to determine how much of a role CCSI actually played in those reductions. It is likely, however, that the addition of full-time staff and other resources in some of the understaffed Phase 3 sites in particular would be likely to expand the impact of those CCSIs.

- The fact that very few of the non-CCSI counties have showed any reduction in placements since 1993 suggests that they could benefit by the introduction of CCSI principles and processes. It is true that these are mostly small counties with relatively few total

placements (typically about 500 or less in any given year across all non-CCSI counties—less than 5% of the total placements for the entire state). Thus it may not always make sense to invest in full-fledged CCSIs in those counties, but shared arrangements with neighboring counties may make sense, such as the Warren/Washington combination.

- The fact that there has been little impact in CCSI counties, especially the Phase 1 and 2 sites, on reducing placements in the juvenile justice system suggests that CCSIs should make a conscious effort to educate Probation and Family Court decision-makers concerning the potential value of CCSI, and should more aggressively seek referrals from those sources in the future.

- Much better data are needed to track placement reductions and to determine whether CCSIs have saved counties and the state money. The state needs to play a key role working with the counties to establish a consistent, reliable process for doing so.

PART THREE: IMPLICATIONS AND RECOMMENDATIONS

The focus of Part Two of this report was on the presentation of data about various aspects of CCSIs throughout the state. The data have presented a "snapshot" of the current status of CCSI implementation, as well as suggesting how CCSIs have evolved since their initiation in several counties in 1993.

At the end of each of the chapters in Part Two, following the presentation of the data, CGR included a concluding summary section of observations and implications. In those concluding sections, CGR attempted to summarize and interpret the major themes that emerged from the data in each respective chapter, and to reflect on what the data might mean for CCSIs and their communities in the future. Throughout the report and those discussions, we have attempted to show both the very real strengths of the CCSIs as they have been implemented in various ways in counties throughout the state, and also the areas in which improvements are needed in the future to build on CCSI strengths and make the initiatives more effective in the future.

CGR encourages the readers to revisit those summary reflections as an introduction to reading this concluding Part Three of the report. In Part Three, many of the themes discussed throughout the report are tied into a final summary discussion of conclusions and implications in Chapter 11, followed by a presentation in Chapter 12 of CGR's specific recommendations for consideration by county and state officials.

11. Final Discussion and Conclusions

CGR has been impressed by the Coordinators' enthusiasm, passion, commitment to the CCSI philosophy and process in the midst of quite challenging circumstances. As one respondent noted: "The children's service system is insanely complicated. It needs continuous and ongoing redefinition."

CCSI as an Evolving Process

The CCSI Initiative is clearly a work in progress, and continues to evolve. Note that 23 CCSIs became operational or obtained CCSI funding between 1997 and 2000, so a significant number of them are still in a relative startup phase. That is important to note for this report, because the survey results reflect the responses of everyone who responded, including 14 of the 25 responding who received state funding and began operations in 1997 or later. CCSI is clearly still evolving and growing, and CGR's discussion and recommendations should be seen in that light.

CCSI is not a single, consistent approach. It is indeed less a program than it is a philosophy or process.

The results of CGR's assessment of the status of CCSI show that the Coordinated Children's Services Initiative cannot be described as a single, consistent approach common to all counties. It is indeed less a "program" than it is a "philosophy" or "process." This reality is reflected in a number of ways:

- It is reflected in the significant variation among the CCSIs with regard to all of the dimensions which are intended to undergird the CCSI philosophy—interagency coordination, use of strength-based individualized care approaches, family involvement at all levels of decision-making, and the use of flexible funds.
- It is reflected in the variety of reasons for which counties originally applied for CCSI funding.
- It is reflected in the different Tier I service approaches and functions.
- It is reflected in the diverse roles and composition of Tier I and Tier II among the CCSIs.
- It is reflected in what CCSIs consider to be their main accomplishments.

- It is reflected in the importance attributed (or not) to reduction in out-of-home placements.
- Indeed, it is reflected in the "philosophy" with which the CCSIs characterize themselves.

This underlying notion of the CCSIs as a philosophy or process is both a blessing and a bane. The Initiative shows both the strengths and shortcomings of not being a traditional "program." On the one hand, it is locally driven, proceeding at each locality's pace and needs, thus avoiding the drawbacks of a prescriptive approach, "one size fits all." CCSI has clearly allowed counties the flexibility to respond to the issues surrounding out-of-home placements in ways that are suitable for them, rather than through a single "cookie cutter" approach. Indeed, there are many reasons to support a notion of CCSIs as a "laboratory" of experiments, some of which work, some of which don't, but all of which are shared with the others.

There is value to the CCSI "non-cookie cutter" process approach. However, the CCSI philosophy must be able to document its impact on improving outcomes.

On the other hand, the lack of a single common approach that characterizes all CCSIs makes it difficult to assess the impact they have, i.e., the difference they are intended to make in their communities—and may perversely jeopardize the financial and political support they need to survive and be successful. Ultimately, CGR's judgment is that there is value to the CCSI "non-cookie cutter" process approach which has evolved. However, it is also our observation that CCSIs can continue to be a viable philosophy and process only to the extent that they can demonstrate that they are in fact making some intended difference in improving outcomes in their communities as a result of their efforts.

Have the CCSIs Been "Successful"?

CCSI has two primary stated "goals:"

Goal #1: Reduction of out-of-home placement rate of children with serious emotional disturbances; and

Goal #2: Development of local structures of decision-making groups which support the principles of CCSI, namely interagency coordination, use of strength-based individualized care approaches, family involvement at all levels of decision-making, and use of flexible funds to support individual service needs.

While these are the "two" goals of CCSI, Goal # 2 and its supporting principles are actually *instrumental* to Goal #1, to reducing the rate of out-of-home placements. More directly, from a purely practical survival perspective, CCSIs are not likely to survive and prosper if they were to show progress *only* with interagency coordination, use of strength-based individualized care approaches, family involvement at all levels, and use of flexible funds—*unless they can at the same time show a positive impact in reducing out-of-home placements*. Reductions in placements need not be the only measure of the value of "systems change" through interagency collaboration, but it surely must be an important measure of whether the time and resources involved in interagency collaboration do result in the value for which they are intended.

Individual case conferencing and systems change roles of CCSIs are complementary; both must occur in order for placement reduction to occur and for CCSIs to be successful.

One of the consistent themes of CCSI over time has been a kind of dichotomy of purpose: Are the CCSIs primarily engaged in individual cases and case conferencing to affect the placement of individual cases, and/or are they primarily engaged in "systems change" through interagency collaboration? The conclusion from this study is that CCSIs are typically engaged in both. Indeed, neither "approach" by itself can really be effective or successful without a substantive engagement with the other.

Consider: in responding to what they consider to be the main accomplishment for Tier I activities, almost three quarters (18) of the CCSIs said that their *main* accomplishment involved family empowerment and/or helping families overall, and 60% (15) of the CCSIs said that enhanced collaboration and communication was their main accomplishment. Ten CCSIs identified *both* of these areas as their main Tier I accomplishment. While these accomplishments are not unrelated to reducing out-of-home placements, it is striking that "reducing out-of-home placements" is not on the radar screen for stated accomplishments of nearly all Tier Is.

There are many promising findings suggesting that CCSIs are successful, but the counties and state must be more intentional about objectively assessing their impact in the future.

Finally, and very importantly, there continues to be insufficient consistently-analyzed data to support any overall objective conclusions about the ultimate "success" of CCSI. The results of CGR's survey show that very little data are collected on a consistent basis, at either the local or state levels, and what is collected is rarely monitored or analyzed on a systematic basis, or

used as a management tool to make program improvements. Although this assessment turned up many promising findings suggesting CCSI successes, CGR—and more importantly the state and counties—continue to be left with too little objective empirical documentation, and too much anecdotal evidence, of the impact that CCSIs are having in their communities. Existing data collection efforts which the state has implemented are important, but they need to be refined to incorporate data on length of stay in placements, total CCSI costs, data on both CCSI and non-CCSI placements, etc.

Goal #1: Reduction of Out-of-Home Placement Rate of SED Children

Available data suggest that CCSIs have contributed to stabilizing or lowering placement rates, but more consistent tracking of impact is needed to draw definitive conclusions.

How successful have CCSIs been in reducing out-of-home placement of children with serious emotional disturbances? As the analysis of the placement data shows, *on average,* the Phase 1and Phase 2 CCSIs have been more successful than the other counties in stabilizing out-of-home placements since their inception. And there is some evidence that suggests that with appropriate expanded resources, CCSIs funded in subsequent phases could also be more successful in reducing placements. But the overall data present a mixed picture. CGR is not in a position to conclude definitively that reductions in placements can be attributed primarily to CCSI efforts, although available data suggest that many CCSIs have contributed to lowering placement rates, at least for those served directly by the CCSIs, and perhaps even on a community-wide basis in a number of counties. But clearly, more consistent ways of monitoring the impact of CCSI efforts on placement reduction are needed in most counties, and at the state level as well.

Goal #2: Development of Local Structures of Decision-Making Groups which Support the Principles of CCSI

The CCSIs have generally been quite successful in the development of local structures of decision-making groups which support the principles of CCSI. More than half of the CCSIs said that interagency collaboration was a strength of their model. Important—and ongoing—strides continue to be taken in the development of these local structures. Some counties have had longstanding interagency collaborative efforts; others are just in the early stages of getting started. In any event, in the development of local structures of decision-making which support the principles of CCSI, and in the development of the underlying components—interagency coordination, use of strength-based individualized care approaches, family involvement—there is no

CCSIs have generally been successful in the development of local structures of decision-making which support the principles of CCSI.

single "template" to follow. CCSI continues to be a learning process for all involved. And of course that argues for having a more systematic way to evaluate and share what is "working" across the CCSIs.

Use of Strength-Based Individualized Care Approaches

All 25 CCSIs said they use strength-based care approaches, but to varying extents. There is significant "unevenness" of the breadth and depth to which such care approaches infuse the various parts of the CCSIs.

Family Involvement in Decision-Making

Generally, CCSIs continue to make important strides in involving families/parents at Tier I and Tier II levels, but the record is uneven. CGR has noted that considerable work still remains to be done in some counties to get parents to the table in effective roles. A third of the CCSIs cited the need to improve the ability to increase and make more effective use of family involvement in the future. For the most part, however, the CCSIs find that effective family involvement is a powerful dimension of what they are about.

Use of Flexible Funds to Support Individual Service Needs

To some extent, the promise of "flexible funding" exceeds the current performance. Nonetheless, CCSIs find that the use of flexible funding is an integral part of their philosophy, and that it is generally quite valuable in enabling families to access services not otherwise available to them. A number of CCSIs are struggling with obtaining the necessary funding to broaden the use of flexible funding in the future.

12. RECOMMENDATIONS

The recommendations which are presented in this concluding chapter are offered for the consideration of both county and state officials. They are based on the assumption that CCSI is a viable model that should be continued and strengthened. But the recommendations are also based on the assumption that CCSI is—and must continue to an even greater extent in the future to be—a partnership between the state (and state agencies) and the counties. The key overriding assumption is that for CCSI to work, to meet its promise of success, and to meet its goals in the future, the partnership on which CCSI is built must be nurtured and strengthened by both the state and CCSI counties in a way which continues to allow for local flexibility, but at the same time provides even stronger support from the state.

For CCSI to work and meets its goals, there must be a strengthened partnership between the state and counties. The partnership implies specific contributions from each, and specific quid pro quos.

At its core, such partnership implies, as recommended below, that the state needs to continue to provide strong consistent financial support for CCSI counties—support which can be relied upon by local governments on an ongoing basis—as well as such things as increased training and technical assistance provided by the state to local CCSIs, the development by the state of policies and regulations which support CCSI principles, and blending of funding streams. In return, the state should hold counties accountable for performance against measurable outcomes. In particular, counties should be able to document that their CCSIs are having an impact in reducing out-of-home placements in their counties and/or that they are having other desirable outcomes associated with stated CCSI goals. The state in turn has a responsibility to work with counties to develop the capacity to measure such outcomes and to track and analyze them over time, and to use them as a management tool to make improvements in CCSI operations. Counties should also be expected as part of the partnership effort to provide strong governmental leadership in support of CCSI principles, as well as making a financial contribution to CCSI operations, which most counties are not now doing.

With these overall assumptions in mind, CGR offers a number of specific recommendations for building on the existing strengths of

CCSIs and improving their operations and impact in the future. In addition to the recommendations which follow, the reader is also encouraged to review the Summary Observations and Implications sections at the end of most of the preceding chapters. Those sections, in addition to referencing some of the recommendations which follow, also include other suggestions and recommendations which should be viewed as supplementing and being complementary to those highlighted below:

Impact of CCSI

- Overall, CGR recommends that each CCSI, in conjunction with and with full support of Tier III at the state level, focus more on what *impact* the CCSIs want to make, and various methods to determine whether they are in fact having that impact. CGR recommends that this impact *primarily,* but not exclusively, be determined by the impact on reducing out-of-home placements—the number and rate of placements, combined with the length of stay in out-of-home placements. Other measures might focus on such issues as school performance and suspensions, reduced juvenile justice involvement, etc.

Data collection

- CGR recommends that all CCSIs should establish a consistent management information system whereby they collect and report comparable data on a consistent basis—at least annually—that would allow a basis for determining and comparing the impact of the CCSIs. These data should include demographic information on children/families served by CCSIs, standardized measures or definitions of "hard to serve" for the children/families served, services received and length of time in CCSI programs, case dispositions, placement and length-of-stay data, etc.

  CGR includes the notion of standardized measures or characteristics of "hard to serve" in order to be able to determine the extent to which CCSIs are dealing with comparable children/families.

- More consistent data definitions and guidelines are clearly needed. It is clear from the survey that numerous different approaches are used in the various counties to define "at risk," placements averted, costs saved, etc. The state needs to work with the counties to develop clear, consistent definitions and guidelines for use in data collection and analyses. State agencies should be available to provide training and technical assistance for counties

needing help in establishing data systems and determining how best to track and analyze the data.

Common Assessment Instrument

- CGR recommends that the CCSIs develop or adopt a common "assessment instrument" to assess the likely risk of placement for children/families referred to CCSI. An initial analysis should be made of what assessment instruments are currently in use by the various CCSIs, and which of these could be more widely adopted (or adapted).

Relationship with the County Government

- CGR recommends that whether officially part of county government or not (e.g., public or non-profit lead agency), each CCSI should have a strong relationship with the highest elected officials of the county (and with heads of such key departments as Department of Community Services/Mental Health and the Department of Social Services). While CGR is not recommending that all CCSI lead agencies be *part* of county government, we are recommending that CCSIs develop and maintain a strong relationship with the county government in order to be as effective as possible. This might include consideration of the model used effectively in several counties whereby a county government agency contracts with a community-based service provider to be the CCSI lead agency, thereby helping maximize strengths of both governmental and non-profit lead agency approaches.

- The necessary continued funding for CCSI—as well as the continued effectiveness of "interagency coordination" and the effective involvement of various county departments and community service providers—are all highly dependent on the strong support of the county government. This support should include a level of financial support from all CCSI counties as an indicator of their commitment to the concept.

Training

- In addition to the previously-mentioned training related to data-related issues, CGR recommends that there be consistent training across CCSIs in the use of strength-based care approaches. While most CCSIs do say that they use these approaches, there is considerable variability across CCSIs, particularly with its use across agencies and systems.

- Training for parents/parent advocates is now inconsistently available across the CCSIs. Since parent involvement is a critical dimension of CCSI, it is important that appropriate training be

consistently available for parents involved in CCSI, in ways that are not now in place.

- There is also value in initial and ongoing training specifically for the CCSI Coordinator in the various roles that person must play.

- In addition, training and orientation are needed in many counties with various key officials to heighten their awareness of the values of CCSI. In addition, training with key service provider professionals would be helpful in many communities, both to help them understand and work with CCSI, and to help them work effectively with parents and parent representatives. These types of training would significantly enhance CCSI operations.

Technical Assistance for "New" and Ongoing CCSIs

- CGR recommends that basic technical assistance (TA) be provided to all newly-designated CCSIs, and indeed on an ongoing basis. Two-thirds of the CCSIs experienced some implementation problems, and most said they did not receive the help they needed from the state in addressing those concerns. The state has now put more resources in place that can help with such TA (and the types of training noted above). State regional teams, the newly-created statewide CCSI Coordinator, and Tier III representatives to each county, as well as more established CCSIs, could be among those available to help with such technical assistance.

Sharing Information

- Given the diversity of approaches by the CCSIs, CGR recommends that ongoing vehicles be strengthened to share information and approaches among the CCSIs, whether through annual conferences, a newsletter, a listserve, and/or even a website devoted exclusively to CCSI.

Create Regional and/or County Discussions

It is clear from the study findings that there are often different understandings of CCSI and of what is expected between CCSI counties and New York State (as represented primarily by Tier III officials). Perceptions of state officials are not always consistent with those of CCSI officials and participants at the county level.

- To address such issues, and to improve communications between the state and the CCSI counties, CGR recommends that over the next few months, Tier III convene a series of regional and perhaps county-specific discussions involving Tier III and county officials involved in CCSI, to discuss various matters of mutual concern. This report and its findings and recommendations could become

the basis, or at least part of the basis, for organizing agendas for such discussions, by identifying some of the issues that need to be addressed. Such discussions, perhaps preceded by a statewide conference at which the overall study findings are presented, could help develop responses of both counties and the state to issues raised by county officials via the survey and throughout the study process, and could help strengthen the state/county partnership discussed at the beginning of this chapter.

Full-Time Coordinator

The tasks facing a new CCSI are formidable, particularly if the initiative is not building on an existing effort. Consider just some of the skills needed and roles played by a CCSI coordinator:

- Mediation
- Negotiation
- Facilitating
- Evaluating
- Case managing
- Recruiting members, including parents
- Training
- Leadership
- Management and fiscal oversight.

❖ More than 40% of the CCSIs do not have a full-time Coordinator. CGR recommends that all counties involved in CCSI should consider a full-time Coordinator position, and that the state help assure that resources are available to help counties—especially the more-recently-funded (and typically less well-funded) CCSI counties—pay for full-time staff.

Overall Stable Funding for CCSIs

Collecting and analyzing information, training, technical assistance, sharing information, using a full-time CCSI Coordinator, paying for parent advocates, using flexible funds—all have significant cost implications. More generally, concerns about stable funding for

the CCSIs was a continuing theme heard again and again from the survey responses.

- CGR recommends that there be a stable source of ongoing funding for CCSIs, especially those in smaller counties with significant numbers of out-of-home placements. Absent stable funding, it is apparent that many of the CCSIs lack sufficient incentive to plan strategically for the future, and/or do not always have the resources to staff adequately to accomplish CCSI goals. Many do not have the resources or wherewithal to show the impact of what they are doing. At the same time, it is imperative that the CCSIs be able to demonstrate the difference they are making, particularly their impact on out-of-home placements.

- This funding can be provided through a variety of vehicles, whether through agency or interagency funding at the state level (OMH, OCFS, Probation, Education, for example) and/or at the county level. Stable state funding support is key, but such funding should also be conditioned upon evidence of county financial support—now missing in most counties.

  Note also that much CCSI funding in recent years has coincided with the availability of State Office of Mental Health Community Reinvestment (CR) funding. It is not clear what would have happened to the evolution of CCSI without CR monies being available, or what the effect would be if such resources become less available in future years. It is hoped that this source of funds will continue to be available to counties in the future.

  CGR also recognizes the difficulty in raising issues involving long-term funding commitments, given the current financial environment of all levels of government in New York State. Nevertheless, the long-term value of CCSI is dependent on adequate, stable funding, and the issue needs to be addressed if there is to be an ongoing commitment to the CCSI concept.

Establishing New CCSI Programs

- Consideration should be given to expanding CCSI principles and processes to more non-CCSI counties, given the fact that very few of them have showed any reductions in placements since 1993. Given that most of these are small counties, it may not always make sense to create full-fledged, fully-staffed CCSIs in each county, but shared arrangements with neighboring counties may

be appropriate in some settings, such as in the Warren/ Washington county model.

Working with Already-Placed Children/Aftercare Focus

- With limited resources, CCSIs must of necessity decide where their efforts are most effectively used. Nevertheless, CGR believes that there are opportunities for working more closely with children already placed out-of-home, and that sufficient resources should be in place to include the target population of those already placed. In too many counties now, discharge and aftercare services are only available for youth and families with whom the CCSI had previously been involved pre-placement. Increased focus on aftercare services can help reduce lengths of stays in placement facilities, and thereby reduce associated costs.

Role/Definition of Tier I and Tier II and Interagency Collaboration

Many CCSIs are encountering difficulties with "interagency collaboration," running the gamut from which agencies actively participate, at what levels, to attendance, to unfocused meetings. Some of this lack of clarity may be due to the lack of focus on a clear purpose for "interagency collaboration."

- CGR recommends that Tier II levels re-commit to a focus on making an impact on out-of-home placements, thereby giving them a way to measure their effectiveness, and to work more closely where appropriate with initiatives such as Integrated County Planning efforts to reduce duplication.

- In particular, there is the relationship of CCSI to a Single Point of Access/Accountability (SPOA). While there are a variety of models being tested for SPOA, we recommend that the State Office of Mental Health explain and support the possible relationship between these two efforts to ensure their mutual effectiveness.

Tier III

The role and impact of Tier III appears to be uneven. In many respects, it has been very responsive to and supportive of CCSI efforts. At the same time, as a "policy" group it has not always been able to provide definitive guidance or reassurances to the counties, or support in addressing various issues such as blended funding, breaking down regulations and funding barriers, etc. Nor is it clear that in fact Tier III always has the authority to play such roles.

- CGR recommends that Tier III clarify and re-articulate its role and authority regarding CCSI, and that it be given the authority to make available more of the training, technical assistance and financial resources recommended in this report.

- Also, the state, through Tier III, needs to be more effective in communicating with and responding to the needs of the counties, as indicated above.

  It should be noted in this context that Tier III has recently expanded its efforts to improve coordination with and support to the CCSI counties, as indicated above. In addition, as this report was being finalized, Tier III was in the process of supporting state legislation that would promote a coordinated system of care that would require more interagency collaboration focused on improving outcomes for children with emotional or behavioral disorders. Such legislation would require Tier III to work with localities in developing guidelines for the flexible use of state and local funds.

Flexible Funds

It is clear that flexible funding plays a significant role in the success of CCSI, and could play an even greater role with more funding. But genuine flexible funding seems to be more of a promise than an actuality. Some of the reason for this lies at the county level, but some lies at the state level as well.

- CGR recommends that increased funds be set aside at both the local and state levels for flexible use by families in counties, and that the vehicles for flexible funding be more clearly articulated for CCSIs in terms of ways they can take advantage of them, what they have to do to devise such vehicles, and what approaches have been successfully adapted or adopted in various CCSIs.

Involving the Education Community in CCSI

Involving the "education community" is a continuing challenge across the CCSIs, for a number of reasons. For many CCSIs, the sheer number of school districts makes "school" involvement a formidable issue. Other issues relate to the appropriate kind of school personnel to involve (pupil personnel staff, social workers, school psychologists, BOCES, superintendents, etc.).

- CGR recommends that CCSIs share any innovative ways in which they have been able to include the "education community" in their efforts—e.g., by holding meetings in the schools, thereby enabling

better participation of school personnel. Finding ways to more effectively involve schools in CCSIs, including top-level participation by superintendents, is key to the effectiveness of CCSI efforts.

Expanding Services for Younger Children

- With evidence showing that more and more younger children are being served by the CCSIs, counties and the state should assess the service mix that exists in each community, to assure that they have sufficient community-based services in place to meet the needs of younger children and their families.

Increased Education of Potential Referral Sources

Data suggest that very few referrals are now being made to CCSIs from such potential referral sources as Family Court, alcohol and substance abuse service providers, the MRDD system, Health Departments and other health-service providers.

- Outreach efforts should be initiated to inform such resources of the potential value of referring children through the CCSI process, where appropriate.

Family Representation

Family representation, while generally in widespread use in both Tier I and Tier II, still faces some problems for some of the CCSIs, partly but not solely related to resources to pay them.

- CGR recommends that CCSIs, at all three Tier levels, re-affirm the value of effective family involvement at all levels, and assure that the necessary support—financial, training, support groups, child care, hiring as staff, etc.—be made available to the CCSIs to enable them to effectively involve parents and families in their efforts.

APPENDIX TABLE 1: TOTAL NUMBER OF PLACEMENTS, BY COUNTY

Total Number of Congregate Care Placements by County, 1993 – 1999, by CCSI Phase										
		Total	Total	Total	Total	Total	Total	Total	Percent change	Percent change
Phase	County	9/93	9/94	9/95	9/96	9/97	1998*	1999*	93--99	96--99
1	Broome	164	158	168	157	152	169	171	4.3%	8.9%
1	Chemung	84	80	70	64	55	57	60	-28.6%	-6.3%
1	Monroe	471	491	423	466	469	483	542	15.1%	16.3%
1	Rockland	163	156	149	144	111	119	126	-22.7%	-12.5%
1	Schenectady	190	183	211	194	208	204	206	8.4%	6.2%
1	Suffolk	313	338	322	366	406	428	461	47.3%	26.0%
1	Ulster	141	124	110	87	97	100	123	-12.8%	41.4%
1	Westchester	591	589	566	526	456	503	461	-22.0%	-12.4%
2	Columbia	38	48	42	57	50	48	53	39.5%	-7.0%
2	Erie	331	339	489	446	445	450	360	8.8%	-19.3%
2	Fulton	32	34	39	32	40	44	47	46.9%	46.9%
2	Greene	31	32	30	19	23	30	40	29.0%	110.5%
2	Jefferson	80	81	76	79	81	81	77	-3.8%	-2.5%
2	Oneida	185	207	191	203	211	188	165	-10.8%	-18.7%
2	Onondaga	269	283	344	295	258	251	240	-10.8%	-18.6%
2	Orange	216	223	191	217	217	227	211	-2.3%	-2.8%
2	Rensselaer	141	161	132	128	132	131	134	-5.0%	4.7%
	Subtotal	**3,440**	**3,527**	**3,553**	**3,480**	**3,411**	**3,513**	**3,477**	**1.1%**	**-0.1%**
3	Allegany	39	27	27	58	43	36	31	-20.5%	-46.6%
3	Cayuga	53	62	64	49	47	52	45	-15.1%	-8.2%
3	Chautauqua	52	65	62	68	54	59	46	-11.5%	-32.4%
3	Dutchess	182	164	158	191	196	179	187	2.7%	-2.1%
3	Essex	6	5	6	9	16	16	16	166.7%	77.8%
3	Herkimer	20	19	24	28	24	33	41	105.0%	46.4%
3	Madison	50	54	44	44	46	41	36	-28.0%	-18.2%
3	Montgomery	27	45	36	35	23	29	25	-7.4%	-28.6%
3	Oswego	51	81	90	83	87	107	140	174.5%	68.7%
3	Putnam	29	24	23	19	29	19	14	-51.7%	-26.3%
3	St.Lawrence	21	21	28	24	41	43	36	71.4%	50.0%
3	Sullivan	39	43	34	53	49	53	46	17.9%	-13.2%
3	Tompkins	19	32	27	30	14	18	14	-26.3%	-53.3%
3	Wayne	29	42	36	36	40	32	33	13.8%	-8.3%
3	Yates	9	8	6	4	7	10	9	0.0%	125.0%
4	Albany	272	262	248	248	303	337	327	20.2%	31.9%
4	Nassau	367	376	337	364	390	423	407	10.9%	11.8%

Total Number of Congregate Care Placements by County, 1993 – 1999, by CCSI Phase										
		Total	Total	Total	Total	Total	Total	Total	Percent change	Percent change
Phase	**County**	**9/93**	**9/94**	**9/95**	**9/96**	**9/97**	**1998***	**1999***	**93--99**	**96--99**
4	Niagara	158	151	136	142	137	153	135	-14.6%	-4.9%
4	Franklin	20	11	11	16	21	29	28	40.0%	75.0%
4	Lewis	5	12	9	6	6	6	3	-40.0%	-50.0%
4	Warren	21	25	27	29	33	28	22	4.8%	-24.1%
4	Washington	20	17	19	20	20	19	26	30.0%	30.0%
4	Wyoming	9	13	17	11	21	21	21	133.3%	90.9%
	Subtotal	**1,498**	**1,559**	**1,469**	**1,567**	**1,647**	**1,743**	**1,688**	**12.7%**	**7.7%**
na	Cattaraugus	79	62	75	83	69	69	63	-20.3%	-24.1%
na	Chenango	23	22	27	21	22	20	28	21.7%	33.3%
na	Clinton	31	29	33	35	34	34	35	12.9%	0.0%
na	Cortland	6	8	8	9	19	25	27	350.0%	200.0%
na	Delaware	8	8	20	10	12	5	8	0.0%	-20.0%
na	Genesee	9	17	12	9	10	16	10	11.1%	11.1%
na	Hamilton	2	1	1	1	0	0	0	-100.0%	-100.0%
na	Livingston	27	30	25	25	23	20	18	-33.3%	-28.0%
na	Ontario	20	25	24	20	29	36	35	75.0%	75.0%
na	Orleans	12	18	24	19	24	21	12	0.0%	-36.8%
na	Otsego	17	20	30	30	39	53	47	176.5%	56.7%
na	Saratoga	92	83	86	98	95	96	87	-5.4%	-11.2%
na	Schoharie	8	11	6	13	17	11	15	87.5%	15.4%
na	Schuyler	9	11	7	7	3	9	7	-22.2%	0.0%
na	Seneca	19	15	20	21	13	28	24	26.3%	14.3%
na	Steuben	48	44	52	39	35	36	48	0.0%	23.1%
na	Tioga	23	20	26	22	23	27	25	8.7%	13.6%
	Subtotal	**433**	**424**	**476**	**462**	**467**	**506**	**492**	**13.6%**	**6.5%**
4	New York City	**6377**	**6889**	**6166**	**6091**	**6840**	**7271**	**6948**	**9.0%**	**14.1%**
	NYS Total	**11,748**	**12,399**	**11,664**	**11,600**	**12,365**	**13,033**	**12,602**	**7.3%**	**8.6%**

* * in 1998 and 1999, reporting months varied by system.

APPENDIX TABLE 2: PLACEMENT RATES, BY COUNTY

Rates of Congregate Care Placement per 1,000 Children under age 20, by county, 1993 - 1999 by CCSI Phase										
		Total	Total	Total	Total	Total	Total	Total	Percent change	Percent change
Phase	**County**	**9/93**	**9/94**	**9/95**	**9/96**	**9/97**	**1998***	**1999***	**93--99**	**96--99**
1	Broome	2.73	2.65	2.86	2.73	2.68	3.03	3.10	13.4%	13.7%
1	Chemung	2.95	2.81	2.46	2.27	1.97	2.06	2.20	-25.5%	-3.1%
1	Monroe	2.19	2.28	1.96	2.17	2.19	2.28	2.59	18.0%	19.4%
1	Rockland	1.99	1.89	1.79	1.72	1.33	1.43	1.51	-24.3%	-12.5%
1	Schenectady	4.66	4.48	5.16	4.79	5.19	5.17	5.30	13.7%	10.5%
1	Suffolk	0.80	0.86	0.81	0.92	1.02	1.07	1.15	44.2%	25.5%
1	Ulster	3.01	2.66	2.37	1.88	2.10	2.19	2.70	-10.5%	43.8%
1	Westchester	2.59	2.56	2.43	2.25	1.95	2.16	1.98	-23.6%	-12.3%
2	Columbia	2.13	2.68	2.33	3.17	2.81	2.72	3.03	42.0%	-4.5%
2	Erie	1.23	1.26	1.82	1.67	1.69	1.74	1.42	15.1%	-15.4%
2	Fulton	1.96	2.07	2.37	1.96	2.47	2.75	2.96	51.3%	51.4%
2	Greene	2.43	2.48	2.30	1.46	1.77	2.30	3.06	25.8%	109.4%
2	Jefferson	2.12	2.11	1.99	2.08	2.16	2.21	2.13	0.6%	2.1%
2	Oneida	2.53	2.85	2.70	2.95	3.11	2.82	2.50	-1.5%	-15.5%
2	Onondaga	1.89	1.99	2.42	2.10	1.86	1.83	1.77	-6.5%	-15.6%
2	Orange	2.08	2.12	1.80	2.03	2.01	2.10	1.94	-6.7%	-4.5%
2	Rensselaer	3.05	3.48	2.85	2.76	2.88	2.88	2.98	-2.1%	7.8%
	Wtd avg	**1.90**	**1.94**	**1.95**	**1.91**	**1.89**	**1.96**	**1.95**	**2.5%**	**1.7%**
3	Allegany	2.13	1.46	1.43	3.11	2.36	2.00	1.73	-18.7%	-44.2%
3	Cayuga	2.08	2.42	2.49	1.92	1.85	2.07	1.82	-12.6%	-5.4%
3	Chautauqua	1.19	1.49	1.42	1.56	1.25	1.39	1.10	-8.2%	-29.8%
3	Dutchess	2.39	2.16	2.07	2.49	2.55	2.34	2.43	1.8%	-2.4%
3	Essex	0.58	0.48	0.57	0.86	1.54	1.57	1.58	173.8%	83.3%
3	Herkimer	0.99	0.94	1.19	1.39	1.21	1.70	2.15	116.2%	54.2%
3	Madison	2.03	2.19	1.79	1.79	1.89	1.69	1.49	-26.7%	-16.8%
3	Montgomery	1.82	3.01	2.39	2.34	1.55	1.98	1.73	-4.8%	-25.9%
3	Oswego	1.19	1.88	2.09	1.93	2.03	2.54	3.33	180.1%	72.3%
3	Putnam	1.11	0.91	0.86	0.71	1.07	0.70	0.51	-54.2%	-27.9%
3	St.Lawrence	0.55	0.55	0.73	0.63	1.08	1.15	0.97	77.8%	55.3%
3	Sullivan	1.89	2.08	1.64	2.56	2.39	2.61	2.28	20.7%	-10.9%
3	Tompkins	0.58	0.96	0.79	0.89	0.41	0.53	0.42	-28.5%	-53.1%
3	Wayne	0.98	1.41	1.19	1.19	1.32	1.06	1.10	11.3%	-7.8%
3	Yates	1.24	1.07	0.80	0.53	0.92	1.33	1.19	-3.9%	124.9%
4	Albany	3.35	3.19	3.01	3.03	3.72	4.18	4.09	22.1%	35.1%

Rates of Congregate Care Placement per 1,000 Children under age 20, by county, 1993 - 1999 by CCSI Phase										
		Total	Total	Total	Total	Total	Total	Total	Percent change	Percent change
Phase	County	9/93	9/94	9/95	9/96	9/97	1998*	1999*	93--99	96--99
4	Nassau	1.10	1.12	1.00	1.08	1.16	1.26	1.22	11.1%	13.2%
4	Niagara	2.45	2.33	2.09	2.19	2.13	2.42	2.17	-11.4%	-1.0%
4	Franklin	1.38	0.75	0.75	1.09	1.44	2.02	1.97	43.0%	81.6%
4	Lewis	0.53	1.27	0.94	0.63	0.63	0.64	0.32	-39.2%	-48.3%
4	Warren	1.17	1.38	1.48	1.60	1.82	1.56	1.23	5.3%	-23.0%
4	Washington	1.10	0.94	1.04	1.09	1.10	1.06	1.46	32.3%	33.5%
4	Wyoming	0.69	0.99	1.28	0.82	1.58	1.59	1.60	131.9%	94.6%
	Wtd avg	**1.52**	**1.57**	**1.48**	**1.58**	**1.66**	**1.78**	**1.73**	**13.6%**	**9.7%**
na	Cattaraugus	2.79	2.19	2.63	2.91	2.44	2.46	2.27	-18.7%	-21.8%
na	Chenango	1.40	1.34	1.65	1.28	1.36	1.26	1.78	27.7%	39.2%
na	Clinton	1.14	1.06	1.26	1.39	1.36	1.38	1.43	25.1%	2.9%
na	Cortland	0.36	0.48	0.49	0.56	1.17	1.54	1.68	361.2%	202.3%
na	Delaware	0.54	0.54	1.35	0.69	0.85	0.35	0.57	4.9%	-18.1%
na	Genesee	0.48	0.89	0.63	0.47	0.53	0.85	0.54	13.4%	14.3%
na	Hamilton	1.55	0.79	0.80	0.78	0.00	0.00	0.00	-100.0%	-100.0%
na	Livingston	1.31	1.43	1.18	1.19	1.09	0.96	0.86	-34.1%	-27.2%
na	Ontario	0.68	0.84	0.80	0.67	0.96	1.21	1.18	73.0%	77.1%
na	Orleans	0.88	1.30	1.71	1.35	1.72	1.51	0.87	-0.9%	-35.8%
na	Otsego	0.87	1.00	1.51	1.52	1.99	2.73	2.43	180.7%	59.8%
na	Saratoga	1.61	1.43	1.46	1.66	1.61	1.63	1.47	-8.8%	-11.6%
na	Schoharie	0.74	1.03	0.56	1.23	1.63	1.07	1.47	98.5%	19.9%
na	Schuyler	1.54	1.88	1.18	1.19	0.51	1.54	1.21	-22.0%	1.5%
na	Seneca	1.95	1.54	2.04	2.15	1.35	2.95	2.54	30.6%	18.2%
na	Steuben	1.55	1.41	1.68	1.27	1.14	1.19	1.61	3.8%	26.8%
na	Tioga	1.35	1.17	1.54	1.32	1.39	1.64	1.54	14.4%	17.1%
	Wtd avg	**1.28**	**1.24**	**1.40**	**1.36**	**1.39**	**1.51**	**1.48**	**15.6%**	**8.5%**
4	New York City	**3.14**	**3.36**	**2.98**	**2.94**	**3.29**	**3.50**	**3.36**	**6.8%**	**14.3%**
	NYS Total	**2.27**	**2.38**	**2.23**	**2.22**	**2.37**	**2.51**	**2.44**	**7.3%**	**9.9%**

* in 1998 and 1999, reporting months varied by system.

CCSI COORDINATOR SURVEY

INSTRUCTIONS FOR COMPLETING THIS SURVEY

Thank you for participating in this survey designed to undertake a comprehensive assessment of the statewide implementation of CCSI. Each CCSI site coordinator is being asked to complete this survey. The findings from the survey are intended to be used in planning and strategy development to support the future of CCSI. Therefore it is extremely important that you answer the questions as completely as possible.

All of the information you provide will be treated in strict confidence. Nothing you tell us will be in any way quoted or attributed back to you or your county. Detailed information about individual programs will not be included in our report.

Please note: *where information exists in written form (e.g., grant applications, written protocols or memos, annual or quarterly reports, etc.), please feel free to highlight and attach the relevant sections rather than writing out a response to a question. Please be sure to note the related question number on your attachment.*

Where we have requested data, please provide the most accurate numbers possible, but use estimates if you do not know the precise numbers.

Where we have asked for information for the year 2000, please use the most current year for which you have full 12-month data. Please indicate if the year is different from what we have asked for.

If you need additional space for your responses, please feel free to attach any continuation pages, making sure to include the question number with your response.

Please return this questionnaire in the envelope provided* no later than January 17, 2001.** *If you have any questions about the survey, please contact Sarah Boyce at* sboyce@cgr.org or (716) 327-7065*, or contact your Tier III representative.* ***Thank you!

IDENTIFYING INFORMATION

Please make any necessary additions or corrections to the information below.

BACKGROUND AND CCSI ADMINISTRATION

1. Is the CCSI Lead Agency a part of: (*Check one*)

- ❒$_1$ County government *(Please specify, then go to Question 2):*
  - ❒ a. Youth Bureau/Youth Services
  - ❒ b. Community Services
  - ❒ c. Mental Health
  - ❒ d. Social Services
  - ❒ e. County Executive's/County Manager's Office
  - ❒ f. Other part of county government (*Please specify*):_____
- ❒$_2$ Local nonprofit organization (*Go to Question 3)*
- ❒$_3$ Other:(*Please specify*)_____(*Go to Question 3)*

2. **A.** If the CCSI Lead Agency is part of <u>county government</u>, how does that affect the success of CCSI?

B. What are the advantages and disadvantages of being part of county government in terms of meeting CCSI goals?
Advantages:

Disadvantages:

(*Go to Question 4)*

3. **A.** If the CCSI Lead Agency is <u>not part of county government</u>, how does that affect the success of CCSI?

B. What are the advantages and disadvantages of being outside of county government in terms of meeting CCSI goals?
Advantages:

Disadvantages:

4. **A.** How was the designation of the current CCSI Lead Agency determined? What was the rationale?

B. Has the Lead Agency changed since CCSI was first funded in your county?
❒$_1$ Yes ❒$_2$ No (*Go to Question 5)*

C. If Yes, what department/agency was it originally?

D. If Yes, why did the designation of the Lead Agency change?

5. During which Phase and year did your CCSI become operational? (*Please check one)*
❒$_1$ Phase I Year:_____
❒$_2$ Phase II Year:_____
❒$_3$ Phase III Year:_____
❒$_4$ Phase IV Year:_____

6. Why did your county originally decide to apply for a CCSI grant?

7. Did your CCSI experience any implementation problems? ❒$_1$ Yes ❒$_2$ No
Please explain.

8. **A.** What kinds of technical assistance, if any, did your CCSI need during the start up period after CCSI implementation funds were received?

B. On a scale of 1-5, where "1" means "none" and "5" means "a great deal," what was the level of technical assistance provided by the State during the start up period after CCSI implementation funds were received? ❒$_1$ ❒$_2$ ❒$_3$ ❒$_4$ ❒$_5$ Please explain.

9. **A.** What kinds of technical assistance, if any, has your CCSI needed since implementation?

B. On a scale of 1-5, where "1" means "none" and "5" means "a great deal," what level of technical assistance has been provided by the State since implementation? ❒$_1$ ❒$_2$ ❒$_3$ ❒$_4$ ❒$_5$
Please explain.

10. In what month and year did your CCSI serve its first family? _____
Month Year

11. In what month/year did you become CCSI coordinator? _____
Month Year

12. **A.** What % FTE is the CCSI coordinator position? _____ (*if 1.0, go to Question 13)*

If the CCSI Coordinator is part time:

B. If you are an employee of a county government department, is the rest of your time spent on other county-related activities? ❒1 Yes ❒2 No

C. If you are employed by a nonprofit organization, is the rest of your time spent on other activities for that organization? ❒1 Yes ❒2 No

13. **A.** What are the current numbers of paid staff for CCSI (including the Coordinator)?

_____ _____ _____
Total # of Staff # Part Time # Full Time

B. Please list staff by title, the number of staff with the title, and a brief description of their role.

Title	#	Brief description of role
1.		
2.		
3.		
4.		
5.		

14. Please check **Yes** or **No** for each of the following questions:
Was **2000** significantly different from previous years, in terms of:

A. Families/children seen ❒1 Yes ❒2 No
B. Tier I activity generally ❒1 Yes ❒2 No
C. Tier II activity generally ❒1 Yes ❒2 No
D. Overall CCSI funding ❒1 Yes ❒2 No
E. Availability of flexible funds ❒1 Yes ❒2 No
F. Family involvement in Tier I ❒1 Yes ❒2 No
G. Family involvement in Tier II ❒1 Yes ❒2 No
H. Other:_____ ❒1 Yes ❒2 No

I. If you answered yes to any question, please explain the change(s).

15. What changes, if any, are needed in how CCSI is administered in your county?

CCSI FUNDING

16. What was the total CCSI budget in each of the following fiscal years:

	2000	**1999**	**1998**	**1st Yr of State CCSI funding**
A. Total Budget (Including flexible funds):	$_____	$_____	$_____	$_____
B. Budget Amount (Excluding flexible funds):	$_____	$_____	$_____	$_____

17. **A.** From the list below, please check each source of funding for the total CCSI budget in FY 2000, and indicate the dollar amount received from each source.

❒1 CCSI State Grant: $_____
❒2 OMH Reinvestment Funds: $_____
❒3 County Funds: $_____
❒4 Other (*Please specify):*_____ $_____
❒5 Other (*Please specify*):_____ $_____

B. From the list below, please check each source of funding for the total CCSI budget in FY 1999, and indicate the dollar amount received from each source.

❒1 CCSI State Grant: $_____
❒2 OMH Reinvestment Funds: $_____
❒3 County Funds: $_____
❒4 Other (*Please specify):*_____ $_____
❒5 Other (*Please specify*):_____ $_____

C. From the list below, please check each source of funding for the total CCSI budget in FY 1998, and indicate the dollar amount received from each source.

❒1 CCSI State Grant: $_____
❒2 OMH Reinvestment Funds: $_____
❒3 County Funds: $_____
❒4 Other (*Please specify):*_____ $_____
❒5 Other (*Please specify*):_____ $_____

D. From the list below, please check each source of funding for the total CCSI budget in your first year of operation, and indicate the dollar amount received from each source.

❒1 CCSI State Grant: $_____
❒2 OMH Reinvestment Funds: $_____
❒3 County Funds: $_____
❒4 Other (*Please specify):*_____ $_____
❒5 Other (*Please specify*):_____ $_____

18. **A.** If you did not receive state grant funding in FY 2000, when was the last year in which you received state grant funding for CCSI?_____

B. What was the dollar amount of the state grant in that year? $_____

C. If your CCSI no longer receives a state grant, how did the county respond financially when state grant funding ended for CCSI?

19. What changes, if any, are needed in the funding of CCSI and why?

CCSI Focus

20. **A.** How would you describe the "philosophy" of your CCSI?

B. What is currently the primary focus of CCSI in your county? (*Please check one)*
❒$_1$ Reducing out of home placements for at-risk children
❒$_2$ Interagency collaboration/systems change
❒$_3$ Both of the above
❒$_4$ Other (*Specify*) _____

C. Has the primary focus changed from what was stated in your original proposal?

❒$_1$ Yes ❒$_2$ No (*Go to Question 21*)

D. If yes, how?

21. Did you model your CCSI on an existing model such as a "hard to place committee" or a local designated assessment service? ❒$_1$ Yes ❒$_2$ No
Please explain.

22. **A.** What are the strengths of your CCSI model?

B. What are the drawbacks, if any, to your CCSI model?

23. During a typical week, about what percent of your CCSI coordinator time is spent on:
A. "case conferencing/case management" activities _____% of time
B. interagency collaboration/systems change _____% of time
C. Other (*Please specify)*_____ _____% of time

CCSI TARGET POPULATION

24. **A.** Does the current target population for CCSI include: (*Check all that apply)*
❒$_1$ children at risk of out of home placement
❒$_2$ children with multiple service needs
❒$_3$ children with an emotional disability/serious emotional and behavioral disturbance
❒$_4$ Other (*Please specify*)_____

B. Are there written criteria that identify the target population for CCSI? ❒$_1$ Yes ❒$_2$ No
If yes, please provide a copy or indicate them here.

C. Has your target population changed over time? ❒$_1$ Yes ❒$_2$ No
If yes, how? Why has there been a change?

25. **A.** Since CCSI began, what impact has it had on reducing: 1) the overall county out of home placement rate? and, 2) the out of home placement rate of children served by CCSI?

B. How is reduction in placement measured?

C. Since CCSI began, what impact has it had on reducing: 1) the overall county average length of stay in out of home placements? and, 2) the average length of stay in out of home placements for children served by CCSI?

D. In keeping children out of institutional placement, what is your estimate of the average annual dollar amount saved? How did you calculate this amount?

TIER I SERVICE APPROACH

26. **A.** Is your Tier I: (*Please check one)*
❒1 A standing committee
❒2 A different committee for each family
❒3 Other:_____

B. How many individuals/parties generally participate in Tier I activities? _____

27. Please indicate <u>which</u> individuals/parties listed in the first column below generally participate in Tier I. Check all that apply and then use the second column to rate their participation in Tier I activities using a scale of 1 – 5 where "1" is "not at all effective," and "5" is "very effective."

Participants (*Check all that apply)*	How would you rate their participation? Not at all Effective				Very Effective
❒a CCSI coordinator	❒1	❒2	❒3	❒4	❒5
❒b Parents of immediate family	❒1	❒2	❒3	❒4	❒5
❒c Parent advocates	❒1	❒2	❒3	❒4	❒5
❒d Supervisory level staff	❒1	❒2	❒3	❒4	❒5
❒e Front line staff	❒1	❒2	❒3	❒4	❒5
❒f Education staff	❒1	❒2	❒3	❒4	❒5
❒g Informal supports (*Specify)*	❒1	❒2	❒3	❒4	❒5
❒1 Family-identified	❒1	❒2	❒3	❒4	❒5
❒2 Tier I representative	❒1	❒2	❒3	❒4	❒5
❒h Other (*Specify*)_____	❒1	❒2	❒3	❒4	❒5

28. How is the "education community" involved at the Tier I level?

29. On a scale of 1—5, where "1" means "not at all defined," and "5" means "very well defined," how well defined is the role of Tier I? ❒1 ❒2 ❒3 ❒4 ❒5

30. Does your Tier I service approach involve: (*Check all that apply*)
❒1 Screening/assessment ❒2 Enrolling the family/child ❒3 Developing a service plan
❒4 Serving only as consultant ❒5 Providing direct services ❒6 Providing flexible funding

31. On a scale of 1—5, where "1" is "not at all effective," and "5" is "very effective," how would you rate the effectiveness of Tier I in achieving CCSI goals? ❒1 ❒2 ❒3 ❒4 ❒5

32. How many children accepted for CCSI service during 2000 had been in out of home placement during the 12 months prior to receiving service? _____

33. **A.** How long <u>on average</u> do children/families stay in CCSI? _____

B. Has the "average length of stay" for families in CCSI changed since you began operation?
❒1 Yes (*Go to Question 33C*) ❒2 No (*Go to Question 34*)

C. <u>If yes,</u> how so? What accounts for the change?

34. What is the typical disposition for those who are "discharged" from CCSI?

35. Please answer the following questions for each of the years 1998 – 2000 during which your CCSI was operational.

	2000 (#)	**1999** (#)	**1998** (#)
A. What is the total number of families served by CCSI?	_____	_____	_____
B. What is the total number of children served by CCSI?	_____	_____	_____
C. How many new families were admitted/served by CCSI?	_____	_____	_____
D. How many new children were admitted/served by CCSI?	_____	_____	_____
E. How many children did you identify as at risk of institutional placement for these years?	_____	_____	_____
F. Among children at risk of institutional placement who received CCSI services, how many did not go into institutional placement as a result of CCSI?	_____	_____	_____
G. For all children receiving CCSI services, how many were placed in residential care in the following systems:			
1. Office of Mental Health (OMH)	_____	_____	_____
2. State Education Department (SED)	_____	_____	_____
3. Office of Children and Family Services (OCFS)	_____	_____	_____
a. Congregate care	_____	_____	_____
b. Secure or non-secure	_____	_____	_____
4. Other (*Please specify*)_____	_____	_____	_____

H. Please explain any significant changes noted above.

I. Has the length of stay in residential care changed for children who received CCSI services? Please explain.

36. Of families referred to CCSI, how many were referred from:

	2000 (#)	**1999** (#)	**1998** (#)
A. Families	_____	_____	_____
B. School	_____	_____	_____
C. Social Services	_____	_____	_____
D. Mental Health	_____	_____	_____
E. Probation	_____	_____	_____
F. Family Court	_____	_____	_____
G. Mental Retardation and Developmental Disabilities	_____	_____	_____
H. Alcohol and Substance Abuse Services	_____	_____	_____
I. Health Dept.	_____	_____	_____
J. Other health care agencies	_____	_____	_____
K. Family/children services providers	_____	_____	_____
L. Other (*Please Specify*)_____	_____	_____	_____

37. **A.** Have the characteristics of families referred to CCSI been changing since CCSI began operation?
❒$_1$ Yes (*Go to Question 37B*) ❒$_2$ No (*Go to Question 38*)

B. If yes, how so?

38. **A.** At the time of referral to CCSI services, how many children were of the following age groups:

	2000 (#)	**1999** (#)	**1998** (#)
Less than 6 years old	_____	_____	_____
6-10 years old	_____	_____	_____
11-15 years old	_____	_____	_____
16 years and older	_____	_____	_____

B. Have you seen any significant changes in the ages of children referred to CCSI since you began operation? Please explain.

39. **A.** Is there typically a waiting list of families awaiting CCSI service?
❒$_1$ Yes ❒$_2$ No (*Go to Question 40*)

B. If yes, how many families generally are on the waiting list? _____

C. What are the main reasons for the waiting list?

40. What is the impact of health insurance coverage (Medicaid, private health insurance, HMO, etc.)—or its absence—on the ability to serve families/children referred to CCSI?

41. **A.** Does your CCSI provide discharge planning/aftercare services for children placed in facilities?
❒$_1$ Yes (*Go to Question 41B)* ❒$_2$ No (*Go to question 42*)

B. Please explain your involvement.

On a scale of 1—5, where "1" means "very little involvement" and "5" means "very much involvement," please rate your CCSI's involvement in discharge planning and aftercare for children placed in residential facilities:

C. who received CCSI services prior to placement ❒1 ❒2 ❒3 ❒4 ❒5

D. who did not receive CCSI services prior to placement ❒1 ❒2 ❒3 ❒4 ❒5

42. If you answered **no** to question 41**,** is this a population and activity that you think CCSI could be or should be involved in? Please explain.

OTHER TIER I ISSUES

43. **A.** What data, if any, does CCSI routinely collect? (*Please identify the data collected, and include any sample forms.*)

B. Do you currently have a data system/MIS for CCSI? ❒1 Yes ❒2 No

C. What data or management information system, if any, would you find helpful to improve the effectiveness of CCSI?

44. What have been the main accomplishments or impact of Tier I activities in your county?

45. How could the functioning of Tier I be improved? What changes, if any, are needed?

TIER II ISSUES

46. How many individuals, agencies and/or other parties currently participate in Tier II? _____

47. On a scale of 1—5, where "1" means "not involved," and "5" means "very involved," how involved in Tier II would you say these parties currently are:

	Not Involved				Very Involved
A. County Office of Mental Health	❒1	❒2	❒3	❒4	❒5
B. State Office of Mental Health	❒1	❒2	❒3	❒4	❒5
C. Office of Mental Retardation & DD	❒1	❒2	❒3	❒4	❒5
D. Office of Alcohol & Substance Abuse	❒1	❒2	❒3	❒4	❒5
E. County Dept. of Social Services	❒1	❒2	❒3	❒4	❒5
F. Probation	❒1	❒2	❒3	❒4	❒5
G. Schools	❒1	❒2	❒3	❒4	❒5
H. Youth Bureau	❒1	❒2	❒3	❒4	❒5
I. County Health Department	❒1	❒2	❒3	❒4	❒5
J. Health care providers	❒1	❒2	❒3	❒4	❒5
K. Children/family services providers	❒1	❒2	❒3	❒4	❒5
L. Family members	❒1	❒2	❒3	❒4	❒5
M. Family court	❒1	❒2	❒3	❒4	❒5
N. Local police	❒1	❒2	❒3	❒4	❒5
O. Faith community	❒1	❒2	❒3	❒4	❒5
P. Business community	❒1	❒2	❒3	❒4	❒5
Q. United Way	❒1	❒2	❒3	❒4	❒5
R. Other (*Please Specify*)_____	❒1	❒2	❒3	❒4	❒5

48. **A.** In general, what level of staff represent agencies on Tier II? (*Check all that apply*)

❒1Agency executives ❒2Department heads ❒3Superintendents
❒4Deputy level staff ❒5Program managers ❒6Other staff representatives

B. Has agency representation on Tier II changed since its original composition?
❒1Yes (*Go to Question 48C*) ❒2No (*Go to question 48D*)

C. If yes, how? Has the number of agencies on Tier II: (*Check one*) ❒1Increased ❒2 Decreased

D. How has the amount of time agency representatives devote to Tier II activities changed over time?
❒1Increased ❒2Remained the same ❒3 Decreased Please explain.

49. Does Tier II have a written "job description" or mission statement? ❒1Yes ❒2No
If yes, please provide a copy.

50. On a scale of 1—5, where "1" means "not at all defined," and "5" means "very well defined," how well defined is the role of Tier II? ❒1 ❒2 ❒3 ❒4 ❒5

51. In what month/year did Tier II first meet? _____
Month Year

52. **A.** How often does the Tier II group meet? (*Check one*)
❒$_1$ Every other week ❒$_2$ Monthly ❒$_3$ Quarterly ❒$_4$ Other (*Please specify*)_____

B. How many Tier II representatives attended the most recent Tier II meeting? _____

C. Is this attendance typical? ❒$_1$Yes (*Go to Question 53)* ❒$_2$No (*Go to Question 52D*)

D. If not, what number is typical? _____

53. What is the relationship of the CCSI Coordinator to Tier II?

54. **A.** How does the Tier I process communicate with Tier II?

B. How does Tier II communicate back to Tier I?

55. **A.** Are there minutes of the CCSI Tier II meetings? ❒$_1$Yes ❒$_2$No (*Go to question 56*)
B. Are minutes distributed to all Tier II participants? ❒$_1$Yes ❒$_2$No
C. Are minutes distributed to individuals other than Tier II participants?
❒$_1$Yes (*Go to Question 55D)* ❒$_2$No (*Go to question 56*)
D. If yes, to whom? (*Please list*)

56. Please explain how Tier II fits within the county government's decision-making structure. Please indicate what issues of county government it has impact on.

57. How is the "education community" involved at the Tier II level?

58. **A.** Has the way Tier II functions changed significantly since CCSI started?
❒$_1$Yes (*Go to Question 58B)* ❒$_2$No (*Go to question 59*)

B. If yes, please explain how.

59. Since CCSI became operational, what were the main systems issues addressed by the local Tier II? How were these systems issues addressed?

60. **A.** On a scale of 1 – 5, where "1" means "not at all effective" and "5" means "very effective," how would you rate the current effectiveness of Tier II? (*Check one*) ❒$_1$ ❒$_2$ ❒$_3$ ❒$_4$ ❒$_5$

B. Do you have a way to measure how effective Tier II is in your county? If so, please explain.

61. What have been the main obstacles, if any, to effective functioning of Tier II?

62. What would you say have been the main accomplishments of Tier II in your county?

63. How could the functioning of Tier II be improved? What changes, if any, are needed?

TIER III ISSUES

64. **A.** What kinds of issues, if any, have you referred to Tier III for consideration?

B. How did Tier III respond to your issues?

65. **A.** What have been the main accomplishments of Tier III?

B. What have been the main obstacles, if any, to the effective functioning of Tier III?

66. On a scale of 1—5, where "1" means "not at all effective" and "5" means "very effective," how would you rate the current effectiveness of Tier III for CCSI? ❒1 ❒2 ❒3 ❒4 ❒5

67. How could the functioning of Tier III be improved?

INTERAGENCY COORDINATION

68. **A.** Which of the following "interagency collaborative" efforts exist in your county? (*Check all that apply*)

❒1 Integrated County Planning (ICP)
❒2 Mental Health Juvenile Justice (MHJJ)
❒3 State Incentive Cooperative Agreement (SICA)
❒4 ACT for Youth grants
❒5 Other (*Please Specify*)_____

B. How does CCSI (at the various Tiers) relate to these other interagency efforts?

69. Generally speaking, would you describe the relationship of these other interagency collaborations as "complementary" (COMP) to CCSI, "working at cross-purposes"(CP) with CCSI, "duplicative" (DUP), or "don't know" (DK): *(Please check all that apply)*

	COMP	CP	DUP	DK
A. Integrated County Planning (ICP)	❒1	❒2	❒3	❒4
B. Mental Health Juvenile Justice (MHJJ)	❒1	❒2	❒3	❒4
C. State Incentive Cooperative Agreement (SICA)	❒1	❒2	❒3	❒4
D. ACT for Youth grants	❒1	❒2	❒3	❒4
E. Other (*Please Specify*)_____	❒1	❒2	❒3	❒4

70. **A.** Does your CCSI measure interagency coordination? ❒1Yes ❒2No (*Go to Question 71)*

B. If yes, how so?

71. In what ways does Tier II support or not support interagency coordination?

72. To what extent does cross training of staff exist as a result of CCSI? What types of cross training? Who is responsible for doing it? Who benefits?

73. On a scale of 1—5, where "1" means "not at all effective," and "5" means "very effective," how would you rate the overall effectiveness of CCSI in improving "interagency coordination" in your county? ❒1 ❒2 ❒3 ❒4 ❒5

USE OF STRENGTH-BASED INDIVIDUALIZED CARE APPROACHES

74. **A.** Does CCSI use strength-based individualized care approaches? ❒$_1$Yes ❒$_2$No (*Go to question 74*-I)

B. If yes, please explain the approach(es) used.

C. What evidence is there that this approach is used within the child serving systems in your county? What role, if any, has CCSI played in implementing such approaches?

D. What training is offered in this area? How often? By whom? For whom? Is the training conducted together for agency staff?

E. Do service plans reflect a strength-based individualized care approach? (*Please indicate "Yes," "No" or "Not Applicable"*)

	Yes	**No**	**NA**
CCSI service plans	❒$_1$	❒$_2$	❒$_3$
Agency service plans	❒$_1$	❒$_2$	❒$_3$

F. How does the local CCSI measure use or impact of strength-based individualized care approaches?

G. Is there evidence that the use of strength-based individualized care approaches has made a difference, e.g., in reducing out of home placements? ❒$_1$ Yes ❒$_2$ No
Please explain.

H. On a scale of 1—5, where "1" means "made no difference at all," and "5" means "made a great deal of difference," how much difference have strength-based individualized care approaches made in the success of CCSI? ❒$_1$ ❒$_2$ ❒$_3$ ❒$_4$ ❒$_5$

I. What additions or changes, if any, are needed in the use of strength-based individualized care approaches that would improve the effectiveness of CCSI?

FAMILY INVOLVEMENT

75. **A.** How would you characterize the involvement of families at the Tier I level?

B. How would you characterize the involvement of families at the Tier II level?

76. **A.** How many family member representatives are there at Tier I? _____ At Tier II? _____

B. Has family representation changed over time for Tier I? ❒1 Yes ❒2 No
Please explain.

C. Has family representation changed over time for Tier II? ❒1 Yes ❒2 No
Please explain.

77. How does CCSI generally support family participation? (*Check all that apply*)
❒1 Stipends ❒2 Transportation ❒3 Child care ❒4 Other (*Please specify*)_____

78. **A.** What difficulties have you had in recruiting parent/family participants for Tier I/TierII?

B. How have you dealt with these difficulties?

C. Is there anything CCSI has attempted to do to encourage more active parent participation in the Tier I process?

D. Is there anything CCSI has attempted to do to encourage more active parent participation in the Tier II process?

79. Please indicate the number of family members currently employed by CCSI at Tier I, by type of employment (employee or contract basis), and by full or part time position.

	Non- contract employees (#)	**Contract basis "employees"** (#)
A. Full time staff	_____	_____
B. Part time staff	_____	_____

C. For whom do these family members work?

80. Please indicate the number of family members currently employed by CCSI at Tier II, by type of employment (employee or contract basis), and by full or part time position.

	Non-contract employees (#)	**Contract basis "employees"** (#)
A. Full time staff	_____	_____
B. Part time staff	_____	_____

C. For whom do these family members work?

81. **A.** What impact does employment status (full time and part time; employee vs contract basis) have on the involvement of family members in CCSI?

B. What type of training is available to family members who are paid staff (Tier I and Tier II)? On what topics? How often?

C. What type of training is available to family members who are not paid staff (Tier I and Tier II)? On what topics? How often?

82. On a scale of 1—5, where "1" means "not active at all," and "5" means "very active," how would you describe the following:

A. how active family representation is at the Tier I level? ❒1 ❒2 ❒3 ❒4 ❒5

B. how active family representation is at the Tier II level? ❒1 ❒2 ❒3 ❒4 ❒5

83. On a scale of 1—5, where "1" means "made no difference at all," and "5" means "made a great deal of difference," what difference has family involvement made in the following:

A. the success of CCSI at the Tier I level? ❒1 ❒2 ❒3 ❒4 ❒5

B. the success of CCSI at the Tier II level? ❒1 ❒2 ❒3 ❒4 ❒5

USE OF FLEXIBLE FUNDS TO SUPPORT INDIVIDUAL SERVICE NEEDS

84. **A.** Are flexible funds available for those families involved in CCSI?

❒1 Yes ❒2 No

B. If no, why not?

If you answered No to question 84, go to the next section, Question 93. If you answered Yes *to question 84, please answer questions 85 – 92 below.*

85. **A.** What are the current sources and dollar amounts of the flexible funding that CCSI can use?

Source _____ $ Amount ____

B. For the following fiscal years, please indicate the total amount of flexible funds budgeted, the sources of those funds, and how much was actually spent.

	Amt. Budgeted	Sources	Amt. Used
2000	$_____	_____	$_____
1999	$_____	_____	$_____
1998	$_____	_____	$_____

C. In 2000, for how many families did you use flexible funding?_____

D. Approximately how often is flexible funding currently used for families/children in CCSI? (*Check one*)

❒1 For most (80+ %) families/children

❒2 For more than half (60- 80%) of all children/families

❒3 For about half (40-60%) of all children/families

❒4 For less than half (< 40%) of all children/families

E. What is the smallest dollar amount spent on flexible funding in 2000 for one family/child? $_____

F. How was it used?

G. What is the largest dollar amount spent on flexible funding in 2000 for one family/child? $_____

H. How was it used?

I. What is a typical dollar amount spent on flexible funding in 2000 for a family/child? $_____

86. Is there a procedure to access the flexible funds? ❒1 Yes ❒2 No
(If yes, please attach a copy of the procedure or describe the procedure).

87. Please rank the following in terms of how often flexible funds were used for these services in 2000, with "1" being "not used at all," and "5" being "used quite frequently:"

	Not used At All				Used Frequently
A. Respite	❒1	❒2	❒3	❒4	❒5
B. Mentor	❒1	❒2	❒3	❒4	❒5
C. Transportation	❒1	❒2	❒3	❒4	❒5
D. Recreational activities	❒1	❒2	❒3	❒4	❒5
E. "Urgent" household expenses (e.g. rent, utilities)	❒1	❒2	❒3	❒4	❒5
F. Co-pay for therapy	❒1	❒2	❒3	❒4	❒5
G. Other (*Please specify*)_____	❒1	❒2	❒3	❒4	❒5

88. About what percent of the time are flexible funds used for
A. One time only expenses _____% **B.** "Ongoing" expenses_____%

89. **A.** How quickly can you access flexible funds? (*Please check one*)
❒1 Immediately (within a day or so) ❒2 Within a week ❒3 Longer than a week
B. Does how quickly you can access flexible funds affect the extent to which CCSI uses these funds? Please explain.

90. On a scale of 1-5, where "1" equals "not at all," and "5" means "very much so," to what extent was your CCSI allowed to blend certain existing funding streams into a single fund which could be used to pay for services and supports to certain children and their families? ❒1 ❒2 ❒3 ❒4 ❒5
Please explain.

91. **A.** Are any changes needed on the issue of flexible funds? ❒1 Yes ❒2 No (*Go to Question 92)*
B. If yes, what are your suggestions?

92. **A.** On a scale of 1—5, where "1" means "not at all valuable," and "5" means "very valuable," how valuable is flexible funding for the effectiveness of CCSI? ❒1 ❒2 ❒3 ❒4 ❒5

B. On a scale of 1—5, where "1" means "not at all helpful," and "5" means "very helpful," to what extent has the use of flexible funds helped break down funding barriers? ❒1 ❒2 ❒3 ❒4 ❒5

C. On a scale of 1—5, where "1" means "not at all helpful," and "5" means "very helpful," to what extent has the use of flexible funds enabled families/children to access services not otherwise available to them? ❒1 ❒2 ❒3 ❒4 ❒5

OVERALL

93. Using a scale of 1—5, where "1" means "not at all responsible," and "5" means "very responsible," please rate the following features in terms of their contribution to the success of CCSI in your county. Then, please indicate, by checking the box in the last (shaded) column, which of these characteristics exist to a high degree in your county.

	Not responsible				Very responsible	Exist to high degree
A. Interagency coordination (Tier I)	❒1	❒2	❒3	❒4	❒5	❒6
B. Interagency coordination (Tier II)	❒1	❒2	❒3	❒4	❒5	❒6
C. Use of strength-based individualized care approaches	❒1	❒2	❒3	❒4	❒5	❒6
D. Family involvement at all levels of decision making	❒1	❒2	❒3	❒4	❒5	❒6
E. Use of flexible funds to support individual service needs	❒1	❒2	❒3	❒4	❒5	❒6
F. CCSI budget/resources/staffing levels	❒1	❒2	❒3	❒4	❒5	❒6
G. County government support	❒1	❒2	❒3	❒4	❒5	❒6
H. Tier II support	❒1	❒2	❒3	❒4	❒5	❒6
I. Tier III support	❒1	❒2	❒3	❒4	❒5	❒6
J. Other (*Please list and rate*)_____	❒1	❒2	❒3	❒4	❒5	❒6
K. Other (*Please list and rate*)_____	❒1	❒2	❒3	❒4	❒5	❒6

94. Which of the characteristics listed above need improvement in your county?

95. On a scale of 1—5, where "1" is "not at all successful" and "5" is "very successful," how would you rate the successfulness of CCSI in your county? ❒1 ❒2 ❒3 ❒4 ❒5

96. Since CCSI became operational, what key conflicts were experienced? Were these conflicts resolved? How?

97. In your opinion, what are the main impediments to a successful CCSI?

98. What are the main things you have learned since becoming the Coordinator that would be helpful for other CCSIs?

Additional Comments:

How much time did you spend completing this survey?_____

Thank you for your time and effort.
Please return this questionnaire in the envelope provided.