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2000 Series

VOLUME III
For the Long Haul: Maintaining Systems of Care Beyond the Federal Investment

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Foreword

It is with great pleasure that we present the second collection of monographs of the *Promising Practices* Initiative of the Comprehensive Community Mental Health Services for Children and Their Families Program. The 2000 Series connotes a time of new beginnings for this six-year-old federal grant program, which assists communities in building fully inclusive organized systems of care for children who are experiencing a serious emotional disturbance and their families. It also represents a year of validation and pride for those who have been involved with this movement for years. As more and more evidence on the effectiveness of the system of care approach amasses we have been able to gain increased support to expand the number of grant communities and the investigation of promising practices within those communities. In his millennium report on mental health, Surgeon General David Satcher stated, "Across the Nation, certain mental health services are in consistently short supply. These include the following: wraparound services for children with serious emotional problems; and multisystemic treatment. Both treatment strategies should actively involve the participation of the multiple health, social service, educational, and other community resources that play a role in ensuring the health and well-being of children and their families." Our grant communities employ these effective approaches in combination with other community-based strategies to help these children and their families thrive. As those of us fortunate enough to participate in this initiative grow and learn, we maintain a commitment to share our knowledge and resources with all communities.

Until recently, throughout this nation, and especially in Native American communities, most children living with a serious emotional disturbance have not received clinically, socially or culturally appropriate care. These young people have been systematically denied the opportunity to share in the home, community and educational life that their peers often take for granted. Instead these children live lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers hundreds and even thousands of miles away from their home. For many of these young people, families and communities, the absence of certain types of information has fueled the continued existence of inadequate and unresponsive service delivery systems. These service delivery networks often feel they have no alternative but to separate these children from their families and place them in costly long-term out-of-home placement. The *Promising Practices* Initiative is one small step to ensure that all Americans can have the latest available information about how best to help serve and support children who live with serious mental health problems at home and in their community.

The first generation of five-year grants has come to an end, and more than 40 new grant communities have joined the movement. These new communities will certainly benefit from the national knowledge base on how best to support and service the mental health needs of children who present major challenges, especially the contributions made by the grant communities themselves. We are proud that the information contained within these monographs by and large has been garnered within the grant communities of the Comprehensive Community Mental Health Services for Children and Their Families Program. The information was gathered by site visits, focus groups, data collected by the national program evaluation involving all grantees, and by numerous interviews

of professionals and parents. We have tried to "mine" the most relevant and helpful information to inform and enlighten the reader.

The 2000 *Promising Practices* series includes the following volumes:

- *Volume I—Cultural strengths and challenges in implementing a system of care model in American Indian communities* examines the promising practices of five American Indian children's mental health projects that integrate traditional American Indian helping and healing methods with the systems of care model.
- *Volume II—Using evaluation data to manage, improve, market, and sustain children's services* explores promising practices in the use of evaluation data, and shares a wealth of ideas and experiences from these sites about using local data in ways that can impact the delivery, management, and sustainability of community-based services for children and families.
- *Volume III—For the long haul: Maintaining systems of care beyond the federal investment,* through example, examines the fundamental strategies grantee sites should consider in order to maintain long-term financial stability, with an emphasis on non-federal funding sources.

As you read through each paper, you may be left with a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic isn't here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.

The communities that have been fortunate enough to participate in our federally funded initiative have been able to incubate solutions and promising practices that work! This series represents a gift of collective knowledge and lessons learned from our grant communities to those struggling to develop effective systems of care throughout the nation.

So the 2000 *Promising Practice* Series is now yours to read share, discuss, debate, analyze and utilize. Our hope is that the information contained throughout this Series stretches your thinking and results in your being more able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community. COMMUNITIES CAN!

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We hope the final result is valuable and helpful to sites struggling with issues of sustainability, and we urge them to pay attention to the important lessons learned, as illustrated in their colleagues' experiences and insights on the following pages.

Executive Summary

Ensuring financial sustainability for interagency systems of care for children with serious emotional disturbance and their families requires overcoming many challenges. Even though one site's approach will not necessarily work for others, the experiences and creative ideas of those who have struggled to put community-based systems of care on a firm financial footing can guide those who have recently received these grants so that their programs, too, can be around for the long haul.

Adopting the systems of care approach promoted in federal law requires a sea change in policy, clinical practice and administration. States and localities are expected to re-orient, re-design and re-finance child mental health services into true "systems" of care. It is in sites that effected the hoped-for sea change—where major and systemic re-thinking and re-orienting have occurred—are judged by stakeholders to be most likely to sustain themselves in a vibrant manner.

Federal law assumes that states and localities will commit to providing additional new funds to match the federal grant. Sites that have accepted that federal money is flexible, but time-limited, and have used their grant to build a partnerships with multiple agencies, families and sponsors find it easier to sustain the program.

This monograph is based on a review of non-federal funds secured by sites, and on conversations with site directors, policymakers and others concerning the most successful strategies to ensure long-range stability for the sites.

Sites have been quite successful in securing funds from various state and local sources, with a heavy emphasis on government funds. Most sites rely primarily on the mental health system, although child welfare agencies also contribute significant amounts. Education and juvenile justice agencies contribute at lower levels. Private funds are small, but often very precious to the site because of their flexibility. Sites obtain third party payments for direct services and have garnered support from local and national foundations, local businesses, charities and community organizations, often in the form of in-kind assistance.

Long-term financial stability requires that sites plan in a thorough and businesslike fashion for future funding and sponsors. Sites need to be entrepreneurial and directors report that sustainability planning is a long-term, iterative process that needs to begin with a long-range sustainability plan written early during the grant. Repeated reviews and revisions will then be necessary, as the plan must be adapted continually to meet new challenges.

All successful sites have good leadership. In several, a single charismatic individual has been instrumental in conceiving and organizing the site. But leaders will come and go and, for some sites, turnovers have caused difficulties. Even the most brilliant idea requires staying power. Leaders themselves must recognize the need to foster a program that is not dependent on one person.

Site directors are not running profit-making businesses, but they can learn from research and experience in the business world. Many business leaders emphasize a facilitation style, based on team work, not a top-down approach. This recognizes and respects the capability of all staff. The leader's role is to keep the organization moving and responding to changing circumstances.

One of the most fundamental aspects found in successful sites is strong, and real, interagency collaboration. The development of true collaborative partnerships creates a means to ensure fiscal accountability for all partner agencies. Successful sites recommend that others build true partnerships, from the beginning, because this is where sustainability begins.

Assisting in the creation of a local parent support organization or strengthening an existing one, is another important step. In certain states, family organizations have played key roles in ensuring sustainability with the legislature and other policymakers.

A strong potential strategy for sustainability is to seek redirection of resources. Initiatives in various states have redirected institutional funds to community-based services. Several sites have benefited from state initiatives to blend resources for meeting the needs of children served by more than one system. Blended funding pools can be created out of *existing* resources or they can involve allocation of *new* resources, secured through the federal grant or other sources and channeled into the pool. However, although blended funding is effective, it is difficult to accomplish.

Without pooling funds, other agencies may provide significant resources to a site through direct contributions, in-kind (staffing) contributions or specific "purchases" of service. Sites have found that purchase of service arrangements can accomplish the same goal as blended funding.

A reinvestment strategy can convince those who control the budget for human services to reinvest other resources in the site. Under reinvestment, the value of specific savings resulting from the improved organization and delivery of services through the site is calculated, in concrete financial terms, and funds that can be "saved" are reinvested in the site.

Managed care can be a pro-active strategy for sustainability or a reactive strategy. Managed care represents an approach for ensuring accountability in service delivery and the issue for sites, is *how* managed care is implemented and their role in delivering services through the managed care

system. Several sites demonstrate that managed care can redirect resources. Sites that have dealt most successfully with Medicaid managed care are those where the public system has organized the managed care approach. Sites that must interact with private managed care companies—either behavioral health care carve-out firms or health care managed care entities, such as health maintenance organizations—have had the most significant problems.

The importance of presenting good data to policymakers cannot be overemphasized. Policymakers need reliable data that points to a clear conclusion of effectiveness of services and cost-effectiveness of the system. Data should be relevant to current political concerns, such as child welfare placement rates, school drop-outs, rising juvenile justice facility populations and easily understood and supported by concrete examples of child and family experiences.

Sophisticated communications and media work are essential for any organization seeking to become an effective agent for social change. It allows a site to inform and mobilize the public, shape the policy agenda and strengthen the site's support in its local community. A media campaign should not run in a vacuum; it should be tied to the organization's priorities, such as securing resources.

Several sites have secured funds for their staff to provide training. This permits the site to garner additional resources to underwrite salaries and overhead costs. The training can have a significant impact on service providers who then are more supportive of the site and its goals.

Some examples of the many sites that have effective strategies to ensure sustainability are:

- Kansas, Rhode Island and Vermont had successful campaigns to secure state appropriations.
- Maine and Rhode Island built a system of care approach into their state mental health laws. In California, systems of care are supported through a child welfare waiver reform.
- Kansas, North Dakota, Philadelphia and Baltimore have influenced improvements in Medicaid to fund community services.
- Three sites have had good experiences using managed care—*Wraparound Milwaukee* is a managed care entity, Lane County funds child services under managed care and the Philadelphia site has a contract with the city's managed care arrangement.
- Blended funding is effective in Rhode Island, Vermont, Stark County, Ohio and purchase of service agreements work well in Santa Barbara and Milwaukee.
- Private, flexible resources are used in San Diego and Baltimore.
- Marketing has been emphasized in Santa Barbara.

- Several sites are skilled at using media: Kansas, Rhode Island, *Wraparound Milwaukee* and North Dakota's Partnership.

Sites can be successful in achieving financial sustainability, but it takes work and much planning. To achieve sustainability, sites must maintain their commitment to the philosophy of a system of care, adapt to broader state policy initiatives, especially managed care, and tap into major entitlement funding and state government resource streams. Reallocating resources is an important part of the solution, and generating broad community support through community organizing, social marketing and media work is essential.

Ideas illustrated in this monograph can help ensure sustainability for other sites and result in these systems being around to help children and families over the long-haul.

Chapter I–Introduction

Securing funds for human services programs is not a given in the current political era. Introducing people to new and different ideas and ways of doing business is never easy and often requires us to challenge established political and programmatic forces. Also, adapting programs to sudden shifts in policy direction, such as the adoption of managed care approaches in state mental health systems, can overwhelm. Those who seek long-term, sustainable interagency systems of care for children with serious emotional disorders and their families, must cope with all these challenges, and more.

The purpose of this monograph is to assist newly-funded sites under the federal Center for Mental Health Services grant in learning from the experiences of veteran graduate sites concerning ideas and strategies to sustain systems of care beyond the end of the grant.

Experience from the first group of graduating sites suggests that most are surviving and many thriving, but that sustainability was not given sufficient focus early in the projects' development. As a result, some programs have struggled as their federal grants have terminated. Newer projects, however, can learn important lessons from the graduates in terms of the overall approach to sustainability and specific strategies. No one site's approach will necessarily work for another, but the experiences, the plotting, and the creative ideas of those who have struggled for five years or more to put community-based systems of care on a firm financial footing can stimulate brainstorming and guide those who have recently received these grants. Then their programs, too, can be around for the long haul.

BACKGROUND

The Comprehensive Community Mental Health Services for Children and their Families Program[1] was designed to create significant change. It was established by Congress in 1992 in response to testimony indicating that children with serious emotional disorders who lack appropriate services get in trouble with the law, drop out of school, are unnecessarily removed from their families and spend unnecessary time in long-term residential placements.[2] Testimony indicated that services for these children were unavailable, or when available were often inappropriate, fragmented and difficult to access.[3] Congress heard testimony on the human and financial costs of this failure to meet children's needs.

Congress learned that children and adolescents with serious emotional disorders and their families need a range of culturally-sensitive services provided through flexible resources that support the child and family and avoid institutional placements. Most of these children have complex needs and receive services from more than one public agency, but interagency collaboration, witnesses pointed out, is rare.[4]

The program authorized in response to these concerns is the Comprehensive Community Mental Health Services for Children and their Families Program (or The Children's Mental Health Services Program for short) of the federal Center for Mental Health Services (CMHS). This program is not, as it is sometimes described, a demonstration program designed to test a new approach. Federal policymakers viewed the program as the next step in a series of child mental health policy reforms. The Children's Mental Health Services Program was built on the solid foundation laid by the Child and Adolescent Service System Program (CASSP). It would implement CASSP concepts, already tested, and would provide the necessary resources to states, communities and Native American Tribes to develop systems of care in their areas. Each grant was to be tailored for the specific community, but also to serve as an impetus for statewide systems change.

To adopt the approach promoted in the federal law requires a sea change in policy, clinical practice and administration. To implement the program, states and localities are expected to re-orient, re-design and re-finance child mental health services into true "systems" of care. According to Ronald Weich, Counsel to the Senate Committee on Labor and Human Resources and the lead congressional staff person to draft the Child Community Mental Health Services legislation, "Congress was attempting to fund system-wide change at the local level and foster a true commitment to system-wide change at the state level."

The congressional legislative history describes the program's purpose. Congress expected the program to provide "seed money to stimulate the development of systems of care"[5] and required that applicants "demonstrate their commitment toward instituting comprehensive coordinated systems of community-based care throughout the state or local area."[6] Congress created requirements for matching funds "in an effort to increase state and local efforts to assure responsibility for the systems".[7] To avoid creating just another grant to local communities without impacting more systemic reforms, the law required state-level engagement. As explained in the legislative history, Congress wanted "to encourage replication of such systems of care throughout the state,"[8] and, therefore, required non-state applicants to obtain comments on their plan from the state. Non-state applicants would receive special consideration for federal funding only if the state contributed funding to the project.

Beginning in FY 1993, states, communities, and Native American tribes were eligible to apply for five-year grants, awarded on a competitive basis, to design and implement an interagency, community-based system of care. The size of the grant was proportional to the number of children to be served. The target population, as defined by the law, included youngsters with serious emotional, behavioral, or mental disorders, up to age 22.

In the first two years, 22 sites in 18 states received funding. Each program served a defined community, ranging from several schools in East Baltimore, Maryland to statewide efforts in Rhode Island and Vermont. Offering a broad range of mental health services involving Mental Health, Child Welfare, Education, Juvenile Justice, and other public agencies, the programs were to be models of best practice in meeting the needs of children and adolescents with serious emotional disorders and their families.

In 1999, these first 22 sites have reached the end of their federal five-year grants. It is significant that those sites that show the hoped-for sea change—where major and systemic re-thinking and re-orienting have occurred—are the most likely to sustain themselves in a vibrant manner. All sites, even the most successful, continue to struggle with some issues, but those that were the most cautious or the most traditional did not achieve the fundamental system reforms needed to ensure long-range improvements in outcomes for children with serious emotional disorders in their community.

The first lesson from the earliest graduates of the program is that to make lasting change and a real impact, sites must be bold and pursue the goal of systems change envisioned by the drafters of the federal law. When they do, and when they focus and plan, they can galvanize support and achieve sustainability.

Notes:

[1] The Comprehensive Community Mental Health Services for Children and Their Families Program was authorized in the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act of 1992 (P.L. 102-321). The program is administered by the Center for Mental Health Services (CMHS) in the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Public Health Service, Department of Health and Human Services.

[2] *Close to Home: Community-Based Mental Health Services for Children*. Hearing before the Select Committee on Children, Youth and Families, U.S. House of Representatives. Washington, D.C., April, 29, 1991.

[3] *Ibid.*

[4] *Ibid.*

[5] Community Mental Health and Substance Abuse Services Improvement Act of 1992, House Report 102-464, concerning Section 104, the Children's and Communities' Mental Health Systems Improvement Act.

[6] *Ibid.*

[7] *Ibid.*

[8] *Ibid.*

Chapter II–Federal Law Requirements

Federal law assumes that each site funded under the Comprehensive Community Mental Health Services for Children and their Families Program will be supported with new resources. Any current spending by public agencies is expected to continue, but the federal grant requires states and localities to commit to providing additional, new funds to match the federal grant. Furthermore, funds may not be transferred from one locality in the state to another in order to meet this match requirement. This approach has a very specific purpose: to influence the long-range financial stability of the sites.

Each grantee must be able to provide a significant, and increasing, match for the federal funds it is awarded. The specific requirements for matching fund levels are—(1) in years one to three, $1 in non-federal funds for every $3 in federal grant funds; (2) in year four, $1 in non-federal funds for every $1 in federal grant funds; and (3) in year five, $2 in non-federal funds for every $1 in federal grant funds.

Matching funds must be:

- non-federal public or private funds (for example, federal Medicaid funds may not be counted);
- funds that are not used to match any other federal payment (for example, state funds used to match federal Medicaid funds may not be counted);
- funds that are spent on the system of care (for example, state child mental health appropriations that are spent in another part of the state may not be counted);
- in either cash or in-kind, fairly evaluated, which may include plant, equipment or services. The cost of space and the cost of personnel are the two most usual forms of in-kind support (for example, the salary of a child welfare staff person "loaned" to work for the system of care can be counted).

Matching funds may not be redirected state or local appropriations but must be *new money.* To ensure this maintenance of effort, when state funds are used as part or all of the match, the law requires that the average amount of funds expended for similar services in the entire state over the past two years count as the base. The new funds, however, must be dedicated to the costs incurred

by the site itself as it operates the system of care.[1] This requirement also means that if a system of care existed before the federal grant was received, new state and local resources are needed for the match. Continuation of previous levels of public spending is not sufficient.

These rules apply for all years of the grant. Programs that obtain significant new money by drawing down federal Medicaid or child welfare funds, cannot use those new resources as the match for later years of the grant. Programs can, however, use new funds, including Medicaid, child welfare and other federal resources, to expand the scope of the program beyond what would have been possible with the original grant and the original non-federal match.

The effect of all these various rules is to require that localities and/or states make a substantial commitment toward any new federal child mental health service system grantee. There are no easy, short-cut answers to obtain the required matching funds. A commitment from the locality and the state is essential in order to obtain a grant. This is intended to ensure that the system, assuming it is viewed as a successful program locally, will have a strong financial and a political base from which it can draw support when federal funds are no longer available.

Other provisions of the law encourage systems to bill for services whenever this is feasible. Grantees must be qualified to collect reimbursement under Medicaid, must charge any relevant private insurance policy and have the flexibility (but this is not a requirement) to charge families with incomes over the poverty level on a sliding scale.

Sites need to be able to secure federal entitlement funds through: Title IV-A (Temporary Assistance to Needy Families, TANF), Title IV-B (grants to states for child welfare prevention and case management services) and Title IV-E (uncapped entitlement program reimbursing states for costs incurred in placing eligible children in foster care and adoptive homes, including costs of training). Similarly, funds can be obtained for school-based related services through the federal Individuals with Disabilities Education Act (IDEA), Parts B and C.

Sites also need to address the issue of the viability of a strong family organization, either locally or statewide. Family organizations have provided extremely important support for sites as their grants run out, but will be unable to do so if they are not well-functioning organizations with a broad base of support among families in the site and in the state.

IMPACT OF FEDERAL FUNDING PHILOSOPHY

The overall impact of the federal requirements is to ensure that federal resources are dedicated to system change. The federal program provides grantees with the freedom to use the substantial resources of the grant to invest in program infrastructure, create new initiatives, engage in community organization, training, marketing or any other activities that will bring long-term stability to the reforms put in place through this grant.

Projects that approach these grants with the concept that the federal money is flexible, time-limited and to be used to change the status-quo and build true partnerships among multiple agencies and families will find this program extremely valuable. The early grantees highlighted in this report have done just that, and these are programs that will most easily sustain their operation into the future. Some of the sites sought these funds to keep basic child mental health services afloat; many of those projects are now having difficulty finding alternative funding sources and sustaining their system of care. Very few sites, however, have failed to make real change in child service delivery in their communities.

Notes:

[1] Office of the General Counsel, U.S. Department of Health and Human Services, in letter to Gary DeCarolis, Center for Mental Health Services, January 12, 1998.

Chapter III–Methodology

This monograph reviews the sources of non-federal funds secured by federal grantees to match their Child Mental Health Services Program grant and presents the strategies and approaches that have proven most successful in ensuring long-range stability for the sites.

The Bazelon Center for Mental Health Law collected data on non-federal matching funds, both cash and in-kind, from the 22 grant recipients in 1998 and 1999. The data pertained to revenues in 1997 and 1998, and identified state and local government resources and private funding. It identified resources raised from mental health, child welfare, education/schools and other public sources.

To identify successful sustainability strategies, telephone interviews were conducted with federal technical assistance directors and federal project officers to identify sites with the greatest capacity to become self-sustaining. Information from the calls and the data were then assessed in order to select a group of sites for further review.

Contacts were then made with individuals connected to the selected sites. This mostly involved discussions with the site directors. In some sites others, such as the family organization, also were contacted. The informants were asked to confirm the accuracy of the data collected earlier from the sites and to provide additional detail on strategies used to ensure sustainability beyond grant funding.

The material in this monograph, including information and advice presented in the general sections, reflects the combined wisdom of all individuals interviewed, informed by the data.

Chapter IV--Experiences of the Original Sites: Sources of Non-Federal Funds

Sites have been quite successful in securing their non-federal matching funds. Funds are collected from various state and local sources with a heavy emphasis on government funds. Sites rely primarily on the mental health system for resources but child welfare agencies also contribute significant amounts to most sites. Education and juvenile justice agencies contribute to many sites, but at lower levels. State education funds are rarely used, although many sites receive local education support.

A listing of the various sources of non-federal funds used across the sites appears in Exhibit IV-1. Not included are state- or local-specific funding initiatives that are not likely to be available or feasible in other states.

"States are the centerpiece for providing and financing children's mental health services,"[1] according to the National Conference on State Legislatures. From this study the single most important source of revenue for child mental health services sites is certainly the various resources controlled by state mental health authorities.

Among the current grantees (data collected on 17 sites), the major child-serving agencies (state and local combined) have a high rate of financial participation. The percentage of sites that report receiving funds from the various agencies is as follows:

Mental Health	100%
Child welfare	68%
Education	63%
Juvenile Justice	42%

Exhibit IV-1: Sources of non-federal funds used across sites.

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

A number of sites also indicated that a portion of their funding came from blended, interagency funding pools created for the system of care.

Twenty-one per cent of the sites that responded are essentially mental health authority programs.[2] Yet few mental health authorities will ever be in a position to support systems of care all around the state with only mental health and Medicaid resources. The failure of some early federal sites to build truly collaborative systems has caused difficulties when they seek to replace lost federal dollars and when states seek to replicate the system of care concept around the state.

State-controlled mental health funds used by the sites include: federal and state Medicaid, the federal mental health block grant and state appropriations. Child welfare agencies at both the state and local level contribute significant resources in the form of both funds and in-kind support. In a number of states the juvenile justice authorities also are important contributors using funds from courts, probation offices, parole and juvenile justice prevention resources. Far more problematic among the major child-serving agencies is education. Although sites have resources from education, this is generally at a low level. Because state education agencies do not participate consistently across the sites, sites must negotiate at the local level with each school district, or even building by building. Even then, support is quite frequently in the form of in-kind resources. In some sites, support from other agencies comes in the form of shared costs of salaries for program staff. For example, day treatment education programs and case management located in various agencies often results in shared staff salary costs.

Local funds come primarily from general fund dollars, either through the mental health or child welfare systems. In some sites, juvenile justice and education provide significant percentages of local revenues.

Private funds are generally raised only in very small amounts, but often they are very precious to the sites because they are extremely flexible. Sites obtain third party payments for direct services and also have garnered support from local and national foundations, local businesses and the United Way. Also, various local charities and community organizations often lend their support, mostly in the form of in-kind assistance. These include various faith-based groups and local programs that can provide services to children with serious emotional disorders and their families.

All sites report that from these various sources they have been able to meet the federal match requirements, and a number of them "overmatch" as they are able to secure more resources than necessary. However, one issue that emerges from this data is the extent to which some sites rely on in-kind match. Nearly a third of the sites receive 50% or more of their matching resources from in-kind sources. Generally speaking, a commitment of hard resources from a partner agency is more

meaningful for sustainability than the commitment of some level of staff time. In-kind match is very soft, and should the partner agency have fiscal issues of its own, it may well be the first cutback to be made. A commitment of resources to the site, either per child served or per fiscal year, represents a more meaningful buy-in from the top of the partner agency.

Despite common patterns, sites have very different mixes of resources. For example, California has state funds for systems of care, Hawaii is under a federal consent decree to comply with IDEA and provide expanded mental health services, local tax levies exist in New York, and Maryland has a number of outside grants to supplement Medicaid and mental health resources.

Sites successes in raising the necessary matching funds during the course of the grant are confirmed by state mental health authority officials. Using a five-point Likert scale, state mental health authorities were asked to assess the sites' successes in raising their matching funds. Overall, these officials rated sites at 3.89, a moderately high assessment and 13 of 19 sites scored either a 4 or a 5.

With respect to raising the necessary funds to replace the federal grant as the five-year grant period ends, state officials expected a similar pattern. Using the same scale, they rated sites likelihood of being sustained as 3.94.

Thus, according to state officials, sites have been reasonably successful in raising the matching funds for the federal grant and they are likely to be equally successful in raising the necessary resources to become self-sustaining. Only a few sites were seen as likely to fail to sustain themselves at a significant level of operation and one third were expected to be very successful.

In the following chapters, we summarize advice from existing sites and their technical assistance providers, and policies adopted in states. This information is intended to be valuable both to site directors and to state and local policymakers as they seek to expand the systems reform envisioned by the founders of the Comprehensive Community Mental Health Services for Children and their Families Program.

Notes:

[1] Craig, R. T. (1990). *What legislators need to know about children's mental health*. Washington, D.C.: National Conference of State Legislatures.

[2] Bazelon Center for Mental Health Law. (1998). *Report on source of matching funds for child mental health service system programs*. Washington, D.C.: Author.

Chapter V–Philosophy and Approach for Successful Sustainability

Developing and then sustaining a system of care is not an easy task, nor is it one likely to move forward in a linear fashion. Instead, numerous stops and starts—caused by changes in leadership, changes in service delivery approaches or pockets of resistance to change—can be expected. Those engaging in such an endeavor must take a long view.

> *"Implementing a system of care takes time...It can take many years to grow but federal funds are only available for five." (Technical Assistance HUB Director)*

A system of care site can rarely be firmly rooted in a five-year period. Some sites develop the groundwork and begin the program prior to applying for federal funds. These sites then have more than five years of experience before federal funds run out. This gives them a clear advantage, as their track records now show. For other sites, where federal money initiates a system of care, withdrawal of federal support after five years can be more problematic. Programs initiated with federal funds need to take particular care to lay a strong groundwork, and must appreciate that much work will be required even after federal funds are withdrawn.

BUDGET PLANNING

Start Early, Adapt and Revise

> *"Sites will come to understand the realities of managing huge underfunded systems. There are lots of problems, much negotiation and very difficult issues to deal with." (County Mental Health Director.)*

Long-term financial stability requires sites to plan in a thorough and businesslike fashion where resources will come from and to identify steps to assure that these funds do, in fact, materialize. Sites need to be entrepreneurial and to engage in multi-year budget planning and fund-raising.

According to sites with experience, new sites should focus on resource issues early, and they should do so in a collaborative effort with all of their partners. Sustainability planning is a long-term, iterative process and many of the early grantees now believe that a long-range sustainability

plan needs to be a focus early during the five-year grant. Sites should also expect to engage in repeated reviews and revisions, as this plan must be worked at continually, updated and adapted to meet new challenges.

While it is important to avoid financial problems in the last few years of the federal grant, it is equally important not to simply chase any revenue stream that comes along. What is needed is a coherent, coordinated strategy to obtain substantial direct-services funding along with the flexible resources that can support the broader mission and goals of the site.

Lessons on financial stability learned from a major foundation demonstration project, the Robert Wood Johnson Mental Health Services Program,[1] were to:

- Take advantage of all applicable federal entitlements;
- Integrate the efforts of all responsible agencies so as to finance a delivery system with resources from various agencies, and
- Reallocate resources from restrictive care to community interventions that occur earlier.
- Additional lessons learned from the federal sites are to:
- Secure specific state-level appropriations;
- Participate in appropriate reforms in Medicaid or other child-serving systems, such as child-welfare reforms, especially those involving the transition to a managed care approach, and
- Look for independent private funds to supplement government funds so as to provide resources for activities governments may not underwrite (such as flexible funding).

Questions to Answer as Part of Budget Planning

- What do you want the program to achieve?
- What is the current financial baseline (exclusive of federal grant funds)?
- Who are potential agency partners who might contribute resources?
- How can it be demonstrated to potential partners and other potential funding sources that the site is a success?
- What is the return on investment in your program?
- How much, realistically, can be recouped from each of these partners each year, and how much from entitlement programs? What is the short fall, and for what types of activities?
- What are all other potential sources of revenue, public and private?

A Business Approach

> *"Think like a business from the beginning. Maximize all funding so you do not have too many eggs in one basket, and tap into Medicaid and child welfare for long-term service funding." (Site Director)*

To initiate planning for sustainability, CMHS requires that applicants develop "a written plan, integrating social marketing principles that are in concert with the community-based system of care." Sites that understand the concept of marketing are among the more successful in achieving sustainability. Marketing, in this context, means using the techniques and approaches known to be effective in helping people understand and accept new ideas and ways of doing business. Social marketing requires that sites take an entrepreneurial approach to their financing plan. Early on, the site needs to know where future income will come from and begin to market its program to secure these resources. The resources may come from other agencies, the legislature or private funding sources.

Sites must decide what needs to be done, who will do it and how, in order to ensure success. This entails doing solid research about what the program's "customers" are looking for. Potential sponsors will appreciate being shown a carefully thought-out plan of where future resources will come from. This gives them reassurance about their own investment and security that the site will thrive and remain effective.

A business plan normally includes a description of the site and its services, an assessment of the target population and of other providers offering similar services in the area. It includes details of long-term goals and anticipated interim steps, along with strategies for achieving these goals. It must also include financial information, both current and projected so as to show increasing fiscal stability over time. The plan should include cost-effectiveness data and cost-benefit ratios that best describe the program's track record.

Some parts of a business plan can be adapted easily from the site's write-up for its grant. The plan must describe the site and its capacity to deliver cost-effective services, information that is also required for a grant application. The business plan, however, must emphasize why the site is unique and meeting an otherwise unmet need.

Sites should expect to have to "sell" the system of care to staff of other agencies, to market its potential to community leaders and describe it clearly and concisely to local and state politicians. Many policymakers, and certainly many staff in other agencies, are jaded about reform in children's services. Too many attempts have been made and too many failures have occurred for them to have

faith in this new approach, unless they can be shown some concrete results. This process can be enhanced if families, and the family organization, are part of a process to develop the marketing plan and purveyors of the plan's message to other audiences, such as other agencies.

Sites may find information on business planning useful. The federal Small Business Administration (www.sba.gov) is a useful resource.

Finding The Resources

Experiences of sites have shown that federal grant funds are best used as flexible funds to initiate and support services and activities for which entitlement programs will not pay. Federal funds can build infrastructure, pay start-up costs for new programs, foster the collaborative process, support community organization, media campaigns and other activities not covered any other way. For ongoing, long-range support for the bulk of the services to be delivered, sites should look to major entitlement programs and other substantial funding streams.

> *"It's a waste of very flexible dollars to use them to pay for interventions." (State project officer.)*

Data on funding sources of existing sites shows:

- Maintaining services by maximizing use of major funding streams is a first priority.
- Securing funds through state and local mental health and child welfare budgets is the second most important priority.
- Developing strong relationships and the purchase of service arrangements with the various parts of the juvenile justice system has proven effective.
- Pursuing education funds is very important, but difficult.
- For some sites, blending of funds from more than one agency has created on-going commitments from other agencies.
- Various parts of the program also may be jointly funded through other state agencies, such as health, substance abuse housing and vocational rehabilitation.
- Local general fund resources can be useful, as can funds negotiated from local agencies.
- Third party payments should not be relied upon for significant funds, but if secured can be critical in funding the activities that ensure sustainability of a system of care. These include health insurance fees (be sure the site is set up to bill for private insurance) and client fees.

- Donations from businesses, foundations or private giving, and fees can provide small amounts of funds that can be used for flexible activities not covered by other funding sources.
- If necessary, sites can consider seeking a loan.

Family organizations (which are non-profit entities) can accept charitable donations, which can be targeted toward the needs of the site. Several family organizations have contributed in-kind and other resources to a site, and tax-deductible contributions are one way for those resources to be obtained.

The marketing and budget plans should also take account of in-kind support. Obtaining in-kind support demonstrates to many funding contributors that the program has a commitment from various community players.

LEADERSHIP

One of the more nebulous but significant factors in sustainability for a site is leadership. Strong leaders have been connected with most of the initial group of CMHS sites. Sometimes these leaders are the directors of the sites themselves and sometimes they are state officials in key positions.

All successful sites have good leadership. In several, a single charismatic individual has been instrumental in conceiving, organizing and securing funding for the system of care. Such leaders are often found in the front of innovative movements. But even the most brilliant idea requires staying power. Leaders will come and go, and in some sites turnover has caused difficulties. Leaders themselves must recognize the need to foster a program that, as it evolves, becomes less dependent on one person.

> *"Sustaining a site means sustaining people. Changes in leadership can mean loss of vision. Often you can get this back, but you lose so much momentum" (Federal HUB Director.)*

Although leadership development and leadership skills are key aspects of a sustainable system of care, leadership can take many forms. Yet, regardless of the leader's preferred style, there are some essential elements to leadership in today's world that those who plan to lead community-based systems of care should know.

Systems change requires a clear vision, the ability to ensure that the vision is implemented, and that the necessary resources are found. There are many ways to accomplish these goals.

Site directors are not running profit-making businesses, but they can learn from research and experience in the business world. Many business leaders have begun to appreciate that changes are needed in the old-style leadership of top-down direction, where information was used as power. Courses for business leaders today emphasize mobilizing staff to become committed to shared goals. Leadership involves a facilitation style, not a top-down approach, and recognizes and respects the capability of all staff. Commitment and creativity is encouraged from all parts of the organization.

Modern business leadership is based on team-work, on the concept that no one can be as smart as everyone acting together. It is open to new ideas from all staff, and all information is shared. It ensures that the project sends a common, consistent and coherent message to all audiences. Everyone connected with the site should be animated and involved, and take pride in what is being accomplished. The leader's role is to keep the organization moving, responding to changing circumstances and evolving.

Such a style benefits leaders of a system of care. It is a strengths-based approach to management in which leaders accept that they do not have all the answers but are willing to facilitate and listen. Such a style is also well-suited for those who have been attracted to the human services field, and it is certainly well-suited to the collaborative nature of a system of care.

For sustainability, such a style ensures that even when there is a charismatic leader who has been critical and instrumental in the early days of development, the project can move on smoothly as leaders come and go. When the leadership style in a site is facilitation, there will be individuals within the organization who will carry on this role during leadership change-overs, ensuring important continuity.

Sites also must consider a leadership role for board members. Selecting to serve on the board individuals who are able to play a role in sustainability is the first step. Those with political ties, links to foundations or corporations as well as individuals with stature in the community should all be considered. All board members also should receive training on the role of a non-profit board, including its role in strategic financial planning. Activities in which board members can be particularly helpful include fund-raising events, capital campaign drives, visits to foundations, corporations and local charities.

RETAINING THE SYSTEM OF CARE PHILOSOPHY

It is not an important policy objective to sustain all of the sites that the federal Child Mental Health Service Program has funded. Sustaining *sites that practice the philosophy of a system of care* is the goal. If that cannot be accomplished, then closing the doors of a site once federal funds run out may be the best solution.

The most successful sites have been those that illustrate and retain key elements in the system of care philosophy. They adhere to the service philosophy of the Child and Adolescent Services System Program, engage in true interagency collaboration, have ensured cultural competence, developed close working relationships with families and the community, and have supported organized family support and advocacy.

The goals and values embodied in the system of care are valuable tools for creating support for the program. For example:

- The child-centered and family-support orientation, if fully implemented, gains significant support from family organizations;
- The individualized, comprehensive array of services ensures that the system will be a valuable resource to other child-serving agencies which, in turn, increases the likelihood of financial support;
- The delivery of services in a culturally-competent manner enhances support from families and the wider community.
- The emphasis on community-based alternatives to residential, out-of-home placement reduces costs and increases effectiveness—major goals of policymakers at all levels that can lead to redirection of funds.

"If you look at the most successful sites, they are the ones that have had success with interagency collaboration and family involvement, etc." (Site Director.)

In the long run, systems that have most closely adhered to the core values of systems of care appear most able to sustain themselves, as well as to grow and clone themselves following termination of the federal grant.

INTERAGENCY COLLABORATION

"Interagency collaboration is priceless" Juvenile justice official whose agency collaborates with and provides funding for a site.

One of the most fundamental aspects found in the most successful early sites is strong, and real, interagency collaboration.[2] The development of true collaborative partnerships, and especially of a single plan of care, creates a means to support and ensure fiscal accountability for all partner agencies. Sites that have appreciated the value of this approach have been more successful in obtaining the ongoing financial support from other systems that will enable them to sustain themselves.

To ensure meaningful collaboration on financial issues, the site's sustainability plan must be developed with, and not for, its collaborating partners. The early sites recommend that others build true partnerships from the beginning, because this is where sustainability begins. Then whatever happens during the life of the site, is dealt with by all partners together. Some of the sites set-up as private, non-profit entities have had difficulty with collaboration because they have been viewed as one among many service providers, rather than as collaborative community partners.

> *"Interagency collaboration is slow work." (Site Director) "There is a need to invest early and then you see the pay off later. It can be hard to convince other agencies of the value in those circumstances." Site Director*

A uniform theme from sites with success in obtaining significant resources from other agencies is the concept that the other agency will buy only services it sees as being of value, particularly those that show results. Thus, limited, specific programs have been developed with individual schools in some sites, or child welfare agencies have committed a specified proportion of their funds to the site for meeting the needs of a specific number of children. In these sites, the first question the site asked itself was, 'what can be done to make the other agency's job easier?' That view ensures that other agencies feel they are customers of the system, obtaining services of value to them and are willing to pay for them.

> *"Our experience has shown us that much time has to be invested from the very start of the grant (to help partner agencies feel ownership); that it's not a financial loss (for them), but a way to leverage a small amount of their funds to benefit a substantial portion of the kids they serve." (Site Director)*

State-level interagency collaboration is also essential to secure policy changes in the state that can ensure success locally. State-level coordinating structures can take a variety of forms and play various roles, but where they exist they too become a means for integrating the system of care philosophy into the fabric of state policymaking. This can result in long-term financial commitments

to the sites. Among the initiatives found in states where sites are located are interagency agreements for blended, pooled funding, purchase of service agreements, capitation payments, and joint funding of certain staff.

Sites with ongoing and collaborative working relationships with other agencies find that by the end of the federal grant period there are significant pay-offs with respect to sustainability:

- The development of mechanisms that bring resources from various agencies into the site.
- The blending of resources into a single funding stream to enhance the effectiveness of the site by providing flexible resources and cutting the administrative burden.
- Efficient use of the resources other systems spend on mental health care, in ways that reduce their reliance on residential services.
- Pooled resources to use as match for entitlement programs, thus expanding resources still further.
- Access to resources not available to mental health (child welfare Title IV-E and Title IV-B funds; education, Special Education and Related Services funds and school health resources, juvenile justice preventive service dollars, etc.)
- Other agencies' support for the program with state legislatures and senior state executive branch policy makers.
- Ties to child advocacy groups that are different from mental health advocacy groups, which can address the need for resources for the site in their advocacy.
- The creation of groups at the state, regional or local level focused on the needs of the most hard-to-serve children, which in turn can bring increased policymaker attention and resources to bear on the problem.

Some of the most successful sites with strong collaborative interagency collaboration are: Stark County, Ohio, Santa Barbara, California, Vermont and Rhode Island. Interagency collaborations with education are particularly difficult, but exist in Rhode Island, Ohio and Solano County, California (where children with high needs in special education are diverted into system of care services).

FAMILY INVOLVEMENT

The involvement of individual families in their child's care and the provision of support (in the form of specific services for families) is an essential principle of the program. However, beyond the obvious programmatic advantages of a philosophy of respect for families, most sites also have reached out to family organizations, or in some cases have created them. This is an important step for a variety of reasons. It ensures that the system is responsive to those it is to serve. It also provides a vehicle through which families can express their support for the system.[3] Family groups should be seen a full partners, working alongside other partners in the system of care. Representation by families should ensure reflection of the population being served in terms of its ethnic, religious, geographic and cultural diversity.

"There is very little now that I do without them." (Site Director about family organization's role in sustainability effort.)

With respect to sustainability, this approach brings several advantages:

- The site can create a broader voice of support within the community and at the state legislative and policy-making levels;
- Family organizations have more flexibility than local agencies in advocating or lobbying with state and local elected officials;
- Family organizations are seen by policymakers as more objective than program administrators when it comes to assessing the value of continuing to fund a site, and
- Family organizations may take on issues directly with other child-serving systems and thereby facilitate more cooperation.

Two family organizations, one in Kansas and one in Rhode Island participated in advocacy for sustainability of existing sites and for the expansion of the system of care approach across their home states (see Chapter VII). In both states, coalitions that included a strong family organization led to political support for significant appropriations.

COMMUNITY ORGANIZING/CULTURAL COMPETENCE

Many community groups, including businesses and volunteer groups, are potential allies. Good community organizing skills are needed to reach out to a variety of local interests whose agenda may not at first appear to coincide with the site's, but which have, in fact, a common interest. Some of the groups tapped by sites include Chambers of Commerce, banks, Rotary Clubs, faith

organizations, United Way, community action agencies, housing project associations and community service organizations. In addition to specific organizations, individual community leaders can be extremely helpful.

Community organizing represents a significant investment of time and effort. It requires gaining a full understanding of the community's own view of its problems and needs with respect to children with serious emotional disorders. Within the community, these children will inevitably be viewed as "problem kids". Education, discussion and negotiation will be necessary before a community organization will become supportive of the site. Nonetheless, there can be a significant pay-off in policymaker support and in the site's ability to secure other local, state or federal grants and contracts if such support is obtained. Community groups have lent their support to fund-raising efforts of sites, have identified new sources of funds, and have opened doors to funders. National foundations, local governments and other funders are impressed by evidence of real community commitment.

Community organizing can lead to several positive results:

- Support from the business community, both in the form of direct financial or in-kind contributions and through lending their support to powerful political interests at the local and state level;
- Support and interest from various civic and community groups, faith organizations, community-service organizations and community agencies can result in their help to publicize the program, contribute volunteer manpower, make space available for site activities and reference the site in their political initiatives in support of expanded community-based services;
- Community support makes it very difficult for policymakers to cutback or cut-off funding when the federal grant runs out;
- Securing local foundation funding can ensure continued operation of activities difficult to underwrite with government funds;
- Securing United Way funding, valuable itself, also can lead to the site influencing the delivery of other programs funded by United Way so that children with serious emotional disturbance are given greater access to these other community resources (however, United Way funding also comes with strings, as the organization limits the recipients other fund-raising activities);

- Securing positive media stories on the site's successes; not only does this help to build political support, but it also will help to balance the public's views of the program should there be any unfortunate incidents with respect to the program or any of the children it serves.

The Baltimore, Maryland site is an example of one which has focused heavily on community organizing in a culturally competent manner, and more details on their activities are presented in Chapter VI.

Steps Towards Sustainability I

1. Develop a business plan—know your income needs for next several years and have solid plans for securing revenue.
2. Be sure you have secured all appropriate revenue from established funding streams, such as Medicaid, Title IV-B, Title IV-E, federal mental health block grant and substance abuse block grant and IDEA.
3. Maintain commitment to the system of care philosophy (why else sustain the program?) Be smart about how the project is led.
4. Conduct strategic planning (and update the plan annually) to determine how the program will market its services. Identify the "customers," their needs and how the site will meet those needs. Include plans for who, how and when to reach out to each such audience and bring them fully into a partnership.
5. Engage in continuous quality improvement.
6. Establish specific collaborative relationships with interagency partners, be sure the site is of value to them and negotiate ongoing funding responsibilities.
7. Develop or align with a strong statewide family organization.
8. Engage in community organizing to secure support from local groups and to learn how they view your program.

Notes:

[1] Cole, R.F., & Poe, S. (1993). *Partnerships for care: Systems of care for children with serious emotional disturbances and their families*. Washington, D.C.: Washington Business Group on Health.

[2] This section does not discuss how to develop interagency collaboration, but how interagency collaboration relates to sustainability. For more information on interagency collaboration see Hodges, S., Newman, T., & Hernandez, M. (1999). Building collaboration in systems of care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume VI*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

[3] For more information on building relationships between a system of care site and family organizations see Osher, T.W., deFur, E., Nava, C., Spencer, S., & Toth-Dennis, D. (1999). New roles for families in systems of care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume I*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Chapter VI–Securing the Resources

This chapter discusses various strategies for securing resources but does not discuss specific examples from the sites in any depth. For examples that illustrate this and other strategies for sustainability, see Chapter VII.

REDIRECTING AND REINVESTING FUNDS

A strong strategy for sustainability is to seek redirection of resources. Policymakers are extremely interested in ways to utilize more efficiently existing public funds, and so the political will exists to adopt policies to redirect funds previously spent on residential or institutional care to community-based services for children. This can be accomplished in several ways:

- Through collaborations with other agencies;
- Using managed care techniques effectively;
- Through a specific reinvestment strategy that shifts spending from one budget item to another.

Redirection strategies have great potential due to the continued overspending on institutional services for children with mental health care needs. Although it is not unusual for a few individuals with high needs to consume a large proportion of health care resources, this phenomena is "extreme in the case of children with severe emotional and behavioral disorder."[1] Most states are heavily invested in high-end services for a very few children. If the site can capture resources spent on institutional services, it can build community supports as an alternative. However, capturing these funds is not easy.

Collaborations for Interagency Funding

One strategy promoted heavily in the early years of the systems of care approach was to blend resources at the state level to create pools of funds available to meet the needs of children served by more than one system using a single, individualized services plan. Blended funding pools targeted high risk children and youth and sought to redirect institutional spending into effective community care. Blended funding pools are effective, but it is often difficult to achieve the high level of interagency collaboration needed to ensure sufficient resources for the task.

Generally, a blended funding approach requires agencies to pool resources and gives all partners a role in determining how funds will be spent. Sites report very significant rewards when this sharing of fiscal responsibility has been achieved. In fact, "the availability of a pool of funds for flexible use (has) provided the foundation and motivating force for real innovation in collaborative service delivery at many sites."[2] For sites in states where state-level policies do not support blending resources, blended funding is probably not an option.

Experiences with blended funding in Rhode Island, Vermont and Stark County (Ohio) and Vermont are described in Chapter VII. Other sites that reported access to blended funding include several counties in California (Solano, San Mateo), Illinois, Maryland, Maine, North Dakota and Virginia.

These blended funding pools have sometimes been created out of *existing* resources, and are generally designed to serve the most seriously impaired children who are coming in contact with more than one public agency and draining resources. State interagency agreements result in pooled resources that are then either allocated at the state level or funneled down to local programs for providing services to a specified child. Local blending of funds can also occur, and sometimes is encouraged in the same states. In other instances, collaborative initiatives have been supported through allocation of *new* resources, secured through the federal grant or from specific state appropriations, which are also channeled into a single, flexible pool.

One important financial gain of interagency pooling is to increase state resources available as Medicaid match. If mental health is the only agency able to draw down federal Medicaid funds for mental health services, it makes sense for other agencies to "give" funds to mental health, which then can match them and provide an even higher level of service for the children the other agency has to serve.

Without the Medicaid match as incentive, it has proven hard to persuade agencies to pool funding. Even where pooled funding exists, sites have found significant limitations in the degree of cooperation from other agencies and the amount of resources they are willing to pool. Some dislike this approach because it requires building interagency service delivery one child at a time, whereas many agencies are looking to expand capacity and serve many children.

There are, however, other mechanisms that can be used to ensure financial commitments from other child-serving agencies. Without a formal "pooling" of funds, other agencies can still provide direct financial contributions to the site, in-kind staffing contributions, and specific "purchases" of service. The purchase of service arrangements accomplishes much the same goal as blended funding, and may be capitated or case-rate payments (e.g., *Wraparound Milwaukee*) or

negotiated arrangements (e.g., Santa Barbara). Agencies also can share the costs of certain staff positions in the system of care. All of these arrangements can redirect funds from institutional care to community services and they can sustain a site successfully without requiring complex shared-governance structures or pooling of resources.

Managed Care

Managed care is not itself either good or bad for sites; it represents an approach, or a set of techniques, for ensuring accountability in service delivery.

Sites can use managed care as a pro-active strategy for sustainability or they may need to be reactive in states where managed care is being implemented. As the experience of several sites indicates, it is possible to take a successful pro-active approach with managed care and use it to redirect resources. The issue for sites, is how managed care is implemented and the role of the site within the managed care system.

Experience suggests that failing to participate in a Medicaid mental health managed care arrangement is a very poor approach to sustainability. Sites should make every effort to become involved in the planning processes when states are adopting managed mental health care that covers children with serious emotional disorder. However, the site's best strategy will depend on how managed mental health care is being organized. There are very different forms of Medicaid managed care:

- A few states have significant, statewide contracts with private, for-profit behavioral health care companies for managing mental health care for those with serious disorders.
- In some states, the state has organized its own managed care entity, using public sector providers and public sector principles;
- In other states, the authority for setting up managed mental health care has been delegated to counties or regional bodies;
- Most states have contracted for Medicaid health care to be delivered through managed care entities, such as health maintenance organizations, but very few expect such entities to serve children with serious emotional disorders.

The sites that have dealt most successfully with Medicaid managed care arrangements are those where the public system has organized the managed care approach. Sites that must interact with private managed care companies—either behavioral health care carve-out firms or health maintenance organizations—have had the most significant problems. Experiences to date with managed care show[3]:

- Managed care *in theory* is highly compatible with the goals of a system of care and emphasizes redirection of residential funds and greater flexibility in providing individualized community-based plans of care.
- Capitated payments to a site can result in a flexible array of services and ensure effective individualized care to children and families, provided the rate is adequate.
- Managed *health care* plans have little appreciation of the complex needs of children with serious emotional disorder and the system of care approach, and they focus on a limited, acute care intervention based on the medical model.
- Interagency collaboration can be weakened or strengthened as managed care is initiated.
- Very few governments have elected to blend other agency funds with Medicaid and mental health as they finance such approaches.
- Managed care can result in lower reimbursement rates—payment may only be made for time spent serving clients, and correspondingly less time is then available for staff to work on collaboration as they must work harder on individual cases.
- On the other hand, some public sector managed care initiatives offer partner agencies the opportunity to pay capitated rates to the system of care, which in those cases strengthens interagency collaboration.
- The degree of cost saving that can be achieved with a shift to managed care must be very carefully calculated. If established systems of care have already redirected resources from intensive to less intensive services, savings from managed care will be significantly reduced. Also, high levels of cost savings have undermined systems of care in some sites where the savings were not allowed to be reinvested locally into community services.

Successful sites report taking considerable time in preparation for managed care. They have engaged in very broad-based planning involving state agencies, other local public agencies, families and key community players. They have planned rationally and strategically, and then moved to implementation slowly so that the system can be adapted based on experience.

Positive site experiences with managed care are described in Chapter VII.

Reinvestment

Reinvestment is a strategy designed to convince those who control the budget for human services that the site can reduce the growth in future costs in mental health and other systems, and to therefore invest in the site today. A reinvestment strategy goes a step further than the data-based approach many sites use to show how they have reduced costs in intensive services child-by-child. Under reinvestment, the value of the specific spending that is avoided as a result of the improved organization and delivery of services through the site is calculated, in concrete financial terms, and the funds that can be "saved" are reinvested in the site.

One advantage of reinvestment is that the site may be able to capture additional funds without waiting for specific savings to accrue. Thus, resources obtained through reinvestment can be used to develop community alternatives, to furnish early intervention and to prevent crises.

A reinvestment strategy requires good data designed specifically for budget officers and/or legislative appropriations committees which must show the results to be achieved. This data must be timely as well as being of high quality, yet also be simple and easily understood.

Budget officers want data that shows the impact of items funded. They want to see how "savings" are real and how they will result from the provision of an alternative set of services. However, evidence can also be circumstantial; scientific evidence, of the specificity and exactness required in a research study, is not needed. To indicate successful outcomes, for example, comparisons can be made between families in the system of care and families in other parts of the state or county. This does not mean creating a research-design comparison group. Budget officers are willing to work in the real world, accepting the preponderance of evidence, even where links between cause and effect may be hard to pin down.

The first step is to identify savings the system can accomplish and to measure and demonstrate those savings. Data on the costs of adverse child outcomes must be gathered. It is first necessary to decide which poor outcomes to focus on.[4] For children with serious emotional disorder, the most obvious costs are out-of-home residential and inpatient placements, but other poor outcomes also have fiscal results. For example, savings are achieved by reducing juvenile justice encounters or alternative school placements. To measure historic data on the cost of bad outcomes, use data that can show both short-term and long-term successes. For example, reduced use of police time or reduced use of emergency services might be a good short-term outcome. Reducing lengths of placements in child welfare and the number of such placements, or cutting juvenile justice incarceration rates might be good long-term outcomes. It may also be possible to assess various risks in fiscal terms and show how a site can reduce the likelihood of future bad outcomes.

However, cost savings and cost avoidance are not the same thing and it is important to be clear with budget officials about what you are doing. A potential cost avoidance strategy, for example, might be the redirection of substance abuse prevention funds based on an assessment of the risk of substance abuse for children who do not receive mental health services. In this scenario, the site must be able to show its program is reducing the likelihood of substance abuse in the youngsters it serves.

To decide which bad outcomes to highlight, sites should engage their partners. The whole community must understand and agree upon the outcomes it sees as important. Different partners may have different goals regarding reinvestment and the specific cost avoidance they want to achieve in their systems. It is best to identify with these partners the services for which utilization is to be reduced and the costs of such services. Further work with partners can then lead to arrangements to collect the data that show whether these goals have been achieved. Then the collaboration can present the evidence—fiscal evidence—in a coherent and simple, compelling way to budget officials and jointly advocate for resources.

It is, therefore, important to identify a few key data elements that are reasonably easy to collect at program entrance and exit. These data must be measurable and they should clearly relate to the established goals of the initiative, but two pieces of corroborating data per goal are usually enough to convince budget officials or legislative committees to redirect the specific dollars identified, and already allocated to children's needs, into community alternatives.

The reinvestment approach is most effective when the budget decision maker has responsibility both for the programs that can be a good investment and the programs for which costs will be avoided. This may require moving high enough up within the state government structure for that to be the case, or approaching legislative committees that have broad oversight responsibilities.

A successful budget strategy also depends on timing. It is best to present your issues when budget managers or legislators are focused on how to balance their total budgets[5]. These times are:

- at the beginning of the budget process within the agencies and in the governor's office
- when the budget is first submitted to the legislature
- as committees act to report out their bills
- as the year goes by and the departments find they have trouble meeting their targets

Reinvestment strategies can fund many sites, particularly those that are focused on reducing high-end services for children and adolescents with the most serious disorders. To date, the approach has been used primarily in California, where the systems of care have a long history of targeting the most in need. Kansas is also using a reinvestment strategy. (See Chapter VII.)

FLEXIBLE THINKING

Sustainability strategies need to be well planned but not be rigid. Sites should be opportunistic. For example, in California sites are seeking to take advantage of a new program funded through a voter-approved tobacco tax that provides resources for comprehensive, integrated services to children from birth to age five.[6] Because the resources are substantial ($750 million a year initially), the pay-off could be significant resources for site services. While not designed to be a mental health initiative, there are several ways sites are positioning themselves to benefit from these newly available resources:

- social-emotional development is a critical component in meeting the initiative's goals: to improve family functioning, ensure that children thrive and enter school ready to learn, and to improve child health;
- while services are focused on child outcomes, they can include an array of family supports as well, so that the strengths-based, family-focused approach of a site could be funded;
- the initiative emphasizes system-building and collaborative partnerships involving numerous agencies, an area in which sites have a proven track record and great expertise to present to decision-makers.

Funds are distributed to counties, which establish county planning bodies responsible for determining, with public input, how the dollars will be spent. Although no funds are yet allocated, several sites (the California five and Santa Barbara, for example), are working to position themselves to be recipients of funds.

PRIVATE SOURCES OF FUNDING

Sites in several states have successfully secured private resources which, while far more limited in amount than the government funds discussed above, have other advantages. Such funds can be extremely flexible and can help close gaps in the funding picture. Private support also enhances the site's credibility. It demonstrates to public policymakers, who control access to the large revenue streams, that the site is providing important community services. Foundations can also

provide significant technical assistance on budget matters and issues pertaining to sustainability. Linkages with private insurance companies illustrate a successful public-private partnership, which is likely to gain the site significant support from policymakers. All of these factors can help ensure future stability for the site, even though the resources obtained through these private entities may not be substantial.

Corporations may make contributions, either in-kind or in cash. Corporations generally prefer to have their giving known, and may ask for their name to be included on products or on the program of an event. Where significant support is obtained, such as underwriting an important part of the program, such sponsors appreciate media recognition as well. Corporate leaders also can play a role in supporting the site through advocacy with policymakers, when they are highly effective. As unusual players in child services advocacy, and with their strong connections to policymakers, corporate leaders in Massachusetts were highly effective in a child advocacy initiative (not related to sites).[7]

Some sites engage in fund-raising events, such as auctions, luncheons or dinners honoring local leaders, media or others. These activities provide both good publicity and small, but flexible resources. Chapter VII provides examples of both foundation fund-raising and an innovative public-private partnership between a state (North Dakota) and a Blue Cross-Blue Shield plan.

TAPPING INTO TRAINING RESOURCES

Several sites have found it very useful to secure funds for their staff to provide training. This gives the site additional resources to underwrite the cost of salaries and overhead. Training can often be worked into staff schedules in a way that does not detract too much from ongoing activities and, in addition to being a source of revenue, it provides other important benefits. The trainees—whether they are from other community agencies or staff already hired in the site—become more familiar with the system of care approach. Parents, who often participate in this training as well, can have a significant impact on service providers and will themselves feel more supportive of the site.

Training can be provided for child welfare, school, juvenile justice or mental health system personnel. Sites have people with specific and sought-after skills and there is a marketable niche for training in systems of care. Once a site has developed a training program and the necessary training materials, they are relatively easy to re-use, making minor adaptations for a particular audience. Many of the older sites now have such materials, which they could make available to newer sites.

Several sites have found that training provides valuable resources and helps spread the understanding of the goals of the program. In Maine, for example, the initial site provides training to new sites being developed around the state as a result of a new state law. North Carolina has found federal resources to support its substantial training program (see Chapter VII).

Sites that engage in significant training extend the system of care philosophy at the service delivery level and help infuse it across the state. Several sites consider training an essential part of system change, and with greater acceptance of systems change, sustainability is more secure. Training also improves child outcomes, which also contributes to sustainability.

USING DATA TO CONVINCE POLICYMAKERS

The importance of presenting good data to policymakers cannot be overemphasized. Data can have a substantial effect—positive or negative. At the same time, however, this does not mean that more and more numbers presented in more and more complex ways is needed. For policymakers, sites need reliable data that can be seen to be fair and reasonable and that points to a clear conclusion of the cost-effectiveness of the system.

Many of the sites with the strongest prospect of continuing and growing following the termination of federal funds have made excellent use of data and evaluation of outcomes. Other sites were slow to realize the importance of data and often did not begin using it until well into the grant. This put them behind in their efforts to show the value of what they were accomplishing. Sites need to plan from the beginning how to use their sustainability data. The federal evaluation initiative provides a natural vehicle for the collection and presentation of such information and provides sites with ready access to experts on evaluation. Full collaboration in this initiative, and a "buying in" within the program itself is critical from the very first.[8]

Policymakers need very specific data and sites should ensure that the information is relevant to current political concerns, easily understood, and supported by concrete examples of child and family experiences. It is essential that data be part of a coordinated campaign to explain the system of care and to generate political support for it. The data should lead the audience to a clear, simple message that is central to the overall purposes of the program and part of the advocacy campaign being waged in support of the site. State or local legislators, senior executive branch officials and budget officers need different data than do program managers or program staff. Each of them also needs somewhat different levels of detail on the site's outcomes and costs.

Senior policymakers focus first and foremost on the cost of government services. A program that shows it has a handle on costs and can predict future needs accurately (even if it requires additional resources) reassures policymakers. Unexpected sudden increases in spending or demands for new money on a crisis basis can seriously undermine a program's support among policymakers, who need predictability. Data on cost savings (system-wide if possible, if not, then for individual children served) are needed, tied to reductions in ongoing costs that policymakers currently are trying to reduce (child welfare out-of-home placements, school drop-outs, out-of-state residential placements, rising juvenile justice facility populations, for example). (See Reinvestment section, above.)

Some essential rules for presenting data to senior policy officials are:

- Use no jargon
- Have one or two simple messages
- Use graphics, but use them well—do not clutter and confuse
- Present the case quickly—take 5-10 minutes with the main presentation as policymakers today have no time (and they can always ask for more)
- Package data with family stories, using several family members at different times
- Show trends—present simple trend lines illustrating cost reductions and improved child scores and outcomes
- Avoid too many program details.

Information on the site should never be limited to hard numbers, no matter how good. It is extremely important to put a face on the system of care. Child and family stories should be used wherever possible to illustrate the points being made by data, especially if the data cannot show system-wide cost savings, usually because of high unmet needs.

Santa Barbara, California, which tailors its data to its audience, has developed reports for policymakers that present a compilation of findings in text, bar graphs, pie charts and other visual arrangements. None of the pages are overloaded with text and although the package contains a very significant amount of data and information on the site, it is an "easy read".

To use data effectively, sites clearly need good information systems. However, federal grant funds may not be spent for these purposes. Sites must find other resources, such as foundations and corporations that might be willing to fund such a concrete undertaking even when they are not

willing to fund services. Sites also should consider the expertise of board members or others concerned about the site's success. For example, in one site, a parent's expertise in this area enabled the site to make use of customized soft-ware.

Specific ways in which data and evaluation can be used to sustain a site include:

- Data on the site's effect on reducing out-of-home placements, residential costs and out-of-state placements will influence legislators and budget officials.
- Assessments of cost savings for specific children, such as children who are the responsibility of the child welfare system, will convince other agencies of the value of collaboration and of adding their resources to the system of care.
- Data on the characteristics of the children served assist the public to understand the program and to counter charges that the system is not serving the target population.
- Evaluation showing improvements in measures of school success (days in school, trends in grades, improvement in child's ability to move up the grades, etc.) can persuade school officials of the value of collaboration and persuade legislators and policymakers concerned with the education system to support the site.
- Overall effectiveness data are of great interest to media, thereby building general community, tax-payer support for the site.

Successful sites all have made very effective uses of their data. Data have been collected and presented under clear and catchy phrases, such as Vermont's "Tower of Doom" or the "Bring Our Children Home." Data have been specialized for certain policy audiences: for example, the information targeted to collaborating agencies in Santa Barbara looks quite different from the information for state legislative officials prepared by Maine.

USING THE MEDIA TO GENERATE SUPPORT FOR FUNDING

Media work allows a site to inform and mobilize the public, shape the policy agenda and strengthen support in the local community. Good media work is pro-active. Sites that stay in contact with the media have good press coverage on a routine basis. Waiting passively for the media to call means remaining invisible until some unfortunate incident precipitates attention.

According to the Benton Foundation and the Center for Strategic Communications, which have developed a set of media guides for nonprofit organizations, the two most critical aspects of an effective communications strategy for organizations engaged in social change are (1) leaders in the

organization devote time and resources to development and planning of a media strategy and (2) media and communications work is an ongoing part of the organizations agenda.[9] Key factors in media success include:

- Personal contacts to build mutual trust resulting in good media relationships over a long period of time;
- a clear strategy and written plan, with timelines, of the coverage the organization needs to support a particular objective (such as passage of a bill, increase in appropriations or changes in state or local policies to facilitate community-based services);
- involvement of top decision-makers and designation of media spokespersons who are senior enough to give the story sufficient depth;
- ensuring that the organization frames the debate;
- presenting information that includes a human interest (child and family stories);
- knowing who the targeted audience is and adjusting the message accordingly;
- keeping the message simple;
- targeting reporters who cover health, children's or social issues;
- being relentless, the same message is repeated over and over again in different ways and in different contexts.

Media work should always be part of the policy agenda and support the site. Although achieving name recognition is useful, the value of media work is in its potential to help make change. Thus, a media campaign should not run in a vacuum, but should be tied to the organization's priorities regarding services and financing. The media will become more interested when there is some new development, such as a site demonstrating new and effective services to children and families so as to keep children safe at home. The site's struggle for funding is also a story.

To influence legislators, keep in mind the broader policy context in which they work, and frame the message accordingly. Be pro-active to ensure the issue is covered from the site's point of view. Finding a catchy phrase, such as keeping kids safe at home, provides a strong message. Consider tying the site's message to broader social messages that are particularly timely. For example, what is the site's role in helping welfare mothers return to work as a result of receiving better services for their children? How is the site helping to prevent violence in schools? Media activities can also be tied to national events. Several sites use Mental Illness Awareness Week or

May is Mental Health Month as a springboard for media activities. Big, national news stories are very good opportunities. The 1999 White House Conference on Mental Health and the release of the Surgeon General's Report on Mental Health were good hooks for local stories. Look for similar future opportunities.

Legislators read local newspapers, including editorials, op eds and letters to the editor. Having your issue covered in the newspaper is, therefore, a relatively straight forward way to reach legislators. Legislators also want to be in the press themselves and successful sites work with the legislator's press office to tie them into the story.

There are well-known approaches for making sure that your media work is effective.[10] Review what has been covered recently in the newspapers, listen to local radio and watch local television. Learn about news media operations, deadlines, styles and services. Seek face-to-face meetings with key media leaders, such as editorial boards of local papers or producers of public affairs programming on local television stations. Contact reporters by phone as well as sending out press materials. Always respond within their deadlines and keep your press list up to date. Press conferences are a lot of work and often not effective. You should have some major news to impart before you go through all the time and trouble. Develop a plan for the media work that defines: the issues and target audience, media channels to be used, messages, activities and materials, the budget and staffing, partners and alliances and evaluation strategies.[11]

Some individuals have a natural interest and flair with the media; make use of such talents where they exist. Spokespeople need to be comfortable doing interviews, have the time and be able to make a good impression both verbally and visually. They must also know and be able to present the substantive issues clearly and well. Develop sound bites and make sure spokespeople all use them.

Have good graphics, two-color materials, a smart logo, etc., but try to avoid making materials look too slick and expensive—that conveys the wrong message about your program. Have a standard press kit available at all times for reporters who are new to the issue. Have available fact sheets on children with serious emotional disorders, details of your program, family and child stories and specific information on the key issue you want covered. Material developed for the national communications campaign and data sheets can be helpful.

Sites making good use of various media include Kansas and Rhode Island (for passage of appropriations and new legislation) and Baltimore, Maryland (generating community support).

Steps Towards Sustainability II

1. Create a state-level policy commitment to the systems of care approach through legislation that provides a commitment to existing sites and an expansion of systems of care across the state.
2. Develop a plan for gaining the support of legislators for funding the site(s). Work in collaboration with family organizations, provider associations and state policymakers to develop a strategy.
3. Begin the process of educating legislators early during the site's operation—invite legislators into the site and provide them with information and data in an ongoing way.
4. Be alert to major policy shifts in the state, such as managed care reforms, new child welfare initiatives or school-based initiatives that focus on children with serious emotional disorders and community-based approaches.
5. Work with state policymakers to review all options to expand resources from federal entitlements, especially Medicaid. Review the limitations in the state's definitions of covered child services and consider whether the state should apply for a federal waiver.
6. Work with budget officers and legislative appropriation committees on a reinvestment strategy to move funding from institutional and other high-end services into wraparound, community-based care through the site.
7. Seek non-traditional sources of funding, particularly for activities such as strategic planning, support of the family organization, advocacy, media work, etc. Funds from local, state or national foundations can help ease a site through the immediate crisis caused by loss of federal funds.
8. Create and maintain contacts with aligned community groups. Ask for their help in securing various forms of funding, including appropriations, foundation grants and community resources such as United Way.
9. Secure all available third-party revenue, including insurance payments.
10. Review other options, such as resources for training.
11. Be smart about collection and presentation of data; collaborate with the federal evaluation program and learn how to use the data for selected audiences to create and send a clear and simple message.
12. Develop a media strategy that establishes working relationships with media, locally and in the state capitol. Place positive stories periodically, and expand the effort around crucial times, such as when appropriations issues are being decided. This can be accomplished by the site or by others on behalf of the site (such as family group or other advocates).
13. Plan ahead. Be flexible. Explore all appropriate options, but in a strategic way.

Notes:

[1] Cole, R. F., & Poe, S. (1993). *Partnerships for care: Systems of care for children with serious emotional disturbances and their families*. Washington, D.C.: Washington Business Group on Health.

[2] Hodges, S., Nesman, T., & Hernandez, M. (1999). Building collaboration in systems of care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume VI. Building Collaboration in Systems of Care.* Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

[3] This material based on information from various sites and upon Stroul, B. A., Pires, S. A. & Armstrong, M. I. (1998). *Special study on managed care: Evaluation of Comprehensive Community Mental Health Services for Children and Their Families Program*. Rockville, MD: Child, Adolescent and Family Branch, Center for Mental Health Services, Department of Health and Human Services.

[4] More information on outcomes assessment is available from the System Accountability Project for Children's Mental Health, Florida Mental Health at the Florida Mental Health Institute, University of South Florida and the Outcome Roundtable for Child Services, Center for Mental Health Services' Division of State and Community Systems Development.

[5] Wyman, N., Evans, J., Chisum, G., & Bautista, B. (1998). *Capturing cash for kids*. Sacramento, CA: Foundation Consortium Comprehensive Integrated Services Reinvestment Project.

[6] The voter initiative is known as Proposition 10 and the enabling legislation is the California Children and Families First Act of 1998.

[7] Blood, M., & Ludtke, M. (September 1999). Business leaders as legislative advocates for children. *The Foundation for Child Development Working Paper Series*: New York, NY: Foundation for Child Development.

[8] For a summary of some the specific approaches to presentation of data and evaluations, see *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume II: Reporting Evaluation Data to Manage, Improve, Market and Sustain Children's Services*.

[9] *Strategic communications for nonprofit* (1991). Washington, D.C.: The Benton Foundation and the Center for Strategic Communications.

[10] *Strategic communications for nonprofit* (1991). Washington, D.C.: The Benton Foundation and the Center for Strategic Communications; and *Building an effective communications program* (1994), developed for the National Center on Child Abuse and Neglect, Administration for Children and Families, U.S. Department of Health and Human Services. Alexandria, VA: Advanced Resource Technologies, Inc.

[11] Taken from *Building an effective communications program* (1994), developed for the National Center on Child Abuse and Neglect, Administration for Children and Families, U.S. Department of Health and Human Services. Alexandria, VA: Advanced Resource Technologies, Inc.

Chapter VII–Strategies for Obtaining Resources

EXPERIENCES OF EXISTING SITES

The following discussion highlights effective approaches used by sites to secure resources and strategies used by state policymakers to ensure support and expansion of systems of care. By singling out specific activities, this monograph does not intend to suggest that these single strategies are *all* it took to ensure sustainability. Successful sites are those with an overall plan that reflects not only a real understanding of systems change and strong adherence to the philosophy of systems of care, but also multiple, inter-linked strategies for securing their resources. Successful sites recognize that no simple, cookie-cutter approach exists. Each site has very unique characteristics—its community, the program itself, its leadership style, its history, the strength of the family organization, the status of Medicaid care reform, and the general political and philosophical approach to child services in the area. All those unique traits will have an effect on which sustainability strategies will be most effective.

Successful plans also engage states. States are critical for ensuring the level of resources needed, and states have the authority to redesign service delivery and redirect funds. A collaborative partnership between local sites and state-level policymakers is, therefore, necessary.

In the two-year study of non-federal funding conducted by the Bazelon Center, states and sites identified the following as successful approaches to sustainability:

- redirecting substantial funds from out-of-state or in-state institutional care;
- blending funds from various child-serving agencies (primarily child welfare);
- adopting a cross-agency system of care to which other agencies are willing to contribute resources or from which they will purchase services;
- advocacy efforts by families, providers and other community entities to increase appropriations from the legislature;
- local fund-raising and community donations, and
- using in-kind support to supplement cash.

However, while some found these approaches successful, others reported their site had attempted the same, and failed. Thus, strategies and approaches must be tailored to local situations.

Approaches that failed for some were: blending funds, securing support from child welfare or education and seeking new appropriations through the state budget. In particular, persuading other agencies to blend funds or contribute funds to the site was a significant struggle in many sites. Even in sites where collaboration occurred, it was reportedly difficult to get contributions proportionate to the savings agencies received as a result of the site's services.

STATE GOVERNMENT RESOURCES

The single biggest contributor to sustainability is state government. Most resources are appropriated through the mental health authority, but child welfare initiatives also are important in some states. Apart from direct appropriations, state governments also have adopted policy initiatives to underwrite the concepts and philosophy of systems of care. These laws enable the sites to secure reliable, ongoing resources and also expand the system of care approach beyond the initial federally-funded site.

Securing State Appropriations

One of the most direct approaches for ensuring a long-range funding base is to secure specific appropriations for interagency systems of comprehensive care. Educating state legislators and budget committees must be ongoing and is best done in a collaborative manner with the community. Sites must have an appreciation for how the political system works and how to engage in political activity. Resources can be obtained by giving policy makers good information and when forces are mobilized to support an appropriation. Sites should ensure that policymakers have information that allows them to:

- define the issue;
- understand problems the site is addressing (e.g., over utilization of residential care);
- explain why a system of care is the answer: define what needs to be changed in service delivery, how that has been done to date, and how it can be expanded;
- assess effectiveness (evaluations and data);
- understand what specific legislative action is needed now;
- show how this legislator can become a leader in the effort, and
- give some indication that there will be rewards, recognition and thanks for their efforts.

There are many ways to influence policy makers. The examples below describe organized campaigns, but sites should not overlook other simple steps that can be taken. For instance, some sites have placed local elected officials on their board, or made an effort to get to know local county commissioners by attending various functions where they will be in attendance. Giving legislators a tour of the program also has been a useful strategy.

The following examples illustrate the discipline required to persuade legislatures to invest significantly in the system-of-care approach. States, sites and/or advocates in the following examples worked hard to show achievement in efforts that spanned over a few years. A continuous flow of new information and new contacts over time paid off in every case.

Kansas

Kansas, which has two federal grants, has secured substantial support for the systems of care approach from the state legislature. In 1999, $7.5 million was appropriated for new spending on children's services. These funds will be used, in part, to sustain the two federal sites, although they will not fully sustain the sites and some staff cuts will still occur as federal funds end. A significant portion of the new appropriation will be used to expand wraparound community-based services to other parts of the state, to be delivered through those (twenty-five) community mental health centers that did not receive federal grant funds. Money for the initiative will come from a combination of state general funds and proceeds from Kansas' share of the settlement in the lawsuit between states and the tobacco companies.

The appropriation was obtained despite the fact that the Executive Branch made no request to increase funding for children's services; the additional $7.5 million was entirely a legislative initiative. When coupled with increased resources through a Medicaid home- and community-based services waiver (see policy section below), there will be $13-14 million of new resources for child mental health services in the state.

According to a leading advocate, this funding represents an "unheard of increase" for the Department of Social and Rehabilitative Services. Moreover, Kansas advocates expect that this level of funding will now be sustained, it will not be a one-year deal.

The work to secure this appropriation resulted from a partnership between the community mental health centers (including the sites) working through their state association and the statewide family organization, *Keys for Networking*. In Kansas, this success was achieved through community

groups (providers and advocates) not through a partnership between state policymakers and local communities. In other states, such as in Vermont and Rhode Island, the state requested the resources, and this request was then supported by advocacy from families and providers.

When the Kansas legislative campaign was launched, it was built on years of past work to establish linkages between individual family members and their legislators. The family organization, *Keys for Networking*, orchestrated and facilitated this process (see box). *Keys for Networking* staff worked continuously to bring in new families, so the legislators had a strong sense of the pervasiveness of the problems and the reality of the solutions to their own district—the campaign could not be dismissed as a crusade from a very few people. At the same time, providers engaged in their own efforts to complement those of the families. All activities were planned and carried out in a concerted manner and everyone carried the same message—emphasizing accountability for meeting children's needs.

Providers and family members made significant use of data from the sites. Also important was information that demonstrated that the Kansas' initiative offers state-of-the-art services for children. The *Partners in Planning* publications and other national materials convinced legislators that the systems-of-care approach was a nationwide, best-practice movement for improving child mental health services. The combination of national literature, local data and grass roots contacts proved compelling.

Key factors in this success were:

- The pervasive and genuine partnership between a family organization and the providers, working through the Association of Community Mental Health Centers of Kansas.
- Joint planning by both organizations, as they conferred weekly, planned press events together and recognized each other's work when the effort was successful.
- Strong and long-term relationships with certain members of the legislature.
- Linkages that were created between members of legislature and specific families and children—by the time the appropriations bill was on the floor, members were rising to speak of experiences of individual children whom they could name.
- Data on the effectiveness of the services.
- Long-term and strong political connections among the family organization and the provider association with legislators and staff.
- Ongoing work to develop, expand, and refine the message.

- Constant presence in the Capitol through various events and visits (see box) by the family organization and the mental health centers.
- A national group (the Federation of Families for Children's Mental Health) provided advice, technical support and encouragement to the family advocacy organization.

Keys for Networking Activities in Support of System of Care Appropriations

Keys for Networking is an established statewide family organization, in place long before the federal sites were funded. It received one of the first CMHS infrastructure grants for parent organizations and started two wraparound pilot projects, which later evolved into the federal sites. Thus, it had both resources and a reservoir of relationships within the state from which to build an advocacy campaign for increased funding for systems of care. The group has maintained diversified funding through nine different sources. With such a diverse funding base, *Keys for Networking* is seen in the state as an independent voice and not as a tool of any provider.

Finding the right strategy to engage legislators to support the systems-of-care approach took time. For example, an effort to link legislators with families by holding a social event at the Capitol failed, as the busy legislators did not attend. Organizing a statewide communication day for families was not the right approach, as families, for various reasons, did not participate.

Learning from these failed attempts, *Keys for Networking* built a network of families, using a computer software program that identified each family's legislative district. Each time *Keys for Networking* made contact with a family, a record was made of who their legislators were. Once the family's immediate problem was resolved and they were connected to local providers, these families were invited to meet with other families in their area who were interested in advocacy. Here they were given the opportunity to become involved. The goal was to identify ten active families for each member of the legislature. For many parents this was a significant cultural shift; they had never done anything like it before. Advocacy was not for everyone, and some chose not to participate, but the modeling of advocacy behaviors by more experienced families resulted in many signing up to be part of this campaign.

Keys for Networking staff then worked with the families to connect their stories with the policy issues. The goal was for legislators to know families in their district so well, they even knew the children's names.

A very successful event was organized on St Patrick's Day. Between two and three hundred people who supported child mental health services came to the parade and rode a fire truck to the Capitol. Parents and providers teamed-up, carrying posters, signs and other items to identify themselves, and marched to the Capitol to visit legislators. Skillful organization helped to make this energetic group look even larger than it was.

After the money had been secured, an event was held that sparked widespread interest among the providers. This event was a three-day Statewide Oscars competition—families, agencies, schools, probation officers, children and others nominated people for awards for outstanding child mental health services, such as Best Respite Care Provider or Child Who Accomplished the Most. Over 300 nominations were received. All nominees and nominators were brought to the Capitol where the finalists met together to define, with concrete examples, the scope and parameters of their services. These discussions were turned into Kansas examples of best practices. This event helped to create a large group of expert and committed individuals who can both demonstrate and train statewide in these new service arenas.

Praising legislators for their work is always a successful technique. *Keys for Networking* planned opportunities to thank legislators and highlight what they had done. For instance, each of these events had significant media appeal. *Keys for Networking*'s excellent use of media coverage is described more fully in

the Use of Media section, below.

"Those who say it can't be done are usually interrupted by those who are doing it" KanFocus Newsletter 5/99.

The partnership has continued even after resources were allocated. A collaborative community-based planning process, involving providers and advocates, is underway to decide how each area will spend its new resources. An all-day meeting was organized, involving all players in child mental health, to define how the new funds should be distributed. The existing sites served as models on how to implement a system of care. By continuing to work together and make decisions together, the families, providers and other stakeholders will be well poised to return to the legislature whenever necessary.

Although the sites have to be reduced a little in scope, the system-of-care approach and the need to develop community services for children and families will be statewide policy from now on. As a result of this legislative campaign for resources, there are long-term changes and a greater understanding of child mental health issues. This will benefit the two sites and lead to a transformation in how the state organizes and delivers services to children in the future.

Rhode Island

A strong coalition effort, involving the family organization and providers working collaboratively with state agencies, resulted in success in obtaining appropriations to sustain *Project REACH*, a statewide federal site. As in Kansas, the coalition emphasized that *REACH* was part of a bigger, nationwide shift in child mental health services, based on the Child and Adolescent Service System Program. Also as in Kansas, the effort came from a concerted effort involving families, advocates and providers.

The first request from the state to the legislature was for $870,000, whereas $1.4 million was required. Within the government, there was grave doubt that state appropriations could, or should, replace the lost federal dollars. However, once advocates had made their case, legislators could see from the data presented to them that the Governor's request was inadequate. Eventually, the state appropriated $1.4 million to cover costs from the time the federal grant ended until the end of the state's fiscal year.

To secure this initial appropriation, testimony in support of *Project REACH* was organized by the coalition. This overcame initial resistance to appropriating the necessary funds. Families and children focused on the avoidance of residential and inpatient care and provided extremely compelling stories. Legislators responded particularly well to parent testimony and to the wide

support the site received from schools, faith groups, community organizations, and partner state agencies. Media coverage (see media section) was also key. Adolescents currently receiving services spoke out publicly on how helpful they found the site's services.

During two legislative sessions, and with a great deal of time and work, the necessary appropriations were secured. The strategy included the following elements:

- A simple, straightforward and consistent message—Local Coordinating Councils of *Project REACH* are helping children and families, are part of national movement to reform child mental health services and have data to prove their effectiveness and value;
- Organization—a task force on the Institutionalization of the Child and Adolescent Service System Program was formed by the child mental health advisory council to educate the legislators. Providers and families scheduled meetings with legislators, organized letter/postcard/email writing campaigns and worked to get media coverage in local papers and on television, using family stories.
- Preparation—The parent support network organized and trained family members for testimony at the budget hearings.
- Feed-back loops—the task force set up a worksheet for local activists and had a written reporting system.

The strategy included a number of elements. Initially, it focused on getting support of a few "champions" in the legislature. Local grass-roots contacts also were employed, as well as state-level testimony and lobbying contacts. The site's evaluation data were extremely helpful in making the case for effectiveness and cost-effectiveness of the site and media work resulted in favorable coverage in both newspapers and on television.

For the first full year without federal resources, FY 2001, significantly more funds will be needed, but the campaign to support the initial $1.4 million has changed attitudes in the state. The Governor is requesting $3.14 million in state funds for FY 2001. This will provide resources to replace the federal funds from the grant and improve services statewide.

Vermont

Vermont represents an example of three important sustainability strategies:

- long-range investment—federal funds were utilized for only five years during a long-term, statewide initiative to develop systems of care.
- innovative use of data.

- federal funds were used to develop new ways of doing business, not for underwriting the ongoing package of services.

Access Vermont is a statewide system of care organized by the state mental health agency, but with strong collaboration from child welfare and other agencies both at the state level and, importantly, also in communities. In 1998-99, the legislature appropriated $1.4 million in new resources to sustain this statewide site.

Vermont's five-year federal grant followed years of investment in a systems of care philosophy. The state received a Child and Adolescent Service System planning grant in 1985, which brought local community mental health centers, child welfare and education systems together with families and other community leaders into interagency teams. These teams perform case reviews and ensure case management through an intensive, individualized wraparound approach. In 1988, a law was passed (Act 264) that defined serious emotional disturbance and created a legal base for the state and local Interagency Teams.

Just when the state applied for its system of care grant from the Center for Mental Health Services (CMHS), the child welfare agency was launching its own new initiative, based on a vision of family preservation. Child welfare aimed to reconceptualize, restructure and refinance a comprehensive system of services for families in crisis. The goals of these two similar initiatives were then merged into a single approach, with the clear and dramatic mission to lower out-of-home placements and reduce "the tower of doom" (a bar graph of out-of-home placements). The initiative was thus an interagency effort to help children in crisis through effective, efficient and creative use of funds, maximizing federal dollars. The federal CMHS program contributed $1.2 million to first year costs, the state contributed $1.4 million.

The organization of regional teams was an important factor. Regions were given small planning grants, and required to involve families as well as relevant local agencies, using Vermont's agreed-upon interagency vision of a system of care. Through a combined interagency state and local planning process, every community became invested in their own local system of care and their own, locally-developed specific goals. The state's goals were fewer admissions into custody, fewer emergency detention orders for child welfare, and fewer children in custody within a year. In order to achieve these goals, child welfare gave the Medicaid match to mental health, and local community mental health centers became fiscal agents for the systems of care.

As federal funds were withdrawn, Vermont, like many other sites, had carry-over funds that reduced the need for new state resources to $300,000 for the first year following the end of the federal grant. This was relatively easy to obtain from the legislature. State officials did not even have to testify; communities working with their legislators were able to secure the resources.

However, in the second year, $1.1 million was needed. The state mental health authority requested this amount in the Governor's budget and the legislature eventually approved it. Important factors in securing these resources were:

- Supporters were able to tap into a hot legislative issue—child welfare. Since legislators were focused on the need to support families to keep children at home, child welfare data was emphasized and child welfare administrators and providers were lead spokespeople.
- The collaborative process between agencies both locally and at the state level helped to create one consistent message statewide.
- Data was very valuable and was used in a creative way (see Vermont's Towers of Doom box).

Reflecting on their experience, Vermont officials recommend that other sites begin by assessing the major concerns of politicians and of the executive branch so they can explain how the site addresses those concerns (in Vermont it was child welfare, out-of-home placements that was the hot button issue). Additional tips include:

- Keep your marketing simple (in Vermont the phrase "tower of doom" caught on).
- Don't seek funding for a "program," instead, seek resources for a function, such as keeping children safe, keeping children at home.
- Find others with the same concerns and partner for systems change.
- Be sure crisis services are there for families—it's critical to have that safety net in order to get families and other agencies to buy-in and support an expansion of community services.

However, while Vermont illustrates a successful appropriation strategy, it still has challenges ahead. Child welfare has benefited from the significant savings in out-of-home costs, but does not contribute a proportionate amount to the system of care, despite these gains. Child welfare agencies also continue to work outside of the system of care and place children into restrictive settings. Engagement with the education system is not consistent, although 80% of the school supervisory unions provide some resources (called Success Beyond Six funding).

Vermont's Tower of Doom

To illustrate in graphic and dramatic form the problem it was addressing, officials representing Vermont Access compiled data on the number of children in custody and expenditures on children in out-of-home placement. The bar graph they used was nicknamed the "tower of doom" and it showed:

- the number of children projected to be in custody based on previous rates and without a system of care,
- the initial plan for how those numbers would be reduced, and
- the actual number of children in custody (projected for upcoming two years).

In this clear visual way, *Vermont Access* could show the dramatic reduction of the "tower of doom." By 2000, the savings these charts will illustrate should be $8 million or more.

STATE POLICIES FOR REPLICATION OF SYSTEMS OF CARE

The above examples represent campaigns to secure appropriations. Often, however, this is not a strong, long-range strategy. Some states have moved further by passing legislation that provides a foundation for systems of care development and expansion. Those grant sites that are located in states where policymakers have demonstrated a commitment to making systems of care the underlying philosophy for state child mental health services have proven some of the most successful sites in terms of their sustainability.

> *"Systems of care must be central to state child system planning and part of it, not parallel to it." (federal project officer)*

Commitment by state legislators and executive branch leaders to a systems of care approach has several important advantages for sustainability:

- The federal grantees become part of a total plan for child mental health services that has long-term support among policymakers, providers, advocates and families and continued financial support for any one federal grantee is not subject to any fundamental challenge.
- The development of several sites around the state expands the number of individuals with knowledge of how to run and how to work in a system of care, building a critical mass that ensures new providers and new administrators quickly come up to speed on the philosophy and there are no sudden and disruptive changes of course.
- Data and evaluations can be conducted across sites and overall effectiveness and cost-effectiveness is even more striking. This can lead policymakers to be far more supportive of continuing the funding for programs as federal funds run out.

- Should the state shift into a managed care approach, the philosophy of the system of care is likely to be central in state-level discussions of managed behavioral health care, ensuring protection for the sites as the state moves to managed care.

Examples of states that made far-reaching policy changes to support system of care development during the course of a federal grant are: Rhode Island, Maine, California, and Vermont (see also section on blended funding, Chapter VI).

Maine

Initially, Maine funded a four-county site through a federal grant received in February 1994. In response to a class action lawsuit, the 1997-98 legislative session enacted a bill to create a task force to consider the development of similar systems of care throughout the state. Representatives from the site, *Wings for Children & Families*, were included on this task force, along with state legislators, family groups, agency representatives and providers. The Task Force developed a statewide plan for local networks of service, with difficult, multi-system cases being supported through Regional Interagency Children's Cabinets.

Prior to the lawsuit and the creation of the task force, the state mental health authority was not mandated to provide any child mental health services. Thus, the task force report represented a significant turning point. It also led, in turn, to another law that created a children's mental health program, defined the responsibilities of the various agencies, set up an oversight committee and allowed Medicaid cost savings to be retained in a Development Fund to expand community services. Enactment of this legislation reflects recognition of the effectiveness of *Wings* as a model approach to care, that was based on improved understanding among legislators resulting from data that demonstrated the site's effectiveness.

This legislation is now supported through a new, and very significant, appropriation of $9 million for new child mental health services. A substantial portion of these new funds will be used by the state mental health authority to contract with *Wings* to provide services. This is not a one-year arrangement; *Wings* has a three-year contract.

Several crises also provided impetus for the legislative initiative. Maine had a history of hospitalizing children at very high rates, 50% higher than other states. When an initiative to return 47 children from one out-of-state residential facility uncovered the fact that only three of them needed this level of care in the first place, this generated great concern. Another crisis occurred when it was realized that the state's main juvenile justice center was improperly using restraints and not providing children services and special education they required. At this point, state legislators

became frustrated about the unavailability of appropriate child services and recognized the need for reform. These two failures in the system thus helped spur action and, once again, experience with *Wings* and the *Wings'* data played an important role.

The interagency collaborative approach of *Wings* is now recognized as an effective response that keeps children in their own communities.

Child Welfare Reform, California

Several federal sites are located in states where the child welfare system, as well as the mental health system, is engaged in reform to improve interagency collaboration and deliver family preservation services. Although these reforms have very similar goals and philosophies, it can be confusing to have two parallel state reforms that must be brought together at the local level. California has a new child welfare reform initiative that several sites believe is very supportive of the mental health system's reform. It is designed specifically to interact with and support the existing (and any future) system of care sites. However, although the child welfare reform represents a promising tool for sustainability, it is not by itself a single, simple solution for any of the sites.

The new child welfare reform rests on legislation that creates flexibility in the use of state child welfare funds and fosters interagency systems of care operating with the wraparound philosophy. This legislation, known as SB 163, is operated through child welfare at the state level. At the same time, the mental health authority continues its own system of care initiative.

California has a long history of passing legislation in support of systems of care. In 1984, the state enacted legislation to fund the Ventura county system of care. After Ventura produced compelling data, particularly on reductions in juvenile justice costs, the legislature, in 1988, passed a bill to replicate this model in three additional counties: Riverside, San Mateo and Santa Cruz. These sites also produced good data on cost reductions, primarily by reducing duplication of services and out-of-home placements. California has received four federal grants that fund the four original plus Solano county, Santa Barbara, Napa/Sonoma and San Diego.

SB163 has set up a five-year pilot program offering counties waivers so they may use state and local foster care funds (but not federal funds) in a flexible manner to provide wraparound services to eligible children and their families as an alternative to group-home care. The goal is to provide services to children who are at risk of group-home placement so as to enable them to remain in, or return to, family environments.

Federal child welfare funds are not part of the initiative, due to barriers in federal rules, but the flexibility in the use of state and local funds provides significant opportunities. No new funds have been appropriated for the project; all pilots must be cost-neutral.

Each county receives a specific allotment of funds to pay for individualized wraparound services for an eligible child. If the child improves and no longer needs the services, the slot remains available and another child can be moved into it. Counties can request any number of slots, but are encouraged to start with a limited number and increase their program as they gain expertise and grow in capacity. Services can be provided to children already in group home placements and children at risk. Funds can be used for staff training as well as for direct services.

To be funded, counties must have interagency collaboration and ensure partnerships with family groups. They must establish family-centered, strengths-based systems of care and must explain how they will link the SB 163 pilot with the county's mental health system of care, where one exists. Collaboration with juvenile justice also is mandated. This philosophy and the specific requirements for interagency and family involvement in the state child welfare agency rules, opens the door for using SB163 to sustain federal sites. Napa county plans to make significant use of the program. The site's interagency governing structure has become the SB163 planning team and resources from SB163 will provide flexible funding to smooth Napa's transition from federal funds. Riverside, Santa Cruz, San Mateo and San Diego counties also receive funding through SB163. Santa Barbara passed up the first year's opportunity, but plans to participate next year.

The state child welfare agency has issued Best Practice Guidelines for the development of family-centered, strength-based assessments, planning and practice. It also has issued Wraparound Standards, developed with input from nationally-recognized experts, which will be operationalized through a Wraparound accreditation process. The emphasis on wraparound makes the reform entirely compatible with the sites and SB 163 is expected to result in increased support from child welfare for the several federal sites and contribute to their sustainability.

Policies for Changing Financing Streams

Even in states with a commitment to the philosophy of a system of care, there can be specific policies within certain financing streams, particularly Medicaid, that inhibit funding for the necessary components of a system of care. A serious strategic examination of state (and local) policies with respect to financing child services can make an enormous difference in the potential for a site to survive the loss of federal funds. Such an examination is best initiated early, preferably before the federal grant is received, but at least shortly thereafter.

Federal Medicaid Waivers

Costs for a broad array of community mental health services to Medicaid-eligible children can be recouped through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medicaid mandate. However, some states have found this array of services still insufficient for funding all of the community-based services needed by children and families in a wraparound approach to care. Medicaid waivers can expand the coverage of community based services and increase reimbursement for sites as well as facilitating expansion of systems of care to other parts of the state.

States can seek federal waivers to expand services and increase the number of children eligible for Medicaid under two different authorities: the Home and Community-Based Care waiver (Section 1915(c)) and the Research and Demonstration waiver (Section 1115.) Both waivers require a cost-neutral approach.

Kansas Home and Community-Based Care (Section 1915(c)) Waiver. Kansas has a home and community-based care Medicaid waiver to finance wraparound services. The waiver targets children at imminent risk of being hospitalized. Site evaluation data and success stories were used to obtain the waiver and site officials helped write the waiver, field tested it, and then trained staff statewide in how to make use of it.

The state has approval from the federal government for 1,000 slots under the waiver, although it began operation using far fewer (each site had less than 30). The waiver establishes four new services: wraparound facilitation, family support and training, respite care and independent living services. Activities can include coaching and assisting the family to increase their understanding of the child's needs and how to choose appropriate services. Wraparound facilitation includes assessment and development of an individualized plan to develop informal community resources to help the child succeed. Respite includes short-term care and supervision of the child.

The waiver funds services developed in both federal sites, which were then well-positioned to take immediate advantage of this new flexibility. Outcomes evaluation of children who received waiver services shows that they excelled on various measures and did better than a comparison group. In addition, families report satisfaction with the services they receive. These positive results should enable Kansas to continue to provide Medicaid funding for flexible services furnished in the two sites and to replace some of the lost federal dollars.

North Dakota Research and Demonstration (Section 1115) Waiver. North Dakota sought a Section 1115 waiver to expand coverage and include a wide array of community services, including early identification and early intervention to children who are Medicaid-eligible and have a serious emotional disturbance. The state determined that a Section 1115 waiver would best match their goals: to shift to a capitated approach in the future and to redirect spending beyond institutional care. The waiver is expected to enable the state to control costs, improve efficiency and maximize federal reimbursement.

The waiver was designed to facilitate a wraparound philosophy and practice. Child and family teams and parent involvement are at the core of service delivery. The waiver will allow an expansion of Medicaid covered services, using the service array provided by the federal site (North Dakota Partnership). Four new Medicaid services are being added: child respite care, parent support and training, independent living and psychosocial rehabilitation (including adventure-based counseling).

The 1115 waiver will first be piloted in one region and then expanded into the two other regions of the state, one of which includes the North Dakota Partnership. It will operate first on a fee-for-service basis and then, once a significant Medicaid client base for child mental health services is established, it will shift to a capitated plan. Regional multi-agency teams will monitor implementation of the waiver and provide quality assurance. A state-level team will monitor the process, provide oversight and draft policies to support the waiver.

In expectation of the waiver, North Dakota expanded its use of Medicaid for community mental health services for children (by 50%) and the state can now use this as its baseline of spending for the waiver request. Because the 1115 waiver requires budget neutrality, this was an important preliminary step.

Other Examples. Other states and sites have been involved in improving Medicaid rules, including Rhode Island and Baltimore, Maryland. The Baltimore site was influential in ensuring that an appropriate listing of community-based services for children was included within the benefit package of Maryland's managed mental health care initiative. Prior to managed care, Maryland Medicaid provided far more extensive rules on adult rehabilitative services than it did for child services. Based on the site's experience and advice, policymakers expanded benefit descriptions to include respite care, intensive home-based services, intensive case management and other community services. This same site also has successfully influenced local policies and ensured the start-up of a crisis response service and development of prevention services.

Managed Care

Few of the first 22 sites are located in areas where managed care has a significant impact. Either enrollment in managed care is still voluntary or children with serious emotional disturbance are not included. However, a few sites are located in states with significant managed care initiatives and these provide examples and lessons for others as managed care penetration increases. Sustainability strategies in these sites necessarily have some unique aspects, based on their state's design of managed care. Different managed care designs include:

- The system of care is organized as a managed care entity (a pro-active strategy that has proven effective);
- The system of care is a contract agency under a public or private managed care plan (a reactive strategy that also has been effective);
- The managed care system is organized primarily through the health care system, with a minimum mental health benefit not designed for a child with serious emotional disturbance (a problem in many areas, but not one that relates directly to sustainability of the site itself), and
- The system of care operates outside of the managed care arrangement, using alternative funding streams (a less than successful approach).

Very few sites are interacting directly with the for-profit behavioral health carve-out companies. When the public system retains control and there are no at-risk contracts with private for-profit entities, managed care has been a very positive experience for sites. In these areas, the system of care philosophy and managed care approaches are compatible and consumer satisfaction appears to be high.

The site where managed care has caused the most significant problems is in a state where all Medicaid clients are enrolled in health maintenance organizations for their mental and physical health care and where these HMOs have subcontracted with for-profit behavioral health care firms for mental health care (New Mexico). Other sites also have had significant difficulties with HMOs with respect to delivery of physical health care for families in the site as well as with respect to delivery of the limited mental health benefit the HMO is supposed to provide. Although children in these plans are entitled to a broader array of services than the HMO provides, accessing those broader services through Medicaid has been problematic.

One site reports difficulty working with a child welfare managed care arrangement where the child welfare system has been privatized and capitated (Wichita).

Sites with more positive experiences with managed care are *Wraparound Milwaukee*, Philadelphia, Pennsylvania, Lane County, Oregon and San Mateo and Solano counties in California. In North Dakota, although managed care has not yet been implemented, the site was viewed by planners as a model for the intended managed care system. In San Mateo, the site has been folded into the county managed care program and the overall system is based on the work and experience of the site.[1]

Lessons Learned Regarding Managed Care

- Individuals who know and appreciate the systems of care concept need to be involved in the development of managed care;
- Stakeholders (particularly families and site directors) must remain heavily involved throughout the planning process and participate on all planning bodies;
- States should expand the array of community mental health services included in their Medicaid definitions before instituting managed care or as it is put in place;
- Sites and sponsoring governmental entities (counties, cities) should seek to be the managed care entity; if this is not feasible, sites should seek a single contract for providing all of a child's careor to be designated a specific level of care within the overall managed care system. Sites should avoid contracts under which they are expected to provide various separate services, billed on a fee-for-service basis, which places responsibility for determining appropriate utilization in the hands of the managed care entity. Such arrangements can undermine a comprehensive approach to care;
- Sites need to receive an appropriate capitation amount or case rate; use historical site data and employ actuaries to be sure of what the site's services really cost;
- Management information systems are critical in managed care operations; sites need appropriate software and infrastructure (e.g., a parent connected with the *Wings Project* in Maine developed an automated care record system and the site uses it to track service costs);
- It can be helpful to use an outside consultant, an expert on managed mental health care, in designing this new approach.

The following examples are all county-wide and county-directed managed care initiatives. *Wraparound Milwaukee* was always envisioned to be a managed care program, the other two sites were up and running when their state made the shift to a managed care approach.

Wraparound Milwaukee, Wisconsin

Wraparound Milwaukee, which now operates as a comprehensive nonprofit managed care entity run by the county, exercised considerable caution in shifting to managed care. The site engaged stakeholders, contracted with actuaries, gained experience in delivering services and collected significant cost data before making the change.

Wraparound Milwaukee was initiated with a federal grant, and was modeled on a pre-existing system of care already established in another Wisconsin county, Dane County. The site operated for its first two years using Medicaid fee-for-service, federal grant funds, state Medicaid funds diverted from inpatient hospitalization and funds from other child serving agencies.

Currently, the site provides services to children identified by child welfare or juvenile justice agencies as needing residential placement, and furnishes intensive community services as an alternative. Outcomes include substantial drops in the use of residential treatment and inpatient psychiatric care, thus reducing Medicaid expenditures. Of the current $26 million *Wraparound Milwaukee* budget, about $8 million comes from child welfare, $8 million from juvenile justice, $8.5 million from Medicaid, and $1.5 million from various mental health sources. Because of this substantial funding base, the federal grant contributed less than 7% of the budget in its final year.

Wraparound Milwaukee began with a pilot for a limited number of children (25) who were in the child welfare or juvenile justice systems and had high needs. Counties in Wisconsin were already responsible for allocating all funds, including residential funds, so the county was interested in a program focused on reducing out-of-home placements. The initial services were successful in keeping children out of residential placements. However, *Wraparound Milwaukee* needed the resources that child welfare and juvenile justice spent on residential services as well as Medicaid funding, in order to furnish needed community care and to do that on a self-sustaining basis (i.e., without the federal grant). With residential placements spiraling out of control, and with a study that found a lack of effectiveness for these residential centers, the county was very willing to expand the project to more children.

Wraparound Milwaukee was then able to establish case rates with child welfare and juvenile justice so those agencies would contribute funds to a blended pool. As a result of these negotiations, child welfare could pay *Wraparound Milwaukee* about $1,000 per case less than the agency had historically paid for its heavy use of residential care. The site also bid successfully on child welfare contracts and began to receive case rate payments to provide services for abused and neglected children to keep them safe at home.

Rates were negotiated separately with Medicaid and based on actual, fiscal experience in delivering services. *Wraparound Milwaukee* negotiated with Medicaid for a capitated monthly rate based on the historical utilization for youngsters initially served through the pilot program and on an analysis of Medicaid expenditures in the site for the previous two years. Some additional data from Dane County also was used to establish the costs of certain services.

To create the Medicaid managed care financing arrangement, both the Medicaid agency and *Wraparound Milwaukee* sought separate actuarial estimates and both came to virtually the same estimate of costs for serving Medicaid-eligible children. The site was then authorized to blend the Medicaid, child welfare and juvenile justice funds to provide services. This gave the site great flexibility and a guaranteed revenue line. Each partner in this collaboration also was satisfied, as each achieved their goals:

- Medicaid was able to take a 5% saving off the top, by cutting its actuarially-based estimate of the cost of services per child by 5%;
- the county saved funds on residential costs and was able to reinvest those savings to serve more children;
- child welfare saw success in service delivery at a reasonable and predictable cost to the agency that was lower than prior expenditures;
- judges saw more services helping more children in the juvenile justice system, and
- families were supportive as their children stayed home and the family received support services.

This site is an example of sustainability stemming from demonstrated results. The savings and improved outcomes for children with significant needs provided strong evidence for the site to use to convince other agencies of the need to expand the program.

Becoming a contractor with child welfare and Medicaid has placed the site in a different role than when it was running a grant program. Sustainability is now not an issue. As long as the program satisfies its "purchasers," contracts should continue. However, reaching this point required thorough planning. *Wraparound Milwaukee* had a concrete plan with action steps. Staff knew what they wanted to do, when they needed to do it and with whom they needed to collaborate.

The program has continued to expand and further service expansions are planned for the future. From 350 children in the first year of the managed care arrangement, it has now grown to serve 650 children. This increase has been made possible partly through the reinvestment of residential treatment funds into community services. Placements in residential treatment from child welfare and juvenile justice have dropped significantly (from 360 to about 130) and county inpatient hospitalizations fell from just over 23,000 days to under 10,000 days for Medicaid eligible children. These reductions freed up $9 million to reinvest in community-based services.

Wraparound Milwaukee officials credit their success in this sustainability strategy to intangible factors. Good relationships with various agency officials were key. Especially important were good relationships with agency staff in decision making positions. For example, the site director is able to make direct contact with the director of child welfare, judges, the chief probation officer, and county executives to get things done. The site marketed itself to all its partners and worked hard at building and maintaining cross-agency relationships.

While the loss of federal grant funds may require some small adjustments, this can be accomplished by tapping some additional funding sources and through other minor adjustments in the utilization of certain services.

Lane County, Oregon

The federal site in Lane County, Oregon was in operation before the state mandated managed care for mental health services under Medicaid and for a while there were fears that managed care would derail it. Sustainability was in serious question because of an initial limited managed care benefit and low capitation rates. However, with hard work, this situation has changed. After two years of managed care, and following some significant adjustments, the site has survived.

Lane County took advantage of the federal grant, with its critical flexibility, to be creative and try new approaches. It set up its governance structure, delivered necessary services in a flexible manner and developed relationships with government and private community partners as well as with the state family organization. Despite a strong start, however, this site is still working on its sustainability strategy. There have been difficulties with agency partnerships and negotiations are now ongoing to determine precisely how each agency will help sustain various parts of the system. Some agencies will pick up the costs of intensive case managers and a shift to a system of care model in child welfare has been helpful. But Lane County also faces lingering problems from a major tax cut that reduced local general fund resources by 25-40%, particularly affecting funding for school-based mental health services.

Part way through the grant, Oregon adopted managed care. Lane County took a full year to plan for managed care. It conducted a community education and planning effort, inviting local capitated health plans to participate. Oregon made the shift to managed care through a competitive bidding process and the site assumed that it would eventually partner with these plans in a managed care bid. However, this partnership did not work out. Lane County then decided to compete for the contract, and was successful bidding against private entities. *Lane Care* is now a single, county-wide managed mental health care entity covering all Medicaid-eligible adults and children in this large county.

The county receives a capitated rate from the state and pays its local providers on a fee-for-service basis. The capitated rate for child welfare children is higher than for other children. Some mental health programs are currently not funded through managed care, such as residential services and day treatment. These programs are part of the benefit package for managed care, but the agencies have direct contracts with the Division of Mental Health and the services are funded through state/regional funds.

Lane Care has contracted with a health plan under an Administrative Services Only arrangement. The health plan co-manages authorizations and does data collection through an excellent Management Information System. The county itself is responsible for contracting, credentialing, consumer relations, provider relations, quality assurance and system building and continues to have strong community linkage.

Community providers have organized into a consortium, to speak to *Lane Care* with one voice. Working under a target for maximum billing each year, the provider consortium recommends how this revenue should be allocated and shared among them in order to stay within *Lane Care*'s budget. To date, these recommendations have always been followed by *Lane Care*.

Lane County has faced significant challenges in the shift to managed care, primarily due to the large reduction (50%) in child mental health funds that accompanied this change. Prior to managed care, urban centers in Oregon received higher Medicaid funding. When capitation rates were established, the funding was equalized throughout the state and some counties received an increase in Medicaid funding and others, such as Lane County, received less. However, prior to managed care there was a large base of Medicaid resources for children's services so this significant reduction has been absorbed without major difficulties. However, children who are not Medicaid-eligible now are served only through a very small state general fund allocation and carry-over federal grant funds. No other resources currently exist for them. This is why interagency negotiations are ongoing and why *Lane Care* is looking to child welfare to help replace some of this loss.

Through rational and strategic planning, this site has survived a shift to managed care, and preserved its system of care for Medicaid children. Throughout the shift, the county retained a positive relationship with its providers. The families' role also has been very important, as they continue to provide a consistent voice to keep the focus on the values of a system of care. In Oregon, the statewide family organization had been in place for several years and had previous relationships with families and others in the community and state. It had developed a community outreach program to promote communication between professionals and parents and has played an important role in supporting the site.

While Lane County continues to have significant struggles over the loss of federal and state government funds, it is working through these problems. A real benefit throughout this process has been the community-based focus of the site. The site considers its managed care system to be local, personal and responsive. It provides high quality services with which consumers are very satisfied. However, the site emphasizes that no site should underestimate the many fiscal problems it will face in moving to managed care.

Lane County's Advice

- State and local policymakers and politicians must support the system-of-care approach;
- Consultants on managed care techniques and approaches are helpful;
- Focus should be on managing care, not managing costs;
- Providers and families must be at the table all the time;
- Families should be given the technical support and financial resources to be full players;
- Site staff must participate in local decision making entities (in Lane County, the director is a voting member of the Commission on Children and Families, and on advisory committees for child welfare and juvenile justice).

Philadelphia, Pennsylvania

In Philadelphia, the shift to managed care also occurred after the site had organized under a different set of assumptions. This significant change occurred during the third year of the grant, and the site is now at the end of the fifth year of federal funding. Initially, the site recognized it would need about $1 million from state or local funds for sustainability. The first hope had been that the city would be able to come up with the resources, but this proved not to be the case.

Although this first sustainability strategy proved naive, the site is now expected to be almost fully sustained through Medicaid managed care and interagency collaboration on financing. The site has shifted to a contract-based financing approach, which is enabling it to integrate Medicaid, block grant dollars, local revenue and other grants into one system.

Pennsylvania delegated to its counties the decision of how to organize Medicaid behavioral health managed care. In Philadelphia, a public sector approach has been taken. A new entity, Community Behavioral Health, was established as a private, non-profit managed care organization under the control of the city. Its Board of Directors consists of the directors of mental health, substance abuse, health and child welfare. Community Behavioral Health has the authority to reinvest its savings, as it is technically a separate private corporation. Employees are not civil service, but are experienced in the public sector and paid at public sector rates.

When shifting to managed care, Philadelphia first expanded the array of Medicaid-covered services. Due to limited coverage under Medicaid fee-for-service, the site's federal grant funds had been used for services that, in other states, can be reimbursed by Medicaid. The shift to managed care, provided an opportunity for mental health officials to work with the county health department to improve Medicaid definitions and create more flexibility without violating federal law. The result has been that Medicaid services are now defined to include all the standard Medicaid community-based services. For example, managed care now picks up the cost of intensive case management and school-based case management, which were all funded through grant dollars prior to managed care. To gain support for this Medicaid expansion, the site used its federal evaluation data along with locally-collected data. Data showed savings when a flexible array of community services were provided.

This move also brought all of Medicaid under the county mental health system's control. Since the site is responsible for the system as a whole, it can utilize both Medicaid and program funding in a more rational, coordinated fashion. Medicaid funds can be combined with other program funds to pay for services still not covered under Medicaid.

The end result is that all site services can be sustained: family respite, family advocacy, family services in schools, afterschool, etc. Funds used are either Medicaid, savings in Medicaid, state block grants or city tax dollars. The site also has about half a million grant dollars left.

Blended Funding

The description of collaboration as an unnatural act between non-consenting adults,[2] is particularly appropriate when discussing how collaborating agencies can pool resources to fund a system of care. Despite a long track record of attempts, blending funding across agencies has been extraordinarily difficult for many sites.

Blended funding requires cross-system planning, involving all appropriate stakeholders as well as representatives of all the contribution agencies. It is most successful where specific financial expectations are spelled out, either in interagency agreements or in state legislation. As other sections of this report clarify, there are strategies that can be used to encourage other child- serving agencies to appreciate the value of the site and its compatibility with, and success in achieving, that agency's own goals. For example, one site having problems securing resources from schools found that presenting school-by-school outcome data on suspension rates and improved academic achievement showed principals how purchasing services from the site would improve the school's achievement scores, a goal of the state Education Department. Local schools are now contributing significant funds to this site.

Sites that have success with state-level interagency blending of funds are Rhode Island, Vermont and Stark County, Ohio.

Rhode Island

Project REACH is a statewide site first funded in 1994. It uses a mix of resources, including $5 million in Medicaid. Rhode Island recently enacted legislation and secured appropriations for blended funding that will support child mental health services statewide.

In 1997, legislation[3] was enacted to mandate that two of eight local coordinating councils be used as pilots for a collaborative effort between mental health and education so as to serve children at-risk for out-of-building, out-of district or out-of-state placements. The local coordinating councils have representation of mental health providers, teachers, businesses, ministers, law enforcement, health providers and recreation directors along with parents and consumers. This interagency initiative is supported primarily by mental health and education funds (state and local special education), with some juvenile justice and child welfare resources. Most child services (but not education) are under a single child services authority, which facilitates collaboration.

In order to embed the principles of systems of care into the fabric of the state's policies and to lay the groundwork for future appropriations necessary to sustain *Project REACH*, the 1997 legislation included an adaptation of CASSP system of care principles. Programs must adhere to CASSP principles and strive to keep children at home in safety. Where this is not possible and children are placed in foster care, these placements are to be close to home. Families are not required to give up custody for their children to participate and all families must be fully involved. Services must be culturally competent. Pooled funding from the state can then be tapped to provide these services. Funds can only be used for additional services not funded by existing agency programs and to secure these new resources, the local agencies must maintain their current level of effort.

The pool of funding has been created from each agency's residential spending (excluding residential spending for children subject to abuse and neglect). The pool thus consolidates categorical funds. Funds are transferred to the local community, which becomes responsible for the full continuum of care, including any necessary residential treatment. In return, the state has provided local communities with flexibility in the use of these funds. The arrangement reduces prior fiscal incentives for residential placements and enables funds to follow the child. Any savings resulting from reduced residential treatment or improved service delivery can be used to develop new community-based services.

The councils are responsible for developing community planning teams that prepare interagency treatment plans for children who need services from more than one agency. Consensus among the community planning team is required; agencies not agreeing to the consensus decision of the team remain solely responsible for funding the child's services. There are mechanisms for both agencies and families/children to appeal decisions they do not like.

For a discussion of the legislative strategy to secure appropriations for this legislative concept of an interagency, blended-funding system of care, see the Securing State Appropriations section at the beginning of this chapter.

Vermont

Vermont has a long history of blending funding, going back to 1985. The federal site, *Vermont ACCESS*, used its federal grant to continue to encourage inter-departmental pooling of funds through State Interagency Teams. The mental health authority controls these funds. The mental health authority found that contributing its federal grant funds facilitated collaboration across agencies and overcame resistance from other agencies to contribute to the pool.

A total of about $11 million each year is placed in the pool by the child welfare, education and mental health agencies and about 140 children statewide are served through individualized, interagency plans of care using these funds. Joint meetings of the involved agencies are held to authorize fund transfers to pay for individual plans of care.

Initially, the blended funds were used to enable child welfare and education resources to draw down Medicaid reimbursement. Each of those agencies gave the mental health authority resources that were then enhanced by using them to match Medicaid.

Stark County, Ohio

Ohio has engaged in interagency pooling of resources for over ten years. In 1987, the state enacted legislation that created an Interdepartmental Cluster for Services to Youth, composed of education, health and human services, youth services and mental retardation/developmental disabilities agencies. An interagency team reviews the cases of multi-problem children and develops programs and services for them. At the county level, similar local clusters are required. The state has a blended funding pool of about $7 million, half to be used for the cases reviewed at the state level and half of which is forwarded to local areas.

The Stark County site participates in this interagency approach. In accordance with state law, the county has developed an interagency council that receives funding from several different funding streams: child welfare, education, juvenile justice and mental health. Medicaid resources also are significant. Funds are administered by the site's governing body, the Stark County Family Council, which includes heads of mental health, child welfare, juvenile justice, education and mental retardation/developmental disabilities agencies, as well as family members and representatives of 200 community agencies and groups (faith organizations, business and child and family groups). The pooled resources support activities that are hard to fund from other sources, including family involvement. Common goals and a common vision have been developed across agencies and partner agencies all have access to financial and outcomes reports on a regular basis. Accurate and up-to-date information keeps the members of the Family Council focused on problem-solving, avoids surprises and minimizes concerns. Resources are reliable, and all partners understand the arrangements and their responsibilities.

Purchase of Service

Some sites adopt a "purchase of service" approach, instead of a formal state-level blending of funds. For example, as discussed above, *Wraparound Milwaukee*'s managed care arrangement, is funded on a case rate basis by child welfare and juvenile justice. After piloting its services and showing strong outcomes, the site shifted to managed care and capitated purchase of service arrangements, which allows it to blend funds from other agencies with Medicaid. Common goals and a common vision were developed across agencies. Data demonstrating the value of the site to other agencies was an important component of success in *Wraparound Milwaukee* and in Santa Barbara (described below), another site with purchase of service arrangements.

Santa Barbara

The Santa Barbara site has been a multi-agency system of care from its inception, and partner agencies provide significant resources. Children have a comprehensive service plan, used by all agencies, and an interagency team serves as the point of contact for the child and family.

Agencies collaborating with the mental health agency include child welfare, juvenile justice (county probation department) and public health. Collaboration takes various forms. It includes cross-training of staff, co-location of staff and shared costs of staff. The site shares in funding costs of staff employed in other agencies, such as probation officers, public health nurses and child welfare social workers who are then responsible for mental health case management for the system of care. Child welfare also provides resources directly to the site, contributing an amount equivalent to the

amount it previously spent on mental health services before the system of care was established. The site then targets child welfare children in greatest need of services, but provides these services in a flexible manner.

Santa Barbara, thus, worked to ensure its services would result in good outcomes for other agencies and result in a single cross-agency system of care. It used strategies that build strong and meaningful interagency collaboration. Staff are jointly funded, cross-trained and co-located. Priority is given to children who are of greatest concern to partner agencies. Funds are used to support staff in partner agencies. Santa Barbara now has a track record of solving the problems all the agencies face. At the same time, the site has paid attention to the administrative realities and problems of inter-agency collaboration.

Santa Barbara continues to market itself so as to sustain its interagency partnerships, see Marketing section below. This ensures continued financial contributions from partner agencies.

Reinvestment in California

Some sites in California (Santa Cruz and Ventura) have made use of a reinvestment initiative even though it is not specifically focused on children with serious emotional disturbance. This California reinvestment initiative, piloted in four counties and now available more broadly around the state, is designed to prevent various social costs such as welfare expenditures by funding prevention and early intervention. Even though few sites have benefited directly, the *budget strategy* of the California reinvestment initiative is applicable to any site and is therefore included here.

For a reinvestment strategy to be successful, stakeholders, evaluators, families and budget personnel must agree on a set of indicators of success that can be measured. According to those with experience with the California reinvestment strategy[4] :

- the site's goals must be in line with the community's own goals and be described in terms of improved outcomes;
- goals must be linked to avoiding an adverse outcome that costs taxpayers money;
- only 3 or 4 goals need be established but cost avoidance must then be measured;
- everyone must be clear on who the target population is and what service strategies are to be provided and funded through reinvested funds;
- the data must be relevant to the goals and meaningful to an audience of budget-makers.

- Not all good outcomes have a measurable cost saving attached to them. But even if they are not quantifiable, other cost savings can be referenced to help demonstrate that savings will out-weigh the cost of the site's program and that the cost data presented are, in fact, highly conservative.

Specific examples of how the California reinvestment strategy has been used are shown in the box.

Reinvestment Examples[5]

Residential Costs

The number of children placed out-of-state or in other residential programs can be tracked and trends identified. Cost projections for residential services can be used if necessary, but more effective is to show real reductions. Multiply the number of children not placed in residential facilities by average costs. This amount can then be reinvested in the site's community alternatives.

A similar approach can be used with child welfare foster care costs. In this instance, projected use of out-of-home placements will almost certainly need to be made because actual reductions will be hard to achieve and many decisions on placement will not be under the control of the site.

Child Protective Services

The number of child protective services referrals and investigations of abuse and neglect provide data on the effectiveness of a site. One program using a reinvestment strategy found a drop from 50 to 28 referrals over a three year period (using data from 18 months before the program to 18 months after), and a drop in investigations from 21 to 10. Calculating the cost of these referrals and investigations provided an estimate of savings.

ACCESSING PRIVATE RESOURCES

Sites using private resources include: San Diego's *Project Heartbeat* (foundations and fund-raising activities), Baltimore, Maryland (three national foundations provide important resources for various hard-to-fund activities) and North Dakota Partnership (where the state is negotiating a partnership with Blue Cross-Blue Shield). Other sites also work with local community groups. For example, in Vermont the Rotary Club in Bennington has a program to "adopt" families with a child with emotional or behavioral disorder and then provides funds for respite for them.

Private Foundations in San Diego

Child services in San Diego are directed through a Board of Supervisors who needed convincing that the county should make the major shift in philosophy required to adopt a strengths based, interagency system of care. While federal grant funds can provide significant support for

services, sponsors of the site determined that other resources were needed as well in order to fund a family organization and conduct training, modeling, and advocacy. Foundations proved to be an excellent source of both fiscal resources and necessary expertise.

A small coalition group led by the Bar Association and including 18 local stakeholders, created *Project Heartbeat* (now the site), which successfully sought private foundation funding more than a year before the county submitted its federal grant application.

Few foundations make grants to public agencies, and so the county of San Diego could not apply.

Funds totaling $1.56 million were received from: Alliance Healthcare Foundation ($53,000), the Annie E. Casey Foundation ($125,000 for each of two years), the California State Bar Foundation ($5,000) and the California Endowment ($1 million over two years). Most of the grants were for only one or two years, and each were relatively small. But they played a key role in inculcating a new philosophy of care in San Diego. Some funds were used for consultants to help develop a business plan and, perhaps even more important than the actual fiscal resources, the site found that foundations are a critical source of independent knowledge, support and backing. The larger foundations, in particular, provided technical assistance on systems change and on how to present system change to policymakers and the community. Foundation staff explained how to work with local public budgets and how to do policy work. Sustainability requires a site to have strong connections with local and state policymakers. The foundation officers and members of foundation boards had a significant influence; they can carry weight with policy makers and they know how to advocate for programs they believe in. For *Project Heartbeat*, accessing this expertise in the private sector was critical to its successful community organizing. The foundations helped develop the necessary information and the advocacy to persuade policymakers to take a new approach. When coupled with federal technical assistance on how to develop and run a system of care, the proto-site had access to the significant outside expertise it needed.

Even though San Diego used these funds to create the right environment to *initiate* their system of care, such an approach is equally applicable to the strategic planning and community organization required to create the climate to *sustain* a site. Foundation funds can be a cushion at any key point in a site's development, such as transition between the federal grant and long-term financing or they can fund strategic planning and advocacy. With larger health foundations emerging around the country, sites will find opportunities; however, those which are public agencies will need to partner with a private, non-profit entity in order to secure foundation resources, because foundations will not fund a public agency.

Accessing Foundation Funds

- Learn who the local foundations are and what they fund or are seeking to fund.
- Check out associations of foundation executives. Foundations are usually staff driven; you need to meet and get to know the directors.
- Remember that foundations want to fund innovation; this creates a good match between the foundation and a system of care site. Sites are doing work foundations want to fund—they are innovative, successful and provide a new way to reduce out-of-home expenditures and keep children out of trouble. These are strong selling points.
- Attend conferences sponsored by the foundations you are interested in, seek out staff from those foundations who may be attending (health or children's conferences).
- Speak out at local public events so the site becomes well known.
- Check out the foundation board members; if you know any of them, they can help.
- Plan your approach. Some foundations want to fund services, others fund advocacy and policy. For a sustainability strategy, the latter are likely to be more useful.
- Consider asking for strategic planning grants, funds for the transition from federal support, funds for the family organization, resources for new and flexible initiatives, training, community education, advocacy and policy development.

Partnership with Private Insurance in North Dakota

In North Dakota, discussions are underway concerning an innovative approach to link public mental health services with private insurance. Blue Cross-Blue Shield (BC-BS) of North Dakota is interested in improving services for those with the most serious disorders—adults with serious mental illness and children with serious emotional disturbance. Traditionally, under BC-BS policies, these are the people who reach the limits of their coverage, sometimes year-after-year. As a result, BC-BS, the North Dakota Department of Human Services, the Mental Health Association and the North Dakota Federation of Families have been exploring, along with several state legislators, avenues to increase the level of services available for BC-BS subscribers.

Blue Cross-Blue Shield is interested in the proven effectiveness of intensive case management and wrap around services used in the public sector. Also, if the public sector providers were engaged earlier, BC-BS officials believe, continuity of care for these children and adults would improve. BC-BS and the state are exploring how to make public sector screening and community based services available to BC-BS subscribers through a process that includes the client, the family, and the treating physician. This would involve a financial arrangement that permits joint funding of case management and a range of flexible alternative services, as appropriate, along with more traditional services. The goal would be to provide stabilization and a reduction in crises for children.

Currently BC-BS and the state are working to determine the exact scope and nature of a contract for a pilot project for children in the Fargo region and an adult project in Bismarck. The program would be voluntary to BC-BS subscribers and will have an evaluation component.

With the involvement of the state to act as an overall manager of care and risk, Blue Cross-Blue Shield officials express optimism that this highly unusual, innovative idea can be implemented. For the state, this improved continuity of care for children who eventually must turn to the public sector will assist in improving care and in funding both the current site and other community-based services around the state.

CULTURALLY COMPETENT COMMUNITY ORGANIZING

As discussed in Chapter V, strong community linkages that are built through culturally-competent means are a very important part of a sustainability strategy. A site that has put a great deal of emphasis on this is Baltimore, Maryland.

Baltimore, Maryland

Baltimore has focused heavily on gaining the confidence, acceptance and support of its community. As a result, it has been able to secure resources for non-billable, less traditional or hard-to-fund activities and expand its services beyond what would otherwise have been available once federal funds terminated.

Community organizing has been part of this site's approach from the very beginning. The site has reached out to various neighborhood organizations and groups, such as:

- housing project associations
- community development programs
- faith-based groups
- African-American sororities and fraternities and
- individual community leaders.

The site considers itself to be building a partnership with the community it serves, an inner-city area of Baltimore. Early in its existence, the site created position descriptions for Neighborhood Liaisons—trained paraprofessional staff who often have grown up in the neighborhoods in which they work. Neighborhood Liaisons work on teams with clinicians to serve children and families. The liaisons know the community and its values and norms and they are able to access community-

based resources such as food and furniture banks and community-based health screening programs. Other staff also work in the community, such as by serving on local boards and governance structures in formal and informal ways.

According to the site director, working with community leaders and community groups requires the same investment, and in many ways the same approach, as working with a family organization. Site staff use a strengths-based approach and listen to the community's assessment of their problems and barriers to solutions. Community leaders are now part of the site's advisory and governance structure and they also work with the site in various less formal ways.

Barriers and difficulties inevitably arise. At first, outreach efforts are likely to be viewed with suspicion. Even when one community group has been won over, others may still challenge site staff to demonstrate their commitment. Inevitably, some ideas will not work out and site leaders must be able to accept this and move on (for example, some of the staff hired for the Baltimore site had to be let go).

Success in this kind of organizing requires:

- A real investment of time, energy and personal commitment in the community;
- Early and sustained contacts with the community, (expect to have to listen and deal with concerns and frustrations stemming from previous experiences with similar programs in the past);
- Meaningful inclusion of community leaders in the site's activities and decision-making;
- Opportunities for community members to participate as staff in the project;
- Significant attention to hiring staff with appropriate cultural background (the Baltimore neighborhood is primarily African-American), recruiting staff from outside the area when this is necessary to achieve this goal;
- Engagement by the site in the agendas of community groups—site activities for children with mental health-care needs must tie in to community activities for children in general;
- Opportunities for community groups to make a difference in children's lives, so they can see the pay off;
- Acting as partners—developing joint programs, joint funding and joint actions to secure financial support for community groups as well as for the site.

Community groups in Baltimore have directly helped the site in fundraising. They have written strong letters of support when the site competes for grants or contracts and helped the site secure United Way and other local, state and federal dollars. In particular, when funding opportunities require an emphasis on cultural competence/appropriateness or demonstration of strong community involvement, these groups have proved invaluable.

Community groups also provide significant in-kind support. The site is able to rent its space at a very low rate ($2/square foot) in a building owned by one of the community leaders. Churches also can make spacious areas available to the site for meetings, trainings and other events.

The site lends its support to efforts of other community agencies and groups to secure their own funding for programs to address families' needs. Joint programming reduces costs. For example, after school and summer programs exist for children in the area. Negotiations, backed up with professional support and training of child-care staff, enabled children with serious emotional disturbance who had previously been excluded to participate. Public housing community organizations have services for families, and the site was able to get children with serious emotional disorder included in these services. The site also shares its own resources with community groups. For example, the site's van can be used to transport not only children who are in the system of care to a particular activity, but also for other children from the community who are attending the same program.

Importantly, once committed to this approach, particularly in neighborhoods where community groups have seen many programs come and go, is it crucial to sustain the commitment. A realistic assessment of whether this can be done should be made up front to avoid repeating past experiences of failure or abandonment for the community.

MARKETING

Many successful sites market their philosophy and services to other agencies and local and state policy makers. Santa Barbara is one example of a site with a comprehensive marketing approach.[6] In Santa Barbara, federal grant funds were always a small part of the program, and seen as resources to leverage other support which, in turn, depended upon a true partnership between agencies. To succeed with that approach, the site adopted a philosophy of facilitation and worked to develop a sense of partnership, collaboration and success with other agencies.

Santa Barbara, California

This site expects to be able to sustain 97% of its federal funding. The preciseness of that estimate reflects the strong business orientation of the program, which has budgeted in detail for the day when federal funds will end. Santa Barbara has many of the elements of success found in more viable sites:

- It used the federal grant as an impetus towards significant reform.
- It emphasizes family involvement and has hired significant numbers of families.
- It limited the use of federal funds—the federal grant was used for services to children with no other coverage, start up costs, infrastructure building and for flexible services not otherwise reimbursable. For ongoing support of services, the site has maximized Medicaid, other entitlements and state and local service funds.
- It built and maintained very strong interagency collaboration.
- It took a business-like approach to budget planning and made excellent use of its data.

This project was initiated with federal funds and built on strong interagency relationships. Other agencies now make a financial contribution to the system, which then allows them to refer families for care (see Purchase of Services discussion above).

Data collection has been key to good marketing. It enabled the site to demonstrate its outcomes. The data are used to show specific outcomes for each partner and are presented in a simple and graphic manner. Santa Barbara has developed fold-out brochures with a single basic design which is then adapted to create slightly different materials for different partner agencies. Each version has a different title and incorporates different data on one page of the fold-out brochure. For school partners, the brochure's title is Learning in School and the data presented are on academic performance. For juvenile justice partners, the title is Abiding by the Law and the data presented are on the total number of referrals to law enforcement and referral patterns. For families, the brochure is entitled Supportive Relationships with Others and the data reported are on improvements in clinical scores and how services have helped families. More detailed data are sent to these agencies *every month*, so that they can see trends and successes. (The site also will shortly begin sending similar reports to families.)

In this way, Santa Barbara makes it clear to these agencies how cost-effective the site is for them and how it is relevant to their goals. This has facilitated a common idea of what the program is doing and helped build a sense of partnership, collaboration and success.

Lessons for others from the Santa Barbara experience include:

- At start up, think about who you will serve—this tells you your market—then identify funding streams for serving them over the long-term and pursue them.
- Work at relationships among various agencies' staff and between staff and families.
- Think like a business from the beginning. Build a budget based first on all available entitlement funds, resources from other agencies and state mental health appropriations. Then present your program of services to potential funders by demonstrating relevance to their goals.

USE OF MEDIA

Good press work can give a boost to campaigns to secure funding. For example, as part of the campaign to pass its new systems of care legislation, Rhode Island worked with local print press and television. Editorials were placed in local newspapers, local television stations interviewed some of the site's parents on their experiences and a video was prepared showing a group of parents involved with *Project REACH*.

In Milwaukee, several stories about *Wraparound Milwaukee* and the foster parents involved in the site have appeared locally, such as when a local TV station did a Christmas show, interviewing staff and families. This site has been particularly successful in connecting its stories to other news. Recently, a paper did a story on the site in conjunction with a story about a new initiative in breast cancer and local press also covered the site in connection with the White House Conference on Mental Health.

The *North Dakota Partnership* has influenced articles on wraparound in the Fargo News and the project has been covered in the Dakota Bell. This site also has tied news coverage to larger events in mental health, such as Mental Illness Awareness Week and has secured local TV coverage of families. Many other sites distribute regular newsletters and press releases.

Sites making particularly good use of media coverage include: Kansas and Baltimore.

Kansas

The campaign to secure appropriations to expand the system-of-care approach in Kansas, described above, included a media strategy. The family organization staff had prior media experience and worked to build relationships between the media and family and provider groups.

They met with the media to interest them in the campaign and then organized events so they had significant media appeal. The media liked events which were unusual, very visual and carried a simple, clear message.

Media opportunities were sought at key times and always related to policy issues. For example, a well-timed story appeared in the local newspaper describing a child who had benefited under the state's Medicaid waiver for home and community based services. Key legislators were mentioned and praised for their support in helping to keep funded a program (the site), which enabled kids to stay at home with their families.

> *"The media are looking for stories, if you will just spend the time with them to show them what you are trying to do for children." Family organization director.*

Legislators paid closer attention to the needs of children when there was media interest. They also appreciated being acknowledged in the media, such as when a rally was held on the Capitol steps to highlight how certain legislators had secured new child mental health appropriations. Four television stations, five radio stations and seven newspapers covered the event. Even legislators who did not attend, paid attention to the issue once the media were involved.

Another recent success was a rally and candle lighting event involving over 1,000 families, children and teachers focused on school safety. It was covered by two radio stations, three television stations and the newspapers, and provided great coverage of child mental health issues at a very low cost ($200). Also very effective was a media awards event, where certificates were given to the media for outstanding coverage of children's issues. Media representatives were extremely pleased to be recognized, and the awards event itself gained further media coverage.

Keys for Networking is maintaining its media presence, to lay the groundwork for any future legislative campaigns.

Baltimore, Maryland

Baltimore has made a concerted effort to obtain coverage on a number of local talk shows, local community papers and the major Baltimore paper, *Baltimore Sun*. Being affiliated with a major university, Johns Hopkins, has enabled the site to gain coverage through the School of Public Health and be included in other media stories or bulletins about University issues.

The Baltimore site operates on the assumption that when the public sees and hears good things happening for children it creates support for the program and lays the groundwork for the political support needed for sustainability. The site has, therefore, invited the media to cover some of its upbeat activities, such as Christmas parties, family events and graduations.

An unusual bill-board campaign also enabled the site to get increased community visibility. A corporation with a vacant billboard donated that space to the site which used it to highlight the work of children from a youth center which trains them in photography. The billboard was entitled There is An Artist in Your Community, and showed pictures by and of the children, along with the name of the program. The billboard campaign, thus, also highlighted a positive message.

TRAINING

Several vehicles exist in most communities for securing training dollars. One source of funds available to all sites is Title IV-E of the Social Security Act, which provides federal support for permanency planning, including foster care maintenance, adoption assistance and administration and training. Federal eligibility rules are complex, but focus on children in low-income, one-parent families who have either been removed or are at risk of removal from home. Title IV-E funds can be used to train service providers, families and other stakeholders as well as child welfare personnel. Funds are open-ended and come through the child welfare agency.

For training purposes, programs are reimbursed at 75% of cost, but this amount is reduced by multiplying it by the percentage of Title IV-E children who are in the foster care system. This formula ensures that Title IV-E only pays its fair share of the training costs. Not all children in foster care are eligible for Title IV-E—generally only 50-80% of them.

Funds can be used to train case managers, for recruitment and licensing of foster homes and other administrative costs. Training for services to children at risk of foster care placement is also covered. The training can be either in-service or short or long-term pre-service education.

Sites emphasizing training include North Carolina (highlighted below), Maine, Santa Barbara, California, and others. Santa Barbara sought expertise from North Carolina in order to use Title IV-E funds and the site now provides training across agencies in a sustained manner.

North Carolina

North Carolina has used Title IV-E funds extensively, partnering with state educational institutions. The funds support development and provision of curricula and of training to support delivery of services for eligible children and adolescents with serious emotional disturbance. The

goal is to ensure that services are provided in a collaborative, culturally sensitive manner, recognizing and respecting family strengths and ensuring a role for families in the planning and development of local comprehensive services. Funds are used for planning, development and evaluation of training as well as the training program itself. Training is both traditional skill-based training and on-the-job training. Some examples are:

- Conducting joint training of mental health and staff of other agencies to better understand child welfare, community-based systems of care and how to use entitlements to maintain family integrity and return children to their families;
- Training in the development of local systems of care. Family volunteers and staff from all child-serving agencies attend various trainings with the goal of improving skills, knowledge and attitudes related to in-home services, family partnerships, case management and interagency collaboration.
- Undergraduate and graduate student training in current theory of community mental health for children and families, including field placements in sites. This provides additional staff for programs as well as opportunities to recruit new staff.
- In-service training for agency personnel on family-centered services. Family members participate and some act as trainers. Training focuses on the partnership role of family members in providing interventions, emphasizing family strengths and family challenges, such as community and domestic violence;
- Cultural competence training for staff, supervisors, administrations of public agencies and of other community agencies.
- Post placement adoption training for adoptive and foster parents and professionals who work with them;
- Training in coordination of services for children aged 0-5 who are in open foster care or child protective services cases or at risk of abuse, neglect or out-of-home placements.

In terms of a sustainability strategy, these funds are very important to the site. In addition, the training generates greater understanding, and therefore greater commitment, to the system of care philosophy among personnel in various other agencies.

Notes:

[1] For a more detailed review of managed care in the sites, see Stroul, B., Pires, S. & Armstrong, M. (1998). *Special study on managed care: Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program.* Rockville, MD: Child, Adolescent and Family Branch, Center for Mental Health Services, Department of Health and Human Services.

[2] Former Surgeon General Jocelyn Elders.

[3] The Coordination of Children's Community Social Services, Education and Mental Health Services Pilot Program.

[4] Presentation by Friedman, Mark (June 1999). Fiscal Policy Studies Institute, Baltimore, Maryland. Georgetown University Technical Assistance Center-sponsored meeting, Stowe, Vermont.

[5] Based on Griffin, M., Rosenblatt, A., Mills, N. & Friedman, M. (1998). *Capturing cash for kids: A workbook for reinvesting in community based prevention approaches for children and families*. Sacramento, CA: Foundation Consortium; and on material from Mark Friedman, Fiscal Policy Studies Institute, Balitmore, MD.

[6] See *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume II: Reporting Evaluation Data to Manage, Improve, Market and Sustain Children's Services.*

Chapter VIII– Conclusion

Sites can be successful in achieving financial sustainability, but it takes work and planning. Such planning should begin right from day one, and over the period of the federal grant, the site should engage in specific actions designed for the day when federal resources are withdrawn.

To achieve sustainability, sites must maintain their commitment to the philosophy of a system of care, adapt to broader state policy initiatives, especially managed care, and tap into major entitlement funding and state government resource streams. Reallocating resources is an important part of the solution, and generating broad community support through community organizing, social marketing and media work is essential.

The monograph provides a summary of numerous ideas for sites seeking sustainability. Several lessons can be drawn from the experience of the early sites:

- During the life of the grant it is important to put in place all appropriate mechanisms to ensure that entitlement funding is secured. A very large percentage of the revenue needed to sustain direct services to children comes from such sources.
- The other most significant source of sustainability funds has been state and local resources. Sites must have strong allies at the state and community level to conduct a successful campaign to secure these funds.
- Sites should not overlook various private sources of funds. Although generally far smaller than government grants, these are more flexible resources.
- During the life of the grant, and not only in the last few years, sites must work to ensure: strong community support, meaningful interagency partnerships and good relationships with key political figures.
- Sites must understand and adopt good business practice, engage in marketing, have strong leadership that is sustained even if key individuals leave, use its data on the program effectively and try to nurture media relationships.

There are numerous specific ways to sustain a site – every site's approach will be different, tailored to its community and reflecting the broader policy context in its state. For some, Medicaid managed care can be a solution. Others can promote and sell the concept of reinvestment. Still

others must look to direct state and local appropriations. Many sites can benefit from seeking private funding from various sources. The various experiences and successes reported in this monograph can assist sites in preparing their own sustainability plans.

However, it is important to recognize that sustainability may be defined differently by different players. Federal policymakers are focused on sustaining the *ideals* of the system of care philosophy and expanding such approaches around the country. At the state level, policymakers need a very pragmatic and *practical* approach to systems reform that comports with other state policy goals. At the local level, where the system of care is implemented, great concern may be focused on "how do I keep the specific services developed under the grant in place and keep the staff in place?" These different perspectives on what sustainability is all about mean that people may approach the strategies and tactics to accomplish it in a very different way. Hopefully, some blending of ideas and goals will emerge to ensure the sustainability of an effective and innovative system of care that fulfills federal policymakers goals, using policies and approaches that are right for the particular state and ensuring ongoing delivery of services locally.

Resources

RESOURCES ON FUNDING SYSTEMS OF CARE FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

Cole, R. F., & Poe, S. (1993). *Partnerships for care: Systems of care for children with serious emotional disturbances and their families*. Washington, DC: Washington Business Group on Health.

Giffin, M., Rosenblatt, A., Mills, N. & Friedman, M. (1998). *Capturing cash for kids: A workbook for reinvesting in community based prevention approaches for children and f amilies*. Sacramento, CA: Foundation Consortium Comprehensive Integrated Services Reinvestment Project. Address: 2295 Gateway Oaks Drive, #100, Sacramento, California 95833 (916/646-3646).

RESOURCES ON MANAGED CARE

Lourie, I.S., Howe, S.W., & Roebuck, L.L. (1996). *Systematic approaches to mental health care in the private sector for children, adolescents and their families: Managed care organizations and service providers.* Washington, D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Child Mental Health.

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998). *Health care tracking project: 1997 Impact analysis*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998). *Health care tracking project: 1997-1998 State survey.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Contracting for managed substance abuse and mental health services: A guide for public purchasers (1998). *Technical Assistance Publication Series, 22*, (DHHS Publication No (SMA) 98-3173). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Partners in planning: Consumers' role in contracting for public-sector managed mental health and addiction services (1998). *Managed Care Technical Assistance Series, Volume 10*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

A family advocates' guide: Managing behavioral health care for children and youth (1996). Alexandria, VA: Federation of Families for Children's Mental Health and Washington, D.C.: Bazelon Center for Mental Health Law.

RESOURCES ON MEDICAID

Making sense of Medicaid for children with serious emotional disturbance (1999). Washington, D.C.: Bazelon Center for Mental Health Law. Address: 1101 15th Street, N.W., Washington, D.C. 20005 (202/467-5730). 1999

RESOURCES ON CHILD WELFARE FUNDING

Information on federal programs for child welfare are summarized on the web site of the U.S. Department of Health and Human Services, Administration for Children and Families at www.acf.dhhhs.gov/programs/cb/programs.

RESOURCES ON FEDERAL JUVENILE JUSTICE FUNDING

Information on federal programs for funding services that prevent brushes with the law by juveniles are summarized on the Department of Justice's web site: http://www.ojp.usdoj.gov

RESOURCES FOR ADVOCACY

Craig, R.T. (1990). *What legislators need to know about children's mental health*. Washington, D.C.: National Conference of State Legislatures.

Friedman, R., Duchnowski, A.J. & Henderson, Elissa L., (Eds.) (1989). *Advocacy on behalf of children with serious emotional problems*. Springfield, IL: Charles C. Thomas.

Information on federal rules regarding lobbying by nonprofits is available from Independent Sector, Charity Lobbying in the Public Interest, Washington, D.C. (202/387-5048), or on their web site at: http//www.independentsector.org/clpi. On the web site, look for the following short fact sheets: *Lobby? You?*, *Charity Lobbying in the Public Interest: Lobbying Is Not For Experts Only*, *Charity Lobbying: It's the Right Thing to Do*, *Basic Information About the*

1976 Law Governing Lobbying by Charities, *Your Nonprofit Organization Should Elect to Come Under the 1976 Lobby Law* and *IRS Letter Alleviates Charities' Concern About Lobbying*.

RESOURCES ON WORKING WITH THE MEDIA

Strategic communications for nonprofits: Strategic media. Available from The Benton Foundation, 1710 Rhode Island Avenue, N.W, 4th Floor, Washington, D.C. 20036. (202/857-7829)

Marketing matters: Building an effective communications program, prepared by Advanced Resource Technologies, Inc., Alexandria, VA for the US Administration for Children and Families, National Center on Child Abuse and Neglect. Available from National Clearinghouse on Child Abuse and Neglect Information, PO Box 1182, Washington, D.C. 20013-1182 (1/800/394-3366).