

METRO CITY IN THE STATE OF WONDER

The State of Wonder is a medium-sized northeastern State. Services for children, youth and families are, for the most part, State-run in Wonder, not county-run, with the State divided into service districts. The service districts for the Department of Children, Youth and Families, which includes child welfare and juvenile justice programs, and the Department of Mental Health, Mental Retardation and Addictions Services, were recently made the same. District I encompasses Metro City, a large metropolitan hub that is home to about 70% of the children and families involved in public systems Statewide, such as child welfare, juvenile justice, and mental health. Metro is also the state capitol. As a city, Metro is divided into eight wards, three of which have large concentrations of children and families in poverty and an overrepresentation of families from these wards involved in public child-serving systems. Metro is racially and ethnically diverse, with large African American and Latino populations in particular.

From a services standpoint, Metro is served by the District I child welfare office, the Area I mental health, mental retardation, and addictions services office, and the Region I social services office, which handles eligibility determination and enrollment for welfare-to-work and Medicaid. The State runs juvenile and adult corrections facilities, a 40-bed adolescent inpatient facility, and a 50-bed adolescent residential treatment facility. Various State agencies also contract for residential treatment, therapeutic group homes, in-home services, and clinic-based outpatient and emergency services. Metro has an overrepresentation of children and youth in out-of-home placements, including residential and hospital care, foster care, and juvenile corrections placements, and there is often a waiting list for outpatient services in the city at the main community mental health clinic that contracts with the Department of Mental Health and which is also the major mental health and substance abuse Medicaid provider in the city.

The city of Metro itself runs, either directly or by contract, housing programs, services to the homeless, employment services, parks and recreation, juvenile detention and delinquency prevention programs, health clinics, and basic city services, such as snow removal and trash pick-up. The recently elected Mayor ran on a platform of reducing juvenile crime in the city by putting more police into neighborhoods and creating more after school programs and summer jobs for youth. The court system runs probation, which is attached to a court social services unit. The public schools are overseen by an elected School Board, which appoints the School Superintendent. The current superintendent has been on the job for two years and continues to wrestle with large expenditures on special education, school safety issues, and absenteeism; on the positive side, however, test scores are starting to improve, driven by the superintendent's emphasis on standards and her ability to get the School Board to approve incentive bonuses for teachers who meet the standards.

Three years ago, two back-to-back reports led Metro City stakeholders to come together around the issue of youth transitioning out of foster care. One report, issued by the

Mayor's Youth Council, documented that nearly 40% of the 18-24 year-old population in the city's homeless shelters were former foster care youth. The second report, undertaken by the State Corrections Department, found a disproportionate number of foster care youth ending up in adult corrections facilities. Both reports also found disproportionate numbers of racial and ethnic minority youth formerly in foster care now among the adult homeless and corrections populations.

On the heels of these reports, the State child welfare agency began to work with the State Medicaid agency to extend Medicaid coverage to youth between 18-21 years of age if they had been in foster care, and the State allocated Chafee independent living funds to the Districts to increase services for the transition-age youth population. With the involvement of Metro City stakeholders, the State child welfare agency also applied for and received a federal child welfare system of care (SOC) grant targeted to help Metro develop a more systematic approach to the issue of transition-age youth in foster care.

In the two years since receipt of the child welfare SOC grant, the following has been accomplished:

- The District I child welfare administrator and the head of the Mayor's Youth Council (a youth-run entity promoting youth development in the city) co-lead the Metro Task Force on Transition-Age Youth, formed in response to the grant opportunity. The Task Force includes a broad group of stakeholders, including major youth-serving systems and agencies such as housing and employment services, mental health and substance abuse, and youth themselves, including youth involved in foster care. Also, the Task Force includes representatives from the 5 Family-to-Family Neighborhood Collaboratives, with which the child welfare system has been partnering for the past four years to prevent child welfare involvement. The Task Force is undertaking planning and overseeing implementation activities.
- At about the 3-month mark of the federal grant in year one, the Task Force sponsored a day-long forum about the initiative with providers, community members, and others to describe its purpose and goals and begin to strengthen stakeholder buy-in. (The State had held a smaller forum prior to the grant application to generate support for the application.)
- Staff has been hired, including a project director and a data specialist, who report to the District I child welfare administrator, and a paid former foster youth who is housed within the Mayor's Youth Council. A first step undertaken by staff, working under the guidance of the Task Force, which meets monthly, was to undertake an analysis of the transition-age youth population, beginning with identifying the number and placement status of 14-18 year olds involved with child welfare. As a result of this analysis, they found that this population was in a variety of placements, including regular foster care, therapeutic foster care, group homes, residential treatment facilities, kinship placements, subsidized adoptive placements, and a not insignificant number had been in and out of state hospital

care and detention. Many of the youth were involved with juvenile justice and mental health or substance abuse; fewer were involved with special education, though many had school-related problems. The analysis also included focus groups with youth, facilitated by the youth staff member, that yielded valuable information about what youth in foster care saw as their strengths and needs in achieving independence. Strengths essentially focused on resiliency characteristics; needs centered on education, jobs, money, housing and having some type of connection to some type of family that would care what happened.

- The District I child welfare administrator meets monthly with the supervisors on her team to make sure they understand the SOC grant as a priority and to determine what steps the agency needs to take to identify and link youth to services and supports. The project director holds monthly meetings with workers and support staff (e.g., data staff) to identify and resolve barriers to implementation. The project director also has brought in resource consultants from national technical assistance centers focusing on transition-age youth (in child welfare and in mental health) to educate the agency and Task Force members about best practices. In addition, the agency is using technical assistance to help it adapt its Family Group Decision Making approach, which it has been using for several years, to incorporate the concept of “youth-guided” decision-making.
- Considerable progress has been made with the Region I social services office, both to expedite Medicaid enrollment of foster care youth about to turn 18 and to link them to public assistance (i.e., TANF) if they qualify, which, in turn, could connect them to job search and retention help. Progress also is being made with the vocational rehabilitation services office to provide job readiness and job assistance services to the subset of transition-age youth with disabilities who qualify for these services, beginning with youth at age 14. Not as much progress has been made yet with the city’s employment services agency or its housing agency to create priorities for the transition-age population, although both are represented on the Task Force. Both of these agencies seem overwhelmed with other, primarily adult, populations; thus, it has been difficult to get their attention.
- For the transition-age youth that are heavily involved with multiple systems, the Task Force is considering a “lead agency” concept, in which several of the agencies (e.g., child welfare, mental health/substance abuse, juvenile justice, education) would jointly fund a coordinated, “wraparound” approach, mobilizing all necessary services and supports into one plan and assigning youth one service manager. While there is strong support for this model, a number of issues still have to be resolved, such as the interface between Family Group Decision Making in child welfare and Wraparound, the role of the Wraparound service manager and that of the child welfare worker and probation officer, *how* to blend or braid the cross-system funding, and what performance expectations to impose on the lead agency. Also, the Task Force wants to make sure that the lead agency

partners with natural helping networks in the community, such as the Neighborhood Collaboratives.

- While private businesses and post-secondary education, such as universities and technical colleges, are not members of the Task Force, the Task Force has met with representatives of these sectors. There is not yet a plan for how to formally link and support youth with these sectors, though both sectors expressed a willingness to meet further. The Task Force also has reached out to leaders in the African American and Latino communities to get their ideas on how to support transitioning youth. One idea posed by African American leaders was to take the “one church, one child” concept and apply it to transitioning youth. These leaders also voiced concern that these youth already are involved, or are at high risk for involvement, in substance abuse and decried the lack of substance abuse prevention and treatment services in the city. The Latino leaders felt that a major issue for transition-age girls was pregnancy prevention, health and wellness, and suggested a need for linkages with the community health clinics, particularly the one clinic in the city serving primarily the Latino population.
- The Task Force asked the project director to begin to look at comprehensive assessment tools that might be used for the transition-age population across systems. With the help of resource consultants and a small subcommittee, the project director is pulling together various instruments to try to find one that is strengths-based, sufficiently comprehensive and age-appropriate.
- The Task Force knows that this population of youth is especially at risk for school failure, which further diminishes their potential for successful independent living. It is considering various ideas for mentors and working with private foundations to develop financial incentives to youth to finish school and go on to post secondary schooling of some type. Also, they want to get the schools to do better transition planning for foster youth who are transitioning out of special education placements, who are at even higher risk. In general, however, there is poor exchange of information between the schools and child welfare as to which youth are in foster care and have Individualized Education Plans (IEPs).
- The youth staff member has been pushing the Task Force to address the issue of “family”, that is, a need to help transition-age youth feel some connection to family. He recently went to a conference in which he heard about the success of “Family Finding”, using Internet search engines to help foster care youth locate extended family, and has passed the information on to the project director.
- There are three family-run organizations in Metro – a Family Voices chapter focusing on children with special health care needs and developmental disabilities; a chapter of the Federation of Families for Children’s Mental Health; and the Foster Family Association. Each is represented on the Task Force, and they have begun to have discussions among themselves as to how they, each and collectively, might best support the transition-age population.

Team S

FAIRVIEW COUNTY

Fairview County is a sprawling “collar county” that grew up around a large Midwestern city. It is located in a county-structured State, in which the counties play a major role in service provision. The State allocates formula grants to the counties, based on population demographics and poverty indicators, for child welfare, juvenile justice, mental health, substance abuse, and welfare-to-work services and supports. The counties augment State dollars, in some cases considerably, through locally raised tax dollars, as well as Medicaid reimbursements generated by county-operated services. The State operates a 30-bed adolescent psychiatric hospital and a 40-bed adolescent residential treatment facility, but it bills the counties for placements in these facilities.

Fairview County is in the fourth year of a federal Substance Abuse and Mental Health Services (SAMHSA) system of care (SOC) grant. Although the grant is a “mental health grant”, it is targeting children involved or at risk for involvement in child welfare who have mental health needs. In fact, the initiative is called, “Improving Child Welfare Outcomes Through a System of Care Approach”. The county received the grant on the strength of its interagency collaboration to build a system of early intervention for infants and young children, which is seen as a national model, and in which the county’s Part C Early Intervention program took the lead in partnership with the county child welfare agency. The State child welfare agency supported the county’s SOC grant application as a means of supporting the state’s overall Program Improvement Plan (PIP) objectives related to reducing the number of children in out-of-home placements, increasing permanency and improving well-being.

Fairview County’s SOC grant is focusing on children and youth in, and at risk for, out-of-home placement and their families (specifically including birth, foster, adoptive, kin and guardian families) and includes some, although not all, of the same entities that collaborated on the early intervention project. Among the major partners is the county-based family-run organization, called Fairview Federation of Families (Triple F), which developed as a result of the early intervention project. Triple F was comprised early on mainly of families with young children who have special needs, including special health care needs, emotional, behavioral and developmental challenges; from its onset, it made special efforts to engage and include families with young children involved in child welfare. With the SAMHSA SOC grant, Triple F also has been expanding its membership to families with older children and adolescents and developing linkages with the Foster Family Association. Triple F receives funding from the SOC grant and a smaller amount from a federal Statewide Family Network Grant that the Statewide chapter of the Federation of Families for Children’s Mental Health received.

An elected board of county supervisors, who appoint agency directors, runs the county. Fairview County is a relatively wealthy county, although it has small pockets of poverty and a growing number of recently arrived immigrant families from such diverse countries as Cambodia and the Serbian-Bosnian republics. It also has a growing Latino population

that has migrated from the city to the suburb. An elected school board and a school superintendent appointed by the county commissioners oversee the public schools in Fairview County. The schools are almost uniformly strong, supported by a strong tax base, but are grappling with the issues posed by an influx of immigrant families, including language and cultural issues and families' lacking basic supports.

The county social services agency provides many child welfare services through contracts with private providers, including family support and in-home services, respite, mentoring, therapeutic foster care, group homes, and residential treatment programs. The county also funds domestic violence programs. The county mental health board contracts with mental health and substance abuse providers, including a large community mental health clinic, which provides outpatient, day treatment, in-home and behavioral aide services, and a substance abuse provider serving adults and adolescents. In addition, the county partners with the school superintendent's office to fund therapeutic pre-school programs. This was one of the initiatives that grew out of the early intervention grant.

Over the past decade, the county has made a generally successful effort to prevent placement of children in out-of-home care, but in the two years preceding receipt of the SOC grant, the county began to see a slow creep upward in the numbers of children and youth in out-of-home placement, including more children in emergency placement and foster care, more youth in detention and more children and youth placed in group homes and residential treatment facilities by all four major child-serving systems (i.e., child welfare, juvenile justice, mental health, and education). The majority of the youngsters placed in group homes and residential treatment are involved in either or both child welfare and juvenile justice, and many of them have behavioral health challenges and are involved in (or should be involved in) special education.

In its SAMHSA SOC grant application, the county attributed the upward trend in out-of-home placements to several factors. It cited as major factors the growth in the population of the county in general, the influx of new immigrant families, as well as Latino families moving from the city, a growing number of families with young children struggling to keep up with the high costs of the county, including high property taxes, and growing waiting lists for home and community-based services and basic supports.

In general, Fairview County has a large number of provider agencies, as well as individual practitioners. Child welfare providers complain that they do not have sufficient flexibility in funding to provide enough in-home and community-based services to keep children at home or to respond effectively when a disruption in placement is imminent. Medicaid providers (some of whom also are child welfare providers) complain that Medicaid rates are too low to support quality care, and that private insurance companies do not understand and therefore will not pay for home and community-based services. Services provided under the Medicaid Rehabilitation Services Option (Rehab), which the State has had for almost a decade, are fee-for-service, but there is discussion at both the State and county levels of implementing a behavioral health carve out for Rehab services because of State/county concerns about rising mental health costs under the Rehab Option. Fairview County believes it could manage Rehab

services more efficiently if it had the authority to enter into managed care arrangements, and it believes the community mental health center has the capacity to assume a “lead provider” role in a managed care arrangement. The county child welfare agency also believes it could achieve better results if it had more flexibility in use of Title IV-E funds.

In the four years that the county has had the SAMHSA SOC grant, it has accomplished the following:

- An Interagency Governance Board was created by the County Supervisors to oversee policy decisions. It includes many of the systems serving children, youth and families (e.g., child welfare, juvenile justice, mental health, education, health) and four family members, two from Triple F (one of whom also is a member of the Foster Family Association) and two representing racial and ethnic communities who do not belong to Triple F. The Board also created a Providers Forum, which includes many residential providers, to provide input on a regular basis to the Board.
- A project director and staff were hired to support the Board’s planning process, which included focus groups with families, child welfare workers, judges, etc., and to support implementation. These staff report directly to the Board.
- The Board provided funding to Triple F to expand its capacity to families with older children and youth. The Board also provided funding to a fledgling family organization focused on mobilizing families in the three main racially and ethnically diverse communities (i.e., Cambodian, Serbian-Bosnian, and Latino). Both organizations have had success in growing their numbers, developing family education and support programs, and in partnering with other system stakeholders in system planning and governance. However, there are often tensions between the organizations, often over the allocation of resources. Also, much of the energies of the organization focusing on racially and ethnically diverse families has been on organizing and on providing family support activities; its work is less formally tied to the service delivery system in child welfare and mental health.
- The Board used some grant dollars and some dollars currently spent by mental health and child welfare to create a new funding pool for intensive care management for children and families involved, or at risk for involvement, in multiple systems. The priority population for this care management is children and youth involved in child welfare who also are involved with mental health and who are in, or at imminent risk of entering, any type of out-of-home placement. The Board contracted with the community mental health clinic (CMHC) to provide this intensive care management, which can be augmented by Medicaid match for children who are Medicaid-eligible. Initially, the CMHC implemented a clinical case management model, using highly trained clinicians, but, over time, it found this approach to be costly, limiting the numbers of children who could be served. The approach also seemed to be too “office-bound” and was failing to

keep engaged many of the children and families with the highest need, including families from the immigrant and Latino communities. Also, problems still remain in working out the role of the CMHC care manager and that of the child welfare worker. However, for families who did stay involved with their care manager, outcomes were generally very positive; in two and a half years, 100 children received care management services with good results. Eighty-six percent of these children remained at home, were reunified, or were moved to permanent arrangements. However, the program had expected to serve nearly four times as many children. The clinic is in the midst of re-designing the care management model, drawing on technical assistance from the federal grant program.

- The Board issued Requests for Proposals (RFP) to develop more behavioral aide, mentoring and in-home services. The RFP stipulated that providers of these services must either be Medicaid Rehab providers or partner with Rehab providers so that Medicaid could be used to cover these services for Medicaid-eligible children. Only two providers in the county -- the community mental health clinic and a large child welfare provider-- applied for the contracts. The Board was hoping that more non-traditional providers, particularly those working in racially and ethnically diverse neighborhoods, would step forward or partner with the larger agencies, but this did not occur.
- The county mental health agency augmented its 24-hour crisis services unit with a Mobile Response and Stabilization (MRSS) team. This team is able to respond to crises in the community, such as at schools, in group homes, etc., and is getting excellent results in keeping children out of hospitals, emergency rooms, and residential facilities. MRSS workers also believe they are helping to prevent disruption in placements, but this specific data element is not tracked. Medicaid Rehab dollars help to pay for mobile crisis services.
- Project staff provided ongoing orientation and training to child welfare workers, supervisors, mental health clinicians, judges, families, school personnel, probation workers, CASA volunteers, and others in a SOC approach. While there is now much greater understanding of SOC principles and values, there is not yet a common practice model utilized across the systems in working with children and families nor is there a commonly understood system design for the system of care.
- Representatives from the Board are in ongoing discussions with the State child welfare agency about the State's giving the county flexibility in use of IV-E funds in return for the county's accepting some measure of financial risk over IV-E expenditures. A major sticking point is the extent to which the State will share risk with the county if costs exceed the county's and the State's expectations. Meanwhile, the State Medicaid agency is preparing to contract with all of the counties, including Fairview, to operate a county-based behavioral health carve- out system either directly or through contracting with an outside vendor.

Team A

THE HEARTLAND PROJECT

The Heartland Project is a three-county, three-year pilot initiative, launched by the State child welfare agency, in a rural region of a largely rural western state. The project evolved out of concern at State and local levels about the “meth crisis” – i.e., growing numbers of home-grown methamphetamine manufacturing labs and meth abuse, leading to increased numbers of children and families coming to the attention of the child welfare system. The Heartland Project is intended to bring together county-based substance abuse providers with the region’s child welfare system to develop a coordinated approach to identify and link to appropriate services families coming to the attention of, or already involved with, child welfare where methamphetamine abuse is a primary issue. The State child welfare agency hopes that a more coordinated approach will prevent placement of children and reduce the length of time children are in placement when removal already has occurred. To support the pilot, the State child welfare agency and the State substance abuse agency collaborated to obtain a small amount of new funding (\$150,000 for each year of the three-year pilot) from the legislature with the idea that success with the pilot might lead to additional state funding for statewide implementation and the opportunity to apply for a federal substance abuse waiver demonstration.

The State child welfare system is organized by regions and is a State-administered system. In contrast, substance abuse and mental health services are county-administered with the state mental health and substance abuse agency providing funding to the counties on a formula basis. The State Medicaid agency has been operating a Medicaid managed care initiative involving physical health care, while mental health and substance abuse services remain fee-for-service within Medicaid. The State has a fairly progressive Rehabilitation Services Option benefit for mental health services within Medicaid, but covers few substance abuse treatment services.

The three contiguous counties that make up the Heartland Project belong to Region I and have a history of collaborating in such areas as rural health care delivery, -- for example bringing telemedicine to the region -- and transportation services, which have been organized fairly effectively through a network of faith-based organizations. One of the counties is home to the headquarters of both the Statewide foster family association and an active chapter of Family Voices, focusing on children with special health care needs. Another county in the region is home to an Indian Tribal reservation with a population of about 400 families. It is a day’s drive to go from one end of the region to another, and a half-day drive from the nearest county to the State capitol.

The main services to children and families in the three-county region include: State-run child welfare services with one regional administrator responsible for all three counties in Region I; State-run juvenile and adult corrections facilities; a 40-bed State-run adolescent residential treatment facility; State-and county-contracted services with two community mental health clinics (CMHCs), which provide both substance abuse and mental health treatment services; one of the CMHCs contracts, in turn, with a residential substance

abuse treatment provider serving adolescents; welfare (i.e., public assistance) offices in each county; county juvenile detention programs; rural health clinics; two school-based health clinics in two of the high schools; individual Medicaid providers; and one hospital. The State child welfare system contracts with three large providers to provide foster care, in-home, shelter and group home care, and adoptions services, as well as independent living skills training and supports for youth transitioning out of foster care. The State implemented the Medicaid Rehabilitation Services Option about two years ago, but there is still a severe shortage of home-and community-based behavioral health services. Public schools are overseen by six local school districts. County services are overseen by elected county commissioners, who appoint agency directors. The three counties successfully applied for a federal rural health services grant, which is enabling them to develop a telemedicine capacity in partnership with the state university and teaching hospital located in the State capitol. The telemedicine grant currently is focusing on outreach, prenatal care, family education and teen pregnancy prevention to improve birth outcomes; the rural health clinics and the school-based clinics are partners in this project.

Leadership for the Heartland Project at the State level comes from the State child welfare director and the State substance abuse agency director, each of whom has designated staff to oversee the pilot and support local implementation. At the local level, leadership is provided by the Region I child welfare administrator and the directors of the two community mental health clinics; the county commissioners also are committed to the initiative.

Since the Heartland Project was launched a year ago, the following has been accomplished:

- The regional child welfare and county mental health directors collaborated to hire a project director, who is housed within child welfare and has a background in substance abuse counseling.
- Local newspapers have carried articles about the project.
- The project director contracted with a local community college to conduct a needs assessment to identify more clearly the scope of the problem and potential resources. The needs assessment identified the meth problem as it affected child welfare as particularly prevalent among families with young children, with high rates of illiteracy and poverty, with access to few resources and isolated from social support systems. Where families did have geographic access to extended family, the study found that many of the extended family members also were involved in a “meth culture”. The study identified a number of potential resources, including: the intensive outpatient services provided by specialized substance abuse staff at the CMHCs; a grant received by one of the CMHCs to implement the Matrix Model, an evidence-based practice for methamphetamine abuse treatment; the mobile crisis teams employed by both CMHCs; a large child welfare-supported private provider, which offered a range of services, including in-home, family education, substance abuse education and counseling, domestic

violence counseling and short-term shelter, and Multi-Dimensional Treatment Foster Care, an evidence-based practice for children and youth with serious emotional and behavioral disorders; the rural health clinics, which many families in the region use as their primary care provider; the two school-based health clinics; and the faith-based organizations throughout the region.

- The project director and substance abuse specialists from the CMHCs held three briefings and orientations for child protective service (CPS) investigators, who are based at the Sheriff's Department, and child welfare workers about the goals of the project and how to refer families when meth abuse is suspected as a primary issue. Essentially, workers contact the project director, who reviews the background information provided by workers to determine appropriateness for referral, and then facilitates linkage of the family to the substance abuse specialists at the CMHCs. The substance abuse specialists provide weekly reports to the project director on families served, and the project director relays this information to workers. In this way, the project director also is able to track the numbers and disposition of families involved in the project.
- The project director and CMHC substance abuse specialists also held briefings and orientations for the county sheriff's departments and for guardians ad litem (GALs) and judges. During the first year of the project, however, there did not seem to be much of a shift in the historic tendency of judges and GALs to support removal of a child or continued out-of-home placement when parental meth abuse was a factor.
- Twenty families were referred for services, with 12 deemed appropriate for the project. Of these 12 families, only 6 became involved in substance abuse treatment services. Of these 6, 3 were involved in the Matrix Model, and 3 were involved in shorter-stay intensive outpatient (IOP) services. Of the 3 families involved in the Matrix Model, 2 were families identified through CPS investigators, and one was a family whose children already were in out-of-home placement. In the cases of those families referred by CPS, children either remained with their family or were reunified after brief emergency shelter placement as a result of positive outcomes in treatment. However, in the case of the family whose children already were in placement, the judge was not yet persuaded to return the children home, in spite of similar positive treatment results. In the case of the 3 families receiving shorter stay IOP services, only one of these parents showed positive treatment results during the course of treatment, and her child remained at home.

The project director, with input from the CMHC substance abuse specialists, prepared an analysis of the first year's experience for the Heartland Project's leadership in the region and at the State level. On the positive side, the analysis pointed out that of 6 parents receiving substance abuse treatment, 4 experienced positive results (a 66% success rate), and in 3 of these 4 families, children were able to remain at home. The report noted, in particular, the success rate of the Matrix Model. The report also

noted as a positive the willingness of two of the three sheriff's departments to work with CPS to link families to services. The analysis devoted much of its focus, however, to a number of challenges impeding more widespread implementation and success and suggested steps to address these problems --

- Child welfare staff was not referring a sufficient number, or necessarily always the appropriate families, for the project. This was partly attributable to staff turnover, as new staff did not routinely receive an orientation about the Heartland Project. The report recommended that all new staff receive an orientation to the Heartland Project as a standard part of their overall orientation and that current staff receive a "refresher" briefing. The report also suggested that a standardized screening tool might be helpful to workers.
- The report noted the better results, comparatively, between families first coming into contact with child welfare (i.e., referred by CPS) and those whose children were already in placement, and suggested the need for a more targeted strategy for families whose children were already removed.
- The analysis noted that, while meth abuse was a primary issue in families involved in the project, they and their children also had many other challenges, such as poverty, illiteracy, lack of connection to social supports and natural helping networks, in some cases, co-occurring mental health and developmental disabilities, lack of access to primary care, and problems with the schools. The report recommended a need for involvement and buy-in from other systems, particularly from local welfare offices (i.e., TANF), the public libraries, which were involved in a major literacy campaign, the schools, the rural clinics, the major private, nonprofit child welfare provider in the region, and faith-based organizations.
- The report noted the difficulty that many families had in getting to and staying involved in services and suggested the need for some type of service coordinator or advocate – perhaps peer family mentors -- to build trust and help families take advantage of existing services and supports.
- While the analysis made many recommendations to increase the number of families involved in the project, it also expressed concern that increased numbers could overwhelm existing providers, particularly the one CMHC implementing the Matrix Model. It suggested a need to explore with State Medicaid officials the possibility of including the Matrix Model as a Medicaid-reimbursable service as one strategy to expand service capacity. The analysis also noted that, if the project succeeded in increasing the numbers of families identified for and engaged in services, an automated tracking system would be needed and expressed concern that the State's child welfare MIS system might not be able to collect and disaggregate data in the way that the Heartland Project might need.
- While the report was optimistic about the families that had successfully completed treatment, it also expressed caution that with the many challenges facing these families, connection to ongoing social supports was critical.