200 Families Phase 2

A Foundation for a Reform Process

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Phase 2 team members

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Background and charge of the 200 Families Phase 2 team:

The Community Services Group (CSG)[1] formed a working group in late 1997 to examine the families in Hennepin County who used the most social services. CSG asked the group to recommend ways to improve service delivery to these families and save costs for the county. The 200 Families working group identified 200 expensive families in Hennepin County and found that these 200 families utilized more than $29 million in human services per year for 1996 and 1997. The team presented their findings to the CSG in April 1998, identifying 13 recommendations to improve service delivery. A central message in the team's recommendations was that the process of improving service delivery to these high cost and complex families would take many steps and that their recommendations only addressed the first steps.

In response to the 200 Families team report, the CSG formed a "200 Families - Phase 2" team to take the findings and recommendations from the first team and further the work. The team was formed in February 1999. **The team's charge was to describe an integrated social service delivery system that would be more cost effective and produce better outcomes for the most expensive social service families in Hennepin County** and report back to the CSG within six months.

The Phase 2 team built on the work of the initial 200 Families team. The Phase 1 team laboriously matched electronic client records using Children and Family Services data as a base then looking across 10 additional data bases to identify departments where services were delivered. Using these identified families, the Phase 2 team continued the work of examining multi-problem families. We recognize that the families in the sample are some of the most expensive and complicated families in the county service delivery system. This is the very reason that there is an interest in defining a service delivery method that will be more effective and more cost efficient. It is important to remember that the vast majority of the families that the county serves are single problem families that receive services from only one department and that the 200 families are not typical clients.

During the case life of these 200 families, several laws, policies and practices have changed in county departments. This is a fact of county life. All of these families were active in 1996 and/or 1997 when the Phase 1 team collected the data. Any case review is always fraught with the problem of on-going changes. Some of the issues identified by the Phase 2 team would not be as problematic in 1999, particularly given increased scrutiny to out of home placement costs.

[1] The Community Services Group is comprised of directors from the following departments: Adult Services, Children and Family Services, Community Corrections, Community Health, Economic Assistance, Health and Human Services Policy Center, Hennepin County Medical Center, Primary Care, Training and Employment Assistance, and Veterans Affairs.

During the past six months, our research has taken us in several directions.

- We took the 200 families identified in Phase 1 and examined some of the data sources not available to the Phase 1 team. Their estimate of $29 million in social services costs per year for these 200 families is a very low estimate. They weren't able to include data on justice system costs, administrative overhead, some staff salaries, and some contracted services.

- We performed a cluster analysis[1] of the 200 families to better understand the types of cases that made up the most expensive families, in terms of service utilization. The cluster analysis grouped families into one of four groups. The largest group had 127 families, which were characterized by multiple service use in Economic Assistance, Children and Family Services, Community Corrections, and Adult Services.

- We examined in-depth 20 families, primarily from the cluster group of 127, to better understand the way social services were delivered to these high cost families. We looked for red flags apparent at the outset of the cases to see whether or how that affected the choice of services offered. We looked at the overlap of services between departments and the degree to which case workers in different departments knew about and coordinated service delivery. And we looked at the amount and types of social services provided, both from staff and through contracted agencies, to understand how much community agencies are involved with these families.

- We reviewed national literature and held conversations with experts around the country in the field of service integration. The concept of service integration has been around for decades but it has never been successfully implemented in a county as large as Hennepin County. Our review of current national thinking on service integration has led us to be cautious of service integration as a solution to high cost cases. There are lessons to be taken from service integration and we have incorporated those into our recommendations.

- We visited several programs within Hennepin County that attempt to target multi-department involved families, or which coordinate services across departments within the county. We took several lessons from their successes and challenges. We also held many conversations with Kristine Martin, the director of Hennepin Powderhorn Partners, another CSG initiative, to share findings with her, both from our research and from her implementation of Hennepin Powderhorn Partners.

[1] Cluster analysis is a statistical exploratory tool for finding natural groups or clusters of items. Its objective is to sort these items (e.g., people, specimens, events, etc.) into groups so that the degree of association is high between members of the same group and low between members of different groups. Although in most situations exactly where the divisions between groups and how many clusters exist is subject to interpretation, these preliminary findings can imply what further analysis can and should be carried out.

- We held a focus group with social service staff to talk about the delivery of services to families with complex Hennepin County involvement. We also met with many staff around the county with expertise in cross-department budgets, information technology, and data privacy. Conversations with these professionals helped us shape our findings and recommendations.

- Finally, we met with staff from the University of Minnesota's Humphrey Institute and Center for Urban and Regional Affairs to talk about our charge and findings. These in-depth discussions helped to crystallize our thinking and led us to our final set of recommendations.

The Phase 2 team has three major recommendations for CSG based on our findings and our original charge. These recommendations should be viewed as the next steps in the process of developing accountability for service outcomes in an urban county, mindful of the cost-effectiveness of these services. Each recommendation follows a discussion of our major findings over the past six months and how those findings led us to the conclusions and recommendations we present.

Recommendation 1 - Form a Service Utilization Review Team to regularly examine high cost and multi-department involved cases.

The difficulty in identifying the costs of the most expensive social service cases in Hennepin County led us to conclude that **there is an invisibility of costs throughout the county** in delivering services. Social workers, their supervisors, and even department directors are unaware of how much a family costs Hennepin County and its taxpayers. Services provided by community agencies cannot be tied back to a particular family and the costs are not isolated. Meanwhile, the families experience multiple assessments, treatment programs, incarcerations, court dates, and thousands of hours of staff time over the course of many years. A comprehensive history of service use is rarely compiled; the best summaries are found in child protection files when the social worker is making a case to terminate parental rights. But even those records only reflect social services specifically aimed at changing dangerous behaviors in the parents. It misses much of the criminal behavior, mental health problems, and services provided by the county that are tangential to the child protection case.

The cluster analysis of the 200 most expensive families found that **the majority of families fit a profile of multiple social service** use rather than simply expensive medical costs or long-term care of disabled children (127 families out of 200). These families are characterized as high receipt of cash grants/food stamps, high use of child services, high contact with Community Corrections, medium receipt of chemical health services, and low medical assistance use. This multiple-service use suggests that no single department (with perhaps the exception of DCFS-Child Protection) would be able to identify these cases as high cost and may not even know that their families are involved in other departments. Yet the cluster analysis showed that multiple department use was clearly the defining quality of high cost cases. In fact, of the 20 families reviewed, 60% had case openings in four departments at the same time.

In our in-depth review of 20 cases, we saw **many missed opportunities for communication and coordination**. While case notes reflected knowledge of other staff working with a particular family, there was little evidence that staff worked out case plans jointly. It would make sense to coordinate child protection and community corrections, when both departments are working towards the sobriety of the caretaking parent. It would also make sense to negotiate the sequence of services for a family, where inpatient mental health or chemical health treatment is appropriate, yet there are pressures to reunify the family and move them from MFIP to work.

Even if there is no best way to sequence treatment and prioritize goals, **simple communication between staff may help staff and department management "connect the dots"** and begin to understand the complexity of the problems these families face. Time and time again we saw families involved in Child Protection, where chemical dependency appeared to be a major factor in their inability to parent. But then chemical health workers uncovered underlying mental illnesses that make chemical dependency treatment much more difficult. Yet these mental health issues were likely unknown to the Child Protection worker, who is left wondering why treatment continues to be unsuccessful over and over again.

The lack of coordination may stem, in part, from the conflicting goals of Hennepin County departments. Each case worker is first accountable to the goals and outcomes of his or her department, not overarching goals for the county. The Phase 1 team recommended that the county establish interdepartmental service and client outcomes. While work has begun on this recommendation, it has proven very difficult to accomplish. In the meanwhile, departments often work at cross purposes in their work with clients towards financial independence, secure housing, better parenting, and resolution of mental and chemical health issues.

Our in-depth analysis of the 20 families and conversations with professionals led us to conclude that **among this group the capacity for positive change is extremely limited or nonexistent. The focus for county social service activity should be on the potential for reduction of harm to children.** We saw families that were involved in Hennepin County for years or a decade where all attempts at treatment for underlying problems failed, and in the end, parental rights were terminated and/or other treatments were stopped. In these cases, there were parts of the system that continued to drive social service involvement beyond a point where it was clear that the behavior of the parents would not change and parental rights needed to be terminated. In these families, as cases languished in court and more attempts at reunification failed, we saw the children move into the juvenile justice system, only to repeat the mistakes of their parents.

We concluded from the literature and our analysis of the 20 families that **the sooner action is taken, the more salvageable the children are.** Time is of the essence for these families. Recent legislative changes concerning Child Protection[1] will focus more efforts early on, with issues being resolved far faster than they were in the past. Thus the legislative mandates that are changing some of the policies and procedures in the Department of Children and Family Services provide a perfect opportunity for other county departments to change the ways in which they do business. The idea of time-sensitive services should be replicated in other departments so that families don't remain involved with the county for years while we slowly work to address their problems. If high cost, complex cases were identified as soon as possible, a concerted effort was made to address the problems or admit we don't know how to, families would receive better services or, at the least, not receive years worth of ineffective services.

We saw the **potential for cost savings**, especially in the termination of parental rights cases when it is obvious that throwing more ineffective treatment at a family does no one good and may ultimately harm younger family members. But we also saw potential for cost savings in better management of high cost cases, where the sequencing of services would be helpful and where communication across departments would help social workers better work with the families. The county has done some experimentation in this area, with targeted populations set apart for specific coordination, such as Delinquents under Ten, IRIS, and the Children's Mental Health Collaborative. But coordination could and should be done on a larger scale.

[1] Adoption and Safe Families Act of 1997, PL 105-89.

As a result of these findings, **we recommend that the county implement a Service Utilization Review Team (SURT) to examine high cost and multi-department involved cases on a quarterly basis.**

1. Each quarter, the SURT should do a computer match of all families in Hennepin County receiving social services to determine which cases are the highest cost and/or are involved in three or more departments simultaneously. This list should be examined by the SURT, cases selected, and the results reported to the CSG, and the Executive Team of Hennepin County.

2. SURT should evaluate each family's social service involvement and determine whether to (a) maintain the case with the SURT team in order to shift service emphasis from treatment to maintenance within the community, (b) maintain the case with the SURT team for a more coordinated team effort of the current case plan, or (c) leave the case in the current department since progress is being made or the family is expected to end its involvement with Hennepin County soon. Cases kept by SURT could benefit from national literature identifying best practices in the field of multiple-service family needs.

3. Cases reviewed by SURT should be tracked to see whether the family's issues are resolved or their involvement with Hennepin County social services ends. Quarterly reports on these past cases should also go to CSG and the Executive Team.

The SURT process should not be prescriptive at this time but rather the team should have the latitude to develop a program which will be evaluated on an on-going basis and changed as needed. This process must be data driven and outcome focused. Rather than attempting to coordinate and integrate services throughout Hennepin County, this process targets service coordination for those cases that need it most -- where current practice is unsuccessful and the lack of success is driving up costs. While good social service practice shouldn't be dictated by cost, lack of attention to the complexity of the case and the costs means that money is spent fruitlessly on families where clearly the services are not helpful. Requiring or offering families services that are unwanted and ineffective is a disservice to both the family and taxpayers.

Implementation of this recommendation should be done immediately. At the present time, it will be a labor-intensive effort to match these families across departments. But it can be done. This effort will become easier as the appropriate infrastructure becomes available. This is our second recommendation.

Recommendation 2 - Develop the infrastructure needed to support SURT and deliver coordinated interdepartmental services while maximizing revenues.

The Phase 1 report documented the **difficulty in gathering data across departments,** in particular cost data on a family-basis. Yet if we are going to be cost-effective in our delivery of services, we must identify and examine cases that cost us the most money.

Faculty from the Humphrey Institute noted that **any new service delivery system would need an underlying infrastructure to support it.** Conversations with staff from the various pilots in Hennepin County also underscored this need. Many of their struggles in implementing their pilots focused on day to day information needs, a lack of systems in place to track outcomes and costs, and other management pieces to support their non-routine business practices. Finally, national literature on service integration always notes the need for supportive infrastructure as essential to integration. Typically, service integration literature points to integration in four primary areas: policy, finance, service delivery, and outcomes. Conversations with professionals within Hennepin County convinced us that **it is possible to develop an infrastructure to support a routine identification of high cost cases.** This would require, however, a data system that can combine data from various systems, add credible cost data, and protect the privacy of the clients in compliance with state and federal laws.

Hennepin Powderhorn Partners is experimenting with many of the pieces of infrastructure necessary to coordinate services across departments, such as a common intake form and shared case notes. We need to build on the lessons learned at Hennepin Powderhorn Partners and perhaps use it as a laboratory for other infrastructure designs that would also support SURT.

Based on this advice, **we recommend that the county develop the infrastructure needed to support SURT and deliver coordinated interdepartmental services while maximizing revenues.** This includes:

1. Common client index, starting with the departments of Children and Family Services, Community Corrections, Adult Services, and Economic Assistance and adding other departments and contracted agencies where possible.

2. Common definitions across delivery systems, in terms of defining the family, clients, costs, cases, and ethnicity, to name a few.

3. Common treatment/care plan intake forms, and file retention timelines.

4. Standardized accounting practices, and taking advantage of revenue maximization, where possible.

5. Standard cross-training between departments.

6. Higher level outcomes across departments that are data driven and policy guidelines that cross department lines.

7. Protocols for sharing data, while complying with federal and state data privacy laws. This may include data sharing agreements across departments, working to clarify the county's position in data privacy, and identifying protocols for obtaining signed releases from clients identified for SURT.

Hennepin Powderhorn Partners, and other experiments by the CSG, could serve as laboratories for some of these infrastructure developments. Policies and procedures could be piloted on a small scale at Hennepin Powderhorn Partners and then brought to a larger scale through the learnings at Powderhorn Partners.

Implementation of this recommendation should be done immediately and concurrently with Recommendation 1. The lessons learned while trying to identify and serve high cost/multiple department families can inform planners in determining the best infrastructure to put in place. Meanwhile, as infrastructure pieces come on line, they can be incorporated into the SURT process to see if they meet the needs for this new process.

While the first two recommendations address the immediate need to evaluate and reorient our most expensive and unsuccessful service delivery to families, it leaves the question of whether these families could have been identified early on and a better service delivery plan implemented from the start. This is our third recommendation.

Recommendation 3 - Develop and implement a client screening and assessment system to more appropriately match clients with needed multi-department services.

Among the 20 families that we reviewed in-depth, **there were obvious "red flags" from the beginning that informed us that these families needed intensive services.** Some of the flags included mothers whose first child was born before age 18, a history of chemical abuse, mental illness, domestic abuse, sexual abuse, criminal justice system involvement, gang involvement, multiple moves, and periods of homelessness. Most of this information was apparent at the first case opening. Yet despite the complexity of the family being served by Hennepin County, the services provided appeared fairly routine: chemical dependency evaluation and treatment, anger management counseling and parenting classes. Services were offered through a variety of culturally-appropriate community providers. When those weren't successful, other agencies were tried, or the same agency tried again. Services should have been coordinated between departments and best practices should have been applied where we have data on successful interventions.

The Department of Children and Family Services is currently implementing a Structured Decision Making protocol on its cases to help evaluate the risk to children in Child Protection cases and the likelihood of a recurrence of abuse or neglect. It also identifies family needs. **Social service literature has been able to identify risk factors** associated with child abuse and neglect, and other tools around the country are being developed and applied to social service delivery systems, based on risk factors and outcomes data.

Several programs in Hennepin County are based in part on risk factors that identify clients for a specific pilot. For example, the Children's Mental Health collaborative works with children who are involved in two or more systems and who are severely and emotionally disturbed. Delinquents Under Ten also identifies children based on family risk factors.

Finally, as noted above, **the sooner action is taken, the more salvageable the children are.** To the extent that we can identify these families early on and target them for intensive services while concurrently planning for the possibility of parental termination is currently the best practice. As stated above, if high cost, complex cases were identified as soon as possible and a concerted effort were made to address the problems or admit we don't know how to, families would receive better services or, at the least, not receive years worth of ineffective services.

Based on these points, **we recommend that the county develop and implement a client screening and assessment system to more appropriately match clients with needed multi-department services.**

The screening should be a predictive model based on national and local data that informs us not only of flags associated with complex and high cost cases but also advises us on best practices for serving these families.

We recommend that the CSG select a team to research and plan this process and report back to the CSG in six months on their progress.

Some final considerations:

There are several considerations that CSG should keep in mind in implementing these recommendations. First, **there needs to be a communications plan** to roll out these recommendations throughout Hennepin County. The communications plan needs to inform Hennepin County staff as to the rationale and goals of the processes. It also needs to include in the information plan other professionals who are involved in the cases, such as the Judges of the Fourth Judicial District, the County Board, social service providers in the community, and the public.

Second, **there needs to be training** developed in conjunction with these recommendations. Hennepin County staff need to be cross-trained, to some extent, in the goals, processes, and outcomes of other departments. There needs to be discussions across departments as to the demands that families involved in multiple departments must meet. And there needs to be a frank discussion of how competing values in departments can lead to perverse incentives that don't serve the family well and don't meet the overall goals for the county.

Third, **there needs to be evaluation** in place for these recommendations as well as other initiatives undertaken by CSG. **The recommendations in this report are part of a reform process, not merely ends in themselves.** These recommendations, as implemented, need to be evaluated as to whether they are meeting the original charge: to integrate social services in a more cost effective manner and produce better outcomes for the most complex social service families in Hennepin County. If the strategies don't meet those goals, then we need to learn why not and develop different strategies. This is an iterative and dynamic process; we shouldn't lose sight of that.

Finally, we need to continually learn and build on the pilots and processes developed by the CSG. Hennepin Powderhorn Partners (and other iterations) may provide a good place to experiment with many of the strategies we recommend in this report. It is our hope that the various county experiments aimed at improving service delivery will build upon each other so that best practices become business as usual in Hennepin County rather than the purview of isolated pilots.

Appendices:

1. Acknowledgements
2. Cluster Analysis
3. Synopsis of the In-depth Review of 20 Families
4. Literature Review

Acknowledgements

Meetings/Conversations with projects/seminars

200 Families, Phase 1 team
Children's Mental Health Collaborative
Delinquents Under Ten
Humphrey Institute Workshop
Language of Poverty Workshop
Hennepin Powderhorn Partners
Project Connect
Project IRIS
Structured Decision Making team

Meetings/Conversations with Individuals

Alan Altshuler, Kennedy School of Government, Harvard University
Pat Batko, Hennepin County DCFS
Debbie Belago and Kris Loris, Hennepin County Economic Assistance
Gary Cunningham, Hennepin County OPD
Bob Distad, Hennepin County Assistant County Attorney
Mary Englen, Hennepin County EA
Julie Forchay, Eisenhower Community Center, Hopkins
Joe Gaspard, Hennepin County EA
David Gray, Placer County, CA
Don Gullingsrud, Hennepin County Administration
Jamie Halpern, Hennepin County Health and Human Services Policy Center
Judy Lee, Hennepin County DCFS
Kristine Martin, Hennepin Powderhorn Partners
Carolyn McHenry, Susan Clauson, Paul Gisselquist, Hennepin County DCFS
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Jessica Simon and Jim Ahrens, Hennepin County DOCC
Lois Yellowthunder, Hennepin County Health and Human Services Policy Center
Esther Wattenberg, CURA Institute
David Weyrens, Hennepin County DCFS

Family Cluster Characteristics

The families were clustered on the following factors:

- Receipt of Cash Grant, or Food Stamps (yes, or no)
- Dollar Value of Medical Assistance – Grouped as high (>$550,000), medium ($215,000-$550,000), or low (<$215,000)
- Receipt of services under Child Services (CF/EC) (yes, or no)
- Receipt of services under Chemical Health (CH/SI) (yes, or no)
- Contact with Community Corrections (yes, or no)
- Number of Case Workers – Grouped as high (9 or more), medium (5-8), or low (<5)

Note: The descriptions here of high, medium, or low service usage are related only to these 200 families, and not to services provided to families county-wide.

Group 1: (10 families)
This group is characterized by very high Medical Assistance dollars (average of $830,000 during 1996-97); low receipt of Child Services, little Community Corrections contact, few case workers (average of 1.3); and no receipt of Cash Grants/Food Stamps, or Chemical Health services. Mean number of *known* children = 1.0; Age of mother at birth of first child = Unknown.

Group 2: (127 families)
This group is characterized by high receipt of Cash Grants/Food Stamps, Child Services, high Community Corrections contact; medium receipt of Chemical Health services, medium number of case workers (average of 7.7); and low Medical Assistance dollars (average of $96,000 during 1996-97). Mean number of *known* children = 4.9; Age of mother at birth of first child = 19.7 years.

Group 3: (32 families)
This group is characterized by higher-than-average Medical Assistance dollars (average of $292,000 during 1996-97); medium Community Corrections contact; few case workers (average of 1.4); and no receipt of Cash Grants/Food Stamps, Child Services, or Chemical Health services. This group is very similar to Group 1, but with lower MA dollars, and higher Community Corrections contact. Mean number of *known* children = 1.1; Age of mother at birth of first child = Unknown.

Group 4: (31 families)
This group is characterized by high receipt of Child Services; medium Community Corrections contact; low-to-medium number of case workers (average of 3.7); and low receipt of Cash Grants/Food Stamps, Chemical Health services, and Medical Assistance dollars (average of $79K during 1996-97). This group is very similar to Group 2, but with lower receipt of Cash Grants/Food Stamps, Chemical Health services, and Community Corrections contact, fewer children (mean of 3.3), and a lower number of case workers (mean of 3.7). Mean number of *known* children = 3.3; Age of mother at birth of first child = 19.9 years.

200 Families Project - Phase 2
Purchase of Service (POS) Payments by Service Category
January 1993 - April 1999

20 In-depth Review Families:

Service Category	1993	1994	1995	1996	1997	1998	1999 (4 mos)	Total All Years
01 Chemical Health	$3,119	$19,406	$18,085	$25,075	$15,539	$12,013	$544	$93,781
02 Child Care	$56,891	$37,021	$40,994	$20,534	$22,455	$12,778	$270	$190,943
03 Correctional Resid	$0	$0	$4,649	$57,051	$112,526	$58,407	$2,057	$234,690
04 Counseling/Therapy	$100	$1,101	$0	$233	$4,553	$2,283	$0	$8,270
05 Day Treatment	$18,770	$45,789	$31,604	$49,870	$66,303	$78,503	$15,741	$306,580
06 Developmental Disabilities	$7,106	$9,570	$13,492	$17,994	$25,118	$12,323	$2,190	$87,793
07 Emergency Shelter	$91,932	$117,517	$221,193	$433,572	$200,442	$90,191	$8,727	$1,163,574
08 Family Comm Supp	$16,569	$0	$0	$0	$0	$0	$1,258	$17,827
09 Family Focus Therapy	$65,200	$26,577	$18,031	$13,483	$17,096	$1,929	$0	$142,316
10 Other	$33,597	$42,961	$15,657	$43,734	$29,188	$35,035	$15,447	$215,619
11 Placement Alternative	$15,158	$6,363	$8,934	$7,102	$13,527	$9,710	$526	$61,320
12 Respite	$5,411	$5,272	$5,678	$5,597	$2,616	$12,869	$1,457	$38,900
13 Rule 1 Foster Care	$353,138	$447,093	$635,324	$775,159	$840,278	$743,295	$224,443	$4,018,730
14 Rule 5 RTC	$0	$4,834	$61,617	$234,680	$403,178	$347,240	$96,557	$1,148,106
15 Rule 8 Group Home	$6,697	$41,777	$34,168	$113,564	$128,319	$117,888	$28,642	$471,055
16 Transp-Bus Cards	$5,604	$5,475	$5,993	$5,863	$7,059	$7,839	$2,172	$40,005
Total All Categories	$679,292	$810,756	$1,115,419	$1,803,511	$1,888,197	$1,542,303	$400,031	$8,239,509

200 Families:

Service Category	1993	1994	1995	1996	1997	1998	1999 (4 mos)	Total All Years
01 Chemical Health	$55,502	$40,117	$63,787	$84,390	$61,648	$41,034	$15,026	$361,504
02 Child Care	$315,919	$452,523	$385,305	$307,712	$280,187	$165,222	$62,229	$1,969,097
03 Correctional Resid	$11,065	$20,654	$42,161	$240,009	$303,252	$222,004	$33,648	$872,793
04 Counseling/Therapy	$14,545	$6,409	$15,913	$18,348	$14,438	$31,417	$7,235	$108,305
05 Day Treatment	$160,769	$156,900	$153,756	$259,238	$294,228	$257,388	$70,529	$1,352,808
06 Developmental Disabilities	$96,646	$122,275	$137,861	$192,924	$243,829	$199,042	$16,157	$1,008,734
07 Emergency Shelter	$570,727	$646,162	$1,076,864	$2,051,432	$1,763,596	$827,780	$123,921	$7,060,482
08 Family Comm Supp	$75,005	$3,060	$9,429	$4,014	$471	$2,830	$8,491	$103,300
09 Family Focus Therapy	$121,665	$132,380	$123,979	$149,967	$188,597	$125,938	$19,527	$862,053
10 Other	$118,618	$202,672	$132,119	$216,578	$270,916	$339,978	$124,474	$1,405,355
11 Placement Alternative	$65,448	$73,283	$74,686	$69,888	$117,137	$102,954	$5,865	$509,261
12 Respite	$34,173	$51,643	$36,079	$57,736	$80,234	$81,377	$21,688	$362,930
13 Rule 1 Foster Care	$2,933,745	$3,845,282	$4,483,634	$5,491,078	$6,315,990	$6,099,716	$1,883,987	$31,053,432
14 Rule 5 RTC	$235,927	$123,841	$609,311	$1,795,995	$2,292,439	$1,170,079	$340,622	$6,568,214
15 Rule 8 Group Home	$64,263	$203,604	$263,862	$448,637	$717,012	$684,437	$178,892	$2,560,707
16 Transp-Bus Cards	$22,805	$30,270	$32,873	$40,377	$46,241	$33,718	$9,456	$215,740
Total All Categories	$4,896,822	$6,111,075	$7,641,619	$11,428,323	$12,990,215	$10,384,914	$2,921,747	$56,374,715

200 Families Project - Phase 2
Purchase of Service (POS) Payments for the 20 In-depth Review Families
January 1993 - April 1999

Family #	Cluster #	1993	1994	1995	1996	1997	1998	1999 (4 mos)	Total
01	2	$61,097	$8,596	$59,034	$186,266	$181,359	$215,935	$78,707	$790,994
02	2	$50,016	$53,275	$85,522	$106,748	$126,780	$147,709	$56,697	$626,747
03	2	$94,877	$96,611	$106,240	$114,155	$119,005	$133,379	$28,823	$693,090
04	2	$0	$2,707	$7,554	$113,343	$118,493	$93,900	$21,395	$357,392
05	2	$49,781	$14,763	$105,257	$81,952	$140,958	$20,393	$0	$413,104
06	4	$0	$0	$32,963	$172,279	$115,272	$76,543	$17,086	$414,143
07	2	$33,129	$31,281	$41,718	$68,921	$123,771	$102,989	$20,051	$421,860
08	2	$65,363	$67,505	$66,269	$86,464	$101,536	$121,701	$33,754	$542,592
09	2	$39,821	$47,964	$45,869	$69,091	$98,031	$135,393	$37,980	$474,149
10	2	$84,606	$103,443	$112,709	$106,401	$56,549	$30,292	$7,891	$501,891
11	2	$21	$47,760	$113,641	$87,071	$16,940	$1,372	$0	$266,805
12	2	$32,350	$57,751	$33,006	$77,783	$85,075	$10,753	$2,586	$299,304
13	2	$0	$1,512	$894	$58,153	$165,153	$67,611	$15,529	$308,852
14	2	$52,631	$75,152	$62,693	$59,647	$39,245	$42,122	$6,790	$338,280
15	2	$0	$0	$8,413	$63,314	$103,168	$94,800	$30,944	$300,639
16	3	$23,574	$27,664	$27,561	$27,636	$46,448	$43,846	$11,508	$208,237
17	4	$0	$13,672	$47,544	$121,217	$103,117	$66,743	$0	$352,293
18	2	$17,229	$43,250	$37,503	$70,486	$1,021	$0	$0	$169,489
19	2	$55,421	$75,383	$68,165	$63,861	$62,335	$69,950	$24,596	$419,711
20	2	$19,376	$42,467	$52,864	$68,723	$83,941	$66,872	$5,694	$339,937
Total for 20 families		$679,292	$810,756	$1,115,419	$1,803,511	$1,888,197	$1,542,303	$400,031	$8,239,509
Total for 200 families		$4,896,822	$6,111,075	$7,641,619	$11,428,323	$12,990,215	$10,384,914	$2,921,747	$56,374,715

200 Families - Phase 2
Demographics of 20 Families Chosen for In-depth Analysis

Ethnicity by Person:	**20 Families**		**200 Families**	
African American	67	47.5%	495	46.1%
Asian	0	0.0%	8	0.7%
Caucasian	26	18.4%	163	15.2%
Hispanic	6	4.3%	24	2.2%
Native American	41	29.1%	312	29.1%
Unknown	1	0.7%	71	6.6%
Total	141	100.0%	1073	100.0%

Ethnicity by Family:				
African American	7	35.0%	80	40.0%
Asian	0	0.0%	3	1.5%
Caucasian	4	20.0%	43	21.5%
Hispanic	0	0.0%	4	2.0%
Native American	1	5.0%	28	14.0%
Mixed	8	40.0%	42	21.0%
Total	20	100.0%	200	100.0%

Cluster Analysis Grouping:				
Group 1	0	0.0%	10	5.0%
Group 2	17	85.0%	127	63.5%
Group 3	1	5.0%	32	16.0%
Group 4	2	10.0%	31	15.5%
Total	20	100.0%	200	100.0%

Summary and Overview of Case Reviewer Findings and Observations from Sample of 20 of 200 Families

In reviewing the files for the 20 families, case reviewers noted the following:

- Very little is known about the families at time of initial assessment. Hennepin County staff have limited ability to look more closely at relatively recent Hennepin County arrivals even though there are significant flags for the cases.
- Initial investigations/assessments were narrow in focus.
- There was a vast amount of time and effort put into reunification even in view of repeated treatment failures.
- Criminality (adult and child), mental illness, domestic violence, chemical health issues, and child sexual abuse was pervasive.
- There was a great deal of tolerance for multiple failed interventions.
- There was a significant lack of consequences for chronic neglect and abuse.
- The staff of various Hennepin County departments were aware of staff in other departments working on the same case. However, the actual level of communication and coordination among staff from different Hennepin County departments is low.
- In the cases reviewed, the overriding issue was the need to move to resolution (typically permanency) more quickly and aggressively at the point when it is quite clear that there is little likelihood of positive change in the family.

Household composition:

Single Headed Household: N=12 (60%)

Number of Families with:

4	children	7
5	"	6
6	"	3
7	"	2
8	"	1
9	"	1

Total number of children: N=107 Mean=5.4 children

Significant risk factors noted in files (percent of families in which observed):

Ongoing domestic violence (95%)
Adult and/or child criminal behavior (noted, charged or convicted) (89%)
Adult chemical dependency (85%)
Children significantly behind in school (75%)
Significant mental health problems, adult and /child (70%)
Mother first birth as a teen (63%)
Frequent household moves (58%)
Homelessness (53%)
Lack of positive/functional kin/friends (53%)
Early sexual activity by children (42%)

Hennepin County operated service activity (January 1993 through April 1999):

Case Openings with:	**Number of Openings**	**% of Cases**
Adult Chemical Health Services	52	80%
Adult Mental Health	32	75%
Child Protective Services	67	95%
Juvenile Probation	--*	60%
Adult Probation	--*	65%

Patterns of Concurrent Case Openings:	**Number of Instances**	**% of Cases**
CPS-Chemical Health-Mental Health	12	60%
CPS-Chemical Health	8	40%
CPS-Mental Health	6	30%

NOTE: Period covered is January 1995 through December 1998

Total direct service hours provided by DCFS and ASD staff: 20,606

Distribution by Department/Division:	**Hours**	**%**
DCFS/CPS	14,224	69%
DCFS/ Mental Health	618	3%
DCFS/Other	4,896	23%
Adult Chemical Health	100	<1%
Adult Mental Health	350	2%
Adult/Child Developmental Disabilities	418	2%
Distribution by Service Activity:		
Case Management	9,306	45%
Court Related (Juvenile)	1,435	7%
Service Coordination	2,306	11%
Client Related Travel	2,063	10%
Other	5,496	27%

* Community corrections information systems were not in place for the entire length of time of the family system involvement.

Hennepin County contracted service activity (January 1993 through April 1999):

Total purchase of service payments: $8,239,509

Distribution by Major Service Category:	Payments	%
Juvenile Correctional Placement	$234,690	3%
Day Treatment	$306,580	4%
Rule 8 Group Home	$471,055	6%
Child Emergency Shelter	$1,163,574	14%
Foster Care	$4,018,730	49%
Residential Treatment	$1,148,106	14%

Reviewer observations: service and staff focus.

	% of Rankings in "Low" Category	% of Rankings in "High" Category
Degree to which activity focused on prevention [of continued maltreatment/ family dysfunction] (Mean=2.3)	36%	5%
Provision/organization of services for the whole family (Mean=3.2)	16%	10%
Level and variety of services used (Mean=3.5)	5%	10%
Use of community/neighborhood based services (Mean=3.3)	5%	21%
Degree of service linkage, service integration –"seamlessness" (Mean=1.9)	33%	0%
Social service staff focus on school readiness of children (Mean=2.0)	26%	0%
Social service staff focus on safety of family members (Mean=2.7)	16%	10%
Social service staff focus on [health] of family members (Mean=2.3)	21%	0%
Social service staff focus on economic self-sufficiency/ reliance (Mean=1.8)	37%	0%

NOTE: Ratings/rankings were made on a scale from 1 (Low) through 5 (High).

Reviewer observations: more positive case outcomes

% of Reviewer Responses of "Yes"

"Was there anything that could have resulted in:

Better service to the family? 42%
Comments: Reviewers noted the need to recognize and address risk factors that appeared to be present early in the life of the case. The need to coordinate between operated and contracted services also was noted. The tension between family preservation/reunification and the safety/best interests of the child was noted and acknowledged.

Faster resolution of issues? 73%
Comments: Reviewer consensus concerning the need to move to permanency earlier and aggressively.

Lower cost to Hennepin County? 47%
Comments: The need to maximize revenue and possibly pool and decategorize HC service funding was noted.

A more rational order of services? 68%
Comment: Attention to coordinating and sequencing chemical dependency and mental health services is needed.

200 Families Phase 2: Case Synopsis, "Family Number 5"

Overview/description

Family Composition/Characteristics:

Adults: Father and Mother; Children: Child1, Child2, Child3, Child4, Child5, and Junior. African American-American Indian heritage. Length of residence for Father in Hennepin County is unknown. Mother moved to Minnesota/Hennepin County in 1986, from a South Dakota Indian Reservation. Both adults left formal schooling in 7th grade. Intermittent employment and public assistance are the only known sources of income.

Significant Case Events with HC DCFS and ASD:

1986: Initial contact with HCDCFS: Request for home study from Tribal Social Services concerning change of guardianship from Child1's biological father in South Dakota to Mother (correspondence indicated some ambivalence concerning such a change from tribal social services and alludes to Mother as likely having fetal alcohol syndrome and Child1 as having fetal alcohol exposure).

1988-1996: Five CH case openings for Mother; CP field case openings, July 1987-February 1989; January 1992-July 1994; December 1994-December 1998. Adult mental health case opening, March through July 1995. A variety of child welfare case openings (six, foster care/ placement related for children), December 1991 through December 1998.

1987 (July): First contact with DCFS/CPS concerning death of infant--drowned in bathtub, child maltreatment determined (failure to supervise).

1988: At least one detox stay for Mother.

1991 (September): DCFS/CPS investigation, failure to protect via domestic violence, maltreatment found (Father the batterer).

1992 (January): Mother gives birth to Child5, positive for cocaine; maltreatment found and Mother begins participation in Project CHILD (Note: this is the first of two cocaine positive infants born to Mother within 18 months.)

1992 (February): Eden CD Treatment program staff contact HCMC Crisis regarding Mother who claims that father of Child5 (Father) "...is Satan..." (first real indication of likely MH issues; no documented mental health assessment until March 1993). Mother leaves Eden against staff advice (with the newborn, Child5) (first of at least six exits from CD treatment programs prior to completion.)

1992: psychological evaluation notes that Child1 is emotionally and behaviorally disturbed, violent and aggressive to other children, adults and animals.

1993 (August): physical abuse allegation/report by HCMC, Child5 the alleged victim and Father the alleged perpetrator; maltreatment not found.

1993 (September): CP field social worker documents in detail futility of additional treatment/service. In November 1993 case transfer summary notes to new CP field social worker indicates that case has been open and closed at least 6 times between 1987 and 1993 without resolution of issues. Includes detail of multiple failed CD treatment stays, multiple shelter/foster care stays for children, failure to follow through with service referrals, multiple failures to complete parenting classes, and missed court hearings.

1994 (March): Mother apparently makes progress regarding CD issues and has just completed home-based service program at MIWRC; case remains open, however, in view of new reports of drug use (alcohol and crack-cocaine) and failure to supervise children.

1994 (June): while family temporarily in a shelter in South Dakota, Child1 and a friend were playing with a pistol which discharged, killing a 13 year old girl in an adjacent room.

1996: Mother is not in the picture any longer (possibly went back to South Dakota) and Father is working IBCA and later with Freeport West with the goal of transfer of custody to him for Child2, Child3, Child4 and Junior. Child5 goes to long term foster care and Child1 is at County Home School.

December 1998: Cases close with DCFS.

1998 (Summer): Child1 (now 16 years old) reappears in juvenile system for a variety of charges including theft, theft auto, fleeing police officer, and 5th degree assault.

Risk Factors/"Flags":

- Child1 has nearly continual involvement with juvenile justice system from age 11.
- Ongoing domestic violence with Father, frequent violations of order for protection.
- Father, Mother and Child1 have extensive criminal/delinquency histories (including DWIs, trespassing, 3rd and 5th degree assault, violation of order for protection, etc).
- Mother frequently could not be located and frequently did not appear for court proceedings/hearings.
- Cognitive limitations for Mother, likely related to fetal alcohol syndrome.
- Mother physically abused as a child.
- Young mother and (eventual) large family.
- Adult CD and mental health issues (significant issues).
- All children behind in school.
- Social isolation.
- Child/infant death.

Service Providers – Hennepin County:

DCFS/CPS
Project CHILD
Adult and Juvenile Probation
County Home School
Adult Mental Health
HC Economic Assistance
Chemical Health Division-ABC Self Esteem Program

Service Providers - Non-Hennepin County:

St. Joseph's Home for Children (child emergency shelter)
Turning Point (CD treatment)
Human Service Associates (child foster care)
Minnesota Indian Women's Resource Center (CD and family based services)
Eden Women's (CD)
Park Avenue (CD)
Wayside (CD)
Ain Da Yung Shelter (child shelter)
River Place Counseling
Minnesota Visiting Nurses Association
STEEP (parenting)
MELD (parenting)
Indian Health Board
Institute on Black Chemical Abuse (now African American Family Services)
Upper Midwest American Indian Center
Bar None (juvenile correctional facility)
Domestic Abuse Program
Kateri House (women's shelter)
Freeport West
Colorado Boys Ranch (juvenile correctional facility)
Prairie Learning Center (juvenile correctional facility)
Gilfillan Residential Treatment Center

DCFS Operated and Contracted Resources Identified:
DCFS purchased services (1993-1998) = $413,104
DCFS direct/operated service hours = 946 hours (891 CPS).

Literature Search for 200 Families Phase 2

A review of this body of literature shows that public attention to the need for coordination of human services has a significant history dating back at least a hundred years in the United States. Historically, a lack of coordination among agencies serving children and families, a narrow focus on the labels children receive when they enter the systems, and a consequent failure to produce appropriate services, are the rule rather than the exception. In general, this body of literature questions the capacity of an assortment of separate and independent public and private service systems to address the comprehensive needs of children, adults and families. This body of literature does provide a consistent set of characteristics needed to effectively coordinate service programs.

A fundamental discussion that confuses and creates barriers for service integration models is "what is meant by service integration?". Human service delivery models labeled (or profess to be) as service integration are sprinkled along a diverse continuum ranging from simple co-location of staff to agencies that blend infrastructure, operations, processes, service delivery, funding and policy. Cited examples, in literature, of service integration are carve-outs, carve-ins, co-location, one-stop-shopping, super-agencies, umbrella agencies, collaboratives, fiscal integration, joint planning and case management. The majority of these efforts were special projects with no comprehensive or lasting system impact; further, they carved out limited resources to special populations leaving the primary service systems intact. A starting point for any agency contemplating is to define what service integration model means for a project.

Major Findings in Literature:

- It is striking how little is really known about outcomes in this era when accountability is so important.
- There is no evidence that integration, in and of itself, saves money or reduces costs.
- No single model or governance structure emerges as the most successful.
- Most successful models have been in areas with relatively small populations.
- Fiscal incentives have been successful in encouraging development of integrated services. Decategorization may result in diminished political support.
- Committed leadership is most cited as the single most critical factor for success.
- Although many people experiencing single problems can be served successfully by categorical programs and achieve relief and recovery from singular difficulties, individuals and families experiencing multiple problems have not been well-served by categorical agencies and services.
- The "non-system" of public financing for health and social services is a bewildering tangle of bureaucratic strings tying little pots of money at the local-level to big barrels of money at the state and federal level with little continuity of purpose beyond targeting exclusive populations and promoting specific services approaches. Large-scale attempts to de-categorize funds for increased flexibility are resisted by special interests that fear loss of services should their specific dollars be mixed with other funds.
- Often, integrated services are achieved and sustained more through the personal and professional initiative of staff than through structural change.