



PROGRESS/CHALLENGES/RECOMMENDATIONS

Our vision is a community with strong families in which children are safe and thriving

AGENCY BACKGROUND:

Nebraska Families Collaborative (NFC) was established as a 501(c) 3 on January 14, 2009. The NFC is comprised of five partner agencies: Boys Town (COA accredited), Child Saving Institute (COA accredited), Heartland Family Service (COA accredited), Nebraska Families Support Network and OMNI Behavioral Health (Joint Commission accredited). Executive leaders from the partner agencies serve on the NFC Board of Directors.

The Nebraska Families Collaborative is built upon a Nebraska tradition of private not-for-profit organizations responding to child and family needs that significantly predates the federal funding of child welfare services in 1935. Each of the partner agencies offer significant history and experience in working directly with children and families.

- Founded by Father Edward Flanagan in 1917, Father Flanagan's Boys' Home (Boys Town) has a 90-plus-year history of saving children and healing families. What began as a small home for homeless boys in downtown Omaha has grown to a national leader in child care, with boys, girls and their families receiving care at the Village of Boys Town, Nebraska, and more than a dozen sites across the country.
- Founded in 1892 by the Rev. A.W. Clark, the Child Saving Institute (CSI) was one of Omaha's first orphanages to help neglected, dependent and abandoned children. CSI was a member of the National Benevolent Association of the Christian Church (Disciples of Christ) for 89 years. In 2002, the Board of Directors decided to leave that national organization so CSI could focus on the needs of the local community and remain a child welfare organization.
- Heartland Family Service was founded in 1875 as The Christian Workers Association, it was one of the first human service agencies in the Omaha community. In the early days, Heartland Family Service offered relief to the destitute by distributing blankets, food and other necessities.
- Nebraska Family Support Network (NFSN) started in 1991 to provide support and services to families of children with mental illness and behavioral disorders. NFSN's mission broadened in 2004 to include collaboration between family organizations, Nebraska Health and Human Services' (HHS) Safety and Protection Division and Nebraska's Behavioral Health Regions.
- OMNI Behavioral Health is a non-profit organization created in 1993. It works to advance healthy life experiences and positive outcomes for the youth and families it serves. OMNI recognizes the importance of cooperation for improving the living conditions of children, adolescents, adults, and their families in the

community. OMNI promotes activities which enhance personal autonomy while promoting the spirit of the global community.

This formation has allowed the NFC to build upon the expertise of these nationally recognized organizations to create a Nebraska-based provider network that builds on the strengths of local providers and community resources.

BENEFITS OF LEAD AGENCY (PUBLIC-PRIVATE-CIVIC PARTNERSHIPS):

- Private investment, infrastructure, and knowledge
- National accreditation through Council on Accreditation (COA) by December 2012
- Identification of diversion and prevention services for families (see IRU handout)
- Decreased caseload size
- Support to families within their communities
- Utilization of a family-centered practice approach where families voice and choice counts
- Aftercare services are offered to all families upon case closure
- Increased oversight and provider accountability of subcontractors
- Flexibility to creatively respond to family, community, and other stakeholder needs
- Increased accountability utilizing meaningful, measureable and manageable data

NFC AGENCY SNAPSHOT:

- NFC expenses in 2010 were \$21.6 million
 - 81% was direct service to children and families (\$17.5 million)
 - 19% was staff and operating expenses
 - 16% was direct staff expense and 3% for administrative staff and operating expenses
- The NFC utilizes approximately forty subcontract agencies that offer a diverse network of services
- The agency is expected to employ a total of 169 full time employees by transition completion date
- Approximately 1077 children and 476 families will **transition** to the NFC beginning in October
- A **total** of 2391 children and 1108 families in the Eastern Service Area will be the responsibility of NFC

SYSTEM PROGRESS & CHALLENGES:

1. Insufficient funding levels that resulted in system instability that required the NFC to assist DHHS when Visinet failed in 2010. Funding challenges have been further exacerbated by the implementation of IMD/PRTF changes necessitated by Medicaid requirements.
 - The NFC and DHHS collaborated to create a new contract to allow the families formerly served by Visinet to transition to the NFC by the end of this year.
 - On a monthly basis, the NFC is sharing its cost data with DHHS to determine adequate funding levels and to develop strategies that will improve system performance.
 - The NFC coordinates care with Magellan, Region 6, and other funding sources/providers to maximize public resources for children and families.
2. The NFC model is based on a provider network system of service delivery that requires it to work closely with its subcontractors to meet CFSR outcomes. A network model has many advantages but it takes more time to make programmatic/system changes than do other models.
 - One major benefit of the NFC partnerships with local providers is there are fewer number of children placed in congregate care outside of the Omaha area. Nebraska child welfare/juvenile justice

contracts have historically been “slot” based contracts rather than outcome-based (performance) contracts.

- As a result, the NFC is meeting regularly with its provider network to move in a plan-full manner to performance-based contracts that tie provider payments to CFSR outcomes.
 - The NFC is regularly reviewing its referral patterns with its provider network to identify service gaps to effectively serve all children and families within a 150-mile radius of Omaha.
3. Nebraska’s child welfare and juvenile justice systems have strong institutional biases in favor of child removals and congregate care that is out-of-compliance with the Americans with Disabilities Act (ADA) and the Olmstead decision as well as national system-of-care principles (see Olmstead handout).
- The NFC employs a wraparound model to partner with children, families, and stakeholders to develop plans of care that will meet child and family needs in the least restrictive settings.
 - In February 2011, DHHS, KVC, and the NFC partnered together to create the Initial Response Unit (IRU). Please see IRU handout.
 - The NFC, in collaboration with DHHS, will implement Structured Decision Making to more accurately assess child risk to guide care planning.
 - In January 2011, the NFC established a Community Advisory Board to further assess stakeholder needs, identify areas of concern and provide feedback to effectively improve our system of care.
 - The NFC continues to increase the monitoring of children placed in out-of-state congregate care facilities, but it is important to note that these out-of-state providers do not have the same oversight as do Nebraska-based providers.

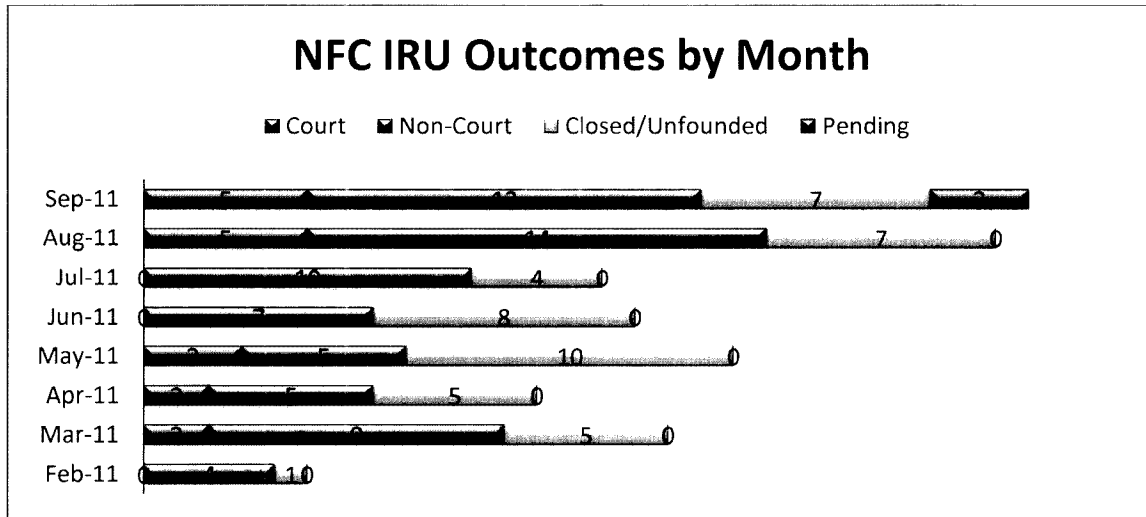
NFC RECOMMENDATIONS:

- Based upon the work of the Nebraska delegation to the National Quality Improvement Center on the Privatization of Child Welfare Services national conference held in May 2011, create a steering committee to guide and support the reform efforts in Nebraska. This committee structure could be modeled off of similar successful models such as the one implemented in Illinois.
- Create a predictable, transparent public funding source that limits financial risk both to lead agencies and subcontractors. A variety of financial models can be used to achieve this goal. Regardless of funding methodologies employed, Nebraska must undertake a global budgeting perspective that avoids cost shifting from funding “silos” such as Medicaid, behavioral health, developmental disabilities, special education, and child welfare/juvenile justice funding streams. It was always intended and agreed upon by both DHHS and lead agencies (five of them at the time) that Nebraska would move to a case rate system by January 2011.
- Respond to the opportunity presented by the passage of S. 1542, The Child and Family Services Improvement and Innovation Act. This legislation would allow the State of Nebraska to pursue a IV-E waiver that would permit DHHS, lead agencies, and providers to focus more on prevention, early intervention, and diversionary services for children and families. It also presents an opportunity to expand and integrate the good work being done under the Court Improvement Project with the Child Welfare reform initiative. (Please refer to Florida IV-E handout)

Since the Initial Response Unit (IRU) began February 9, 2011 a total of three hundred and eleven (311) families were assisted through this process. The Intent of the IRU is to partner a lead contract (both KVC and NFC) in the Eastern Service Area with staff from Initial Assessment and to co-staff the needs of families while preventing them from accessing the system unnecessarily.

The IRU and Initial Assessment (IA) staff have been working with families to engage and participate in services. Approximately 44% (138) of families transferred to ongoing case management services as non-court involved (voluntary services). The IRU staff has also assisted in providing families with community resources enabling families to close without the need for ongoing case management services. One hundred eight (108) families (35%) have been closed or unfounded. The IRU has worked with 311 families from February 9 – September 22 2011 and only fifty-one (16%) of these families became court involved. Since inception a total of 261 children have remained in their family homes with ongoing case management services.

Specific to Nebraska Families Collaborative (NFC) data a total of 139 families were offered assistance through the IRU. Only 12% of families that NFC IRU have worked with have been court involved. The following chart depicts NFC IRU Outcomes by Month.



This data shows that this process is working and families now have the ability to access case management services and supports without having to access the judicial system. This allows for families to maintain and prevent unnecessary removals so that families can develop what they need while maintaining in their natural environments safely at home.



Child Welfare Privatization: Finding the Line between Fact and Fiction

The Texas Alliance for Child and Family Services Responds to the
Center for Public Policy Priorities' Report

October 28, 2008

The Texas Alliance of Child and Family Services (the Alliance) is a 33 year-old nonprofit organization dedicated to strengthening services to children and families in Texas. As a statewide association the Alliance strives to accomplish this goal by advocating for adequate funding, strong protections for children and families, and innovative, responsive service delivery and care coordination. Alliance members are organizations that provide the full array of direct services to vulnerable clients, many of whom are under the conservatorship of the Texas Department of Family and Protective Services (DFPS). Members of the Alliance also include non-service provider organizations and professionals who support our mission.

Child Welfare Privatization: Finding the Line between Fact and Fiction

The Texas Alliance for Child and Family Services Responds to the
Center for Public Policy Priorities' Report

The Center for Public Policy Priorities (CPPP) recently released report, *Drawing the Line between Public and Private Agency Responsibilities in Child Welfare: The Texas Debate*, presents information and draws conclusions regarding the privatization of child welfare services that appear extreme, do not mesh fully with the latest research, and, most importantly, are destructive to the public-private partnership so critical to the Texas system. The rhetoric in the report is at times unduly antagonistic to private nonprofit agencies, which form the backbone of the Texas service delivery system. This is troubling at a time when we need to improve the dialogue, learn from each other, and work together as partners to improve outcomes for those impacted by abuse or neglect.

In order to ensure that Texas legislators and others charged with planning any future privatization reform have accurate information about what's working and what's not in other jurisdictions, the Texas Alliance of Child and Family Services (the Alliance), a statewide association committed to quality child welfare services, reached out to independent experts and researchers who have no vested interest in the end result of the Texas privatization debate. We asked them to review and comment on the CPPP's findings and recommendations for the sole purpose of helping us understand the factual landscape regarding the privatization of child welfare services and the extent to which the CPPP report accurately reports other states' experiences. In the following pages, we highlight what they had to say.¹

The Report Is Best Viewed As an Opinion Piece Rather Than Research

Madelyn Freundlich, a respected expert in child welfare privatization notes, "This report is not an examination of the Texas debate as the title suggests, but rather, it is an opinion piece about the privatization of child welfare services and case management in which the CPPP makes the case against privatization. The Foreword suggests that it is an 'exploration' in the spirit of collaborative work between public and private agencies; the text, however, reveals neither an exploration nor a spirit of collaboration. As an opinion piece, it can be expected that it will draw on only those data and arguments that support the CPPP's position—and the report must be read in that light. Of great concern are the numerous misstatements and mischaracterizations that are made, even given the biased perspective that one expects from an opinion piece."

While selectively citing the "negative" portions of some USF studies, the Center failed to interview any of the USF team members who have conducted the multi-year evaluation of Florida's privatized Community-Based Care system.

Mary Armstrong, lead evaluator for Florida's Community-Based care system, University of South Florida (USF)

¹ See Attachment C for a brief description of the individuals who contributed to this report.

Throughout the report, the CPPP alludes to its qualitative research involving interviews with “stakeholders” in both Florida and Kansas. What the report fails to do is provide any details on its methodology, leading our experts to question the design and scope of this research. The report fails to provide such information as: How many stakeholders were interviewed in each state? What were the characteristics of each sample? How were the stakeholders chosen? Absent these data, it is not appropriate to rely on what “some” or “several” stakeholders said or believed. The methodological limitations work against the paper’s claim that the CPPP relied on “research” and further demonstrates that the paper is, in reality, an opinion piece.

The “National Context” Is Outdated and In Some Instances Simply Wrong

Many of the report’s findings are based upon studies conducted a decade or more ago when only Kansas had privatized child welfare services and little was known about the impact of child welfare privatization. States and counties have learned much in the intervening years; but readers are not told about the important lessons learned. For example, there is no reference in the CPPP report to the synthesis of research contained in a series of topical privatization papers developed under the auspices of the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. There is scant mention of the work of the National Quality Improvement Center on the Privatization of Child Welfare Services (QIC-PCW) and when one QIC-PCW study was cited, findings were misinterpreted.

Whether by accident or intent, the report distorted the findings of the QIC-PCW study that looked at the extent of child welfare privatization. By under-reporting the prevalence of privatization, readers of the CPPP report might conclude that contracting for case management and other core services is a risky idea that is resoundingly rejected by states. Such an impression would be untrue.

Charlotte McCullough, nationally recognized researcher in child welfare privatization

As one example of inaccuracies, Charlotte McCullough, a nationally recognized pioneer in child welfare privatization research, noted factual errors in the CPPP’s description of the nature and extent of privatization. The report stated that the QIC-PCW found that “44 states are not currently privatizing case management services (p.19).” What the QIC-PCW actually found is that of the 44 states and the District of Columbia that participated in their 2005 study, eight jurisdictions do privatize case management for some target populations or geographic areas and five have large scale privatization efforts.² Furthermore, while the CPPP report correctly notes that nine states that participated in the QIC 2005 study indicated they had rolled back former privatization initiatives, the CPPP report failed to mention that one state indicated large scale plans to privatize in the next year, another described an expansion of a current effort, and several states noted other privatization initiatives in the planning or early implementation phase.

² National Needs Assessment & Knowledge Gap Analysis Findings (September 20, 2006). The National Quality Improvement Center on the Privatization of Child Welfare. Full report available at: <http://www.uky.edu/SocialWork/qicpcw/documents/QICPCWKnowledgeGapsAnalysisFindings.pdf>.

The Report Arbitrarily Defines Which Child Welfare Services Cannot Be Privatized

The report defines which services can and cannot be privatized and for which services performance-based contracts are appropriate without a reasoned basis for these conclusions. The report makes the claim that case management is a primary function of government and that privatization of that service therefore “breaks the critical link between democracy and the most fundamental government decisions, putting the objective of child protection—to keep children out of harm’s way—seriously at risk (p.9).”

Ms. McCullough notes, “If the inherently governmental argument had been made against the privatization of protective service investigations, even proponents of privatized services would not have disagreed. Where the argument derails is when the report blurs the investigation function with case management services.”

Today, all states retain the child investigation and protection functions that officials believe to be critical to meeting their legal responsibility for the safety and well-being of children in the child welfare system. Otherwise, across the country, private providers, to varying degrees, deliver direct services to families, including case management.³

In addition to its “inherently governmental argument,” the report also asserts that private agencies would somehow function outside federal and state laws, a claim that Ms. Freundlich rejects. “There is no reason that legislatively directed mandates could not be implemented under privatized arrangements.... The concerns about the loss of responsiveness ‘to the democratic process’ does not make sense since privatizing services would in no way subvert the rule of law and it is disheartening to see the report make such assertions.”

The report repeatedly blends child protective services investigations with foster care and adoption services in an attempt to generate fears about private agencies’ ability to properly provide the services that children and families need. These statements mischaracterize the nature of child welfare privatization.

Madelyn Freundlich, nationally recognized expert on child welfare privatization

Interestingly, the CPPP failed to reference a recent ASPE report that specifically addresses the roles of public and private agencies in child welfare and recognizes the role of private agencies in case management. Among other things, that report notes, “Rules within Titles IV-B and IV-E allow states to make their own decisions about how to assign certain responsibilities to private providers. Several states or jurisdictions have transferred, or are in the process of transferring, significant if not primary case management authority to private providers. Kansas, Florida, and

³ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (March 2008), Topical Paper #3: Evolving Roles of Public and Private Agencies in Privatized Child Welfare Systems, p. 5. Available online at: <http://aspe.hhs.gov/hsp/07/CWPI/roles/index.htm>.

Illinois, for example, maintain that the federal requirements for states to have 'overall responsibility' for cases can be fulfilled through administrative oversight, quality assurance, and monitoring. Several direct service contracts in Washington D.C. and New York City have moved in this direction as well. In these states or jurisdictions, a public agency caseworker does not review day-to-day case management decisions for some contracts; instead, contract monitors from the state or county monitor large numbers of cases and/or evaluate overall contractor performance."⁴

The Description of Privatized Case Management Bears No Resemblance to Reality

All of the experts the Alliance contacted were troubled by the way in which "case management" was defined. The experts noted that CPPP would have readers inaccurately believe that case managers—whether in a public or private agency—single handedly plan and make decisions for children in foster care. Even within public agencies, case managers have no such authority.

The CPPP report argues that only public workers can perform case management functions, in part because case managers "prosecute the legal case to its final conclusion," which directly affects the "people's rights." This statement is simply false. While everyone is in agreement that case managers and their supervisors play key roles in planning and making decisions for children, it is the courts that make the final decisions as to whether a child will enter foster care and if so, the permanency outcome for the child. Attorneys prosecute cases; the case manager is a witness who provides reports and at times is called to testify. The same realities hold true for case managers in both public and private agencies.

Case management is poorly defined in the CPPP article. It is represented throughout the article that case managers are making legal decisions on behalf of families and acting independently of any state agency. In fact, our case managers do not make legal decisions on behalf of children and families....
Andry Sweet, V.P of Operations, Children's Home Society of Florida (CHS)

This point was underscored by Andry Sweet, Vice President of Operations for Children's Home Society of Florida, "Our [private agency] case managers do not make legal decisions on behalf of children and families. The State of Florida retained Children's Legal Services (CLS), and it is the attorneys that present the cases in court. It is ultimately the judge who makes decisions on reunifications, termination of rights and all other judicial orders impacting the family. Our case managers in most cases are co-located with CLS and meet in staffings just as state employees used to do to review the cases and recommend an appropriate course of action to the judge based on the parents' compliance with the case plan. Our role is to work directly with families through a case planning process and make recommendations to the court based on our observations and interactions with the parent(s) and child(ren). This is no different than the role public employees played in the child welfare system in Florida before privatization."

⁴ Ibid.

All states that have privatized some (or all) of their post-investigation case management functions for some (or all) children in state custody have proceeded on an understanding of ultimate decision-making responsibility through public agency oversight and monitoring. Florida, Kansas, and other states with privatization initiatives have undergone subsequent federal reviews of both programs and their Title IV-E eligibility determination practices. There is no evidence that these states have lost Title IV-E funds as a result of privatization. Nor is there evidence that the federal government has put these states on notice that their practices and policies fail to comply with Title IV-E regulations.

It is clear that the report is attempting to engender fears about the arbitrary use of power by private agency case managers – which are wholly unfounded in light of the true role of case managers.

Madelyn Freundlich

The report would also have readers believe that following the child protective service investigation, “private agencies take over.” Even when a state chooses to privatize all services post-investigation, public agencies in no way abdicate their oversight responsibilities. Even under a “fully” privatized system, the public agency retains ultimate case authority through oversight. All states set performance standards, and then monitor performance through contract monitoring and quality assurance systems. Other responsibilities retained by the public agency include contract procurement, program funding, research and policy agenda setting.⁵

Had the CPPP report looked to the previously referenced QIC-PCW Needs Assessment study, it would have found ample evidence that its claims regarding all-powerful private agency case managers were inaccurate. The QIC-PCW includes specific examples of how different states handle legal decision-making and court-related responsibilities when private agencies assume responsibility for case management. For example, the QIC-PCW looked at seven jurisdictions with privatized case management systems. Rather than finding the private agency “taking over the case,” the QIC-PCW reported that each had systems in place to ensure that decisions were reviewed by appropriate concerned parties, with designated attorneys presenting the state’s case, and the courts playing the dominant decision-making role.

In summary, all privatized systems must be based on a clear understanding of the importance of the legal protections for children and families served by the child welfare system. However, in contrast to the impression left by the CPPP report, there has been no evidence that courts abdicate their authority or responsibilities when private agency workers assume case management duties.

The Report Is Full of Contradictory Claims and Half Truths

While most of the anti-privatization rhetoric in the CPPP report is focused on case management, the report does not hesitate to offer an opinion about potential danger in other areas, including the following:

⁵ Ibid.

The Child Welfare Workforce & Caseloads

The report states, "Privatization leads to the loss of Child Protective Services' greatest asset—its workforce—which undermines the long-term goal of improving CPS (p. 11)." It goes on to state, "Contrary to the claims of private providers, CPS caseworkers are not likely to join the private provider workforce if their jobs are privatized (p. 11)."

When it comes to worker turnover, the report gets it half right. The child welfare system does have a chronic workforce problem that cuts across public and private agencies. Workforce issues do obviously have to be carefully considered when any state moves towards privatization. However, if privatization is done properly, there is no reason to believe that privatization negatively impacts the workforce. The report fails to present a balanced discussion of the real issues and ignores the progress that some private agencies have made in addressing worker turnover and spiraling caseloads.

Ms. Sweet took exception to the portrayal of the workforce and caseload issues in post-privatization noting, "We have seen a significant decline in turnover since we assumed our first case management contract in October, 2003. Just in the past year, our turnover has dropped 8%. The workforce has become more stable over time with the lengths of stay for child welfare case managers increasing from 2.7 years in 2004 to 3.7 years in 2007." She also noted other inaccuracies:

- ♦ The CPPP article suggests that state employees are negatively impacted in the transition to private providers and do not transition to private agencies. This was simply not the case in Florida. The vast majority of DCF employees were hired by private agencies that assumed case management responsibilities. In Florida, private agencies had to increase the workforce beyond what the public system had in order to lower caseloads and increase retention. Florida accomplished this by over-hiring which reduced caseloads and led to greater retention
- ♦ The report states that the Texas CPS turnover rate for "CPS workers" is 34% and it reports that in 2005, the average turnover rate in Florida was 31% (p. 26). The report fails to note that 2005 was a transition year. Even in the worst possible time to evaluate turnover, Florida's rate was lower than Texas. The CPPP report cites that Florida

It is unfair to call Florida or Kansas or any other state with a privatization effort a failure for not "eradicating" all the problems within the system. No system, public or private, could honestly say they have done this. But what Florida has achieved in the area of case manager retention and caseload sizes cannot be minimized either. Despite some fairly significant barriers, privatized case management providers were able to attract state workers and build a strong workforce in Florida.

Andry Sweet, CHS

By achieving accreditation standards in case management caseloads, we are seeing an increase in retention of employees. So while we have not "eradicating" the problems in the child welfare system, we have made significant strides in providing services in a manner that is consistent with accreditation standards and best practice.

Andry Sweet, CHS

caseloads in 2005 were on average 24 per worker (p. 26). For this same time period, in Texas, the caseloads averaged 44.5 for children in substitute care services (Texas Department of Family and Protective Services Data Book 2007, in the FY ending 2006). It is not clear in the CPPP report whether caseloads are on the decrease or increase in Texas, but Florida data clearly reveal that caseloads have dropped under privatization, and they continue to drop, as indicated in Figure 1.

Figure 1 Source: FSFN - Clients Active As Dependents Report, December, 2007, and July, 2008

	December, 2007	July, 2008
RANGE (across Districts/Regions):	13 to 20	11 to 18

Foster Care and Adoption Services

While the CPPP report rejects privatized case management out of hand, it takes a more balanced approach to contracting for foster care and adoption services. Many of its observations about how states should proceed in privatizing these services are self-evident, non-controversial, and fully supported by a decade of research.

However, the report soon veers into statements about what a state should not do, such as dismantle its public foster care and adoption infrastructure. As Ms. McCullough notes, "The justifications for the strong warning against reducing the public sector presence are interesting hypotheses which may reflect the opinion of the authors but they are not backed by any empirical evidence."

Performance-based Contracting

The report acknowledges that performance-based contracting, if done right, may improve service delivery (p.11). But it then states unequivocally and without any evidence that "[performance-based contracting] is less effective when used to improve case management."

The odd reasoning for the assertion appears to be that it is hard to translate competing priorities into measurable outcomes that could be included in contracts. No one would assert that that child welfare practice is not fraught with complexity; but it is as if the authors are totally unaware of the Child and Family Service Review (CFSR) outcomes and how states have used those as a starting point for the development of performance-based contracts for case management and other core child welfare services. Instead, the report relies upon and misinterprets cautions

The CPPP draws a line in the sand and states that performance-based contracts are not appropriate for case management services. There is no empirical evidence to support this assertion. In fact, this claim stands in stark contrast to the impressive outcomes some states have achieved when performance-based contracts were introduced. Illinois comes to mind.

Charlotte McCullough

raised by studies that are over a decade old, pre-dating most of the current performance-based contracts.

Ms. Freundlich notes, "In two places, the report compares setting outcomes for case management with asking a district attorney to convict the guilty and not the innocent. This analogy is false, despite the CPPP's repetition of it. Performance-based contracting most certainly could be used to hold private agencies accountable for providing effective case management, as properly defined. Several outcomes come to mind: determining the permanency plan for the child within X months; ensuring that children visit with their parents X times a month, unless the court orders otherwise; ensuring caseworker visits with children X times a month."

The report also raises the issue of conflict of interest that allegedly results from performance-based contracts. Ms. Freundlich also takes exception to this claim. "What exactly is the conflict of interest that CPPP is so concerned about? CPPP says that it is the fact that private agencies earn financial incentives and face financial disincentives based on their performance on achieving the stated outcomes—which seems to represent a confluence, not a conflict, of interests. In fact, the very structure of financial rewards and penalties based on outcomes which are typical in performance-based contracts, has been the centerpiece of countless proposals to restructure federal and state child welfare financing to remove the 'per diem' incentives to keeping children in foster care."

Of concern is CPPP's apparent belief that the state is incapable of selecting private providers with a solid mission, governance structure, infrastructure and service capacity to well serve children and families. It seems to assume that every private agency is driven by financial concerns, which might be an argument in relation to for-profits but is harder to accept with respect to not-for-profits.

The Report Misrepresents the Florida Community-Based Care Experience

The overview of the privatization efforts in both Kansas and Florida is supposedly based upon the author's site visits and interviews with unnamed stakeholders in 2007 and the analysis of data on each state's pre- and post-privatization performance. Given the similarities between Texas and Florida in terms of population size and expenditure, our experts focused their critique on the report's depiction of Florida and did not comment on the description of Kansas.⁶ However, given the number of inaccuracies in the CPPP's description of Florida's experience,

⁶ While we do not include details on the inaccuracies relative to Kansas, Charlotte McCullough notes that the description of Kansas is seriously flawed. "Either the authors are unaware of how Kansas significantly restructured its current contracts in 2005 or they simply choose to focus on earlier contracts that were in place in 2000. In either case, given the inaccuracies in the description of the payment and performance features, I am concerned about any conclusions CPPP reached as it is impossible to tell whether CPPP is up-to-date on what is occurring in the state."

we strongly urge readers of the CPPP report to view the Kansas conclusions with a degree of skepticism.

Mary Armstrong, the lead USF evaluator for the multi-year, multi-faceted evaluation of the Florida Community-Based Care system, notes the CPPP's selective use of data in evaluation reports and the lack of inclusion of data that showed positive trends. "It is true that the findings in Florida are 'mixed' and not all positive but I think it's important to present all the findings together so that a complete picture is presented." For example, the report presents several

Even though the authors of the report obviously used USF's evaluation reports because these reports are cited, the findings are not accurately portrayed and often only the negative findings are presented.

Mary Armstrong, USF

examples of lead agencies not meeting the state standards and goals for performance indicators. Dr. Armstrong concedes this is true but she also points out that what the report fails to present are findings on how lead agencies are making progress in coming closer to the state standards.

Placement stability is mentioned in the CPPP report as an area where Florida has not performed well. While the report correctly identifies this as an area needing improvement, it also fails to note the progress that has been made. Citing a Florida DCF business plan from FY 06, CPPP reports the average percentage of children statewide with three or more placements within the first 12 months as 18.8% (p 26). Dr. Armstrong notes, "The CPPP does not report that for FY 06-07, the percentage of children with three or more placements within 12 months had dropped to 13%."

Dr. Armstrong also notes that the CPPP fails to present the analysis of findings that was included in the USF reports that CPPP cites. This information, she maintains, is helpful for public and private agencies to have in order to fully understand current performance and improve future performance. For example, USF found that lead agencies in Florida that had shorter average lengths of stay and a higher proportion of children exiting care had the highest proportions of recurrence of maltreatment and of children re-entering care. She notes, "The presentation of these findings creates a dialogue among the public and private partners about strategies to deal with this complex relationship among findings. The findings also create an opportunity, in the context of a public-private partnership, to discuss key shared values (e.g. children whenever possible should be at home with their families) and sharing of the risks related to these values."

The CPPP also put a negative spin on data that was not consistent with the USF's evaluation interpretation of findings. For example, one USF study mentions a finding that children who were reunified were four times more likely to re-enter foster care than children who were discharged for other reasons, such as relative placements and adoption. Dr. Armstrong states, "The [CPPP] report leaves the reader with the impression that this is somehow 'bad'. Our interpretation of this finding is that reunified families need intensive services and support, especially in the first six months post-discharge."

Finally, Dr. Armstrong notes that the CPPP report cites a 2006 Florida OPPAGA report finding that DCF contract oversight was inadequate, but what it does not mention is that OPPAGA released a subsequent report with findings that contract oversight has much improved. "As we know, this trend supports previous findings from other privatization reforms, such as health and behavioral health managed care, where the state agency needs to learn how to transition from provider to purchaser roles."

The CPPP report seems to be inconsistent in its insistence on the one hand, that privatization is not a panacea (a very legitimate statement), and its critiques, on the other hand, that privatization in Kansas and Florida did not solve all the problems of the child welfare system. As Ms. Freundlich notes, "It would appear that CPPP would expect privatization in Kansas and Florida to resolve all problems in child welfare in order to deem any aspect of privatization in those states a success."

Furthermore, Ms. Sweet of CHS of Florida noted, "We believe that it is unfair and misleading to present data points from different periods during transition without showing the overall trend of data from pre- to post-privatization. CPPP reported only a snapshot of data during a period when the system was still transitioning to a privatized model. More recent data presented in state evaluation reports show clearly that Florida is trending in the right direction."

The CPPP report implies that any progress made in Florida was due to increased funding and not privatization. Ms. Sweet sees three factors contributing to the state's success: (1) a Title IV-E waiver, (2) increased funds, and (3) privatization. "Because of the reduction in caseloads due to permanency, the CBC's in Florida invested the savings in these 'front end' services which further reduced the numbers of children in care. These services were customized at a community level based on the local needs. The Title IV-E waiver is important to allow the funding flexibility so that dollars follow children and families, rather than funding 'programs' that provide reimbursement for children residing in 'out-of-home care.' The increased funds were needed to draw down the federal funds for all the increased adoptions and services provided by diversion workers on the front end. We essentially needed more state dollars to maximize our federal earnings. So our funding increased, but so did our federal revenue maximization."

(Note: Children's Home Society did a thorough

Could Florida have done this without privatization? No. Private providers were able to create new services, generate resources and savings from achieving permanency goals and reinvesting in their community....They do this through consulting with their local Boards (of community leaders). They do this without having to go through a legislative budget request process...as most governmental agencies do to shift resources. In fact most business decisions are vastly simplified. CBC's are simply able to operate more like a true business and can react quickly to the changing needs of families in a community and shift resources to meet these changing priorities.

Andry Sweet, CHS

analysis of the CPPP report and included charts with more accurate and timely data to show the distortions in the Florida description. The CHS analysis is included in its entirety as Attachment B).

The Report Distorts the Success of Texas in Meeting Key Outcomes

States could be compared on a variety of factors that would lead to very different conclusions about their overall performance, including historical, political, social and cultural factors. The CPPP's comparison of Texas, Kansas and Florida actually shows what one would expect when any set of states are compared—some states do better and some do worse on different outcome measures regardless of the degree to which services have been privatized.

The Child and Family Services Review (CFSR) is the federal government's program for assessing the performance of state child welfare agencies with regard to achieving positive outcomes for children and families. The CFSR assesses state performance on 23 items relevant to seven outcomes and 22 items pertaining to seven systemic factors. The Children's Bureau conducts the CFSR at five-year intervals to assess the performance of state child welfare agencies, track outcomes for children and families in each state, and assist states in enhancing their capacity to improve outcomes for children and families in the child welfare system. The CFSR uses data from 1) a statewide assessment prepared by the state using aggregate administrative data (AFCARS and NCANDS) 2) the State Data Profile prepared by the Children's Bureau, 3) reviews of a pre-determined number of cases from different regions in the state, and 4) interviews or focus groups with state and local stakeholders to evaluate processes and outcomes for children and families in the child welfare system. Kansas, Texas and Florida have all completed their second CFSR, although only Kansas has received the final report from its onsite visit. The statewide assessments are available from all three states.

The CPPP report makes comparisons of Texas to Florida and Kansas on several key CFSR permanency and safety indicators and boldly concludes, "Texas' public system performs as well as or better on key child and family outcomes as privatized systems, despite spending less per child." That conclusion, however, appears to be based upon questionable and non-comparable data drawn from different state data systems and reports, with some findings from the first round of CFSRs thrown in for good measure.

Without knowing the data sources, it is difficult, if not impossible, to know how valid these comparisons are. Are the same algorithms, with the same definitions, used in both states? It is simply impossible to tell with the incomplete citations provided.

Mary Armstrong, USF

While the CPPP report correctly notes that final reports from the second round of CFSRs for Texas and Florida are not yet available, it does not appear that CPPP used the statewide assessments from those states to reach its conclusions. CPPP appears to have relied upon a variety of different reports and a hodge-podge of data sources with many of the citations lacking the detail required to verify the data.

Rather than trusting the indecipherable data described in the CPPP report, we decided to examine safety and permanency outcomes/indicators using each state's assessment that was prepared prior to the second round of the federal Child and Family Services Reviews.⁷

The state assessments for Texas and Florida include data from FY 05 through the 12-month period ending March 31, 2007. The data for Kansas' second CFSR goes from FY 03 through the 12-month period ending September 30, 2005. By using the standardized statewide assessments we can look at performance across all three states in FY 05 and we can compare Texas and Florida for the 12-month period ending in March 31, 2007 (for which comparable Kansas data are not available). We do not claim this analysis based solely on the statewide assessments is a substitute for the level of detail and findings that are in the final reports. We do believe, however, that this approach which relies upon more recent, common data elements is preferable to the hit and miss approach used by the CPPP.

Texas Surpasses Florida and Kansas in 4 CFSR Measures (all three states meet national standards in three of these areas)

Using more comparable and current data, the CPPP report is correct in its praise of Texas' performance in a few areas in FY 05 and for the 12-month period ending March 31, 2007.

- ♦ Exits to adoption in less than 24 months – national median = 26.8%: Texas achieved adoption in a shorter time than either Kansas or Florida in both FY 05 and in the 12-month period ending March 31, 2007. However, it is important to note that all three states met the national median.
- ♦ Exits to adoption, median LOS – national median = 32.4 months: Again, Texas outperforms both Florida and Kansas in FY 05 and for the 12-month period ending March 31, 2007, but again all three states met the national median.
- ♦ Re-entries to foster care in less than 12 months – national median = 15%: Texas reported a lower rate of re-entry within 12 months in both FY 05 and for the period ending March 2007. However, again, it is important to note that both Florida and Kansas were also lower than the national median.
- ♦ Absence of maltreatment – national median = 94.6%: Texas reported a higher rate for absence of maltreatment in 2005 than either Kansas or Florida and for the period ending March 31, 2007, Texas performed better than Florida. Kansas also met the national median in 2005 (Kansas data not available for 2007). Florida did not meet the national median for the 12-month period ending March 31, 2007.

⁷ All of the data reported here is included in the Children's Bureau website as the state assessment for Round 2, http://basis.caliber.com/cwig/ws/cwmd/docs/cb_web/SearchForm.

Texas Lags Behind Florida and/or Kansas in 14 CFSR Measures

Texas' boasting rights evaporate on all of the following measures in which the state was bested by either Kansas or Florida, or both. In some instances from FY 05 to the period ending March 31, 2007, Texas appears to be trending toward poorer outcomes:

- ♦ Exits to reunification, median stay in foster care – national median = 6.5 months: Florida and Kansas performed better than Texas in FY 05 and Florida performed better for the 12-month period ending March 31, 2007. None of the three states met the national median.
- ♦ Exits to reunification in less than 12 months – national median = 69.9%: Texas outperformed Florida and Kansas in FY 05, but in the period ending March 31, 2007, Texas (65.9%) was behind Florida (66.5%). Neither state met the national median.
- ♦ Entry cohort reunification < 12 months – national median = 39.4%: Florida (46%) performed better than Texas (33.9%) or Kansas (28.9%) in FY 05 and for the period ending March 31, 2007, Florida at 44.4% far surpassed the national median and Texas at 36.9%.
- ♦ Absence of child abuse and neglect in foster care (12 months) – national median = 99.68%: Kansas met the national median and performed better than Texas on this measure in 2005. Neither Texas nor Florida met the national standard for the period ending March 31, 2007; though Texas performed fractionally better than Florida (Texas was 99.55% versus Florida at 99.43%).
- ♦ Median time to investigate (hours) an allegation of child abuse and neglect: Florida's performance, less than 24 hours in both FY 05 and for the 12-month period ending March 31, 2007, far surpassed Texas (>96 but <120 hours) for the period ending March 2007.
- ♦ Children in care 17+ months adopted by end of year – national median = 20.2%: Florida outperformed Kansas and Texas on this measure in FY 05. For the period ending March 31, 2007, Florida was at 36.7% to 19.6% for Texas.
- ♦ Children in care 17+ months achieving legal freedom within 6 months – national median = 8.8%: Again Florida outperformed both Texas and Kansas in FY 05 and far outperformed Texas in the period ending March 31, 2007, with 23.7% to Texas' 4.3%.
- ♦ Legally free children adopted in less than 12 months – national median = 45.8%: Florida performed better than Texas or Kansas in FY 05. For the 12-month period ending March 31, 2007, Florida had 60.9% to Texas' 35.8%.
- ♦ Exits to permanency prior to 18th birthday for children in care 24+ months – national median = 25%: Florida and Kansas surpassed Texas in FY 05 and met the national

median. For the period ending March 31, 2007, Florida was at 33.3% compared to 18.7% for Texas.

- ♦ Exits to permanency for children with TPR – national median = 96.8%: Florida outperformed Texas and Kansas in FY 05 and for the period ending March 31, 2007, but none of the three states met the national median.
- ♦ Children emancipated who were in foster care for 3+ years – national median 47.8% (LOWER is preferable): Kansas outperformed both Florida and Texas in FY 05 (37.5% to Texas' 63.4%). For the period ending March 31, 2007, Florida (43%) outperformed Texas (59.6%).
- ♦ Two or fewer placement settings for children in care less than 12 months – national median = 83.3%: Florida outperformed both Texas and Kansas in FY 05 and in the period ending March 31, 2007, Florida was at 80.9% to 80.1% in Texas. None of the three states met the national median.
- ♦ Two or fewer placements for children in care for 12-24 months – national median= 59.9%: Florida's performance surpassed both Texas and Kansas in FY 05, and for the period ending March 31, 2007, Florida was at 59.8%, just short of the national median, while Texas was at 52.6%.
- ♦ Two or fewer placements for children in care for 24+ months – national median=33.9%: While CPPP was quite critical of Florida for its placement stability problems, Florida at 34.3% surpassed Texas and Kansas on this measure in FY 05. For the period ending March 31, 2007, Florida (27.5%) again surpassed Texas (20.8%) but both states failed to meet the national median.

The CPPP report is correct when it states that results in Florida and Kansas are mixed. What the report does not state is the same is true for Texas' system and for all other states for that matter.

When comparable data are used, the CPPP report is simply inaccurate when it claims that Texas performed as well as Florida and Kansas on CFSR measures. At best, we found that Texas outperformed Florida and Kansas on only four CFSR measures and in three out of the four areas, all states met the national median. In all remaining CFSR composite measures we reviewed, Texas was outperformed by either Kansas or Florida.

Since 2005, Florida's caseload has decreased as Texas' caseload has increased. Florida's entry rate has been higher than Texas' entry rate but Florida has been far more successful in moving children through its system to permanency. For the time period covered by the second statewide assessment, Texas continued to have more children entering care than leaving care, causing the caseload to increase.

Charlotte McCullough

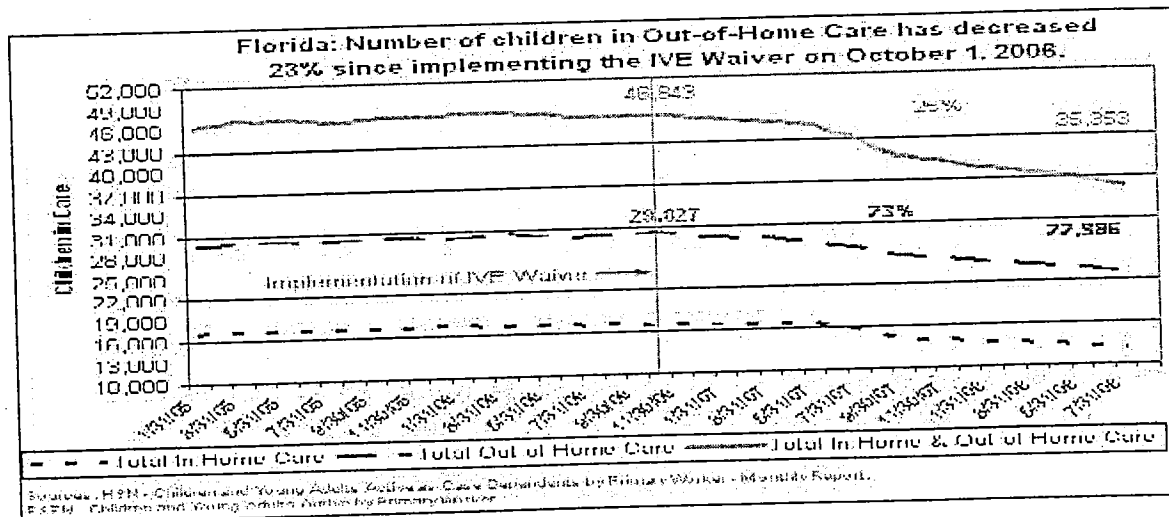
Is Texas Heading in the Right Direction?

What the CPPP report also failed to mention are trends in caseloads over time in Texas as compared to Florida. Ms. McCullough examined the case flow information from the statewide assessment for both Texas and Florida. She notes,

- When you look at the children in foster care on the first day of year using the FY 05 data, you find that Florida's foster care caseload was higher than that of Texas (27,762 in Florida to 24,175 in Texas).
- But, despite the fact that Florida has higher numbers of children entering the system, the caseloads on the last day of March 2007 show Florida with significantly fewer children in foster care than Texas (28,314 in Florida as compared to 30,971 in Texas).
- For the 12-month period ending March 31, 2007, Texas's caseload grew by 1,712 while Florida had a net loss of 382 children.⁸

Ms. Sweet notes, "Florida has been so successful in achieving permanency that the number of children in care (both in home and out of home) has dropped significantly, as depicted in Figure 2." It would be of interest to see a similar graph of the Texas system over the same time period.

Figure 2 Source: DCF Performance Dashboard, www.myflorida.com⁹



⁸ See Attachment A for further caseload detail.

⁹ The Alliance is grateful to the Children's Home Society of Florida for providing Figure 2. See Appendix B for full CHS comments.

The Examination of Spending in Texas, Florida and Kansas Is Not Accurate

The CPPP report argues throughout the report that the Texas system is underfunded—an assertion that child advocates would support. On the other hand, the report exaggerates how far Texas lags behind Florida and Kansas and for that matter other states. With incomplete citations provided, it was difficult to ascertain why the CPPP believed Texas ranked 47th nationally.

The CPPP report does not give complete sources for many of its expenditure claims, and in at least one instance, the source that is cited by the CPPP for its claim regarding child protection ranking appears to be incorrect (the report cited by CPPP does not rank states on child protection spending and therefore it could not be the source for Texas ranking). The report cited focuses on the changes in spending in all categories across states from 2002-2004. It shows that Texas (like most states) increased spending across the board in all funds that support child welfare. The actual source for the CPPP ranking of Texas as 47th in spending may be a different Urban Institute report that examines spending from different lenses—from the rate of spending per child in the general population, to spending related to victims of abuse or neglect and spending for children in foster care, to the percent of general fund expenditure overall. As depicted in Table 1, it is true that report ranks Texas as 47th in spending per child in the general population (which is the only finding the CPPP report choose to highlight) but the report also found that Texas spends more per foster child than either Kansas or Florida and well over what is spent in 21 other states. This finding is not included in the CPPP report.

Regarding cost, the report casts in a negative light Florida's increase in spending per child on child welfare in 2005 and 2006. Given that Florida previously ranked very low nationally on child welfare spending, and even in FY 2005 ranked 36th in state spending, this argument is strange. It is unclear why an advocate organization would decry spending more resources on high-risk children and families.

Mary Armstrong

Table 1: Various Measures of State Fiscal Commitment to Child Welfare and National Ranking (SFY2000)¹⁰

State	Per child in general population (rank)	Per victimized child (rank)	Per foster child (rank)	Percent of general fund expenditures (rank)
Florida	\$201 (32 nd)	\$20,214 (27 th)	\$19,390 (44 th)	1.45 (31 st)
Kansas	\$258 (20 th)	\$20,606 (26 th)	\$26,212 (37 th)	1.03% (39 th)
Texas	\$110 (47 th)	\$14,078 (38 th)	\$35,358 (29 th)	.88% (41 st)

¹⁰ Geen, Rob. Improving Child Welfare Agency Performance through Fiscal Reforms: An Assessment of Recent Proposals. Paper prepared for the Joint Center on Poverty Research Conference Child Welfare Services Research and Its Policy Implications March 20-23, 2003. Washington, DC.

Rather than looking solely at the overall level of spending from one state to another, it is arguably more useful to examine how states allocate funds to support at-risk children and families, prevent the necessity for out-of-home care placement, and achieve more timely and lasting permanency for children. The following recent studies provide different perspectives on spending in Texas and other states.

The Nelson A. Rockefeller Institute of Government's State Spending on Children's Services project issued a report in 2007 ranking state spending for children from 1992, 1998, 2003 and 2004. It analyzed how spending has changed over time. Spending data is presented in three categories:

- ♦ Education: Elementary and secondary education
- ♦ Health: Medicaid, MCHBG, SCHIP
- ♦ Non-Health/Non-Education: Adoption Assistance, Child Welfare Services (Title IV-B, Subpart 1), Promoting Safe and Stable Families (Title IV-B, Subpart 2), Foster Care, AFDC, JOBS, Emergency Assistance, TANF, AFDC Child Care, Transitional Child Care, At-Risk Child Care, CCDF, Child Support Enforcement, and EITCs

The report finds that Texas is certainly not among the big spenders for children, but it also ranks above twenty other states. As depicted in Table 2, Texas ranks 30th in total spending per child across the three categories. Florida ranks 40th and Kansas ranks 27th. All three states are below the national average. In terms of spending as a percent of GSP, Texas ranks above Florida and below Kansas.

Table 2: Total Spending Per Child as Percent of Gross State Product, Indexed and Ranked (FY 2003)¹¹

State	Total spending for children -% GSP	Rank	Total spending per child	Rank
Texas	4.33	28	\$5,239	30
Florida	3.59	44	\$4,614	40
Kansas	4.49	18	\$5,425	27
U.S.	4.29%		\$5,803	

To compare Texas' spending over time with that of Florida and Kansas, data was downloaded from the national resource database managed by the Child Welfare League of America (CWLA). As depicted in Table 3, all states have increased funding significantly between 1998 and 2004. The increases in Florida and Kansas were primarily the result of increased federal and state

¹¹ State Funding for Children: Spending in 2003 and How It Changed From Earlier Years (April 2007), Nelson A. Rockefeller Institute of Government, Albany, NY.

funds; in Texas the increase comes primarily from federal and local funds (increases of over 120% for each) and less from state funds (a 21% increase).

Table 3: Federal/State/Local Funding From 1998-2004

Year	1998	2004	1998, 2004	1998	2004	1998, 2004	1998	2004	1998, 2004
State	<u>Child Welfare Expenditures Funded with Federal Funding</u>	<u>Child Welfare Expenditures Funded with Federal Funding</u>	<u>Percent Change in Federal Child Welfare Expenditures</u>	<u>Child Welfare Expenditures Funded with STATE FUNDING</u>	<u>Child Welfare Expenditures Funded with STATE FUNDING</u>	<u>Percent Change in State Child Welfare Expenditures</u>	<u>Child Welfare Expenditures Funded with LOCAL FUNDING</u>	<u>Child Welfare Expenditures Funded with LOCAL FUNDING</u>	<u>Percent Change in Local Child Welfare Expenditures</u>
FL	\$354,888,359	\$485,593,314	36.8%	\$144,389,973	\$404,417,285	180.1%	N/A	\$6,962,229	N/A
KS	\$64,685,152	\$119,978,058	85.5%	\$52,762,917	\$109,801,245	108.1%	N/A	N/A	N/A
TX	\$254,182,298	\$559,992,577	120.3%	\$219,723,197	\$266,052,861	21.1%	\$4,681,114	\$17,644,802	128.2%

Source: <http://ndas.cwla.org>; Downloaded 9/2/08

Table 4 provides state specific information about total child welfare financing and the proportion of federal Medicaid and Title IV-E dollars to the total amount of child welfare funding that each state receives from the federal government. The Medicaid funding includes only Medicaid spending for Medicaid Targeted Case Management and Rehabilitative Services for children in the child welfare system and does not include health care costs covered by Medicaid. Table 4 reveals that Texas relies upon Medicaid for 13% of its child welfare funding (the national average is 10%).

Table 4: Child Welfare and Medicaid Funding By State (SFY 2002)

State	Total Child Welfare Spending (Federal, State & Local)	Total Federal Child Welfare Spending ^	Federal Title IV-E Spending	% of Federal Title IV-E Spending to Total Federal Child Welfare Spending	Federal Medicaid Spending *	% of Federal Medicaid Spending to Total Federal Child Welfare Spending
Florida	766,109,440	436,772,421	183,180,612	42%	3,978,767	1%
Kansas	183,960,499	114,299,519	38,346,048	34%	22,963,462	20%
Texas	824,978,690	540,113,780	160,891,955	30%	70,498,771	13%
U.S. Total	22,156,246,128	11,304,449,369	5,553,276,701	49%	1,102,120,905	10%

Source: The Urban Institute. The Cost of Protecting Vulnerable Children IV. Available online.
 *Federal Spending includes dollars from Title IV-E, Title IV-B, TANF, SSBG, Medicaid, SSI, and Survivor's Benefits.

In summary, what we discovered is that Texas, Florida and Kansas have increased spending for their child welfare systems over the past few years. Texas spends more than both Florida and Kansas in some spending categories and less in others. In terms of national rankings, none of the three states are ranked highly for their child welfare spending and each struggles to have adequate resources to support services that will meet federal and state child and family safety, permanency and well-being requirements. With the funds that are available, all states have made some progress on CFSR outcomes but the results are mixed—Texas' performance exceeds that of Florida and Kansas in some areas, and lags behind in others. None of the three states is expected to pass the second round of the CFSRs.

Final Thoughts

The National Quality Improvement Center on the Privatization of Child Welfare (QIC-PCW) has cautioned against the use of loaded terms and hyperboles in weighing the pros and cons of privatizing child welfare services, "Instead of public vs. private service delivery, states are better served by asking how best to actualize the community's potential, both public and private, toward providing the best response to child welfare issues" (QIC, 2006 Needs Assessment p 26).

It is unlikely that the Alliance would have gone to the effort to fact check the CPPP report if it had not been as confrontational about public vs. private service delivery, and not been as extreme in depicting private nonprofit organizations as driven by financial and conflicting concerns. These are the nonprofit organizations, with whom the Texas Department of Family and Protective Services (DFPS) contracts for services, that raised over \$28 million in 2006 (the latest cost report information) to support state payment rates and improve services to the children they serve.

In fact, the QIC-PCW research found that while many were concerned that privatization would focus on the fiscal aspects of child welfare to the detriment of client needs and outcomes, this does not appear to have happened. Studies report that all parties involved, both public and private, are driven by improving outcomes in the best interests of the children and families (QIC, 2007 Program and Fiscal Design, p.24). At a time when Texas continues to struggle to meet outcomes for children and families that are satisfactory by national standards, we must do everything possible to strengthen, not undermine, the public-private collaboration called for to solve the serious problems we are facing.

In the coming weeks, the Alliance will release its proposed recommendations for partnering with DFPS in new ways to solve the long-standing problems that are referenced in the CPPP report and addressed in this document. We in the nonprofit community look forward to honest, candid, and respectful dialogue with the DFPS and other child welfare stakeholders. We believe that a stronger public-private partnership is needed for us to begin to reverse negative trends and improve services for all children and families served by the child welfare system.

Children and families in Texas deserve no less than our best collective efforts.

Attachment A: Statewide Assessments for the 2nd Round of the CFRS

Point-in Time Permanency Profile	FY 05 ¹²			12-Month Reporting Period 07 ¹³		
	# of Children			# of Children		
	TX	FL	KS	TX	FL	FL
I. Foster Care Population Flow						
Children in foster care on 1 st day of year	24,175	27,762	5,659	29,259	28,726	28,726
Admissions during the year	16,595	21,911	3,084	16,483	20,918	20,918
Discharges during the year	12,161	20,047	2,931	14,771	21,300	21,300
Children in care on last day of the year	28,609	29,626	5,812	30,971	28,344	28,344
Net change during the year	4,434	1,864	153	1,712	-382	-382
II. Placement Types for Children in Care						
	# (%) of Children			# (%) of Children		
	TX	FL	KS	TX	FL	FL
Pre-Adoptive Home	1,017 (3.6)	301 (1)	251 (4.3)	848 (2.7)	334 (1.2)	334 (1.2)
Foster Home (relative)	6,397 (22.4)	13,229 (44.7)	1,202 (20.7)	8,681 (28)	12,700 (44.8)	12,700 (44.8)
Foster Home (non-relative)	12,405 (43.4)	11,575 (39.1)	2,753 (47.4)	12,761 (41.2)	10,846 (38.3)	10,846 (38.3)
Group Homes	2,540 (8.9)	1,070 (3.6)	157 (2.7)	2,607 (8.4)	1,082 (3.8)	1,082 (3.8)
Institutions	3,219 (11.3)	2,868 (9.7)	225 (3.9)	3,378 (10.9)	2,800 (9.9)	2,800 (9.9)
Supervised IL	29 (.1)	33 (.1)	22 (.4)	14 (0)	32 (.1)	32 (.1)
Runaway	791 (2.8)	460 (1.6)	70 (1.2)	613 (2)	477 (1.7)	477 (1.7)
Trial Visit Home	1,955 (6.8)	0	553 (9.5)	1,816 (5.9)	0	0
Missing Placement information	259 (.9)	90 (.3)	2 (0)	252 (.8)	73 (.3)	73 (.3)
Not Applicable	0	0	577 (9.9)	0	0	0

¹² The second CFRS for Kansas was conducted the week of June 11, 2007. The data for Kansas' second statewide assessment included the period from October 1, 2004-September 30, 2005 (AFCARS and NCANDS Data). The FY 05 data from both Florida and Texas are data each state included in its second statewide assessment. There is no Kansas data comparable that of Texas and Florida for the 12-months ending March 31, 2007.

¹³ Texas had its second CFRS on March 24-28, 2008; the second CFRS for Florida was conducted on January 7-11, 2008.

Attachment A: Statewide Assessments for the 2nd Round of the CFRS

		FY 05			12-Month Reporting Period 07		
Length of Time To Achieve Permanency (Median Months)							
	Median months			Median months			TX
	TX	FL	KS	FL	KS	TX	
Reunification	10.7	8.5	12.7	8.5		11.5	
Adoption	24.2	32.1	30.9	29.3		24.1	
Guardianship	0	12.2	14.5	12.2		0	
Statewide Aggregate Data Used to Determine Substantial Conformity: Composites 1 through 4							
Permanency Composite 1: Timeliness and Permanency of Reunification (Standard 122.6 or higher)							
	TX	FL	KS	FL	KS	TX	
State score on Permanency Composite 1	127.2	110.1	115.6	111.7		120.1	
Exits to reunification in less than 12 months – national median = 69.9%	70.8%	60.9	60.9%	66.5% X		65.9%	
Exits to reunification – median stay = 6.5 months	9.7	10.1	9.3 X	9.1 X		10.3	
Entry cohort reunification < 12 months – national median = 39.4%	33.9%	46%	28.9%	44.4%		36.9%	
Re-entries to foster care in less than 12 months – national median = 15%	4.6%	11%	7%	13%		5.5%	
Permanency Composite 2: Timeliness of Adoptions (Standard 106.4 or higher)							
	TX	FL	KS	FL	KS	TX	
State score on Permanency Composite 2	98.4	111.2	86.3	124.2		97.4	
Exits to adoption in less than 24 months – national median = 26.8%	49.1%	29.8%	29.2%	36.7%		49.3%	
Exits to adoption, median LOS – national median = 32.4 months	24.2	32.1	30.9	29.3		24.1	

Green indicates best score, yellow indicates met national standard, red X means compares favorably but does not meet national standard.

Attachment A: Statewide Assessments for the 2nd Round of the CFRS

Permanency Composite 2 (cont)						
	FY 05			12-Month Reporting Period 07		
	TX	FL	KS	FL	TX	TX
Children in care 17+ months adopted by end of year – median = 20.2%	18.5	23.8%	23.7%	36.7%	19.6	19.6
Children in care 17+ months achieving legal freedom within 6 months – national median = 8.8%	4.1%	12.4%	7.4%	13.7%	4.3%	4.3%
Legally free children adopted in less than 12 months – median = 45.8%	37.2%	54%	28%	60.9%	35.8%	35.8%
Permanency Composite 3: Permanency for Children/Youth in Foster Care a Long Time (Standard 121.7)						
State score	87.7	123.2	123.9	125.7	93.1	93.1
Exits to permanency prior to 18 th birthday for children in care 24+ months – national median = 25%	17.8%	32.2%	29.8%	33.3%	18.7%	18.7%
Exits to permanency for children with TPR – national median = 96.8%	87.3%	92.1%	91.1%	90.9%	88.2%	88.2%
Children emancipated who were in foster care for 3+ years – national median 47.8% (LOWER is preferable)	63.4%	48.8%	37.5%	43.5%	59.6%	59.6%
Permanency Composite 4: Placement Stability (National standard 101.5 or higher)						
State score	77.3	92.9 X	77.5	88.1 X	82.9	82.9
Two or fewer placement settings for children in care less than 12 months – national median = 83.3%	77.3%	81.7% X	74.2%	80.9% X	80.1%	80.1%
Two or fewer placements for children in care for 12-24 months – median = 59.9%	48.1%	61.7%	49.4%	59.8%	52.6%	52.6%
Two or fewer placements for children in care for 24+ months – median = 33.9%	16.9%	34.3%	22.9%	27.5% X	20.8%	20.8%

Attachment A: Statewide Assessments for the 2nd Round of the CFSR

Child Safety Profile	# (%) of Children			# (%) of Children		
	TX	FL	KS	FL	TX	TX
Disposition of CA/N Reports						
Substantiated & indicated	38,787 (24)	76,648 (51.8)	1,954 (13.8)	78,610 (50.9)	42,233 (26)	
Unsubstantiated	92,508 (57.1)	71,174 (48.1)	12,192 (86.2)	75,672 (49)	91,051 (56.2)	
Other *	30,600 (18.9)	182 (.1)	0	263 (0.2)	28,857 (17.8)	
Statewide Aggregate Data Used to Determine Substantial Conformity with CFSR						
Absence of maltreatment – national median = 94.6%	95.9	88.7%	94.6%	89.7%	96.1	
Absences of CA/N in Foster care (12 months) – national median = 99.68%	99.45	99.46%	99.87%	99.43%	99.55X	
Median hours time to investigate (hours)	>120 but <144	24	>24, <48	24	>96 but <120	
Statewide Data Used to Establish Substantial Conformity in Round 1						
Recurrence of maltreatment (6.1 % or less)	4.1	11.3	5.4	8.9	10.3	
Incidence of CA/N in foster care (.57% or less)	.44	.42%	.07%	.37%	.45%	

* Other: Used by states for cases that fall outside the substantiated and unsubstantiated categories such as those "closed no finding," "not a victim," "no alleged maltreatment," and/or "unknown/missing."

Attachment B: The Children's Home Society of Florida

October 21, 2008

Dear Ms. Holman:

Recently, the Center for Public Policy Priorities (CPPP), released a report entitled, "Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate"; hereinafter referred to as "CPPP report." In this report, CPPP compared the privatization experiences of Kansas and Florida to the currently publicly funded system of child welfare in the State of Texas. As a private case management and child welfare service provider in Florida, we were distressed by the conclusions drawn by CPPP.

CPPP concluded that:

1. "Permanency for Florida's children has improved, but the rates of re-entry and re-abuse have increased" (CPPP, p. 25)
2. "Rapid privatization would make our adoption capacity crisis worse" (CPPP report, p. 36)
3. "In states that have substantially privatized child protection, these efforts have produced 'mixed results', and no state has completely or even substantially eradicated problems within its system. First and foremost, privatization has failed to solve the main problem plaguing the child welfare system—high case worker turnover, heavy caseloads, and inadequate resources for services to families." (CPPP report, p. 19)

Children's Home Society of Florida has been operating since 1902. Being the oldest and largest child welfare provider in Florida, our organization has seen many changes in the delivery of child welfare services. We agree with the CPPP article in that there is a clear distinction between a service provider (recruiting, licensing and operating foster and group care services, recruiting adoptive families and placing children) and case management of children in care. But that is about the only point on which we agree with the CPPP report.

Children's Home Society of Florida has operated programs in both a publicly funded system of care (providing foster and adoptive services) and now in a privatized system (where we continue to operate those services and privatized case management). We are currently providing case management to nearly 25% of the children in Florida in the child welfare system.

In reviewing this report, we felt compelled to respond to a number of inaccuracies and misleading information pertaining to the privatization movement in the State of Florida. The three conclusions above made by CPPP are not supported by the most recent data and what we know to be true for children and families in our state.

In addition to these three inaccuracies from the CPPP report, in general, we have great concern over the tone of the CPPP article and a perceived bias of the reviewers against privatization. Should you have any questions about this response, please contact me at: andry.sweet@chsfl.org or 321-397-3000.

Sincerely,

Andry E. Sweet
Vice President of Operations,
Children's Home Society of Florida

Attachment B: The Children's Home Society of Florida

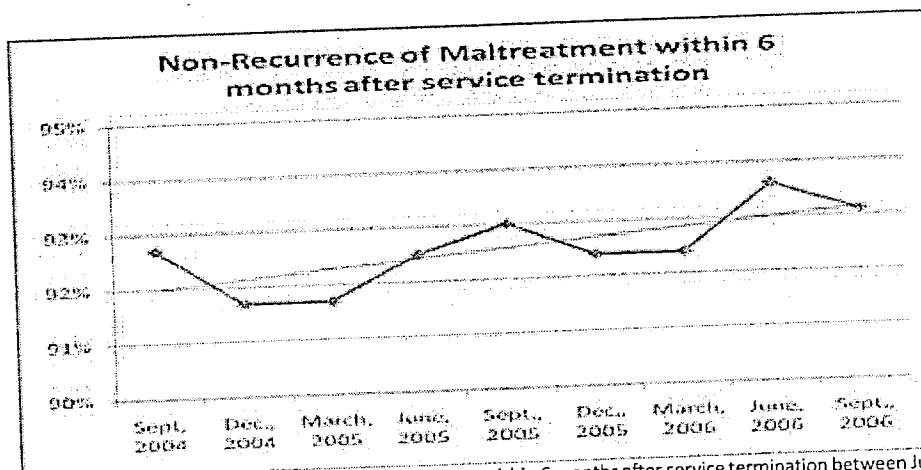
Response to CPPP Report

Before responding to inaccuracies of the CPPP report, we feel that we must clarify the definition of case management in Florida. Case management is poorly defined in the CPPP article. It is represented throughout the article that case managers are making legal decisions on behalf of families and acting independently of any state agency. In fact, our case managers do not make legal decisions on behalf of children and families. The State of Florida has retained Children's Legal Services (CLS), the attorneys present the cases in court. It is ultimately the judge who makes decisions on reunifications, termination of rights and all other judicial orders impacting the family. Our case managers in most cases are co-located with CLS and meet in staffings just as state employees used to do to review the cases and recommend an appropriate course of action to the judge based on the parents' compliance with the case plan. Our role is to work directly with families through a case planning process and make recommendations to the court based on our observations and interactions with the parent(s) and child(ren). This is no different than the role public employees played in the child welfare system in Florida before privatization.

Response to (1) "Permanency for Florida's children has improved, but the rates of re-entry and re-abuse have increased" (CPPP, p. 25)

Re-entry rates have actually improved, the percent of children not re-entering the system has actually increased (see Figure 1). The data presented in the CPPP report was misleading in that it used one data point from 2005. The State of Florida target is 93% of children will not re-enter care within 6 months of exit from care. CBC lead agencies have been meeting this measure since June, 2006.

The CPPP article cites that at the end of FY 2005, 11% of children were victims of re-abuse or neglect within 6 months of exiting care. However, in reviewing the "Report to the Legislature: Evaluation of the Department of Children and Families Community-Based Care Initiative, Fiscal Year 2005-2006," University of South Florida, January, 2007, it was noted that "Children included in this cohort may not have ever been served by a CBC lead agency" since they were served in FY 2004-2005, prior to full privatization. In fact, according to the most recent statistics, Florida is meeting the 7% target, 93.1% of children are not re-abused or neglected within 6 months following exit from care.



Data Source: Table 4. Non-Recurrence of Maltreatment within 6 months after service termination between July, 2004 and September, 2006. "Report to the Legislature: Evaluation of Community Based Care Initiative, Fiscal Year 2006-2007", University of South Florida, January, 2008., page 74.

Attachment B: The Children's Home Society of Florida

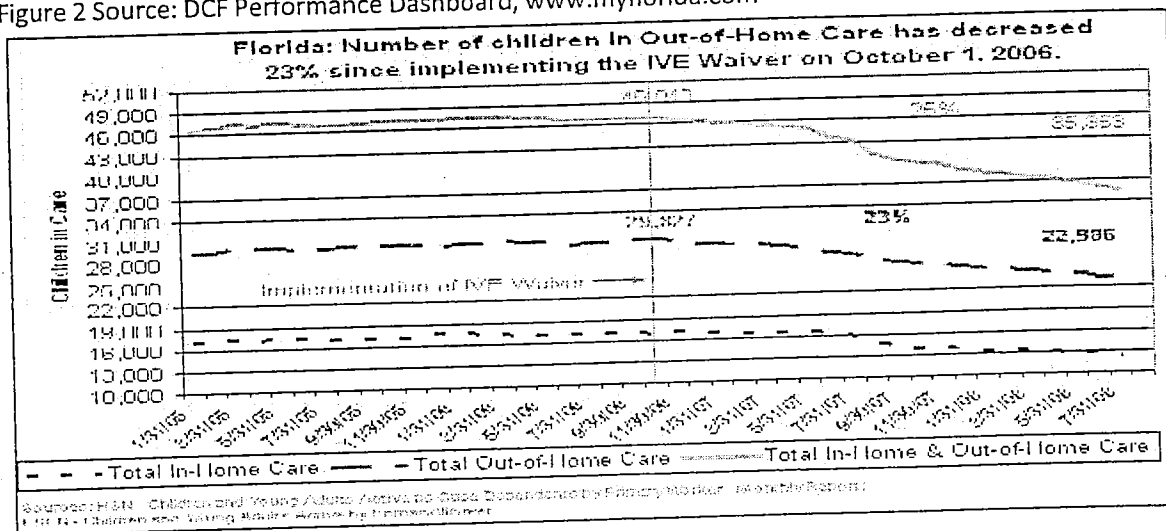
According to CPPP, Florida's privatization has yielded, "mixed results" on "key outcome measures related to the safety and well-being of children." Because of the complexity of moving services from the public to the private sector, the seemingly best indicator to measure success would be data from the first full year post-privatization. CPPP used the Performance Evaluation reports from USF for FY 2005-2006 (the final year of transition when many CBC's became fully operational). While it is possible CPPP did not have the data from the most recent fiscal year, the report on the first full year "post privatization" 2006-2007 was released in January, 2008; and yet the report produced by CPPP was completed in August, 2008.

Specifically, the CPPP report cites that "no lead agency performed at or above the State average across all safety and permanency outcomes." "Report to the Legislature: Evaluation of the Department of Children and Families Community-Based Care Initiative, Fiscal Year 2005-2006," University of South Florida, January, 2007.

The most recent report from the University of South Florida, "Report to the Legislature: Evaluation of the Department of Children and Families Community-Based Care Initiative, Fiscal Year 2006-2007," released January, 2008, acknowledges that Florida (as is the case with most states) CBC lead agencies "as a whole did not meet the performance targets," but that "agencies were more successful at meeting the performance target for the outcomes of safety and permanency. Statewide, lead agencies achieved a compliance rate of above 80% on Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect, Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate, and Permanency Outcome 1: Children have permanency and stability in their living situations. Furthermore, two lead agencies achieved the state and federal 95% compliance standard for Safety Outcome 1, three lead agencies exceeded the standard for Safety Outcome 2, and six lead agencies reported above 90% compliance on Permanency Outcome 1."

In fact, Florida has been so successful in achieving permanency that the number of children in care (both in home and out of home) has dropped significantly. There are more than 10,000 fewer children in care today than there were during transition (January, 2005), see figure 2.

Figure 2 Source: DCF Performance Dashboard, www.myflorida.com

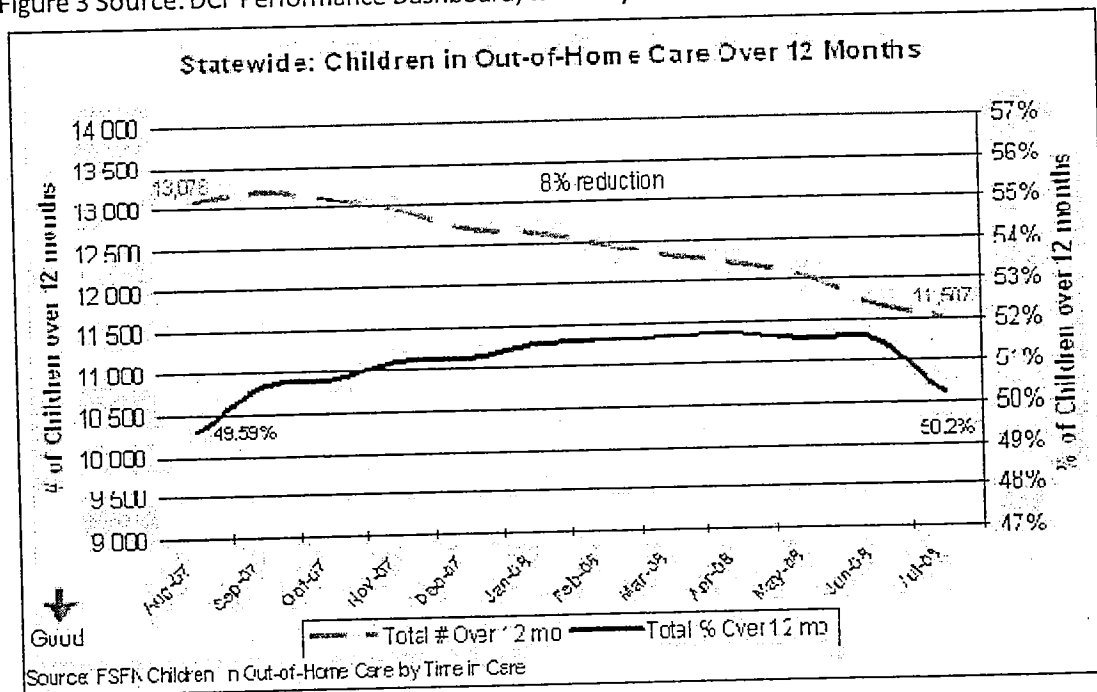


Out of Home Care

The CPPP article cites from the "Report to the Legislature: Evaluation of the Department of Children and Families Community-Based Care Initiative, Fiscal Year 2005-2006," University of South Florida, January, 2007, that the percentage of children in out-of-home care more than 12 months has remained higher than the State of Texas. However, the report does not cite that the overall number of children in out-of-home care has dropped 25%, and that the percent in care over 12 months has dropped 8% (over 2,500 children who were in the system more than 12 months) have achieved permanency.

There could be a variety of factors to explain why the percentage of children hasn't decreased at the same rate of the overall number of children in out-of-home care over 12 months. Because of the significant drop, it is possible that the children remaining in out of home care are far more severe and complex cases. In several places in the CPPP article, they point out that in Florida there is an increase in the "percentage" of children in out-of-home care more than 12 months, and an increase in percentage of children with 3 or more placements. The percentages are higher, but that is indicative of the fact that we are managing far fewer children in out-of-home care and of those in care, there is a greater severity of childhood emotional trauma and behavioral problems which would inflate this percentage. The reality is that the numbers of these "out-of-home care" children are trending downward, see Figure 3.

Figure 3 Source: DCF Performance Dashboard, www.myflorida.com



According to "Report to the Legislature: Evaluation of Community-Based Care Initiative, Fiscal Year 2006-2007," University of South Florida, January, 2008, "Over the time period January-March 2004 through April-June 2006, the percent of children who exited out-of-home care within 12 months increased by 7% across all lead agencies.

Attachment B: The Children's Home Society of Florida

Is it the Title IV-E waiver, increased funding or was it privatization?

The CPPP article suggests that, in Florida, we have had some limited success, but that it is due to the changes we made (not necessarily associated with privatization). The CPPP report suggests that increased funding played a significant role in our ability to improve outcomes in some areas. Some may suggest that the significant drop in caseload was due to the implementation of the IV-E waiver. This waiver allows the State of Florida CBC's to use federal Title IV-E funds for children both in home and out of home. The flexibility also allowed for out-of-home care funds to be used on the "front end" of the system of care.

Many CBC's developed Diversion, Community Intervention/Prevention, and Alternative Response Systems to work with families referred by Protective Investigators. These three strategies allowed investigators to refer to an alternative family resource specialist that would provide case management type activities and help divert the family from the court system wherever possible.

Because of the reduction in caseloads due to permanency the CBC's "invested" the savings in these "front end" services which further reduced the numbers of children in care. These services were customized at a community level based on the local needs.

So was it the waiver, increased funding or privatization? It's all three. The waiver is important to allow the funding flexibility so that dollars follow children and families, rather than funding "programs" that provide reimbursement for children residing in "out-of-home care." The increased funds were needed to draw down the federal funds for all the increased adoptions and services provided by diversion workers on the front end. We essentially needed more state dollars to maximize our federal earnings. So our funding increased, but so did our federal revenue maximization.

Could we have accomplished this significant reduction without the waiver? Yes, but the reduction in out-of-home care would have taken longer, because we would not have been able to reinvest right away in the "front end." We would have lost the federal IV-E match because of having fewer children in out-of-home care. We sustained our federal Maintenance of Effort primarily through an increased rate of adoptions—more than twice the rate in the year prior to privatization.

Could we have done this without privatization? No. The importance of private providers implementing the waiver is that the CBC's work with local partners, county and city governments, United Way's and other community investors who want to address child abuse in their community. Private providers are more able to create new services, generate resources and savings from achieving permanency goals and reinvesting in their community. And they do this through consulting with their local Boards (of community leaders). They do this without having to go through a legislative budget request process or seek budget amendments from several layers of management as most governmental agencies do to shift resources. In fact most business decisions are vastly simplified. Purchasing equipment, leasing space, payroll and accounting are managed by the local CBC. These processes in state agencies are more often centralized and bureaucratic and can slow down changes in system of care needs for a community. CBC's are simply able to operate more like a true business and can react quickly to the changing needs of families in a community and shift resources to meet these changing priorities. And in Florida, that is what they are doing.

Response to (2) "Rapid privatization would make our adoption capacity crisis worse" (CPPP report, p. 36)

Florida's adoption rate has increased substantially since privatization. Last FY (ending June, 2007) Florida's privatized system exceeded all previous adoption records set by the State of Florida. SOURCE: Press Release, Department of Children and Families, June 30, 2008, "Florida sets New Record for Number of Children Placed in Adoptive Homes." In fact, 3,674 adoptions were finalized in 2007-2008, exceeding the previous adoption record set before privatization in 2003-2004 of 3,389 adoptions. The percent of children adopted within 24 months has increased from 27.9% in 2004 to 41.5% in 2007.

Children's Home Society of Florida has been providing adoption services for over 100 years. Since privatization, the number of children adopted through our agency has skyrocketed. In fact, we finalized more adoptions fiscal year, ending June, 2008 (1,079 adoptions), than we have in any other single year in our history as a child placing agency.

Response to (3) "In states that have substantially privatized child protection, these efforts have produced 'mixed results,' and no state has completely or even substantially eradicated problems within its system. First and foremost, privatization has failed to solve the main problem plaguing the child welfare system—high case worker turnover, heavy caseloads, and inadequate resources for services to families." (CPPP report, p. 19)

It is unfair to call Florida a failure for not "eradicating" the problems within the system. No system, public or private, could honestly say they have done this. But what Florida has achieved in the area of case manager retention and caseload sizes cannot be minimized either.

Despite some fairly significant barriers, privatized case management providers were able to attract state workers and build a strong workforce in Florida.

In Florida Statute, the State of Florida required private agencies to run accredited case management programs. Case management was not accredited in the public sector in Florida. Our biggest challenge was not convincing public case managers to come work for us; it was that we had to hire more case managers than were currently available in the public sector. To complicate matters, there were significant vacancy rates under the Department of Children and Families before privatization occurred. Therefore, during transition, in partnership with our CBC's across the state, we ensured that every state employee eligible for employment with us was made a job offer. We honored salaries in almost every case, and were able to offer benefits on the first day of employment, waiving the waiting period (as we would with most new employees). CBC Lead Agencies attracted longer-term employees into contract and quality management positions that were oftentimes at a higher salary than they made with the State.

It is true that many of the benefits the state offered were better than private providers. In our employee recruitment phase, private providers came together and created a matrix of benefits offered by each agency, so state employees had information on how we all compared to each other. They had a choice of benefit options and made applications to providers that best fit their individual needs.

Attachment B: The Children's Home Society of Florida

We made educational exception waivers for supervisors and managers that did not have master's degrees. We offered tuition reimbursement programs to help them get their master's degree for their position.

Most of the public sector case managers did transition to CBC Lead Agencies and providers of case management services. Some who had many years with the state, who were closer to retirement and didn't want to lose their state retirement benefits, decided to stay with the state in other positions.

Because we needed more workers than the state had to offer, we created partnerships with universities to create IV-E internships with their schools of social work. This program allowed paid internships for fresh recruits. In CHS, we used some of our entry level positions in other programs (group homes, prevention programs, homemaker programs) as "feeder programs" for case management. Youth child care workers and family support workers who earned their bachelor degrees through our tuition reimbursement program were groomed to enter the case management program.

The CPPP article suggests that in some CBC's vacancies were as high as 22% and the overall vacancy rate was 9%. The year that was cited by CPPP was 2005, which as mentioned before was during our final transition year. We did not have enough workers to fill positions needed to meet our accredited standards of less than 20 children per worker. Why? There were simply not enough state case managers (even if 100% filled positions were transferred) to lower caseloads to the 20:1 standard. The CPPP article suggests that state employees are negatively impacted in the transition to private providers, and do not transition. This was simply not the case in Florida.

In Florida, we had to increase our workforce to lower caseloads to increase retention. In 2006, we evaluated the relationship between caseload size and turnover and found a statistical correlation ($r=0.89$) between caseload size and turnover of staff—meaning when caseloads are higher, our turnover was higher. We initially had to increase staffing (over hire), which in turn reduced caseloads, which in turn retained staff. We filled vacancies until caseloads dropped to approximately 15-16 children, and then through normal attrition downsized.

So evaluating our success at retaining case managers by looking at our vacancy rate is really looking at a moving target. Our caseloads have dropped, so it is true we did not fill vacancies, but because it was not warranted. When this started to occur, CBC's fought for the IV-E waiver so they could begin ramping up diversion programs. Employees who had been in case management for years were excited about working with families on the "front end" and many were able to move into these positions as we converted traditional case managers into this new field. We have found that by creating these additional opportunities, we have increased job satisfaction, and kept staff who were looking for new challenges.

CPPP suggests that the Texas CPS turnover rate for "CPS workers" is 34%. The report referenced, produced by the State of Texas, defined their turnover rate as: "DFPS turnover is calculated using the method required by LBB performance measure for CPS caseworker turnover: (the total number of full time, regular employees who terminated during the period and remained terminated DIVIDED BY the average number of full time, regular filled positions on the last day of each quarter in the period) TIMES 100 to produce a percentage."

It is unclear if this is a rolling quarterly turnover rate or an annual rate. Despite that, CPPP reports that in 2005, the average turnover rate in Florida was 31% (CPPP report, p. 26). Again this was in a transition year. So even in the worst possible time to evaluate turnover, our rate was lower than Texas.

Attachment B: The Children's Home Society of Florida

For Children's Home Society of Florida, we have seen a significant decline in turnover since we assumed our first case management contract in October, 2003. Just in the past year, our turnover has dropped 8% in our dependency programs. The workforce has become more stable over time. Many strategies were put in place to increase employee retention as highlighted in the "Children's Voice," Child Welfare League of America, July/August 2008, "A Little Effort Goes a Long Way: Strategies for Preventing Staff Turnover," By Kathryn Brohl (Children's Home Society of Florida), and we found that lengths of stay for child welfare case managers increased from 2.7 years in 2004 to 3.7 years in 2007.

Caseloads

CPPP cites that our Florida caseloads in 2005 were on average 24 per worker (CPPP report, p. 26). For this same time period, according to the Texas Department of Family and Protective Services Data Book 2007, in the FY ending 2006, caseloads averaged 44.5 for children in substitute care services, which according to their definition is children in paid out-of-home care or living with relatives (note: workers in "family-based services" averaged 20.3 per worker). They do not provide a combined caseload size that is comparable to Florida.

What we know in Florida is that with the drop in the number of children in care, our caseloads have dropped from 24 per worker, and they continue to drop. According to the state's SACWSIS system, FSFN, caseload sizes continue to drop as indicated in caseload sizes from December, 2007 to July, 2008, see Figure 4.

Figure 4 Source: FSFN - Clients Active As Dependents Report, Dec. 2007 and July, 2008

Florida District	Dec., 2007	July, 2008
District 10	18	14
District 11	17	14
District 12	15	12
District 13	13	11
District 14	18	11
District 15	16	13
District 7	15	13
District 8	20	18
District 9	17	13
District 1	15	14
District 2	15	11
District 3	16	14
District 4	17	13
Suncoast District	18	14
RANGE:	13 to 20	11 to 18

By achieving accreditation standards in case management caseloads, we are seeing an increase in retention of employees. So while we have not "eradicated" the problems in the child welfare system, we

Attachment B: The Children's Home Society of Florida

have made significant strides in providing services in a manner that is consistent with accreditation standards and best practice.

Conclusion

As a result of our attention to the workforce and reducing the number of children in care, our outcomes are improving. In most cases, as CPPP pointed out, we are exceeding the performance of the State of Texas. The major areas where we are not exceeding are in outcomes pertaining to percentages of children in care which we have addressed in this response.

Furthermore, we believe that it is unfair and misleading to present data points from different periods during transition without showing the overall trend of data from pre to post privatization. CPPP reported only a snapshot of data during a period when the system was still transitioning to a privatized model. More recent data presented in this response and in recent state evaluation reports show clearly that Florida is trending in the right direction.

Attachment C: Our Experts

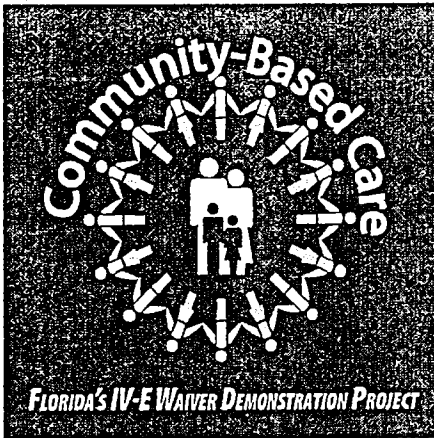
We are grateful to the following individuals for helping us in our fact-finding and to Charlotte McCullough for her assistance in weaving comments together in this document.

Madelyn Freundlich, M.S.W., M.P.H., J.D., L.L.M., holds master degrees in social work and public health and two degrees in law. She has more than 20 years of experience in child welfare practice, program development and implementation, training, policy and research. Among the issues on which her work has focused is the privatization of child welfare services, beginning with her work on the impact of managed care approaches on child welfare in the early 1990s, and continuing into the present with her work that has assessed the implementation of privatization of child welfare services in communities across the United States. That work has been utilized as a resource by states across the country in considering the privatization of their child welfare services. Ms. Freundlich currently is a principal and consultant with Excal Consulting Partners. She has worked in the national arena for both the Child Welfare League of America (as General Counsel and Director of Child Welfare Services) and for Children's Rights (as Policy Director).

Charlotte McCullough, M. Ed., has been tracking, analyzing, designing and implementing new finance, contracting and quality management models for child welfare and related systems for over a decade. She has worked extensively on contract reform issues with both public and private agencies in over a dozen states, including Texas. She served as a member of senior management team at the Child Welfare League of America (CWLA) for 13 years and was the principal investigator for three published 50-state management, contracting and finance surveys. She has been a consultant to George Washington University, Georgetown University and Children's Rights on research projects focused on child welfare contracting reforms. She has presented before national, state and local forums on child welfare privatization, including testimony before Congressional and state legislative committees. She has written extensively about all aspects of privatization. In 2007-2008, she reviewed and co-authored several topical papers on child welfare privatization that were supported by the Office of the Assistant Secretary for Planning and Evaluation, USDHS, to supplement the work of the national QIC-PCW. Ms. McCullough is currently a principal and consultant with McCullough & Associates.

Mary Armstrong, Ph.D., has over 25 years experience in public sector managed care, children's health insurance, child welfare and social services. She currently is Assistant Professor and the Director of the Division of State and Local Support, Department of Child and Family Studies at the University of South Florida. Dr. Armstrong is principal investigator for a multi-year evaluation of Florida's child welfare privatization initiative, Community-Based Care.

Andry Sweet, M.S., Vice President of Operations for Children's Home Society of Florida has over 19 years experience in child welfare and behavioral health service delivery in the state of Florida. CHS was founded in Jacksonville in 1902 by church and civic leaders as part of a national movement to find homes for orphaned children. CHS is the oldest and largest private not-for-profit organization providing services to children and families in Florida and the fourth largest in the nation. CHS has been continuously accredited since 1982 by the National Council on Accreditation (COA). In 2006-2007, CHS's 2000 employees served more than 97,000 children and families in over 1000 locations across Florida.



Evaluation Brief 3 FLORIDA'S IV-E WAIVER DEMONSTRATION PROJECT

August 2011

Evaluation Brief on the Status and Activities Related to Florida's IV-E Waiver Demonstration Project: Four Years Post-Implementation
M.I. Armstrong, A.C. Vargo, S. Kip, N. Jordan, P. Sharrock, C. Sowell, S. Yampolskaya

Background of Florida's Title IV-E Waiver

In 1996, the Florida Legislature mandated the outsourcing of child welfare services, known as Community-Based Care (CBC), through the use of a lead agency design. The intent of the original statute was to strengthen the support and commitment of local communities in caring for children and reunifying families while increasing the efficiency and accountability of service provision. Currently, all 67 counties in Florida have implemented CBC through contracts with 19¹ lead agencies.

In addition to CBC implementation, the Title IV-E Waiver Demonstration Project was implemented statewide October 1, 2006. The five-year Waiver under Title IV-E of the Social Security Act was authorized by the Administration for Children and Families (ACF).

Purpose and Specific Aims of the IV-E Waiver Evaluation

The purpose of the IV-E Waiver evaluation is to examine whether an expanded array of community-based services available via the flexible use of Title IV-E funds will reduce the number of children in out-of-home care, expedite permanency through reunification or adoption, maintain child safety, increase child well-being, and reduce administrative costs associated with providing child welfare services. This brief summarizes evaluation findings and includes data gathered from all lead agencies serving Florida's 67 counties covering State Fiscal Year (SFY) 01-02 through SFY 10-11, depending on the data source and measures.

Evaluation Model

A theory of change for this evaluation informed the methodology and was based on: (a) federal and state government expectations of the intended outcomes of the Waiver, (b) the evaluation team's hypotheses about practice change based on knowledge of the unique child welfare arrangements throughout the State of Florida, and (c) stakeholder feedback. Five analysis components were used to address the hypotheses, and data from various information sources within each component were triangulated as part of the evaluation design (see Figure 1).

¹ Effective April 1, 2011, CBC of Central Florida (previously CBC of Seminole) is the lead agency for Seminole, Orange, and Osceola counties. This reduces the number of lead agencies from 20 to 19.

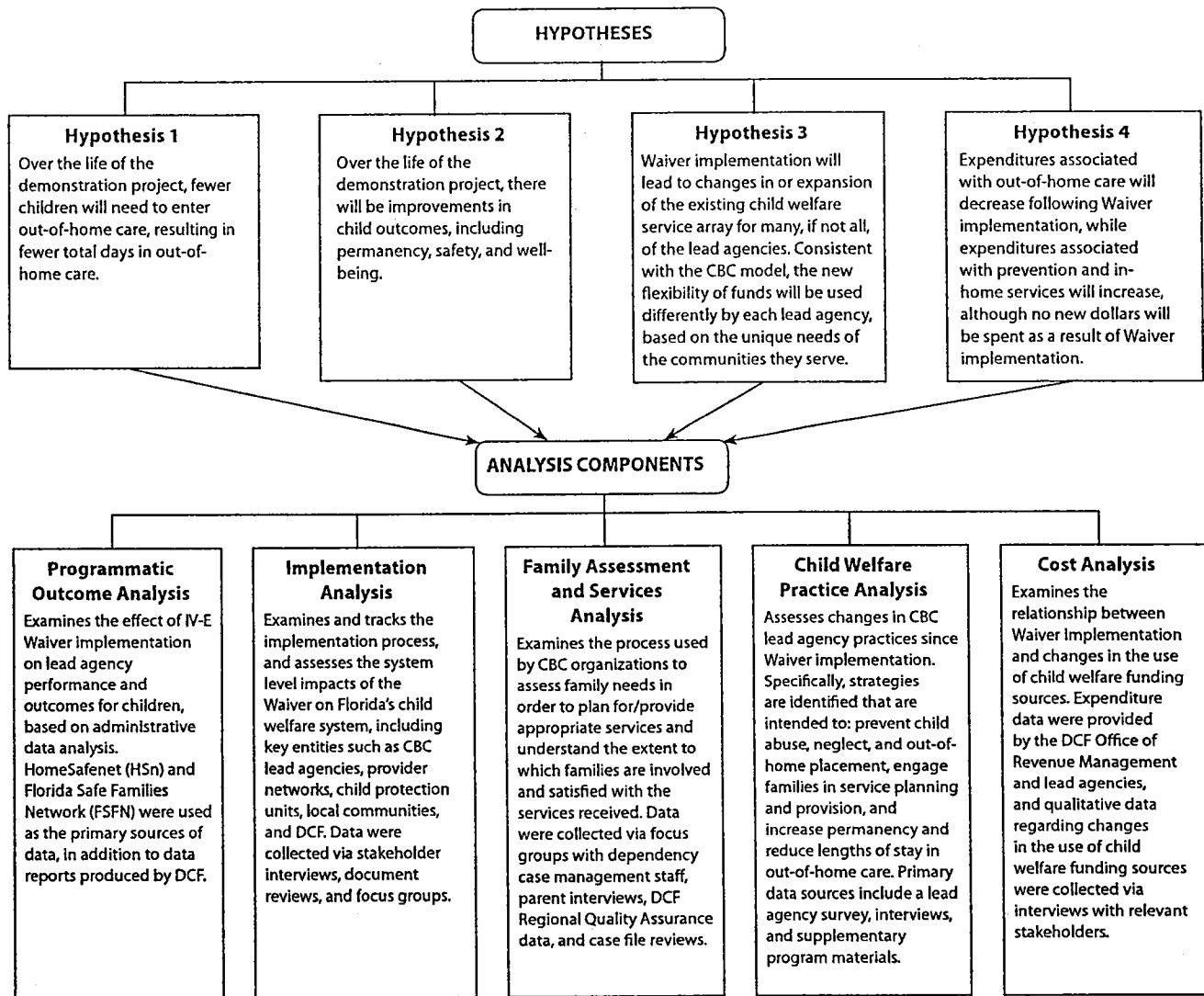


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Figure 1. Evaluation Design



Findings

Findings are detailed as they relate to the four hypotheses, in an effort to convey the story of Florida's IV-E Waiver impact to date.

Hypothesis 1

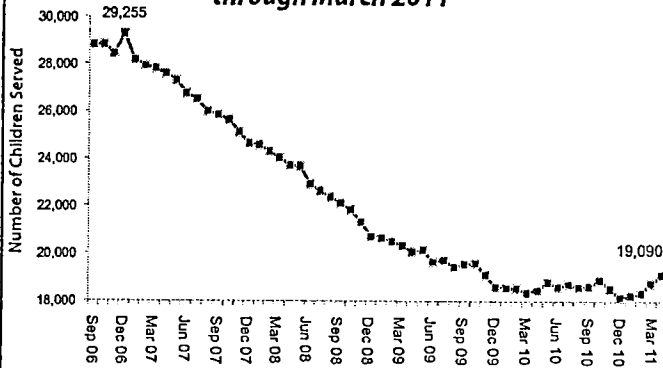
Over the life of the demonstration project, fewer children will need to enter out-of-home care, resulting in fewer total days in out-of-home care.

Since implementation of the IV-E Waiver (SFY 06-07), the number of children served in out-of-home care per year decreased by 37%, from 29,255 as of September 30, 2006 to 19,090 as of March 31, 2011² (see Figure 2).

However, these data do not identify whether the characteristics of children placed in out-of-home care have changed over time. Therefore, the following research questions were examined: (a) Can discrete subgroups of children served in out-of-home care be identified? If these subgroups can be identified, then (b) Did the nature of these subgroups change over the first three years of the Waiver? and (c) How do these subgroups compare in terms of the likelihood of being served in a certain placement category to include: placement with relative or non-relative; licensed-based family or facility care; mental health or substance abuse treatment facility?

To compare children served in out-of-home care in SFY 05-06 with children served in SFY 08-09, a latent class analysis (LCA) was conducted (Clogg, 1995; Lazarsfeld & Henry, 1968). Table 1 summarizes the subgroup descriptions for the SFY 05-06 and SFY 08-09 populations.

Figure 2. Total Number of Children Served in Out-of-Home Care from September 2006 through March 2011



² Data provided by the Florida Department of Children and Families (DCF).

Table 1. Profiles of Children Served in Out-of-Home Care in SFY 05-06 and SFY 08-09

SFY 05-06 (N=50,532)	SFY 08-09 (N=36,779)
Subgroup Descriptions	
Children with Complex Needs (11%) <ul style="list-style-type: none"> • Average Age = 7.7 years • Male = 59% • African American = 42% • Physical Problems = 100% • Emotional Problems = 68% • Need Special Care = 54% • Parental Rights Terminated = 26% • Parental Substance Abuse = 20% 	Children with Complex Needs (8%) <ul style="list-style-type: none"> • Average Age = 7.9 years • Male = 60% • Female Single Parent Family = 57% • Physical Problems = 100% • Emotional Problems = 61% • Need Special Care = 60% • Parental Rights Terminated = 33%
Families with Complex Needs (40%) <ul style="list-style-type: none"> • Average Age = 7.3 years • Domestic Violence = 20% • Absence of Caregiver = 32% 	Families with Complex Needs (62%) <ul style="list-style-type: none"> • Average Age = 3.2 years • Domestic Violence = 16% • Parental Substance Abuse = 44% • Absence of Caregiver = 23%
Families with Substance Abuse Problems (28%) <ul style="list-style-type: none"> • Average Age = 5.6 years • Parental Substance Abuse = 100% • Parental Rights Terminated = 9% 	Older Abused Children (30%) <ul style="list-style-type: none"> • Average Age = 12.6 years • Female = 54% • Female Single Parent Family = 53% • Parental Substance Abuse = 25% • Physical Abuse = 12% • Behavior Problems = 8% • Sexual Abuse = 6%
Children with Neglect History (20%) <ul style="list-style-type: none"> • Average Age = 5.5 years • African American/Hispanic = 53% • Parental Rights Terminated = 9% 	

Children with Complex Needs were identified in both SFY 05-06 and SFY 08-09 as a distinct group of children in out-of-home care. All of these children had physical problems and about two-thirds had emotional problems. These children were also more likely to be placed in licensed facility-based care. One-quarter to one-third had parents whose parental rights were terminated.

Children in **Families with Complex Needs** were also identified among children served in out-of-home care in SFY 05-06 and SFY 08-09, although their distinguishing characteristics differed slightly. For the SFY 05-06 subgroup, the mean age was approximately seven years, and the group was characterized by a relatively high probability of having parents with domestic violence issues and a relatively high probability of having an absent caregiver. In addition, children in this subgroup were more likely to be placed with either a relative or a non-relative caregiver, and compared to all subgroups except *Children with Complex Needs*, these children had a much higher probability of being placed in licensed facility-based care. For SFY 08-09, the average age was three years and these children had a high probability of having parents with domestic violence and substance abuse issues, and an absence of caregivers.



A subgroup of **Older Abused Children** did not emerge in SFY 05-06 but constituted 30% of all children in out-of-home settings in SFY 08-09. These children were older (average age =13 years) and were more likely to have experienced sexual and physical abuse and to have had behavioral problems. Despite the absence of emotional problems, *Older Abused Children* were as likely to be placed in facility-based care and in mental health and substance abuse facilities as *Children with Complex Needs*.

Finally, **Children with Neglect History** and children in **Families with Substance Abuse Problems**, which were identified as subgroups in SFY 05-06, were not identified in SFY 08-09.

Hypothesis 2

Over the life of the demonstration project, there will be improvements in child outcomes, including permanency, safety, and well-being.

Family Engagement

Parents, case managers, and CBC and DCF leadership provided information related to family participation in case planning, decision making, and community-based services received. Most parents reported being engaged by case workers and participating in assessment and planning for their family's needs. Case managers reported facilitating such processes. Improvement in family engagement was perceived to be a result of efforts to divert families away from the dependency system, which has led to a more voluntary and self-directed process for caregivers and provided case managers with more time to engage families and individualize service plans that include informal community supports. Parents reported participating in services such as counseling, mentoring, behavior analysis, substance abuse services, parenting classes, child care assistance, and meal planning.

There has been a shift in beliefs about how to best support child well-being, with an emphasis on keeping children in their homes and providing the services and supports needed to enhance parenting capacity and maintain child safety. Strategies identified by CBC and DCF leadership to promote permanency include outreach and support to kinship caregivers, expediting timely adoptions, and working with the judicial system to develop concurrent strategies that support permanent living arrangements for children.

Quality of Practice Standards

Case management quality assurance data were examined and aggregated by Child and Family Services Review (CFSR) items related to assessment of needs, family engagement, and service planning and provision. Improvement was identified in seven of nine CFSR items from July-December 2008 to January-June 2010. The three CFSR items with the highest level of achievement during January-June 2010 were: services to family to protect children in the home and prevent removal or re-entry into foster care (88%), mental health of child (84.8%), and educational needs of child (82.1%). The items most in need of improvement during January-June 2010 were: relationship of child in care to parents (49.6%), caseworker visits with parents (51.6%), and physical health of child (58.6%).

Outcome Measures – Adoption and Reunification

There is a trend indicating a continuing improvement in the lead agencies' performance in child outcomes related to permanency. An examination of permanency indicators revealed that the proportion of children who achieved timely permanency through adoption finalized within 24 months significantly increased over time, from 33.6% prior to Waiver implementation to 42.5% in SFY 09-10. There was also an increase in the number of children reunified with their families of origin, from 65.3% prior to Waiver implementation to 67.5% in SFY 09-10.



Hypothesis 3

Waiver implementation will lead to changes in or expansion of the existing child welfare service array for many, if not all, of the lead agencies. Consistent with the Community-Based Care model, the new flexibility of funds will be used differently by each lead agency, based on the unique needs of the communities they serve.

Prevention of Child Abuse, Neglect and the Need for Out-of-Home Placement

Since implementation of the IV-E Waiver, every CBC lead agency has reported an expansion of services and strategies intended to prevent families with a report of abuse or neglect from requiring out-of-home placement or deeper involvement with the child welfare dependency system. The array of in-home services available to families now includes short-term crisis intervention, coordinated and intensive counseling and case management provided as frequently as needed, parent education and support, and specialized services intended for families dealing with substance abuse or domestic violence.

Primary and secondary prevention efforts, such as community education and awareness campaigns and neighborhood service centers aimed at families with no involvement in the child welfare system and those with high risk factors, have also increased.

Expansion of Family Engagement in Services Planning and Provision

The use of family team conferencing practices to involve families in assessment, planning, and service provision has continued to expand across the State, from 25% of lead agencies reporting its use at baseline to 70% reported in SFY 09-10. Survey findings indicate that lead agencies are using three primary models: family team conferencing, family group decision making, and a wraparound approach that includes the key family involvement components. The greatest variations seem to exist in eligibility criteria, the type of participant feedback that is collected, and data that is tracked concerning attendance, fidelity, and outcomes. Lead agencies indicated that the community and staff perception and buy-in related to the use of family team conferencing have improved, and benefits of

its use include helping parents to identify strengths and needs, and recognize and accept the support that is present and stay focused on achieving the family plan. Inadequate staff time and training resources, a lack of parent involvement, and limited transportation for potential family participants were reported as ongoing challenges.

Practices to assist relative and non-relative caregivers, such as relative caregiver specialists, support groups, training opportunities, and flexible funding to meet temporary needs, are reportedly more broadly available.

Furthermore, during SFY 09-10, DCF began implementing a family-centered practice (FCP) model statewide through the use of a train-the-trainer series, the integration of FCP principles into pre-service training curricula, and funding and support of FCP innovation sites.

Achieve Permanency and Reduce Lengths of Stay in Out-of-Home Care

Strategies to reduce lengths of stay in out-of-home care have not seen as significant an expansion as prevention and family engagement strategies but have still experienced an increase since Waiver implementation. For example, Family Finding, intended to increase family connections and permanency options for children in foster care and Youth Villages Intercept, an intensive in-home services program to support children and families with the transition home and into the community, are available in an increased number of service areas.

Innovative Practices

In addition to family team conferencing and Family Finding mentioned above, Solution-Based Casework, Nurturing Parenting Programs, Parenting with Love and Limits, and foster parent mentoring have been initiated or expanded since the Waiver.

Appropriateness of Services

Strategies designed to improve the efficiency and appropriateness of services include the use of resource specialists, co-location of child welfare and child protection staff, and service utilization reviews. In addition, findings indicate a growing use of interdisciplinary teams that bring specialized expertise in areas such as parental substance abuse, domestic violence, infant mental health, housing, and the educational rights of children.



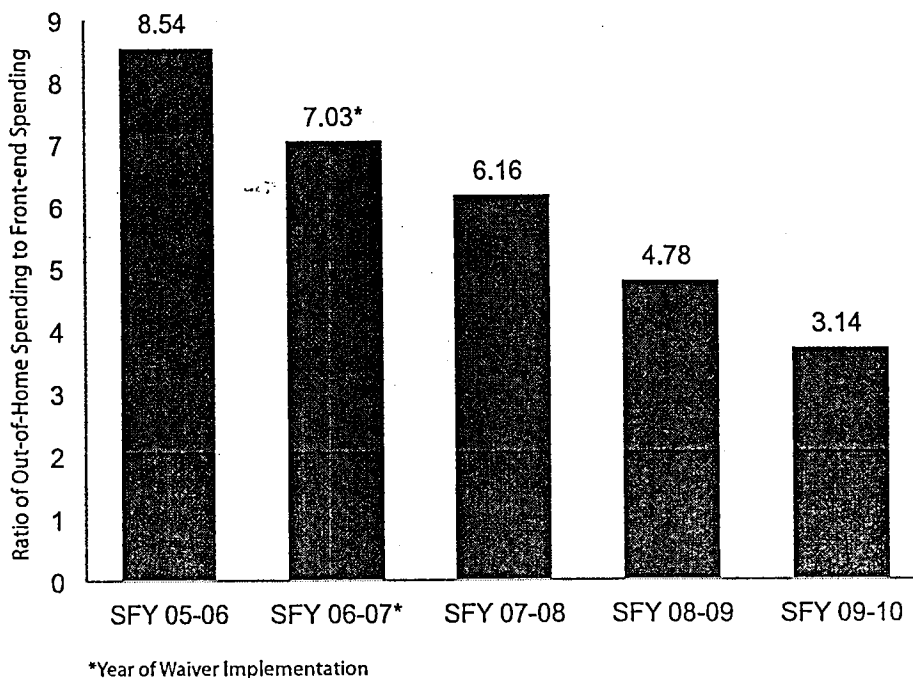
Hypothesis 4

Expenditures associated with out-of-home care will decrease following Waiver implementation, while expenditures associated with prevention and in-home services will increase, although no new dollars will be spent as a result of Waiver implementation.

Expenditures for licensed out-of-home care have dropped from \$179.5 million during the year before Waiver implementation (SFY 05-06) to \$136.7 million in SFY 09-10, a decrease of 24%. Similarly, dependency case management expenditures decreased from \$356 million during SFY 05-06 to \$316.9 million during the fourth year of Waiver implementation, which represents an 11% decrease. Consistent with our hypothesis, front-end services expenditures have increased substantially during the Waiver period, from \$21.0 million in SFY 05-06 to \$43.6 million in SFY 09-10, an increase of 108%.

In addition, the ratio of out-of-home care spending to front-end services spending has consistently and substantially decreased since Waiver implementation (see Figure 3). During the year prior to Waiver implementation, lead agencies statewide spent \$8.54 on out-of-home care services for every dollar spent on front-end services. This ratio dropped to \$3.14 in SFY 09-10, a decrease of 63% from SFY 05-06. The spending flexibility afforded by the IV-E Waiver has led to beneficial changes in Florida's child welfare spending. Expenditures for other client services, primarily for helping families complete case plans, have increased by 75% during the Waiver period. The Waiver has also helped free up additional funds for foster and adoptive parent training and maintenance adoption subsidies, both of which support higher completed adoption rates. Additional funding for independent living services for youth transitioning out of the child welfare system has been driven primarily by the Waiver.

Figure 3. Ratio of Out-of-Home Care Expenditures to Prevention/Diversion/Family Preservation/In-Home Expenditures by State Fiscal Year



Conclusion

As indicated in this brief, DCF and the CBCs have made substantial progress towards safely reducing the number of children in Florida's child welfare system in out-of-home care. Lead agencies are shifting resources to the front end of the system and into diversion and early intervention services. Practice-level changes include a shift towards family-centered practice principles and models as well as innovations in early intervention and diversion services.

This brief also addresses whether and in what ways the profile of children served in out-of-home settings has changed over time as the number of children in out-of-home care decreases. Although, in general, similar profiles emerged in both SFY 05-06 and SFY 08-09, the distinguishing characteristics and/or size of the groups changed. More analysis is

needed to further distinguish the key characteristics of these children and their service needs.

In addition, findings indicate that the spending flexibility afforded by the IV-E Waiver has led to beneficial changes in Florida's child welfare spending and has also allowed for additional funds to be used for foster and adoptive parent training and maintenance adoption subsidies, both of which support higher completed adoption rates. Additional funding for independent living services for youth transitioning out of the child welfare system has been driven primarily by the Waiver.

In summary, this brief illustrates the strong progress that Florida's child welfare system has made in achieving the goals outlined in the evaluation hypotheses. Renewal of the Waiver for a five-year period will give Florida the time needed to focus energy on critical practice improvement areas.



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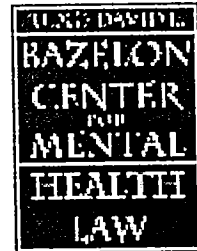
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MERGING SYSTEM OF CARE PRINCIPLES WITH CIVIL RIGHTS LAW
Olmstead Planning for Children with
Serious Emotional Disturbance

Questions, Answers and Recommendations
for State Policymakers and Advocates

Bazelon Center for Mental Health Law
November 2001



This document was developed by the Bazelon Center for Mental Health Law for the Targeted Technical Assistance project of the National Association of State Mental Health Program Directors (NASMHPD) and the Division of State and Community Systems Development (Mental Health Block Grant) of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

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Olmstead Planning for Children with Serious Emotional Disturbance: Merging System of Care Principles with Civil Rights Law

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Olmstead Planning for Children with Serious Emotional Disturbance: Merging System of Care Principles with Civil Rights Law

Introduction

Children with serious emotional disturbance have the civil right to receive services in the most integrated setting appropriate to their needs.¹ They further have the human right to be raised in their families and communities, with their individual needs guiding the service array provided. These civil and human rights are embodied in the Americans with Disabilities Act (ADA) and the values and principles of the System of Care.²

The Supreme Court held, in *Olmstead v. L.C.*, that under the ADA, it is discrimination for a state needlessly to institutionalize an individual with a disability. The court specifically noted that one way states can show they are meeting their obligations under the ADA is to have a comprehensive, effectively working plan to serve people in the most integrated setting appropriate to their needs. Based on this suggestion, almost all states have begun Olmstead planning. Unfortunately, little effort has been made to include children with serious emotional disturbance in meaningful ways.

In addition to the ADA, the System of Care principles and values describe an appropriate children's mental health service system. The System of Care was developed in the 1980s to ensure appropriate services and supports for children with serious emotional disturbance, most of whom receive services from multiple agencies.³ One of the principles calls for children to be served in the least restrictive setting that meets their needs. These principles have generally been accepted by the mental health professional community as the standard of practice for children's mental health care. Implementation, however, has lagged behind and generally been limited to select sites.

For many children, these rights and principles exist only on paper. To quote the Surgeon General's Conference Report on Children's Mental Health, "the nation is facing a public crisis in mental health care for infants, children and adolescents."⁴ This neglect of children with severe mental health needs has tragic policy and personal consequences:

1) The emerging problem of "stuck kids"

In many states, children remain "stuck" in emergency rooms, hospitals and residential treatment facilities because intensive community-based

Unfortunately, in states' Olmstead planning, little effort has been made to include children with serious emotional disturbance in meaningful ways.

**"It is a national tragedy that American parents feel forced to have their children locked up simply in order to obtain desperately needed mental health services."
Paul Wellstone**

services are unavailable or unaffordable. For example, a June 2000 *Boston Globe* article documented a growing problem in Massachusetts, where children are remaining in hospitals long after their discharge date because of a lack of alternatives. A Massachusetts State Senator quoted in the article said, "These kids aren't stuck. These kids are imprisoned and the Commonwealth is violating their civil rights."⁵ The phenomenon is not limited to Massachusetts. Over the past five years, Yale-New Haven Hospital's emergency room in Connecticut has seen a nearly 60-percent increase in acute psychiatric cases. These children remain as "boarders" in the emergency room because appropriate placements and services are unavailable. A psychiatrist who presented the data at a conference received confirmation from her colleagues that this is, in her words, "a nationwide epidemic."⁶ It is also extremely costly. A recent study from Nebraska concluded that the state could save \$6.5 million if it efficiently moved children with mental health needs to appropriate less restrictive placements.⁷

2) Relinquishment of parental custody in order to access services

We have addressed this issue in great detail elsewhere, but it is unconscionable that in at least half the states, families are being told to give their children up to the child welfare system in order to access mental health care.⁸ The National Alliance for the Mentally Ill (NAMI) reports that approximately one in five families of children with serious emotional disturbance were told to give up custody of their child to the state to get help.⁹ With federal enactment of the Adoption and Safe Families Act, these parents risk losing their children permanently.¹⁰

3) Criminalization of children with serious emotional disturbance

The same NAMI report confirms that parents are also told to call the police and turn their children over to the juvenile justice system to get mental health care. Thirty-six percent of the families surveyed reported that their children were placed in juvenile justice because needed services were not available.¹¹ A Florida mental health advocate with the Broward Public Defender told *The Miami Herald* that "when law enforcement tells parents they have to have their kids arrested in order to access treatment, that unfortunately is the truth. The shameful truth."¹² In some states, children who are in acute need of psychiatric care are actually placed in facilities intended for juvenile offenders because no hospital psychiatric crisis bed is available.¹³ "It is a national tragedy that American parents feel forced to have their children locked up simply in order to obtain desperately needed mental health services," says Paul Wellstone, the Democratic Senator from Minnesota. "This is a horrendous symptom of the discrimination against mentally ill children rampant in our health care system today."¹⁴

This paper highlights the need for Olmstead efforts to address this discrimination by focusing specifically on children with serious emotional disturbances. It begins with a brief discussion of the *Olmstead* decision and

principles to guide an Olmstead planning process. It then sets forth the values and principles of a System of Care. It outlines the current status of Olmstead planning for children before setting out some questions that must be answered in developing a comprehensive plan for children that is responsive to their civil and human rights.

The document is designed to give some guidance to family advocates and state policymakers interested in statewide, systemic reform. It is our hope that they will use it to expand and guide their efforts to ensure that children are not left behind in the civil rights movement on behalf of individuals with disabilities.

Overview of the *Olmstead* Decision and the Principles of a Comprehensive Plan for Implementation

Two adult women with mental retardation and mental illness brought suit against the state of Georgia, claiming that they were being needlessly segregated in institutional settings in violation of the Americans with Disabilities Act. They prevailed in the lower courts and Georgia sought and was granted review by the United States Supreme Court.

The Supreme Court held first that “unjustified institutional isolation of persons with disabilities is a form of discrimination.”¹⁵ The court reached this conclusion based on two principles: 1) such institutional placement “perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life”; and 2) confinement in an institution “severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”¹⁶

Although the *Olmstead* case involved two adult women, the reasoning is perhaps even more applicable to children. Needlessly segregating children contributes to the stigma and stereotype that they are bad children with bad parents who are not worthy of participating in their home communities. Placing children in institutions also cuts off their ability to participate in family outings, religious services, community activities, cultural enrichment and educational opportunities. Most important, needless confinement severely hampers family relationships, which are critical to mental health and development.

After finding that needless institutionalization is discrimination, the Supreme Court noted that states could defend against such a claim if they could show that providing services in a more integrated setting would be a fundamental alteration of the state’s program.¹⁷ In discussing fundamental alteration, the court recognized that states need some leeway to maintain the range of facilities needed and to administer services with an even hand. It stated that “if, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved

at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated, the reasonable modification standard would be met."¹⁸

The decision did not elaborate on the components of a "comprehensive, effectively working plan." However, the federal government has given states some guidance on that issue. In a letter to state Medicaid Directors dated January 14, 2000, the Center for Medicaid and State Operations within the then Health Care Financing Administration and the Office of Civil Rights provided some initial technical assistance recommendations on developing a plan.

Six principles are set forth in that document:

- 1) Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings.
- 2) Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.
- 3) Take steps to correct current and future unjustified institutionalization of individuals with disabilities.
- 4) Ensure the availability of community-integrated services.
- 5) Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.
- 6) Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

System of Care Values and Principles

The values and principles of a System of Care (see box opposite) are similar to those needed for an effective plan, with additional emphasis on the unique relationship between children and families, the role of multiple agencies in addressing children's needs, the importance of early identification and intervention, and the need to plan for transitions from childhood to adulthood.¹⁹ First elaborated in 1986, the System of Care is widely accepted in the literature and among mental health professionals as the guiding philosophy for providing mental health services for children with serious emotional disturbances.²⁰

However, in practice, most systems of care have been created in select communities. For example, the Robert Wood Johnson Foundation, the Center for Mental Health Services within the Substance Abuse and Mental Health Administration, and the Anne E. Casey Foundation have each administered grant programs in specific sites. These extensive grant programs have yielded much information on best practices, but generally have not led to systemic or statewide reforms. Olmstead planning represents an opportunity to incorporate System of Care values and principles into widespread reform efforts.

Olmstead planning represents an opportunity to incorporate System of Care values and principles into widespread reform efforts.

System of Care Values and Principles

Core Values:

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

Guiding Principles:

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

The Current Status of Olmstead Planning for Children

According to the National Council of State Legislatures (NCSL), Olmstead planning is underway in some 40 states.²¹ However, NCSL's report does not discuss planning for children's services. A review by the

National Association of State Protection and Advocacy Systems (NAPAS) suggests that efforts on their behalf lag behind. NAPAS recently surveyed disability advocates²² and found that out of 18 states²³ responding, only four²⁴ used a needs assessment specifically designed for children. Only three states²⁵ were including children soon to leave the school system in their planning efforts. Only three states²⁶ cover children in the foster care system and not a single state plan addresses the needs of children soon to leave detention or juvenile justice centers. Furthermore, only half of the states responding to the survey²⁷ indicated that children in residential treatment centers were specifically identified and addressed by the state plan.

NAPAS has collected state planning documents since the Olmstead decision. We reviewed those documents in preparation for this report and our findings confirm the survey. Very little attention is given to serving children in less restrictive settings, with few details and little recognition of the multiple agencies currently serving children with serious emotional disturbances. The few exceptions to this general rule are highlighted below as models for other states as they continue their planning efforts.

Some Questions to Ask About Olmstead Planning for Children

Combining the Olmstead and System of Care principles, we have devised a set of questions for state policymakers and advocates to consider when evaluating the adequacy of their state Olmstead plan for children with serious emotional disturbances.

1. Are youth with serious emotional disturbance, their families, and child advocates full participants in the Olmstead planning process?

Both the Olmstead and the System of Care principles call for full participation by youth and their families in all aspects of service delivery and planning, which should include system planning. Many of the state planning documents reviewed do not indicate the involvement of child and family advocacy groups in the Olmstead system-planning process. The University of South Maine, however, conducted focus groups of parents with children with special needs to better inform the Olmstead planning process in that state.²⁸

Recommendation: States should make every effort to include representatives from family organizations such as the Federation of Families for Children's Mental Health and the local affiliates of NAMI's Child and Adolescent Network, as well as some youth or young adults themselves, who can give input into planning. Members of other child advocacy groups and individuals from a mental health advocacy organization, such as a chapter of the National Mental Health Association, who have a particular knowledge of and interest in children's issues should also be included in planning. To supplement actual participation by families and youth in the

planning process, states should consider holding focus groups of families and youth to get information on the current barriers and strengths of the mental health service system for children with SED.

2. Does the plan identify the number of children in needlessly segregated settings or at risk of entry into these settings?

Both the Olmstead and the System of Care principles recognize that children should be served in the most integrated setting. The System of Care principles also note the multiagency involvement of many of these children. Accordingly, the plan should identify the number of children who are at risk of placement or currently placed in needlessly segregated settings by education, mental health, child welfare and juvenile justice agencies. It would be particularly useful to have estimates of the number of children who have been placed inappropriately in child welfare and juvenile justice because of mental health treatment needs and data on children who are in those systems appropriately but are currently placed in needlessly segregated settings. In reviewing state planning documents, we found no plans that included such an analysis and few plans that included data on the at-risk population or on children who are dually diagnosed (developmental disability and serious emotional disturbance or substance abuse and serious emotional disturbance).

Some states' plans do contain estimates of children in particular systems who were in restrictive settings. For example, Indiana had developed an Olmstead data-collection tool for all of its agencies. The Division of Mental Health completed the tool and included an attachment with a chart of children and adolescents in institutional care vs. community care.²⁹ In an Olmstead working document, Connecticut's Department of Children and Families noted that it served approximately 750 children and youth in residential settings as of April 2000, and approximately 20 percent (150) could be served in more integrated settings.³⁰ In the Working Plan for the State of Missouri, the Department of Mental Health noted that 76 children under 18 were currently in residential treatment and 49 were in non-institutional community-based residential settings, such as their natural home, independent apartments or supported living. Although the department did not indicate how many of the children in more restrictive settings could be placed in the community, it was asking for additional appropriations to fund community-based services for children with serious emotional disturbances and those dually diagnosed with both developmental disabilities and SED.³¹

Recommendation: Olmstead plans for children with SED should include data on the current number of children in each system (education, mental health, child welfare and juvenile justice) who are placed in restrictive settings and the number who could be served in more integrated placements. It should also include data on the number of children at risk of institutional placement and the number of children who have been inappro-

States should make every effort to include representatives from family organizations in their Olmstead planning, along with some youth or young adults themselves.

priately placed in child welfare and juvenile justice because mental health treatment was not available. Finally, there should be a clear explanation of how the data were gathered.

Admittedly, it may be difficult to obtain accurate data because children are served by several systems, each with its own approach to record-keeping. It would therefore be necessary, in planning, to identify barriers to data collection and then explore ways to obtain the data needed for Olmstead implementation.

3. Does the plan describe an assessment process specifically designed for children and their families and for the purpose of ascertaining what is needed for the child to live in the community?

The System of Care principles emphasize the importance of providing individualized services in accordance with the unique needs and potential of each child. Implementing *Olmstead* also requires a process for identifying individual strengths and needs. The assessment process for children with serious emotional disturbance has generally been problematic because of its exclusive focus on instruments that will calculate the degree of impairment, rather than ascertaining what is needed to serve a child in the most integrated setting.

The Surgeon General's report points out that "much of the mental health world operates from a deficit perspective, requiring families to prove their needs, rather than strengths, to get services."³² There are a number of possible explanations for this, including the stigma of SED, the training of mental health providers, the negative circumstances associated with coming into contact with child welfare and juvenile justice, and the requirements to qualify for state-funded services and Medicaid services under options and waivers.³³ Generally, families must establish that children meet an institutional level of care, which has often been defined by looking at deficits.

According to a recent report by the National Institute of Mental Health (NIMH), another problem in assessment of children with SED is that "assessment of functioning has lagged behind assessment of clinical symptoms."³⁴ The report notes that functional assessments are particularly critical for children because symptoms are often complicated by the rapid developmental processes and do not fit into categorical classifications of mental disorders. Moreover, social, cultural, psychological and other factors influence children's experience and reporting of symptoms and current assessment processes does not capture this well.³⁵

Few state planning documents discuss an assessment process for children. Those that do tend to use specific instruments, which should be analyzed to determine whether they adequately focus on strengths and determine what is needed to serve children with SED in the most integrated setting appropriate. Indiana is developing an assessment tool for children (HAPI-C), similar to the current tool used for adults, the HAPI-A, described as a "health related quality of life instrument for people with

Olmstead plans should include data on the number of children at risk of institutional placement and the number who have been inappropriately placed in child welfare and juvenile justice because mental health treatment was not available.

mental illnesses and addictions.” The HAPI-C is designed to provide a level-of-functioning component and clinical-outcome data.³⁶ North Carolina’s plan indicates that it will use the Child and Adolescent Level of Care Utilization System (CALOCUS), a standardized assessment protocol developed by the American Association of Community Psychiatrists, to assess first a 10-percent sample of residents of schools for children with serious emotional disturbance and state psychiatric institutions and then the entire population of these facilities. Importantly, the state intends to use a similar process for children at high risk of institutional placement.³⁷ Maine is using three assessment instruments: the CALOCUS, supplemented when appropriate by the Child and Adolescent Functional Assessment Scale (CAFAS) and the Behavioral and Emotional Rating Scale (BERS), used to measure emotional and behavioral strengths.³⁸ A report from South Carolina addresses the at-risk population by suggesting that Medicaid’s Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) should be expanded to include a more comprehensive behavioral assessment in the screening, to facilitate earlier identification of children with these disabilities and the early provision of appropriate services.³⁹

Recommendation: The assessment process should focus on what is needed for an individual child to receive community-based services. It is important to keep in mind that the Olmstead obligations are not synonymous with requirements for Medicaid and state funding. Moreover, to the extent that funding is relevant, states have much flexibility in determining the child’s level of care and can use a balanced approach to achieve the objective of providing and funding community-based services.

Further analysis is needed to develop and circulate useful assessment processes for children with SED to determine what is required to serve them in the most integrated settings appropriate. Such assessments should include: 1) first and foremost, a focus on the child and family, emphasizing their strengths and an understanding of their cultural issues, through a process that values and centers on their input; 2) an evaluation of what would be required for the child to function at home, at school, with peers, in social activities, etc.; 4) age-appropriate questions; and 5) inclusion of any co-occurring issues, such as developmental disability or substance abuse.

The Office of Civil Rights at the Department of Health and Human Services (OCR) is developing some guidance on assessment parameters for all populations of people with disabilities. Given the problems and paucity of tools identified above, it would be very helpful if OCR or another federal agency, such as the Center for Mental Health Services, provided resources for the development of guidelines specifically for a comprehensive Olmstead assessment process for children with SED. These parameters should focus on information that should be gathered to determine how to serve the particular child in the community. To the extent that states prefer to use a specific assessment tool, one should be developed or recommended specifically for Olmstead implementation, i.e. determining what services

The assessment process should focus on what is needed for a child to receive community-based services. Given the problems and paucity of tools, it would be very helpful if a federal agency provided resources for the development of guidelines specifically for a comprehensive Olmstead assessment process for children.

and supports are needed to serve the child with SED in the most integrated setting. This effort can build on the current research analyzing and promoting strengths-based instruments for other purposes.⁴⁰

4. Does the plan discuss treatment planning and offer children and families choices about services?

The Olmstead and System of Care principles indicate that families and children should be full participants in all aspects of planning for the services to be provided to them. The Surgeon General's Report notes the importance of "includ[ing] youth in treatment planning by offering them direct information, in developmentally appropriate ways, about treatment options. As much as possible, allow youth to make decisions and choices about preferred intervention strategies."⁴¹

Few state planning documents discuss treatment planning and options for children and families. Washington planning documents, however, indicate that youth who are involved in the child welfare system participate in service planning and sign the treatment plan.⁴²

As noted above, focus groups of parents of children with special needs, including mental health, were conducted in Maine as part of an Olmstead planning process. These focus groups stressed the importance of choice and indicated that parents were "very satisfied with programs that allowed them to hire in-home support staff, such as behavioral specialists or personal care attendants (PCA) for their children."⁴³

The Maine focus groups also highlighted many problems with treatment planning that should be addressed in an Olmstead plan. Parents reported frustration with the fragmented service system. Families had to repeat information to various providers and agencies and wondered why the information was not better coordinated. Parents also had to use their informal networks to find the name of a provider who was reliable, and they learned "key phrases" to use when asking providers how to access services. The parents found that even health professionals were uninformed about most disabilities and many traveled out of state to get help because of the dearth of services. For example, Maine only has one pediatric neurologist.⁴⁴

Indiana's planning document recognizes the importance of choice for families and the need to specify state activities to address this issue. The document notes that parents have almost no choice in institutional placements, which are geographically determined by region of residence. They also have had limited choice of community services because services were also allocated by geographic area, called catchment areas, and provided by a local community mental health center. Indiana has broken down these geographic boundaries, added providers outside the mental health centers and allowed consumers to choose other providers. The state is also taking specific action:

To ensure that families are aware of the choice that they have available to them and to ensure that they have the information they need to participate in their own treat-

Indiana's planning document recognizes the importance of choice for families. Its plan has broken down existing geographic boundaries, added providers outside the mental health centers and allowed consumers to choose other providers.

ment and recovery, the Division is entering into an agreement for Consumer Counseling services. This counselor will be responsible for providing information and choice to all consumers of community based services.⁴⁵

Recommendation: Advocates and policymakers should evaluate the extent to which Olmstead plans specifically document the degree to which families and children (at age-appropriate levels) have adequate choice in providers and services. It is also important for the plan to address how families and children will have input in the treatment planning process itself (including accommodating language and other barriers to participation), and whether the treatment planning process is integrated across agencies. If there are deficits in any of these areas, the plan should include specific steps to remedy the problems.

5. Does the plan provide for transitions throughout childhood and between childhood and adulthood?

An NIMH report summarized this principle: "Childhood is characterized by change, transition, and reorganization; understanding the reciprocal influences between children and their environments throughout the developmental trajectory is critical."⁴⁶ The System of Care principles note the importance of ensuring smooth transition to the adult system.

Very few plans specifically address transitional issues. Indiana's planning document notes that the lack of specific services available for children transitioning into adulthood was one of the most significant barriers identified during the Olmstead needs-assessment process.⁴⁷

An Illinois document discusses the requirements under the Individuals with Disabilities Education Act for transition planning in an IEP beginning at age 14.⁴⁸ It also recommends that the state fund and support increased transition-assistance programs so that "young people with disabilities and their families gain the knowledge and skills that they need to achieve a positive transition to the community."⁴⁹ Missouri's plan also cites the lack of involvement of schools in transition planning as a barrier; the plan recommends additional funding and a mandate for school districts to meet the requirements of the Olmstead decision.⁵⁰

A South Carolina report discusses the need to strengthen transitional planning for children who are returning to the community to include family and natural support-system members and representatives from all agencies providing services, including education and vocational rehabilitation. The report notes the need to take into account the impact on the family of the child's return home and suggests that any plan should include resources to support the family in the transition.⁵¹

Recommendation: Advocates and policymakers should assess whether the Olmstead plan documents the extent of transition planning and services in all of the agencies that serve children, any barriers to transitioning and the

A South Carolina report discusses the need to strengthen transitional planning for children who are returning to the community to include family and natural support-system members and representatives from all agencies providing services, including education and vocational rehabilitation.

specific steps to address the barriers or deficits. Transition planning should include all significant changes— i.e. preschool to kindergarten, grade school to middle, middle to high, developmental transitions, changes in placements and the transition to adulthood.

6. Does the plan discuss the development and funding of an adequate service array?

Several plans note the need for more of a particular service. Maine gives the number of children on wait lists for several services: case management, residential treatment, respite and recreational services.

According to a recent NIMH study, "the lack of availability and infrastructure support for treatments, prevention programs, and services is as high as it was in the early 1980s."⁵² Both the Olmstead and the System of Care principles require a full array of available community-based mental health services needed to serve children appropriately. Accordingly, it is essential for Olmstead plans to evaluate the service array as well as the infrastructure support and financing issues.

None of the plans reviewed for this report undertakes a thorough analysis of the service array or gives concrete information and data on the availability of each service. Several note the need for more of a particular service, most often respite care for families.⁵³ Maine gives the number of children on wait lists for several services: case management, residential treatment, respite and recreational services.⁵⁴ A report from South Carolina notes shortages in a number of mental health services for children, including: behavioral support personnel trained in appropriate functional assessments; development of behavior support plans; training for staff and families as they implement the plans; counseling; and psychiatric services. The report also documents the lack of supports statewide to allow children to take part in social, recreational and vocational activities essential to their development, staff trained to assess, identify and work with children with co-occurring disorders, wraparound-service workers statewide, and trained school personnel to work with children with SED.⁵⁵

Many of the plans that include children with serious emotional disturbance note the need for additional funding of community-based services for this population. Indiana's planning document states that lack of funding is the most significant barrier to Olmstead implementation.⁵⁶ Missouri notes that the Division of Mental Health has requested significant additional funding for services and supports to help families keep their children with SED at home and to expand the availability of treatment family homes in order to provide a home-like setting for children who must be removed from their own homes for a period of time.⁵⁷ Missouri's planning document also discusses a joint request for funding from the Division of Comprehensive Psychiatric Services and the Division of Mental Retardation and Developmental Disabilities (MRDD) to address the current lack of appropriate treatment alternatives for children who have developmental and mental health disorders.⁵⁸

A few of the documents specifically address some of the funding sources for additional mental health services. Missouri's analysis states that it is considering the efficacy of a waiver for children with mental health and

substance abuse needs.⁵⁹ It further notes that Missouri currently has a waiver to disregard parental income, but it is only utilized in the Division of MRDD and serves only 200 children. The state is considering exercising the TEFRA 134 option (also known as the Katie Beckett option), a Medicaid option that would allow the state to disregard parental income for any child with a disability and allow that child to live at home with appropriate Medicaid services.⁶⁰ The Maine focus groups noted the critical importance of the TEFRA 134 option for allowing children with inadequate private insurance to avoid institutionalization and get services in the community. One parent stated, “Katie Beckett coverage was a life-saver, without it my child would not have been able to get any counseling at all.”⁶¹

Recommendation: Advocates and state policymakers should review whether the Olmstead plans have a full discussion of the array of mental health services in the state and their availability throughout the state, particularly in rural areas.⁶² The plan should note whether there are wait lists, either actual or in effect, and time lags in accessing services. It should address relevant workforce issues, such as the difficulties in finding and retaining behavior aides and respite workers.⁶³ It should also detail financing, including a consideration of all of the possible means for securing additional funds through waivers, options, parity laws and other methods.

7. Does the plan ensure that high quality services will be available?

The Olmstead and System of Care principles require that children receive services to address their needs appropriately. This includes effective services delivered in a culturally competent manner.

NIMH recently commissioned an exhaustive study to set forth a research agenda for children’s mental health. The report analyzes all of the research findings on the efficacy of particular mental health treatments. It concludes that “most of the services available in most communities have no empirical evidence.”⁶⁴ Yet the availability of effective interventions across the country is minimal.⁶⁵

The report states that “treatments with strong evidence for youth with severe emotional disorders include multisystemic therapy,⁶⁶ intensive case management, and treatment foster care; for a number of other treatments (e.g. mentoring, family education and support), there is at least one randomized clinical trial.⁶⁷ Moreover, an important body of research is uncovering ineffective treatments. These include peer group-based interventions among high-risk adolescents, nonbehavioral psychotherapies, group homes and inpatient hospitalizations (improvements are not maintained after a child is returned to the community).⁶⁸

The state planning documents reviewed do not specifically address the relative availability of effective and ineffective treatments. Nor do they discuss training of staff and providers to encourage use of effective treatments. Some plans, however, do indicate a need to increase treatment

Missouri is considering the use of waivers and options that would allow the state to disregard parental income for any child with a disability and thus enable that child to live at home with appropriate Medicaid services.

foster homes, one of the services found effective for children with SED.⁶⁹

For services to be appropriate, they must be effective and culturally competent. The state planning documents generally do not assess the availability of culturally competent providers and services, including those who speak different languages or use sign language.

Recommendation: Although there is a need for further research measuring the effectiveness of particular treatments, Olmstead plans should reflect current knowledge. Plans should assess the availability of the most and least effective services and specify how resources will be adjusted to provide more of the effective services and less of the others. The plans should also address the availability of culturally competent services and steps that will be taken to develop them where needed.⁷⁰

Plans should assess the availability of the most and least effective services and specify how resources will be adjusted to provide more of the effective services and less of the others.

8. Does the plan provide for quality improvement and data to track the outcomes that are important to children and families?

Olmstead principles state that quality assurance, quality improvement and sound management should support implementation of the state’s plan. There is a critical shortage of data at the federal and state level that would allow for any analysis of progress under *Olmstead* in serving children in the most integrated setting. For example, there are no federal data on the number, percent and growth of residential vs. community-based services. The categories of Medicaid services that can be tracked are too general to allow for analysis of particular services such as residential treatment or behavioral health aides. Similarly, the state Olmstead planning documents did not track the number of children receiving institutional vs. community care, receiving particular types of treatment, and remaining on wait lists for services over time. This information will be critical to determine whether Olmstead planning is effective in achieving the goals of allowing more children to live in the most integrated setting appropriate to their needs.

A number of outcome indicators have been identified to assess the impact of the systems of care for children with SED and their families. These include the effect on: 1) out-of-home and out-of-community placements; 2) utilization of restrictive service options, including inpatient and residential treatment, and increased use of less restrictive placements and services; 3) youngsters’ functioning; 4) educational status; 5) law enforcement status; 6) family involvement; 7) satisfaction with services; 8) access to services; and 9) costs.⁷¹ The state planning documents reviewed did not adequately discuss or plan for measuring these or similar outcomes over time. Quality-assurance efforts discussed were often limited to licensing and accreditation and outcomes were often measured by performance on particular tests, such as the Child Behavioral Checklist (CBCL) or Child and Adolescent Functional Assessment Scale (CAFAS).

Recommendation: Olmstead plans should discuss quality assurance and outcome measures for ensuring that children are receiving services in the

most integrated setting appropriate for their needs. Data should be compiled and reported in a way that allows both the state and all stakeholders to track progress in moving children to less restrictive settings and enabling them to achieve true community integration in school and at home, and outside of the criminal justice system.

9. Does the plan specifically address the challenges of multi-agency involvement in children's lives?

System of Care principles emphasize that children with SED should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services. Such linkages would reduce the incidence of children's being taken from their families and communities and entering child welfare and juvenile justice systems to get access to mental health services—services that, even in these systems, are usually in short supply.

There is little detail on interagency planning and development efforts in state planning documents. A few plans mention specific interagency initiatives to address service delivery, but do not give much information. For example, Arizona's draft Olmstead plan discusses a single joint purchase-of-care (SPOC) process, developed in collaboration between the Department of Economic Security, the Department of Juvenile Corrections and the Administrative Office of the Arizona Supreme Court to streamline the purchasing system of behavioral health care for children.⁷² An Arkansas report of the Olmstead Working Group mentions Together We Can, an interdepartmental program that includes education, health and human services and integrates agencies based on local teams. Counties must choose to participate and, to date, 22 local teams are working to ensure that community-based services are available to children with behavioral health needs.⁷³ Iowa notes that it is holding a series of facilitated work groups to develop a cross-agency action plan to improve availability of and access to mental health services.⁷⁴ A South Carolina report suggests increased inter-agency coordination using existing programs, such as the Interagency System of Care for Emotionally Disturbed Children teams, to regularly staff children in institutional settings or at risk of placement into such settings.⁷⁵

It is important for Olmstead plans to reflect the relationship between agencies and the fact that children seeking mental health services now often become part of a particular system as a matter of chance, not need.

Recommendation: Children with serious emotional disturbance have significant multi-system involvement. It is important for Olmstead plans to reflect the relationship between agencies and the fact that children seeking mental health services now often become part of a particular system as a matter of chance, not need. Juvenile justice and child welfare placements often remove children from their homes and communities, and Olmstead plans should assess the degree to which children are being placed in these systems because of the lack of mental health services. Because all children should be receiving an education, an Olmstead plan should also assess the coordination and availability of educational services with those provided by other agencies.

Conclusion

Steven Hyman, Director of the National Institute of Mental Health, said it best when describing the state of children's mental health services:

There is a terrifying gap between what we do know and how we act, between the services we could offer and those we do offer, and between what families can afford and what families can access.⁷⁶

The Olmstead planning process provides a unique opportunity to address these gaps. Using the System of Care principles that have been developed and widely accepted in the children's mental health field and the Olmstead principles set forth by the federal government, stakeholders and states should create a plan for systemic change in children's mental health. Dr. Bernard Arons, Director of the Center for Mental Health Services, used the analogy of a surfer treading water in the ocean, waiting for the right wave to come along. "That wave is here," he said, "particularly for children's mental health."⁷⁷ The Olmstead planning process can and should be the wave carrying children with serious emotional disturbances to shore. It is a matter of human and civil rights.

Notes

1. The Supreme Court stated that individuals have such a right unless the state can show that implementation would be a fundamental alteration. *Olmstead v. L.C.*, 119 S.Ct. 2176, 2188 (1999).
2. Children also have rights under the Individuals with Disabilities Education Act (IDEA), including the right to services in the least restrictive setting appropriate for the child.
3. Stroul, B. & Friedman, R. A System of Care for Children with Severe Emotional Disturbance (1986). The System of Care principles and values were developed for the Child and Adolescent Service System Program (CASSP), currently administered by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration. Children's Mental Health: Creating Systems of Care in a Changing Society, Stroul, ed. (1996) at xxii.
4. *Report of the Surgeon General's Conference on Children's Mental Health* (2000) at 13.
5. Knox & Demner, "Trapped in a Mental Ward: State Lacks Programs for troubled youth," *The Boston Globe*, June 4, 2000 at A1.
6. *Id.* *The Washington Post* confirmed this by noting that at Johns Hopkins Hospital in Baltimore, visits to the ER by youngsters in psychiatric crisis have tripled and at Children's National Medical Center in Washington DC, admissions have doubled in the past year. Trafford, A. "Boarder Kids, on the Edge," *The Washington Post*, Health Section, June 27, 2000 at 25.
7. Larzelene, R., Chmelka, B. & Irvine, R. "Shrinking Treatment Capacity in Nebraska: Program, Treatment and Financial Implications." Presentation, October 5, 2001, Child & Family Coalition of Nebraska Conference.
8. Bazelon Center for Mental Health Law, *Relinquishing Custody: The Tragic Failure to Meet Children's Mental Health Needs* (1999).
9. National Alliance for the Mentally Ill, "Families on the Brink" (1999) at 10.
10. This statute is designed to move children quickly to permanency and imposes

very strict deadlines for considering whether to terminate parental rights. Although parents can argue that their child meets one of the statutory exceptions, the court makes the final decision.

11. *Id.*
12. Miller, "Parents: System Promised Help, Instead Delivers Harm," *The Miami Herald*, June 29, 2000 at 1A.
13. Knox & Demner, *Boston Globe*, June 4, 2000 at A1.
14. Cusak, "Arrest My Kid, He Needs Mental Health Care," *The Progressive*, 2001. <http://www.progressive.org/amc0701.html>
15. 119 S.Ct. at 2187.
16. *Id.*
17. 119 S.Ct. at 2188.
18. 119 S.Ct. at 2189.
19. Stroul, B. & Friedman, R. A. *System of Care for Children and Youth with Severe Emotional Disturbances* (1986).
20. Stroul, B., *Children's Mental Health: Creating Systems of Care in a Changing Society* (1996) at 3.
21. National Conference of State Legislature, *The States' Response to the Olmstead Decision: A Status Report* (March 2001), indicating that 40 states have Olmstead task forces, of which several are opting to engage in activities to expand community-based services without developing a formal plan, and 14 states now have finalized plans or working drafts (available at www.ncsl.org/programs/health/Forum/olmsreport.htm). Updates to the report are expected in December 2001 or January 2002.
22. Priaux, E., National Association of Protection and Advocacy Systems, *Olmstead Progress Report: Disability Advocates Assess State Implementation After Two Years*, at 12.
23. Alabama, Arizona, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Maryland, Massachusetts, Missouri, Montana, Ohio, Rhode Island, South Carolina, Texas, Washington and Wisconsin.
24. Indiana, Maryland, South Carolina and Wisconsin.
25. Colorado, Indiana and Texas.
26. Indiana, Maryland and Wisconsin.
27. Alabama, Georgia, Indiana, Maryland, Missouri, Rhode Island, South Carolina, Texas, Washington and Wisconsin.
28. Ormond, Ziller & Richards, *Living In the Community: Voices of Maine Consumers*, Institute for Health Policy (2001). South Carolina's Department of Mental Health Workgroup also conducted focus groups around the state. South Carolina Home and Community-Based Services Task Force Report (Aug. 31, 2001) at I-3.
29. Indiana Division of Mental Health, *Olmstead Data Collection Tool, SED Children and Adolescents at Attachment V. North Dakota's Olmstead Work Group White Paper* also details the number of children in out-of-home placement (1,720 unduplicated youth per year) and the percentage in residential treatment (35%) and family homes (65%). White Paper (November 6, 2000) at 9.
30. DSS Working Document, "Choices are for Everyone: Continuing the Movement Toward Community-Based Supports in Connecticut" (September 12, 2000) at 19. A working document from Washington State's Department of Social and Health Services Children's Administration indicates that 30-40 of the children in their care are ready to return to their own homes or community-based settings, are ready to enter foster care from an institution, or are at risk of institutionalization. *Olmstead Planning Document* at 6.

31. Working Plan for the State of Missouri (December 29, 2000), Activity 1 at 7-8; Activities 6 and 7 at 40.
32. *Report of the Surgeon General's Conference on Children's Mental Health* (2000) at 33.
33. Caldwell, B., Lezak, A., MacBeth, G., & Newton-Logsdon, G., *Overcoming Barriers to Serving Our Children in the Community: Making the Olmstead Decision Work for Children with Mental Health Needs and Their Families* (draft of September 10, 2001) at 27.
34. The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Development and Deployment, "Blueprint for Change: Research on Child and Adolescent Mental Health" (2001) at 46. Hereinafter, "Blueprint for Change."
35. *Id.*
36. Indiana Division of Mental Health, Olmstead Data Collection Tool, SED Children and Adolescents at 12.
37. *Serving Persons with Disabilities in Appropriate Settings: the North Carolina Plan* (Dec. 28, 2000), Chapter 7 at 4 (defining children at risk as those with three or more institutionalizations in the past year, children with one or more admissions for more than two consecutive months in the past year, and children to have been accepted to state-run residential units but on the wait list.)
38. Maine's Plan Development Work Group for Community Based Living: DMHMRSAS: Children's Services (http://community.muskie.usm.maine.edu/Materials/dmh_child.htm) at 4.
39. South Carolina Home and Community Based Services Task Force Report (Aug. 31, 2001) at IV-29.
40. See Early, T.J. (2001) Measures for practice with families from a strengths perspective. *Families in Society: The Journal of Contemporary Human Services*, 82(3), 225-232; Graybeal, C. (2001). Strengths-based social work assessment: Transforming the dominant paradigm. *Families in Society: The Journal of Contemporary Human Services*, 8(3), 233-242; Epstein, M.H. (1999). The development and validation of a scale to assess the emotional and behavioral strengths of children and adolescents. *Remedial and Special Education*, 20 (5), 258-262; Lyons, J.S., et al., Strengths of children and adolescents in residential settings: Prevalence and associations with psychopathology and discharge placement. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(2), 176-181. See also Canino G., Costello, J.E., & Angold A., (1999). Assessing Functional Impairment and Social Adaptation for Child Mental Health Services Research: A Review of Measures. *Mental Health Services Research* (12) at 93-108.
41. *Report of the Surgeon General's Conference on Children's Mental Health* (2000) at 9.
42. Washington Department of Social and Health Services, Children's Administration, Olmstead Planning document at 2.
43. Ormond, Ziller & Richards, *Living In the Community: Voices of Maine Consumers*, Institute for Health Policy (2001) at 29.
44. *Id.* at 32-34.
45. Indiana Division of Mental Health, Olmstead Data Collection Tool, SED Children and Adolescents at 11.
46. "Blueprint for Change" at 4.
47. Indiana Division of Mental Health, Olmstead Data Collection Tool, SED Children and Adolescents at 13.
48. Report on Illinois' Activity in Response to the Americans with Disabilities Act in Light of the *Olmstead* Decision, Steering Committee of HR 0765 (December 20, 2000) at 23.

49. *Id.* at 24.
50. Working Plan for the State of Missouri (December 29, 2000), Activity 8 at 12.
51. South Carolina Home and Community Based Services Task Force Report (Aug. 31, 2001) at IV-28.
52. "Blueprint for Change," at 21.
53. Living In the Community: Voices of Maine Consumers (July 2000) at 30 (noting wait lists of approximately five months for respite services); South Carolina Home and Community Based Services Task Force Report (Aug. 31, 2001) at III-21 (noting that respite is the need most frequently cited by families with disabilities and stating that barriers to additional respite services include insufficient capacity, both in terms of trained providers and money to pay them, and federal prohibitions on using Medicaid to pay family members for respite).
54. Maine's Plan Development Workgroup for Community Based Living: DMHMRSAS: Children's Services (http://community.muskie.usm.maine.edu/materials/dmh_child.htm) at 5.
55. South Carolina Home and Community Based Services Task Force Report (Aug. 31, 2001) at III-19.
56. Indiana Division of Mental Health, Olmstead Data Collection Tool, SED Children and Adolescents at 13.
57. Working Plan for the State of Missouri (December 29, 2000), Activities 6 and 7 at 40. Texas' plan also notes the need for a community based model through which children in crisis can be placed out of home, but not be required to enter the foster care system. Such a program "allows families to make decisions regarding alternative family options for their child without the stigma associated with CPS, which presumes abuse and neglect." Texas Promoting Independence Plan (January 2001) at App. D.
58. Working Plan for the State of Missouri (December 29, 2000), Activities 6 and 7 at 40.
59. Working Plan for the State of Missouri (December 29, 2000), Activity 6 and 7 at 29. South Carolina's Home and Community Based Services Task Force Report also notes that children in the mental health system do not qualify for the state's existing waiver programs. Task Force Report (August 31, 2001) at III-22.
60. Working Plan for the State of Missouri (December 29, 2000), Activity 6 and 7 at 29-31, 35.
61. Ormond, Ziller & Richards, 2001, at 74.
62. See Bazelon Center for Mental Health Law, *Making Sense of Medicaid*, (1999) for discussion of the full array of services that can be funded under Medicaid.
63. South Carolina's Home and Community Based Task Force Report includes some recommendations for direct care and in-home care workers recruitment, retention and training. Task Force Report (Aug. 31, 2001) at IV-32.
64. "Blueprint for Change" at 67, citing English (in press).
65. *Id.*
66. *Id.* at 69 defines multisystemic therapy (MST) in detail. MST involves working with the child and family in the child's environment to create conditions in which antisocial behavior will be reduced and prosocial behavior increased. The therapist's time is spent in the settings where the child and family are; the therapists do not have or use private offices.
67. *Id.* at 68.
68. *Id.* at 67. See also, *Mental Health: A Report of the Surgeon General* (1999) at 171 ("given the limitations of current research, it's premature to endorse the effectiveness of residential treatment for adolescents").

69. Working Plan for the State of Missouri (December 29, 2000), Activities 6 and 7 at 40; Texas Promoting Independence Plan (January 2001) at App. D.
70. For a detailed discussion of cultural competence and a list of major cultural competence principles, see Isaacs-Shockley, et al., "Framework for a Culturally Competent System of Care," in *Children's Mental Health: Creating Systems of Care in a Changing Society* (1996) at 23-37.
71. Stroul, McCormack and Zaro, "Measuring Outcomes in Systems of Care" in Stroul, B., *Children's Mental Health: Creating Systems of Care in a Changing Society* (1996) at 319-320.
72. Arizona Draft Olmstead Plan (June 2001) at 30.
73. Report of the Olmstead Working Group (February 2001) at xxvii.
74. The Iowa Olmstead Report (August 31, 2000) at 3.
75. South Carolina Home and Community Based Services Task Force Report (Aug. 21, 2001) at IV-40.
76. *Report of the Surgeon General's Conference on Children's Mental Health* (2000) at 18.
77. *Id.* at 19.