



IV-E Waiver Demonstration Evaluation  
Final Evaluation Report  
SFY 11-12

**Prepared by:**

Amy C. Vargo, M.A.  
Mary I. Armstrong, Ph.D.  
Neil Jordan, Ph.D.  
Patty Sharrock, M.S.W.  
Cathy Sowell, L.C.S.W.  
Svetlana Yampolskaya, Ph.D.

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## **Executive Summary**

### **Background**

Florida was granted a Waiver to certain provisions of Title IV-E of the Social Security Act of 1935 which allowed the state to use certain federal funds more flexibly, for services other than room and board expenses for children served in out-of-home care. The Waiver was granted as a demonstration project, and required the state to agree to a number of Terms and Conditions, including an evaluation of the effectiveness of the Waiver. The Terms and Conditions explicitly state three goals of the Waiver demonstration:

- Improve child and family outcomes through the flexible use of Title IV-E funds;
- Provide a broader array of community-based services, and increase the number of children eligible for services; and
- Reduce administrative costs associated with the provision of child welfare services by removing current restrictions on Title IV-E eligibility and on the types of services that may be paid for using Title IV-E funds.

As specifically required by the Terms and Conditions under which the Waiver was granted, this evaluation seeks to determine, under the expanded array of services made possible by the flexible use of Title IV-E funds, the extent to which the state was able to:

- Expedite the achievement of permanency through either reunification, adoption or legal guardianship;
- Maintain child safety;
- Increase child well-being; and
- Reduce administrative costs associated with providing community-based child welfare services.

The Waiver was implemented statewide in October 2006 through changes in contracts with Community-Based Care (CBC) lead agencies.

The Terms and Conditions of the Waiver require three parts to the final evaluation: process, outcome and costs analyses. The evaluation design has been further refined so that the process analysis contains three distinct parts: an implementation analysis; a family assessment and services analysis; and a child welfare practice analysis. Along with the required programmatic outcomes analysis the report includes a cost analysis. This results in an evaluation with five major components.

Primary data was collected via interviews, focus groups, and surveys with a variety of stakeholders. Secondary data analysis was performed with extracts from the Florida Safe

Families Network (FSFN, Florida's statewide SACWIS system), Florida Department of Children and Families (DCF; the Department) case management quality of practice reviews, the National Survey of Child and Adolescent Well-Being (NSCAW) study, the Florida Accounting Information Resource (FLAIR), and the Florida DCF Office of Revenue Management. The final report content is organized by each of four hypotheses generated by the goals expressed in the federal Terms and Conditions under which the Waiver was awarded.

## **Findings**

Four key contextual and organizational factors facilitating implementation of the Waiver during the project emerged: philosophy of care, organizational efficiencies, communication and collaboration, and community perception and involvement. Challenges to Waiver implementation included the pace of implementation, recruitment and retention of case management staff, and challenges associated with a number of fiscal issues.

**Hypothesis 1: Over the life of the demonstration project, fewer children will need to enter out-of-home care.** Over the last seven years (FFY 04-05 through FFY 10-11), the number of children placed in out-of-home care statewide decreased from 20,987 in FFY 04-05 to 15,217 in FFY 10-11. This represents a reduction of 27% in children entering out-of-home care, and supports Hypothesis 1.

**Hypothesis 2: Over the life of the demonstration project, there will be improvements in child outcomes, including child permanency, safety, and well-being.** Florida has generally met the goals expressed in Hypothesis 2. Florida has maintained safety, expedited permanency, and generally improved well-being. However, there are specific areas where well-being could be enhanced. Specific to permanency, the proportion of children who achieved timely permanency through reunification, permanent guardianship, or adoption increased over the life of the Waiver. Placement stability improved, as demonstrated by an increasing proportion of children with no more than two placements within 12 months of removal from home. Specific to safety, the number and proportion of children who experienced a recurrence of maltreatment after exiting care decreased over the Waiver period, and the proportion of children who re-entered out-of-home care also decreased.

Regarding child well-being, DCF quality of practice data, and national survey data demonstrated improvements in the ongoing assessment of children and families' needs, frequency and quality of case manager visits, family engagement and involvement in planning and decision-making, and efforts to provide adequate and appropriate referrals and services to protect children. Areas for improvement include the ongoing assessment of fathers' needs;

assessment of children's dental, educational and physical health needs and provision of needed services; frequency of case manager visits with parents; and engagement of fathers in services.

**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 CBC model, the new flexibility of funds will be used differently by each lead agency, based on the unique needs of the communities they serve.** Interviews and surveys with CBC lead agency staff and providers indicate there has been a significant expansion in the service array. Expansion of services for prevention and to expedite permanency were particularly pronounced. In addition, the CBC lead agencies reported substantial modifications to their practice model to support family engagement and delivery of this expanded array of services. These practice changes include implementation of family team conferencing, family group decision-making, and a more family-centered approach. Findings from the child welfare practice analysis support Hypothesis 3.

**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.** There is clear evidence that hypothesized changes in spending for out-of-home care and front-end services have occurred since the Waiver was implemented in October 2006. By the end of Waiver implementation, expenditures for licensed out-of-home care decreased by 18% compared with out-of-home care spending two years prior to Waiver implementation. Front-end services expenditures more than tripled during the same period. The ratio of licensed out-of-home care expenditures to expenditures for front-end services in the final year of Waiver implementation was over 70% lower than this ratio was two years prior to Waiver implementation, which further demonstrates a shift in spending away from out-of-home care to prevention, diversion, family preservation, and other in-home services. Flexibility afforded by the Waiver enabled full use of federally appropriated IV-E funds during Waiver implementation and a significant increase in the use of State funds for front-end services. The State also demonstrated evidence of meeting the maintenance of effort requirement<sup>1</sup> associated with the Waiver contract. Although the available data do not allow us to determine a precise magnitude of reduction, qualitative data strongly suggest that administrative costs have been reduced in conjunction with Waiver implementation.

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<sup>1</sup> Requirement that any expenditure savings resulting from the Waiver be used to fund other child welfare services.

## Recommendations

The following recommendations are offered to the Florida Department of Children and Families and Florida's Community-Based Care lead agencies:

- Compared to children without physical health or emotional problems, children with physical health or emotional problems were less likely to experience timely reunification or placement with relatives and were at higher risk to experience re-entry into out-of-home care. Due to this finding, we recommend that with renewal of the IV-E Waiver, flexible funds be used to improve permanency and safety outcomes for children with physical and emotional problems.
- In addition, considering that there was no significant reduction in the rate of re-entry, we recommend that CBCs continue their efforts to address safety issues and to further prevent re-entry into out-of-home care in Florida's child welfare system.
- Based on the findings from the analyses of the Florida quality of practice data and national survey data, improvement is needed in the areas of the ongoing assessment of fathers' needs, the frequency of case manager visits with mothers and fathers, assessing children's dental health needs, supporting parents' participation in case planning and decision making, and providing physical and dental health services to children.
- Even though an expansion of the service array has occurred, findings indicated that not all programs have adequate capacity to meet the needs of children and families served in the child welfare system. Therefore, we recommend that the legislature, DCF, CBC lead agencies, and community providers devise a strategy to facilitate more even distribution of services and supports available to children and families involved in the child welfare system to ensure adequate access across all individuals, especially in rural areas.
- Although qualitative data suggest there was a reduction in administrative costs during the course of the Waiver, DCF should provide guidance to CBC lead agencies to ensure administrative costs are reported in a consistent manner.
- DCF should continue pursuing renewal of the IV-E Waiver. The financial flexibility afforded by the Waiver has enabled CBC lead agencies to increase spending for prevention, diversion, family preservation, and other in-home services that are viable substitutes for out-of-home care for many children and families.

## **Introduction and Overview**

### **Federal Child Welfare Legislation**

There are several key federal legislative acts that have impacted the provision of child welfare services nationwide: the Social Security Act of 1935, the Adoption Assistance and Child Welfare Act of 1980, the Family Preservation and Support Services Program Act of 1993, the Social Security Act Amendments of 1994, the Adoption and Safe Families Act (ASFA) of 1997, the Foster Care Independence Act of 1999, the Fostering Connections to Success and Increasing Adoptions Act of 2008, and the Child and Family Services Improvement and Innovation Act of 2011.

As part of the Social Security Act (1935), Title IV's intent is to "Increase the flexibility of States in operating a program designed to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives." The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) created Title IV-E in an effort to strengthen foster care assistance for children in the child welfare system. In 1994, Congress passed the Social Security Act Amendments (P.L. 103-432), which gave the U.S. Department of Health and Human Services (HHS) authority to approve State demonstration projects pertaining to the "waiver" of certain provisions of Title IV-E of the Social Security Act governing federal programs related to foster care and other child welfare services. The waiver provisions allowed states flexibility in the use of federal funds to provide services promoting safety, well-being, and permanency for children in the child welfare system (U.S. Department of Health and Human Services, Administration for Children & Families, 2010).

Most recently, the Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) restored waiver authority to extend programs funded under Title IV-B and Title IV-E through federal fiscal year 2016 and authorized new demonstration projects through federal fiscal year 2014.

### **Florida's IV-E Waiver Demonstration Project**

Florida's Title IV-E Waiver demonstration project was authorized by the HHS Administration for Children and Families (ACF) and implemented statewide in October 2006. The core assumption of a flexible funding waiver is that allocating fixed amounts of Title IV-E funds to child welfare agencies will result in new or expanded services that prevent out-of-home placements and facilitate child safety, permanency, and well-being. Another belief is that the

cost of the new services will be offset by subsequent savings in foster care expenditures. In Florida, funds are distributed to private, non-profit community-based lead agencies.

Florida's flexible funding demonstration targets Title IV-E eligible and non-eligible children under the age of 18 who were receiving in-home child welfare services or who were in out-of-home placements at the start of the project implementation, and all families who entered the child welfare system with an allegation of maltreatment. The purpose of the Waiver is to demonstrate that allowing federal IV-E foster care funds to be used for a wide variety of child welfare services rather than being restricted to licensed out-of-home care, as is normally the case under federal law, will result in improved outcomes for children and families.

Florida's Department of Children and Families (DCF; the Department) has contracted with the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida (USF) to evaluate Florida's statewide IV-E Waiver demonstration project. The purpose of the IV-E Waiver evaluation is to determine the effectiveness of expanded child welfare services and supports in improving permanency and safety outcomes for children in or at risk of entering out-of-home placement. The evaluation team has submitted progress reports every six months regarding the status of the Waiver evaluation. This is the final evaluation report for Florida's initial five-year statewide IV-E Waiver demonstration project.

### **Florida and the Florida Child Welfare System**

Florida has 5,373 square miles of water and more than 1,128 miles of coastline. The state comprises 53,624 square miles of land and was populated by 18,511,620 persons in 2010 (U.S. Census Bureau, 2006-2010) including 1,207,042 people living in 33 rural Florida counties. An additional 2.1 million persons live in the rural portions of Florida's 34 urban counties. Tallahassee is the state capital and the largest cities are Jacksonville, Miami, Orlando, and Tampa. According to the latest estimates, 75.0% of the state's population is White, 16.0% is Black/African American, and 22.5% is of Hispanic/Latino origin (U.S. Department of Agriculture Economic Research Service, 2012).

There were over 350 persons per square mile in 2010, and the general population increased by 15.8% from 2000. The median age in 2000 was 39 years (U.S. Census Bureau, 2000) and in 2010 this changed to 40.3 years (U.S. Census Bureau, 2006-2010).

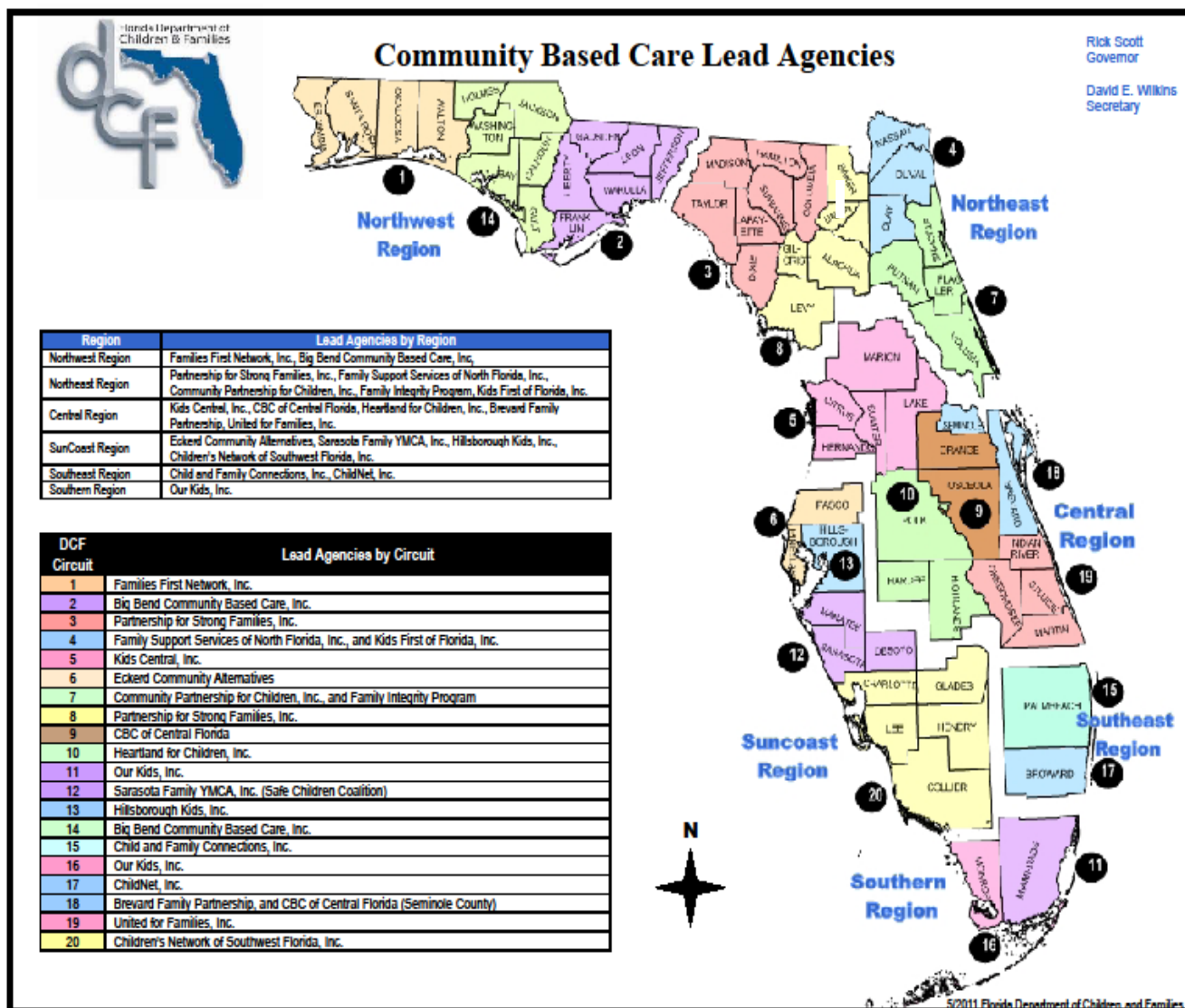
Children under the age of 18 represent 21.7% of the total population in Florida (U.S. Census Bureau, 2006-2010), and 23.6% of children live in poverty (U. S. Census Bureau, 2010). Of the 3,048,621 persons of all ages living in poverty, 30.5% were under the age of 18

years (U. S. Census Bureau, 2010). Forty-eight percent of children live in low-income households (The Annie E. Casey Foundation, KIDS COUNT Data Center, 2010).

Child-related calls to the Florida Abuse Hotline have remained relatively stable from 2007 to 2010. In March 2010, the number of calls to the Hotline was 16,189, a decrease of 494 from March 2007 (<http://www.dcf.state.fl.us/programs/abuse/docs/ChildRptsRcvd.pdf>). The rate per 1,000 children in Florida who were the subject of an investigated report of child maltreatment also changed little from 2007 (84.2 per 1,000) to 2010 (81.9 per 1,000), and child maltreatment victims, defined as a child who is the subject of a maltreatment report for which the disposition is substantiated, saw little change from 2007 (n=53,484) to 2010 (n=53,969) (National Child Abuse and Neglect Data System; <http://www.ndacan.cornell.edu/>).

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 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. Lead agencies are responsible for all child welfare services except for child protective investigations. Investigations are performed either by DCF staff or by the Sheriff's Office. All of Florida's 67 counties operate under the CBC model, with 19 lead agencies throughout the state holding contracts with the Department to provide child welfare services. Lead agency regional circuit locations are illustrated in Figure 1.

Figure 1. Florida's community-based care lead agencies\*



\*Available online at: [http://www.dcf.state.fl.us/cbc/docs/lead\\_agency\\_map.pdf](http://www.dcf.state.fl.us/cbc/docs/lead_agency_map.pdf)

During the five years of Florida's IV-E Waiver there have been a number of environmental and contextual factors that had an impact on Waiver implementation. First, Florida's economy was negatively affected by the country's economic recession. Florida's unemployment was consistently higher than the national unemployment rate. For example, in January 2011 the national unemployment rate was 9.1% and Florida's rate was 11.9%. As recently as December 2011, Florida's unemployment rate of 9.9% continued to be higher than the national unemployment rate of 8.5% (Bureau of Labor Statistics; [www.bls.gov/lau/](http://www.bls.gov/lau/)). The

economic downturn resulted in severe budget constraints, which translated into layoffs of state employees and reductions in provider budgets.

A direct challenge to the Waiver's success was the Barahona case, which occurred in Miami in February 2011, shortly after the new Governor and new state agency leaders were in place. The Barahonas, adoptive parents, were accused of torturing their 10-year old adopted son, and torturing and murdering his twin sister. As a result of this case, an investigative panel was created that produced a report revealing serious issues in Florida's child welfare system (Lawrence, P., Martinez, R., & Sewell, J., 2011). The panel produced a set of short-term recommendations that led to mandatory training and changes in practice for child protective investigations and case management. Most importantly, the Department embarked upon a long-term action plan to achieve sustainable improvements in child safety and well-being, known as the Child Protection Transformation Project. This project is in the early implementation phase and targets significant improvements in key areas related to the Child Abuse Hotline, child protective investigations, and child welfare case management. The Barahona case and other child deaths over the past 18 months highlighted the need for additional reforms in Florida's child welfare system and the importance of Waiver renewal.

### **Purpose and Specific Aims of the Evaluation**

The purpose of the IV-E Waiver evaluation was to address the Waiver Terms and Conditions related to process, outcome, and cost, and to test the expectation that an expanded array of community-based services available through the flexible use of Title IV-E funds would:

- expedite the achievement of permanency through either reunification, adoption, or legal guardianship;
- maintain child safety;
- increase child well-being; and
- reduce administrative costs associated with providing community-based child welfare services.

This report includes data gathered from all lead agencies serving Florida's 67 counties and covers FFY 04-05 through FFY 10-11, depending on the data source and measure.

## Conceptual and Methodological Framework of the Evaluation

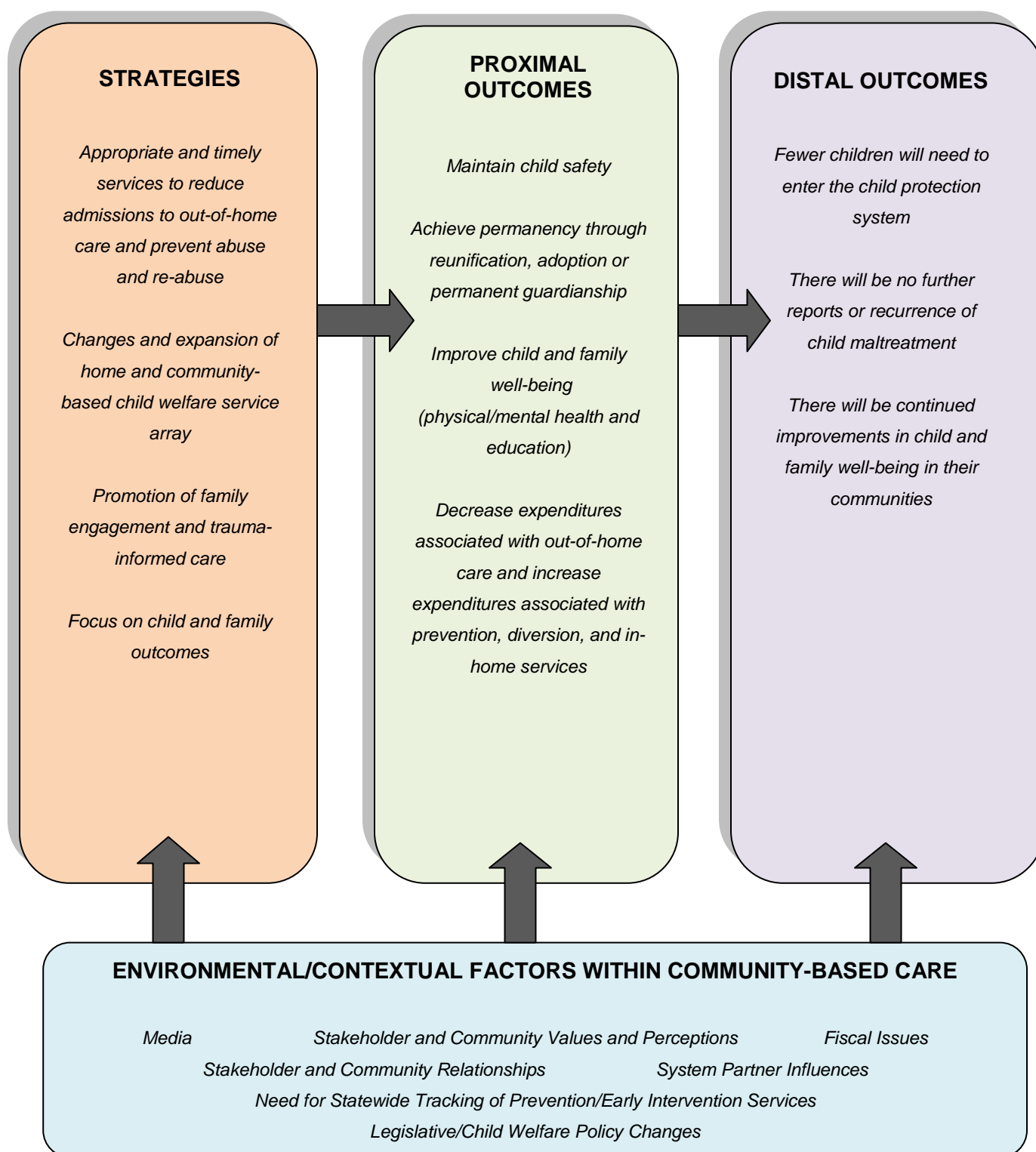
### Theory of change and logic model.

An important task for the evaluation was to refine the theory of change underlying the IV-E Waiver implementation in Florida. *Theory of change* refers to a plausible and logical explanation of how a program aims to produce changes (Hernandez, Hodges & Cascardi, 1998; McLaughlin & Jordan, 1999). The initial version of the theory of change was based on (a) federal and state government expectations of the intended outcomes of the Waiver implementation, and (b) the evaluation team's hypotheses about practice changes developed from knowledge of the unique child welfare service arrangements throughout the State. The original theory of change was described as follows:

- Waiver implementation will result in increased flexibility of IV-E funds, which have historically been earmarked for out-of-home care services. The new flexibility will allow these funds to be allocated toward services to prevent or shorten the length of child placements into out-of-home care.
- Consistent with the Community-Based Care model, it is expected that the new flexibility of funds will be used differently by each lead agency, based on the unique needs of the communities they serve. However, it is expected that Waiver implementation will lead to changes in, or expansion of, the existing child welfare service array for many, if not all, lead agencies.
- These changes in practice are expected to affect child outcomes, including child permanency, safety, and well-being.
- Over the life of the demonstration project, it is expected that fewer children will need to enter out-of-home care. Therefore, costs associated with out-of-home care are expected to decrease following Waiver implementation, while costs associated with prevention and in-home services will increase, although no new dollars will be spent as a result of Waiver implementation.

During the course of the Waiver, the evaluation team reviewed the initial theory of change with lead agency and Department leadership stakeholders via interviews and focus groups. We asked stakeholders what changes they would make to the theory of change model, based on what they were experiencing during Waiver implementation. A number of themes emerged, including new elements that needed to be added as well as refinements in the theory's four assumptions. As a result, the logic model has been refined to reflect stakeholder input based on the implementation experience (see Figure 2).

Figure 2. Theory of change logic model for Florida's IV-E Waiver demonstration



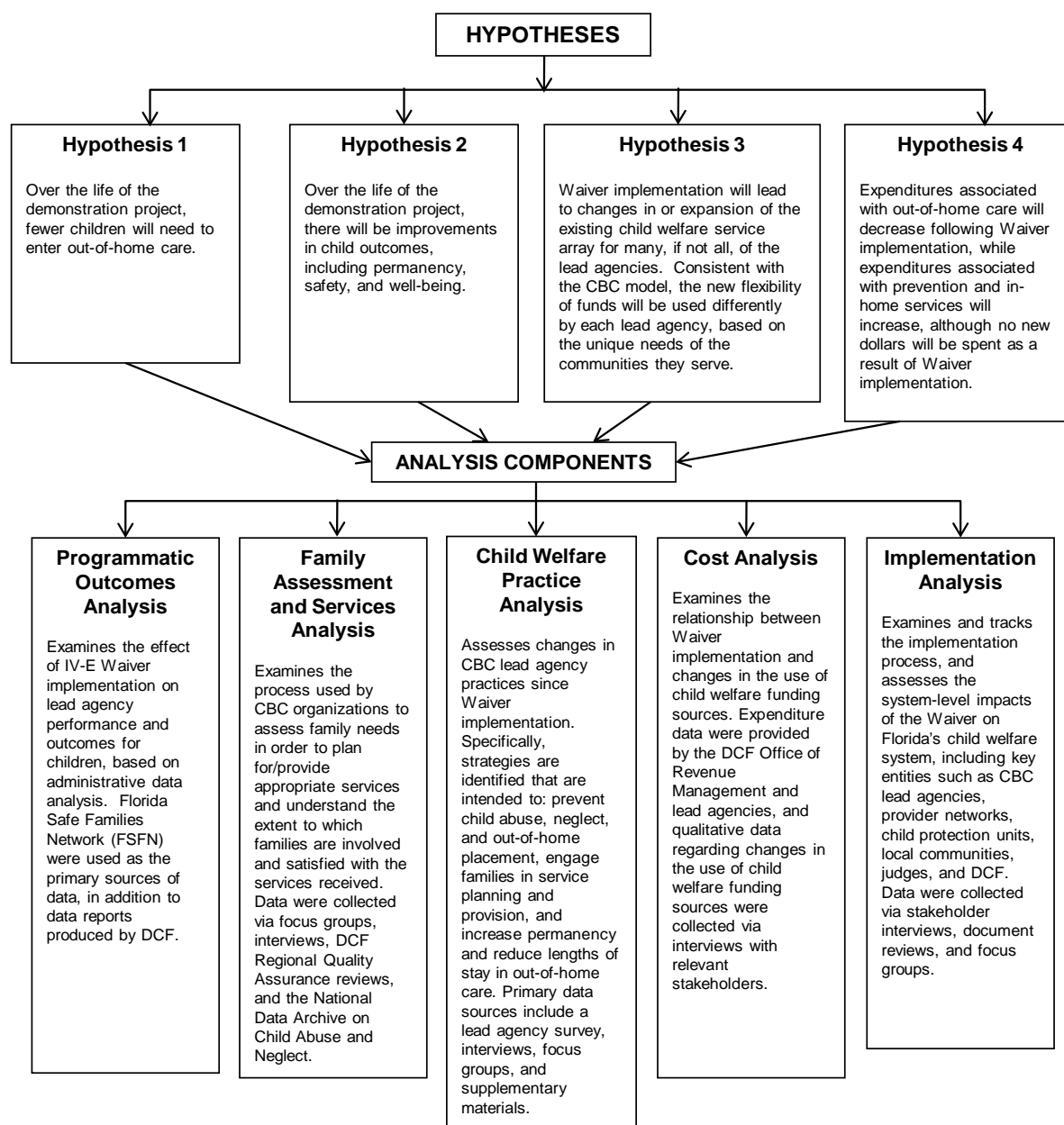
### **Methodological approach for the evaluation design.**

Five analysis components address the hypotheses and data from various information sources within each component and are triangulated as part of the evaluation design (see Figure 3). The evaluation maximizes the strengths of using a longitudinal research design while limiting intrusiveness to the CBC lead agencies. Whenever feasible, existing data sources were utilized to minimize participant requests. For example, for the programmatic outcomes analysis, Florida Safe Families Network (FSFN), the DCF-managed, statewide data system for Florida's child welfare system, was the primary source of data for information about child characteristics and child placements while in out-of-home care. For the family assessment and services analysis, the Florida DCF case management quality of practice reviews and the National Survey of Child and Adolescent Well-Being (NSCAW), the only national, longitudinal data on families that were subjects of child maltreatment investigations or assessments conducted by child protective services agencies in the United States, were two primary data sources. In addition, the evaluation was designed to be participatory, with input from DCF, CBC lead agencies, and community partners.

This report is organized according to the four hypotheses, the Waiver's Terms and Conditions, and the following topics for each of the analysis components:

- Programmatic Outcomes Analysis: Quantitative analysis of administrative data that are related to child permanency and safety. Measures of permanency and safety were examined over time. The effect of predictors was also assessed.
- Implementation Analysis: Qualitative analysis of telephone and in-person interviews and focus groups with lead agency leadership, Department leadership, case manager supervisors, residential providers, and judges across the five years of the Waiver. Qualitative analysis of interviews and documents, and quantitative analysis of child-level outcomes via case study methodology specific to four lead agencies in order to illustrate the impact of the Waiver. Examples of topics covered include child level outcomes, changes to the service array, prevention and diversion supports and services, parental involvement, and workforce issues.

Figure 3. Evaluation design



- Family Assessment and Services Analysis: Qualitative analysis of data from case manager focus groups and parent interviews, and quantitative analysis of data from Florida DCF case management quality of practice reviews and the NSCAW study that are related to the assessment of needs, family participation in case planning and decision making, service provision, and satisfaction with services.
- Child Welfare Practice Analysis: Analysis of statewide service array data to assess changes in the availability, accessibility, intensity, and appropriateness of community-based services since Waiver implementation. Data collection methods include a CBC lead agency annual survey focused on service array, family team conferencing, and innovative practices; interviews with CBC lead agency leadership and contracted program staff; document reviews of program data and materials; and focus groups with case managers.
- Cost Analysis: Quantitative analysis of state-level, pre- and post-Waiver implementation CBC expenditure data to assess (a) trends in child welfare expenditures by type of service, and (b) how key funding sources were used during the Waiver period.

## **Contextual and Organizational Factors Affecting IV-E Waiver Implementation**

The implementation analysis team utilized a variety of methods to understand better the contextual and organizational factors that impacted the implementation of the Waiver. These strategies included focus groups with lead agency and Department executive staff, residential providers, and case management supervisors that were conducted throughout the five years of the Waiver. In addition to these focus groups, data was taken from four case studies of lead agencies: Family Support Services of North Florida, Inc. (FSS), Kids Central, Inc. (KCI), Families First Network, Inc. (FFN), and Eckerd Community Alternatives (Eckerd). In addition, individual interviews were conducted with a random sample of five judges statewide at the end of the Waiver period in order to understand their perceptions about the Waiver (see Appendix A for data collection protocol). The findings are organized by facilitators, barriers, and contextual challenges that affected early implementation, and the themes from the judges' interviews.

### **Terms and Conditions 3.2 Process Evaluation Domains:**

- The organizational aspects of the demonstration, such as the planning process, staff structure, funding committed, administrative structures, and project implementation, including ongoing monitoring, oversight, and problem resolution at various organization levels;
- The role of the courts in the demonstration and the relationship between the child welfare agency and court system, including any efforts to jointly plan and implement the demonstration;
- Contextual factors, such as the social, economic and political forces that may have a bearing on the replicability of the intervention or influence the implementation or effectiveness of the demonstration. This discussion should note any possible confounding effects of changes in these systems or changes from any other demonstrations or reforms that were implemented during the title IV-E waiver demonstration; and
- The barriers encountered during implementation, the steps taken to address these barriers, and any lessons learned during implementation.

### **Facilitators to Implementing the IV-E Waiver**

During the first year of Waiver implementation, lead agency leadership were asked to identify what contextual variables influenced implementation and what was helpful to implementation (Vargo et al., 2007). Four key themes emerged: philosophy of care,

organizational efficiencies, communication and collaboration, and community perception and involvement.

### **Philosophy of care.**

Lead agency directors recognized that they were tasked with changing their agency and their staff's philosophy of care and core beliefs about children and their families. At a fundamental level, the shift was towards believing that children are safer and happier when they are able to remain in their homes rather than entering out-of-home care. A related belief is not removing children due to poverty or neglect, but providing services in the home to stabilize the family and keep the family unit intact. In addition, parents who may have hurt their child or had a substance abuse problem, deserve a second or fifth chance to regain custody of their children. All of these philosophical changes began to occur during the first year of Waiver implementation and took hold as time passed. Agencies sometimes struggled with case management and residential provider agencies, in terms of encouraging them to offer more prevention and diversion services. There was a clear change in the market that had to occur alongside a change in philosophy. At an individual case manager level, this shift allowed case managers to reverse their funding-driven decision making regarding connecting a child to services. For the first time, service referral decisions could be based on what the child and family needed rather than what current funds could pay for. Finally, focus group participants stressed that part of the philosophical shift had to do with stepping away from looking at kids in care as purely a number to decrease, and drilling down to reducing length of stay so as to improve the quality of that child's experience and limit their time away from their family.

### **Organizational efficiencies.**

Focus group participants were asked during the first year of Waiver implementation if they had gained any organizational efficiency due to the IV-E Waiver. While there was general acknowledgement that the overall level of paperwork had decreased and that changes to the invoicing process were helpful in terms of no longer needing to delineate between IV-E and non-IV-E expenditures, the need to retain IV-E eligibility information for adoption cases remained, and thus large scale organizational efficiencies were not seen.

### **Communication and collaboration.**

It was generally acknowledged in focus groups that lead agencies and the Department convened for a successful planning process leading up to and during implementation of the

Waiver. However, at times, temporary tension was experienced on both sides due to changes in leadership at the Department level, a reorganization effort across the state and within DCF Central Office, concurrent reform efforts (e.g., fixed-price contracting for services, independent fiscal monitoring, a Pilot Program at ChildNet and Our Kids CBC lead agencies, implementation of FSFN - a new data management system, and changes to performance measures), interaction with the Legislature, and negative attention from the media due to child deaths. When looking at any public-private partnership, all of these contextual factors can and will continue to impact communication and collaboration.

Views on whether there had been enough training on the IV-E Waiver during early implementation were somewhat mixed. The one area that seemed to be lacking was information on changes in invoicing and potential fiscal ramifications. In addition, a method for allocating the Waiver's 3% increase equitably to agencies was a significant point of contention during the first year of the Waiver. Finally, there was some disagreement as to whether certain groups of stakeholders, such as protective investigators, should receive training on the Waiver, with the concern that they continue to make placement decisions based on safety concerns only.

### **Community perception and involvement.**

During any large scale implementation effort there will always be broader community factors impacting the ease of implementation. The three most prominent themes from first year focus groups were a misunderstanding of the culture of poverty, community perception that the Waiver brought in extra money to the community, and various county-level differences that added to the complexity of some lead agencies' capacity to implement change. Prior to the Waiver being implemented, focus group participants stated that PIs, judges, and case managers were more likely to remove a child due to poverty-related issues such as a lack of food, transportation, or child care. With funding restrictions lifted, these more concrete services could be provided in order to allow a child to safely remain in the parent's care. However, changing the local community's perception that poverty was not intentional abuse or neglect was something lead agencies had to work on over the long term.

In addition, there was some sorting out of misperceptions that needed to take place during the first year of the Waiver regarding the notion that lead agencies were getting extensively more funding by virtue of the Waiver to provide additional services. Often a lead agency competes with other local provider groups for smaller grants and fundraising efforts, and there was the initial perception that due to the IV-E Waiver the lead agency would no longer need these community resourced funds.

Finally, lead agency participants in focus groups reported challenges implementing the Waiver across often very diverse geographic areas with differing needs. Some counties experienced a surge of prescription drug abuse during the time of the Waiver. Others struggled with a concentration of methamphetamine labs and high rates of domestic violence and substance abuse. Other communities dealt with challenges that came with serving rural communities with a high percentage of non-English speaking migrant workers. While these challenges would have been present with or without the IV-E Waiver, the extent to which lead agency leadership was able to address them helped facilitate Waiver implementation.

### **Challenges Related to Waiver Implementation**

Focus groups with lead agencies, DCF Central Office staff, child protective investigators and judges conducted during the early phase of Waiver implementation identified a number of challenges. These included pace of implementation, training and educational needs, recruitment and retention of case management staff, and financing and fiscal issues.

#### **Pace of implementation.**

CBC lead agency directors were clear that the path to IV-E Waiver success was related to freeing up funding from out-of-home care services and moving it toward the front end of the system. While agencies agreed this was good operating procedure and in line with a developing philosophy of care that children were much better off with their families than in foster care, making this switch took time. To the extent that some lead agencies had capital that they could move to the front end, these agencies were viewing themselves as early implementers. To the extent that any agency was financially strained with a large out-of-home care population to care for, directors acknowledged that changes at their location would not occur overnight. As will be seen in Hypotheses 1 and 4, change did occur statewide over time when it came to decreasing the volume of children in foster care and spending less on foster care and more on prevention and diversion. However, the pace at which each agency was able to accomplish these changes varied due to site-specific capacity and circumstances.

#### **Education needs.**

Another focus group theme was the need for community education concerning at-risk children and families. Community values about issues such as the difference between symptoms of poverty and indicators of abuse or neglect impact the decisions of child protective investigations. As described by one participant, “When the news camera goes into that poverty

home, the average American says, I wouldn't leave my child in there, too" (Armstrong et al., 2007, pg. 17). Participants emphasized that the child welfare system needs to help the community understand family preservation by demonstrating positive examples of how a family can be supported in the community.

### **Recruitment and retention of case managers.**

As conveyed by some focus group participants, despite efforts to retain case managers, lead agencies were facing high turnover of case management staff. Suggestions included efforts to professionalize case management, and to increase case manager specialization so that certain case managers focus only on infants or only on teens, or to divide staff based on child disabilities and/or levels of need.

### **Fiscal challenges.**

Two fiscal issues surfaced through data collection in the first six months of the Waiver. First, even though it was nearly the end of the State fiscal year, lead agencies did not know what amount of new IV-E funds they would ultimately receive during that state fiscal year<sup>2</sup>. Some agencies felt that the timing and uncertainty about the funding amount did not support the Waiver's theory of change, and would not lead to any additions to their service array. While lead agencies had loosened restrictions on how they fund services they were already offering, many did not want to initiate any new services because "it is bad business practice to spend money you don't know that you have" (Armstrong et al., 2007, pg. 15). An upfront infusion of new funds was needed to implement alternative services in order to begin to realize cost savings which could then be used for ongoing funding of the alternative services. The second challenge described by the lead agencies was existing state budget issues.

Fiscal challenges were also raised during the next phase of data collection. Several agencies expressed concern about the long-term sustainability of the CBC model under the Waiver because the Waiver limits annual increases in IV-E funding to 3%, without regard to any changes that might occur in the number of children coming into care. In a few focus groups, CBC lead agencies reported concerns that FFY 06-07's 3% funding increase afforded by the Waiver was not equitably distributed by the Legislature. There were similar concerns about increases in the costs of providing and contracting for services not being met by adequate

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<sup>2</sup> Although the Waiver demonstration and accompanying funding occurred on a federal fiscal year basis, lead agency contracts and budgets operated on a state fiscal year basis. The state fiscal year begins July 1 and ends the following June 30.

increases in revenue, leading to reductions in the kinds of creative, front-end services the Waiver was intended to facilitate.

Perhaps the strongest theme emerging from lead agency focus groups was that these organizations were feeling increased financial risk. Since the onset of community-based care in 1996, lead agencies have always been at-risk and contractually obligated to assume liability for each child in their geographic area that comes to their front door. In addition, due to current and projected budget cuts, cost of living increases, and perceived responsibility shifting of the care for children needing more intensive, high-end services from other social service organizations, agencies were more acutely feeling the impact of such risk.

The Department shared some of the CBC lead agencies' fiscal concerns, but the Department's financial concerns were more focused on implementing the SFY 07-08 mandated 4% budget cut and SFY 08-09's projected 10% budget cut. Additionally, there were two operational concerns pertaining to fiscal issues reported by the CBC lead agencies. Some agencies reported that there was insufficient training regarding changes in the revenue maximization process. Although the eligibility determination process has been simplified due to the Waiver, one agency reported that the ACCESS Florida Program was still operating under an old model early in the fiscal year. The DCF Central Office was concerned that some CBC lead agencies had not yet adopted the new eligibility determination process (Vargo et al., 2007).

### **Contextual challenges.**

Focus group participants acknowledged that some challenges such as state budget cuts and poor interagency collaboration will exist whether or not there is a IV-E Waiver. However, they pointed out that long-standing issues need to be addressed to facilitate the positive impact the Waiver will have over time. Specific barriers noted include historic inequities in funding levels and rising costs of providing care. "The IV-E Waiver flexibility should not overshadow the general need for more resources" (Armstrong et al., 2007, pg. 16). Some participants reported that due to increasing costs of living (e.g., cost of housing and transportation), they were having a difficult time attracting providers to come into their local jurisdictions.

### **Perspective of Judges on Issues Pertinent to the IV-E Waiver**

Interviews with five judges were conducted in the final phase of the Waiver in order to gain current perspectives about the Waiver from this key constituency group.

### **Understanding of the IV-E Waiver.**

All judges interviewed had a clear understanding of the Waiver five years post-implementation. As one judge stated, the IV-E Waiver allows judges to finally follow something similar to the code doctors apply to their patients, which is to first “do no harm.” This judge felt that no longer having to remove children from their families in cases where services could now be paid for avoided causing children the trauma of being separated from loved ones. For example, this judge reflected on his first case after Waiver implementation, when it dawned on all parties that it would cost less money to help a mother pay rent than it would to remove her children due to inadequate housing.

Another judge reflected on what might happen to their local child welfare system should the IV-E Waiver not be renewed:

It would be disastrous to dispense with the IV-E Waiver because it would result in children being brought into care in order to obtain services for those children and it would totally overwhelm our court system. I would have to get another Circuit Judge in this Division if my volume of business suddenly tripled because that is about what it would be and it would be overnight. It wouldn't be a gradual ramping up of work for the court system. It would be the dam would break, and we would be inundated in a matter of days.

The majority of judges felt that the Waiver was a very positive venture for Florida. although one judge voiced concerns about underfunding out-of-home care options.

### **Education, training, and planning for the Waiver.**

Only one of five judges reported receiving anything in writing explaining the Waiver. In this instance, the judge received a one-page fact sheet detailing intended purposes of the Waiver and explaining the inherent funding flexibility. While some judges were aware that local planning meetings had occurred at the time of Waiver implementation, none of the judges remembered being invited to such meetings. To the extent that judges were involved with a local community alliance or redesign initiative, they did state that the IV-E Waiver was often discussed throughout the last five years.

Additionally, one judge explained longitudinal issues regarding the judicial understanding of the Waiver during the five-year time period:

All of us on the dependency bench at the time didn't truly understand the breadth of it, and I don't think initially we did anything any differently, if you want to know the honest truth, or very few things differently. I think over time, however, we have come to

recognize and have been better educated on the benefits of the Waiver and how many things come within it and, therefore, I think it has definitely changed our approach as far as what we order initially in terms of assessments for children, and I think we have come to order more things and to expect more information and, therefore, to make better informed decisions.

### **Impact of IV-E Waiver.**

When judges were asked if the IV-E Waiver has had an impact on removal, reunification, and permanency decisions, four primary themes emerged: an expanded service array has led to fewer removals, availability of in-home services has led to more timely reunifications, time is no longer wasted debating how to accomplish and pay for something necessary for a child, and cases primarily due to poverty are usually no longer seen inside their courtrooms. Judges stressed that throughout the Waiver period, Florida law has always required the same thing: a finding that the provision of services would avoid the necessity of removal. However, this was often much harder to do prior to Waiver implementation. Judges also stressed that the Waiver's flexibility has not changed the fact that they struggle with an overall lack of funding for Florida's child welfare system.

When asked to speak to the Waiver's impact on Florida's child welfare system as a whole, the following issues emerged: impact of lead agency and Department leadership on facilitating Waiver goals, the overall decrease in removal of children from out-of-home care, increased creativity seen within service offerings, and unintended consequences such as perhaps a lack of resources for out-of-home care.

A judge who had been in the dependency division long enough to see changes in lead agency and Department leadership stressed that leadership changes played a very important role in improving funding for services and communication about them. In addition, whenever the DCF Secretary changed during the course of the Waiver, different priorities were stressed. Judges indicated that they believed that fewer removals occurred since Waiver implementation. Judges expressed that removing a child from their home is not something any of them enjoy doing, and due to this and all of the abuse cases they hear, many dependency judges rotate onto a different bench to take a break for a couple of years. One judge summarized the changing pattern since the Waiver was introduced:

You tell me my choice is leave a child in a home that I think is dangerous or remove them and those are my only choices, of course, who is not going to order a removal. You tell me there are some more options out there and that I can have services in place; I

can get things accomplished and still have the child remain at home, absolutely fewer children are going to be removed.

Another judge mentioned that he had seen increased creativity in service offerings since Waiver implementation. He gave the example of a parent's house being so dirty that the child comes to the attention of the system. The local lead agency has contracted with a janitorial service to visit the house three times: the first time the janitorial service would clean the house from top to bottom, the second time they would come back a week later and show the parent how to clean the house from top to bottom, and the third time they would come out they would watch the parent clean the house from top to bottom. This solution, in many cases, prevented a child's removal.

Regarding the unintended consequences of the IV-E Waiver, one judge felt strongly that while the front end of the system had benefitted from the Waiver, a general lack of new funding for Florida has perhaps led to instances of reunifying a child too early or not making the type of foster care placement truly appropriate for a child. In this judge's words:

Everything you do has a downside and upside, and, naturally, kids need to be with their parents whenever they can, and relatives are generally a better choice than foster care for kids, too, but anything you do like this, if it is taking money from one place and putting it into another, then that means the place that we took it away from is suffering.

## **Summary**

This section provides an overview of the organizational and contextual factors that affected implementation of the Waiver and current perspectives of judges on the Waiver. Facilitators of Waiver implementation included philosophy of care, organizational efficiencies, communication and collaboration, and community perception and involvement. Barriers to Waiver implementation that were identified were provider capacity to implement changes related to the Waiver, training and educational needs, recruitment and retention of case management staff, and financing and fiscal issues. Contextual challenges that were noted included lack of interagency collaboration, historic regional inequities in funding levels for child welfare services, and rising costs of providing appropriate services. Judges had a clear understanding of the Waiver's intent but acknowledged that this understanding occurred slowly over time throughout the court system. Regarding the Waiver's impact on the child welfare system, judges believed that today's expanded service array has led to fewer removals, availability of in-home services has led to more timely reunifications, time is no longer spent debating how to pay for something

necessary for a child, and cases primarily due to poverty are usually no longer seen inside their courtrooms.

## **Hypothesis 1**

*Over the life of the demonstration project, fewer children will need to enter out-of-home care.*

## **Methodology**

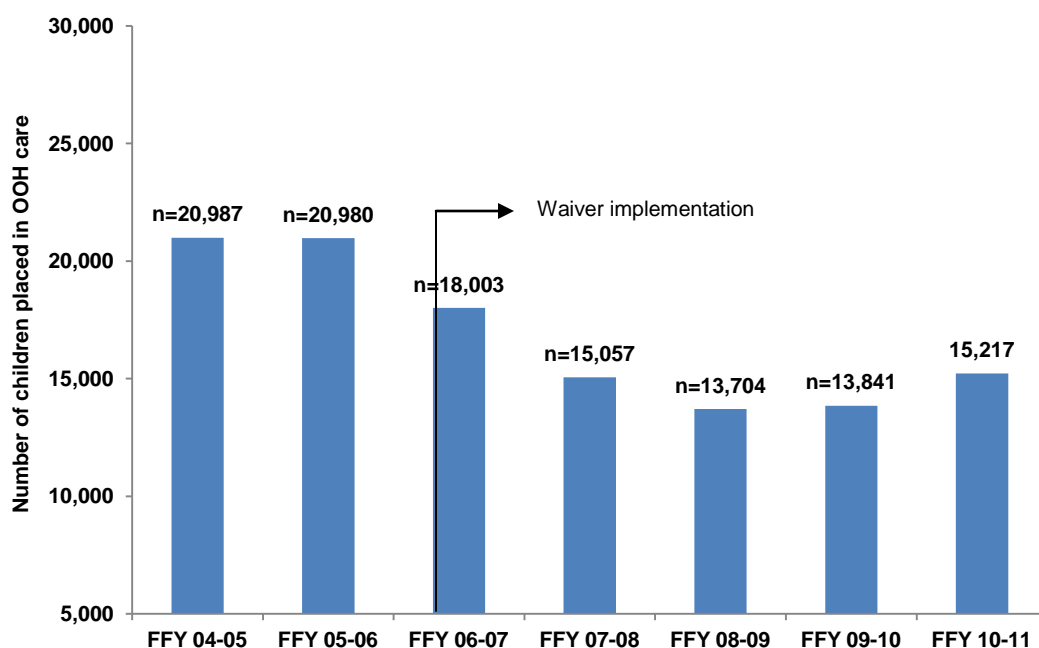
One of the goals of this evaluation was to examine changes in the number of children who entered out-of-home care. Specifically, it was expected that as a result of Waiver implementation, there would be an increased allocation of resources toward in-home and prevention services, resulting in a decrease in the number of children placed in out-of-home care. To examine changes in the number of children placed in out-of-home care, federal fiscal year entry cohorts were compared.

## **Findings**

### **Children placed in out-of-home care.**

This indicator was defined as all children who were removed from home and subsequently placed in out-of-home care during a specific fiscal year (see Appendix B, Measure 1). Over the last seven years (FFY 04-05 through FFY 10-11), the number of children placed in out-of-home care statewide decreased from 20,987 in FFY 04-05 to 15,217 in FFY 10-11 (see Figure 4). This represents a 27% reduction in the number of children entering out-of-home care. This finding supports Hypothesis 1, that over the life of the Waiver, fewer children will need to enter out-of-home care. The results of analysis of variance (ANOVA) showed that this reduction is statistically significant (see Appendix C, Table 1).

Figure 4. Number of children placed in out-of-home care (FFY 04-05 through FFY 10-11)



#### **Impact of the reduction of the number of children in care on residential providers.**

It was important for this evaluation to include input from Florida's residential providers, as they experienced the decrease in demand for out-of-home care services from a different perspective than lead agencies. Three realities co-occurred during the IV-E Waiver process. First, Florida alongside the rest of the nation, went through and is still going through an economic downturn where both state and local funding are not as prolific as in the past. Second, fewer children are coming into out-of-home care as a result of the Waiver, thus fewer residential beds are needed. Third, children who are in care have much more serious behavioral problems and are more likely to have experienced sexual, physical, and emotional abuse than the population of children who were placed in out-of-home care prior to IV-E Waiver implementation (Vargo, et. al. 2010).

Residential providers and lead agency leadership were asked about the impact of the Waiver on residential providers during focus groups. This data was reported in semi-annual progress reports 6 (Armstrong et al., 2009) and 7 (Vargo et al., 2010). In some areas of the state, strategic planning meetings had been called by lead agency leadership to help prepare residential providers for the reduction in out-of-home clients. As one lead agency director explained, "We did not want to hurt the agencies by slashing dollars...so we very strategically approached each one of them and got them engaged in the prevention side of the world" (Vargo

et al., 2010, pg. 21). Alternately, providers in other areas of the state reported that they heard of changes through the grapevine, but did not have information flowing to them in a formal manner regarding what to expect and how to adapt.

Regardless, it was necessary for residential facilities to adapt to the changing climate. For larger facilities or those offering more than just residential care, making changes was a bit easier than for smaller, residential-only locations. Providers usually went one of three routes or some combination thereof: diversifying into prevention and diversion services, changing target population, or going out of business. For example, some facilities have elected to focus on serving larger sibling groups, pregnant teens, or adolescents with more complex needs. Another example is a runaway shelter that adapted quickly to a request to develop an in-home early intervention team. However providers chose to adapt though, it was clear that they would need ongoing training and support from their lead agency regarding how to better serve an increasingly complex client population.

#### **Impact of the reduction of the number of children in care on case managers/workforce.**

Data regarding the impact of this reduction is drawn from the previously mentioned lead agency leadership focus groups and case studies, as well as focus groups targeted specifically for case managers. Two prominent themes from these data are that the reduction of the number of children in care has led to case managers having smaller caseloads, more time to engage families, and thus increased morale of case managers and corresponding increases in staff retention/reductions in turnover.

As case management becomes more strength-based, families are treated better and workers feel better about themselves. Additionally, respondents described how case managers can now focus on breaking the cycle of intergenerational problems such as poverty and lack of education. Another explanation for an increase in case manager morale is that case managers are now able to see the lifespan of a case due to shorter lengths of stay, and therefore may be feeling a greater sense of ownership and accomplishment. Overall, focus group participants who were case managers or who supervised case managers, reported less burnout and a shift toward more positive energy.

As caseload sizes decreased at some lead agencies and morale increased, coupled with an economic downturn, case managers began staying in their current job positions longer. This trend allowed lead and provider agencies to start cultivating a more stable, more knowledgeable, and more experienced workforce.

Directors indicated that since Waiver implementation, their jobs have felt more rewarding due to fewer obstacles to helping children and their families and a new sense of confidence that what they are doing really does make a difference. As one CEO explained, “We are no longer just a band-aid for the situation ... we are helping families over the long term” (Armstrong et al., 2009, pg. 19). Another focus group participant reiterated, “Overall, the negativity and helplessness and hopelessness that existed in the dependency system is reduced because we are functioning at a different level” (Vargo et al., 2010, pg. 20).

In summary, both case managers and lead agency leadership have experienced many positive impacts of IV-E Waiver implementation. More importantly, these positive impacts have also reached children and their families. During some of our focus groups and case studies, participants were asked to reflect on the sustainability of these positive outcomes, and what would happen if the Waiver were not renewed. At a service and practice level, some respondents felt that losing the IV-E Waiver might set their system of care back by 20 years. Explained one participant: “you would see an over-capacity foster care system where you've got children sleeping on floors, case workers with around 40 or more cases, and a system that really isn't able to work on their quality improvement process” (Vargo et al., 2011, pg. 64).

All respondents felt that child-level outcomes would worsen without renewal of the IV-E Waiver. Respondents explained that prior to the Waiver, most parents were simply told to take a parenting class and to have a few clean drug screens, and their children would be returned, rather than providing families with the continuum of services they really needed to raise their children. Therefore, if the Waiver were not to be renewed, it is thought that recidivism rates would dramatically increase. Finally, it was believed that the larger community as a whole would suffer should the IV-E Waiver not be renewed. A respondent explained,

What does losing the Waiver mean to a city, to a state? It means you're going to have a large portion of your population that will become even greater have-nots than they are today. The IV-E Waiver has given us the opportunity to provide job training, educational opportunities, and allowed families to re-engage in a process they've been locked out of in the past (Vargo et al., 2011, pgs 65).

## **Summary**

As originally hypothesized, the number of children that entered out-of-home care significantly declined during the Waiver period. This decline impacted residential providers who had to change populations served, move from out-of-home care beds to the prevention arena, or consider closing their doors as the demand for residential facilities decreased. Lead and

provider agencies experienced smaller caseloads, more time to engage families, and in some areas increases in morale and declines in turnover rates.

## Hypothesis 2

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

Findings from three analysis components relevant to Hypothesis 2 (programmatic outcomes, family assessment and services, and implementation analyses) are reported in this section. The programmatic outcomes analyses tracks changes in the child outcomes listed below in the Terms and Conditions over six successive annual cohorts of children. The family assessment and services analyses utilize data related to child and family well-being from case managers, parents, Florida DCF case management quality of practice reviews, and the National Survey of Child and Adolescent Well-Being (NSCAW) study. The implementation analysis data provide contextual and implementation process information that informs our understanding of the quantitative findings from the administrative data analyses.

### **Terms and Conditions 3.3 Outcome Evaluation Domains:**

- Do children achieve permanency more quickly through either reunification or adoption?
- Has child safety been maintained?
- Has child well-being increased?

For each research question, the State or its evaluation contractor will establish and track appropriate outcome measures, including, but not limited to:

- Number and proportion of children exiting foster care within 12 months of removal from the home;
- Number and proportion of children remaining in foster care 12 months following removal from the home;
- Mean/median length of stay in foster care; and
- Number and proportion of children adopted within 24 months of out-of-home placement.

The State's evaluation will track all outcome measures in relation to gender, age, race, and, as appropriate, placement type or setting.

## **Programmatic Outcomes Analysis**

The flexible funding associated with the IV-E Waiver demonstration project allowed for the use of IV-E funds for various services and activities beyond out-of-home care maintenance

and administration. Waiver legislation was developed as a strategy to stimulate the implementation of innovative services, enhance existing interventions, and expand services known to be effective in achieving improved child safety, permanency, and well-being outcomes for children within the child welfare system. It was expected that an increase in the variety of services, improvement of service provision, and improvement in child welfare practices would positively impact child outcomes including timely permanency, greater placement stability, prevention of re-entry into out-of-home care, and recurrence of maltreatment.

Several key outcomes related to permanency and safety were hypothesized to improve over time and were examined in this outcomes analysis<sup>3</sup>. First, an increased array of services available for families or caregivers should substantially increase the number of children who achieve timely permanency (i.e., reunification with parents, placement with relatives or permanent guardians, or adoption). Second, enhanced services provided to families after reunification should significantly reduce the number of children re-entering out-of-home care, and reduce the number of children who experience recurrence of maltreatment after services have ended. Finally, enhanced services provided to children while they are in out-of-home care should lead to a reduction in the number of placements and length of stay in out-of-home care. To examine these hypothesized outcomes, specific indicators were developed and calculated. The indicators were selected and developed in collaboration with the Florida Department of Children and Families. Some of the selected measures are replications of federal CFSR measures developed by the Administration for Children and Families. In addition, the impact of several child and family characteristics on outcome indicators was assessed.

### **Methodology.**

The outcomes analysis tracks changes in six successive cohorts of children who were followed from the time they were either placed in or exited from out-of-home care. Two pre-implementation (baseline) cohorts (FFY 04-05 and FFY 05-06) and four post-IV-E Waiver implementation cohorts (FFY 06-07 through FFY 09-10) were included in the analysis. The overall study design includes the comparison of successive annual cohorts of children entering/exiting out-of-home care or children whose services ended. All indicators were calculated statewide, and cohorts were constructed based on a federal fiscal year. The data used to produce these indicators covered the period FFY 04-05 through FFY 10-11. The following indicators were examined:

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<sup>3</sup> Child and family well-being outcomes are examined in the family assessment and services component, which appears beginning on page 50.

### ***Permanency indicators***

- Proportion of children who achieved permanency within 12 months of removal
- Proportion of children who were either reunified or placed with relatives within 12 months of removal
- Proportion of children who were adopted within 24 months of removal
- Median length of stay in out-of-home care
- Proportion of children experiencing two or fewer placements within 12 months of removal

### ***Safety indicators***

- Proportion of children who exited out-of-home care and re-entered within 12 months
- Proportion of children with recurrence of maltreatment within six months of service termination

### ***Predictor variables***

- Child age
- Child race
- Child gender
- Presence of child emotional problems
- Presence of child physical health problems
- Parental substance abuse
- History of domestic violence in the family

### ***Characteristics of children in out-of-home care***

All children that were placed in and/or exited out-of-home care during FFY 04-05 through FFY 09-10 were included in the study. Of these youth, 50% were male. The average age was almost 7 years ( $M = 6.6$ ,  $SD = 5.4$ ). A majority of children (61%) were White, 29% were African-American, 9% were Hispanic, and the remaining 1% were from other racial or ethnic groups. A substantial proportion of these youth (45%) had parents with substance abuse problems, and 16.7% of these youth came from families with domestic violence histories. In addition, 7.3% of

children who were placed in out-of-home care had physical health problems, and 3.3% had emotional problems<sup>4</sup>.

### ***Sources of data***

The data sources for the quantitative child protection indicators used in this report were data abstracts taken from the Florida Safe Families Network (FSFN).

### ***Analytical approach***

The analyses for all above mentioned indicators were conducted for the whole state. Although we utilized all available observations for the state of Florida and no sampling was done, we employed inferential statistics. The use of inferential statistics was based on the following assumptions: (1) the population members are drawn from a hypothetical super-population, such as children exiting into permanency in the future. Therefore, we have a sample of *potential* or *possible* cases; (2) any observation includes measurement error; and (3) the outcomes are the result of a random process applied to each member of the population, conditional on covariates (Brillinger, 1986). Effect sizes (e.g., odds ratios) were used to present and interpret statistical findings because they represent the magnitude and direction of the relationships of interest and are relevant even under the assumption that the analytic dataset represents the “true” population.

The unit of analysis for all aforementioned indicators was at the state level. Statistical analyses consisted of life tables (a type of event history or survival analysis<sup>5</sup>), Cox regression analyses (Cox, 1972)<sup>6</sup>, analysis of variance (ANOVA), and chi-square tests of association.

### ***Limitations***

It is important to note a few limitations in conducting the programmatic outcomes analysis. below. First, the study design did not include a comparison group (e.g., counties where the Waiver was not implemented) because the Waiver was implemented statewide. Because a comparison group was not available, longitudinal comparison was performed using baseline cohorts. No time by group interaction was conducted. Second, due to data limitations, predictor

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<sup>4</sup> The percentage of children with emotional problems reported here is substantially lower than estimates in the literature based on state and federal data. Similarly, the estimates of children from families with substance abuse and domestic violence problems may be low due to an underreporting of these problems.

<sup>5</sup> Survival analysis, referred to here as event history analysis, is a statistical procedure that allows for analyzing data collected over time as well as for utilizing information about cases where the event of interest did not occur during data collection (e.g., children who did not exit out-of-home care during the 12-month period). This technique allows for calculation of the probability of an event occurring at different time points (e.g., in 12 months after entering out-of-home care).

<sup>6</sup> A type of event history analysis that allows for inclusion of predictor variables or factors that were hypothesized to affect the outcomes.

variables were limited to child demographic characteristics, presence of child physical health or emotional problems, and only two family characteristics: (a) presence of domestic violence in the family and (b) parental substance abuse. There may be other unmeasured factors that are related to the outcomes analyzed below. Third, changes in placement stability were examined using aggregate data rather than child level data and, therefore, statistically significant differences were not examined. Fourth, the number of children with emotional problems is likely underestimated in FSFN data sets. Previous findings based on Florida data indicated that about 40% of children served in out-of-home care had mental health problems (Clark, C., Yampolskaya, S., & Robst, J., 2010). A study based on a nationally representative sample of children who were investigated by child welfare indicated that approximately 42% of children have significant mental health issues (Hurlburt et al., 2004; Leslie et al., 2000).

### **Findings.**

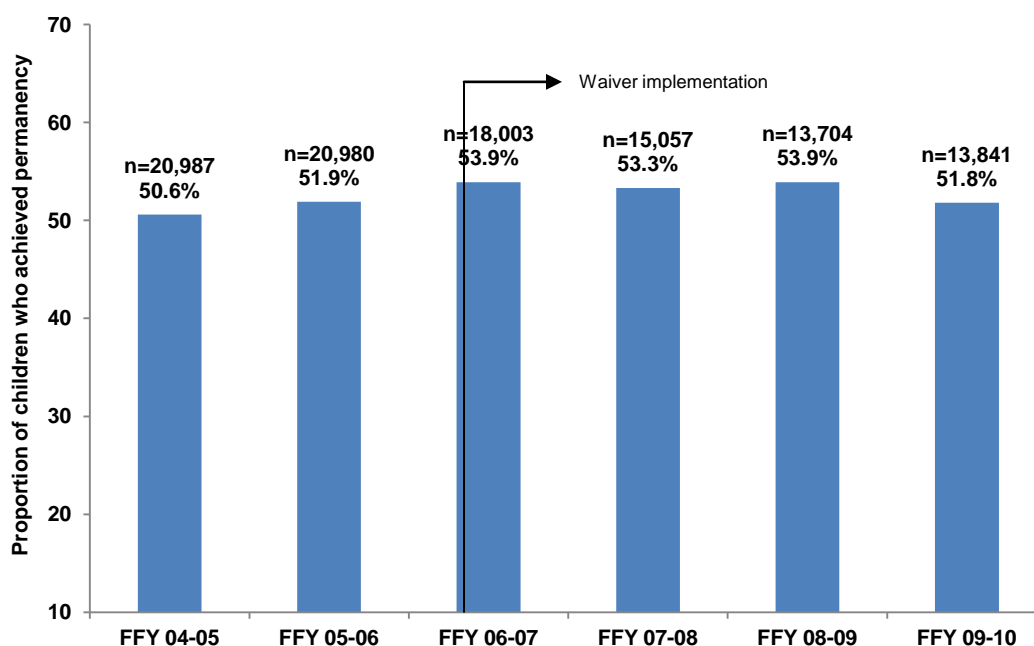
#### ***Proportion of children who entered out-of-home care and achieved permanency within 12 months of removal***

The proportion of children who exited out-of-home care into permanency during the first 12 months after the most recent removal was calculated for six consecutive cohorts based on FFY 04-05 through FFY 09-10. *Exit into permanency* consists of the following reasons for discharge: (a) finalized adoption, (b) guardianship to relatives or non-relatives, (c) long-term custody to relatives or non-relatives, (d) living with other relatives, or (e) reunification with parents or original caregivers.

All children who entered out-of-home care during FFY 04-05 through FFY 09-10, as indicated by the removal date in FSFN, were followed for 12 months, and the proportion of children who exited out-of-home care into permanency (e.g., discharged for permanency reasons) was calculated (see detailed description of this indicator in Appendix B, Measure 2).

As illustrated in Figure 5, the highest proportion of children exiting out-of-home care into permanency was observed in the FFY 06-07 and FFY 08-09 entry cohorts (53.9%). Although the FFY 09-10 cohort had a slightly lower proportion of children exiting into permanency than did the FFY 08-09 cohort, there was a small but statistically significant increase in the proportion of children exiting out-of-home care into permanency over the full Waiver period (see Appendix C, Table 2). There is no national standard for this measure.

Figure 5. Proportion of children exiting out-of-home care who achieved permanency within 12 months of removal



### ***The effect of child and family characteristics on timely permanency***

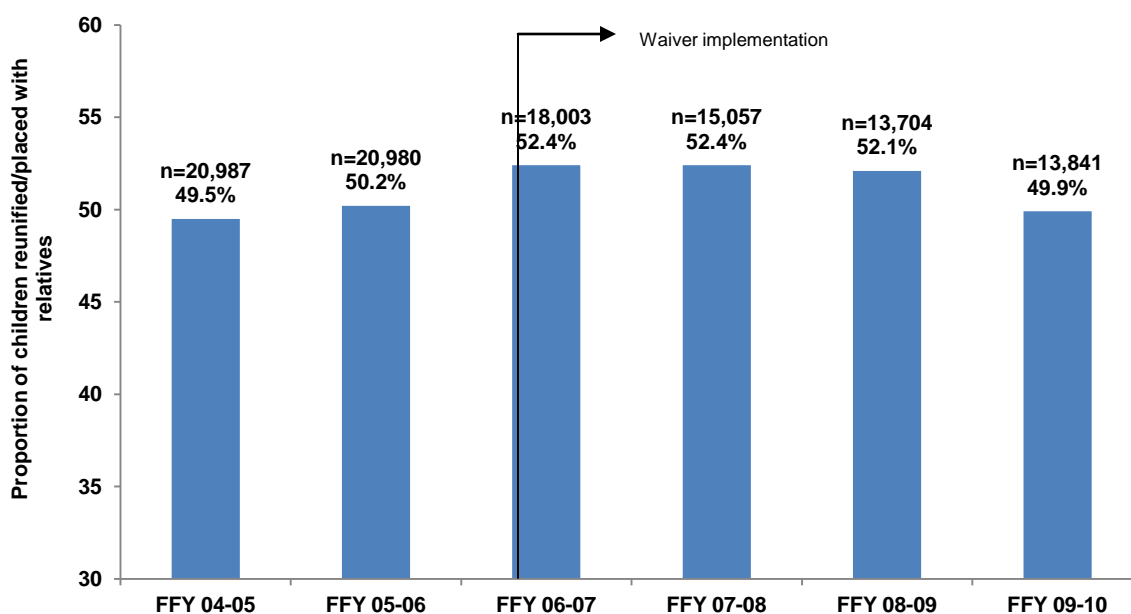
When predictor variables were examined using Cox regression, child age, race, presence of emotional problems, physical health problems, parental substance abuse problems, and domestic violence in the child's family were found to be significantly associated with timely achievement of permanency. Youth with physical health problems were 34% less likely to achieve permanency within 12 months than children who did not have these problems (see Appendix C, Table 3). Youth with emotional problems and youth whose parents had substance abuse problems were 13% and 5%, respectively, less likely to achieve permanency within 12 months than children who did not have these problems. African-American youth were 6% less likely to achieve permanency within 12 months of entry, and each additional year of age was associated with 1% lower odds of exit into permanency within 12 months of entry. Children from families with domestic violence problems were 16% more likely to achieve permanency within 12 months of entry into out-of-home care than children who came from families without these problems.

***Proportion of children who entered out-of-home care and achieved permanency through reunification or placement with relatives within 12 months of removal***

The proportion of children who entered out-of-home care and were subsequently discharged due to reunification or placement with relatives during the 12 months after entry was calculated for federal fiscal year cohorts that entered care during FFY 04-05 through FFY 09-10. Only three reasons for discharge were included in the calculation of this indicator: (a) long-term custody to relatives, (b) relative guardianship, including other guardianship and living with other relatives, or (c), reunification with parents or original caregivers (see detailed description of this indicator in Appendix B, Measure 3).

As illustrated in Figure 6, across the entire evaluation period, there was a slight increase in the proportion of children who were reunified or placed with relatives over time, and this increase was statistically significant (see Appendix C, Table 4). There is no national standard for this measure.

*Figure 6. Proportion of children reunified or placed with relatives within 12 months of removal*



***The effect of child and family characteristics on timely reunification or placement with relatives***

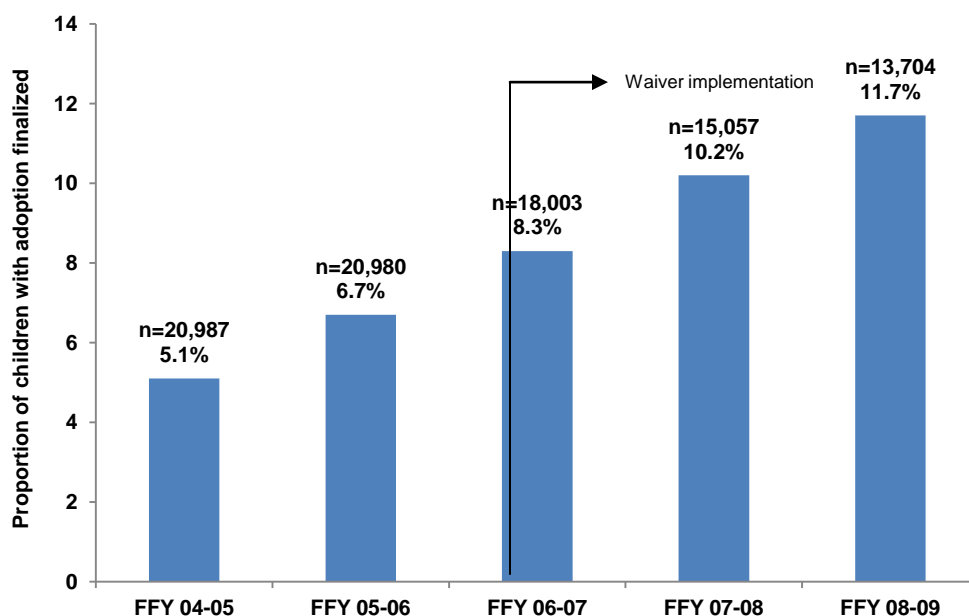
When the effects of child and family characteristics were examined, all predictors except child gender were found to be significantly associated with timely reunification or placement with relatives (see Appendix C, Table 5).

Specifically, older children and children who came from families with domestic violence issues were more likely to be either reunified or placed with relatives. In contrast, children who had physical or emotional problems were less likely to experience timely discharge from out-of-home care to reunification or placement with relatives. Children with physical health problems were 50% less likely and children with emotional problems were 22% less likely to be reunified or placed with relatives. African-American youth and children whose parents had substance abuse problems were also less likely to be reunified or placed with relatives within 12 months.

***Proportion of children where adoption was finalized within 24 months of removal***

The calculation for this indicator was based on entry cohorts of children who were removed and placed in out-of-home care during a specific fiscal year. Beginning with FFY 04-05, five cohorts of children were tracked for 24 months after their removal from home to determine if they were adopted within this timeframe (see Appendix B, Measure 4). Figure 7 shows the proportion of children, by FFY entry cohort, who were adopted within 24 months of their removal from home. The average proportion of children who were adopted within 24 months of their removal across all examined fiscal years was 8.4%. The proportion of children with adoption finalized within 24 months significantly increased after the Waiver began. Specifically, the proportion of youth achieving finalized adoption more than doubled, from 5.1% for the FFY 04-05 cohort to 11.7% for the FFY 08-09 cohort (see Appendix C, Table 6). Although there is a national standard for this indicator, the algorithm used for the national standard is based on exit cohorts, whereas the algorithm used for this report is based on entry cohorts. However, in semi-annual progress report 5 (Vargo et al., 2009), when the algorithm used to calculate adoption was similar to that used for the national standard, the average proportion of children in Florida who were adopted within 24 months was 39.1%. The national standard for this indicator is 32% (U.S. Department of Health and Human Services, Administration for Children and Families, 2001).

Figure 7. Proportion of children with adoption finalized within 24 months of removal



### ***The effect of child and family characteristics on timely adoption***

Most child and family predictors examined were significantly associated with timely adoption. The strongest predictors were presence of physical health problems, presence of emotional problems, and domestic violence (see Appendix C, Table 7). Children with physical health problems were three times more likely to be adopted than children without physical health problems. Youth with emotional problems were 51% more likely to be adopted, while White youth and children whose parents had substance abuse problems were 15% and 14%, respectively, more likely to be adopted within 24 months. Younger children were more likely to be adopted, and each year of younger age corresponds to a 14% increased likelihood of timely adoption.

Two factors were significantly associated with lower odds of timely adoption. Youth from families with domestic violence were 36% less likely to be adopted. Boys were 9% less likely to experience timely adoption than girls.

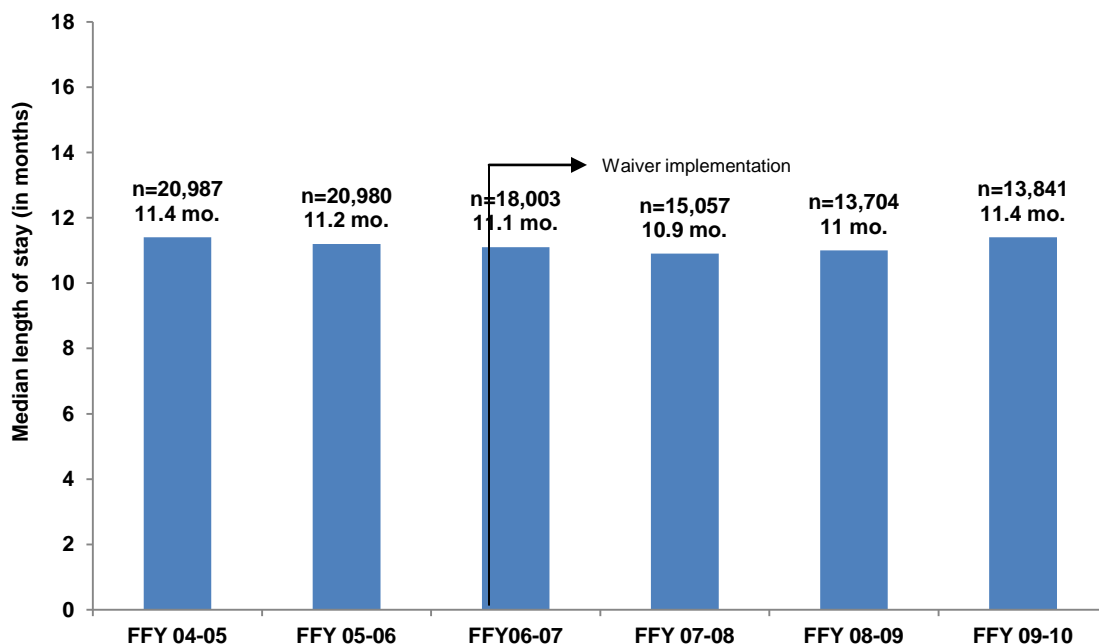
### ***Median length of stay***

Statewide performance on permanency, based on entry cohorts, was also examined by calculating the median length of stay in out-of-home care for children who exited out-of-home care, regardless of how permanency was achieved (see Appendix B, Measure 5). Figure 8

shows the median length of stay for children who entered out-of-home care in FFY 04-05 through FFY 09-10 and exited out-of-home care for any reason. The median length of stay in out-of-home care for children who entered out-of-home care in FFY 04-05 was 11.4 months. For the FFY 08-09 cohort the median length of stay dropped to approximately 11 months, but then increased by 0.4 months for the entry cohort FFY 09-10. The median length of stay across all examined fiscal years was approximately 11 months.

Although a statistically significant decrease in the median length of stay in out-of-home care was observed ( $OR = 1.02, p < .05$ ), the resulting odds ratio was close to 1.00 indicating that the magnitude of the decrease is negligible (see Appendix C, Table 13). There is no national standard for this measure. As was previously mentioned, no change in the median length of stay may be related to the changes during the waiver period in the characteristics of the population of children served in out-of-home care (Vargo et. al., 2010).

*Figure 8. Median length of stay for children in out-of-home care and exiting for any reason*



### ***Stakeholder perspectives on achieving permanency***

Midway through the Waiver, interviews for the implementation analysis revealed a number of strategies that lead agencies used to promote permanency. The examples involve supports for relative caregivers, efforts to increase timely adoptions, changes in practice when children are placed in shelters, and concurrent changes in the judicial system. Some permanency challenges were also identified.

One lead agency placed a strong emphasis on relative caregivers so that when a removal is necessary, the preference is a relative caregiver so that the child remains within the family and community. Another lead agency introduced a number of supports and services for kinship caregivers. Through a grant from the Kellogg Foundation the lead agency has implemented a comprehensive training curriculum for kinship caregivers, “basically a MAPP (Model Approach to Partnerships in Parenting) class for relative caregivers” (Vargo et al., 2010, pg. 40). The kinship caregiver program now includes three case managers, two navigators who are paraprofessionals, and a peer mentor who is a grandmother raising her grandchildren and who mentors other caregivers. Other resources include monthly support groups, assistance with applying for state benefits, and an attorney on contract who helps caregivers with wills and trusts, obtaining power of attorney when necessary, and adoption proceedings.

Another lead agency put into place a new strategy for situations where a child is removed and placed in a shelter. When this happens, a case manager is present at the shelter within 24 hours and works jointly with the CPI for 10-12 days. The goals are to engage the family earlier, increase the identification of relatives, and conduct more thorough assessments of what the child and family needs.

One lead agency recently introduced an innovative practice that facilitates timely adoptions. Adoption Chronicles is a method for recruiting adoptive families through videotaping an interview with the child who is available for adoption. The videos are then posted on a website where prospective adoptive families can view them. The belief is that this approach is less intrusive for the child. Prospective adoptive families can also create a videotape that can be shared with a child.

Changes were identified in how the judicial system viewed families including permanency-related decisions. For example, in the past when children were removed from an offending parent and placed with a non-offending parent, the court insisted on keeping the case open and working the reunification plan. Now the court is allowing closures of cases with non-offending parents. Another change is when a family is involved with the child welfare system and a baby is born, previously this baby would be placed in care if the family did not have the other children back. Now with prevention and diversion services in place, case managers are able to work with the family and keep the baby at home. In the past, one positive drug screen could have meant removal. Another case manager commented that judges seem to be more understanding about the economic struggles of families today. One lead agency employs Dependency Court Resource Facilitators who are moving cases to permanency. This service provides a neutral and non-adversarial approach to addressing barriers to meeting the family's

permanency goal. Common issues which lead to facilitation include working out visitation schedules, discussing case plan proposals, and identifying resources for case plan completion.

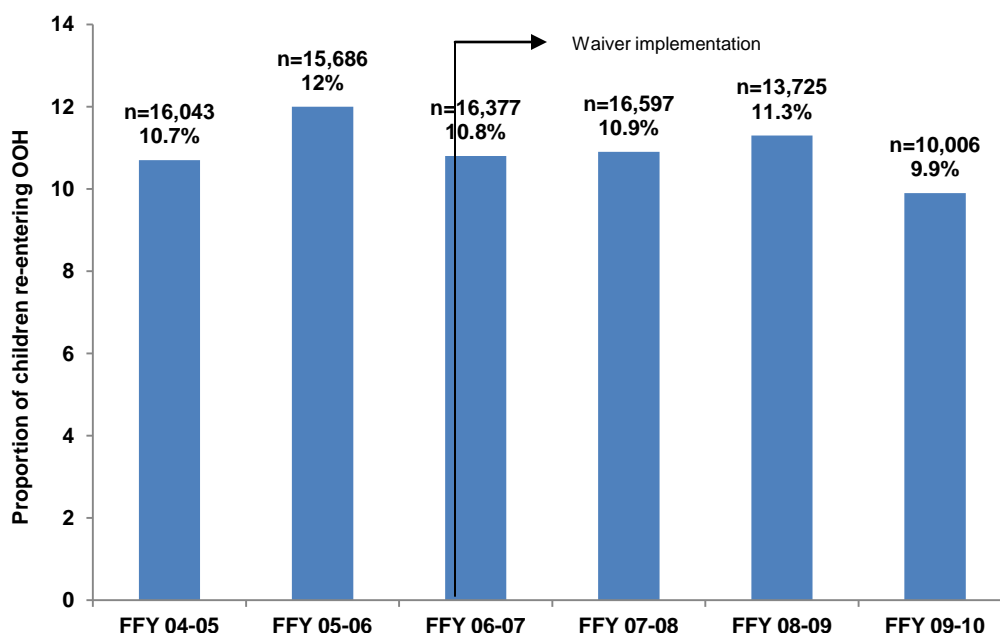
Concern was expressed by residential providers midway through the Waiver period that children were reunified with their family when it was sometimes unclear whether the parents had received the services that they needed in order to care for their child. When reunified children need to be placed again, the children are more disruptive, angry and confused. Finally, the perception of some residential providers was that “sometimes the dollar drives the placement, not the level of care” (Vargo et al., 2010, pg. 41). The concern was that children with complex and challenging behaviors were being placed in lower levels of care, then disrupt, and need to be placed at a higher level of care rather than initially placing the child in the most clinically-appropriate placement (Vargo et al., 2010).

#### ***Proportion of children re-entering out-of-home care within 12 months of exiting***

The calculation for this indicator was based on exit cohorts of children who were discharged from their first out-of-home care placement for reunification or placement with relatives and who were subsequently followed for 12 months to determine if they re-entered out-of-home care (see Appendix B, Measure 6).

Figure 9 shows the proportions of children reunified or placed with relatives during FFY 04-05 through FFY 09-10 and who subsequently re-entered out-of-home care within 12 months after exit. The average proportion of children who re-entered out-of-home care within 12 months after their discharge across all cohorts was 10.9%. Although the proportion of children who re-entered out-of-home care decreased from 10.7% for the FFY 04-05 exit cohort to 9.9% for the FFY 09-10 exit cohort, the results of Cox regression analysis indicated no significant change in re-entry rates over time (see Appendix C, Table 9). Therefore, safety for children was maintained. A State meets the national standard for this indicator if, of all children who entered foster care during the year under review, 8.6% or fewer of those children re-entered foster care within 12 months of a prior foster care episode (U.S. Department of Health and Human Services, 2001).

Figure 9. Proportion of children re-entering out-of-home care within 12 months after exiting for reasons of reunification or placement with relatives



### ***The effect of child and family characteristics on re-entry into out-of-home care***

When factors associated with re-entry were examined, all examined child and family characteristics were significant predictors for re-entry into out-of-home care (see Appendix C, Table 10). Youth with emotional problems were 37% more likely to re-enter out-of-home care, while youth with physical health problems had 12% higher odds of re-entry than youth without these problems. Compared with Hispanic youth, White and African-American youth were 35% and 21%, respectively, more likely to re-enter out-of-home care. Children whose parents had substance abuse problems were 11% more likely to re-enter out-of-home care.

There were three factors associated with lower odds of out-of-home care re-entry. Youth from families with domestic violence problems were 9% less likely to re-enter out-of-home care, while boys were 4% less likely than girls to re-enter out-of-home care. Each additional year of age corresponded to a 3% lower likelihood of re-entry.

### ***Stakeholder perspectives on re-entry into out-of-home care***

Several implementation analysis focus group participants believed that there is a relationship between lengths of stay and re-entry rates and provided various reasons for this. The longer a child is in care, the harder it is for the family to sustain the child's return. The belief is that children return home "with a list of issues they didn't leave [their homes] with" (Vargo et

al., 2009, pg. 27). In addition, the longer a child stays in care, the more likely they will have multiple placements and bounce around the system causing more trauma and damage to the child. Another perspective was that the longer a child is in care, the more difficult it becomes for parents to follow a case plan.

Other participants were not convinced about the aforementioned relationship between out-of-home care lengths of stay and probability of re-entry and instead believed that other factors contributed to re-entry. For example, there may not be agreement locally about reunification decisions between legal services, the judiciary, GALs, parents, and the lead agency. Two focus groups described “reunifications over our objection” (Vargo et al., 2009, pg. 27), situations where the case manager did not feel that the parents were ready to resume care but either the parent(s), the GAL, or the judge disagreed and the child was returned home. One lead agency tracks these decisions and how many of the children come back into care. Other respondents noted that the federal timelines regarding reunification “don’t always align with the timelines that it takes parents to overcome whatever issues brought them to our attention” (Vargo et al., 2009, pg. 27). The timing of the steps of family engagement and service provision are unique for each family. And, it takes time for parents to both complete tasks on the case plan and make “some changes in their behaviors that are going to stick” (Vargo et al., 2009, pg. 27).

Another distinction was made about what is classified generally as reunifications. In some situations, re-entry happens due to failed guardianship or kinship care arrangements. At times, this may be due to lack of supportive services for guardians. Several participants noted that we need to develop a continuum of care for relative caregivers. Despite the flexibility of the Waiver, “we still continue to support children in licensed care in a different fashion than we do with children in relative placements” (Vargo et al., 2009, pg. 27-28). It was noted that due to the nation’s economic situation, many guardians are experiencing financial stress.

A few participants noted that the system needs to grapple with the issue of what is an acceptable re-entry rate. Many families in the child welfare system have either substance abuse issues. Research shows that many of these parents will relapse about seven times and some will not recover fully. This knowledge needs to be integrated into child welfare practice. For example, a decision may still be made to reunify a child, but a safety plan including alternative placement arrangements, perhaps with relatives, needs to be in place for these families at the time of reunification.

Finally, participants noted that once the case plan has been completed, treatment services and community supports need to be in place to ensure a successful reunification.

Participants emphasized that services need to be offered to parents before reunification as well as afterwards. Some lead agencies are using Family Team Conferencing with families at the time of reunification. Another agency offers reunification support groups to all parents with children in foster care. Participants spoke about the need for immediate “follow home care” with appropriate services once a child has been returned. It was noted that some parents need more than the six months of services post-reunification that are statutorily required and that this can be difficult to finance. A related challenge is locating long-term informal supports for at-risk families (Vargo et al., 2009).

***Recurrence of maltreatment within six months after services were terminated***

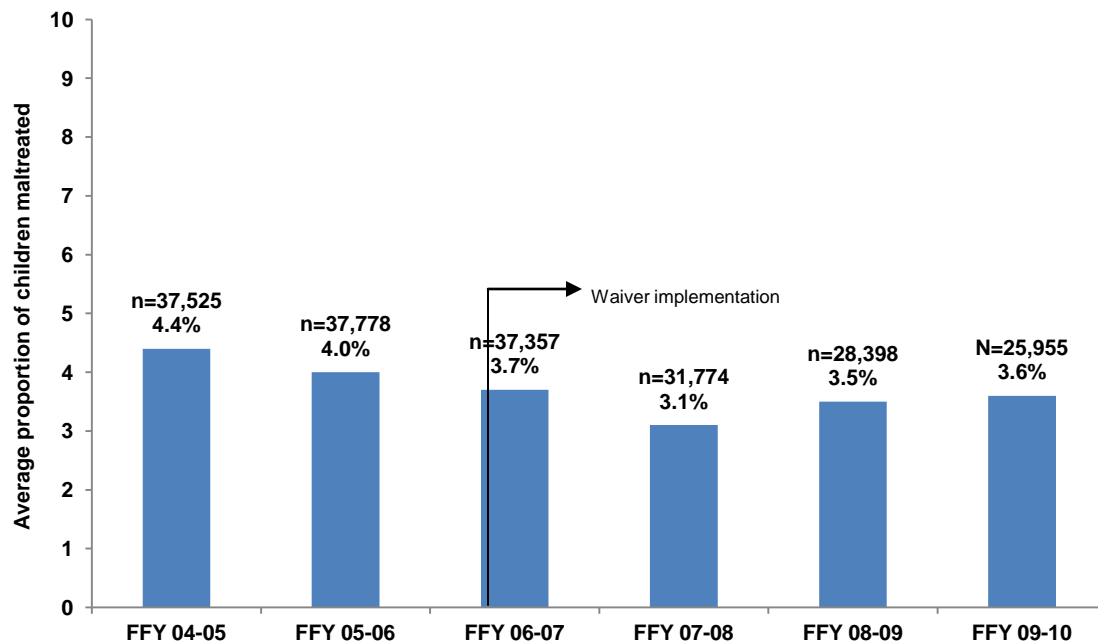
The calculation for this indicator was based on exit cohorts of children whose services were terminated due to either: (a) discharge from a removal episode during the federal fiscal year, or (b) exit from in-home services during the federal fiscal year, with no removal episode. These children were followed for six months to determine if they were reported as the victims of subsequent verified maltreatment (see Appendix B, Measure 7)<sup>7</sup>.

The average proportion of children across all examined federal fiscal years that experienced recurrence of maltreatment was 3.7%. After the FFY 04-05 cohort, the proportion of children experiencing recurrence of maltreatment gradually declined across the following five exit cohorts (Figure 10). The results of Cox regression analysis indicated that this decline was statistically significant (see Appendix C, Table 11). There is no national standard for this specific measure.

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<sup>7</sup> All recurrence of maltreatment measures published prior to 2006 reported to the National Child Abuse and Neglect Data System (NCANDS) included cases with verified maltreatment or some indication of maltreatment.

Figure 10. Average proportion of children who were maltreated within six months after service termination



### ***The effect of child and family characteristics on recurrence of maltreatment***

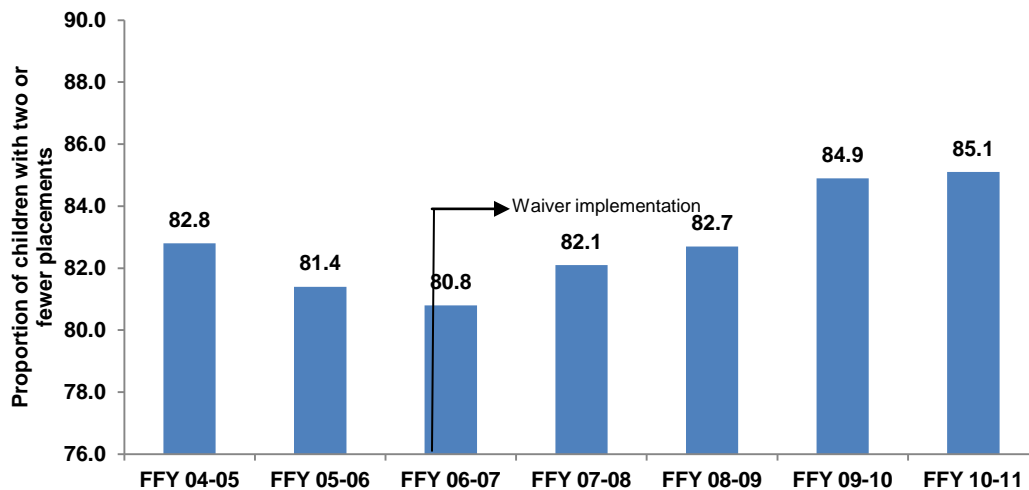
Four factors were significantly associated with recurrence of maltreatment (see Appendix C, Table 12). Children from families with a history of domestic violence and children whose parents had substance abuse problems were twice more likely to experience recurrence of maltreatment than children whose families did not have these problems. The presence of physical health problems was associated with 43% higher odds of recurrence of maltreatment. Younger children were more likely to experience recurrence of maltreatment, and each decreasing year of age corresponded to a 5% increased likelihood of recurrence of maltreatment.

### ***Proportion of children experiencing two or fewer placements within 12 months of removal***

This indicator is based on cohorts of children who were in out-of-home care at least eight days but less than 12 months (see Appendix B, Measure 8). The proportion of children with two or fewer placements within 12 months of removal date was examined for seven federal fiscal years beginning with FFY 04-05 (U.S. Department of Health and Human Services, 2007; U.S. Department of Health and Human Services, 2009). The proportion of children with no more than

two placements within 12 months across the examined years was approximately 82.8%. Figure 11 shows that the percentage of children with no more than two placements increased by 2.3 percentage points during the evaluation period, from 82.8% during FFY 04-05 to 85.1% during FFY 10-11 (<http://cwoutcomes.acf.hhs.gov/data/downloads/pdfs/florida.pdf>)<sup>8</sup>. A state meets the national standard for this indicator if, of all children who have been in foster care less than 12 months from the time of the latest removal, 86.7% or more children had no more than two placement settings (U.S. Department of Health and Human Services, 2001).

*Figure 11. Proportion of children experiencing two or fewer placements within 12 months of removal*



### ***Stakeholder perspectives on achieving placement stability***

Throughout the implementation analysis focus group discussions, participants mentioned several approaches to facilitating and improving their performance on placement stability. Many of these facilitators are, at least in part, enabled by the flexibility that the IV-E Waiver provided to their local systems. The emergent themes related to facilitating placement stability were timely and appropriate assessment of children and matching to services, foster home recruitment, retention and capacity, identifying and supporting relative placements, providing behavioral support training to all placement types, and targeted review committees.

Appropriate assessment at the front end of service delivery was commonly mentioned as a way to deter placement instability down the road. Identifying children's needs earlier through

<sup>8</sup> No tests of statistical significance were performed due to unavailability of child-level data for this measure.

appropriate assessment tools and matching them to the needed services as soon as possible was seen as critical.

Another strategy was more careful examination of a potential removal by several different experts before it actually takes place. In addition, some lead agencies were holding monthly placement review meetings, where each placement change is discussed and hashed out as to whether it could have been avoided and what might have been done differently.

Alternately, other lead agencies hold such meetings for cases that are at risk of placement disruption, (e.g., those due to behavioral challenges) and attempt to put the necessary supports in place to avoid disruption. Yet another step being taken is that lead agencies are using data to zero in on specific target groups within their out-of-home care population who are having the most placement disruptions. Teens are often in this category. Therefore, more targeted case management and wraparound services are being directed toward these groups. For example, one lead agency has identified 40 teens that change placements the most within their system and has created a special case management unit with very low caseloads in an attempt to increase stability over time for these youth.

In the implementation analysis focus groups, it was generally acknowledged that philosophy of care and values inherent to a lead agency's administration and leadership impact decisions regarding practice, and subsequently, child level outcomes including placement stability. Lead agency respondents discussed examples when they have sided with the best interest of a child and changed a placement rather than maintaining a placement to maintain superior performance on the placement stability measure. For instance, if a child initially had to be placed outside of his or her community or school district due to a lack of local placement options, some participants felt strongly that, should a more local placement become available, it was worth strong consideration to move the child back to familiar surroundings. One stakeholder explained, "I don't care how many times we have to move them. I will get a child back to their own area and their own school" (Vargo et al., 2009, pg. 32).

Another example offered was if a sibling group comes into care and the only option at entry is to split the children up in different homes due to lack of capacity. Once a foster home becomes available that is willing to take the entire sibling group, lead agencies often prefer to make this placement change to reunite siblings. Stakeholders who discussed such examples during the focus groups expressed that it was unfortunate in these cases that doing what seemed best for the child technically counted against their agency's performance on the placement stability indicator.

As philosophical perspectives shift on removing children from their families of origin, and more in-home services can be funded via the IV-E Waiver, the focus of the discussion may eventually turn to avoidance of removal/placement in and of itself. As one stakeholder articulated, “More and more I am becoming a believer that kids need to stay with their own families. I don’t care how good a home you put them in, children want their own parents. I have a fundamental problem with [placement stability] as a measure of system failure because the failure is the placement into care, and after that it is all downhill” (Vargo et al., 2009, pg. 32).

Finally, stakeholders had concerns about moves related to the mental health functioning of children in care and that changes in levels of care should be delineated and not counted toward overall placement moves. One stakeholder explained, “Any kind of plan, structures, step down for the child results in blowing your placement stability; we are struggling with that” (Vargo et al., 2009, pg. 33). Put simply, every change is not necessarily a bad change for a child, including increasing or decreasing a level of care, when it is clinically appropriate. One lead agency is asking its higher level of care placement providers to keep a child who is ready to be stepped down for a lower rate, with the incentive that if they retain that child for a specified amount of time after the step down occurs; they receive a monetary bonus as a reward for facilitating stability (Vargo et al., 2009).

**Terms and Conditions 3.2 Process Evaluation Domain:**

- Were needs assessments conducted for eligible children and families, and did the assessments identify services and interventions appropriate for the unique circumstances and characteristics of families?
- To what extent were enrolled families engaged in case planning and decision making?
- Did families participate in community-based services and programs to the degree expected?
- Were participants satisfied with the services provided through the demonstration?

### **Family Assessment and Services Analysis Methodology**

The findings related to the Terms and Conditions process evaluation domains above are primarily from the family assessment and services analysis which collected and utilized data from four sources: case managers, parents, Florida DCF case management quality of practice reviews, and the National Survey of Child and Adolescent Well-Being (NSCAW) study. Data from the implementation analysis are used to inform our understanding of the findings.

### **Case manager focus groups.**

Five focus groups were conducted with case managers in two Florida Circuits, each served by a separate CBC lead agency. The focus groups were conducted at case management organization offices and included five to 12 case management staff per group for a total of 38 participants. Case managers discussed the assessment, case planning, and service provision processes as practiced in their service areas (Vargo et al., 2009).

### **Parent interviews.**

The evaluation team worked with one lead agency to recruit parents for interviews (Vargo et al., 2010). A lead agency representative made the first contact with parents and obtained their written consent to release their contact information to the evaluation team. Once this information was received, an evaluation team member contacted each parent to confirm their willingness to voluntarily participate in an interview. All interviews were scheduled for times convenient to parents and conducted via telephone. Participating parents were sent a \$25.00 money order. In total, 11 parents were interviewed: six were involved in prevention program services (a voluntary program established by the lead agency), three took part in voluntary protective services (VPS) cases, and two had children placed in out-of-home care.

### **Florida DCF case management quality of practice reviews.**

Although aggregated data from the Florida DCF case management quality of practice reviews were presented in previous IV-E Waiver evaluation reports (Armstrong et al., 2010; Vargo et al., 2011), case-level analysis was conducted for the final report to determine if any significant differences over time existed. The primary data was collected as part of DCF's regularly scheduled quality assurance reviews for state fiscal years 2008-2009, 2009-2010, and 2010-2011. Data was collected for only three quarters in SFY 09-10 due to special reviews related to psychotropic medications and in SFY10-11 due to a special focus on cases with the permanency goal of another planned permanency living arrangement (APPLA). Twenty-three standards were selected for analysis that align with the Child and Family Services Review (CFSR) items. Appendix D provides a brief description of each standard.

### **NSCAW study.**

To allow for a pre-post comparison of Waiver implementation NSCAW data was utilized (Armstrong et al., 2011). Funded by the Administration for Children and Families within the U.S. Department of Health and Human Services, the NSCAW study generated the only national,

longitudinal data on families that were subjects of child maltreatment investigations or assessments conducted by child protective services agencies in the United States. These data are nationally representative of all families investigated for maltreatment in the U.S. during the sampled time periods, excepting only those states whose human subject protection protocols required that families be contacted first by state child welfare professionals instead of NSCAW survey representatives.

State and national level NSCAW data is presented from three cohorts of children and their families: (a) NSCAW I for Florida, which sampled from families investigated or assessed for maltreatment between October 1999 and December 2000, (b) NSCAW II for Florida, which sampled from families investigated or assessed for maltreatment between February 2008 and April 2009, and (c) NSCAW II National cohort. In both NSCAW I and NSCAW II Florida cohorts, five primary sampling units from the state were included, each corresponding to the service area of a single lead agency. Survey questions were parallel across cohorts. Only survey items that aligned with Florida DCF case management quality of practice standards related to family well-being were selected for analysis. Although NSCAW primary data collection occurred in multiple waves, only baseline data for each cohort were included in the current report. For additional information and a full description of the NSCAW primary data collection procedures, see Armstrong et al., 2011.

## **Findings**

### **Child and Family Assessments.**

#### ***Safety assessments***

Regarding the assessment process utilized to ensure that the most vulnerable children are identified and removed from the home when necessary, child welfare leadership staff indicated that it is beneficial when there is early involvement of CPI supervisors in case assessments such as clinical reviews with case managers at the front end of a case. It was also suggested that disagreements between CPIs and case managers regarding child removal decisions be documented for judicial proceedings, which would be especially useful when these types of decisions need to be reversed. Empowerment and support, rather than blaming, of child protective investigators and case managers in high profile death cases and in their use of professional judgment also was identified by child welfare leadership respondents as a factor that facilitates appropriate safety assessments. A related concern was that case managers will be prescribed to use checklists, act quickly, and move forward with child removal because that is the “safest” thing from a system perspective rather than taking the time to comprehensively

assess and observe a family (Armstrong, et al., 2008, pg. 57). Another support that is offered to CPIs in some areas is a cross-functional risk protocol that ensures multi-level reviews of decisions regarding high risk families.

### ***CPI assessments and resource identification***

The importance of strong relationships between the lead agency and the child protective investigation entity as a vehicle to ensuring that CPIs are knowledgeable of available services and resources was emphasized by child welfare leadership staff. Several characteristics of such a relationship included a shared set of values (e.g., a commitment to prevention and child protection), frequent and regular meetings at the leadership level, joint efforts to implement new approaches such as Alternate Response Systems or the presence of parents at ESI meetings, and the immediate identification and resolution of problems.

Similarly, the “collaboration and partnership at the early stages of investigation” (Armstrong, et al., 2008, pg. 57) was discussed. One example was the presence of representatives from community resource organizations as well as formal service providers at diversion staffings. When community resource representatives are actively participating in these staffings, it is sometimes possible to prevent the formal transition of a family to a lead agency. One lead agency reported actively involving CPIs, the State’s Attorney’s office, and the Circuit Administrator in the creation of their diversion strategy in order to ensure that their voices were represented and integrated into the design. In addition, the presence and participation of parents and all relevant child welfare stakeholders at planning meetings can contribute to everyone having a higher level of comfort with the decisions made.

Another strategy for partnership promotion mentioned by leadership staff was the co-location of lead agency staff, contracted partners and community partners, community mental health providers, early intervention programs, and kinship providers with Child Protective Investigation units. Referred to in one location as Resource Row, an important role of the co-located staff is to share decision-making, and offer “on the spot” and “face to face” consultation with CPIs regarding safety assessments and appropriate service options (Armstrong, et al., 2008, pg. 57). One lead agency reported having Care Network Consultants who are mental health experts that are co-located with CPIs. The consultant goes with the CPI on home visits and offers assistance with assessing a family’s mental health needs and accessing appropriate services. Other consultants are co-located with the placement department and assist with placement decisions including the provision of appropriate mental health services.

Challenges related to the identification of resources included high turnover rates of CPI staff and/or case managers, the large volume of cases in urban areas, and the perceptions of lead agency staff regarding CPIs (and vice-versa) that are sometimes tied to a misunderstanding about the respective roles of CPIs and CBC case managers or a lack of trust regarding the competence of the other staff.

### ***Needs assessments for children and families***

Case managers reported that families' needs are adequately identified through collective efforts and various sources of information. These included an assessment they complete and electronically enter into the FSFN system, CPI assessment reports, prior abuse reports, and Comprehensive Behavioral Health Assessments (CBHAs). It was particularly noted that the CBHAs are a very helpful resource that can greatly contribute to assessment and case planning efforts. One lead agency reportedly was developing an electronic version of the CBHA to facilitate the compilation and analysis of CBHA data on child and family demographics and service needs.

While some case managers indicated that the tasks in case plans are based on the assessed needs of families, others indicated that case plans are based primarily on the CPI findings and plea agreements which may or may not identify all family needs. However, it was also mentioned that sometimes parents participate in services that are not on the case plan if they believe it is in their best interests. In fact, some parents reported obtaining individual counseling or continuing substance abuse services such as drug screening and supportive group services that extended beyond their case plan requirements.

Suggested barriers to families accessing appropriate services included a limited number of agencies offering: mental health counseling, dental and medical services, public housing and employment services; support groups or services to aid parents in managing a child with special mental health/emotional needs; play therapy; services to treat a child victimized by domestic violence and sexual abuse; substance abuse treatment; domestic violence classes; and transportation issues especially for families living in remote areas.

Residential providers reported concerns related to challenges in accessing substance abuse treatment for adolescents in residential care, including finding a provider that is geographically accessible, transportation to treatment, and identifying who is paying for treatment and transportation. In rural areas, dental services reportedly are difficult to access; any dental work beyond a cleaning means travel to an urban area and waiting for an appointment (Vargo et al., 2010, pg. 39).

Case managers stated that they must check the availability of services when developing case plans to make a best effort at ensuring that parents will be able to complete their case plan tasks. If the services are known to be unavailable, then they are not included in the case plan. One case manager aptly summed these findings by saying, “It is really hard sometimes to really help our families out, because they don’t have the tools that they need to get the help that they need” (Vargo et al., 2009, pg. 41).

In addition, some case managers believed that not all services meet the individual needs of the parents. The appropriateness of services in certain situations was called into question, such as a four-hour domestic violence class for parents who had been arrested multiple times for the issue or parents completing parenting classes while incarcerated. One case manager stated “...of course you are going to be a good parent in prison, there are no kids around...” (Vargo et al., 2009, pgs. 41-42). There was also mention of situations where domestic violence classes were being replaced with anger management classes for reasons of cost savings, the judge deeming the evidence as insufficient, or witnesses recanting previous statements or refusing to testify in court. Limits on the frequency of counseling services was an additional issue that was raised by case managers. Case managers suggested that individualized services such as in-home parenting skills training or individual counseling would be more beneficial to parents in order to meet their unique needs. For example, a parent may need to learn how to make a grocery list or how to prepare a meal and feed the child, but if this content is not included in classes then “somebody is missing something” (Vargo et al., 2009, pg. 42). In-home parenting services, whenever possible, would allow for observation of parent learning and skill utilization. However, case managers acknowledged that the provision of in-home services is not as financially feasible as having a parent attend classes and obtaining in-home services reportedly depends on each case manager’s ability to justify the need.

Overall, case managers generally agreed that even though there are gaps in the service base, access to services has improved. One participant openly advocated for continuation of the IV-E Waiver stating, “...you take away the IV-E Waiver, our services will go down tremendously...” (Vargo et al., 2009, pg. 42).

According to the Florida quality of practice data, there was significant improvement over time in the percentage of cases where an ongoing assessment of the child’s and out-of-home provider’s needs occurred (Table 1). Ongoing assessment of mothers’ needs improved but not significantly, and that of fathers’ needs remained about the same over time which is an area needing special attention in the future.

Table 1.

*Florida Quality of Practice Data Related to Ongoing Assessments by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
48.0 Ongoing Assessment of Child's Needs*	85.7	88.0	89.9
50.0 Ongoing Assessment of Mother's Needs	74.6	77.9	77.1
52.0 Ongoing Assessment of Father's Needs	55.8	57.5	55.3
54.0 Ongoing Assessment of Out-of-Home Care Provider*	85.9	88.4	90.1

\* $p < .05$ 

Regarding specific needs of caregivers, an examination of NSCAW data revealed that the percentage of caregivers that were perceived by case managers as needing substance abuse services or mental health services and that were subsequently assessed declined from 1999-2000 to 2008-2009 in Florida (Table 2). These differences were not statistically significant. The percentage of needed and completed Florida substance abuse assessments in 2008-2009 exceeded that of the national cohort, but this was not the case for mental health needs.

Table 2.

*Percentage of Permanent Caregivers Perceived by Case Managers as Needing Substance Abuse Services or Mental Health Services that Received an Assessment by Cohort*

NSCAW Cohort	% of Permanent Caregivers Needing Substance Abuse Services or Mental Health Services that Received an Assessment	
	Substance Abuse	Mental Health
1999-2000 Florida	76.07	53.94
2008-2009 Florida	63.24	48.38
2008-2009 National	60.72	59.99

Regarding specific needs of children, Florida quality of practice data showed significant improvement over time in the percentage of cases where children were assessed for mental and behavioral health needs but a significant decline in the percentage of assessments conducted for physical health needs (Table 3). The percentage of cases with educational needs assessments declined over time but not significantly, and dental health assessment remains the area most in need of improvement.

Table 3.

*Florida Quality of Practice Data Related to Specific Assessments for Children by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
58.0 Educational Needs Assessment	85.9	84.4	83.7
61.0 Physical Health Needs Assessment*	80.9	71.9	70.9
63.0 Dental Health Needs Assessment	50.2	47.5	45.8
65.0 Mental and Behavioral Health Needs Assessment*	87.2	89.2	91.3

\* $p < .05$

NSCAW data indicated similar educational assessment findings. The percentage of children perceived by case managers to need services to identify learning needs and that subsequently received an assessment ranged from 83% to 87% across cohorts (Table 4). For the national cohort, the four most commonly reported reasons why children did not receive these assessments were: (a) it was determined not to be needed, (b) the child or the caregiver refused, (c) the child was ineligible, and (d) the child was wait-listed.

Table 4.

*Percentage of Children Perceived by Case Managers as Needing Services to Identify a Learning Problem or Developmental Disability in the Last 12 Months that Received Services to Identify Need by Cohort*

NSCAW Cohort	% of Children Needing Services to Identify Learning Needs that Received the Assessment
1999-2000 Florida	86.96
2008-2009 Florida	83.33
2008-2009 National	85.42

For children perceived by case managers to need services for emotional, behavioral, or attention problems, NSCAW data showed that the rates of formal assessment did not differ significantly across cohorts or by out-of-home placement status (Table 5). It is important to note that although the Comprehensive Behavioral Health Assessment (CBHA) is the formal assessment that is required for children placed in out-of-home care in Florida, the NSCAW protocol question did not specifically refer to the CBHA when asking about assessing children's mental, behavioral, or attention problems. In addition, for a child placed in a kinship out-of-home placement who does not have Medicaid at the time of removal, the relative is responsible for

applying for Medicaid for the child. The completion of a CBHA cannot occur until the child is Medicaid eligible.

Table 5.

*Percentage of Children Perceived by Case Managers as Needing Services that Received a Formal Assessment for Emotional, Behavioral, Attention Problem by Cohort*

NSCAW Cohort	% of Children Needing Services that Received Formal Assessment for Emotional, Behavioral, Attention Problem	
	Children in Sample	Children Placed in OOH Care
1999-2000 Florida	62.33	91.53
2008-2009 Florida	74.37	76.99
2008-2009 National	77.56	86.72

Since assessment of child and family needs is an ongoing process throughout a child welfare case, it is also informative to examine factors associated with visits between case managers and families. As seen in Table 6, NSCAW data showed a significantly greater majority of permanent caregivers and youth in the 2008-2009 Florida cohort that reported meeting or talking with their case managers or social workers within the last six months than those in the 1999-2000 cohort and the national 2008-2009 cohort ( $p < .01$ ).

Table 6.

*Percentage of Permanent Caregivers and Youth Meeting with Case Manager/Social Worker in Last Six Months by Cohort*

NSCAW Cohort	% Meeting or Talking with Case Manager/Social Worker in Last Six Months	
	Permanent Caregivers	Youth
1999-2000 Florida	71.07*	58.14
2008-2009 Florida	95.46	100.00
2008-2009 National	74.93	76.12

\* No permanent male caregivers were interviewed in this cohort.

In addition, the Florida quality of practice data revealed significant improvement over time in the frequency and quality of visits between case managers and families to sufficiently address issues pertaining to the safety, permanency, and well-being of the child (Table 7). However, the frequency of visits with parents remains an area in need of considerable attention given that FY10-11 data indicates that of the cases reviewed, only 45% and 31% of case manager visits with mothers and fathers, respectively, were of sufficient frequency to address issues pertaining to the safety, permanency goal, and well-being of the child.

Table 7.

*Florida Quality of Practice Data Related to Case Manager Visits by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
56.3 Case Manager Visits – Frequency – Child*	49.7	70.2	66.9
57.3 Case Manager Visits – Quality – Child*	59.7	70.4	73.5
56.1 Case Manager Visits – Frequency – Mother*	31.2	47.3	44.8
56.2 Case Manager Visits – Frequency – Father*	20.7	32.6	31.0
57.1 Case Manager Visits – Quality – Mother*	56.6	72.3	73.2
57.2 Case Manager Visits – Quality – Father*	44.6	58.6	62.7

\*  $p < .05$ **Family participation in case planning and decision making.**

It was clear from case manager reports that they recognize the importance of building rapport with parents if they are to engage them in the assessment process and that this was an ongoing effort that occurs throughout the life of the case. Because parents may already feel intimidated from the initial investigation conducted by CPIs, case managers noted the importance of approaching parents in a non-confrontational, non-aggressive manner. Other specific strategies described by case managers to engage parents included explaining their role to parents (e.g., to help parents obtain services and reunify the family), asking parents to describe the reasons for their involvement in the child welfare system, asking parents what they think they need to address in the family's current situation, explaining the forms they will complete and the process the parent will experience during their involvement with the child welfare system, and focusing parents on the needs of the child first before moving to services that will assist parents in improving the family's situation. In addition to obtaining the individual and unique perspectives of children and families, school personnel were named as informative collateral reporters to learn about specific needs of a child (e.g., behavior issues) in order to ensure the provision of necessary services.

Parents provided similar feedback. Identification of needs and case planning was primarily accomplished in a collaborative manner between parents and case managers, and to some extent, with the involvement of the affected children, service providers, and school personnel. Parent descriptions of their assessment and case planning experiences included: "it was a joint effort," "it felt like we could be open and honest...they were real good," completing "life would be better if" statements, and "we sat down and discussed it and came up with something that we all agreed on" (Vargo et al., 2010, pg. 33). Some parents also discussed

ongoing efforts by child welfare professionals that included regular follow-up to gauge utility and adequacy of services, and additional needs. There was one parent that had a dissimilar experience. Related to an out-of-home care case, this respondent stated, “we were told, we were not asked” (Vargo et al., 2010, pg. 33) about service needs and case plan tasks, and indicated doing “what they [child welfare representatives] wanted” (Vargo et al., 2010, pg. 33) instead of taking it to trial, because the parent’s desire was to regain custody of the child.

Barriers to successful case planning as described by case managers included the absence of case managers and service providers that can communicate with families in their native language. Spanish and the various dialects of Creole were two languages that were specifically mentioned. There was a concern among case managers that families either may be agreeing to case tasks that they do not fully understand or that they cannot gain the full benefit from services provided by someone who speaks a different language. It was further noted that if parents must travel outside of the area to obtain services from language-appropriate providers, then transportation can very well become an additional barrier. It was suggested that CPIs might also benefit from having additional resources to address language barriers in order to put them in a better position to divert families from formal involvement in the child welfare system.

Case plan development was reported by case managers to occur in different ways. One approach is part of the mediation process wherein the case manager brings a proposed case plan and the parent and representing attorney review and revise the case plan as they deem appropriate with the case manager, DCF attorney, and the CPI, if present. However, one case manager stated, “Mediation is more of a battle of wits between the attorneys...it is not meaningful for the family or the children what you come up with sometimes.” (Vargo et al., 2009, pg. 43). In addition, the use of mediation “too soon” (Armstrong, et al., 2008, pg. 55) in the assessment process can be a deterrent to good decision-making because the family’s status and functioning are not yet fully understood. The practice recommendation from one group of child welfare leadership respondents was to use mediation shortly before adjudication (i.e., 30-45 days after the case is opened) rather than when the child is in a shelter setting, so that a comprehensive assessment including the CBHA can be completed and a relationship between the family and case manager can begin to develop.

One case manager reported that there is no standardized process to involve parents in developing the case plan; rather it is the responsibility of individual case managers to ensure that the parent’s input is solicited and considered. Family team conferencing (FTC) and similar planning methods were described by some case managers as a more meaningful process to utilize in place of the current mediation and case planning strategies depending on the

allegations and family dynamics (domestic violence and severity of sexual abuse may rule out a case for FTC). In FTC and like methods, feedback is solicited and considered in a collaborative manner with participation by the parents/caregiver, children (if age appropriate), the parents' attorney, DCF attorney, CPI, and the case manager. There is a focus on what the family believes their needs are, family histories, existing support systems, etc. Case managers also indicated that they direct parents' attention on preserving the child's safety and well-being, and encourage them to try services and then evaluate the benefits. It was stated that "for the most part" (Vargo et al., 2009, pg. 44) parents are able to identify some of their own needs.

According to NSCAW data, there was an increase in the percentage of parents included in the case planning process from 1999-2000 to 2008-2009 in Florida when family group decision making (FGDM) or other similar models were utilized for placement decisions or safety planning (Table 8), although this increase was not statistically significant. Not surprisingly, mothers were included to a greater extent than fathers overall. However, the inclusion of fathers at the state level exceeded what was occurring at the national level, though this was not the case for mothers.

Table 8.

*Parents Included in Placement Decisions or Safety Planning When FGDM-type Models Utilized by Cohort*

NSCAW Cohort	% of Parents Included in Placement Decisions or Safety Planning When FGDM Used	
	Mothers	Fathers
1999-2000 Florida	67.86	39.29
2008-2009 Florida	72.50	40.00
2008-2009 National	78.39	34.67

Florida child welfare quality assurance data indicated a significant improvement over time in case managers encouraging and supporting mothers to participate in decisions related to the child's needs and activities, as well as making concerted efforts to actively involve all case participants (mother, father, child, out-of-home provider) in case planning (Table 9). Although additional improvement is needed in efforts to engage both mothers and fathers in the decision making process, fathers remain the population that needs substantial attention.

Table 9.

*Florida Quality of Practice Data Related to Case Planning and Decision Making by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
36.0 Mother's Participation in Decision Making*	49.3	53.8	58.9
37.0 Father's Participation in Decision Making	38.6	39.5	40.0
55.0 Family Involvement in Case Planning Process*	63.4	69.1	74.9

\* $p < .05$

**Family participation in community-based services.**

The Florida quality of practice standards acknowledge that engaging families in services is crucial to successfully achieving permanency goals. These data reveal significant improvement over time in case manager efforts to engage mothers and fathers by addressing any identified barriers that may preclude their involvement in services (Table 10). However, there remains a need for further improvement especially for engaging fathers.

Table 10.

*Florida Quality of Practice Data Related to Engaging Parents in Services by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
51.0 Engaging Child's Mother*	68.2	72.7	76.6
53.0 Engaging Child's Father*	52.9	58.2	59.8

\* $p < .05$

Case managers generally agreed that parents should participate in, and not just attend, classes in order to obtain a completion certificate from the provider. The extent of the information case managers received from providers varied however. Case managers from one area reported receiving progress reports on each parent that describe various elements of participation such as attendance, arriving to class on time, verbal contribution, and completing homework. Case managers from another area indicated that completion certifications for parenting or anger management classes are given to parents if they merely fulfill the attendance requirement which offers no indication of actual parent participation or benefit. Progress notes from providers were mentioned as a way to have more detailed information on parent participation in services. Some case managers stated that they only receive such notes when

more individualized or in-home services are provided, but others stated that they obtain detailed information from some providers simply by calling them.

Case managers also agreed that completion of classes or services does not guarantee that parents have gained necessary knowledge or that they will utilize what they learned to improve their family's situation. Case managers believed that the impact of these classes depends on whether or not the parent realizes a need for change and their desire to change, "they [parents] have to want to get help...we can't force them into doing anything", "it is all up to the parent, the parent will put in and get out as much as the parent wants to" (Vargo et al., 2009, pg. 46). Emphasizing the need for greater confidence that parents are benefitting from services, another case manager commented, "It is a leap of faith to make sure these kids are okay when they go back [reunify]..." (Vargo et al., 2009, pg. 46).

Parents identified a variety of services in which they and their children participated. These included individual and group counseling, substance abuse services, child mentors, child behavior analysis, child care assistance, parenting classes, and help with meal planning and organizational skills. There were several parents that reportedly did not receive particular services that they had requested including a tutor and mentor for their children. Recognizing the severity of one child's overall needs and little sustained improvement, the parent requesting the mentor suggested the possibility that some resources may have been used for "maybe another child that they knew they could help" (Vargo et al., 2010, pg. 34).

As part of the NSCAW study, case managers provided data on the referral and receipt of services for children perceived to have special educational, physical health, and dental health needs. These findings underreport the percentage of children receiving services because they exclude children who were not referred by the case manager due to the fact that they were already receiving the service. As shown in Table 11, the receipt of these types of services declined from 1999-2000 to 2008-2009.

The most common reasons why children from the 2008-2009 national cohort did not receive these services after being referred included: (a) the child or the caregiver refused the service (education, physical, dental), (b) the child was ineligible for the service (education), (c) the child was wait-listed for the service (education, dental), and (d) the service was not available in the area or transportation problems (education, physical).

Table 11.

*Percentage of Children Perceived by Case Managers as Needing Services for Special Education, Physical Health, or Dental Care in the Last 12 Months that were Referred and Received Services by Cohort*

NSCAW Cohort	% of Children Needing Physical, Dental, Special Education Services that were Referred and Received the Service		
	Special Education	Physical Health	Dental Health
1999-2000 Florida	77.78	100.00	80.51
2008-2009 Florida	42.85	78.94	66.73
2008-2009 National	89.82	99.00	94.97

Similar findings emerged from the Florida quality of practice data. Table 12 indicates a decline in the percentage of cases where children received services for educational needs and a significant decline related to physical and dental health services.

Table 12.

*Florida Quality of Practice Data Related to Service Provision by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
59.0 Educational Services	81.3	82.6	80.7
60.0 Educational Service Outcomes	83.1	78.3	79.8
62.0 Physical Health Services*	81.7	68.8	64.4
64.0 Dental Health Services*	67.4	48.8	54.7

\* $p < .05$

Regarding services to address children's emotional, behavioral, or attention problems, case managers in the NSCAW study were asked if children needed these services within the last 12 months and if they received counseling services. Across all cohorts, the majority of children perceived as needing services received counseling after being referred (Table 13). None of the differences were statistically significant. Most commonly, all children in the national cohort sample did not receive counseling services as a result of referral because: (a) the caregiver or child refused services, (b) the child was wait-listed for services, or (c) the service was determined not to be needed.

Table 13.

*Percentage of Children Perceived by Case Managers as Needing Services for Emotional/Behavioral Problems that were Referred and Received Counseling Services by Cohort*

NSCAW Cohort	% of Children Needing Services for an Emotional, Behavioral, or Attention Problem that were Referred and Received Counseling	
	All Children in Sample	Children in Out-of-Home Care
1999-2000 Florida	91.31	93.49
2008-2009 Florida	89.88	100.00
2008-2009 National	90.60	95.68

Similar to the findings for all children in the NSCAW sample (Table 13), Florida quality of practice data indicated a non-significant decline in the provision of services over time to meet children's mental and behavioral health needs (Table 14).

Table 14.

*Florida Quality of Practice Data Related to Mental/Behavioral Health Service Provision by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
66.0 Mental and Behavioral Health Services	81.9	81.7	80.2

Florida case managers are also responsible for ensuring that services are provided to families to keep children safe in their homes, to prevent entry into out-of-home care, and to complete referrals for appropriate services for children in in-home and out-of-home care. As seen in Table 15, there was significant improvement over time in these areas. Improvement over time was also found in the area of providing supervision, support, and services to manage risks to children once they are reunified with their families to prevent re-entry into out-of-home care.

Table 15.

*Florida Quality of Practice Data Related to Service Provision to Protect Children in Their Homes by State Fiscal Year*

Quality of Practice Standard Number and Description	SFY 08-09	SFY 09-10	SFY 10-11
	Percent of Cases Achieving the Standard		
4.0 Service to Protect the Child*	86.6	93.7	92.8
6.0 Service Referrals*	83.2	88.1	91.0
10.0 Management of Risks	69.2	75.4	75.4

\* $p < .05$

### **Family satisfaction with community-based services.**

Findings from focus groups conducted with case managers indicated that parent satisfaction with services was assessed through supervisors calling families to verify the completion of case managers' home visits and requesting feedback; and conducting monthly, quarterly, or annual satisfaction surveys with random samples of parents. While some case managers reported hearing parents comment on services, "you get a lot of feedback" or "most of them have said things are good, it has helped me a lot, this is what I needed" (Vargo et al., 2009, pg. 47), it appeared that not all parents offer opinions to case managers regarding their satisfaction with services. The majority of parents interviewed stated that no one other than the interviewer had solicited their opinions of services received. One parent stated, "I am trying to graduate, I am not going to tell them I hate them" (Vargo et al., 2010, pg. 37). Another parent stated that the case manager would inquire about satisfaction with services during regular visits.

Regarding parenting classes, some case managers reported parent dissatisfaction such as, "She just talked, I haven't learned anything" (Vargo et al., 2009, pg. 47) or that there were many parents that found the parenting classes "a waste of time because they focus on younger children when they have teenagers" (Vargo et al., 2009, pg 47). However, other case managers stated that parents considered the parenting classes helpful, "a lot of times the parents will come and say they really bonded with one of the parenting instructors...and how they benefited..." (Vargo et al., 2009, pg. 47).

Parents participating in interviews rated their overall satisfaction with services on a 5-point scale: 5=very satisfied, 4=satisfied, 3=neither satisfied nor dissatisfied, 2=dissatisfied, and 1=very dissatisfied. Just over half of parents (55.5%) were satisfied or very satisfied. The remainder was equally dissatisfied or very dissatisfied (44.4%). An examination of parent ratings of individual services using the same 5-point scale revealed predominately moderate to high

levels of satisfaction (see Table 16). Regarding the low rating of the residential program, the parent believed that the program did not fit the child's needs and another program was being sought.

Table 16.

*Mean Parent Satisfaction Ratings of Individual Services*

<b>Service*</b>	<b>N of Services</b>	<b>Mean Satisfaction Rating</b>
Child care programs	2	4.50
Family counseling	3	4.00
Child mentors	3	3.66
Parenting support/education	3	3.66
Child counseling	6	3.33
Adult counseling	3	3.33
Substance abuse services	3	3.00
Behavior analyst	2	3.00
Residential program	1	1.00

\* Only those services that were clearly and directly related to service plans are included.

Overall, parents indicated that services were helpful for their families. Referring to the individual counseling in which their children participated, two parents commented, “he felt like he could talk to someone freely...relieve some of his anxiety...he would look forward to his appointments with the counselor”, and “they were, after a period of time, able to talk about how they felt, they were told it is not your fault” (Vargo et al., 2010, pg. 34). Children's mentoring services appeared to benefit both children and parents: it helped “them [the children] get away and also kind of gave me a break because it was 24/7, no relief” and “it was more of a help for myself...at least I was able to talk to somebody about what [the child] was doing” (Vargo et al., 2010, pg 33).

Another parent described the adult individual counseling as helpful in “dealing with all the stress” (Vargo et al., 2010, pg. 34). Parents credited substance abuse services for helping them stay “clean and sober” and “it helped me get some confidence about myself...gave me the knowledge that I am not alone” (Vargo et al., 2010, pg. 34).

Several parents identified individual services that were not helpful or did not have sustaining effects. In one case, the child evidently had complex and long-standing emotional, behavioral, and developmental needs that were not being fully met despite various efforts. The parent acknowledged the continual efforts made by providers and the additional behavioral services in the home (though at one point behavioral services reportedly were not provided for

an approximate two-month period), but improvements were not long-lasting, “we were constantly trying to have to come up with new things...she made progress with him, but the last six months [the child] was just rapidly going downhill” (Vargo et al., 2010, pg. 35). In a second case, the parent described a similar experience where the child would “maintain for a few hours, but then it was just like out of sight, out of mind” (Vargo et al., 2010, pg. 35). Reportedly, this child also had educational and behavioral needs that were not fully addressed. According to the parent, this child had more recently entered a juvenile justice facility and was receiving everything he needed there. Another parent evidently realized no benefit from parenting classes stating “everything they taught us I was already doing” (Vargo et al., 2010, pg. 35). This statement compares to the belief of some case managers that not all services meet the individual needs of parents and that completion of classes does not guarantee that parents benefit from the content or experience.

In addition to specific services, some parents commented on the helpfulness of case managers, making such statements as: “not only did we go over what is working, what is not, but it was someone to talk to that would kind of like encourage me,” “every month she had something new for us to try and it helped a lot...she came into our house like a friend,” and “she made sure I had all her contact information in case I ever needed help with anything” (Vargo et al., 2010, pg. 35). Two parents noted special and unexpected efforts made by their case managers: financial assistance with one month’s mortgage payment (“an incredible blessing”) (Vargo et al., 2010, pg. 35) and holiday gifts for the children.

Two parents described less positive experiences. One characterized the case managers originally assigned to their case as “taking a back seat” (Vargo et al., 2010, pg. 35). Although they were replaced with workers that were more active, issues remained with meeting the child’s overall needs. Another stated that even though the case managers were “really nice...they haven’t done anything for me, I have done everything by myself” (Vargo et al., 2010, pg. 35).

Several parents identified additional needs for their families. One parent expressed a desire for individual training to handle the child’s behavioral episodes, but reportedly was not offered any such assistance. One explanation may be found in case manager reports of a limited number of agencies offering support groups or services to aid parents in managing children’s special needs and behaviors. This same parent thought that having more time with the behavior analyst or adding a mentor to the child’s service array may have been beneficial in order to provide additional one-on-one time to deal with the child’s behaviors. Similarly, another parent would have liked the child to have had more frequent visits with the mentor and sessions

with the child counselor since there was not much improvement exhibited by the child with the provided services.

The range in quality of mentor services provided to the children was pointed out by one parent, “some were pretty horrible” and “some of them were absolutely awesome” (Vargo et al., 2010, pg. 37). Even though the parent said the children were assigned new mentors if needed, the children eventually decided they did not want to continue the service after repeated ‘no shows’ by the mentors. Indicating a need for better engagement skills, one parent suggested that the counselor who “tried so hard so fast to get so personal,” be more like the case manager who “built a relationship with us, it was awesome...she kind of built a trust thing between us before anything, but the counselor she moved way too fast too soon” (Vargo et al., 2010, pg. 37).

Possible improvements in substance abuse services were discussed by two parents. As part of additional follow-up services, one parent voiced a need for more randomness in drug screenings, stating that knowing when they were going to occur “wasn’t really giving me the accountability that I needed” (Vargo et al., 2010, pg. 37). In the second case, the parent was also dissatisfied with the manner in which random drug testing was carried out, but for the opposite reason. The parent did not know what day the testing would occur so if the tester came out when the parent was not home, it resulted in an automatic “positive” which was then reported to the court.

## **Summary**

Overall, longitudinal trends for safety and permanency indicators indicated a continuing improvement in the lead agency’ performance on these indicators. An examination of permanency indicators revealed that the proportion of children who achieved timely permanency, as indicated by the number of children who exited out-of-home care for permanency reasons and the average proportion of children with adoption finalized within 24 months, significantly increased over time.

Although the number youth in out-of-home care declined across the Waiver period, the median length of stay in out-of-home care did not change during the Waiver period., This finding suggests that children served in out-of-home care in recent years have, on average, more intense needs than prior to the Waiver, and children diverted from out-of-home care entry likely have less intense needs. When profiles of children served in out-of-home care were examined using data from fiscal year 2005-2006, the results of latent class analysis (Vargo et al., 2010) revealed four distinct subgroups: *Children with Complex Needs*, children from *Families with*

*Substance Abuse Problems, children from Families with Complex Needs, and Children With Neglect Histories. In fiscal year 2008-2009 the class of Children with Neglect History, which was identified in SFY 05-06, was not identified in SFY 08-09, and only children with more intense needs (e.g., Children with Complex Needs, children from Families with Complex Needs) were identified in FY08-09.*

The number of children who experienced recurrence of maltreatment after being served in the child protection system significantly decreased over the Waiver period, and the proportion of children who re-entered out-of-home care slightly decreased, although no statistically significant difference was observed. Finally, lead agencies' performance in achieving placement stability improved as was shown by a trend of an increasing percentage of children with no more than two placements within 12 months of removal from home. In summary, findings suggest that during the Waiver implementation period, progressively more children achieved timely permanency while remaining safe.

When the impact of child and family characteristics on outcome indicators were examined, results showed that age, parental substance abuse, history of domestic violence, and the presence of child health problems and emotional issues played an important role in predicting outcomes. Examination of child demographic data indicated that although younger children were more likely to be adopted, they were also more likely to re-enter out-of-home care after reunification. Compared to children without health problems, children with physical health or emotional problems were less likely to experience timely reunification or placement with relatives and were at higher risk for experiencing re-entry into out-of-home care. Although children with physical health problems were more likely to experience recurrence of maltreatment, the strongest predictors for repeated verified maltreatment were parental substance abuse and history of domestic violence. While children who came from families with domestic violence issues were more likely to experience recurrence of maltreatment, it appears that they are somewhat less likely to re-enter out-of-home care. One possible explanation for this finding may be the nature or the type of maltreatment these children experience. It is more likely that children whose parents have domestic violence problems experience threatened harm as a type of maltreatment, which was not associated with re-entry into out-of-home care (Barth, Weigensberg, Fisher, Fetrow, & Green, 2008).

Reported strategies to improve permanency outcomes for children included strongly emphasizing the consideration of kinship caregivers when removals are necessary; providing supports, services, and training for kinship caregivers; and offering assistance with adoption proceedings. However, there was acknowledgement that despite the increase in the array of

services since Waiver implementation, additional services may be needed to address the needs of kinship caregivers or guardians as a way to prevent these placements from failing. To assist in sustaining child reunifications, it was also suggested that a safety plan be developed in the event parents relapse (not uncommon when there are substance abuse issues) and the child's safety is again placed at risk.

Reported strategies to improve placement stability for children included conducting monthly placement review meetings, reviewing cases at risk of placement disruption, and focusing special attention on specific groups of children in out-of-home care identified as having more placement disruptions. However, it was also reported that changing a child's placement can be beneficial for the child and should not necessarily be counted against agency performance. Examples of such placement changes included returning a child to his/her home community when a placement becomes available after the child was originally placed outside the community, reuniting siblings into one out-of-home placement when they initially had to be separated, and moving the child to a higher or lower intensity level-of-care placement when clinically appropriate.

Assessment of the needs of children and families reportedly occurs through collective efforts and various information sources with Comprehensive Behavioral Health Assessments greatly contributing to need identification and case planning efforts. However, there was concern that not all needs are being sufficiently addressed, such as a four-hour domestic violence class for repeat offenders, substituting domestic violence classes with anger management classes, or providing counseling only one time per month to children and families. In-home parenting skills or counseling services were suggested as alternatives that could offer more individualized assistance to families.

Though there is room for further progress, Florida quality of practice data indicated a significant increase over time in the ongoing assessment of children's overall needs and a non-significant increase in the assessment of mothers' needs. A smaller percentage of fathers' needs were assessed and this is an area needing special attention. Regarding specific needs, there was a significant increase over time in the assessment of children's mental health needs, but a significant decline in assessing children's physical health needs and non-significant declines in assessing children's educational and dental needs. Compared to the other areas, assessment of children's dental needs occurred in less than a majority of cases. In addition, the frequency and quality of case manager visits with children and families significantly improved over time. However, the insufficient frequency of visits with mothers and fathers remains an area needing attention.

Maintaining rapport and engaging with families reportedly is a priority among case managers and occurs throughout the life of the case. Case managers described strategies they use to accomplish this and most parents provided similar feedback. One barrier to successfully engaging families is case managers and services providers not speaking families' primary language (e.g. Spanish or Creole), which could lead to parents agreeing to case plan requirements that they do not fully understand or not gaining full benefit from services. According to NSCAW and Florida quality of practice data, there were increases in the percentage of parents included in case planning and decision making, though inclusion of fathers was found to occur in less than majority of cases.

Additionally, there were significant increases over time in the percentage of cases where case managers made sufficient efforts to engage mothers and fathers by addressing any identified barriers that may preclude their involvement in services with fathers needing additional attention. Case managers agreed that participation in services is needed if parents are to gain knowledge and successfully implement new skills to improve their family's situation. Receiving progress reports from providers was suggested as a way to more fully ensure that parents are benefitting from services.

According to Florida quality of practice data, there were significant increases over time in the percentage of cases where concerted efforts were made to ensure that services were provided to keep children safely in their homes to prevent entry into out-of-home care and to complete referrals for appropriate services for children in in-home and out-of-home care. There was a non-significant increase in the percentage of cases where supervision, support, and services were provided to prevent children's re-entry into out-of-home care after being reunified with their families.

Analyses of NSCAW and Florida quality of practice data indicate decreases over time in the percentage of cases where services were provided to address children's educational, physical health, dental health, and mental health needs. To varying degrees, the majority of children were found to be receiving these services, though physical and dental health were the areas most in need of improvement.

Case managers reported different experiences regarding receiving parent feedback on services, both positive and negative feedback. Just over half of parents interviewed reported being satisfied with the services they had received. Parents also described how services such as individual counseling, mentoring services, or substance abuse services had helped them and their children. Several parents mentioned more intensive needs of their children that, despite

efforts, were not being fully addressed. The helpfulness of case managers was also discussed by parents and a few parents reported having less positive experiences.

Though there have been demonstrated areas of improvement in ensuring the well-being of children and families, there remains room for further progress. These include additional attention in the areas of ongoing assessment of fathers' needs, the frequency of case manager visits with mothers and fathers, assessing children's dental health needs, supporting parents' participation in case planning and decision making, and providing physical and dental health services to children.

## **Recommendations**

- Compared to children without physical health or emotional problems, children with physical health or emotional problems were less likely to experience timely reunification or placement with relatives and were at higher risk to experience re-entry into out-of-home care. Due to this finding, we recommend that with renewal of the IV-E Waiver, flexible funds be used to improve permanency and safety outcomes for children with physical and emotional problems.
- In addition, considering that there was no significant reduction in the rate of re-entry, we recommend that CBCs continue their efforts to address safety issues and to further prevent re-entry into out-of-home care in Florida's child welfare system.
- Based on the findings from the analyses of the Florida quality of practice data and national survey data, improvement is needed in the areas of the ongoing assessment of fathers' needs, the frequency of case manager visits with mothers and fathers, assessing children's dental health needs, supporting parents' participation in case planning and decision making, and providing physical and dental health services to children.

### 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 community they serve.*

#### **Terms and Conditions 3.2 Process Evaluation Domains:**

- The number and type of staff involved in implementation, including the training they received, as well as their experience, education and characteristics.
- The service delivery system, including procedures for determining eligibility, referring subjects for services, the array of services available, the number of children/families served and the type and duration of services provided.
- The availability, accessibility, intensity, and appropriateness of community-based services provided under the waiver demonstration as compared to the intensity and availability of such services prior to implementation of the demonstration.
- Did the capacity of Lead Agencies to provide appropriate services and interventions, and of the State's child welfare system as a whole increase?

For each of the factors described above, the process analysis should note any differences in implementation among participating counties and Lead Agencies.

The primary purpose of the child welfare practice analysis component is to determine what changes, if any, have occurred in the availability, accessibility, intensity, and appropriateness of child welfare community-based services and practices since implementation of the Waiver. In Florida, 19 lead agencies are responsible for the administration and provision of service across 20 geographic circuits. The size and demographic characteristics of each service area vary greatly and within this system lead agencies are given flexibility to determine and develop a system of care that best meets the needs of its community within the bounds of legislative statute and administrative code. Within this context of a community-based care framework, each lead agency was allowed to use the funding flexibility provided by the Waiver in a manner that was determined to best meet the broad goal of improved permanency, safety, and well-being outcomes for children and families and more specifically that an expanded array

of prevention and diversion services would allow the state to safely reduce the number of children requiring out-of-home placement.

### **Child Welfare Practice Methodology**

To assess what changes in the type and capacity of child welfare services have occurred across the state since implementation of the Waiver a survey was administered with the CBC lead agencies on approximately an annual basis. Since the initial baseline assessment survey was completed in 2006, four service array surveys have been utilized to capture the expansion of services and strategies specifically intended to (a) prevent child abuse, neglect and the need for out-of-home placement, (b) engage families in services planning and provision, and (c) increase permanency and reduce lengths of stay in out-of-home care. Information about the availability and capacity of community services and supports that are often utilized by families involved in the child welfare system such as adult education, housing assistance, job training, and subsidized childcare was also requested. Findings from the survey data indicated that family team conferencing/family group decision making was one of the primary strategies that CBC lead agencies had expanded since the Waiver as a means of engaging families in service planning and provision. As a result a family team conferencing survey was administered in 2010 to gain detailed data related to implementation, training, coaching, eligibility, referral procedures, capacity, family attendance, and outcomes. Similarly, an innovative practices survey was administered in 2011 to capture in-depth data about specific innovative or best practices that CBC lead agencies had implemented or expanded since the Waiver. Data was captured for each practice concerning availability, eligibility, referral procedures, funding, staff selection and training, quality assurance, duration, outcomes, and implementation successes and challenges. Follow up interviews with lead agency representatives and documentation requests related to specific programs and practices were conducted as needed throughout the duration of the Waiver evaluation. In addition, focus groups with child welfare case managers were conducted in each of the six DCF geographic regions of the state during the end of SFY 10-11 to gain their perspective related to the status of child welfare practice, changes that have occurred in the service array since implementation of the Waiver, factors that influence the provision of quality practice, and recommendations for improvement, especially if the Waiver is extended. Findings from CBC leadership focus groups and four lead agency case studies with Family Support Services of North Florida, Inc. (FSS), Kids Central, Inc. (KCI), Families First Network, Inc. (FFN), and Eckerd Community Alternatives (Eckerd) were also used to address the Terms and Conditions related to the child welfare practice analysis.

The findings presented below represent an analysis of the data collected over the five years of the Waiver to demonstrate changes in and expansion of the child welfare service array since Waiver implementation and describe differences where they exist among the CBC lead agencies.

## **Findings**

Consistent with the hypothesis, the types of strategies and practices used by Community-Based Care lead agencies and the array of services available to children and families involved with the child welfare system have changed substantially since the implementation of the Waiver in FFY 06-07. Furthermore, consistent with the intent of the Waiver, significant changes have occurred in the area of prevention and diversion, the manner in which families are engaged in planning and service provision, and services and practices to safely reduce a child's length of stay in out-of-home care. Lead agencies have also recognized that continued improvement is needed in the area of child and family well-being and have implemented strategies to better address children's physical, education, and mental health needs.

### **Strategies to prevent child abuse, neglect, and the need for out-of-home placement.**

Across the five years of the IV-E Waiver, CBC lead agencies have reported initial and continued expansion of the array of services and practices intended to prevent child abuse and neglect and divert families involved in the child welfare system from requiring out-of-home placement to maintain child safety and well-being. Although the central focus of prevention and diversion initiatives are tertiary efforts aimed at preventing the recurrence of abuse or neglect and diverting families from deeper involvement in the system, CBC lead agencies have made significant efforts to broaden the scope to include an expanded utilization of primary and secondary strategies intended to stop the occurrence of child abuse and neglect across the general population and within families considered to be at high risk.

Primary prevention strategies that were increased during the Waiver period include enhanced community information and referral services that are available to anyone in the community and collaborative community campaigns to develop integrated strategies to decrease the rate of child abuse and neglect and provide education and awareness concerning the issue. The prevention initiatives include partnerships with the CBC lead agencies, faith-based organizations, DCF, schools, and other provider organizations in the service area. The existence of neighborhood service centers was reported by twelve lead agencies and four of

these reported that either the center had been created since the IV-E Waiver or the capacity had been substantially increased. Neighborhood service centers are typically located in areas that have been identified to be at high risk for abuse and neglect and offer a variety of educational opportunities and services such as housing, employment, financial management assistance, parent workshops, and community resource information. Two examples of service centers that have emerged since the Waiver include the Cassat House and the Library Partnership. Cassat House ([www.fostercareredesign.org](http://www.fostercareredesign.org)), a family and abuse prevention service center managed by Family Support Services of North Florida (FSS), is located in an area of Jacksonville that was identified as having the highest concentration of abuse and neglect reports. It is intended to provide families with the tools to enable them to build and strengthen healthy families, such as financial assistance, food stamps, and parenting classes. One of FSS's long-term goals throughout this Waiver period has been to become embedded in the community so that people feel more comfortable about reaching out for help before more serious problems develop that result in children coming into care. The Library Partnership ([www.librarypartnership.org](http://www.librarypartnership.org)), a collaborative effort between the Alachua County Library District, Casey Family Programs, and Partnership for Strong Families, is located in an area of Gainesville that had the highest rate of child abuse calls to the abuse hotline. The mission of the Library Partnership is to provide resources to families in three areas of focus: family support and child development, health and safety, and self-sufficiency.

The expansion of domestic violence prevention services for teens and families was reported by six agencies. These services are available to individuals who are considered to be at risk of or have been exposed to domestic violence. One of these programs, Peaceful Paths, was featured as an innovative practice (Vargo et al., 2009). The domestic violence prevention services are offered in a group format for youth and parents that are held in community-based locations such as schools and aftercare centers. Youth-based groups teach children how to identify abuse, build self-esteem, and resolve conflicts without violence. A related prevention program that has been implemented by one lead agency since the Waiver, Parents Under Construction, is also focused on school-aged youth. The developmentally-tailored curricula teaches pre-school through high school age students and their parents lessons pertaining to parenting styles, realities of raising children, communication skills, parenting myths, positive discipline techniques, and non-violent conflict resolution.

All of the CBC lead agencies reported an expansion of tertiary prevention strategies and practices since implementation of the Waiver that are intended to allow families that have been involved in an allegation of abuse or neglect to safely remain intact and receive services in their

home and community. Seventeen of the 19 agencies indicated that a concentrated area of expansion has been intensive in-home family preservation services. Ten of these agencies contract or provide in-home services that are specifically targeted to help families with substance abuse issues. Families with an open case of abuse or neglect either at the child protective investigation or community-based service stage are eligible for referral. Typically intensive in-home services are designed to be short term ranging in duration from 45 to 90 days and consist of visits by a counselor and case manager with the family at least weekly to multiple times per week. The type of service and support provided to families is based on need and include crisis counseling, parent education related to the safety and well-being of the child, behavior management, budgeting, housekeeping, emergency cash assistance, and community resource referrals.

Safe at Home, an intensive in-home program that pairs a Master's level clinician and a case manager, was reported as being utilized by five lead agencies. Families that have met the criteria for probable cause to remove a child from the home are eligible and services are provided for 90 to 120 days. Families are then stepped down to a less intensive in-home or community-based service if successful. Another example of an intensive in-home services program is Youth Villages Intercept, a national program that was expanded in 2008 with availability in three large service areas: Tampa, Miami, and Lakeland. The program uses a multi-systemic approach that includes family therapy, parenting skills education, developing positive peer support groups, and assistance in accessing community resources to support children and their families with the transition home and prevent the need for out-of-home care. Out-of-home diversion services typically last four to six months, while the duration of reunification services is generally six to nine months.

Seven lead agencies reported the expanded availability of mobile in-home crisis intervention services intended to provide immediate de-escalation of a high risk home environment. Referrals are usually made by child protective investigators, child welfare case managers, or diversion staff for families that are at risk of requiring out-of-home placement to maintain child safety and services are provided on a short-term basis.

As a strategy used to prevent child abuse and neglect and divert families from requiring out-of-home placement, 11 agencies reported the increased capacity and availability of in-home and community-based parent education and training programs. Of these, seven agencies reported an expanded use of Nurturing Parenting Programs based on the curriculum developed by Dr. Stephen Bavolek (<http://www.nurturingparenting.com/>). Dependent upon the service area, eligibility criteria ranges from families at risk of abuse, to families with a report of abuse or

neglect, to those working toward reunification from out-of-home care. The program utilizes pre- and post-assessments to track a parent's progress toward gaining the desired knowledge and skills. Another parent training program being used by one agency that is intended to prevent families with in-home services from requiring out-of-home care and reduce lengths of stay for children already in care is Parenting with Love and Limits. The program follows a ten-week curriculum that is a combination of parent education and family therapy and relies upon various treatment fidelity standards to ensure that the clinician is following the protocol as intended. Parenting with Love and Limits was highlighted as an innovative practice in a previous evaluation report (Armstrong et al., 2009).

Lead agencies also reported the increased use of strategies that are designed to connect families with needed resources and supports at the initial stage of their contact with the child protection or child welfare system. A resource specialist or facilitator was reported by 16 agencies as an expanded practice since Waiver implementation. The purpose of this position is to provide timely support to the child protective investigator or case manager concerning resources, supports, and services available in the community that might reduce the level of risk to the child and decrease the likelihood of out-of-home placement. In order to increase efficiency and collaboration, resource specialists are co-located with child protective investigators or diversion case management staff. The provision of resource specialists has been featured in previous evaluation reports as an innovative practice and most recently in semi-annual progress report 9 (Vargo et al., 2011). Similarly, intake specialists or multi-disciplinary intake teams are being used by 10 lead agencies to improve the timeliness and appropriateness of resource and service referrals at the beginning of a case, typically when it is being opened for services by the lead agency, but also at the time of initiation of a child protective investigation.

Another significant change in practice that has been made possible by the Waiver is the increased use of flex funds to help families involved in allegations of abuse or neglect by purchasing items or services that could decrease the risk level and prevent the need for out-of-home placement such as beds, cribs, and utilities or rent assistance. Although 13 agencies reported a greater availability of flex funds, the majority also indicated that the capacity does not meet the needs of the community. Agencies described implementing strict eligibility procedures to maximize the efficient utilization of flex funds and make efforts to augment these funds by obtaining donations of goods and services from local businesses and non-profit agencies that are designed to meet the specific needs of a family.

Due to the increased number of children being diverted from out-of-home placement and served by in-home services, the majority of the lead agencies have significantly expanded case management resources for these families. Eleven agencies indicated that they have increased the capacity of case management units devoted to diversion services and four of these agencies created new diversion case management units since the Waiver. Findings from case manager focus groups indicated that case managers in areas with special units that serve diversion or family preservation cases view this as a beneficial unit structure. However, the majority also emphasized that because the children remain in the home, these cases are most often higher risk than out-of-home cases, require more frequent visitation and contact, and often demand more resources to help ensure safety for the child.

While the availability of prevention services described above has greatly increased across the state since Waiver implementation, the primary challenge reported by agency leadership and case manager focus group participants is that in many service areas the capacity and accessibility do not meet the full needs of the community. Lead agencies that serve rural areas noted limited or no availability of intensive in-home services in these communities and indicated that it can be a challenge to contract agencies and counselors to provide service in these areas due to the long distances from one location to another. Similarly, case managers located in areas where services have increased characterized this shift as a strength of the Waiver, however the service or practice was not always available or accessible to families in the entire service area due to insufficient program capacity, distance and limited transportation resources. Furthermore, not all agencies indicated an increased availability or presence of practices that were considered to be most beneficial such as in-home family preservation services, in-home parenting, crisis intervention, or flex funds.

Another challenge that has occurred during the Waiver period is the limited ability to track the effectiveness and outcomes of the expanded availability and utilization of prevention and diversion services. Not all families that utilize these services are being entered into Florida Safe Families Network (FSFN), Florida's Statewide Automated Child Welfare Information System (SACWIS), specifically the primary and secondary services described above. Some agencies have developed their own tracking and monitoring systems, but to create the ability to capture data on a statewide basis, DCF has designed a FSFN component for secondary prevention cases that is scheduled to be implemented during SFY 11-12 (see Appendix E). Data from this component was not available for the current evaluation, but will be a valuable data source for the upcoming evaluation, if the Waiver is renewed.

### **Strategies to engage families in service planning.**

Findings from the lead agency surveys indicated that the availability of family team conferencing or family group decision making as a strategy to engage families in service planning and provision has increased significantly. At baseline, five lead agencies indicated the use of these practices compared to 15 reporting their use in 2011. The majority (n=11), of the agencies reportedly are practicing family team conferencing based on the model developed by the Child Welfare Policy and Practice Group (CWPPG, 2001). Family group decision making developed by the American Humane Association (2008) is used by two agencies and a family team wraparound approach is used by two agencies. The use of family team conferencing varies across agencies and includes accepting referrals for families at the time a case is open to child protective investigations, those receiving voluntary protective services, in-home services, out-of-home care, preparing for reunification, and at the point of a placement move. A detailed description of the implementation of family team conferencing across the state was provided in semi-annual progress report 7 (Armstrong et al., 2010).

CBC lead agencies also reported increased availability of services and practices to engage and support relative and non-relative caregivers. Eleven agencies indicated that they have expanded the capacity of educational and support services for caregivers and six reported the use of designated relative caregiver specialists to improve the accessibility of services for caregivers. One example of a relative caregiver program is the GAP Project developed in 2007 by Devereux Kids and contracted by Heartland for Children, the lead agency in Circuit 10. The purpose of the program is to assist relative and non-relative caregivers within the first 30 days of a child being placed into their home and includes an orientation for all new caregivers, community resource information, and assistance in completing forms related to receiving services for the child in their care such as relative caregiver funds, temporary cash assistance, and Medicaid. The program also produces a monthly newsletter with information that is pertinent to relative caregivers.

In collaboration with DCF and Casey Family Programs, the lead agencies have also begun to implement family-centered practice across the state. During SFY 09-10, a family-centered practice (FCP) model was developed and three innovation sites were selected by DCF to begin focused implementation. Parallel to this process, DCF conducted statewide FCP training with CBC and contracted agency staff in each circuit of the state. In addition, the mandatory pre-service training curricula for case managers, child protective investigators, and supervisors was revised to incorporate the FCP practice principles articulated within the model. The core components of Florida's FCP model are family engagement, extensive and frequent

assessment, team-based planning and decision-making, and individualized planning and services matched to needs. The implementation plan of family-centered practice includes an external evaluation that is being completed by Ounce of Prevention Fund of Florida.

While the majority of the service areas indicated an increased emphasis on family engagement and family-centered practice, it was also reported that an insufficient amount of time for case management staff to spend with parents can be a barrier to family engagement. Findings indicated that a reduction in caseload size that has occurred since the Waiver in some areas has helped to address this issue and has allowed more time for case managers to engage children and their families, as well as time for staff to be trained on family-centered practice. One stakeholder explained, “they [case managers] are not just chasing paper, they are not just meeting deadlines, they are actually engaging in conversation, communication with the client and putting in life-sustaining opportunities to change the dynamics of that family” (Vargo et al., 2010, pg. 20). As another way to alleviate this barrier, seven lead agencies reported increasing the capacity of family support workers to assist case managers and families in carrying out tasks of the case plan such as supervised visitation, transportation to court, and transportation for children to attend recommended services. Even after the increased capacity, the majority of case managers and lead agency survey respondents noted that availability of family support workers did not fully meet the needs of their service area.

### **Strategies to increase permanency and reduce a child’s length of stay in out-of-home care.**

All of the CBC lead agencies reported increased efforts to reduce a child’s length of stay in out-of-home care and improve permanency outcomes for children and families. Lead agencies reported integrating these strategies to impact the effectiveness of case work practice at varying points and throughout the duration of a child welfare case.

One strategy with the intent to improve the efficiency and outcomes of case work practice throughout the life of the case is the addition and increased capacity of permanency specialists, reported by eight lead agencies. These positions are specialized case workers that are assigned to a case to insure that all appropriate courses of actions are being taken to move the child toward reunification, adoption, or alternative permanency option as safely and quickly as possible.

At the point of a child’s intake into the child welfare system family finding and diligent search specialists are being utilized to increase the likelihood that a child and family can be connected with supportive external family and friends and potential placement options.

Agencies are also using Family Finding to locate supportive connections and potential permanent families for youth who have been in care for an extended period of time and do not have a viable permanency plan. Family Finding has been implemented by eight lead agencies during the Waiver, an increase from one lead agency (Our Kids) that had a family finding program at the beginning of the Waiver in 2006. Family Finding was most recently featured as an innovative practice in semi-annual progress report 9 (Vargo et al., 2011) and a detailed description of the practice, referral and eligibility procedures, staffing structure, training, coaching, and quality assurance mechanisms can be found therein.

Agencies also reported implementing evidence-based child welfare practice models that supply a framework to guide case work practice and decision making. One example is the introduction of solution-based or solution-focused casework, reported by six lead agencies, a family-centered model of child welfare assessment, case planning, and ongoing casework that emphasizes working in partnership with families, focusing on everyday family life tasks, and promoting skill development. Two agencies have incorporated the solution-based casework model developed by Dana Christensen ([www.solutionbasedcasework.com](http://www.solutionbasedcasework.com)) into practice and the other four are utilizing elements of solution-based or solution-focused casework within their case management programs. Another, Structured Decision Making (SDM), implemented by Our-Kids of Miami-Dade, Inc. is a model that consists of a set of assessment tools and guidelines that are designed to be used at each decision point over the course of a case. A detailed description of SDM and information about staff selection, training, and quality assurance was presented in a previous evaluation report (Vargo et al., 2011). In addition, one lead agency implemented the Greenbelt certification program that is focused on improving quality of service, problem solving and data analysis skills.

During a child's stay in out-of-home care supportive services are being provided to foster parents to improve placement stability and foster parent retention. The availability of foster parent liaisons has experienced an increase in capacity in six services areas and foster parent mentor programs that utilize veteran foster parents to teach and mentor new foster parents have been initiated or expanded by seven lead agencies. A detailed description of the foster parent mentoring program developed by United for Families, the lead agency that serves four primarily rural counties in the central region of Florida can be found in semi-annual progress report 9 (Vargo et al., 2011). In addition to these specific practices, the Quality Parenting Initiative (QPI) has been implemented across the State to improve the professionalism of foster parenting through enhanced training resources, communication, teamwork, and partnerships with child welfare staff. QPI also emphasizes the important role that foster parents have in supporting

biological parents toward successful reunification with their children by implementing co-parenting strategies between foster parents and biological parents, and mentoring and training opportunities by foster parents for biological parents.

Practices to improve the effectiveness of the collaboration between the court system, the family, lead agencies, and DCF have been implemented and expanded during the Waiver period. Four lead agencies reported the creation of a court service liaison or specialists that help to expedite the referral and receipt of services for families to shorten the duration of the child welfare case and time in out-of-home care. Similarly, two lead agencies reported increased availability of dependency court resource facilitators. For example, FFN, the lead agency in Circuit 1, which covers the four counties at the western most part of the Florida panhandle, reported that a court facilitator is located in every dependency court in their circuit. The facilitator provides a neutral and non-adversarial means to address barriers to case plan compliance including developing agreed upon case plan tasks, visitation schedules, and improving service accessibility.

As a strategy to increase the likelihood that a child and family will experience a successful transition out of the foster care system, agencies are utilizing enhanced visitation and reunification support for biological families and adoption support services for adoptive families. Enhanced visitation support was reported by 11 lead agencies as a practice that has gained capacity during the Waiver. It is intended to prepare a parent for visits with the child to improve the interaction between the parent and child and increase the effectiveness of parenting, bonding, and discipline techniques during the visit by providing coaching and training with the parent prior to and during visits. Thirteen agencies reported an expansion of reunification services that include clinical services provided by a therapist or counselor and in-home trainers that mentor parents in the fundamentals of budgeting, parenting, accessing services and navigating the various social and educational services available to the family. The duration of these enhanced services varies by agency and is dependent upon the needs of the family.

Eleven lead agencies indicated the availability of pre-adoption support services had increased in their service area over the Waiver period. Furthermore, three of the agencies reported that they had created new programs to support adoptive families prior to placement and finalization and eight of the agencies have added or increased the availability of adoption specialists. An adoption specialist is typically assigned to a case when the case plan permanency goal becomes adoption and is a resource in addition to the case manager. The purpose is to ensure the quality completion of all adoption-related procedures and processes

such as home studies, child studies, and adoptive parent training and to ensure that the prospective adoptive parents are receiving all of the information and support that they need to prepare for a successful adoption. Expanded post-adoption support services since Waiver implementation were reported by 13 lead agencies. Typically, post-adoption programs support families after the adoption is finalized by assisting with linkages and referrals to community services and support systems, facilitating respite care, offering training on how to manage systems for children with special needs such as developmental disabilities and specialized mental and physical health services, organizing support and education parent groups, and providing funding and support for adoptive families whose children need residential treatment.

Even while diversion case management capacity has increased across the state, a minority of agencies also indicated that they have increased the capacity of dependency case management to try to decrease caseloads and allow case managers to more effectively satisfy the needs of the case. This effort has included increasing the ratio of supervisors to case managers so that more effective support and oversight can occur.

**Strategies to improve child and family well-being (educational, physical, and mental health needs).**

Evaluation findings indicate that several practices have been expanded or initiated with the intent of improving the accessibility, availability, and appropriateness of educational, physical, and mental health services provided to children in care.

The use of educational liaisons or specialists was reported by six lead agencies to improve the coordination of services between the child welfare and educational systems. The liaisons are specialized workers with experience in educational counseling or similar field who work closely with a child's school, teacher, and educational support staff to ensure that a child's educational needs are being met.

Similarly four lead agencies are using nurse liaisons and specialists to coordinate with the medical system to ensure that a child's physical needs are being met. Also to improve a child's access to medical care, six lead agencies noted the increased capacity of medical foster care during the Waiver period.

As a strategy to improve the accessibility and appropriateness of mental health services, Kids Central, Inc., the lead agency in Circuit 5 covering five counties in the central region of Florida, has funded consultant positions that assist with navigating the mental health system. One position is located within the placement department to assist placement staff and foster parents with accessing appropriate mental health services for children. The other positions are

co-located with CPIs to assist them with mental health assessments and obtaining needed services for families involved in an allegation of abuse or neglect.

Also to address a child's emotional and behavioral health needs while in care, a majority of the lead agencies reported increased availability and capacity of behavior analysts and management services that are provided to help foster parents learn effective ways to manage children's challenging behaviors.

### **Community services and supports.**

CBC lead agencies were asked to report the availability, accessibility, and the extent to which service and supports often utilized by families involved in the child welfare system meet the needs of their community, such as adult education, housing assistance, job training, transportation and subsidized childcare.

A minority of the lead agencies (n=6) indicated that the availability of adult specific services such as adult education, employment assistance, and job training has increased during the Waiver period. However, the majority (n=13) have seen no change and nine reported that the capacity of the services is not sufficient to meet the needs of the community. Similarly, family planning, pregnancy, parenting, parent advocacy, and homemaker services were stated to only meet some of the community need.

Other areas that reportedly have experienced increased capacity yet still do not meet the needs of the community that are focused on children include subsidized childcare, tutoring, early intervention services for children zero to five years of age, services for developmentally disabled children, and specialized after school programs.

Community services to support the overall well-being of the family were also noted to be insufficient by the majority of lead agencies include housing assistance, transportation services, utilities assistance, and food bank services. While the capacity of many services and supports were reported to be inadequate, seven lead agencies noted an increase in community information and referral services that help families gain access to the resources that do exist in each community.

### **Summary**

Findings from the child welfare practice analysis support the hypothesis that Waiver implementation will lead to changes in and expansion of the service array and that within the context of a community-based care model, the flexibility of funds will be used differently by each lead agency, based on the unique needs of the communities they serve.

Furthermore, consistent with the intent of the Waiver, the State has experienced a significant increase in primary, secondary, and tertiary services and practices to prevent child abuse and neglect and divert families from the out-of-home system of care. Expanded capacity has occurred within intensive in-home programs, parent education programs, domestic violence prevention and mobile crisis units. In addition, new partnerships and collaborative efforts have been developed to reduce the occurrence of abuse and neglect among the general population and families at risk. Lead agencies and DCF have also co-located a greater number of child protection and case management service units and added resource specialists and service coordinators to improve access and appropriateness of service for families involved in an abuse or neglect investigation.

To improve engagement with families in assessment, service planning, and provision lead agencies have expanded the capacity and availability of family team conferences and family group decision making. In addition, the child protection and child welfare systems have seen statewide implementation of family-centered practice with concentrated efforts in three innovation sites. Supports and services to relative and non-relative caregivers have also gained capacity.

The focus of the expanded service array has not only been on prevention and diversion but also on improving permanency outcomes and reducing lengths of stay in out-of-home care. Lead agencies reported the use of enhanced services to support visitation, reunification, and adoption and efforts to improve coordination with the court, educational, physical, and mental health systems.

While changes in and an expansion of the community-based service array have occurred, adequate capacity and availability does not exist across the entire state specifically related to in-home services for families diverted from out-of-home care and adult and child specific community services and supports that help to promote the safety and well-being of families. Furthermore, a limited aspect of the Waiver evaluation within the context of community-based care is the difficult nature of assessing the effectiveness and outcomes of the vast array of services, practices, and strategies being used by 19 CBC lead agencies and their multiple case management and service providers.

## **Recommendation**

- Even though an expansion of the service array has occurred, findings indicated that not all programs have adequate capacity to meet the needs of children and families served in the child welfare system. Therefore, we recommend that the legislature, DCF, CBC

lead agencies, and community providers devise a strategy to facilitate more even distribution of services and supports available to children and families involved in the child welfare system to ensure adequate access across all individuals, especially in rural areas.

## 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 implementation.*

### **Terms and Conditions 3.4 Cost Evaluation Domains:**

- The cost analysis will examine the costs of key elements of the services received by children and families and compare these costs with those of the usual services/placements prior to implementation of the demonstration.
- Compare the costs of the demonstration with those of services traditionally provided to children and their families. Where feasible, a cost-effectiveness analysis will be conducted by examining the relationship between the demonstrations' costs and outcomes.
- The cost analysis will also include an examination of the use of key funding sources, including all relevant Fed sources such as titles IV-A, IV-B, IV-E, and XIX of the Social Security Act, as well as State and local funds.

With the initial Waiver period now complete, there is sufficient data to determine the fiscal effectiveness of Florida's IV-E Waiver. Consistent with the cost evaluation domains listed above, we have evaluated two components of fiscal effectiveness: (a) the extent to which CBC lead agencies invested a larger proportion of child welfare services funds on front-end services (prevention, diversion, and early intervention services) relative to the level of resources used for licensed out-of-home care services, and (b) how key funding sources were used during the course of the Waiver. We also assessed the extent to which Florida met the maintenance of effort requirement associated with the Waiver, and whether Waiver implementation was associated with a relative reduction in IV-E administrative costs.

### **Cost Analysis Methodology**

To assess CBC lead agency expenditures by type of service, statewide expenditures were extracted from the Florida Accounting Information Resource (FLAIR) for the two years prior to Waiver implementation (FFY 04-05 and FFY 05-06) and the five-year Waiver implementation period (FFYs 06-07 through FFY 10-11). FLAIR data were combined with expenditure data from the DCF Office of Revenue Management in order to capture expenditure adjustments that were not recorded in FLAIR. Expenditures were categorized by type of service using appropriate Other Cost Accumulator codes in consultation with the DCF Office of Revenue Management. Analysis of out-of-home services includes family-based foster care,

relative placements, and institutional care, which is comprised of residential treatment, group home, shelter care, and independent living. Analysis of front-end services includes prevention, diversion, family preservation, and other in-home services that can be reported in FSFN. Total expenditures reported in this analysis include all expenditures associated with service provision for youth receiving services from lead agencies and excludes expenditures incurred by DCF or lead agencies for maintenance adoption subsidies and protective investigation training.

There are some limitations associated with these analyses of expenditures by type of service. Because throughout the Waiver period FSFN only allowed providers to report front-end services for children and families with an open case, the actual number of children and families receiving any child welfare service is higher than the numbers provided in this report. Another limitation of these analyses is that child-level cost data for all services is unavailable. One consequence of this limitation is the inability to provide child-level analyses of changes in expenditures. Another limitation is the inability to look at the distribution of costs across cohorts of youth. Finally, although the IV-E Waiver has been hypothesized to affect some of the spending changes reported here, the lack of a valid comparison group (due to statewide implementation of the Waiver) prevents concluding that all spending changes were attributable to the Waiver rather than other policy or system changes.

To assess the use of key funding sources and the maintenance of effort requirement, we combined analysis of the aforementioned FLAIR data with analysis of a worksheet detailing expenditures by fund source that was produced during Fall 2011 by the DCF Office of Revenue Management. To assess whether IV-E administrative costs were reduced, we reviewed relevant DCF documents and conducted interviews with relevant DCF and lead agency stakeholders.

## **Cost Analysis Findings**

### **Changes in spending by type of service during Waiver implementation.**

There have been notable changes in child welfare spending by type of service during the five-year Waiver period (see Table 17). As hypothesized, expenditures for licensed out-of-home care dropped from \$163.4 million during FFY 04-05 (two years prior to Waiver implementation) to \$133.7 million in FFY 10-11 (the final year of the Waiver), a decrease of 18%. Also consistent with our hypothesis, front-end services expenditures increased substantially during the Waiver period, from \$15.0 million in FFY 04-05 to \$45.7 million in FFY 10-11, an increase of 205%. Dependency case management expenditures slightly decreased by 0.6%, from \$312.4 million during FFY 04-05 to \$310.5 million during the final year of Waiver implementation. Expenditures for other services (primarily adoption and independent living) modestly decreased by 3%, falling

from \$124.7 million during FFY 04-05 to \$121.0 million in FFY 10-11. Total child welfare expenditures fell by less than 1% during the Waiver period, declining from \$615.54 million in FFY 04-05 to \$610.9 million in FFY 10-11.

Table 17.

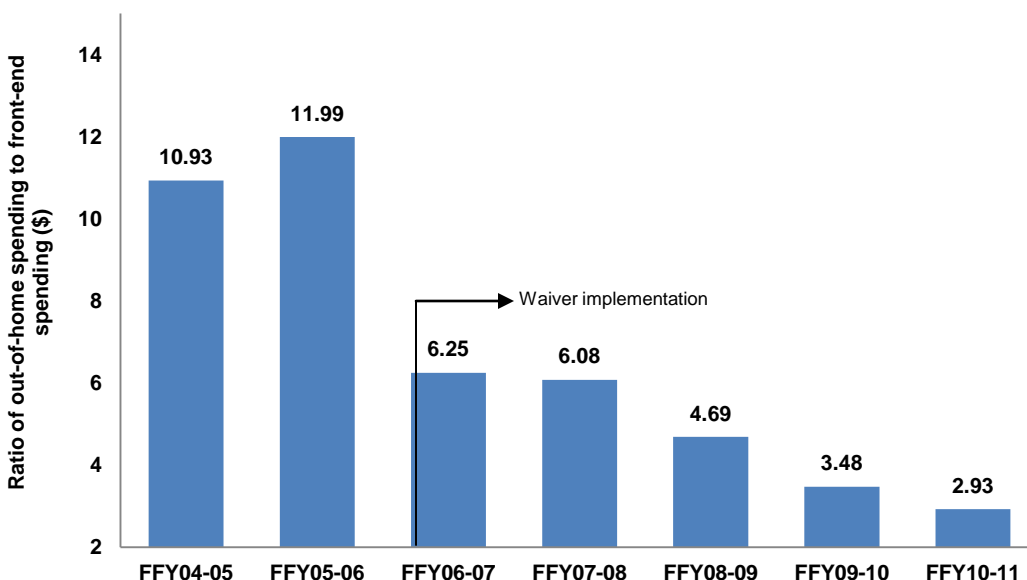
*Child Welfare Expenditures by Federal Fiscal Year by Type of Service (in million \$)*

Type of Service	FFY 04-05	FFY 05-06	FFY 06-07	FFY 07-08	FFY 08-09	FFY 09-10	FFY 10-11	FFY 10-11 minus FFY 04-05	% Change
Licensed out-of-home care	163.4	194.4	184.0	167.5	144.9	134.1	133.7	-29.7	-18.2
Dependency case management	312.4	384.7	315.1	325.6	311.5	310.8	310.5	-1.9	-0.6
Front-end services	15.0	16.2	29.4	27.6	30.9	38.6	45.7	30.7	205.4
Other	124.7	122.5	78.8	88.5	102.0	121.1	121.0	-3.7	-3.0
Total	615.5	717.8	607.3	609.1	589.4	604.7	610.9	-4.6	-0.7

NOTE: Some totals and differences may be off by one decimal place due to rounding.

Consistent with the hypothesis that the Waiver would allow funds previously restricted to out-of-home care to be used for prevention, diversion, family preservation, or other in-home services, the ratio of out-of-home care spending to front-end services spending has consistently and substantially decreased since Waiver implementation (see Figure 12). During the two years prior to Waiver implementation, lead agencies statewide spent \$10.93 and \$11.99, respectively, on out-of-home care services for every dollar spent on front-end services. By the final year of Waiver implementation, this ratio dropped to \$2.93, a decrease of 73% from FFY 04-05.

Figure 12. Ratio of estimated out-of-home care expenditures to estimated prevention/diversion/family preservation/in-home expenditures by federal fiscal year



#### Changes in spending by fund source during Waiver implementation.

The Waiver has also afforded Florida flexibility with regard to how the State has used federal and state resources for youth in the child welfare system. This flexibility has been manifested in two notable ways. First, the Waiver allowed Florida's child welfare system to access 100% of the federally-appropriated IV-E funds each year since Waiver implementation began in FFY 06-07. This was a change in practice from before the Waiver, when the system was only able to access 92.5% (FFY 04-05) and 99.1% (FFY 05-06) of the IV-E budget. Second, the more flexible use of IV-E funds enabled a much larger use of State funds for front-end services. The largest increase in categorical spending of State funds during the Waiver period occurred with non-Temporary Assistance to Needy Families (TANF) funds for prevention, intervention, and in-home supports (see Table 18). The State increased its level of non-TANF funds for these services from \$27.6 million in FFY 04-05 to \$68.9 million in SFY 11-12.

Table 18.

*Title IV-E Level of Effort by Fund Source, Base Year (FFY 04-05) vs. Current Year (SFY 11-12)*

Fund Source	Actual FFY 04-05 Expenditures		Planned SFY 11-12 Expenditures for IVE-IVB Services	
	Federal	State	Federal	State
IV-E Foster Care Maintenance	50,754,233	35,152,434	0	19,349,893
IV-E Foster Care Administration w/o SACWIS <sup>9</sup>	83,178,110	83,178,099	166,473,146	80,311,054
IV-E Foster Care Training	2,368,959	789,652	0	2,362,488
Title IV-B, Part 1	15,655,725	11,347,611	13,464,325	4,481,615
Title IV-B, Part 2	14,228,992	1,315,263	13,756,932	432,736
Chafee IL Match	7,889,242	3,547,100	6,014,947	1,503,106
Education and Training Voucher	3,521,171	603,723	2,396,966	599,242
State Independent Living Beyond Match Requirement	0	514,660	0	19,250,167
State Funded Maintenance Payments - Non IV-E	0	38,787,380	0	29,930,112
Prevention, Intervention, In-Home Supports State Funded - Non TANF	0	27,640,388	0	68,926,694
Medicaid Administration - Child Welfare	1,271,308	1,271,308	1,165,988	1,165,988
State Access and Visitation - Child Welfare	404,817	0	650,000	0
Promoting Safe and Stable Families - Marriage Grants	534,747	0	0	0
Child Abuse Prevention and Treatment	769,651	0	1,978,011	0
Community-Based Child Abuse Prevention - Family Resource and Support	1,454,155	363,538	2,175,608	352,378
TANF MOE - Child Welfare	0	44,630,295	0	80,515,545
TANF Federal - Child Welfare	96,501,978	0	57,032,570	0
SSBG Funded Child Welfare Federal	15,859,779	0	8,453,232	0
SSBG II Funded Child Welfare Federal	41,216,118	0	41,343,985	0
Other State Funded Title IV-B-or IV-E Equivalents	0	56,816,263	0	36,769,684
TANF/State Funded Adoption Assistance Non-Title IV-E	7,662,366	9,761,620	14,330,425	17,480,664
Title IV-E Adoption Assistance Subsidy Payments	37,056,174	25,856,004	55,940,141	44,943,792
TOTAL	380,327,525	341,575,338	385,176,276	408,375,158
Adjustment arising from factors other than Waiver beyond the State's control <sup>10</sup>	(4,411,205)	(1,015,722)	(30,181,062)	0
ADJUSTED TOTAL	375,916,320	340,559,616	354,995,214	408,375,158
SUM OF FEDERAL & STATE ADJUSTED TOTALS	716,475,936		763,370,372	

<sup>9</sup> All federal IV-E Foster Care expenditures (maintenance, administration, and training) are no longer reported separately, and are summed in the administration line item.

<sup>10</sup> Represents federal award adjustments since FFY 04-05 that were beyond Florida DCF's control. The \$30.2 million adjustment for SFY 11-12 represents the annual federal increase to Florida's budget due to the Waiver. This increase cannot be used to meet the State's "savings" requirement pursuant to Section 2.2(m) of the Title IV-E Waiver Terms and Conditions contract.

**Maintenance of effort.**

Florida's Title IV-E Waiver provides a fixed amount of federal funding for foster care. This federal funding level was based on actual expenditures from FFY 04-05 (the "base" year) and increased 3% annually. Section 2.2(m) of the Florida Waiver Terms and Conditions (page 7) requires that savings resulting from the Waiver be used for the further provision of child welfare services; this clause is also referred to as "maintenance of effort." The language of the relevant provision is as follows:

Ensure that any "savings" resulting from the Waiver demonstration, whether they are savings to the Federal government, to the State, or to a county or to another jurisdiction within the State, will be used for the further provision of child welfare services. For the purposes of this provision, "savings" means any amount that would have been expended for conventional Title IV-E purposes in the absence of this demonstration, or that could have been expended under Title IV-B of the Act.

In order to ensure that this requirement was met at the end of Waiver implementation, the DCF Office of Revenue Management compared planned expenditures for SFY 11-12 to actual base year expenditures (see Table 18). In calculating base year and current year planned expenditures, two sets of adjustments were made. The base year requirement has been reduced for reductions in federal funds (and associated state matching funds) that are unrelated to the Waiver. In addition, the amount of planned SFY 11-12 federal funds includes an adjustment for the annual 3% increase noted above. This adjustment prevents a reduction in state commitment due to increased federal funds. In other words, the State's funding level for child welfare services cannot be reduced because of the annual federal funding increase.

When adjusted for reductions in federal funds (and associated state match) unrelated to the Waiver, the base year funding requirement was \$716,475,936. Planned expenditures for SFY 11-12, after adjustment for Waiver related increases, are \$763,370,372. This difference of \$46,894,436 indicates that the State of Florida will exceed the maintenance of effort requirement in SFY 11-12, assuming all planned expenditures are actually incurred.

**Reduction of IV-E administrative costs.**

One of the Waiver Terms and Conditions the State agreed to was an expectation that the Waiver would be associated with a relative reduction in IV-E-related administrative costs per child served or per child day. Before the Waiver and dating back to the period prior to the

State's shift to community-based care, DCF used random moment sampling (RMS)<sup>11</sup> of staff to determine how costs should be allocated to various fund sources for administrative and direct service provision. Using the RMS approach required significant resources to maintain a worker database, create the samples, forward them to a sampling administrator, locate the worker, take the sample and return the sample to the central office. In addition, the sample had to be validated, and there needed to be a minimum number of valid samples for the federal government to accept the sample as legitimate. In addition, DCF used a stand-alone system for each district to capture various direct service expenditures. This standalone system used several hundred expenditure OCAs to identify and attribute child welfare expenditures by client eligibility and fund source. With the advent of community-based care, CBC lead agencies took on the responsibility of identifying which OCAs were appropriate for the expenditures they incurred.

The flexibility of the IV-E Waiver allowed DCF and the CBC lead agencies to simplify the above processes, and thereby, reduce the proportion of overall child welfare expenditures devoted to administration. DCF was able to significantly revamp its method of allotting funds to CBC lead agencies and reporting procedures for CBC lead agencies. The Waiver allowed DCF to dramatically reduce the number of OCAs needed to manage all child welfare funds, which simplified budgeting and reporting for both DCF and the lead agencies. In particular, DCF was able to reduce CBC reporting requirements for expenditures to a single-page report. The Waiver also changed the way CBC lead agencies managed their spending, as they were no longer hampered by the need to prioritize how to use all allotted funds. Instead, the fiscal management simplification afforded by the Waiver allowed CBC leadership to concentrate on programs and service delivery while DCF monitored spending levels by fund source. Lead agency stakeholders reported that the Waiver significantly simplified their processes for administrative oversight and use of funds, resulting in a reduction in the time and resources devoted to fiscal administration. One disadvantage of this new reporting approach is that there is not a systematic way for CBC lead agencies to consistently report administrative costs, and lead agency stakeholders have differing views about how certain administrative costs should be ascertained.

In summary, although the available data do not allow us to determine a precise magnitude of reduction, these qualitative data strongly suggest that administrative costs have been reduced in conjunction with Waiver implementation.

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<sup>11</sup> RMS is a common methodology used in social service settings to determine how staff with multiple responsibilities allocate their time across activities. RMS is also a Department of Health and Human Services-allowable method for determining the federal share of child welfare administrative costs.

## **Fiscal Issues Pertinent to IV-E Waiver Implementation**

Four major themes arose from lead agency leadership focus groups, interviews, and surveys during the IV-E Waiver time period: why flexibility in funding is critical to improvements in practice, co-occurring fiscal challenges impacting IV-E Waiver implementation, issues involved in shifting resources from the back to front end of the service system, and creative prevention strategies that can now be funded due to the IV-E Waiver.

### **Funding flexibility.**

As mentioned earlier in the report, the flexibility in using funds has been extremely critical to the majority of stakeholders. Lead agencies have been able to expand front-end services in order to prevent unnecessary placement of children that was often due to the inaccessibility of immediate access to services. At the beginning of the Waiver, lead agency contracts had recently changed from cost reimbursable to fixed price, allowing unspent state funds to be carried forward to the next fiscal year, further adding to this funding flexibility. In similar fashion to how the Waiver's funding flexibility brought about more appropriate and timely services for children, moving away from cost reimbursable contracts ended the feeling of pressure to spend money inefficiently at the end of each state fiscal year with the 'use it or lose it' mentality. Collectively these changes helped decrease the complexity of spending categories within Florida's child welfare system. As one participant explained of previous years: "It is like if you put your paycheck into 120 different bank accounts and then went to the grocery store and had to figure out which bank accounts to draw from for what you were buying" (Armstrong et al., 2007, pg. 14).

The flexibility also brought about a "prospect of change," and this sentiment was expressed in many first and second year focus groups (Vargo et al., 2007, pg.14). The hope was that the Waiver would ideally serve as a trigger toward development of a more effective system of care, and that the Waiver would inspire stakeholders to elevate the local community debates on the service delivery system (Vargo et al., 2007).

### **Funding challenges.**

There have been several funding challenges that have occurred alongside implementation of the IV-E Waiver. They include: fixed-price contracting, having to pick up uncovered expenses for the Florida Agency for Persons with Disabilities (APD) and Medicaid, lack of control over the legal system and key players, no new IV-E dollars beyond the 3%

annual increase, previous year end deficits for some lead agencies, not knowing the total lead agency budget for the current operating year, historic inequities in funding, and the rising costs of providing care.

While fixed-price contracting was seen by many stakeholders as a positive change, others identified pitfalls. Should an agency experience an influx in children coming into out-of-home care, directors worried that deficits would occur because there was no mechanism for adjusting a current year's contracted amount. Agencies stressed the tough environment in which they operated where dollars in their contracts could only decrease, but the number of children in care could increase at any time.

Several lead agencies reported that they were concerned about influxes of children with developmental disabilities whose care had previously been the responsibility of APD. Concern was expressed that partially due to the flexibility of the Waiver, and partially due to continued budget cuts to historically under-funded agencies such as APD, the Department of Juvenile Justice (DJJ) and Medicaid, the CBC system has become a primary funding source for children traditionally, and in many cases, more appropriately served by other organizations.

Child Welfare Legal Services (CWLS) was another aspect of the system that lead agencies felt has significantly impacted their financial viability and the number of children in out-of-home care. Participants explained that they often felt a lack of control over the time it takes CWLS to file motions and set up hearings, which in turn impact lead agency performance. Additional factors mentioned were problems when parents' attorneys stalled the process, shortages of Guardians ad Litem, and the fact that the dependency judges chair community alliances in many counties, so the idea of an alliance stepping in to hold the legal system accountable has not always worked due to this perceived conflict of interest.

In addition, during the first year of the Waiver, lead agency stakeholders expressed anxiety about lack of clarity around how new IV-E dollars would be distributed. Because this impacted their bottom line, some were more hesitant to set up new services for which they were not sure they could sustain funding. Previous year-end deficits, historical inequities in funding, and rising costs of providing care were also issues. One participant explained, "The IV-E Waiver flexibility should not overshadow the general need for more resources" (Armstrong et al., 2007, pg. 16). Some participants reported that due to increasing costs of living (e.g., cost of housing and transportation), they were having trouble attracting providers to come into their local jurisdictions (Armstrong et al., 2007).

### **Shifting resources from out-of-home care.**

Many of the lead agency leadership focus group participants discussed both philosophical and strategic efforts to refocus their resources from the back end to the front end of the system. A philosophical shift occurred during the five years of the Waiver in terms of not just thinking about preventing re-abuse once a family has had a substantiated report, but also primary prevention (e.g., sponsoring creative strategies such as community education programs on parenting). As one stakeholder explained, “we really have to be up front and prevent harm of children in the first place” (Vargo et al., 2010, pg. 63). Respondents tied this shifting of resources toward prevention directly to the IV-E Waiver.

More concretely, when faced with budget cuts, one lead agency CEO explained,

We prioritized in-home programming...and where we had to take programmatic cuts we took them on the back end, traditional case management. That was a tangible strategy on our part to continue the momentum that we think we have created with the Waiver (Vargo et al., 2010, pg. 63).

Another lead agency spoke in terms of shifting FTE, “We moved about 12 FTE's from case management to front-end programs last year and will probably move about eight more this year” (Vargo et al., 2010, pg. 63).

Other agencies have been able to directly increase the amount of money they spend on diversion. One CEO explained that over the course of the past five years their lead agency has gone from investing \$1.5 million to \$5 million in diversion services. Yet another lead agency has been able to allocate \$1.5 million to after-school programs, summer and holiday camps, and other community programs located in at-risk geographic areas (Vargo et al., 2010).

### **Directing resources toward creative prevention strategies.**

Many examples of prevention and diversion services were mentioned during focus groups. The definition of prevention was quite broad. Some think in terms of preventing children from remaining in out-of-home care. The Family Finding model has been used to help locate relative placement options for children in care who have often previously been told they had no relatives. This has led to more social supports for youth. Corresponding relative and kinship care services have been augmented in some places to handle the increasing number of relative placements. This has included material support (e.g., food, clothing, holiday gifts for children), legal counsel should a relative or parent become incarcerated, and support groups both for the relative caregivers and the children being raised by them.

Other respondents thought in terms of primary prevention of maltreatment and specific things that could be done to educate and help community members. One participant explained, “A majority of the people we serve are not in the child welfare system – they are self-referrals in the community. Hooking them up to those benefits they didn't even know they were entitled to helps them dramatically” (Vargo et al., 2010, pg. 62). Respondents talked about reducing feelings of isolation regarding economic strain, and the benefit of people realizing they were not alone. Still other respondents discussed prevention related to focusing on older children in the system who are teenage parents, with the hope of preventing their children from entering the system at any point in the future by providing more wraparound support to the mother (Vargo et al., 2010).

## **Summary**

Although the evaluation design does not allow us to infer a causal relationship, there is clear evidence that hypothesized changes in spending for out-of-home care and front-end services have occurred since the Waiver was implemented in October 2006. By the end of Waiver implementation, expenditures for licensed out-of-home care decreased by 18% compared with out-of-home care spending two years prior to Waiver implementation, while front-end services expenditures more than tripled during the same period. The ratio of licensed out-of-home care expenditures to expenditures for front-end services in the final year of Waiver implementation was over 70% lower than this ratio was two years prior to Waiver implementation, which further demonstrates a shift in spending away from out-of-home care to prevention, diversion, family preservation, and other in-home services. Flexibility afforded by the Waiver enabled full use of federally appropriated IV-E funds during Waiver implementation and a significant increase in the use of State funds for front-end services. The State also demonstrated evidence of meeting the maintenance of effort requirement associated with the Waiver contract. Although the available data do not allow us to determine a precise magnitude of reduction, qualitative data strongly suggest that administrative costs have been reduced in conjunction with Waiver implementation.

## **Recommendations**

- Although qualitative data suggest there was a reduction in administrative costs during the course of the Waiver, DCF should provide guidance to CBC lead agencies to ensure administrative costs are reported in a consistent manner.

- DCF should continue pursuing renewal of the IV-E Waiver. The financial flexibility afforded by the Waiver has enabled CBC lead agencies to increase spending for prevention, diversion, family preservation, and other in-home services that are viable substitutes for out-of-home care for many children and families.

## **Summary and Discussion**

This is the final evaluation report for Florida's first five-year Title IV-E Waiver demonstration project. The purpose of this flexible funding Waiver was to demonstrate that allowing federal IV-E foster care funds to be used for a wide variety of child welfare services rather than being restricted to out-of-home care, as is normally the case under federal law, would result in improved outcomes for children and families. As the findings in this report illustrate, the demonstration has been successful. Specifically, the evaluation of the IV-E Waiver tested the expectation that an expanded array of community-based services available through the flexible use of Title IV-E funds would:

- expedite the achievement of permanency through either reunification, adoption, or legal guardianship;
- maintain child safety;
- increase child well-being; and
- reduce administrative costs associated with providing community-based child welfare services.

This report addresses all the process, outcome and cost evaluation requirements in the federal Waiver Terms and Conditions for the Florida Child Welfare Waiver demonstration project and is organized by the four hypotheses of the evaluation plan. The first section of the report describes the organizational and contextual factors that influenced the implementation of the Waiver during the initial phase of Waiver implementation. Four key themes emerged regarding organizational and contextual influences that facilitated implementation: philosophy of care, organizational efficiencies, communication and collaboration, and community perception and involvement. The implementation challenges included pace of implementation, the need for education of child protective investigation staff and community members, recruitment and retention of case management staff, and financing and fiscal issues. As is highlighted throughout the report, some of these factors such as philosophy of care, communication, community perceptions, and fiscal challenges affected Waiver implementation throughout the life of the Waiver. In retrospect, these factors are key to the implementation of any major child welfare system reform (Malm, K., Bess, R., Leos-Urbal, J., Geen, R., & Markowitz, T., 2001).

The remainder of the report is organized by the four hypotheses of the Waiver evaluation plan. The first hypothesis is that with an expanded array of early intervention and intensive in-home services, fewer children will need to enter out-of-home care. Over the two baseline years of the evaluation and the five Waiver years (FFY 04-05 through FFY 10-11), the number of

children served in out-of-home care statewide decreased from 20,987 in FFY 04-05 to 15,217 in the FFY 10-11. This represents a reduction of 27% in the number of children entering out-of-home care. This finding supports the first hypothesis. Clearly there has been a dramatic reduction in the number of children in out-of-home care over the time of the Waiver, although it is interesting to note that the number of children served in out-of-home settings in FFY 10-11 (n = 15,217) increased from 13,841 in FFY 09-10. One of the unanswered questions is what is a reasonable number of children in out-of-home settings for a state the size of Florida? Perhaps the rates have “bottomed out,” or perhaps the increase is a result of contextual factors such as reactions to a series of child deaths and the Barahona case that took place in February 2011.

The second hypothesis for the Waiver evaluation is that child outcomes related to permanency, safety and child well-being will improve over the life of the Waiver. In this progress report, two different methods were used to examine child outcomes. The first methodology used to address this hypothesis was longitudinal analysis of FSN data in order to examine trends in permanency and safety for children over the course of the Waiver. Overall, longitudinal trends for safety and permanency indicators indicated a continuing improvement in the lead agencies’ performance on these outcomes. In particular, the proportion of children who achieved timely permanency, as indicated by the number of children who exited out-of-home care for permanency reasons within twelve months and the number of children with adoption finalized within 24 months, significantly increased over time.

An examination of safety indicators showed that the average proportion of children who experienced recurrence of maltreatment after being served in the child protection system significantly decreased over the life of the Waiver, and the proportion of children who re-entered out-of-home care slightly decreased, although the decrease was not statistically significant. Finally, lead agencies’ improved performance in achieving placement stability was demonstrated by an increasing proportion of children with no more than two placements within 12 months of removal from home throughout the Waiver period, although Florida’s performance is still slightly below the national standard of 86.7%. In summary, findings from the longitudinal analyses suggest that during the IV-E Waiver implementation years; progressively more children achieved timely permanency while remaining safe. When the effects of child and family characteristics on outcome indicators were examined, results showed that child’s age, parental substance abuse, history of domestic violence, and the presence of child health problems and emotional issues played an important role in predicting outcomes.

The second approach used to assess child outcomes related to child and family well-being is the family assessment and services analysis methodology. This analysis collected and

utilized data from four sources: case managers, parents, Florida DCF case management quality of practice reviews, and the NSCAW study.

Case managers reported that maintaining rapport and engaging with families is a priority and occurs throughout the life of the case. Case managers described strategies they use to maximize family engagement, and most parents provided similar feedback. One barrier to successfully engaging families is some case managers and services providers not speaking families' primary language (e.g., Spanish or Creole), which could lead to parents agreeing to case plan requirements that they do not fully understand or not fully benefiting from services. According to NSCAW and Florida quality of practice data, there were increases in the proportion of parents included in case planning and decision making, though inclusion of fathers was found to occur in a minority of cases.

Additionally, there were significant increases over time in the proportion of cases in which case managers made sufficient efforts to engage mothers and fathers by addressing any identified barriers that may preclude their involvement in services. Case managers noted that participation in services is needed if parents are to gain knowledge and successfully implement new skills to improve their family's situation.

According to Florida quality of practice data, there were significant increases over time in the proportion of cases where concerted efforts were made to ensure that services were provided to keep children safely in their homes and to complete referrals for appropriate services for children in in-home and out-of-home care. There was a non-significant increase in the proportion of cases where supervision, support, and services were provided to prevent children's re-entry into out-of-home care after being reunified with their families. Analyses of NSCAW and Florida quality of practice data indicate decreases over time in the proportion of cases where services were provided to address children's educational, physical health, dental health, and mental health needs. To varying degrees, the majority of children were already receiving these services, although meeting physical and dental health needs were the areas most in need of improvement.

Despite the noted improvements in ensuring the well-being of children and families, there remains room for further progress. These areas include additional attention to the ongoing assessment of fathers' needs, the frequency of case manager visits with mothers and fathers, assessing children's dental health needs, supporting parents' participation in case planning and decision making, and providing physical and dental health services to children. The findings from this analysis of the Florida quality of practice of data and comparison with NSCAW cohorts

underscore the importance of Waiver renewal for focusing on needed improvements at the case management practice level that are needed for Florida's children and families.

Findings from the child welfare practice analysis support the evaluation's third hypothesis that Waiver implementation will lead to changes in and expansion of the service array and that within the context of a community-based care model, the flexibility of funds will be used differently by each lead agency, based on the unique needs of the communities they served. Florida's child welfare system has experienced a significant increase in primary, secondary, and tertiary services and practices to prevent child abuse and neglect and divert families from the out-of-home system of care. Expanded capacity has occurred within intensive in-home programs, parent education programs, domestic violence prevention and mobile crisis units. In addition, new partnerships and collaborative efforts have been developed to reduce the occurrence of abuse and neglect among the general population and families at risk. Since Waiver implementation, lead agencies and DCF have also co-located a greater number of child protection and case management service units and added resource specialists and service coordinators to improve access and appropriateness of service for families involved in an abuse or neglect investigation.

To improve engagement with families in assessment, service planning, and service provision, lead agencies have expanded the capacity and availability of family team conferences and family group decision making. In addition, the child protection and child welfare systems have seen statewide implementation of family-centered practice with concentrated efforts in three innovation sites. Supports and services to relative and non-relative caregivers have also gained capacity.

While changes in and an expansion of the community-based service array have occurred, adequate capacity and availability do not exist across the entire state. The most pressing service gaps are specifically related to prevention and early intervention services, in-home services for families with children diverted from out-of-home care, and adult and child specific community services and supports that help to promote the safety and well-being of families.

The fourth hypothesis examined in the evaluation is related to cost; this hypothesis assumes that expenditures related to out-of-home care will decrease over the time of the Waiver, and that expenditures related to prevention and in-home services will increase. There is clear evidence that hypothesized changes in spending for out-of-home care and front-end services have occurred since the Waiver was implemented in October 2006. By the end of Waiver implementation, expenditures for licensed out-of-home care decreased by 18%

compared with out-of-home care spending two years prior to Waiver implementation, while front-end services expenditures more than tripled during the same period. The ratio of licensed out-of-home care expenditures to expenditures for front-end services in the final year of Waiver implementation was over 70% lower than this ratio was two years prior to Waiver implementation, which further demonstrates a shift in spending away from out-of-home care to prevention, diversion, family preservation, and other in-home services. Flexibility afforded by the Waiver enabled full use of federally appropriated IV-E funds during Waiver implementation and a significant increase in the use of State funds for front-end services. Finally, the State demonstrated evidence of reducing administrative costs and meeting the maintenance of effort requirement associated with the Waiver contract.

Overall, this final evaluation report of Florida's IV-Waiver illustrates a complex picture that includes some positive and optimistic trends, such as the shift in expenditures from out-of-home care to prevention and in-home services, and in child outcomes related to permanency, safety, and well-being. However, many challenges persist regarding child well-being indicators and at the practice level, as indicated in the analyses of NSCAW and Florida quality of practice data and the case manager focus group findings. These remaining challenges at the practice level are not surprising, given that child welfare systems present a challenging environment in which to implement best or innovative practices, due to their organizational complexity and the varying needs of children and families served in these systems (Aarons & Palinkas, 2007).

As many studies have demonstrated, the development and validation of evidence-based practices in mental health, substance abuse, and child welfare has not been matched by effective implementation of these practices in community settings (Aarons, 2005; Simpson, 2002). These persistent barriers point to the need for Waiver renewal, with a concerted focus on the process of implementation of evidence-based and promising practices during both child protective investigations and in child welfare case management practice and services.

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## Appendix A. Judges Interview Protocol

### ***Introduction***

The Florida Mental Health Institute of the University of South Florida is under contract with the Florida Department of Children and Families to evaluate the implementation of Florida's IV-E Waiver demonstration project, effective October 1, 2006. The purpose of this interview is to collect information about how the Florida IV-E Waiver was planned and implemented in your area and how the IV-E Waiver is changing child welfare practice.

- 1) What is your current understanding of the IV-E Waiver?
- 2) What type of information, training, or educational materials specific to the IV-E Waiver have you received, if any?
- 3) Were you a part of any joint planning efforts with the local lead agency regarding implementation of the IV-E Waiver? Please describe.
- 4) Have you changed the way you make removal, reunification, or permanency decisions since the IV-E Waiver was implemented? Please explain and elaborate on any changes.
- 5) What are your views regarding how the IV-E Waiver has impacted child welfare practices (e.g., array of services, changes in cost allocations and spending, child and family outcomes)?
- 6) What do you see as the strengths of the current child welfare system?
- 7) What do you see as the barriers or challenges of the current child welfare system?
- 8) In your opinion, how can you and other people in your position help families overcome barriers or challenges within the child welfare system?
- 9) What, if any, are the issues with respect to coordination of responsibilities and functions of Private Investigations, the Court and Lead Agency services?
- 10) Do you think that the IV-E Waiver has had an impact on your relationship with the Community-Based Care lead agency?
- 11) Is there any additional information you would like to share regarding implementation of Florida's IV-E Waiver or the Community-Based Care system in Florida?

## Appendix B. Description of the Measures

Measure 1. Proportion of children entered out-of-home care anytime during a specific fiscal year

### *Methodology*

<b>Definitions</b>	A “child” is any unmarried person under the age of 18 years who has not been emancipated by order of the court. “Out-of-home care” means care for children in an active removal episode (between removal date and discharge date), regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care.
<b>Algorithm</b>	This is a count of all children who were removed from home and placed into out-of-home care anytime during a specific fiscal year.
<b>Data Sources</b>	Data were extracted from FSFN

Measure 2. Proportion of children achieving permanency within 12 months of removal

### *Methodology*

<b>Definitions</b>	“Out-of-home care” means care for children in an active removal episode (between removal date and discharge date), regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care. “Permanency” means (a) reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker, (b) placement with a relative, and (c) adoption finalized, that is when the Court enters the verbal order finalizing the adoption, and (d) dismissed by the court.
<b>Algorithm</b>	This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. In this instance, because every child had 12 months follow-up data this measure is identical to a percent where the numerator is the number of children who exited out-of-home care for permanency reasons within 12 months after entry. The denominator is all children who entered out-of-home care at any time during a specific fiscal year (as indicated by the removal date in FSFN).
<b>Data Sources</b>	Data were extracted from FSFN.

Measure 3. Proportion of children who entered out-of-home care and achieved permanency through reunification or placement with relatives within 12 months of removal.

### **Methodology**

<b>Definitions</b>	<p>“Out-of-home care” means care for children in an active removal episode (between removal date and discharge date), regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care.</p> <p>“Permanency” means (a) reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker, (b) placement with a relative, and (c) adoption finalized, that is when the Court enters the verbal order finalizing the adoption, and (d) dismissed by the court.</p> <p>“Reunification” means the return of a child who has been removed to the removal parent or other primary caretaker.</p> <p>“Placement with relatives” means long-term custody to relatives, or guardianship to relatives.</p>
<b>Algorithm</b>	<p>This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. In this instance, because every child had 12 months follow-up data this measure is identical to a percent where the numerator is the number of children who were discharged from out-of-home care for reasons of reunification or placement with relatives. The denominator is all children who entered out-of-home care at any time during a specific fiscal year (as indicated by the removal date in FSFN).</p>
<b>Data Sources</b>	Data were extracted from FSFN.

Measure 4. Proportion of children where adoption was finalized within 24 months of removal.

### **Methodology**

<b>Definitions</b>	<p>“Out-of-home care” means care for children in an active removal episode (between removal date and discharge date), regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care.</p> <p>“Adoption” means adoption finalized, that is when the Court enters the verbal order finalizing the adoption</p>
<b>Algorithm</b>	<p>This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.<sup>1</sup> In this instance, because every child had 24 months follow-up data this measure is identical to a percent where the numerator is the number of children who were discharged from out-of-home care for reasons of adoption. The denominator is all children who entered out-of-home care at any time during a specific fiscal year (as indicated by the removal date in FSFN).</p>
<b>Data Sources</b>	Data were extracted from FSFN.

Measure 5. Median length of stay for children entering out-of-home care.

**Methodology**

<b>Definitions</b>	“Out-of-home care” means care for children in an active removal episode (between removal date and discharge date), regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care.
<b>Algorithm</b>	This measure is presented in number of months. An estimate of the median number of months spent in out-of-home care is generated by Life Tables, which is a type of Event History Analysis. This measure reports the number of months at which half of the children are estimated to have exited out-of-home care into permanency.
<b>Data Sources</b>	Data were extracted from FSFN.

Measure 6. Proportion of children re-entering out-of-home care within 12 months of exiting.

**Methodology**

<b>Definitions</b>	“Out-of-home care” means care for children in an active removal episode (between removal date and discharge date), regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care.
<b>Algorithm</b>	This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. In this instance, because every child had 12 months follow-up data this measure is identical to a percent where the numerator is the number of children who entered out-of-home care within 12 months after exit for permanency reasons only. Only children who exited out-of-home care for reasons of reunification and placement with relatives were included in the analysis. The denominator is all children who had a Discharge Data in FSFN during a specified fiscal year (i.e., exit cohorts) and who were discharged for reasons of either reunification or placement with relatives. The measure is based on children who exited their first episode of out-of-home care.
<b>Data Sources</b>	Data were extracted from FSFN.

Measure 7. Maltreatment within six months after services were terminated.

**Methodology**

<b>Definitions</b>	Abuse and neglect are defined by Chapter 39, F.S. and include both actual harm and threatened harm.
<b>Algorithm</b>	<p>This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. In this instance, because every child had 6 months follow-up data, this measure is identical to a percent where the numerator is the number of children whose cases were closed due to either findings of "verified" maltreatment within six months after services terminated:</p> <p>Discharge from a removal episode during the federal fiscal year, or to exit from in-home services during the federal fiscal year and had not removal episode in that case. The denominator is the number of children whose case whose cases were closed (i.e., discharged from a removal episode or exited from in-home services) during a specific federal fiscal year.</p>
<b>Data Sources</b>	Data were extracted from FSFN.

Measure 8. The proportion of children experiencing two or fewer placements within 12 months of removal.

**Methodology\***

<b>Definitions</b>	<p>"Out-of-home care" means care for children in an active removal episode (between removal date and discharge date), regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care.</p> <p>"Placements" means specific placement settings during a removal episode.</p> <p>"Removal date" means the date a child is removed from the home, the beginning of a removal episode, which can include one or more placement settings</p>
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\*Data reported for this indicator was obtained from the following sources: U.S. Department of Health and Human Services, 2007; U.S. Department of Health and Human Services, 2009, and <http://cwoutcomes.acf.hhs.gov/data/downloads/pdfs/florida.pdf>

## APPENDIX C. Results of Statistical Analyses

Table 1.

*Results of ANOVA. Number of Children Entered Into Out-of-Home Care by Cohort (FFY 04-05 through FFY 10-11)*

Cohort	Number of children served	<b>N = 298,527</b>	
		<i>F</i>	<i>df</i>
FFY 04-05	20,987	68134.09*	6
FFY 05-06	20,980		
FFY 06-07	18,003		
FFY 07-08	15,057		
FFY 08-09	13,704		
FFY 09-10	13,841		
FFY 10-11	15,217		

*Note.* \* $p < .05$ .

Table 2.

*Results of Cox Regression. Children who Achieved Permanency Within 12 Months by Cohort (FFY 04-05 through FFY 09-10)*

	<b>Children Entered Out-of-Home Care (N = 117,789)</b>		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.14	5721.91*	1.16

*Note.* \* $p < .05$ .

Table 3.

*Results of Cox Regression. Child Characteristics Associated with Timely Permanency (FFY 04-05 through FFY 09-10)*

	Children Entered Out-of-Home Care (N = 117,789)		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.15	5563.78*	1.16
Age	-0.01	139.89*	0.99
Gender	0.01	3.77	1.01
White**	0.02	1.96	1.02
Black**	-0.06	16.11*	0.94
Physical health problems	-0.42	677.30*	0.66
Emotional problems	-0.14	33.70*	0.87
Domestic violence	0.14	281.16*	1.16
Substance Abuse	-0.04	35.77*	0.95

Note. \* $p < .05$

\*\* Hispanics and Other race/ethnicity was used as a reference category

Table 4.

*Results of Cox Regression. Children who Achieved Permanency through Reunification or Placement With Relatives by Cohort (FFY 04-05 through FFY 09-10)*

	Children Entered Out-of-Home Care (N = 117,789)		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.01	5.35*	1.00

Note. \* $p < .05$ .

Table 5.

*Results of Cox Regression. Child Characteristics Associated with Timely Reunification or Placement With Relatives (FFY 04-05 through FFY 09-10)*

	Children Entered Out-of-Home Care (N = 117,789)		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.01	0.89	1.00
Age	0.01	116.76*	1.01
Gender	0.03	11.14*	1.03
White**	-0.01	0.30	0.99
Black**	-0.08	19.48*	0.92
Physical health problems	-0.69	1015.62*	0.50
Emotional problems	-0.25	55.40*	0.78
Domestic violence	0.23	565.05*	1.25
Substance Abuse	-0.03	17.34*	0.97

Note. \* $p < .05$

\*\* Hispanics and Other race/ethnicity was used as a reference category

Table 6.

*Results of Cox Regression. Children with Adoption Finalized Within 24 Months by Cohort (FFY 04-05 through FFY 08-09)*

	Children Entered Out-of-Home Care (N = 117,789)		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.18	1073*	1.20

Note. \* $p < .05$ .

Table 7.

*Results of Cox Regression. Child Characteristics Associated with Timely Adoption (FFY 04-05 through FFY 08-09)*

	Children Entered Out-of-Home Care (N = 117,789)		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.19	1176.43*	1.21
Age	-0.15	5185.45*	0.86
Gender	-0.10	34.85*	0.91
White**	0.14	13.91*	1.15
Black**	-0.01	0.12	0.99
Physical health problems	1.10	1815.64*	3.01
Emotional problems	0.41	120.14*	1.51
Domestic violence	-0.45	334.84*	0.64
Substance Abuse	0.13	62.40*	1.14

Note. \* $p < .05$

\*\* Hispanics and Other race/ethnicity was used as a reference category

Table 8.

*Results of Cox Regression. Median Length of Stay in Out-of-Home Care by Cohort (FFY 04-05 through FFY 09-10)*

	Children Entered Out-of-Home Care (N = 102,572)		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.02	106.40*	1.02

Note. \* $p < .05$ .

Table 9.

*Results of Cox Regression. Children Re-entering Out-of-Home by Cohort (FFY 04-05 through FFY 09-10)*

	<b>Children Exited Out-of-Home Care (N = 89,792)</b>		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.01	0.001	1.00

Note. \* $p < .05$ .

Table 10.

*Results of Cox Regression. Child Characteristics Associated with Re-entry into Out-of-Home Care (FFY 04-05 through FFY 09-10)*

	<b>Children Exited Out-of-Home Care (N = 89,792)</b>		
	B	$\chi^2(1)$	Odds Ratio
Cohort	0.01	0.01	1.00
Age	-0.03	448.31*	0.97
Gender	-0.04	9.18*	0.96
White**	0.30	68.63*	1.35
Black**	0.19	29.05*	1.21
Physical health problems	0.12	7.75*	1.12
Emotional problems	0.32	31.70*	1.37
Domestic violence	-0.09	23.03*	0.91
Substance Abuse	0.10	46.83*	1.11

Note. \* $p < .05$

\*\* Hispanics and Other race/ethnicity was used as a reference category

Table 11.

*Results of Cox Regression. Children With Recurrence of Maltreatment Within Six Months After Service Termination by Cohort (FFY 04-05 through FFY 09-10)*

	<b>Children Whose Services Were Terminated (N =198,087)</b>		
	B	$\chi^2(1)$	Odds Ratio
Cohort	-0.28	991.15*	.78

Note. \* $p < .05$ .

Table 12.

*Results of Cox Regression. Child Characteristics Associated with Recurrence of Maltreatment Within Six Months After Service Termination (FFY 04-05 through FFY 09-10)*

	<b>Children Whose Services Were Terminated (N = 198,087)</b>		
	B	$\chi^2(1)$	Odds Ratio
Cohort	-0.22	586.96*	0.81
Age	-0.05	370.62*	0.95
Gender	-0.02	0.92	0.98
White**	0.10	3.04	1.11
Black**	0.08	2.06	1.08
Physical health problems	0.36	40.97*	1.43
Emotional problems	0.12	2.19	1.12
Domestic violence	0.80	1086.389*	2.21
Substance Abuse	0.79	1003.385*	2.21

Note. \* $p < .05$

\*\* Hispanics and Other race/ethnicity was used as a reference category

Appendix D. CFSR Items with Applicable DCF Case Management (CM) Quality of Practice Standards\*

**CFSR Item 3: Services to family to protect child(ren) in the home and prevent removal or re-entry into foster care.**

CM Standard 4: SERVICES TO PROTECT THE CHILD. Concerted efforts were made to provide or arrange for appropriate services for the family to protect the child and prevent the child's entry into out-of-home care.

CM Standard 6: SERVICE REFERRALS. Completed service referrals were consistent with the needs identified through investigative assessment(s), and other assessments related to safety.

CM Standard 10: MANAGEMENT OF RISKS. Concerted efforts were made during post-placement supervision to manage the risks following reunification and prevent re-entry into out-of-home care.

**CFSR Item 16: Relationship of child in care with parents**

CM Standard 36: MOTHER'S PARTICIPATION. The mother was encouraged and supported to participate in making decisions about her child's needs and activities.

CM Standard 37: FATHER'S PARTICIPATION. The father was encouraged and supported to participate in making decisions about his child's needs and activities.

**CFSR Item 17: Needs and services of child, parents, foster parents**

CM Standard 48: ONGOING ASSESSMENT OF THE CHILD'S NEEDS. An ongoing assessment of the child(ren)'s needs was conducted to provide updated information for case planning purposes.

CM Standard 50: ONGOING ASSESSMENT OF THE MOTHER'S NEEDS. An ongoing assessment of the mother's needs was conducted to provide updated information for case planning purposes.

CM Standard 51: ENGAGING THE CHILD'S MOTHER. Concerted efforts were made to support the mother's engagement with services.

CM Standard 52: ONGOING ASSESSMENT OF THE FATHER'S NEEDS. An ongoing assessment of the father's needs was conducted to provide updated information for case planning purposes.

CM Standard 53: ENGAGING THE CHILD'S FATHER. Concerted efforts were made to support the father's engagement with services.

CM Standard 54: ONGOING ASSESSMENT OF OUT-OF-HOME CARE PROVIDERS. An ongoing assessment of the out-of-home care providers or pre-adoptive parent's service needs was conducted in order to ensure appropriate care for the child.

**CFSR Item 18: Child/family involvement in case planning**

CM Standard 55: CASE PLANNING PROCESS - FAMILY INVOLVEMENT. Concerted efforts were made to actively involve all case participants (mother, father, child, out-of-home provider) in the case planning process.

**CFSR Item 19: Worker visits with child**

CM Standard 56.3: SERVICE WORKER VISITS - FREQUENCY OF VISITS - CHILD. The frequency of the services worker's visits with all case participants was sufficient to address issues pertaining to the safety, permanency goal, and well-being of the child.

CM Standard 57.3: SERVICE WORKER VISITS – QUALITY OF VISITS – CHILD. The quality of the services worker's visits with case participants was sufficient to address issues pertaining to the child's safety, permanency and well-being.

**CFSR Item 20: Worker visits with parents**

CM Standard 56.1: SERVICE WORKER VISITS – FREQUENCY OF VISITS – MOTHER. The frequency of the services worker's visits with all case participants was sufficient to address issues pertaining to the safety, permanency goal, and well-being of the child.

CM Standard 56.2: SERVICE WORKER VISITS – FREQUENCY OF VISITS – FATHER. The frequency of the services worker's visits with all case participants was sufficient to address issues pertaining to the safety, permanency goal, and well-being of the child.

CM Standard 57.1: SERVICE WORKER VISITS – QUALITY OF VISITS – MOTHER. The quality of the services worker's visits with case participants was sufficient to address issues pertaining to the child's safety, permanency and well-being.

CM Standard 57.2: SERVICE WORKER VISITS – QUALITY OF VISITS – FATHER. The quality of the services worker's visits with case participants was sufficient to address issues pertaining to the child's safety, permanency and well-being.

**CFSR Item 21: Educational needs of child**

CM Standard 58: EDUCATIONAL NEEDS ASSESSMENT. Concerted efforts were made to assess the child's educational needs.

CM Standard 59: EDUCATIONAL SERVICES. If educational needs were identified, necessary educational services were engaged.

CM Standard 60: EDUCATIONAL SERVICE OUTCOMES. Services effectively reduced or resolved the issues that interfered with the child's education.

**CFSR Item 22: Physical health of child**

CM Standard 61: PHYSICAL HEALTH NEEDS ASSESSMENT. Concerted efforts were made to assess the child's physical health care needs.

CM Standard 62: PHYSICAL HEALTH SERVICES. Concerted efforts were made to provide appropriate services to address the child's identified physical health needs.

CM Standard 63: DENTAL HEALTH NEEDS ASSESSMENT. Concerted efforts were made to assess the child's dental health care needs.

CM Standard 64: DENTAL HEALTH SERVICES. Appropriate services were provided to address the child's identified dental health needs.

**CFSR Item 23: Mental health of child**

CM Standard 65: MENTAL AND BEHAVIORAL HEALTH NEEDS ASSESSMENT. An assessment(s) of the child's mental/behavioral health needs was conducted.

CM Standard 66: MENTAL AND BEHAVIORAL HEALTH SERVICES. Appropriate services were provided to address the child's mental/behavioral health needs.

\* Though there are 23 case management quality of practice standards included here, Standards 56 and 57 have three components each (mother, father, child) that are described and examined separately.

APPENDIX E. Policy Clarification and Implementation Plan for "Recording Information in Florida Safe Families Network for All Children Served"



State of Florida  
Department of Children and Families

Rick Scott  
Governor

David E. Wilkins  
Secretary

**DATE:** March 9, 2012

**TO:** Regional Directors  
CBC CEOs  
Sheriffs' Offices

**THROUGH:** John K. Cooper, Assistant Secretary for Operations  
Debra Ervin, Acting Director Family and Community Services

**FROM:** Patricia Armstrong, Director Office of Child Welfare

**SUBJECT:** Policy Clarification and Implementation Plan for "Recording Information in Florida Safe Families Network for All Children Served" As of July 1, 2012

**ACTION REQUIRED:** Disseminate to Circuit Leadership, CBC Lead Agencies, CPI Supervisors and all other appropriate staff.

**DUE DATE:** July 1, 2012 implementation deadline.

**PURPOSE:** The purpose of this memorandum is to provide: 1) policy clarification as to when case management services must be provided and 2) implementation guidance for appropriately recording in FSFN all services funded with Title IV-E Waiver and other federal funds through Community-Based Care (CBC) Lead Agency Contracts. In order for FSFN to become federally certified and avoid substantial federal financial penalties, FSFN functionality must be used consistently statewide by all child welfare case management providers for children who need protective actions. All information comprising the official case record must be directly entered into and maintained by FSFN.

**BACKGROUND:** The statewide automated child welfare information system (SACWIS), known as the Florida Safe Families Network (FSFN) was developed with federal funds to have one statewide, uniform method of creating an electronic child welfare record that captures all investigations conducted and any services received. As recidivism rates in child welfare have traditionally been high, having one child record that captures information over time is critical to document:

- Emerging or escalating patterns of abuse or neglect.
- Services provided in the past and whether they were effective.
- Contact information for all providers, past and present.
- One consistent child welfare record, with all information necessary should the family move to another location in Florida and come to the attention of another agency.

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

- One dependable case record system for all children served despite multiple providers involved and case management provider changes.

Florida's Title IV-E Demonstration Waiver provided assurances that ongoing evaluations would be conducted to study the types of services provided and their efficacy in preventing future encounters with the child welfare system. FSFN data is used for federal and state reports to measure child welfare outcomes, to track numbers of children served, and multiple other data analyses. Florida has other federal fund sources that require tracking of children served and the service array provided, including the Promoting Safe and Stable Families (PSSF) and Independent Living. It should also be noted that the equity allocation model for 25% of recurring core services funding includes a factor that derives from in-home trend reports. These reports are produced based on in-home case counts from FSFN where a living arrangement has been entered.

Currently, a FSFN Case is opened or remains open for only children and families that require traditionally defined "case management." There is no consistency for documentation of services provided. Although functionality is available within FSFN to accommodate each CBC's unique service array by allowing each CBC to create and maintain "Service Types" multiple other ancillary information systems have been developed. The Services module in FSFN is currently utilized only when a system generated payment is required. There are thousands of closed case records in FSFN that do not contain any information about other types of services provided with Title IV-E Demonstration Waiver funds or Promoting Safe and Stable Families (PSSF) federal funds.

An adequate federal audit trail is lacking. Reliable data is not available to accurately inform the Demonstration Waiver evaluation and the state's request for extension of the Waiver. DCF has been found to be out of compliance with federal SACWIS requirements for certification in part due to these ancillary systems and a lack of one, statewide child welfare records system.

During the month of November 2011, five CBC Lead Agencies volunteered to participate in a pilot project to improve methods for capturing information on all children served. The pilots tested draft definitions and new FSFN functionality for recording secondary prevention services. It was learned during the pilot that many children are receiving services that are secondary prevention in nature, intended to strengthen family protective capacities through the provision of family support services. The new screen in FSFN, with modifications recommended by pilot sites, will provide a dependable method for capturing information on these family support services.

It was also learned in the pilot sites that there are at least an equal number of children receiving in-home protective interventions. These children and their families, tracked in ancillary systems are not currently in FSFN. The new screen developed for recording information about family support services is not an acceptable solution for tracking the children served who need protective actions.

**ACTIONS REQUIRED:** To proceed with critical steps to improve use of the FSFN as the state's single, official child welfare records system and conform to existing law requiring case management services in cases where children need protective interventions, the following actions are required:

- 1) The definitions in the attachment, "Defining and Documenting Services in FSFN for Children Receiving Family Support of Protective Actions" will be adopted for use effective July 1, 2012 to describe whether children are receiving "Family Support" or "Protective Actions." CPIs will continue to determine whether or not with the provision of protective actions a child can safely remain at home. In all such cases where children need protective actions to remain safe at home or placement in out of home care, follow-up case management services are required. Case Transfer Staffings conducted with investigator and CBC will confirm the need for case management services and the expected level of ongoing protective oversight to be provided.
- 2) As of July 1, 2012, CBCs will ensure that cases involving protective actions receive case management and thus are input into FSFN and comply with all other documentation requirements. Case management models may vary, including the use of a therapist or other qualified child welfare professionals to provide case oversight including home visits. Case management responsibilities are outlined in 65C-30.007 and case managers must be certified in accordance with s.402.40, F.S. Case managers should be the Primary Worker in FSFN. Documentation will be provided as follows:
  - a. Record services provided in FSFN case notes
  - b. Record dates of services provided, including beginning and end date
  - c. Type of service provided
  - d. Person or provider providing the service
  - e. A "Living Arrangement" will be created as it is linked to business rules for cases that involve case management and thirty day visits are required.
  - f. Family assessments and case plans may be completed in an agency-specific format until such time as agency's service array is captured in FSFN Services Module, not later than July 1, 2013. At a minimum, the case plan document shall meet the requirements of Section 39.601, F.S.; 42 USC § 675(1) and 42 USC § 675(5)(b).
- 3) As recommended by the pilot sites, the Department is making changes to the FSFN screen formerly referred to as "Secondary Prevention." The Department will develop a Statewide Policy Guidance Workbook for use of the new FSFN functionality. Changes to the screen are:
  - a. Rename the new Secondary Prevention screen to "Family Support."
  - b. Remove the edit limiting use of this page and allow documentation of any child, regardless of maltreatment finding.
  - c. Remove the automated messages indicating ineligibility for Prevention when either findings of Not Substantiated or Verified are documented.

- d. Remove the requirement to document a Risk Factors summary; this will remain optional.
  - e. Add reference values for Assignment Types, Job Class and Case Type to support identification of Family Support cases.
- 4) As of July 1, 2012, CBCs will use the new FSFN functionality to capture the following information on all Family Support cases:
- a. All child and parent demographics
  - b. Referral source
  - c. Dates for service beginning and end
  - d. Record services provided in FSFN case notes:
  - e. Dates of services provided, including beginning and end date
  - f. Type of service provided
  - g. Person or provider providing the service
  - h. Status of the child and family at closure
- 5) Regional Directors should alert CBCs to immediately begin activities necessary for full implementation of the new functionality for family support and the case management activities required for cases involving protective actions. CBCs should proceed with agency and organizational readiness activities including:
- a. Workflow assessments to determine how CPI referrals for Family Supports should be operationalized.
  - b. Creating the new organization structures (units and workers) in FSFN that will be necessary.
  - c. Developing and implementing the training needed for the purpose of documenting these services.
- 6) The Office of Child Welfare will develop a method for periodic audits of the information recorded using new FSFN functionality to ensure appropriate referral and use of Family Support services.

**FOLLOW-UP:** Counts of all children receiving "Family Support" or protective services will be available within FSFN after July 1, 2012. In order to further advance the FSFN system toward SACWIS compliance, FSFN must provide a means to support the business of conducting assessments, documenting service plans and documenting service delivery for all populations of children served. The Department recognizes that the current FSFN system provides a Family Assessment and Case Plan/Judicial Review functionality that focuses on the families involved in court ordered supervision. Over the next fiscal year, the Department, in partnership with the CBC and Provider community will develop system tools within FSFN that will support this process for all children and families served. This process will provide adequate time to design, develop and implement the tools in FSFN as well as provide the time for each CBC to transition from any ancillary system developed to fill this gap. By July 1, 2013, each CBC will fully use FSFN to record assessments, service planning, and service delivery for all families served.

**CONTACT INFORMATION:** If you have any questions, or for additional information please contact Linda Radigan at [Linda\\_Radigan@dcf.state.fl.us](mailto:Linda_Radigan@dcf.state.fl.us) or (850) 717-4679.

**ATTACHMENT:** "Defining and Documenting Services in FSN for Children in Family Support, Imminent Risk of Removal, or Removal Status" (3/7/2012)