Phase 5- Florida Title IV-E Demonstration Evaluation Semi-Annual Progress Report (10/2016-03/2017)

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Executive Summary

Background

On October 1, 2006 Florida was granted a Waiver to certain provisions of Title IV-E of the Social Security Act of 1935. The Waiver 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 Florida Title IV-E 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 Demonstration. The Terms and Conditions explicitly state three goals of the Demonstration project:

- 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 Demonstration extension was granted (October 1, 2013 through September 30, 2018), 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.
- Reduce administrative costs associated with providing community-based child welfare services.

The Terms and Conditions of the Demonstration require a process, outcome, and cost analyses. Primary data was collected for this semi-annual report via focus groups with case managers and child protection investigators. Primary data was also collected from case management organizations during this reporting period, but will be reported on in the next report after a greater sample size is reached. Secondary data analysis was performed for this report

with extracts from the Florida Safe Families Network (FSFN, Florida's statewide SACWIS system), Florida Continuous Quality Improvement (CQI)[1], and Florida Medicaid.

Findings

Services and practice analysis. The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. This component also assesses changes in practice to improve processes for the identification of child and family needs and facilitation of connections to appropriate services, including enhanced use of in-home services to increase successful family preservation and reunification. For the current report, updates are provided for three distinct elements of this analysis: the service array assessment, the evidence-based practice fidelity assessment, and the caseworker practice focus group analysis.

***Service array assessment*.** This element of the analysis was designed to assess the current child welfare service delivery system, including procedures for determining eligibility and referring families for services, the array of services available to system-involved families, the number of children and families served within the past 12 months, and the type and duration of services provided. To capture these data, a service array survey was developed and administered to each CBC Lead Agency at the end of January 2017. Analysis of the survey findings will be completed for the October 2017 semi-annual progress report.

***Evidence-based practice fidelity assessment*.** Two evidence-based practices (EBPs), Wraparound and Nurturing Parenting, have been identified and agreed upon by the Department and the evaluation team during this reporting period. These practices were selected based on their reported use across multiple regions of the state and recent initiatives that have encouraged expansion of their implementation throughout the state. Both practices are frequently used as in-home service interventions, and thus are also congruent with the goal of the Demonstration to prevent placement in out-of-home care.

***Caseworker practice focus group analysis*.** This element of the analysis was designed to gather frontline perspectives regarding current child welfare practice and the availability of services to meet the needs of system-involved families, particularly in relation to the goals of the Demonstration to reduce out-of-home placements and expedite permanency.

[1] Specifically, Florida data used for this report comes from the Federal Onsite Review Instrument (OSRI) and Online Monitoring System (OMS).

Focus groups were conducted with case managers (n = 78) during February and March of 2016 and with child protective investigators (n = 63) during July 2016 in five circuits. These sites were selected using a stratified random sampling process based on child removal rates (as reported in the CBC Lead Agency Trends and Comparisons Report, June 26, 2015). Two focus groups were conducted with case managers in each circuit, and with child protective investigators in four of the five circuits; one circuit opted to have a single focus group. The selected circuits were as follows: Circuit 4, Circuit 19, Circuit 12, Circuit 11, and Circuit 15. For the purpose of this report, the term *child welfare professional* is used when referring to *both* child protective investigators and case managers as one group.

Findings from the focus groups reveal a number of strengths and challenges that relate to the Demonstration. One important strength is that the majority of the participants value family preservation and believe in the concept of keeping children in the home. These values place child welfare professionals in alignment with the goals of the Demonstration. At the same time, however, child welfare professionals have concerns about ensuring child safety when children remain in the home, and voiced a certain degree of distrust towards system-involved families.

Focus groups also underscored assessment as a critical component of casework and the value of conducting a holistic and comprehensive assessment. Discussions emphasized the utilization of multiple methods and data sources to identify family needs, particularly the use of collateral contacts such as extended family, neighbors, and school personnel. Many participants expressed that the use of such a holistic approach contributes to better identification of appropriate services to address family needs. Some expressed concern over how invasive the process seems to be for families. Child protective investigators did not necessarily perceive the new practice model as impacting the way they make safety decisions, although they were still in the early implementation stage at the time of the focus groups. Many child welfare professionals expressed having trouble understanding the distinction between risk and safety, as well as when to offer voluntary versus mandatory services. Responses suggest that there may be a tendency to remove children in situations where court-ordered in-home services could be appropriate. More training and guidance are needed to support child welfare professionals in making appropriate case decisions with regard to the use of in-home versus out-of-home interventions.

Several challenges were identified that affect the use of in-home services. One challenge was limited availability or accessibility of appropriate services to meet the needs of families. Having a diverse and robust service array was described as a critical support and is one of the goals of the Demonstration. Most participants reported challenges that included a

lack of certain needed services, long waitlists for services, lack of transportation, and barriers created by insurance or lack thereof. The most frequently reported service needs included affordable housing, child care, substance abuse treatment, and more providers who go to the home. Relatedly, the perceived liability that is placed on child welfare professionals has a strong impact on decision-making processes. Most child welfare professionals in the focus groups expressed feeling that they are held solely accountable for what happens on their case, and this fear that they will be held personally responsible if something happens to a child under their care appears to be associated with a greater inclination to remove children.

Outcome analysis: resource family analysis. The outcome analysis tracks changes in the number and proportion of foster families who received new licenses during five consecutive state fiscal years (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, and SFY 15-16). Circuits 4, 17, and 20 had the highest proportions of new licensed families based on the number of children served throughout the five years. For example, in SFY 11-12 Circuit 17 had 19.6% of newly licensed families, Circuit 20 had 17.7% of foster families recruited that year, and Circuit 4 had 16.4% of newly recruited families. During the following four years, the proportion of new licensed families for Circuit 4 ranged between 5.2% and 7.8%, whereas for Circuit 17 this proportion ranged from 4.5% to 7.3%. Finally, Circuit 20 had 5.7% of new licensed foster families in SFY 12-13 and 6.5% in SFY 14-15. Overall, the proportion of newly recruited families dropped from 11.6% in SFY 11-12 to 3.3% in SFY 12-13 and then slightly increased to 4.2% in SFY 15-16.

Outcome analysis: child and family well-being analysis. The constructs of child and family well-being were examined per the applicable Florida CQI items. These outcomes focus on improving the capacity of families to address their child's needs; and providing services to children related to their educational, physical, and mental health needs. Overall, the findings for this report indicate slight improvement for performance items and well-being outcomes, although, at the state-level, none of the improvements were significant. Circuits 2, 10, 14, 15, and 17 most notably, stand out as consistently obtaining a higher percentage of strength ratings for many performance items. Circuits 1, 3, and 8, however, appear to be less effective in the quality of child welfare practices relevant to the safety, permanency, and well-being of children. Families' enhanced capacity to provide for the needs of their children, Well-being Outcome 1, continues to be an area of concern with just 54% of out-of-home care cases and 46% of in-home cases rated as substantially achieved**.** Concentrated efforts to improve assessing and addressing the needs of parents, as well as the frequency and quality of caseworkers visits with parents would improve scores for this outcome. Ratings for in-home

and foster cases were similar at both the circuit-level and state-level generally; with one exception, Performance Item 15, where a greater percentage of out-of-home care cases scored as a strength compared to in-home cases.

Cost analysis. The cost analysis examined the relationship between changes in expenditures and changes in outcomes across the 20 circuits. The flexibility provided by the Demonstration was designed to enable lead agencies to shift resources to services that best fit the needs of families and youth. The maltreatment rate declined between the pre- and post-Demonstration extension periods. However, rates of achieving guardianship, permanency, and reunification also declined, leading to an increase in the length of stay in out-of-home care. In addition, the proportion of youth who received in-home services and did not require subsequent out-of-home care declined. However, such changes may be due to other factors besides the Demonstration extension; for example, the child welfare practice model. Overall, there was a minimal relationship between changes in spending patterns and changes in outcomes. Only the rate of abuse in out-of-home care appeared to have a relationship with spending patterns. Circuits that shifted resources from out-of-home care averaged less abuse in out-of-home care compared to circuits that increased the share of expenditures spent on out-of-home services.

Sub-study one: cross-system services and costs. One of the goals of the Demonstration was to better match youth and families with needed services. Optimally these services would be provided while the youth remained at home, and could prevent the need for removal from the home. One very important funding source for services, especially for children and youth, is the Medicaid program. The goal of the cross system services and cost sub-study is to better understand the Medicaid-funded services received by youth before and after entering out-of-home care. This report addressed three questions related to health care service utilization among youth in the child welfare system: 1) changes in the use of health care services between the year before removal and the year after removal from the home, 2) whether the use of health care services could be used as a proxy for need, and whether health care needs were associated with the likelihood of achieving permanency, and 3) whether the receipt of behavioral health services while in out-of-home care could reduce the number of placements, and help avoid placements in correctional facilities. Overall, the substudy found that Medicaid expenditures increased considerably in the year after removal, and that a model could be used to predict which youth were likely to have greatest increase in service use. The substudy also found a link between health care needs and permanency outcomes, placement stability, and placement in correctional facilities.

Sub-study two: services and practice analysis/outcome analysis for safe, but high risk for future maltreatment. To ensure that children whose safety is at risk are correctly identified and that their families receive the proper services, the Florida Department of Children and Families (DCF) initiated a multi-year effort to develop and implement the child welfare practice model (DCF, 2014). One feature of the child welfare practice model is a distinction between children who are unsafe, and therefore require DCF intervention, and children who are at risk, for whom families can be offered voluntary Family Support Services. It was expected that children assessed using the child welfare practice model would be more likely to receive the services they need, less likely to experience another referral, less likely to experience recurrence of maltreatment, and less likely to enter out-of-home care. To better understand the impact of the child welfare practice model, particularly with regard to the provision of voluntary services, two groups of cases were identified and selected for study. This section of the report provides an initial description of the identified groups for comparison on child outcomes, including safety and placement in out-of-home care, and aspects of casework practice. The next semi-annual progress report will include findings from the analysis of child outcomes and casework practice for these two groups.

The practice analysis for sub-study two includes two components: a set of case file reviews, followed by corresponding interviews with case managers and parents. Eckerd Community Alternatives (Circuit 6) was selected for this analysis by identifying the number of cases from each agency that met the intervention criteria and selecting the agency with the highest number of qualifying cases. The case file reviews will compare the two groups to examine practice changes implemented under the child welfare practice model and the impact that such changes have had on family engagement and participation in voluntary services. A case file review protocol was developed for this purpose. The subsequent interviews will further explore issues related to family engagement from the perspectives of case managers and parents involved in the intervention cases that were reviewed.

Introduction

The Florida Department of Children and Families (the Department or DCF) has contracted with the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF) to develop and conduct an evaluation of Florida's IV-E Waiver Demonstration Project extension (Demonstration) that is effective through September 30, 2018. Florida's original five-year IV-E Waiver Demonstration Project was implemented in October 2006. The contract for Florida's IV-E Demonstration extension evaluation was executed in January of 2015 with the University of South Florida (USF). This document provides an update of evaluation components completed during the reporting period of October, 2016 through April, 2017.

The context for Florida's Demonstration extension includes the implementation of Florida's Child Welfare Practice Model (child welfare practice model) which provides a set of core constructs for determining when children are unsafe, the risk of subsequent harm to the child, and strategies to engage caregivers in achieving change. Child protective investigators (CPIs), child welfare case managers, and community-based providers of substance abuse, mental health, and domestic violence services share these core constructs. The goal is that implementation of the child welfare practice model will support decision making of CPIs, child welfare case managers, and their supervisors in assessing safety, risk of subsequent harm, and strategies to engage caregivers in enhancing their protective capacities including the appropriate selection and implementation of community-based services.

Other key contextual factors for the Demonstration include the role of Community-based Care (CBC) lead agencies as key partners as well as the broader system partners including the judicial system. Community-Based Care (CBC) lead agencies are organized in geographic Circuits, and they provide out-of-home care and related child welfare system services within those circuits.

The Demonstration extension continues to result in flexibility of IV-E funds. The flexibility allows these funds to be allocated toward services to prevent or shorten the length of child placements into out-of-home care or prevent abuse and re-abuse. Consistent with the CBC model, the flexibility has been used differently by each lead agency, based on the unique needs of the communities they serve. The Department has developed a typology of Florida's child welfare service array that categorizes services into four domains: family support services, safety management services, treatment services, and child well-being services. The typology provides definitions and objectives for the four domains as well as guidance regarding the conditions when services are voluntary versus when services are mandated and non-negotiable.

Evaluation Plan

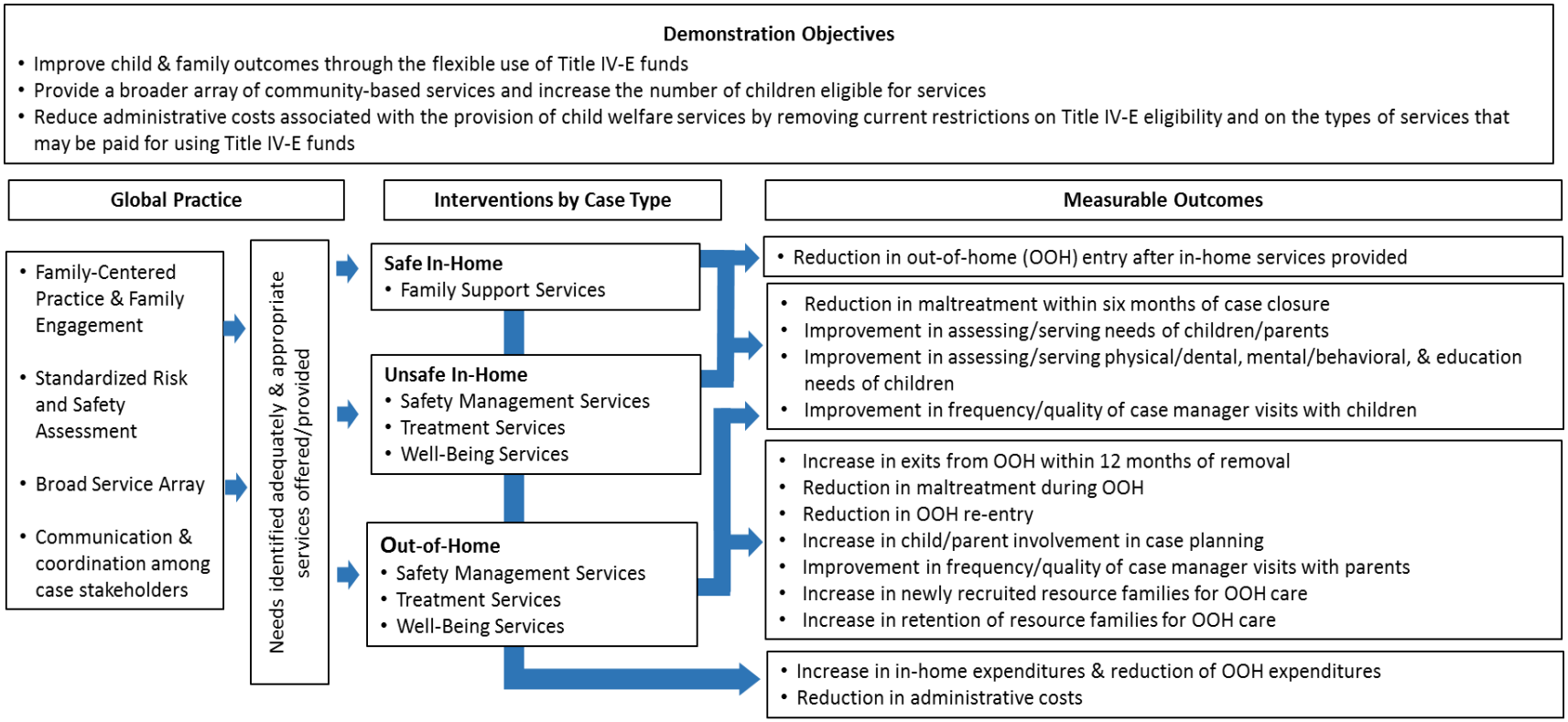
The goal of Florida's Demonstration extension is to impart significant benefits to families and improve child welfare efficiency and effectiveness through greater use of family support services and safety management services offered throughout all stages of contact with families. The evaluation design and outcome variables were selected for purposes of examining these aspects of Florida's child welfare system. The Administration for Children and Families has outlined Terms and Conditions for the Demonstration's extension. The Terms and Conditions include a requirement that the Demonstration evaluation be responsive to the hypotheses that an expanded array of Community-Based Care services be available through the flexible use of Title IV-E funds will:

- Improve physical, mental health, developmental, and educational well-being outcomes for children and their families
- Increase the number of children who can safely remain in their homes
- Expedite the achievement of permanency through either reunification, permanent guardianship, or adoption,
- Protect children from subsequent maltreatment and out-of-home care re-entry
- Increase resource family recruitment, engagement, and retention
- Reduce the administrative costs associated with providing community based child welfare services

The above listed outcomes are not addressed in every semi-annual report, but will continue to be addressed periodically throughout the evaluation of the Demonstration extension.

The Evaluation Logic Model (see Figure 1) displays the Demonstration objectives and how the implementation of the child welfare practice model can yield measurable outcomes for the Demonstration project.

Figure 1. IV-E Demonstration Project Evaluation Logic Model



Definitions:

Safe In-Home: The investigator determines that children are safe from impending danger but are at high or very high risk for maltreatment based on the completed Risk Assessment.

Unsafe In-Home: The investigator determines that there are present danger threats to the children, but there is at least one caregiver with sufficient protective capacities to maintain the children safely in the home with an active safety plan.

Out-of-Home: The investigator determines that there are present danger threats to the children and there is no caregiver with sufficient protective capacities to maintain the children safely in the home. Children are removed and placed in out-of-home care, and conditions for return that address the immediate danger threats to children are established.

The evaluation is comprised of four related components: (a) a process analysis containing an implementation analysis and services and practice analysis, (b) an outcome analysis, (c) a cost analysis, and (d) two sub-studies. The goal of the implementation analysis is to identify and describe implementation of the Demonstration extension. The services and practice analysis includes an examination of progress in expanding the array of community-based services, supports, and programs provided by CBC lead agencies or other contracted providers, as well as changes in practice to improve processes for identification of child and family needs and connections to appropriate services. The outcome analysis tests the relevant hypotheses listed in the amended Florida Demonstration Terms and Conditions by examining a variety of child-level outcomes that are expected to result from the extension of the Demonstration project. The cost analysis examines the relationship between Demonstration implementation and changes in the use of child welfare funding sources

The first sub-study employs a cost analysis. It is important to examine how changes in the child welfare services provided to youth also affect service use and costs for other public sector systems. Specific public-sector systems that are examined are Medicaid, Juvenile Justice, and Baker Act (involuntary examinations). The analysis examines trends in service use and costs for youth served by the child welfare system and other state systems.

The second sub-study examines and compares child welfare practice, services, and several safety outcomes for two groups of children: (a) children who are deemed safe to remain at home, yet are at a high or very high risk of future maltreatment in accordance with the child welfare practice model (intervention group) and are offered voluntary Family Support Services, and (b) a matched comparison group of similar cases during the two federal fiscal years immediately preceding the extension of the Demonstration (FFYs 11-12, 12-13), where the children remained in the home and families were offered voluntary prevention services.

The USF Institutional Review Board (IRB) has approved the evaluation plan. All study activities are conducted in accordance with the applicable regulations, laws, and institutional policies to ensure safe and ethical research and evaluation practice and to preserve the integrity and confidentiality of study participants and data. Informed consent is obtained from all participants. Electronic documents containing identifying information are password protected and stored on a secure drive accessible only to evaluation staff. Hard copies of documents are kept in locked filing cabinets when not in active use. When applicable, evaluation staff will obtain review and approval from state and lead agency IRBs.

This semi-annual report includes the results from aspects of the IV-E Demonstration evaluation. The process analysis includes updates on stakeholder interviews with leadership

personnel at Case Management Organizations, the current status of the service array survey, the selection and evaluation plan of two evidence-based practices, and provides a complete analysis of focus groups conducted with Child Protective Investigators and Case Managers. The focus groups were conducted in Circuits 4,11, 12, 15, and 19 with a total of 141 participants (78 case managers and 63 child protective invetigators. The focus groups were conducted January through July of 2016. The outcomes analysis includes the examination of the proportion of foster families who received new licenses in relation to children served in out-of-home care, and findings related to well-being indicators. The cost analysis provides a cost effectiveness analysis examining the relationships between expenditures on specific types of services and outcomes across circuits. Sub-study one examined three areas related to health care service utilization among youth in the child welfare system: 1. Changes in the use of health care services between the year before removal and the year after removal from the home, 2. Whether the use of health care services could be used as a proxy for need, and whether health care needs were associated with the likelihood of achieving permanency, and 3. Whether the receipt of behavioral health services while in out-of-home care can reduce the number of placements, and help avoid placements in correctional facilities. Sub-study two describes the identified groups for comparison on child outcomes, including safety and placement in out-of-home care, and aspects of casework practice.

Process Analysis

The process analysis is comprised of two research components: an implementation analysis and a services and practice analysis. Descriptions of these components are provided below. Each evaluation component will be ongoing and span the duration of the Demonstration.

Implementation Analysis

The goal of the implementation analysis is to identify and describe implementation of the Demonstration extension within the domains of individual roles, Demonstration impact, joint collaboration and communication efforts, and recommendations acquired throughout the process. This semi-annual report includes an update on the status of key stakeholder interviews conducted during the reporting period of October 2016 through March 2017.

Status update. Members of the evaluation team have been conducting interviews with leadership personnel at case management organizations (CMOs) throughout the state of Florida (See Appendix A interview protocol and Appendix B for informed consent document). The evaluation team has currently completed 10 stakeholder interviews with representation from 10 circuits.

Next steps. Evaluation team members plan to collect more CMO leadership interviews during the next semi-annual reporting period. A full analysis of the stakeholder interviews will be available for the Phase 6 semi-annual evaluation progress report.

Services and Practice Analysis

The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. This component also assesses changes in practice to improve processes for the identification of child and family needs and facilitation of connections to appropriate services, including enhanced use of in-home services to increase successful family preservation and reunification. For the current report, updates are provided for three distinct elements of this analysis: the service array assessment, the evidence-based practice fidelity assessment, and the child welfare professional practice assessment.

Service array assessment. This element of the analysis was designed to assess the current child welfare service delivery system, including procedures for determining eligibility and referring subjects for services, the array of services available to system-involved families, the number of children and families served within the past 12 months, and the type and duration of services provided. To capture these data, a service array survey (see Appendix C) was developed and administered to each CBC Lead Agency via *Qualtrics*, a web-based survey program. The survey protocol was finalized and administered at the end of January 2017.

Reminder emails were sent to each agency at 15-, 30-, and 45-days post-administration. Data collection is still in process at this time. Approximately 11 CBCs have submitted their partially completed survey thus far, and several others are currently in the process of completing their survey. Analysis of the survey findings will be completed for the next progress report.

Evidence-based practice fidelity assessment. Two evidence-based practices (EBPs) have been identified and agreed upon by the Department and the evaluation team. The selected EBPs are Wraparound and the Nurturing Parenting Program. These practices were selected based on their reported use across multiple regions of the state and recent initiatives that have encouraged expansion of their implementation throughout the state. Both practices are frequently used as in-home service interventions, and thus are also congruent with the goal of the Demonstration to prevent placement in out-of-home care. A proposed evaluation plan to assess fidelity of practice implementation for these EBPs is provided here. The plan includes two phases: an implementation assessment phase and a fidelity assessment phase.

***Phase 1: implementation assessment*.** The initial phase will determine the extent to which each EBP has been implemented throughout the state of Florida. The purpose of this phase is to identify which agencies are currently in the process of implementing each practice or have already implemented them, how far along they are in the implementation process, what kinds of cases the EBP is being used for (e.g. family support services, in-home, out-of-home) and whether the practice has been tailored in any way for different types of cases, and whether the agency is currently collecting and using fidelity data to inform implementation efforts. To collect this data, an initial email will be sent out to each CBC Lead Agency asking whether any of their contracted service providers offer either of the above mentioned EBPs, and requesting the CBC to provide contact information for those agencies. Once the service providers have been identified, a survey will be administered via *Qualtrics* to each agency in order to gather the specified information on their current implementation status. The survey will also inquire about their interest in participating in Phase 2, the fidelity assessment.

***Phase 2: fidelity assessment*.** This phase will entail the measurement and analysis of practice fidelity for each EBP. Follow up will occur with those providers who indicate an interest in participating in the fidelity assessment. For agencies who are already collecting their own fidelity data, the evaluation team will inquire as to whether the agency is willing to share their data in order to avoid duplication of effort. For agencies who are not currently collecting fidelity data but are interested in doing so, the evaluation team will explain the available tools and options for measuring fidelity, and explore each agency's capacity to incorporate the measures.

The proposed measures and methods that will be offered to providers are described for each practice.

Wraparound. Several tools have been developed by the National Wraparound Initiative to measure fidelity of Wraparound implementation. For the purpose of this evaluation, two instruments are proposed. Participating providers will have the option of selecting one or both measures, based on their preference and capacity. The first instrument is the Wraparound Fidelity Index Short-Form (WFI-EZ). The WFI-EZ is a self-administered survey that consists of 37 items measuring experience in Wraparound, outcomes, and satisfaction. Both parent and youth response versions are available. For agencies that would like to incorporate this measure, Wraparound facilitators would be asked to administer the survey to clients approximately three months after the initiation of Wraparound services. The survey can be administered as either a paper version or an electronic survey. Completed surveys will be returned to the evaluation team for analysis.

The second instrument is the Team Observation Measure (TOM). The TOM contains 20 items that assess adherence to standards of high-quality wraparound during team meeting sessions. Although initially developed for use by external evaluators, the TOM can also be used as a supervision tool. For agencies interested in incorporating the TOM, the evaluation team would train supervisors of Wraparound facilitators on the use of the tool. Supervisors would be expected to observe each of their staff and complete the TOM at least once per quarter on each Wraparound facilitator that he/she supervises. Completed TOMs will also be returned to the evaluation team for analysis.

Nurturing parenting. At present, the Nurturing Parenting program does not have any explicit fidelity tools, but the program does have a clearly articulated set of practice standards and principles that can be used in developing fidelity tools. Similar to the methods proposed for the Wraparound fidelity assessment, the evaluation team would develop two measures for the Nurturing Parenting program, of which participating providers can select to use one or both. The tools will be an observation protocol and a client survey based on the specified principles of the Nurturing Parenting program. The evaluation team currently has an observation tool that was developed for a different parenting education program, which could be modified to meet the particular requirements of this program. The client survey will need to be developed from scratch. The evaluation team will also reach out to other researchers who have familiarity with the Nurturing Parenting program for feedback on the development of these fidelity instruments.

Child welfare professional practice focus group analysis. This element of the analysis gathered frontline perspectives regarding current child welfare practice and the

availability of services to meet the needs of system-involved families, particularly in relation to the goals of the Demonstration to reduce out-of-home placements and expedite permanency. Preliminary findings were presented in previous reports (Vargo, et al., 2016; Armstrong, et al., 2016). A full analysis of the focus group findings is presented here. The term child welfare professional is used in the discussion below to refer generally to both child protective investigators and case managers, and as such, this term is used when themes apply to both groups. Where findings apply to only one group or the other, specification is provided.

Methods. Focus groups were conducted with case managers (n = 78 participants) during February and March of 2016 and with child protective investigators (n = 63 participants) during July 2016 in five circuits. As described in previous reports (Vargo, et al., 2016 and Armstrong, et al. 2016), these sites were selected using a stratified random sampling process based on child removal rates (as reported in the CBC Lead Agency Trends and Comparisons Report, June 26, 2015). Circuits were stratified into three categories: low removal rates (less than five removals per 100 investigations), moderate removal rates (five to six removals per 100 investigations), and high removal rates (greater than six removals per 100 investigations). Next, two Circuits were randomly selected from each category using a random number generator. While this process initially produced six selected Circuits, during the scheduling process for the case management focus groups, one CBC was unable to get focus groups scheduled with evaluation team members during the needed timeframe, resulting in five Circuits that were included in the data collection. The selected circuits were as follows: Circuit 4, Circuit 19, Circuit 12, Circuit 11, and Circuit 15.

After site selection, the CEO of each CBC was contacted via email with an explanation of the evaluation activities and a request for their assistance in organizing the focus groups with their case management agencies. Two case manager focus groups were conducted for each circuit to maximize the ability of staff to participate. Focus groups varied in size from as few as four to as many as twelve participants and included case managers who handle in-home, out-of-home, and mixed caseloads. A few of the focus groups also included other support staff, such as supervisors and court liaisons.

DCF Regional Managers were similarly contacted via email with an explanation of the evaluation activities and a request for their assistance in organizing the focus groups with child protective investigators in their circuit. Two focus groups were conducted with child protective investigators in four of the five circuits, and one circuit opted to have a single focus group. In four out of the five circuits, child protective investigations were handled entirely by DCF, while one circuit was split between one county that had DCF child protective investigations and one

county in which the Sheriff's office conducted the investigations. For this circuit, one focus group was conducted with DCF investigators and a separate focus group was conducted with the Sheriff's office investigators (n = seven participants). Focus groups varied in size from four to twelve participants. Focus group participants were primarily child protective investigators, but a few focus groups included supervisors as well.

A semi-structured interview guide (see Appendix E for focus group protocol) was used to facilitate the focus group sessions. The focus groups were audio-recorded with the permission of participants. Verbal informed consent was obtained from all participants prior to beginning the sessions. All audio files were transferred to a secure, password protected computer following the interviews and then immediately deleted from the recorder. The audio files were transcribed into a Word document and coded using ATLAS.ti version 6.2, a qualitative data analysis software program. A grounded theory approach was used to analyze the transcripts, whereby codes were created based on key themes and concepts that emerged from the data. Resulting codes were further analyzed to examine their relation to one another in order to identify sets of codes that touch on similar or related topics or that frequently co-occur within the data set.

***Findings: Themes*.** The focus groups conducted with child protective investigators and case managers explored a variety of topics related to efforts that promote family preservation, expedite permanency, and connect families to appropriate services that meet their needs. Child welfare professionals identified factors that support them in achieving these goals, and barriers that impede their ability to achieve these goals. While several themes are identified in the following analysis, it is important to recognize that there is variability in child welfare professional perspectives, and the findings presented here are based on their perceptions. Child welfare professionals differ in terms of experience, training and education, age, gender, race/ethnicity, and cultural and family backgrounds, and as a result they bring different perspectives with them to the field. The analysis therefore exposes various perspectives arising through the focus group interviews while also identifying common themes. Another important contextual factor, furthermore, is that the child welfare practice model was in the early implementation stage at the time the focus groups were conducted, and some of the findings therefore reflect the fact that participants were preliminary stages of the change process. Findings are organized by the following domains: 1) attitudes and beliefs about child welfare, 2) assessment and decision-making processes, 3) family engagement processes, 4) organizational supports and barriers, 5) community services and resources, and 6) interagency relationships and collaboration.

Attitudes and beliefs regarding families, the child welfare system, and in-home services. Child welfare professionals emphasized that child safety was first and foremost their primary concern, and the primary focus of the current child welfare system in Florida. This strength was unanimously reported across all the focus groups. Respondents added that they also address permanency and well-being of children, but that ensuring child safety was the dominant concern: "Obviously we're all based on child safety. So when we actually go out to the house, our primary concern is the children, to make sure that they're safe in the house." The focus on child safety was reiterated at multiple points throughout the focus groups, for example, when discussing the use of in-home services or decision-making around the removal of children.

While child welfare professionals emphasized child safety in these conversations, many also discussed safety within the context of efforts to preserve the family unit. For example, one child protective investigator provided the following description:

> I would say the primary purpose of the Child Welfare System is to ensure that the safety of children… that children are safe in the homes with their parents and families. And if they're not safe, how can we help the families to make – ensure that they are safe and that we can help, um, minimize abuse and neglect in families?

This narrative clearly emphasizes a belief that the role of child welfare workers is to ensure child safety within the child's original family. Other participants expressed similar beliefs that their role included "strengthening families," "preserving the family," or "keeping families together" while ensuring a safe environment for the children. These statements indicate that participants view family preservation as a critical component of their work, but stress that child safety must come first. In further describing their role, participants identified aspects such as linking families to services, empowering families to be self-sufficient, and building the capacities of parents to care for their children. Although it was acknowledged that sometimes children could not be kept safe with their families, the greatest emphasis was on trying to keep families together, either through prevention services or reunification.

The dialogues that emerged indicated a strong valuation of family preservation among both case managers and child protective investigators. Both indicated that whenever possible they would prefer to keep children in their homes. Child protective investigators across all five circuits generally stated that removal is a last resort, reserved for those cases where all other options have been exhausted. As one participant stated, removal is pursued only "if nothing at home works."

Thus, child protective investigators emphasized that under the recently implemented child welfare practice model, efforts are made to preserve the family first, and removal is only undertaken if children's safety cannot be ensured in the home.

Case managers similarly expressed beliefs that it was better to keep the family together if child safety can be ensured. Most commonly, the perceived benefit to using an in-home approach was a reduction in the trauma experienced by the children. Across all the focus groups, participants expressed that, most of the time, children want to stay with their parents and that this was generally less traumatizing for them. As one individual expressed, "What kid doesn't wanna be with their parents?" Participants noted how disruptive removals can be for children, as in the following example:

> You want to, um, do the least amount of trauma on a kid that you can. She talked about the trauma of being removed from your parents. That also means you lose the other extended family that you had. Sometimes it means you have to change schools, and your friends, and all those other things. So, if the child can safely remain in the home, that's always the most beneficial to them.

Removing children from their parents frequently results in also separating them from extended family members, siblings, friends, and their community. Some participants expressed that the act of removal itself might be more traumatizing to the children than the actual abuse or neglect, emphasizing the impact that removal has on a child's mental health and sense of self. The following excerpt from one focus group illustrates this perception:

> You know, they've told me over the years working at, you know, 'Every home is different. They don't ask me what I like to eat, they don't ask me what my religion is.' And after they've been moved two or three times, they – they tell you, 'I forget who I am. I forget,' because everything in their life is not the way it used to be and it affects them mentally, you know?

As this narrative suggests, not only is the removal process traumatizing, but it may also be experienced by children as a punishment, giving the impression that they have done something to deserve it. Some participants further emphasized that keeping children in the home was less traumatic for the entire family. One individual expressed, "I think the trauma to the – to the whole family, you know, that's to me is important, not to traumatize the parents either, you know." The following narrative, provided in response to a question about the benefits of in-home services, further illustrates this theme:

> And it is completely – it's got to be completely overwhelming, because I think sometimes we forget because we see it every day, we forget how traumatic and life altering that is, no matter that they brought it on themselves, you know? It's still they just have their children removed from them, and now we're throwing all this on them, and it's a lot. It's a lot at one time. And sometimes I think we forget that.

Thus, participants viewed the use of-in-home services as less traumatic for both children and parents involved with the child welfare system.

In addition to reducing trauma experienced by families, some participants described an improved ability to address the family's needs as another benefit to using an in-home services approach. First, participants expressed that they were better able to assess the family dynamics and situation if the family remains together. One case manager, for example, explained that,

> I think it allows you to see how they interact and function as a family, because it's hard to see a family function when the kid's over here and the parent's over here. You know, it gives you that full view of what really goes on and, on a day to day basis… And the bond between them.

A more in depth assessment then facilitates the ability of the child welfare professional to identify the family's needs and connect family members to appropriate services. Not only is this beneficial in conducting the initial family assessment, but it was further noted that it also enables case managers to better assess the progress that the family has made over time "because they're all together and you can see them together." Case managers felt that when the children are kept in the home, they are better able to observe changes in the parents' behaviors towards the children.

Furthermore, it was noted that the services provided to the family through this approach are more likely to meet the family's needs, because providers are also able to assess the entire family unit. "Hopefully, the services are more beneficial being that you're in the family, surrounding the issue… If they're doing the services in the home, they're able to actually see the family in their setting, their normal, um, routine," one case manager explained. As one child protective investigator expressed, "It gives the parents an actual chance to learn." Parents can begin to make behavior changes and apply new skills that they learn through services immediately, and providers can tailor their services and offer feedback to parents based on observations of the family. Finally, participants felt that using an in-home services approach was beneficial in holding parents accountable since their children remained in their care while being monitored by DCF or the case management agency. Across a number of the focus

groups, one perception was that for some parents, having their children removed was like a "vacation" or "honeymoon" because it relieves them of their parental responsibilities. Thus, some case managers felt that keeping children in the home while working with the family was a more effective means for maintaining the responsibilities of parents towards their children.

In summary, case managers and child protective investigators are supportive of family preservation and the use of in-home services; however, they remained concerned about ensuring safety when children were served in the home. Child welfare professionals reported that keeping children in the home left them with a heightened concern for child safety. Addressing her colleagues in one focus group, for example, a case manager stated, "I guarantee every one of you all, like, you'll be doing something random with your family or your friends, and something will pop into your head, and you're like, oh… is this kid okay right now?"

Child welfare professionals attempt to address these concerns through the implementation of safety plans and safety management services. Typically, this involves a combination of formal and informal supports, as indicated in the following narrative from a case manager:

> Are there family members around who can help alleviate that? Will there be people who could check in on them? Um, is there a service provider who can come into the home who will also be there to monitor whether or not these things are happening? Is that child old enough to, you know, self-report...So, maybe we need to be in the home twice a week, and making sure that everything's okay.

Child welfare professionals worried more about children with families receiving in-home services and safety plans than the children placed in out-of-home care.

Also embedded within these concerns are certain assumptions about the relative safety of children in out-of-home care and beliefs about the inadequacies of their biological families. Many participants explicitly stated they were concerned about the safety of children who remain in the home with their parents but did not express concerns about the safety of children in out-of-home placements. One respondent, for example, expressed that, "there's less to worry about when they're out-of-home, 'cause, like, your foster parent is licensed; you know they're safe." It was also widely acknowledged that safety plans are only necessary for children who remain in-home or who are placed in a family-made arrangement (e.g. an arrangement made by the parents prior to the involvement with the child welfare system), where the child is living temporarily with a relative, neighbor, or family friend rather than licensed foster care. Some participants expressed frustration at the burden of proof that is required to remove children or at the very least mandate services. These themes suggest that, despite policies to create a more

standardized child welfare practice with clearer requirements for evidence to justify system involvement, child protective investigators and case managers sometimes continue to act on their personal judgments and “instincts” in assessing the safety of children. These themes also suggest that child welfare professionals need further training in family engagement skills.

Other comments made during the focus group discussions expressed distrust towards child welfare involved families. The assumption among child welfare professionals that some clients are dishonest was viewed as contributing to the adversarial dynamic of the client-child welfare professional relationship. A related perception was that some families lack the motivation to change, particularly if they are receiving voluntary in-home services or if their children are placed with a family member, which allows them to maintain regular contact. Some case managers expressed a sense that parents do not take in-home cases seriously, even when they are court-ordered, since they have not lost custody of their children and will refuse to engage in services.

Similarly, if the children are placed with a relative, such as a grandparent, some participants perceived that parents might not be motivated to engage in services because they are still able to see their children as much as they want and may find the arrangement acceptable or even preferable as it relieves them of their parental responsibilities. Some participants further expressed that parents have a sense of entitlement and are more concerned with receiving economic and material benefits than they are about the well-being of their children. This is not to suggest that all child welfare professionals hold such views, however, such beliefs and attitudes were expressed across multiple focus groups. While many participants did express sympathy towards the families with whom they work and particularly their difficult economic circumstances, another themes was personal responsibility and the need for families to become self-sufficient, rather than relying on social service agencies to provide them with assistance.

The distrust towards families extends beyond the nuclear family to the relatives, who were perceived as sometimes unreliable in holding up their agreed upon responsibilities when they are engaged as family supports. This distrust was expressed both towards relatives engaged with in-home safety plans (e.g. a relative moves into the home with the parent and child or agrees to conduct regular check-ins with the parent and child) and those providing out-of-home placements. Some participants also expressed concerns that relative caregivers allow parents access to their children in conflict with court orders and visitation plans.

While many participants expressed skepticism towards child welfare involved families, they simultaneously exhibited empathy and recognized that not all families fit these

characterizations. Several child welfare professionals expressed that they understood why families see them as "the bad guys" because, they admitted, they would not want DCF showing up at their house either and would be equally defensive. They also acknowledged the myriad of barriers that many clients face especially the interaction of economic barriers, lack of access to resources, mental health issues, and the impact of generational system involvement. As one case manager shared, "Some parents are just so, like she said, so far gone, they have nothing to give. They're overwhelmed, life has not been good to them, they have no support system." Thus, in many of the focus groups, participants oscillated between criticizing families and empathizing with families, and between valuing family preservation and questioning the abilities of families to ensure child safety. These attitudes and beliefs have important implications for how families are assessed by child welfare professionals and decision-making about the types of interventions that are used. These processes are explored in the next section.

Assessment and decision-making processes. Assessment comprises one of the core functions of child welfare child welfare professionals, and participants emphasized the importance of a good, thorough assessment to inform decision-making. Assessment was described as an ongoing process that continues throughout the life of the case. The investigator completes an initial assessment, and then, for cases that are transferred to case management, the case manager is expected to build upon the investigator's assessment and continue to complete updates every 90 days. The ongoing nature of the assessment process allows child welfare professionals not only to identify areas where progress has been made, but also to identify new and changing needs that may arise over the course of the case. As one case manager explained, "I think it's really an ongoing thing, because as you have families, they – you may get a case for certain allegations and then the longer that you have it, you realize there also [are] these issues." As indicated by participant responses, the view of assessment as an ongoing process is deeply embedded within their practice.

Assessment was also an area where a clear role differentiation emerged between child protective investigators and case managers. As described by participants, assessments fulfill three primary purposes: 1) to determine the safety and risk of children and make decisions about removal accordingly, 2) to determine the family's needs and identify appropriate services, and 3) to assess changes in needs and progress made over time. Child protective investigators emphasized their role as "first responders," which focuses on assessing the immediate safety of children and typically does not allow them the opportunity to assess change over time. "We're only involved for 60 days," investigators emphasized, "so we can't [assess change]." Case managers, on the other hand, articulated that while they continue to assess safety on an

ongoing basis, only the investigator has the authority to make removal decisions; therefore, case managers perceived that any safety concerns they feel warrant a removal must be reported to DCF to make this decision. It should be kept in mind that the practice model was still in the early implementation stage at this time, and these perceptions may not accurately reflect policy. Overall, safety determination (in the sense of making removal decisions) was understood to be primarily a child protective investigator responsibility, while assessment of change over time was considered primarily a case management responsibility.

Per the child welfare practice model, the protocol used by both child protective investigators and case managers is the Family Functioning Assessment (FFA). The FFA is the process by which information is gathered, analyzed and assessed to determine child safety in the household where the alleged maltreatment occurred. This process provides a current analysis by the child welfare professional responsible at different points in time, beginning with the Family Functioning Assessment-Investigations. After a case involving an unsafe child is transferred to ongoing case management, the family assessment is documented in the Family Functioning Assessment-Ongoing Services (FFA-Ongoing) and Progress Updates (CFOP 170-1, Chapter 2).

As described by participants, the FFA is designed to provide a holistic, comprehensive assessment of the family's strengths and needs, and was described as being much less "incident-driven" than in the past. Participants explained that through this assessment process, they try to get "the whole picture" of the family, which includes looking into their past history, current parenting practices, the home environment, and their support network. As one child protective investigator described, "We have to look at the story of this family. What got them to where they are, at this point? What changed? What happened?" Another expounded that, "You wanna get down to the root problems and how the family functions and you have to discuss with each family what's going on, what's the triggers, what's the stressors, how do you – how do you deal with these issues, how do you function on a daily basis? So learn those rules." Therefore, the assessment goes beyond looking into the specific allegations of the abuse report in order to better understand the full context of the family.

Participants stressed the incorporation of multiple data sources in producing a comprehensive family functioning assessment: interviews with all members of the immediate family as well as relatives, schools, neighbors, health care and other service providers; reviewing their prior history with DCF or other criminal history; drug testing if there are substance abuse allegations; observations of the home and family interactions; and the use of professional assessments by licensed providers (e.g. mental health or substance abuse

evaluations, domestic violence assessments, etc.). Observation in particular was identified by both child protective investigators and case managers as a critical source of information, both in making the initial family assessment and in assessing changes over time. As one case manager expressed, “I think the biggest thing is seeing them – us seeing them in the home, in that environment, with the kids, how they interact with one another.” There also was an understanding of how observation is interconnected to communication.

Thus, observation was perceived as a critical method both for making safety determinations and for assessing progress. Additionally, both child protective investigators and case managers expressed that getting to know the family is critical in being able to truly assess their needs and changes in their behavior. As one child protective investigator described, “We really get to, like, know them. It's more than just something on a piece of paper. We go out, we talk to them, we see firsthand what is or isn't going on and what's working for the families.” Participants privileged this first-hand knowledge of the family, seeing it as something that distinguishes them and their qualifications compared to others working in the system. It is through an intimate knowledge of the family and their dynamics that child welfare professionals are able to observe when changes have occurred, as indicated in the excerpts provided above. Child welfare professionals can see when there are changes in a family’s interactions and behaviors because they know what those dynamics looked like before and have learned the family’s patterns of behavior by getting to know them over time.

Assessing progress and change, however, was also perceived to be a challenging and somewhat problematic endeavor. Under the child welfare practice model, case managers explained that the focus is now on behavior change, as opposed to in the past when parents were primarily assessed by whether or not they completed their case plan. Although this change was endorsed by participants as better criteria for assessing parents’ progress, it requires child welfare professionals to operationalize and find ways to document “evidence” of behavior change. Case managers acknowledged that this assessment is often subjective in nature, based largely on their personal knowledge and observations of the family, as discussed above. Although they stated that they also utilize provider reports to the extent that they receive them, case managers stated that the quality of these reports varies widely. For example, some providers update the case manager on a weekly basis about the client’s progress, while others simply notify the case manager when a client has been discharged. Thus, case managers frequently have to make their own judgments about the extent to which behavior change has actually occurred.

Child welfare professionals indicated that assessment is not a clear-cut, “black and white” process, but rather involves ambiguities which must be navigated by the child welfare professional to make a determination about what is “enough” to ensure child safety. The subjective nature of this process, emphasized by participants, produces inconsistencies in practice, whereby various child welfare professionals and even supervisors may interpret the same set of information differently and arrive at different conclusions regarding the appropriate decision. Some of these issues may reflect the early stage of implementation with regard to the practice model and the fact that child welfare professionals were still learning the new protocols and developing their skills.

Many focus groups, particularly among child protective investigators, reiterated that the current Family Functioning Assessment (FFA) process reflects a considerable practice change. Reactions towards this component of the child welfare practice model were mixed. Some had positive evaluations of it, expressing that the assessment produces a better understanding of the whole family than under the old practice model. The following narrative illustrates this perception:

> I think before we kind of maybe didn’t get the whole picture, you know what I mean? Like, we were kind of out there, incident-based focus, looking at the maltreatment. And now we’re kind of looking at the whole family in general and asking a lot more questions.

From the perspective of this investigator, the FFA process provides a more holistic picture of the family situation, enables a better assessment of the family’s needs, which ideally will reduce the likelihood of the family coming back into the system if the entirety of those needs are addressed. While others shared similar perceptions about the value of implementing this more comprehensive assessment process, some investigators felt that the assessment process was too intrusive. There are significant strengths to gathering extensive collateral information, as it allows the child welfare professional to obtain a more holistic and comprehensive assessment of the family’ on the other hand, the process can be very intrusive for families.

Another theme expressed is that an unintended consequence of the child welfare practice model may be an increase in removals; because investigators are learning more about the comprehensive needs of their clients but find their community lacks the resources to address those needs, and thus feel their only option is to remove children. As other participants expressed, this is not a fault in the logic of the practice model per se, but an issue of insufficient resources to adequately support the child welfare practice model. These reported challenges may also be another reflection of the practice model being in the early implementation stage.

Another widely reported concern was the amount of time required to complete the FFA, coupled with the tight timeframe in which child welfare professionals have to do it. Many child protective investigators expressed that it was difficult to provide the level of in-depth assessment expected in the allotted time. It was frequently reiterated by child protective investigators that the current assessment process requires considerably more time to complete than the previous protocol, and caseloads had not been reduced accordingly to accommodate this change. This frustration was not unique to investigators; case managers similarly expressed that they found it challenging to meet their deadlines for completing assessments, particularly when the case is first transferred to them. There was considerable variability across sites in the extent to which case managers were practicing under the new practice model (from as much as 95% implementation to as little as 6% implementation, according to data from DCF's March 2016 Child Welfare Key Indicators Monthly Report) as implementation was ongoing at the time. The amount of time required to complete assessments, however, appeared to be a concern regardless of implementation status. One case manager characterized the situation as, "We have a week to design the next year of somebody's life." Not only do case managers have a very limited timeframe to complete their initial assessment when they receive a case, but there is added pressure by the fact that they have to use this assessment to create the family's case plan. Although the expectation with the child welfare practice model is that the case manager will build upon the investigator's FFA, it was emphasized by participants that they cannot rely on the work of the investigator. One reason for this is that the level of sufficiency of information required for investigations is less than what is needed for case managers. Given that the investigators themselves expressed that they feel like they do not always conduct as accurate or comprehensive an assessment as expected, furthermore, it is not surprising that case managers often feel like they must start over fresh.

Meanwhile, there was also a sense among some investigators that this process was simply delaying decisions that were seen as inevitable. In one focus group, for example, it was expressed that investigators are now putting significantly more time into their job and still "getting to the same place… All your shelters that you would have sheltered before you're sheltering now, and vice versa. You know when you have a shelter." Thus, they did not perceive that the new assessment process had an impact on their decisions regarding child safety. Again, this may be related to where various sites were at in terms of implementation at the time the focus groups were conducted. In some other focus groups, it was reported that this process also produces a delay in the initiation of services, as expressed in the following narrative:

> But it's also frowned upon to say, well, upfront we know what services are needed; per methodology we're supposed to gain all of this information and then at the end we're supposed to determine what services. Sometimes we go out there and we're like, 'I know exactly what you need.' But we're not allowed to say that because that's not what methodology wants. We want to gain all of this information and at the end we all come to a decision of what the family needs.

Since child protective investigators perceived that they are required to complete the FFA prior to making service recommendations or referrals, and in fact some even reported having referrals rejected because their FFA was not complete, this can result in delaying services for families. Numerous investigators stated that such delays occur. For those families in need of immediate intervention to address safety concerns, such delays could result in the removal of children who might otherwise be maintained in the home with appropriate services.

Some child protective investigators, furthermore, disagreed with the ideology behind the child welfare practice model and the FFA. Whereas case managers generally tended to conceive of their role as social work, investigators were more likely to see their role as limited to investigation and did not necessarily identify as social workers. This is not to imply that all investigators felt this way, but a substantial number did express such beliefs. Thus, the requirements of the child welfare practice model involves components that they perceived to be outside their role and with which they did not feel comfortable. The following excerpt illustrates this resistance:

> R1: Making us more like a – from a psychological perspective, versus the, you know, the old way… Like, all right, well, I guess I have to understand you, sir… I don't want to understand you.
>
> R2: It might be a social service, but our title is investigator, and it's not social worker.
>
> R3: But they're trying to make us a social worker.

In other focus groups, it was similarly expressed that child protective investigators do not possess the qualifications to conduct the kind of psycho-social assessment expected for the FFA and were not provided with adequate resources and supports to take on this role. Thus, great deal of tension appears to persist around the child welfare practice model and the changes in expectations for front-line workers. However, it is important to note that the state is in the early implementation of the new practice model and the uncertainty of the child welfare professionals at this time is not unanticipated. These findings suggest that more training and coaching to reinforce and enhance these new skills may be beneficial.

One important distinction under the child welfare practice model is the differentiation between safety and risk. The safety assessment concerns whether or not there currently exists a concrete, clearly identifiable threat to the child's safety, referred to as "danger threats." Danger threats may include imminent (occurring in the present moment) or impending (will occur within the foreseeable future) dangers that threaten the safety of children if left unresolved. According to the child welfare practice model, the presence of either type of danger threat requires child welfare intervention, whereby services are "non-negotiable," although there is the possibility of pursuing either an in-home or out-of-home case. In contrast, the assessment of risk concerns the identification of family characteristics that have been indicated by research to be associated with a greater likelihood of child maltreatment. The results of this assessment yield a classification of the family that ranges from "low" to "very high" risk of future maltreatment, but the key distinction is that the children are currently safe (i.e. there is no imminent or impending danger). Under the child welfare practice model, families considered "high" or "very high" risk but for whom there is no actual presence of danger towards the children are to be offered voluntary services, rather than receiving formal, mandatory child welfare intervention (Florida Department of Children and Families, 2015). This approach recognizes that being at-risk does not mean that maltreatment is currently occurring or that the occurrence of maltreatment is inevitable, and thus proposes to limit the use of mandatory intervention for those families where there are clearly identifiable threats to child safety.

While this approach is built upon recognized best practices in child welfare, such as actuarial risk assessment and differential response, focus group discussions indicated that child welfare professionals have struggled with the implementation of this aspect of the child welfare practice model. As indicated earlier, some of the concerns expressed by child welfare professionals were that the assessment process (i.e. the FFA) is too subjective, and that safety criteria may be interpreted differently by various individuals, leading to different possible conclusions that could be reached for the same case. Child welfare professionals acknowledged that it can be difficult to set aside personal beliefs and values when making a safety assessment, as expressed in the following quote from a case manager:

> And it does come down to, again, to child safety, because maybe they've done everything, maybe they're – we haven't seen great, uh, behavioral change, but is the child unsafe? And if they're not, there's even-I mean, I think sometimes it can tend to project our own, you know, thoughts of what we think, you know, like the perfect family is or whatever. That-it's not-that doesn't have to be that, to be a safe home for a child, and that's sometimes that, you know, maybe it's not what we would hope it would be, but is

> this, you know, a safe environment for a child to return to. It can be tough sometimes to say I don't see that there are any real safety concerns. I don't feel good about it, but…

Findings indicated that many child welfare professionals struggle with reconciling this disjuncture between child safety and their personal ideas about what a "good family" should look like.

In addition, comments made across case manager and child protective investigator focus groups suggest that not all workers understand the distinction between safety and risk, or the correct procedures to follow based on their assessment results. This finding reiterates the fact that child welfare professionals were still in the early stages of implementing the practice model. One area that seemed to cause considerable confusion was with regard to assessing "imminent" versus "impending" danger threats. The concept of imminent danger appeared to be fairly clear among child welfare professionals, but impending danger was more difficult to comprehend and distinguish from risk. The following statement from one case manager, for example, illuminates the uncertainty child welfare professionals feel about what actions they are able to take with regard to impending danger:

> I find it difficult as a professional, um, to assess the imminent and impending danger. You know, we have this safety plan to cover our behinds, you know, and I find that very difficult, that I can remove all day for that, you know, immediate safety, but because I – you know, it may happen in two months, that's impending, you can't really do anything on that. And so I find it challenging to deal with that transition.

This comment reveals a misperception that children cannot be removed on the grounds of impending danger and that the child welfare agency is essentially powerless to enforce family interventions in such situations. Such commentary may be indicative of some confusion between impending danger versus risk.

Another area where child welfare professionals demonstrated a lack of understanding at the current stage of implementation was with regard to the use of voluntary versus non-voluntary services. Numerous child protective investigators described a process of trying to offer families voluntary in-home services first, and if the family fails to comply with those services, proceeding with the removal of the children and mandatory services. This is problematic for a few reasons. First, services are not actually voluntary if families are threatened with the removal of their children for non-compliance. Second, the child welfare practice model clearly states that if children are unsafe, services are non-negotiable; this means that offering "voluntary" services to families with unsafe children, as a number of child protective investigators acknowledged doing, is inconsistent with the practice model and operating

procedures. While they can offer in-home services with a safety plan to such families, these services should never be offered as "voluntary" if the children have been determined to be unsafe. Thus, it was apparent that child protective investigators did not fully understand when it was appropriate to offer voluntary versus mandatory services to families, and often seemed to conflate voluntary services and in-home services as being one and the same. This may also indicate confusion over judicial and non-judicial cases among some staff. A possible explanation for the confusion expressed by child welfare professionals is that they were using outdated language rather than not understanding the child welfare practice model. During one focus group, when further pressed by the interviewer as to whether they ever implement court-ordered in-home services, rather than voluntary services, before reaching a conclusion that removal is necessary, the participants stated that if they have sufficient evidence to file for court-ordered services they simply remove the children immediately because the same burden of proof is required. They further indicated that this is what Children's Legal Services (CLS) has instructed them to do. Thus, these responses suggest that despite the widespread agreement that removal is a last resort, child protective workers may in fact be resistant to try in-home interventions if they have the option to remove children.

The expressed inclination to remove was further illuminated and partially explained through child welfare professional discussions about safety plans. Safety plans were described as the primary strategy for trying to maintain children safely in the home while working with families, but a number of challenges to safety plan implementation and maintenance were reported. While respondents identified that certain conditions must be met in order to implement an in-home safety plan, they expressed that safety plans are frequently insufficient and do not alleviate their concerns for child safety. The required conditions to implement a safety plan identified during the focus groups include the ability to control the danger threat, having a safety manager (i.e. a non-offending family member or professional who can ensure the safety of children) in place, and having the family's agreement to cooperate with the safety plan. Many child welfare professionals, however, expressed that safety plans were promissory in their nature (i.e. they are based upon a promise by the parents to comply) and that it was difficult to monitor compliance, especially since they may not have the time to check in with the family as often as they would like or feel they should. Furthermore, in some of the discussions among child protective investigators, it was clear that personal beliefs and biases towards families could have an effect on investigator decisions about whether to attempt to implement a safety plan. As described earlier, some participants indicated distrust towards family members who are called upon to serve as supports for safety plans, expressing a belief that these

individuals are often unreliable. Some respondents indicated that personal history with the family could have a significant impact on case decisions. In one focus group, the following conversation transpired:

> R1: If they have a bad history and they've screwed me over in the past, I'm taking the kid, you know.
>
> R2: You're taking the kid, you're not going to safety plan. And I… I don't like safety plans. They never work.

There seems to be a lack of confidence in the safety planning process, which contribute to investigators' hesitance to try in-home interventions. These findings indicate that more training and coaching are needed on safety planning. Additionally, child welfare professionals reported having had the experience of safety plans that fall through and ultimately lead to a removal. Participants reported that when a removal occurs after more than one "failed" safety plan, they often get reprimanded in court for not taking action sooner, or conversely, the court may question the reasoning for removal after so much time has passed, making it more difficult to convince the court that children are unsafe.

These experiences tend to create discomfort among child welfare professionals towards the use of in-home safety plans. Another issue of concern for front-line workers is that they are generally held accountable for safety and removal decisions. From the perspective of participants, this is unfair because they do not have complete control over these decision-making processes. At times, the child welfare professionals may disagree with the decisions that are made, yet they are the ones who frequently come under fire for those decisions. As one case manager described,

> We don't make the decis[ions]… like we present everything to the courts and to the judges and they make the decisions so ultimately, the case manager's not deciding whether to keep the kid in home or not, you know. But we get blamed for everything that happens.

Across the five circuits, it was reported that decisions about whether or not to remove children entailed a joint decision-making process among (at the very least) the investigator, their supervisor, and an attorney from Children's Legal Services (CLS). Higher-level administrators from the DCF office may be brought in as needed. A number of participants expressed the perception that ultimately the decision to remove is driven by CLS and whether or not there is legal sufficiency. Among case managers, frustration was expressed that they have no role in the decision-making process; if they have an in-home case that they believe warrants a removal, they must file an abuse report and wait for a decision from DCF. Among child

protective investigators, on the other hand, there were considerable frustrations expressed over a perceived diminishing of their power in removal decisions. As one investigator explained,

> We're not allowed to make our own decisions anymore… if I want to remove a child, I have to go through you, then through you, do a phone call with all of you, and then do another phone call with somebody else. All while I'm standing in a house where people are screaming at me because they're really mad at me 'cause [of] what I'm trying to do. It used to be… I could make that decision and I feel like a lot of it [has been] taken away from us.

This sentiment was echoed across the child protective investigator focus groups. Whereas it was reported that in the past they had the authority to make removal decisions on their own, they are no longer able to do so, and this was a source of contention.

Child welfare professionals expressed feeling that they have limited power when making case decisions, but are held accountable when a negative outcome occurs. A strong sense of personal responsibility was reflected among participants. During one focus group, for example, one participant expressed constantly feeling "just really worried about, you know, you don't want to hear on the news that that child is dead." Agreeing with this statement, another individual added, "I always worry that I'll miss something, you know, that I'll miss some sign." In a different focus group, a child welfare professional described feeling that, "I wouldn't be able to live with myself if something happened, um, to a child, because I wasn't doing enough for that family. I would feel too responsible." Many of the comments from child welfare professionals indicate that the pressures of responsibility and accountability placed on them often result in practice being guided by liability.

> That's what I was gonna say: liability… it's terrifying to put your name on a recommendation that... when others are disagreeing with you, and you're the one taking, like, the less safe argument. And by less safe, I mean, like, you know, like, cookie-cutter safe or unsafe. I've only done it once in two years. I've only put my name and my butt on the line once.

Child welfare professionals expressed the inclination to establish legal sufficiency to shelter children rather than implement in-home services first.

Related to these concerns over liability, there were additional concerns that inappropriate safety and removal decisions were being made. Interestingly, the concerns expressed had a dichotomous nature, with some focus groups emphasizing a belief that unsafe children were being maintained in-home who should not be, while other focus groups underscored a belief that too many children were being removed unnecessarily. These

discussions were most prevalent among case managers who, as noted previously, typically do not have a role in removal decisions. In addition, these perceptions also likely reflect the early stage of implementation and the fact that some sites had only recently begun the transition to the new practice model. In one focus group, for example, case managers discussed their concerns about CPI's decision to refer families with significant safety issues to a voluntary intensive family preservation program. One case manager stated, "And I feel like once they make that decision, 'We're not gonna remove, we're gonna put in [program],' then that- that's it… it's hard to get them back onboard with, 'you still have the ability to remove the child…'" One interesting finding is that these concerns were expressed among circuits with both higher than average and lower than average removal rates. Alternatively, an example of case manager perceptions that children are being removed unnecessarily is provided in the following excerpt from a focus group conducted in a different circuit:

> I just feel like we're just sheltering kids, and I also just feel like they just shelter kids instead of putting services in the home and helping the parents and trying to be more supportive with the parents and just snatch them out automatically, and it's not fair…

This conversation indicates a perception that insufficient efforts are being made upfront to try to keep children in the home before resorting to the removal of children, and that many removals could be prevented through greater use of in-home services. The diverse perspectives that emerged across circuits suggests that child welfare practice, particularly with regard to removal decisions and the use of in-home interventions, is highly variable across geographic areas. This diversity in perspectives also likely reflects the early implementation stage of the practice model and variability in the extent to which different circuits have implemented the model. Several comments from focus group participants, furthermore, suggest that at times child protective investigators may alter or modify their assessments to obtain the decision that they want; for example, overriding a safety assessment in which a child was deemed safe in order to refer the family to an intensive in-home service program that only accepts families where children are considered unsafe. These findings illuminate the ways in which assessment and decision-making processes are still susceptible to individual interpretations and judgments and indicate the need for more training and coaching to improve consistency.

Family engagement processes. Family engagement was recognized among both child protective investigators and case managers as a critical aspect of casework practice that facilitates accurate family assessments, family buy-in, and participation in services. It was widely acknowledged across participants that lack of family buy-in is one of the greatest challenges to their work. The confrontational nature of the child welfare system complicates the

situation: parents feel forced into services, may blame child welfare professionals for the fact that their child has been removed, and have difficulty seeing the child welfare professional as someone who is there to help them within this context. “And it doesn’t make providing services any easier when they already see us as somebody who’s not on their team,” one case manager concluded. Another added, “It’s hard to break that stereotype and get them to understand that we’re here for their support or we’re here to support them so they can get what they need… A lot of times they come at us very angry, so you have to break that down before you team.” Similarly, a child protective investigator explained that often families “don't trust DCF, they've had bad experiences in the past with the old system, um, so you have to overcome that.” Participants noted that non-judicial cases could be especially challenging, as parents may feel less obligated to comply given that services are voluntary. On the other hand, judicial cases may create stronger feelings of resentment that must be overcome to work successfully with the family. Thus, effective engagement processes are vital for both types of cases, and child welfare professionals consistently emphasized the need to “build rapport” with clients.

While a shared understanding of the importance of family engagement and rapport building was relayed across focus groups, there was a great deal of variability in terms of the strategies that child welfare professionals reported for engaging families. This suggests that, at least to some extent, family engagement processes are not defined so much by adherence to a strict set of practice guidelines, but rather, child welfare professionals bring their own individualized approaches and personalities into their practice. The perception that every child welfare professional has their own methods for engaging with families was expressed in several focus groups. It was reported that different families may respond better to different approaches, and thus the variability in family engagement strategies might be seen as a strength, enabling child welfare agencies to reassign child welfare professionals as needed to better match with the characteristics and personalities of families. Overall, findings indicate that there is no single, clearly defined set of practices for family engagement, and many child welfare professionals emphasized that, like services, family engagement strategies need to be individualized to the particular family.

Although responses varied, certain strategies did emerge as part of a common framework for family engagement. Three strategies that were most frequently reported among focus group participants were communication with families, soliciting family input, and incorporating family supports. Child welfare professional discussions regarding communication generally emphasized a belief in full disclosure. Many child welfare professionals expressed that they explain the entire process to the family at the beginning of the case, including the

possible actions the agency could take, the expectations of the parents and changes that they need to make, and the possible consequences and outcomes that could result. These narratives further stressed the importance of being upfront and honest in their communications with families. Child welfare professionals used expressions such as “brutally honest,” “truth-telling,” or “being real” with families. Being upfront and honest were seen as critical pieces in establishing trust with families, and thus being able to engage families effectively. In addition, several child welfare professionals also underscored the importance of explaining the situation in words that the family understands. The following excerpt from a child protective investigator focus group illustrates this aspect of the communication process:

> R1: Right, in a respectful manner. And when, um, we are discussing it and I’ll break it down, word for word, based on what is happening with their families. So it comes back to, as I say, education. A lot of them have maybe a high school education. Maybe as high as a high school. And when we’re going in and we’re giving them these, um, big college words and we’re giving them… It’s like we tuned them out. So once we throw things at them that they don’t understand…
>
> R3: They tune us out.

Communicating effectively with families requires the child welfare professional to be able to assess the family’s level of comprehension and speak to families in ways that are respectful of the family and using words that they understand.

Communication was furthermore discussed by child welfare professionals as an ongoing process throughout the life of the case. Child welfare professionals expressed that it was important to communicate regularly with clients regarding their case progress and to keep clients informed about the status of their case. For example, child welfare professionals described communicating to parents when they are not in compliance or have not made sufficient behavior changes and what the consequences will be for their actions. Case managers also indicated that they are in contact with parents regarding their progress towards permanency. Both child protective investigators and case managers expressed that they check in with clients periodically to see how their services are going, and some even call or text clients to remind them of appointments.

Soliciting family input regarding their needs, goals, and services was another widely reported strategy across both child protective investigators and case managers. Just as it is critical for the child welfare professional to communicate clearly and effectively with the family, it was considered equally important to provide the family with opportunities to communicate their perspectives. The family assessment process includes interviews with both immediate, and

when possible, extended family members or other collaterals to obtain a holistic picture of the family's strengths and needs. Families are also often included in the development of their case plans, and among some case management agencies (although not all) family team conferencing is used to engage the family and the family's support system in the identification of the family's needs and possible services. Among those child welfare professionals that used some form of family team conferencing, this was viewed as a particularly effective approach.

Child welfare professionals expressed that they attempt to identify and include all the individuals that are important in the family's life. This may include various relatives as well as neighbors or close friends. They also indicated a strong focus on including children's voices in this process. "We talk with the kids too, if they're of an older, more verbal age. You know, we ask them how their relationship is with their parents," one child protective investigator explained. Another investigator elaborated that they may ask children for their perceptions regarding, "What is it that you wish that was different with your parents? Like, what do you think that they need help with? What do you need help with?" Case managers similarly expressed the value of including children's perspectives: "You can learn a lot by talking to kids."

In addition to obtaining necessary information about the family situation, soliciting family input also facilitates family engagement by giving families a voice and demonstrating the agency's interest and commitment to helping the family address their perceived needs. A case manager explained this in the following way: "Listening to them when they talk and addressing whatever their concerns are, you know? Make it important what, you know, to ask what their needs are. Am I listening to them?" Another case manager expressed that, "We kind of ask them, 'Okay, what's your perspective of why the children were removed? What do you think could be... put in place to help you and your family?'" These narratives illustrate the importance that is placed on understanding and validating family perceptions of the current situation. As one child protective investigator explained, "We can identify and make recommendations, but we try to make them kind of identify their own needs, so that you can better provide them with the appropriate services." This and similar responses reflect an effort to reduce some of the confrontational aspects of the system by emphasizing the role of the child welfare professional as "helper." The emphasis on helping families, rather than criticizing or castigating them, aids in this rapport building process. The following approach described by a case manager exhibits a similar philosophy:

> And I even tell them you know, regardless of what happened and what got your kids involved, what do you think you need that could make you a better parent? Like, we're all not perfect, we could all work on something, and I normally get them to help me make

> their case plan. So I normally-I have what is, you know, in the petition, but I also sometimes add other things that they say they need because if you're involved in this we might as well do everything we can to make sure this never happens again. So you tell me what you need so that we don't ever have to do this again. And they're usually pretty forthcoming and honest. You do have the occasional parent who's not going to do anything, but the-I think, and if you go about it in a way where, you know, let's forget everything that just happened, just tell me what you think you could work on, and parents are-they respond well to that.

Child welfare professionals enacting this approach offer the family an opportunity to move forward by focusing on the future and what they want for their family, rather than dwelling on the past. Overall, by soliciting family input, child welfare professionals reported being better able to identify services that are an appropriate "fit" for the family and having more success in getting families to engage in services since families feel like their opinions and needs have been taken into account.

Closely related to soliciting family input, the incorporation of family supports in safety and case plans comprised another critical strategy in the family engagement process. The incorporation of family supports extends the concept of "family engagement" beyond the nuclear family to recognize the role of the family's broader support network in ensuring child safety. Thus, not only are relatives and other supports asked for their input regarding the family's needs, they may also be engaged as active participants in the child welfare intervention. As one child protective investigator explained, "We, you know, look at the family support system. And if they have [an] adequate support system who's willing and committed, you know? We try to utilize the resources that the family has." In this way, child welfare professionals encourage the family to use their natural support system so the family is not going through the system alone, which may increase the likelihood of success. This gives extended family members a role and also recognizes alternative family structures and arrangements that clients may already utilize or could utilize to prevent a removal and keep the family together. In the words of one case manager, "I think that, um, other family members should be involved. Because I've always learned that it takes a village to raise children, and it really does." Furthermore, it was expressed that the incorporation of family supports may provide additional encouragement for the family or even facilitate the process of getting the family engaged in services when families are resistant to the child welfare intervention. The following narrative from an investigator illustrates this point:

> I think getting their families involved. I mean, I personally am not a fan of calling up a relative and asking them, because then, you know, their business is out there. But in the cases where it's needed, I think getting their family's support in their little circle to help encourage [them]. 'Cause sometimes, it can't come from us. Yeah, we're an outsider coming in, but they also see this star [the CPI badge], and they go, 'Nope, not talking to you, done.' So that's when we have to gather the family and say, 'Okay, let's have a little intervention meeting with all of us.' And you guys, kind of come in and say, 'This is what we've been seeing for X amount of years. You do need the help, let them help you.'

Relatives may be equally distrusting of child welfare professionals and resistant to intervention by the child welfare system. "It's a positive and a negative," one child welfare professional explained, "because with that mentality of, you know, 'We're the bad guy,' a lot of the people that are safety supports will not be completely forthcoming with us." This further reiterates the importance of effective family engagement practices in order to establish the necessary trust and rapport that precedes the ability to work successfully with families.

Additional aspects of family engagement that were discussed during focus groups included empathizing with families, empowering families, the use of encouragement and positive reinforcement, and the ability to set aside personal biases, including the importance of cultural competence skills. There was considerable variability in discussions of family engagement, suggesting a variety of approaches are used by different child welfare professionals. All contain a similar emphasis on how critical effective family engagement is to the success of the case. It was not clear from the focus groups responses to what extent child welfare professionals have learned the skills about how to interact and engage effectively with families. One final observation is that the practice guidelines do specifically encourage the use of motivational interviewing, particularly with regard to encouraging families with safe-but-high-risk children to engage in voluntary services. During the focus group interviews, however, motivational interviewing was not specifically mentioned although some components were discussed. It is important to note that the focus groups with case managers (but not those with child protective investigators) occurred prior to the release of CFOP 170-9, which addressed family engagement..

Organizational supports and barriers. While there is a considerable degree of flexibility and variability at the practice level, front-line practice is nevertheless shaped to a substantial degree by organizational structures and processes. Research indicates that organizational culture and climate have important implications for front-line practice, including the

implementation of evidence-based practices, quality of practice, and service outcomes (e.g. Glisson & Green, 2011; Glisson et al., 2008; Smith & Donovan, 2003). Child protective investigators and case managers who participated in the focus groups identified a number of organizational factors that either support them in their work or present barriers to their ability to effectively perform their job functions.

Two of the greatest supports described by child welfare professionals were their co-workers and supervisors. Teamwork was described as one of the most positive and important aspects of the job. Child welfare professionals expressed that they rely on their co-workers for both emotional support (e.g. venting, commiserating) and support in completing case tasks. For example, investigators described coming together to help with interviewing large families or "tag-teaming" on cases (e.g. if one child welfare professional has a particularly difficult case, another child welfare professional will team up with them to help tackle it). Similarly, case managers described "picking up the slack" when a co-worker is overloaded, explaining that they will complete home visits, transport children, help with paperwork, or "do whatever we have to do" to help their colleagues out when they are overwhelmed and falling behind. "If you don't have someone to support you, you're not going to stay in this field for long," one case manager concluded. Both case managers and investigators described their relationships with their co-workers as being like a second family, and emphasized that this support system is what gets them through the tough days.

Additionally, teamwork was identified as an important component of decision-making processes. Child welfare professionals expressed that they frequently seek support from co-workers in the form of advice and brainstorming when it comes to case decisions. The following excerpt from a child protective investigator focus group illustrates this process:

> Just kind of… just feeding off one another. Discussing these cases, you know, with our supervisors or, you know the PIs and being able to come together collaboratively because we have to be able to depend on one another. Um, and in a supervisor role you have to depend on your PIs to come back to relay the information to you from what they've seen, what they've gathered. Um, and you have to be able to build that trust with one another to understand that, okay, what they're seeing is-is what they're seeing and you guys can collaboratively come together and to do what is in the best interest for that child… So just being able to have that support system where you're not just making these tough decisions on your own.

Case managers described this aspect of teamwork in very similar ways, as demonstrated by the following example:

> Yeah, you have a – you have a family's lives in your hand, several people of that family. And I think sometimes thinking that you have to make a decision, it's nice to bounce that decision off of someone… And because things are so confidential, it's nice to have that one go-to person that can say I don't know, I would rethink that.

Co-workers provide critical support by offering additional opinions, insights, and ideas to one another. This enables child welfare professionals to benefit from the knowledge and experiences of their peers as they work through their cases, and also relieves them from the pressure of making difficult decisions on their own.

Similarly, supervisor support was discussed as providing many of these same functions and was considered particularly crucial to the success of child welfare professionals. One child protective investigator explained,

> I think it goes back to your supervisor. I've been fortunate, you know, to have some… really interesting units I was in over the course of my career. Uh, I had really strong supervisors. Um, and they can make good decisions when you're staffing cases with them. I think that's the biggest thing… Um, so I think that… basically, I think that as an investigator, I always have believed that… I still believe that to this day, your supervisor will make you or break you.

Supportive supervisors were described as those who enable open communication, are available to their staff beyond normal office hours, offer assistance on case tasks, are willing to go out into the field with child welfare professionals, provide guidance in decision-making, and do not micromanage. Child welfare professionals especially appreciated how important it was to have supervisors and other agency leadership support them when they are in the process of removing children and finding placements, which frequently occurs outside of standard office hours and can be an extraordinarily lengthy process. Supervisory and leadership support are critical in this environment, where child welfare professionals have an enormous amount of responsibility and can easily become overwhelmed. Having a supervisor who is dependable, available, and willing to step up when needed was consistently reported across focus groups as the greatest support to child welfare professionals, although it was also noted that the quality of supervisors varies. Most focus group participants reported having a positive relationship with their supervisors, however, some participants reported negative supervisory relationships in the past, as in the following example:

> I've been out at four o'clock in the morning running three kids at every different side of town and my supervisor is nowhere to be seen, and then I've been on the opposite end where my supervisor… "I got your fax… I got this form done, you just make sure the kids

> are fed." So when you're able to like sit down and breathe after doing that it-it takes a load of stress off of you and it just feels amazing and you're like, 'I'm never leaving this supervisor.' You're like 'I can do this again. I'll stick with you until the end.'

Having a "good" supervisor makes a world of difference for child welfare professionals, while having a "bad" supervisor can ultimately be the driving force that leads a child welfare professional to resign. These findings indicate the importance of ensuring high quality supervisors with both the right skill sets and the right work ethic. Furthermore, creating a supportive work environment also extends further up, and begins with the administration. Unfortunately, a number of child welfare professionals expressed feeling that they lack the support they need from the upper management and administration at their agencies, which is reflected, for example, in their discussions about liability and accountability presented earlier.

In addition, case managers described having other staff at their agencies who provide support. One agency reported that new case managers are assigned a job coach while going through the certification process. The job coach provides consultation and guidance to the worker on their initial cases and serves as an extra support and mentor in addition to the supervisor. Several focus groups identified Family Support Workers as specialized staff who provide assistance with tasks such as supervising visitations and transporting children. Most of these discussions emphasized the need for more support workers, stating that, "there's never enough." In one focus group, participants specifically expressed the perception that these specialized positions were being reduced or eliminated. "I feel like some of those positions were taken away – like, somebody to do just medications, somebody to do home studies, somebody to do visitations," a case manager remarked. The limited number of support workers employed by case management agencies means that case managers cannot depend on having these staff available to assist them. While these staff were highly valued for the support they provide to child welfare professionals, participant responses indicate that the demand far outweighs the supply.

Responses regarding training were mixed, with pre-service training described often as a barrier to competent practice. The initial training provided to new child welfare professionals was considered problematic among both child protective investigators and case managers. The primary concern was that this training does not adequately prepare new child welfare professionals for the job. A strength that was noted, on the other hand, was that there are plenty of opportunities for ongoing training, and that these trainings generally entail relevant topics and information that keep child welfare professionals up-to-date. These trainings were

positively received by child welfare professionals: “Every time you go into a training you do come out with something really valid or new, um, that will make the job a little bit easier.” Concerns expressed by child welfare professionals were that new employees do not receive enough practical training, such as how to use FSFN, how to type a Family Functional Assessment, or how to complete a home study. The perception that training is mainly focused on passing the test and not on the actual mechanics of doing the job was expressed across several focus groups. This was frustrating for child welfare professionals, as they feel that they are the ones who ultimately have the burden of training new employees how to do the job correctly. Participants felt that there needed to be more hands-on, field-based learning experiences incorporated throughout the training process to properly prepare new child welfare professionals. The following narrative expands on this idea:

> When I became a case manager, I learned more from the month I spent in the office shadowing case managers than I did in the 10-week training… I don't think you can be prepared for this job without being in the field and-and-and observing other case managers. And I think that if they could prepare people better in the first place, we would have less turnover.

Field-based learning was considered critical but perceived as lacking from the current training curriculum. In addition, participants perceived that inadequate preparation of new child welfare professionals contributes to problems with employee retention.

One of the greatest challenges reported by participants was the workload, which many described as unrealistic. Specifically, child welfare professionals cited the timeframe demands for completing various tasks, the sheer amount of tasks required, including the burden of paperwork and reporting requirements, coupled with the pressures of maintaining low caseloads and not accruing too much overtime. Many expressed that there simply is “not enough time in the day” to complete everything that is expected of them. As one case manager expressed, “I mean you could work seven days a week, 24 hours a day, and you’d still have stuff to do.” Another described the situation as “constantly playing catch up.” At the same time, however, child welfare professionals’ hours are carefully monitored by the agency, leading to further conflict as child welfare professionals try to meet their deadlines while receiving contradictory messages about needing to keep their hours under control. Being instructed to flex out their hours but also complete an exhaustive list of tasks was a common complaint among focus group participants. High caseloads and understaffing further exacerbate this situation, as one case manager explained:

> I think the most difficult part is the caseload amount. Um, the amount of families that we have, the amount of kids that we have is almost absurd. Um, and to be able to do everything for every family, you know, to the level that's expected is, you know, nearly impossible… You know, uh, there's so many different roles that a case manager has, that you just feel like, you know, you're spread very, very thin.

Many child welfare professionals reported that they are carrying caseloads above what is recommended. For example, some investigators described receiving as many as seven new cases in a single week, and it was reported that case managers at some agencies are carrying 20 or more cases with as many as 40 children on their caseload (since most cases involve two or more siblings). Not only are child welfare professionals experiencing higher than recommended caseloads, but the implementation of the child welfare practice model has also increased the workload for each case, further contributing to the sense that they are being asked to meet impossible expectations.

The impact of high caseloads and a heavy workload contributes to several negative outcomes. First, it requires child welfare professionals to prioritize tasks and make critical decisions about what they realistically can and cannot get done. This means that some cases may get more attention than others, or certain tasks may get pushed aside. In the words of one investigator, “Everybody’s just found ways to cut the corners.” The high workload also interferes with the family engagement process, as child welfare professionals expressed that they do not have as much time to spend with families as they would ideally like to spend. Finally, the heavy workload and perceived unrealistic expectations eventually lead to worker burnout. One respondent described the process as follows:

> Your [the CPI’s] overtime is a little much right now so you need to…but I [the supervisor] also need that 45-day case that needs to be submitted. But it's like, you're not thinking about the worker and the stress and the fact that I [the CPI] haven’t been home, I haven’t eaten at my actual house in like a week. I've been eating fast food, it's like I need a break. I need to detox from this job, but you're not helping me do that by just saying, “Do this, do this, do this, make sure this is due.” It's not helping us in the long run, which gives DCF a huge turnover because we feel all that stress and we don’t want to do this anymore and then we're just done. We're burned out.

Thus, the amount of tasks and responsibilities that are placed on child welfare professionals, combined with insufficient staff supports, were reported as some of the most significant barriers that affect the ability of child welfare professionals to be effective in their job.

Closely related to workload challenges, participants described turnover as another particularly burdensome aspect of their job. They attributed turnover to a lack of passion for this type of work, poor preparation, poor compensation, and employee burnout created by the unrealistic workload. Child welfare professionals recognized that it "takes a special type of person to do this job." From their perspective, child protection employment is not a job that is taken just for a paycheck; those that enter this field (and stay) do so largely because of their passion for child safety and working with families. "It's really, it's not a job, it's a calling. It's something that is within you. People that stay have a burning desire," an investigator explained. While this may not be true for all child welfare professionals who stay in the field long-term, respondents perceived that it was true for many. One suggestion was that the hiring process needs to be more selective in order to identify individuals who are a good fit for this line of work and likely to stick around. There were no clear recommendations offered, however, for how to achieve this. Participants noted that the majority of new hires are fresh out of college and take this position as their first job without knowing much about it; many of these employees do not stay more than six months after they learn the realities of the job.

Child welfare professionals also mentioned that they were experiencing more turnover than new hires at the time of the focus groups, leading to understaffing among many agencies. This has been one factor, although not the only factor, contributing to high caseloads. They reported that when an employee quits, it creates a ripple effect of burden. Child welfare professionals that stay are left to take on the cases of the employee that quit along with new cases coming in. Some circuits, for example, reported being understaffed by at least 30 child protective investigators. Even when employees who resign are replaced, it takes several months for new employees to learn the job and be ready to take on a full caseload. Thus, turnover has a long lasting impact on agencies that continues for some time even after vacant positions are filled.

Additionally, child protective investigators reported that at times the child abuse hotline makes their job more difficult. Investigators provided various examples of the hotline accepting reports that they felt should be screened out, such as parents involved in custody battles calling in reports on one another, reports where there is no child victim, and incidents that occurred in the past (with no present danger indicated) and being marked as "immediate." This takes up a significant amount of time for the investigators when they could be devoting their efforts to more complex and legitimate cases. There was widespread consensus among participants that hotline workers are poorly trained and do not properly screen the reports they receive, which then adds to high caseloads when too many "frivolous" cases are accepted. Furthermore,

investigators found it especially frustrating that they are required to complete a full FFA for such cases, which they felt they should not have received in the first place. As one investigator described, “The FFA just causes way too much work. It really is, and it's ridiculous when there are no indicators of any abuse or neglect, and the family's fine, [but] you still have to do that whole thing.” It was suggested that a briefer assessment should be allowed for those cases in which the allegations are not verified by the investigator, since it produces a substantial burden to complete a full FFA on a case that does not go to court and also produces a substantial invasion of a family’s privacy, as discussed previously.

Finally, funding was also considered a significant barrier among child welfare professionals. Participants did note some strengths related to funding, such as the ability to use funds for prevention/diversion services and the availability of “flex funds,” which can be used to assist families with short-term financial needs like paying electric or utility bills. The increased flexibility provided by the Title IV-E Waiver is likely a critical source for these funds. For the most part, however, funding was described as being insufficient. Diversion services were perceived to be particularly underfunded; child welfare professionals expressed that there is not enough availability of these types of services. Some further expressed the belief that child welfare services statewide are not funded at the level that they need to be, and this prevents agencies from hiring sufficient staff to handle the workload. Furthermore, it was reported that there is often no money available to pay for services, which leaves families who do not qualify for Medicaid and do not have private insurance stuck in the predicament of being unable to access the services they need. One child protective investigator explained the scenario in the following manner:

> And I’ve had cases where the family, they don’t have Medicaid ‘cause they don’t qualify for Medicaid. They might have a private subsidy insurance. However, the service providers don’t take that insurance. It has to be Medicaid. Okay, call CBC. Is there anything you can do to help us? ‘No. Tell them to call their insurance company.’ I’ll call the insurance company. ‘Oh, unfortunately, we don’t cover that.’ They don’t… you know, so we don’t even have funding that’s set aside to assist those families who don’t fit a certain criteria but, okay, they still need that help.

A similar problem emerges when families who do have Medicaid exceed their service limits. For example, a case manager described a scenario in which there was a child who needed additional therapy, but Medicaid would only pay for twelve sessions. Responses suggest that Title IV-E funds are not being used as proactively as they could be to ensure access to services.

These funding issues create challenges for child welfare professionals trying to initiate services quickly in order to maintain children safely in the home. Child welfare professionals reported that when they request funds to pay for services because the family cannot afford them, they frequently encounter resistance. Among child protective investigators, the fact that funds are largely controlled by the CBCs presents an additional barrier; requests for flex funds or service funding are often denied or take an excessive amount of time to process (e.g. it was reported to take an average of 45 to 60 days to receive requested funds, if they are approved).

Community resources. Community resources and services were simultaneously identified as one of the greatest supports and one of the greatest barriers for child welfare professionals. Across sites, availability of a robust array of services, one of the key objectives of the Waiver Demonstration, and positive relationships with service providers were perceived to be critical supports that affect the ability of child welfare professionals to be effective in their job. "The availability of services is the key in our job. It has to be. You have to have something out there available, readily available," one investigator explained. Child welfare professionals indicated that "good service providers" make their job easier by providing additional supports to the family as well as providing additional assessments and information about the family's needs and progress. As described previously, child welfare professionals frequently rely on the expertise of providers when making their assessments of family needs and progress. They also rely on providers to address the family's identified needs as specified in the family's case plan, such as participation in therapy or completion of parenting classes. In this regard, the availability of community services and resources is one of the most crucial components to the success of a case.

Providers that offer in-home services were identified as a particularly important and beneficial resource, especially for families with limited means of transportation and multiple service needs. As one case manager expressed,

> We do have a couple of programs that have recently started that do services – multiple services in-home, which is very helpful and beneficial for our families because the expectation of people getting to somewhere each week, several times a week and work, so they can get housing and sustain housing, I think those are challenges for our parents. So, when we can utilize providers that can go in-home, um, we do, um, because it's a lot easier for them to be compliant with those type of services.

"Those are our most successful cases, is when we have providers go into the home," another case manager stated. The majority of participants expressed a belief that in-home services could be extremely beneficial for families and appeared to prefer these services where they

were available. The most commonly identified in-home services included parenting programs, therapy, targeted case management, and wraparound programs. Many participants, however, reported limited availability of these types of services in their communities, and some reported a complete lack of service providers who work with families in the home.

The importance of having a variety of community-based services was strongly emphasized, particularly given the complexity of needs among many system-involved families. The multiplicity of family needs requires the availability of many different services and supports. Not all participants felt that they have a sufficient variety of services to meet the diverse needs of families available to them. "Finding the right service that you really think is going to benefit your parent in their particular situation," presented a considerable challenge from their perspective. The ability to individualize case plans to each family's unique needs is limited by the availability of services within the community.

There was considerable variability reported across the participating sites in the availability of community resources. Some child welfare professionals indicated good availability of services in their community and described strong relationships with their service providers. One investigator, for example, voiced the perception that, "I think we're fortunate enough to be in a circuit where... we have a ton [of services]." Others indicated that service availability was extremely limited, emphasizing that the array of services varies greatly by county. "I think it depends on the community, because I came from ---- [county], which is very rural, and there's nothing there. Um, I mean there's stuff, but there's not," a different investigator explained. However, child welfare professionals across all participating communities identified gaps in the availability of services in their community or limited variety of services, which make it difficult to provide services that meet families' individualized needs. Some reported a lack of options for services, for example, having only one mental health or substance abuse provider in the entire county. Availability of service providers that offer flexible appointment hours, such as evenings or weekends, was reported as another significant challenge for families, particularly for parents trying to maintain full-time jobs.

The inability to connect families to appropriate services to meet all of their needs was a source of frustration for child welfare professionals. "The crazy thing is, you think you know what a family needs, and then when you go to actually set that in motion, it's not there, and it's not what you thought," one child welfare professional described. Another child welfare professional expressed that, "These bigger services [e.g. homelessness services, psychiatric services] that we really need, that might be that lynchpin between safe and unsafe, is where we're getting tripped up, and it makes us look bad. It really does." Thus, a lack of critical

services can have serious consequences for children and families coming into contact with the child welfare system, as they may be the determining factor in a removal or permanency decision.

While the array of available services varied among communities, child welfare professionals across sites consistently reported a lack of affordable housing and subsidized childcare. Many child welfare professionals reported that a majority of the families on their caseload require housing assistance, but housing programs such as Section 8 have limited availability, waitlists as long as two to three years, and in some communities was reported to be entirely unavailable. Some case managers even reported having clients who were working their case plan while homeless. This is often a barrier to reunification for families.

Similarly, childcare was described as being a nearly universal need among clients. Investigators explained that DCF can only provide families with referrals for time-limited subsidized childcare, which was felt to be insufficient. "Unfortunately, you kind of leave them in limbo because we can offer them for 60 days and then after 60 days you're kinda like back in the same crippling position because they can't afford [childcare]," one investigator expounded. This concern was expressed across other focus groups of child protective investigators. Child welfare professionals conveyed concern that offering this kind of short-term assistance to families struggling with economic insecurity did little to improve their circumstances and ability to ensure the long-term safety of their children. Another challenge reported in some, but not all communities, was a lack of childcare available for parents who work the night shift.

Given the extent to which poverty was reported to be a problem for system-involved families, the insufficient availability of services to assist in meeting families' basic needs represents a significant challenge. In addition to these critical services, psychiatric and substance abuse services (for both children and adults), as well as services for low functioning parents, were also identified as significant needs for system-involved families with limited availability across many communities. One site also identified that services for children with autism spectrum disorders were severely lacking.

Finally, a lack of local placement options for children requiring removal was identified as a significant challenge in nearly every community. Child welfare professionals identified challenges with placing children in a timely manner (e.g. less than 3 hours) due to an inadequate number of licensed foster homes within their county as well as a lack of emergency shelters or insufficient capacity of existing shelters. In some of the smaller, rural communities, child welfare professionals reported having no foster homes whatsoever. The limited availability of foster homes means that it can take several hours to find an appropriate placement, during

which time the children are frequently waiting either at the DCF or case management office. Agencies often have to resort to placing children outside their county, with the undesirable outcome of separating children from their family and community. This makes it more difficult for parents to maintain their bond with their children, as it may not be feasible for them to visit regularly with the children if they are placed particularly far away. Placement outside of the local area can be a significant disruption to the child's life and sense of normalcy. As one case manager described, "They may be two counties over, or three counties over, or on the other side of the state. And you know, their friends are gone, their school is gone, their after-school activities…" Keeping sibling groups together and finding placements for teenagers were identified as additional challenges. Many foster parents reportedly have set restrictions on what children they are willing to take, with a strong preference for younger children. This has further negative ramifications for older youth, as conveyed by one investigator: "A lot of the teenagers become broken when we are trying to place them, because they feel rejected." Concerns about the quality of available foster homes were also articulated, particularly a perceived lack of engagement by foster parents in the care of children and an expectation that child welfare professionals transport children to all their appointments and activities. Thus, placement options appear to be a critical community resource that require further development.

In further discussing the service array, child welfare professionals identified a number of barriers to service access. One of the first challenges lies with the referral process, which was reported to vary by the provider agency. Thus, some providers accept electronic referrals, some require a paper referral to be faxed to their office, and some require a phone call. Each provider has their own referral form, which leads to redundant and time consuming work on the part of the child welfare professional since most of the forms ask for the same information. Furthermore, it was reported that some of the referral forms are quite lengthy (e.g. 2 – 6 pages), which may serve as a disincentive to utilize those services since child welfare professionals do not have the time to complete an overly lengthy form. A suggestion from one focus group was to find a way to streamline the referral process, such as creating a single referral form that could be used for all provider agencies and creating a mechanism to pre-populate the form with information that has already been entered into FSFN.

Further challenges with the referral process related to having the referral accepted by the service provider. One issue that was reported, which has the effect of delaying service initiation, is the amount of information that agencies want to receive from child welfare professionals before they accept the case. In addition, child welfare professionals expressed that referrals sometimes get "kicked back" by providers, but there is not clear communication as

to why the case was not accepted. Often, the result is that child welfare professionals pursue other services for their clients instead and avoid using those providers in the future. Finally, it was reported that once a referral is accepted, there is poor follow up by some providers to actually engage the family in services, and child welfare professionals receive little communication from these providers about what is happening. For example, child welfare professionals stated that some providers follow up simply by sending the family a letter in the mail, and if the family does not respond, they close the case out as non-compliant without any further effort to make contact. When these situations occur, the child welfare professional then has to start over with the referral process, since they often do not find out until the provider has already closed the case.

Next, participants reported long waitlists as a significant barrier to connecting families with appropriate, timely services. Most child welfare professionals indicated that they have experienced challenges with insufficient provider capacity and long waitlists. Waitlists for services result in significant time lapses between a service referral and service initiation. Investigators described how they would make a referral, only to find that providers often had waitlists that were several weeks or even months long. The delay created by provider waitlists can severely hinder family engagement. It also prolongs the family's involvement with the child welfare system, as it creates delays in their ability to complete their case plan. As a case manager explained, "With such limited providers, the appointments fill up. So I mean, parents are wanting to complete services right away, but they can't get an appointment for several months." Furthermore, long waitlists for services could also mean the difference between being able to implement an in-home safety plan and needing to remove a child, since immediate services may be crucial to ensuring the child's safety. If services are not readily available, child protective investigators may be reluctant to implement an in-home safety plan. This again indicates a considerable misalignment between what is happening in practice and the theory of change behind the Demonstration. Communities need to have a robust array of services available to support family preservation.

Even among child welfare professionals who reported fairly good availability of services, initiating services was frequently reported to be a problem. Some participants indicated that a degree of delay occurs regardless of the presence or absence of waitlists. The entire process of connecting families to needed services can be subject to delay at numerous points along the way, from completing the service referral, to having the referral accepted, to getting the family's intake completed, and then receiving services.

Another barrier to service access reported by child welfare professionals were the parameters established by providers that preclude some families from receiving certain services. Many providers have criteria in place for their programs such as particular diagnostic criteria or family risk levels, which seems to create barriers for some families who may have a need for a particular service but do not meet the established threshold. This may be due to the particular service or practice model used by the provider, depending on the intervention and the target population specified by the evidence-base. This can make it especially daunting for child welfare professionals trying to connect families to appropriate services to meet their needs if the family does not fit the particular criteria for the services available in the community. As one case manager described, “And then when you contact a service provider, sometimes that client does not fit their criteria. So, okay, you go back to the drawing board. Who do we have? We don’t have anyone else.” Child protective investigators further noted that some service providers would advertise offering services for high risk families, and then turn down families referred by investigators who were assessed as high risk because they were either “too high risk” or “not high risk enough.” The perceptions shared by focus group participants suggest that some families are left with no options for services if they do not meet the criteria specified by providers.

Lack of insurance coverage was another commonly reported problem among focus group participants. The most common insurance issues were families not having any insurance coverage, providers not accepting a family’s insurance, and insurance companies not covering the full cost of the recommended amount of services. Child welfare professionals reported that many of the providers they use do not take private insurance, but rather accept Medicaid only. Reportedly, even if they find a provider who will accept the family’s private insurance, they then face obstacles from the insurance company, who may place restrictions on how much they are willing to cover and may impose large deductibles or co-pays

Child welfare professionals typically do not know what insurance various providers do or do not accept, so they are often unable to consider this when making service referrals for clients. “We never know up front that they don't accept this particular insurance,” a child protective investigator explained. “So we'll hear about it after our case is closed and we've moved on. And what do we do then? Once the case is closed, who will – we-we can't refer.”

Families without private insurance and who do not qualify for public insurance (e.g. Medicaid), either due to their income level or immigration status, present a considerable challenge. Some families have limited income, but it is not low enough to qualify for Medicaid, and they do not have insurance offered through their employer. Some may be able to qualify for

public insurance for their children, but not for themselves. Child welfare professionals expressed that there are many families who fall within this Medicaid gap, and it can be extremely difficult accessing services for them. In fact, the removal of their children from the home may actually result in the parents losing Medicaid coverage.

Undocumented immigrants represent another very challenging population for the child welfare system in terms of connecting families to services. Some of the focus groups included communities with significant immigrant populations, and their ability to access services even for the children was described as severely limited. Since these individuals cannot qualify for Medicaid or most other social welfare services, child welfare professionals have relatively few, if any, service options to offer them unless the family pays out-of-pocket (which they frequently cannot) or the child welfare agency pays for services.

Even when providers offer sliding scale fees for low-income families, it was reported that this still might be more than families can afford. Furthermore, some services are not covered by any insurance, such as Batterer's Intervention Programs, so clients are required to pay for these services out-of-pocket. When families cannot afford to pay for their services, it falls to the child welfare agencies to cover the costs, but as described earlier, child welfare professionals expressed that it is often difficult to get the necessary authorization from the CBC lead agencies. Comments from child welfare professionals suggest that this is particularly the case for families receiving diversion services, and this may serve as another incentive to bring the family into the dependency system. "It's pretty much impossible [to get services for families] without health insurance, unless you go through like dependency, basically," one investigator concluded. A number of participants noted that dependency cases are sometimes initiated, just so the family can get access to the services and resources they need.

Other barriers that impede families' access to services include transportation and cultural or language issues. A number of the focus group communities reported having limited or non-existent public transportation systems. Rural communities in particular indicated that lack of transportation was a considerable challenge. Counties that are large geographically but have services that are concentrated within a relatively small area also problematic, as families in some parts of the county must travel substantial distances in order to access services. Even where public transportation is available, it may take several hours for a family to get to an appointment.

The cultural diversity of the families served by the child welfare system can also make it challenging for child welfare professionals to identify appropriate services. Sometimes finding a provider who speaks the family's language is not possible. Spanish-speaking services are more

readily available in a number of communities, but child welfare professionals noted that they deal with many different ethnic populations, including a burgeoning Haitian population in some communities and individuals from various parts of Latin America, some of whom speak indigenous languages. It was noted in one focus group that they do have the Language Line, a phone-based interpreter service, which offers interpretation for a variety of languages, but child welfare professionals expressed that they do not have interpreters for every language. In addition, some families may require assistance with their comprehension skills, as they may not understand the concepts used by providers, child welfare professionals, and other stakeholders involved in their case. Thus, communicating effectively with clients from diverse backgrounds was viewed as a critical skill that many service providers lack.

In addition to challenges with the limited availability and accessibility of a variety of services, participants expressed concerns about the quality and effectiveness of available services. Some providers were perceived as being good partners and providing high quality services. "We all have service providers that are our favorites and that we know really work well with families, so I think most case managers have an idea of where they want to refer families versus other providers," one case manager explained. Preferred providers were described as being very hands-on, providing good documentation and consistent communication to child welfare professionals, and demonstrating a willingness to testify in court. Many providers, however, did not fit this description according to participants. Concerns about the quality of service providers included providers who do minimal work, barely engage with families (e.g. spending only 5-10 minutes with the family for appointments), and provide limited and poor communication about the clients' progress to child welfare professionals.

Domestic violence services, such as batterers' interventions, were especially regarded as being ineffective, as were many of the available substance abuse services. The quality of mental health services within some communities was also considered questionable. Concerns were expressed that many providers, such as counselors, are not licensed, since many agencies use registered interns. In addition, there was a perception that many providers are overburdened, which further contributes to poor quality work.

Child welfare professionals perceived poor service provision as contributing to case failure and families re-entering the system. According to one case manager, "I think if we had quality services, then maybe we wouldn't see this continuous cycle of people entering the child protection system." Most participants reported having at least some issues with the quality of services and providers available in their community.

In addition, indicated that information about the effectiveness of various service interventions is generally not available for informing decisions about what services to use. In every focus group, participants indicated that they do not receive data or information about the effectiveness of specific service interventions of evidence-based practices. Many child welfare professionals were unfamiliar with the concept of evidence-based practice, and could not say whether any such services were available in their community. Overall, the dominant perception among participants was that while child welfare professionals do their best to connect families to appropriate resources, the services that families receive are often not sufficient to meet all their needs due to the issues described here with availability, accessibility, and quality.

Interagency relationships and collaboration. The final theme that emerged from the focus groups concerns interagency relationships and the ways in which these impact child welfare professionals and, ultimately, the families they serve. The child welfare system entails a network of interacting agencies and entities. Key players identified by focus group participants included child protective investigators, case managers, law enforcement, children's legal services (CLS), parent attorneys, Guardian ad Litems (GALs), judges, and service providers. Child welfare professionals emphasized that these interagency relationships are critical to the success of the child welfare system and the ability of child welfare professionals to carry out their job effectively. In discussing these relationships, they described a double-edged sword: the multi-agency structure of the child welfare system means there are multiple agencies with eyes on the children and families, who are able to bring together diverse perspectives and skill sets to meet their needs. However, the diversity of perspectives often means that not everyone is on the same page and there may be disagreement over the appropriate course of action to take with a given case. This can pose barriers to child welfare professionals as they attempt to address family needs while working with various system partners.

Collaboration among system partners was described as an important support for child welfare professionals. When they are able to bring all parties together to work towards a common goal, child welfare professionals expressed that the process runs much more smoothly. Among some case managers, for example, it was emphasized that since the court plays an important role in case decisions, it was important to build rapport with those partners so the court will take the case managers seriously. Focus group participants further described strategies that included reaching out to partners such as the GALs in advance and discussing the case status before court so there are "no surprises." In addition, it was expressed that when positive relationships were established with these partners, the child welfare professional could

utilize them to relieve some of the child welfare professional's burden. For example, case managers described that there were some GALs who helped in getting additional resources to families. Child protective investigators identified that having partnerships in place with community-based organizations facilitated the process of getting services for a family. As discussed in the previous section, having good communication and collaboration with providers was perceived as an important support. Participants particularly appreciated providers who kept them updated on a family's progress with services and were willing to testify in court.

While examples of collaborative relationships were provided at each site, overall, there was a perception of significant variability with regard to relationships with various system partners. Thus, across sites, focus group participants reported that some agencies, or in some cases certain individuals within agencies, were very communicative and collaborative, while others were not. It was reported, for example, that some providers did not keep case managers informed about clients' progress in services, when they were discharged, or when a client failed to engage in services. Among child protective investigators, relationships with law enforcement were described as highly variable. Some offices expressed that they are able to work closely with law enforcement and have very positive relationships, while others felt that law enforcement does not understand child welfare and that officers were not always sensitive as to how to work with these families.

Relationships with partners in the court system were perhaps the most tenuous from the perspective of child welfare professionals. Both investigators and case managers expressed challenges in working with CLS. A common perception was that CLS' assessment of legal sufficiency often drives removal decisions, and that there was little opportunity for child welfare professionals to discuss concerns or questions with CLS. This becomes especially problematic when child welfare professionals are blamed in court over a failure to remove unsafe children; case managers in particular felt that CLS did not have their back when this happens. Relationships with GALs were also reportedly contentious. While some GALs were reported to be supportive, case managers felt that the majority tended to be judgmental and "come in with their own standards" that they try to apply to families. Communication with GALs was described as poor or severely lacking among many case managers, which often resulted in feelings of betrayal during court hearings. Case managers described having numerous experiences in which the GAL reported something in court that they had never communicated to the case manager previously and that contradicted the information reported by the case manager. Such incidents make the case manager look bad in front of the judge and can have serious implications for the case, as it was reported that the opinions of GALs were typically taken more

seriously in court than those of the case managers. This was a source of much frustration for case managers, who expressed feeling as though they spend the most time with the family, but their opinions are not valued. Judges were similarly reported to be highly variable, with some taking a very pro-family stance, and others who are very critical of families. This can also have a significant impact on a case, as the judge may challenge the case manager's recommendations if they do not align with the judge's personal position.

Focus groups also revealed a considerable amount of tension between case managers and child protective investigators. While there was reported variability in the relationship between case managers and investigators both by county and among individual child welfare professionals, a lack of cohesion between the two entities emerged as a widespread problem. Once again, the early implementation stage of the practice model is an important contextual factor in considering these findings. In a previous section, it was noted that there are often disagreements over safety determinations. Conversely, some investigators conveyed feeling that case managers "nit-pick" too much over minor issues, and that collaboration was hindered by a focus from CBCs and case management on only doing what is specifically required in their contracts. There was acknowledgement among some that the relationship has become increasingly strained as greater responsibilities have been shifted over the years from investigators to case management. Some participants, however, identified strategies that they believed have improved the relationship in recent years. One participant described that they have increased the amount of contact between investigators and case managers during the case transfer process. Some investigators go out with the case manager to introduce them to the family and facilitate the transition. It was also noted that in some counties the child protective investigator and case management offices are co-located, which facilitates greater communication and collaboration as child welfare professionals are able to interact face-to-face on a regular basis.

One further concern expressed by case managers involved the ways in which investigators engaged with families. A number of case managers perceived investigators' interactions as often aggressive and disrespectful towards families. They also expressed that investigators often fail to adequately inform families about what to expect or in some cases actually misinform families about what will happen. Some child protective investigators also acknowledged that this is a problem, expressing agreement that there needs to be a better approach to working with families. When investigators initiate an adversarial relationship with families, it can taint the entire process moving forward and plant the seed of resistance among

families. Case managers end up inheriting these issues and must try to undo the damage that has been caused if they are going to work successfully with the family.

These discussions about interagency relationships alluded to a perception of a lack of cohesion among the various partners and stakeholders within the child welfare system. Child welfare professionals saw this as a problem that directly affects their job and their relationship with the families on their caseload. They expressed that the various agencies and stakeholders with whom they must work (e.g. CLS, parents' attorneys, GALs, judges) often have different goals and differing opinions on the direction to take with a case. In addition, not all system partners are knowledgeable about the services that are actually available in the community, which may result in service recommendations that case managers are unable to fulfill. This becomes problematic when families are promised services by other system partners (such as the parents' attorney), and then case managers have to explain to the family (and to attorneys, judges, etc.) that those services do not exist within the community.

A prominent theme was the perception that various system partners do not receive sufficient training on child welfare, which may contribute to some of the tensions and disagreements across partners. One concern expressed was a perceived failure among some providers to treat clients within the context of the family, focusing instead on clients as individuals rather than parents who need to care for their children. For example, it was reported that substance abuse providers give clients the message that "relapse is okay," but this approach fails to recognize the danger posed to children when a parent relapses

Lack of provider understanding of the child welfare system was a cause of ongoing frustration, since it resulted in families receiving different and contradicting messages from service providers that do not align with the goals or requirements of the child welfare system. Similar concerns were expressed over the lack of experience or training in child welfare among GALs, which results in some having unrealistic ideas or expectations for families. Furthermore, it was also reported that various system partners such as GALs and judges do not know or understand the child welfare practice model.

Related to the lack of knowledge about child welfare, child welfare professionals described their perceptions of a lack of respect from system stakeholders and poor understanding of the realities of casework. It was reported that other stakeholders (e.g. CLS, GALs, judges) often did not take their input, expertise, and opinions seriously. They perceived that they are treated with disrespect by various system stakeholders and their concerns about child safety and the families on their caseload are often disregarded, yet they are also the primary individuals held accountable for anything that happens on the case. Child welfare

professionals expressed feeling that system partners do not understand what their job entails, and frequently have unrealistic expectations for them.

Participants were very aware of the negative connotations and stereotypes associated with DCF and case management. They reported that they are viewed as "baby snatchers" and there is a persistent perception that they are simply out to take children away from their families. This can be a barrier to obtaining buy-in from clients. Additionally, child welfare professionals felt that the negative reputation of DCF contributes to community silence. In the words of one investigator, "Everyone goes inside, shuts the door as soon as you show up. Like, 'I'm not talking to DCF. I'm not going to be a snitch.' And it's like, 'Well, I need your help in order to protect these kids.'" Overall, child welfare professionals perceived that the system tends to be experienced by families as confusing and not user-friendly, largely as a result of the poor cohesion and conflicting perspectives across agencies and stakeholders. This perception tends to exacerbate the hostility and resentment frequently exhibited by system-involved families. Child welfare professionals expressed that they would like to see greater communication and collaboration within the system, as they perceived that when this does occur it facilitates their ability to work effectively with families and leads to better outcomes.

Summary. Findings from the focus groups reveal a number of strengths and challenges that relate to the Demonstration. One important strength is that the majority of child welfare professionals value family preservation and believe in the concept of keeping children in the home. These values place child welfare professionals in alignment with the goals of the Demonstration. At the same time, however, child welfare professionals have concerns about ensuring child safety when children remain in the home, and voiced a certain degree of distrust towards system-involved families. There was acknowledgement among some participants of the adversarial nature of the system, and numerous discussions suggested that child welfare professional practice is often coercive. That being said, child welfare professionals did emphasize the importance of family engagement and discussed their child welfare practice in terms of efforts to partner with families. Beliefs and attitudes of child welfare professionals are a critical but often overlooked component of Waiver implementation. Many child welfare professionals expressed support for in-home services, but more can be done to increase their confidence in the effectiveness of these interventions.

Focus groups also underscored assessment as a critical component of casework and the value of conducting a holistic and comprehensive assessment. Discussions emphasized the utilization of multiple methods and data sources to identify family needs, particularly the use of collateral contacts such as extended family, neighbors, and school personnel. Many

participants expressed that the use of such a holistic approach contributes to better identification of appropriate services to address family needs. Some expressed concern over how invasive the process seems to be for families. Child protective investigators did not necessarily perceive the new practice model as impacting the way they make safety decisions, although they were still in the early implementation stage at the time of the focus groups. Many child welfare professionals expressed having trouble understanding the distinction between risk and safety, as well as when to offer voluntary versus mandatory services. Responses suggest that there may be a tendency to remove children in situations where court-ordered in-home services could be appropriate because child welfare professionals believed all in-home services were voluntary, or in some cases were instructed by CLS to remove children if there was enough evidence for a court order. More training and guidance are needed to support child welfare professionals in making appropriate case decisions with regard to the use of in-home versus out-of-home interventions. Child welfare professionals expressed the need for more hands-on and field-based training incorporated into pre-service training to better prepare child welfare professionals for the job.

Several challenges were identified that affect the use of in-home services. One challenge was limited availability or accessibility of appropriate services to meet the needs of families. Having a diverse and robust service array was described as a critical support and is one of the goals of the Demonstration. Most participants reported challenges that included a lack of certain needed services, long waitlists for services, lack of transportation, and barriers created by insurance or lack thereof. The most frequently reported service needs included affordable housing, child care, substance abuse treatment, and more providers who go to the home. Relatedly, the perceived liability that is placed on child welfare professionals has a strong impact on decision-making processes. Most child welfare professionals in the focus groups expressed feeling that they are held solely accountable for what happens on their case, and this fear that they will be held personally responsible if something happens to a child under their care appears to drive a greater inclination to remove children. Excessive workloads and high caseloads further add to this strain and limit the amount of time child welfare professionals spend on each case.

Finally, an area in need of improvement is child welfare system collaboration and cohesion. Although examples of good collaborative relationships were provided by some participants, by and large participants expressed that the various agencies and stakeholders with whom they must work (e.g. CLS, parents' attorneys, GALs, judges, providers, etc.) are often not on the same page. Although having multiple stakeholders with diverse perspectives

was acknowledged as a strength of the child welfare system, participants felt that these stakeholders frequently do not work well together and do not always agree on the best way to proceed with a particular case. Furthermore, participants perceived that their input, expertise, and opinions were often not taken seriously by others, and reported that they were treated with disrespect by various system stakeholders. This lack of cohesion across the system and the devaluation of child welfare professionals contribute to challenges in the ability of child welfare professionals to work effectively with the families on their caseload, as they attempt to balance the differing demands of various stakeholders and are frequently demeaned in front of their clients. The findings therefore indicate a need for greater communication and education about the goals of the Waiver with system stakeholders, and concerted efforts to improve system collaboration.

Next steps. Data collection for the service array survey will be completed in April 2017, and analysis of the findings from the survey will be presented in the next progress report. Phase 1 of the evidence-based practice fidelity assessment will begin in April 2017 and will also be completed for the next progress report. Planning for Phase 2 of the evidence-based practice assessment will commence once responses from Phase 1 are received and provider agencies expressing an interest in participating have been identified. Development of the fidelity protocols for the Nurturing Parenting Program will occur during this time as well. Implementation of Phase 2 is anticipated to begin in the fall of 2017, and no later than January 2018.

Outcome Analysis

Resource Family Indicators

There were 23,579 children in out-of-home care on December 31, 2016 (Department of Children and Families, 2017). Considering the number of children served in out-of-home care, foster homes are a critical resource within the child welfare system and recruiting foster families is an important task. Therefore, the goal of this section of the report is to examine changes in the proportion of foster families who received new licenses in relation to children served in out-of-home care.

Method.

The proportion of new licensed foster families. The outcome analysis tracked changes in the number and proportion of foster families who received new licenses during five consecutive state fiscal years (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, and SFY 15-16). Proportions of newly licensed foster families and the number of children served in out-of-home care were calculated by circuit and statewide.

***Sources of data*.** The data sources for the quantitative indicators used in this report were data abstracts taken from the Florida Safe Families Network (FSFN) in October 2016.

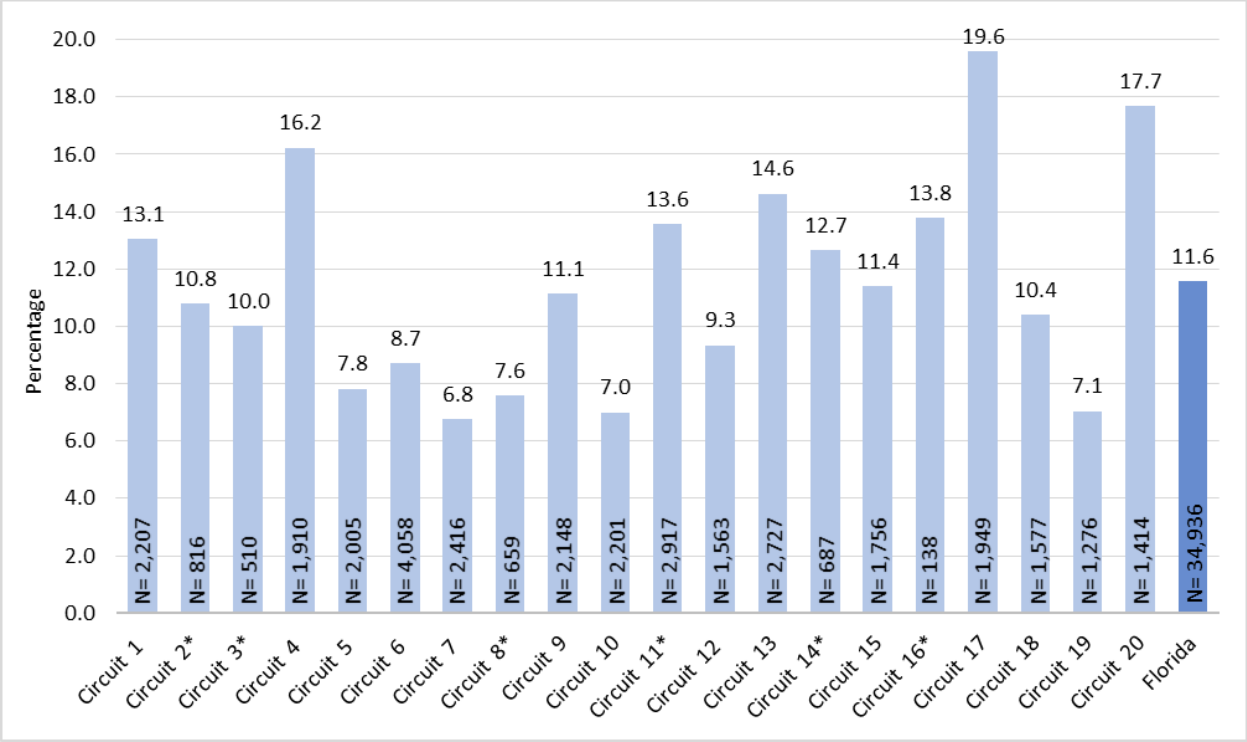
***Analytical approach*.** Statistical analyses consisted of descriptive statistics and logistic regression. All analyses were conducted using SPSS software.

Findings.

***The proportion of new licensed foster families recruited during a specific state fiscal year*.** This indicator is required under the Terms and Conditions of the evaluation, and relates to the effectiveness of the child welfare system in recruiting new foster families and the ability of lead agencies to provide a sufficient number of placements for children removed from home. All foster families who received licenses for the first time during a specific fiscal year were included (see description of the measure in Appendix E, Measure 1). The proportion of foster families recruited during a specific fiscal year was calculated based on the number of children served. Figures 2 – 6 (see also Appendix F, Tables F1- F5) show the number and the proportion of foster families who received new licenses and the number of children served during five state fiscal years by lead agency and circuit.

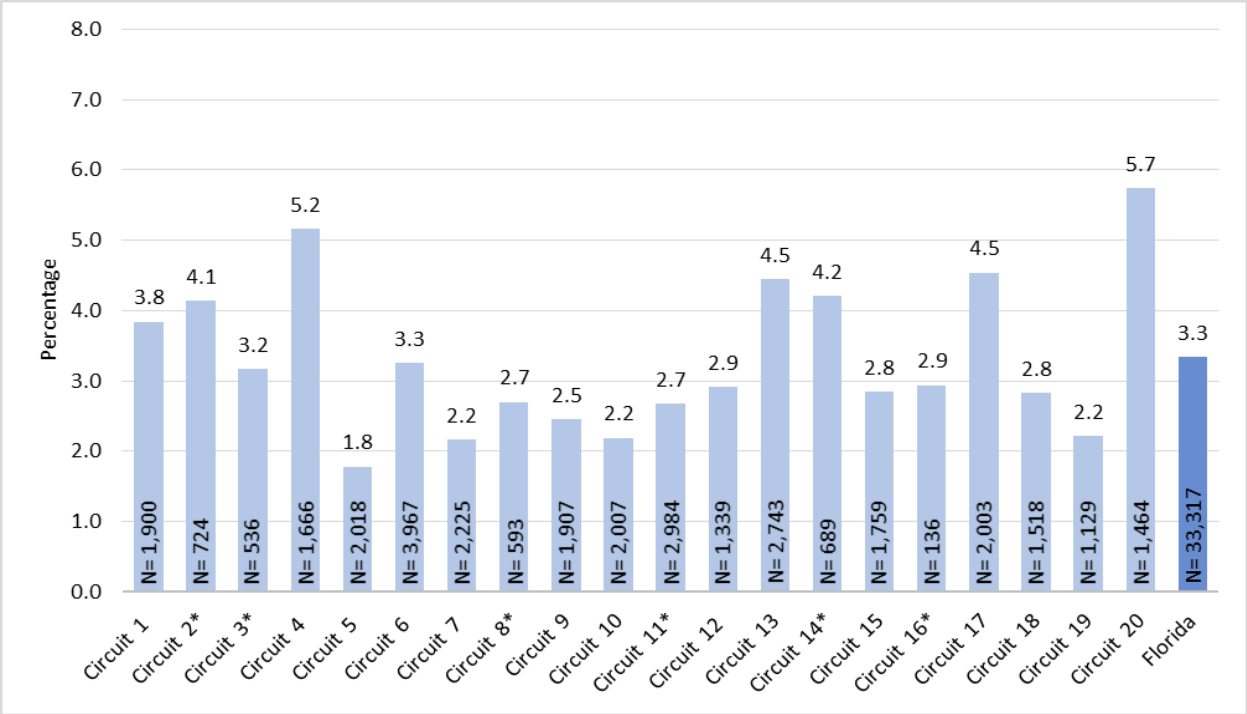
As indicated in Figure 2, during SFY 11-12 the number of foster families that received licenses ranged from 50 (Circuit 8, Partnership for Strong Families) to 399 (Circuit 13, Eckerd Community Alternatives), with an average of 199 newly recruited foster families across circuits and lead agencies. Circuit 17 (ChildNet-Broward) had the highest proportion of newly recruited families in SFY 11-12 – 19.6%, and Circuit 7 (Community Partnership for Children, Inc.) had the lowest proportion of newly recruited recruited families during this year – 6.8%.

Figure 2. Children Served in Out-of-Home Care and Proportion of New Licensed Foster Families Recruited by State Fiscal Year 2011-2012



Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

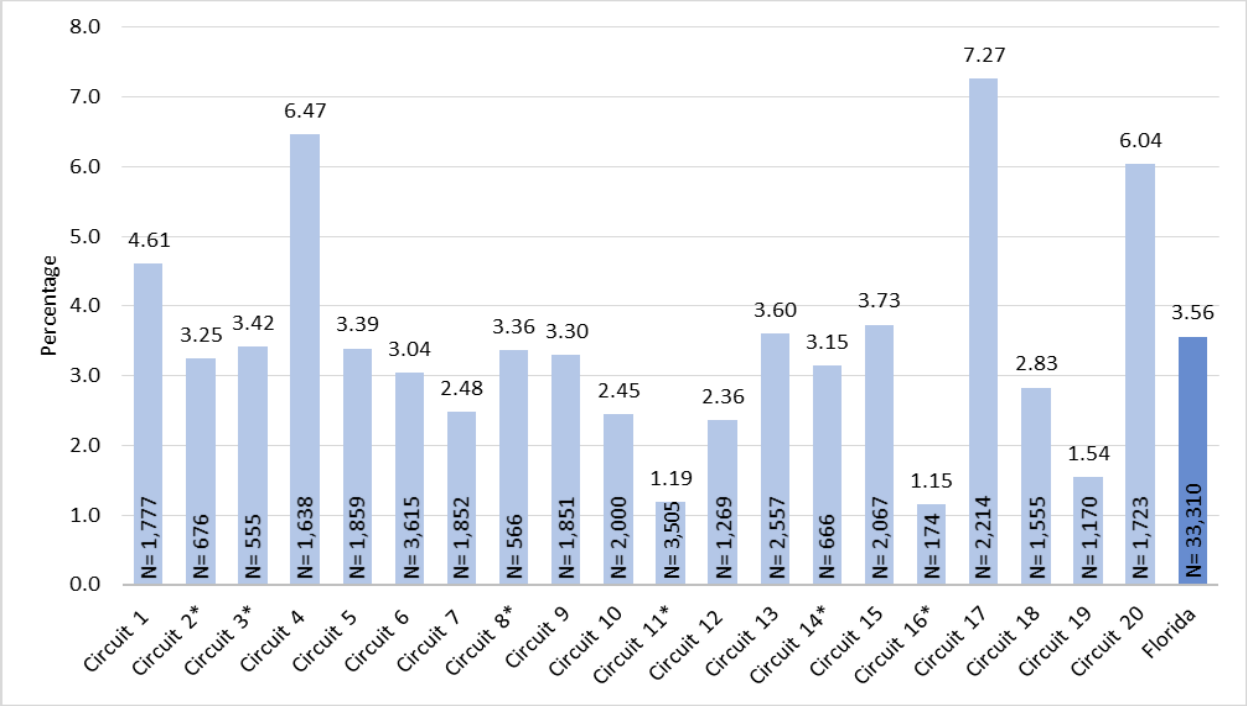
Figure 3. Children Served in Out-of-Home Care and Proportion of New Licensed Foster Families Recruited by State Fiscal Year 2012-2013



Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

When the proportions of foster families who received licenses in SFY 12-13 were examined (see Figure 3), results indicated that Circuits 20 and 4 (Children's Network of Southwest Florida and Family Support Services of North Florida, Inc) had the highest proportion of newly recruited foster families (5.7% and 5.2%, respectively). In contrast, Circuit 5 had the lowest proportion of newly recruited foster families – 1.8%. The average number of foster families who received licenses in SFY 12-13 across circuits was 55 (see Table F2, Appendix F).

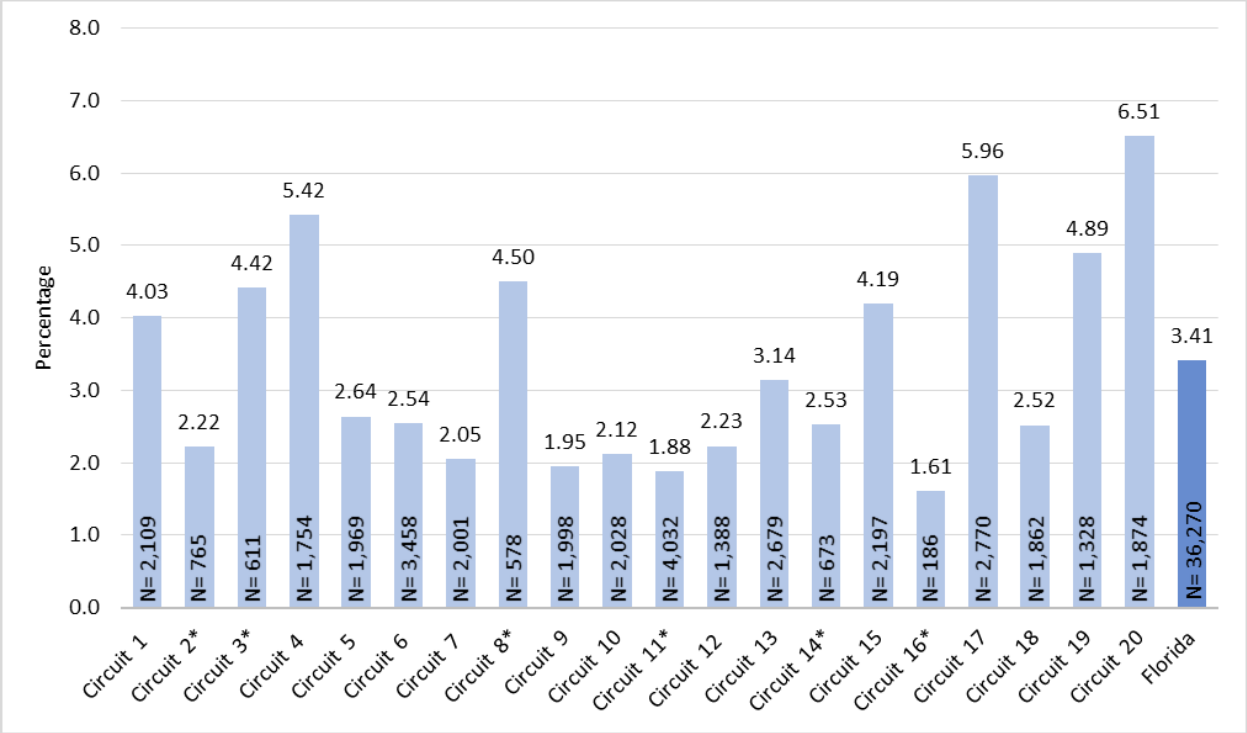
Figure 4. Children Served in Out-of-Home Care and Proportion of New Licensed Foster Families Recruited by State Fiscal Year 2013-2014



Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

As presented in Figure 4, the highest rate of newly recruited foster families identified in SFY 13-14 was for Circuit 17 (7.3%), and the lowest rate (1.2%) was for Circuits 11 and 16 (Our Kids of Miami-Dade/Monroe, Inc.).

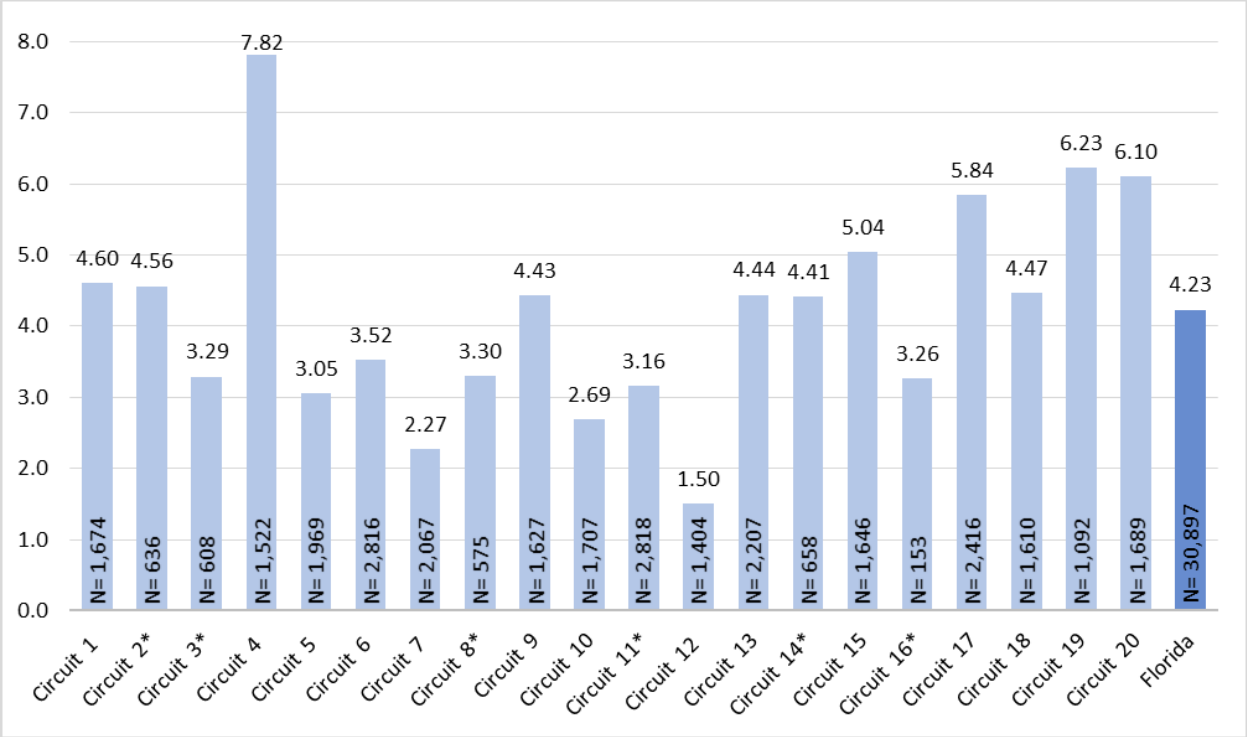
Figure 5. Children Served in Out-of-Home Care and Proportion of New Licensed Foster Families Recruited by State Fiscal Year 2014-2015



Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

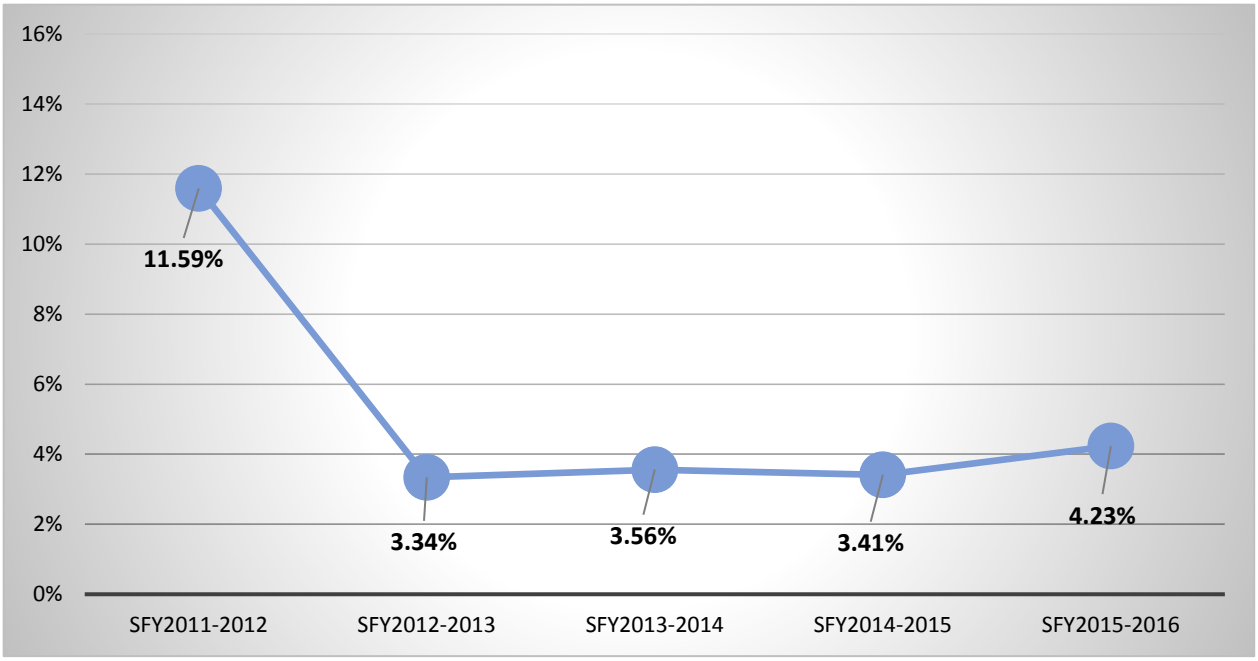
In SFY 14-15 Circuit 20 had the highest proportion of newly recruited foster families (6.5%). Circuits 11 and 16 (Our Kids of Miami-Dade/Monroe, Inc.) remained the lowest recruiting entities with an average of 1.8% (see Figure 4Y). Finally, in SFY 15-16, Circuit 4 had the highest proportion of foster families recruited – 7.8% and Circuit 12 (Sarasota Family YMCA, Inc.) had the lowest proportion of foster families who received a license that year – 1.5% (see Figure 6).

Figure 6. Children Served in Out-of-Home Care and Proportion of New Licensed Foster Families Recruited by State Fiscal Year 2015-2016



Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits

Figure 7. Proportion of New Licensed Foster Families Recruited in the State of Florida During State Fiscal Years 2011-2012 through 2015-2016



Overall, the proportion of newly licensed foster families decreased over time from 11.5% in SFY 11-12 to 4.2% in SFY 15-16, with an average across years of 5.2% (see Figure 6).

Summary. Although there is considerable variability among circuits on the measured indicator, there is a trend indicating that Circuits 4, 17, and 20 had the highest proportions of newly licensed families based on the number of children served throughout the five years. For example, in SFY 11-12 Circuit 17 had 19.6% of newly licensed families, Circuit 20 had 17.7% of foster families recruited that year, and Circuit 4 had 16.4% of newly recruited families. During the following four years the proportion of newly licensed families for Circuit 4 ranged between 5.2% and 7.8%, whereas for Circuit 17 this proportion ranged from 4.5% to 7.3%. Finally, Circuit 20 had 5.7% of newly licensed foster families in SFY 12-13 and 6.5% in SFY 14-15. Overall, the proportion of newly recruited families dropped from 11.6% in SFY 11-12 to 3.3% in SFY 12-13 and then slightly increased to 4.2% in SFY 15-16. Approximately 70% of newly recruited families were retained during the 12 month period (Vargo et al., 2016).

Limitations. First, examination of the proportions of newly recruited families did not account for lead agencies/circuits characteristics except for the number of children they served in out-of-home care. Second, the findings focused only on newly recruited families and did not account (i.e., did not include) for the number of foster families currently employed by the lead agencies. Finally, the study design did not include a comparison group (e.g., counties where

the extension of the IV-E Demonstration was not implemented), because the Demonstration was implemented statewide. Therefore, the comparison was only made among the lead agencies/circuits.

Next steps. In the next semi-annual progress report, evaluation team members will continue to track changes in the following child safety indicators: (a) proportion of children who were NOT removed from their primary caregiver(s) and were placed into out-of-home care within 12 months of the date their in-home case was opened; (b) proportion of children who did NOT reenter out-of-home care within 12 months of discharge; and (c) the number and proportion of children who did NOT experience verified maltreatment within six months of case closure (i.e. termination of out-of-home services or in-home supervision). The analysis will be extended to include two additional cohorts of children who were discharged from out-of-home care in SFY 14-15 and 15-16 to assess the trends regarding child safety.

Child and Family Well-Being

In SFY 15-16, Florida transitioned from quality of practice case reviews and quality service reviews, adopting use of the federal Child and Family Services Reviews (CFSR) Onsite Review Instrument (OSRI) and Online Monitoring System (OMS) for Florida's continuous quality improvement reports (CQI) reviews. The OSRI reflects federally established guidelines to conduct ongoing case reviews (U.S. Department of Health and Human Services, 2014; (https://training.cfsrportal.org/resources/3105#Onsite Review Instrument and Instructions). Through the use of the OSRI, CBCs review cases to ascertain the quality of child welfare practices relevant to the safety, permanency, and well-being of children.

Data sources and data collection. As shown in Table 1, child and family well-being outcomes focuses on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, and mental health needs. These outcomes are comprised of the items as shown. Florida CQI Child and Family Well-Being Outcomes 1, 2, and 3 are rated as Substantially Achieved (SA), Partially Achieved (PA), or Not Achieved (NA); accompanying items are rated as either a strength or an area needing improvement. Item ratings are used to calculate a summated rating of the items addressing each outcome. The CFSR Onsite Review Instrument and Instructions (USDHHS, 2014) includes details regarding the review process.

Table 1

CFSR Well-Being Outcomes and Items

CFSR Well-Being Outcome 1 Families have enhanced capacity to provide for their children's needs	
Item 12	Needs and Services of Child, Parents, and Foster Parents
Item 13	Child and Family Involvement in Case Planning
Item 14	Caseworker Visits with Child
Item 15	Caseworker Visits with Parents
CFSR Well-Being Outcome 2 Children receive appropriate services to meet their educational needs	
Item 16	Educational Needs of the Child
CFSR Well-Being Outcome 3 Children receive adequate service to meet their physical and mental health needs	
Item 17	Physical Health of the Child
Item 18	Mental/ Behavioral Health of the Child

Data analysis. The following shows the number of cases reviewed that have been rated as substantially achieved or as a strength for items related to well-being outcomes by Circuit. Results reported below represent finalized CQI data form the OSRI submitted on or before March 31, 2017. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17. It is important to recall that the period under review is 12 months prior to review of the case. As such, the PUR for the first quarter of SFY 15-16, is the first quarter of the previous fiscal year. Due to insufficient data, Circuit 16 has been omitted from Circuit-level analyses; only one case review was completed as of the date the CFSR data were pulled.

The Phase 4 Florida Title IV-E Waiver Demonstration Evaluation Semi-Annual Progress Report (Vargo et al., 2016b) detailed baseline CFSR ratings for in-home cases separately from out-of-home care cases to allow for comparisons to be made between the two. Findings reported here compare baseline data to ongoing CFSR ratings for both in-home and out-of-home care cases. To assess for significant differences between baseline data and data obtained through ongoing review, Wilcoxon matched-pairs signed-rank test was used. This is a non-parametric statistic used to compare ratings when the samples are not independent. This

is the most appropriate test because ongoing review ratings included data reported at baseline. Significant differences were only assessed for state-level ratings.

Findings.

CFSR well-being outcome 1. The first well-being outcome pertains to enhancement of the family's capacity to provide for the needs of their children. Four items (12-15) encompass the first well-being outcome. Item 12 is further disaggregated into items 12A, 12B, and 12C to assess how the needs of the child(ren), parents, and foster parents/caregivers, respectively, were addressed.

Item 12. This item pertains to the assessment of needs and the provision of appropriate services for children, parents, and foster parents/caregivers. Three sub-items were aggregated for this item: needs assessment and services to children, needs assessment and services to parents, and needs assessment and services to foster parents/caregivers. As shown in Table 2, statewide, 60% of in-home cases and 67% of out-of-home care cases reviewed were rated as a strength at baseline. Ongoing review shows the percentage of cases rated as a strength statewide improved to 62% for in-home cases but remained at 67% for out-of-home care cases. Significant change did not result ($p > 0.05$). Similarly, the percentage of cases rated as a strength improved with the more recent data for most circuits for both in-home and out-of-home care cases. Most notably, Circuits 8 and 13 improved by more than ten percentage points for in-home cases. Circuits 1, 3, and 8 showed the lowest percentage of cases rated as a strength; however, a substantial percent of cases were rated as a strength for Circuits 2, 14, 15, and 17 for both in-home and out-of-home care cases at both time points. With few exceptions, at the circuit-level, a greater percentage of out-of-home care cases compared to in-home cases were rated as a strength.

Table 2

Item 12: Needs and Services of Child, Parents, and Foster Parents/Caregivers

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	22% (n=7)	49	22% (n=11)	46	39% (n=19)	67	42% (n=28)
C 2	9	89% (n=8)	9	89% (n=8)	18	78% (n=14)	32	72% (n=23)
C 3	12	17% (n=2)	17	12% (n=2)	17	24% (n=4)	25	20% (n=5)
C 4	47	53% (n=25)	66	58% (n=38)	78	68% (n=53)	116	65% (n=75)

C 5	23	61% (n=14)	27	59% (n=16)	49	61% (n=30)	75	59% (n=44)
C 6	26	69% (n=18)	39	74% (n=29)	44	73% (n=32)	65	74% (n=48)
C 7	35	71% (n=25)	56	75% (n=42)	63	79% (n=50)	89	80% (n=71)
C 8	16	6% (n=1)	23	17% (n=4)	21	29% (n=6)	31	32% (n=10)
C 9	30	57% (n=17)	44	57% (n=25)	49	63% (n=31)	68	68% (n=46)
C 10	33	67% (n=22)	50	70% (n=35)	46	72% (n=33)	73	75% (n=55)
C 11	31	52% (n=16)	46	41% (n=19)	42	60% (n=25)	69	58% (n=40)
C 12	10	70% (n=7)	11	73% (n=8)	33	79% (n=26)	65	77% (n=50)
C 13	15	60% (n=9)	27	78% (n=21)	55	62% (n=34)	74	68% (n=50)
C 14	14	93% (n=13)	13	92% (n=12)	25	96% (n=24)	25	96% (n=24)
C 15	33	79% (n=26)	47	85% (n=40)	51	86% (n=44)	72	88% (n=63)
C 17	28	89% (n=25)	43	88% (n=38)	39	85% (n=33)	65	83% (n=54)
C 18	22	59% (n=13)	37	59% (n=22)	30	50% (n=15)	54	56% (n=30)
C 19	32	59% (n=19)	44	64% (n=28)	48	67% (n=32)	67	69% (n=46)
C 20	35	69% (n=24)	44	68% (n=30)	52	65% (n=34)	64	69% (n=44)
State	485	60% (n=292)	693	62% (n=429)	806	67% (n=538)	1196	67% (n=806)

Note. Figures may not total to 100% due to rounding. Data Source: CFSR Online Monitoring System Date retrieved: March 31, 2017
Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Items 12A, 12B, and 12C. As already stated, Items 12A, 12B, and 12C give more detail into how the needs of the child(ren), parents, and foster parents/caregivers, respectively, were assessed and addressed. As shown in Tables 3, 4, and 5, the percentage of cases rated as a strength varied for these three items. For in-home cases, 83% of cases reviewed were rated as a strength for addressing the child's needs relative to just 66% of cases rated as a strength for addressing the needs of parents statewide at baseline. Some improvement was observed in ongoing reviews, although not significantly ($p > 0.05$). Similarly, 87% of out-of-home care cases were rated as a strength in meeting the needs of children compared to 70% of in-home cases being rated as a strength in meeting the needs of parents. These ratings remained unchanged in ongoing review. For out-of-home care cases, the greatest percentage of cases were rated as a strength in meeting the needs of foster parents/caregivers compared to the needs of the child or parents. Marked improvements between baseline and ongoing review were observed for in-home cases in Circuit 8 (25% to 39%) and Circuit 3 (25% to 41%) in meeting the needs of

children, as well as in Circuits 8 (6% to 17%) and 13 (67% to 81%) in meeting the needs of parents. For out-of-home care cases, substantial improvements are shown in Circuit 8 (43% to 55%) in meeting the needs of children and in Circuit 18 (36% to 48%) for meeting the needs of parents.

Table 3

Item 12A: Needs Assessment and Services to Child

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	59% (n=19)	49	63% (n=31)	46	70% (n=32)	67	73% (n=49)
C 2	9	89% (n=8)	9	89% (n=8)	18	89% (n=16)	32	91% (n=29)
C 3	12	25% (n=3)	17	41% (n=7)	17	47% (n=8)	25	52% (n=13)
C 4	47	87% (n=41)	66	88% (n=58)	78	87% (n=68)	116	85% (n=99)
C 5	23	83% (n=19)	27	81% (n=22)	49	82% (n=40)	75	87% (n=65)
C 6	26	81% (n=21)	39	82% (n=32)	44	89% (n=39)	65	91% (n=59)
C 7	35	89% (n=31)	56	91% (n=51)	63	94% (n=59)	89	94% (n=84)
C 8	16	25% (n=4)	23	39% (n=9)	21	43% (n=9)	31	55% (n=17)
C 9	30	87% (n=26)	44	91% (n=40)	49	86% (n=42)	68	90% (n=61)
C 10	33	91% (n=30)	50	92% (n=46)	46	87% (n=40)	73	90% (n=66)
C 11	31	84% (n=26)	46	78% (n=36)	42	86% (n=36)	69	78% (n=54)
C 12	10	80% (n=8)	11	82% (n=9)	33	94% (n=31)	65	92% (n=60)
C 13	15	87% (n=13)	27	93% (n=25)	55	91% (n=50)	74	92% (n=68)
C 14	14	93% (n=13)	13	92% (n=12)	25	100% (n=25)	25	100% (n=25)
C 15	33	94% (n=31)	47	96% (n=45)	51	94% (n=48)	72	94% (n=68)
C 17	28	96% (n=27)	43	98% (n=42)	39	95% (n=37)	65	94% (n=61)
C 18	22	73% (n=16)	37	81% (n=30)	30	93% (n=28)	54	91% (n=49)
C 19	32	100% (n=32)	44	100% (n=44)	48	90% (n=43)	67	90% (n=60)
C 20	35	89% (n=31)	44	89% (n=39)	52	90% (n=47)	64	89% (n=57)
State	485	83% (n=401)	693	85% (n=587)	806	87% (n=698)	1196	87% (n=1044)

Note. Figures may not total to 100% due to rounding. Data Source: CFSR Online Monitoring System Date retrieved: March 31, 2017

Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Table 4

Item 12B: Needs Assessment and Services to Parents

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	25% (n=8)	49	24% (n=12)	35	40% (n=14)	52	46% (n=24)
C 2	9	100% (n=9)	9	100% (n=9)	12	83% (n=10)	25	76% (n=19)
C 3	12	17% (n=2)	17	18% (n=3)	11	9% (n=1)	16	13% (n=2)
C 4	47	60% (n=28)	66	62% (n=41)	64	73% (n=47)	96	72% (n=69)
C 5	23	70% (n=16)	27	67% (n=18)	29	66% (n=19)	52	60% (n=31)
C 6	26	81% (n=21)	39	85% (n=33)	35	74% (n=26)	54	76% (n=41)
C 7	35	74% (n=26)	56	77% (n=43)	57	81% (n=46)	80	81% (n=65)
C 8	16	6% (n=1)	23	17% (n=4)	15	27% (n=4)	23	30% (n=7)
C 9	30	63% (n=19)	44	61% (n=27)	44	75% (n=33)	59	75% (n=44)
C 10	33	76% (n=25)	50	76% (n=38)	37	70% (n=26)	60	75% (n=45)
C 11	31	65% (n=20)	46	57% (n=26)	37	73% (n=27)	53	68% (n=36)
C 12	10	80% (n=8)	11	82% (n=9)	26	85% (n=22)	47	83% (n=39)
C 13	15	67% (n=10)	27	81% (n=22)	44	66% (n=29)	58	69% (n=40)
C 14	14	100% (n=14)	13	100% (n=13)	17	100% (n=17)	17	100% (n=17)
C 15	33	85% (n=28)	47	89% (n=42)	39	92% (n=36)	51	92% (n=47)
C 17	28	93% (n=26)	43	91% (n=39)	27	85% (n=23)	45	87% (n=39)
C 18	22	64% (n=14)	37	62% (n=23)	22	36% (n=8)	42	48% (n=20)
C 19	32	59% (n=19)	44	64% (n=28)	42	62% (n=26)	58	66% (n=38)
C 20	35	69% (n=24)	44	68% (n=30)	45	71% (n=32)	54	76% (n=41)
State	485	66% (n=319)	693	67% (n=461)	638	70% (n=446)	942	70% (n=664)

Note. Figures may not total to 100% due to rounding. Data Source: CFSR Online Monitoring System Date retrieved: March 31, 2017

Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Table 5

Item 12C: Needs Assessment and Services to Foster Parents/Caregivers

	In-Home Cases				Out-of-Home Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	---	---	---	---	46	63% (n=29)	65	66% (n=43)
C 2	---	---	---	---	17	100% (n=17)	31	97% (n=30)
C 3	---	---	---	---	17	47% (n=8)	25	48% (n=12)
C 4	---	---	---	---	78	87% (n=68)	113	86% (n=97)
C 5	---	---	---	---	47	82% (n=41)	70	89% (n=62)
C 6	---	---	---	---	43	98% (n=42)	63	95% (n=60)
C 7	---	---	---	---	61	95% (n=58)	87	94% (n=82)
C 8	---	---	---	---	20	55% (n=11)	30	63% (n=19)
C 9	---	---	---	---	44	84% (n=37)	61	85% (n=52)
C 10	---	---	---	---	43	98% (n=42)	68	99% (n=67)
C 11	---	---	---	---	41	83% (n=34)	68	76% (n=52)
C 12	---	---	---	---	32	94% (n=30)	62	92% (n=57)
C 13	---	---	---	---	53	94% (n=50)	69	96% (n=66)
C 14	---	---	---	---	22	95% (n=21)	22	95% (n=21)
C 15	---	---	---	---	46	96% (n=44)	66	97% (n=64)
C 17	---	---	---	---	35	97% (n=34)	58	91% (n=53)
C 18	---	---	---	---	28	100% (n=28)	52	100% (n=52)
C 19	---	---	---	---	43	98% (n=42)	61	97% (n=59)
C 20	---	---	---	---	51	90% (n=46)	62	90% (n=56)
State	---	---	---	---	766	89% (n=682)	1133	89% (n=1004)

Note. Figures may not total to 100% due to rounding. Data Source: CFSR Online Monitoring System Date retrieved: March 31, 2017

Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Item 13. This item pertains to efforts made to involve the parents and children (if developmentally appropriate) in case planning processes. Statewide, 60% of in-home cases and 66% of out-of-home care cases reviewed were rated as a strength at baseline, as shown in

Table 6. Significant improvements were not observed in ongoing review ($p > 0.05$). Although the percentage of cases rated as a strength was similar for both in-home and out-of-home care cases for most circuits, a greater percentage of out-of-home care cases were rated as a strength, with the exception of a few circuits. A substantial percentage of in-home cases were rated as a strength for Circuits 14 (79%), 15 (97%) , and 17 (82%) at baseline and Circuits 7 (80%) , 13 (78%) and 15 (98%) by ongoing review. For out-of-home care cases, a substantial percentage of cases were rated as a strength for Circuits 2 (86%), 6 (86%), and 15 (87.5%) at baseline and for Circuits 6 (88%), 14 (85%), and 15 (91%) in ongoing review. Circuit 8 had the lowest percentage of cases rated as a strength at baseline for both in-home (12.5%) and out-of-home care cases (19%); however, these scores improved in ongoing review (17% and 23%, respectively). The number of in-home cases rated as a strength in Circuit 3 and the number of out-of-home care cases rated as a strength for Circuit 5 fell by nine percentage points in ongoing review.

Table 6

Item 13: Child and Family Involvement in Case Planning

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	22% (n=7)	49	24% (n=12)	43	35% (n=15)	62	44% (n=27)
C 2	9	56% (n=5)	9	56% (n=5)	14	86% (n=12)	28	82% (n=23)
C 3	12	33% (n=4)	17	24% (n=4)	14	21% (n=3)	22	18% (n=4)
C 4	47	66% (n=31)	66	65% (n=43)	75	72% (n=54)	113	70% (n=79)
C 5	23	61% (n=14)	27	59% (n=16)	35	69% (n=24)	58	60% (n=35)
C 6	26	69% (n=18)	39	74% (n=29)	36	86% (n=31)	56	88% (n=49)
C 7	35	74% (n=26)	56	80% (n=45)	60	60% (n=36)	85	68% (n=58)
C 8	16	12.5% (n=2)	23	17% (n=4)	16	19% (n=3)	26	23% (n=6)
C 9	30	40% (n=12)	44	36% (n=16)	48	60% (n=29)	65	58% (n=38)
C 10	33	61% (n=20)	50	56% (n=28)	42	76% (n=32)	67	79% (n=53)
C 11	31	32% (n=10)	46	28% (n=13)	39	46% (n=18)	61	44% (n=27)
C 12	10	70% (n=7)	11	73% (n=8)	29	83% (n=24)	57	82% (n=47)
C 13	15	73% (n=11)	27	78% (n=21)	51	84% (n=43)	65	82% (n=53)
C 14	14	79% (n=11)	13	77% (n=10)	20	85% (n=17)	20	85% (n=17)

C 15	33	97% (n=32)	47	98% (n=46)	48	87.5% (n=42)	68	91% (n=62)
C 17	28	82% (n=23)	43	77% (n=33)	32	75% (n=24)	56	75% (n=42)
C 18	22	64% (n=14)	37	65% (n=24)	28	46% (n=13)	50	52% (n=26)
C 19	32	53% (n=17)	44	52% (n=23)	48	67% (n=32)	65	68% (n=44)
C 20	35	71% (n=25)	44	75% (n=33)	49	63% (n=31)	61	64% (n=39)
State	485	60% (n=290)	693	60% (n=414)	727	66% (n=483)	1085	67% (n=729)

Note. Figures may not total to 100% due to rounding. Data Source: CFSR Online Monitoring System Date retrieved: March 31, 2017
Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Item 14. This item considers the sufficient frequency and quality of visits between caseworkers and children to promote achievement of case goals in ensuring the safety, permanency, and well-being of the child. As depicted in Table 7, 59% of in-home cases reviewed and 69% of out-of-home care cases reviewed were rated as a strength statewide at baseline. Ongoing review showed the percentage of cases rated as a strength improved to 60% for in-home cases but fell to 68% for out-of-home care cases. Neither change was found to be significant ($p > 0.05$). Similarly, the percentage of cases rated as a strength improved or remained unchanged for most circuits for both in-home and out-of-home care cases at ongoing review in the frequency and quality of caseworkers' visits with children. Most notably, Circuits 3 and 7 improved by seven percentage points for in-home cases, but Circuits 11 and 17 fell by seven percentage points. Although Circuit 1 showed the lowest percentage of cases rated as a strength at baseline for out-of-home care cases (20%), ongoing review showed marked improvement (30%). For ten circuits, ongoing review showed a decrease in the percentage of out-of-home care cases rated as a strength.

Table 7

Item 14: Caseworker Visits with Child

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	16% (n=5)	49	22% (n=11)	46	20% (n=9)	67	30% (n=20)
C 2	9	33% (n=3)	9	33% (n=3)	18	56% (n=10)	32	50% (n=16)
C 3	12	17% (n=2)	17	24% (n=4)	17	29% (n=5)	25	28% (n=7)

C 4	47	62% (n=29)	66	58% (n=38)	78	67% (n=52)	116	63% (n=73)
C 5	23	61% (n=14)	27	59% (n=16)	49	73% (n=36)	75	75% (n=56)
C 6	26	81% (n=21)	39	82% (n=32)	44	91% (n=40)	65	91% (n=59)
C 7	35	54% (n=19)	56	61% (n=34)	63	65% (n=41)	89	63% (n=56)
C 8	16	12.5% (n=2)	23	17% (n=4)	21	29% (n=6)	31	32% (n=10)
C 9	30	43% (n=13)	44	48% (n=21)	49	43% (n=21)	68	47% (n=32)
C 10	33	82% (n=27)	50	82% (n=41)	46	89% (n=41)	73	93% (n=68)
C 11	31	55% (n=17)	46	48% (n=22)	42	71% (n=30)	69	54% (n=37)
C 12	10	60% (n=6)	11	64% (n=7)	33	88% (n=29)	65	82% (n=53)
C 13	15	87% (n=13)	27	85% (n=23)	55	93% (n=51)	74	89% (n=66)
C 14	14	86% (n=12)	13	85% (n=11)	25	92% (n=23)	25	92% (n=23)
C 15	33	91% (n=30)	47	91% (n=43)	51	86% (n=44)	72	90% (n=65)
C 17	28	93% (n=26)	43	86% (n=37)	39	95% (n=37)	65	94% (n=61)
C 18	22	55% (n=12)	37	57% (n=21)	30	60% (n=18)	54	59% (n=32)
C 19	32	31% (n=10)	44	34% (n=15)	48	50% (n=24)	67	52% (n=35)
C 20	35	69% (n=24)	44	75% (n=33)	52	77% (n=40)	64	75% (n=48)
State	485	59% (n=287)	693	60% (n=417)	806	69% (n=557)	1196	68% (n=817)

Note. Figures may not total to 100% due to rounding. Data Source: CFSR Online Monitoring System Date retrieved: March 31, 2017
Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Item 15. This item considers the sufficient frequency and quality of visits between caseworkers and children's parents to promote achievement of case goals in ensuring child safety, permanency, and well-being. As shown in Table 8, statewide, 44% of in-home cases and 36% of out-of-home care cases reviewed were rated as a strength at baseline. Improvements were observed in ongoing review, although not significantly ($p > 0.05$). For most circuits and statewide, a greater percentage of in-home cases compared to out-of-home care cases were rated as a strength in the frequency and quality of caseworkers' visits with children's parents. However, ongoing review showed the percentage of out-of-home care cases rated as a strength improved for eleven circuits. Most notably, Circuits 1 and 18 improved by ten or more percentage points. The lowest percentage of cases rated as a strength in ongoing review for both in-home and out-of-home care cases was observed for Circuits 3 (6% and 0%, respectively) and 8 (4% and 9%, respectively).

Table 8

Item 15: Caseworker Visits with Parents

	In-Home Cases				Out-of-Home Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	32	19% (n=6)	49	20% (n=10)	36	28% (n=10)	53	38% (n=20)
C 2	9	67% (n=6)	9	67% (n=6)	11	64% (n=7)	23	48% (n=11)
C 3	12	8% (n=1)	17	6% (n=1)	11	0% (n=0)	16	0% (n=0)
C 4	47	49% (n=23)	66	56% (n=37)	63	51% (n=32)	94	51% (n=48)
C 5	23	26% (n=6)	27	30% (n=8)	26	31% (n=8)	46	26% (n=12)
C 6	26	54% (n=14)	39	56% (n=22)	32	59% (n=19)	51	63% (n=32)
C 7	35	46% (n=16)	56	52% (n=29)	55	24% (n=13)	76	30% (n=23)
C 8	16	6% (n=1)	23	4% (n=1)	14	7% (n=1)	22	9% (n=2)
C 9	30	30% (n=9)	44	30% (n=13)	43	30% (n=13)	57	32% (n=18)
C 10	33	70% (n=23)	50	66% (n=33)	37	43% (n=16)	60	50% (n=30)
C 11	31	26% (n=8)	46	24% (n=11)	38	26% (n=10)	54	20% (n=11)
C 12	10	50% (n=5)	11	55% (n=6)	24	71% (n=17)	44	66% (n=29)
C 13	15	80% (n=12)	27	78% (n=21)	45	40% (n=18)	58	43% (n=25)
C 14	14	79% (n=11)	13	85% (n=11)	16	56% (n=9)	16	56% (n=9)
C 15	33	55% (n=18)	47	66% (n=31)	38	50% (n=19)	50	56% (n=28)
C 17	28	64% (n=18)	43	65% (n=28)	24	29% (n=7)	42	36% (n=15)
C 18	22	55% (n=12)	37	54% (n=20)	22	14% (n=3)	42	26% (n=11)
C 19	32	31% (n=10)	44	36% (n=16)	42	19% (n=8)	58	26% (n=15)
C 20	35	40% (n=14)	44	41% (n=18)	44	25% (n=11)	52	25% (n=13)
State	485	44% (n=214)	693	47% (n=323)	621	36% (n=221)	914	39% (n=352)

Note. Figures may not total to 100% due to rounding. Data Source: CFSR Online Monitoring System Date retrieved: March 31, 2017

Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Well-Being outcome 1 ratings. Table 9 details ratings for this outcome pertaining to families having the enhanced capacity to provide for their children's needs. The ratings shown are a compilation of the ratings for items 12 through 15. Statewide, 45% of in-home cases and 53% of out-of-home care cases met the standards for substantial achievement of Well-being

Outcome 1 at baseline. Ongoing review showed only slight improvement (to 46% and 54%, respectively) though not significantly ($p > 0.05$). At the circuit-level, although the percentage of cases rated as a strength was similar for in-home and out-of-home care cases, enhanced capacity to provide for children's' needs was greater for out-of-home care cases. The lowest percentage of cases rated as a strength for both in-home and out-of-home care cases at baseline was observed for Circuits 1 (9% and 28%, respectively), 3 (8% and 18%, respectively), and 8 (6% and 24%, respectively). Although some improvement was observed in ongoing review in Circuit 1 (to 12% and 31%, respectively), the percentage of cases rated as a strength fell for Circuits 3 (to 6% and 12%, respectively) and 8 (to 4% and 23%, respectively). For in-home cases, Circuits 7 (from 46% to 54%) and 13 (from 60% to 70%) showed marked improvement in ongoing review.

Table 9

Well-Being Outcome 1: Family's Enhanced Capacity to Provide for Children's Needs

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths SA**	**N**	**% Strengths Baseline**	**N**	**% Strengths SA**
C1	32	9% (n=3)	49	12% (n=6)	46	28% (n=13)	67	31% (n=21)
C 2	9	44% (n=4)	9	44% (n=4)	18	61% (n=11)	32	47% (n=15)
C 3	12	8% (n=1)	17	6% (n=1)	17	18% (n=3)	25	12% (n=3)
C 4	47	43% (n=20)	66	44% (n=29)	78	54% (n=42)	116	53% (n=62)
C 5	23	39% (n=9)	27	41% (n=11)	49	55% (n=27)	75	49% (n=37)
C 6	26	62% (n=16)	39	62% (n=24)	44	66% (n=29)	65	69% (n=45)
C 7	35	46% (n=16)	56	54% (n=30)	63	48% (n=30)	89	51% (n=45)
C 8	16	6% (n=1)	23	4% (n=1)	21	24% (n=5)	31	23% (n=7)
C 9	30	37% (n=11)	44	32% (n=14)	49	39% (n=19)	68	43% (n=29)
C 10	33	48% (n=16)	50	50% (n=25)	46	61% (n=28)	73	68% (n=50)
C 11	31	29% (n=9)	46	22% (n=10)	42	36% (n=15)	69	35% (n=24)
C 12	10	50% (n=5)	11	55% (n=6)	33	73% (n=24)	65	74% (n=48)
C 13	15	60% (n=9)	27	70% (n=19)	55	58% (n=32)	74	62% (n=46)
C 14	14	71% (n=10)	13	69% (n=9)	25	84% (n=21)	25	84% (n=21)
C 15	33	79% (n=26)	47	85% (n=40)	51	73% (n=37)	72	78% (n=56)
C 17	28	82% (n=23)	43	79% (n=34)	39	72% (n=28)	65	72% (n=47)

C 18	22	50% (n=11)	37	51% (n=19)	30	40% (n=12)	54	44% (n=24)
C 19	32	34% (n=11)	44	34% (n=15)	48	50% (n=24)	67	52% (n=35)
C 20	35	49% (n=17)	44	52% (n=23)	52	56% (n=29)	64	56% (n=36)
State	485	45% (n=219)	693	46% (n=321)	806	53% (n=429)	1196	54% (n=651)

Note. Figures may not total to 100% due to rounding.
Note. SA= Substantial Achievement
Data Source: CFSR Online Monitoring System
Date retrieved: March 31, 2017
Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

CFSR well-being outcome 2. The second well-being outcome pertains to receipt of appropriate services to meet the educational needs of children. Only one item encompasses this outcome which evaluates efforts made to assess children's educational needs and appropriately address those needs. To avoid redundancy, since the results of Item 16 mirror those of Well-Being Outcome 2, only the results of the Outcome 2 will be shown. Also, due to the few number of applicable in-home cases at the circuit level, caution should be taken when interpreting results for in-home cases.

Well-Being outcome 2 ratings. Table 10 details ratings for this outcome pertaining to receipt of appropriate services to meet the educational needs of children. Statewide, 64% of in-home cases and 81% of out-of-home care cases met the standards for substantial achievement of Well-being Outcome 2 at baseline. Some improvement was observed in ongoing review (to 68% and 82%, respectively), although not significantly ($p > 0.05$). Similarly, at the circuit-level, with few exceptions, improvements were also observed between baseline and ongoing review of out-of-home care cases. Over 80% of out-of-home care cases were rated as a strength for nine circuits at baseline. Ongoing review showed eleven circuits with 80% or more cases rated as a strength. Most noticeably, 100% of cases were rated as a strength for Circuit 2 and Circuit 14. The lowest percentage of out-of-home care cases rated as a strength at baseline was observed for Circuits 3 (55%) and 8 (29%), however, Circuit 3 saw marked improvement in ongoing review (to 63%).

Table 10

Well-Being Outcome 2: Appropriate Services to Meet Children's Educational Needs

	In-Home Cases				Out-of-Home Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths SA**	**N**	**% Strengths Baseline**	**N**	**% Strengths SA**
C1	6	17% (n=1)	9	22% (n=2)	36	69% (n=25)	51	78% (n=40)
C 2	3	100% (n=3)	3	100% (n=3)	16	100% (n=16)	28	96% (n=27)
C 3	0	---	0	---	11	55% (n=6)	19	63% (n=12)
C 4	8	62.5% (n=5)	12	75% (n=9)	61	89% (n=54)	94	89% (n=84)
C 5	5	80% (n=4)	5	80% (n=4)	39	85% (n=33)	55	84% (n=46)
C 6	14	71% (n=10)	17	76% (n=13)	33	76% (n=25)	46	83% (n=38)
C 7	3	100% (n=3)	3	100% (n=3)	45	80% (n=36)	68	84% (n=57)
C 8	2	0% (n=0)	2	0% (n=0)	14	29% (n=4)	21	29% (n=6)
C 9	3	67% (n=2)	4	75% (n=3)	38	92% (n=35)	57	93% (n=53)
C 10	7	43% (n=3)	12	67% (n=8)	35	94% (n=33)	57	96% (n=55)
C 11	22	77% (n=17)	36	75% (n=27)	35	77% (n=27)	62	69% (n=43)
C 12	6	67% (n=4)	7	71% (n=5)	26	81% (n=21)	55	84% (n=46)
C 13	7	86% (n=6)	14	79% (n=11)	47	79% (n=37)	63	79% (n=50)
C 14	0	---	0	---	22	100% (n=22)	22	100% (n=22)
C 15	7	71% (n=5)	10	80% (n=8)	44	91% (n=40)	60	92% (n=55)
C 17	1	100% (n=1)	1	100% (n=1)	38	74% (n=28)	54	75% (n=48)
C 18	3	67% (n=2)	4	75% (n=3)	26	77% (n=20)	47	85% (n=40)
C 19	2	0% (n=0)	2	0% (n=0)	41	76% (n=31)	54	74% (n=40)
C 20	7	14% (n=1)	7	14% (n=1)	42	71% (n=30)	52	75% (n=39)
State	107	64% (n=68)	149	68% (n=102)	649	81% (n=523)	975	82% (n=801)

Note. Figures may not total to 100% due to rounding.
Note. SA= Substantial Achievement
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Date retrieved: March 31, 2017
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CFSR well-being outcome 3. The third well-being outcome pertains to receipt of adequate services to meet the physical and mental health needs of children. Results of the items for this outcome are shown in Table 10 and 11. Again, due to the few number of

applicable in-home cases at the circuit level, caution should be taken when interpreting results for in-home cases.

Item 17. This item addresses accurate assessment and receipt of appropriate services for the physical health needs of children. This item also addresses children's dental health needs. As shown in Table 11, 64% of in-home cases and 77% of out-of-home care cases reviewed were rated as a strength at baseline. Ongoing review showed a slight decline for in-home cases (to 63%) and remained unchanged for out-of-home care cases. Significant change between baseline and ongoing review was not found ($p > 0.05$). At the circuit level, there was evidence of improvement in efforts to assess and address children's physical health in ten circuits. The lowest percentage of out-of-home care cases rated as a strength at baseline was observed for Circuits 3 (47%) and 8 (57%), however, Circuit 3 saw marked improvement of thirteen percentage points in ongoing review. Substantial improvement was also observed for Circuit 18 (from 67% to 78%).

Table 11

Item 17: Physical Health of the Child

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	7	43% (n=3)	12	50% (n=6)	46	59% (n=27)	67	61% (n=41)
C 2	1	100% (n=1)	1	100% (n=1)	18	100% (n=18)	32	91% (n=29)
C 3	1	100% (n=1)	1	100% (n=1)	17	47% (n=8)	25	60% (n=15)
C 4	11	82% (n=9)	15	87% (n=13)	78	97% (n=76)	116	94% (n=109)
C 5	4	25% (n=1)	6	33% (n=2)	49	82% (n=40)	75	84% (n=63)
C 6	20	55% (n=11)	22	55% (n=12)	44	91% (n=40)	65	91% (n=59)
C 7	7	86% (n=6)	11	91% (n=10)	63	59% (n=37)	89	60% (n=53)
C 8	6	0% (n=0)	7	14% (n=1)	21	57% (n=12)	31	61% (n=19)
C 9	10	90% (n=9)	14	86% (n=12)	49	92% (n=45)	68	90% (n=61)
C 10	8	75% (n=6)	15	87% (n=13)	46	93% (n=43)	73	95% (n=69)
C 11	26	69% (n=18)	41	54% (n=22)	42	74% (n=31)	69	68% (n=47)
C 12	6	100% (n=6)	7	100% (n=7)	33	70% (n=23)	65	68% (n=44)
C 13	7	43% (n=3)	14	36% (n=5)	55	85% (n=47)	74	86% (n=64)
C 14	0	---	0	---	25	92% (n=23)	25	92% (n=23)

C 15	3	67% (n=2)	4	75% (n=3)	51	71% (n=36)	72	71% (n=51)
C 17	1	100% (n=1)	2	100% (n=2)	39	72% (n=28)	65	65% (n=42)
C 18	5	60% (n=3)	6	50% (n=3)	30	67% (n=20)	54	78% (n=42)
C 19	3	33% (n=1)	3	33% (n=1)	48	60% (n=29)	67	63% (n=42)
C 20	5	40% (n=2)	6	50% (n=3)	52	71% (n=37)	64	73% (n=47)
State	132	64% (n=84)	188	63% (n=118)	806	77% (n=620)	1196	77% (n=920)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 31, 2017
Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Item 18. This item addresses accurate assessment and receipt of appropriate services of the mental and behavioral health needs of children. Table 12 shows 71% of in-home cases and 73% of out-of-home care cases reviewed were rated as a strength at baseline. Although some improvement was observed in ongoing review (to 73% and 74%, respectively), these improvements were not found to be significant ($p > 0.05$). Eight circuits showed improvement in efforts to assess and address children's mental and behavioral health needs. Most notably, Circuits 7, 8, and 10 showed the largest margin of improvement in out-of-home care cases reviewed with an increase of thirteen or more percentage points in ongoing review. Although the lowest percentage of out-of-home care cases rated as a strength at baseline was observed for Circuits 1 (44%), 3 (27%), and 8 (0%), Circuits 1 and 8 markedly improved in ongoing review (to 51% and 15%, respectively).

Table 12

Item 18: Mental/ Behavioral Health of the Child

	In-Home Cases				**Out-of-Home Care Cases**			
	N	**% Strengths Baseline**	**N**	**% Strengths Ongoing**	**N**	**% Strengths Baseline**	**N**	**% Strengths Ongoing**
C1	17	47% (n=8)	22	52% (n=12)	27	44% (n=12)	37	51% (n=19)
C 2	0	---	0	---	14	93% (n=13)	21	86% (n=18)
C 3	1	100% (n=1)	2	100% (n=2)	11	27% (n=3)	16	25% (n=4)
C 4	19	79% (n=15)	26	77% (n=20)	45	84% (n=38)	69	87% (n=60)
C 5	6	33% (n=2)	7	29% (n=2)	20	85% (n=17)	33	82% (n=27)
C 6	14	79% (n=11)	18	83% (n=15)	22	91% (n=20)	33	88% (n=29)

C 7	12	92% (n=11)	19	95% (n=18)	31	65% (n=20)	51	78% (n=40)
C 8	6	50% (n=3)	9	44% (n=4)	8	0% (n=0)	13	15% (n=2)
C 9	13	77% (n=10)	20	80% (n=16)	23	83% (n=19)	38	87% (n=33)
C 10	14	71% (n=10)	19	74% (n=14)	22	68% (n=15)	38	82% (n=31)
C 11	20	75% (n=15)	31	71% (n=22)	28	89% (n=25)	53	75% (n=40)
C 12	3	100% (n=3)	3	100% (n=3)	22	77% (n=17)	43	77% (n=33)
C 13	6	67% (n=4)	10	60% (n=6)	37	68% (n=25)	53	66% (n=35)
C 14	3	100% (n=3)	3	100% (n=3)	17	94% (n=16)	17	94% (n=16)
C 15	17	82% (n=14)	22	86% (n=19)	33	85% (n=28)	48	85% (n=41)
C 17	4	75% (n=3)	5	80% (n=4)	28	71% (n=20)	48	73% (n=35)
C 18	6	67% (n=4)	8	75% (n=6)	15	73% (n=11)	27	63% (n=17)
C 19	4	50% (n=2)	9	78% (n=7)	34	62% (n=21)	42	64% (n=27)
C 20	13	54% (n=7)	17	53% (n=9)	27	67% (n=18)	35	63% (n=22)
State	178	71% (n=126)	251	73% (n=182)	464	73% (n=338)	715	74% (n=529)

Note. Figures may not total to 100% due to rounding.
Data Source: CFSR Online Monitoring System
Date retrieved: March 31, 2017
Note. The baseline period represents data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17; ongoing reviews are for the period under review (PUR) for SFY 15-16 through Quarters 1, 2, and 3 of SFY 16-17

Well-Being outcome 3 ratings. CFSR Well-Being Outcome 3 pertains to receipt of adequate services to meet the physical and mental health needs of children. Caution should be taken when interpreting the results for in-home cases due to the low number of applicable cases for many circuits. As shown in Table 13, 65% of in-home cases and 70% of out-of-home care cases reviewed statewide met the standards of substantial achievement at baseline in adequately servicing the physical and mental health needs of children. Ongoing review showed only slight improvement in in-home cases (to 66%) and a slight decline in the percentage of cases rated as a strength for out-of-home care cases (to 69%). These changes were not found to be significant ($p > 0.05$). Although the percentage of cases rated as a strength was similar for in-home and out-of-home care cases statewide, substantial achievement was greater for out-of-home care cases. The lowest percentage of cases rated as a strength for out-of-home care cases was observed for Circuits 1, 3, and 8 at both baseline and ongoing review, each of these circuits showed improvement (48% to 51%, 24% to 32%, and 43% to 45%, respectively). For ten circuits, ongoing review showed a decrease in the percentage of out-of-home care cases

rated as a strength. Most notably, Circuit 2 and Circuit 11 decreased by ten or more percentage points.

Table 13

Well-Being Outcome 3: Appropriate Services to Meet Children's Health Needs

	In-Home Cases				Out-of-Home Care Cases			
	N	**% Strengths Baseline**	**N**	**% Strengths SA**	**N**	**% Strengths Baseline**	**N**	**% Strengths SA**
C1	21	48% (n=10)	30	53% (n=16)	46	48% (n=22)	67	51% (n=34)
C 2	1	100% (n=1)	1	100% (n=1)	18	94% (n=17)	32	84% (n=27)
C 3	2	100% (n=2)	3	100% (n=3)	17	24% (n=4)	25	32% (n=8)
C 4	25	80% (n=20)	35	80% (n=28)	78	88% (n=69)	116	87% (n=101)
C 5	8	25% (n=2)	10	20% (n=2)	49	80% (n=39)	75	80% (n=60)
C 6	24	58% (n=14)	30	63% (n=19)	44	89% (n=39)	65	88% (n=57)
C 7	15	87% (n=13)	26	92% (n=24)	63	54% (n=34)	89	56% (n=50)
C 8	10	20% (n=2)	14	29% (n=4)	21	43% (n=9)	31	45% (n=14)
C 9	18	83% (n=15)	28	82% (n=23)	49	86% (n=42)	68	84% (n=57)
C 10	19	68% (n=13)	29	76% (n=22)	46	85% (n=39)	73	89% (n=65)
C 11	29	59% (n=17)	44	48% (n=21)	42	74% (n=31)	69	62% (n=43)
C 12	6	100% (n=6)	7	100% (n=7)	33	67% (n=22)	65	63% (n=41)
C 13	8	50% (n=4)	15	40% (n=6)	55	69% (n=38)	74	66% (n=49)
C 14	3	100% (n=3)	3	100% (n=3)	25	92% (n=23)	25	92% (n=23)
C 15	17	82% (n=14)	22	86% (n=19)	51	69% (n=35)	72	68% (n=49)
C 17	5	80% (n=4)	7	86% (n=6)	39	59% (n=23)	65	54% (n=35)
C 18	9	56% (n=5)	11	55% (n=6)	30	63% (n=19)	54	65% (n=35)
C 19	6	50% (n=3)	11	73% (n=8)	48	50% (n=24)	67	55% (n=37)
C 20	16	50% (n=8)	21	52% (n=11)	52	63% (n=33)	64	61% (n=39)
State	243	65% (n=157)	348	66% (n=230)	806	70% (n=562)	1196	69% (n=824)

Note. Figures may not total to 100% due to rounding.
Note. SA= Substantial Achievement
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Summary and next steps. Overall, ongoing reviews generally showed slight improvement for items and well-being outcomes, although, at the state-level, none of the improvements were found to be significant. Circuits 2, 10, 14, 15, and 17 most notably, stand out as consistently obtaining a higher percentage of strength ratings for many items. Circuits 1, 3, and 8, however, appear to be less effective in the quality of child welfare practices relevant to the well-being of children. Families' enhanced capacity to provide for the needs of their children, Well-being Outcome 1, continues to be an area of concern with just 54% of out-of-home care cases and 46% of in-home cases being rated as substantially achieved**.** Concentrated efforts to improve assessing and addressing the needs of parents, as well as the frequency and quality of caseworkers visits with parents would improve scores for this outcome. Ratings for in-home and foster cases were similar at both the circuit-level and state-level with one exception, a greater percentage of out-of-home care cases scored as a strength compared to in-home cases. For item 15, a greater percentage of in-home cases scored as a strength compared to out-of-home care cases.

Subsequent reports will continue to disaggregate well-being outcome findings to allow for comparisons between in-home and out-of-home care cases. Although the baseline data reported here will carry forward into the next report, findings of the ongoing review will consist of the most recent Florida CQI data available at that time (the PUR for SFY 15-16 through Quarter 1 of SFY 17-18).

Cost Analysis

The cost analysis required under the Terms and Conditions, and proposed in the Demonstration Evaluation Plan, includes a cost-effectiveness analysis examining the relationship between expenditures and outcomes. In the current report a modified cost-effectiveness analysis examines the relationships between expenditures on specific types of services (out-of-home care, prevention services, and adoption subsidies) and outcomes across circuits.

There has been considerable work on costs in child welfare. Studies typically relate the costs to the benefits of a program, although there can be a greater emphasis placed on the comparison of costs or the comparison of benefits depending on the study. For example, Zaveri, Burwick, & Maher (2014) compared four program models (Healthy Families America, Nurse Family Partnerships, Parents as Teachers, and SafeCare). A number of studies compare the costs of a program with the cost savings from improved outcomes. In general, the implementation of evidence-based practices has been associated with significant reductions in costs (Lee, Aos, & Miller, 2008). In other words, the cost of the intervention has been more than

offset by reductions in other areas. For example, Maher, Corwin, Hodnett & Faulk (2012) found that the monetary savings from the Nurturing Parenting Program were not quite sufficient to offset the costs in the short run. However, the authors note that inclusion of long-term benefits and cross system savings would likely be more than adequate to offset the costs.

A standard cost-effectiveness analysis compares the costs of the intervention with the outcomes or another measure of "effectiveness." Equation (1) summarizes a standard cost-effectiveness computation where *i* denotes the intervention and *c* the control group:

$$\textit{Incremental Cost-Effectiveness Ratio} = (\Delta \text{ Cost}_i/\Delta \text{ Outcome}_i) - (\Delta \text{ Cost}_c/\Delta \text{ Outcome}_c) \quad (1)$$

In essence, the formula computes the cost associated with a one-unit improvement in outcomes. The service or intervention with the lower cost per unit of improvement in the outcome is the more cost-effective option.

There are several requirements for a cost-effectiveness analysis to be performed. First, there must be data available on outcomes and the cost of services. Second, there must be variation in outcomes between the treatment and comparison groups. In the absence of significant differences in outcomes, a cost-effectiveness analysis becomes a simple comparison of costs.

There are numerous challenges with performing a cost-effectiveness analysis of the Demonstration. A number of outcome variables have been computed and presented in previous Demonstration project semi-annual evaluation progress reports. While several outcomes are available at the child-level, statewide cost data at the individual level are not available, nor are data available on specific services provided to families and youth. As noted above, most studies examining cost-effectiveness have focused on specific interventions (e.g., the Nurturing Parenting Program). Given the lack of available data, the evaluation team cannot assess the cost-effectiveness of specific interventions or programs. A second challenge to conducting cost-effectiveness analysis is that the Demonstration wasn't implemented with a framework that included explicit comparison groups. The Demonstration is statewide, and thus all children and youth who are eligible to receive the intervention services. Third, typically an economic cost analysis includes both direct and indirect costs associated with the intervention. Direct costs include personnel costs (salary and benefits) for staff involved in service delivery and purchases directly related to the intervention. Indirect costs often include the value of the study participant's time. Data on indirect costs, even at an aggregated level, are not available for this analysis. Fourth, the Demonstration was designed to be cost neutral (in terms of IV-E dollars) and thus was not intended to produce a change in costs. Thus, there is no clear marginal cost associated with the Demonstration. Florida has increased investment overtime in

independent living, maintenance adoption subsidies, and case management as part of an increased investment in permanency solutions, while also managing a relatively recent uptick in children and youth coming into care. Thus, there may be a change in total costs due to a number of other factors and not the Demonstration.

Given these important challenges, there are several differences between the analysis in this report and a standard cost-effectiveness analysis. First, as noted above, we do not have a comparison group. Instead, the relationship between costs and outcomes is examined across circuits. Second, given the lack of data on indirect costs, this analysis focuses on direct costs only. Third, given that the Demonstration does not have an explicit cost, we cannot examine the cost of the intervention specifically; however, the model itself from a comprehensive perspective places more focus on permanency and reunification goals, which by effect can be demonstrated by a differentiation of investment levels from out-of-home care/foster care spending to a much higher investment in in-home services, adoption subsidy and supports, as well as prevention services, including services around independent living post age 18. The Department did not use Waiver funds to cover these costs, but rather they provided more funding to meet the increased demands in maintenance adoption subsidies. The state shifted investment to the front-end of the model with the goal of maintaining the family safely or finding a permanency solution like adoption. Thus, instead of looking at changes in total costs, the analysis looks at changes in the distribution of spending. In summary, this analysis examines the relationship between the distribution of direct costs and outcomes for each DCF Circuit. The following sections provide more detail on the outcome and expenditure data used in the analysis, as well as additional information on the methodology.

Methods

Outcomes data. Eleven outcomes have been reported by year and circuit in previous Semi-Annual reports as part of the Demonstration Evaluation. For a full description of how each outcome was computed, please refer to the identified Semi-Annual report.

The following indicators were included in the *Florida Title IV-E Waiver Demonstration Project Extension Semi-Annual Report #2*:

- Proportion of children and youth who achieved permanency within 12 months of removal (Permanency);
- Median length of stay in out-of-home care (Length of stay);
- Proportion of children and youth who were reunified within 12 months of removal (Reunification);

- Proportion of children and youth who exited out-of-home care into permanent guardianship (i.e., long-term custody or guardianship by relatives or non-relatives) within 12 months of removal (Guardianship);
- Proportion of children and youth who were adopted within 24 months of removal (Adoption).

The following indicators were included in *Phase 3- Florida's Title IV-E Demonstration Evaluation Semi-Annual Progress Report (09/2015-03/2016)*:

- Rate of verified maltreatment as a proportion of the State's child population (Maltreatment rate);
- Proportion of children and youth who were NOT removed from their primary caregiver(s) or placed into out-of-home care within 12 months of the date their in-home case was opened (Remained in-home);
- Proportion of children and youth who did NOT re-enter out-of-home care within 12 months of discharge (No reentry).

The following indicators were included in *Phase 4- Florida's Title IV-E Demonstration Evaluation Semi-Annual Progress Report (04/2016-09/2016)*:

- Rate of abuse or neglect per day while in out-of-home care (Abuse in foster care);
- The number and proportion of new licensed foster families that were recruited during a specific fiscal year and have remained in an active status for at least 12 months (New foster families);
- The average number of months that licensed foster families remain in an active status (Months active).

These 11 variables served as the outcomes for the cost analysis.

Expenditures. Data for each CBC were provided by the DCF Office of Financial Management. Specifically, total expenditures for numerous service categories were reported by fiscal year (SFY 11-12 through SFY 15-16). The *Phase 4 Title IV-E Demonstration Evaluation Semi-Annual Progress Report* presented the proportion of total expenditures spent on out-of-home care services, residential group care services, prevention services, maintenance adoption subsidies, and case management services. Categories included dependency case management (OCA DCM00), prevention services for families not currently dependent (OCA PVS00), maintenance adoption subsidies from IV-E funds (OCA WR001), licensed foster care (OCA LCFH0), and licensed residential group home care (OCA LCRGE). The same service categories are used in this analysis. In addition, three of the expenditure categories are associated with out-of-home care. Thus, these three service categories -- dependency case

management, licensed foster care, and licensed residential group care -- are combined into a single out-of-home service category. Proportions are used instead of nominal dollars because the number of families and youth served varies considerably across circuits. Thus, differences in dollars across circuits are more likely to reflect size of the operation, and not a particular emphasis on in-home versus out-of-home services. In addition, saving money is not a primary goal of the Demonstration. Rather, the goal is to better match services with the needs of families and youth in order to improve outcomes. While it would be preferable to examine specific programs or services that the Demonstration may enable lead agencies to implement instead of service categories, such detailed data are not available.

Research questions.

1) How did the outcomes change between the pre- and post-Demonstration extension periods across circuits?

2) How did the distribution of expenditures change between the pre- and post-Demonstration extension periods across circuits?

3) What was the relationship between changes in the distribution of expenditures and changes in outcomes across circuits?

Why would the distribution of costs be related to outcomes? The distribution of expenditures may be related to outcomes for numerous reasons. For example, the distribution may reflect an overall philosophy of the lead agency (or lead agencies) operating in a circuit. Lead agencies have flexibility in the services provided to children and youth, and the Demonstration provides greater flexibility to use resources for in-home prevention services. Lead agencies may choose to devote a greater share of resources to prevention when children and youth can be kept safely in the home.

Alternatively, the distribution of spending may reflect the needs of the families and youth being served, and not an organizational philosophy. A determination that a child is unsafe often leads to the child being removed from the home. Thus, out-of-home expenditures are, to some degree, driven by the need to provide a safe setting for children and youth. Similarly, reunification is sometimes not attainable, and adoption will be the goal. Once again, it is the needs of the population being served that generates expenditures in specific service categories, not necessarily the philosophy of the organization.

Finally, an emphasis on one type of service, either due to lead agency decisions or the needs of families and children, can have implications for seemingly unrelated outcomes. For example, an emphasis on prevention services may result in some children and youth not needing to be removed from the home. These families probably had fewer challenges and

needs than families where out-of-home care was still needed. As such, a focus on prevention can result in a change in the characteristics of families in out-of-home care (because those families with fewer needs remain intact). Thus, only those families with the greatest needs are in out-of-home care, and the average length of stay for youth in out-of-home care may actually increase with the greater emphasis on prevention services.

Analysis

The analysis began with an assessment of whether there was variation in the use of the service categories across circuits, and whether there was variation across circuits in the outcome variables. Basic descriptive statistics (mean, minimum, maximum, median) were examined to determine whether there was variation in the use of services and the outcome variables. Second, the cost analysis examined the Pearson correlation coefficients to determine if there were significant associations between each of the service category variables. In order to interpret the results, it is important to understand the trade-off between expenditures. Lead agencies do not have unlimited dollars, and placing an emphasis on prevention services implies a reduction in some other area of expenditures. While the descriptive statistics provide some context, the three research questions are directly addressed in the last part of the analysis. Thus, the third part of the analysis examines changes in outcomes and expenditures for each circuit between pre- and post-implementation of the Demonstration extension. The goal is to determine whether there is a relationship between changes in expenditure patterns and changes in outcomes across circuits.

Findings

Descriptive statistics for the 11 outcome variables are provided in Table 14. There is one observation per circuit per lead agency per year. In other words, circuits in which multiple lead agencies operate have separate observations for each lead agency. Slightly more than 90% of children and youth who left out-of-home care did not re-enter out-of-home care. Nearly 90% of children and youth receiving in-home services did not require out-of-home care. Over 40% of children and youth with adoption as the primary goal in the case plan were adopted within 24 months. Comparisons of the minimum and maximum for each outcome variable suggest that there is sufficient variation around the mean to anticipate that differences in services may lead to differences in outcomes. In other words, it is likely that there is sufficient variation in services to examine the relationship between services and outcomes across circuits.

Table 14

Outcomes

Outcome	Obs	Mean	Min	Max	Median
Child Outcomes					
Remained in-home	69	89.92	79.30	96.40	90.00
Abuse in foster care	92	2.29	0.80	5.70	2.20
Guardianship	69	12.26	3.60	27.90	11.20
Adoption within 24 months	46	42.75	18.80	74.40	41.15
Reunification	69	32.05	21.00	46.20	32.10
Achieved Permanency	69	48.47	32.40	64.00	48.20
Length of stay (months)	69	12.80	10.00	17.80	12.50
No reentry	69	90.56	75.50	95.60	90.80
System Outcomes					
Maltreatment rate	92	13.63	6.65	27.74	12.90
New foster families	92	72.38	38.10	94.40	72.30
Months active (months)	84	10.29	8.00	13.00	10.00

Note. Data are from the Phase 2, Phase 3, and Phase 4 Semi-Annual Evaluation Progress Reports. All values are percentages except for length of stay and months active. A description of each outcome is provided in the data section. There is one observation per circuit per lead agency per year. The number of years data are available ranges from two (adoption, SFY2011/12 – SFY2012/13) to four (maltreatment rate, abuse in foster care, and new foster families, SFY 2011/12 – SFY 2014/15)). Data retrieved on January 15, 2017.

Spending by category is presented in Table 15. As noted above, these spending categories relate to specific OCAs and thus do not represent all spending by a lead agency. On average these service categories account for 75% of the expenditures by a lead agency, although the percentage varies between 64% and 82% in the sample time frame. Licensed foster care accounts for 5.8% of expenditures, ranging from 3.1% to 13.0%. Residential group care accounts for 10.3% of expenditures, while dependency case management represents over 40% of expenditures. Prevention services account for only 5.0% of total expenditures, while adoption subsidies represent 14.3% of expenditures. As with the service outcomes, there is considerable variation around the mean in the spending categories. Thus, it appears there is also sufficient variation in spending to examine the relationship between spending and outcomes.

Table 15

Spending by Category (n=92)

	% of total	Min	Max	Median
Foster care	5.8%	3.1%	13.0%	5.6%
Residential group care	10.3%	4.6%	22.0%	9.6%
Prevention services	5.0%	0.0%	13.2%	5.3%
Adoption subsidies	14.3%	5.4%	23.7%	14.2%
Case management	40.4%	23.6%	51.1%	40.8%

Note. Data are from the Phase 4 Semi-Annual Evaluation Progress Report. The data do not total to 100%. The analysis was limited to specific OCAs. There is one observation per circuit per lead agency per year. Data retrieved on January 15, 2017.

Before examining the relationship between expenditures and outcomes, it is important to understand the trade-off between expenditure categories. Lead agencies have flexibility in the services they provide, and the relative emphasis between in-home and out-of-home services may differ across lead agencies. Such differences should be reflected in how their expenditures are distributed between service categories. Pearson correlation coefficients are reported in Table 16. The correlation matrix was expanded to include a fourth spending category; the proportion of expenditures spent on 'other' services. This represents the percentage of expenditures not accounted for by the three primary categories. The significant negative correlations indicate a trade-off between out-of-home expenditures and prevention services, and between out-of-home expenditures and adoption subsidies. The insignificant correlation (p=.7209) indicates that there does not appear to be a significant trade-off between prevention services and adoption subsidies. Expenditures on 'other' services are also inversely related to out-of-home expenditures. Thus, consistent with expectations, changes in expenditures in one service category (prevention, adoption, 'other') are associated with changes in expenditures for out-of-home services.

Table 16

Pearson Correlation Coefficients (n=92)

	Mean	Std Dev	1	2	3	4
Percentage of Expenditures						
1. Out-of-home	0.564	0.059	--			
2. Prevention	0.050	0.032	-.539**	--		
3. Adoption subsidies	0.143	0.039	-.674**	.038	--	
4. Other expenditures	0.242	0.031	-.514**	-.038	0.004	--

Note. Data are from the Fall 2015, Spring 2016, and Fall 2016 Semi-Annual Evaluation reports. Retried January 15, 2017.

The above analysis examined differences across circuits. However, to determine whether changes in costs are associated with changes in outcomes, and whether such changes might be associated with the Demonstration extension, it is important to examine how costs and outcomes changed between a pre-Demonstration extension period and a post-Demonstration extension period. SFY 11-12 and SFY 12-13 are included in the pre-Demonstration extension period, and SFY 13-14, SFY 14-15, and SFY 15-16 are included in the post-Demonstration extension period. Several outcome variables have a single year of data in the post-Demonstration extension period (permanency, length of stay, reunification, guardianship, remained in-home, and no reentry), while others had two years of outcome data (maltreatment rate, abuse in foster care, and new foster families). One outcome (months active) had all three years of post-data, while the adoption rate had zero years of post-data.

Thus, for each expenditure category and each outcome, the difference between the pre- and post-Demonstration extension periods is examined. More specifically, the averages in the pre- and post-periods are compared to determine the direction of change. It is important to note that the pre-period in this analysis is not really a pre-Demonstration period. Florida had a Demonstration in place prior to the current Demonstration extension. Thus, the evaluation analysis of outcomes and costs focuses on whether the Demonstration extension has altered costs and outcomes relative to the original Demonstration. In addition, the Florida Department of Children and Families instituted the child welfare practice model during the same timeframe. The child welfare practice model likely resulted in changes in the same outcomes included in this report. Thus, changes in outcomes (and costs) may be attributable to the Demonstration extension, the child welfare practice model, or some other factor.

The results in Table 17 report the changes in expenditures and outcomes between the pre- and post-Demonstration periods and are used to answer Research Question #1 and Research Question #2. Among the expenditure categories, there has been an increasing trend

among the proportion of expenditures spent on adoption subsidies in 18 of the 20 circuits. There has been an increasing trend in prevention and out-of-home expenditures in expenditures in 7 of the 20 circuits. The findings for prevention services indicate that 12 circuits had an increase in the proportion of expenditures for prevention between the pre- and post-extension periods. Among the outcome variables, the analysis of pre-post changes also shows a decreasing trend in the maltreatment rate, as well as permanency through reunification or placement in permanent guardianship. In addition, there was an increasing trend in length of stay and the proportion of children and youth that received in-home services who entered out-of-home care within 12 months.

Table 17

Changes Between Pre- and Post-Extension Periods - Number of Circuits with Positive and Negative Changes

	Positive	**No change**	**Negative**
Expenditures			
Out-of-home	7	0	13
Prevention	12	0	8
Adoption	18	0	2
Child Outcomes			
Remained in-home	2	1	17
Abuse in foster care	8	1	11
Guardianship	5	0	15
Adoption	X	X	X
Reunification	4	0	16
Permanency	4	0	16
Length of stay	14	0	6
No reentry	10	0	10
System Outcomes			
Maltreatment rate	3	0	17
New foster families	13	0	7
Months active	9	3	8

Note. Data are from the Fall 2015, Spring 2016, and Fall 2016 Semi-Annual Evaluation reports. Retried January 15, 2017.

The final set of results examines the relationships between changes in expenditure shares and outcomes. The circuits are sorted into groups based on spending patterns. For example, 8 circuits had an increasing share of expenditures spent on prevention and adoption services and a decreasing percentage on out-of-home services. Another 3 had an increase in

the adoption share and a decrease in prevention and out-of-home services, while 4 circuits saw an increase in out-of-home and adoption and a decrease in prevention. Three circuits had an increase in all three spending categories; presumably accompanied by a decrease in other expenditures. Finally, there was one circuit that had a decline in all three expenditure categories, and one that had an increase in prevention and a decrease in out-of-home and adoption.

For each expenditure group, the average change in each of the outcomes was computed. The results, presented in Table 18, can be used to determine if there are any patterns between changes in expenditures and outcomes, and answer Research Question #3. The change in the proportion of children and youth in foster care who were abused was positive among circuits than had an increase in the out-of-home share of expenditures, but tended to be negative in circuits that had a decline in the out-of-home proportion of expenditures. This was the only outcome that suggested a relationship between the pattern on expenditures and changes in outcomes. Several outcomes exhibit consistent results regardless of the pattern of expenditures: rate of guardianship, length of stay, permanency, and the proportion of children and youth that receive in-home services who do not enter out-of-home care. Other outcomes have no clear pattern.

Table 18

Changes in Outcomes by Spending Groups

				Child Outcomes							System Outcomes		
Out-of-Home	Prevent	Adopt	# Circuits	Remained in-home	Abuse in foster care	Guardianship	Reunification	Permanency	Length of stay	No reentry	Maltreatment rate	New foster families	Months active
-	-	-	1	-3.85	1.15	0.2	5.7	5.5	-1.15	-2.05	0.28	10.35	1.5
-	-	+	3	-3.3	-0.23	-1.63	-3.77	-5.42	1.02	2.6	-4.22	5.52	0
-	+	-	1	-7.95	0.4	-2.45	-7.45	-10.4	3.5	1.6	-0.25	-19.8	-0.5
-	+	+	8	-2.86	-0.61	-2.41	-3.61	-5.38	2.03	-1.07	-2.39	2.81	0.29
+	-	+	4	-0.58	0.09	-3.35	0.4	-2.8	0.65	1.31	1.39	-1.9	-0.5
+	+	+	3	-1.4	0.6	-0.42	-3.65	-3.28	0.62	0.65	-2.71	4.82	1.17

Note. Data are from the Fall 2015, Spring 2016, and Fall 2016 Semi-Annual Evaluation reports. Retrieved January 15, 2017. Outcome values reflect percentage point changes except for length of stay and months active, where the changes reflect a change in mean value.

Discussion

The cost analysis examined the relationship between changes in expenditures and changes in outcomes across the 20 circuits. Instead of focusing on nominal dollars, the analysis examined the share of total expenditures spent on out-of-home care, prevention services, and adoption subsidies. The flexibility provided by the Demonstration was designed to enable lead agencies to shift resources to services that best fit the needs of families and youth. For example, being able to provide more in-home services may enable some children and youth to remain in the home and not require out-of-home care. In other words, the goal was not to save money, but to shift resources between types of services in order to improve outcomes. Indeed, one of the requirements of the Demonstration is cost neutrality. States are not allowed to use the greater flexibility in funding to reduce the level of dollars they commit to children and youth in the child welfare system.

A variety of outcomes were assessed that have been reported in prior Demonstration evaluation semi-annual progress reports. There was a clear pattern in many outcome variables. The maltreatment rate declined between the pre- and post-Demonstration extension periods. However, rates of achieving guardianship, permanency, and reunification also declined, leading to an increase in the length of stay in out-of-home care. In addition, the proportion of children and youth who received in-home services and did not require subsequent out-of-home care declined. As noted earlier though, such changes may be due to other factors (E.g., policy changes) besides the Demonstration extension.

Overall, there was a minimal relationship between changes in spending patterns and changes in outcomes. Only the rate of abuse in foster care appeared to have a relationship with spending patterns. Circuits that shifted resources from out-of-home care had lower average abuse rates in foster care compared to circuits that increased the share of expenditures spent on out-of-home services. Other outcomes showed no clear relationship with changes in expenditures.

Why is there such a limited relationship between spending patterns and changes in outcomes? First, as noted above, the pre-period in this analysis is not a pre-Demonstration period. The evaluation analysis of outcomes and costs has focused on whether the Demonstration extension has altered costs and outcomes relative to the original Demonstration. Second, the Florida Department of Children and Families is phasing in the child welfare practice model during the same time frame. The child welfare practice model may be associated with changes in the same outcomes assessed in this evaluation. It is important to include additional

years of data to determine whether this is an outcome of the child welfare practice model or merely reflects temporary effects from the implementation of a new system.

Next Steps

Upcoming analysis for the next semi-annual report will include a more detailed analysis of the expenditure data. The next report will examine how expenditures vary across CBCs based on the characteristics of children and youth served by the CBCs. Finally, aggregated expenditure data dating back to SFY 04-05 will provide information on patterns across a time period that includes a pre-Demonstration period, an (original) Demonstration period, and a Demonstration extension period. This may provide a clearer picture of the overall effects of the IV-E Waiver.

Sub-Study One: Cross-System Services and Costs

The cross system services and cost sub-study has several goals for this semi-annual report. In general, the sub-study continued to analyze the Medicaid-funded service utilization among children and youth in Florida's child welfare system. One of the primary goals of the Florida's IV-E Demonstration is to provide greater flexibility of the use of funds to better meet the needs of youth and families. To an important degree, such needs are addressed through the use of child welfare services funded by federal funding sources [e.g., Title IV-B, Title IV-E, Temporary Assistance for Needy Families (TANF), and Social Services Block Grants (SSBG)] and funds allocated to child welfare services by the Florida state government. However, the Medicaid program is also an important source of services to meet the needs of children and youth in the child welfare system. A number of salient issues and questions merit additional research. This sub-study addresses some of these questions to help better understand the physical and behavioral health care needs of children and youth when they enter out-of-home care, and the implications of those needs in terms of achieving placement stability and permanency.

This report addressed three questions related to health care service utilization among children and youth in the child welfare system. First, the report examines changes in the use of health care services between the year before removal and the year after removal from the home. Second, we considered whether the use of health care services could be used as a proxy for need, and whether health care needs were associated with the likelihood of achieving permanency. Third, we considered whether the receipt of behavioral health services while in out-of-home care can reduce the number of placements, and help avoid placements in correctional facilities. Below we discuss each question in more detail.

The first goal is to further examine health care utilization in the year prior to removal from the home, and in the year after removal. The year prior to removal marks a time period when parents continued to have considerable control for care received by children and youth. The effect of parents on the child's health care is more limited once the child enters out-of-home care. The difference in treatment between the year prior to removal and the year after removal serves as an approximate measure of how much parental behavior limited the care received by children and youth. In addition, such modelling provides a tool for anticipating the extent of unmet need when a child or youth enters out-of-home care. Children and youth with high levels of predicted unmet need could be prioritized in terms of receiving assessments so that they can be promptly connected to needed care.

The second purpose is to examine whether physical and behavioral health care needs are associated with the likelihood of the child being in a permanent placement. In order to better understand the extent to which permanency is being achieved in a timely way for children and youth placed in out-of-home care, this section of the report focuses on levels of health care utilization and its association with permanency outcomes including reunification with original caregivers, placement or guardianship with relatives or non-relatives, and adoption.

The third goal of this stub-study is to examine the stability of placements, and the likelihood of placements in correctional facilities. Placement stability is important to child well-being, but is often challenging when the child or youth has considerable behavioral health needs. This question examined whether the provision of outpatient mental health services and the provision of specific categories of outpatient services are associated with fewer placements. In addition, the sub-study examined whether provision of outpatient mental health services and specific categories of outpatient services is associated with a lower likelihood of placement in a correctional facility.

Background

Medicaid expenditures. A number of studies have examined Medicaid-funded health care services received by children and youth in the foster care system. Medicaid-funded services are appropriate for analysis because the vast majority of children and youth in the foster care system are enrolled in the Medicaid program. Children and youth in the foster care system tend to use much higher levels of both physical and mental health services than other youth (CMHS and CSAT, 2013; Gen, Sommers, & Cohen, 2005; Halfon, Berkowitz, & Klee, 1992; Harman, Childs, Kelly, & Kelleher, 2000; Takayama, Bergman, & Connell, 1994). Harman et al., (2000) found that youth in the foster care system have expenditures similar to youth eligible for Medicaid due to disability, and much greater than youth eligible due to Temporary Assistance for Needy Families (TANF).

Children and youth in the foster care system are often physically and/or emotionally abused, and frequently have unmet physical and mental health needs when entering out-of-home care (Thompson, Lindsey, English, Hawlet, Lambert, & Browne, 2007). This might imply that children and youth were not receiving adequate treatment prior to their entry into out-of-home care. There are a number of potential factors related to unmet need. One potential factor is that parents are in control of the child's health care when the child or youth resides at home. While much research has focused on the gatekeeping functions of managed care organizations and physicians, parents have considerable control over the health care received by children and youth. A lack of help-seeking behavior may be particularly prevalent in households where the

child is being abused and/or neglected, and where there are high rates of parental substance abuse and domestic violence. It is important to determine how much parental behavior limits the receipt of needed care by children and youth. Thus, unlike previous literature, this sub-study does not compare children and youth in foster care with other youth. It has been well established that children and youth in the foster care system use more services than other youth. The goal is to determine the degree to which health care expenditures changed between the year before entering out-of-home care and the year after entering out-of-home care. While not a perfect measure, it should give us some understanding of the extent of unmet need of children and youth entering out-of-home care, and enable examination of factors associated with greater unmet need.

Outcomes. Addressing the needs of families and youth is an important goal of the Demonstration. When appropriate, services should be provided in-home as long as the child is safe. However, in some cases it is necessary to remove the child. In such cases, achieving a timely permanent placement for children and youth who are in out-of-home care due to abuse, neglect, or abandonment is one of the primary goals of the child welfare system, and improving permanency outcomes is one of the key goals associated with the Demonstration project. Permanency is critical because it is inherent to the well-being of a child (U.S. Department of Health and Human Services (2014) and it is difficult to improve child well-being without achieving permanency. In addition, research has shown that children and youth are at risk to experience a variety of adverse outcomes when permanency is not achieved (Aguiniga, Madden, & Hawley, 2015; Murphy, Zyl, Camargo, & Sullivan, 2012; Newton, Litrownik, & Landsverk, 2000; Zima, Bussing, Freeman, Xiaowei, Belin, & Forness, 2000).

Although reunification is the most common permanency goal, the U.S. Department of Health and Human Services (U.S. DHHS, 2015) recognizes other ways a child can achieve permanency including placement with a fit and willing relative or non-relative custodian; acquiring legal guardianship, and adoption (U.S. DHHS, 2008). While reunification is an important permanency outcome, adoption and guardianship have become frequent permanency solutions and are regarded as positive outcomes for children and youth who cannot be reunified with their parents (Park & Ryan, 2009).

Child physical and behavioral health problems may have an important effect on the likelihood of achieving permanency. Physical health problems are common among children and youth entering out-of-home care. This reflects a combination of factors including the physical effects of maltreatment, the lack of preventative care, and in many cases, exposure to poverty. Flaherty and Weiss (1999) found that 44% of children and youth entering foster care had a

physical health problem, and Hillen and Gafson (2015) found that 35-45% of children and youth entering foster care had chronic or untreated physical health conditions. Chernoff, Coombs-Orme, Risley-Curtiss, and Heisler (1994) found that 92% of a sample of children and youth had at least one physical health problem when entering out-of-home care and 53% were referred for additional treatment. Child emotional and behavioral problems are also common among children and youth in the foster care system with 50-60% of children and youth exhibiting signs of mental health problems (Burns et al., 2004; Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Garland et al., 2000).

Studies on the relationship between physical and mental health status and child welfare outcomes have found that physical and mental health problems can play an important role in successful placement in foster care and the likelihood of reunification. For example, a number of studies have assessed the importance of placement stability in the child welfare system. Rubin, O'Reilly, Luan, and Locallo (2007) examined the relationship between placement instability and child behavior. The authors found that a greater number of placements led to poorer child behavior. Similarly, Rubin et al. (2004) examined the effect of placement stability on mental health costs among children and youth in foster care. The authors found that children and youth with more placements were more likely to have higher mental health costs. Causation could go in both directions, however, as mental health may be associated with child welfare placements. For example, Landsverk, Davis, Ganger, Newton, and Johnson (1996) found that youth with poorer psychosocial functioning at baseline had a lower likelihood of reunification. In addition, youth with physical health problems were also less likely to be reunified (Cheng & Li, 2012; McDonald, Poertner, & Jennings, 2007; Wells & Guo, 1999) or adopted (Cheng & Li, 2012; McMurtry & Lie, 1992). Similarly, youth with a mental health diagnosis spend a longer time in out-of-home care (Glisson, Bailey, & Post, 2000; Kemp & Bodonyi, 2002). In an effort to disentangle the relationship, Newton, Litrownik, and Landsverk (2000) found that youth with higher Child Behavior Checklist (CBCL) scores when entering foster care had greater instability, and that youth with greater instability had lower CBCL scores one year after entering foster care.

There are numerous reasons why child functioning may influence the likelihood of permanency. Landsverk et al. (1996) discussed three reasons related to reunification. First, children and youth identified as having special needs, such as physical and psychological problems, may be less likely to be reunified with parents that exhibited an inability to deal with such needs. Second, caseworkers may relate child functioning with household functioning. Consequently, children and youth with physical or behavioral problems may be viewed as being

at greater risk if reunified due to poorer household functioning. Third, children and youth with considerable problems may be at greater risk of maltreatment even when the caseworker does not equate youth and household functioning.

Prior research has focused on the role of child behavior in placement stability, reunification, and adoption. As noted above guardianship is also an important child welfare placement. Additional research is needed on the role of mental and physical health in the likelihood of being placed with guardians, as well as an overall measure of permanency.

Despite the importance of physical and behavioral health, direct measures of physical and behavioral health are not always available, and in other cases provide limited information. Thus, this report assesses whether service use may serve as a proxy for need. The report uses health care utilization as a measure of health care need, and compares prevalence rates derived with utilization data with prior research using direct measures.

Research Questions

1) How did the use of health care services change between the year before removal and the year after removal from the home? Can a model be developed to predict which children and youth will have a substantial increase in service utilization?

2) Are physical and behavioral health care needs associated with the likelihood of achieving permanency?

3) Is the receipt of behavioral health services while in out-of-home care associated with reductions in the number of placements, and a lower likelihood of placement in correctional facilities?

Data

The sample was identified from the Statewide Automated Child Welfare Information System (SACWIS), which in Florida is the Florida Safe Families Network (FSFN). Subjects were children and youth, ages 0-18, who were removed from their home by child protective agencies in the state of Florida from July 1st, 2011 to June 30th, 2014.

Health care need was measured by the use of health care services. Identifiers (Social Security Numbers) for children and youth who entered out-of-home care were merged with Medicaid claims and encounter data to determine health care service utilization by children and youth in the year prior to removal, and the year after removal. The specific measures differ across research questions, and described in more detail below in the methods section associated with each research question. Medicaid data were an appropriate source of healthcare information for children and youth in the child welfare system. The vast majority of children and youth become eligible for the Medicaid program upon entering out-of-home care.

In addition, most children and youth were already Medicaid enrolled in the year prior to removal due to other enrollment eligibility criteria, such as caregiver income. Indeed, children and youth entering out-of-home care who were at least one year old at removal averaged 319 days of Medicaid coverage in the year prior to removal. Thus, Medicaid funded services are likely to represent a substantial portion of healthcare received by children and youth in the year prior to entering out-of-home care.

Claims and encounter data included all fee-for-service claims, Prepaid Mental Health Plan (PMHP) encounters, Health Maintenance Organization (HMO) encounters, and encounters from the Statewide Medicaid Managed Care (SMMC) program. Prior to 2014, Medicaid enrollees had two primary options. First, there was the traditional fee-for-service program for physical health care services. Behavioral health services were carved-out and provided through the Prepaid Mental Health Plan. Alternatively, Medicaid beneficiaries could also enroll in a HMO that would be responsible for both physical and behavioral health care. Caregivers had the same options for their youth as any other Medicaid enrollee prior to the youth's removal from the home. Once the child or youth entered out-of-home care, their mental health services were provided through a PMHP specifically established for children and youth in the child welfare system. In 2014, the choice between fee-for-service and managed care was removed, and the Statewide Medicaid Managed Care (SMMC) program transitioned most enrollees in the fee-for-service program into managed care plans responsible for both physical and behavioral health. In addition, a specialty plan (Sunshine Health Child Welfare Specialty Plan) was created that specializes in providing services to children and youth in the child welfare system. Children and youth in the child welfare system may be enrolled in either a standard managed care plan or the specialty plan.

Variables. The variables used in the analyses differed across the research questions. Provided below is an overview of the variables that were used. The methods section for each research question includes a more detailed discussion of the specific measures used.

FSFN data was the source of demographic variables (age, race, gender), as well as the date the child entered out-of-home care and the reason the children and youth entered out-of-home care. Examples of out-of-home care placements include foster homes, group care homes, residential care, licensed kinship care, and approved relative and non-relative placements. Reasons for entering out-of-home care include abuse, neglect, threatened harm, and care unavailable. Abuse includes physical abuse, sexual abuse, or emotional abuse. Neglect consists of both physical neglect, such as being withheld appropriate access to food and water, and medical neglect, such as denial of access to necessary healthcare services.

Threatened harm is composed of prospective physical abuse, prospective sexual abuse, and prospective emotional abuse. In these cases, children and youth were threatened with harm, but no abuse had yet occurred. Care unavailable includes cases where the caregiver is incarcerated or upon caregiver death. The lack of a caregiver is not technically considered maltreatment, but requires action by the Department of Children and Families.

Child welfare outcomes were defined based on the placement of children and youth. Permanency is a primary goal when children and youth enter out-of-home care. Permanency can mean being reunified with caregivers (usually parent or parents), being adopted, or being placed into guardianship. A guardianship is considered a long-term placement although the parents do not legally lose their parental rights. The following permanency indicators were examined: proportion of children and youth who achieved permanency within 12 months of removal; proportion of children and youth who were reunified within 12 months of removal; proportion of children and youth who exited out-of-home care into permanent guardianship (i.e., long-term custody or guardianship by relatives or non-relatives); and proportion of children and youth who were adopted within 24 months. The National Standard for permanency in 12 months for children and youth entering foster care is 40.5% (U.S. DHHS, 2015).

A number of additional variables were utilized. First, there was a dichotomous variable denoting whether there was proof of domestic violence in the home. In addition, assessments were made concerning whether there was inadequate supervision, poor housing, or whether caregivers voluntarily give up custody (abandonment, relinquish custody, adoption dissolution). Finally, a variable was available in the FSFN system denoting if the child had extremely severe emotional and/or behavioral problems; in other words, very severe behavioral problems that are well above the criteria for severe emotional disturbance (SED).

Medicaid data provided information on each service received by children and youth. Data was available on the dates of service, diagnoses, units of service, and expenditures for each service. Expenditures denoted the amount paid to the provider of service by the Medicaid program (when the youth was enrolled in the fee-for-service program) or the managed care organization (when the youth was enrolled in a Medicaid HMO or a SMMC plan). Services were classified as physical or behavioral health based on the primary diagnosis on the claim or encounter. Health care utilization was examined in the year prior to removal and the year after removal. Services were classified based on the primary diagnosis (a primary diagnosis of ICD-9 290-319 denoted behavioral health services) for the claim/encounter and the service type (some provider types and procedure codes are specific to behavioral health conditions) listed on the claim/encounter.

Research Question One

Methods. The analysis began with an assessment of descriptive statistics for the sample. Children and youth may have been removed from their home multiple times. As such, to more precisely measure the impact of parental behavior, we limited the sample to the first observation for each child or youth in this analysis. In addition, children and youth were not necessarily observed for a full year prior to entering out-of-home care or after entering out-of-home care. Children and youth may not have been eligible for Medicaid for the entire year prior to removal. In addition, approximately one-third of children and youth were reunified with their parents during the first year after removal. Children and youth who were reunified were retained in the sample, but the health care services received after reunification were excluded because there was a combination of parental influence and potentially continued oversight by case managers. Thus, expenditures were annualized for the period before and after entering out-of-home care using the following formula:

Annualized expenditures = Expenditures/Proportion of year

In the year prior to removal, the proportion denoted the proportion of the year the child or youth was Medicaid enrolled. In the year after removal, it was the proportion of the year before reunification occurred. The extrapolation to a full year can result in biased standard errors. Thus, observations were weighted by the proportion of the year. For children and youth with a full year of data, the weight was 1.0 while youth observed for less than a year had lower weights.

The primary analysis examined factors associated with expenditures in the year after entering out-of-home care. The regression took the form:

$$Expend_{it} = \beta_1 \cdot Expend_{i,t-1} + \beta_2 \cdot Demog_i + \beta_3 \cdot Maltreat_i + \beta_4 \cdot Diagnosis_{i,\,t-1} + \mu$$

$Expend_{it}$ represents health expenditures on youth *i* in the year after entering out-of-home care, and $Expend_{i,t-1}$ denotes expenditures in the year prior to out-of-home care. Separate models were estimated for physical health service expenditures, mental health service expenditures, and total expenditures. *Demog* denotes demographic variables (age, race, gender). *Maltreat* includes child welfare variables denoting the reasons for removal and other descriptors of the parental household (whether there was sexual abuse, physical abuse, emotional abuse, medical neglect, physical neglect, other neglect, threatened harm, a caregiver unavailable, domestic violence, parental substance abuse, child substance abuse, poor housing, and inadequate supervision). *Diagnosis* includes 21 diagnostic categories denoting physical and mental health diagnoses received in the year prior to removal. Eighteen diagnostic categories are typical ICD-9 groupings (e.g., mental disorders, diseases of the respiratory system) and contain numerous

diseases/diagnoses in each category. A diagnostic group denoting a diagnosis consistent with child maltreatment was also included. Child maltreatment was defined based on the following ICD-9 codes: child maltreatment syndrome (995.5), adult maltreatment ages 15+ (995.80-995.85), effects of hunger and thirst (994.2-994.3), child abuse by a perpetrator (E967), criminal neglect (E968.4), and evaluation for suspected abuse and neglect (V71.81). A diagnostic group indicated a designation of very severe emotional and behavioral problems in the FSFN data, while another group denoted a claim and/or encounter for a well-child visit (V20.2). To achieve a parsimonious model, coefficients were required to be significant at the $p<.05$ level to be retained in the model.

Descriptive statistics. Descriptive statistics are presented in Table 19. Variables are measured for the year prior to removal (e.g., diagnoses) or during the course of the investigation by child protective investigators that resulted in removing the child from the home (e.g., demographics and maltreatment variables). The sample averages 7.5 years of age and the majority of children and youth are White (60.7%). Twenty-six percent of the sample received a mental health diagnosis in the prior year, while 21.8% had diseases of the respiratory system (e.g., asthma, pneumonia) and 21.9% had at least one claim or encounter with diagnosis of symptoms and ill-defined conditions (e.g., headache, nausea, abdominal pain). Only 26.2% of children and youth had a well-child visit in the year prior to removal. Despite all children and youth in the sample being in out-of-home care, only 1.5% had a diagnosis consistent with child maltreatment in the year prior to removal [e.g., child maltreatment syndrome (ICD-9 995.5), adult maltreatment ages 15+ (995.80-995.85), effects of hunger and thirst (994.2-994.3), child abuse by a perpetrator (E967), criminal neglect (E968.4), and evaluation for suspected abuse and neglect (V71.81)]. Parental substance abuse was common (42.7%), but other factors associated with removal from the home varied across youth. A small percentage of children and youth were reported in the FSFN database as having extremely severe emotional and/or behavioral problems (2.9%). Given that 50-60% of children and youth are expected to have behavioral health needs, the low percentage highlights the severity of the problems necessary to be classified in FSFN as having an extremely severe emotional or behavioral problem. The very low percentage also highlights the need to use additional data (e.g., Medicaid) to capture the behavioral health problems faced by children and youth.

Table 19

Descriptive Statistics at the Time When Child or Youth is Removed from Home

Variable	%
Mean Age (in years)	7.54 (SD= 4.97)
Race	
Black	32.6%
Mixed race	5.6%
Other race	1.1%
White	60.7%
Gender	
Female	50.2%
Diagnostic groups during prior year	
Infectious diseases (ICD-9 001-139)	11.0%
Neoplasms/cancers (ICD-9 140-239)	0.4%
Endocrine and metabolic diseases (ICD-9 240-279)	2.4%
Diseases of the blood (ICD-9 280-289)	1.9%
Mental disorders (ICD-9 290-319)	25.5%
Diseases of the nervous system (ICD-9 320-359)	1.8%
Diseases of the sense organs (ICD-9 360-389)	15.6%
Diseases of the circulatory system (ICD-9 390-459)	1.1%
Diseases of the respiratory system (ICD-9 460-519)	21.8%
Digestive disorders (ICD-9 520-579)	6.7%
Genitourinary system (ICD-9 580-629)	4.4%
Complications of pregnancy (ICD-9 630-679)	0.4%
Skin and subcutaneous diseases (ICD-9 680-709)	8.5%
Musculoskeletal system (ICD-9 710-739)	4.3%
Congenital anomalies (ICD-9 740-759)	1.6%
Symptoms and ill-defined conditions (ICD-9 760-779)	21.9%
Injury and poisoning (ICD-9 780-799)	12.1%
Diagnosis indicative of maltreatment (see text)	1.5%
Well care visit (V20.2)	26.2%
Maltreatment Variables	
Physical abuse	15.4%
Sexual abuse	4.0%
Emotional abuse	1.7%
Medical neglect	3.1%
Physical neglect	3.2%
Neglect	17.4%
Abandonment/relinquish custody	12.0%
Threatened harm	3.9%
Parental substance abuse	42.7%
Caregiver unavailable (death/prison)	12.3%
Domestic violence	16.1%
Child substance abuse	1.3%
Inadequate supervision	16.3%
Poor housing	12.2%
Behavioral Problems	

Extremely severe child emotional and/or behavioral problems	2.9%
Number of children and youth	34,987

Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 1/10/2017

Service utilization. Summary statistics for expenditures are reported in Table 20. In the year prior to entering out-of-home care, physical health service expenditures averaged $1,082 while behavioral health service expenditures averaged $703. Total expenditures averaged $1,784. Expenditures were higher in the year after removal. Physical health service expenditures averaged $1,740 and behavioral health service expenditures averaged $2,191 in the year after removal. Thus, the increase in behavioral health services was more pronounced than the increase in physical health services. Median physical health expenditures were $564 and median behavioral health expenditures were $830 in the year after removal. Several categories have a median of $0 (e.g., physical health and behavioral health inpatient), indicating that fewer than half of the children and youth had a service in that category. The majority of the increase in both physical and behavioral health services was for outpatient services. Physical health outpatient services more than doubled and behavioral health outpatient services increased by over 300%.

Table 20

Expenditures Before and After Entering Out-of-Home Care

	Mean $	**SD**	**Median**
Year Before Out-of-Home Care			
Physical Health Inpatient	568	8,279	0
Physical Health Outpatient	514	2,939	49
Physical Health Total	$1,082	9,579	$50
Behavioral Health Inpatient	245	3,201	0
Behavioral Health Outpatient	457	2,122	0
Behavioral Health Total	$703	4,173	$0
Total Expenditures	$1,784	10,777	$141
Year After Entering Out-of-Home Care			
Physical Health Inpatient	554	6,635	0
Physical Health Outpatient	1,187	3,897	559
Physical Health Total	$1,740	8,628	$564

Behavioral Health Inpatient	293	3,496	0
Behavioral Health Outpatient	1,898	3,978	820
Behavioral Health Total	$2,191	5,716	$830
Total Expenditures	$3,931	10,714	$1,757
Number of Children and Youth	34,987		

Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 1/10/2017

Regression results. Regression results are provided in Table 21. Separate regressions were estimated for physical health expenditures, behavioral health expenditures, and total expenditures. Physical health expenditures in the year following removal were associated with expenditures in the prior year. Factors associated with sizable effects on expenditures included the presence of extremely severe behavioral problems ($1,901), neoplasms/cancers ($2,841), endocrine disorders ($3,151), nervous system disorders ($5,681), diseases of the circulatory system ($5,118), congenital anomalies ($6,592), and a diagnosis indicative of maltreatment ($1,212). A finding of medical neglect was also associated with greater service use in the year after removal ($2,904). All factors with sizable coefficients were fairly rare conditions with the finding of medical neglect (3.1%) being most prevalent. Several additional factors were associated with modest increases in physical health expenditures (e.g., diagnosis of a mental health condition), and several factors were associated with modestly lower expenditures in the following year.

Behavioral health service use in the year after removal was also associated with prior utilization. In addition, the presence of extremely severe behavioral problems ($4,347) or a mental health diagnosis ($1,634) was associated with greater expenditures. Children and youth that were victims of sexual abuse ($761), physical abuse ($547), and neglect (medical $475 or unspecified $268) also had higher behavioral health service use in the year after removal.

Total expenditures were a function of extremely severe behavioral problems ($6,658), neoplasms ($2,242), endocrine disorders ($3,101), mental health diagnoses ($2,254), diseases of the nervous system ($5,508), diseases of the circulatory system ($5,956), congenital anomalies ($6.140), and diagnoses indicative of maltreatment ($1,235). The presence of sexual abuse ($1,028), physical abuse ($452), and medical neglect ($3,169) were also associated with higher total expenditures in the year after removal.

Table 21

Characteristics Associated with Unmet Need (n=34,987)

	Physical Health (PH) Expenditures			**Behavioral Health (BH) Expenditures**			**Total Expenditures**		
	Coef	Std error	p value	Coef	Std error	p value	Coef	Std error	p value
Intercept	1767	107	<.0001	459	82	<.0001	2320	139	<.0001
Age	-71	10	<.0001	134	6	<.0001	68	12	<.0001
Female				178	57	0.0019			
PH prior year expenditures	0.07	0.00	<.0001						
BH prior year expenditures				0.22	0.01	<.0001			
Total prior year expenditures							0.10	0.00	<.0001
Extremely severe behavioral health problems	1901	267	<.0001	4347	174	<.0001	6658	328	<.0001
Diagnosis in prior year									
Infectious diseases				-250	98	0.011	-434	190	0.0224
Neoplasms/cancers	2841	683	<.0001				2242	833	0.0071
Endocrine and metabolic diseases	3151	300	<.0001				3101	367	<.0001
Diseases of the blood	1529	332	<.0001				1426	406	0.0004
Mental disorders	321	108	0.003	1634	70	<.0001	2254	133	<.0001
Diseases of the nervous system	5681	342	<.0001				5508	417	<.0001
Diseases of the sense organs	-399	128	0.0018				-380	169	0.0249
Diseases of the circulatory system	5118	429	<.0001	960	268	0.0003	5956	525	<.0001
Diseases of the respiratory system				-194	76	0.0112	-386	157	0.0136
Digestive disorders	1009	185	<.0001				984	228	<.0001
Genitourinary system	724	222	0.0011	291	143	0.0413	1041	275	0.0002
Complications of pregnancy				-1914	433	<.0001	-1992	827	0.0159

Skin and subcutaneous diseases	683	225	0.0024						
Musculoskeletal system				-431	149	0.004			
Congenital anomalies	6592	357	<.0001				6140	435	<.0001
Ill-defined conditions									
Injury and poisoning				412	96	<.0001	824	176	<.0001
Diagnosis indicative of maltreatment	1212	368	0.001				1235	450	0.006
Child Welfare Variables									
Physical abuse				547	84	<.0001	452	160	0.0047
Sex abuse				761	147	<.0001	1028	279	0.0002
Unspecified neglect				268	79	0.0006			
Medical neglect	2904	255	<.0001	475	163	0.0035	3169	311	<.0001
Physical neglect									
Threat of harm									
Caregiver unavailable	-402	126	0.0014	-214	82	0.0087	-650	155	<.0001
Domestic violence	-432	123	0.0004	-170	79	0.0314	-560	150	0.0002
Parental substance abuse	-306	91	0.0008	-388	62	<.0001	-761	116	<.0001
Inadequate supervision	-270	120	0.0248						
Observations	34987			34987			34987		
Log likelihood	-371316			-346568			-376024		
AIC	742677			693174			752090.6		

Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 1/10/2017

Discussion. This research question examined factors associated with higher unmet need for children and youth. Unmet need was estimated based on the relationship between characteristics measured prior to removal and the health care service use after removal. As expected, service use prior to removal was associated with service use after removal. However, when controlling for service use prior to removal, a number of factors were associated with expenditures in the year after removal. Mental health disorders were associated with higher unmet need, as were several less common physical health diagnostic groups (e.g. neoplasms including various cancers; endocrine disorders including diabetes; circulatory disorders including heart problems; and diseases of the nervous system including multiple sclerosis and cerebral palsy). Victims of sexual abuse, physical abuse, and/or medical neglect also had greater unmet need when entering out-of-home care.

Behavioral health needs were less likely to be met than physical health needs when the child or youth was at home. Behavioral health services increased considerably after removal from the home. However, some of this increase may have been caused by the removal. Being removed from the home can be a traumatic experience for a child or youth, even a child who is being maltreated at home. Indeed, adjustment reaction is a common diagnosis for youth after removal from the home. Thus, some of this increase is likely due to unmet need and some likely reflects additional needs for children and youth in out-of-home care. This might reflect a belief by parents that youth would not benefit from mental health care, or that parents did not recognize or perceive a need for such care. Physical health needs also were unmet in some areas. In particular, children and youth that had less common but expensive disorders had considerable unmet need (e.g., neoplasms, endocrine disorders, circulatory disorders, and nervous system disorders). The presence of extremely severe emotional and behavioral problems was associated with unmet physical health needs. However, the presence of physical health conditions was not associated with unmet behavioral health needs.

Prior research has suggested that 33-50% of children and youth living in out-of-home care had not received mental health services in the prior 18 months despite meeting the clinical criteria for a mental health diagnosis (NCASW, 2012). The substantial increase in behavioral health outpatient expenditures is consistent with such findings. The magnitude of the increase suggests that even those children and youth who received services still had considerable unmet needs.

There are several practical policy implications from this study. First, we know that children and youth enter out-of-home care with considerable health care needs. However, there is often a lag between when a child or youth enters out-of-home care and when an assessment

occurs. Such delays can cause exacerbation of problems during such a crucial time for the children and youth. Models that can predict which children and youth will have the greatest unmet need could help triage children and youth such that youth with the highest anticipated need receive some degree of priority. For example, youth who have extreme severe emotional and/or behavioral problems, suffer from medical neglect, or suffer from neoplasms, endocrine disorders, circulatory disorders, nervous system disorders, or congenital anomalies are likely to have significant health care needs. A type of risk score could be easily computed, such that those children and youth with the highest score would be expected to have the highest need. The median time from removal until a behavioral health assessment is approximately 32 days in Florida (computed by author as time of removal to the date of service of the first claim/encounter with a procedure code of an assessment; e.g., H0031 mental health assessment by non-physician or 90791 psychiatric diagnostic evaluation), and children and youth with substantial unmet need should receive assessments as soon as possible. In addition, the model predictions can provide additional information for case managers to use when establishing treatment plans for children and youth.

Research Question Two

Methods. This analysis of child permanency outcomes began with a description of the sample. Given that this analysis simply seeks to assess health care need, there is no need to exclude multiple observations for children and youth. Child welfare outcomes were examined using three logistic regressions with dependent variables that denoted whether the child or youth was adopted, reunified with their caregiver(s), or exited out-of-home care into permanent guardianship within 12 months after entering out-of-home care. In addition, a logistic regression was estimated with a dependent variable that denoted permanency was achieved within 12 months (for reunification or guardianship) or 24 months (for adoption). Independent variables included health care need (see below for measures), race (white, black; reference: other), whether the child or youth was female, age in years, and a categorical variable denoting the reason for removal from the home (abuse, neglect, caregiver unavailable; reference: threatened harm). A hierarchy was used for the reason for removal with children and youth placed in out-of-home care for multiple reasons categorized under the most severe classification (abuse>neglect>threatened harm>caregiver unavailable).

Proportional hazards models were used to examine the time until achieving permanency. While the logistic regressions required placements within 12 months (or 24 months for adoption) after removal, the proportional hazards models utilized the time until permanency regardless of whether it occurred in the first 12 months. Observations for children

and youth who did not achieve a permanent placement were considered censored. The independent variables were the same as the logistic regressions.

Health care need was measured as the total units of physical health inpatient services, physical health outpatient services, behavioral health inpatient services and behavioral health outpatient services. For children and youth that used physical health inpatient services, behavioral health inpatient services and behavioral health outpatient services, we consider the youth to have physical or behavioral health care needs if they used the service. Most children and youth used physical health outpatient services, thus we considered the youth to have notable physical health needs if utilization was above the median for the sample. Units of service were used instead of Medicaid expenditures because payment rates can differ between the fee-for-service program, the PMHPs, HMOs, and the newer SMMC plans. In addition, all services were measured on a per-youth per-month (PYPM) basis to account for the differing observation periods across children and youth. For each service, in the year after removal only services received prior to permanency were included. For children and youth who did not achieve permanency, health care use was measured for the entire year after removal from the home.

Service utilization patterns were consistent with the presence of health care needs both before and after removal. For example, youth with no behavioral health service use in both periods probably did not have substantial mental health needs. On the other hand, youth with no use in the pre-period but use in the post-period either had unmet need in the prior year, or the service use may reflect the trauma of removal or abuse while in out-of-home care. Children and youth with use in the pre-period but not in the post period may have been resilient leading to low need when maltreatment ceased. Finally, children and youth with use in both periods had clear mental health needs. Utilization variables were created for each service to determine whether the use of behavioral health inpatient or outpatient services were indicative of different conditions.

Given that the relationship between health services and outcomes was examined, it is important to note that the analysis cannot conclude whether service use causes better or worse outcomes. Analysis of the question of whether services led to better outcomes would require carefully constructed comparisons between children and youth with similar functioning. Rather, consistent with prior research, the goal is to determine whether children and youth with greater physical health needs or behavioral health needs have poorer child welfare outcomes. Some children and youth are likely to have unmet needs and for such youth, health care need was

understated. Such measurement error would lead to conservative estimation of the relationship between health care need and permanency outcomes.

Descriptive statistics. Descriptive statistics for the sample of 42,873 removals are reported in Table 22. The average age at the time of entry into out-of-home care was 6.6 years old (SD=5.2). Nearly half of all children and youth were removed due to neglect, while 19.4% were removed due to abuse. The sample was nearly evenly split between boys and girls, and the majority of children and youth were white. Among the outcome variables, 35.6% of children and youth were reunified with their caregivers within 12 months. Another 11.9% were placed with guardians within 12 months and 9.5% were adopted within 24 months.[2] Thus, 57.2% of removals achieved permanency within federal guidelines.

Table 22

Descriptive Statistics

	%
Mean Age	6.63 (SD=5.23)
Permanency Outcomes	
Permanency	57.2%
Adoption	9.5%
Reunification	35.6%
Guardianship	11.9%
Race	
White	63.9%
Black	36.1%
Gender	
Female	49.6%
Male	50.4%
Reason for Removal	
Abuse	19.4%
Neglect	49.9%
Threatened harm	21.1%
Other	9.6%
Number of Removals	42,782

Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 10/20/2016

[2] The Federal measure for adoption outcomes represents the number of youth adopted within 24 months divided by the number of youth with adoption listed in the case plan as the primary goal. For the purposes of this analysis, we also used the 24 month timeline but did not limit the sample to only those with adoption listed as the primary goal. Hence the adoption rate of 9.5% in this sub-study is well below the rate using the official definition.

Service use patterns in the year prior to removal and the year after removal are explored in Tables 23 and 24. The average units of services used by children and youth in the year before and after removal are reported in Table 23. Utilization of physical health inpatient services declined between the year before and after removal. Utilization of other services, particularly outpatient services increased in the year after entering out-of-home care.

Table 23

Service Utilization (n=42,782)

	Year Prior to Removal	**Year After Removal**
	Mean PMPM Units (Std Dev)	Mean PMPM Units (Std Dev)
Physical Health Inpatient	0.18 (5.74)	0.08 (0.97)
Physical Health Outpatient	2.89 (30.0)	6.64 (47.2)
Behavioral Health Inpatient	0.03 (0.57)	0.05 (2.67)
Behavioral Health Outpatient	0.91 (8.03)	4.05 (13.7)

Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 10/20/2016

Changes in service utilization, based on whether the child or youth used services, between the year before removal and the year after removal from the home are reported in Table 24. As noted above, children and youth that used physical health inpatient, behavioral health inpatient, and physical health outpatient services were considered to have health care needs. Because most children and youth used physical health outpatient services, youth are identified as having health care needs if they used more than the median number of services. Based on these criteria, service use was examined in the year before and year after removal. For example, from Table 6, 3.6% of children and youth have behavioral health outpatient services only in the year prior to removal (Use-No use), 38.6% only in the year after removal (No use-Use), 11.3% in both years (Use-Use) or 46.6% in neither year (No use-No use).

The pattern differed considerably for inpatient and outpatient services. Eleven percent of children and youth had a physical health inpatient stay in the year prior to removal (8.6% only in the year before removal and 1.7% in both the year before removal and year after removal). Among physical health outpatient services, more than 28% were above the median in both periods. Another 21.8% were below the median before removal from the home but above the median after removal. Among behavioral health outpatient services, 38.6% of children and youth did not use services before removal but did after removal. Once again, this suggests there was either unmet need for behavioral health services before the children and youth was

removed from the home, or that the trauma of removal resulted in a need for services. Fifty-three percent of children and youth in the sample received behavioral health outpatient services in the study period (38.6% only after removal, 3.6% only before removal, and 11.3% both before and after removal). However, there is a distinct difference between the pre- and post-periods. Only 15% of children and youth received behavioral health outpatient services in the year prior to removal (3.6% + 11.3%). Fifty percent of children and youth received behavioral health outpatient services after removal (38.6%+11.3%).

Table 24

Changes in Units of Services - Year Prior to Removal and Year After Removal

	Children and youth	**%**
PH Inpatient		
No use – No use	37,253	86.9%
No use - Use	1,210	2.8%
Use – No use	3,668	8.6%
Use - Use	745	1.7%
PH Outpatient		
Low use – Low use	13,869	32.4%
Low use – High use	9,356	21.8%
High use – Low use	7,571	17.7%
High use – High use	12,080	28.1%
BH Inpatient		
No use – No use	42,096	98.2%
No use - Use	428	1.0%
Use – No use	251	0.6%
Use - Use	101	0.2%
BH Outpatient		
No use – No use	19,970	46.6%
No use - Use	16,541	38.6%
Use – No use	1,535	3.6%
Use - Use	4,830	11.3%

Note. No use-No use (and Low use-Low use) denotes no (or low) service use in both the year before removal and year after removal. No use-Use (or Low use-High use) denotes no (or low) service use in the year prior to removal, but use of services in the year after removal. Use-No use (or High use-Low use) denotes service use in the year prior to removal, but not in the year after removal. Use-Use (or High use-High use) denotes service use in both periods.
Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 10/20/2016

Logistic regression results examining how changes in health care utilization are associated with child welfare outcomes are reported in Table 25. Adoption (OR=1.78, CI: 1.45-

2.17) was more likely among children and youth with physical health inpatient use in both periods while reunification (OR=0.60, CI: 0.50-0.72) and guardianship (OR=0.55, CI: 0.41-0.75) were less likely. Children and youth with physical health inpatient use in the post period but not in the prior year were also more likely to be adopted (OR=1.76 CI: 1.48-2.10), but less likely to be reunified with caregivers (OR=0.53, CI: 0.46-0.61) or placed with guardians (OR=0.71, CI: 0.58-0.89). Children and youth with physical health inpatient use in the year before removal were less likely to be reunified with their caregivers (OR=0.79, CI: 0.73-0.86) or placed with guardians (OR=0.68, CI: 0.60-0.78), but were more likely to be adopted (OR=1.37, CI: 1.23-1.52). Overall, permanency was less likely with physical health inpatient stays in either the year before or after removal. High physical health outpatient use in either period was associated with a lower likelihood of reunification, and a higher rate of adoption. Children and youth with high physical health outpatient use in the year prior to removal but not the year after were more likely to be placed with guardians (OR=1.19, CI: 1.09-1.29). Children and youth with low use only in the prior year were less likely to be placed with guardians than youth with low use in both years (OR=0.86, CI: 0.79-0.94).

Behavioral health inpatient use in both periods was significantly associated with a lower likelihood of permanency (OR=0.33, CI: 0.19-0.59). This result was largely driven by a strong relationship between behavioral health inpatient use and a lower likelihood of placement with guardians (OR=0.15, CI: 0.04-0.63). Behavioral health inpatient use in one period, either before or after removal, was associated with a lower likelihood of adoption or guardianship. Behavioral health outpatient use in both periods was associated with a lower likelihood of permanency (OR=0.45, CI: 0.42-0.48). The inverse relationship was found for the likelihood of reunification and guardianship. Similar results were found for children and youth with behavioral health outpatient use only in the year after removal. Children and youth with behavioral health outpatient use only in the year prior to removal were more likely to be reunified with caregivers (OR=1.19, CI: 1.07-1.33) and adopted (OR=1.21, CI: 1.03-1.43).

Table 25

Changes in Health Care Service Use and Child Welfare Outcomes

	Permanency			**Adoption**			**Reunification**			**Guardianship**		
	OR	95% CI		OR	95% CI		OR	95% CI		OR	95% CI	
Health Care Service Use/Need												
PH Inpatient												
Use-Use	0.83	0.70	0.97	1.78	1.45	2.17	0.60	0.50	0.72	0.55	0.41	0.75
Use-No use	0.85	0.78	0.91	1.37	1.23	1.52	0.79	0.73	0.86	0.68	0.60	0.78
No use-Use	0.70	0.62	0.80	1.76	1.48	2.10	0.53	0.46	0.61	0.71	0.58	0.89
PH Outpatient												
High use-High use	0.87	0.83	0.92	1.49	1.35	1.64	0.73	0.69	0.78	1.06	0.98	1.15
High use-Low use	1.00	0.94	1.06	1.27	1.14	1.41	0.87	0.82	0.93	1.19	1.09	1.29
Low use-High use	0.77	0.73	0.82	1.12	1.01	1.24	0.81	0.77	0.86	0.86	0.79	0.94
BH Inpatient												
Use-Use	0.33	0.19	0.59	0.15	0.02	1.06	0.71	0.42	1.20	0.15	0.04	0.63
Use-No use	0.57	0.44	0.75	0.32	0.14	0.72	0.99	0.74	1.31	0.40	0.24	0.68
No use-Use	0.48	0.36	0.63	0.34	0.16	0.73	0.62	0.49	0.80	0.24	0.14	0.41
BH Outpatient												
Use-Use	0.54	0.50	0.58	0.98	0.86	1.12	0.52	0.48	0.56	0.70	0.63	0.78
Use-No use	1.15	1.04	1.28	1.21	1.03	1.43	1.19	1.07	1.33	0.96	0.83	1.12
No use-Use	0.55	0.52	0.57	1.05	0.97	1.13	0.50	0.48	0.52	0.73	0.68	0.78
Age	0.99	0.99	0.99	0.95	0.94	0.95	1.00	0.99	1.00	1.05	1.04	1.05
White	0.99	0.91	1.07	0.96	0.84	1.11	0.91	0.84	0.99	1.26	1.11	1.42
Black	0.97	0.89	1.05	0.77	0.68	0.89	1.04	0.96	1.13	1.08	0.95	1.21
Female	0.99	0.95	1.03	1.11	1.04	1.19	0.93	0.89	0.97	1.04	0.98	1.10
Reason for Removal												
Abuse	1.08	1.01	1.15	0.64	0.57	0.72	1.83	1.71	1.95	0.47	0.43	0.52
Neglect	0.95	0.91	1.00	0.77	0.71	0.84	1.30	1.23	1.37	0.71	0.66	0.76

Other	1.01	0.94	1.09	1.09	0.97	1.23	1.05	0.97	1.14	0.88	0.79	0.98
Observations	42782			42782			42782			42782		
Likelihood ratio	1344.9		<.0001	975.2		<.0001	1939.7		<.0001	782.5		<.0001

Note. OR denotes the odds ratio; 95% CI the 95% confidence interval. No use-Use (or Low use-High use) denotes no (or low) service use in the year prior to removal, but use of services in the year after removal. Use-No use (or High use-Low use) denotes service use in the year prior to removal, but not in the year after removal. Use-Use (or High use-High use) denotes service use in both periods.
Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 10/20/2016

Table 26 contains the proportional hazards results for the time until permanency. As noted earlier, youth did not have to achieve permanency within 12 months for this outcome. The first specification examines service use in the year prior to removal. Behavioral health inpatient and outpatient service use were associated with a longer time until achieving permanency. Physical health service use was not associated with the time to permanency. The second specification examined the role of changes in service use. While levels of physical health care in the prior period were not associated with permanency, changes in physical health care use were significantly associated with outcomes. Children and youth with physical health inpatient use in both the pre- and/or post-period or use only in the year after removal had a longer time until permanency. Children and youth with high physical health outpatient care in both the pre- and post-periods or only the year after removal had a longer time until permanency. Use of behavioral health inpatient services in either the pre- or post-period or both periods was associated with a longer time until permanency. The results for behavioral health outpatient use were inconsistent. Children and youth with behavioral health outpatient use in both the year before and year after removal (Use-Use), or only in the year after removal (No use-Use), had a *longer* time until permanency. Children and youth with behavioral health outpatient use only in the year before removal (Use-No use) had a *shorter* time until permanency; although this result was only marginally significant (p=.08).

Table 26

Proportional Hazard Results

	Coef	**Std err**	**p value**	**Coef**	**Std err**	**p value**
PH Inpatient	0.0017	0.0022	0.4193			
Use-Use				0.1938	0.0339	<.0001
Use-No use				0.0272	0.0162	0.0944
No use-Use				0.1763	0.0252	<.0001
PH Outpatient	0.0000	0.0001	0.8987			
High use-High use				0.0199	0.0116	0.086
High use-Low use				0.0042	0.0124	0.7328
Low use-High use				0.0627	0.0112	<.0001
BH Inpatient	0.0358	0.0085	<.0001			
Use-Use				0.3107	0.0959	0.0012
Use-No use				0.2258	0.0588	0.0001
No use-Use				0.4607	0.0491	<.0001
BH Outpatient	0.0043	0.0008	<.0001			
Use-Use				0.3801	0.0150	<.0001
Use-No use				-0.0392	0.0224	0.0805
No use-Use				0.3500	0.0092	<.0001

AIC	107544.3			105365.5		
Log likelihood	-53759.1			-53362.9		
Observations	41315			41315		

Note. None-None (and Low-Low) denotes no (or low) service use in both the year before removal and year after removal. None-Use (or Low-High) denotes no (or low) service use in the year prior to removal, but use of services in the year after removal. Use-None (or High-Low) denotes service use in the year prior to removal, but not in the year after removal. Use-Use (or High-High) denotes service use in both periods.
Note. Data sources: SFY 11/12 - 13/14 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 10/20/2016

Discussion. The report examined the relationship between child physical and mental health service use and permanency outcomes. Overall, over 50% of children and youth achieved permanency within federal guidelines, which is above the national standard of 40.5%.

The findings indicate that children and youth with physical or behavioral health problems are less likely to achieve permanency. Greater attention should be paid to the question of why these children and youth are less likely to achieve permanency. For example, are the services received by children and youth ineffective? What else could be done to help these children and youth achieve a successful outcome?

Some children and youth have service use prior to removal but not after removal. Such children and youth may be extremely resilient and their needs are not substantial once maltreatment stops. For example, children and youth with behavioral health outpatient services in the year prior to removal but not the year after are more likely to achieve permanency. However, the relationship differs across services. For example, children and youth with physical health inpatient use in the prior year and not in the year after removal are less likely to achieve permanency. To some degree, this relationship is a function of the fact that some children and youth are removed from their home shortly after birth. As such, they have used physical health inpatient services in the year prior to their removal, but that high use is simply due to their birth. While rates of adoption are higher for children and youth that used physical health inpatient services, that does not offset the low rate of reunification, and the overall likelihood of permanency is lower.

Children and youth with no service use in the year prior to removal, but who used services in the year after removal, may have substantial unmet needs prior to removal. Thus, actual need in the pre-removal period is probably similar to the need indicated by the utilization patterns in the post-removal period. Consequently, outcomes for such children and youth were expected to be similar to youth that had service use in both periods. Indeed, the direction of the relationship between service use and permanency as well as the magnitude of the effect are similar for each service type.

Turning the focus from the service mix to specific permanency outcomes, we can see considerable differences across outcomes. Children and youth with physical health needs are more likely to be adopted, but youth with behavioral health needs are less likely to be adopted. Reunification is less likely when the child or youth has substantial physical health needs, and is less likely when the youth has behavioral health needs although the results are not as clear. Guardianship is less likely when the child or youth had physical or behavioral health inpatient use. Guardianship is also less likely when the child or youth had behavioral health needs addressed through outpatient services.

Children and youth who have behavioral health outpatient use in the prior year but not in the year after are more likely to be reunified. These children and youth might be the subject of additional research to determine whether their behavioral health needs remained low after returning home or whether the issues that led to the initial use resurfaced.

The study measured health care need using health care service utilization. Clearly, some degree of unmet need is likely to remain. A study of Florida Medicaid enrollees found that 70% of adults who indicated a need for mental health treatment received mental health treatment (Cai & Robst, 2015). This is consistent with SAMSHA reports that 71% of people with major depression receive treatment (SAMHSA, 2016). However, it is likely that this figure is higher for children and youth in the child welfare system. All children and youth are supposed to undergo an initial assessment, which includes an assessment for mental health needs. Children and youth are then provided treatment planning services or targeted case management services based on the initial assessment. While parents may avoid taking the youth for treatment if the youth's condition is due to maltreatment, a foster parent does not have the same incentive to avoid medical attention for the youth (assuming the foster parent is not mistreating the youth).

Approximately 50-60% of foster children and youth have behavioral problems (Burns et al., 2004; Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Garland et al., 2000). Fifty-three percent of children and youth in our sample received behavioral health services in the study period. Thus, overall utilization rates are consistent with prior research using direct measures of behavior. However, there is a distinct difference between the pre- and post-periods. Only 15% of children and youth received behavioral health outpatient services in the year prior to removal. Fifty percent of children and youth received behavioral health outpatient services after removal. Thus, a secondary finding of this paper is that the use of services after removal appears to be consistent with estimates of behavioral problems among youth in foster care. Use of services prior to removal is clearly an underestimate of need.

Thus, behavioral health service use after removal may provide an alternative measure of behavioral health need for studies that lack direct measures of physical or behavioral health. Prevalence rates are similar to direct measures. In addition, the results for permanency are similar to prior research indicating that children and youth with greater physical and behavioral health needs have a lower likelihood of achieving permanency.

Research Question Three

Methods. The study employed a longitudinal design in which an entry cohort of children and youth placed in out-of-home care was followed for 12 months after the date they were placed in out-of-home care. The entry cohort included all children and youth, from birth to 18 years of age, who were first placed in out-of-home care in Florida between July 1, 2014 and June 30, 2015. Thus, the analysis of placements used a different time period than the other research questions in this sub-study.

Statistical analyses consisted of linear regression and logistic regression. The analysis examined factors associated with the number of placements in the year after entering out-of-home care. The regression took the form:

$$\#\ Placements_i = \beta_1 \cdot Demog_i + \beta_2 \cdot Maltreat_i + \beta_3 \cdot Diagnosis_i + \beta_4 \cdot BH\ services_i + \mu$$

Placements denotes the number of placements during the year. FSFN is the source of placement data for children and youth. The analysis also examined the probability of being placed in a correctional facility in the year after being placed in out-of-home care. The logistic regression took the form:

$$Correctional\ placement_i = \beta_1 \cdot Demog_i + \beta_2 \cdot Maltreat_i + \beta_3 \cdot Diagnosis_i + \beta_4 \cdot BH\ services_i + \mu$$

Correctional placement is a dichotomous variable that indicates the child or youth was placed in a correctional facility during the year. DCF defines a correctional placement to include juvenile detention, other juvenile justice facilities, and jails. Correctional placements are included in the placement data examined above. Thus, FSFN was the source for all correctional placement data. Due to the serious nature of correctional placements, they were also examined as a separate outcome.

The independent variables included child demographics (age at time of placement in out-of-home care, race including Caucasian, African American, Hispanic and other race/ethnicity, and gender), variables associated with the maltreatment (physical abuse, sexual abuse, neglect, threatened harm), and caregiver loss. Caregiver loss (due to death or incarceration), while not child maltreatment, can require child welfare intervention to ensure child safety. In addition, variables related to health status and treatment in the year after entering out-of-home care were included in the regression specification. These included the

presence of physical health problems, mental health diagnoses (depression, anxiety, conduct disorder, attention deficit hyperactivity disorder, adjustment reaction disorder, bipolar disorder, other youth disorders, and any alcohol and drug related disorders), and outpatient behavioral health services (number of behavioral health assessment services, number of behavioral health treatment planning services, number of basic outpatient services, number of targeted case management services, and number of intensive outpatient services). This research question focused exclusively on behavioral health services, and thus did not include variables measuring physical health care services. The focus on behavioral health services is motivated by the existing literature, which has emphasized the link between behavioral health and placement stability. It might also be more likely that emotional and/or behavioral problems will result in children and youth moving between placements more often than physical health problems.

Findings. The results of multiple linear regression analysis are presented in Table 27. The average number of placements for all children and youth was 2.48 (*SD* = 3.10). Among child demographic characteristics, child age, or African American race/ethnicity were significantly associated with the number of placements. In particular, older youth and African American children were more likely to have greater number of placements.

With the exception of sexual abuse, child maltreatment was not associated with the number of placements. Among maltreatment types, history of sexual abuse was the only significant predictor of greater number of placements. Caregiver loss (due to death or incarceration) was also related to a greater number of placements.

Presence of a mental health disorder was significantly associated with an increased number of placements. Among examined disorders, adjustment reaction disorder and anxiety were the only diagnoses that were not significant predictors. Presence of physical health problems was also significantly and related to an increased number of placements. However, the effect for physical health problems was much smaller than mental health problems, and provision of physical health services (while important) is not expected to improve placement stability to a significant degree. Thus, the report focuses on the receipt of behavioral health services.

Results of linear regression indicated that provision of certain categories of mental health services was associated with a lower likelihood of further placement disruption. Specifically, a greater number of assessment, treatment planning, and basic outpatient services were associated with fewer placements. Based on the standardized beta coefficients, provision of assessment services had the strongest influence on the reduction of the number of

placements. Overall, results indicated that 13% of the variance in placement stability was explained by the examined predictor variables.

Table 27

Summary of Multiple Regression Analysis for Number of Out-of-Home Placements for All Children and Youth Placed in Out-of-Home Care During Fiscal Year 2014-2015 (n = 17,719)

Variable	*B*	*SE B*	*β*
Child Age	0.09**	0.01	0.15
Child Gender	0.01	0.05	0.00
Child Race[a]			
White	0.19	0.1	0.03
Black	0.25*	0.1	0.04
Hispanic	-0.45**	0.12	-0.04
Caregiver Loss	0.26**	0.06	0.04
History of Child Maltreatment[b]			
Sexual abuse	0.38**	0.13	0.02
Physical abuse	0.09	0.07	0.01
Neglect	0.04	0.06	0.01
Physical Health Problems	0.11*	0.05	0.02
Mental Health Diagnoses			
Adjustment reaction disorder	0.15	0.08	0.02
Conduct disorder	0.54**	0.13	0.04
Attention deficit disorder	0.25*	0.11	0.02
Bipolar disorder	2.42**	0.16	0.14
Depression	1.28**	0.17	0.07
Anxiety	-0.09	0.19	0.00
Alcohol and drug related disorders	2.93**	0.19	0.12
Other youth mental health disorders	1.22**	0.15	0.70
Outpatient Behavioral Health Services			
Number of behavioral health assessment services	-0.05**	0.01	-0.06
Number of basic outpatient services	-0.17**	0.04	-0.04
Number of Targeted Case Management services	-0.01	0.01	-0.01
Number of intensive outpatient services	-0.03	0.02	-0.01
Number of behavioral health treatment planning services	0.40**	0.09	0.05

Note. [a]The reference group for race is other race/ethnicity. [b]The reference group for child maltreatment is threatened harm. *$p < .05$. **$p < .01$. $R^2 = .356$.

Note. Data sources: SFY 14/15 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 3/15/2017

Table 28 presents findings from logistic regression analysis examining whether the youth had a correctional placement (as reported in FSFN). The sample was limited to youth ages 10 and above since correctional placement is very rare at younger ages. Two percent of youth had a correctional placement during the year. Results of multivariate logistic regression indicate that age, gender, caregiver loss, presence of physical health problems, mental health disorders including alcohol and drug disorders, conduct disorder, bipolar disorder, and other youth disorders were associated with placement in a correctional facility. Specifically, age corresponds to the likelihood of placement in a correctional facility in such a way that being one year older increases the odds of placement by 28%. Males were over two times more likely to be placed in a correctional facility (OR = 2.19; $p < .001$). Loss of a caregiver increased the odds of placement by 41% but history of child maltreatment was not related to involvement with the justice system. Among mental health disorders, alcohol and drug disorders, conduct disorder, and bipolar disorder were the strongest predictors of placement in a correctional facility, with conduct disorder related to 2.39 times increased odds of being placed. Youth who were diagnosed with either bipolar disorder or alcohol and drug disorders were 2.3-2.7 times more likely to be placed in a correctional facility (OR = 2.34 and 2.68, respectively; $p < .001$) compared to youth who did not have a mental health diagnosis. The presence of physical health problems (as reported in FSFN) was negatively associated with justice system involvement. Youth with physical health problems were approximately 34% less likely to be placed in a correctional facility (OR = .66; $p < .01$).

Table 28

Factors Associated with Placement in a Correctional Facility Among Youth Aged 10 or Older Placed in Out-of-Home Care During Fiscal Year 2014-2015 (n =4,541)

Risk Factors	***β***	**Wald $\chi^2_{(1)}$**	**OR**	**95% CI**
Child Age	0.24	50.69**	1.28	[1.19, 1.36]
Child Gender	0.78	30.60**	2.19	[1.66, 2.89]
Child Race[a]				
White	0.24	0.73	1.27	[0.74, 2.18]
Black	0.46	2.8	1.58	[0.92, 2.70]
Hispanic	-0.38	0.94	0.69	[0.32, 1.47]
Caregiver Loss	0.34	6.01*	1.41	[1.07, 1.86]
History of Child Maltreatment[b]				
Sexual abuse	-0.29	0.8	0.75	[0.40, 1.41]
Physical abuse	-0.4	3.04	0.67	[0.43, 1.05]
Neglect	-0.13	0.57	0.88	[0.63, 1.23]

Physical Health Problems	-0.41	8.24**	0.66	[0.50, 0.88]
Mental Health Diagnoses				
Adjustment reaction disorder	-0.02	0.01	0.98	[0.70, 1.38]
Conduct disorder	0.87	20.73**	2.39	[1.64, 3.47]
Attention deficit disorder	0.08	0.18	1.08	[0.74, 1.58]
Bipolar disorder	0.85	18.74**	2.34	[1.59, 3.43]
Depression	-0.18	0.6	0.83	[0.53, 1.32]
Anxiety	0.11	0.19	1.12	[0.67, 1.87]
Alcohol and drug related disorders	0.99	25.69**	2.68	[1.83, 3.93]
Other youth mental health disorders	0.65	9.27**	1.92	[1.26, 2.92]
Outpatient Behavioral Health Services				
Number of behavioral health assessment services	-0.06	6.67*	0.95	[0.91, 0.99]
Number of basic outpatient services	-0.15	3.87*	0.86	[0.75, 1.00]
Number of Targeted Case Management services	-0.01	0.69	0.99	[0.97, 1.01]
Number of intensive outpatient services	-0.03	0.43	0.97	[0.88, 1.07]
Number of behavioral health treatment planning services	0.29	3.33	1.35	[0.98, 1.85]

Note. [a]The reference group for race is other race/ethnicity. [b]The reference group for child maltreatment is threatened harm. *$p < .05$. **$p < .01$.
Note. Data sources: SFY 14/15 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 3/15/2017

When the effect of outpatient mental health services was examined, the provision of assessment services and the number of basic outpatient services were significantly associated with correctional facility placement. Specifically, provision of one additional assessment service decreased the odds of placement by 5% (OR = .95; $p < .05$) while an additional basic outpatient service decreased the odds of placement by 14% (OR = .86, $p < 0.5$).

Discussion. Overall, findings indicated that caregiver loss and presence of mental health disorders predict undesirable outcomes, such as greater number of out-of-home placements and placement in a correctional facility. However, provision of mental health outpatient services may help prevent these adverse outcomes. The findings suggest that provision of outpatient mental health services has a greater impact on prevention of placement instability compared to prevention of involvement with the justice system. Assessment services have the strongest prevention potential. It appears that receipt of assessment services is significantly associated with reduced chances of involvement in the justice system and fewer out-of-home placements. These findings suggest a need for increased efforts to provide outpatient mental health services and especially underscore the need for regular

comprehensive mental health assessments that include evaluation of the type and the quantity of mental health services needed for the child.

Summary

One of the goals of the Demonstration was to better match youth and families with needed services. Optimally these services would be provided while the child or youth remained at home, and could prevent the need for removal from the home. One very important funding source for services, especially for children and youth, is the Medicaid program. The goal of the cross system services and cost sub-study is to better understand the Medicaid-funded services received by children and youth before and after entering out-of-home care. This report addressed three questions related to health care service utilization among children and youth in the child welfare system. First, the report examined changes in the use of health care services between the year before removal and the year after removal from the home. Second, we considered whether the use of health care services could be used as a proxy for need, and whether health care needs were associated with the likelihood of achieving permanency. Third, we considered whether the receipt of behavioral health services while in out-of-home care can reduce the number of placements, and help avoid placements in correctional facilities. Overall, the sub-study found that Medicaid expenditures increased considerably in the year after removal, and that a model could be used to predict which children and youth were likely to have greatest increase in service use. The sub-study also found a link between health care needs and permanency outcomes, placement stability, and placement in correctional facilities.

Limitations

The secondary data analysis design implicitly holds several limitations. First, as always, administrative data are likely to be imperfect. For example, reliable reporting of social security numbers in both FSFN and Medicaid records was assumed when compiling complete data for each subject. However, neither department/agency uses social security numbers as a primary identifier (DCF has a client ID, while Medicaid has its own identifier). Errors and incomplete information may have resulted in missed matches. Second, while the focus of the analysis of expenditures was on how parents can limit health care, all children and youth in the child welfare system are enrolled in a Medicaid managed care plan that has its own gatekeeping protocols. In addition, children and youth could have switched Medicaid managed care plans when removed from the home, and thus changes in service use may reflect differences in service authorizations across plans. It would be difficult to disentangle the parental and managed care gatekeeping effects. Third, the analysis of permanency outcomes measured health care need based on service use. As a result, the measure of need is imperfect and

subject to some degree of error. However, the overall prevalence rates are consistent with prior research. Finally, the analysis of placements examines services after entering out-of-home care. There is the potential for reverse causation (i.e., the number of placements may influence the number of services received). In addition, the number of placements is only a proxy for the child's trajectory. For example, a youth that requires residential treatment when they entered out-of-home care, then was stepped down to a therapeutic group home, and then to a foster home may be on a very different path than a youth who began in a foster home and then progressed to more intensive treatment over time.

Next steps

Substance use problems are common among parents in cases of child maltreatment. Studies find one-third to two-thirds of child abuse cases involve parental substance use (HHS, 1999). Others suggest that these results may be conservative (e.g., Barth, 2009). Parental substance abuse is an important risk factor for child abuse or neglect (Dubowitz et al., 2011). Children of parents with substance use problems are more likely to enter out-of-home care and more likely remain in out-of-home care longer (Barth, Gibbons, & Guo, 2006; HHS, 1999).

Connecting parents to needed services can be an important step in avoiding the need to remove the child from the home, or in achieving reunification if the child is removed from the home. The purpose of this analysis is to analyze Florida Substance Abuse and Mental Health Information System (SAMHIS) and Medicaid data to examine access and service utilization for parents in the child welfare system with substance use needs.

One of the primary goals of the Florida's IV-E Waiver Demonstration is to provide greater flexibility in the use of funds to better meet the needs of youth and families. To an important degree, DCF funded services can meet these needs. However, the Medicaid program is also an important source of services to meet the needs of families in the child welfare system. A number of important issues and questions merit additional research. Thus, to better understand the behavioral health care services received by parents with substance use problems, the sub-study will conduct an analysis of SAMH and Medicaid-funded services received by parents with youth in the child welfare system.

Because placement in out-of-home care is one of the most intrusive interventions used by child welfare agencies, the decision to remove a child from the home must occur only when the child's safety is at significant risk and cannot be ensured through less intrusive means. Thus, child protection workers should consider first all efforts directed to keep children in the care of their families while addressing immediate safety concerns. The decision-making

process is complicated for the CPS professionals because they are not always able to predict whether the course they choose for a given child is the best one (Pinto, & Maia, 2013).

To ensure that children whose safety is at risk are correctly identified and that their families receive the proper services, the Florida Department of Children and Families (DCF) initiated a multi-year effort to develop and implement the child welfare practice model (DCF, 2014). One feature of the child welfare practice model is a distinction between children who are unsafe, and therefore require DCF intervention, and children who are at risk, for whom families can be offered voluntary Family Support Services. It was expected that children assessed using the child welfare practice model would be more likely to receive the services they need, less likely to experience another referral, less likely to experience recurrence of maltreatment, and less likely to enter out-of-home care. To better understand the impact of the child welfare practice model, particularly with regard to the provision of voluntary services, two groups of cases (described below under Outcomes Analysis) were identified and selected for study. This section of the report aims to describe the identified groups for comparison on child outcomes, including safety and placement in out-of-home care, and aspects of casework practice. The next IV-E Waiver semi-annual progress report will describe findings from the analysis of child outcomes and casework practice for these two groups.

Sub-Study Two: Services and Practice Analysis/Outcome Analysis for Safe, but High Risk for Future Maltreatment

Because placement in out-of-home care is one of the most intrusive interventions used by child welfare agencies, the decision to remove a child from the home must occur only when the child's safety is at significant risk and cannot be ensured through less intrusive means. Thus, child protection workers should consider first all efforts directed to keep children in the care of their families while addressing immediate safety concerns. The decision-making process is complicated for the CPS professionals because they are not always able to predict whether the course they choose for a given child is the best one (Pinto, & Maia, 2013).
To ensure that children whose safety is at risk are correctly identified and that their families receive the proper services, the Florida Department of Children and Families (DCF) initiated a multi-year effort to develop and implement the child welfare practice model (DCF, 2014). One feature of the child welfare practice model is a distinction between children who are unsafe, and therefore require DCF intervention, and children who are at risk, for whom families can be offered voluntary Family Support Services. It was expected that children assessed using the child welfare practice model would be more likely to receive the services they need, less likely to experience another referral, less likely to experience recurrence of maltreatment, and less likely to enter out-of-home care. To better understand the impact of the child welfare practice model, particularly with regard to the provision of voluntary services, two groups of cases (described below under Outcomes Analysis) were identified and selected for study. This section of the report aims to describe the identified groups for comparison on child outcomes, including safety and placement in out-of-home care, and aspects of casework practice.

Methods

Outcomes analysis. Two groups were identified: (a) the intervention group, that is the group of children assessed under the child welfare practice model, and (b) the comparison group, that is, those children who were assessed prior to the implementation of the child welfare practice model. The intervention group was identified based on the following characteristics: (a) children who were assessed under the child welfare practice model between February 1, 2015 and June 30, 2016, and (b) who were deemed safe to remain at home, yet are at a high or very high risk of future maltreatment in accordance with the child welfare practice model. A matched comparison group included similar cases with the dates for maltreatment reports between July 1, 2011 and July 1, 2012. These children remained in the home. Voluntary services were offered to all families in both groups.

Matching cases between the intervention and comparison groups was accomplished using the propensity scoring method (Rosenbaum & Rubin, 1984). This technique allows for equating group differences simultaneously on multiple variables by reducing all relevant characteristics to a single composite score (Rubin, 1997). Cases for the comparison group were selected by matching on child demographic characteristics and variables that differentiate between groups (e.g., maltreatment type). Since the implementation of the child welfare practice model was phased in as sites were approved for full implementation across the state, there was a larger number of cases available for the comparison group during the fiscal year preceding the Demonstration extension. Therefore, cases were matched using the nearest neighbor technique, wherein cases for the comparison group were selected based on propensity scores that are closest to propensity scores of the cases in the intervention group (Dehejia & Wahba, 2002).

There were 16,948 cases in the intervention group. After selecting the matched cases, the comparison group consisted of 15,831 cases. The average age for both groups was 7.7 years. As shown in Table 29, both groups consisted of 51% males. The average age for this sample was almost 8 years (M = 7.7; SD = 5.00) ranging from birth to 18 years. A majority (59% for intervention group and 58% for the comparison group) of children were Caucasian, 29% were African-American, approximately 4% were Hispanic, and the remaining 8% were from other racial or ethnic groups. A substantial proportion (45% for the intervention group and 43% for the comparison group) of these youth had parents with substance abuse problems, and approximately 33% of the youth came from families with domestic violence histories.

The most prevalent types of maltreatment among study cases were threatened harm (65%) and neglect (43%), followed by neglect (55% for the intervention group and 54% for the comparison group), physical abuse (15.6% for the intervention group and 15.3% for the comparison group) and sexual abuse (3%). Approximately one percent of children experienced a caregiver loss due to death, incarceration, long-term hospitalization, or abandonment.

Because the groups were matched, the results of analysis of variance (ANOVA) and chi-square test indicated no significant differences between groups when the groups were examined on each of the covariates (i.e., child characteristics) included in the propensity score.

Table 29

Characteristics of Children in the Intervention and the Comparison Groups

Child Characteristics	**Two Groups**	
	Intervention Group (N = 16,948)	Comparison Group (N = 15,831)
Gender (Male)	51%	51%
African American	29%	29%
Hispanic	4.1%	4.5%
Caucasian	59.0%	58.0%
Age	*M* = 7.7 (*SD* = 5.0)	*M* = 7.7 (*SD* = 4.9)
Maltreatment types		
Sexual abuse	3.0%	3.0%
Physical abuse	15.6%	15.3%
Neglect	54.5%	53.7%
Threatened harm	64.9%	64.9%
Parental substance abuse	44.7%	42.7%
Domestic violence	35.5%	30.1%
Caregiver loss	1.0%	1.0%

Practice analysis. The practice analysis includes two components: a set of case file reviews, followed by corresponding interviews with case managers and parents. Eckerd Community Alternatives (Circuit 6) was selected for this analysis by identifying the number of cases from each agency that met the intervention criteria and selecting the agency with the highest number of qualifying cases. Once the agency was identified, a random sample of ten cases was drawn from the intervention group, and another random sample of ten cases from the comparison group. The case file reviews will compare the two groups to examine practice changes implemented under the child welfare practice model and the impact that such changes have had on family engagement and participation in voluntary services. A case file review protocol was developed for this purpose (see Appendix G). The subsequent interviews will further explore issues related to family engagement from the perspectives of case managers and parents involved in the intervention cases that were reviewed.

Next Steps

For the next semi-annual progress report, a longitudinal design will be utilized to track outcomes for the intervention and comparison groups. The outcomes that will be examined in the sub-study focus on child safety and include subsequent maltreatment reports, the occurrence of verified maltreatment after the initial voluntary case is opened, a subsequent in-home dependency case opened, and a subsequent out-of-home dependency case opened. The data source for all outcome evaluation questions will be FSFN.

Case file reviews will be conducted during the summer of 2017. The case manager and family interviews will then be scheduled and completed following the case file reviews. An interview protocol will be developed after the case file reviews are completed and will be informed by findings from the reviews. Findings from the practice analysis will be presented in the next semi-annual progress report.

Summary

This report is the semi-annual progress report for the period October 1, 2016 – March 31, 2017 for Florida's IV-E Demonstration. The Demonstration evaluation includes four related components: (a) a process analysis comprised of an implementation analysis and a services and practice analysis, (b) an outcome analysis comprised of safety, permanency, resource family and child well-being indicators, (c) a cost analysis, and (d) two sub-studies. This report includes findings from the services and practice analysis of the process analysis component, two components of the outcome analysis (resource families and child and family well-being indicators), the cost analysis, and the two sub-studies.

Services and Practice Analysis

The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. This component also assesses changes in practice to improve processes for the identification of child and family needs and facilitation of connections to appropriate services, including enhanced use of in-home services to increase successful family preservation and reunification.

Focus groups were conducted with case managers during February and March of 2016 and with child protective investigators during July 2016 in Circuits 4, 19, 12, 11, and 15. A stratified random sampling process based on child removal rates (as reported in the CBC Lead Agency Trends and Comparisons Report, June 26, 2015) was used to select the circuits. Two case manager focus groups were held in each circuit (n=10); two child protective investigator focus groups took place in four circuits and one focus group in one circuit (n=9).

The analysis is organized by the following domains: 1) attitudes and beliefs about child welfare, 2) assessment and decision-making processes, 3) family engagement processes, 4) organizational supports and barriers, 5) community services and resources, and 6) interagency relationships and collaboration.

One important strength related to attitudes and beliefs is that the majority of participants valued family preservation and believe in the concept of keeping children in the home. These values place child welfare professionals in alignment with the goals of the Demonstration. Participants emphasized the importance of family engagement and discussed their child welfare practice in terms of efforts to collaborate with families. At the same time, participants expressed concerns about ensuring child safety when children remain in the home when needed services are not readily accessible.

Focus groups also underscored assessment as a critical component of casework and the value of conducting a holistic and comprehensive assessment. Discussions emphasized the utilization of multiple methods and data sources to identify family needs, particularly the use of collateral contacts such as extended family, neighbors, and school personnel. Some participants observed that they think the assessment process can be intrusive for some families. The focus group discussions indicated that some child welfare professionals have trouble understanding the distinction between risk and safety, as well as when to offer voluntary versus mandatory services. Responses suggest that there may be a tendency to remove children in situations where court-ordered in-home services could be appropriate because participants believed all in-home services were voluntary.

Participants reported several challenges related to the use of in-home services. One obstacle was limited availability or accessibility of appropriate services to meet the needs of families. Other challneges included long waitlists for services, lack of transportation, and barriers created by insurance or lack thereof. The most frequently reported service needs included affordable housing, child care, substance abuse treatment, and more in-home service providers. In addition, participants shared that excessive workloads and high caseloads limit the amount of time they can spend on each case.

Finally, many participants reported poor collaboration and a lack of cohesion among the various partners and stakeholders that comprise the child welfare system. Although examples of good collaborative relationships were provided, many caseworkers expressed that the various agencies and stakeholders with whom they work (e.g. CLS, parents' attorneys, GALs, judges, providers, etc.) do not always agree on the best way to proceed with a particular case. Furthermore, participants reported that their expertise and opinions were often not taken seriously, and some shared examples of being treated with disrespect by various system stakeholders. This lack of cohesion across the system contributes to the inability of caseworkers to work effectively with families as they attempt to balance the differing demands of various stakeholders.

Outcome Analysis: Resource Family Indicators

The outcome analysis for this report tracks changes in the proportion of foster families who received new licenses during five consecutive state fiscal years (SFY 11-12, SFY 12-13 SFY 13-14, SFY 14-15, and SFY 15-16). Proportions of newly licensed foster families and the number of children served in out-of-home care were calculated by the Circuit and statewide.

Although there is considerable variability among Circuits on this indicator, Circuits 4, 17, and 20 had the highest proportions of new licensed families based on the number of children

served throughout the five years. For example, in SFY 11-12 Circuit 17 had 19.6% of newly licensed families, Circuit 20 had 17.7% of foster families recruited that year, and Circuit 4 had 16.4% of newly recruited families. During the following four years, the proportion of new licensed families for Circuit 4 ranged between 5.2% and 7.8%, whereas for Circuit 17 this proportion ranged from 4.5% to 7.3%. Finally, Circuit 20 had 5.7% of new licensed foster families in SFY 12-13 and 6.5% in SFY 14-15. Overall, the proportion of newly recruited families dropped from 11.6% in SFY11-12 to 3.3% in SFY 12-13 and then slightly increased to 4.2% in SFY 15-16.

Outcome Analysis: Child and Family Well-Being

In SFY 15-16, Florida transitioned from quality of practice case reviews and quality service reviews and adopted use of the Child and Family Services Reviews (CFSR)— federally-established guidelines to conduct ongoing case reviews (U.S. Department of Health and Human Services, 2014). Through these CFSRs, CBCs review cases to ascertain the quality of child welfare practices relevant to the safety, permanency, and well-being of children. The report examined the status of three CFSR outcomes that focus on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, mental health needs. The report compared baseline data to ongoing CFSR ratings for both in-home and out-of-home care cases.

Overall, ongoing reviews show slight improvement for performance items and well-being outcomes, although, at the state-level, none of the improvements was statistically significant. Circuits 2, 10, 14, 15, and 17 stand out as consistently obtaining a higher percentage of strength ratings for many performance items. Circuits 1, 3, and 8, however, appear to be less effective in the quality of child welfare practices relevant to the well-being of children. Families' capacity to provide for the needs of their children, Well-being Outcome 1, is an area in need of improvement statewide with only 54% of out-of-home care cases and 46% of in-home cases rated as substantially achieved. Concentrated efforts to conduct quality assessments and provision of services to meet the identified needs of parents, as well as the frequency and quality of caseworkers' visits with parents would improve this outcome.

Cost Analysis

The cost analysis required under the Terms and Conditions includes a cost-effectiveness analysis examining the relationship between expenditures and outcomes. In this report, a modified cost-effectiveness analysis examined the relationships between expenditures on specific types of services (out-of-home care, prevention services, and adoption subsidies) and outcomes across the 20 circuits. Instead of focusing on nominal dollars, the analysis

examined the share of total expenditures spent on out-of-home care, prevention services, and adoption subsidies. There was a clear pattern in many outcome variables. The maltreatment rate declined between the pre- and post-Demonstration extension periods. However, rates of achieving guardianship, permanency, and reunification also declined, leading to an increase in the length of stay in out-of-home care. In addition, the proportion of youth who received in-home services and did not require subsequent out-of-home care declined

Overall, there was a minimal relationship between changes in spending patterns and changes in outcomes. Only the rate of abuse in foster care appeared to have a relationship with spending patterns. Circuits that shifted resources from out-of-home care averaged less abuse in foster care compared to circuits that increased the share of expenditures spent on out-of-home services. Other outcomes showed no clear relationship with changes in expenditures.

As noted earlier in the report, the pre-period in this analysis is not a pre-Demonstration period. The evaluation analysis of outcomes and costs focused on whether the Demonstration extension has altered costs and outcomes relative to the original Demonstration. Second, the Florida Department of Children and Families began phased-in implementation of the child welfare practice model during the same period. The child welfare practice model may be associated with changes in the same outcomes assessed in this evaluation. It is important to include additional years of data to determine whether this an outcome of the child welfare practice model or merely reflects temporary effects from the implementation of a new system.

Sub-Study One: Cross-System Services and Costs

This sub-study addressed three questions related to health care service utilization among youth in the child welfare system. First, the report examined changes in the use of health care services between the year before removal and the year after removal from the home. Second, the sub-study examined whether the use of health care services could be used as a proxy for need, and whether health care needs were associated with the likelihood of achieving permanency. Third, the sub-study examined whether the receipt of behavioral health services while in out-of-home care could reduce the number of placements, and help avoid placements in correctional facilities.

The first question examined factors associated with higher unmet need for youth. Unmet need was estimated based on the relationship between characteristics measured prior to removal and the health care service use after removal. As expected, service use prior to removal was associated with service use after removal. However, when controlling for service use prior to removal, a number of factors were associated with expenditures in the year after removal. Mental health disorders were associated with higher unmet need, as were several

less common physical health diagnostic groups (e.g. neoplasms including various cancers; endocrine disorders including diabetes; circulatory disorders including heart problems; and diseases of the nervous system including multiple sclerosis and cerebral palsy). Victims of sexual abuse, physical abuse, and/or medical neglect also had greater unmet need when entering out-of-home care.

The second research question examines service use in the year prior to removal. Behavioral health inpatient and outpatient service use were associated with a longer time until achieving permanency. Physical health service use was not associated with the time to permanency. The study also examined the impact of changes in service use. While levels of physical health care in the prior period were not associated with permanency, changes in physical health care use were significantly associated with outcomes. Youth with physical health inpatient use in both the pre- and/or post-period or use only in the year after removal had a longer time until permanency. Youth with high physical health outpatient care in both the pre- and post-periods or only the year after removal had a longer time until permanency. Use of behavioral health inpatient services in either the pre- or post-period or both periods was associated with a longer time until permanency. Behavioral health needs were less likely to be met than physical health needs when the youth was at home. Behavioral health services increased considerably after removal from the home. Overall, Medicaid expenditures increased considerably in the year after removal, and a predictive model can be used to show which youth were likely to have the greatest increase in service use.

Third, the sub-study examined whether the receipt of behavioral health services while in out-of-home care is associated with the number of placements, and with placements in correctional facilities. Findings indicated that caregiver loss and presence of mental health disorders predict undesirable outcomes, such as greater number of out-of-home placements and placement in a correctional facility

Sub-Study Two: Services and Practice Analysis/Outcome Analysis for Safe, but High Risk for Future Maltreatment

One feature of the child welfare practice model is a distinction between children who are unsafe, and therefore require DCF intervention, and children who are at risk, whose families can receive voluntary Family Support Services (provided to safe children in high or very high risk households to increase protective factors). It was expected that children assessed using the child welfare practice model would be more likely to receive the services they need, less likely to experience another referral, less likely to experience recurrence of maltreatment, and less likely to enter out-of-home care. Two groups of cases were selected for study: (a) the intervention

group, that is children assessed under the child welfare practice model, and (b) the comparison group, that is, children who were assessed prior to the implementation of the child welfare practice model. A matched comparison group included similar cases with the dates for maltreatment reports between July 1, 2011 and July 1, 2012. Matching cases between the intervention and comparison groups was accomplished using the propensity scoring method (Rosenbaum & Rubin, 1984). Because the groups were matched, the results of analysis of variance (ANOVA) and chi-square test indicated no significant differences between groups on each of the covariates (i.e., child characteristics) included in the propensity score.

The practice analysis for sub-study two includes two components: a set of case file reviews, followed by corresponding interviews with case managers and parents. Eckerd Community Alternatives (Circuit 6) was selected for this analysis by identifying the number of cases from each agency that met the intervention criteria and selecting the agency with the highest number of qualifying cases. Once the agency was identified, a random sample of ten cases was drawn from the intervention group, and another random sample of ten cases from the comparison group. The case file reviews will compare the two groups to examine practice changes implemented under the child welfare practice model and the impact that such changes have had on family engagement and participation in voluntary services.

Lessons Learned

The goal of the Demonstration is to increase the number of children who can safely remain at home. A common theme across several components of this report are Circuit-level variations in issues related to this goal, including performance on resource family indicators and child and family well-being indicators, differences in the use of CBC appropriations by service type, and differences in child welfare professional perspectives. The evaluation will continue to examine and track these cross-Circuit variations and make related recommendations.

The caseworker focus group analysis points to a number of practice implications. Family-centered practice, including beliefs and attitudes of child welfare professionals about family engagement, are a critical strategy for reaching the goals of the Demonstration. If critical services are not readily available, caseworkers may be inclined to remove children in order to ensure safety. Relatedly, the perceived liability of child welfare professionals has a strong impact on decision-making processes. Most participants expressed feeling solely accountable for what happens on their case, and this drives a greater inclination to remove children. Many child welfare professionals support use of in-home services; however, increased communication and knowledge about available services within the local community is needed to increase confidence in the effectiveness of these interventions.

Second, although child welfare professionals' values are, for the most part, in alignment with the goals of the Demonstration, the intention of the practice model is to facilitate a more comprehensive assessment process. Child protective investigators and case managers need more training and guidance in making appropriate case decisions with regard to the use of in-home versus out-of-home interventions. This aligns well with the focus group participants' recommendations for more hands-on and field-based training.

Overall, ongoing Child and Family Service Reviews showed slight improvement for performance items and well-being outcomes, although, at the state-level, none of the improvements were found to be significant. Circuits 2, 10, 14, 15, and 17 consistently obtained higher percentages of strength ratings for many items. Circuits 1, 3, and 8 appear to be less effective in the quality of child welfare practices relevant to the well-being of children. Concentrated efforts to conduct quality assessments and provide services to meet the identified needs of parents, as well as the frequency and quality of caseworker visits with parents would improve this outcome.

The findings of sub-study one indicate that the provision of mental health outpatient services may help prevent adverse outcomes with a greater impact on prevention of placement instability compared to prevention of involvement with the justice system. Findings also indicate that timely assessment services have the strongest prevention potential. It appears that receipt of assessment services is significantly associated with reduced chances of involvement in the justice system and fewer out-of-home placements.

Next Steps

For the implementation analysis, the remainder of the key stakeholder interviews with a random sample of the leadership of lead agency case management organizations will be completed. The interview protocol is based on the evaluation questions in the Demonstration Terms and Conditions as well as the analysis of the focus groups with case managers and child protective investigators. The analysis and findings from these interviews will be included in the next progress report.

For the services and practice analysis, data collection will be completed for the service array assessment, and analysis of the findings from the survey will be presented in the next progress report. Phase 1 of the evidence-based practice fidelity assessment will begin in the spring of 2017 and will also be completed for the next progress report. Planning for Phase 2 of the evidence-based practice assessment will commence after receipt of responses from Phase 1 and provider agencies expressing an interest in participating have been identified. Development of the fidelity protocols for the Nurturing Parenting program will occur during this

time as well. Implementation of Phase 2 will begin in the fall of 2017, and no later than January 2018.

The evaluation will continue to track changes in child safety indicators examining: (a) proportion of children who were NOT removed from their primary caregiver(s) and were placed into out-of-home care within 12 months of the date their in-home case was opened; (b) proportion of children who did NOT reenter out-of-home care within 12 months of discharge; and (c) the number and proportion of children who did NOT experience verified maltreatment within six months of case closure (i.e. termination of out-of-home services or in-home supervision). The analysis will include two additional cohorts of children who were discharged from out-of-home care in SFY 14-15 and SFY 15-16 to assess the trends regarding child safety.

Regarding the child and family well-being outcomes, subsequent reports will continue to disaggregate well-being outcome findings to allow for comparisons between in-home and out-of-home care cases. Although the baseline data reported here will carry forward into the next report, findings of the ongoing review will consist of the most recent Florida CQI data available at that time (the PUR for SFY 15-16 through Quarter 1 of SFY 17-18).

Upcoming activities for the cost analysis will include a more detailed examination of the expenditure data. The next report will examine how expenditures vary across CBCs based on the characteristics of youth served by the CBCs. Finally, aggregated expenditure data starting in SFY 04-05 will provide information on patterns across a time that includes a pre-Demonstration period, an (original) Demonstration period, and a Demonstration extension period. This may provide a clearer picture of the overall effects of the IV-E Waiver.

Connecting parents to needed services can be an important step in avoiding the need to remove the child from the home, or in achieving reunification if the child is removed from the home. The purpose of this analysis is to analyze Florida Substance Abuse and Mental Health Information System (SAMHIS) and Medicaid data to examine access and service utilization for parents in the child welfare system with substance use needs. One of the primary goals of the Demonstration is to provide greater flexibility in the use of funds to better meet the needs of youth and families. To an important degree, such needs are addressed through DCF funded services. However, the Medicaid program is also an important source of services to meet the needs of families in the child welfare system. A number of important issues and questions merit additional research. Thus, to better understand the behavioral health care services received by parents with substance use problems, sub-study one will conduct an analysis of SAMH and Medicaid-funded services received by parents with youth in the child welfare system.

For sub-study two, a longitudinal design will be utilized to track outcomes for the intervention and comparison groups. The outcomes that will be examined in this sub-study focus on child safety indicators and include subsequent maltreatment reports, the occurrence of verified maltreatment after the initial voluntary case is opened, a subsequent in-home dependency case opened, and a subsequent out-of-home dependency case opened. The data source for all outcome evaluation questions will be FSFN.

Case file reviews will be conducted during the summer of 2017. The case manager and family interviews will then be scheduled and completed during the fall of 2017. An interview protocol will be developed after the case file reviews are completed and will be informed by findings from the reviews. Findings from the practice analysis will be presented in the next semi-annual progress report.

For the sub-study on cross system services and costs, the next report will examine the differences across time and across circuits in more detail. In particular, the relationship between youth characteristics and service use will be examined to determine how much of the changes over time and across circuits can be explained by differences in youth characteristics. Youth that only received DCF in-home services will also be included and compared to youth that received out-of-home services. Finally, the relationship between service use patterns will be examined as well as whether changes in service use are associated with outcomes.

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Appendix A

Interview protocol

Case Management Organization Leadership

1. What are your views regarding how the IV-E Waiver extension has impacted lead agencies and/or case management organizations (e.g., changes to the service array, changes in cost allocations and spending, etc.)?
2. One of the expectations with the IV-E Waiver was that fewer children would need to enter out-of-home care. Have you seen this trend in your local system? What impact has it had on your organization and staff (e.g., case managers and supervisors)?
    a. Have you implemented any strategies to address turnover issues?
3. As your case managers prepare for and attend court proceedings, what has been the role of the courts in facilitating the goal of fewer children needing to enter out-of-home care?
4. Are there any ways in which your lead agency or case management organization has uniquely adapted the flexibility that came with the IV-E Waiver to your local system's and community's needs? Please explain.
5. Please discuss any relevant asset mapping or needs assessments that were done in conjunction with the Waiver extension, or to facilitate service system changes desired as the result of Waiver extension.
6. What adaptations has your organization made to increase attention to Family Support and Safety Management Services in relation to what the IV-E Waiver allows?
    a. To what extent have CPIs increased attention to Family Support and Safety Management Services in relation to what the IV-E Waiver allows?
7. Another expectation of the IV-E Waiver is that changes in practice (e.g., implementation of the state service delivery model) would lead to improved outcomes for children. Have you been able to change practice as a result of the IV-E Waiver? And if so, has it had an impact on child safety, permanency or well-being over time? How so?
    a. Can you describe any barriers or supports/facilitators?
8. Whether your work is done at the policy or practice level, what are some of the current social, cultural, economic and political issues that most often impact the work that you do for children and families?

Appendix B

Verbal Informed Consent

Verbal Informed Consent to Participate in Research Involving Minimal Risk

Information to Consider Before Taking Part in this Research Study

Pro # __5830146300____

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called: **Title IV-E Waiver Demonstration Evaluation**

The person who is in charge of this research study is Mary I. Armstrong, Ph.D**.** This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. Other research team members include Amy Vargo, Svetlana Yampolskaya, Melissa Johnson, John Robst, Monica Landers, and Areana Cruz.

The research will be conducted at child welfare agencies, stakeholder offices, and through phone interviews in Florida.

This research is being sponsored by The Department of Children and Families.

Purpose of the study

The purpose of this research study is to examine the process, effectiveness, and impact of Florida's IV-E Waiver Demonstration Project and Community-Based Care. Specifically, the study focuses on implementation, organizational characteristics, monitoring, accountability, child level outcomes, cost effectiveness, and quality of services. The findings from this study will help guide policy recommendations regarding Community-Based Care and the IV-E Waiver.

Why are you being asked to take part?

We are asking you to take part in this research study because you are a judge, magistrate, or other courtroom personnel that works in or is affiliated with a child welfare agency, or have been

identified as having knowledge about certain aspects of Florida's Title IV-E Waiver and Community-Based Care.

Study Procedures:

If you take part in this study, you will be asked to give us your opinions through an interview that will take about 30-45 minutes to complete. The interview will be audio-recorded (with your permission) to make sure our notes are correct.

Total Number of Participants:

A total of 200 individuals will participate in the study at all sites over the next five years.

Alternatives / Voluntary Participation / Withdrawal:

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study. Your decision to participate or not participate will not affect your job status in any way.

Benefits:

There are no direct benefits anticipated as a result of your participation in this study. However, some personal positive aspects that you might experience are:

- You may enjoy sharing your opinions about this important topic.
- It may be beneficial that your responses could be combined with those of other individuals like yourself in a report that will be disseminated about the IV-E Waiver and Community-Based Care.
- You will help us learn more about the IV-E Waiver and Community-Based Care. What we learn from your input may help other areas as they refine their child welfare system.

Risks or Discomfort:

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study. Some people may get angry or excited when responding about some of their experiences. If you have any difficulty with a question, you may skip it and come back to it later. If necessary, you may choose not to respond to the survey and/or complete it at another time.

Compensation:

You will receive no payment or other compensation for taking part in this study.

Costs:

It will not cost you anything to take part in the study.

Privacy and Confidentiality:

We will keep your study records private and confidential. Certain people may need to see your study records. Anyone who looks at your records must keep them confidential. These individuals include:

- The research team, including the Principal Investigator, study coordinator, and all other research staff.
- Certain government and university people who need to know more about the study, and individuals who provide oversight to ensure that we are doing the study in the right way.
- Any agency of the federal, state, or local government that regulates this research. This may include employees of the Department of Health and Human Services.
- The USF Institutional Review Board (IRB) and related staff who have oversight responsibilities for this study, including staff in USF Research Integrity and Compliance.
- The sponsors of this study and contract research organization. The Department of Children and Families, the agency that paid for this study, may also look at the study records.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

You can get the answers to your questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, or experience an unanticipated problem, call Mary Armstrong at 813-974-4601.

If you have questions about your rights as a participant in this study, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.

Consent to Take Part in this Research Study

I freely give my consent to take part in this study. By participating in this interview, I understand that I am agreeing to take part in research. I have received a copy of this form for my records.

Appendix C

FL IV-E Demonstration Evaluation Service Array Survey

Thank you for taking the time to respond to this survey request. This survey is part of the evaluation for Florida's Title IV-E Waiver Demonstration Project, and is intended to gather information about the current child welfare service array available throughout the state of Florida. We understand that you have been cooperating with the Department of Children and Families in their efforts to collect information about your service array over the past months. We have coordinated this effort with the Department to avoid any duplication of effort and further burden to you. The information requested through this survey is specifically required by the Title IV-E Waiver terms and conditions. We appreciate you taking the time to provide this additional information.

Through this survey, you will be asked to provide information about the services available in your community to child welfare involved families, including eligibility criteria, service capacity, the number of families served during the past year, and procedures for assessing the services provided. Please feel free to include/engage any CBC staff that you deem appropriate or necessary in helping to answer these questions, but please only submit one survey from your CBC lead agency.

Your participation in this survey is voluntary but highly encouraged. Your responses are very important to us and will be used to assess changes in the service array over time, as well as identify any areas where there are service gaps. This will help the state of Florida to think strategically about areas where services could be enhanced and target the most critical needs.

If you have questions specific to this survey, please contact Melissa Johnson.
Phone: (813) 974-0397 Email: mhjohns4@usf.edu

If you have other questions about the evaluation, please feel free to contact the Principal Investigator, Mary Armstrong, at any time. Phone: (813) 974-4601 Email: miarmstr@usf.edu

I understand that my participation is voluntary, and by completing this survey I am giving my consent to participate.

- ❍ Yes
- ❍ No

Please indicate which CBC Lead Agency you represent.

- ❍ Families First Network
- ❍ Big Bend CBC, Inc.
- ❍ Partnership for Strong Families
- ❍ Kids First of Florida, Inc.
- ❍ Family Support Services of North Florida, Inc.
- ❍ St. Johns County Board of Commissioners
- ❍ Community Partnership for Children, Inc.
- ❍ Partnership for Strong Families
- ❍ Kids Central, Inc.
- ❍ CBC of Central Florida
- ❍ Heartland for Children
- ❍ Brevard Family Partnership
- ❍ Eckerd Community Alternatives
- ❍ Sarasota Family YMCA, Inc.
- ❍ Children's Network of Southwest Florida
- ❍ ChildNet Inc.
- ❍ Devereux Families Inc.
- ❍ Our Kids of Miami-Dade/Monroe, Inc.

In the following pages, you will be asked to provide information about the services provided in the following four categories: Family Support Services, Safety Management Services, Treatment Services, and Child Well-being Services. You will be asked about each of these service categories separately. The following definitions should be used in determining which category a particular service falls under:

Family Support Services: voluntary supportive services targeted at building a family's protective factors to prevent future child maltreatment among at-risk families. These services are offered to families where children are determined to be safe but at risk of future maltreatment.

Safety Management Services: actions activities, tasks, or imposed situations for the purpose of managing or controlling identified danger threats until the diminished caregiver protective capacities can be enhanced. These may include formal or informal services provided by professionals and non-professionals, must take immediate effect and be immediately available and sufficient to control the identified danger threats.

Treatment Services: specific, formal services or interventions designed to enhance diminished caregiver protective capacities and achieve fundamental change in a caregiver's functioning and behavior associated with the identified danger threats that have caused the child(ren) to be unsafe.

Child Well-being Services: specific, formal services or interventions that are designed to enhance certain desired conditions in the life of the child and assure that the child's physical, emotional, developmental, and educational needs are addressed. Services should be directly related to child strength and needs indicators.

Section 1: Family Support Services

This first set of questions concerns the availability and utilization of Family Support Services in your service area. Family Support Services are defined as voluntary supportive services targeted at building a family's protective factors to prevent future child maltreatment among at-risk families. These services are offered to families where children are determined to be safe but at risk of future maltreatment.

1. What are the processes for determining client eligibility for Family Support Services? (e.g. What are the eligibility criteria? How are clients assessed for eligibility?)

2. What are the procedures for referring clients to Family Support Services

3. Please answer the questions in the matrix below regarding Family Support Services provided in your community. Please identify each Family Support Service by name in the first column, then provide the additional information requested about each service in the other columns. There are spaces provided to list up to 15 distinct Family Support Services; please fill in as many rows as needed to identify each Family Support Service offered in the area(s) served by your lead agency.

Name of Family Support Service	Who provides this service? (Please provide agency name and contact info - phone number and/or email.)	What are the intended goals of the service?	In which counties of your service area is this service available? (Please list specific counties or ALL if available in every county served by your CBC.)	What is the capacity limit for this service (# of clients/ families that can be served at a time)?	What is the median/typical service duration (in months)?	How many families were referred to this service during the past 12 months?	How many families received this service during the past 12 months?

Section 2: Safety Management Services

This section concerns the availability and utilization of Safety Management Services provided in your service area. Safety Management Services are defined as actions activities, tasks, or imposed situations for the purpose of managing or controlling identified danger threats until the diminished caregiver protective capacities can be enhanced. These may include formal or informal services provided by professionals and non-professionals, must take immediate effect and be immediately available and sufficient to control the identified danger threats. Five overarching categories of services are identified: behavior management, crisis management, social connection, separation, and resource support. For the purpose of this survey, we ask that you focus on the available formal Safety Management Services in your community.

1. What are the processes for determining client eligibility for Safety Management Services? (e.g. What are the eligibility criteria? How are clients assessed for eligibility?)

2. What are the procedures for referring clients for Safety Management Services?

3. Please identify each formal Safety Management Service by name in the first column, then provide the additional information requested about each service in the other columns. There are spaces provided to list up to 15 distinct Safety Management Services; please fill in as many rows as needed to identify each Safety Management Service offered in the area(s) served by your lead agency.

Name of Safety Management Service	Please indicate which of the following safety service categories this service falls under: • Behavior Mgmt • Crisis Management • Social Connection • Separation • Resource Support	Who provides this service? (Please provide agency name and contact info - phone number and/or email.)	What are the intended goals of the service?	In which counties of your service area is this service available? (Please list specific counties or ALL if available in every county served by your CBC.)	What is the capacity limit for this service (# of clients/ families that can be served at a time)?	What is the median/typical service duration (in months)?	How many families were referred to this service during the past 12 months?	How many families received this service during the past 12 months?

Section 3: Treatment Services

This section concerns the availability and utilization of Treatment Services provided in your service area. Treatment services are specific, formal services or interventions designed to enhance diminished caregiver protective capacities and achieve fundamental change in a caregiver's functioning and behavior associated with the identified danger threats that have caused the child(ren) to be unsafe. These may include mental health, domestic violence, substance abuse, parenting, or other services intended to increase the caregiver's protective capacities.

1. What are the processes for determining client eligibility for Treatment Services? (e.g. What are the eligibility criteria? How are clients assessed for eligibility?)

2. What are the procedures for referring clients for Treatment Services?

3. Please identify each Treatment Service by name in the first column, then provide the additional information requested about each service in the other columns. There are spaces provided to list up to 15 distinct Treatment Services; please fill in as many rows as needed to identify each Treatment Service offered in the area(s) served by your lead agency. Please DO NOT include assessment services (such as mental health assessments) in your responses; only identify actual treatment interventions. If a contracted professional assessment is used to determine treatment needs, this can be noted in the eligibility criteria column.

Name of Treatment Service	Please indicate which of the following service categories this service falls under: • Mental Health/ Individual Therapy • Family Therapy • Domestic Violence • Substance Abuse • Parenting • Other	Who provides this service? Please include the agency name and contact information (email and/or phone number).	What are the intended goals of the service?	In which counties of your service area is this service available? (Please list specific counties or ALL if available in every county served by your CBC.)	What is the capacity limit for this service (# of clients/ families that can be served at a time)?	What is the median/typical service duration (in months)?	How many families were referred to this service during the past 12 months?	How many families received this service during the past 12 months?

Section 4: Child Well-being Services

This section concerns the availability and utilization of Child Well-being Services provided in your service area. Child Well-being Services are specific, formal services or interventions that are designed to enhance certain desired conditions in the life of the child and assure that the child's physical, emotional, developmental, and educational needs are addressed. Services should be directly related to child strength and needs indicators.

1. What are the processes for determining client eligibility for Child Well-being Services? (e.g. What are the eligibility criteria? How are clients assessed for eligibility?)

2. What are the procedures for referring clients for Child Well-being Services?

3. Please identify each Child Well-being Service by name in the first column, then provide the additional information requested about each service in the other columns. There are spaces provided to list up to 15 distinct Child Well-being Services; please fill in as many rows as needed to identify each Child Well-being Service offered in the area(s) served by your lead agency. Please DO NOT include assessment services (such as mental/behavioral health assessments) in your responses; if a contracted professional assessment is used to determine a child's service needs, this can be noted in the eligibility criteria column.

Name of Child Well-being Service	Please indicate which of the following service categories this service falls under: • Physical Health • Mental/Behavioral Health • Developmental Needs • Educational Needs • Other	Who provides this service? Please include the agency name and contact information (email and/or phone number	What are the intended goals of the service?	In which counties of your service area is this service available? (Please list specific counties or ALL if available in every county served by your CBC.)	What is the capacity limit for this service (# of clients/ families that can be served at a time)?	What is the median/typical service duration (in months)?	How many children were referred to this service during the past 12 months?	How many children received this service during the past 12 months?

Section 5: Provider Contracts

This final set of questions asks about some aspects of your provider contracts.

1. Do you require your contracted providers to be trained in trauma-informed care?

❍ Yes

❍ No

2. Do you require your contracted providers to be knowledgeable/skilled in working with clients who have co-morbid conditions? Co-morbidity is defined as the presence of two disorders or illnesses that occur simultaneously in an individual, and which interact to affect the course and prognosis of each condition. This may include any combination of co-occurring mental health, substance abuse, domestic violence, or physical health conditions.

❍ Yes

❍ No

3. Do you require your contracted providers to measure client-level outcomes and assess service effectiveness?

❍ Yes

❍ No

4. If you answered YES to the previous question, do you receive this information/data from your providers?

❍ Yes

❍ No

5. Do you require your contracted providers to measure/assess service fidelity?

❍ Yes

❍ No

6. If you answered YES to the previous question, do you receive this information/data from your providers?

❍ Yes

❍ No

This concludes the Child Welfare Service Array Survey

Thank you for your participation!

Appendix D

Focus Group Interview Guide

This focus group is being conducted as part of the evaluation for the Florida Title IV-E Waiver. The Waiver allows states the flexibility to use federal funds normally allocated to foster care services for other child welfare services, such as in-home and diversion services to prevent out-of-home placement, or post-reunification services to reduce the likelihood of recidivism. The intent of these questions is to better understand your practice and your perceptions of the services available to child welfare involved families in your community, including both the strengths and the challenges or barriers present in the current child welfare system. Your participation in this discussion is completely voluntary. We value your opinions and experiences, and we want to know what you think could be done to improve the system in your community and throughout the state of Florida.

1. In your opinion, what is the primary purpose of the child welfare system?
    - What is your role?
2. What things support you in doing your job well? What things make it difficult for you to do your job?
3. What do you think are the greatest challenges or barriers for families involved in the child welfare system? (e.g. in caring for their children, in completing their case plan, in making sustainable changes to improve their personal and family functioning)
    - How do you support and encourage the families on your caseload?
4. How do you identify and assess family needs?
    - How are families engaged in this process? (Probe: parents, children, others)
    - What are the processes for connecting clients to appropriate services based on their identified needs?
5. How do you assess a family's progress and changes over time (e.g. behavior change)?
    - How is the family engaged in this process?
6. How does practice differ between in-home and out-of-home cases?
7. How are decisions made about whether a child can remain safely in the home or needs to be removed?
    - What factors, indicators and/or evidence inform these decisions?
    - Under what circumstances can an in-home safety plan be implemented?
    - What circumstances warrant the removal of the child?

- What strategies are used to avoid unnecessary out-of-home placement?

8. What are your primary concerns about keeping children in the home when there is a substantiated report of abuse or neglect?
    - What could be done to alleviate these concerns?
9. What do you think are the benefits of keeping children in the home while working with families?
    - What services are available to support family preservation?
10. For out-of-home cases, how are decisions made about reunification and when a child can be returned home?
    - What factors, indicators or evidence inform these decisions?
    - What services are available to support successful reunifications?
11. To the best of your knowledge, how would you describe the availability of services for families involved with the child welfare system in your community?
    - To what extent are adequate services available to meet the various needs of clients? What EBPs are used? What are the current barriers/gaps in the service array?
12. What do you like most about your job? What do you like least or find most challenging?
13. What would you like to see change about the current child welfare system?

Appendix E
Measures

Measure 1: The number and proportion of new licensed foster families that have recruited during a specific fiscal year.

This measure is a percent. The numerator is all foster families who received licenses for the first time during a specific fiscal year. The denominator is all children who were placed in out-of-home care and received at least one day of services during a specific fiscal year.

Appendix F

Results of Statistical Analyses

Table F1

Number of New Licensed Foster Families Recruited in State Fiscal Year 2011-2012

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	288	2,207	13.05
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.*	88	816	10.78
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families*	51	510	10.00
Circuit 4	Clay, Duval, Nassau	Kids First of Florida, Inc. Family Support Services of North Florida, Inc.	310	1,910	16.23
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	157	2,005	7.83
Circuit 6	Pasco, Pinellas	Eckerd Community Alternatives	353	4,058	8.70
Circuit 7	St. Johns, Flagler, Putnam, Volusia	Community Partnership for Children, Inc.	163	2,416	6.75
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families*	50	659	7.59

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 9	Orange, Osceola	CBC of Central Florida	239	2,148	11.13
Circuit 10	Hardee, Highlands, Polk	Heartland For Children	154	2,201	7.00
Circuit 11	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.*	396	2,917	13.57
Circuit 12	DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	146	1,563	9.34
Circuit 13	Hillsborough	Eckerd Community Alternatives	399	2,727	14.63
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.*	87	687	12.66
Circuit 15	Palm Beach	ChildNet, Inc.	200	1,756	11.39
Circuit 16	Monroe	Our Kids of Miami-Dade/Monroe, Inc.*	19	138	13.77
Circuit 17	Broward	ChildNet, Inc.	382	1,949	19.60
Circuit 18	Seminole, Brevard	CBC of Central Florida Brevard Family Partnership	164	1,577	10.40
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC	90	1,276	7.05
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	250	1,414	17.68
State of Florida			4,051	34,936	11.59

Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

Table F2

Number of New Licensed Foster Families Recruited by State Fiscal Year 2012-2013

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	73	1,900	3.84
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.*	30	724	4.14
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families*	17	536	3.17
Circuit 4	Clay, Duval, Nassau	Kids First of Florida, Inc. Family Support Services of North Florida, Inc.	86	1,666	5.16
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	36	2,018	1.78
Circuit 6	Pasco, Pinellas	Eckerd Community Alternatives	129	3,967	3.25
Circuit 7	St. Johns, Flagler, Putnam, Volusia	Community Partnership for Children, Inc.	48	2,225	2.16
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families*	16	593	2.70

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 9	Orange, Osceola	CBC of Central Florida	47	1,907	2.46
Circuit 10	Hardee, Highlands, Polk	Heartland For Children	44	2,007	2.19
Circuit 11	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.*	80	2,984	2.68
Circuit 12	DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	39	1,339	2.91
Circuit 13	Hillsborough	Eckerd Community Alternatives	122	2,743	4.45
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.*	29	689	4.21
Circuit 15	Palm Beach	ChildNet, Inc.	50	1,759	2.84
Circuit 16	Monroe	Our Kids of Miami-Dade/Monroe, Inc.*	4	136	2.94
Circuit 17	Broward	ChildNet, Inc.	91	2,003	4.54
Circuit 18	Seminole, Brevard	CBC of Central Florida Brevard Family Partnership	43	1,518	2.83
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC	25	1,129	2.21
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	84	1,464	5.74
State of Florida			1,113	33,317	3.34

Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

Table F3

Number of New Licensed Foster Families Recruited by State Fiscal Year 2013-2014

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	82	1,777	4.61
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.*	22	676	3.25
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families*	19	555	3.42
Circuit 4	Clay, Duval, Nassau	Kids First of Florida, Inc. Family Support Services of North Florida, Inc.	106	1,638	6.47
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	63	1,859	3.39
Circuit 6	Pasco, Pinellas	Eckerd Community Alternatives	110	3,615	3.04
Circuit 7	St. Johns, Flagler, Putnam, Volusia	Community Partnership for Children, Inc.	46	1,852	2.48
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families*	19	566	3.36

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 9	Orange, Osceola	CBC of Central Florida	61	1,851	3.30
Circuit 10	Hardee, Highlands, Polk	Heartland For Children	49	2,000	2.45
Circuit 11	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.*	42	3,505	1.19
Circuit 12	DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	30	1,269	2.36
Circuit 13	Hillsborough	Eckerd Community Alternatives	92	2,557	3.60
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.*	21	666	3.15
Circuit 15	Palm Beach	ChildNet, Inc.	77	2,067	3.73
Circuit 16	Monroe	Our Kids of Miami-Dade/Monroe, Inc.*	2	174	1.15
Circuit 17	Broward	ChildNet, Inc.	161	2,214	7.27
Circuit 18	Seminole, Brevard	CBC of Central Florida Brevard Family Partnership	44	1,555	2.83
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC	18	1,170	1.54
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	104	1,723	6.04
State of Florida			1,189	33,310	3.56

Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

Table F4

Number of New Licensed Foster Families Recruited by State Fiscal Year 2014-2015

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	85	2,109	4.03
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.*	17	765	2.22
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families*	27	611	4.42
Circuit 4	Clay, Duval, Nassau	Kids First of Florida, Inc. Family Support Services of North Florida, Inc.	95	1,754	5.42
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	52	1,969	2.64
Circuit 6	Pasco, Pinellas	Eckerd Community Alternatives	88	3,458	2.54
Circuit 7	St. Johns, Flagler, Putnam, Volusia	Community Partnership for Children, Inc.	41	2,001	2.05
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families*	26	578	4.50

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 9	Orange, Osceola	CBC of Central Florida	39	1,998	1.95
Circuit 10	Hardee, Highlands, Polk	Heartland For Children	43	2,028	2.12
Circuit 11	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.*	76	4,032	1.88
Circuit 12	DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	31	1,388	2.23
Circuit 13	Hillsborough	Eckerd Community Alternatives	84	2,679	3.14
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.*	17	673	2.53
Circuit 15	Palm Beach	ChildNet, Inc.	92	2,197	4.19
Circuit 16	Monroe	Our Kids of Miami-Dade/Monroe, Inc.*	3	186	1.61
Circuit 17	Broward	ChildNet, Inc.	165	2,770	5.96
Circuit 18	Seminole, Brevard	CBC of Central Florida Brevard Family Partnership	47	1,862	2.52
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC	65	1,328	4.89
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	122	1,874	6.51
State of Florida			1,237	36,270	3.41

Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

Table F5

Number of New Licensed Foster Families Recruited by State Fiscal Year 2015-2016

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	77	1,674	4.60
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.*	29	636	4.56
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families*	20	608	3.29
Circuit 4	Clay, Duval, Nassau	Kids First of Florida, Inc. Family Support Services of North Florida, Inc.	119	1,522	7.82
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	60	1,969	3.05
Circuit 6	Pasco, Pinellas	Eckerd Community Alternatives	99	2,816	3.52
Circuit 7	St. Johns, Flagler, Putnam, Volusia	Community Partnership for Children, Inc.	47	2,067	2.27
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families*	19	575	3.30

Circuit	Counties in Circuit	Lead Agencies	Number of New Licensed Foster Families	Number of Children served	Recruitment Rate
Circuit 9	Orange, Osceola	CBC of Central Florida	72	1,627	4.43
Circuit 10	Hardee, Highlands, Polk	Heartland For Children	46	1,707	2.69
Circuit 11	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.*	89	2,818	3.16
Circuit 12	DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	21	1,404	1.50
Circuit 13	Hillsborough	Eckerd Community Alternatives	98	2,207	4.44
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.*	29	658	4.41
Circuit 15	Palm Beach	ChildNet, Inc.	83	1,646	5.04
Circuit 16	Monroe	Our Kids of Miami-Dade/Monroe, Inc.*	5	153	3.26
Circuit 17	Broward	ChildNet, Inc.	141	2,416	5.84
Circuit 18	Seminole, Brevard	CBC of Central Florida Brevard Family Partnership	72	1,610	4.47
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC	68	1,092	6.23
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	103	1,689	6.10
State of Florida			1,308	30,897	4.23

Note. *Because this lead agency serves two circuits, the number of families recruited was divided according to the proportion of children served between two circuits.

Appendix G

Sub-Study Two Case File Review Protocol

Date of Case Review _____ / ____ / _____ FSFN ID#_____

Reviewed by: _____

Part 1: Investigation	
1. Date case open to investigation: ____ / _____ / _____ 2. Assigned CPI: _____	
3. Gender of Child(ren) in family: Child 1: ☐Female ☐Male Child 2: ☐Female ☐Male Child 3: ☐Female ☐Male Child 4: ☐Female ☐Male Child 5: ☐Female ☐Male	4. Birthdates of Child(ren): Child 1: ____ / _____ / _____ Child 2: ____ / _____ / _____ Child 3: ____ / _____ / _____ Child 4: ____ / _____ / _____ Child 5: ____ / _____ / _____
5. Adults in household in relation to children: Adult 1: _____ Adult 2: _____ Adult 3: _____ Adult 4: _____	6. Birthdates of adults: Adult 1: ____ / _____ / _____ Adult 2: ____ / _____ / _____ Adult 3: ____ / _____ / _____ Adult 4: ____ / _____ / _____
7. Maltreatment allegations and findings from investigation:	

Allegation	Investigation findings	Result
1.		☐ Substantiated ☐ Unsubstantiated
2.		☐ Substantiated ☐ Unsubstantiated
3.		☐ Substantiated ☐ Unsubstantiated

4.		☐ Substantiated ☐ Unsubstantiated
5.		☐ Substantiated ☐ Unsubstantiated
6.		☐ Substantiated ☐ Unsubstantiated

8. Identify who was included in the initial family assessment process, and how they were engaged by the investigator in this process:

Individual	Included?	If yes, how were they engaged? If no, provide any available information as to why not.
Mother/ female legal guardian	☐Y ☐N	
Father/ male legal guardian	☐Y ☐N	
Children	☐Y ☐N	
Other household members (please identify):	☐Y ☐N	
Other relatives/ extended family outside the household (please identify):	☐Y ☐N	

Other non-relative collaterals (e.g. neighbors, friends, school, health providers, etc. Please identify):	☐Y ☐N	

9. What other sources of information were used to complete the family assessment?

10. Did the family assessment contain the following elements:

Caregivers'/parents' capacity to protect and nurture the children. ☐Y ☐N

Observations of interactions between the children and household members. ☐Y ☐N

Whether the children can live safely in the current home or placement. ☐Y ☐N

Factors that may place the children's safety at risk. ☐Y ☐N

An assessment of the family's strengths and resources. ☐Y ☐N

An assessment of the family's needs that hinder providing a safe and stable home. ☐Y ☐N

Identification of special needs of the child and family. ☐Y ☐N ☐N/A

The family's perspective of their needs and strengths. ☐Y ☐N

11. What are the identified family strengths?

12. What are the identified family needs?

13. What were the safety and risk determinations?

Case referred to FSS? ☐Y ☐N Date of referral: ____ / _____ / _____

14. Describe any strategies or practices evidenced in the file that were used to obtain family buy-in and encourage family engagement in services:

15. Any additional notes related to the investigation/ initial assessment process:

Part 2: Case Management

1. Date case open to FSS: ____ / _____ / _____ 2. Assigned CM: _____

3. If applicable, were updated family assessments completed to reflect current and relevant information impacting the child(ren)'s level of risk? ☐Y ☐N ☐N/A

Date(s) of subsequent assessments: ___ /___ / ____ ___ /___ / ____ ___ /___ / ____ ___ /___ / ____

Is there evidence that the family was engaged in the ongoing assessment process? ☐Y ☐N

Explain/describe:

Was each updated assessment signed and approved by the CM supervisor? ☐Y ☐N ☐N/A

4. Additional notes related to family assessment:

5. List the name and date of completion for all other assessments of the child(ren) and family included in the file.

Name of assessment:	Purpose of assessment	Date of assessment:
		___ / ____ / ____
		___ / ____ / ____
		___ / ____ / ____
		___ / ____ / ____

6. List the type and date of any staffings/meetings held to discuss needs and service planning for the family and who attended. Include family team meetings/family group decision making meetings, if applicable.

Staffing type: _____ Date: ___ / ____ / ____

Who attended:

Staffing type: _____ Date: ___ / ____ / ____

Who attended:

Staffing type: _____ Date: ___ / ____ / ____

Who attended:

7. Is there evidence that the family *participated and was engaged* in the staffing(s)?
☐Y ☐N

Explain/describe:

8. Is there evidence that the voice of the family was considered during the staffing/service planning process?

☐Y ☐N

Explain/describe:

9. Were the needs and strengths of the family as identified through the assessment process discussed in the staffings/family meetings? ☐Y ☐N

Explain:

10. Were formal services and informal supports identified that match the needs and strengths of the family?

☐Y ☐N

List the identified services and supports:

11. Is there evidence of follow up by the CM on service recommendations, referrals, service receipt, and any challenges encountered by the family? ☐Y ☐N Explain/describe:
12. Is there evidence that the CM communicates with the family regarding their services and progress on a regular basis (e.g. at least every 30 days) ☐Y ☐N Explain/describe, including frequency of face-to-face and other contacts:
13. Is there evidence that the CM follows up with concerns expressed, questions asked, or additional needs identified by the family during home visits or other contacts? ☐Y ☐N Explain/describe:
14. Describe any strategies or practices evidenced in the file that were used to encourage family engagement in services:
15. Identify strengths of the case management process as evidenced in the file.

16. Identify challenges of the case management process as evidenced in the file.
17. Date case closed: ____/____/____ Summary/description of family progress and reason for case closure: