How States Developed Plans to Meet a Federal Mandate: Addressing the Challenges of the Child and Family Services Reviews

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ABSTRACT

Much of the child welfare literature addresses risk factors, incidence, and consequences of abuse and neglect, and innovative programs, services, and interventions designed to serve at-risk and maltreated children, youth, and their families. Less attention has been given to how state and local governments oversee the public child welfare system and respond to federal mandates, especially in achieving positive outcomes for this vulnerable population.

In 1997, the Congress enacted the Adoption and Safe Families Act (ASFA). This legislation mandates that all states meet certain performance and accountability standards regarding safety, permanency, and well-being of children served by their child welfare systems. These issues are important for the approximately 500,000 children in foster care at any point in time. There is also significant concern for the millions of children involved in the child welfare system through investigations, court proceedings, and both mandated and voluntary services.

A significant effort resulting from ASFA is the Child and Family Services Reviews (CFSRs). The myriad requirements under ASFA and the CFSRs create a federal mandate for changes in the way state child welfare systems meet the needs of the children, youth, and families they serve and a process for improving federally defined outcomes.

This study examined how states responded to federal requirements of the CFSRs. Specifically, it looked at how states proposed to address shortcomings identified in relation to two individual child and family well-being outcomes and two systemic factors where they had

failed to meet conformance criteria in their CFSR. It is important to understand how the federal-state process transpired to ameliorate these conditions without additional federal funding to implement the CFSR requirements.

Results of this study describe six states' strategies related to two well-being outcomes, specifically in the areas of education, physical health, and mental health, and two systemic factors, service array and agency responsiveness to the community, as identified in their Program Improvement Plans (PIPs). Four central themes emerge: complexity of the problems, knowledge base and data to guide improvements, resource availability, and collaboration among agencies. These themes help inform states on the potential benefits and challenges in responding to federal mandates.

DEDICATION

It is hoped that this project will highlight the importance for all stakeholders – public, private, and community – that thoughtful and intentional planning, effective collaboration and coordination, and the commitment of our time, our energy, and our resources are essential to improving the well-being of children and their families.

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LIST OF ABBREVIATIONS

AACWA	Adoption Assistance and Child Welfare Act
ACF	Administration for Children and Families
ACYF	Administration on Children, Youth, and Families
AFDC	Aid to Families with Dependent Children
AFCARS	Adoption and Foster Care Analysis and Reporting System
ASFA	Adoption and Safe Families Act of 1997
CFSP	Child and Family Services Plan
CFSR	Child and Family Services Review
EPSDT	Early Periodic Screening, Diagnosis, and Treatment (child health component of Medicaid)
HHS	Department of Health and Human Services
NCANDS	National Child Abuse and Neglect Data System
PIP	Program Improvement Plan
SACWIS	Statewide Automated Child Welfare Information System
TANF	Temporary Assistance for Needy Families
UMRA	Unfunded Mandates Reform Act of 1995

CHAPTER 1 – INTRODUCTION

States have developed a variety of strategies to address mandated outcomes associated with the federal Adoption and Safe Families Act of 1997 (ASFA) and ensuing federal requirements of the Child and Family Services Reviews (CFSRs). As part of the CFSRs, states must meet federal outcome requirements for child safety, permanency, and well-being. This study investigates the responses of states to the CFSR well-being requirements in order to elucidate the complexity and challenges associated with meeting this relatively new mandate. This chapter provides a broad overview of ASFA and the CFSRs, the characteristics of the child welfare system in the United States, and the scope and purpose of this study.

ASFA and the CFSRs are administered under the Children's Bureau, located within the federal Department of Health and Human Services' (HHS) Administration for Children and Families (ACF). The ASFA legislation mandates that all states, including the District of Columbia and Puerto Rico, meet certain performance and accountability standards regarding the safety, permanency, and well-being of children in their child welfare systems. In this context, safety refers to protecting children from abuse and neglect. Permanency relates to efforts either to maintain children in their own home or, when this is not possible, establish a stable living environment with other relatives, foster parents, or adoptive parents. Well-being addresses the child's education, physical health, mental health, and overall functioning of the family. States have special responsibility in these three domains for the approximately 500,000 children in foster care at any point in time. Additionally, states are responsible for children involved in all aspects of the child welfare system, from child protection investigations to services for those youth who have left foster care.

The myriad requirements under ASFA and the CFSRs create a federal mandate for changes in the way state child welfare systems meet the needs of the children, youth, and families they serve and a process for improving outcomes. There is a significant history of efforts to improve outcomes for children and their families served by the child welfare system, including federal oversight, state legislation, and lawsuits aimed at the administering agencies. Over the past two decades, the field of child welfare has also been influenced by the broader movement to enhance performance accountability for government services. A critical component of improving performance accountability is having appropriate measures and reliable data to enable a process of continuous quality improvement. Within ASFA and the CFSRs there are specific requirements to assess and measure how states meet federally defined outcomes for the safety, permanency, and well-being of the children, and how they meet conformance criteria on systemic factors related to the states' operation of their child welfare systems. The CFSR process is intended to promote continuous quality improvement through an ongoing cycle of review of the states and increasingly higher standards of performance.

Prior to its enactment, the ASFA legislation was reviewed under the strict criteria of the federal Unfunded Mandates Reform Act of 1995 (UMRA). UMRA was intended to restrain Congress from imposing federal mandates on the states without accompanying funding. When ASFA was reviewed under UMRA, it was determined *not* to be an unfunded mandate, although there are no additional funds provided to the states under the legislation. In fact, there is a threat of financial penalty for non-conformance through the reduction of federal payments to the states for child welfare services. However, as a result of ASFA and the ensuing CFSRs, states are now required to implement program improvements and broad systemic changes, many of which require additional funding or at a minimum, the reallocation of funding. Consequently, in

responding to these federal requirements, states may actually view ASFA and its ensuing CFSR provisions as constituting an unfunded federal mandate, rather than simply a mandate.

The issue of mandated outcomes in child well-being is important to consider in the field of public administration and policy because it elucidates how legislation and policy are implemented and funded, relationships among levels of government, and the role of government in attending to the needs of vulnerable populations. These are some of the most challenging issues facing society in terms of the state intervening in the role of the family, society promoting child development and well-being, and multiple agencies and policies interacting at the federal, state, and local level. This is where using legislation and policy to affect some condition or situation can be expected to be the most complex and challenging, because it relates to some of the most complex forms of human knowledge and behavior.

Child welfare systems generally serve a disadvantaged population. The children and families interacting with child welfare systems are often characterized by chronic social problems (Webb & Hardin, 2003) such as poverty, family dysfunction, mental illness, substance abuse, domestic violence, and residence in deprived neighborhoods. Further, from the perspective of the parents, child welfare services are often not voluntary or welcome.

The long term outcomes for children with significant involvement in the child welfare system are affected by these factors, as well as the trauma of their maltreatment, and separation from their families. Children involved in the child welfare system experience higher rates of mental illness, lower academic achievement, and poorer physical health than youth in the general population (Austin, 2004; Burns et al., 2004; Christian, 2003; Simms, Dubowitz, & Szilagyi, 2000; Webb & Harden, 2003; Wulczyn, Barth, Yuan, Harden, & Landsverk, 2005). The factors that lead to children entering the child welfare system in the first place contribute greatly to these

outcomes; however once involved in the system, children experience frequent moves and other disruptions that often exacerbate the instability and discontinuity in their lives (Austin, 2004). Some of the problems have been attributed to the way the child welfare work is funded and administered.

How the Child Welfare System Operates

The child welfare system in this country is a complex labyrinth of policies and funding that involves the federal, state, and local governments. At the federal level, the Administration for Children and Families within the Department of Health and Human Services is at the center, and is responsible for interpreting and funding the federal legislation that is subsequently implemented at the state and local levels. Several other federal level agencies and programs also play a significant role in the lives of children and their families involved in the child welfare system, particularly in the area of well-being that includes physical health, mental health, and education. Specifically, multiple agencies within the Department of Health and Human Services have programs related to the physical and mental well-being of children and families, as does the Department of Education (DOE) with regard to educational well-being.

The system is similarly complex at the state and local level in that there are multiple agencies at these levels of government that also play a key role in the lives of children and their families. Although the funding for child welfare services comes predominantly from the federal government, states and, to some degree, localities also enact legislation and provide funding to support the child welfare system. These systems are typically organized under the states' social services agencies, although there is variance among the states in how the programs are structured and administered.

There are two primary ways that the federal government functionally defines the states' administration of their child welfare agencies. States are generally either state administered, or state supervised/county administered. According to the federal Children's Bureau, thirty-eight states are categorized as state administered, and twelve states are categorized as state supervised/county administered.[1] In general, state administered systems oversee both the administration and funding for child welfare services throughout the state. In state supervised/county administered systems, the state delegates administrative responsibility and substantial control to counties or other local entities with variation in the proportion of local funding required for services.

Depending on the administrative structure of the child welfare system within a state, the local governments may also develop policies and practices that guide the system and may appropriate local funding for some of the components of administration and service delivery. Further, within states and localities the areas of physical health, mental health, and education are also typically managed and funded by agencies other than the agency that administers child welfare. States also vary greatly in the legislation, policies, and procedures that require or support collaboration across these agencies.

The ASFA and the CFSRs are intended to promote this cross-agency collaboration on behalf of children and families involved in the child welfare system. The CFSR includes seven individual child and family outcomes and 23 associated measures that pertain to the safety, permanency, and well-being of children. In addition, the CFSR includes seven broad systemic factors with 22 corresponding measures considered to underlie effective child welfare practice at the state and local level. These systemic factors address aspects of state child welfare agency

[1] Source: http://www.acf.hhs.gov/cb

operations relevant to achieving the desired individual child and family outcomes. These systemic factors also address the state child welfare agency's ability to incorporate broad stakeholder input and collaborate in the planning, coordination, and delivery of services.

The requirement to meet conformance in the CFSR areas of physical health, mental health, and education poses a significant challenge for the states. As described above, the intergovernmental nature of child welfare services is complex. The CFSR effectively requires the state child welfare agency to achieve conformance in these well-being outcomes, even though they lack control over the other state and local agencies that provide services in the physical heath, mental health, and educational arenas. In addition, this conformance must be accomplished in the context of what may be viewed as an unfunded mandate with the threat of financial penalties.

Scope and Purpose of the Study

One of the most complex areas of law, policy, regulation, and enforcement relates to the roles and responsibilities of parents and the government for the safety, care, education, and well-being of children. This study examined one specific area of the states' response to federal legislation and policy mandating responsibility for the well-being of children involved in the states' child welfare systems. Understanding of these issues must be based on both the broad context of child welfare systems and the specifics of the ASFA legislation and CFSR policy.

The purpose of the study is to inform states on the benefits and challenges of responses to federal mandates in the human services arena, examine the role of collaboration across different levels of government to meet an important societal need, and help ensure the effectiveness of public investment in promoting the well-being of vulnerable children and their families. This research examined how states responded to the federal requirements of improving the individual

child and family well-being outcomes, and meeting conformance criteria on the systemic factors related to the operation of their child welfare systems intended to enhance these outcomes. As noted above, the CFSR includes seven individual and family outcomes and seven systemic factors. Three of these outcomes are related to child well-being. Two of the well-being outcomes and two systemic factors were selected as the focus of this study. The two well-being outcomes selected are:

- Children receive appropriate services to meet their educational needs
- Children receive adequate services to meet their physical and mental health needs

The two systemic factors selected are:

- Service array
- Agency responsiveness to the community

The two well-being outcomes were selected for this study because they represent particular challenges in the administration of public child welfare services. Outcomes in the well-being areas of education, physical health, and mental health typically require coordination and collaboration with and among other public and private agencies. Child welfare agencies generally do not have authority over the policies and resources of these agencies. These other agencies are not held accountable for child welfare outcomes, nor are they required to allocate specific resources for children served by the child welfare agency.

The two systemic factors noted above (Service Array and Agency Responsiveness to the Community) were selected because the indicators or measures associated with them draw attention to the availability, accessibility, and individual appropriateness of a state's services, as well as a state's coordination and collaboration with others to meet the needs of children and their families.

Research Questions

The intersection of the two well-being outcomes and two systemic factors best illuminates the issues and challenges state child welfare agencies face in responding to a complex mandate. Further, because additional federal funding was not made available to the states to implement the requirements of the CFSRs, the assumption underlying this research is that the CFSRs are effectively an unfunded federal mandate and that the states had to make decisions regarding their approaches to address the CFSRs within that context. The research question guiding this study takes these factors into consideration: How did states respond to the complex requirements of the federal CFSRs regarding well-being outcomes, given the need for the involvement of multiple systems? Two related questions are also addressed. First, how does the way that child welfare systems operate make addressing the well-being components particularly challenging? Second, how do the relationships among different levels of government and across different agencies affect the child welfare agencies' capacity and ability to assure child well-being?

A Public Policy Framework for Describing the Challenges of Child Well-being

Significant shortcomings were identified in all fifty-two states and jurisdictions during the initial CFSRs, thus each state had to respond to these shortcomings by developing a Program Improvement Plan (PIP) that detailed the state's proposals to address the findings of the CFSR. This study reviews the states' strategies for meeting the CFSR well-being requirements through a detailed examination of the PIPs and subsequent federally required reporting. Results of this study will help to inform states on the benefits and challenges of responses to federal mandates in the human services arena. This work also provides a view of some of the ways collaboration occurs across different levels of government to meet an important societal need. Further,

promoting the well-being of vulnerable children and families is an important investment in the future and ensuring the effectiveness of this investment is a critical public policy issue.

This study identifies four broad themes that characterize the common challenges states faced in addressing the well-being requirements of the CFSRs. For purposes of this research, the framework for describing the challenges that states faced in meeting the well-being requirements of the CFSRs is based on the work of Mazmanian and Sabatier (1989). Policy implementation is a major concern in the social services arena where the issues are confounded by complex human and social problems, limited knowledge and information regarding effective programs and interventions, inadequate funding and constraints on the way resources can be used, and insufficient collaboration among relevant child serving agencies. Application of relevant components of such a framework can be a useful way to examine these challenges. In the human services policy arena, specifically children's mental health and welfare reform (Friedman, 2003; Riccucci et al., 2004), the Mazmanian and Sabatier framework has most recently been used to both illustrate the challenges and guide those concerned with optimizing effective policy implementation.

Policy implementation is a dynamic process that is complicated by a number of factors and variables. Mazmanian and Sabatier (1989) conclude that identifying and recognizing the potential effect of these variables and how they can and do affect the implementation of policy is an important step toward understanding and anticipating obstacles.

Several methods are used to explore the states' approaches to meeting the CFSR well-being requirements. The results of the analysis are described using the variables identified in the Mazmanian and Sabatier framework. This framework encompasses three categories of variables that can affect policy implementation. They are: (1) tractability of the problem, (2) ability of

statute to structure implementation; and (3) non-statutory variables that affect implementation. Discussion of the results in the context of these variables is used to ground this research in the broader discourse of public child welfare policy and administration. It also serves to identify areas where the implementation of the CFSR continuous quality improvement process, particularly in addressing well-being outcomes, can be expected to face certain obstacles. This framework is discussed in detail in Chapter 5, and its elements are used to describe the results, frame the conclusions, and advance the discussion of the way that child welfare is administered by the states. The three categories of variables in the Mazmanian and Sabatier framework were used following the research and analysis component of this study and were not used to frame the approach, guide the research questions, nor to select and code the data and information.

CHAPTER 2 – BACKGROUND AND CONTEXT FOR CHILD WELFARE SERVICES

This study is concerned with the administration of public child welfare services. In this context, it seeks to address several questions: How did states respond to the complex requirements of the federal CFSRs regarding well-being outcomes, given the need for the involvement of multiple systems? How does the way that child welfare systems operate make addressing the well-being components particularly challenging? How do the relationships among different levels of government and across different agencies affect the child welfare agencies' capacity and ability to assure child well-being?

This chapter begins by providing the background necessary to understand the complex development of policy and practice in child welfare. It includes a brief history of the different service systems most relevant to child welfare, with a specific focus on the systems affecting child well-being. This history provides the context in which child welfare systems operate. It spans the timeframe from the beginnings of these systems in the United States through the enactment of the Adoption and Safe Families Act of 1997 and its ensuing CFSRs. Understanding the child well-being mandate necessitates inclusion of the intersection of child welfare policy with the role of other public child serving systems.

The child welfare policy literature is then reviewed, specifically as it is relevant to the recent mandate of child well-being as an outcome for children and their families served by child welfare agencies. This includes a detailed description of the CFSR process and its role in the federal mandate for improving services and outcomes in child welfare. The discussion extends beyond the child welfare field to help explain the issues of complexity, the need for a sound knowledge base and reliable data, resource and funding concerns, and the challenges and benefits of collaboration in effecting change.

The chapter concludes with an identification of some of the gaps in the child welfare policy literature concerning the challenges in meeting the well-being needs of children and their families. This study contributes to the child welfare policy literature by highlighting the importance of developing knowledge about mandates, systems, and outcomes; enhancing and coordinating resources; and improving collaboration among different levels of government and the various relevant agencies at each level.

Background and History of Systems and Policies Affecting Child Welfare

Since the origins in this country of what is known as "the child welfare system," policymakers and practitioners alike have continuously gained knowledge and expertise regarding the needs of children and families served by the system. Aspects of this knowledge have culminated in significant federal legislation intended to improve the outcomes for children served by the child welfare system and to promote the effective operation of these systems.

As a broad discipline, the field of child welfare covers national and international arenas and encompasses both policy and practice across the various domains affecting the lives of children and their families. The field of child welfare incorporates a range of issues such as child and family rights, culture, poverty, health, education, government and private sector roles and responsibilities, service delivery, funding and financial management, system effectiveness, and accountability. However, not all of these issues have been addressed to the same degree in child welfare policy research and literature.

To appreciate more fully the complexity of the child welfare system in the United States, it is important to understand some of the history and context of legislative developments that established the framework for its present mandate, funding, and operations. However, one can not look at the issues related to children and their families and their involvement in public

systems simply from the perspective of the child welfare system. Many other public sector systems provide services to children and their families, and particularly to vulnerable children and families that are determined to be at-risk for negative outcomes or are behaving outside of societal norms. Especially for those children in the child welfare system with emotional or behavioral disabilities, effective service delivery may require simultaneous or successive involvement of the educational system, the juvenile justice system, and the mental health system (Anderson, 2000).

Each of the systems evolved from early movements and each has developed its own mission and mandates at the federal level. There are also numerous conditions and developments at the state and local level that have influenced the implementation of these mandates, associated policies, and practices. Although each system serves children, youth, and their families, each has its own values, educational and professional requirements for its staff, eligibility criteria and funding mechanisms, and approaches to accountability. There is broad recognition (Anderson, 2000; Hutchison & Charlesworth, 2000; Altshuler, 2003; Christian, 2003; Webb & Harden, 2003; Allen & Bissell, 2004) of the great overlap among these systems at the federal, state, and local level with regard to the populations they serve, funding availability for programs and services, and policies and practices to deliver the services. However, historically there has been little coordination of the programs and services available through these systems and little collaboration across the agencies that deliver them. The result is a fragmented service delivery system that is often difficult for children, youth, and families to navigate and access (Ledford, 2001). This system is limited in its ability to address their needs comprehensively, and lacks any coherent approach to addressing performance accountability and defining outcomes. To provide context for the many issues facing the child welfare system, a

brief overview of the major legislation guiding three of the other primary public systems that serve at-risk children and youth is provided, as well as a more detailed review of the child welfare system.

Establishing the Educational System

The federal role in establishing public education in the states began with the Ordinance of 1785 which reserved land in every township for public schools (Tyack, 1987). One of the important results of the land grants established by Congress was that they helped to subsidize the creation of common schools. This inducement served to stimulate leaders in the new states to provide public education among the array of institutions designed to build a republican form of government. Throughout the nineteenth and first half of the twentieth century, state constitutional provisions, state and local relationships, and federal Supreme Court actions shaped the development of public schools and the role of state and local governments in educating children (Butts, 1978).

The Elementary and Secondary Education Act of 1965 (ESEA) was a significant piece of legislation aimed at reducing inequality in education by providing federal aid to most of the 18,000 school districts in the U.S. at the time (Butts, 1978). The Act was renamed the No Child Left Behind (NCLB) Act of 2001. The roles of federal, state, and local governments in addressing the educational needs of children continue to be defined as evidenced by NCLB. One of the components of NCLB was the reauthorization of the federal McKinney-Vento program which helps to ensure access to public education for homeless children and youth including, in some cases, children awaiting a foster care placement (United States Department of Education, 2004).

Development of the public educational system has a long history. Attention to the educational needs of children with disabilities also has a long history, emerging as an issue in North America more than a century ago (Winzer, 1993). Since that time, there has been continued modification of the educational system to develop the resources, services, and accountability deemed necessary to educate children with special needs. The landmark legislation in the educational arena for these youth was passed in 1975 with the Education for All Handicapped Children Act (EAHCA). The legislation was enacted to create the entitlement that all eligible children receive a free and appropriate public education. This federal legislation was renamed the Individuals with Disabilities Education Act (IDEA) in 1990 and was reauthorized in 2004. In part, IDEA governs how states and public agencies provide special education and related services to children and youth with disabilities. States must comply with IDEA's standards and procedural requirements to remain eligible to receive federal funds to support educational programming (Stein, 1998).

Children involved in the child welfare system, particularly children and youth in foster care, comprise one of the most vulnerable populations served by the educational system (Zetlin, 2006). Compared with non-foster youth, children in foster care have higher rates of absenteeism, are more likely to be below grade-level, have poorer academic performance, and are identified as special education eligible at disproportionate rates (Goerge, 1992; Christian, 2003).

Establishing the Juvenile Justice System

The juvenile court system was founded in 1899. The creation of the juvenile court system was a milestone in the relationship of the state to families and children. It formalized the state's concern with the protection of children by "creating an institution whose sole purpose it was to deal with young people, and whose philosophy rested squarely on the notion that the best

interests of the child should be of concern to the state" (Stein, 1998, p. 37). By the mid-1920's, most states had juvenile justice systems. As more and more youth were institutionalized and for longer periods of time, more formal courts were established in the 1960's (Stein, 1998).

The Juvenile Justice and Delinquency Prevention Act (JJDPA) was enacted in 1974. It was designed to reduce unnecessary and inappropriate detention of juveniles, as well as to encourage states to develop program initiatives in the prevention and treatment of juvenile delinquency (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 1992). Congress reauthorized the JJDPA in 2002. This legislation established the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the federal Department of Justice to support state and local efforts to improve the juvenile justice system and prevent delinquency through the development and implementation of effective and coordinated prevention and intervention programs.[2]

In most jurisdictions, the courts that oversee juvenile justice issues also handle child welfare cases (Stein, 1998). Even though these courts have their own specialization in child and family matters, issues such as inexperienced judges, multiple judges involved in a single case over its course, and overcrowded dockets (Stein, 2000) contribute to the challenges facing the child welfare system in working with the court.

Establishing the Mental Health System

The first U. S. hospital for the mentally ill opened in Williamsburg, Virginia in 1773 (National Institute of Mental Health [NIMH], 1998). The treatment approach for most serious mental illness continued from that early time to consist of institutionalization in large asylums.

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[2] Source: http://ojjdp.ncjrs.org

An early change to this practice with regard to children began to develop in the 1920's, with the utilization of outpatient and community based Child Guidance Clinics.

The initial federal legislation related to mental health, the National Mental Health Act (NMHA), was not enacted until 1946. This Act established the National Institute of Mental Health (NIMH) and was the precursor for the development and expansion of community-based mental health services for adults and children throughout the country (NIMH, 1998). The NIMH is the lead federal agency for research on mental and behavioral disorders and is one of 27 components of the National Institutes of Health (NIH), an agency within the federal Department of Health and Human Services. The mission of NIMH is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior, and mandates a focus on those with the most serious mental illness.[3] The role of NIMH is primarily research. The majority of public funding for treatment and support services for both children and adults with severe mental illness is provided through the joint federal and state Medicaid program. Medicaid programs are comprised of federal, state, and local dollars and are intended to serve the most disabled and vulnerable children and adults with severe chronic illness and disabilities, such as mental illness.[4] Despite broad recognition of the need, the federal policies related to children's mental health lack coordination across agencies and there are far too few resources to address the needs of children with mental illness (Koyanagi, 1994; Simms, Dubowitz, Szilagyi, 2000; Burns et al., 2004; Koppelman, 2004).

Mental problems of both children and parents constitute a major risk factor for involvement in the child welfare system (Simms et al., 2000). Mental health problems in

[3] Source: http://www.nimh.nih.gov

[4] Source: http://www.nami.org

children are often associated with a history of maltreatment (Webb & Harden, 2003; Wulczyn et al., 2005) and children in foster care are more likely to have a mental health condition (Rosenbach, 2001). In addition, parents in some cases may decide that it is in their child's best interest to relinquish custody to the state child welfare agency in order to access the mental health services needed by their child (Bazelon, 1999). As a result, there are multiple and complex relationships between these two systems.

Establishing the Child Welfare System

The generally recognized beginning of the child protection movement in the United States occurred in 1875 with the formation of The Society for the Prevention of Cruelty to Children. This organization, based on the principles of The Society for the Prevention of Cruelty to Animals, was established as a result of the large number of maltreated children coming to the attention of this animal welfare agency (Helfer, Kempe, & Krugman, 1997).

It was not until the early 1900's that child welfare services were formally addressed in public policy. The first child welfare agencies were created following the establishment of the U.S. Children's Bureau in 1912. Not only did this federal bureau have the responsibility to represent the interests of children, it was the federal government's initial endeavor in the provision of social services other than public health and education.

The next major federal milestone that marked the beginning of funding for child welfare services for children and their families occurred in 1935. At that time, provisions in the Social Security Act established aid to dependent children and funding for child welfare services. Subsequent to the funding provisions for children and families in the 1935 Social Security Act, almost three decades passed before significant federal legislation was enacted to address the

needs of vulnerable children and their families. Until 1961, there was no formal, federal foster care program in the United States (Sanders, 2003).

When the federal Aid to Families with Dependent Children (AFDC) Foster Care program was established, funding was provided to states to care for children who could not safely remain with their families. Even then, federal funding was only provided for services to those families who received AFDC benefits. While this 1961 provision provided funding for services for the children placed into foster care, it failed to design a mechanism for moving children out of foster care and caused what would come to be called the "foster care abyss" (Sanders, 2003, p. 215). The provision did little to give states the incentive to implement strategies to keep children with their families or to develop permanent, stable settings for them when remaining at home was not possible.

The next major piece of federal legislation was the Child Abuse Prevention and Treatment Act (CAPTA), enacted in 1974. CAPTA provided ongoing financial assistance to states for the development of prevention and treatment programs for children and families, as well as funding for a federal office focusing on child abuse and neglect.

The Indian Child Welfare Act (ICWA) was enacted in 1978 to regulate the provision of services and foster care placement of Indian children. This legislation set forth certain rights and requirements regarding children who are members of a tribe or are eligible for membership in a tribe. These rights apply to child protection, adoption, guardianship, termination of parental rights actions, runaway/truancy matters, and voluntary parental placement of children. The ICWA was created to re-establish tribal authority over the removal, placement, and adoption of Native American children. The goal of the act was to strengthen and preserve the culture and structure of Native American families. Under the ICWA, when a child is removed, either for

foster care or adoption, the law requires that the child be placed with extended family members, other tribal members, or other Indian families. However, there has been little in the way of federal mechanisms for accountability or funding for ICWA.

A Turning Point: The Move toward Accountability in Federal Child Welfare Policy

Subsequent to the 1961 legislation that established the AFDC program, nearly 20 years passed before Congress took a comprehensive look at the general structure of federal funding for children who were abused or neglected. At this time, Congress created a new framework for foster care with the passage of the Adoption Assistance and Child Welfare Act of 1980 (AACWA). This Act responded to both national and state reports documenting the crisis in the child welfare system and the limited federal oversight regarding children in foster care (Sanders, 2003). This legislation continued federal foster care funding for children from AFDC-eligible families, with additional protections to help ensure that children only entered foster care after "reasonable efforts" to keep them with their family were made. AACWA also required that children be placed in the least restrictive, most family-like setting appropriate to meet their needs. Further, it required periodic reviews of the care children received.

The Act also required that child welfare agencies make "reasonable efforts" to reunify children with their families and help move children to permanent living situations in a timely way. Children eligible for federal foster care funding automatically became eligible for federal adoption assistance and for health care assistance under the Medicaid program. Eligibility for this assistance was particularly important (Allen & Bissell, 2004) because it removed fiscal disincentives for state child welfare agencies to move children to adoption and allowed states to continue to provide necessary medical assistance for children adopted from foster care. AACWA attempted to reduce the flow of children into the foster care system through its

"reasonable efforts" provisions. However, Blome (1996) notes that the term "reasonable efforts" was vaguely defined in the Act and was open to varied interpretation by state agencies and courts.

The underlying intention of the AACWA was to avoid removal from the family and to facilitate reunification for children with their families in cases where their removal was required. The newly articulated goal of securing permanency in the placement arrangements for children in foster care reflected a major shift in the policies concerning the needs of children in the child welfare system. It sought to create a disincentive for lengthy foster care stays. AACWA moved the system away from merely providing funding to maintain children in foster care, to an emphasis on preventing the need for foster care in the first place or, when removal was necessary, to providing services for the purposes of reunifying children with their families (Sanders, 2003).

In response to the implementation of AACWA, most states enacted their own legislation that required periodic reviews for children in foster care, specifying that reasonable efforts had to be made to prevent a child's placement into foster care (Allen & Bissell, 2004). Many of these laws also promoted reunification with the child's family, as well as other options for permanent, stable living situations.

From the mid-1980s through the 1990s the federal government took important steps to address numerous challenges facing the child welfare system. Some of these steps addressed problems created by earlier policies. For example, building upon prior legislation, greater attention was given to older youth and to services to prevent children from entering and remaining in foster care unnecessarily. To this end, the Independent Living Initiative was passed by Congress in 1985, providing assistance to states to help youth who "age-out" of foster care

(Allen & Bissell, 2004). This initiative highlighted the needs of older youth in relation to the finding that they frequently exited foster care without appropriate and necessary services such as housing, education, vocational supports, and skills to help them transition to adulthood and successful independent living.

Another example of legislative change designed to address problems created by earlier policies was the Multiethnic Placement Act (MEPA), enacted in 1994. This legislation was designed to highlight the unique challenges faced by children of color in foster care. MEPA addressed concerns about delays these children experienced with regard to securing a permanent living situation by requiring child welfare agencies to actively recruit both foster and adoptive families that reflected the diversity of children in its care (Allen & Bissell, 2004). Further, it addressed the controversy regarding interracial adoptions and codified federal court interpretations of civil rights law which protected children served by federally assisted child welfare programs from discrimination based on race and national origin. MEPA clarified that the race, ethnicity, and culture of a child played a role, but could not be the sole factor in determining the most appropriate placements for children (Allen & Bissell, 2004).

The lack of funding for prevention-oriented services also gained attention in the mid-1990s. In response to concerns that federal funding to states for children in foster care actually gave states incentive to place children into foster care rather than providing services to families to keep their children in their own homes, Congress created the Family Preservation and Support Services Program in 1993 (Hutchison & Charlesworth, 2000). This legislation provides funding to states for a broad range of services to assist children served by the child welfare system.

Even with the various laws enacted to address the needs of children in the child welfare system, concerns continued about children languishing in foster care (Allen & Bissell, 2004). To

address these concerns and others, such as reducing the length of time children remain in foster care and reducing the number of children awaiting adoption, Congress sought legislation to address more comprehensively the many challenges facing the child welfare systems across the country. The resulting legislation, the Adoption and Safe Families Act of 1997 (ASFA), stressed the importance of a permanent living situation for children and emphasized that placement into foster care was only to be a temporary option for abused and neglected children.

The Adoption and Safe Families Act of 1997

ASFA is viewed by many as a move toward greater performance accountability and improved outcomes for children and families. Initial results do indicate measurable improvements (Sanders, 2003; Allen & Bissell, 2004; Courtney et al., 2004; Wulczyn et al., 2005). However, these authors also caution the child welfare community about the potential for unintended consequences.

Under ASFA the federal government is, for the first time, attempting to hold states accountable for achieving quantifiable outcomes for children involved with the child welfare system. These outcomes focus on safety, permanency and stability of living arrangements, and the well-being of children.

ASFA has influenced the child welfare system in a number of important ways (Allen & Bissell, 2004). It emphasizes that the intent of foster care is to provide a safe and temporary setting while children await permanent homes. It requires that dispositional court hearings to determine the continued appropriateness of placement and services are to be held no later than 12 months after a child's placement into foster care, rather than the 18 months specified in earlier requirements. With some exceptions, it requires, for the first time in federal law, that child welfare agencies initiate the termination of parental rights when a child has been in foster care

for 15 of the most recent 22 months, or whose parents have killed or seriously injured another child in the family. Also for the first time in federal law, ASFA directly addresses the health and safety of children with regard to child welfare agency decision-making about the removal of children from their homes, the return of children to their homes, and the services children and families receive whether the child is in foster care or living at home. For example, the provisions to ensure the health and safety of children in foster care include required criminal record checks of both foster and adoptive parents, and the licensing of foster homes. With its emphasis on permanence, ASFA specifically identifies placements with relatives and/or legal guardians as acceptable options and recognizes the importance of relatives as caregivers for children in foster care, as well as the potentially beneficial role that relatives can play in expediting a child's exit from foster care.

ASFA has also helped to promote accountability in child welfare. It requires that, to the extent possible, outcome measures should be developed from data in the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS), and mandates the preparation and submission of an Annual Report to Congress regarding state-specific performance.

ASFA mandates that states improve their efforts to provide children with permanent families. Related to this pursuit, ASFA provides financial incentives for states to increase the number of adoptions for children in foster care by providing payments to states when they exceed a defined baseline derived from previous adoption performance data for their own state.

The Child and Family Services Reviews (CFSRs)

In the context of this study, the most significant federal policy change that resulted from ASFA is the Child and Family Services Reviews (CFSRs). Although originally mandated by

Congress in 1994 as a review of states' performance in the delivery of services to children and families served by the child welfare system, the CFSR was clarified under ASFA emphasizing a focus on outcomes for children and families. Through a process of publishing a Notice of Proposed Rulemaking (NPRM), receipt and consideration of comments, and development of the final Rule, HHS established the regulations for the CFSRs in 2000. The CFSRs now provide a more comprehensive examination of states' abilities to improve outcomes for children and families.

The CFSRs assess state performance incorporating input from a broad range of stakeholders. The reviews are intended to enhance a state's ability to assist children and families to achieve three broad outcomes – safety, permanency, and well-being.

To meet the requirements of the CFSRs, a statewide assessment and an on-site review of the state's child welfare system were conducted in each state. This involved the state's self-assessment, stakeholder input, analysis of statewide data, and individual case reviews. Seven individual child and family outcomes and seven systemic factors were evaluated as a part of this assessment. States determined not to be in "substantial conformity" in any of these areas assessed are required to develop and implement a Program Improvement Plan (PIP). Federal regulations prescribe that states not successfully achieving their required improvements described within their PIPs will sustain financial penalties.

The CFSR considers individual outcomes related to the educational, physical health, and mental health needs of children in the child welfare system. Additionally, it includes the stability of the foster care placements, the proportion of children re-entering foster care, continuity of family relationships, the connections that are preserved for children in foster care, the proximity of the foster care placement to the child's home, whether placements occur with siblings, visits

with the child's parents and siblings, and several other components related to safety, permanency, and well-being. The CFSR also considers broad systemic factors that affect children and families in the child welfare system. These include the state's child welfare information system, case reviews, quality assurance, training, service array, agency responsiveness to the community, and the licensing, recruitment, and retention of foster parents.

Many factors affect the ability of the child welfare system to achieve the outcomes prescribed in the CFSR. Parental rights challenges, child poverty and its associated risk factors (i.e. poor health outcomes, and lack of services and resources among other relevant agencies and organizations), and class action suits are just a few of the factors that put pressure on the child welfare system and strain its ability to perform. Allen and Bissell (2004) note additional factors such as policies affecting welfare eligibility, policies affecting immigrant children, and access to physical and mental health care also have a major influence on the child welfare system. Understanding the complexity of these systems, knowledge regarding what works and what does not, as well as the resources and collaboration needed to create and maintain an effective service delivery system, are all crucial to aligning policy and practice in child welfare.

Assessing State Performance through the CFSRs

The CFSR process incorporates three phases. In the first phase, each state is engaged in a self-assessment of its child welfare system, which includes an assessment of the state's AFCARS and NCANDS data provided back to the state by the federal Children's Bureau in a table of selected data elements, input from stakeholders, and incorporation of other available data and reports. An on-site assessment of each state involving detailed case reviews in three local jurisdictions within the state, as well as a review of systemic factors of the state child welfare agency and input from state and local stakeholders, is conducted by the Children's Bureau in the

second phase. The Children's Bureau analyzes information from these first two phases of the CFSR process to determine whether a state is in "substantial conformity" with the seven individual child and family outcomes and the seven statewide systemic factors. This process results in a final report on the state's performance.

In the third phase of the CFSR, the state develops a PIP to address the areas identified as needing improvement as a result of the self-assessment and findings of the on-site review. The amount of improvement expected is negotiated between the state and the federal Administration for Children and Families (ACF) Regional Office that oversees the administration of a number of the federal social programs. The PIP implementation period, in terms of the federal determination of achieving agreed upon improvements, is two years, the start and end of which had to be defined more precisely in an Information Memorandum released by the federal Children's Bureau in 2005.

By the end of 2004, every state (including the District of Columbia and Puerto Rico) had participated in the first two phases of the CFSR. No state achieved conformance with all seven individual child and family outcomes and seven systemic factors, thus all states were required to develop, negotiate, and implement a PIP to enhance the intended outcomes and systemic factors. As of September 2007, all but two states had completed the federally defined 2-year PIP implementation period. Of the 30 states where the Children's Bureau has completed its evaluation, 28 states were deemed to have achieved their PIP goals and implemented the required PIP activities, thereby avoiding federal financial penalties[5]. Because the CFSR process is designed to promote continuous quality improvement, when the federally defined PIP

[5] http://www.acf.hhs.gov/programs/cb/cwmonitoring/general_info/pipstatus.htm

implementation is completed, the CFSR cycle begins again. The second round of CFSRs began in federal fiscal year 2007, with the first on-site reviews beginning in March of 2007.

A PIP consists of four components: (1) general information, including necessary contact information for key stakeholders; (2) a written plan detailing the work to be undertaken in the PIP; (3) an agreement indicating approval of the PIP by the ACF Regional Office and the state; and, (4) a tracking "matrix" that summarizes the various components of the PIP and allows tracking of the progress and completion dates through quarterly status reports. States are required to submit a PIP if found to be out of conformance on any one of the seven individual child and family outcomes or the seven systemic factors identified in the CFSR.

ASFA and the CFSRs do not specifically dictate funding requirements or changes in practice at the state and local level. However, increases in funding for the state and local child welfare system and practice changes, such as improved service coordination across state agencies, may be necessary in order to meet the federal requirements and intended outcomes.

How States Are Measured on the CFSR Individual Outcomes and Indicators

States are assessed on whether they achieve "substantial conformity" with each of the seven individual child and family outcomes. To receive a rating of substantial conformity for an outcome, at least 90 percent of the applicable child welfare cases reviewed within the state during the CFSR must be rated as having "substantially achieved" that outcome. In addition, for a state to be considered in substantial conformity with Safety Outcome 1 and Permanency Outcome 1 (see Appendix A), it is necessary for the state also to meet national standards for specified outcome measures. These national standards were derived from state data that were already available through previous federal reporting requirements in AFCARS and voluntary reporting in NCANDS for six of the "indicators" associated with these safety and permanency

outcomes. The national standards were established and set at approximately the point where 25% of the states that reported data had better and 75% had worse outcomes. In the context of this study, it is important to note that there are no nationally standardized data elements relating to the three well-being outcomes, nor the remaining two safety and permanency outcomes. Instead, these outcomes are assessed using qualitative data from the cases reviewed in the on-site component of the CFSR.

How States Are Measured on the Statewide Systemic Factors and Indicators

For the seven systemic factors and their associated 22 indicators, states are rated on a scale for each factor. The criteria for these ratings are specified in the CFSR instructions. States are determined to be either "in substantial conformity" or "not in substantial conformity" with the systemic factor. Each of the 22 indicators incorporated in the systemic factors is rated either as a "Strength" or an "Area Needing Improvement." The systemic factors are rated on a 1 to 4 scale, with ratings of 3 and 4 being indicators of substantial conformity.

The first round of the CFSR onsite reviews and federal findings was completed between 2001 and 2004. During this period none of the states achieved substantial conformity on all of the measures and every state was required to develop a PIP. This should be of significant concern to states because if states continue to be in non-conformity at the end of the federally defined two year PIP implementation, ASFA requires that they be assessed a financial penalty (Pew, 2004).

Importance of the CFSRs and their Limitations

The ability of states to provide services to children and families across the state, and the accessibility of these services to families, is evaluated in the CFSR process. Access to services is predicated on a number of conditions and constraints, such as the complexity of the systems,

eligibility for various funding mechanisms, and resource availability, including Medicaid or private insurance. A state's child welfare system is limited in its ability to control these circumstances. Reforming human service delivery systems to meet the needs of the populations they serve is a complex undertaking with a considerably discouraging history, as past evaluation efforts have demonstrated (Rosenblatt, 2003). Rosenblatt also notes that the challenges are even more complicated when the process is comprehensive and involves myriad goals. The challenges states face in properly addressing required regulations and provisions is demonstrated by the role that state and federal courts have played in directing the operation of child welfare systems in more than two dozen cities and states across the country (Stein 2000).

As described previously, child welfare systems represent a complex set of policies, regulations, and service initiatives involving federal, state, and local governments. State child welfare policy development is an interactive process shaped not only by the needs and values of the local population and the political forces in the state, but also by federal legislation, regulation, resources, and incentives. Judicial actions, community-level efforts, and activities of advocacy groups and charitable organizations also influence how state child welfare policy is formulated. Because federal programs provide major sources of revenue for state and local child welfare services, much of the practice at the state and local levels is shaped by the need to comply with legislation and regulations that govern the use of the federal funds.

There are significant limitations with the CFSRs and questions about how adequate the process is for guiding system improvement. One limitation is that the CFSR performance measures do not take into account differences between states in the characteristics of the children and families receiving child welfare services, or the variance among the states' local delivery systems. Courtney et al. (2004), provide the example that the differences in outcomes among

states may have more to do with child and family demographics than the performance of the states' programs, given that children's ages and race, and other geographic and demographic factors, relate to outcomes such as reunification with family and adoption.

A second limitation or challenge in evaluating the results of the CFSRs is that changes in performance at one point in the child welfare system can have marked effects at other points in the system that confound performance measurement. One potential problem with the federal CFSR measures is the concern that they will lead to unintended consequences as states change their policies and practices. For example, given the possibility of fiscal penalties for failure to meet the performance measures, states have a strong incentive to alter policy and practice to improve on the outcomes for which they are not meeting the measures. This could have the result that a state meeting the standard on recurrence of abuse, but not on timely reunification, might tend to return more children to an unsafe situation to improve performance on the timeliness measure (Orlebeke, Wulczyn, Mitchell-Herzfeld, 2005). Courtney et al. (2004), suggest that the focus of the CFSR should be to understand better *why* states are effective in achieving particular outcomes, rather than merely assessing whether or not states conform to criteria. Through this knowledge, the child welfare systems might be better able to achieve positive change in child and family outcomes over time.

A third area where there are limitations in the CFSR process relates to the well-being outcomes. The measures for the well-being outcomes are not well-defined and therefore create difficulties in terms of understanding cause and effect. Wulczyn et al. (2005) cite the long history within the child welfare system of "one-size-fits-all solutions" as particularly problematic. With a legal mandate to focus on child protection, safety, and permanency, the system has paid less attention to what is known about well-being and human development.

Because well-being is a broad concept that encompasses the phases of development throughout childhood, Wulczyn et al. assert that too strong an emphasis on well-being could bring about an expanded role for government in the way services are delivered in the community and the types of childhood conditions to which the child welfare system would need to respond. While state services to children who are, for example, obese or emotionally disturbed might improve their well-being, their condition may not be solely due to parental inadequacy and, therefore, not within the traditional scope of child welfare.

State performance in meeting the educational needs of children in the child welfare system as assessed as part of the federal CFSRs, is the fourth area of limitations. Although the CFSRs draw attention to the educational needs of these children, the reviews are limited in what they examine (Christian, 2003) and in the extent to which they can hold states accountable for educational outcomes. The program improvement requirements and financial penalties associated with the reviews only apply to state child welfare agencies, not state education departments, local school systems, or individual schools. Meeting the educational needs of children in the child welfare system requires coordinated efforts among these and other entities. Further, the CFSR reviews only assess whether child welfare agencies are making efforts to address children's educational needs (Christian, 2003), they do not include measures regarding the child's educational attainment or something as important as whether or not the child is performing at grade-level.

The CFSR reviews focus on performance assessed in terms directly related to the experience of children served by child welfare agencies. Since the promulgation of the CFSR measures, child welfare experts in public agencies and academic institutions have documented that the measurements can produce an inaccurate picture of changes in performance over time.

Although the measures are intended to track improvements in performance, for many states these measures could suggest, for example, that the average time to reunification is getting longer because the state has focused on reunifying children who have been in foster care for a long time (Orlebeke, Wulczyn, & Mitchell-Herzfeld, 2005). This is the fifth area where CFSR limitations have been identified in the review conducted for this study.

The sixth area where limitations have been identified includes several broad criticisms. The CFSR process is linked directly to the creation of state plans of action for addressing weaknesses identified through the review. Although this represents an important milestone in child welfare policy in creating a performance accountability system based on outcomes for children and their families, there are shortcomings in the individual measures, their interactions, and the overall CFSR process. For example, Wulczyn et al. (2005) point out that the initial CFSRs did not include any direct measures of well-being. Thus, it is a significant challenge for states to meet conformance in these vaguely defined well-being areas as part of a comprehensive approach that links specific needs and effective approaches to improved outcomes.

Challenges in Current Child Welfare Policy

After more than four decades of development, the national policy framework that affects children and families served by the child welfare system and that helps to ensure that children are in safe and stable families continues to evolve. As discussed, this framework is a complex arrangement of federal, state, and local laws, and associated regulations, administrative procedures, and practices. The knowledge base and data necessary to inform the operation of child welfare systems is similarly complex. The various resources and funding structures that affect how child policy is implemented are also complex with a significant portion of the federal funding for child welfare and foster care services coming from the Social Security Act. Title IV-

B and Title IV-E of the Social Security Act respectively, include the federal funding to the states for administering child welfare services and foster care and adoption assistance services.

In assessing the many components of the child welfare policy framework and their impact on the safety, permanency, and well-being of children served by state child welfare systems, it is critical to consider how well the components are coordinated and the level of collaboration needed across the various relevant agencies. Allen and Bissell (2004) point out that it is especially important to look at the actions and reactions among the various components to best understand how to improve functioning and outcomes.

Knowledge Base and Data Necessary for Improving Performance in the Child Welfare System

The need for coordination among state and local human service agencies to improve outcomes is derived from a number of concerns. More than a decade ago, Agranoff (1989) cited the growing expectation for state and local governments to develop strategies and resources for addressing the needs of their child populations and to deal effectively with the complex interdependencies among the relevant human service and educational systems. Koyanagi (1994) discussed growth in program expenditures, lack of efficiency and duplication of efforts across public agencies, limited accountability, and the difficulties families encounter in their attempts to access services for their children, as major challenges for public human service institutions. This emphasis on increased demands for services, accountability, productivity, and flexibility is further supported by the work of Cohen and Cohen (1999).

Hutchison and Charlesworth (2000) conclude that the ineffectiveness of the child welfare system is wide-spread and that improvements in the system are necessary. Chipungu and Bent-Goodley (2004) support this view and suggest that reforms that promote agency accountability through the use of data and outcomes will help policymakers and administrators improve service

delivery to children and families.

The child welfare system faces multiple challenges in serving and supporting families and children. Across the country, there was unprecedented growth in the number of children in out-of-home care during the 1980's and 1990's. Wulczyn et al. (2005) note that the foster care population increased from approximately 300,000 to almost 540,000 between 1980 and 1997. During this timeframe there were also significant changes in the policy framework guiding foster care practice and organizational challenges that complicate efforts to serve children in foster care. Agencies often have difficulty providing adequate, accessible, and appropriate services for the children in their care and for their families. A variety of issues compromise efforts to adequately serve and monitor families, such as foster families leaving foster parenting within their first year because of frustration with the child welfare system and the overwhelming responsibility for children in their care. There are many organizational problems and challenges as well, such as large caseloads, high staff turnover, data limitations, and the disproportionate representation of children of color involved in the child welfare system (Chipungu & Bent-Goodley, 2004).

With the significant expansion of social programs during the 1960s, program evaluation became an integral part of policymaking, planning, and administration. In the early 1970s economic recession contributed to a reappraisal of the effectiveness of these social programs. Declining support for public services led to funding and program cuts and increased calls for accountability. Since then, performance standards and outcome monitoring have become critical to program management, as both public and private funding sources demand greater accountability. The federal Government Performance Results Act of 1993 (GPRA), legislation requiring federal agencies to establish performance goals and monitor federally funded programs

in their work with states, provided yet another impetus in the movement for better evaluation of child welfare services (Courtney, Needell, & Wulczyn, 2004).

Between 1996 and 2004, the number of investigations by child welfare agencies of child welfare maltreatment grew substantially, from approximately 2 million[6] to more than 3.5 million[7]. Increasingly, the families and children who came to the attention of the agencies presented complex needs requiring the provision of multiple services. Chipungu and Bent-Goodley (2004) highlight that child welfare agencies typically do not have control over many of the services needed. Therefore, child welfare agencies must attempt to develop effective inter-organizational relationships with other pubic and private service systems to ensure that their clients have access to these services. Serving children in foster care by developing the necessary structures and measures for establishing accountability is a major public concern. Chipungu and Bent-Goodley (2004) cite utilization and analysis of timely, accurate, and relevant administrative data as an important means for understanding problems, identifying emerging issues, monitoring agency efforts, and establishing accountability. For the child welfare system, the activities emerging from the AACWA such as state self-assessment and review guidelines for the enforcement of Title IV-B and Title IV-E of the Social Security Act were the beginning of increased attention to the outcomes movement in child welfare. In 1986, Congress amended Title IV-E of the Social Security Act and added directives for establishing and implementing a mandatory foster care and adoption reporting system. Courtney et al. (2004) note that it was not until 1994, however that the funding actually became available to help states implement these systems which became known as the Adoption and Foster Care Analysis and Reporting System, or AFCARS.

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[6] http://www.acf.hhs.gov/programs/cb/pubs/ncands96/section2.htm
[7] http://www.acf.hhs.gov/programs/cb/pubs/cm04/chapterthree.htm

The Omnibus Budget Reconciliation Act of 1993 provided enhanced funding for development of a broader reporting system known as the Statewide Automated Child Welfare Information System, or SACWIS. States could choose a stand-alone AFCARS system for which the federal government would match 50% of the costs of development, or receive a 75% federal match for development of a SACWIS system. SACWIS was intended to integrate multiple federal reporting requirements, including AFCARS reporting, Title IV-A (TANF-Temporary Assistance to Need Families), NCANDS data, Title XIX (Medicaid), and Title IV-D (child support enforcement). Because of the federal cost share benefit and the ability and appeal of integrating multiple information systems, most states opted for SACWIS (Courtney et al., 2004).

Beginning in 1994, new federal regulations (45 CFR 1357) were put in place to assist states in planning and describing their service array. As a condition of continued federal child welfare funding, these regulations required states and tribes to develop comprehensive five-year plans called the Child and Family Services Plan (CFSP). States were also required to submit an annual update, the Annual Progress and Services Report (APSR), to the federal Administration for Children and Families. The reports were to include the collection and analysis of statewide information on gaps and availability of services to meet child and family needs. This information was to include trends and indicators in the areas of the well-being of children and families, the needs of children and families, and the nature, scope, and adequacy of existing child, family, and related social services. The CFSP was viewed as an opportunity for states to lay the foundation for a system that was coordinated, integrated, culturally relevant, and family focused. In addition to services funded under Title IV-B of the Social Security Act, several other components of the state child welfare systems' federally funded services were to be included in the CFSP, such as services provided through the Child Abuse Prevention and Treatment Act, the

Chafee Foster Care Independence Act, and the Education and Training Vouchers funding. Further, following the enactment of ASFA, states were also to integrate the goals, strategies, benchmarks, and outcomes resulting from the CFSR (ACF, Program Instructions, PI-04-01.)

Collaboration and Coordination across Systems Affecting Child Well-Being

Along with growth in caseloads and the call for improved performance, recognition of child welfare agencies' responsibility for addressing aspects of children's lives beyond the domains of child safety and stable living arrangements evolved. As discussed earlier in this chapter, the educational, juvenile justice, and mental health systems have seen their own developments in best practices and accountability. Because of numerous developments at the federal, state, and local level in these systems, the complexity of their mandates, policies and practices, and the limited coordination and collaboration throughout the intergovernmental hierarchy, the child welfare system is limited in its ability to address the needs in a child's life outside of the safety and permanency purview of its system's primary mandates. A further challenge is that the children served by the child welfare system are often seriously disadvantaged and likely to have poor outcomes in their health, developmental, and educational domains (Simms et al., 2000). Zetlin et al. (2006) note that in light of the poor educational outcomes for children in foster care, it is especially important for child welfare agencies and schools to collaborate on supporting these children. Altshuler (2003) suggests that positive systemic change must rely on joint planning and goal setting.

The National Conference of State Legislatures (2003) is one source that highlights the concerns regarding the educational needs of children in foster care. Education is an area often neglected by overburdened child welfare systems whose concern is primarily children's physical safety. Altshuler (2003) cites numerous studies documenting that children in foster care perform

significantly worse in school than do children in the general population. The educational deficits of children in foster care are reflected in higher rates of grade retention, lower scores on standardized tests, higher absenteeism, tardiness, truancy, and dropout rates (Christian, 2003). Because children in foster care often experience numerous changes in their living arrangements, this also requires changes in school, thus affecting the stability necessary for children to establish relationships and routines and to perform to their full potential.

The lack of accessible and appropriate mental health services is another area of concern that affects outcomes for children in foster care. The United States has never had a formalized child mental health policy (Koyanagi, 1994). Instead, the delivery of child mental health services has been driven by a series of indirect policies that grew out of the child welfare, special education, juvenile justice, and adult mental health systems. The lack of a comprehensive child mental health policy has contributed to the inability to find ways to ensure that children with mental health needs who are also involved in the child welfare system receive appropriate services (Friedman, 2003; Webb & Hardin, 2003). A consequence of this is that parents may sometimes relinquish custody of their children and place them into foster care in order to obtain public services to meet their children's mental health needs (Bazelon, 1999). Lourie and Hernandez (2003) note that this practice further confounds the role of the child welfare system and its ability to meet the needs of the children in its care, because the needs of these children could best be met while remaining in their parents' custody.

Resources, Funding, and Federal Mandates

State and local governments are increasingly concerned about policies that involve financial obligations and potential penalties, either through payments back to the federal government or reduction of federal funding for programs. It is especially problematic when

these initiatives do not provide additional funding for implementing the requirements contained within the policies. Under these circumstances, there is often an "implementation gap" (Friedman, 2003) with state and local governments making minimal changes and looking to control the cost of compliance rather than using the policy to bring about more effective practices and achieve better outcomes.

To some extent this concern is related to the large number of federal intergovernmental regulations relevant to human services. Falconer and Berry (1995) discuss the emergent history of the occurrence of federal mandates during the 1960s and 1970s and cite a 1984 Advisory Commission on Intergovernmental Relations report indicating that 36 major federal intergovernmental regulations with the primary focus of "social regulation" had been enacted as of 1980. The 1980s led to growing concerns about federal mandates, specifically the sustained federal regulatory activism and the decline in federal grant funding to state and local governments.

Further, the momentum for the federal Balanced Budget Amendment in the early 1990s needed support from the states, and governors were reluctant to support the amendment without some protection from unfunded federal mandates. A concern was that the pressure for new programs and policies would remain constant, that the budget implications for entitlements would increase, and that the requirements for a balanced budget would shift the cost of entitlements to the states. In their analysis of unfunded mandates reform, Gullo and Kelly (1998) cite local concerns in addition to state concerns about federal mandates, and highlight local governments' pursuit of their own legislation to curb the impact of these mandates through major local government advocacy groups. In a study on the impact of federal mandates related

specifically to Medicaid policy, Grogan (1999) confirms the importance for state and local governments to include federal mandates in their various models of policymaking.

These concerns along with economic recession during the 1990s and the states' complaints about federal mandates imposed without corresponding fiscal compensation, ultimately led to the passage of the Unfunded Mandate Reform Act (UMRA) in 1995. In his research on unfunded federal mandates and the plethora of federal legislation reviewed under UMRA, Posner (1997) concludes that UMRA was broadly accepted by leaders in intergovernmental and federalism circles as an attempt to institutionalize restraint on Congress regarding the imposition of mandates. Posner concludes, however that although this legislation was viewed as a major milestone in addressing the effect of federal mandates on state and local governments, it was not without its limitations.

The majority of federal rules impacting states are not unfunded mandates; rather, they are conditions of federal financial assistance. Accompanying federal funding is seldom complete, however, resulting in states having to allocate their own funds to fulfill new requirements, thus causing them to reorder their priorities to meet the fiscal requirements of mandates. In her review of federal mandates and state Medicaid decision-making, Grogan (1999) discusses concerns that arise when states experience fiscal stress because they have limited opportunity to increase revenues or take other measures to respond to federal mandates. Consequently, states may be forced to restrict funding and expenditures in the areas where they do have discretionary power.

Describing UMRA

UMRA defines a federal mandate as "any provision in legislation, statute, or regulation that would impose an enforceable duty upon state, local or tribal governments, except a condition

of federal assistance; or a duty arising from participation in a voluntary federal program." In large entitlement grant programs, a new condition or a reduction in federal financial assistance is also considered a mandate, but only if states lack the flexibility to offset new costs or the loss of federal funding with reductions elsewhere in the program. The UMRA contains four titles. Title I imposes procedural requirements and is designed to have Congress bear in mind specified cost thresholds when reviewing legislation and to consider whether to provide funding for mandates imposed on governments. The threshold is $50 million for governmental entities and $100 million for the private sector. Title II requires federal agencies to assess the effect of proposed regulatory actions on state, local, and tribal governments and on the private sector. Under Title III the Advisory Commission on Intergovernmental Relations (ACIR) is directed to prepare three reports for Congress that include: (1) a review of the role of mandates in intergovernmental relations, (2) a study of the measurement and estimating issues, and (3) a review of federal court rulings to identify the requirements placed. Finally, Title IV authorizes federal courts to compel agencies to comply with Title II of the Act.

Several policy experts conclude that UMRA's influence on potentially very large financial obligations for states is limited and that the definition of mandate is construed very narrowly (Gullo & Kelly, 1998; Posner, 1997; Gullo, 2004). In situations where UMRA's definition of a mandate does not apply, states often consider compliance with new conditions on existing grant programs similar in effect to a mandate. In a study of the legislation passed by Congress between 1996 and 2003 (Gullo, 2004), a clear pattern emerged regarding federal mandates since UMRA's passage, that is, most legislation considered by Congress did not contain federal mandates as defined by the Act.

UMRA's Impact

Under UMRA, Congress must both pay for newly mandated programs and identify the federal agency charged with reducing or eliminating the mandate requirement, if full funding is not to be provided. Alternatively, if funding is not to be appropriated, then Congress must indicate its intent to impose an unfunded mandate by casting a specific vote on the matter in their deliberations regarding the subject legislation.

UMRA provides insights into why and how it will contribute to minimizing the negative and costly impact of federal mandates. Specific requirements in UMRA direct federal agencies to minimize fiscal burdens, to create a process for input in the development of regulatory proposals, and to develop a plan to consider the impact on small governments. However, Falconer and Berry (1995) assert that state and local governments need to continue to be attentive to the impacts of proposed federal mandates, because relying on federal legislation alone for protection from onerous and costly mandates may not result in minimizing the burden on states and localities.

Given UMRA's limitations (Gullo & Kelly, 1998), federal legislation may contain mandates to states and local governments, yet not meet the funding thresholds established in the act. This was evidenced by a Congressional Budget Office (CBO) review of the Adoption and Safe Families Act of 1997 (ASFA) wherein ASFA was determined not to be an unfunded mandate; rather, that it would be a cost-saving measure, or, at a minimum, cost neutral due to improved performance of child welfare systems (H. R. Rep. No. 105-77, 1997). While in the long-term this may well be true, in the short-term states likely consider ASFA and the CFSRs as an unfunded federal mandate, or at a minimum a mandate without sufficient federal financial support to effectively implement its many requirements.

Determining the precise cost of mandates within states is difficult given the variability of the many issues involved. St. George (1995) concludes that the comparison of the benefits of federal funding and the cost of unfunded mandates is also challenging because of a lack of good data on the cost of mandates. Further, Kelly (1994b) notes that the degree of state and local fiscal stress that is caused by federal mandates is not able to be determined any more precisely than their actual cost. Many factors and conditions contribute to the level of fiscal stress and budget challenges within states. The National Association of State Budget Officers (NASBO) report, The Fiscal Survey of States (June, 2005), discusses many of these factors in its analysis, including two federal mandate areas, education and health care costs (Medicaid), and a broad range of other revenue and tax issues. These mandates and the expenditure and revenue issues are closely related to states' overall capacity, flexibility, and investments in child well-being.

Potential Benefits of Unfunded Federal Mandates

In his review of unfunded federal mandates, St. George (1995) posits that, with regard to important policy issues, the imposition of unfunded mandates may be the most efficient means of achieving legitimate national standards. St. George notes that a major cause of states' experiences of fiscal stress relates to the failure of their own revenue systems. Further, he asserts that it is not necessarily efficient for the federal government to finance its mandates and that implementing levels of government should have a financial stake in addressing costs. St. George concludes that if federal mandates were to be fully funded, state and local governments may have less incentive to address new problems and defer action in the area in question. Posner's work (1998) supports this and characterizes state and local governments as "middlepersons" responsible for implementing many federal initiatives and suggests that their performance has a critical bearing on national goals and values. Posner does caution, however, that although the

costs of federal mandates are not necessarily visible at the federal level, at some point, they may well threaten to undermine the capacity of state and local governments to respond to their own unique needs.

Complexities and Challenges in Implementing the CFSR

There are many complexities and challenges in addressing the needs of vulnerable children through implementing child welfare policy, specifically the CFSRs. In the context of the CFSRs, a primary area of concern is the relationship of state child welfare agencies with the federal government and other state and local agencies in fulfilling their mandates under federal and state law and achieving the improvements required under ASFA and the CFSRs.

Policies affecting children and families, like most major policy areas, are established at various levels of government. One of the central functions of public policy is ensuring that certain levels of government can effectively influence the actions of other levels of government. In the implementation of policies, this is often more a function of the relationships among these different levels of government than which level of government establishes the policy (Friedman, 2003).

The new federal emphasis on outcomes in child welfare has helped to hasten states' interest in improving performance. However, (Orlebeke et al. (2005) note that the federal effort to measure performance and states' efforts to understand performance are hindered by a number of complexities and limitations. While some of these issues are specific to the child welfare system and its interaction with other child and family serving systems, it is useful to consider these child welfare issues in a broader context than the narrow domain of child welfare policy. Some general principles are clearly relevant to child welfare policy and the role of the CFSR in improving child well-being. These include the relationships and interactions among levels of

government and among different state and county agencies providing human services, policy development, and funding for services.

The relationship among multiple levels of government and their ability to develop, interpret, finance, and implement social policies is a long-standing concern among practitioners and scholars. Conlan (2006) reviews some disconcerting trends, as well as some more positive developments, over the last half century. The content of the social policies where federal, state, and local governments are all actors is wide-ranging, complex, and involves the vertical and horizontal relationships (Friedman, 2003) among governments and non-profit organizations. In addition to implementing policy, governments are also responsible for overseeing the delivery of services, accounting for funding, and, to varying degrees, achieving outcomes in a variety of domains such as education, health, welfare, and other social service areas.

The roles and responsibilities of different levels of government have received attention and analysis for more than eighty years – practically since the time that cooperative federalism first began during the New Deal era in the 1930's. Agranoff (2001) and others (Clark, 1938; Elazar, 1962; Wildavsky, 1984; Kincaid, 1997), conclude that the cooperation between the federal and state governments is conducted mostly without a "map" and that even when it is in the same field or policy domain, it is unplanned and uncorrelated with other activities of government. Over the last decade, social services policy literature has focused heavily on Medicaid and welfare reforms (Johnston & Romzek, 1999; Cho et al., 2005). These policy arenas clearly demonstrate the problems and challenges of implementing policies across levels of government for disadvantaged populations who are not well represented politically. However, the social services literature, specifically the child welfare policy literature, has not dealt

effectively with the complex inter-dependencies among the human service and educational systems that serve children (Agranoff & Pattakos, 1989; Ledford, 2001).

Intergovernmental relationships in the social policy domain and the management of activities "is more than an occasional task" (Agranoff, 1999) and has a profound effect on the scope, design, and effectiveness (Cohen & Cohen, 1999) of services, and one that requires intentional strategies to meet requirements and accomplish objectives set forth in broad mandates. Agranoff and Pattakos (1989), citing a large human services sector study conducted by the International City Management Association (ICMA) in 1984, conclude that trans-jurisdictional challenges will generally overlay the internal challenges governments face for the foreseeable future.

Because child welfare policy affects and involves multiple levels of government and service sectors, the need for effective intergovernmental relationships is of paramount importance when striving to accomplish goals.

The Role of the States in Addressing Child Well-Being

State policy development is an interactive process shaped not only by the needs and values of local populations and political forces in the state, but also by federal legislation, regulation, resources, incentives, judicial action, and community-level efforts (Webb & Harden, 2003). The delivery of child welfare services is primarily a state responsibility, although in some states this responsibility is shared between the state and its localities. Although federal laws and regulations provide guidance and minimum standards for key aspects of service provision, the work at the state and local level requires considerable autonomy and discretion in deciding how to implement services. Webb and Harden (2003) note that, in terms of how child welfare

services are provided, this decision-making authority results in substantial variation across states and localities.

Current child welfare reform efforts expand beyond child protection and placement stability to include child well-being (Wulczyn et al., 2005). This presents new opportunities for child welfare agencies and other service providers to develop collaborative relationships. However, child welfare officials whose responsibility is typically governed by legal mandates may be reluctant to enter into agreements to participate in collaborations where they perceive that they may relinquish control of the cases under their care. Other child serving systems, such as the educational system, are not held accountable in the same way for children who may be harmed or killed while under their care (Webb & Harden, 2003). Thus, for a system to expand its focus beyond child safety to include child well-being understandably presents challenges (Wulczyn et al., 2005).

Child well-being encompasses education, physical health, and mental health. These domains, for the most part, are beyond the scope of state and local child welfare systems (Altshuler, 2003; Wulczyn et al., 2005). Further, the resources necessary to influence the well-being outcomes are also typically outside of the boundaries of the child welfare system. The options available to the child welfare system are limited without the health care system, schools, and the mental health system as partners (Wulczyn et al., 2005).

With rapid changes in technology, new and complex social problems, and resource and funding limitations, there are both new challenges and new opportunities. There is more media attention to the performance of child welfare agencies, and the data for assessing performance is constantly improving. Greater emphasis on accountability comes from both the federal government and its laws and policies, and from legislators, stakeholders, and voters at the state

and local level. These conditions bring a greater need for coordination and cooperation across and among governments. The challenges and potential benefits of this shift from the single agency/one level of government approach to a coordinated, inter-agency, inter-governmental approach, is recognized by many scholars (Koyanagi, 1994; Friedman, 2003; Page, 2003; Cho et al., 2005).

In the design and delivery of child welfare services, local and state governments are faced with mandates to improve services and outcomes from many sources ranging from federal requirements to court decisions. While the focus of this study was the responses of states to the federal well-being mandates of the CFSRs, this must be understood not only in the context of the complexities of intergovernmental relationships, but in light of competing demands for finite resources and funding.

Contribution to the Literature

Much attention has been given in child welfare research and policy literature, on the one hand to the risk factors, incidence, and consequences of abuse and neglect, and on the other to innovative programs, services, and interventions designed to serve at-risk and maltreated children, youth, and their families. There has been little attention to the role that state and local governments play in these matters. This is particularly true in regard to the strategies state and local government child welfare systems must employ to meet the needs and achieve positive outcomes for this vulnerable population.

This study contributes primarily to the child welfare policy literature with an emphasis on states' efforts to meet the intended federal outcomes for the children and families served by their child welfare systems. It specifically addresses the complexity of child well-being concerns and

the corresponding complexity of governmental roles, responsibilities, and relationships, resource and funding issues, and challenges of collaboration.

The federal child welfare legislation relevant to this study is the Adoption and Safe Families Act of 1997 (ASFA) and the ensuing federal requirements of the Child and Family Services Reviews (CFSRs). As noted earlier, when ASFA was reviewed by the Congressional Budget Office (CBO), as required under UMRA, it was determined not to be an unfunded mandate to states. With the lack of additional federal funding to states to implement the requirements of ASFA, and the potential for federal financial penalties for non-conformity, the dynamics between mandates, funding, and states' actions raise important questions. Interestingly, given the significant public policy, administrative, and resource allocation implications, particularly for state and local governments, the child welfare policy literature is limited in addressing these concerns. Thus, attention in the literature is warranted to inform policymakers and other interested stakeholders about responding to the federal mandates related to child welfare.

CHAPTER 3 – METHODOLOGY

This chapter describes the methodology for addressing the research questions: How did states respond to the complex requirements of the federal CFSRs regarding well-being outcomes, given the need for the involvement of multiple systems? How does the way that child welfare systems operate make addressing the well-being components particularly challenging? How do the relationships among the different levels of government and across different agencies affect the child welfare agencies' capacity and ability to assure child well-being?

The federal requirements under ASFA and associated components of the CFSR process, including final reports resulting from the states' self-assessments and on-site reviews, obliged the states to propose a Program Improvement Plan (PIP), take action to improve the outcomes for children and families served by their child welfare systems, and improve the systemic factors related to the operation of their systems. In this study, there is a particular emphasis on two of the individual child and family well-being outcomes and two related systemic factors of the CFSRs.

For purposes of framing the methodology, both the federal requirements and the findings of the federal reviews indicating the outcomes and systemic factors for which each state was found not to be in substantial conformity, are considered first. The states' approaches to addressing the CFSR requirements related to well-being are then reviewed in detail.

Many intervening conditions could potentially influence the states and their ability to address the requirements of the CFSRs. The fiscal situations and level of fiscal stress within a state, the administrative structure of the state's child welfare system and whether it is primarily administered by the state or the local jurisdictions, the demographics of the state and its population and the state's political culture, are among the intervening variables that could affect

the states' actions. The research considers these variables and the states' responses to the well-being requirements of the CFSRs, but does not involve detailed comparisons between states, or analysis of the impact of these intervening variables.

Several methods were used to identify situations where prevailing state conditions influenced the states' approaches for addressing the CFSR well-being requirements. The methods included content analysis of the various CFSR reports for each state, interviews with state leaders, and interviews with national level experts.

Approach

The methodological approach in this research is a case study involving six states examined in detail. The study is primarily empirical, relying on data gathered from CFSR documents from each of the six states, interviews with state leaders from each of the six states, and interviews with national level experts. Although both qualitative and quantitative methods are used to analyze the data and information gathered, the overall approach and analysis is qualitative as it is best suited for the *"how"* questions that guide this research (Yin, 1994).

As indicated in Chapter 1, this study examines the process by which states address the shortcomings identified during the CFSR process as they relate to child and family well-being. The purpose of the study is to inform states on the benefits and challenges of responses to federal mandates in the human services arena, examine the role of collaboration across different levels of government to meet an important societal need, and help ensure the effectiveness of public investment in promoting the well-being of vulnerable children and their families.

Although actual service delivery to children and their families occurs at the local level of government, the focus of this study is directed at the state level as it is the states that have the responsibility for coordination and development of the PIPs to ensure compliance with the

elements of the CFSR. While this research does not examine all states reviewed under the CFSR, a review of six states' strategies yields an understanding of the breadth of factors and issues relevant to states' actions within the context of implementing a federal mandate without additional federal funding.

The research for this study was conducted in two stages. Stage I included review of the federal CFSR documents provided to states, participation in the Children's Bureau CFSR Consultant Reviewer Training (Atlanta, Georgia in March, 2003), and an intensive review of one state, Virginia. This stage established the basis from which to explore other states' responses to the well-being components of the CFSR. In the one-state review, relevant CFSR reports and the state's PIP were examined. In addition, discussions with relevant state stakeholders in the state's child welfare, mental health, education, and budget agencies, informed the process. This review and extensive experience with Virginia's child welfare legislation, policy, and practice (Ledford, 2001) helped to identify potential challenges for state child welfare agencies, assisted in developing an understanding of some of the intervening conditions likely to be found in other states, and guided the overall approach to studying the six states selected for examination. The specific findings from this one-state review are not discussed in this study; rather, the issues and challenges arising in Virginia provided a general understanding of state responses to child and family well-being concerns in the CFSR. The work conducted in Stage I enhanced the theoretical sensitivity (Strauss & Corbin, 1990) for this study, particularly in relation to guiding the review and analysis of six states' CFSR documents and developing the categories of questions used with the state leader and national level expert interviews.

The CFSR documentation and one-state review in Stage I were used as the foundation to pursue Stage II of the research. Stage II examined, in detail, six states that had completed the

federally defined PIP implementation period[8]. Because the qualitative research field places an emphasis on change and process, and the variability, complexity, and interrelationships among conditions and actions (Strauss & Corbin, 1990), using this two-stage approach facilitated the identification of many of these potential issues and interrelationships likely to be found in the detailed state-by-state examination.

Among the CFSR's three broad areas – safety, permanency, and well-being – this study focused on specific well-being outcomes and the relevant systemic factors, as discussed in Chapter 1, that most closely associate to these outcomes. The well-being outcomes examined in this study are:

- Children receive appropriate services to meet their **educational** needs
- Children receive adequate services to meet their **physical** and **mental health** needs

And, the two systemic factors are:

- Service array
- Agency responsiveness to the community

A focus specifically on the well-being outcomes illuminates the issues and challenges associated with implementing a broad federal mandate because state child welfare agencies have the least control over these outcomes. It is this area that requires the most coordination and collaboration with and among other public and private agencies serving children and their families.

Three methods were used to collect and examine the state data and information for this study. Using multiple research methods and triangulating the data allowed for a more complete understanding of the complexity of factors involved with addressing the requirements of the

[8] The PIP implementation period begins when the ACF regional office and state reach agreement on the PIP and typically ends two years later.

federal CFSR mandate. These multiple sources of evidence essentially provided multiple measures of the same phenomena, an important approach for gaining an understanding from different perspectives (Tashakkori & Teddlie, 2003). Specifically, a content analysis of a variety of source documents, key stakeholder interviews with state leaders, and elite interviews with national level experts were used as the methods to collect and analyze the data and information.

The states' documents and data resulting from the CFSR processes and the PIPs, the subsequent federally required quarterly reports, and final reports were examined using content analysis. Using this existing CFSR documentation to determine states' approaches and actions had several benefits. First, the need for primary data collection was eliminated because the PIPs and other documents were readily available in a compiled format through the National Clearinghouse on Child Abuse and Neglect Information, (now called the Child Welfare Information Gateway http://www.childwelfare.gov).

Further, because the PIPs resulted from the states' self-assessments and findings from the on-site reviews, they are the most relevant documents available for understanding the states' proposed responses to achieve the improvements required by the CFSRs. They are written, detailed plans intended to address comprehensively the areas identified as needing improvement. The PIP constitutes the contract between the state and the federal government regarding the what, when, and how of the required improvements in the state's child welfare system in order to avoid federal financial penalties. Thus, they included a breadth of information in multiple categories regarding states' strategies and actions for responding to the federal mandate.

The state reports, PIP documentation, and subsequent quarterly reports are narrative and voluminous, thus several characteristics precluded using a software-based approach for the content analysis. First, the documents were reported in a variety of formats, including word

processing, spreadsheets, and PDF documents. The PDF files in particular, were not amenable to the use of software for the analysis. Second, there was great variability in the language used among the states, and even within different sections of the same report, to describe similar issues and concepts. For example, provision of children's mental health services was identified variously using terms including mental health, behavioral heath, psychological services, special needs, behavioral problems, emotional problems, and MH services. These limitations necessitated a manual approach to the content analysis. Because of this, a detailed reading and compiling of key information from the documents was required to extract the relevant information and data. Specifically, each state's reports and PIP documents were printed and organized in sequential order by state. These hard copy documents were read and re-read using color-coding and notations to identify common problems, challenges, approaches, and results. This manually coded information and data were then entered into tables and spreadsheets for each of the three indicators associated with the two selected well-being outcomes and the six indicators associated with the two selected systemic factors included in this study. These results were compiled both within each of the six study states and across the six states and formed the basis for further analysis. This process resulted in defining and coding major categories, and identification of specific details and other attributes of the data necessary to determine the variety of strategies and activities proposed by the states and the challenges the child welfare agencies faced in addressing the selected well-being outcomes and systemic factors. As described by Strauss and Corbin (1990), coding data is necessary to examine and compare information, make connections among categories of information, identify core categories to validate relationships among the data and information, and to help integrate concepts.

Interviews with key stakeholders, who are state government leaders within the child welfare system, were the second method of analysis used in this research. These interviews elucidated the states' strategies and challenges among the six states selected for this research and some of the more general findings of the CFSR process.

Finally, the third method of analysis used for this research was elite interviews with several experts in child welfare policy from university, non-profit, and relevant federal agency settings. These interviews provided useful insights and better understanding of the general context of child welfare policy development, federal, state, and local relationships as they relate to child welfare policy, and the implications of implementing federal mandates. These interviews were conducted subsequent to, and were informed by, the content analysis of the state documents, and state leader interviews.

Notes on the response to each interview question, as well as other comments offered, were taken during each of the interviews with the state leaders and national level experts. Their responses and comments were then summarized into working documents, one for all of the state leaders, a second for the national level experts, and a third across all of the interviews. The summaries from the interviews were also coded and annotated to identify common issues, challenges, and approaches, and to highlight some of the positive benefits of the CFSR process described in the interviews.

Research Design

Selection of the States for this Research

As briefly discussed in Chapter 2, the CFSR process incorporates three phases. In the first phase, each state is engaged in a self-assessment of its child welfare system. In phase two, an on-site assessment of each state involving three local jurisdictions within the state as well as

the state child welfare agency and state and local stakeholders is conducted by the federal Children's Bureau. In the third phase, the state develops and implements a PIP to address the areas identified as needing improvement as a result of the self-assessment and findings of the on-site review. The timeframe for the state to meet their agreed upon improvements described in their PIP is two years from the date of acceptance.

By the end of 2004, all states, including the District of Columbia and Puerto Rico, had participated in the first two phases of the CFSR and have currently either fully completed phase three or are in the process. The second round of CFSRs began in federal fiscal year 2007, with the on-site reviews beginning in March, 2007.

State Selection Criteria and State Characteristics

State selection took into account a range of factors and issues related to the states' characteristics. The first criterion for identifying the states for this study is that all of the states must have fully completed close-out of their PIP. The states identified for this study are among the first states that had completed the federally defined two-year PIP period by the end of calendar year 2004. This brought the number of states for consideration to eleven, however because the District of Columbia was included in this number, and is not a state, the actual number of states for consideration applying this first criterion was ten.

To focus this study on well-being, the second criterion used to identify states is those states that had not met "substantial conformity" in all three of the well-being outcomes. Substantial conformity requires that the state achieve the outcome in 90% of the cases reviewed

during the on-site component of the CFSR[9]. This brought the number of states for consideration to seven.

As discussed in Chapter 1, only two of the three well-being outcomes were selected for this study, Well-being Outcome 2, children receive appropriate services to meet their educational needs, and Well-being Outcome 3, children receive adequate services to meet their physical and mental health needs. This is because these outcomes are most clearly dependent on collaboration with other agencies and represent a mandate beyond the more basic, core services expected by a child welfare agency.

The rationale for use of these criteria is that the states not meeting "substantial conformity" on these outcomes would have to develop strategies to address these outcomes and include this in their PIPs. All states identified for this research achieved an eighty-six or below on each of the well-being outcomes, thus did not meet "substantial conformity" on any of them.

The states' achievement score on the two systemic factors that most closely related to the well-being outcomes, also discussed in Chapter 1, was considered, however it was not a criterion for state selection. Those factors are: Service Array, and Agency Responsiveness to the Community. The systemic factors are rated on a 1 to 4 scale, with a score of 3 or 4 required to meet the "substantial conformity" threshold. It was not necessary for this research that the states either met or did not meet conformity on the two systemic factors, because the focus of the analysis is about the relationship of the systemic factors to the well-being outcomes, not the systemic factors themselves, which may relate to all of the outcomes. All but one state selected for this study met conformity for the two systemic factors.

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[9] The determination of substantial conformity was essentially "pass/fail". States scoring below 90% had to address the outcome in their PIP, regardless of whether their score 51% or 89%. States at 90% or above did not need to address the outcome in their PIP.

The federal ACF region in which the state is located was the third criterion used for state selection. Regional ACF offices oversee the administration of a number of the federal social programs, including Temporary Assistance for Needy Families (TANF), Tribal TANF, Foster Care, Child Welfare, and Adoption Assistance. These regional offices provide technical assistance, resources, and information to various entities that are responsible for administering these programs. Because the ACF provides technical assistance and oversight of the CFSR process to the states, the role of the regional ACF office in development of the states' PIPs is another factor potentially contributing to variation among the states.

There are ten regional ACF offices in the country. The states identified for this study represent five different regional offices. The selection of two states within one ACF regional office jurisdiction allowed for the inclusion of a state supervised/county administered state, an important factor as this is one of the potential intervening conditions that can affect a state's ability to implement federal requirements. The regional ACF office criterion brought the final number of states for inclusion in this research to six.

Using the selection criteria described above, the six states identified for study were: Arizona, Georgia, Indiana, Massachusetts, North Carolina, and Oregon. Table 1 represents the application of the selection criteria to the states.

Table 1: States Selected for Analysis[10]

			Outcomes % Achievement			Systemic Factors Rating	
State	**Date PIP Completed**	**ACF Region**	**WB 1***	**WB 2***	**WB 3***	**Service Array****	**Responsiveness to Community****
Arizona	11/2004	IX	70	85	59	3	4
Georgia	10/2004	IV	72	76	63	2	3
Indiana	8/2004	V	60	71	70	4	4
Massachusetts	11/2004	I	76	86	69	3	3
North Carolina	12/2003	IV	68	80	68	3	4
Oregon	7/2004	X	76	82	81	3	4

[10] Source: CRS Report for Congress - Child Welfare: State Performance on Child and Family Services Reviews, dated June 29, 2005. *90% must be achieved to meet the "substantial conformity" criterion for the outcomes. **The rating scale for the systemic factors is 1 to 4. A rating of 3 or 4 must be achieved to meet "substantial conformity" for the systemic factors.

Selected CFSR Outcomes and Factors

Table 2, identifies the two well-being outcomes and the two systemic factors, and their related indicators, selected for this research. The entire set of individual child and family outcomes and the systemic factors in the CFSR process is included in Appendix A.

Table 2: Select Well-Being Outcomes, Systemic Factors, and Related Indicators
Child and Family Well-Being Outcomes
Outcome Well-Being 2
Children receive appropriate services to meet their educational needs
Item 21: Educational needs of the child
Outcome Well-Being 3
Children receive adequate services to meet their physical and mental health needs
Item 22: Physical health of the child
Item 23: Mental health of the child
Systemic Factors
Service Array
Item 35: The state has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency
Item 36: The services in Item 35 are accessible to families and children in all political jurisdictions covered in the state's CFSP[11]
Item 37: The services in Item 35 can be individualized to meet the unique needs of children and families served by the agency
Agency Responsiveness to the Community
Item 38: In implementing the provisions of the CFSP, the state engages in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child and family service agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP
Item 39: The agency develops, in consultation with these representatives, annual reports of progress and services delivered pursuant to the CFSP
Item 40: The state's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population

[11] The Child and Family Services Plan (CFSP), required under provisions of Title IV-B of the Social Act and other federal child welfare related legislation, process began in 1994 and requires states and tribes to develop comprehensive five-year plans and submit an annual update, the Annual Progress and Services Report (APSR), to the Administration for Children and Families. The reports are to include statewide information on gaps between availability of services and family needs, including the areas of the well-being of children and families; the needs of children and families; the nature, scope, and adequacy of existing child and family and related social services. Source: http://www.acf.hhs.gov/programs/cb/laws_policies/policy/pi/pi0305.htm

Selection of only six states presents a concern about sample size and the ability to gain full representation of the multiple and interacting conditions affecting states' actions. Thus, careful attention was given to ensuring that a range of conditions were present among the states selected to make certain that the information and data and the stakeholder interviews would adequately illuminate the challenges facing the states in meeting the federal mandate of the CFSRs.

To this end, once the six states were identified, additional characteristics were considered to assess the balance of variability and commonality among the states, such as administrative structure of the state's child welfare system, rural and urban characteristics, political culture, fiscal stress, and child population. Several sources, in addition to the CFSR documents, were used to determine these factors.

Among the states identified, five of the six states have a state-administered child welfare system, while one has a state supervised/county administered system. Also, because service delivery occurs in localities, the number of counties within the state was another factor considered. The number of counties within the six states identified for this study range from 14 to 159. Further, each of the six states contains both rural and urban areas.

With regard to political culture, the political party affiliation of the governor(s) in office during the period of time between 2001 and 2004 was also identified. The 2001 to 2004 timeframe encompassed the period in which the states' self-assessments, on-site reviews, PIP development, and the federally defined PIP implementation period occurred. The importance of this particular factor, where relevant, is discussed in Chapter 5.

The National Association of State Budget Officers (NASBO) and the National Governors Association (NGA) publish a report, the *Fiscal Survey of States*, twice annually. This report

includes both aggregate and individual state data on revenue and expenditure measures, including Medicaid. A state's Medicaid spending is a significant source of funding for medical and mental health expenses for children, particularly children in the child welfare system. The fiscal year 2004 annual percentage growth rate in total expenditures for the states' Medicaid programs (combined state and federal funds), and percent change in Medicaid enrollment, were included.

Certain demographics from the 2000 Census are also provided. They are population, percent change in the population between 1990 and 2000, percent of persons under 5 years old, percent of persons under 18 years old, percent of the population who are foreign born, median household income, and percent of persons below the federal poverty level. These particular Census demographics were included because they relate to some of the underlying risk factors for abuse and neglect and the service array that may be required and available.

State characteristics, demographics, child welfare data for FY 2002 for the total number of victims of child maltreatment, the number of youth that entered foster care, and the number of youth served[12], are provided as additional context for the population served by each of the states during the approximate mid-point of their PIP implementation period. CFSR results on the selected well-being outcomes and systemic factors are also provided state-by-state for the six states examined for this research.

As noted earlier, the CFSR process incorporates three phases – the state's self-assessment, an on-site review, and the PIP. A written document is developed as a result of completion of each of these phases. In phase 1, each state developed a written self-assessment of

[12] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children Youth and Families, Children's Bureau, Child Welfare Outcomes 2002: Outcomes Report on Safety Permanency, Well-being.

their performance on the outcomes and systemic factors based on available data, reports, and input from stakeholders. This self-assessment document included such things as an explanation of challenges and new initiatives.

In phase 2, the federal and state team compiled the results of the on-site review and the federal CFSR team developed the final report for the state. This final report highlighted strengths observed and areas identified as being not in substantial conformity. Then, in phase 3, the state developed its PIP in response to the findings from the self-assessment and the final report. The PIPs included specific action items and levels of improvement expected and became the two-year plan the ACF and the state used to gauge progress.

The state self-assessment, the state final report, the initial PIP, subsequent state quarterly reports to HHS, and the final PIP report were reviewed for each of the six states selected. These documents were obtained through resources of the federal Children's Bureau.

Interview Process

Once the documents were reviewed and analyzed to determine general findings, a set of interview questions was developed to guide the discussion for interviews with state representatives and national level experts familiar with the CFSR process and PIP implementation. Interviews with the state leaders and the national level experts followed the protocol detailed for Exemption of Research Involving Human Subjects in the Institutional Review Board (IRB) process utilized by Virginia Polytechnic Institute and State University. The research met the exemption standard because the research was of minimal risk to the subjects, did not involve any special class of subjects, and involved the collection or study of existing data and documents from sources that were publicly available. Also, because this research qualified

as exempt, informed consent was not required. Additionally, no compensation was provided to interviewees [13].

The interviewees were provided with an introductory letter, via electronic mail, describing the project prior to the interview. The letter contained a statement indicating that if the interviewee wished to remain anonymous, any comments made would not be attributed and would only be used in general terms to expand the understanding of the written data and information obtained from publicly available reports. The interviews were not audio-taped, but extensive notes were taken during the interviews.

This interview guide focused on three areas of concern. Early review of the CFSR results indicated that collaboration and resource issues were critical areas that warranted more detailed research in order to understand the dynamics of state responses to the CFSR. Thus, the interview questions included three general CFSR related questions, three inter- and intra- agency collaboration and service related questions, and four resource related questions. The questions guiding the interviews with the state leaders are provided in Table 3.

[13] IRB approval was granted effective December 12, 2005.

Table 3: Interview Guide for State Leaders

General CFSR-related Questions

1. In your view, was your state more concerned with "passing" the CFSR to avoid federal sanctions, with developing better policies and procedures, or about equally with both? Please explain.

2. In preparing for and participating in the CFSR and in implementing and monitoring your PIP, how did your state differentiate between children receiving services in their own homes versus children receiving services in an out-of-home placement?

3. In contributing to the "areas needing improvement" how important were (1) the design and implementation of programs, (2) demographic factors (age, race, family income, parents' education, urbanicity, etc.), (3) human and financial resources of the agency? Further, how did your PIP address these three areas? Please explain.

Inter- and Intra- Agency Collaboration and Service-related Questions

4. In reviewing your state's self-assessment, the federal final report, and your state's PIP, numerous references are made to "policies" in place that guide practice. In what ways does practice lag behind policy – specifically in case management, assessment and service delivery in the areas of mental health and education?

5. How effective was your state in collaborating with the leadership at the state and local level in the educational, mental and physical health agencies in development of the PIP? Discuss what worked, what did not and what initiatives and/or efforts are still in the works.

6. What other changes were made (outside of the PIP) within your state to make improvements in your child welfare system in preparation for the next round of CFSRs (e.g., enhanced communication with administrative and political state leadership, enhancements to data availability or analysis etc.)?

Resource-related Questions

7. What was the relationship between the "program" agencies (e.g., social services, education and mental health) and your state's budgeting agencies/processes related to funding the PIP?

8. How informed/aware and/or supportive has your state/local legislature been regarding the CFSR, PIP implementation, etc.?

9. What additional funding was made available to your state to develop and implement your PIP? Is the funding broken down by the specific outcomes and systemic factors? How would you characterize the adequacy of any funding changes directed toward accomplishing the PIP?

10. In your opinion, what are the biggest challenges to meeting the well-being outcomes for children and their families in your state?

The state representatives interviewed were identified through assistance from Child Welfare League of America (CWLA) staff in Washington, D. C. familiar with the CFSR process. Once each state leader was identified and agreed to participate in the interview, the interview guide and introductory letter describing the research were sent to them via email in advance of the interview to inform them of the nature of the questions and interview process and to help them prepare to respond. Interviews were scheduled and conducted with representatives from each of the six states selected. Each of the state leaders interviewed worked within their state's child welfare arena and had each been recommended as the person most knowledgeable about the CFSR process in the state. While their respective job titles and roles differed, each had been assigned a leadership position in their state's CFSR efforts (see Appendix C for a listing of the state representatives). The first interview was conducted in person and was approximately 90 minutes in duration. The subsequent interviews were conducted by telephone and ranged in duration from approximately 30 minutes to approximately 2 hours.

Following each interview, email correspondence was sent to each of the state child welfare leaders, including a summary document of the edited notes taken during the interview. This correspondence indicated that the notes from all six of the interviews would be collapsed to identify themes, commonalities of issues, and areas that stood out as differences. Interviewees were also assured that comments would not be attributed to any specific person. Further, the email invited the interviewees to review the notes for accuracy of the content to ensure the intended response. Four of the six state leaders provided a timely response with minor comments and edits. The remaining two state leaders did not respond to the interview follow-up. Subsequent email correspondence was then sent to them indicating the critical timing of this element in this research and the plan to move forward with finalizing analysis of the interviews.

Following completion of the state representative interviews and analysis of the responses, interviews were conducted with national level experts in the field of child welfare to elucidate other perspectives on the responses of the states and the challenges they faced (see Appendix E for a listing of the national level experts). CWLA staff also provided assistance in identifying the national level experts. As with the state leader interviews, once each national level expert was identified and agreed to participate in the interview, email correspondence was sent to them indicating that the interview notes would be collapsed to identify themes, commonalities of issues, and trends, as well as national implications. They were also assured that comments would not be attributed to any specific person. The interviews were scheduled in advance and conducted by telephone. Each of the national level expert interviews was approximately 60 minutes in duration.

One interviewee indicated that he did not need to review the notes taken during the interview based on his understanding that he would not be quoted directly. Email correspondence to the other two national experts invited them to review the notes for accuracy. One of the national level experts who asked for the opportunity to review the notes provided a timely response with minor edits, the other expert acknowledged that he had received the interview notes, but did not provide any comments or clarifications.

The questions guiding the interviews with the national level experts were similar in content to the interview questions with the state leaders. They included three general CFSR related questions, three inter- and intra- agency collaboration and service related questions, and four resource related questions, but with a focus on the national level perspective. Table 4 presents the questions for the national level expert interviews.

Table 4: Interview Guide for Elite Interviews – National Level Experts

General CFSR-Related Questions

1. In your view, were states more concerned with "passing" the CFSR to avoid federal sanctions, with developing better policies and procedures, or about equally with both? Please explain.

2. In the CFSR, how important was it to differentiate between children receiving services in their own homes versus children receiving services in an out-of-home placement? Why?

3. In developing plans to address the items identified as "areas needing improvement" how important were (1) improving the overall design and implementation of programs, (2) utilizing analysis of demographic factors to focus or tailor approaches, (3) enhancing human and financial resources of the agency? Further, how well did the PIPs address these three areas?

Inter- and Intra- Agency Collaboration and Service-Related Questions

4. With regard to the outcomes in the CFSR related to well-being, does practice lag behind policy – specifically in case management, assessment and service delivery in the areas of mental health and education? Or, vice versa.

5. How effective were states in collaborating with the leadership at the state and local level in the educational, mental and physical health agencies in development of the PIP? Discuss what worked, what did not.

6. What other changes were made (outside of the PIP) within states to make improvements in their child welfare systems in preparation for the next round of CFSRs (e.g., enhanced communication with administrative and political state leadership, enhancements to data availability or analysis etc.)?

Resource-related Questions

7. What were some of the more common relationships between the "program" agencies (e.g., social services, education and mental health) and different states' budgeting agencies/processes related to funding the PIP? Were there any less common arrangements that seemed to work particularly well?

8. How informed/aware and/or supportive have the state and federal legislatures been regarding the CFSR, PIP implementation, etc.?

9. What additional funding and resources were made available to states to develop and implement their PIP? Was funding broken down by the specific outcomes and systemic factors? How would you characterize the adequacy of any funding changes directed toward accomplishing the PIP?

10. In your opinion, what are the biggest challenges for states in meeting the well-being outcomes for children and their families? What is the one most important change in policy and/or funding that needs to be addressed to improve child well-being outcomes?

Limitations of this Study

Case study research presents a number of limitations, most notably the ability to generalize. The complex array of differences among the states with regard to their populations, budgets, administrative structure of their child welfare systems, levels of fiscal stress, the challenges and/or benefits of the timing of the states' development of their PIPs, and the variation among the federal regional ACF offices charged with working with the states and negotiation of their PIPs, were among the many factors influencing the CFSR process in each state.

The selection of only six states from among all of the states undergoing the CFSR process limited the ability to fully explore the different roles and dynamic interactions of these factors. An additional limitation of this study relates to the role of the individuals interviewed within the six states. There was limited state level input in that there was only one leader per state interviewed and each was within the child welfare agency. There was no input from family or youth participants involved in the child welfare system, nor from any of the other state agencies that play a part in addressing child well-being. Relying solely on the perspective of individual state representatives within the state's child welfare system can not be expected to fully reflect the breadth and complexity of the practices and policies of the state and the processes of the state's engagement of the CFSR.

A limitation resulting from the state selection process is that the findings may be less relevant for states at the extremes of populations and conditions. For example, the states with the largest child welfare populations, such as California, Florida, Illinois, and New York, and the

states with the smallest child welfare populations, Deleware, Idaho, North Dakota, and Wyoming[14] may be substantially different from the states selected for this study.

Another limitation comes from the variability in the reports and products of the CFSRs, particularly those generated by the states – the Statewide Assessment, Program Improvement Plan and PIP reports. While the CFSR process in each state produced a large volume of descriptive material regarding some of the issues and initiatives in education, physical health, and mental health of system-involved children, it did not always assure that all of the relevant issues were addressed, or that the PIP strategies directly related to the areas assessed as needing improvement. Further, the relevant information could appear in different parts of the reports, in different contexts of the state's collaborative initiatives, and in varying levels of detail. Each state's CFSR documents were reviewed in their entirety and the sections relevant to the two selected well-being outcomes and the two related systemic factors were systematically coded. However, the review and coding process may not have captured every individual comment related to well-being that may have appeared in other sections of the CFSR documents.

Further, the scope of this study naturally imposes some additional limitations. There are many interesting issues that were not explored either through the document review or interviews. Some of these include the relationship between states' PIP strategies and state characteristics and demographics; analysis of what the states claimed they accomplished in the eight quarterly reports during the federally defined PIP implementation period; and the correlation between states' strategies and improvements in child well-being.

[14] http://ndas.cwla.org - Children in out of home care on 9/30 of federal fiscal year 2002.

CHAPTER 4 – RESULTS

This chapter is presented in five sections. Section I includes an overview of how all states[15], fared in the first round of the CFSR process on all of the outcomes and systemic factors. As discussed earlier, not all of the individual child and family outcomes and systemic factors are addressed in this study which focuses on the research questions: How did states respond to the complex requirements of the federal CFSRs regarding well-being outcomes, given the need for the involvement of multiple systems? How does the way that child welfare systems operate make addressing the well-being components particularly challenging? How do the relationships among the different levels of government and across different agencies affect the child welfare agencies' capacity and ability to assure child well-being?

Providing a broad overview of all of the CFSR results for all of the states is intended to give a perspective on the range of the reviews and the extent of work expected for the states in responding to the diverse areas that were identified as needing improvement.

Sections II through V focus only on the six states selected for this study. Section II provides a brief discussion and presentation of demographics and characteristics potentially relevant to the CFSR well-being outcomes for each of the six states selected for study. For the six states under review, Section III provides state-by-state findings for the well-being outcomes and the two related systemic factors. This review encompasses the states' self-assessment, ACF final report, PIP, and the subsequent quarterly reports. Section IV presents a summary of the strategies proposed by the states' to achieve improvements in the well-being outcomes not meeting conformity in the CFSR. Finally, Section V of this chapter highlights the findings from interviews with the six state child welfare leaders and the national level experts. The results

[15] The state count includes both the District of Columbia and Puerto Rico.

from all five sections provide the data and information which are reviewed in Chapter 5, applying the variables of the Mazmanian and Sabatier framework, to understand how the states responded to the CFSR well-being requirements.

Section I: Overview of States' Conformance with the CFSR Individual Outcomes and Systemic Factors

As noted in Chapter 2, the CFSR rated the states on both individual child and family outcomes and statewide systemic factors. There are seven individual outcomes with 23 associated measures and seven broad systemic factors with 22 associated measures. These are presented in Table 5 below.

Table 5: CFSR Individual Child and Family Outcomes and Systemic Factors

The CFSR established seven **individual child and family outcomes** that pertain to safety, permanency and well-being, with 23 associated measures. They are:

Safety

Outcome S1: Children are first, and foremost protected from abuse & neglect
- Item 1: Timeliness of initiating investigations of reports of child maltreatment
- Item 2: Repeat maltreatment

Outcome S2: Children are safely maintained in their homes whenever possible and appropriate
- Item 3: Services to family to protect child(ren) in home and prevent removal
- Item 4: Risk of harm to child

Permanency

Outcome P1: Children have permanency and stability in their living situations
- Item 5: Foster care re-entries
- Item 6: Stability of foster care placement
- Item 7: Permanency goal for child
- Item 8: Reunification, guardianship, or permanent placement with relatives
- Item 9: Adoption
- Item 10: Permanency goal of other planned permanent living arrangement

Outcome P2: The continuity of family relationships and connections is preserved for children
- Item 11: Proximity of foster care placement
- Item 12: Placement with siblings
- Item 13: Visiting with parents and siblings in foster care
- Item 14: Preserving connections
- Item 15: Relative placement
- Item 16: Relationship of child in care with parents

Table 5: CFSR Individual Child and Family Outcomes and Systemic Factors

Child and Family Well-Being

Outcome WB1: Families have enhanced capacity to provide for their children's needs

Item 17: Needs and services of child, parents, foster parents
Item 18: Child and family involvement in case planning
Item 19: Worker visits with child
Item 20: Worker visits with parents

Outcome WB2: Children receive appropriate services to meet their educational needs

Item 21: Educational needs of the child

Outcome WB3: Children receive adequate services to meet their physical and mental health needs

Item 22: Physical health of the child
Item 23: Mental health of the child

In addition, the CFSR includes seven broad **systemic factors** with 22 corresponding measures which are considered to underlie effective child welfare practice at the state and local level. These systemic factors address aspects of state child welfare agency operations relevant to achieving the desired individual outcomes for children and families. They are:

Statewide Information System

Item 24: State is operating a Statewide Information System that, at a minimum, can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within immediately preceding 12 months, has been) in foster care.

Case Review System

Item 25: Provides a process that ensures that each child has a written plan to be developed jointly with the child's parent(s) that includes the required provisions

Item 26: Provides a process for the periodic review of the status of each child, no less frequently than once every 6 months, either by a court or by administrative review

Item 27: Provides a process that ensures that each child in foster care under the supervision of the state has a permanency hearing in a qualified court or administrative body no later than 12 months from the date the child entered foster care and no less frequently than every 12 months

Item 28: Provides a process for termination of parental rights proceedings in accordance with the provisions of ASFA

Item 29: Provides a process for foster parents, pre-adoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be heard in, any review or hearing held with respect to the child

Quality Assurance System

Item 30: The state has developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of the children

Item 31: The state is operating an identifiable quality assurance system that is in place in the jurisdictions where the services included in the CFSP (Child and Family Service Plan) are provided, evaluates the quality of services, identifies strengths and needs of the service delivery system, provides relevant reports, and evaluates program improvement measures implemented

Table 5: CFSR Individual Child and Family Outcomes and Systemic Factors

Training

Item 32: The state is operating a staff development and training program that supports the goals and objectives in the CFSP, addresses services provided under Titles IV-B and IV-E, and provides initial training for all staff who deliver these services

Item 33: The state provides for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP

Item 34: The state provides training for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities that care for children receiving foster care or adoption assistance under Title IV-E that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children

Service Array

Item 35: The state has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency

Item 36: The services in Item 35 are accessible to families and children in all political jurisdictions covered in the state's CFSP

Item 37: The services in Item 35 can be individualized to meet the unique needs of children and families served by the agency

Agency Responsiveness to the Community

Item 38: In implementing the provisions of the CFSP, the state engages in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child and family service agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP

Item 39: The agency develops, in consultation with these representatives, annual reports of progress and services delivered pursuant to the CFSP

Item 40: The state's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population

Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 41: The state has implemented standards for foster family homes and child care institutions which are reasonably in accord with recommended national standards

Item 42: The standards are applied to all licensed or approved foster family homes or child care institutions receiving Title IV-E or IV-B funds

Item 43: The state complies with Federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children

Item 44: The state has in place a process for ensuring the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed

Item 45: The state has in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children

Tables 6 and 7 provide an overview of the extent to which all states either met or did not meet conformance on all of the individual outcomes and all of the systemic factors. As depicted in table 6, only 25% of all states reviewed met conformance on Safety Outcome 1 (children are first, and foremost protected from abuse & neglect) and only 12% on Safety Outcome 2 (children are safely maintained in their homes whenever possible and appropriate). For the two permanency outcomes, the results are even worse with only 6% of the states conforming on Permanency Outcome 1 (children have permanency and stability in their living situations) and 12% conforming on Permanency Outcome 2 (the continuity of family relationships and connections is preserved for children). This is striking given that the primary and core responsibility of state child welfare systems is the safety and stability of children in its care.

For the three well-being outcomes, the percentage of states meeting conformance is even more notable. No state met conformance for Well-being Outcome 1 (families have enhanced capacity to provide for their children's needs). For the two well-being outcomes that are the focus of this study, performance across all states was also quite poor. Less than 28% the states met conformance for Well-being Outcome 2 (children receive appropriate services to meet their educational needs), and only one state met conformance for Well-being Outcome 3 (children receive adequate services to meet their physical and mental health needs). The well-being outcomes present complex challenges to state child welfare agencies because they have the least control over these outcomes. It is this area that requires the most coordination and collaboration with and among other public and private agencies.

Table 6: All States' Conformance on Individual Child and Family Outcomes							
	Safety 1	**Safety 2**	**Permanency 1**	**Permanency 2**	**Well-Being 1**	**Well-Being 2**	**Well-Being 3**
Total # of states reviewed	52	52	52	52	52	52	52
# of states found in conformance	13	6	3	6	0	14	1
# of states found not to be in conformance	39	46	49	46	52	38	51
% of states found in conformance	25%	12%	6%	12%	0%	27%	2%
% of states found not to be in conformance	75%	88%	94%	88%	100%	73%	98%

Table 7 summarizes all states' conformance on all of the systemic factors for the CFSRs. In general, states fared better on these factors than on the individual outcomes. For all states, there was a high level of conformance on three of the factors: 83% on their Foster Care and Adoption Licensing, Recruitment and Retention; 87% on the Statewide Information System to provide to basic data on children in foster care; and 94% on Responsiveness to Community Needs. Approximately two-thirds of the states were in conformance on their Quality Assurance System (67%), and their Training of staff and providers (65%). The poorest performance related to providing an accessible array of services (Service Array 44%), and operating an effective Case Review System (25%).

The two systemic factors deemed most relevant to child well-being are Responsiveness to the Community and Service Array. There is an obvious contrast between the conformance rate on the Responsiveness to the Community factor, which indicates that the agency consults with

stakeholders and other public and private child and family service agencies, and the poor performance on the Service Array factor, which relates to the services in place to assess strengths and needs and provide appropriate interventions. Only one out of four states met conformance criteria on the Case Review System factor, indicating that even when services are provided, they are not adequately planned or monitored.

Table 7: All States' Conformance on Systemic Factors

	Statewide Information System	Case Review System	QA System	Training	Service Array	Responsiveness to Community Needs	Foster Care and Adoption: Licensing, Recruitment, and Retention
Total # of states reviewed	52	52	52	52	52	52	52
# of states found in conformance	45	13	35	34	23	49	43
# of states found not to be in conformance	7	39	17	18	29	3	9
% of states found in conformance	87%	25%	67%	65%	44%	94%	83%
% of states found not to be in conformance	13%	75%	33%	35%	56%	6%	17%

Section II: Six States' Demographics and Characteristics Relevant to the Well-Being Outcomes

State and local governments have regulatory, fiscal, and service delivery responsibility for a broad variety of matters including for example, education, environment, human services, public safety, and transportation. Multiple factors contribute to a state's and its localities' willingness and ability to address the needs of their populations related to these matters. Some

needs are not necessarily common across an entire population. For some consumers of public services there is not a strong political base or constituent groups to advocate for sufficient or effective services. There are also biases regarding particular populations, or the population's needs are especially complex and challenging. All of the conditions described above are especially applicable in child welfare. As a result of these factors, the outcomes of the governments' interventions are often compromised.

This section presents selected factors, demographics, and characteristics for each of the six states selected for study that are considered by this author to be particularly and specifically relevant to the CFSR well-being outcomes. A brief discussion regarding their relevance and how they may affect the states' approaches to addressing the areas identified as needing improvement in the CFSR is also provided.

The state data and information discussed in this section were gathered through a variety of sources. The census information presented in the tables that follow for each state under the heading "Select Census and Medicaid Data" was obtained from the U.S. Census Bureau from the 2000 census[16]. The Fiscal Year 2004 information on the two items "annual percentage growth rate in total Medicaid expenditures" and "percent change in Medicaid" was obtained from a publication by the National Governors Association[17]. The information presented in the tables under the headings "Characteristics and Select Demographics" and "Results from the CFSR" came from several sources including state websites, federal Children's Bureau resources, and the states' CFSR documents[18].

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[16] http://www.census.gov
[17] The Fiscal Survey of States, June 2005.
[18] Individual state government websites; http://www.acf.dhhs.gov/programs/cb; http://www.childwelfare.gov; Child Welfare Outcomes 2002: Annual Report to Congress.

Select Census and Medicaid Data

For each of the states reviewed, the tables show the state's overall population and population growth during the previous decade. It also shows the percent of the population under the age of five years and under the age of eighteen years, as well as the percent of the population that was foreign born. States with larger populations will obviously require larger human services and educational systems. States with a higher percentage of young children may be required to devote a greater proportion of their overall resources to the specific kinds of services designed to meet their needs, for example Head Start and subsidized child care. The percent of the population under the age of eighteen has implications for overall education, child welfare, juvenile justice, and children's mental health services. When median household income and percent living below the poverty level are considered, there are also implications for a broad range of health and social service programs and expenditures, as well as the tax base by which the state funds these services. One example of this is Medicaid. The tables show the annual percentage growth rate in expenditures and the percent change in the Medicaid enrollment numbers between federal Fiscal Year 2003 and 2004, the timeframe near the end of the states' PIP completion.

Characteristics and Select Demographics

Data for each of the six states identifies the type of administrative structure of the state's child welfare system and indicates how many counties there are in the state. FY 2002 data on the total number of children identified as victims of maltreatment[19], the total number of children who entered foster care during the fiscal year and the total number of children in foster care at

[19] The National Child Abuse and Neglect Data System (NCANDS) collects and reports data on child victimization based on each individual states' legislation, definition and polices, thus there is not a single national definition of child maltreatment.

any time during the year is also included. This information is provided as a context for the scope of the state's child welfare system, however it is important to note that these numbers exclude all of the children receiving services from the states' child welfare system who are not in state custody, e.g., children who may be abused or neglected yet remain living with their family. The federal foster care and adoption data system only requires states to report on children in state custody.

The federal HHS Administration for Children and Families (ACF) regions are key players in assisting states with implementation of their child welfare systems. There are ten regions across the country, constituting another potential source of variation in federal/state collaboration.

Because states' governors play a key role in legislation, funding, and establishing priorities for state initiatives, the political affiliation of the governor(s) in office during the years between 2001 and 2004 is also provided and will be discussed where relevant.

Results from the CFSR

Specific information from the CFSR findings for each of the six states is included in tables. The federally defined PIP completion date is provided as a temporal reference point. The maximum annual federal financial penalty estimate, should the state not successfully complete any of its PIP, is shown to give a perspective on the potential federal revenue loss for non-compliance with the CFSR.

States must achieve a satisfactory rating on 90% of the cases reviewed during the CFSR in order to be in substantial conformity on the outcome. The percent achieved on all three of the well-being outcomes is provided in the tables. The states' ratings on the two systemic factors

considered particularly relevant for this research are included as well. The rating scale for the systemic factors is 1 to 4. Ratings of 3 and 4 are indicators of substantial conformity.

Overview of State Characteristics

The six study states are described and discussed in alphabetical order. Each state's section begins with a brief overview followed by a table that includes the data and information on the factors noted above and a small diagram of the state indicating the location of the capital denoted by a star (★) with outlines of the counties for a perspective on their relative size and location. The data compiled for each state provides a "snapshot" or an overall description of many factors potentially relevant to child welfare.

Arizona

The 2000 Census reported that Arizona has a population of 5,130,632 with 26.6% of its population below 18 years of age and 7.5% below the age of five. Arizona ranked 20th among the states in overall population size and 2nd in population growth during the decade. Almost 13% of Arizona's population is foreign born compared to approximately 11% of the overall U.S. population. The median income for Arizona is $40,558 compared to $41,994 nationwide. The percent of families with children under the age of 18 years living below the poverty level nationwide was 9.2%, while Arizona's was 15.2%. For FY 2004, the average annual growth rate in Medicaid expenditures for the entire U.S. was 8.7%; however Arizona's was more than 17%. Arizona experienced an increase in Medicaid enrollment of 1.7%, while the average across the country was 3.9%. Thus, Arizona shows approximately double the growth rate in Medicaid expenditures, with only about half of the growth rate in enrollment compared to the country as a

whole. The significance of this situation will be discussed further in terms of the CFSR findings and state response.

Arizona has 15 counties and has a state-administered child welfare system. This means that for its 15 counties, the state's Division of Children, Youth and Families (DCYF) provides the leadership and centralized administrative support services for their programs across six districts throughout the state. The FY 2002 child welfare data show that Arizona had 5,114 victims of child maltreatment, 5,069 children who entered foster care, and 10,974 children in foster care during the fiscal year. Arizona, along with five other far western states, is served by the 9th federal ACF region, headquartered in San Francisco, California. This federal regional office also serves American Samoa, California, Hawaii, Nevada, Guam, and Palau. This is the only federal regional office involved with states in this study that serves jurisdictions not subject to the ASFA and ensuing CFSRs. During the timeframe between 2001 and 2004, Arizona had two governors – a Republican from 1997 to 2003, then a Democrat beginning in 2003.

For the three well-being outcomes, Arizona scored 70% for Well-being outcome 1, 85% for Well-being outcome 2, and only 59% for Well-being outcome 3. Arizona met substantial conformity for both systemic factors examined. Although there was the potential for an estimated $885,269 in federal penalties, because Arizona fully and successfully completed its PIP within the required timeframe, it was not assessed a financial penalty.

Table 8-1: Arizona

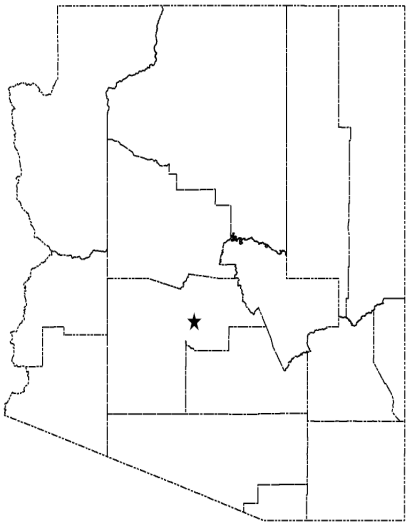
State Map with Counties	Select Census and Medicaid Data	
	Population	5,130,632
	% of population change between 1990 and 2000	40%
	% of population under the age of 5 years	7.5%
	% of population under the age of 18 years	26.6%
	% of the population foreign born	12.8%
	Median household income	$40,558
	% of families with children < 18 years of age living below the poverty level	13.9%
	Annual percentage growth rate in total Medicaid expenditures	17.3%
	% change in Medicaid	1.7%
	Demographics and Characteristics	
	Number of counties	15
	Federal ACF Region	IX
	Governor(s) political party between 2001 and 2004	Republican and Democrat
	Administrative structure of the child welfare system	State-administered
	Total number of child maltreatment victims	5,114
	Total number of youth who entered foster care	5,069
	Total number of youth served	10,974

Table 8-2: Arizona

Results from the CFSR	
PIP Completion Date	11-25-04
Estimated penalty for Non-compliance	$885,269
Well-being 1 – Enhanced Parental Capacity	70%
Well-being 2 – Education	85%
Well-being 3 – Physical and Mental Health	59%
Systemic factor – Service Array	3
Systemic factor - Agency Responsiveness to the Community	4

Georgia

The 2000 Census reported that Georgia has a population of 8,186,453 with 26.5% of its population below 18 years of age and 7.3% below the age of five. Georgia ranked 10th among the states in overall population size and 6th in population growth during the decade. A little more than 7% of Georgia's population is foreign born compared to approximately 11% of the overall U.S. population. The median income for Georgia is $42,433 compared to $41,994 nationwide. The percent of families with children under the age of 18 years living below the poverty level nationwide was 9.2%, while Georgia's was 13.9%. For FY 2004, the average annual growth rate in Medicaid expenditures for the entire U.S. was 8.7%; however Georgia's was more than 11%. Georgia experienced an increase in Medicaid enrollment of 6%, while the average across the country was 3.9%.

Georgia has 159 counties and a state-administered child welfare system. In Georgia, the state's Department of Human Resources (DHR), which is responsible for administering more than 80 programs, also oversees the Division of Family and Children Services (DFCS). This division employees more than 8,000 staff members of which more than 7,700 work in county-based offices. They provide a variety of social services including protective services to abused and neglected children and their families, and assessment, placement, and treatment services for children in foster care.

The FY 2002 child welfare data show that Georgia had 41,206 victims of child maltreatment, 9,766 children who entered foster care, and 22,578 children in foster care during the fiscal year. Georgia, along with seven other southern states, is served by the 4th federal ACF region, headquartered in Atlanta, Georgia. This federal regional office also serves Alabama, Florida, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. Georgia had

two governors during the 2001 and 2004 timeframe – a Democrat from 1999 to 2003, and a Republican beginning in 2003. For the three well-being outcomes, Georgia scored 72% for Well-being outcome 1, 76% for Well-being outcome 2, and only 63% for Well-being outcome 3. Georgia did not meet substantial conformity for the systemic factor – Service Array, but did meet conformity for systemic factor – Agency Responsiveness to the Community. Although Georgia concluded its PIP on October 1, 2004, HHS determined that Georgia failed to successfully complete all the requirements and fined the state $4.3 million through a disallowance in federal funds from Title IV-B and Title IV-E. HHS determined that Georgia completed PIP activities on 4 of the 7 individual outcomes and all 3 systemic factors not initially meeting substantial conformity during the review. However, the state failed to complete twelve of the PIP required action steps related to Permanency 1: Children have permanency and stability in their living situations; Well-Being 1: Families have enhanced capacity to provide for their children's needs; and Well-Being 3: Children receive adequate services to meet their physical and mental health needs. The penalty assessed to Georgia in the amount of $4.3 million and noted in an undated letter from the federal Children's Bureau[20], differs significantly from the estimated penalty of $2,424,200 indicated in table 9-2 below. The Children's Bureau letter provides a detailed chart showing how the amount of the disallowance was calculated across several years. The penalty calculation extends beyond the two year PIP implementation timeframe. Because Georgia had already received the federal funds prior to the penalty letter from the Children's Bureau, the state was advised that they must repay the funds, rather than have the penalty withheld from future Title IV-B and/or Title IV-E funds paid to the state.

[20] www.childwelfare.net/cfsreview. Item dated Fall, 2006: Georgia's PIP Penalty Letter from DHHS.

Table 9-1: Georgia

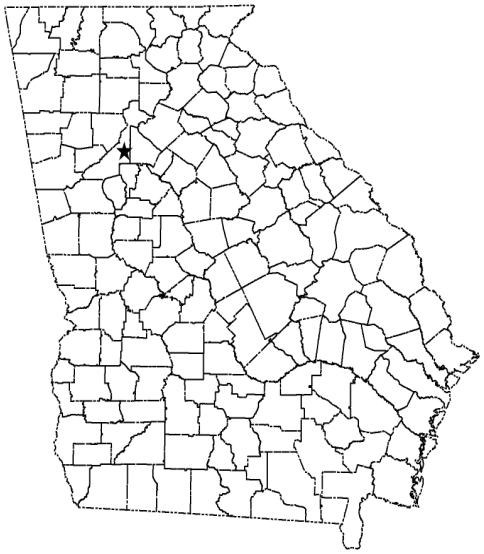
State Map with Counties	Select Census and Medicaid Data	
	Population	8,186,453
	% of population change between 1990 and 2000	26.4%
	% of population under the age of 5 years	7.3%
	% of population under the age of 18 years	26.5%
	% of the population foreign born	7.1%
	Median household income	$42,433
	% of families with children < 18 years of age living below the poverty level	13.0%
	Annual percentage growth rate in total Medicaid expenditures	11.2%
	% change in Medicaid	6.0%
	Demographics and Characteristics	
	Number of counties	159
	Federal ACF Region	IV
	Governor(s) political party between 2001 and 2004	Democrat and Republican
	Administrative structure of the child welfare system	State-administered
	Total number of child maltreatment victims	41,206
	Total number of youth who entered foster care	9,766
	Total number of youth served	22,578

Table 9-2: Georgia

Results from the CFSR	
PIP Completion Date	10-1-04
Estimated penalty for Non-compliance	$2,424,200
Well-being 1 – Enhanced Parental Capacity	72
Well-being 2 – Education	76
Well-being 3 – Physical and Mental Health	63
Systemic factor – Service Array	2
Systemic factor - Agency Responsiveness to the Community	3

Indiana

The 2000 Census reported that Indiana has a population of 6,080,485 with 25.9% of its population below 18 years of age and 7% below the age of five. Indiana ranked 14th among the states in overall population size and 27th in population growth during the decade. Only 3.1% of Indiana's population is foreign born compared to approximately 11% of the overall U.S. population. The median income for Indiana is $41,567 compared to $41,994 nationwide. The percent of families with children under the age of 18 years living below the poverty level nationwide was 9.2%, while Indiana's was 10.2%. For FY 2004, the average annual growth rate in Medicaid expenditures for the entire U.S. was 8.7%; however Indiana's was 19%. Indiana experienced an increase in Medicaid enrollment of 5.3%, while the average across the country was 3.9%.

Indiana has 92 counties and has a state-administered child welfare system. The state's Department of Child Services is a freestanding cabinet level agency that reports directly to the Governor. This new agency was established in January 2005 by executive order of the Governor to provide greater attention and oversight in children's services. It administers child support, child protection, adoption, and foster care services throughout the state of Indiana. During the CFSR timeframe the Child Protection Services agency was still within the state's Family and Social Services Administration (FSSA).

The FY 2002 child welfare data show that Indiana had 20,416 victims of child maltreatment, 5,844 children who entered foster care, and 13,229 children in foster care during the fiscal year. Indiana, along with five other central states, is served by the 5th federal ACF region, headquartered in Chicago, Illinois. This federal regional office also serves Illinois,

Michigan, Minnesota, Ohio, and Wisconsin. During the timeframe between 2001 and 2004, Indiana's two governors were both Democrats.

For the three well-being outcomes, Indiana scored 60% for Well-being outcome 1, 71% for Well-being outcome 2, and 70% for Well-being outcome 3. Indiana met substantial conformity for both systemic factors examined. Although there was the potential for an estimated $965,132 in federal penalties, because Indiana fully and successfully completed its PIP within the required timeframe, it was not assessed a financial penalty.

Table 10-1: Indiana

State Map with Counties	Select Census and Medicaid Data	
	Population	6,080,485
	% of population change between 1990 and 2000	9.7%
	% of population under the age of 5 years	7.0%
	% of population under the age of 18 years	25.9%
	% of the population foreign born	3.1%
	Median household income	$41,567
	% of families with children < 18 years of age living below the poverty level	9.5%
	Annual percentage growth rate in total Medicaid expenditures	19.0%
	% change in Medicaid	5.3%
	Demographics and Characteristics	
	Number of counties	92
	Federal ACF Region	V
	Governor(s) political party between 2001 and 2004	Democrat
	Administrative structure of the child welfare system	State-administered
	Total number of child maltreatment victims	20,416
	Total number of youth who entered foster care	5,844
	Total number of youth served	13,229

Table 10-2: Indiana

Results from the CFSR	
PIP Completion Date	8-30-04
Estimated penalty for Non-compliance	$965,132
Well-being 1 – Enhanced Parental Capacity	60
Well-being 2 – Education	71
Well-being 3 – Physical and Mental Health	70
Systemic factor – Service Array	4
Systemic factor - Agency Responsiveness to the Community	4

Massachusetts

The 2000 Census reported that Massachusetts has a population of 6,349,097 with 23.6% of its population below 18 years of age and 6.3% below the age of five. Massachusetts ranked 13th among the states in overall population size and 41st in population growth during the decade. Approximately 12% of Massachusetts's population is foreign born compared to approximately 11% of the overall U.S. population. The median income for Massachusetts is the highest of all of the six states selected for study at $50,502 compared to $41,994 nationwide. The percent of families with children under the age of 18 years living below the poverty level nationwide was 9.2%, while Massachusetts' was 10.12%, the lowest of the six states. For FY 2004, the average annual growth rate in Medicaid expenditures for the entire U.S. was 8.7%, while Massachusetts' was 7.6%. Massachusetts experienced a decrease in Medicaid enrollment of 3.5%, only one of two states among the six to experience a decrease, while the average increase across the country was 3.9%.

Massachusetts has 14 counties and a state-administered child welfare system. For its 14 counties, the state's Department of Social Services (DSS), an agency within the Executive Office of Human Services, provides social services to children and families either directly by DSS staff or through private agencies with DSS contracts across 29 area offices throughout the state.

The FY 2002 child welfare data show that Massachusetts had 34,995 victims of child maltreatment, 6,555 children who entered foster care, and 18,058 children in foster care during the fiscal year. Massachusetts, along with five other New England states, is served by the 1st federal ACF region, headquartered in Boston, Massachusetts. This federal regional office also serves Connecticut, Maine, New Hampshire, Rhode Island, and Vermont. During the timeframe between 2001 and 2004, both Massachusetts governors were Republicans.

For the three well-being outcomes, Massachusetts scored 76% for Well-being outcome 1, 86% for Well-being outcome 2, and 69% for Well-being outcome 3. Massachusetts met substantial conformity for both systemic factors examined. Although there was the potential for an estimated $858,550 in federal penalties, because Massachusetts fully and successfully completed its PIP within the required timeframe, it was not assessed a financial penalty.

Table 11-1: Massachusetts

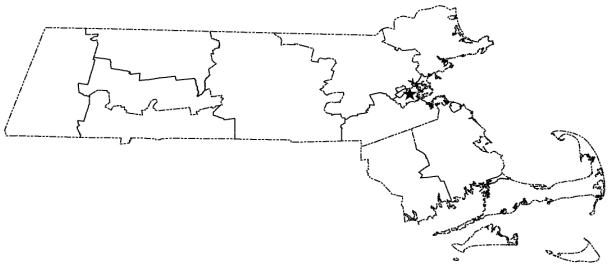
State Map with Counties	Select Census and Medicaid Data	
	Population	6,349,097
	% of population change between 1990 and 2000	5.5%
	% of population under the age of 5 years	6.3%
	% of population under the age of 18 years	23.6%
	% of the population foreign born	12.2%
	Median household income	$50,502
	% of families with children < 18 years of age living below the poverty level	9.3%
	Annual percentage growth rate in total Medicaid expenditures	7.6%
	% change in Medicaid	-3.5%
	Demographics and Characteristics	
	Number of counties	14
	Federal ACF Region	I
	Governor(s) political party between 2001 and 2004	Republican
	Administrative structure of the child welfare system	State-administered
	Total number of child maltreatment victims	34,995
	Total number of youth who entered foster care	6,555
	Total number of youth served	18,058

Table 11-2: Massachusetts

Results from the CFSR	
PIP Completion Date	11-27-04
Estimated penalty for Non-compliance	$858,550
Well-being 1 – Enhanced Parental Capacity	76
Well-being 2 – Education	86
Well-being 3 – Physical and Mental Health	69
Systemic factor – Service Array	3
Systemic factor - Agency Responsiveness to the Community	3

North Carolina

The 2000 Census reported that North Carolina has a population of 8,049,313 with 24.4% of its population below 18 years of age and 6.7% below the age of five. North Carolina ranked 11th among the states in overall population size and 9th in population growth during the decade. Only 5.3% of North Carolina's population is foreign born compared to approximately 11% of the overall U.S. population. The median income for North Carolina is $39,184 compared to $41,994 nationwide. The percent of families with children under the age of 18 years living below the poverty level nationwide was 9.2%, while North Carolina's was 13.3%. For FY 2004, the average annual growth rate in Medicaid expenditures for the entire U.S. was 8.7%, while North Carolina's was almost 12%. North Carolina experienced an increase in Medicaid enrollment of 4.6%, while the average across the country was 3.9%.

North Carolina has 100 counties and is the only state among the six states to have a state supervised/county administered child welfare system. The state's Department of Social Services (DSS) provides the oversight, support, training, technical assistance, and consultation to the local staff who work directly in the programs to deliver the services and benefits for families and children within the 100 localities. At the state level, the statutorily based Social Services Commission has the authority to establish rules for social services programs established by federal legislation.

The FY 2002 child welfare data show that North Carolina had 5,114 victims of child maltreatment, 5,069 children who entered foster care, and 10,974 children in foster care during the fiscal year. North Carolina, along with five other southern states, including Georgia, is served by the 4th federal ACF region, headquartered in Atlanta, Georgia. North Carolina's incumbent governor, a Democrat, was in office during the timeframe between 2001 and 2004.

For the three well-being outcomes, North Carolina scored 70% for Well-being outcome 1, 85% for Well-being outcome 2, and only 59% for Well-being outcome 3. North Carolina met substantial conformity for both systemic factors examined. Although there was the potential for an estimated $1,142,516 in federal penalties, because North Carolina fully and successfully completed its PIP within the required timeframe, it was not assessed a financial penalty.

Table 12-1: North Carolina

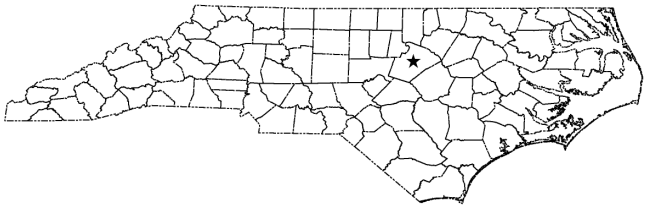
State Map with Counties	**Select Census and Medicaid Data**	
	Population	8,049,313
	% of population change between 1990 and 2000	21.4%
	% of population under the age of 5 years	6.7%
	% of population under the age of 18 years	24.4%
	% of the population foreign born	5.3%
	Median household income	$39,184
	% of families with children < 18 years of age living below the poverty level	12.3%
	Annual percentage growth rate in total Medicaid expenditures	11.8%
	% change in Medicaid	4.6%
	Demographics and Characteristics	
	Number of counties	100
	Federal ACF Region	IV
	Governor(s) political party between 2001 and 2004	Democrat
	Administrative structure of the child welfare system	State-supervised/ county-administered
	Total number of child maltreatment victims	35,523
	Total number of youth who entered foster care	5,615
	Total number of youth served	14,931

Table 12-2: North Carolina

Results from the CFSR	
PIP Completion Date	12-28-03
Estimated penalty for Non-compliance	$1,142,516
Well-being 1 – Enhanced Parental Capacity	68
Well-being 2 – Education	80
Well-being 3 – Physical and Mental Health	68
Systemic factor – Service Array	3
Systemic factor - Agency Responsiveness to the Community	4

Oregon

The 2000 Census reported that Oregon has a population of 3,421,399 with 24.7% of its population below 18 years of age and 6.53% below the age of five. Oregon ranked 28th among the states in overall population size and 11th in population growth during the decade. Approximately 8.5% of Oregon's population is foreign born compared to approximately 11% of the overall U.S. population. The median income for Oregon is $40,916 compared to $41,994 nationwide. The percent of families with children under the age of 18 years living below the poverty level nationwide was 9.2%, while Oregon's was 12.4%. For FY 2004, the average annual growth rate in Medicaid expenditures for the entire U.S. was 8.7%, while Oregon's decreased by almost 3%. Oregon also experienced a decrease in Medicaid enrollment of 11.4%, while the average across the country increased by 3.9%.

Oregon has 36 counties and has a state-administered child welfare system. Oregon's Department of Human Services is the state's health and human services agency. Its Children, Adults, and Families Division administers child welfare services through a centralized operational support office that provides assistance to sixteen service delivery areas and more than 110 field services offices across the state.

The FY 2002 child welfare data show that Oregon had 9,228 victims of child maltreatment, 5,095 children who entered foster care, and 13,747 children in foster care during the fiscal year. Oregon, along with three other Northwestern states, is served by the 10th federal ACF region, headquartered in Seattle, Washington. This federal regional office also serves Alaska, Idaho, and Washington. During the timeframe between 2001 and 2004, Oregon had two governors, both Democrats.

For the three well-being outcomes, Oregon scored 76% for Well-being outcome 1, 82% for Well-being outcome 2, and 81% for Well-being outcome 3. Oregon met substantial conformity for both systemic factors examined. Although there was the potential for an estimated $620,000 in federal penalties, because Oregon fully and successfully completed its PIP within the required timeframe, it was not assessed a financial penalty.

Table 13-1: Oregon

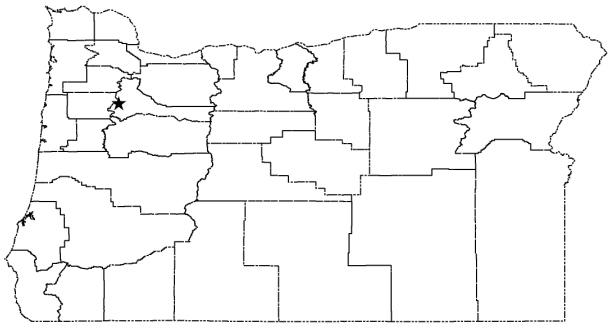
State Map with Counties	Select Census and Medicaid Data	
	Population	3,421,399
	% of population change between 1990 and 2000	20.4%
	% of population under the age of 5 years	6.5%
	% of population under the age of 18 years	24.7%
	% of the population foreign born	8.5%
	Median household income	$40,916
	% of families with children < 18 years of age living below the poverty level	11.6%
	Annual percentage growth rate in total Medicaid expenditures	-2.8%
	% change in Medicaid	-11.4%
	Demographics and Characteristics	
	Number of counties	36
	Federal ACF Region	X
	Governor(s) political party between 2001 and 2004	Democrat
	Administrative structure of the child welfare system	State-administered
	Total number of child maltreatment victims	9,228
	Total number of youth who entered foster care	5,095
	Total number of youth served	13,747

Table 13-2: Oregon

Results from the CFSR	
PIP Completion Date	7-9-04
Estimated penalty for Non-compliance	$620,000
Well-being 1 – Enhanced Parental Capacity	76
Well-being 2 – Education	82
Well-being 3 – Physical and Mental Health	81
Systemic factor – Service Array	3
Systemic factor - Agency Responsiveness to the Community	4

Summary of Six States' Relevant Child and Family Well-Being Outcomes Results

Table 14 below provides a summary of the federally defined PIP completion dates, estimated potential federal penalties, and CFSR scores on the selected well-being outcomes and systemic factors for the six states selected for this study. None of the six states met the 90% conformity criteria for the well-being outcome related to education (WB 2), nor the well-being outcome related to physical and mental health needs (WB 3). For the two relevant systemic factors, Georgia was the only state among the six that did not meet conformance on one of the factors (score of "2" on service array).

Table 14: Summary of the Relevant CFSR Parameters and Scores for the Six Study States

Item	**States**					
	Arizona	**Georgia**	**Indiana**	**Massachusetts**	**North Carolina**	**Oregon**
PIP Completion Date	11-2004	10-2004	8-2004	11-2004	12-2003	7-2004
Estimated Federal Potential Penalty	$885,269	$2,424,200	$965,132	$858,550	$1,142,516	$620,000
Well-being (WB) Outcomes (90% required for conformity)						
WB 2: Education	85%	76%	71%	86%	80%	82%
WB 3: Physical and Mental Health	59%	63%	70%	69%	68%	81%
Systemic Factors (rating of 3 or 4 required for conformity)						
Service Array	3	2	4	3	3	3
Responsiveness to Community	4	3	4	3	4	4

Section III: State-by-State Findings for the Six Study States

This section provides details of the state-by-state findings of the two relevant individual well-being outcomes and the two relevant systemic factors for the six states under review in this study. The analysis encompasses the review of numerous documents for each state. These include the states' self-assessment, ACF final reports, PIPs, and the subsequent quarterly reports. These documents were reviewed and synthesized and elements were extracted to working documents and spreadsheets for further detailed analysis.

Arizona

Arizona achieved a score of 85% in well-being outcome 2 (education needs) and 59% in well-being outcome 3 (physical and mental health needs), and thus did not meet the required 90% achievement score for the cases reviewed during the CFSR to be determined in substantial conformity on these measures. For the systemic factors, Arizona did achieve conformity in the service array and responsiveness to community needs measures with a rating of 3 and 4, respectively. For the individual outcomes rated as needing improvement, shortcomings in the educational, physical health, and mental health areas were identified. A detailed work plan was developed in response to the CFSR findings that included proposed action steps to achieve the goals and associated benchmarks and tasks to measure progress.

Areas Identified as Needing Improvement for Well-being Outcome 2 - Education

For the children in foster care, the CFSR results for well-being outcome 2, item 21 (educational needs of the child), cited frequent changes in school settings, lack of assessments, failure of the agency to address educational needs in the child's service plan, and lack of educational advocacy on the part of the agency for the child, as the areas needing improvement.

Further, for the in-home cases reviewed, the CFSR found that the educational needs of the children were not addressed by the child welfare agency.

Benchmarks and Tasks Proposed for Well-being Outcome 2 - Education

To improve in the educational area, Arizona's PIP included strategies that focused on improvements in policies and procedures, training and identification of barriers. Specific benchmarks and tasks proposed are highlighted in Table 15.

Table 15: Highlights of Arizona's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 2 - the Educational Needs
Improve educational stability by reducing changes in schools due to placement instability
Improved policy and procedures on educational services for children in out-of-home care finalized and communicated to field staff via on-line policy manual and/or e-mail
First session of Training Institute including improved policy and procedures on educational services for children in out-of home care held
Training on improved out-of-home care plan development policy provided to existing staff and supervisors via means to be determined
Identify and address systemic barriers to assessment of educational needs and provision of services to meet those needs
First meeting held of a statewide committee of ACYF staff and external stakeholders to identify and implement strategies to improve educational services for children involved in ACYF (Arizona's Children, Youth and Families) cases
Written recommendations for improving educational services for children involved in ACYF cases provided to ACYF administration

Areas Identified as Needing Improvement for Well-Being Outcome 3 – Physical Health

For well-being outcome 3, item 22 (physical health of the child), the CFSR found that foster parents were not provided with complete health information at the time children were placed with them and that there often was not up-to-date medical and dental information in the agency's case record for the child, nor were the initial medical assessments completed. This finding is contrary to the established state policy identified during the statewide assessment regarding the health care of children. Further, the CFSR identified that physical examinations were not performed to substantiate abuse for children who were alleged victims of sexual abuse.

This was of particular concern because of the significant number of cases reviewed that had sexual abuse issues. Another area needing improvement relates to the lack of providers and the lack of transportation in the rural areas of Arizona and how these factors affect the availability and access to medical and dental services in the rural areas of the state.

Benchmarks and Tasks Proposed for Well-Being Outcome 3 – Physical Health

To make improvements in the physical health area, Arizona's PIP included strategies to increase collaboration and coordination with providers, improve communication with case managers, make health care information more available to case managers and foster parents, and target provider recruitment efforts to specific areas of the state. Highlights of the specific benchmarks and tasks proposed are provided in Table 16.

Table 16: Highlights of Arizona's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Physical Health Needs
Increase availability of and access to health care providers who will treat foster children in rural areas
CMDP (Comprehensive Medical and Dental Program – the health care program for Arizona's children in foster care) Provider Network Directory printed, listing primary care providers and dentists with provider agreements to participate in the network
Via CMDP member satisfaction survey, survey mailed to case managers and out-of-home caregivers regarding transportation needs related to obtaining health care services
Action plan written to increase CMDP's role in funding medically necessary, non-urgent transportation of children to health care appointments when the out-of-home caregiver and case manager are unable to transport
Procedures written for monitoring and maintaining a CMDP Provider Network in all areas of the state
Increase case manager and caregiver access to medical and dental history information
First meeting held of committee to explore opportunities to increase the rate at which AHCCCS (Arizona Health Care Cost Containment System) health plans send completed Transition Forms to CMDP for children transitioning to CMDP upon entering foster care
Process developed and written for CMDP to provide health plan Transition Forms to case managers
First meeting held of committee to explore methods to increase the frequency with which health care information is collected for children upon entry into foster care and shared with caregivers and health care providers

Table 16: Highlights of Arizona's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Physical Health Needs
The electronic transfer of health care information will be monitored to determine if modifications are needed, and written recommendations provided to the child welfare agency's management
Increase the percentage of children whose identified physical health care needs are addressed in service planning
First meeting held with the Training Institute to review and revise material on the role of the case manager in assessing and addressing health care needs of children in foster care
Pilot implemented in Maricopa County and corresponding policy to add a health care plan as part of the case plan
Training provided in each district to case managers and supervisors regarding health care planning, via specialized training sessions developed jointly by the child welfare agency and CMDP
Process written for CMDP to e-mail or call case managers to ensure case managers are aware of identified needs or services recommended on EPSDT (Early Periodic Screening, Diagnosis, and Treatment – child health component of Medicaid) forms
Health care providers with an interest in providing services to children in foster care recruited, and training held for these providers regarding the unique needs of foster children
Increase the percentage of children who receive an initial medical screening according to policy
Contracts revised to increase and define the role of licensing agency staff in educating foster and adoptive caregivers to arrange for medical and dental care as required by policy
Health care providers with expertise in conducting initial health care exams for foster children identified and recruited in largest metropolitan areas, and e-mail or memo provided to staff in those areas, listing the identified providers
Results of Medical Examination Pilot Project analyzed for implications regarding timely completion of initial health care screenings, and written recommendations provided to administration
In collaboration with identified providers, protocol written to increase case manager or caregiver access to timely and comprehensive examinations
Workshop held at the Children Need Homes Annual Conference to educate foster caregivers regarding initial medical examinations and health care services

Areas Identified as Needing Improvement for Well-Being Outcome 3 - Mental Health

For item 23 (mental health of the child) in well-being outcome 3, the CFSR found that the barriers that existed to meeting children's mental health needs included the inability of the agency to secure assessments for children, refusal of providers to serve children, lack of mental health assessments, delays in assessments, referrals, and treatment, and lack of coordinated services. Additionally, individualized services, such as in the area of substance abuse for

children and attachment and bonding therapy, were lacking. For the cases in which sexual abuse was an issue, both assessment and treatment were lacking. It was specifically noted that for the in-home cases, there was a lack of follow-up treatment for identified needs.

Benchmarks and Tasks Proposed for Well-Being Outcome 3 – Mental Health

To ameliorate shortcomings in the mental health area, Arizona's PIP included strategies focused on improving access to Medicaid funded services, clarifying polices and procedures, staff and provider training, and enhancing collaboration and coordination with other relevant agencies. Highlights of the specific benchmarks and tasks proposed are provided in Table 17.

Table 17: Highlights of Arizona's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Mental Health Needs
Increase the percentage of children referred for and receiving a mental health assessment through Medicaid
Policy and procedures on initial mental health assessments on children entering out-of-home care written and communicated to field staff via on-line policy manual and/or e-mail
First session of Training Institute including improved policy and procedures on initial mental health assessments held
Training on improved policy and procedures on initial mental health assessments provided to existing staff and supervisors via means to be determined
Improve access to mental health services by reducing service denials by Medicaid Providers
Agency interface with the Division of Behavioral Health Services (DBHS) Issue Resolution developed, including internal process and procedures, and tracking of Issue Resolutions submitted to DBHS
All District Mental Health Specialists trained on Issue Resolution process and procedures
Process and procedure for filing and tracking Medicaid appeals written
Training provided to all District Mental Health Specialists on Medicaid Appeals
Cross System Advocacy Training provided for all District Mental Health Specialists
Policy requiring an action when the Hotline is notified of a possible incident of sexual abuse between children in out-of home care finalized and communicated to agency staff via email
Case managers and supervisors trained on new policy via means to be determined
First of ongoing collaborative meetings between CMDP and the child welfare agency held to explore strategies to improve coordination of mental health services for children involved in the child welfare agency
Action plan written including steps to implement strategies to improve coordination of mental health services for children involved in the child welfare agency
Improve mental health service planning and provision for children with higher or more complicated needs

Table 17: Highlights of Arizona's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Mental Health Needs
Hybrid Multidisciplinary Team convened in Maricopa County and first meeting held to review cases of children with higher or more complicated needs
Increase access to child specific Medicaid mental health services
First of ongoing meetings held between the child welfare agency, the Department of Health Services (DHS), and the Regional Behavioral Health Authority to explore strategies to increase access to specialized mental health services including services to address sexual abuse, child substance abuse, attachment and bonding, and grief and loss issues
Improved procedures written defining and describing methods for accessing specialized Medicaid child mental health services
Improved procedures distributed to case managers and other staff via presentation at Program Manager's meeting, Child Welfare Training Institute, and e-mail
Increase access to mental health services to support placement stability
Story boarding process to review Governor's Task Force recommendations initiated, to develop action plan
In conjunction with DHS, and where necessary, policy and procedures for the Placement Preservation service developed
In conjunction with DHS, Placement Preservation Teams convened statewide, and child welfare case managers notified of the availability of the service

Systemic Factors

Although, Arizona met conformity for the two systemic factors explored for this study, the CFSR did identify a number of concerns. Related to the array, accessibility and individualization of services across the state, stakeholders universally identified mental health services as a major challenge, and this was particularly true for non-English speaking clients. Residential drug and alcohol treatment facilities in the state were identified as needs, as was post-finalization of adoption services, family foster homes for youth, and specialized homes for children with emotional needs. It was also recommended that the agency explore more effective strategies to engage a greater number of families in services.

It was noted that the transfer of services and continuity of care when a child moves from one community to another and the availability of services, particularly Medicaid funded services, mental health services, adequate placement resources, residential treatment programs, and crisis

shelters was limited in rural areas in the state and that travel distance for services further limited access.

With regard to the state's child welfare agency's ability to meet the extraordinary and unique needs of children and families, stakeholders interviewed noted that flexible funding and services outside the scope of specified contracted services were not available. The need for specialized mental health services, especially for children with severe emotional disturbances and victims of sexual abuse, was cited by stakeholders and noted in the case record reviews. Additionally, the stakeholders interviewed noted an increasing need for specialized services to address the unique behavioral and therapeutic needs of the youth dually involved in the child welfare and juvenile justice systems.

For the responsiveness to the community systemic factor, stakeholders interviewed expressed concerns about the child welfare agency's ability to protect children from abuse and/or neglect. It was noted that this may be due to a lack of understanding on the part of stakeholders regarding the criteria for referral, the threshold of risk for removal of a child from his family and the responses to and provision of services for cases that are not [formally] investigated. The CFSR stakeholder interviews also cited the need to improve collaboration with the educational and probation systems in some areas of the state.

Because Arizona met conformity for both the service array and responsiveness to the community systemic factors, the PIP did not include strategies for improvement in these two areas.

Georgia

Georgia achieved a score of 76% in well-being outcome 2 (education needs) and 63% in well-being outcome 3 (physical and mental health needs), and thus did not meet the required

90% achievement score for the cases reviewed during the CFSR to be determined in substantial conformity on these measures. For the systemic factors, Georgia received a rating of 2 on the service array factor, therefore did not achieve conformity in this area. Georgia did achieve conformity on the responsiveness to community systemic factor and received a 3 rating. For the individual outcomes rated as needing improvement, shortcomings in the educational, physical health, and mental health areas were identified. A detailed work plan was developed in response to the CFSR findings that included proposed action steps to achieve the goals and associated benchmarks and tasks to measure progress.

Areas Identified as Needing Improvement for Well-Being Outcome 2 - Education

The results for well-being outcome 2, item 21 (educational needs of the child), cited challenges for the state's large jurisdiction as well as challenges for the smaller jurisdictions reviewed as part of the CFSR. In the larger site, the problem of multiple school placements for children in foster care was noted. A lack of up-front educational assessments to identify educational needs, educational needs not consistently addressed in case plans, and the need for case managers to go beyond simply looking to see if children were on grade level to be able to identify other problems in school were also noted. Further, the need for early identification of developmental problems for children that could later affect their educational needs was mentioned.

In the smaller jurisdictions, some of the cases reviewed either lacked educational assessments or the assessments were delayed. Follow through on identified educational needs needed to be improved. Also, for the cases that were transferred to other jurisdictions, adequate follow-up on the child's educational needs needed to be done by case managers.

Additionally, stakeholders reported that children's educational needs needed to be incorporated better in state plans and that more advocacy for children in foster care was needed with the school systems, particularly when schools indicated that they did not want to accept the children into their schools. It was also noted that case managers did not have sufficient time to advocate for special education services, and that educational funding needed to be allocated for the children in group and residential care settings.

Benchmarks and Tasks Proposed for Well-Being Outcome 2 - Education

To make improvements in the educational area, Georgia's PIP focused on a strategy to require all counties to begin to use the CPRS (Case Plan Reporting System), the state's automated child welfare information system, to develop case plans for each child entering foster care. The state's Department of Education was asked to download a listing of Georgia's public schools and other relevant education information, and incorporate it into the CPRS so that it is readily available on all case plans. Enhancements to the CPRS Education Screen were also proposed to ensure that case management staff could gather information necessary to address the individual educational needs for each child. The specific benchmarks and tasks proposed are highlighted in Table 18.

Table 18: Highlights of Georgia's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-being Outcome 2 - the Educational Needs
Change placement policy to require all counties to use the CPRS for each child entering foster care
Expand fields on the Education Screen in CPRS to include additional questions, e.g., "Has the child had an educational assessment within the last 12 months?" "Does the child's educational plan reflect and incorporate the findings of the most recent comprehensive assessment?" "Have the details of the child's education needs been provided to the placement resource?" "If the child is below school age, has there been a developmental assessment?" "Is the child developmentally delayed?" "Have the child's educational needs been provided to the boarding county if the child is placed out of county?"

Areas Identified as Needing Improvement for Well-Being Outcome 3 – Physical Health

For well-being outcome 3, item 22 (physical health of the child), the CFSR identified concerns that children's health issues are not always addressed for obvious and specific health problems in the larger jurisdiction reviewed. In the smaller sites, consistent case manager follow-up on assessments and medical appointments, and ongoing problems with service availability, particularly for dental needs due to a lack of providers that accept Medicaid for dental care, were cited as problems.

At the state level, even though the state had capacity for health coverage for all children in foster care through the state's Peachcare program and Medicaid, they were not able to adequately connect children to this resource. The health option for youth over the age of 18 years was also cited as a problem.

Both the lack of provider resources in rural areas of the state that limited accessibility to services, and the lack of transportation in rural areas, were cited as serious issues.

Benchmarks and Tasks Proposed for Well-Being Outcome 3 – Physical Health

To make improvements in the physical health area, Georgia's PIP included strategies to provide technical assistance to the child welfare agency's staff and private providers on conducting comprehensive assessments, examine existing polices and training for its effectiveness, and conduct their own statewide case review analysis to determine progress toward achieving their goals. Highlights of the specific benchmarks and tasks proposed are provided in Table 19.

Table 19: Highlights of Georgia's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Physical Health Needs
Develop policy on a descriptive usage of how the county mini-grants and the Safe and Stable Families Programs can be used to meet the health needs and provide services to children in CPS and Foster Care cases. This will encourage the use of these programs to add more resources to service families in each county.
Continue to require all providers to complete a Multi Discipline Team Meeting for each Comprehensive Child and Family Assessment to determine the appropriate health needs and services of all children entering foster care program within the first 30 to 60 days of the child entering care.
Complete technical assistance to DFCS staff and private providers on how to complete a comprehensive assessment and how to use the collected information to make the most appropriate health decision at the beginning of the child's stay in foster care. The FP/BP information will also be used to develop more effective case plans for the child and family.
Complete technical assistance to DFCS staff and private providers of the content of the comprehensive assessment and how to use the collected information to meet the health, mental health, dental and educational needs of the child and family.
Complete technical assistance to DFCS staff and private providers as to how to use the collected information to meet the child's needs as it related to post substance abuse counseling, monitoring and support as a part of the early intervention process and/or in-home intensive treatment services.
Complete a monthly county-by-county report as it relates to the First Placement/ Best Placement Wraparound Services used for each child in foster care.
Complete an annual statewide review of the First Placement/Best Placement Program to include on site case reviews of 50 randomly selected cases. This review will be similar to the federal on site review. Children, caregivers/families and other stakeholders will be interviewed. Fulton will be included at each annual review.
Complete an annual review throughout the state of the First Placement/ Best Placement Wraparound Services Program by completing on-site case reviews during the same time as completing the random selected case review.
Continue to assess the effectiveness and impact of the First Placement/Best Placement Program and Wraparound Services Program in reducing the number of children in foster care once the family's needs and services have been met.
Establish a larger state review group, which will include more stakeholders to review and provide technical assistance to counties and the annual statewide review of the First Placement/ Best Placement Program and Wraparound Services to include on site case reviews of 50 randomly selected cases.
Examine policy and training effectiveness for DFCS staff and private providers. Recommend additional training and policy changes. Test whether needs and services to children and families changes after training and policy changes.
Identify, if appropriate, other factors that may contribute to the needs and/services of children and families not being met while in foster care.

Areas Identified as Needing Improvement for Well-Being Outcome 3 - Mental Health

For item 23 (mental health of the child) in well-being outcome 3, the CFSR found in the larger jurisdiction reviewed, that concerns were noted regarding mental health needs of children. The record reviews identified a lack of routine assessment of mental health needs for children served by the child welfare system. It was also noted that the assessments in the case records did not address the underlying issues affecting victims of child abuse and neglect, such as loss issues.

In the smaller jurisdictions reviewed, although services were provided to assess the children's mental health needs, in some cases the follow-up treatment was not provided due to the lack of services. Staff turnover of mental health professionals was identified as an issue, and changes in the child's placement and case manager resulted in mental health services not following the child, thus children did not receive follow-up as required. In addition, the transfer of cases from one county to another resulted in the interruption of treatment. For one site reviewed, long waiting lists for mental health services existed, and affordable and available mental health services for the families of children outside of foster care, were not readily available.

At the state level, stakeholders reported that mental health is a significant challenge, particularly for preventative and early intervention services. Stakeholders interviewed reported that services mostly were not available in rural areas, and although the state had increased resources for mental health over the previous decade, barriers to accessing services existed and the system's capacity remained limited. Stakeholders also noted the need for services at the community level for those Juvenile Justice involved youth who entered the child welfare system.

Benchmarks and Tasks Proposed for Well-Being Outcome 3 – Mental Health

To ameliorate shortcomings in the mental health area, Georgia's PIP included strategies focused on identifying and developing a statewide uniform process to ensure access to a timely and comprehensive mental health assessment for children entering foster care.

Georgia also proposed to develop a statewide vision for a coordinated service delivery system for children and families and support the on-going development of resource lists, working with United Way and other existing resource databases. They also proposed to begin development of a statewide database on children's mental health resources, to identify the areas most in need of resource development and develop strategies to meet those needs. Georgia also planned to enhance the CPRS Health Screen and require the use of the CPRS to ensure that the information about a child's mental health is documented so as to eliminate breaks in mental health services. Georgia proposed to provide additional support and training for the effective use of the system by case managers. Highlights of the specific benchmarks and tasks proposed are provided in Table 20.

Table 20: Highlights of Georgia's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Mental Health Needs
Goal: Identify or develop a uniform process to ensure that children have access to a statewide mental health assessment that is timely and comprehensive. Assess First Placement/Best Placement process to determine if it can be made uniform and timely to serve as a vehicle for this purpose. 1. Using the CPRS, develop a process to evaluate completion of assessments for all children entering. 2. Assess and report current percentage of completed and timely assessments of children entering care. Select validated instruments for risk assessment, as well as more comprehensive diagnostic assessments for mental health, mental retardation and substance abuse. Develop and enforce statewide multi-agency protocol for assessment, including necessary confidentiality safeguards. Determine utilization by all counties of approved instruments pursuant to protocol. Development and enforcement of formal agreements between agencies to use common assessment protocol.

Table 20: Highlights of Georgia's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Mental Health Needs
Goal: The statewide multi-agency protocol will include a formal communication process for dissemination of assessment findings for case plan development. Develop a CPRS supervision tool to ensure comprehensive assessment findings are followed in the case plan and training. Determine percent of staff case plans that reflect strengths and needs identified in the comprehensive assessment. Case managers have the capacity to work closely with children and families in order to ensure sustained access to needed treatment resources. Goal: Development of a statewide vision for coordinated service delivery system to children and families. Support the on-going development of resource lists, working with United Way and other existing resource databases.
1. Begin development of statewide database on children's mental health resources – focusing on needs identified (in assessment process) for which no service is currently available. 2. CPRS will be amended to include data collection for recommendations made during the assessment process.
Identify through database the areas most in need of resource development and begin development strategies to meet those needs.
Strengthen and make mandatory the Case Plan Reporting System to ensure that information about the child's mental health is documented to eliminate breaks in mental health services. Provide additional support and training so case managers can use the system effectively.
On the Health Screen in CPRS, add a required field that must be addressed if the "Date of Last Psychological Assessment" is not provided by the case manager. This functionality will be added during the re-write of CPRS. Develop a report to collect data from CPRS that will show case manager's appropriate use of these fields.

Systemic Factors

Although Georgia met conformity for one of the two systemic factors explored, the CFSR identified concerns related to both the service array factor, for which Georgia rated a 2 and therefore did not meet conformity, and the responsiveness to the community factor, for which they rated a 3 and did meet conformity.

With regard to the array of services (item 35), the most critical service need identified was the availability of foster parents for children requiring an out-of-home placement. This service gap was identified as a particular problem for adolescents, children with serious emotional and behavioral issues, and teen mothers needing to be placed with their own children.

The lack of available foster parents creates situations for children that cause them to be placed in a series of short-term emergency placements or in prolonged shelter placements, as well as leading to placement disruptions and multiple placements.

Another critical service area identified by stakeholders included the need for comprehensive resource directories to be made available to case managers that includes statewide, regional, and local services. Specific information on service gaps indicated the need for expanded intensive in-home services to eliminate waiting lists, and expanded out-of-home care to include the immediate availability of foster homes, particularly for medically fragile children and children that needed therapeutic settings. Additionally, quality mental health services, services for families with serious multiple issues such as mental illness, family violence, and substance abuse, an adequate service delivery system for sexually abused children, and an adequate treatment continuum for adults and youth that are perpetrators of sexual abuse, were also identified as needed services. Georgia was also cited as needing an expanded pool of dentists available to children in foster homes.

For item 36 under service array (services accessible across the state), stakeholders interviewed noted that the needed continuum of individualized, community based services was not accessible or available to families and children in all political jurisdictions across the state. This was cited as a particular problem for mental health, substance abuse, and domestic violence related services.

For service array item 37 (individualized services), in some of the records reviewed, individualizing services for families and children was not a universal practice among service providers and case managers. In the larger site, services were more standardized, rather than individualized. An example was provided citing that anger management services were

provided, but not the needed substance abuse services. The need to focus more on what families and children need, rather than what services are available, was highlighted. Further, it was noted that case managers and supervisors were not always aware of what services did exist.

Benchmarks and Tasks Proposed for Systemic Factor – Service Array

In their PIP, Georgia established the goal to have an array of services that assesses the strengths and needs of children and families in order to create a safe environment, to enable children to remain safely with their parents and to help children in foster and adoptive placements achieve permanency. To accomplish this goal, Georgia proposed to conduct a statewide needs assessment of existing support services to determine the gaps in their service array and to improve accessibility to mental health, family violence, and substance abuse treatment services. They also proposed to expand the treatment continuum for sexual abuse and intensive in-home services, as well as out-of-home services to include regular, medically fragile, and therapeutic foster homes.

Proposed steps to carry out these efforts included collaboration with providers, stakeholders, and consumers, development of a comprehensive web-based directory of existing service resources, and development of curriculum and training for agency staff and providers. Highlights of the specific benchmarks and tasks proposed are provided in Table 21.

Table 21: Highlights of Georgia's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving the Systemic Factor – Service Array (Items 35-37)
State has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency.
Conduct a statewide needs assessment of existing support services to determine gaps in service array and accessibility to include mental health, family violence, substance abuse treatment, and post treatment services, treatment continuum for sexual abuse, intensive in-home services, out of home services to include the immediate availability of foster homes, medically fragile foster homes, and therapeutic foster homes.
Collaborate with providers, stakeholders and consumers to address gaps in the service array and develop a continuum of services accessible statewide. Compile and post a comprehensive web-based directory of existing local and statewide service resources.
Resource Directories will be made available to all front line case managers and supervisory staff.
Develop curriculum and deliver training to staff and providers to enhance capacity to assess underlying family needs that create safety concerns for children.

Because Georgia met conformity for the responsiveness to the community systemic factor, strategies for improvement were not provided.

Indiana

Indiana achieved a score of 71% in well-being outcome 2 (education needs) and 70% in well-being outcome 3 (physical and mental health needs), and thus did not meet the required 90% achievement score for the cases reviewed during the CFSR to be determined in substantial conformity on these measures. For the systemic factors, Indiana rated a score of 4 for both the service array and responsiveness to community needs systemic factors, therefore achieved conformity for these measures. For the individual outcomes rated as needing improvement, shortcomings in the educational, physical health, and mental health areas were identified. A detailed work plan was developed in response to the CFSR findings that included proposed action steps to achieve the goals and associated benchmarks and tasks to measure progress.

Areas Identified as Needing Improvement for Well-Being Outcome 2 - Education

For the children in foster care, the CFSR results for well-being outcome 2, item 21 (educational needs of the child), cited limitations in the case workers ability to follow-up on the educational needs of youth due to high caseload volume and staffing shortages. It was also noted that documentation addressing educational needs, such as identification of special education needs and developmental assessments for drug exposed children, was lacking in the case records. Also, in some localities, foster parents had not received copies of the education records for the children placed with them.

Benchmarks and Tasks Proposed for Well-Being Outcome 2 - Education

To improve in the educational area, Indiana's PIP included strategies to clarify policies and increase training for staff and foster parents about the educational needs of children. They also proposed to enhance their child welfare information system to include data fields specific to educational planning for children adjudicated through the court as a "child in need of services" (CHINS). Indiana also proposed to require case managers to attend school meetings that were held to discuss children's educational needs. Specific benchmarks and tasks proposed are highlighted in Table 22.

Table 22: Highlights of Indiana's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 2 - the Educational Needs
Desired outcome is to have the educational needs of children who are adjudicated CHINS addressed.
Provide training to staff and foster parents regarding the educational needs of children. Develop a policy directive, training curriculum, and provide training to staff and foster parents. This will be measured through Quality Assurance reviews.
Modify the case plan within the child welfare information system to include educational data fields. Conduct training on case plan revisions, including service delivery assessments. This will be measured through Quality Assurance reviews.
Develop policy to complete initial mental health screening of children who have been taken into custody or adjudicated CHINS and of the parent, guardian, or custodian. Implement policy changes statewide.

Table 22: Highlights of Indiana's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 2 - the Educational Needs
Develop policy requiring staff attendance at the FSP/IEP/ITP of children in care or adjudicated CHINS. Develop training curriculum and implement training for staff and foster parents. This will be measured through Quality Assurance reviews.

Areas Identified as Needing Improvement for Well-Being Outcome 3 – Physical Health

For well-being outcome 3, item 22 (physical health of the child), the CFSR found that immunizations were not documented in some case records and neither health problems nor medical services were addressed in the case record. Further, in some cases the assessments did not identify serious health needs such as prenatal/in-the-womb drug exposure and developmental delays, and there was evidence that medical examinations were not always done in a timely manner.

The CFSR also noted that there was no standardized procedure for when case managers were to provide medical records to foster parents and children's medical "passports" were not regularly provided to foster parents. When they were provided, foster parents did not know how to use them. There was also a concern noted about the barriers to children in foster care getting necessary medical care, because a number of health care providers did not accept the state's Hoosier Health Care plan.

Areas Identified as Needing Improvement for Well-Being Outcome 3 – Mental Health

Although item 23 (mental health of the child) was rated as an area needing improvement, the CFSR only cited two shortcomings in the area. The CFSR found that in some localities, children did not receive timely treatment for their mental health needs due to delays in assessments and in the delivery of services. It was also noted that neither service referral

agreements nor subsequent case plans followed-up on the behavioral, emotional, and substance abuse needs identified in the assessments.

Benchmarks and Tasks Proposed for Well-Being Outcome 3 – Physical and Mental Health

Indiana's PIP combined their proposed strategies for items 22 (physical health of the child) and 23 (mental health of the child) for outcome 3, thus they are combined in this section as well. To make improvements in the physical health and mental health areas, Indiana's PIP included strategies to address the physical and mental health needs of every child taken into custody or adjudicated a CHINS. They proposed to evaluate progress by utilizing the Quality Assurance review process and the timelines outlined by the Council on Accreditation (COA) standards. These require a physician to address the physical health needs of children within 30 days of the child entering foster care and a dental assessment to be completed for children age three and older within 30 days of entering care. Highlights of the specific benchmarks and tasks proposed are provided in Table 23.

Table 23: Highlights of Indiana's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 - the Physical and Mental Health Needs
Develop policy to complete a physical health examination of children who have been taken into custody or adjudicated CHINS, including a dental health examination consistent with COA standards. Implement the policy statewide.
Develop policy to complete initial mental health screening of children who have been taken into custody or adjudicated CHINS; and of the parent, guardian, or custodian as well. Designate funding and conduct pilot screenings in two counties. Implement policy statewide.
Provide training to staff and foster parents on medical passports and documenting medical information. Develop training curriculum and measure progress through the QA review process.

Systemic Factors

Although, Indiana met conformity for the two systemic factors explored, the CFSR did identify a number of concerns. Regarding the array of services, shortages were identified statewide in foster homes for special needs children and for substance abuse and sexual perpetrator services. In one locality, there were shortages of foster family homes, housing, substance abuse services, group home services, services for the hearing impaired, pregnancy, and services provided for Spanish speaking parents. In another locality, there was a service gap in the step down from residential services to lesser restrictive therapeutic foster care. It was also noted that children entering foster care did not obtain prescriptions due to a delay in Medicaid applications. Disabled children in need of rehabilitative services were designated a "child in need of service" (CHINS) to allow access to funding so that child welfare could pay for their services.

For Item 36, services accessibility across the state and transportation to and from services were identified as problems, especially outside of normal business hours and in most rural areas of the state. There were delays in accessing services because the demand for services exceeded the supply available.

The ability to individualize services was limited in some localities due to problems in case planning and the lack of comprehensive assessments. Consequently, the likelihood of identifying needed services on an individual basis and then following through with the service provision was greatly diminished. Deficits were noted in services to developmentally-delayed and mentally ill children and their parents.

For the agency responsiveness to the community systemic factor, it was noted that although the child welfare agency encouraged foster parent support groups in all localities, the ability to sustain them was sporadic.

Because Indiana met conformity for both the service array and responsiveness to the community systemic factors, their PIP did not include strategies for improvements in these areas although concerns were noted.

Massachusetts

Massachusetts achieved a score of 86% in well-being outcome 2 (education needs) and 69% in well-being outcome 3 (physical and mental health needs), and thus did not meet the required 90% achievement score for the cases reviewed during the CFSR to be determined in substantial conformity on these measures. For the systemic factors, Massachusetts did achieve conformity in the service array and responsiveness to community needs measures with a rating of 3 for each of them. For the individual outcomes rated as needing improvement, shortcomings in the educational, physical health, and mental health areas were identified. A detailed work plan was developed in response to the CFSR findings that included proposed action steps to achieve the goals and associated benchmarks and tasks to measure progress.

Areas Identified as Needing Improvement for Well-Being Outcome 2 - Education

The CFSR results for well-being outcome 2, item 21 (educational needs of the child), noted key problem areas that were identified from the case record reviews. These included lack of case worker follow-up on issues such as school failure and truancy, lack of documentation in children's service plans regarding the agency's efforts to meet children's educational needs, and the inconsistent provision of school records to foster parents. Despite these problem areas, it

was noted that case workers generally had regular contact with schools and attended school meetings, often with the parent. DSS staff and foster parents advocated strongly for necessary educational services for children, particularly for the early identification of developmental delays and for the provision of early intervention services. Case workers generally made good efforts to keep children in their same school when they were placed in out-of-home care.

A number of stakeholders reported that case workers, with the help of educational consultants, paid close attention to the educational needs of children in foster care. In addition, they described a pilot advocacy program designed to minimize school disruptions for children in foster care and indicated that this program resulted in a close working relationship between the child welfare agency and the schools.

Stakeholders also noted that issues related to the educational system's resistance to admitting special needs foster children and an unwillingness to share the cost of services, negatively affected the ability of the child welfare agency to ensure that the educational needs of special needs children were addressed.

Areas Identified as Needing Improvement for Well-Being Outcome 3 – Physical Health

For well-being outcome 3, item 22 (physical health of the child), the CFSR found that children's medical needs, the services provided, and the immunizations needed or received were not documented in many of the case records reviewed. In a majority of the applicable cases, children did receive initial health screenings according to state policy. However in the cases that involved adolescents who experienced frequent placement changes; the required screenings were not received. It was also noted that there was a lack of follow-through with health care providers and that children's health conditions were not treated within a few days. Specifically, in only approximately one-third of the cases reviewed, did case managers attend to specific medical

problems. Additionally, during interviews stakeholders reported that there was a general lack of available dental services. Further, children's health records were not consistently provided to foster parents at the time a child was placed even though the agency frequently relied on foster parents to ensure the provision of health services to children in their care.

Areas Identified as Needing Improvement for Well-Being Outcome 3 - Mental Health

For item 23 (mental health of the child) in well-being outcome 3, key findings from the CFSR case record reviews and case-specific interviews found that in a number of cases, mental health services were lacking, including: (1) required initial screenings were either not provided or not documented; (2) providers were either non-responsive or failed to develop a working relationship with the child; (3) providers failed to submit reports on the progress of children/youth; and (4) in one case in which sexual abuse was assessed and services recommended, there was no evidence in the case record that services were ever provided.

During interviews, stakeholders expressed the opinion that there are significant gaps in mental health services and that "turf issues" in the system impeded the timely delivery of services.

Benchmarks and Tasks Proposed for the Well-Being Outcomes 2 and 3 – Education, Physical Health, and Mental Health

Rather than detailing and tying its benchmarks and tasks directly to specific shortcomings identified in the CFSR process, Massachusetts approached its PIP by proposing strategies that addressed the range of areas needing improvement and incorporated these strategies into eight major goals. These eight goals were reviewed to determine which components were most relevant to the two well-being outcomes under consideration in this study. Because the child welfare agency was undertaking a significant reform effort during the time that their PIP was

initially developed, Massachusetts amended its PIP in July 2004 and received federal approval for the amendments. The strategies referenced in the initial PIP and amended PIP goals that relate to education, physical and mental health are described below and listed in Table 24.

The focus areas for Massachusetts improvements in well-being outcomes 2 and 3 include development of a comprehensive assessment process that assesses the medical, mental health, and educational needs of children, examination and revisions, as necessary, of their policies, procedures, forms, and practices regarding assessment. Because the child welfare system in Massachusetts is unionized, the improvement efforts must be done through bargaining with the union.

Massachusetts also proposed to develop training curricula to address the service needs of families with substance abuse, chronic neglect issues, and those where the parents are adolescents. Their proposed training plan also included training on educational, medical, and mental health needs of children. It also proposed to address the particular needs of special populations, including high-risk adolescents, and to include tools for the early and accurate identification of domestic violence, mental health, and substance abuse issues.

A new strengths-based, child-centered, family-focused, and community-connected service planning process that reflects the individualized needs of children and families was proposed, as well as a new service planning tool.

Additionally, Massachusetts proposed to improve the available service array so that it is more responsive, flexible, accessible, and able to meet the identified needs of all family members. They planned to work with the state legislature and other stakeholders to establish a budget and an improved procurement process as a means to develop a more flexible service

delivery system. Their plan also included a review of their existing system of purchased services to ensure its support for a continuum of services.

Specifically regarding physical and mental health needs for children in foster care and their families, Massachusetts proposed to continue their work with key stakeholders from other public agencies. For example, they proposed to implement key recommendations from the child welfare and public health agencies' strategic plan to address substance abuse issues and staff training and consultation needs as they relate to the children and families served by the child welfare agency. Further, because substance abuse, domestic violence, and mental health expertise and skills were identified as needing improvement, Massachusetts proposed to bring in the expertise and create a tracking system for these issues.

Table 24: Highlights of Massachusetts' PIP and Amended PIP Strategies in Response to Areas Identified as Needing Improvement for Improving the Well-Being Outcomes 2 and 3 – the Educational, Physical Health, and Mental Health Needs
Under Goal 1: Research, design and implement a comprehensive assessment process that is child-centered, family-focused and community-connected
Assess the medical, mental health and educational needs of children
Obtain agreement with the National Resource Center on Family-Centered Practice to assist in the review of the DSS assessment tool, policy and practice and training needs.
Establish agency workgroup to work with the National Resource Center on assessment and service planning issues
Examine and revise as necessary current policy and procedures, forms and practice regarding assessment to ensure that they reflect values stated above.
Meet with union to bargain over the impact of implementing new or revised policy, procedures, forms, etc.
Develop training curriculum to train staff to address service needs of families with substance abuse or chronic neglect issues or with adolescent family members.
Develop training on educational, medical and mental health needs of children.
Train staff that provide training.
Under Amended PIP Goal 1: Research, design and implement a comprehensive intake and assessment process that is child centered, family-focused and community-connected.
Address the particular needs of special populations, including high-risk adolescents.
Include tools for the early and accurate identification of domestic violence, mental health and substance abuse issues.

Table 24: Highlights of Massachusetts' PIP and Amended PIP Strategies in Response to Areas Identified as Needing Improvement for Improving the Well-Being Outcomes 2 and 3 – the Educational, Physical Health, and Mental Health Needs
Under Goal 2: Develop a new service planning process that is strengths-based, child-centered, family-focused and community-connected, building upon the Department's current service planning pilot to reflect the individualized needs of identified children and families.
Obtain agreement with the National Resource Center on Family-Centered Practice to assist in the review of the service planning process, policy, practice, and training needs.
Utilize agency workgroup to work with the National Resource Center on assessment and service planning issues.
Examine and revise as necessary current policy and procedures, forms and practice regarding service planning to ensure that the service planning process reflects the values stated above and is inclusive of all family members.
With assistance from the National Resource Center, develop training curriculum to train staff to address service planning process.
Train staff that provide training. Train statewide field staff.
Revise automated version of service planning tool as necessary.
Implement new service planning tool.
Under Goal 3: Continue to improve the Department's service array so that it is responsive, flexible and accessible and able to meet the identified needs of all family members. Services should be child-centered, family-focused and community-centered and follow from the needs identified.
Request a consolidated account in the DSS budget as a means to develop a more flexible service system. Request filed with the state legislature.
Assemble workgroup to review current system of purchased services to ensure that it supports a continuum of services that is community-connected and family-centered.
Develop a work plan to review procurement policies and purchased services.
Conduct six-month review of procurement system. Review and implement recommendations of procurement workgroup.
Continue work with DMA/DMH/MBHP to meet the mental health needs of DSS children and families.
Assemble workgroup to review current system of purchased services to ensure that it supports a continuum of services that is community-connected and family-centered.
Develop a work plan to review procurement policies and purchased services.
Under Goal 4: Reduce the time it takes for children in out-of-home placement to achieve permanency. Permanency includes reunification, adoption, guardianship and independent living.
Develop enhanced wrap-around services to move DSS children out of group care or prevent placement of children with emotional disturbance into group care settings.
Develop and implement six pilot program sites to provider enhanced wrap-around services to families with children with serious emotional disturbance.
Under Goal 5: Continue to implement key recommendations from the DSS/DPH strategic plan to address substance abuse issues as they relate to the children and families served by DSS.

Table 24: Highlights of Massachusetts' PIP and Amended PIP Strategies in Response to Areas Identified as Needing Improvement for Improving the Well-Being Outcomes 2 and 3 – the Educational, Physical Health, and Mental Health Needs
Complete a substance abuse needs assessment in the remaining Areas Offices in the Western, Northeast, Central and Boston Regions.
Connect Area Offices to local substance abuse treatment providers by establishing necessary protocols to facilitate client access to treatment.
Increase substance abuse resources for DSS families.
Implement statewide urine drug testing across all DSS Regions by selecting a drug testing vendor and implementing drug testing system statewide.
Provide each DSS Area Office with training on the impact of substance abuse on child welfare families. Provide substance abuse case consultation to DSS Area Office staff.
Ensure access and provide coordinated care to families residing in the women and children's substance abuse residential programs.
Identify a substance abuse continuum of care for adolescents in collaboration with other state agencies, as part of an interagency group.
Continue cross-system collaboration with key stakeholders, focusing on treatment needs of DSS clients and resource needs for adolescents.
Under Amended PIP Goal 5: Continue to implement key recommendations from the DSS/DPH strategic plan to address substance abuse issues as they relate to the children and families served by DSS.
Gather information and continue ongoing statewide needs assessment on substance abuse services available for child welfare clients. Communicate changes in access to services to the staff in the field.
Collaborate with DPH as they re-procure their substance abuse continuum of care, working to prioritize DSS families in treatment.
Under Goal 6: Identify and address the unique service and placement needs of the Department's adolescent population.
Continue analysis of ways to better serve the Child in Need of Service (CHINS) population.
Develop procedures for identifying CHINS youth.
Explore ways in which Family Group Conferencing might be adapted to address the issues in CHINS cases.
Maintain a comprehensive approach to life skills training for youth in out-of-home placement.
Under Amended PIP Goal 6: Improve the Department's ability to address the unique service needs of adolescents
Substance abuse/domestic violence/mental health: A great deal of work needs to be done around expertise and skills in these areas. Offices to bring domestic violence expertise to the areas and create a tracking system for these issues.

Systemic Factors

Massachusetts met conformity for the two systemic factors explored; however the CFSR did identify a number of concerns. For example, even though the area of service array was rated

as a strength, in some cases identified needs were not met. In particular, the lack of available and accessible mental health services, as well as alcohol and drug in-patient treatment services was noted. In addition, the review identified a shortage of placement resources, especially specialized foster homes.

Stakeholders interviewed identified a comprehensive list of services needed that included placements for adolescents discharged from hospitals, affordable housing, services for fathers, more culturally responsive service, and bilingual treatment providers (this included resources and services for tribal children as well). Substance abuse evaluations, drug testing and in-patient treatment for adolescents, outpatient mental health services, and mental health services for targeted populations were also identified as gaps. The need for additional shelters for victims of domestic violence, additional parent skill-building services, therapeutic after school programs, dental care for children in foster care, services for the hearing impaired, and informal community supports for families to prevent involvement or re-involvement with the child welfare agency were also noted.

Service accessibility across the state was another challenge area noted for the state. While the extent of the problem appeared to be worse in some areas, primary among these needs were access to mental health services, special education services, and substance abuse assessment and treatment services, especially for adolescents.

During interviews, stakeholders expressed concerns about ongoing issues between the child welfare, mental health, mental retardation, and public education agencies that created barriers for children and families in accessing services from these agencies. It was also reported that special education coordinators in some schools often resisted cost sharing for special services and posed opposition to accepting troubled adolescents. Some stakeholders claimed that

the approach by some schools to "informally" provide special education services may have denied some children their rights and services guaranteed by federal law.

Stakeholders in each of the sites reviewed noted service access issues either because of transportation, scheduling, child care problems, or because of long waiting lists for the services. Particular challenges were noted for the rural areas, specifically that families have limited access to certain services and it was noted that families had to travel outside of their area to obtain services. Finally, the lack of public transportation was noted as a reason for limiting access to services.

Despite strengths in the individualized services area, the need for better assessments and tailoring of services at varying intensity levels was found in some of the cases reviewed. It was noted that funding for services tended to be less family-focused for the families whose child had been removed from the home, than the funding for the services provided to intact families.

Although agency responsiveness to the community was rated as a strength, a tribal representative spoke strongly about the need for the child welfare agency to include the tribe in decision-making and consultation on a regular basis.

As mentioned in the service array area above, both reviewers and stakeholders interviewed noted ongoing coordination issues between the child welfare, mental health, mental retardation, and education departments. This negatively affected families' access to the services provided by these agencies, thus affecting the coordination efforts with other federally funded programs serving the same population. Reviewers found that the child welfare agency had a number of approaches to coordinate services with other federally funded programs; however stakeholders emphasized the need for greater collaboration, sharing of information across systems, and cost sharing among agencies.

Because Massachusetts met conformity for both the service array and responsiveness to the community systemic factors, the PIP did not include specific strategies for improvement although concerns in these two areas were noted.

North Carolina

North Carolina achieved a score of 80% in well-being outcome 2 (education needs) and 68% in well-being outcome 3 (physical and mental health needs), and thus did not meet the required 90% achievement score for the cases reviewed during the CFSR to be determined in substantial conformity on these measures. For the systemic factors, North Carolina did achieve conformity in the service array and responsiveness to community needs measures with ratings of 4 and 3, respectively. For the individual outcomes rated as needing improvement, shortcomings in the educational and mental health areas were identified. A detailed work plan was developed in response to the CFSR findings that included proposed action steps to achieve the goals and associated benchmarks and tasks to measure progress.

Areas Identified as Needing Improvement for Well-Being Outcome 2 - Education

The CFSR results for well-being outcome 2, item 21 (educational needs of the child), cited numerous educational issues, particularly for adolescents. These issues that would likely disrupt school success included situations in which youth had a history of expulsions, multiple repetition of grades, multiple school changes, pregnancy which threatened school completion, and/or mental health issues. It was noted in some of the cases reviewed that the children's caretakers were more involved in meeting the children's needs than the caseworkers.

Some of the stakeholders interviewed noted a breakdown in communication between the child welfare agency and the education system. Examples included the schools not having

certain child specific information they needed, as well as the schools not sharing certain child specific information the child welfare agency needed. Some stakeholders also reported that information sharing between the child welfare agency and schools was even less effective for the children receiving child welfare services in their own homes, than for those children placed out of their home and in foster care.

It was noted that screening for whether educational needs exist is not routinely done by social workers in the in-home cases. This was of particular concern for adolescents, because a failure to address educational needs can further exacerbate behavioral issues which may eventually lead to removal from their home.

Areas Identified as Needing Improvement for Well-Being Outcome 3 – Physical Health

Item 22 (physical health of the child) within well-being 3 was rated as a strength, however both item 22 and item 23 (mental health) must be rated a strength in order for the well-being outcome to meet conformity. Although the physical health area was rated as a strength, reviewers found that the physical health of children served in their homes was not routinely screened or addressed. In several of the in-home cases reviewed, fairly serious physical health needs, i.e., hepatitis B, pregnancy, and leukemia, were not addressed.

Areas Identified as Needing Improvement for Well-Being Outcome 3 - Mental Health

Item 23 (mental health of the child) within well-being outcome 3 was not rated as a strength. Stakeholders interviewed expressed a serious concern that the mental health system was overloaded. They identified waiting lists for certain services, resulting from understaffing of the mental health facilities, mental health services not being focused on helping families or the department achieve children's permanency goals, ability of the services to address grief issues,

children not always having the same mental health counselor, and psychiatric assessments not completed in a timely manner for children in group homes, as concerns.

Although residential services were available to address mental health issues for children and youth, foster and adoptive parents frequently had difficulty obtaining effective treatment. It was reported that children's behaviors had to escalate to a level that required placement out of the home to obtain mental health services.

Additionally, more so for in-home case situations than for the cases in which children were placed in foster care, mental health screenings were not routinely done by social workers. Mental health issues were either not identified or were identified but there was not follow-through on treatment, or the mental health needs of family members were met for some and not met for others.

Stakeholders reported that developmentally disabled mothers did not seem to receive mental health supports to help them resolve child abuse and neglect issues. It appeared that these mothers tended to be determined not able to parent, particularly in a domestic violence case, and stakeholders felt there were not enough linkages between Mental Health, Domestic Violence, and Child Protective Services.

Payment and funding issues were identified as barriers to accessing services and stakeholders expressed concern about the managed care system creating problems in allowing certain services to be funded for certain family members. An example is substance abuse services. These services where changed from being DSS funded to Mental Health funded, which resulted in some services no longer being covered.

Benchmarks and Tasks Proposed for Well-Being Outcomes 2 and 3 – Education, Physical and Mental Health

North Carolina was among the first states in the country to undergo the CFSR and to complete its PIP. Of the six states selected for this research, North Carolina was the earliest to finalize its PIP and is the only state that has a state-supervised county-administered child welfare system. Similar to Massachusetts, North Carolina did not directly link its proposed strategies to specific shortcomings identified in the CFSR; rather, they combined strategies related to the entire well-being area. This section in their PIP was reviewed to determine which components were most relevant to the two well-being outcomes under consideration in this study. Further, because North Carolina was among the earliest states to undergo the CFSR, they renegotiated several of their proposed benchmarks with their federal regional office to better report data related to the CFSR. This renegotiation did not affect the well-being outcomes.

The strategies proposed in the PIP that relate to the education, physical health, and mental health needs of youth and families served by the child welfare agency, are described below and listed in Table 25.

North Carolina proposed to develop standards for, and to redesign, their in-home services to assure greater family involvement and attention to the well-being outcomes. They also proposed to develop an assessment structure that included the child well-being measures, educational needs, domestic violence, and substance abuse needs of children and their families. Their plan indicated that they would continue to build upon partnerships already established with their Division of Mental Health, Department of Juvenile Justice, and Department of Public

Instruction by utilizing a comprehensive Systems of Care[21] (SOC) concept to ensure that individualized services were identified and delivered in a timely way.

Table 25: Highlights of North Carolina's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving the Well-Being Outcomes 2 and 3 - the Educational, Physical, and Mental Health Needs
Analyze and Redesign In-Home Services Develop standards for in-home services to assure greater family involvement, contacts, and attention to well-being outcomes. Begin implementation of new standards.
Redesign Risk Assessment/Safety Assessment/Family Assessment Develop assessment structure that addresses critical family issues such as child well being measures, educational needs, domestic violence, substance abuse, and other safety and risk factors. This impacts all outcomes and items.
Ensure that all areas impacting child safety and well-being are examined in depth so that services are focused on family needs and family strengths.
Self Assessment by All Counties and Monitored by Division Develop a mechanism to ensure that counties are implementing the state's program improvement plan. This impacts all outcomes and items and ensures that counties are implementing the requirements in the Program Improvement Plan.
Implement the System of Care (SOC) Concept in Child Welfare Continue to build SOC in partnership with Division of Mental Health, Department of Juvenile Justice, and Department of Public Instruction. This impacts all outcomes and items and ensures that individualized services are identified and delivered in a timely way.
Implement wrap-around services for children and youth who are at the highest risk of placement due to mental health issues and/or delinquent behaviors in order to keep children out of DSS custody and reduce the number of children entering out-of-home placements, and to promote placement and permanency for children with behavioral mental health needs in family settings in the community.
Specific Strategies Directed toward achieving Well-Being Outcomes 2 and 3 (educational needs) and (physical and mental health needs)
Redesign In-Home Services
Clarify policy regarding children's involvement in case planning
Redesign case plan tools and process
Work with secretary of DHHS to form critical partnerships between domestic violence organizations and DSS.
Provide more consistent service delivery across state and involve children in their case planning as appropriate.

[21] Systems of Care is an approach to service delivery that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs. http://www.systemsofcare.samhsa.gov

Systemic Factors

Although, North Carolina met conformity for the two systemic factors explored, the CFSR identified a number of concerns. With regard to the array of services systemic factor, although North Carolina's efforts to implement a Systems of Care approach were viewed as a strength, reviewers noted that frontline staff was not familiar with the concept and therefore training was needed.

During interviews, stakeholders acknowledged that the existing gaps in services were community issues that require collaboration and can not be resolved by the child welfare agency alone. There was an overall concern about the lack of resources across the entire continuum of services needed by the population served by the child welfare agency. These gaps and lack of resources include substance abuse and residential care, treatment for sexually abused children, group and in-home placements, therapeutic homes, evaluations for services, funding for mental health services, front-end services, such as family preservation and family support services, and services to the growing Hispanic population due to language and other cultural barriers.

Stakeholders noted concerns about the lack or effectiveness of mental health, substance abuse, and domestic violence services in some areas of the state. Further, concerns were expressed about the lack of coordination between the child welfare and mental health agencies at the frontline staff level, particularly with regard to the in-home cases, in that families do not have ready access to mental health care for their children or for the parents.

As far as service accessibility across the state, front-end services, such as family preservation and family support services, were inadequate in some areas of the state even to the extent of not being well-known or even existing. Also, it was reported that substance abuse

services were not provided in the communities where they were needed the most. The lack of transportation services was also noted as barrier to accessing treatment services.

The review found that the child welfare agency's practice does not appear to be family-centered in that the focus was on the child rather than the family. This leads to less effective engagement of the parents and less effective delivery of services to parents to help them meet their child's needs. A very high caseload for case workers was cited as contributing to the inability to individualize services.

Regarding the agency responsiveness to the community systemic factor, the CFSR noted concerns about the lack of planning to address the service needs of the growing Hispanic and Asian populations in the state. It also was noted that communications with Tribal representatives should occur on a more routine and frequent basis.

Stakeholders interviewed suggested that the child welfare agency would be able to strengthen their ongoing partnerships with community partners by involving them more routinely in quality assurance efforts, to include periodic reviews and policy development.

On the coordination with other federally funded programs serving the same population measure, the CFSR found strong collaboration at the state level among agencies, but that coordination is not as effective locally. It was perceived that this was largely due to the autonomy and independence of the county-based child welfare agencies.

Because North Carolina met conformity for both the service array and responsiveness to the community systemic factors, the PIP did not include strategies for improvement although concerns in these two areas were noted.

Oregon

Oregon achieved a score of 82% in well-being outcome 2 (education needs) and 81% in well-being outcome 3 (physical and mental health needs), and thus did not meet the required 90% achievement score for the cases reviewed during the CFSR to be determined in substantial conformity on these measures. For the systemic factors, Oregon achieved conformity in the service array and responsiveness to community needs measures with a rating of 3 and 4, respectively. For the individual outcomes rated as needing improvement, shortcomings in the educational, physical health, and mental health areas were identified. A detailed work plan was developed in response to the CFSR findings that included proposed action steps to achieve the goals and associated benchmarks and tasks to measure progress.

Areas Identified as Needing Improvement for Well-Being Outcome 2 - Education

The CFSR results for well-being outcome 2, item 21 (educational needs of the child), cited that in some cases reviewed, no attention was given to meeting the educational needs of the youth in foster care who were not in school and/or not following through with plans for a general education diploma (GED). Other cases reviewed had unmet educational needs due to the failure of caseworkers to follow through when needs were identified and caseworker action, such as paperwork, service referral, or advocacy was needed. In more than half of the cases reviewed for the children in foster care, the case file did not contain the child's school records. Further, approximately one-third of case files reviewed had no indication that educational records had been provided to foster parents.

Benchmarks and Tasks Proposed for Well-Being Outcome 2 - Education

To improve in the educational area, Oregon's PIP included strategies that focused on training for child welfare agency staff, foster parents, and private providers who work with youth and families. Oregon also indicated that they would improve the policies related to meeting children's educational needs and include information about the requirements regarding case files containing educational records. The specific benchmarks and tasks proposed are highlighted in Table 26.

Table 26: Highlights of Oregon's Benchmarks and Tasks Proposed in the Detailed Work Plan for Improving Well-Being Outcome 2 - the Educational Needs
Provide training on educational issues to staff, foster parents, and contractors.
Provide training for staff, foster parents and independent living contractors regarding educational issues, such as surrogacy, advocacy roles, early childhood brain development, early intervention, early childhood special education, Head Start, K-12 Special Education and educational services for at-risk students.
Case files to contain educational records.
Revise and strengthen the education policy to address issues relating to children's educational needs, including the timely inclusion of required educational information in case files.
Develop packets of educational resource materials and listing of community resources for caseworkers, foster parents, and independent living contractors.

Areas Identified as Needing Improvement for Well-Being Outcome 3 – Physical Health

Although item 22 (physical health of the child) within well-being outcome 3, was rated as a strength, the CFSR cited that in some cases, children's medical or dental needs were identified but treatment was not provided due to a lack of the child welfare agency's follow-up or ability to resolve the barriers that limited access to service. Stakeholders reported that obtaining dental care for children in foster care was difficult, and in particular foster parents reported having to make considerable effort trying to convince dental providers to serve their children.

Stakeholders also noted that health screenings were not as thorough as they had been under the previous Medicaid (EPSDT) program and were concerned about how well children's needs were identified.

Benchmarks and Tasks Proposed for Well-Being Outcome 3 – Physical Health

Because Oregon met conformity for item 22 – physical health of the child, they did not specifically propose strategies to address this measure; however they did reference efforts to address physical health in their PIP strategies related to mental health. These references are combined with the mental health strategies and are included in Table 27 below.

Areas Identified as Needing Improvement for Well-Being Outcome 3 - Mental Health

For item 23 (mental health of the child) in well-being outcome 3, the CFSR indicated that some children for whom mental health treatment needs were identified did not receive the services. The barriers included difficulty accessing services, treatment that was not consistent nor at an adequate level to address needs, and a lack of follow-through on the delivery of the services. It was noted that in the rural communities, there were not resources for specialized and complex child mental health needs, and that access to services required travel to larger metropolitan areas.

Stakeholders interviewed cited a particular concern about services available to the families regaining custody of their children, yet due to the children's complex emotional and behavioral needs, families had difficulty accessing appropriate services, thus children re-entered foster care. Stakeholders noted a need for more mental health practitioners whose expertise could address the unique needs of children in foster care.

As was the case with physical health care screenings, stakeholders noted that mental health screenings were also not as thorough as they had been under the previous Medicaid (EPSDT) program, thus children's needs were not able to be identified effectively.

Benchmarks and Tasks Proposed for Well-Being Outcome 3 – Mental Health

To address shortcomings in the mental health area, Oregon's PIP emphasis was on increasing enrollment into their available managed care plans for children served by their child welfare system as a means to improve access to appropriate care and treatment services. They also proposed to provide training to staff and foster parents on how to access appropriate and culturally competent mental health services and include specific training on how to challenge the managed care organization's decisions and file grievances, when necessary.

Oregon's strategies also focused on implementing policy clarifications for children to receive adequate, timely, necessary, and culturally competent mental health, medical, and dental services. The policies would also provide assurances that case files were to contain complete and up-to-date health records. Highlights of the specific goals and actions steps proposed are provided in Table 27.

Table 27: Highlights of Oregon's Goals and Action Steps Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 – the Physical and Mental Health Needs
Improve access to culturally competent appropriate care by increasing enrollment into managed care plans.
Staff will work with DHS Health Services staff to enroll all non-exempt children into managed care plans (MHO). Explore enrollment for children that have third party (private) insurance. Increase enrollment into Oregon Health Plan and managed care plans for children placed in all non-paid foster care placements.
Provide training to DHS staff, CHS staff, and foster parents on how to access appropriate and culturally competent mental health services. Training will include instructions on how to challenge decisions and file a grievance if necessary. Include OMHAS staff, MHOs, CHS, and JRP in curriculum design and field training. Include training in DHS Core Training.

Table 27: Highlights of Oregon's Goals and Action Steps Proposed in the Detailed Work Plan for Improving Well-Being Outcome 3 – the Physical and Mental Health Needs
Take appropriate action on all follow-up treatment recommendations for mental health services.
CHS staff will follow-up on all appropriate recommendations for mental health treatment and document action taken.
Assure that the case file includes complete, up to date health records.
Write clear policy for children receiving adequate, timely, necessary and culturally competent mental health, medical and dental services.

Systemic Factors

Although, Oregon met conformity for the two systemic factors explored, the CFSR did identify a number of concerns. For the array of services systemic factor, stakeholders noted that services to teens were seriously lacking. They identified a need for appropriate in-home services, foster care placements, and additional residential treatment services. In particular, they noted that access to residential treatment required long waiting lists and that there were not adequate post-treatment resources. Stakeholders also noted a lack of comprehensive, consistent independent living programs for older youth and that this was a particular problem in certain areas of the state. Foster and therapeutic foster homes were also lacking. Stakeholders interviewed indicated that the child welfare agency over utilizes some foster homes, filling them to the maximum licensing limit even when the children were difficult to manage and a full number of children overloads the family.

Stakeholders identified a need for medical, dental, and mental health services and noted that these services needed to be better designed to meet the needs of children and their families, particularly for young children, and the unique needs of children in foster care. Stakeholders also identified the need for enhanced drug and alcohol services and more residential programs

for parents to receive treatment while their children can reside with them. Better bilingual and bicultural services and services for youth sex offenders were also needed.

Service accessibility across the state was limited. For the rural areas, it was indicated that children and families had to go to a major metropolitan area for certain services such as psychological evaluations, specialized mental health services, and intensive treatment resources. However, the most critical unmet need identified in the rural areas was transportation to get to the available services.

Regarding individualized services, although Oregon's child welfare agency was engaged in the Systems of Care philosophy, it was noted that they needed their contracted service providers to move toward this same creative, flexible, and individualized approach to service delivery.

In the agency responsiveness to the community systemic factor, stakeholders indicated that improvement was needed in communication among case workers and foster parents, and in some cases with the Court Appointed Special Advocates (CASAs)[22]. Stakeholders also noted that Tribal staff had to make extra efforts at communication and were not always well informed at the case level. They indicated that communication problems increased when the case was handled by a branch geographically distant from the Tribe.

Despite the child welfare agency's collaboration efforts, stakeholders cited that for the coordination with other federally funded programs serving the same population measure, in at least one community it was noted that the community's expectation that the child welfare agency

[22] A Court Appointed Special Advocate (CASA) is a trained volunteer who is appointed by a judge to represent the best interests of a child in court. Most of the children served by CASAs are victims of abuse and neglect.

resolve all child/family issues, resulted in the community partners not taking responsibility for providing community resources to serve families.

Because Oregon met conformity for both the service array and responsiveness to the community systemic factors, the PIP did not include strategies for improvement although concerns in these two areas were noted.

Summary of State Findings

A three-stage process was used to summarize the areas needing improvement from the states' self-assessments and the federal report of CFSR findings related to the two well-being outcomes and two systemic factors reviewed. First, a working document was developed for each state listing the major findings related to the specific CFSR indicators as listed in Table 2 (page 62). Next, all of these findings were compiled by indicator across the six states to identify commonalties among the areas needing improvement for the selected well-being outcomes and systemic factors identified in the final federal review reports of each state's CFSR. Table 28 represents the third stage of the process and provides a summary of the areas needing improvement across the six states for the selected well-being outcomes and systemic factors.

It is important to note that, due to the variability in the CFSR process and the resulting reports, there was not a specific response from each state for each of the items listed in Table 28. So, for example, three states were identified as needing improvements in providing information to foster parents regarding the child's physical health needs. In two states, child physical health was rated as a strength, so there was no mention of providing physical health information to foster parents. In the remaining state, the PIP strategies included a plan for providing physical health information to foster parents, however, the issue was not identified as a problem in the federal report for CFSR findings for the state. As another example, five of the six states noted

problems in addressing child and family needs in rural areas of their state, but the problem was mentioned under physical health for Arizona and Georgia, under mental health for Georgia and Oregon, and in the Service Array systemic factor for Indiana, Massachusetts and Oregon. The information presented in Table 28 provides an overview of the most common problems identified in the CFSR process as they relate to well-being. However, states may still have experienced problems in specific areas even though that item is not marked for that state in Table 28.

As noted, Table 28 identifies the major areas needing improvement related to the selected well-being outcomes and the related systemic factors. The majority of the issues (28 out of 33) were identified by more than one state. The most common issues relate to a lack of assessments and screening for educational, physical and/or mental health conditions, a failure to document and address the child's needs in the case record and service plan, limited services across the continuum of services especially in mental health and in rural areas, a lack of unique or specialized services, and a lack of caseworker follow-up. Lack of transportation was noted by two states under the physical health outcome and by three additional states under the systemic factor of Service Array. There will be additional analysis of these findings in Chapter 5 – Analysis, Conclusions, and Recommendations.

Table 28: Summary of Key Issues Identified as Areas Needing Improvement in the Child and Family Well-being Outcomes and Related Systemic Factors						
Issue	**States**					
Relevant Well-being Outcomes and Systemic Factors	**Arizona**	**Georgia**	**Indiana**	**Massachusetts**	**North Carolina**	**Oregon**
WELL-BEING OUTCOMES						
Educational						
Lack of assessments and/or screenings	X	X	X		X	
Needs not addressed or included in child's service plan/case record	X	X	X	X		X
Lack of caseworker follow-up on child's needs			X	X	X	X
Lack of advocacy by child welfare agency staff for children in foster care	X	X				X
Frequent school changes	X	X				
Information not provided to foster parents			X	X		X
School system resistance to serve special needs foster children				X		
School system unwillingness to share in the cost of services/adequate educational funding		X		X		
Communication between child welfare and educational system					X	
Physical Health						
Medical assessments, screenings, services not completed or delayed	X		X	X	X	
Information not provided to foster parents	X		X	X		
Current medical/dental information not documented in the case record	X	X	X	X		
Physical Health (cont'd)						
Lack of caseworker follow-through on securing services		X	X	X	X	
Lack of dental services				X	X	
Lack of providers that accept health care plan	X	X	X			
Limited coverage under state health plan					X	
Lack of services, particularly specialized services		X				
Lack of provider availability in rural areas	X	X				
Lack of transportation	X	X				
Service access for youth over 18 years of age		X				

Table 28: Summary of Key Issues Identified as Areas Needing Improvement in the Child and Family Well-being Outcomes and Related Systemic Factors						
Issue	**States**					
Relevant Well-being Outcomes and Systemic Factors	**Arizona**	**Georgia**	**Indiana**	**Massachusetts**	**North Carolina**	**Oregon**
Mental Health						
Lack of assessments/screenings	X	X	X		X	
Limited coverage under state health plan					X	X
Limited service availability across continuum	X	X	X	X	X	X
Lack of case documentation regarding provision of services			X	X		
Limited services and resources in rural areas		X				X
Case transfers disrupting treatment		X			X	
SYSTEMIC FACTORS						
Service Array						
Adequate number of foster homes	X	X	X			
Mental health treatment			X	X		X
Services limited in rural areas			X	X		X
Service Array (cont'd)						
Unique/specialized services	X	X	X	X	X	X
Transportation			X	X	X	
Caseworkers not informed about existing services		X			X	
Responsiveness to community						
Culturally appropriate services	X			X	X	X
Service coordination and collaboration		X		X	X	

Section IV: Summary of States' Program Improvement Strategies for Well-Being

The state by state summaries provided in Section III detail the efforts that states agreed to make as part of their PIPs to achieve the necessary improvements in education, physical health, and mental health well-being outcomes. The approach taken by two of the six study states was based on broad goals that cut across all of the areas needing improvement, including the well-being outcomes. Another two of the study states combined strategies for meeting physical and mental health needs. The remaining two study states identified strategies in three separate sections of their PIPs specific to education, physical health, and mental health needs. The one

study state that failed to meet conformance in the systemic factor of service array proposed strategies in this area.

Across all of the six states the strategies to improve education, physical health, and mental health outcomes generally relied on a few broad approaches. These include the following:

- Develop curriculum and provide training for trainers, staff, foster parents, and providers regarding the well-being needs of children, particularly those youth placed out of their homes;
- Incorporate assessment results and identified needs in service plans;
- Improve and clarify policies related to the well-being needs of children. Examine and assess necessary policy changes;
- Hold meeting(s) with relevant stakeholders and explore strategies to improve coordination of services;
- Increase access to services, particularly physical health and mental health; and
- Implement recommendations from internal and cross-agency workgroups and communicate, as appropriate, with staff and other stakeholders.

There were clear differences among the six states in the detail with which each of these approaches was described and whether or not there were mechanisms, such as quality assurance reviews, to monitor progress. Some of the PIPs identified specific challenges and issues that needed to be addressed. For example, in one state an action plan was written to increase funding for medically necessary non-urgent transportation of children to health care appointments. In another state, the PIP called for implementing a Systems of Care service delivery model for children and youth who are at the highest risk of out-of-home placement due to mental health

issues in order to keep children out of state custody. More commonly across the six states, however, the strategies proposed were quite general in nature. As examples, states proposed PIP strategies described as "develop training on educational, medical, and mental health needs of children" and "ensure that all areas impacting child safety and well-being are examined in depth so that services are focused on family needs and family strengths." With the exception of one state, the design of the PIP did not take into account demographic factors such as age, race, and poverty.

There was little discussion in the PIPs for the six states reviewed about the level of resources that would be required to implement the strategies related to well-being improvements. Further, there were not well-defined strategies for obtaining funding, or plans for re-allocation of existing funding tied to the proposed changes in training, policy enhancements, or increased access to services. Three states did manage to increase their child welfare staffing around the same time as PIP implementation, but in only one of these states was this attributed to some extent to the CFSR. Two other states had to complete their federally defined PIP period during a time that large numbers of experienced staff left the state's child welfare agency. In one of these states this was due to lay-offs and associated early retirements, and in the other, it was related to a change in the state's public employee retirement system which motivated senior staff to retire.

In summary, the PIP strategies related to child well-being for the six states were broad in nature, did not adequately consider demographics, and did not bring to bear specific new resources to meet the broad range of needs, nor fundamentally engage the education, physical health, and mental health agencies in the PIP process. Despite these shortcomings, there were positive benefits noted in all of the states and five of the six states were deemed by the federal CFSR process to have made adequate progress to avoid the threatened financial penalties.

Section V: Findings from the Interviews

This section provides the findings from interviews with the six state leaders and the three national level experts. It is organized by the three major categories of the questions explored during the interviews. These categories are: (1) General CFSR-related questions, (2) Inter- and Intra- Agency Collaboration and Service-related questions; and (3) Resource-related questions. The interview categories and questions were developed following a review of HHS documents describing the intent of the CFSRs and the states' data and information resulting from the CFSRs. The three general categories of questions provided a context to better understand how states approached the CFSR, what coordination and service factors contributed to their ability to achieve the outcomes, and how resource availability affected their results.

Interviews were conducted with a state government leader within the child welfare system from each of the six states selected for this study and three national level experts in child welfare policy from university, non-profit, and relevant federal agency settings. The state leader interviews focus was on their own individual state, while the national level experts spoke more generally about all of the states that underwent the CFSR.

Question 1: *In your view, was your state more concerned with "passing" the CFSR to avoid sanctions, with developing better policies and procedures or about equally with both? Please explain.*

Five of the six state leaders interviewed indicated that their state was concerned equally with both passing the CFSR and with developing better policies and procedures, while one state leader emphatically stated that the focus in their state was more concerned with improving services to children than with passing the CFSR. Each of the three national level experts interviewed indicated that in general, states approached the CFSR process with both outcomes in mind – passing the CFSR to avoid sanctions and improving their child welfare system.

State leaders spoke about the opportunity that the CFSR provided to make much needed improvements in their child welfare systems – changes which the state had previously identified prior to the CFSR. In general, the states had already been in some phase of reform when the CFSR was conducted and the CFSR was then seen as a tool to focus their efforts and to bring attention to the issues among the leadership within their state. State leaders also indicated that the CFSR provided a tool for the states to implement quality assurance techniques using data and information in ways that they had not done previously. Each of the six state leaders emphasized their state's interest in improving outcomes for the children and families they served. This view was supported by the national level experts as well. During the discussions with the national level experts, they each confirmed this; however all were not sure that the benefits to the states outweighed the costs. One national expert noted that the states approached the CFSR with the recognition that they would need to develop a PIP because they were not likely to meet conformity in each of the required outcome areas.

Question 2: *In preparing for and participating in the CFSR and in implementing and monitoring your PIP, how did your state differentiate between children receiving services in their own homes, versus children receiving services in an out-of-home placement?*

Typically, a state's child welfare system has responsibility for children whose families are investigated for abuse and neglect of their children and for children who have been removed from their homes and placed into foster care in various settings, ranging from a family-like home, to residential treatment centers. Many at-risk children remain with their families with supports, services, and supervision provided by the child welfare agency.

The well-being outcomes within the CFSR process did not differentiate between the populations of children who were served in their homes versus out of their homes. The second question was asked because the ability for the child welfare system to positively affect these

outcomes differs greatly between the two populations. This difference is due to the authority the child welfare system has once a child enters their custody and, typically, the level of services provided.

Four of the six state leaders indicated that their state did not differentiate between the two populations when developing their PIP. One state leader indicated that they used the opportunity the CFSR provided to improve their entire system, rather than focusing on sub-populations served by the system. The other three indicated that on items such as meeting timelines, they may have approached elements within their PIPs differently, but that they emphasized the need to improve service access and service array, school readiness, and educational outcomes for all the children they served. Two of the national experts interviewed indicated that states in general across the country did not differentiate between the in-home and out-of-home populations when developing their PIPs.

The approaches are often very different for children served at home versus those removed and placed into foster care because of the issues of safety and permanency for the children that the CFSR process is designed to affect. For example, the measures related to time to reunification and prevalence of re-entry into foster care apply only to the foster care population. On the other hand, recurrence of maltreatment during a six month period is much more likely for children receiving services at home than for those removed from their parents, especially when the length of time the child is out of their home is generally longer than the six month period over which recurrence was measured in the CFSRs.

Question 3: *In contributing to the "areas needing improvement" how important were (1) the design and implementation of programs, (2) demographic factors (age, race, family income, parent's education, urbanicity, etc.), (3) human and financial resources of the agency? Further, how did your PIP address these three areas? Please explain.*

The national experts agreed that how states prioritized the factors identified in question #3 differed across the states. In their overall view, states did not develop their PIPs based on the demographics of their child welfare population, nor on the human and financial resources readily available to the agency. Rather, the majority of the changes proposed in states' PIPs were designed to serve the entire child welfare population and resources were then identified and pursued to achieve those changes, as opposed to working within their existing resource availability.

Among the state leaders' responses to question #3, only one state indicated that they did consider age and race as important factors to address in the PIPs. In particular, this state's focus was on improving outcomes for older adolescents in foster care and reducing the over-representation of African American youth in their child welfare caseload.

Question 4: *In reviewing your state's self-assessment, the federal final report, and your state's PIP, numerous references are made to "policies" in place that guide practice. In what ways does practice lag behind policy – specifically in case management, assessment and service delivery in the areas of mental health and education?*

This particular question was developed under the assumption that states had best practice policies in place to guide the operation of their child welfare systems and that it would be the agencies' practices that were lacking. However, four of the state leaders said that, in their states, policy clearly lagged behind the practice of their front line staff. The explanation offered by one state was that there is just one policy manual, yet hundreds of case managers that implement the policies to fit the varied situations of children and families. Another example described how the union in that state was intimately involved in policy formulation which caused policy development to sometimes take years. Practices, however, moved forward, often without specific policies behind them. In another state there is a good working relationship across a broad stakeholders group that includes state and county staff from multiple agencies, parent

representatives, and legislators. This has led to improved practices, but without any formal policies or formal memorandum of understanding (MOU).

Two of the national level experts supported this view, and one indicated that it was varied by state and was mixed across the country. The issue of comprehensive needs assessments for children and their families was cited as an example relating directly to the well-being outcomes. Without clear policies requiring thorough assessments, it is difficult to determine the child's most pressing needs in the well-being domains. Another national expert noted the cyclical nature of continuous quality improvement with evidence-based practice being applied and validated. This leads to corresponding changes in policy, refinements, and incorporation of even newer research evidence. It was also noted that the policies and practices most crucial for well-being involve mental health and educational systems as well, and the shortcomings should not all be laid at the doorstep of the child welfare system.

In the two states where the leaders indicated that practice lagged behind policy, issues of barriers to fully implementing the policies were cited in both cases. In one state there was a clear appreciation for the breadth, quality and holistic intent of policies, yet the front line staff was not able to fully achieve the level of involvement in multi-system collaboration envisioned in the policy. In part, this was due to the lack of infrastructure and personnel to support it. Consequently, this created a very challenging experience for frontline staff who knew they were not in compliance with policy. The other state leader described struggles to meet the core requirements of safety and permanency and noted that staff had neither the skills nor resources to successfully implement policies supporting the well-being outcomes. Knowledge and skills in the mental health and education arenas is not the core competency for child welfare staff, and "safety always trumps the rest".

Question 5: *How effective was your state in collaborating with the leadership at the state and local level in the educational, mental and physical health agencies in development of the PIP? Discuss what worked, what did not and what initiatives and/or efforts are still in the works.*

Three of the state leaders noted that there had been very effective collaboration among the child welfare, education, mental health, and physical health agencies. However, two of these same states also indicated that while the collaboration was effective at the state level, it fell short and needed work at the local level. The local level issues were beyond the ability of the state child welfare agency to positively effect change. In the educational area, one state described very relaxed laws governing home-schooling as a challenge. It was noted that this is a particular challenge in the rural areas of the state because of considerable variation among local school superintendents in their application of the policies. Another state leader also citing education as an issue described a situation wherein the school system filed a complaint seeking information about the number of foster parents in their school district because of the high number of children in their schools who were in foster care.

The two states that indicated that there was not effective collaboration in place, indicated that it has improved since the CFSR. One state noted that during the CFSR the collaborative process consisted of bringing staff from various agencies together and then informing them what the child welfare agency planned to do. Since then, they have approached their collaboration more as partners to improve their strategies in a limited number of areas. The other state leader said that their child welfare agency was "pretty much on their own" with regard to the responsibility for achieving the CFSR outcomes. Since the CFSR, a new initiative of the governor based on a family and child team concept, had led to significantly improved collaboration among the child welfare, public health, and educational agencies across most jurisdictions in the state.

One of the national level experts indicated that he did not have a perspective on this particular question, thus did not have enough information about the collaboration within states to comment. The other two experts however, did have knowledge on the issue of collaboration and both noted that the states that had a history of effective collaboration used these existing relationships very effectively during the CFSR process. For these states, the results were positive in terms of their ability to garner support from other systems. It was noted that among those states that did not have effective collaborations prior to the CFSR, those states that appeared to have attempted to create the relationships simply for the purposes of the CFSR achieved only short-lived and ineffective collaborations.

Question 6: *What other changes were made (outside of the PIP) within your state to make improvements in your child welfare system in preparation for the next round of CFSRs, e.g., enhanced communication with administrative and political state leadership, enhancements to data availability or analysis etc.?*

For question #6, all six of the state leaders and each of the three national level experts indicated that states proposed and implemented other changes to make positive changes in the operation of the child welfare system, in addition to the specific approaches they proposed in their PIPs. The majority of these changes related to improving the quality of data and the use of data in guiding policy and practice. One of the national experts said that "improvements in data quality and the thoroughness of the data is one of the most notable changes nationwide."

Improvements in states' quality assurance systems for monitoring outcomes were noted by both state leaders and national experts. Enhanced collaboration with stakeholders often went beyond what was required by the PIP. In the case of collaboration with the juvenile courts, this

was further supported by a parallel federal and state initiative aimed specifically at improving the role of the courts in child welfare (the Court Improvement Program[23]).

Question 7: *What was the relationship between the "program" agencies, e.g., social services, education and mental health, and your state's budgeting agencies/processes related to funding the PIP?*

For question #7, four of the state leaders indicated that they were not aware of efforts among the program agencies to engage or educate the state's budgeting agency about the implications of the CFSR and the PIP to the state's budget. Rather, there was consensus among the responses from these four leaders that the child welfare agency merely included "line items" within their budget requests for funding particular aspects of the PIP like they would have for any other type of initiative. The other two state leaders indicated that the state's child welfare agency did bring special attention to their budgeting agency about the CFSR process and about the potential implications to the state should they not successfully accomplish what had been agreed upon in their PIP. They both stated that this was a very effective approach and that it engaged a positive dialogue while broadening the state's understanding of the shared responsibility intended by the CFSR. Additionally, while one of these two leaders indicated that they engaged their state's budgeting office in the CFSR process, they were able to move forward with many of their proposed changes without the budgeting agency having to provide funding in some of the areas.

Two of the national experts indicated that they did not have the level of knowledge about the issue of relationships between the program and budgeting agencies within the states to comment. The third national expert echoed earlier comments regarding this question and indicated that the ability for a state to effectively engage their budgeting process regarding the

[23] http://www.acf.hhs.gov/programs/cb/programs_fund/state_tribal/ct_imprv.htm

CFSR and the PIP depended greatly on existing relationships within the state. Again, efforts to try and build these relationships solely around the CFSR were generally not successful.

Question 8: *How informed/aware and/or supportive has your state/local (state/federal) legislature been regarding the CFSR, PIP implementation, etc.?*

Question #8 was framed differently for the state and national level leaders. The state leaders were asked about the state and local legislatures and the national experts were asked about the state and federal legislatures.

The responses to question #8 varied among the state leaders. One state leader noted that their child welfare agency worked strategically to inform their legislature and that members were very much aware of the CFSR process, its implications, and of the child welfare agency's efforts to achieve the required outcome thresholds. In two states, the leaders interviewed stated that their legislatures were not made aware of the CFSR process. One state leader indicated that several members of their legislature were very aware of the CFSR and its implications for the state and that these were the legislators who were typically more interested in children's services in general. The child welfare agency made a conscious effort to make these members aware of the CFSR as a way to gain support within the legislature for policy, funding, and other improvements to the system. The leader from the remaining state noted that although the child welfare agency did not set out to inform their legislature about the CFSR, the legislature has begun to show an interest because of the issues that arose from the review and in the media as a result of the review.

The perspectives among the national level experts varied greatly in their responses to this question as well. One expert responded to the question referencing only the state legislatures. As was the case in several earlier questions, it was stated that the level of communication with the states' legislatures, their awareness and whether or not they were supportive was a mix across

the country. It varied based on the historical patterns related to the level of engagement of the legislature that existed in the states prior to the CFSR. Another of the national experts stated that the federal legislature (Congress) was not at all supportive of the states in the CFSR process and that the child welfare agencies were "on their own." The third national level expert provided a different perspective and indicated that the federal legislature (Congress) was very much aware and very supportive of the states with regard to the CFSR. Support for this perspective includes numerous Congressional hearings and studies by the General Accounting Office (GAO), as well as the creation and funding of a network of national resource centers to provide training and technical assistance to the states.

Question 9: *What additional funding was made available to your state to develop and implement your PIP? Is the funding broken down by the specific outcomes and systemic factors? How would you characterize the adequacy of any funding changes directed toward accomplishing the PIP?*

Four of the state leaders stated that no additional funding was made available to them to develop and implement the PIP. One leader stated that they were not sure, but did not think so. The remaining state leader reported that funding was made available for one position statewide to coordinate the efforts of the CFSR and the PIP. Further, the state leaders indicated that the funding that was available in the states was not adequate to implement the changes they proposed in their PIPs. In one state, the child welfare agency received state funding to hire a significant number of front line staff. This effort was not related to the CFSR and the PIP; rather, it was a legislative mandate regarding caseload standards.

Again for question #9, the responses from the national level experts varied and were consistent with their perspectives provided in response to question #8. One expert stated that additional funding was not provided to the states and that the existing funding levels within the states were inadequate to achieve the outcomes. Another expert explained that whether

additional funding was made available within states and whether or not it was adequate, depended on the state's history with regard to its focus and commitment to youth and families. The third national level expert stated that while additional federal dollars were not specifically made available to states for them to implement their PIPs, there was flexibility within the federal Title IV-E funding stream for some of the work. Additionally, the federal government made a significant resource investment in providing free technical assistance to the states. There was great variability among the states regarding their interest in accessing this resource.

Question 10: *In your opinion, what are the biggest challenges to meeting the well-being outcomes for children and their families in your state?*

For question #10, numerous challenges were noted in regard to a state's ability to meet the three well-being outcomes. The perceived challenges were strikingly different between the state leaders and the national level experts.

The challenges cited by state leaders included collaboration, funding, training, community attitude and culture, changing front line practices, increasing awareness within communities, clarifying staff roles, staffing issues, and coordination with the education, physical health, and mental health agencies. The national level experts agreed with the state leaders regarding the need for funding and training. They identified additional challenges not mentioned by the state leaders. These included the need for a clear vision and commitment from leadership within the states, the lack of consistent practices among child welfare professionals, states' ability to develop an adequate array of resources, and the need for better defined and more detailed outcomes in order to have specificity in the steps taken to achieve improvements. The focus on failure of the federal child welfare funding was also cited as another major challenge. The example provided cites Title IV of the Social Security Act and its apparent focus on parental failure. Different components of Title IV relate to different parental inadequacies. TANF

(Temporary Assistance to Needy Families) is intended to provide financial support when the adults in a household are inadequate breadwinners. Title IV-D addresses child support when a non-custodial parent fails to provide their economic resources. Title IV-B and IV-E attempt to address situations when parents fail to provide safety for their children. These funding mechanisms do not address the investments that would be required to meet the well-being needs of children and families involved in the child welfare system.

Summary of Interview Responses

Across the different questions there was considerable agreement among the state leaders and national experts. A summary of their responses is provided in Table 29. There was broad consensus that states' responses to the CFSRs was motivated by both a recognized need to develop better policies and procedures and by the desire to pass the review to avoid federal financial penalties. While there was a major focus on the design and implementation of programs, consideration of demographic features of the service population was limited and the states did not do much to differentiate between the services that were provided to children remaining in their own homes versus those placed in out-of-home care. There were understandable timing differences in policy and practice, with each lagging behind the other under specific conditions. The changes resulting from CFSR implementation were seen in the context of ongoing quality improvement strategies, but the budgeting and funding agencies and the state legislatures were not consistently informed and, therefore, not always supportive of the process. In addition to the need for improved collaboration and a general lack of dedicated funding to implement the PIPs, a range of challenges was cited by the state leaders and national level experts. These issues and challenges will be addressed in Chapter 5 as they relate to the variables in the Mazmanian and Sabatier framework.

Table 29: Summary of Responses from Interviews with State Leaders and National Experts		
Interview Questions: 1 through 10	**State Leaders**	**National Experts**
1: Regarding CFSR, the state was more concerned with		
passing to avoid a penalty		
developing better policies and procedures	1	
both	5	3
2: Differentiated between in-home and out-of-home cases		
did	2	1
did not	4	2
3: Importance of		
design & implementation of programs	4	1
demographic factors	1 yes / 5 no	1 some states
enhancing resources	2 yes / 1 no	1 some states
4: Policies		
practice lagged behind policy	2	
policy lagged behind practice	4	
both		2
5: Collaboration		
effective	3	2 (if existing)
not effective	2	
6: Other changes planned for the next CFSR	6	3
7: Relationships to budgeting & funding agencies	2 yes / 4 no	2 unsure 1 (if existing)
8: Legislature awareness	1 yes / 2 no 3 somewhat	2 (if existing)
9: Additional funding dedicated for PIP	1 yes 5 no	2 no 1 (if existing)
10: Challenges		
Collaboration	1	1
Funding	1	1
Training	1	
community attitude/culture	1	
leadership commitment; clear vision		2
changing practice	1	
consistent practices		1
increasing awareness	1	
clarifying roles	2	
adequacy of staffing and resources	1	1
educational services	2	
physical health services	1	
mental health services	3	
a need for better defined and more detailed outcomes		1

CHAPTER 5 – ANALYSIS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter provides a summary and analysis of the major issues identified in this study and recommendations for further research. The Mazmanian and Sabatier (1989) policy implementation framework serves as a guide for the discussion of the issues and grounds this research in the broader discourse of public child welfare policy and administration. Further, it is used to identify areas where the implementation of ASFA, specifically the CFSR elements related to well-being in the areas of education, physical health, and mental health, can be expected to face specific obstacles. These authors note that the framework can be used in many ways, from a checklist of factors to a complex analysis of multiple and dynamic conditions. Several observations from Mazmanian and Sabatier's book, *Implementation and Public Policy*, are particularly germane to use of their framework in the context of examining the effectiveness of the CFSR process for improving child well-being. On a general level, they recognize the necessity of identifying the many variables that contribute to the task of "changing the status quo through governmental action" and that it is difficult to adequately describe the implementation process given that the interaction among the variables continues throughout the process of implementation. Further, some social problems are more difficult to deal with than others, making tractability a primary and pervasive issue. This is especially true when a public policy issue is broadly recognized as relatively intractable and it also requires engagement of otherwise independent agencies and organizations.

Mazmanian and Sabatier note that a policy decision ideally identifies the problems that need to be addressed, specifies the objectives of the policy, and provides a structure for the implementation process. It follows that, in assessing the outcomes of the ASFA and CFSR

implementation, it is important to examine the strategies employed to achieve those outcomes in the context of the details of the policy and the conditions in which implementation occurs.

Highlights of the research results presented are summarized according to the three major categories of variables found in the Mazmanian and Sabatier framework (see Figure 1). The issues identified in the states' CFSR documents and by the state leaders and national level experts are typically influenced by multiple variables described in the model. As can be expected, some of the variables have played a more salient role in the successes and failures of the CFSR in improving child well-being. The discussion that follows examines some of the more prominent connections between the major issues identified in the CFSR process and the variables in the policy implementation framework.

Figure 1:
Components Identified by Mazmanian and Sabatier in their Conceptual Framework of the Policy Implementation Process

1. **Tractability of the Problem**
    a. Technical difficulties
    b. Diversity of target group behavior
    c. Target group as a percentage of the population
    d. Extent of behavioral change required

2. **Ability of Statute to Structure Implementation**
    a. Clear and consistent objectives
    b. Incorporation of adequate causal theory
    c. Initial allocation of financial resources
    d. Hierarchical integration within and among implementing institutions
    e. Decision rules of implementing agencies
    f. Recruitment of implementing officials
    g. Formal access by outsiders

3. **Non-statutory Variables Affecting Implementation**
    1. Socioeconomic conditions and technology
    2. Public support
    3. Attitudes and resources of constituency groups
    4. Support from sovereigns
    5. Commitment and leadership skill of implementing officials

4. **Stages in the Implementation Process**
    a. Policy outputs of implementing agencies
    b. Compliance with policy outputs by target groups
    c. Actual impacts of policy outputs
    d. Perceived impacts of policy outputs
    e. Major revision in statute

CFSR Well-Being Requirements in the Context of an Implementation Framework

Federal legislation generally provides broad direction which must be implemented with detailed policies, decisions, and actions. Legislation enacted by Congress to establish objectives "usually gives only a general hint of what will actually be done by the agency responsible for carrying out the program and how successful it will be at winning the cooperation and compliance of persons affected by it" (Mazmanian & Sabatier, 1989, p. 4). Successful implementation then is likely to require measurement of outcomes leading to adjustments in legislation and policy in order to "forge subsequent links in the causal chain so as to obtain the desired results" (Pressman & Wildavsky, 1973, p. xv). This is particularly applicable to the implementation of the ASFA legislation, and specifically the CFSR well-being outcomes. The CFSR processes do not prescribe to states what they must do to achieve conformity on the measures. Rather, they set thresholds for the percentage of cases selected for review that must meet a standard of success in order for the state to be deemed in conformance. Another and more significant concern is that, while the CFSRs do incorporate explicit references to well-being and include somewhat specific indicators, the well-being outcomes and their associated measures are not particularly well defined. Well-being is a broad concept involving a child's developmental processes throughout their childhood and adolescence. Thus, the indicators associated with the outcome areas are not nearly as tangible as the measures associated with safety and permanency, the core and fundamental responsibility of the child welfare system.

Mazmanian and Sabatier identify a number of variables that affect the achievement of objectives in the public policy implementation process. They divide these variables into three broad categories: (1) tractability of the problem(s) being addressed; (2) ability of the statute to structure favorably the implementation process, and (3) non-statutory variables affecting

implementation. Further, they detail the various stages of the implementation process and the relationship of these stages to the likelihood of successful implementation of policy. Mazmanian and Sabatier's three categories of variables and the stages of implementation are described below in relation to the CFSR findings related to well-being. As the results of the analysis and the conclusions and recommendations are explored, the relevant variables are discussed to help illustrate the challenges the states faced as they went about developing and implementing their PIPs.

Tractability of the Problem

In the context of public policy implementation, tractability refers to the ease with which the desired changes can be defined, managed, and controlled. Several variables influence tractability in the analysis of the implementation process related to improving well-being outcomes for children and their families. These variables include: technical difficulties, diversity of target group behavior, target group as a percentage of the population, and extent of behavioral change required. Mazmanian and Sabatier describe these variables as follows:

a. Technical difficulties. Achievement of a program goal is dependent upon a number of technical prerequisites, including an ability to develop performance indicators and an understanding of the primary causal linkages affecting the problem.

b. Diversity of target group behavior. The more diverse the behavior being regulated or the service provided, the more difficult it is to structure clear regulations, and therefore greater discretion must be given to implementers. This aspect of tractability can sometimes be ameliorated through greater emphasis on economic incentives.

c. Target group as a percentage of the population. The smaller and more defined the target group is, the more likely it will be to mobilize political support and consequently achieve the statutory objectives.

d. Extent of behavioral change required. The amount of behavioral change required to achieve objectives is a function of the number of people in the target group and the amount of change required of them. The greater the amount of change, the more problematic successful implementation will be.

In this context, improving the well-being of children involved in the public child welfare system is a rather intractable problem. The entire target group of children involved in the child welfare system is a relatively small proportion of the general population, but with great diversity in the behaviors being addressed, services being provided, and behavioral changes required. In fiscal year 2002, the median rate of entry into foster care was 4.5 children per 1,000 children in the general population.[24] The number of children receiving services from the state child welfare agency is, of course, higher, with in-home services aimed at preventing the removal of children from their homes and their placement into foster care. For the six study states during the timeframe covered in this research, the proportion of children receiving services ranged from 8 to 16 per 1,000 children in the state. Due to the lack of consistent processes to assess and report the children's well-being needs comprehensively, reliable data are lacking regarding the proportion of these children who would need services to ensure or improve their well-being. Few states have information systems that can identify the incidence of these needs across the service population, or in specific jurisdictions. As an example, one of the state leaders commented that the children's medical needs, the services provided, and the immunizations needed or received were not documented in many of the case records. In other words, children in the child welfare system represent less than 2% of the child population and there is an inadequate understanding of their needs. These needs are certainly very diverse, ranging from physical disabilities, to dental health, to school problems, to serious psychiatric disorders. The CFSR documents reviewed in this study identified a lack of adequate education, physical health and mental health assessments, a lack of documentation of the results of assessments that *were*

[24] Child Welfare Outcomes 2002, pages III-2.

conducted, and shortcomings in providing relevant child specific assessment information to foster parents who provide care for children.

For some of these conditions, such as dental health, there is broad agreement about the diagnosis and treatment necessary to ameliorate the problems. For other conditions, such as mental health needs, the diagnoses, treatment interventions, and even who in the family needs to receive interventions, is much less clear. This is confounded in the child welfare population because of the typical scenarios of removal of the child from the family, adversarial relationships with the parents, multiple placements of the child, and the unavailability of funding to provide needed services. In the CFSR results for the study states, a lack of specialized services was noted as an area needing improvement for all six states in the systemic factor of service array. A lack of culturally appropriate services was identified for four of the six states in the systemic factor of responsiveness to the community. In several states, the CFSR documents identified the shortage of caseworkers and service providers fluent in Spanish as a pressing need.

There are technical difficulties in reliably identifying the broad range of problem areas in education, physical health, and mental health of children involved in the child welfare system. For many of the situations encountered there is not clear agreement on the basic measurement of the child's or family's problem or its etiology or effective interventions. States generally did not have reliable data on the well-being of their child welfare population at the beginning of CFSR implementation to serve as a baseline against which to measure improvement, and lacked a clearly articulated knowledge base on the type and intensity of intervention necessary to improve specific well-being outcomes. For example, one of the state leaders reported that caseworkers were more likely to base service decisions on the level of risk in a family, rather than determine

their specific service needs through the use of a comprehensive assessment that could identify the interventions demonstrated as effective for particular needs.

Other technical difficulties relate to the overall capacity of child welfare agencies. CFSR results indicated that several of the states lacked the basic resource of an adequate number of foster homes. This is correlated with the problem of frequent placement changes. This leads to changes in school settings, which interfere with the child's educational progress. This was noted in the present research for some of the same states lacking an adequate number of foster homes. Placement instability for the child also disrupts the continuity of physical and mental health services. One of the national experts explained that when children's stability is frequently interrupted, the other systems tasked with educational and mental health services are also affected in their ability to provide services for the child welfare population.

Mazmanian and Sabatier contend that a small and well-defined target population is more likely to mobilize political support. However, for some target groups with limited political influence and public support, such as those involved in child welfare, the fact that they are less than 2% of the population further limits their political power, particularly because they do not constitute a well-defined group. The broad diversity of child welfare problems and the small percentage of the population affected would seem to contribute to relative intractability.

All of these issues are exacerbated in rural areas of the states examined in this study because there is not a critical mass of these relatively infrequent conditions to justify the development of the array of services and resources for assessment and treatment. The CFSR documents reviewed for the study states identified a lack of services and resources for both physical and mental health in rural parts of the state as an area needing improvement. When these services were available in nearby urban areas, two states identified transportation and

scheduling issues as limiting access to these services for rural families. These results clearly indicate that the area of well-being in child welfare systems is relatively intractable.

Ability of Statute to Structure Implementation

There are both interesting opportunities and clear challenges regarding the ability of ASFA and the CFSR to structure policy implementation at the state and local level related to improving well-being outcomes for the children and families served by child welfare systems. The variables in the Mazmanian and Sabatier framework related to the ability of statute to structure implementation include: clear and consistent objectives, incorporation of adequate causal theory, initial allocation of financial resources, hierarchical integration within and among implementing institutions, decision rules of implementing agencies, recruitment of implementing officials, and formal access by outsiders.

a. Clear and consistent objectives. The clearer the objectives and instructions are to implementers, the more the policy outputs will be consistent with the directives.

b. Incorporation of adequate causal theory. Major reform efforts include, at least implicitly, a causal theory of the method by which its objectives are to be realized. This requires that the primary causal linkages between the governmental intervention and program objectives be understood, as well as the responsible implementers having purview over enough of the critical linkages to achieve the objectives.

c. Initial allocation of financial resources. Funding is critical in any social service program and a funding threshold is necessary for there to be a possibility of achieving objectives. Funding availability above this threshold is proportional to the likelihood of achieving the objectives.

d. Hierarchical integration within and among implementing institutions. Obtaining coordinated action within and across agencies is a well documented challenge in the implementation literature. This challenge is particularly difficult in implementing federal legislation that relies on state and local agencies for program delivery in a heterogeneous system.

e. Decision rules of implementing agencies. Federal legislation that clearly specifies the formal decision rules of the implementing agencies can influence the implementation process.

f. Officials' commitment to statutory objectives. Unless officials in the implementing agencies are soundly committed to the achievement of the objectives, achievement is unlikely.

g. Formal access by outsiders. Parties outside of the implementing agency may be affected positively or negatively by different components of the process.

Considering all of these variables, the results presented suggest that ASFA legislation and CFSR requirements have only a limited ability to structure the implementation of changes in state and local policies, procedures, and services that will be successful in improving child and family well-being. For every one of these variables there were problems noted in the CFSR documents and expert interviews.

Child safety has long been a clear and consistent objective of child welfare systems. But, child well-being is not so clearly and consistently defined in the policies and procedures of these agencies. Four of the state leaders indicated that policy lagged behind practice in child well-being, while the other two state leaders said that practice lagged behind policy. The disconnect between policy and practice was also noted by two of the national level experts. The results for these states identify several areas where the CFSR requirements do not provide adequate direction for implementation, such as the level of caseworker follow-through necessary to secure services, the case record documentation regarding the provision of services, and the standards for staffing and resources.

It has been recognized throughout the CFSR process that child welfare agencies have little or no jurisdiction over the host of factors leading to a family's involvement in the child welfare system or the interventions needed to address, in particular, the child and family well-being domain. There is obviously not a clearly structured and integrated hierarchy of mandated activities by health, mental health, and education agencies for the children served by the child

welfare system. There are also no sanctions or inducements for the agencies to participate in achieving the desired outcomes. State leaders and national experts interviewed for this study identified as challenges both the broad issue of collaboration and specific issues related to the coordination of education, physical health, and mental health services with child welfare services. The CFSR documents reviewed indicate that there are basic problems of communication between child welfare and educational systems, a lack of educational assessments and screenings, and deficiencies in the child's service plans regarding educational needs. It was also noted that there was resistance among school systems to serving the special needs of children in foster care and an unwillingness to share in the cost of services.

Similar issues were identified in the CFSR documents regarding the provision of physical and mental health services, including lack of timely assessments and screenings, limited health care coverage for necessary services, and the lack of transportation to access services. The states in this study reported limited success in getting the governors and legislators to create inducements and sanctions among education, physical health, and mental health agencies in response to the requirements of ASFA legislation and the CFSR findings. The examples cited of successful collaborations in these areas were based primarily on historical relationships among these agencies that preceded the CFSR. For the states that were not as successful with collaboration during the CFSR, there was nothing formally in place to require it. The efforts to improve the working relationships among the agencies took on the form of another mandate placed on the child welfare system without accompanying funding. As a result, these initiatives tended to be short-lived and ineffective.

As discussed in Chapter 1, the expectations inherent in the ASFA and the CFSR regarding well-being function as an unfunded mandate. Child welfare systems in general are

struggling with adequacy of funding, workforce issues, growing caseloads with more serious and complex problems, and increased performance accountability for outcomes. There are major limitations in terms of having an adequate causal theory linking government intervention to the achievement of child well-being. The well-being outcomes in the CFSR do not constitute precise and clear objectives to be achieved for the children served by the system. The research on effective intervention supports an integrated systems model, but this approach was broadly implemented in only one of the states studied. Given the basic lack of structured collaboration in coordinating services for children in the child welfare system, there is neither a process of formal decision rules, nor commitment to the statutory objectives of ASFA and the CFSR by the implementing officials in the physical health, mental health, and education agencies.

A more positive perspective on the ASFA and CFSR legislation is its success in calling attention to the need for greater coordination among child serving agencies to improve well-being outcomes. It has also made obvious the lack of data regarding the prevalence of well-being problems, services provided, and the effectiveness of those services. One of the national experts stated that probably the most pervasive impact of the CFSRs has been improvement in the quality of data and the use of data in making policy and resource allocation decisions.

Regarding formal access by outsiders, the CFSR process required stakeholder input in the state's self-assessment and gathered additional stakeholder input in the on-site review process. However, in the review of all of the documents for this study, there was very little evidence of input from parents or youth and limited stakeholder involvement in developing the PIPs. While several state leaders did note their state's efforts to recruit parent representation on committees or councils, there did not appear to be a formal mechanism in any of the states studied to solicit ongoing input from the families or youth receiving services.

Non-statutory Variables Affecting Implementation

The Mazmanian and Sabatier framework notes the importance of several non-statutory variables affecting implementation. These include: socioeconomic conditions and technology, public support, attitudes and resources of constituency groups, support from sovereigns, and commitment and leadership skill of implementing officials.

a. Socioeconomic conditions and technology. Variability in the social, economic and technological conditions among governmental agencies over time affects the achievement of objectives. Further, as other social problems move to the forefront of the jurisdictions' agenda, continuing support to allocate scarce resources to address the original legislation will likely diminish.

b. Public support. Deviation in public support is a variable. Media and political attention to issues tend to cycle, beginning with initial arousal of public concern, followed by a decline as costs and other issues reach the political agenda. Conversely, dramatic events related to the initial problem can re-ignite the public support.

c. Support from sovereigns. The "sovereigns" of implementing agencies are those entities that control the legal and financial resources, e.g. the legislature, courts, chief executive, etc. A major challenge in implementing intergovernmental programs is that various implementing agencies are responsible to different sovereigns, with different policies, and potentially conflicting directives.

d. Commitment and leadership skill of implementing officials. Commitment to the objectives is largely a function of the professional norms, personal values and support of the agency officials. Leadership skill in the political and managerial areas varies and is not necessarily predictable regarding whether officials will, or will be able to, maintain control over program costs and sustain morale and commitment as they relate to achieving objectives.

In the implementation of ASFA and the CFSR to promote child well-being, there are many examples of the challenges posed by these non-statutory variables. Some of the obstacles were recognized as long-term impediments to good child welfare practice long before the ASFA legislation. The limited and inconsistent support for child welfare services among legislators and the public is well known. There is often a reaction to some horrific case in the media which can

lead to firing staff, class action litigation, and court decrees. In one of the two states from this study where significant new resources were made available for additional staffing, this enhancement was attributed to public attention associated with several high profile child fatalities. However, sustained and positive public support for quality child welfare services is rare and is affected by changing conditions that capture the public's attention and lead to the reallocation of resources.

There are clear variations in socioeconomic conditions, allocation of resources to child welfare, and technological capacity across the states. In light of these differences, there have been criticisms during the CFSR process that attempts to hold all states to uniform standards are unfair (Courtney et al.; 2004; Wulczyn et al, 2005). Most of the state leaders and each of the national level experts reported that the states were concerned with passing the CFSR to avoid a penalty, as well as developing better policies and procedures in their child welfare systems. In addition, several informants noted the impact of the level of support and commitment and the leadership skills of the various implementing officials. This factor applied to the broad range of those involved, from the Federal Regional Offices, state governors, court leaders, and critical stakeholders, not just to the state child welfare officials. States where a commitment by skilled leaders was maintained over the course of the CFSR process recognized the benefits this brought. Likewise, the lack of skilled and committed leaders was noted as a serious problem in other states.

Stages in the Policy Implementation Process

Through the lens of the Mazmanian and Sabatier framework, the process of implementing the CFSRs at the state level can be viewed in terms of several stages. The first stage is *the policy outputs* of implementing agencies. The second stage is *target group*

compliance with policy outputs, followed by the *actual* and *perceived impact* of the policy outputs. Finally, there may be *major revisions* to the statute or policy, based on such things as the results during implementation, changing conditions, and advocacy on the part of affected stakeholders.

To develop *policy outputs*, legislative objectives need to be translated from regulations into specific details by the implementing agencies in order to change operating procedures. Consequently, the effort and sophistication of the officials in the implementing agencies to provide the technical analyses in a way that effectively converts general rules to specific objectives is critical. Further, this detail needs to be understood at multiple levels across a large number of situations.

For each state, the stage of determining policy outputs in the context of the CFSR was tied to the stages of the CFSR itself. First, the state did a statewide self-assessment based on the outcomes and systemic factors specified in the regulations. This provided the state and the Children's Bureau with a broad outline of the areas where the state believed it was performing within the standards, and the areas likely needing to be addressed. The states had an opportunity to begin working on revising their policies and procedures at this point. Some of the states reviewed were already in the process of ongoing system reform and some modifications were made based on the self-assessment stage of the CFSR. As an example, one of the state leaders noted that the state had identified deficiencies in their child welfare system prior to the federal review, but that the CFSR did result in adjusting the priorities among the areas needing improvement.

The next stage of the CFSR, the on-site review and final report, identified the areas where the combined inputs of self-assessment, data profiles, case reviews, and stakeholder input

determined the outcomes and systemic factors requiring improvement. The PIP was the state's response, in terms of proposed policy outputs, to address these "areas needing improvement." Both the review of the PIPs and the input from state and national experts indicate that the policy outputs tended to be limited to broad changes in policy and training. Particularly in the well-being areas, this was linked to some of the previously mentioned variables of diversity of the target group and behavioral changes involved, a lack of reliable data on the extent and nature of the specific well-being problems, limited knowledge on effective ways to address the problems, limited influence on the other agencies whose collaboration was important, and limited resources to provide expanded services.

The second stage of policy implementation is *target group compliance* with policy outputs. A number of dynamics come into play regarding whether or not the target groups will comply with requirements. These include the number and diversity of the target group, the model by which policy change is expected to lead to behavioral change, and an assessment of the relative costs and benefits of following directives, particularly whether there are penalties or sanctions for noncompliance. Depending on the state, the CFSR "areas needing improvement" affect from hundreds to tens of thousands of individual child welfare cases, thus creating a complex environment in which to achieve conformity. In a system as complex as child welfare, and especially with the well-being outcomes, there are many "target groups" involved in the policies, procedures, and services affecting these cases. Each one has a different role to play in responding to the change requirements and a different assessment of the relative costs and benefits.

Take, for example, the issue of the need for a comprehensive assessment of the child's well-being at the time in-home services or out-of-home placement begins. If, as part of the PIP,

the state agency adopts a new policy to require a mental health assessment of all children removed from their homes, this would require changes on the part of a range of staff within the agency as well as judges, mental health care providers, parents, foster parents, and others involved in the cases, a change in the resources required to implement the policy, and changes in the array of services provided to meet the identified mental health needs. Compliance on the part of each of these "target groups" can not be assured by a simple policy change.

The *actual impact* of policy outputs is the third stage of the implementation process. For each of the six states reviewed, the PIP lead to a variety of impacts as evidenced in the proposed changes in policies, procedures, training plans, and inter-agency collaboration. The states all succeeded in negotiating a PIP with their respective federal ACF regional office that was deemed to address sufficiently the identified areas needing improvement. The state leaders all noted positive impacts of beginning to implement their PIP strategies. Five of the six states succeeded in completing their federally defined PIP implementation period without financial penalty, suggesting that the actual impacts were in conformance with the objectives of the CFSR. The remaining state completed all PIP required activities for the educational well-being outcome and the service array systemic factor, as well as three other outcomes and two other systemic factors that were found to be in need of improvement. However, the physical health and mental health well-being outcome area, as well as two other outcome areas, continued to be out of substantial conformity. This indicates that, for the most part, the selected states achieved the impacts required for the first round of the CFSRs.

An important area of concern regarding actual impacts is that compliance with the objectives may bring about substantive impacts not initially envisioned. An example of this cited by one of the national experts is the adoption of improved quality assurance procedures that

mirror the CFSR leading to increased appreciation for the reporting of outcomes and monitoring improvements. There was broad recognition of the benefits of improved data collection nationwide. This has allowed many states to create information systems which permit them to look at the effects of what they are doing, even beyond what HHS requires.

The fourth stage of the implementation process involves the *perceived impact* of policy outputs. While the actual impacts of implementing a particular policy are often difficult to measure in a comprehensive and systematic way, evaluation of the perceived impacts, in particular by the implementing entities, may lead to the perception that the resulting objectives are inconsistent with the enabling legislation. One of the national experts noted that, in response to the CFSR final reports, some states focused on the obvious resource problems of high caseloads, insufficient training, and high supervisor to caseworker ratios and developed an approach to address these issues without the analysis that tells what needs to be done. As a result, the objectives were aimed toward symptoms of the agencies' long-standing resource issues, rather than understanding and addressing the complex service and collaboration challenges that would lead to improved well-being outcomes. Another concern regarding the perceived impacts relates to whether or not the long-term political support remains over time, enduring the competing interests among other initiatives. Two of the national level experts talked about improvements in the level of understanding and support of the CFSR process on the part of state legislatures. Another important component in ensuring political support over time involves continued and expanded developments within juvenile justice systems to recognize their crucial role in child welfare cases and to build upon the training, policies, resources, and support necessary to enhance the effectiveness of collaboration.

The fifth stage of the implementation process concerns *major revisions* in the initial statute or legislation. The degree of change associated with the evolution of a particular legislative initiative is a function of a number of factors that include perceived impacts, policy priorities, changing socioeconomic conditions, and political and implementing agencies' support. In the case of the ASFA and the CFSRs, there have been adjustments in some of the data indicators for safety and permanency outcomes and clear growth in understanding the implications of the legislation and its importance for continuous quality improvement in child welfare practice. However, to date there have been no major changes in the ASFA legislation as a result of round one of the CFSRs.

Applying the Policy Implementation Framework to Improving Child Well-Being

The discussion in the remainder of this chapter focuses on the four major themes that emerged from the CFSR data, information, and analysis for this study. These four themes characterized the common challenges that the six study states experienced in addressing well-being, specifically in the areas of education, physical health, and mental health, in the context of the CFSRs. The discussion also addresses how these broad factors can interact in complex and dynamic ways. The themes represent different constellations of interacting variables within the Mazmanian and Sabatier framework. Table 30 shows which of the framework's variables were identified in components of this research, the literature reviewed, CFSR findings, PIPs, or expert interviews. The four themes are:

- complexity of the problems,
- knowledge base and data to guide improvements,
- resources available to address the problems, and
- collaboration among the relevant stakeholders.

Table 30: Major Themes in Addressing Child Well-being in Relation to the Mazmanian and Sabatier Framework Variables				
Mazmanian & Sabatier Select Variables	**Complexity of the Problem**	**Knowledge Base and Data to Guide Improvements**	**Resources Available to Address the Problems**	**Collaboration among the Relevant Stakeholders**
Tractability				
Technical difficulties		X		
Diversity of target group behavior	X	X	X	
Target group as a % of the population			X	X
Extent of behavioral change required	X	X		
Ability of the statute to structure implementation				
Clear and consistent objectives	X	X		X
Incorporation of adequate causal theory		X	X	
Initial allocation of financial resources			X	
Hierarchical integration within and among implementing institutions	X	X	X	X
Decision rules of implementing agencies	X	X		X
Recruitment of implementing officials			X	X
Formal access by outsiders				X
Non-statutory variables affecting implementation				
Socioeconomic conditions and technology		X	X	
Public support			X	X
Attitudes and resources of constituency groups				
Support from sovereigns			X	X
Commitment and leadership skill of implementing officials				X
Stages in the Implementation Process				
Policy outputs of implementing agencies	X	X	X	X
Compliance with policy outputs by target groups			X	X
Actual impacts of policy outputs		X	X	
Perceived impacts of policy outputs				
Major revision in statute				

Complexity of the Problems

The well-being needs of children and youth involved in the child welfare system are extraordinarily complex. The populations served range from infants to young adults in urban, suburban, and rural settings. The families involved in child welfare are characterized by higher rates of poverty, substance abuse, mental illness, domestic violence, and other disadvantages when compared to the general population. Children from these disadvantaged backgrounds that have the additional impact of severe neglect and/or abuse, exhibit a broad range of problems in terms of their educational, physical, and mental well-being. The maltreatment can range from a single serious incident of physical or sexual abuse, to a chronic pattern combining neglect, physical abuse and emotional maltreatment over many years. The child's stage of development also plays a role in the impact of the maltreatment and the subsequent need for intervention to improve well-being. Thus, the needs of a child who is severely neglected from birth with subsequent serious impacts on physical and emotional development will be very different from those of a child whose maltreatment occurred in adolescence. Given the various forms of maltreatment occurring singly or in combination, under a variety of different circumstances, practically every known form of educational, physical, and mental problem can result. There are also circumstances where the abuse or neglect may be, to some extent, a maladaptive response by caretakers to the difficulties posed by an existing developmental, physical, or emotional disorder of the child. The cultural and linguistic background of the child and family can be another source of complexity in the population served by the various systems, one which varied across the six study states and among their urban and rural areas. As a result, it is a challenge to develop clear and consistent policy objectives to address these varied situations and needs.

Another level of complexity is the multiple systems involved in addressing the needs of children and the variation in these systems across states and across jurisdictions within states. For example, Arizona is a state administered child welfare system with 15 counties and North Carolina is a state supervised/county administered system with 100 counties. The way that public education, physical health, and mental health services are structured in different states, and in different counties within a state, means that many of the services needed by children and youth involved in the child welfare system must be provided by agencies outside of its purview. Additionally, because these children may be involved with multiple systems, including juvenile justice, each system has its own perspective of the child and family processes, and its own decision rules for screening and intake, assessing needs, and planning for, delivering, evaluating, and modifying or terminating interventions.

As a result, the policy outputs of each of these agencies could be expected to pose complexities, even if there were no challenges in terms of resources available and overall level of collaboration among the agencies.

Knowledge Base and Data to Guide Improvements

One of the lessons learned overall from the CFSR is the importance of having good data on which to base decisions regarding policy and practice. Basic data on the types of maltreatment and demographics of the children and families served is fundamental for service and resource planning. Comprehensive data on the behavioral changes sought and the likely impact of selected interventions are also needed to guide policy and practice changes.

Each of the disciplines of education, physical health, and mental health has its own knowledge base and expertise regarding assessments, interventions, monitoring progress, and evaluation of outcomes, as well as its own definitions for what constitutes success. At the

beginning of the CFSRs, the statewide assessments revealed that there was little in the way of comprehensive and consistent assessment regarding the needs of children and their families in the education, physical health, and mental health well-being domains. For the six states studied, none met substantial conformity in the well-being outcomes. Nationwide, only 27% of the states met substantial conformity in the education outcome and only 2% (one state) met substantial conformity in the physical and mental health well-being outcome.

A significant challenge with the CFSR well-being domains is the technical difficulties of a lack of consistent data reporting across the states and the lack of federal attention in holding the states accountable for reporting the elements that are found in the federal data systems (AFCARS and NCANDS). The CFSR process did not include quantitative measures or clear and consistent objectives for the states related to the well-being outcomes. In the review of the self-assessment reports of the six states, data on the well-being needs of children were limited and inconsistent. Thus, there is little foundation for characterizing the assessed problems of children and families, selecting the service interventions necessary to address the problems, monitoring the progress of the interventions, and determining when outcomes are achieved. This interacts with the issues of complexity of the problems noted above, in that just to provide comprehensive assessments in the well-being area requires attention to a full range of disparate areas of functioning. Each of the disciplines of education, physical health, and mental health has numerous tools available that are appropriate to age, gender, and presenting problems. Assuming child welfare practice could somehow incorporate such a comprehensive array of assessments, public child welfare agencies are still lacking in their ability to define effective interventions, monitor progress, and evaluate outcomes in the disciplines outside of their core competency areas of safety and permanency. Several of the state leaders interviewed emphasized that safety and permanency would always

take priority over the well-being concerns. This is one of the areas of recommended policy outputs resulting from the CFSRs. The federal Children's Bureau has made technical assistance and materials available to the states through their network of national resource centers to promote improvements in comprehensive assessments of children and families, both at intake and across the course of intervention.

The CFSR has drawn attention to the importance of comprehensive assessments, data systems needed to track cases and evaluate service effectiveness, and methods necessary for consistent communication with parents, foster parents, schools, treatment providers, and others regarding the well-being needs of children. The comprehensive assessment should guide the overall case plan to address safety, permanency, and well-being, and inform the quality assurance process to ensure the case plan is followed, that services are provided, and that outcomes are achieved. This issue is discussed in the federal Children's Bureau CFSR documents. Further, the need for reliable data for improving child welfare policies and practices was prominent in the comments made by the six state leaders and national level experts interviewed. This suggests the need for a broader and more effective application of information technology to identify actual impacts of policy outputs and support continuous quality improvement in the cycle of assessment-intervention-evaluation-understanding and modification.

Resources Available to Address the Problems

Resource issues affecting the well-being outcomes of children involved in the child welfare system can be grouped into several main areas. The first relates to the workforce and human resources of the child welfare agencies themselves. The second relates to resources for the placement of children in either foster care or treatment settings. The third area involves the availability of services that must be provided by other agencies or individuals outside of the child

welfare agency. An overarching resource issue is the availability of an adequate level of funding for staff, placement resources, and the purchase of services. Inadequate resources in all of these areas contribute to the difficulties state and local child welfare agencies face in meeting the well-being needs of children and their families.

With regard to workforce and human resource issues, public child welfare agencies experience high rates of staff turnover and are often under-staffed. This condition was noted by several of the study states in the CFSR documents and state leader interviews. Staff turnover, combined with high caseloads, too often results in situations where inexperienced frontline staff has neither adequate training nor the time to address the multiple and complex circumstances of the cases they are responsible for managing. The training for child welfare staff in their core competency areas of child protection is a major undertaking for child welfare agencies. Although the federal government has recognized this by making training funds available to states through Title IV of the Social Security Act, the research found that child welfare caseworkers generally have not had specific and in-depth training in the disciplines associated with the various well-being domains that they are likely to encounter. One of the states indicated that this had been clearly recognized as an inherent limitation on their resources that would not be addressed by any additional training of child welfare staff.

It was evident through this research that the public child welfare agencies struggled with having adequate placement resources for the children they served, both a sufficient number of placement options and an appropriate array of services along the necessary service continuum. This resulted in children being placed in settings that were not adequate to meet their needs on a short-term basis, while awaiting a more appropriate placement to be found. It is often particularly difficult to find an appropriate and available placement resource for a child with

serious educational, medical or mental health problems. When these problems are present, moving the child from placement to placement can exacerbate their problems, interfering with both the continuity of educational, medical, and mental health treatment, and the child's sense of belonging, acceptance, and stability. Research conducted by the federal Children's Bureau on the first round of the CFSRs shows that placement stability is important for achieving well-being outcomes (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, n.d.).

To meet the well-being outcomes, child welfare agencies have to arrange for the provision of a broad array of services for a service population that is very diverse and, at the same time, constitutes only a small proportion of the child population. The CFSR reports and the interviews conducted reveal that a range of needed services are either inadequate or all together absent in many communities among the six study states. These service deficits include assessments and services for youth and adults with developmental disabilities, dental services, and domestic violence, substance abuse, sex offender, and mental health services. It is also a challenge to provide services that are both culturally and linguistically appropriate for the diverse populations served by child welfare. Access to the services that do exist is often limited by factors such as transportation, scheduling and the unwillingness of some providers to accept payment from Medicaid and other publicly funded programs. The CFSR documents for the six study states and other related literature, as well as the interviews with the state and national level experts, all cite these problems, and emphasize that they are particularly pronounced in rural communities.

All of these resource issues result, at least partially, from an overall lack of funding for child welfare. While merely "throwing money" at the problems will not resolve them, an

adequate level of funding to recruit, train, and retain public staff and foster parents, to purchase services, and to improve coordination and collaboration among child and family serving agencies, would go a long way toward improving outcomes for children and their families. Many of the comments from the state leaders suggested that they often knew what services were needed, but these services simply were not available. These financial supports to the child welfare and related systems must be accompanied by development of best practices models and demonstration of the cost-effectiveness of interventions in order to foster long-term support from both the public and the elected, appointed and publicly employed leaders at the state and local level.

As discussed earlier, none of the six states studied were found to be in substantial conformity for the education, physical health, and mental health well-being outcomes and all were required to address these outcomes in their PIPs. Each of the state leaders interviewed said that no additional federal or state funding was made available to implement their PIP strategies. One of the states did dedicate funding for one position to coordinate the PIP. Two other states significantly increased their child welfare staffing. In one case, the increase was in response to several high profile child fatalities. In the other case, the staffing increase was attributed to a combination of the requirement to implement the PIP and their governor's recognition of what was needed to improve effective case management in their child welfare system. But, for the most part, PIP strategies proposed and implemented for the six study states did not rely on new resources. In two of the states, there was actually a large loss of staff during the PIP period due to a funding short-fall that lead to early retirement of some of the most senior staff in the state agency.

The nature of the PIPs was broad and there was little in the way of new resources in the PIP strategies and policy outputs, as adopted by states in implementing the CFSRs and approved by the Regional Offices of the Administration for Children and Families. To some extent, this can be seen as a tacit recognition that the CFSR well-being requirements constitute an unfunded federal mandate. The policy outputs were broad and compliance was, for the most part, deemed to be adequate to avoid fiscal penalties. However, the actual impacts of these changes fall far short of meeting the many and diverse well-being needs of children and families who are involved in the child welfare system.

Collaboration among the Relevant Stakeholders

The CFSR process recognizes the importance of community involvement and effective collaboration and coordination among stakeholders. This is especially important in addressing well-being outcomes because of the necessity to engage and involve other agencies, as well as the private sector, in the assessment and delivery of services for a relatively small proportion of the population whose needs are serious and complex.

In reviewing the CFSR documents for the six states, there were numerous references to challenges regarding collaboration, communication, and coordination, at both the individual and system levels. Communication problems between case workers and foster parents, caseworkers and the schools, and caseworkers and the child's Court Appointed Special Advocate (CASA) were cited as barriers to achieving the well-being outcomes. For example, when caseworkers placed a child in a foster home, the foster parent was not provided with the child's education or health records. Another example includes caseworkers not providing the school system with the education records of children that move from one school to another, and the schools not sharing education information with caseworkers when children move due to the lack of placement

stability in the treatment setting. These occurrences contribute to the delays children experience in having a consistent, individualized education plan.

Each of the state leaders interviewed cited cross-agency collaboration as a major challenge; however, they all stated that the relationships and coordination of efforts among the state agencies did improve during the two year federal PIP implementation period and beyond. This was evidenced by the development of statewide multi-agency and multi-disciplinary teams. Several of the state leaders noted that while coordination had improved among relevant state agencies, there were still significant challenges at the local level as the education, physical health, and mental health agencies operated with extensive autonomy from their respective state agencies. The situation was even more pronounced at the local level because of the inability of the state agencies to effectively partner with the private sector medical and mental health service providers. Overall, there was little attention in the CFSR process to these local issues outside of the three jurisdictions selected for the CFSR on-site review.

In speaking more broadly on the issue of collaboration, each of the national level experts consistently noted one most striking factor. The states that already had a process in place for ongoing collaboration with their stakeholders (whether in mental health, courts, tribes, education, or any of the other groups that have a stake) were much more effective in using that collaboration through the CFSR and the PIP planning process to identify clear and consistent objectives, develop appropriate policy outputs, and measure the actual impacts of those policy changes. States that did not have the ongoing collaboration in place and tried to collaborate just for the CFSR may have made short-term gains in "getting through the CFSR hurdle." However, the national level experts agreed that this does not sustain itself over time and does not support ongoing improvements. It is very hard to establish meaningful collaborative relationships in a

short period of time and have it be effective. Some of the states that built upon existing efforts used them effectively for the CFSR, and others did not.

A central message of the CFSR process is that it is a vehicle for making ongoing improvements and that these efforts should not stop when the PIP ends. Some states rallied around the CFSR with regard to collaboration, and it is evident whether the commitment is on a long-term basis or not. One national expert cited a recent PIP analysis of the states on the case review system of the juvenile and domestic relations courts as an example, and suggested that the principles used would apply to the well-being outcomes domains as well. States that considered their efforts to be the most effective were the ones that had cross-training with court agency personnel and regular ongoing meetings between the courts and the child welfare agency. This example confirms that regular collaboration plays a big role for the states in implementing the PIP strategies.

In a general statement regarding collaboration across all 50 states, one national level expert stated that the effectiveness of the collaboration varied by states, but where it was very prominent, it was judged by the states and in the CFSR observations as much more effective in terms of implementing their goals. In the well-being areas, it was noted that although some states did, the majority of states did not seem to collaborate well in terms of sorting out how to address the well-being indicators, specifically around education and mental heath.

Summary of the Discussion

The relationship among the federal, state, and local governments is an important public policy issue. The interaction among these levels of government is especially crucial in child welfare practice. A particularly complex example is seen in the response of the states to the federal mandates arising from ASFA and the CFSRs for improving the operation of child welfare

systems and the individual well-being outcomes for children and their families served by the system. In the context of the Mazmanian and Sabatier framework this can be seen as a "perfect storm" scenario, with multiple factors converging and interacting to create a serious threat to success. There are clear challenges in all of the main categories of the model, i.e. tractability of the problem, ability of the statute to structure implementation, and the implications of non-statutory variables. These play out in four major themes. The problems are complex and the knowledge base to address them is inadequate. There is a significant challenge posed by resource limitations and much work needs to be done on improving collaboration and coordination among the relevant stakeholders.

The states examined made extensive efforts to identify the policy and practice changes necessary to conform to the CFSR requirements. Despite generally vague PIPs with regard to strategies for improving education, physical health, and mental health outcomes, and a lack of clear data demonstrating such improvements, these efforts were deemed adequate in the context of the CFSRs. Five of the six states reached adequate conformance to avoid financial penalties. Both state leaders and national experts indicated that there were identifiable improvements in both systemic factors and outcomes. These efforts could be much more effective, however, if they were conceptualized and carried out according to a comprehensive, multi-agency statewide planning process that intentionally utilizes the knowledge base from the field of public policy and administration as exemplified in the Mazmanian and Sabatier policy implementation framework.

Recommendations for Further Research and Implications for Theory and Practice

This research contributes to the child welfare policy literature with an emphasis in the practice arena. Because practices relate to policy development, decision-making, resource

development, allocation and reallocation of funding, and the coordination and delivery of services, it is important to understand how these concepts interact in a complex area of public policy. This research examined some of the challenges which states faced in responding to a federal mandate to address child well-being.

The work presented here also contributes to the field of public policy analysis. There was a clear correspondence between the variables of the Mazmanian and Sabatier framework and the challenges identified in the CFSR documents and expert interviews. This serves as another example of the utility of the framework in public policy analysis. The CFSR well-being requirements provide an interesting application for the framework, primarily because of relatively intractable problems requiring collaboration among multiple agencies.

The four broad themes identified in this study, complexity of the problems, knowledge base and data to guide improvements, resources available to address the problems, and collaboration among relevant stakeholders, may be applicable in looking at other situations of implementing public policy. These themes could be considered in a retrospective study analyzing the challenges that were faced in implementing a public policy initiative in fields as divergent as environmental protection and welfare reform. It could be even more interesting to apply these themes prospectively to the development of new legislation and policies in order to understand and address the challenges and potential pitfalls before the laws are passed and the policies are finalized.

Further research could examine how the federal mandate and state responses develop over successive rounds of the CFSRs. Researchers could also examine specific components of the ASFA and the CFSR implementation identified in this study. For example, outcomes for children and families involved with child welfare could be significantly improved if the field of

public administration focused on the collaboration between public education and public child welfare. The issues of building the public and political will to understand and prioritize the unique educational needs of this vulnerable population, allocating sufficient resources to meet these needs, and ensuring effective cross-system collaboration are all important areas needing additional research. Similar research in the mental health area as it relates to child welfare could also be beneficial to the field.

There are also many public policy research opportunities regarding federal and state government relationships. For example, additional research on child welfare financing, coordination of policies and programs regarding children, and changes to the federal data reporting requirements on child and family well-being could greatly enhance the literature and contribute to improved systems and outcomes for children and their families.

In the context of child and family well-being, the CFSRs present a "first time" opportunity for child welfare agencies and other child and family serving systems to look seriously at their existing structures, policies, procedures, data systems, human resources, and collaborative relationships as they relate to the comprehensive needs of children, youth, and their families involved in the public child welfare system. This study provides an overview of the well-being component of the CFSR process. It describes the role of four broad categories influencing the response of states to the well-being mandates of ASFA and the CFSRs. Each one of these categories could serve as a focus for more detailed examinations within the administration of public child welfare.

Child welfare systems have responsibility for the lives of children and the functioning of families in ways that no other public system has. Other state and local agencies are typically charged with improving conditions related to a specific problem area, such as housing,

employment, education, substance abuse, or mental health. While their clients' problems may be serious and complex, the knowledge about effective interventions limited, and the resources for interventions insufficient, the situations are usually more straightforward than in child welfare. Some situations in child welfare are more akin to law enforcement, with life and death decisions being made on the basis of limited information. In child welfare services, the complexities of child development, family dynamics, social inequities, and intergenerational violence are combined with the problems of mental health, substance abuse, and the lack of education, housing, and financial resources that other agencies see in relative isolation.

Child welfare has the additional challenges of increasing caseloads, frontline staff turnover and other human resource issues, a tremendous and ever-growing range of personal and interpersonal dysfunction among the children and families served, financing that is both insufficient and overly constrained, and public attitudes that generally range from indifferent to ill-informed. It is no wonder, then, that child welfare services have a history that is viewed as rife with problems. The media report almost exclusively on the failures that occur. The courts address countless cases that are usually not stories of success, and class action suits focus on patterns of failure to protect children from harm, failure to meet the needs of children, or failure to support the rights of parents or other relatives. As a result, public child welfare agencies are generally seen as embattled and overwhelmed.

The challenges are certainly daunting as both agencies and their case workers are faced with administering complex federal, state, and local laws and regulations, while having to stay abreast of knowledge in the field. They must operate within service, resource, and funding constraints, and engage other child serving systems that have their own priorities.

In this context, sometimes there was a tendency for the child welfare field to view the CFSRs as another unfunded federal mandate that was ill-conceived, not based on reliable measures, and would add to the burdens faced by the agencies without offering the needed support for innovative service models, enhanced resources, or resolution of underlying problems. While this view has, to some extent, been born out in the first round of the CFSRs, it is also important to recognize the benefits of implementing the CFSR policy and engaging the states and communities.

In a way never before attempted, ASFA and the CFSRs have set forth a national effort to engage the federal and state governments in a process of continuous quality improvement. The goal is to improve the lives of vulnerable children and their families and improve the operation of the systems that underlie the services. The reviews have created a process to evaluate both individual outcomes and systemic factors and mechanisms to improve the reviews and results over time.

Overall, the CFSRs have made obvious the need for improved knowledge and data about the children and families served and a better understanding of the effectiveness of interventions. They have created a heightened awareness of the challenges facing child welfare systems and some of the broader community, county, state, and federal changes that are needed to address the challenges.

In the area of child and family well-being, there is still broad concern with the way that the mandate of child welfare has been expanded and no consensus on the scope of responsibility for the well-being of children in the state's custody, children served by the child welfare agency while still in their parents' custody, and children whose well-being may be compromised through various situations within and outside of the parents' control. Still, the concern with well-being is

a critically important step in child welfare policy reflected in the CFSRs and the broader call for accountability in public services.

Many of the short-term and long-term problems children in the child welfare system experience can be seen as related to inadequate concern for their well-being. The high rates of negative outcomes for maltreated children, both those placed into foster care and those receiving services in their own homes, are linked to a failure to see that the well-being needs of these children are met. Well-being is a central construct for healthy child development, with safety and permanency as two of the crucial components. Optimizing the chances for children to develop into healthy adults and good parents for the next generation relies on a complex and inter-related set of conditions including attachment, nutrition, health care, positive discipline, and education in both knowledge and values.

For children who experience maltreatment, this process is already jeopardized. If society is to intervene in a way that does more good than harm, there must be a concerted effort to understand and address well-being needs and the way that our child welfare policies should operate. For example, the permanency needs of a child should not be viewed merely as a process of complying with state and federal mandates. Permanency planning should also consider the age and developmental stage of the child, the role of the maltreatment trauma in their capacity to form attachments, and a host of other considerations that our combined best-practice knowledge identifies as important.

The attention to child and family well-being as a mandate in child welfare policy is in its infancy with its inclusion in ASFA and the CFSRs. It offers the hope for a more enlightened, effective, and humane approach to public child welfare services that are still struggling with the issues of safety and permanency. If research and scholarly pursuit of best practices and effective

policies can be matched with the necessary resources and collaboration across agencies and across levels of government, there can be positive benefits not only in child welfare, but among all of the public and private agencies and professionals that provide services to children and their families.

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APPENDICES

Appendix A: CFSR Individual Child and Family Outcomes and Systemic Factors

The CFSR established seven **individual child and family outcomes** that pertain to safety, permanency and well-being, with 23 associated measures. They are:

Safety

Outcome S1: Children are first, and foremost protected from abuse & neglect
- Item 1: Timeliness of initiating investigations of reports of child maltreatment
- Item 2: Repeat maltreatment

Outcome S2: Children are safely maintained in their homes whenever possible and appropriate
- Item 3: Services to family to protect child(ren) in home and prevent removal
- Item 4: Risk of harm to child

Permanency

Outcome P1: Children have permanency and stability in their living situations
- Item 5: Foster care re-entries
- Item 6: Stability of foster care placement
- Item 7: Permanency goal for child
- Item 8: Reunification, guardianship, or permanent placement with relatives
- Item 9: Adoption
- Item 10: Permanency goal of other planned permanent living arrangement

Outcome P2: The continuity of family relationships and connections is preserved for children
- Item 11: Proximity of foster care placement
- Item 12: Placement with siblings
- Item 13: Visiting with parents and siblings in foster care
- Item 14: Preserving connections
- Item 15: Relative placement
- Item 16: Relationship of child in care with parents

Child and Family Well-Being

Outcome WB1: Families have enhanced capacity to provide for their children's needs
- Item 17: Needs and services of child, parents, foster parents
- Item 18: Child and family involvement in case planning
- Item 19: Worker visits with child
- Item 20: Worker visits with parents

Outcome WB2: Children receive appropriate services to meet their educational needs
- Item 21: Educational needs of the child

Outcome WB3: Children receive adequate services to meet their physical and mental health needs
- Item 22: Physical health of the child
- Item 23: Mental health of the child

In addition, the CFSR includes seven broad **systemic factors** with 22 corresponding measures which are considered to underlie effective child welfare practice at the state and local level. These systemic factors address aspects of state child welfare agency operations relevant to achieving the desired individual outcomes for children and families. They are:

Appendix A: CFSR Individual Child and Family Outcomes and Systemic Factors (cont'd)

Statewide Information System

Item 24: State is operating a Statewide Information System that, at a minimum, can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or w/in immediately preceding 12 months, has been) in foster care

Case Review System

Item 25: Provides a process that ensures that each child has a written plan to be developed jointly with the child's parent(s) that includes the required provisions

Item 26: Provides a process for the periodic review of the status of each child, no less frequently than once every 6 months, either by a court or by administrative review

Item 27: Provides a process that ensures that each child in foster care under the supervision of the state has a permanency hearing in a qualified court or administrative body no later than 12 months from the date the child entered foster care and no less frequently than every 12 months

Item 28: Provides a process for termination of parental rights proceedings in accordance with the provisions of ASFA

Item 29: Provides a process for foster parents, pre-adoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be heard in, any review or hearing held with respect to the child

Quality Assurance System

Item 30: The state has developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of the children

Item 31: The state is operating an identifiable quality assurance system that is in place in the jurisdictions where the services included in the CFSP (Child and Family Service Plan) are provided, evaluates the quality of services, identifies strengths and needs of the service delivery system, provides relevant reports, and evaluates program improvement measures implemented

Training

Item 32: The state is operating a staff development and training program that supports the goals and objectives in the CFSP, addresses services provided under Titles IV-B and IV-E, and provides initial training for all staff who deliver these services

Item 33: The state provides for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP

Item 34: The state provides training for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities that care for children receiving foster care or adoption assistance under Title IV-E that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children

Appendix A: CFSR Individual Child and Family Outcomes and Systemic Factors (cont'd)

Service Array

Item 35: The state has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency

Item 36: The services in Item 35 are accessible to families and children in all political jurisdictions covered in the state's CFSP

Item 37: The services in Item 35 can be individualized to meet the unique needs of children and families served by the agency

Agency Responsiveness to the Community

Item 38: In implementing the provisions of the CFSP, the state engages in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child and family service agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP

Item 39: The agency develops, in consultation with these representatives, annual reports of progress and services delivered pursuant to the CFSP

Item 40: The state's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population

Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 41: The state has implemented standards for foster family homes and child care institutions which are reasonably in accord with recommended national standards

Item 42: The standards are applied to all licensed or approved foster family homes or child care institutions receiving Title IV-E or IV-B funds

Item 43: The state complies with Federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children

Item 44: The state has in place a process for ensuring the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed

Item 45: The state has in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children

Appendix B: Interview Guide/Questions for State Leaders

General CFSR-related Questions

1. In your view, was your state more concerned with "passing" the CFSR to avoid federal sanctions, with developing better policies and procedures or about equally with both? Please explain.

2. In preparing for and participating in the CFSR and in implementing and monitoring your PIP, how did your state differentiate between children receiving services in their own homes, versus children receiving services in an out-of-home placement?

3. In contributing to the "areas needing improvement" how important were (1) the design and implementation of programs, (2) demographic factors (age, race, family income, parent's education, urbanicity, etc.), (3) human and financial resources of the agency? Further, how did your PIP address these three areas? Please explain.

Inter- and Intra- Agency Collaboration and Service-related Questions

4. In reviewing your state's self-assessment, the federal final report, and your state's PIP, numerous references are made to "policies" in place that guide practice. In what ways does practice lag behind policy – specifically in case management, assessment and service delivery in the areas of mental health and education?

5. How effective was your state in collaborating with the leadership at the state and local level in the educational, mental and physical health agencies in development of the PIP? Discuss what worked, what did not and what initiatives and/or efforts are still in the works.

6. What other changes were made (outside of the PIP) within your state to make improvements in your child welfare system in preparation for the next round of CFSRs, e.g. enhanced communication with administrative and political state leadership, enhancements to data availability or analysis etc.?

Resource-related Questions

7. What was the relationship between the "program" agencies, e.g. social services, education and mental health, and your state's budgeting agencies/processes related to funding the PIP?

8. How informed/aware and/or supportive has your state/local legislature been regarding the CFSR, PIP implementation, etc.?

9. What additional funding was made available to your state to develop and implement your PIP? Is the funding broken-down by the specific outcomes and systemic factors? How would you characterize the adequacy of any funding changes directed toward accomplishing the PIP?

10. In your opinion, what are the biggest challenges to meeting the well-being outcomes for children and their families in your state?

Appendix C: Listing of State Child Welfare Representatives Interviewed

1. Arizona – Katherine Guffey, Department of Economic Security, Phoenix, AZ.

2. Georgia – Martha Okafor, Deputy Director of Programs and Policy, Department of Family and Child Services, Atlanta, GA.

3. Indiana – Stephanie Beasley, Deputy Director of Field Operations, Indiana Department of Child Services, Indianapolis, IN.

4. Massachusetts – Liz Skinner-Reilly, Federal Grants Coordinator/DSS Federal Liaison, Boston, MA.

5. North Carolina – Candice Britt, Special Projects Coordinator, Family Supports and Child Welfare Section, Division of Social Services, Department of Health and Human Services, Raleigh, NC.

6. Oregon – Maria Duryea, Child Welfare Research and Report Manager, Children, Adults and Families Division, Office of Program, Performance and Reporting, Department of Human Services, Salem, OR.

Appendix D: Guide/Questions for Elite Interviews – National Level Experts

General CFSR-related Questions

1. In your view, were states more concerned with "passing" the CFSR to avoid sanctions, with developing better policies and procedures or about equally with both? Please explain.

2. In the CFSR, how important was it to differentiate between children receiving services in their own homes, versus children receiving services in an out-of-home placement? Why?

3. In developing plans to address the items identified as "areas needing improvement" how important were (1) improving the overall design and implementation of programs, (2) utilizing analysis of demographic factors to focus or tailor approaches, (3) enhancing human and financial resources of the agency? Further, how well did the PIPs address these three areas?

Inter- and Intra- Agency Collaboration and Service-related Questions

4. With regard to the outcomes in the CFSR related to well-being, does practice lag behind policy – specifically in case management, assessment and service delivery in the areas of mental health and education? Or, vice versa.

5. How effective were states in collaborating with the leadership at the state and local level in the educational, mental and physical health agencies in development of the PIP? Discuss what worked, what did not.

6. What other changes were made (outside of the PIP) within states to make improvements in their child welfare systems in preparation for the next round of CFSRs, e.g. enhanced communication with administrative and political state leadership, enhancements to data availability or analysis etc.?

Resource-related Questions

7. What were some of the more common relationships between the "program" agencies, e.g. social services, education and mental health, and different states' budgeting agencies/processes related to funding the PIP? Were there any less common arrangements that seemed to work particularly well?

8. How informed/aware and/or supportive have the state and federal legislatures been regarding the CFSR, PIP implementation, etc.?

9. What additional funding and resources were made available to states to develop and implement their PIP? Was funding broken-down by the specific outcomes and systemic factors? How would you characterize the adequacy of any funding changes directed toward accomplishing the PIP?

10. In your opinion, what are the biggest challenges for states in meeting the well-being outcomes for children and their families? What is the one most important change in policy and/or funding that needs to be addressed to improve child well-being outcomes?

Appendix E: Listing of National Level Experts Interviewed

1. Shay Bilchik, President and CEO, Child Welfare League of America, Washington, D.C.

2. Theresa Gullo, Chief, State and Local Government Cost Estimates Unit, Congressional Budget Office, Washington, D. C.[25]

3. Dr. Jerry Milner, Senior Child Welfare Specialist, Children's Bureau, Administration for Children and Families, Department of Health and Human Services, Washington, D.C.

4. Dr. Fred Wulczyn, Research Fellow, Chapin Hall Center for Children, University of Chicago, Chicago, Illinois.

[25] Not a structured interview. A brief telephone conversation was conducted with this contact in the early stages of this research to ascertain the CBO's role in determining UMRA's impact on proposed federal legislation.