Senate Task Force on Department of Children, Youth and Families And the Family Care Network

Recommendations for the Future

October 14, 2014

THE ANNIE E. CASEY FOUNDATION

Child Welfare Strategy Group

Today I will report briefly on our assessment findings and respond to discussion during the previous Task Force meetings with a national perspective

- Our assessment focused on Rhode Island's over-reliance on group placements, and found positive and innovative accomplishments toward achieving your goals
- Your population of teens in group care is hindering progress toward your goals, especially when compared to other jurisdictions
- There are three primary factors that impact costs in child welfare; Rhode Island may have problems with all three
- Making the transition will require attention to DCYF and to your providers

Note: Most of the cross jurisdictional analyses use 2012 data from AFCARS, the most recent data available.

The Annie E Casey Foundation was asked to assess the use of congregate care in Rhode Island

Data Analysis	• Analyzed state level longitudinal cohort and other data to understand priority issues and placement patterns
Policy & Document Review	• Detailed review of DCYF policies • Comprehensive review of recent state initiatives such as Rhode Island's Federal IV-E Waiver, Phase 1 and Phase 2 of System of Care, Global Medicaid Waiver, and SAMHSA System of Care Expansion Implementation • Review of legislative reports and relevant proposed legislation
Finance Review	• Examination of budget process and assessment of opportunities to create cost savings to fund community services
Pathway Process Mapping	• Detailed Pathway Process Mapping sessions with CPI and intake workers (**10**), and FSU workers in all four regions (**22**)
Interviews & Focus Groups	• Interviews and focus groups with state and regional leaders representing DCYF, State of Rhode Island General Assembly, Family Court, Child Advocate, RIDE, Network lead agencies and FCCPs (**45**) • Interviews and focus groups with DCYF frontline staff, including CPI, intake, placement, FSU, pre-permanency and post-permanency supervisors (**14**), pre- and post-permanency workers (**4**) and DCYF attorneys (**3**) • Observation of DCYF Placement Unit • Interviews and focus groups with frontline staff in each Network, including NCCs (**13**), NCC supervisors (**9**) and staff responsible for resource family recruitment, development and support (**12**) • Interviews and focus groups with stakeholders, including provider agencies (**5**), GALs (**2**), and birth parent attorneys (**3**) • Interviews and focus groups with consumers, including youth (**19**), birth parents (**7**) and resource parents (**9**)
Surveys	• Surveyed CPI, intake, placement, FSU, pre-permanency and post-permanency supervisors (**36**) • Surveyed CPI, intake, placement, FSU, pre-permanency and post-permanency workers (**111**)

DCYF has an innovative plan for children, youth and families, intended to unify its services across divisions, while demonstrating a strong commitment to System of Care principles

Phase I:
Prevention services offered through Family Care Community Partnerships (FCCP)

- Community-based services and supports, using the wraparound planning model to prevent family involvement with DCYF, and to support family preservation and child well-being
- Each of the 4 FCCP's are advised by a Community Advisory Board

Phase II:
Development of the Family Care Networks to re-balance the service array to focus less on congregate care

- Services include congregate care, treatment foster care and community based services.
- The Title IV-E waiver to support traditional placement services as well as enhanced family support services and home and community-based services for at risk and post placement children, youth and families.
- The Global Medicaid waiver to support evidence-based practices: Multi-Systemic Therapy, Parenting with Love and Limits, Strengthening Families and Preserving Family Networks.

DCYF has developed many innovative systemic practices and been awarded grants and waivers to support these practices

System-wide Innovations

- Strong commitment to community and parent engagement and prevention, including development of FCCPs, and commitment to Evidence2Success

- Development of and support for System of Care, and movement to the Family Care Networks Contract with Foster Forward to support foster parents, and being a model site for services to older youth with the Consolidated Youth Services Program which includes the Jim Casey Youth Opportunities Initiative's ASPIRE services and the RICORP managed YESS Aftercare Services.

- Participation in the Juvenile Detention Alternatives Initiative to reduce the use of detention for youth

- RI DCYF is participating in the Pew Foundation's Result's First Initiative, which emphasizes the use of evidence based practices and provides a cost benefit model for evaluating the effectiveness of services and programming. RI DCYF will be one of the first states in the country to apply the Result's First Initiative to both juvenile justice and child welfare programs.

- In 2014 Successfully completed the Program Improvement Plan as part of the Child and Family Service Review.

- Partnering with the RI Family Court in the establishment of a Permanency Committee focused on improving and supporting the permanency planning process for children, youth and families.

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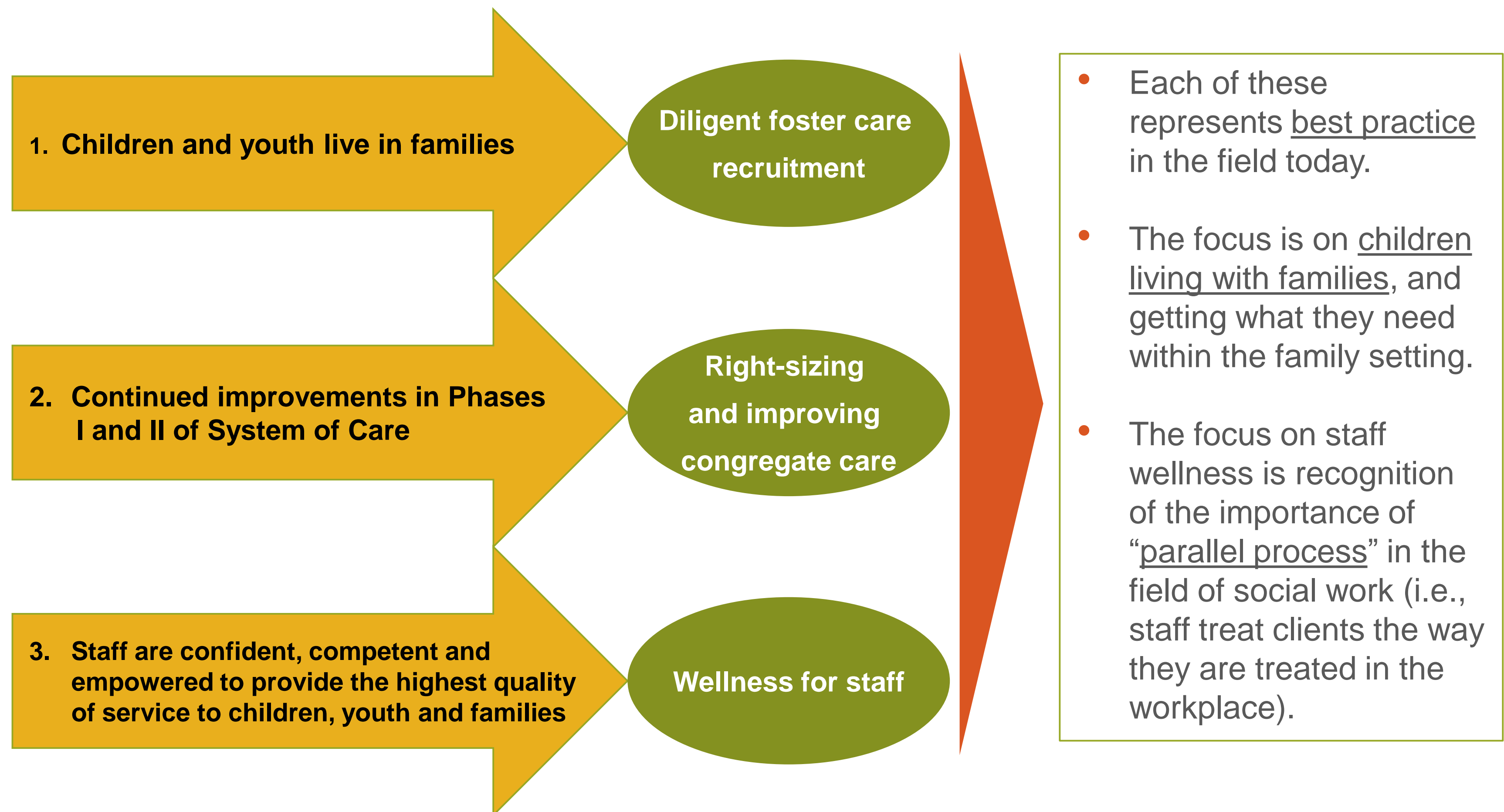
Grants and Awards

- Implementation Cooperative Agreements with SAMHSA for the expansion of the Comprehensive Community Mental Services for Children and Their Families Program ($4 million over 4 years)
- Title IV-E waiver to add flexibility to the System of Care
- Diligent recruitment grant from federal government
- Grant for promoting well-being and adoption after trauma

DCYF has a clear vision and system improvement plan for children, youth and families

Within its mission of partnering with families and communities to raise healthy children in a safe and caring environment, the Department has articulated clear goals, strategies, objectives, action steps and the rationale for change



- Each of these represents best practice in the field today.
- The focus is on children living with families, and getting what they need within the family setting.
- The focus on staff wellness is recognition of the importance of "parallel process" in the field of social work (i.e., staff treat clients the way they are treated in the workplace).

DCYF's permanency outcomes are generally in line with those of other states

Type of Discharge for Children Exiting Care	State % 2010	State % 2011	State % 2012	51 State Median
Reunified with parent, primary caretaker	60%	56%	54%	53%
Adoption	13%	15%	15%	21%
Guardianship	7%	9%	11%	6%
Living with other relatives	3%	2%	2%	4%
Emancipation and runaway	12%	14%	13%	10%
Transfer to another agency	4%	3%	4%	1%

NOTE: Exit cohort data over-represent children with short stays.

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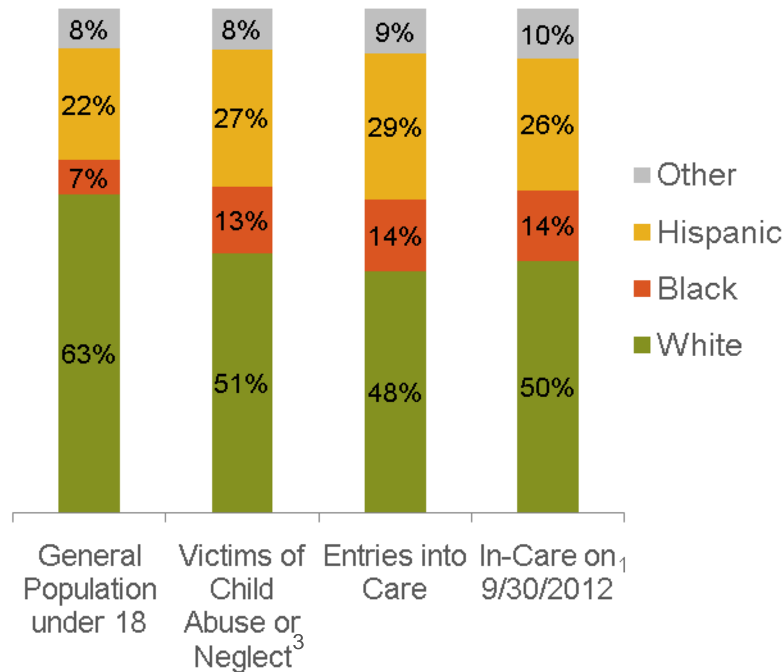
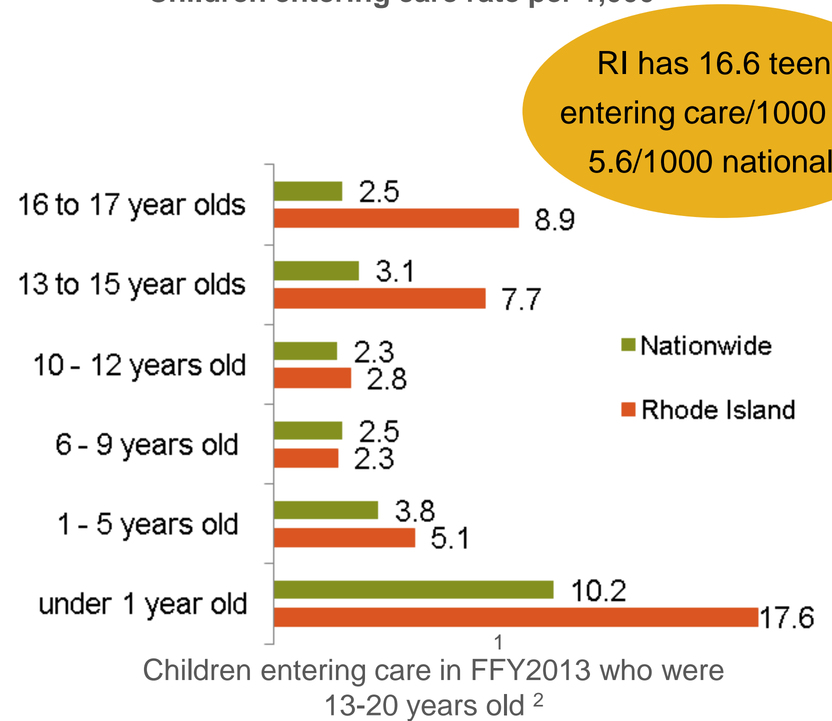
DCYF children in care are disproportionately children of color and are more likely to be older youth

Representation in the system by race



Compared to the general population of children in Rhode Island, Black and Hispanic children are over-represented in your system

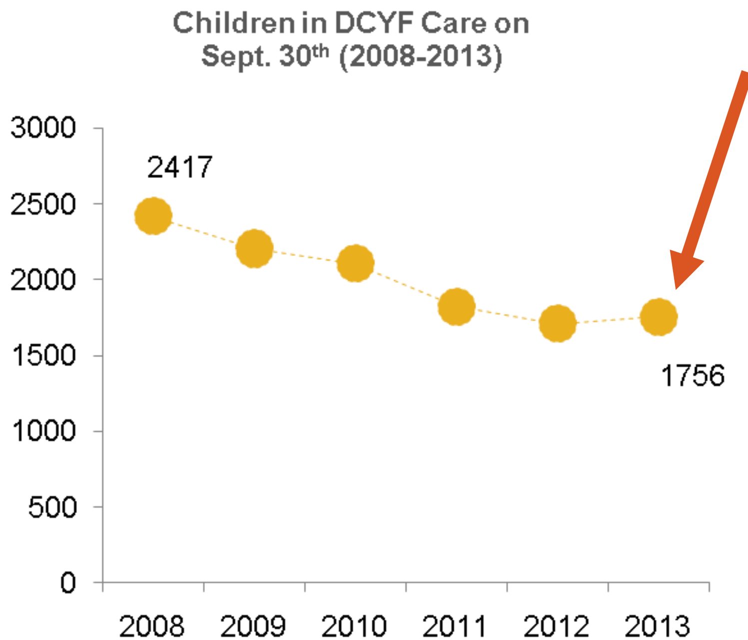
Children entering care rate per 1,000[1]

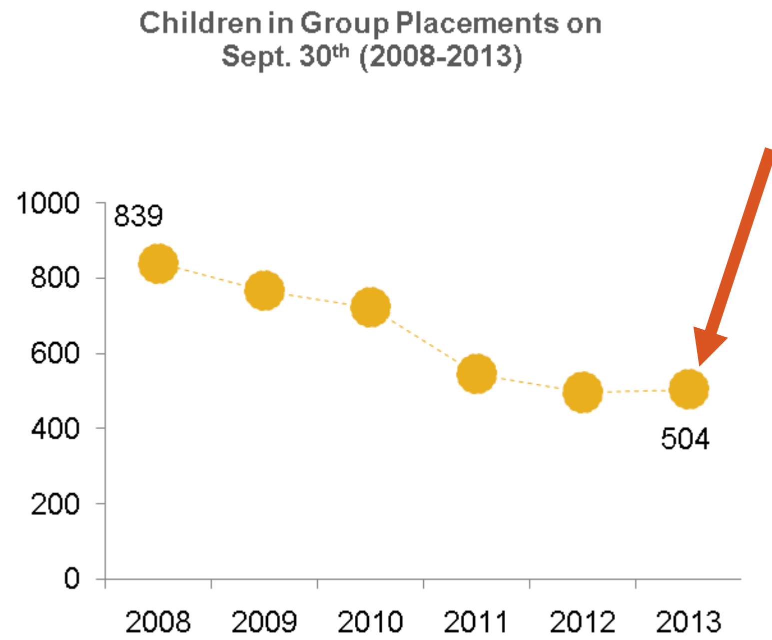


Older youth account for nearly half of all entries and enter care at a rate much higher than the national median

1: AFCARS Foster Care Public Use Files FFY2012
2: State submitted AFCARS A/B Merged Files
3: Child Maltreatment 2012, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2013

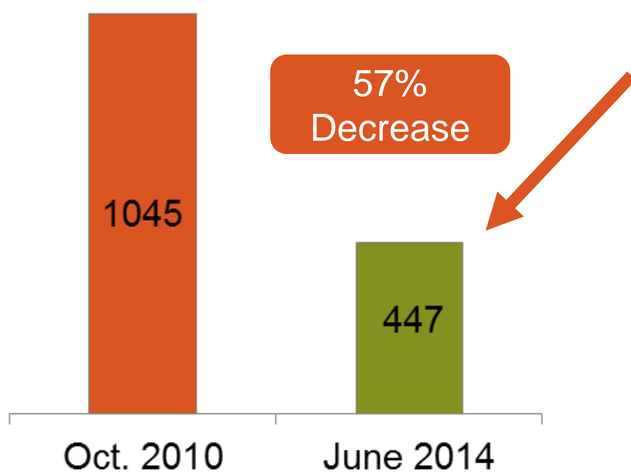
Rhode Island had made significant progress in reducing the overall population of children in care and in group placements, but both have begun to increase this year

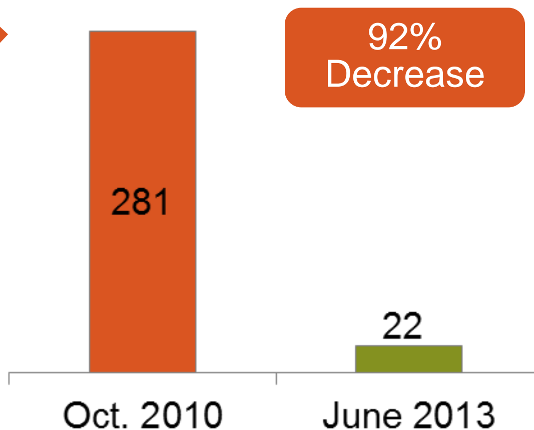


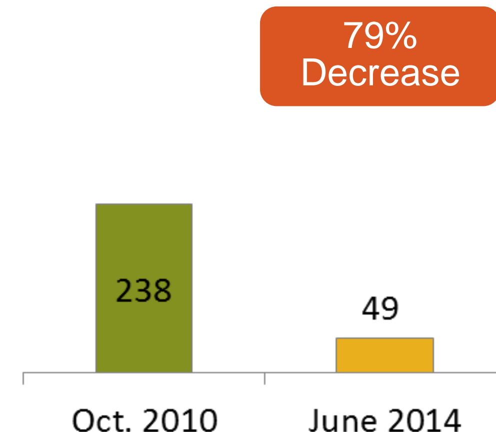


Source: State submitted AFCARS A/B Merged Files

Connecticut, almost three times the size of Rhode Island, has about twice the number of kids in care and roughly the same number of kids in congregate care

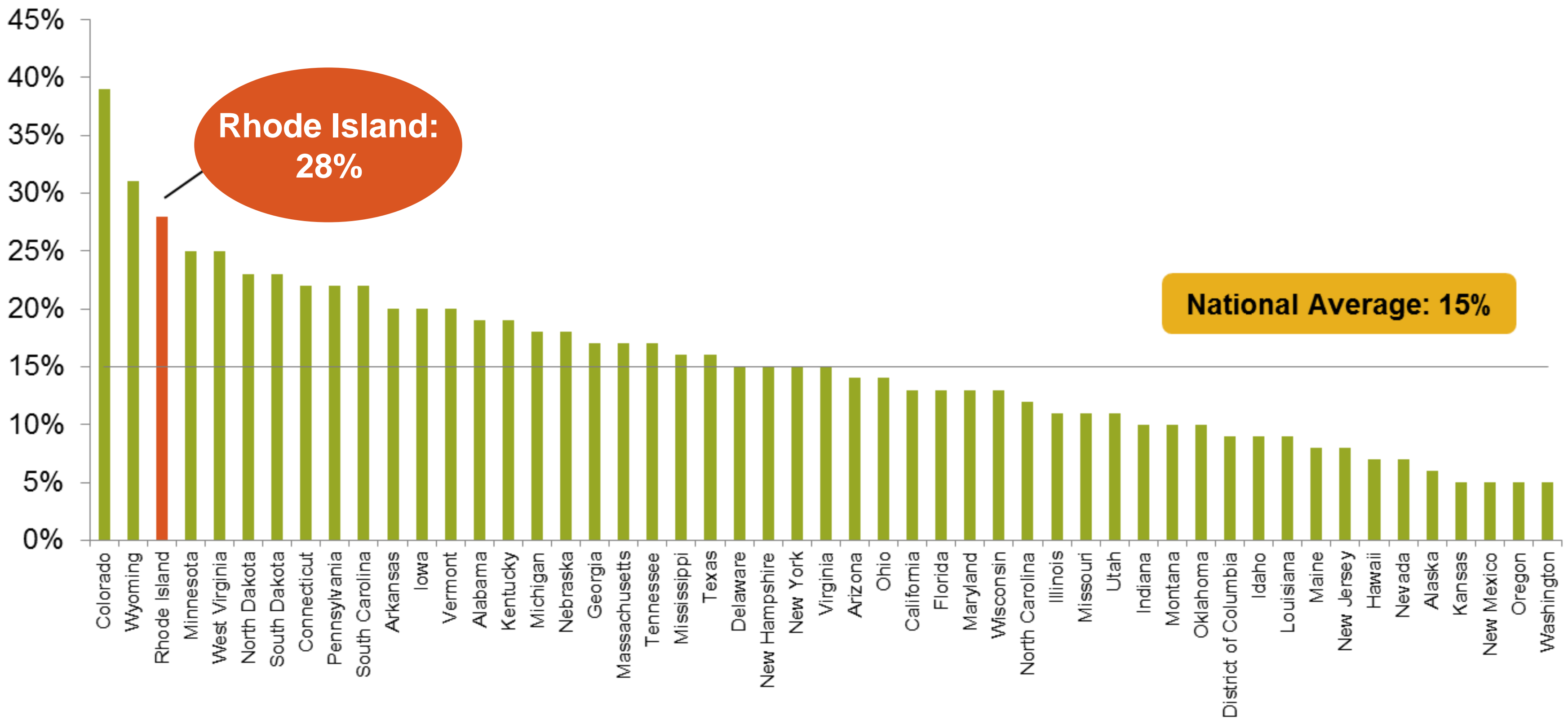






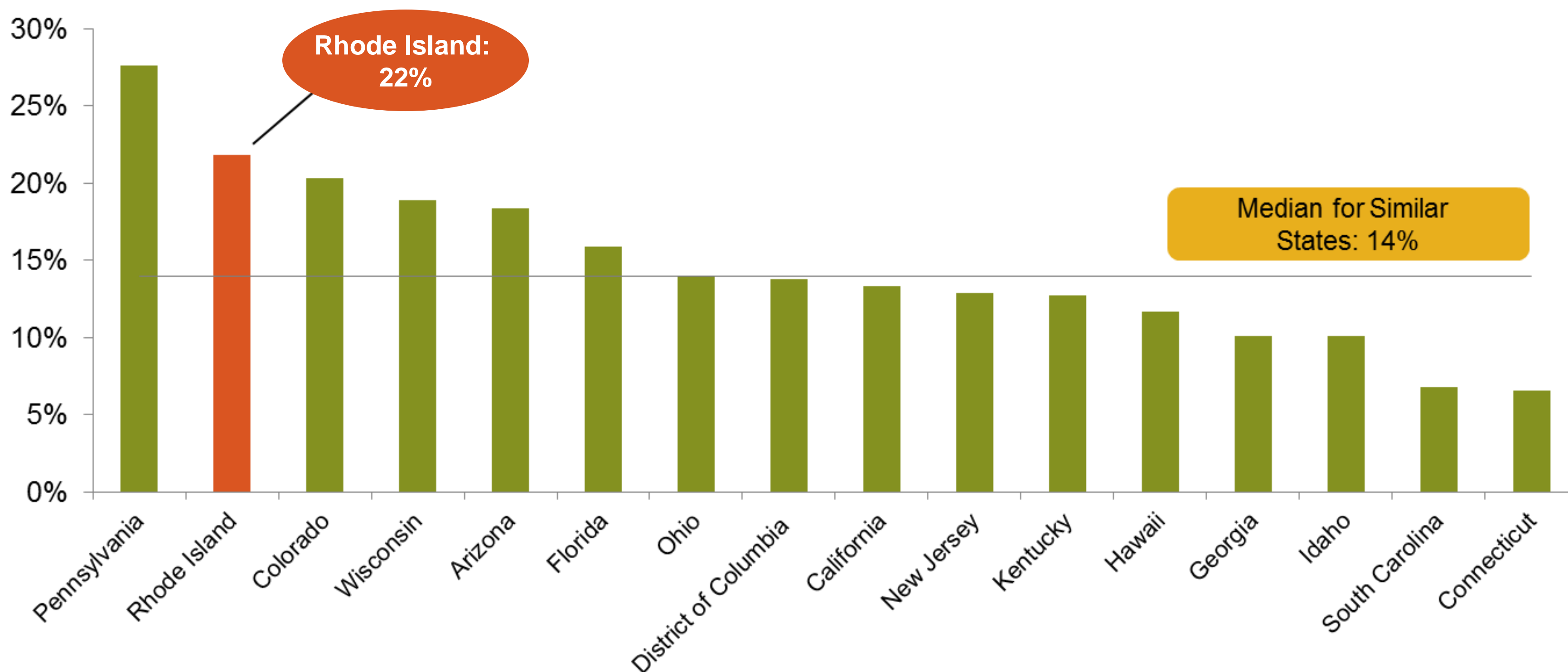
Connecticut had **3,428 children in care** in June 2014.
Efforts to reduce the use of group care have succeeded.
Proportion of kids in congregate care = 13%.

Even with reductions in the use of group placements, DCYF has a much greater percentage of kids in group settings than most states – almost twice the national average



Source: AECF KIDSCOUNT Data 2012

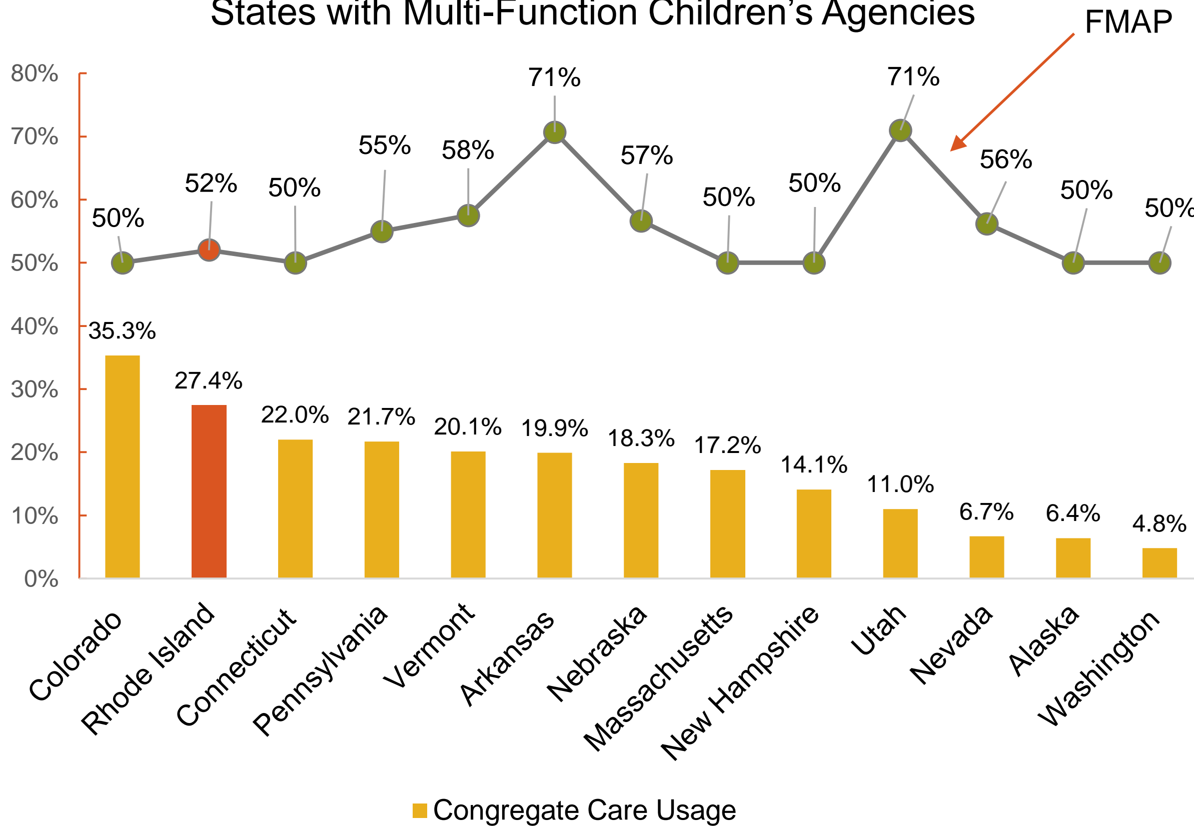
Compared to states that count re-entries similarly, Rhode Island has the second highest rate of re-entries, meaning that a ***large portion of kids and families did not receive effective services***



Source: AFCARS Data 9/30/2012

Definition: C1.4: Of all children discharged from foster care to reunification in the 12-month period prior to the year shown, what percentage reentered care in less than 12 months from the date of discharge? RI is one of 16 states that count trial home visits as an exit from care , thus theoretically making the re-entry numbers higher.

Rhode Island has inordinate numbers of kids in group placements, even among states with combined children's agencies*



When compared to other states with combined children's agencies, Rhode Island's use of group placements is high.

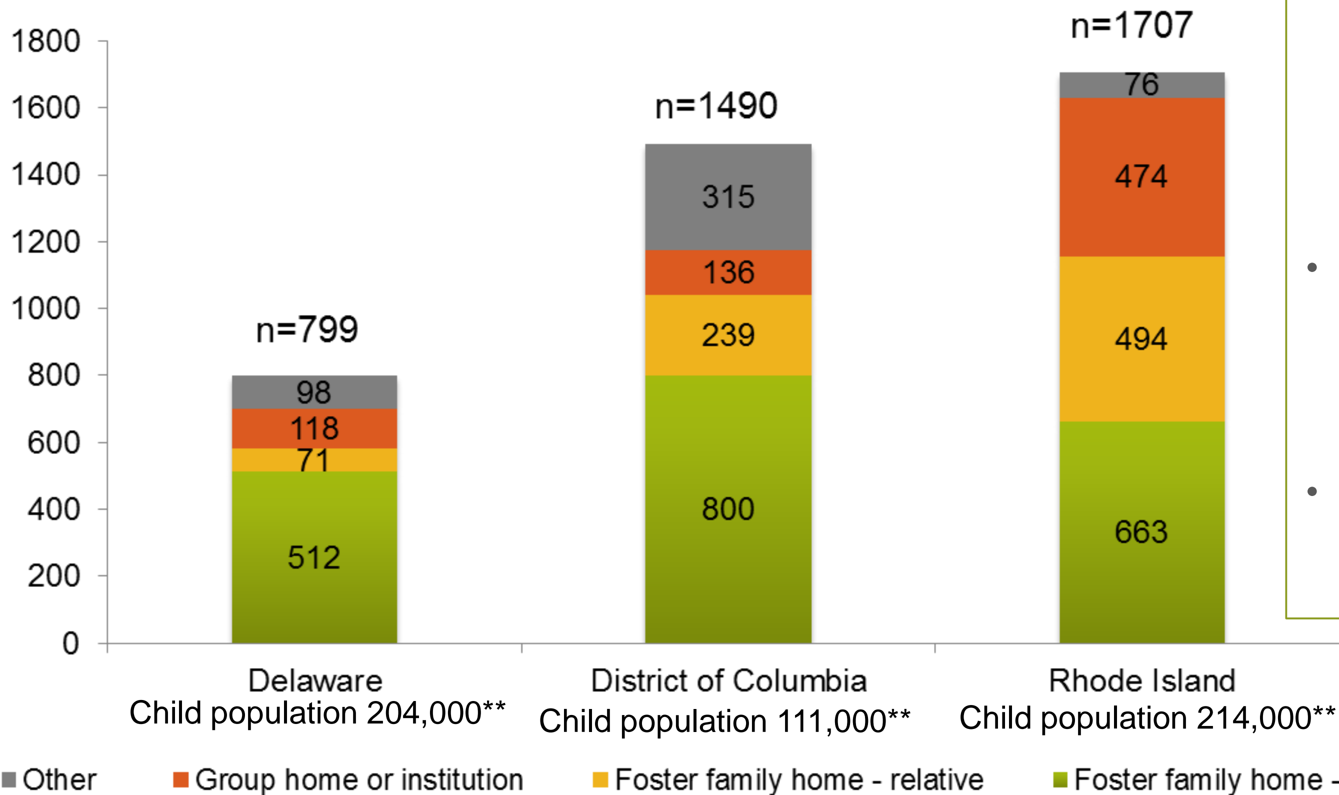
Six of these 13 states have lower per capita incomes than RI, as measured by higher Federal Medical Assistance Percentages (FMAP).

*Agencies with child welfare, juvenile justice and children's mental health reporting to the same director.

1: AFCARS Foster Care Public Use Files FFY2012

2: "Federal Financial Participation in State Assistance Expenditures," Federal Register, November 10, 2010 (Vol 75, No. 217), pp 69082-69084.

In comparison to jurisdictions of comparable size, Rhode Island had far more kids in congregate care*



- Rhode Island does a great job placing kids with relatives, but still has higher proportions of kids in group placements.
- Among kids 13 and over, only 14% are placed with relatives – a missed opportunity.
- Kids placed with relatives have a lower probability of re-entry.

*AECF KIDSCOUNT Data, 2012, the latest year for which comparable data are available
"Other" includes Runaway, Supervised independent living, Trial home visit, and Pre-adoptive home
**Kids Count, 2013 population estimates from US Census Bureau

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There are three variables that impact the bottom line in child welfare

- **Volume**: The number of kids entering care
- **Duration**: The length of time kids stay in care
- **Acuity**: The severity of needs of the kids entering care

Volume is related to the "front door" to the child welfare system

- Do DCYF workers have caseloads that allow them to undertake sound protective investigations and oversight of in-home cases, such that they feel confident kids will be safe at home?
- Are family support services available in the community to ensure that family issues can be addressed while children remain at home?

NO

- DCYF **caseloads are unacceptably high**, primarily because of high vacancy rates. When this happens, you can be sure that more kids will be removed from their families.
- **Cuts in the availability of preventive services** have reduced options for preserving families.

Duration is related to achieving timely permanency and attention to a child's best interests

- Do DCYF workers have caseloads that allow them to undertake ongoing permanency efforts, even while a child is receiving therapeutic treatment?
- Do providers push DCYF or the networks to step children down to lower levels of care when treatment has improved functioning?

?

- Staff **caseloads are unacceptably high**, primarily because of high vacancy rates. When this happens, staff focus on the front end of the system, not children already in placement, resulting in longer lengths of stay.
- Providers who have faced significant budget cuts are under huge pressure to keep beds filled because their high **fixed costs**, and occupancy becomes critical to survival.
- **Training and turnover rates** may have hurt the Networks' ability to manage care effectively.

Acuity is related to the needs of the kids involved with the system

- Do DCYF workers have the skills and tools to make good decisions about which kids should be referred to the Networks?
- Do DCYF workers have low level options (i.e., foster homes) for kids who do not need to be referred to the networks, and the time to locate them?
- Do the networks have family-based clinical services available as needed? And incentives to use them?

NO

- Staff do not have **valid assessment tools** to help decide when kids need higher levels of care.
- **DCYF does not have a robust regular foster care system** or ongoing capacity to undertake family search and engagement.
- Providers who have faced significant budget cuts are under huge pressure to keep beds filled because they must deal with fixed costs first, thus have been **unable to develop family and community based alternatives** to residential care.

Based on those three problems, three areas will be discussed

- **Assessment**: Assessment for the purpose of placement can be accurately and efficiently undertaken, and data can be aggregated into a performance management system able to answer the question: ***Is the child better off because of the system's intervention?***

- **Foster care**: Having a robust foster parent recruitment, development and support function that meets the needs of the kids entering care is always cost effective.

- **Meeting the needs of teens**: Teens with behavior problems can be effectively served in the community at far less cost than group placements.

Annie E Casey and The Duke Endowment have invested in an assessment tool and performance management system that turns easy-to-collect raw data into useful analyses

Easy-to-answer questions, all answered on the same reliable scale

(no training or clinical expertise needed)

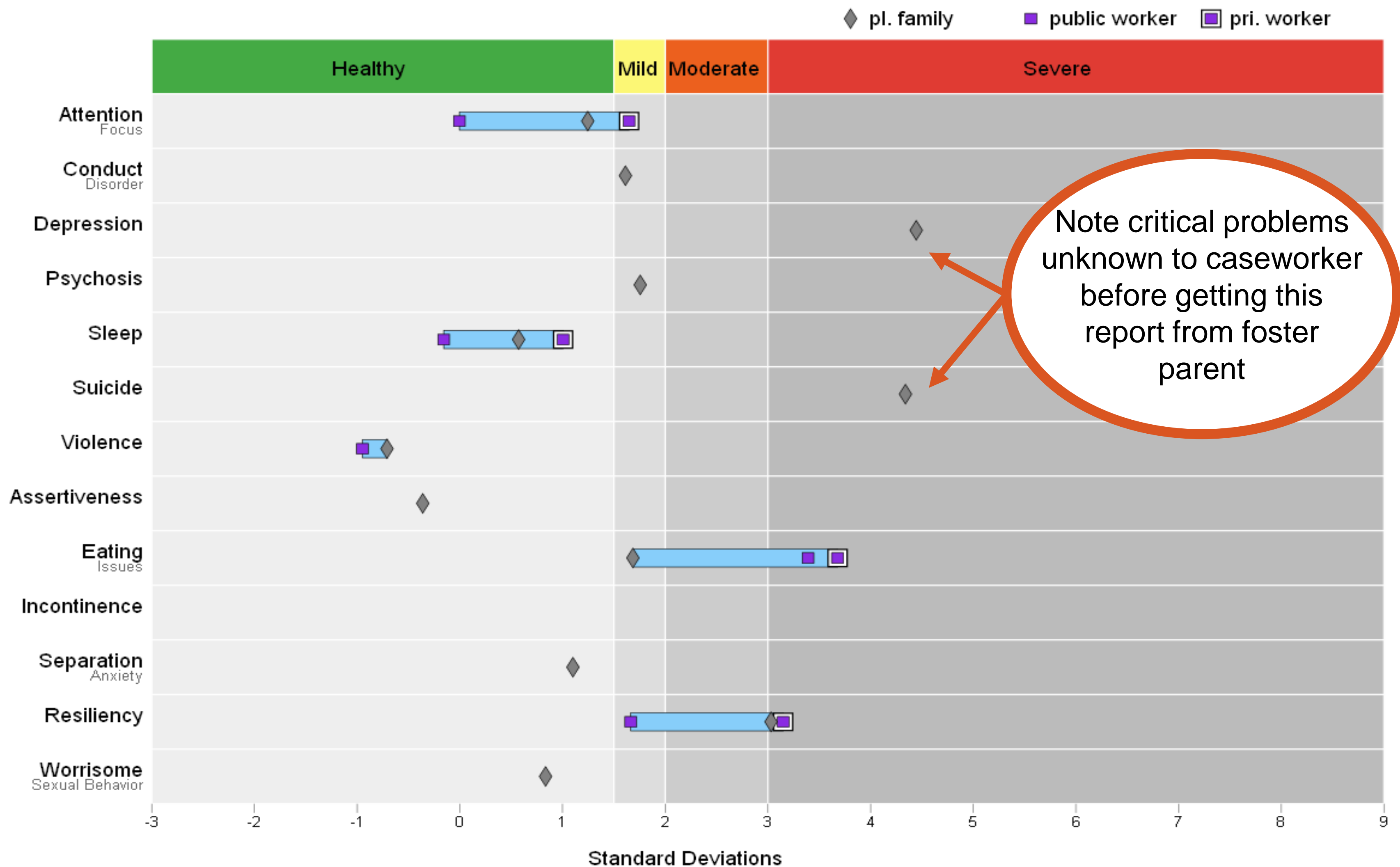
All	Most	A lot	Some	A little	None	Indicate how much of the time during the past few days you have
○	○	○	○	○	○	felt down or depressed
○	○	○	○	○	○	felt little or no interest in most things
○	○	○	○	○	○	felt restless
○	○	○	○	○	○	felt worthless
○	○	○	○	○	○	felt hopeless
○	○	○	○	○	○	felt nervous or anxious
○	○	○	○	○	○	felt easily irritated or annoyed
○	○	○	○	○	○	felt confused, in a fog, or dazed

(This is a sample of the total set of questions)

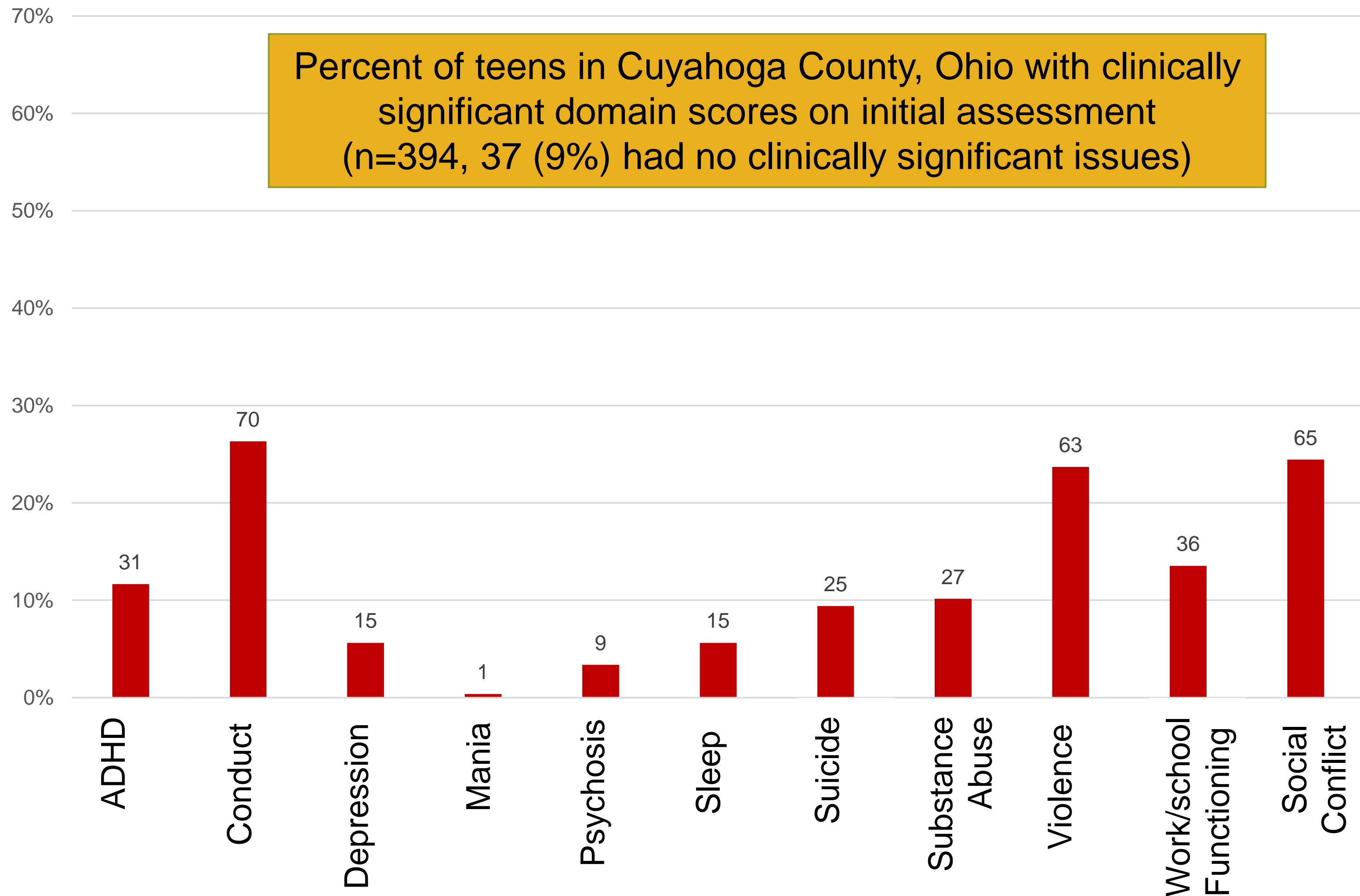
English, Spanish, Portuguese, Chinese, German, Dutch, Haitian, Vietnamese, Cape Verdean

Kraus, D., Seligman, D., & Jordan, J.R., (2005). Validation of a behavioral health treatment outcome and assessment tool designed for naturalistic settings: The treatment outcome package. Journal of Clinical Psychology, 61, 285–314.
Kraus, D., Boswell, J., Wright, A. Castonguay, L., & Pincus, A., (2010). Factor Structure of the Treatment Outcome Package for Children. Journal of Clinical Psychology, 66, 627-640.

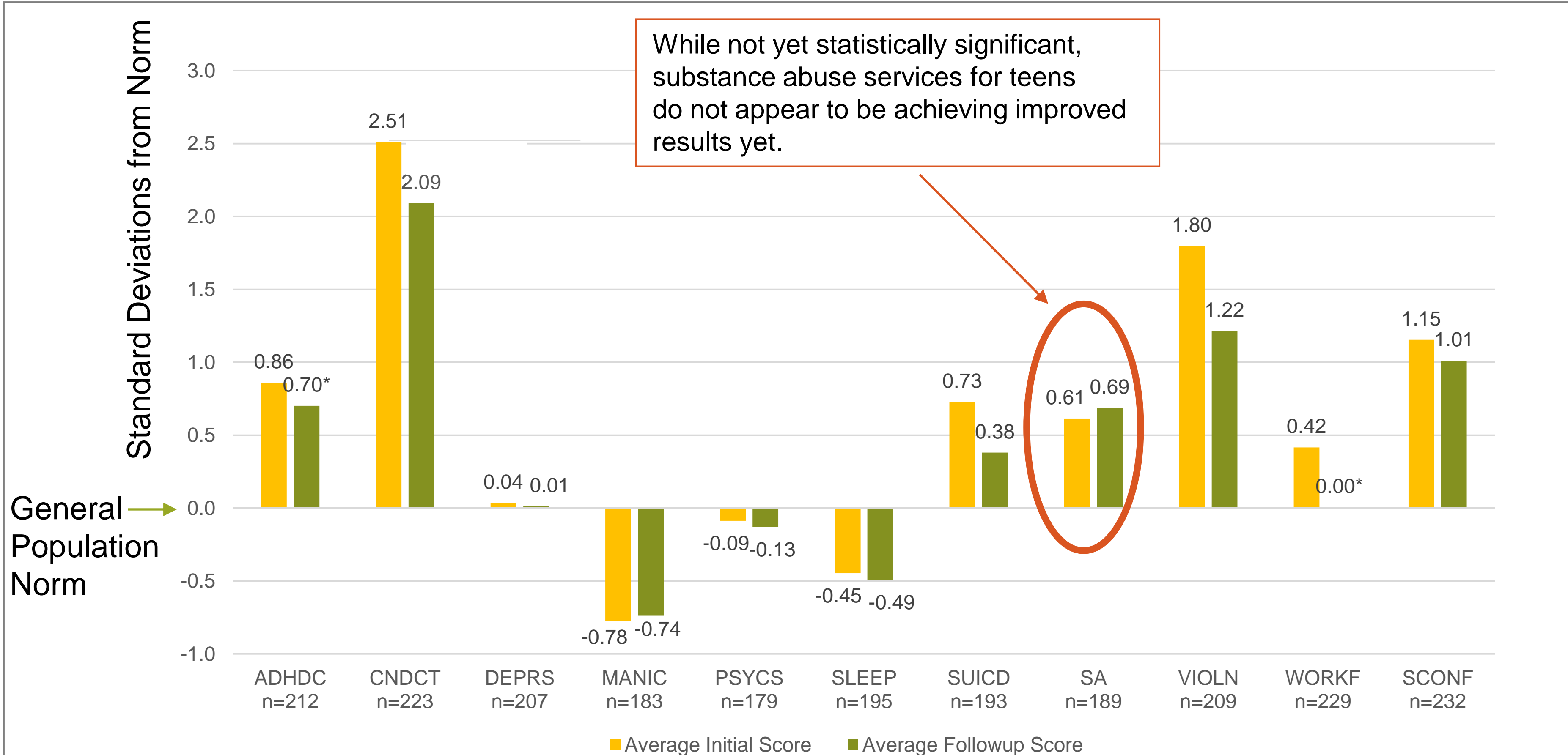
The process and the reports allow 360° reviews of kids' behaviors and can provide caseworkers and care managers with new and important information



For the first time ever, TOP data are telling us about the prevalence of specific issues for children within the child welfare population



Very early outcome data from Cuyahoga County, OH are finally answering the question: *Is anyone better off because of the agency's or providers' interventions?* (n = 266)



Yellow bars represent initial assessment scores and green bars represent follow up assessment scores; scores higher than "0" are worse than the general population norm. Scores below "0" are better than the general population. Green bars lower than yellow bars represent improvement over time.

*Statistically significant. Eight of the 13 domain scores for children 6-12 showed statistically significant improvements (n = 837).

The TOP performance management process scientifically identifies providers' strengths and weaknesses in improving behavioral health/well-being outcomes, which is useful for quality improvement

De-identified Residential Programs

Providers	Assertiveness	Incontinence	Depression	Psychosis	Separation Anxiety	Sleep	Suicide	Eating Disorders	Violence & Aggressiveness	ADHD	Conduct Disorders	Mania	Social Conflict	School Functioning
A	✓							✓	✓					
B									✓			✓		
C			✓			✓			✓		✓		✓++	✓++
D											✓++	✓++		✓
E		✓	✓	✓++		✓			✓	✓	✓++	✓++		✓
F				✓++		✓	✓					✓		
G			✓++	✓++		✓++	✓		✓++	✓	✓	✓++	✓++	✓
H							✓		✓++		✓			
I			✓			✓++						✓++		
J					✓		✓		✓++	✓	✓			
K						✓	✓++							
L			✓	✓						✓++	✓		✓	✓
M	✓	✓++	✓	✓	✓	✓	✓	✓++		✓	✓			✓
N				✓			✓++		✓++			✓		
O							✓		✓	✓	✓	✓	✓	✓
P				✓++		✓++	✓					✓		
Q			✓	✓		✓++			✓++	✓	✓++	✓++		✓
R				✓		✓	✓		✓		✓++	✓		
S				✓										
T			✓				✓++			✓	✓++		✓++	✓++

*This table represents all children in residential care in the subject state, N = 1,174 over a 2 year period.
The report shows the effectiveness of residential treatment providers in achieving improvements in children's behavioral health issues; the same analysis works for all types of placements and providers.

KEY: Top 10% (✓++)
Above average (✓)

Traditional foster care and kinship support are ***critical service areas*** needing significant new investments, and can prevent the need for higher cost services

- When caseworker vacancies are a problem, staff who recruit, develop and license foster families, and staff used to undertake family search and engagement (or caseworker time to do so) is inevitably sacrificed to deal with the front door.
- Staff to recruit, develop and license foster family homes, especially targeting the kids entering care (teens) must be specialized and protected to assure the function is undertaken well. (Teen family homes are found through targeted recruitment methods, not advertising campaigns or partnerships with businesses.)
- Additional staff or contract funds may be needed to support foster families and kin caregivers when they need help –
  - 24/7 help in crisis situations
  - help with behavioral issues.
- Staff to undertake family search and engagement, when reunification is not an option should be available. They can get teens out of care and back to living with family. (DCYF does a great job of kinship placements for younger kids, but not for teens.)
- Foster family stipend rates may need to be increased.

A national study completed in 2007 established Minimum Adequate Rates for Children (MARC) in Foster Care (Have you increased foster family rates since then?)

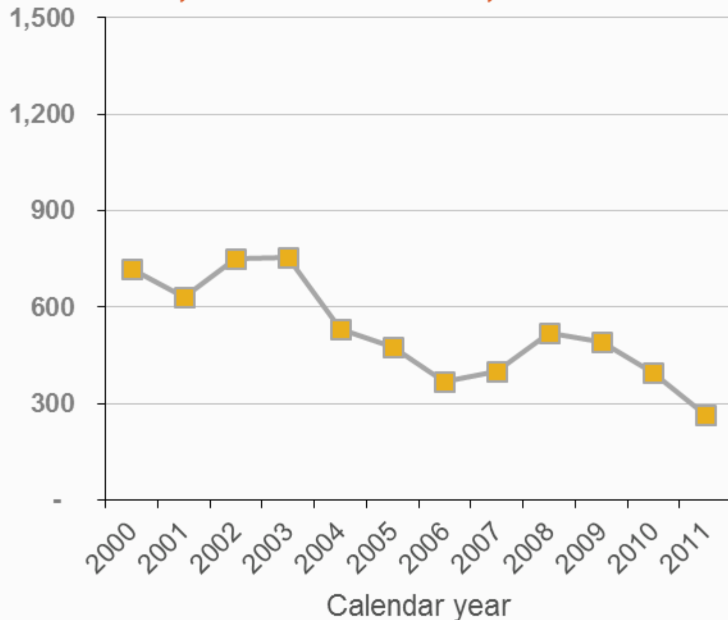
	In 2007, to hit the MARC, rates needed to increase by:		
	Age 2	Age 9	Age 16
National Average	**29%**	**41%**	**39%**
Connecticut	0%	13%	14%
Massachusetts	56%	65%	56%
Maine	25%	36%	40%
New Hampshire	80%	89%	76%
Rhode Island	**65%**	**99%**	**89%**
Vermont	48%	53%	52%

Hitting the Marc: Establishing Foster Care Minimum Adequate Rates for Children. Children's Rights, National Foster Parent Association, University of Maryland School of Social Work, 2007. The reports establishes Foster Care Minimum Adequate Rates for Children (the "Foster Care MARC") based on an analysis of the real costs of providing care, including the cost of providing food, clothing, shelter, daily supervision, school supplies, personal incidentals, insurance and travel for visitation with a child's biological family. It was calculated by analyzing consumer expenditure data reflecting the costs of caring for a child; identifying and accounting for additional costs particular to children in foster care; and applying a geographic cost-of-living adjustment, in order to develop specific rates for each of the 50 states and the District of Columbia. It includes adequate funds to meet a child's basic physical needs and cover the costs of "normalizing" childhood activities, such as after-school sports and arts programs, which are particularly important for children who have been traumatized or isolated by their experiences of abuse and neglect and placement in foster care.

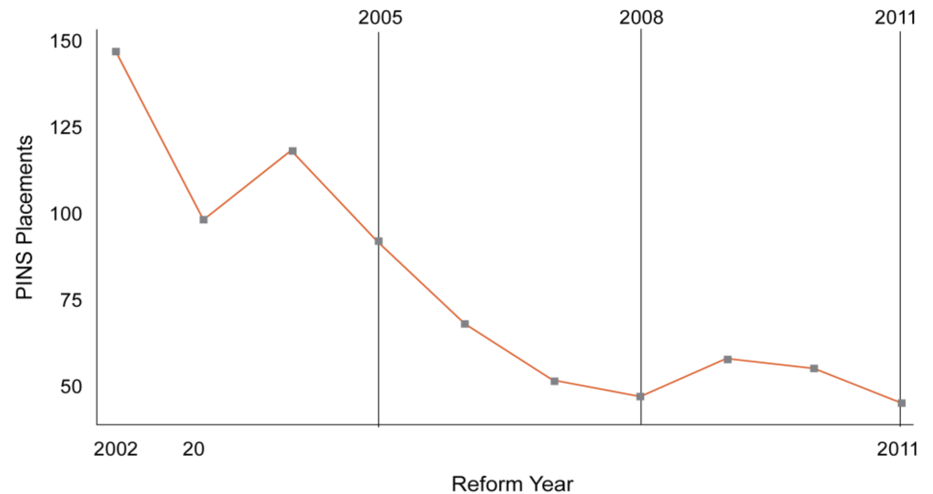
In 2011, Casey looked at promising programs to prevent family disruptions due to teen behavioral issues; reforms in New York state were noteworthy

New York City dramatically reduced placements using gatekeeping, screening and assessment and a tiered array of services, which supported help to keep families together

Erie County NY used a similar approach and also emphasized inter-agency collaboration and data analysis to manage utilization and outcomes, with a focus on providing help to parents and youth to stay together



Annual Placements to Residential Treatment of Youth with Behavior Problems



In NYC, most families received information, advocacy and referrals; of those served, only 22% required higher level, more intensive services

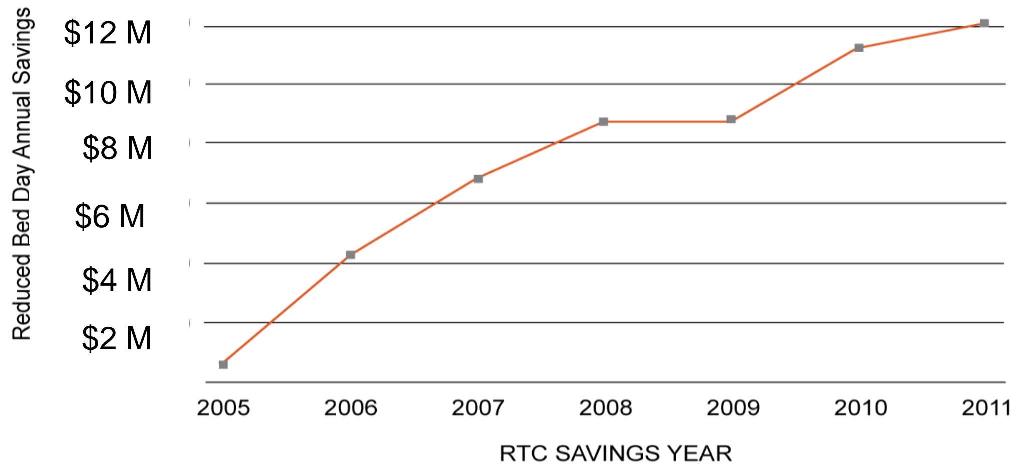
Service Type	Services Delivered in 2011	
Information and Advocacy	**2875**	**36%**
Referrals to Other Services	**2194**	**27%**
Level 1 Crisis Stabilization	801	
Level 2 Functional Family Therapy*	504	
Level 3 Multi-Systemic Therapy*	228	
Level 4 Multi-Dimensional Treatment Foster Care* (Out of home 9 – 12 months)	245	
TOTAL LEVELS 1 – 4	**1778**	**22%**
Families refused, withdrew or were being served elsewhere	1150	14%
Total families seen	**7997**	**100%**

* Evidence-based programs

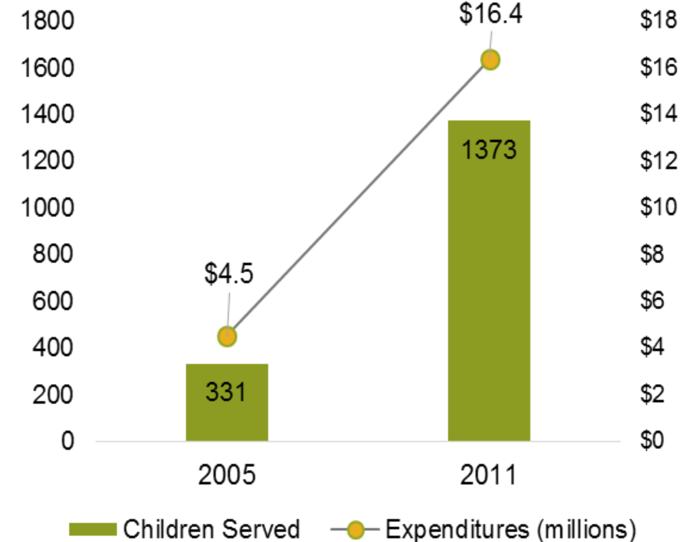
Chart compiled by authors based on data supplied by ACS FAP administration.

In Erie County, savings from placement reductions have been redirected into community-based wraparound services to help parents and youth deal with behavioral health issues at home together

By 2011, Erie County had saved almost $12 million in residential treatment costs

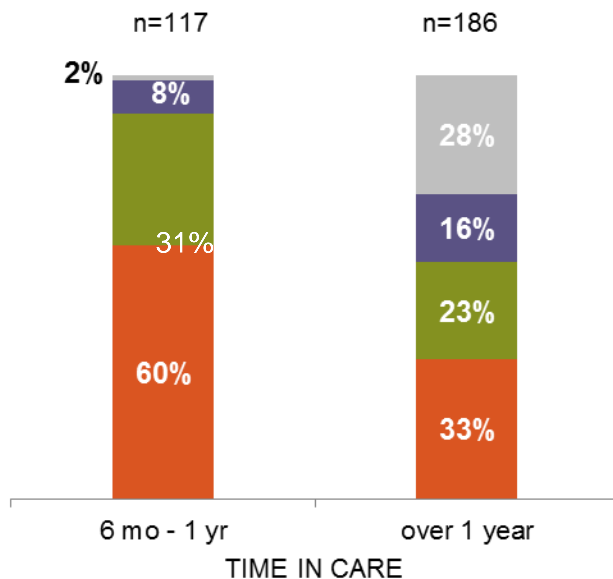


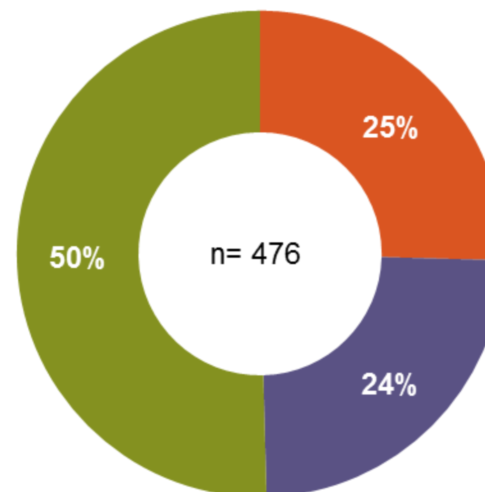
The County chose to re-invest the savings in order to serve more youth and families with early intervention services



Wraparound services for families and youth have promoted healthier family relationships and prevented the need for family disruption.

Delaware, a state very similar to Rhode Island, also had a problem related to teens with behavioral issues

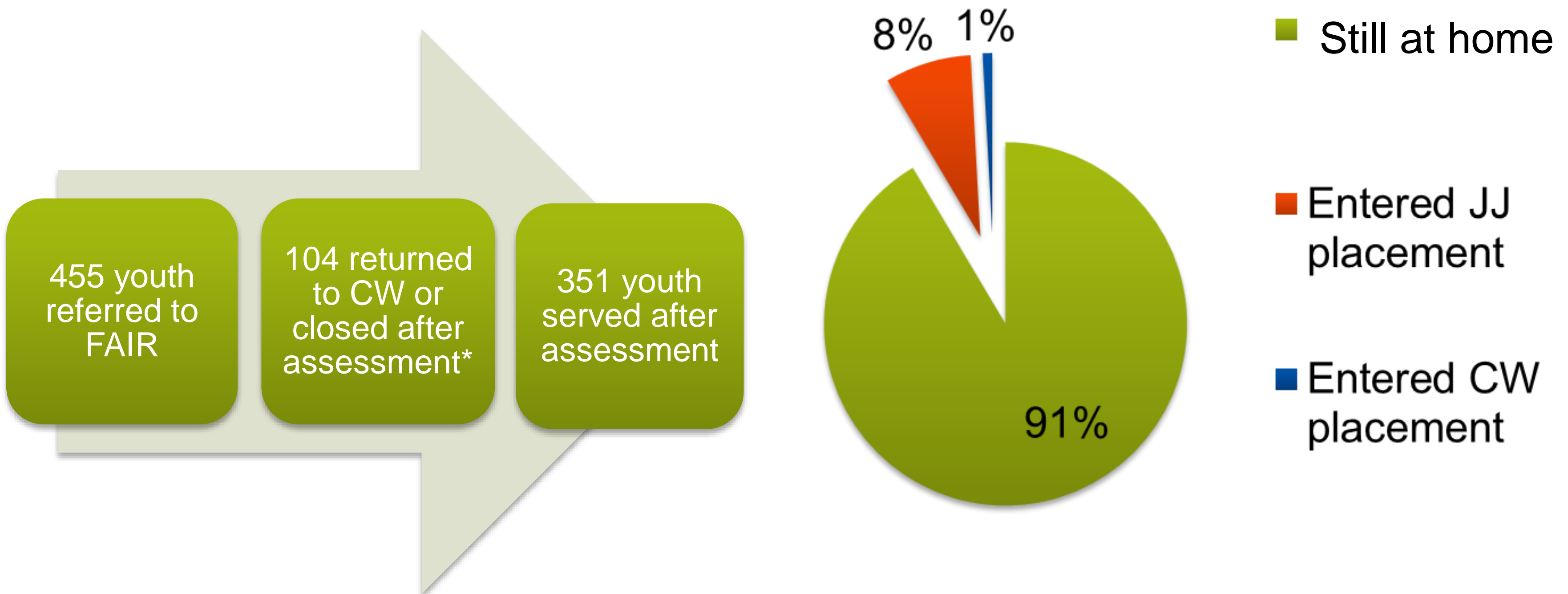




Teens experienced high rates of placement instability and institutional placements – the system was not meeting their long term developmental needs.

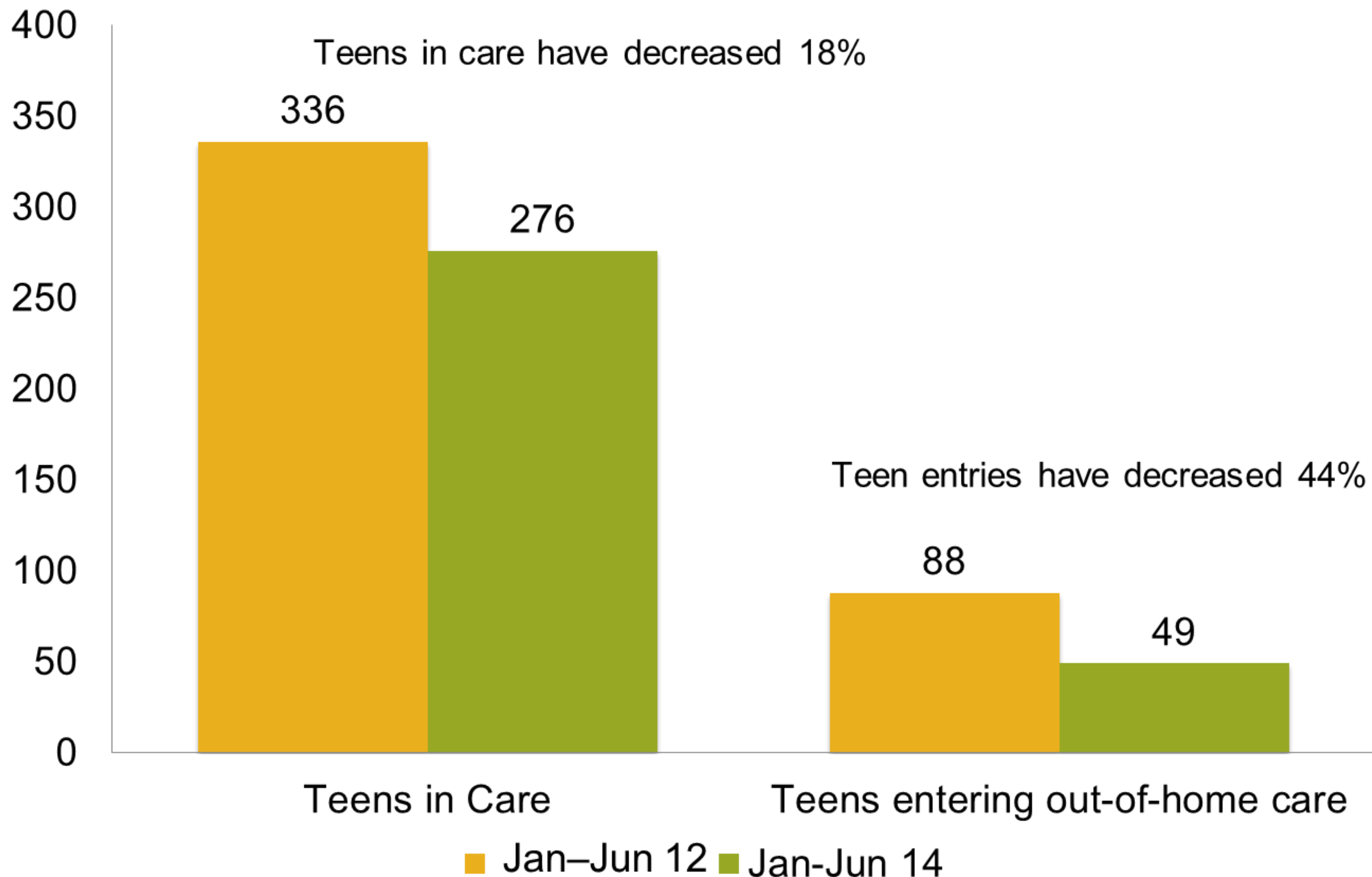
The Delaware FAIR program was launched in 2013, based on NY's experience and has had great success diverting teens from out-of-home placements

Of the 351 youth served by FAIR after assessment between 3/13 and 7/14, 91% of them have so far been diverted from out-of-home placements



*50 declined; 23 were sent back to CPS for safety issues; 31 were closed for lack of need

The success of the FAIR program has contributed to the decline in the number of teens in care and entering care, with more families able to successfully manage teen behaviors at home



Today I will report briefly on our assessment findings and respond to discussion during the previous Task Force Meetings with a national perspective

- Our assessment focused on Rhode Island's over-reliance on group placements, and found positive and innovative accomplishments toward achieving your goals given resource limitations
- Your population of teens in group care is hindering progress toward your goals, especially when compared to other jurisdictions
- There are three primary factors that impact costs in child welfare; Rhode Island may have problems with all three
- Making the transition will require attention to DCYF and to your providers

The development of alternatives to congregate care means re-tooling, and shifts in the business models of your current group care providers

Help providers shift away from their reliance on facilities

- You have a group of providers currently providing congregate care who have fixed costs, and employ staff in their communities.
- You don't want them to go out of business; you want them to shift their business models.

Help providers develop specialized residential programs

- You still have significant numbers of kids going out of state for treatment.
- When rates don't keep up with costs, providers will not/ cannot take the most difficult kids, therefore kids more likely to go out of state.
- (There will continue to be very limited need for out of state placements.)

- You need a rate setting process based on actual costs, with room to increase rates for providers to develop specialized services.
- You need a plan to close less therapeutic facilities, offering providers opportunities to re-tool.

Current circumstances inhibit the ability of your providers to reduce their commitment to congregate care

- Based on experience in other states, and the statements of providers at the first Task Force meeting:
  - Your rates do not allow the level of therapeutic interventions needed for some of the kids needing high levels of care.
  - Some of the most needy kids are sent out of state (but there will always be *some* kids out of state).
  - Your congregate care providers are serving many kids who could remain in the community, and probably keeping them longer than necessary.
  - Your congregate care providers probably do not have the capacity to shift away from residential care, without additional funding.

Assumptions about what you want to achieve:

- You want to serve kids close to home (in state);
- You want to keep your providers in business;
- You want to reduce the use of group settings;
- You want to keep families together when possible or serve kids in the most family-like settings.

What would I do in your shoes…
(But each will require more resources or a shift in resource allocation)

Assessment

- Install the TOP assessment and performance management system to start to understand what kids need, what's working, and who's doing a good job at meeting those needs.

Caseloads

- Get DCYF caseloads down to reasonable levels, by making sure vacancies are filled, even if it requires overfilling slots.

Foster and kinship families

- Invest in and protect staff for foster family recruitment, development and licensing, especially focused on teens.
- Increase investment in foster and kinship family support.

Provider services

- Develop a program to divert teens with behavior problems from placement (like Delaware).
- Develop a rate setting process with residential providers to understand current funding situation.
- Work with residential providers to decide which have capacity to take more difficult kids and which should close. Work with both groups to shift their business models, which would include rate increases, or funds to shift to community-based services.

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