PHASE 9
FLORIDA TITLE IV-E WAIVER DEMONSTRATION EVALUATION FINAL REPORT
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Executive Summary

Background

On October 1, 2006 Florida was granted a Waiver to certain provisions of Title IV-E of the Social Security Act of 1935. The Waiver allowed the state to use certain federal funds more flexibly, for services other than room and board expenses for children served in out-of-home care. The Florida Title IV-E Waiver was granted as a Demonstration project, and required the State to agree to a number of Terms and Conditions, including an evaluation of the effectiveness of the Demonstration. The Terms and Conditions explicitly state three goals of the Demonstration project:

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

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

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

The Terms and Conditions of the Demonstration extension require a process, outcome, and cost analyses. Primary data was collected via interviews and focus groups with the Department of Children and Families (DCF), Community-Based Care (CBC) lead agencies, case management organization (CMO) leadership, case managers, and child protective investigators (CPI) and supervisors. Secondary data analysis was performed with extracts from the Florida Safe Families Network (FSFN), Florida's Continuous Quality Improvement - Child and Family Services Reviews (CFSR), DCF Office of Revenue Management, Medicaid, Statewide Medicaid Managed Care (SMMC) program, the Substance Abuse and Mental Health Information System (SAMHIS), and the Department of Juvenile Justice (DJJ).

Findings

Implementation analysis. The primary goal of the implementation analysis was to describe implementation of the Demonstration Project, to track changes, and to identify lessons learned. Interview data were gathered from child welfare stakeholders in Florida from January of 2015 through March of 2019. The interviews were coded using a qualitative data analysis software (Atlas.ti 6.2), and an interrater reliability process was completed by evaluation team members at each phase of the evaluation.

The implementation analysis findings from stakeholder interviews showed that the goals of the Demonstration have been supported throughout the child welfare system in Florida. Each stakeholder described an increase in the types of services available for families. Stakeholders also described the increased focus on keeping children safely in the home. Although there were still challenges reported that affected child welfare work. Common challenges described were turnover among case managers and CPIs, increases in out-of-home care, lack of housing resources, and a lack of substance abuse and mental health services. Participants reported that the need for mental health and substance abuse services was increasing. Participants perceived the increases were due to increases in opioid use and increased recognition of mental health concerns through the assessment process implemented by the child welfare practice model. Poverty, lack of housing, generational DCF involvement, and a negative perception of DCF were reported barriers for child welfare involved families across stakeholder groups.

Services and practice analysis. The purpose of the services and practice analysis was to assess progress in expanding the service array under the Demonstration extension. This includes implementation of evidence-based practices and programs, changes in practice to improve processes for identification of child and family needs, connections to appropriate services, and enhanced use of in-home services to increase successful family preservation and reunification. A service array survey, an evidence-based practice (EBP) survey (Wraparound and Nurturing Parenting), follow-up interviews regarding the two evidence-based practices, and focus groups with case managers and CPIs were conducted by evaluation team members.

Findings related to the service array identified a variety of services provided throughout the state. A significant strength identified through the evaluation was that there is a wide array of evidence-based practices that have been implemented in various parts of the state. Although service utilization data are limited due to a combination of poor survey response rates and lack of tracking mechanisms among lead agencies, the data that were made available to the evaluation provided a partial picture. The data were most complete with regard to family

support services and safety management services, and indicate that lead agencies provided a variety of services to prevent families from formally entering the child welfare system and to help children remain safely in their home. Expansion of these services has been one of the primary focuses under the Demonstration extension.

Two rounds of focus groups were conducted with case managers and CPIs regarding current child welfare practice. Findings from the focus groups revealed a number of strengths and challenges that relate to the Demonstration. One important strength was that the majority of caseworkers valued family preservation and believed in the concept of keeping children in the home. These values remained consistent over time and place caseworkers in alignment with the goals of the Demonstration. However, caseworkers expressed substantial concerns about ensuring child safety when children remain in the home. While these concerns persisted over time, there appeared to be increased support among respondents for the use of in-home approaches and increased confidence in safety planning in the second round of focus groups.

Permanency, safety, and resource families outcome study. Several key outcomes related to child safety, timely permanency, and well-being were hypothesized to improve over time and were assessed in the outcomes study. Permanency outcomes examined included the proportion of children who achieved permanency within 12 months of removal, the proportion of children who were either reunified or placed with relatives within 12 months of removal, and the proportion of children with finalized adoptions. Safety outcomes examined were the proportion of children who did not re-enter out-of-home care within 12 months of their most recent discharge from out-of-home care and the proportion of all children who did not experience maltreatment within six months of case closure. Resource family outcomes that were examined were the number and proportion of licensed foster families that were active at the end of a specific fiscal year and have remained in an active status for at least 12 months and the proportion of newly recruited licensed foster families during a specific fiscal year.

Overall, longitudinal trends for permanency indicators revealed a steady trend. There is a trend of a declining proportion of children who achieved timely permanency including reunification; the adoption rates remained high and steady over time. An examination of safety indicators showed that the proportion of children who continue to stay safe remained stable over time. Re-entry into out-of-home care remained stable over time and approximately 91% of children did not re-enter out-of-home care across the Demonstration extension years. When the effects of child and family characteristics on outcome indicators were examined, results showed that child age, physical health and behavioral problems, parental substance abuse, and history of domestic violence played an important role in predicting child outcomes. Findings also

indicated considerable variability over time in the proportions of licensed foster families that were active after 12 months and the proportion of newly licensed foster families. Examination of statewide rates over time suggested that proportion of licensed foster families that were active after 12 months and the proportion of newly licensed foster families remained stable.

Child and family well-being outcome study. The constructs of child and family well-being have been examined according to the applicable CFSR outcomes and performance items. The outcomes and performance items focus on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, mental health needs. The hypothesis of the child and family well-being outcome analysis was that there would be an improvement in the physical, mental health, developmental, and educational well-being outcomes for children and their families. CFSR outcomes and performance items were examined over time. At the state-level for both in-home and foster care cases from baseline (data pulled from the FL CQI case reviews online system on September 30, 2016) to final ongoing review (data pulled from the FL CQI case reviews online system on October 01, 2018) period the changes were not statistically significant. For in-home cases Circuits 8 (Alachua, Baker, Bradford, Gilchrist, Levy, and Union Counties) and 19 (Indian River, Martin, Okeechobee, and St. Lucie Counties) showed improvements over time across most performance and well-being outcome items. Circuit 5 (Citrus, Hernando, Lake, Marion, and Sumter Counites) showed declines over time across most performance and well-being outcome items. For foster care cases, Circuit 3 (Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, and Taylor Counties) showed improvements over time across most performance and well-being outcome items. Circuit 5, 11 (Miami-Dade County), and 12 (Desoto, Manatee, and Sarasota Counties) showed declines over time across most performance and well-being outcome items.

Cost study. The cost analysis was divided into two sections. First, the cost analysis examined whether the Demonstration implementation was associated with changes in the use of child welfare funding sources. Findings indicated that front-end prevention services (family support services) increased during the initial Demonstration and the Demonstration extension. The number of children in out-of-home care was lower in the initial Demonstration and Demonstration extension compared to the pre-Demonstration period. Consistent with one of the goals of the Demonstration, the ratio of expenditures for licensed foster care to expenditures for front-end prevention services has trended downward over time. There was a minimal relationship between changes in spending patterns and changes in outcomes. Only the rate of abuse in foster care appeared to have a relationship with spending patterns. The 13 circuits

that shifted resources from out-of-home care had lower average maltreatment rates while the child was in foster care compared to the 7 circuits that increased the share of expenditures spent on out-of-home services.

The cost study also examined child-level cost data reported by lead agencies through the Florida Safe Families Network (FSFN). Findings indicated that children with high cost cases require a disproportionate share of resources. Overall, children with high cost cases tend to be older, Black, more likely to be a victim of sexual abuse and/or neglect, with parents that were more likely to abandon the child or be unable to provide care. However, parental substance abuse or domestic violence in the household was less common. Such children were more likely to have very severe behavioral problems. Children that had high child welfare costs also tended to have high Medicaid costs.

Sub-study one: cross-system services and costs. A sub-study specific to the cost analysis was divided into three sections. The first section analyzed Medicaid enrollment and claims/encounter data for children who received out-of-home services, as well as, services funded through State Substance Abuse and Mental Health (SAMH) funding sources. The second section examined Medicaid and SAMH funded services for children receiving in-home child welfare services. Finally, the third section examined three questions related to predicting health care needs, determinants of permanency, and determinants of child juvenile justice placements and involuntary examinations.

A number of interesting results emerged from section one. The vast majority of youth that were enrolled in the Medicaid program after removal from the home were also enrolled prior to removal. However, service penetration was much higher after removal from the home. The pattern of service use also differed before and after removal. Physical health inpatient services were more common before removal. Behavioral health outpatient services were much more common after removal from the home.

Findings from section two suggested that the majority of children who receive in-home child welfare services are Medicaid enrolled and used Medicaid-funded services. SAMH was not a substantive funding source for these children. More children used Medicaid funded services after in-home child welfare services began, although use declined over the duration of in-home child welfare services. Medicaid-funded service use was not associated with the reason for in-home child welfare services.

Factors associated with higher unmet need for children and youth receiving out-of-home child welfare services were examined in section three. Unmet need was estimated based on the relationship between characteristics measured prior to removal and the health care service

use after removal. Service use prior to removal was associated with service use after removal. However, when controlling for service use prior to removal, a number of factors were associated with expenditures in the year after removal. Mental health disorders were associated with higher unmet need, as were several less common physical health diagnostic groups. Victims of sexual abuse, physical abuse, and/or medical neglect also had greater unmet need when entering out-of-home care. Children and youth with physical or behavioral health problems were less likely to achieve permanency. Children and youth with physical health needs were more likely to be adopted and youth with behavioral health needs were less likely to be adopted. Reunification was less likely when the child or youth had substantial physical health needs, and was less likely when the youth had behavioral health needs although the results were not as clear as some measures of need were not significantly associated with reunification. Guardianship was less likely when the child or youth had physical or behavioral health inpatient use. Guardianship was also less likely when the child or youth had behavioral health needs addressed through outpatient services. Children and youth who had behavioral health outpatient use in the prior year but not in the year after removal were more likely to be reunified. Findings indicated that caregiver loss and presence of mental health disorders predicted undesirable outcomes, such as greater number of out-of-home placements and placement in a correctional facility.

Sub-study two: Safe at Home and at High Risk for Future Maltreatment – Services and Practice Analysis/Outcome Analysis. To ensure that children whose safety is at risk are correctly identified and that their families receive the proper services, the Florida Department of Children and Families (DCF) implemented the Florida child welfare practice model. The child welfare practice model dictates that all families whose children are assessed as safe but at high or very-high risk for future maltreatment are to be offered voluntary family support services that target the building of family protective factors to improve the long-term safety of children in the home. This sub-study examined child welfare practice, services, and safety outcomes for families who received family support services. A matched comparison group was used to assess whether outcomes were improved for children whose families received family support service interventions.

Overall, findings indicated that children in the intervention group (i.e., who were assessed using the new child welfare practice model) had better outcomes compared to children in the comparison group (i.e., those who were assessed using standard practice). Specifically, children in the intervention group had a lower rate of recurrence of maltreatment, lower rate on entry in out-of-home care, and lower re-entry rate.

Findings from the services and practice analysis indicated that families who received voluntary family support services were connected to a variety of services and supports to address their needs and build their protective factors. Strengths of family support services identified during focus groups with providers were that these programs provided families with much needed services, allowed for supervision within the home, gave families an outlet to discuss and address stressors, and increased awareness of resources in the community and how to access them. In several focus groups, participants described low rates of subsequent abuse or maltreatment reports as evidence of their programs' successes. Several participants described the use of family support services as an improvement upon previous voluntary services, and also emphasized a focus on providing quality services, rather than focusing on the quantity of services.

Policy Implications and Recommendations

1. Advocate for an increase in funding for frontline staff and support staff for frontline workers. This refers to both salary increases and an increase in funding to hire more staff
2. Develop funding strategies to fill current service gaps at the community-level (particularly safety management services, affordable housing, childcare, and substance abuse treatment) and expand the availability of providers who offer in-home services
3. Reinforce requirements for CBC lead agencies and their contracted providers to measure and track fidelity to evidence-based practices and programs that they are using
4. Ensure that CBC contracts with service providers include language requiring the evaluation and demonstration of service effectiveness and requirements for assessing and reporting client outcomes to the child welfare agency/case manager
5. Reinforce standardized processes and expectations for collaborative casework between CPIs and case managers that are in place, such as joint home visits and family assessments during the transition from investigation to case management
6. Engage CBC lead agencies identified in the evaluation that have developed and implemented effective in-home service programs and approaches to provide mentoring and implementation assistance to other lead agencies
7. Expand funding for family support services so that low and moderate risk families can also participate (some but not all lead agencies have done this; requires expanded funding)
8. Utilize models (such as the model developed in Sub-study One of this evaluation) that can predict which children and youth will have the greatest unmet need in order to help

triage children and youth such that youth with the highest anticipated need can be connected to needed services promptly

9. There is a need for increased efforts to provide outpatient mental health services and especially underscore the need for regular comprehensive mental health assessments that include evaluation of the type and the quantity of mental health services needed for the child

Introduction and Overview

The Florida Department of Children and Families (the Department or DCF) contracted with the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF) to develop and conduct an evaluation of Florida's Demonstration extension. The Demonstration allowed for flexibility in the use of federal IV-E funds granted to the state's child welfare agencies. The flexibility in funds allowed child welfare agencies to develop and implement innovative programs that emphasize parental involvement and family connections while ensuring the safety and well-being of children.

Background and Context

The Demonstration was implemented in an effort to decrease the number of children placed into out-of-home care and to reduce the length of stay for children in out-of-home care. The increased flexibility in funds through the Demonstration allowed child welfare agencies to develop and implement innovative programs that emphasize parental involvement and family connections while ensuring the safety and well-being of children. The Demonstration extension was implemented to build on the lessons learned and progress made in Florida's child welfare system of care during the initial Demonstration period.

The context for Florida's Demonstration extension included the implementation of Florida's Child Welfare Practice Model (child welfare practice model), which provides a set of core constructs for determining when children are unsafe, the risk of subsequent harm to the child, and strategies to engage caregivers in achieving behavior change. Child protective investigators (CPIs), child welfare case managers, and community-based providers of substance abuse, mental health, and domestic violence services share these core constructs. The goal was that implementation of the child welfare practice model supported decision making of CPIs, child welfare case managers, and their supervisors in assessing safety, risk of harm, and strategies to engage caregivers in enhancing their protective capacities, including the appropriate selection and implementation of community-based services. Other key contextual factors for the Demonstration include the role of Community-Based Care (CBC) lead agencies as key partners. CBC lead agencies are organized in geographic Circuits, and they provide foster care and related child welfare system services within those circuits.

It was expected that the Demonstration extension would continue to result in the flexibility of IV-E funds. The flexibility allowed for these funds to be allocated toward services to prevent or shorten the length of child placements into out-of-home care, prevent abuse, and prevent re-abuse. Consistent with the CBC model, the flexibility of the Demonstration has been used differently by each lead agency, based on the unique needs of each community. The

Department has developed a typology of Florida's child welfare service array that categorizes services into four domains: family support services, safety management services, treatment services, and child well-being services. The typology provides definitions and objectives for the four domains as well as guidance regarding the conditions when services are voluntary versus when services are mandated and non-negotiable.

Purpose of the Demonstration

The purpose and goals of the Demonstration extension were to:

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

Over the life of the Demonstration extension, it was expected that fewer children would need to enter out-of-home care and stays in out-of-home care would be shorter, resulting in fewer total days in out-of-home care. Costs associated with out-of-home care were expected to decrease following implementation of the extension, while costs associated with in-home services and prevention would increase, although no new dollars will be spent as a result of the extension implementation.

Target Populations

Florida's Demonstration did not contain the measurement of a Demonstration group and a control/comparison group. Rather, the measurement of success used the comparison of child and family outcomes at periods before and throughout the Demonstration extension period, as well as maintaining cost neutrality over the five years with a capped allocation of Title IV-E foster care funds. Children and families benefited from a wide array of services and resources as a result of the Demonstration. Restrictions were removed that prevented a child and his/her family from receiving critical services in the home, and they were replaced with the flexibility to provide targeted in-home services where it is possible to do so and still maintain child safety. Florida's Demonstration served all children already known to the child protection system, as well as new cases reported for alleged maltreatment throughout the life of the project.

The Evaluation Framework

Logic Model

Florida's Demonstration extension was guided by a theory of change. The theory of change is based on federal and state expectations of the intended outcomes of the Demonstration, and the hypotheses about practice changes developed from knowledge of the

unique child welfare service arrangements throughout the state (see Figure 1 for logic model and Figure 2 for the theory of change). No changes were made to the logic model and theory of change, they remained as they were originally conceived.

Figure 1. Florida Child Welfare IV-E Waiver Logic Model

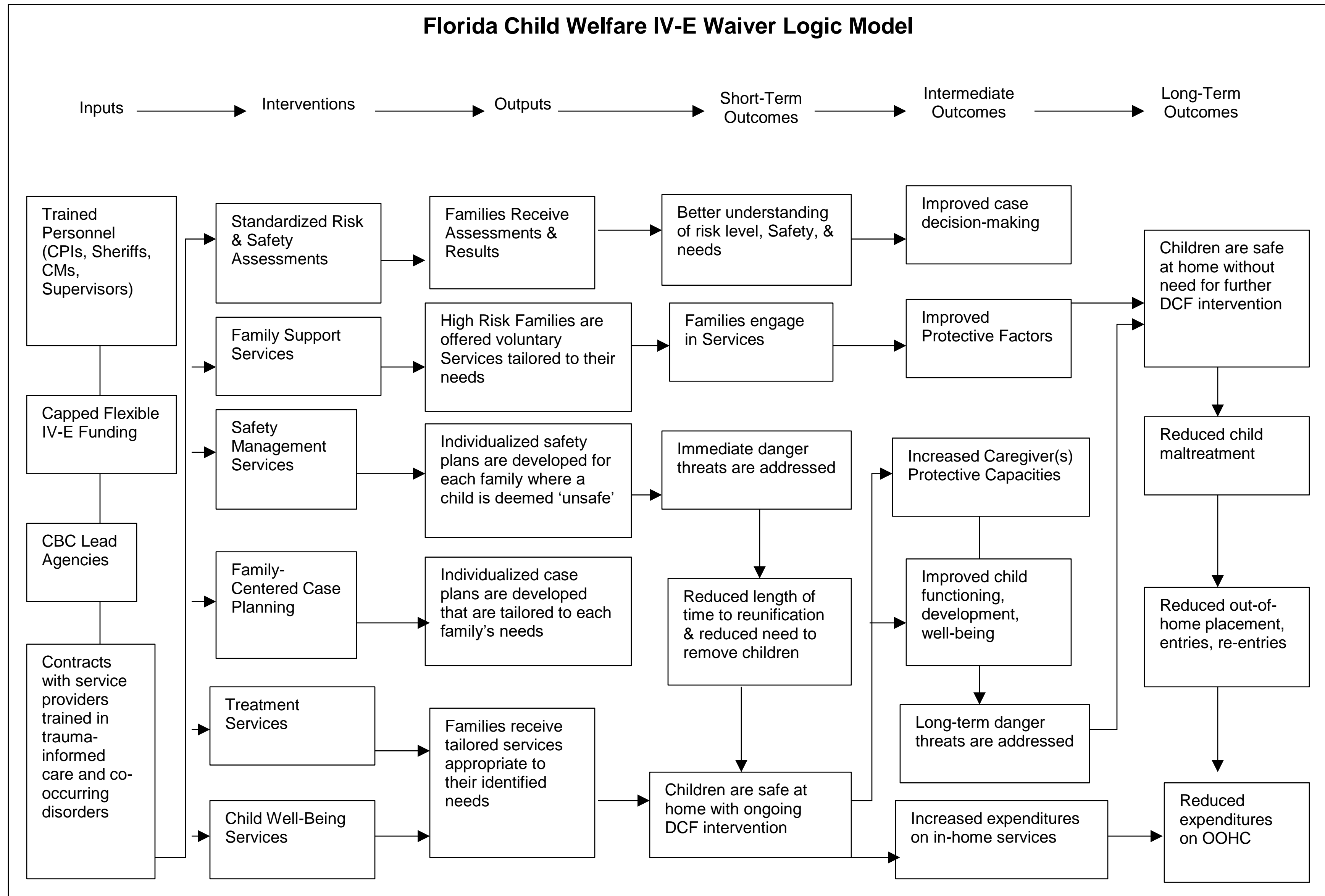


Figure 2. Florida Theory of Change

IV-E Waiver Global Outcome Chain

Child welfare caseworkers (e.g. CPIs and case managers) implement family-centered practice and family engagement strategies

AND

Caseworkers utilize standardized Risk and Safety Assessments for all cases that are investigated

AND

A broad array of community-based child welfare services is available to children and their families through the flexible use of Title IV-E funds

AND

Communication and coordination among caseworkers (CPI and/or case managers), service providers, courts, families, and any other key stakeholders to the case occurs

SO THAT

Child and family needs are identified and appropriate services are offered/provided to address those needs

SO THAT

Families receive effective services and interventions for their individualized needs

SO THAT

Children's physical, mental, behavioral, and educational needs are met and children show improved well-being

AND

Caregivers increase their protective capacities and protective factors to eliminate danger threats to their children

SO THAT

Children can be reunified in a timely manner (<12 months) and/or remain safely at home with their caregiver(s) without ongoing intervention by DCF

AND

There are no subsequent occurrences of child maltreatment within the family

SO THAT

Over time there is a reduction in entries and re-entries into OOH care and an increase in families receiving in-home services

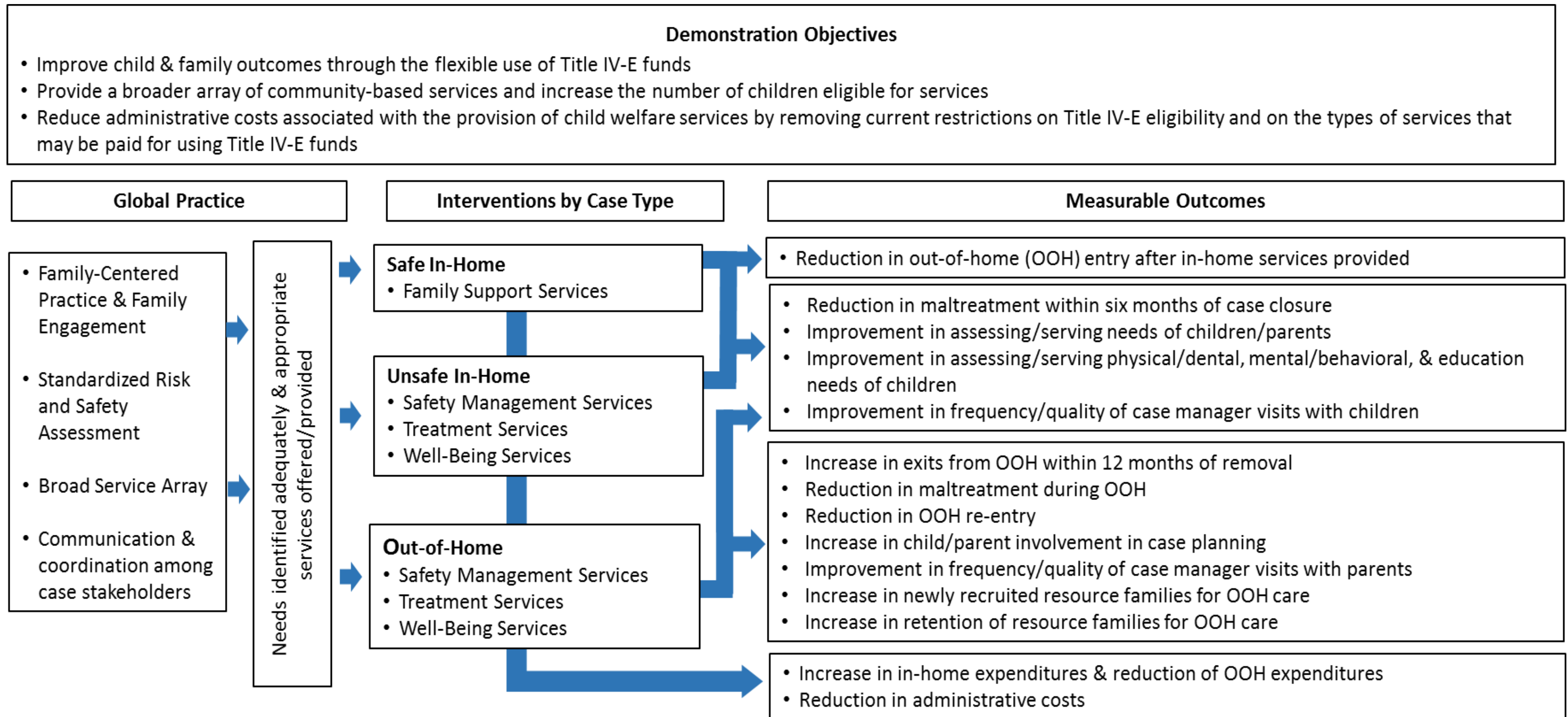
AND

Administrative costs and expenditures associated with OOH care are reduced.

Overview of the Evaluation

The evaluation is comprised of four related components: (a) a process analysis comprised of an implementation analysis and a services and practice analysis, (b) an outcome analysis, (c) a cost analysis, and (d) two sub-studies. USF constructed an evaluation plan for the Demonstration extension period and developed an evaluation specific logic model (Figure 3). The Evaluation Logic Model displays an overview of the Demonstration objectives and how the implementation of Florida's practice model can yield measurable outcomes for the Demonstration project. The four components of the evaluation and the two sub-studies are described below including key questions, data sources and data collection, and data analysis plans. The evaluation methodology consisted of the comparison of child and family outcomes at periods before and throughout the Demonstration extension.

Figure 3. IV-E Demonstration Project Evaluation Logic Model



Definitions:

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

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

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

Data Sources and Data Collection Methods

The process analysis collected data through document reviews, stakeholder interviews, and focus groups. A mixed methods approach was utilized to conduct the services and practice analysis to draw together data from multiple sources and triangulate findings. Surveys, document reviews, interviews, and focus groups were data collection methods utilized for the services and practice analysis. The data sources for the outcomes analysis were data abstracts taken from the Florida Safe Families Network (FSFN), and data from the Federal Onsite Review Instrument (OSRI) and Online Monitoring System (OMS). Data for the cost analysis was derived from DCF Office of Revenue Management and FSFN. Data for sub-study one was derived from Medicaid, Statewide Medicaid Managed Care (SMMC) program, the Substance Abuse and Mental Health Information System (SAMHIS), and the Department of Juvenile Justice (DJJ). Data for sub-study two were derived from FSFN, case file reviews from Eckerd Connects in Circuit 6 (Pasco and Pinellas counties), and focus groups with family support service providers.

Data Analysis

Process analysis. Qualitative data analyses was performed to assess differences in implementation and organizational capacities during implementation of the initial Demonstration project and the Demonstration extension. Qualitative data was transcribed and analyzed with ATLAS.ti, a computer software program. The analysis classified responses into themes that comprehensively represent all participants' responses to every question. Themes were based on topics covered in the interview protocol. Direct quotations, used in reports or other communications, were edited for clarity and to remove identifying information. Quantitative data was exported to SPSS statistical analysis software program for analysis, which will include descriptive statistics and, when appropriate, comparative analyses will also be performed.

Outcomes analysis. Statistical analyses consisted of life tables (a type of event history or survival analysis[1]), Cox regression analyses (Cox, 1972)[2]. All analyses were conducted using SPSS software. For the child well-being analysis a Wilcoxon matched-pairs signed-rank test was used to assess for significant differences between baseline data and that obtained through ongoing review. This is a non-parametric statistic used to compare ratings when the samples are not independent. This was the most appropriate test because ongoing review

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

[2] A type of event history analysis that allows for inclusion of predictor variables or factors that were hypothesized to affect the outcomes.

ratings include data reported at baseline. Significant differences are only assessed for statewide ratings.

Cost analysis. FSFN data was utilized for the cost analysis for information on child age, race, and gender, as well as substance abuse for parent or child, domestic violence, reasons for removal, and other household characteristics. In addition, there was information on child outcomes (reunification, guardianship, adoption, remained in out-of-home care, or aged out of the child welfare system). Child level data were available from SFY 13-14 through SFY 16-17. The data included child identifiers, fiscal agency (typically the lead agency), service batch, service type, and payment. Medicaid claims and encounter data utilized included all fee-for-service claims and encounters from the Statewide Medicaid Managed Care (SMMC) program. The Substance Abuse and Mental Health Information System (SAMHIS) provided data for substance abuse and mental health services paid through the state's SAMH program.

Sub-Study 1: Cross-System Services and Costs. The sub study analysis examined trends in service use and costs for youth served by the child welfare system and other state systems. A cohort analysis was conducted following youth who entered the child welfare system at different points in time to examine how services, costs, and outcomes in other public-sector systems varied depending on whether the youth entered the child welfare system before or after implementation of the Demonstration extension. This sub study utilized FSFN data, Medicaid data, Department of Juvenile Justice (DJJ) data, and Baker Act data.

Sub-Study 2: Safe at Home and at High Risk for Future Maltreatment – Services and Practice Analysis/Outcome Analysis. This sub-study examined and compared child welfare practice, services, and several safety outcomes for two groups of children. The first group was children who were deemed safe to remain at home, yet were at a high or very high risk of future maltreatment in accordance with the child welfare practice model (intervention group) and were offered voluntary Family Support Services. The second group was a matched comparison group of similar cases during the two federal fiscal years immediately preceding the Demonstration extension (FFYs 11-12, 12-13), where the children remained in the home and families were offered voluntary prevention services. Voluntary services are/were offered to all families in both groups.

Limitations

Process analysis. One primary limitation existed with the implementation analysis data, interview data is largely based on each interviewee's perceptions of key issues. A number of challenges were encountered that significantly impacted data collection for the Service Array Survey. Several CBCs expressed feeling overly burdened by the survey request, due to a

coinciding DCF service assessment. Although the data requested through this survey was different from the data collected through the DCF assessment, there was a perception that the effort was duplicative. This may have contributed to the low response rate. Furthermore, some of the data requested, such as number of families referred to a service type (family support, safety management, treatment, and child well-being services) and number of families who received the service, were difficult for CBCs to provide because these data are not currently entered into FSFN or another administrative data system. Thus, the amount of effort required to gather the requested data was extremely burdensome, and in some cases, CBCs were unable to provide the requested data.

Outcomes study. It is important to note a few limitations in conducting the outcome analysis. First, the study design did not include a comparison group (e.g., counties where the extension of the Demonstration project was not implemented) because the Demonstration was implemented statewide. Because a comparison group was not available, longitudinal comparison was performed using entry or exit cohorts and no time by group interaction was examined. Second, this study was limited to measures of lead agency performance that relate to selected child permanency and safety outcomes. Finally, the findings do not account for the effects of child or family socio-demographic characteristics or any of the lead agency or Circuit characteristics.

Cost study. The primary limitation to the analysis is the relatively straightforward research design. Because the Demonstration was implemented statewide, a randomized or quasi-experimental research design could not be used to assess the impact of the Demonstration on costs. Instead, the primary methods utilized analysis of trends over time to determine whether the Demonstration is associated with expected changes. No causal relationships can be determined using such an approach.

Sub study one. The secondary data analysis design implicitly holds several limitations. First, administrative data are likely to be imperfect. Second, while the focus of the analysis of expenditures was on how parents can limit health care, all youth in the child welfare system are enrolled in a Medicaid managed care plan that has its own gatekeeping protocols. In addition, youth could have switched Medicaid managed care plans when removed from the home, and thus changes in service use may reflect differences in service authorizations across plans. It would be difficult to disentangle the parental and managed care gatekeeping effects. Third, the analysis of permanency outcomes measured health status based on the use of health care services. As a result, the measure of health status is imperfect and subject to some degree of error. However, the overall prevalence rates using this method are consistent with prior

research. In addition, the use of physical, dental, and behavioral health services is also a well-being outcome, and not solely an input to the process. Finally, the analysis of placements examines services after entering out-of-home care. There is the potential for reverse causation (i.e., the number of placements may influence the number of services received). In addition, the number of placements is only a proxy for the child's trajectory.

Sub-study two. One of the primary limitations of this research was the quasi-experimental design. Cases were not randomly assigned to the intervention or comparison groups. Hence, there may have been other characteristics of these cases that contributed to the differences in outcomes. Second, the intervention was conducted in different environments (i.e., different counties, different lead agencies). Thus, it was not possible to disentangle effects due the intervention from those due to the local factors. Finally, only safety outcomes were examined.

Another limitation concerns the case file reviews. Originally, the intent was to compare a set of cases that received family support services under the child welfare practice model (intervention group) with a set of cases that received voluntary services prior to the implementation of the child welfare practice model (comparison group) to examine the impact that these practice changes have had on family engagement, service provision, and participation in voluntary services. There were some unexpected challenges that required an alteration to this approach, in that the evaluation team was unable to draw a comparison group as initially proposed.[3] As a result, the team was only able to review a set of cases that met the intervention group criteria, and therefore only a descriptive analysis of family support services under the current child welfare practice model could be provided.

Additionally, the findings presented here are limited in that they present the perspectives of family support service providers, but not the perspectives of families. The original evaluation proposal included interviewing families who received these services to gather their perceptions, and compare these with the perceptions of providers. These interviews could not be completed for this report due to delays in initiating data collection for the sub-study. However, families are currently being recruited to participate in interviews as part of the Community-based Child

[3] A comparison group was drawn using FSFN, however, the lead agency reported that they could not find the cases that matched the FSFN numbers provided. After multiple attempts to re-draw the sample with the same results, the evaluation team asked the lead agency if they could draw a sample from their files using the comparison group criteria, but the agency reported that it was unable to do so. At this point, the decision was made to abandon the inclusion of a comparison group for the case file reviews.

Abuse Prevention Evaluation mentioned previously, and their perspectives will be examined as part of this ongoing research endeavor.

Evaluation Time Frame

The evaluation activities occurred during the time periods proposed in the initial evaluation plan. The evaluation activities corresponded with the implementation of the child welfare practice model. The evaluation team and the Department of Children and Families worked together to reduce duplicative efforts and to utilize findings efficiently.

The Process Study

The process study is comprised of two related research components: an implementation analysis and a services and practice analysis. Descriptions of these components are provided below.

Implementation Analysis

The goal of the implementation analysis was to identify and describe implementation of the Demonstration extension within the domains of leadership, environment, organizational capacity, and infrastructure, Demonstration impact, and conclusions acquired throughout the process. This final evaluation report includes methods for data collection and data analysis including a coding scheme, and findings from stakeholder interviews conducted during the evaluation reporting periods of October 2013 through September 2018.

Key Research Questions

The primary goal of the implementation analysis is to describe the implementation of the extended Title IV-E Demonstration and track changes regarding the following items identified in the amended Florida Terms and Conditions document:

1. What was the planning process for the Demonstration extension?
2. Who was involved in implementation of the Demonstration extension and how were they trained?
3. What were the implementation strategies used by the lead agencies (e.g., training, coaching) and the stakeholders' perceptions of success of these strategies?
4. Were the organizational supports (e.g., leadership, organizational policies, and quality assurance activities) in place to support implementation of the Demonstration extension at the state and CBC levels? Were these resources utilized to implement an expanded service array?
5. What were the confounding social, economic, and political forces coinciding with implementation of the Demonstration extension?
6. What challenges were encountered during the Demonstration extension implementation and how were they overcome?

Data Sources and Data Collection

The data sources for the implementation analysis include semi-structured stakeholder interviews and focus groups in order to assess the contextual factors that may enhance or impede the implementation of the Demonstration (see Appendix A for interview protocols). Each interview was conducted with one to five stakeholders present, depending on participants' availability. The interviews and focus groups focused on implementation strategies, supports,

and resources that have been utilized, contextual and environmental factors, and factors that were relevant to the current child welfare system in Florida.

Members of the Demonstration evaluation team at the University of South Florida conducted the stakeholder interviews. The interviews were audio-recorded with the permission of the participants. Audio files were uploaded to a secure, shared site and files were then transcribed. The same project team members who conducted the interviews completed the coding and data analysis. All participants provided fully informed consent according to University Institutional Review Board policy (see Appendix B for informed consent document).

Sample

Interviews and focus groups were conducted in-person or via telephone with relevant stakeholders at Community-Based Care lead agencies (CBCs), Case Management Organizations (CMOs), the Department, with Judges and Magistrates, and with Child Protective Investigator (CPI) Supervisors over the course of the evaluation. Participant recruitment was conducted via email or telephone based on available information. Contact information for CBC stakeholders were obtained through a public listing of CBC CEOs in Florida, as well as, through assistance from the evaluation partners at the Department. Contact information for Judges and Magistrates were obtained through an online search of current dependency judges and magistrates. Contact information for CPI Supervisors were obtained from regional contacts with the Department provided to the evaluation team by partners at the Department. Each participant had an active role within Florida's child welfare system.

Data Analysis

Interview data were coded using overarching domains that provided a framework for conceptualizing systems change. Data was analyzed with ATLAS.ti 6.2, a qualitative analysis computer software program. Interviewee responses were classified into codes that comprehensively represent participants' responses to each question. Axial coding in ATLAS.ti 6.2 was used to group codes by domain and to see how ideas and emergent themes clustered. Selective coding was applied to pull specific examples from transcripts that were illustrative of key points (see Appendix C for code lists).

Results

CBC and DCF leadership. Twenty-two interviews were completed with participants from January of 2015 through March of 2016. Team members participated in an interrater reliability process that achieved a reliability score of 65%. There was agreement among stakeholders that since the initiation of the Demonstration in October 2006 there has been consistency over time in the vision and goal: to safely reduce the number of children in out-of-

home care. One observation was that many individuals in leadership roles at both DCF and CBCs understand and have fully supported the Demonstration's goals over time. There was also recognition of how changes in leadership and policy direction at federal, state, and local levels create new priorities and affect ongoing reforms such as Florida's Demonstration project.

Regarding environmental factors that influence the Demonstration, the most common factors noted by respondents were spikes in out-of-home care and contextual variables such as domestic violence, substance abuse, mental health, and human trafficking. Regarding the reasons for increases in out-of-home care, respondents discussed their perceptions of the role of the media in child deaths, the child welfare practice model, turnover in child protective investigators and case managers, and changes in how CPIs conduct investigations as contributing factors to the increases in out-of-home care.

Organizational capacity included infrastructure characteristics that directly supported the implementation and sustainability of the Demonstration. An organizational impact reported by stakeholders was the diversification and growth of services. The most common services mentioned were safety management, family support services, prevention services, diversion services, and in-home services. Some stakeholders also spoke to having the ability to transition to services that are evidence-based and/or specialized for target populations.

The most commonly expressed concern was continued tracking and documentation of Title IV-E eligibility; there was both confusion and frustration about this requirement. A key theme regarding the impact of the Demonstration was its impact on organizational structure. The Demonstration has become an integral part of daily operations and has helped organizationally by allowing Demonstration funds to be shifted to allow for spending in different areas such as hiring new staff and spending money on prevention and diversion programs.

Judges and magistrates. Fourteen interviews were completed with judicial participants from April of 2016 through October of 2016. Team members participated in an interrater reliability process that achieved a reliability score of 72%. Judges and magistrates interviewed saw their primary role within the child welfare system as ensuring that everyone was doing what they were supposed to be doing, from parents to case managers. Judges also sought to be active participants in local, state and national child welfare policy and practice discussions outside the courtroom.

One important finding within the implementation data was the distinction between judicial decisions and judicial processes, and whether they are impacted by the Demonstration. Respondents indicated that the Demonstration had not had an impact on the judicial decisions they made. The most common explanations were that judicial decisions are derived from

Florida statutes; and that decisions are based on the testimony presented regarding factors such as parental compliance and the danger to the child if not removed or re-unified. However, interviewees also noted that the Demonstration has impacted the judicial process, in that there are now additional resources and services that case managers and child protective investigators can access for families. Additionally, a global change in vision and values was mentioned such that the Court's focus now is trying to keep families together, and an emphasis now is on safety and family engagement rather than risk.

Another issue that was discussed with respondents was the impact of the Demonstration on access to and availability of services and resources for families. Strengths that were identified included better access to services, the capacity to offer more individualized services to families, and the use of evidence-based practices in the child welfare system. Specific service gaps identified by interviewees include intensive/specialized mental health treatment services for parents and therapeutic interventions, including parent/child therapy, family therapy, and intensive treatment services for youth.

Judges and magistrates also communicated that staff turnover at the case management and CBC leadership level were hindrances to the child welfare system. Burdensome caseloads for case managers were also observed as a challenge to effectively serving families involved in the child welfare system. Judges and magistrates unanimously reported that child protective investigators had an inherent passion for child welfare work. Judges and magistrates reported turnover, lack of resources, and vicarious traumatization as obstacles to the effective practice of child protective services.

Interviewees were asked whether they had received training or informational materials related to Florida's IV-E Demonstration. The consensus was that judges and magistrates are not as familiar with the Demonstration. Judges and magistrates reported many different ways in which they jointly plan and communicate with other stakeholders involved in the child welfare system. Court improvement meetings were the most common collaboration effort reported. Both judges and magistrates reported attending these meetings regularly.

Judges and magistrates offered several diverse recommendations for improving the child welfare system for children and families. As previously indicated, judges and magistrates differ in their length of time hearing dependency cases, whether or not they focus solely on dependency issues, and they also differ in their approaches to cases and rulings on cases. This variance was reflected in a rich collection of suggestions for system improvement; the one overlap was a focus on services to treat mental health issues. Additional topics addressed in individual interviews were issues regarding primary prevention, investigations, timing of

services, family engagement, the frequency of visitation, accessibility and availability of services, case manager retention, and funding.

CMO leadership. Fourteen interviews were completed with CMO leadership participants from November of 2016 through March of 2017. Team members participated in an interrater reliability process that achieved a reliability score of 78%. There were several strengths identified by stakeholders relating to child welfare practice. One major strength reported by multiple respondents was the ability to maintain strong relationships with lead agencies, investigators, the Sheriff's Office, state attorneys, and judges. CMO leadership also reported being able to help more children in-home, improve the quality of casework, and have increased flexibility in funding, which allowed for the expansion of prevention, diversion, and post-reunification services.

Some challenges reported by interviewees included: CPI and case manager staff turnover, CPIs not completing the necessary tasks prior to case transfer, and newer CPIs being quicker to remove children than experienced CPIs (stakeholders suggested this might be due to a lack of knowledge about resources offered by the CBC). It was reported by participants across 12 Circuits that CPIs were not adhering to the child welfare practice model in the same way that CMOs were expected to adhere to the child welfare practice model. Spikes in out-of-home care were also reported by interviewees. The perception of some interviewees was that the implementation of the child welfare practice model was directly related to the spikes in out-of-home care. Respondents also indicated that legislative officials lacked knowledge about the complexities of the child welfare system which made it difficult to get the needed funding and policy changes they desired for Florida's child welfare system.

A prominent and consistent theme throughout was concern that new administration at the Federal level may not realize the value of continuing Demonstrations in states that are coming to the end of their Demonstration term, who have utilized the Demonstration to provide much needed services to children and families.

CBC leadership. Eleven interviews were completed with CBC lead agency leadership participants from October of 2017 through March of 2018. Team members participated in an interrater reliability process for interview coding that achieved a reliability score of 73%. The findings from these interviews were organized under the following themes: family support services, safety management services, treatment services, child well-being services, rapid safety feedback reviews, and Demonstration impact.

Family support services. Interviewees reported several family support services that have been successful for the families they serve. Responses ranged from co-locating staff to

the use of California Clearinghouse evidence-based practices. At least 13 different family support services were reported as being the most successful for families: Nurturing Parenting, Nurturing Fathers, Wraparound family support models, Behavioral Educational Therapy, and a Family In-Home Research Support Team. Respondents from 10 circuits reported offering evidence-based or promising practices including Family Connections Program, Nurturing Parenting, Nurturing Fathers, the C.A.R.E.S. model, Multisystemic Therapy, Home Builders, Family Builders, and Children to Action Teams.

Safety management services. Interviewees were also asked to describe which safety management services have been the most successful for the families served by their agency. Respondents unanimously stated that they offer both formal and informal safety management services. Formal safety management services noted included crisis management teams, safety management services teams, mobile response teams, Family Builders, ERAT (Emergency Response Assessment Team - available to CPIs), House Next Door (available to case managers), and SMART (Safety Management Active Response Team - program for CPIs designed in partnership with CPIs). Informal safety management services included faith-based community programs, relationships with learning coalitions, and supports identified by case managers.

Treatment services. Leadership at lead agencies were asked which treatment services they had found to be the most successful for parents and caregivers served by their CBC. First, respondents talked about the importance of a wraparound approach with families, as seen in the Placement Partnership Program, which was described as being very family-centered, where informal supports were valued as much as formal supports. Second, respondents discussed the positive impact of co-locating services for families, as seen in the Kids in Distress model where services inclusive of parent education, domestic violence intervention, substance abuse outpatient treatment, and mental health counseling and therapy are coordinated for families. Third, respondents discussed the value of behavioral analysis being included in programs, as happens in Parenting for Success. Fourth, the importance of services that "put trauma first" was discussed. Fifth, the practice of having a behavioral health consultant work with CPIs to help investigators identify parents with mental health issues was noted. Sixth, stakeholders noted programs treating substance abuse such as the FIT (Family Intensive Treatment) program.

Child well-being services. Leadership at CBCs were asked which child well-being services such as educational, physical health, dental health, and behavioral health they found to be the most successful for children served by their CBC. Emergent themes included

improvements in dental care, discussion of the impact of the Child Welfare Specialty Plan, use of non DCF or Medicaid resources to fund well-being services, more trauma-informed services, behavioral services geared toward the younger population, teams of nurses, and educational mentors.

Rapid safety feedback reviews. Stakeholders were asked whether the Rapid Safety Feedback reviews have improved practice for their CBC. The majority of respondents felt that the reviews were helpful and useful. Reasons given for this included the ability to address safety concerns in real time, being able to focus on the most vulnerable population (0-3 years with substance abuse and domestic violence accusations), having another learning tool to support the coaching process between supervisors and case managers, and simply having "another set of eyes" on randomly selected cases as a vehicle for bringing new and different issues to the attention of lead agencies. For those respondents that did speak specifically to how the reviews had helped improve practice, there was a perception that the reviews had increased the quality and frequency of family visits.

Demonstration impact. The final set of interview questions for the implementation analysis addressed issues related to the ending of the federal Demonstrations. There was consensus among the interviewees that the loss of the Demonstration funds would be irreplaceable and would have a highly detrimental impact on Florida's child welfare system of care. Several interviewees also noted that state general revenue resources in Florida are "scarce" for human services such as child welfare, mental health, and substance use services. Another theme that emerged from the interview data was the loss of the child welfare system of care that CBCs gradually built over the course of Florida's two Demonstrations. CBCs across Florida have capitalized on the Demonstration's potential by keeping the focus on the front-end of the system and therefore reducing the number of child removals and the number of children coming into the formal dependency system. Respondents also noted that the Demonstration's funding flexibility allows an immediate response to concrete needs and crises that families sometimes experience. There was consensus across respondents that prevention services and programs would be highly vulnerable to elimination or reduction with the loss of Demonstration funds. Respondents identified many examples of violence prevention programs, family preservation services, mentoring, immediate response crisis intervention, teenage pregnancy prevention using evidence-based approaches, deployment of specialized personnel to child protective investigation units, assisting families with transportation and housing issues, and safety management services.

On the other hand, most interviewees identified a number of alternative funding sources that could partially make up for the loss of Demonstration funds. One theme that emerged from several participants was the goal of diversification of funding sources. Examples included contracts with county governments and state contracts, HUD funds through the local homeless services network, contracts with Career Source, use of Medicaid providers for substance use and mental health treatment services, and use of mental health and substance use block grant funds. Potential local resources included local United Ways, Children's Services Councils, private foundations and donors, and pursuit of opportunities jointly with Casey Family Programs. A strength noted by some participants regarding the identification of future alternative funding is the strength of the partnership today between the Department, the Florida Coalition for Children (FCC), and the CBCs.

CPI Supervisors. Fifteen interviews and focus group with four participants were completed with CPI supervisors from November of 2018 through March of 2019. Team members participated in an interrater reliability process for interview/focus group coding that achieved a reliability score of 94%. The findings from these interviews were organized under the following themes: role, removal decision process, family support and safety management services, availability of services, challenges and barriers for families, interagency relationships, issues that impact child welfare work, and recommendations for change.

Role. Child protective investigator supervisors predominantly viewed their roles as facilitators to the child welfare investigation process. Participants described themselves as supports for child protective investigators, leaders of a team or unit, CPIs "first point of contact," and coaches for investigators. One participant stated,

> I coach these investigators to their full potential and encourage their continued growth, and I supervise a unit of investigators and together we ensure that safety of the kids that come into our unit on the investigations we receive.

CPI supervisors also described their role as ensure child safety and well-being. They fulfilled this role by assisting investigators in making appropriate safety decisions.

Removal decision process. Nearly all of the CPI supervisor participants described the decision process regarding the need for a removal or if the child can remain safely in the home as a multi-step process. First, the CPI would respond to an abuse report by going out to the home to conduct an investigation according to the child welfare practice model guidelines. Part of the investigation process was to determine present or impending danger. If the CPI assessed that the child or children were unsafe and a removal might be needed, they would contact their supervisor, if the supervisor agreed with the CPIs decision in the field, the program

administrator would be contacted. From that point, Children's Legal Services (CLS) would become involved. CPI supervisors noted that occasionally CLS would send the case back saying that it did not meet legal sufficiency. One participant stated,

> It's based on what the CPI's observations are. They relay that back to me and we go through the criteria, see if we can safety plan. Then that information is trickled up to the program administrator. Once the program administrator is on board for a removal, then we staff it with our Children's Legal Services. And sometimes Children's Legal Services agree, and sometimes they don't, which sends us back to do safety planning, like, they don't feel there's enough sufficiency, that's the common phrase used by Children's Legal Services when there's a denial of removal.

Family support and safety management services. Participants were asked about any adaptations CPIs have increased attention to family support and safety management services. Few respondents indicated that they were unaware of any adaptations made. Other respondents indicated the assessments done by CPIs during an investigation help the CPI determine what services might be needed for families involved in the child welfare system. One participant said,

> They'll discuss all that with the family upfront. And so like a big part of that is just that initial contact with the family trying to identify what are some of the issues that are presenting. It's really important that the CPI, and I know within my role I support and guide them to determining which families are going to be a good fit for family support services or safety management services. Then we've made it very easy within our service center for a CPI. Once they identify that need it's very easy at that point to get the family referred right away.

It was also noted that co-located diversion staff have been essential for CPIs in linking families to the appropriate family support and safety management services. Other participants reported actively looking for the available services within the community. One participant stated,

> The adaptations, we've gone out and looked for different services because we do have a lot of drugs mixed with the domestic violence with dads or moms sometimes being the perpetrator of the violence, so we did find like a sober BIP service that's in the next county over and they will take people [from this County], so, going through community partners and finding out what else is nearby, reaching out to other counties that are closer to the county line.

Availability of services. CPI supervisors reported a number of services that CPIs have the ability to refer to. Housing, child care, basic needs (electricity payments, food, etc.), mental

health, substance abuse, domestic violence, batterer's intervention, diversion, prevention, parenting, and in-home services were all reported as services that CPIs could refer. One participant noted,

> We have family prevention services, family preservation. We have in home education, domestic violence, mental health, substance issues. It all depends on a case by case scenario and what's going on with that particular family for us to be able to determine what services are needed in the home or what type of service would be better for the family. We provide daycare services. We even also provide furniture in the home, beds for these kids to sleep on and become a proper family. If we come across a family that don't have any beds. We do as much as possible with clothes, food, we do anything possible that we can do for the family.

CPI supervisors also reported that service availability and other resources to assist families were limited. Housing resources were most commonly reported as lacking in communities. One participant described,

> Well, we have Stewart-Marchman available, however, most of the time they're not fully staffed so, we can't get our families in, certainly not in any, sort of, immediate time frame. And definitely almost not within a short time frame. We don't have any homeless services that are viable. We have some domestic violence services. We do have a shelter available. They're almost always full so, we struggle, sometimes, with getting local assistance for their families. We're limited. We don't have a lot.

Challenges and barriers for families. Participants were asked to describe the challenges or barriers that families involved in a child welfare investigation encounter. Lack of available services and service providers, socioeconomic status, and the negative perception of the Department were the most commonly reported challenges families face. In regards to services, participants noted that providers frequently are unable to engage families quickly. For example, mental health and substance abuse providers often have waitlists. It was also noted, that there were not enough providers to meet the needs of child welfare involved families which led to the waitlists. Socioeconomic status was also reported as a barrier. For some families this meant that they were living below poverty level, and for other families it meant that they had private insurance, but still were unable to afford services. One participant stated, "So, with our parents who do have Medicaid, it's easier for them to be linked to providers. But we have parents who, they're working parents, and although they work, they can't afford it. And so, that's a problem." Perception of the Department was another primary challenge for families. CPI supervisors noted the importance of the rapport building that CPIs have to develop due to

negative perceptions of the Department. Generational involvement, previous experiences, and media involvement were all reported as contributors to the negative perceptions of the Department. One participant stated,

> The barriers are the fact that a lot of parents don't come in because when they hear the Department of Children and Families, they get scared and they're not aware that there's other services out there we can actually provide to keep these children in the home but we actually need actual documentation and allegations and I mean, they have to provide us with as much information as to regards to the family as possible so that we can ensure that the appropriate services are being placed in the home.

Interagency relationships. Most of the participants described their relationships with other child welfare serving entities as positive (CBCs, CMOs, and the judiciary). Respondents indicated that each agency does their best to communicate with one another even if they do not always agree. It was reported that each agency primarily cared for the safety and well-being of children. Some respondents reported that case management staff would do joint visits with CPIs and that the relationships were collaborative. One participant stated,

> Awesome relationship with case management as well. Investigators here, they also have a good relationship with case managers and their supervisors. Like I said, I can always email and call them, and to an MDT [multi-disciplinary team] or staffing, it's always been open communication and, you know, especially when the investigators, they get an investigative report that involves a child that's already in the dependency system, we immediately contact them to notify them that we have an open report.

Issues that impact child welfare work. Funding, increases in substance abuse, and low socioeconomic status were all reported as factors that affect child welfare work. One participant stated, "I mean as far as economic, that's always an issue because, we don't have the funding. Nobody has the funding. There's never any funding for what we feel like would be adequate services sometimes so that's always a problem." Participants reported that funding for some services had been cut and the services were eliminated as a result, and that funding for services were already not enough prior to being cut. It was reported that funding for more substance abuse services was needed in communities. Another participant described how child welfare workers were seeing an increase in substance abuse issues, but there were not enough service providers to meet the growing need. Low socioeconomic status and homelessness were commonly reported issues as well. One participant stated,

> When families are homeless and they have no place to live and they have no jobs. I mean, we do have services where, let's say, parents are having financial hardship and

> they're about to be homeless, but they do have a job. We have services with Neighbor to Family who also provides financial support for this family. But, in order for them to get the financial support they have to have some kind of income.

Recommendations for change. CPI supervisors had some recommendations for changes they would like to see within the child welfare system. Administrative level changes recommended were more support staff within CPI units, upgraded computers and technology given to child welfare workers, changes to the hotline, and changes to statute to align with the child welfare practice model were the administrative level change requests. One participant stated,

> In Florida, I would start with the hotline. I think for us to change our welfare system, it has to stop - it has to start at the beginning. We can change everything here, how we do things, but when we get reports for kids who don't have sweaters, who live in central Florida, there's a problem with that, right? Or, if we get reports because there's a 10-year-old staying at home or outside playing in the street, there's a problem with that.

On the community level, the primary recommendation was for an increase in service providers and housing. It was unanimously reported that child welfare involved families were in need of housing resources. Another commonly reported service need was substance abuse services. One respondent stated,

> We need in home substance abuse. We need substance abuse and counseling that'll go to the house and see the parents who have no transportation. They need better funding for the inpatient services because a lot of people, they don't have Medicaid and they're in between where they're not quite poor enough to qualify for Medicaid but, don't make enough in order to pay for their own services as far as, you know, going into an inpatient facility.

Discussion

The implementation analysis consisted of a total of 75 stakeholder interviews and one stakeholder focus group. The implementation analysis findings from stakeholder interviews showed that the goals of the Demonstration have been supported throughout the child welfare system in Florida. Each stakeholder described an increase in the types of services available for families. Stakeholders also described the increased focus on keeping children safely in the home. Although there were still challenges reported that affected child welfare work. Common challenges described were turnover among case managers and CPIs, increases in out-of-home care, lack of housing resources, and a lack of substance abuse and mental health services. Participants reported that the need for mental health and substance abuse services were

increasing. Participants perceived the increases were due to increases in opioid use and increased recognition of mental health concerns through the assessment process implemented by the child welfare practice model. Poverty, lack of housing, generational DCF involvement, and a negative perception of DCF were reported barriers for child welfare involved families across stakeholder groups.

Services and Practice Analysis

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

Florida's child welfare system entails a public-private partnership, in which the initial child protective investigations are conducted by DCF or the local Sheriff's offices, and all subsequent services (e.g. case management, foster care, etc.) are facilitated through contracted CBC lead agencies. There are currently 19 CBCs responsible for the administration and provision of child welfare services, each of which are given the flexibility to develop a system of care based on local community needs. Within this context, each lead agency was allowed to use the funding flexibility provided by the Demonstration to meet the goals of improved permanency, safety, and well-being outcomes for children and families, and more specifically to expand the array of child welfare services that would allow the state to safely reduce the number of children requiring out-of-home placement and expedite permanency for those children who do enter out-of-home care. The services and practice evaluation sought to identify and describe processes and practices developed at both the state and local levels in response to the Demonstration goals.

Key Research Questions

1. What are the array of services available, including evidence-based practices and programs?
2. What are the procedures for assessing child and family needs, including types of assessments used, and determining client eligibility?
3. What are the referral processes and mechanisms?
4. What practices are being used to effectively engage families in services?
5. What are the intended goals, types, and duration of services provided?
6. What is the number of children and families served for each service offered?

7. To what extent have EBPs been implemented with fidelity?

Data Collection

A mixed-methods approach was used in order to draw together data from multiple sources and triangulate findings. Data were collected at multiple time points throughout the Demonstration extension to assess changes over time. Furthermore, findings from the initial Demonstration were reviewed and compared with those from the Demonstration extension to examine the extent to which expansion of the service array continued throughout the extension period, as well as practice changes that were implemented to address challenges identified during the initial Demonstration. Specific methods for data collection and analysis are described.

Document review. Critical documents relating to the service array and child welfare practice, including written policies, practice guidelines, and procedures were collected and reviewed by the evaluation team. This data collection primarily focused on identifying any documentation that concerned changes in the following: the array of services available to children and families in the child welfare system, assessment procedures and criteria for determining service eligibility, safety and case planning practices, referral processes and procedures, guidelines for coordination and monitoring of services, and reporting and documentation requirements. Additionally, relevant external reports, including the Florida Child Welfare Services Gap Analysis Report (Armstrong & Greeson, 2014), the Service Array Survey conducted by DCF (2016), the individual Regional Annual Progress and Services Reports completed (2016), and the Florida Children's Service Array and Gap Analysis Report (Cruz, et al., 2018) were reviewed to maximize the utility of concurrent research and assessments while also avoiding duplication of work.

Service array survey. The intent of the service array survey was to collect data pertaining to the service delivery system, including procedures for determining eligibility, referring subjects for services, the array of services available, the number of children and families served, and the type and duration of services provided, as specified in the Terms and Conditions. The survey was administered to the leadership of each CBC lead agency, and asked respondents to identify the types of services offered by their agency in each of the four service categories established by DCF (family support services, safety management services, treatment services, and child well-being services; see protocol in Appendix D). For each service they identified, they were then asked to provide the following information: the intended goal(s) of the service; whether the service is evidence-based or evidence-informed; current service availability and capacity; the number of children and families referred and served during the past

12 months; the median service duration; and screening, eligibility, and referral procedures. The survey also included questions about the provider networks that lead agencies contract with to assess the extent to which contracted providers are certified in trauma-informed care, capable of addressing co-morbidity (e.g., working with clients who have co-occurring disorders such as mental illness and substance abuse problems), and knowledgeable about the child welfare system and the unique needs of families involved with the child welfare system.

The survey was administered from January to April of 2017 using *Qualtrics*, a web-based survey program. Each lead agency director was sent an email with a link to complete the survey. The directors were instructed to engage the appropriate relevant staff within their agency in order to complete the survey. A multi-wave mailing strategy was used to maximize the response rate, whereby reminder emails were sent to each non-responding agency at 15-, 30-, 45-, and 60-days after the initial administration.

Evidence-based practice assessment. One objective of the Demonstration projects, as set forth by the Children's Bureau, was to expand the implementation and utilization of evidence-based practices (EBPs) among child welfare systems. Given Florida's philosophy of community-based care, the array of child welfare services is not dictated by the state, rather it is established at the local level in response to the particular community needs. As such, specific services vary from one community to the next, but the state has emphasized the expanded use of evidence-based, evidence-informed, and promising practices. Evaluation activities, as described above, sought to identify and document the array of EBPs implemented throughout the state. Following initial identification of a variety of EBPs, and in collaboration with the state, the evaluation team selected two EBPs for a more in-depth assessment of their implementation, utilization, and practice fidelity. The selected practices were Wraparound (www.nwi.org) and the Nurturing Parenting Program (www.nurturingparenting.com). Both practices are identified as Level 3 – Promising Practices according to the criteria established by the California Evidence-Based Clearinghouse (www.cebc4cw.org). These practices were selected based on their reported use across multiple regions of the state and recent initiatives that have encouraged expansion of their implementation throughout the state. Both practices are frequently used as in-home service interventions, and thus are also congruent with the goal of the Demonstration to prevent placement in out-of-home care.

To assess the extent to which each practice had been implemented statewide, a brief survey was developed and administered to each of the CBC lead agencies (see protocol in Appendix E). This survey was intended to gather information about which lead agencies included these specific services in their service array, how they were using the services (based

on Florida's four service categories: Family Support Services, Safety Management, Treatment, and Child Well-being services), how far along the agency was in implementing the service, and whether the agency was currently measuring fidelity. The survey was administered to the lead agency directors in similar fashion to the prior service array survey using *Qualtrics*. Administration occurred from May to August of 2017, with reminder emails sent to non-responders at 15-, 30-, 45-, and 60-days after the initial administration. Subsequently, additional follow up was conducted by email from September to December of 2017 with agencies that still had not responded to the survey in order to ensure that a response was received from all 19 lead agencies.

Once responses were received from all lead agencies, the evaluation team began reaching out to those agencies who reported that they include either of the two EBPs in their service array to learn more about their service delivery and fidelity protocols. Phone interviews were scheduled with lead agencies, and in some cases with their contracted providers, to learn more about how these services were being used, whether practice had been tailored in any way for different types of cases (e.g. in-home versus out-of-home), and what, if any, data the agency was collecting related to service implementation and fidelity, including specific fidelity tools that the agency used. Agencies were also asked to provide service utilization data for State Fiscal Year (SFY) 17-18. For those agencies that reported they were currently measuring fidelity, the evaluators further inquired as to whether the agency would be willing to share their fidelity data and tools. For agencies that did not currently have fidelity protocols in place, the evaluators offered to compile a set of available fidelity tools and distribute these statewide.

Caseworker focus groups. Focus groups were conducted with case managers and child protective investigators to assess perceptions among front-line staff regarding changes in practice and the service array, including implementation successes and challenges. A semi-structured focus group guide (see Appendix F) was developed to facilitate the sessions, with questions focused on practice issues such as assessment procedures, changes in practice guidelines and expectations, processes and procedures for identifying family needs and determining eligibility for services, the availability and accessibility of a variety of services including in-home services and evidence-based practices, and effective methods to engage families in services. Focus groups were conducted at two distinct time points during the evaluation. An initial round was completed from February to July of 2016 in five circuits across the state, and a second round was conducted from June through August of 2018 in three circuits.

Circuits were selected for the first round of focus groups using a stratified random sampling process based on child removal rates, which were obtained from the CBC Lead Agency Trends and Comparisons Report (DCF, June 26, 2015). Circuits were stratified into three categories: low removal rates (less than five removals per 100 investigations), moderate removal rates (five to six removals per 100 investigations), and high removal rates (greater than six removals per 100 investigations). Next, two Circuits were randomly selected from each category using a random number generator. While this process initially produced six selected Circuits, during the scheduling process for the case management focus groups, one CBC was unable to get focus groups scheduled with evaluation team members during the needed timeframe, resulting in five Circuits that were included in the data collection. The included circuits were Circuits 4 (Duval, Nassau, and Clay counties), 19 (Indian River, Martin, Okeechobee, and St. Lucie counties), 12 (DeSoto, Manatee, and Sarasota counties), 11 (Miami-Dade), and 15 (Palm Beach county).

For the second round of focus groups, random sampling was again used to select circuits for participation, but those circuits and/or lead agencies that participated in the first round of focus groups were excluded from the sampling to ensure that a new set of agencies was engaged. Since an updated report on removal rates was not available, the sample was not stratified this time. Initially four circuits were selected for this round, but once again, one circuit was unable to schedule focus groups within the designated timeframe, and was subsequently impacted by Hurricane Michael, resulting in the decision to cease further scheduling efforts. The circuits included in the second round were Circuits 9 (Orange and Osceola counties), 18 (Seminole and Brevard counties), and 20 (Charlotte, Collier, Glades, Hendry, and Lee counties).

Once sites were selected, the CEO of each CBC lead agency was contacted via email with an explanation of the evaluation activities and a request for their assistance in organizing the focus groups with their case management agencies. The lead agencies were given the option of convening one or two focus groups with case management staff; the majority opted for two focus groups to maximize participation. Focus groups varied in size from as few as three to as many as twelve participants and included case managers who handle in-home, out-of-home, and mixed caseloads. A few of the focus groups also included other support staff, such as supervisors and court liaisons. There were 78 staff who participated in the first round, and 24 staff who participated in the second round of case manager focus groups (n = 102 total).

DCF Regional Managers were similarly contacted via email with an explanation of the evaluation activities and a request for their assistance in organizing the focus groups with child protective investigators in their circuit. Similar to the case management groups, the majority

opted to convene two CPI focus groups for their circuit. In most of the counties encompassed by the participating circuits, child protective investigations were handled by DCF, however, in two counties the investigations were handled by the local Sheriff's office; one of these Sheriff's offices did participate in a focus group. Focus groups varied in size from four to twelve participants. Focus group participants were primarily child protective investigators, but some focus groups included supervisors as well. There were 63 staff who participated in the first round, and 25 staff who participated in the second round of CPI focus groups (n = 88 total).

Verbal informed consent was obtained from all participants prior to beginning the focus group interview. Focus group sessions were audio-recorded with the permission of participants. Following the sessions, all audio files were transferred to a secure, password protected computer and then immediately deleted from the recorder. No identifying information was collected from the participants.

Sample

All CBC lead agencies were included in the sampling for the two surveys. A primary point of contact was identified for each agency (e.g. a CEO or Executive Director), and links for each survey were emailed directly to this contact. Responses to the service array survey were received from 11 lead agencies, however, only 6 of these responses were sufficiently complete to allow for inclusion in the analysis. Although the original evaluation plan was to administer the survey a second time towards the end of the Demonstration period, the poor response rate (n = 6) as well as reporting that the participant burden on lead agencies was too great resulted in a revision to this plan to focus instead on the evidence-based practice assessment. Responses to the evidence-based practice survey were received from all 17 lead agencies.

The sample for the focus groups included a total of 190 participants (102 from case management agencies and 88 from child protective investigation offices). Focus groups were conducted in 8 circuits, which were randomly selected, as described above. For each selected circuit, directors at the lead agencies and DCF regional directors were asked to invite front-line staff (e.g. case managers and investigators) to participate in the focus groups. Lead agency directors were encouraged to include case managers representing both in-home and out-of-home cases. Demographic data were not collected from focus group participants.

Data Analysis

Documents were reviewed by a member of the study team and coded to capture domains and concepts of relevance to the research questions. A combination of deductive coding, using codes identified in advance based on the research literature and the stated Demonstration goals, and inductive coding, identifying themes and concepts that emerge from

the data, was utilized. In particular, analysis of documents was used to (1) identify innovative or evidence-based practices and services being used throughout the state and (2) inform an understanding of child welfare practice expectations. In this way, the analysis of documents provided both an understanding of how formal policies and practices were aligned with the goals of the Demonstration, and a guide for the evaluation to examine how frontline practice, explored through focus groups, compared with written policy.

Audio files from the focus groups were transcribed into a Microsoft Word document and coded using *ATLAS.ti* version 6.2, a qualitative data analysis software program. A grounded theory approach was used to analyze the transcripts, whereby codes were created based on key themes and concepts that emerged from the data. Resulting codes were further analyzed to examine their relation to one another in order to identify sets of codes that touch on similar or related topics or that frequently co-occur within the data set. Furthermore, an iterative process was used, whereby insights gained from initial data collection and analysis (including findings from the document reviews) were used to inform the development and refinement of subsequent data collection protocols and analyses.

Case management and CPI focus groups were coded and analyzed separately (see Appendix G for code list), allowing for the identification of distinct patterns of beliefs, perceptions, and experiences within each group. The findings from both sets of focus groups and the document reviews were then triangulated for further analysis to explore common and divergent themes. Additionally, findings from the first round of focus groups were compared with those from the second round of focus groups to explore changes in frontline perceptions and practices over time.

Data collected through the evidence-based practices surveys were exported to *SPSS* version 22.0 statistics software for analysis. Basic descriptive statistics were calculated, such as frequencies, means, and medians, depending on the type of data concerned. The intent of the analysis was to be descriptive of the services provided, not comparative across lead agencies, since many factors affect the number and types of services that are available in different communities. These findings were also triangulated with related qualitative data.

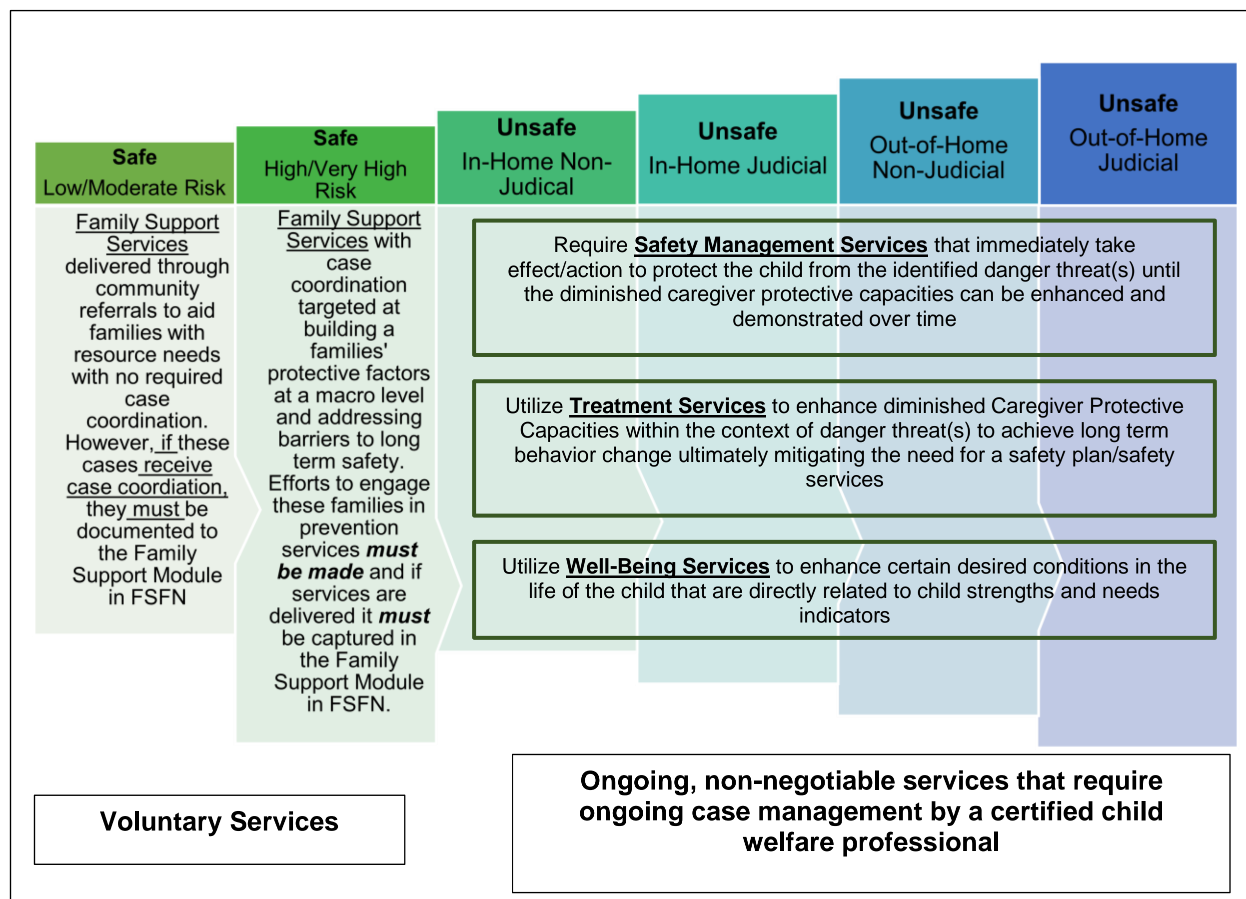
Results

Findings from the services and practice analysis are organized according to two topical areas. First, findings related to the service array are described, including the evidence-based practice assessment. Subsequently, the report examines findings pertaining to child welfare practice, with a particular focus on frontline practice among child protective investigators and

case managers. For each section, findings from multiple data sources are triangulated to provide a comprehensive picture of Florida's child welfare service array and practice.

Service array. Florida's child welfare framework of community-based care means the services provided to children and families may vary greatly from one community to the next. Through the child welfare practice model, DCF has provided an overarching structure for the types of services that lead agencies must provide, which includes four core service categories: family support, safety management, treatment, and child well-being services. Figure 4 provides an overview of this service array structure and definitions for the different service categories. A core tenet of this model, also illustrated in Figure 4, is a differentiation between families whose children are deemed safe but at risk for future maltreatment, who may be offered voluntary family support services, and families whose children are deemed unsafe, and for whom services are mandatory. Under this model, DCF has established expectations for each CBC to ensure adequate services are available within each of the identified service categories. Findings from the services and practice analysis point to a variety of ways in which the service array has expanded under the Demonstration extension, as well as ongoing and emergent challenges related to the service array.

Figure 4. Florida's Child Welfare Service Array



Responses to the service array survey were received from six lead agencies, representing four of the six DCF Regions: Northwest, Northeast, Central, and Suncoast. Of these, two agencies covered areas that were mostly urban or suburban, while the remaining four agencies covered areas that were predominantly rural (e.g. population density below 500/square mile). Thus, although responses were received from only a small portion of lead agencies (35%), the data collected represent a fairly diverse cross-section of Florida's child welfare agencies. Findings from the survey on the number of children and families referred for services and the number that received services are summarized in Table 1. These data reflect services that were provided approximately from 2016 to 2017. It should be noted that there is missing data for some of the services, since lead agencies had limited data on certain services that are provided through external contracted agencies. Overall, the most complete data available were for family support and safety management services.

All responding agencies reported that they require their service providers to be trauma-informed, and four reported that they require providers to be knowledgeable in serving clients with co-morbid conditions. Four of the lead agencies reported that they require their providers

to assess client-level outcomes, but one of these four indicated that they do not receive these outcomes data from their providers. Four lead agencies also reported that they require their providers to assess program fidelity, and all four reported that they receive these fidelity data from their providers.

Table 1

Results from the Service Array Survey: Services Provided (2016-2017) (n = 6 CBCs)

Service Category		**Typical Duration (months)**	**# Children/Families Referred[1,2] (past year)**			**# Children/Families Served[1,2] (past year)**		
			Range	**Mean**	**Total**	**Range**	**Mean**	**Total**
Family Support Services	Family Support	1 – 6	195 - 2731	1132	6789	148 - 2268	915	5488
Safety Management Services	Behavior Management	1 – 4.5	171 - 707	392	1175	120 - 707	315	1258
	Crisis Management	1 – 2.5	57 - 771	414	1657	55 - 749	239	1197
	Social Connection	1 – 4.5	80 - 1691	662	2649	55 - 1374	474	2371
	Separation	1 – 9	29 - 3784	1290	3870	25 - 1699	459	1834
	Resource Support	1 – 3	57 - 749	279	1117	55 - 749	241	1205
Treatment Services	Individual Therapy	3.5 – 9	162 - 514	395	1186	117 - 483	325	975
	Family Therapy	1.5 – 7	40 - 655	260	779	29 - 624	217	866
	Domestic Violence	3 – 4	-	50	50	28 - 67	48	95
	Substance Abuse	2.5 – 7	164 - 891	528	1055	58 - 292	163	489
	Parenting	2.5 – 6	111 - 1363	570	1711	85 - 1008	362	1449
	Reunification	4 – 6	20 - 225	123	245	20 - 137	79	157
Child Well-Being Services	Physical Health	-	-	-	-	-	-	-
	Mental Health	3 – 8	5 - 268	138	414	5 - 188	102	307
	Developmental Needs	-	-	237	237	-	237	237
	Educational Needs	3.5+	46 - 106	76	229	46 - 105	72	215

[1]For some services, data were not available on the number of children/families referred and served. Numbers reported are based on the agencies that were able to provide this data and thus do not necessarily reflect the actual number of children and families served across the six responding agencies.
[2] Numbers might be duplicative if a family was referred to and received more than one service; thus, a family receiving two different services would be counted twice.

Critical feedback on the service array was also obtained through the focus groups with case managers and child protective investigators. Diversity and availability of services varied

greatly across the focus group sites. Overall, participants emphasized the importance of having a variety of community-based services readily available to meet the multiple and diverse needs of system-involved families. Providers that offered in-home services were identified as a particularly important and beneficial resource, especially for families with limited means of transportation and multiple service needs. The most commonly identified in-home services included parenting programs, therapy, targeted case management, and wraparound programs, however, many participants reported limited availability of these types of services in their communities, and some reported a complete lack of service providers who work with families in the home. Furthermore, most caseworkers agreed that there was a need for greater variety of services. Rural communities reported a lack of services to be a significant challenge. The ability to individualize case plans to each family's unique needs was limited by the availability of services within the community. Additional findings pertaining to each of the service categories are described next.

Family support services. Responses from the lead agencies were largely consistent with regard to client eligibility criteria for family support services: most identified families as being eligible for these services if the children have been deemed safe but are at high or very high risk of future maltreatment as determined by the CPI's assessment. One agency stated that all families whose children are safe are eligible for services regardless of risk level, and another CBC indicated that they accept moderate to very high risk families for Family Support Services. Most agencies further stated that the CPI refers the family directly to the Family Support Services provider, but some agencies have intake staff who take referrals from the CPI and then assign the family to a service provider. Two agencies also noted that families can contact the agency directly if they are in need of services without going through the CPI process; in this way, families can seek prevention services on their own before the situation escalates to the point where a maltreatment report is made. Family support services were reported to last, on average anywhere from one to six months. Across the six lead agencies, there were 6,789 families that were referred for family support services, and 5,488 families received these services in the previous twelve months. Provision of these services is explored in greater depth in Sub-Study 2 of this report.

Safety management. For safety management services, lead agencies indicated that client eligibility was based on the identification of present or impending danger by the CPI. Two lead agencies also specified that the family must have a Safety Plan, and one agency stated that cases involving a drug-exposed newborn or a child death with surviving children are automatically referred to safety management, regardless of whether present or impending

danger is identified. All lead agencies reported that the CPI refers the family for safety management services, in many cases directly to a contracted service provider, but two lead agencies have specialized intake staff who receive the referrals from CPIs and assign the case to services. Some agencies further specified that referrals were accepted 24 hours a day and safety management providers were deployed within two hours if crisis stabilization is required.

Safety management services fall into several sub-categories, which include behavior management, crisis management, social connections, separation, and resource support. Not every lead agency offered services in all sub-categories, but each agency identified services in at least two or more sub-categories. Based on the numbers reported, the most frequently used category of safety management service was social connections, with 2,371 families served across the six lead agencies. The least frequently reported category was crisis management, with 1,197 families served. The median service duration, across categories, ranged from less than one month to nine months. Many of these services were intended to be intensive and time limited.

The extent to which safety management services were sufficiently available seemed to vary across communities. Inadequate capacity and waitlists for services were identified as significant challenges during the caseworker focus groups. Child protective investigators indicated that at times, long waitlists could mean the difference between being able to implement an in-home safety plan and needing to remove a child, since immediate services may be crucial to ensuring the child's safety. Another challenge reported by investigators was that initiation of services may be delayed as a result of assessment, authorization, and intake processes that must be completed first. Overall, the focus group findings highlighted the critical need to ensure that all communities have sufficient safety management services available that can be implemented immediately with families.

Some lead agencies have developed comprehensive diversion programs, which have demonstrated success in reducing out-of-home placement. For example, through its Family Assessment Support Team (FAST) program, Family Support Services of North Florida significantly reduced their out-of-home placements and is serving nearly half of the children in their care with in-home family preservation services (Office of CBC and ME Financial Accountability, 2017). Programs such as FAST provide a model for other lead agencies to follow in further developing their safety management services and demonstrate that these services can keep children safe and be cost-effective at the same time.

Treatment Services. Procedures for determining client eligibility for treatment services were more varied than for the two previous service categories. Three lead agencies indicated

that the assigned case manager assesses the parents through the Family Functioning Assessment and identifies any mental health, substance abuse, or domestic violence needs. One lead agency simply stated that clients with a current open abuse investigation or an open case with case management are eligible for services, and another agency reported that parents with substance abuse and/or co-occurring mental health needs are eligible with no indication as to how those needs are assessed. One agency reported that each provider has their own specific eligibility criteria, and that the provider conducts an intake assessment to determine client needs. Most lead agencies indicated that the primary case manager is responsible for service referrals, although in some cases a CPI might refer a family for services prior to transferring the case. Four agencies indicated that there is a staff position at the lead agency that either reviews and approves referrals before they are submitted to providers, or is available to consult with case managers to determine the most appropriate services and providers for a particular client.

The variety of services falling under this category included individual therapy, family therapy, parenting programs, substance abuse treatment, domestic violence services, and reunification services. Median service duration for treatment services ranged from roughly one month to nine months. The most frequently used treatment service was parenting services, with a reported 1,093 families served across the six lead agencies in the previous twelve months. The least frequently used category of service was domestic violence, with a reported 343 families served in the previous twelve months, although missing data may account for some of the seemingly lower utilization. Many domestic violence providers have strict policies regarding confidentiality, and therefore it may be challenging for lead agencies to confirm the number of clients who actually receive such services. One somewhat surprising finding was the relatively low numbers reported for substance abuse services, as substance abuse was identified as a significant issue during focus groups with child protective investigators and case managers.

Focus group participants identified concerns with inadequate and poor quality treatment services. While participants expressed that quality services did exist, these were often described as being few and far between. In particular, domestic violence services, such as batterers' interventions, and substance abuse services were frequently reported as being ineffective or of poor quality. The quality of mental health services within some communities was also considered questionable, and many rural communities lacked options, having only one provider for the entire county. Concerns were also expressed that many mental health providers, such as counselors, were not licensed, and that many providers were overburdened, which further contributed to poor quality work. Lack of insurance was another issue that

prevented many families from accessing services. Additionally, caseworkers across sites consistently reported a lack of affordable housing and subsidized childcare. Caseworkers reported that a majority of their families need these services, but they were plagued by limited or no availability and waitlists as long as two to three years, and this often became a barrier to reunification for families who had otherwise completed the requirements of their case plan.

Child well-being services. Responses regarding eligibility criteria and referral procedures for Child Well-being Services were similar to those for Treatment Services, with lead agencies indicating that many service providers have their own specific criteria and referral processes. Case managers are typically responsible for identifying child needs and submitting referrals, either directly to the service provider or to a CBC staff person who reviews and approves the request before assigning to a provider. One lead agency identified specific assessments that are used to determine need: the Ages and Stages Questionnaire, the Adverse Childhood Experiences Questionnaire, and the Family Functioning Assessment. This agency also noted that on judicial cases, all children are referred for a Comprehensive Behavioral Health Assessment, which is completed by a certified professional and provides specific service recommendations for the child.

Four primary sub-categories of Child Well-Being Services were identified, which include physical health, mental/behavioral health, developmental needs, and educational needs. A substantial amount of service utilization data was missing, and therefore assessment of the actual number of Child Well-Being Services provided is extremely limited. Based on the data received, the most frequently utilized category of service was mental/behavioral health services, with a reported 307 children served in the previous twelve months. The least frequently used category of service (not counting physical health, for which no utilization data was provided) was developmental needs, with a reported 210 children served in the previous twelve months.

Evidence-based practice assessment. The evaluation further explored the implementation and use of evidence-based practices (EBPs) within the child welfare system throughout the state. Review of documents, including regional service reports and a statewide service array and gap analysis (Cruz, et al., 2018) identified 21 distinct EBPs that lead agencies reported to be available through their child welfare service array. These are highlighted in Table 2, which shows the distribution of these services by DCF region and is organized according to the level of evidence. The most widely implemented EBPs, according to these findings, were 1) Trauma-Focused Cognitive Behavioral Therapy (n = 16 lead agencies), 2) Child-Parent Psychotherapy (n = 15 lead agencies), 3) Motivational Interviewing (n = 15 lead agencies), and 4) Eye Movement Desensitization Reprocessing (n = 14 lead agencies). A number of the

practices identified, furthermore, are either explicit family preservation programs (e.g. Homebuilders, SafeCare, Family Connections) or practices that can be used to support family preservation efforts (e.g. Nurturing Parenting, Wraparound, Family Group Conferencing, Functional Family Therapy, etc.). Implementation and expanded use of these practices was made possible through a variety of funding mechanisms, including Medicaid, which was the most commonly reported funding source (Cruz, et al., 2018), as well as flexible use of funding provided through the Demonstration.

Table 2

Evidence-based Practices in Florida's Child Welfare System

EBP	Number of Lead Agencies Reporting Availability by Region					
	NW (n=2)	NE (n=5)	Central (n=4)	Sun (n=3)	SE/So. (n=3)	Total (n=17)
Level 1 (n = 6 EBPs)[1]						
Motivational Interviewing	2	4	3	3	3	15
Parent-Child Interaction Therapy (PCIT)	1	2	1	1	2	7
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	2	5	3	3	3	16
Eye Movement Desensitization and Reprocessing (EMDR)	2	5	2	2	3	14
Safe Environment for Every Kid (SEEK)	0	1	0	0	0	1
Coping Cat	0	1	1	0	0	2
Level 2 (n = 6 EBPs)[2]						
Homebuilders	1	1	0	0	0	2
SafeCare	0	0	0	0	1	1
Child Parent Psychotherapy (CPP)	2	5	2	3	3	15
Functional Family Therapy (FFT)	0	2	0	0	3	5
Multi-systemic Therapy (MST)	1	1	0	1	3	6
Together Facing the Challenge (TFTC)	0	0	0	2	1	3
Level 3 (n = 9 EBPs)[3]						
Child and Family Traumatic Stress Intervention (CFTSI)	1	0	0	0	1	2
Combined Parent/Child Cognitive Behavioral Therapy (CP/C CBT)	1	4	2	1	3	11
Theraplay	0	2	0	0	2	4
Wraparound	2	3	2	1	3	11

Family Group Conferencing (FGC)/ Family Group Decision Making (FGDM)	0	2	3	1	1	7
Family Connections	0	2	1	0	0	3
Trust-based Relational Intervention (TBRI)	1	1	0	1	0	3
Nurturing Parenting Program (NPP)	1	3	4	3	1	12
ACT Raising Safe Kids	0	1	0	2	0	3

[1]Level 1 is defined as a 'well-supported practice' for which there have been at least two rigorous randomized controlled trials completed in different practice settings.
[2]Level 2 is defined as a 'supported practice' for which for which there has been at least one rigorous randomized controlled trial completed.
[3]Level 3 is defined as a 'promising practice' for which there has been at least one study performed that utilizes some form of control (e.g. comparison group).

Two practices were selected for a more in-depth exploration of their implementation and utilization throughout the state. These were the Wraparound model (www.nwi.org) and the Nurturing Parenting Program (www.nurturingparenting.com). Selection of these practices was based on their fairly widespread use, their relevance to the Demonstration goals, and the fact that expansion of both practices had been a focus of ongoing statewide initiatives. Additional data collection sought to assess how these programs were being used, the extent to which they had been implemented with fidelity to the program models, what processes were being utilized to measure fidelity, and how many children and families were receiving these services. Table 3 provides an overview of which lead agencies reported the inclusion of these practices as part of their service array, the service categories to which they apply (family support services (FSS), safety management (SM), treatment (Txmt), or child well-being (CWB)), and fidelity protocols. As shown in Table 3, 64.7% of lead agencies reported use of Wraparound, and 70.6% reported use of Nurturing Parenting.

Table 3

Provision of Wraparound and Nurturing Parenting

Wraparound						
Region	**CBC**	**FSS**	**SM**	**Txmt**	**CWB**	**Fidelity**
Northwest	Families First Network	X				Team Observation Measure (TOM)
	Big Bend CBC		X	X		Monitoring tool developed by Managing Entity
Northeast	Family Support Services of North Florida		X		X	Does not measure fidelity
	Family Integrity Program (St. John's County)	X		X	X	Does not measure fidelity
	Community Partnership for Children	X				Team Observation Measure (TOM)

Central	Embrace Families		X		X	Wraparound Fidelity Index (WFI)
	Brevard Family Partnership	X	X		X	Team Observation Measure (TOM)
Suncoast	Eckerd Community Alternatives	X				Does not measure fidelity
Southeast	ChildNet	X	X	X		Team Observation Measure (TOM); Survey
	Communities Connected for Kids	X				Team Observation Measure (TOM); Survey
Southern	Our Kids	X	X	X	X	Does not measure fidelity
Totals	11	8	6	4	5	7 (63.6%) agencies with fidelity protocols
Nurturing Parenting						
Region	**CBC**	**FSS**	**SM**	**Txmt**	**CWB**	**Fidelity**
Northwest	Families First Network	X				Does not measure fidelity
Northeast	Family Support Services of North Florida		X	X	X	Does not measure fidelity
	Partnership for Strong Families			X		Does not measure fidelity
	Family Integrity Program (St. Johns County)	X		X	X	Does not measure fidelity
Central	Brevard Family Partnership	X		X		Does not measure fidelity
	Embrace Families	X	X			Does not measure fidelity
	Heartland For Children	X	X	X		Case File Review Tool (provider developed)
	Kids Central, Inc.	X		X	X	Performance Measures Tool (self-developed)
Suncoast	Eckerd Community Alternatives	X				Does not measure fidelity
	Sarasota YMCA	X		X		Does not measure fidelity
	Children’s Network of Southwest Florida			X	X	Does not measure fidelity
Southern	Our Kids	X	X		X	Does not measure fidelity
Totals	12	9	4	8	5	2 (16.7%) agencies with fidelity protocols

As shown in Table 3 above, lead agencies reported using Wraparound for a variety of purposes, but most frequently reported its use as a family support service (72.7%). Slightly over half of the agencies (n = 6) characterized their status as moderate to full implementation of the Wraparound model, while the remaining agencies reported being in earlier stages of implementation. Eligibility criteria varied depending on how the program was used. For example, agencies using Wraparound as a family support service offered the program to families whose children were deemed safe but at high or very high risk of future maltreatment according to the CPI assessment. Three agencies reported that Wraparound was provided to families whose children are assessed to be unsafe and at-risk of removal, and have a safety plan in place to keep the children at home. Two agencies specified that the service was provided to families whose children had substantial mental health issues.

Sixty-three percent of the agencies that were using Wraparound reported that they or their contracted providers measured fidelity to the model. The fidelity tool most commonly in use was the Team Observation Measure (TOM), an instrument available through the National Wraparound Initiative that is completed during family team meetings. While there was considerable consistency in the fidelity tools that agencies used, the extent to which fidelity data were readily available and being analyzed varied considerably. Most agencies stated that they received reports from their providers, but typically these focused on established performance measures and did not require providers to compile aggregated fidelity data. For example, one lead agency explained that their Wraparound providers completed the TOM and then used it to provide immediate feedback directly to the Wraparound facilitators; they did not provide the completed instruments or aggregated data to the lead agency, rather, they were only required to report on their performance measures.

Two lead agencies shared copies of their Wraparound reports. Four identified fidelity criteria were highlighted from each agency (see Table 4). While the criteria differed between the agencies, as shown in the table, they capture similar components, including family engagement, satisfaction with services, and transition planning. The data presented in Table 4 indicate that both agencies performed fairly well on the measures examined, although some areas show room for improvement. In particular, transition from services appeared to be an area that presented significant challenge for Agency 2, with fewer than half of their cases achieving a successful transition.

Table 4

Fidelity Data for Wraparound Service Delivery

Agency 1		**Agency 2**	
Fidelity Criteria	**% of cases that met criteria**	**Fidelity Criteria**	**% of cases that met criteria**
Families referred to program engaged in Wraparound process. (Performance Goal: 90%)	81.1% (471 cases)	The Wraparound team had at least monthly contact with the family.	93% (91 cases)
Family teams consist of at least 51% informal and community supports. (Performance Goal: 90%)	90.2% (490 cases)	The youth/family participated in the planning process, e.g. helped choose their services and treatment goals.	84% (52 cases)
Families and referral sources were be satisfied with services provided. (Performance Goal: 95%)	97.5% (446 cases)	Families that participated in Wraparound were satisfied with their services.	82% (52 cases)
Families whose cases were successfully closed had a transition plan.	100% (133 cases)	Families were successfully transitioned from services (e.g.	37% (91 cases)

(Performance Goal: 95%)		needs were met and case closure mutually agreed upon).	

Additional data was solicited from each lead agency regarding the utilization of Wraparound services for the most recent fiscal period, State Fiscal Year 17-18. These data are presented in Table 5 and include the number of families referred, the number of families that received services, and the typical service duration. As seen in the table, a number of agencies were unable to provide the requested data. For those agencies that provided data, the number of families served varied greatly, ranging from 53 to 790 families. This likely reflects a combination of factors, including population size (e.g. rural vs. urban communities), how the service is used (i.e. which service categories it is applied to), and the number of Wraparound providers available within each community.

Table 5

Wraparound Utilization, SFY 17-18

Region	CBC (n = 11)	Families Referred	Families Served	Average Duration
Northwest	Families First Network	398	264	6-9 months
	Big Bend CBC	93	198	4 months
Northeast	Family Support Services of North Florida	790	790	1-6 months
	Family Integrity Program	Data Unavailable	Data Unavailable	Data Unavailable
	Community Partnership for Children	Data Unavailable	Data Unavailable	Data Unavailable
Central	Embrace Families[1]	114	121	4 months
	Brevard Family Partnership	Data Unavailable	Data Unavailable	6 months
Suncoast	Eckerd Community Alternatives	94	53	3-6 months
Southeast	Childnet	Data Unavailable	Data Unavailable	9-12 months
	Communities Connected for Kids	Data Unavailable	Data Unavailable	9-12 months
Southern	Our Kids	Data Unavailable	Data Unavailable	Data Unavailable
Totals		1,489	1,426	

[1]Not all counties included in data reported.

As with Wraparound, agencies reported multiple service uses for the Nurturing Parenting Program, with the most frequently reported uses being family support service (75%) and treatment service (66.7%). Implementation of Nurturing Parenting appears to have expanded considerably during the Demonstration extension; in the final evaluation report produced at the end of the initial Demonstration period (Vargo, et al., 2012), it was reported that seven lead

agencies had implemented the program, whereas 12 lead agencies reported implementation during the current evaluation. While use of Nurturing Parenting has grown tremendously throughout the state, few agencies reported having protocols in place to measure fidelity. Most expressed that this was due to a lack of fidelity tools available through the program developer. Only two agencies reported that they assessed fidelity, and both had developed their own tools for this purpose, which combined components of the Nurturing Parenting program criteria along with agency-established performance measures and used a case file review process. Both agencies offered to share their fidelity tools and data with the evaluation.

Review of the fidelity tools identified four similar criteria that related specifically to the delivery of the Nurturing Parenting program model. These were 1) administration of the pre-test assessment, 2) development of an individualized family service plan, 3) delivery of parenting sessions, and 4) administration of post-test assessments. Table 6 provides a comparison of these fidelity criteria between the two agencies and the proportion of reviewed cases that met each criteria. One key difference between the two agencies' fidelity criteria was a focus on the content provided during parenting sessions (Agency 2) as opposed to a focus on the number of sessions completed (Agency 1). Another difference was a focus on whether clients met a minimum threshold on the post-test assessment (Agency 1) as opposed to simply whether clients completed the post-test assessment (Agency 2, although the agency did provide the completed assessments to the evaluation team for analysis). As shown in Table 6, both agencies performed well on their established fidelity criteria, although one caveat worth noting for Agency 1 is that apparently only half of the cases completed their services. Since it was reported that the program is often provided as a family support service, it is possible that the voluntary nature of these services often results in early termination by families.

Table 6

Fidelity Data for Nurturing Parenting Service Delivery

Agency 1 (n = 40 cases)		Agency 2 (n = 30 cases)	
Fidelity Criteria	**% that met criteria**	**Fidelity Criteria**	**% that met criteria**
The pre-test assessment (AAPI) was completed within the first 6 hours of service initiation.	97.4%	Pre-test assessments (AAPI, NSCS, & observation) completed at beginning of service initiation.	100%
A family nurturing plan was developed within the first 10 hours with the family's participation and includes individualized goals that address safety and risk issues.	91.7%	A family service plan was developed based on the family's needs identified through the AAPI pre-test assessment.	100%

If the case closed successfully, the family completed at least 12 or more parenting sessions.	95% (20 cases)	Content covered in the parenting sessions matched service plan, and sessions included the following: homework, parenting skill activity, and family nurturing time.	100%
Families that completed NPP achieved a score of 4 or higher on each of the 5 parenting constructs on the AAPI post-test.	100% (20 cases)	Post-test assessments (AAPI, NSCS, observation) were completed at the end of the program.*	100%

Note. If applying Agency 1's criteria of scoring at least 4 or higher on each construct, 70% of the 30 cases met this criteria.

Additional data gathered on the utilization of Nurturing Parenting are presented in Table 7 for State Fiscal Year 17-18. Once again, a number of agencies were unable to provide the requested data, but for those who did, the number of families served ranged from 53 to 495. Across all agencies that reported utilization data, approximately 2,050 families were referred to Nurturing Parenting, and 1,534 received the service.

Table 7

Nurturing Parenting Utilization, SFY 2017-2018

Region	CBC (n = 12)	Families Referred	Families Served	Average Duration
Northwest	Families First Network	174	107	6 months
Northeast	Family Support Services of North Florida	Up to 790*	Up to 790*	1-6 months
	Partnership for Strong Families	Data Unavailable	Data Unavailable	Data Unavailable
	Family Integrity Program	Data Unavailable	Data Unavailable	Data Unavailable
Central	Brevard Family Partnership	Data Unavailable	Data Unavailable	Data Unavailable
	Embrace Families	Data Unavailable	Data Unavailable	15 weeks
	Heartland for Children	Data Unavailable	Data Unavailable	12-16 weeks
	Kids Central, Inc.	205	89	4 months
Suncoast	Eckerd Community Alternatives	94	53	3-6 months
	Sarasota YMCA	787	495	10-12 weeks
	Children's Network of Southwest Florida	Data Unavailable	Data Unavailable	12 weeks
Southern	Our Kids	Data Unavailable	Data Unavailable	Data Unavailable
Totals		2,050*	1,534*	

Note. FSSNF offers Nurturing Parenting as part of their FAST in-home services program; FAST workers are trained in the NPP model and provide the service to those clients who have a need for parenting skill development, but the agency does not track which FAST clients do or do not receive NPP.

Casework practice. The focus groups conducted with child protective investigators and case managers explored a variety of topics related to efforts that promote family preservation, expedite permanency, and connect families to appropriate services that meet their needs. Child welfare professionals identified factors that supported them in their work, and barriers that impeded their ability to achieve these goals. While several themes are identified in the following analysis, it is important to recognize that there is variability in the experiences and perceptions of child welfare professionals. The analysis exposes various perspectives arising through the focus group interviews while also identifying common themes. Findings related to casework practice are organized according to the following domains: 1) purpose of the child welfare system, 2) attitudes towards in-home services, 3) safety assessment and decision-making, and 4) family engagement processes. Several themes are explored within each domain. Furthermore, findings from the first round of focus groups (2016) are compared with findings from the second round (2018) to identify areas of consistency as well as changes that have occurred over time.

Purpose of the child welfare system. Case managers and child protective investigators unanimously identified child safety as the primary objective of the child welfare system and their leading concern as professionals. This finding was consistent throughout both sets of focus groups; the phrase "keeping children safe," or some variant was stated in every focus group when discussing the purpose of the child welfare system. Respondents added that they also address permanency and well-being of children, but that ensuring child safety was first and foremost, "Obviously we're all based on child safety. So when we actually go out to the house, our primary concern is the children, to make sure that they're safe in the house." The focus on child safety was reiterated at multiple points, for example, when discussing the use of in-home services or decision-making around the removal of children.

Expanding on this, many respondents discussed child safety within the context of efforts to preserve the family unit and emphasized the use of a family-centered approach. "It's more you deal with the family whole as a unit. It's no longer just focused on the child. It's the family," one case manager explained. Among both child protective investigators and case managers, there was a strong sense that their objective was "to do everything possible to keep the families together." As one investigator clarified, "Our ultimate goal is not to remove the child. It's for us to implement services so that you can help yourself to make sure that this doesn't happen again."

Child protective investigators emphasized that under the new child welfare practice model, efforts were made to preserve the family first, and removal was only undertaken if children's safety cannot be ensured in the home. Removal was generally described as a last, although sometimes necessary, resort. One investigator explained,

> We try to do everything in our power not to remove a child. But if we have situations [where] we have a resistant parent or the home is just in a state where we can't leave the child and know that he's safe when we leave the home, we might not have any choice.

Case managers similarly expressed beliefs that it was better to keep the family together if child safety can be ensured. Most commonly, the perceived benefit to using an in-home approach was a reduction in the trauma experienced by children. Several participants expressed that the act of removal itself might be more traumatizing to the children than the actual abuse or neglect, emphasizing the impact that removal has on a child's mental health and sense of self. Others noted that keeping children in the home was less traumatic for the entire family. In situations where removal was deemed necessary, the focus continued to be on preserving the family unit, as clearly articulated by case managers, "Our goal is always reunification."

Along these lines, participants described a related objective as strengthening families and building their protective capacities. "It's about tools in the toolbox, right? ...Making sure our families that we work with have the right tools, the resources to handle whatever situation that comes across them," a child protective investigator stated. A case manager articulated that their goal is to "increase parenting skills, so they can keep their children safe." Other participants expressed similar beliefs that their role included "strengthening families," "preserving the family," or "keeping families together" while ensuring a safe environment for the children. These statements indicate that participants viewed family preservation as a critical component of their work, but stressed that child safety must come first. Furthermore, the findings indicate that caseworkers were strongly aligned with the goals of the Demonstration to reduce child removals and preserve families, and this remained consistent throughout the Demonstration extension. The consistency of these findings over time suggests that the values of child safety *and* family preservation have been firmly embedded within the child welfare system.

Attitudes towards in-home services. Caseworkers identified a number of benefits associated with the use of an in-home or family preservation approach to child welfare. One of the primary benefits from the perspective of caseworkers was a reduction in trauma to both the children and parents. In addition to reducing trauma experienced by families, some participants described an improved ability to address the family's needs as another benefit to using an in-home services approach. First, participants expressed that they were better able to assess the family dynamics and situation if the family remained together. One case manager explained,

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

A more in-depth assessment then facilitates the ability of the caseworker to identify the family's needs and connect family members to appropriate services. Case managers felt that when children were kept in the home, they were better able to observe changes in parents' behaviors towards the children.

Furthermore, it was noted that the services provided to the family through this approach were more likely to meet the family's needs, because providers were also able to assess the entire family unit. "Hopefully, the services are more beneficial being that you're in the family, surrounding the issue… If they're doing the services in the home, they're able to actually see the family in their setting, their normal routine," one case manager explained. A child protective investigator added that, "It gives the parents an actual chance to learn." Parents can begin to

make behavior changes and apply new skills that they learn through services immediately, and providers can tailor their services and offer feedback to parents based on observations of the family.

Finally, participants felt that using an in-home services approach was beneficial in holding parents accountable since their children remained in their care while being monitored by DCF or the case management agency. Across a number of the focus groups, one perception was that for some parents, having their children removed was like a "vacation" or "honeymoon" because it relieved them of their parental responsibilities. A slightly different take offered by a case manager was that having the children in the home kept the parents motivated to stay on track.

> Those kids are the strongest motivation. I've had a child where I had to take the kid from the home 'til I found a suitable safety manager… mom went out and [binged]… She had no reason to stay clean… And so, keeping them in the home, when they're rolling over in the middle of the night and they see their child in the bed next to them, sometimes that's enough motivation for them to keep doing good.

Similarly, a child protective investigator asserted that families were more receptive and thus easier to engage in services if the children remained in the home. Conversely, other participants believed that removing children created a greater motivator for parents, "You take somebody's kids away, they are a lot more motivated to behavior change because they want those kids back." Thus, while a number of caseworkers felt that keeping children in the home while working with the family was a more effective means for maintaining parental responsibilities and motivation, this perception was not shared by everyone. Personal experience appears to play a critical role in shaping these attitudes, as caseworkers with little or no experience with in-home cases were most likely to express skepticism.

While child welfare professionals were generally supportive of family preservation, they reported that keeping children in the home left them with a heightened concern for child safety. As one case manager described, "You'll be doing something random with your family or your friends, and something will pop into your head, and you're like, oh… is this kid okay right now?" One reason for this was a concern that caseworkers were not seeing the whole picture in the beginning, as families might try to hide what was going on. Related to this, a number of respondents described cases in which they had a bad feeling or were certain something was not right in the home but were unable to prove their suspicions.

Embedded within these concerns were certain assumptions about the relative safety of children in out-of-home care and beliefs about the inadequacies of their biological families.

Many participants explicitly stated they were concerned about the safety of children who remain in the home with their parents but did not express concerns about the safety of children in out-of-home placements. One respondent conveyed the sense that a child's circumstances were much more stable in out-of-home care compared to when they remain in the home, "There's a calm, consistent home, where you can 85-plus percent guarantee their safety in that home. Whereas, most of my [in-home cases] safety is variable per day." Child welfare professionals generally worried more about children who remained in the home with a safety plan than they did about children who were removed, despite their acknowledgement of the trauma caused by removal. These findings revealed a degree of uncertainty about the extent to which in-home services can ensure child safety.

Child welfare professionals attempted to address their concerns through the implementation of safety plans, safety management services, and more frequent home visits. Typically, this involved a combination of formal (service providers) and informal supports (e.g. extended family members, friends, neighbors). Most case managers reported making weekly, and sometimes more frequent, home visits for their in-home cases. Another common strategy was to have a relative or other close family support move into the home to help monitor the situation. On the other hand, a concern was whether these family supports could be trusted, as one case manager explained, "Whether the people who are managing the safety plan are really going to provide you accurate information… I think that's always a fear in the back of your head." A child protective investigator provided a similar response, "Are they actually following the safety plan? Is the safety manager just blowing smoke?" In response to these concerns, it was explained by respondents during the second round of focus groups that there had been a lot of additional training and resources provided around safety planning. As one case manager described,

> That's what we spend a lot of time focusing and training on the importance of safety plans and how that's it, if you have a good safety plan in place and you're monitoring it appropriately, I don't know that you can actually prevent it, you can reduce the chance of things happening, but you will see what's happening and hopefully we can, you know, intervene quick enough… And so we work with our families, we try to identify those protective factors and assess them exactly right so that we know where they need help and then make sure that we have the right services there, and then we're monitoring... I think 99 percent of the time when we do those things, you know, things work out well for us.

While concerns about safety plans and the ability to ensure children's safety in the home continued, caseworkers in the second round of focus groups expressed increased confidence in their abilities to develop and monitor safety plans. Furthermore, although some resistance remained, for the most part respondents appeared to embrace a shift towards more in-home services, as one case manager summarized, "And ideally, a couple years from now, we're hoping that this is the primary role of case management, is [non-judicial in-home services] as opposed to taking the judicial action."

Safety assessment and decision-making. The assessment process was identified as key to ensuring child safety and was described as an ongoing process that continued throughout the life of the case. Per the policy and practice guidelines, an initial assessment of the child's safety and risk is completed by the child protective investigator. The differentiation between safety and risk is an important distinction established under the child welfare practice model. The safety assessment concerns whether there currently exists a concrete, clearly identifiable threat to the child's safety, referred to as "danger threats." Danger threats may include imminent (occurring in the present moment) or impending (will occur within the foreseeable future) dangers that threaten the safety of children if left unresolved. According to the child welfare practice model, the presence of either type of danger threat requires child welfare intervention, whereby services are "non-negotiable," although there is the possibility of pursuing either an in-home or out-of-home case.

In contrast, the assessment of risk concerns the identification of family characteristics that have been indicated by research to be associated with a greater likelihood of child maltreatment. The results of this assessment yield a classification of the family that ranges from "low" to "very high" risk of future maltreatment, but the key distinction is that the children are currently safe (i.e. there is no imminent or impending danger). Under the child welfare practice model, families considered "high" or "very high" risk but for whom there is no actual presence of danger towards the children are to be offered voluntary services, rather than receiving formal, mandatory child welfare intervention (Florida Department of Children and Families, 2015). This approach recognizes that being at-risk does not mean that maltreatment is currently occurring or that the occurrence of maltreatment is inevitable, and thus proposes to limit the use of mandatory intervention for those families where there are clearly identifiable threats to child safety.

Once the initial assessment is completed by the investigator and the case transfers to case management, the case manager is expected to build upon the investigator's assessment and complete updates every 90 days. According to focus group participants, the ongoing nature

of the assessment process allowed caseworkers not only to identify areas where progress had been made, but also to identify new and changing needs arising over the course of the case. Participant responses at both time points indicated that this view of assessment as an ongoing process was deeply embedded within their practice.

Assessment was also an area where a clear role differentiation emerged between child protective investigators and case managers. As described by participants, assessments fulfilled three primary purposes: 1) to determine the safety and risk of children and make decisions about removal accordingly, 2) to determine the family's needs and identify appropriate services, and 3) to assess changes in needs and progress made over time. Child protective investigators emphasized their role as "first responders," which focused on assessing the immediate safety of children and typically did not allow them the opportunity to assess change over time. "We're only involved for 60 days," investigators emphasized, "so we can't [assess change]." Case managers, on the other hand, articulated that while they continued to assess safety on an ongoing basis, only the investigator had the authority to make removal decisions; therefore, case managers indicated that any safety concerns they believed warranted a removal must be reported to DCF to make this decision. Overall, safety determination (in the sense of making removal decisions) was understood to be primarily a child protective investigator responsibility, while assessment of change over time was considered primarily a case management responsibility. These findings remained consistent over time.

Respondents during both the first and second rounds of focus groups identified the primary tools they use for conducting their assessments as those specified by the child welfare practice model: the safety and risk assessment (completed by CPI) and the family functioning assessment (FFA, completed by both CPI and case management). The FFA is the process outlined in DCF policy by which information is gathered, analyzed and assessed to determine child safety in the household where the alleged maltreatment occurred. This process was designed to provide a current analysis of the family situation by the child welfare professional responsible at different points in time, beginning with the Family Functioning Assessment-Investigations. After a case involving an unsafe child is transferred to ongoing case management, the family assessment is documented in the Family Functioning Assessment-Ongoing Services (FFA-Ongoing) and Progress Updates (CFOP 170-1).

Evaluations of the assessment process and tools varied among participants and over time. During the initial set of focus groups, many respondents, particularly child protective investigators, reiterated that the Family Functioning Assessment (FFA) process reflected a considerable practice change, and it was evident that caseworkers were still adjusting to the

child welfare practice model, which was in the early implementation stage at the time. Some had positive reactions, expressing that this assessment produced a better understanding of the whole family compared to the process used under the previous practice model. The following narrative illustrates this perception,

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

From this perspective, the FFA process provided a more holistic picture of the family situation and enabled a better assessment of the family's needs, which ideally would reduce the likelihood of the family coming back into the system if the entirety of those needs were addressed.

On the other hand, some investigators during the first round of focus groups felt that the assessment process was too intrusive. Related to this perspective, respondents expressed that an unintended consequence could be an increase in removals because investigators were learning more about the comprehensive needs of their clients, but often found their community lacked the resources to address those needs. As a result, investigators reported that at times they felt their only option was to remove children if the resources to address their safety concerns were not available. Respondents indicated that this was not a fault in the logic of the practice model per se, but an issue of insufficient resources to adequately support the child welfare practice model.

Another widely reported concern was the amount of time required to complete the FFA, coupled with the tight timeframe in which caseworkers have to complete their assessment. Many child protective investigators expressed that it was difficult to provide the level of in-depth assessment expected in the allotted time and given the size of their caseloads. Across sites, it was reported during the first round of focus groups that caseloads had not been reduced accordingly to accommodate the child welfare practice model. As a result, investigators felt that they did not always conduct as accurate or comprehensive an assessment as expected. This frustration was also shared by case managers, one of whom characterized the situation as, "We have a week to design the next year of somebody's life." Although the expectation with the child welfare practice model was that the case manager would build upon the investigator's FFA, case managers emphasized that they could not rely on the work of the investigator, since their assessments were often rushed and incomplete.

Additionally, there was a sense among some investigators that this process was simply delaying decisions that were seen as inevitable. In one focus group it was expressed that

investigators were now putting significantly more time into their job and still “getting to the same place… All your shelters that you would have sheltered before you’re sheltering now, and vice versa. You know when you have a shelter.” Similar perceptions were shared in other focus groups that the implementation of the child welfare practice model had not impacted their decision-making. Thus, they did not perceive that the new assessment process had an impact on their decisions regarding child safety. In some focus groups, furthermore, it was reported that the assessment process produces a delay in the initiation of services. Child protective investigators in the first round of focus groups believed that they were required to complete the FFA prior to making service recommendations or referrals, and some even reported having referrals rejected because their FFA was not complete. This resulted in delaying services for families. For those families in need of immediate intervention to address safety concerns, such delays could result in the removal of children who might otherwise be maintained in the home with appropriate services.

Some child protective investigators, furthermore, disagreed with the ideology behind the child welfare practice model and the FFA. Whereas case managers generally tended to conceive of their role as social work, investigators were more likely to see their role as limited to investigation and did not necessarily identify as social workers. Although this was not true of all investigators, a substantial number did express such beliefs. For example, an investigator expressed that “It might be a social service, but our title is investigator, and it's not social worker.” In response, another participant added, “But they're trying to make us a social worker,” further conveying that a transformation of their role was occurring, which they did not support. In other focus groups, it was similarly expressed that child protective investigators did not feel comfortable with the changes to their role or possess the qualifications to conduct the kind of psycho-social assessment expected for the FFA and were not provided with adequate resources and supports to take on this role.

Another challenge identified during the initial focus groups involved implementation and understanding of the risk and safety assessments. Some caseworkers expressed concern that the assessment process (i.e. the FFA) was too subjective, and that safety criteria may be interpreted differently by various individuals, leading to different possible conclusions that could be reached for the same case. Caseworkers acknowledged that it can be difficult to set aside personal beliefs and values when making a safety assessment, as expressed by one case manager,

> I think sometimes it can tend to project our own thoughts of what we think the perfect family is or whatever… It can be tough sometimes to say I don't see that there are any real safety concerns. I don't feel good about it, but…

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

Furthermore, comments made across focus groups in the first round of data collection suggested that not all workers understood the distinction between safety and risk, or the correct procedures to follow based on their assessment results. One area that seemed to cause considerable confusion was with regard to assessing "imminent" versus "impending" danger threats. The concept of imminent danger appeared to be fairly clear among caseworkers, but impending danger was more difficult to comprehend and distinguish from risk. The following statement illuminates the uncertainty caseworkers felt about what actions they are able to take with regard to impending danger,

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

This comment reveals a misperception held by many caseworkers at the time that children could not be removed on the grounds of impending danger and that the child welfare agency was essentially powerless to enforce family interventions in such situations. Such commentary may be indicative of confusion between impending dangers versus risk.

Similarly, many caseworkers demonstrated poor understanding with regard to the use of voluntary versus non-voluntary services. Numerous child protective investigators described a process of trying to offer families voluntary in-home services first, and if the family failed to comply with those services, proceeding with removal of the children and mandatory services. This practice clearly contradicted the expectations outlined in the child welfare practice model and operating procedures, which states that if children are unsafe, services are non-negotiable. It was apparent from their responses that child protective investigators did not fully understand when it was appropriate to offer voluntary versus mandatory services to families, and often seemed to conflate voluntary services and in-home services as being one and the same. During one focus group, when further pressed by the interviewer as to whether they ever implemented court-ordered in-home services, rather than voluntary services, before reaching a conclusion that removal was necessary, the participants stated that if they have sufficient

evidence to file for court-ordered services, they simply removed the children because the same burden of proof was required. They further indicated that this was what Children's Legal Services (CLS) had instructed them to do, suggesting that the state's legal department was either not informed or not on board with the child welfare practice model in some jurisdictions. These responses further suggested that despite the widespread agreement that removal was a last resort, there might actually be substantial resistance to try in-home interventions if child protective investigators have the option to remove children.

Overall, there seemed to be a lack of confidence in the safety planning process at the time the first set of focus groups was conducted, which contributed to investigators' hesitance to try in-home interventions. Numerous respondents experienced safety plans that fell through and ultimately lead to a removal, which created further discomfort about the use of in-home safety plans. A significant concern for front-line workers was that they were generally held accountable for safety and removal decisions, regardless of how much control they actually had over those decisions. A strong sense of personal responsibility was reflected among participants. One participant, for example, expressed constantly feeling "just really worried about, you know, you don't want to hear on the news that that child is dead." Another caseworker described feeling that, "I wouldn't be able to live with myself if something happened, um, to a child, because I wasn't doing enough for that family. I would feel too responsible." Liability was a substantial issue that appeared to greatly influence casework practice and safety decisions, with many respondents expressing that they would rather err on the side of caution (e.g. remove the child) than take a chance with an in-home safety plan.

As these findings indicate, there was a great deal of tension at the time the first round of focus groups took place around the child welfare practice model and the changes in expectations for front-line workers. By the time the second round of focus groups occurred, it appeared that some of these tensions had been resolved or subsided, although some challenges remained. Implementation of the child welfare practice model was much further along by this point and focus group participants demonstrated greater understanding and comfort with the assessment process. Numerous respondents indicated that they found the tools to be effective and felt that the child welfare practice model had improved their ability to assess safety. One reported benefit of the child welfare practice model was having a clearly articulated procedure and everyone on the same page. As one investigator described,

> There's a whole new process from beginning to end, from pre-commencement to closure of a case. There's much more follow-up with your supervisor as well as the higher ups.

> Everybody has an eye on everyone's cases now, so it's a lot more evolved and a full process.

Another investigator similarly shared that, "Using the safety methodology model and the family functioning assessment, I think those things have improved our ability for further interviewing and doing these family assessments." These narratives indicate that a perceived strength of the child welfare practice model was that it provided for a more thorough and comprehensive assessment process and a greater degree of shared accountability than in the past.
On the other hand, some respondents still articulated uncertainties about the child welfare practice model and whether the assessment tools were the most effective options. Some child protective investigators continued to voice concern that there was a considerable degree of subjectivity in the assessment process. This concern was consistent with findings from the first round of focus groups, which suggests that these issues still have not been fully resolved.

Investigators also continued to struggle with a perceived lack of clarity in assessing danger threats and some of the nuances involved in how safety determinations are made. For example, some respondents were unclear about the influence that a family's prior history (or lack thereof) has on the significance of the safety assessment. A case manager, furthermore, questioned whether the assessment tools currently in use were the best tools available, suggesting that the State might consider exploring other tools that have gone through more extensive testing, "I just think there's a plethora of opportunities and tools that have been developed nationwide that could be looked into to evaluate our families better."

While attitudes towards the child welfare practice model were mixed, respondents did report that improvements had been made over the past couple years, particularly in terms of creating better guidelines and resources for safety planning. Caseworkers perceived that there had been significant improvements in the strength and quality of their safety plans. As noted previously, a lot of additional focus and training had been put towards this over the previous year. One change appeared to be a more rigorous assessment of individuals (such as relatives or friends) who were being incorporated as safety managers. This was still perceived as extremely challenging, as one case manager explained,

> Vetting out safety managers are really hard, because, you know, you have to know what their motivation is. You know, is their motivation to be protective of the child or are they the parents' friend and they're just trying to help their friend out?

Responses indicated that more thorough and careful vetting processes were being implemented, as well as regular follow up to ensure that safety managers comply with their requirements and maintain communication with the caseworker.

Respondents also reported greater utilization of formal safety management services, such as in-home providers that can help to monitor safety, compared to the prior round of focus groups. Additional reported changes were greater specificity in the safety plans and ensuring that safety plans included concrete actions and resources as opposed to promissory statements. While some respondents continued to express largely negative attitudes towards the use of safety plans, overall there was much greater support for safety planning compared to the past. Several respondents even reported great success with safety plans and their ability to prevent removals through effective safety planning.

A number of challenges were also identified during the second round of focus groups with regard to conducting safety assessments. One of the primary challenges reported was family resistance, typically fueled by a lack of trust or fear of the child welfare system. Families may deny caseworkers access to the home or children, refuse to answer questions, or provide dishonest answers to the caseworker. Another significant challenge, and closely related to family resistance, was the perception that caseworkers were always working with partial information. Even with a comprehensive assessment, respondents articulated that they never really knew everything about a family. Speaking to this issue, one case manager explained,

> It's difficult assessing the child's safety when we're only in there a snapshot of times, and you have to have that rapport with your families to be able to understand what they're talking about, and what they're really sharing, and what the overall picture really looks like when you're not there.

Caseworkers further expressed that even when families cooperated, parents were typically on their "best behavior" when the caseworker was present, thus limiting their ability to assess what the family dynamics actually looked like. Another limitation that was noted was the ability of children to communicate with the caseworker. Particularly when very young children were involved (e.g. infants, toddlers), the caseworker had to rely on information from other sources. Furthermore, the child's perception of normality and their attachment to their caregiver also shaped the testimony they provided to caseworkers. Similar challenges were noted with regard to information gathered from collateral sources, who may have their own biases that influence their cooperation with caseworkers and what they share. In general, respondents recognized that much of their assessment relied on the perceptions of people, which were necessarily subjective and partial. On the other hand, by triangulating information from a variety of sources, including collateral interviews, observations of the family, and prior reports, they reported that they were able to overcome some of these limitations. While many respondents felt that the assessment process was not perfect, most expressed the perception that it had

improved and was more comprehensive than the previous assessment procedures. The findings suggest that progress has been made, and continued training and mentoring would be beneficial to support workers in further developing and enhancing their skills.

Family engagement processes. Family engagement was widely recognized as a critical aspect of casework practice that facilitates accurate family assessments, family buy-in, and participation in services. Findings in this domain were largely consistent between the first and second round of focus groups. Among respondents, lack of buy-in and resistance from families were described as some of the greatest challenges they face and must overcome to be successful on a case. Their narratives highlighted the importance of having well-developed engagement skills.

Respondents offered several perspectives regarding the lack of buy-in often encountered, particularly in the early stages of a case. One explanation provided was that families struggle with acknowledging or accepting that there is a problem or that change is possible, especially if the issues are generational and have become normalized over time. A case manager explained,

> The initial recognition is just very difficult for some people to handle, or realize, understand. And if people don't recognize, and understand what's going on… it's going to be a difficult journey, if you don't understand what the issue, the core issue is.

Respondents expressed that it can be difficult to get families on board and find their own personal motivation to change in these circumstances. Participants further noted that non-judicial cases could be especially challenging, as parents may feel less obligated to comply given that services are voluntary. On the other hand, judicial cases may create stronger feelings of resentment that must be overcome to work successfully with the family. Effective engagement processes were regarded as vital for both types of cases, and respondents consistently emphasized the need to build rapport with clients.

Caseworkers felt that the confrontational nature of the child welfare system further complicated the situation, parents often feel forced into services, may blame caseworkers for the fact that their child has been removed, and have difficulty seeing the caseworker as someone who is there to help them within this context. "And it doesn't make providing services any easier when they already see us as somebody who's not on their team," one case manager concluded. Similarly, a child protective investigator explained that often families "don't trust DCF, they've had bad experiences in the past with the old system, so you have to overcome that."

Negative perceptions of the child welfare system, and DCF in particular, which abound in popular discourse add another layer to this resistance. This sentiment was especially prevalent among child protective investigators. “We’re always the villain, though. You just learn to accept it with the job,” one investigator lamented. “I don’t even turn on the news because they never say anything good about DCF. They never talk about those kids that we save every day.” Across focus groups, child protective investigators struggled with the constant criticism they faced, receiving the bulk of the blame if a child who was known to the system but not sheltered dies, while simultaneously being reproached as the people who take kids away. This popular image of DCF stood in stark contrast to how investigators viewed their actual role. “We don't need to be the evil people. We can be the people that help you and support you. That's what our families don't understand sometimes,” a child protective investigator asserted. Thus, in order to work effectively with the families on their caseload, respondents emphasized that they must change the perception families often have that the caseworker is working against them. There was a great deal of variability in terms of the strategies that caseworkers reported for engaging families. This suggests that, at least to some extent, family engagement processes are not defined so much by adherence to a strict set of practice guidelines, but rather, caseworkers bring their own individualized approaches and personalities into their practice. The perception that every caseworker has their own methods for engaging with families was expressed in several focus groups. It was reported that different families may respond better to different approaches, and thus the variability in family engagement strategies might be seen as a strength, enabling child welfare agencies to reassign caseworkers as needed to better match with the characteristics and personalities of families. Several common themes emerged with regard to engagement processes. Across the focus groups and across the two rounds of data collection, five key strategies for effective family engagement were identified: communication with families, being empathetic, soliciting family input, incorporating family supports, and use of encouragement and praise.

Caseworker discussions regarding communication generally emphasized a belief in full disclosure. Many caseworkers expressed that they explain the entire process to the family at the beginning of the case, including the possible actions the agency could take, the expectations of the parents and changes that they need to make, and the possible consequences and outcomes that could result. These narratives further stressed the importance of being upfront and honest in their communications with families. Caseworkers used expressions such as “brutally honest,” “truth-telling,” or “being real” with families. Being upfront and honest were seen as critical pieces in establishing trust with families, and thus being

able to engage families effectively. In addition, several caseworkers underscored the importance of breaking the situation down and explaining it in ways that are respectful and using words that the family understands.

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

There were also barriers to communication identified by participants. A substantial issue was the ability to communicate with families who do not speak English. While it was reported that an interpreter service was available for certain languages, such as Spanish, respondents noted that they work in communities with considerable immigrant populations who speak other languages, including various Central American dialects and Creole, for which interpretation was not always available. Even when an interpreter was available, respondents perceived the need to use an interpreter as creating a barrier in their efforts to build a relationship with the family since they were unable to connect with the family directly. As one respondent explained,

> Sometimes in those types of situations, and I've had cases where it bothers me that I can't speak, you know, maybe Creole or something else, because sometimes you want to really have that person truly understand the severity of the situation, and it's just like, 'Oh, okay'… It doesn't translate well. You're just hearing translation, but you don't translate the meaning, there is a feeling behind it as well.

Furthermore, caseworkers expressed concern that particular child welfare language does not always translate easily, and if the interpreter does not understand the child welfare field, they may not explain the concepts correctly.

Communication was also reported to be a challenge when it came to writing safety plans, not only with families who do not speak English but also with families who have limited literacy, as they are unable to actually read the safety plan that was developed. Although caseworkers walk through the safety plan verbally with the family, respondents expressed concern that after they leave the house, all the family has is a written document to refer back to,

and may be hesitant to call the caseworker with questions about the safety plan. These communication issues presented significant challenges to family engagement.

A second theme was an emphasis on demonstrating empathy and compassion. Respondents described strategies that included self-disclosing in order to relate to clients, allowing clients to vent and validating their feelings, and trying to view things from the client's perspective. One investigator explained,

> Would I want a CPI coming to my house, ringing my doorbell, talking about oh, you know, your house is nasty or something like that? You got to put yourself in their shoes. This is a stranger accusing them of something, you know. So, you have to have that empathy.

This was reiterated many times during the course of the focus groups. "At times you have to drop that title of an investigator and just be like, look, I can see you eye to eye… And yeah, just being willing to be that listening ear." Another investigator characterized it as "approaching them as a person and not an authority figure." Similarly, a case manager emphasized, "Showing them that we care and we believe in them, kind of giving them that sense of hope that we're on their side. We're not out to get them, but we really want to support them." Furthermore, focus group discussions indicated an effort by caseworkers to avoid blaming parents, recognizing that many of their clients are doing the best they can in very difficult circumstances (e.g. poverty, mental illness, raising children with special needs).

Soliciting family input regarding their needs, goals, and services was another widely reported strategy across both child protective investigators and case managers. Just as it is critical for the caseworker to communicate clearly and effectively with the family, it was considered equally important to provide the family with opportunities to communicate their perspectives. Investigators and case managers alike indicated that they engage families directly in the assessment process and encourage families to identify their own needs, as well as provide input about specific services they would like to receive or have received in the past. An important caveat was ensuring that the inclusion of the family's voice was meaningful. A child protective investigator explained,

> It's kind of like, making sure that when we make decisions, it's not just what we want or what we feel like this is what they need. Making sure that they are in that process, they're telling us, 'This is what I may need.'

Respondents reported that the family assessment process included interviews with both immediate, and when possible, extended family members or other collaterals to obtain a holistic picture of the family's strengths and needs. Families were also often included in the

development of their case plans, and among some case management agencies (although not all) family team conferencing was used to engage the family and the family's support system in the identification of the family's needs and possible services. Among those caseworkers that used some form of family team conferencing, this was viewed as a particularly effective approach. During the second round of focus groups, furthermore, several respondents cited the use of motivational interviewing as a key strategy to engage families in conversations about their goals and facilitate their desire to change.

Caseworkers expressed that they attempted to identify and include all the individuals that were important in the family's life. This may include various relatives as well as neighbors or close friends. They also indicated a strong focus on including children's voices in this process. "We talk with the kids too, if they're of an older, more verbal age. You know, we ask them how their relationship is with their parents," one child protective investigator explained. Case managers similarly expressed the value of including children's perspectives, "You can learn a lot by talking to kids."

In addition to obtaining necessary information about the family situation, soliciting family input also facilitated family engagement by giving families a voice and demonstrating the agency's interest and commitment to helping the family address their perceived needs. A case manager explained this in the following way, "Listening to them when they talk and addressing whatever their concerns are. Make it important to ask what their needs are. Am I listening to them?" As one child protective investigator explained, "We can identify and make recommendations, but we try to make them kind of identify their own needs, so that you can better provide them with the appropriate services." This and similar responses reflected an effort to reduce some of the confrontational aspects of the system by emphasizing the role of the caseworker as "helper." Overall, by soliciting family input, caseworkers reported being better able to identify services that were an appropriate "fit" for the family and engage families in services when families felt like their opinions and needs were taken into account.

Closely related to soliciting family input, the incorporation of family supports in safety and case plans comprised another critical strategy in the family engagement process. The incorporation of family supports, as discussed in the focus groups, extended the concept of "family engagement" beyond the nuclear family to recognize the role of the family's broader support network in ensuring child safety. Thus, not only were relatives and other supports asked for their input regarding the family's needs, they were also engaged as active participants in the child welfare intervention. One child protective investigator explained that they "look at the family support system. And if they have [an] adequate support system who's willing and

committed, we try to utilize the resources that the family has." In this way, caseworkers encouraged the family to use their natural support system so the family was not going through the system alone, which may increase the likelihood of success. This gave extended family members a role and also recognized alternative family structures and arrangements that clients may already utilize or could utilize to prevent a removal and keep the family together. In the words of one case manager, "I think that other family members should be involved. Because I've always learned that it takes a village to raise children, and it really does."

Furthermore, it was expressed that the incorporation of family supports may provide additional encouragement for the family or even facilitate the process of getting the family engaged in services when families were resistant to the child welfare intervention. On the other hand, it was reported that relatives may be equally distrusting of caseworkers and resistant to intervention by the child welfare system. "It's a positive and a negative," one caseworker explained, "because with that mentality of, you know, 'We're the bad guy,' a lot of the people that are safety supports will not be completely forthcoming with us."

Finally, the use of encouragement and praise was a prominent theme across focus groups, especially among case managers. Respondents noted that it was important to build the self-confidence of their clients, which entailed recognizing the client's accomplishments and efforts, encouraging them to use new skills developed through their services, and praising them when they did something well. For example, one case manager reported that she provided ongoing encouragement by "celebrating every small victory they have." The concept of advocating for the families on their caseload was often discussed in relation to encouragement. Respondents described advocating on behalf of their families for more community resources and for other system partners to recognize the efforts families were making. Several respondents also emphasized the importance of taking a strengths-based approach. One case manager expressed that,

> Sometimes, I think what we see and what the Department sees may be not always the same. So, sometimes we have to be their advocate. We might be the only one saying, 'Hey, let's try to look at strength-based,' as opposed to maybe a different way.

There was considerable variability in discussions of family engagement, suggesting a variety of approaches are used by different caseworkers. All discussions, however, contained a similar emphasis on how critical effective family engagement was to the success of a case. Furthermore, many similar themes were observed between the first and second round of focus groups, but one difference was the reported use of motivational interviewing, which was not mentioned at all during the initial set of focus groups but was frequently mentioned by

participants during the second round. DCF's practice guidelines specifically encourage the use of motivational interviewing, particularly with regard to encouraging families with safe-but-high-risk children to engage in voluntary services, and the Department released additional policy during 2016, CFOP 170-9, which further addressed standards for family engagement. These standards were clearly reflected in many of the responses provided by focus group participants, for example, assessing the parent/legal guardian's thoughts and feelings about the circumstances surrounding their child welfare involvement, and encouraging them to offer their perspective regarding their needs and the services that could help them.

Discussion

Findings related to the service array identified a variety of services provided throughout the state. Although service utilization data are limited due to a combination of poor response rates and lack of tracking mechanisms among lead agencies, the data that were made available to the evaluation at least provide a partial picture. The data are most complete with regard to family support services and safety management services, and indicate that lead agencies provided a variety of services to prevent families from formally entering the child welfare system and to help children remain safely in their home. Expansion of these services has been one of the primary focuses under the Demonstration extension, however, caseworkers expressed concerns about the adequate availability of such services. Long waitlists (e.g. four or more weeks; in some cases, several months) for certain services and lack of in-home providers were reported during focus groups with frontline staff. The most critical gaps in the service array identified by staff included affordable housing, subsidized childcare, and substance abuse. Addressing these gaps should be prioritized.

A significant strength identified through the evaluation was that there is a wide array of evidence-based practices that have been implemented in various parts of the state. Twenty-one evidence-based practices that had been implemented by one or more lead agencies were identified, including several that had been implemented nearly statewide. Further exploration of two selected evidence-based practices, the Wraparound model and the Nurturing Parenting Program, revealed that both practices are frequently used as family support services. A majority of agencies using the Wraparound model reported that they measured fidelity to the model (63.6%), with the most commonly reported tool being the Team Observation Measure. The extent to which these agencies aggregated and analyzed fidelity data, however, was limited and varied greatly. The findings suggest that agencies might benefit from more intentional analysis and use of available fidelity data. On the other hand, the majority of agencies using Nurturing Parenting reported that they did not measure fidelity. This was largely due to a lack of

fidelity tools from the program developers, and many agencies expressed interest in learning about possible fidelity tools. Two agencies reported that they had developed their own fidelity tools and offered to share their data. While the tools differed, they both addressed certain key principles of the program model. The findings overall suggest that greater attention to fidelity is needed throughout the state, and that lead agencies would benefit from further guidance on how to implement fidelity protocols.

Regarding casework practice, findings from the focus groups revealed a number of strengths and challenges that relate to the Demonstration. One important strength was that the majority of caseworkers valued family preservation and believed in the concept of keeping children in the home. These values remained consistent over time and place caseworkers in alignment with the goals of the Demonstration. At the same time, however, caseworkers expressed substantial concerns about ensuring child safety when children remain in the home, and exhibited a certain degree of distrust towards system-involved families, as well as skepticism about the effectiveness of in-home services, which can impact case decision-making. While these concerns persisted during the second round of focus groups, there appeared to be increased support among respondents for the use of in-home approaches and increased confidence in safety planning.

Focus groups also identified assessment as a critical component of casework and emphasized the value of conducting a holistic and comprehensive assessment. During the first round of focus groups, there were mixed reactions to the new assessment procedures implemented under the child welfare practice model; primary concerns included the amount of time required to complete the assessments and the invasiveness of the process for families. Findings further indicated that more comprehensive assessments did not necessarily translate into better decisions when it comes to determining risk and safety. A number of investigators explicitly stated that the implementation of the child welfare practice model had not had any impact on the way they made safety decisions. There was also evidence in the focus group discussions that many caseworkers had trouble understanding the distinction between risk and safety, as well as when to offer voluntary versus mandatory services. When the second round of focus groups was conducted, there continued to be variability in caseworker perceptions of the assessment procedures, but there were not as many overtly negative reactions as during the initial focus groups. Several respondents indicated that they believed their assessments had improved as a result of the child welfare practice model. The primary concerns during the second set of focus groups involved the subjectivity of the assessment process and the extent to which they must rely on people to provide the necessary information.

The importance of effective family engagement was emphasized across both rounds of focus groups. This was viewed as particularly critical in overcoming family resistance to services and completing accurate family assessments. Responses indicated that engagement strategies may vary across workers, but five core strategies were identified: communication with families, being empathetic, soliciting family input, incorporating family supports, and use of encouragement and praise. These findings were largely consistent between the first and second rounds of focus groups, however, one difference that did emerge was the reported use of motivational interviewing, which was not mentioned during the initial focus groups, but widely noted during the second round of focus groups.

Several significant challenges were identified that have an impact on the use of in-home services. One challenge was limited availability or accessibility of appropriate services to meet the needs of families. Unfortunately, most communities reported a lack of certain needed services, long waitlists for services, lack of transportation, and barriers created by insurance or lack thereof. If critical services are not readily available to implement immediately, caseworkers may be inclined to remove children in order to ensure safety. Relatedly, the perceived liability that is placed on caseworkers has a strong impact on decision-making processes. Most caseworkers expressed feeling that they are held solely accountable for what happens on their case, and this fear that they will be held personally responsible if something happens to a child under their care drives a greater inclination to remove children.

These findings remained consistent between the two rounds of focus groups, despite the Demonstration's focus on expanding the service array. Overall, the implication of these findings is that caseworkers need to have sufficient safety management services available in their local community to implement immediately and they need to have confidence in the effectiveness of those services. While some communities have developed and demonstrated extremely effective in-home service approaches, other communities continue to struggle with insufficient resources and are in need of further capacity development.

The Outcomes Study – Permanency, Safety, and Resource Families

The Demonstration extension allowed Florida to use title IV-E funds for services and programs beyond foster care maintenance including services that focus on improving child outcomes, such as reduction of abuse and neglect, promotion of permanency and family preservation. It was expected that by taking advantage of this opportunity, Florida CBCs would develop and implement preventive programs and intervention services, which in turn would result in fewer children placed in out-of-home care, fewer children who were maltreated after services were terminated, and more children who achieved permanency outcomes. In addition,

recruitment of foster parents who are able to provide a nurturing environment is essential to child well-being. Several key outcomes related to child safety, timely permanency, and well-being were hypothesized to improve over time and were assessed in the outcomes study.

To examine these hypothesized outcomes, specific indicators were developed and calculated. The indicators were selected based on the requirements outlined in Terms and Conditions and were developed in collaboration with the Florida Department of Children and Families. In addition, the impact of several child and family characteristics on outcome indicators was assessed. Specific indicators were developed and calculated to address these research questions. In addition, the impact of several child and family characteristics on outcome indicators was assessed.

Key Research Questions

Permanency Outcome Evaluation Questions

1. What is the number and proportion of all children exiting out-of-home care regardless of the reason for discharge within 12 months of the latest removal?
2. What is the median length of stay for children in out-of-home care (i.e., the number of months at which half of the children are estimated to have exited out-of-home care into permanency)?
3. What is the number and proportion of children who were reunified (i.e., returned to their parent or primary caregiver) within 12 months of the latest removal?
4. What is the number and proportion of children who exited out-of-home care into permanent guardianship (i.e., long-term custody or guardianship by relatives or non-relatives) within 12 months of the latest removal?
5. What is the number and proportion of children with finalized adoptions (i.e., the date of the Court's verbal order finalizing the adoption) within 24 months of the latest removal?

Safety Outcome Evaluation Questions

1. What is the number and proportion of children who were removed from their primary caregiver(s) and were placed into out-of-home care within 12 months of the date their in-home case was opened?
2. What is the rate of verified maltreatment as a proportion of the State's child population and/or as a proportion of the child population in each DCF Circuit?
3. What is the number and proportion of children that experience verified maltreatment while receiving out-of-home child welfare services?

4. What is the number and proportion of children that experience verified maltreatment within six months of case closure (i.e., termination of out-of-home services or in-home supervision)?
5. What is the number and proportion of children who re-enter out-of-home care within 12 months of their most recent discharge from out-of-home care?

Resource Family Outcome Evaluation Questions

1. What is the number of new and active licensed foster families that have been recruited?
2. What is the number of licensed foster families that have remained in an active status for at least 12 months?
3. What is the average number of months licensed foster families remain in an active status?

Key Outcomes

Permanency Outcome Indicators:

- Proportion of children who achieved permanency within 12 months of removal
- Proportion of children who were either reunified or placed with relatives within 12 months of removal
- Proportion of children with finalized adoptions

Safety Outcome Indicators:

- Proportion of children who did NOT reenter out-of-home care within 12 months of their most recent discharge from out-of-home care
- Proportion of all children who did NOT experience maltreatment within six months of case closure

Resource Family Outcome Indicators:

- The number and proportion of licensed foster families that were active at the end of a specific fiscal year and have remained in an active status for at least 12 months
- Proportion of newly recruited licensed foster families during a specific fiscal year

Cohorts

The outcomes analysis tracks changes in several successive state fiscal years (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, SFY 15-16, and SFY 16-17). The overall study design consisted of a longitudinal comparison of successive annual cohorts of children from birth up to age 18, who were involved with the child welfare system during the course of the Demonstration extension and during the last two state fiscal years (SFYs 11-12 and 12-13) of the originally approved Demonstration project.

Sample

Characteristics for children in out-of-home care. All children that were placed in and/or exited out-of-home care during SFY 11-12 through SFY 17-18 were included in the study. Of these youth, 51% were male. The average age was approximately 6 years (*M* = 6.4, *SD* = 5.3). A majority of children (67%) were White, 36% were African-American, 0.5% were Asian, and the remaining 0.5% were from other racial or ethnic groups. A substantial proportion of these youth (47%) had parents with substance abuse problems, and 18% of these youth came from families with domestic violence histories. In addition, 1.8% of children who were placed in out-of-home care had physical health problems, and 3.3% had behavioral problems.

Sample for the entry cohorts. Of children who were included in the SFY 11 through SFY 16-17 entry cohorts, 51% were male. The average age was approximately 6 years (*M* = 6.4, *SD* = 5.3). A majority of children (66%) were White, 33% were African-American, 0.5% were Asian, and the remaining 0.5% were from other racial or ethnic groups. A substantial proportion of these youth (47%) had parents with substance abuse problems, and 17% of these youth came from families with domestic violence histories. In addition, 2% of children who were placed in out-of-home care had physical health problems, and 3% had behavioral problems.

Sample for the exit cohorts. Of children who were included in the SFY 11 through SFY 16-17 exit cohorts 51% were male. The average age was approximately 6 years (*M* = 6.4, *SD* = 5.3). A majority of children (66%) were White, 33% were African-American, 0.4% were Asian, and the remaining 0.6% were from other racial or ethnic groups. A substantial proportion of these youth (46%) had parents with substance abuse problems, and 16% of these youth came from families with domestic violence histories. In addition, 5% of children who were placed in out-of-home care had physical health problems, and 4% had behavioral problems.

Methods

All indicators were calculated and presented based on state fiscal years. The following indicators were examined:

Predictor Variables

- Child age at the time the child was placed into out-of-home care
- Child gender
- Child race categorized into African American, Caucasian, and Other
- Maltreatment type including (a) sexual abuse, (b) physical abuse, (c) neglect, and (d) threatened harm defined as documentation reviewed yields a preponderance of evidence that the child is at real, significant and plausible threat of harm (State of Florida Department of Children and Families, 2017).

- Caregiver absence. Although the absence of a caregiver (e.g., incarceration or death of a parent) is not included in Florida Statutes as a type of child maltreatment, this category is recorded in the child information data set because a protective response is required.
- Presence of child serious physical health problems
- Presence of child behavioral problems
- Parental family structure
- Parental substance abuse
- History of domestic violence in the family

Data Sources

The data sources for the permanency, safety, and resource family indicators used during the evaluation were data abstracts taken from the Florida Safe Families Network (FSFN).

Data Analysis

Statistical analyses consisted of life tables (a type of event history or survival analysis[4]), Cox regression analyses (Cox, 1972)[5]. All analyses were conducted using SPSS software.

Results

Permanency

Proportion of children who exited into permanency within 12 months of the latest Removal. The proportion of children who exited out-of-home care into permanency during the first 12 months was calculated for the six entry cohorts including SFY 11-12, SFY 12-13, and SFY 13-14, SFY 14-15, SFY 15-16, and SFY 16-17. *"Exited into permanency"* is defined as an exit status involving any of the following reasons for discharge: (a) reunification with parents or original caregivers, (b) permanent guardianship (i.e., long-term custody or guardianship) with a relative or non-relative, (c) adoption finalized, and (d) dismissed by the court (see the description of the indicator in Appendix H, Measure 1).

As shown in Figure 5, the overall proportion of children who exited out-of-home care into permanency within 12 months for the state of Florida decreased from 50.4% for the cohort SFY 11-12 to 35.8% for the cohort SFY 16-17. Results of Cox regression analysis indicated that it was a significant decrease. National standard for entry cohort is 40.4% (Federal Register, 2014). This trend is consistent with the national trend indicating that from FY 2006 to FY 2016,

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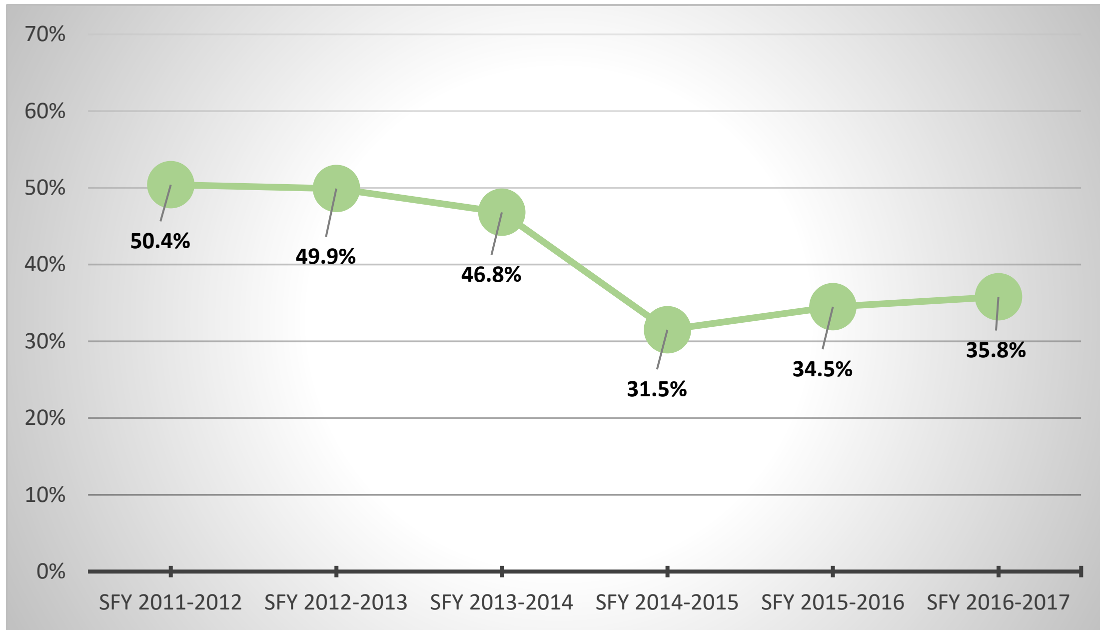
[4]Survival analysis, referred to here as event history analysis, is a statistical procedure that allows for analyzing data collected over time as well as for utilizing information about cases where the event of interest did not occur during data collection (e.g., children who did not exit out-of-home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

[5] A type of event history analysis that allows for inclusion of predictor variables or factors that were hypothesized to affect the outcomes.

there were decreases in the percentages of children who left the system to reunite with their parents or primary caregivers or live with other relatives while increases in the percentages of children who exited out-of-home care for reasons of adoption and guardianship (Child Welfare Information Gateway, 2017).

Figure 5. Number and Proportion of Children who Exited Out-of-Home Care for Permanency Reasons within 12 Months of Last Removal in the State of Florida by Entry Cohort



The effect of child and family characteristics on timely permanency. When predictor variables were examined using Cox regression, child age, Asian race, presence of physical health problems, behavioral problems, family structure, parental substance abuse problems, and domestic violence history were found to be significantly associated with timely achievement of permanency. Older children were more likely to achieve permanency, and each additional year of age corresponds to a 1% higher odds of exit into permanency within 12 months of entry. Children who were Asian were 22% more likely to achieve permanency. In contrast, children with physical health problems were 22% less likely and children who behavioral problems were 39% less likely to achieve permanency within 12 months compared to children who did not have these problems (see Appendix I, Table I1). Children who came from single parent families were less likely to be permanently placed (11% less likely if they came from a single male family and 8% less likely if they came from a single female family) compared to children who came from a two-parent family. Presence of parental substance abuse problems reduced the odds of timely permanency by 8%, but history of domestic violence

increased the odds of achieving permanency by 14%. The size effect for these associations was very small (odds ratio of 0.93 and 1.14, respectively) suggesting that these associations were very weak.

Proportion of children who were reunified with their original caregivers within 12 months. The proportions of children who entered out-of-home care in SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, SFY 15-16, and SFY 16-17 were discharged for reasons of reunification during 12 months after the latest removal was calculated for these entry cohorts (see the description of the indicator in Appendix H, Measure 2). As shown in Figure 6, the proportion of children reunified within 12 months of the latest removal for the state of Florida decreased from 34.3% in SFY 11-12 to 29.9% in SFY 16-17, a small but significant decline over time (see Appendix I, Table I2). National standard is not available for this indicator.

Figure 6. Proportion of Children who Reunified within 12 Months of the Latest Removal in the State of Florida by Cohort

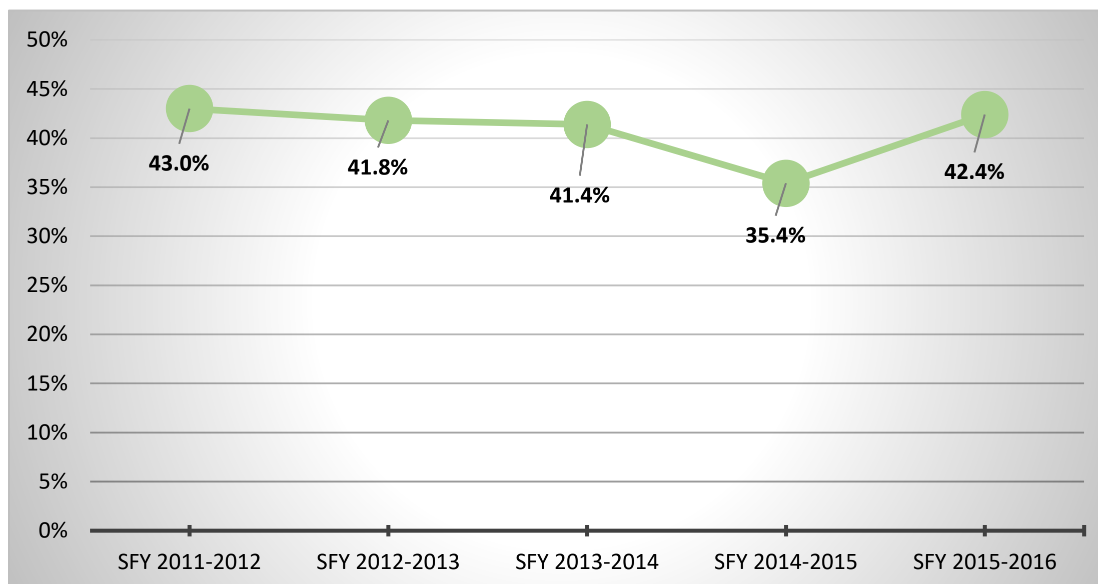
The effect of child and family characteristics on timely reunification or placement with relatives. When the effects of child and family characteristics were examined, child age, child race, presence of physical health problems, behavioral problems, family structure, parental substance abuse problems and history of domestic violence in the family were found to be significantly associated with timely reunification or placement with relatives (see Appendix I, Table I2). Specifically, older children were more likely to be reunified with each additional year

of age corresponding to 1% higher odds of being reunified with original caregivers. Children who were White were 5% less likely to be reunified, however, the effect size (i.e., odds ratio of 5%) was very small suggesting that this association is very weak. In contrast, Asian children were 21% more likely to be reunified with their parents. Children with physical health problems were 49% less likely and children with behavioral problems were 15% less likely to be reunified. Children whose parents had substance abuse problems were 14% less likely to achieve reunification, but children who came from families with domestic violence problems were 21% more likely to experience timely reunification. Compared to children who came from a two-parent family, children who came from a single parent families were less likely to be reunified - 6% less likely if they came from a single male family and 8% less likely if they came from a single female family. Although family structure (i.e., single female parent family) was significantly negatively associated with reunification, the effect size (i.e., odds ratio of 6% and 8%) was very small suggesting that these associations are very weak.

Adoption. The proportion of children who entered out-of-home care and were discharged within 24 months after placement in out-of-home care because of adoption was calculated for the SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, and SFY 15-16 entry cohorts. Entry cohorts for this indicator represent all children who were initially placed in out-of-home care and had *adoption* in their case plans as their primary goal. This indicator includes only one reason for discharge, “adoption finalized” (see Appendix H, Measure 3). Based on the Adoption and Safe Families Act of 1997 (ASFA) requirements regarding the length of the out-of-home care episode for children whose parents’ rights were terminated, the proportion of children who exited out-of-home care because of adoption was calculated for 24 months.

Figure 7 shows the proportions of children adopted within 24 months of their latest removal based on entry cohorts. As shown in Figure 7, the proportion of children with finalized adoption for the state of Florida declined by 7.6% in SFY 14-15, but increased back by 7% in SFY 15-16. The lower rate of adoption seems to correspond to a higher rate of reunification in SFY 14-15 and SFY 15-16.

Figure 7. Proportion of Children with Finalized Adoptions within 24 Months of the Latest Removal in the State of Florida by Cohort

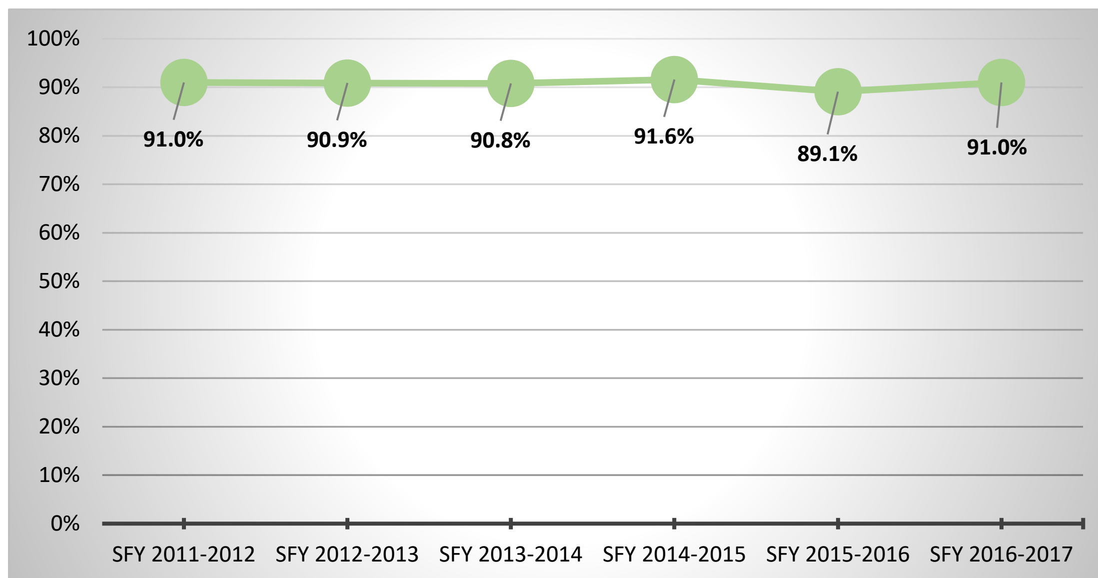


The effect of child and family characteristics on timely adoption. Several child and family predictors examined were significantly associated with timely adoption. The strongest predictors were child age and presence of physical health problems (see Appendix I, Table I3). Older children were more likely to be adopted and each additional year of age corresponded to a 2% increased likelihood of timely adoption. Children with physical health problems were over two times more likely to be adopted than children without physical health problems. Two factors were significantly associated with lower odds of timely adoption. Children with behavioral problems were 25% less likely to experience timely adoption and children who came from families with domestic violence issues were 15% less likely to be adopted.

Safety

Proportion of children who did NOT reenter out-of-home care within 12 months of their most recent discharge from out-of-home care for permanency reasons. Re-entry into out-of-home care was defined as all children who exited out-of-home care for permanency reasons during a given fiscal year (see description of the indicator in Appendix H, Measure 4). As shown in Figure 8, for the state of Florida the proportion of children without re-entry decreased by 2% by SFY 15-16 but then increased back to 91% in SFY 16-17. Results of Cox regression analysis indicated no statistically significant difference in re-entry into out-of-home care over time.

Figure 8. Proportion of Children Exited Out-of-Home Care and Who Did Not Reenter within 12 Months



The effect of child and family characteristics on re-entry into out-of-home care. When factors associated with re-entry were examined, child demographic characteristics, child physical health problems, behavioral problems, parental substance abuse, and domestic violence history of the family where the child came from were significantly associated with re-entry into out-of-home care. In particular, older children were more likely to experience re-entry and each additional year of age was associated with 1% increased odds of re-entry. Compared to children of other race/ethnicity, White children or African American children were more likely to re-enter out-of-home care (26% increased odds for White children and 28% increased odds for African American children). Children who had physical health problems were over two times less likely to experience re-entry and children with behavioral problems were 23% more likely to experience re-entry into out-of-home care. Children who came from the families with substance abuse issues were 10% less likely to reenter out-of-home care. Domestic violence was not a significant predictor for re-entry into out-of-home care (see Appendix I, Table I4). National standard for re-entry into care is 8.3%.

Rate of verified maltreatment as a proportion of the State's child population. The average proportion of child maltreatment victims per 1,000 children in the population for the state was 13.5% in SFY 11-12, 12.9% in SFY 12-13, 11.9% in SFY 13-14, and decreased to 10.9% in SFY 14-15. Overall, there was a reduction in the proportion of child maltreatment victims per 1,000 children in the population by 2.6% from SFY 11-12 to SFY 14-15. The results of ANOVA indicated that this reduction is statistically significant.

Abuse during foster care by fiscal year. Overall, the statewide rate of abuse in licensed foster care through the four-year period between SFY 11-12 and SFY 14-15 was less than 5%. ANOVA results indicated that there is no statistically significant difference between the average number of verified maltreatment reports during services received in each examined fiscal year over time (Vargo et al., October, 2016).

Proportion of all children who did NOT experience maltreatment within six months of case closure by State Fiscal Year. The proportion of children who did NOT experience verified maltreatment within 6 months of service termination slightly increased from 95.9% in SFY 11-12 to 96.5% in SFY 15-16. Federal standards that refer to similar indicators (i.e., Absence of Abuse within 6 months, or absence of maltreatment recurrence within 12 months) are 94.6% and 99% (HHSD, 2014). Although there was a trend indicating an increase in the number of children who did not return to the child welfare system after their services were terminated, the results of Cox regression analysis identified no statistically significant difference in maltreatment recurrence over time (Armstrong et al., April, 2018.

Resource Families

The number and proportion of licensed foster families that were active at the end of a specific fiscal year and have remained in an active status for at least 12 months. This measure examined the subset of foster families who were active at the end of a specific fiscal year and remained in an active status at the end of the year. The proportions of foster families who were active at the end of a specific fiscal year and remained in an active status at the end of the next fiscal year were calculated for SFY 14-15, SFY 15-16, SFY 16-17, and SFY 17-18.

Table 8 shows by lead agency, the proportion of licensed foster families that were active at the end of a specific fiscal year and remained in an active status for at least 12 months. As shown in Table 8, Our Kids of Miami-Dade/Monroe, Inc and Family Support Services of North Florida have the highest proportions of licensed foster families (80.6% and 82.6%, respectively) that remained active for at least 12 months in SFY 14-15. In contrast, Children’s Network of SW Florida and Partnership for Strong Families have the lowest proportion (69%) of these families in SFY 14-15.

For SFY 15-16 Embrace Families (Seminole) and Our Kids of Miami-Dade/Monroe, Inc had the highest proportions of licensed foster families that were active after 12 months 88.2% and 80.8%, respectively. Families First Network had the lowest proportion of licensed foster families who were in active status after 12 months – 68.4%.

In SFY 16-17 it was again Our Kids of Miami-Dade/Monroe, Inc that had the highest (82.8%) of foster families that remained in an active status for at least 12 months. Partnership for Strong Families had the lowest proportion of such families in that year (63.3%).

Finally, in SFY 17-18 Brevard Family Partnership had the highest (79.4%) of foster families that remained in an active status for at least 12 months and Communities Connected for Kids had the lowest proportion of licensed foster families that were active after 12 months (see Table 8).

Table 8

Proportion of licensed foster families that were active during a specific Fiscal Year and have remained in an active status for at least 12 months

Counties in Circuit	Lead Agencies	SFY 14-15	SFY 15-16	SFY 16-17	SFY 17-18
		%	%	%	%
Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Washington, Wakulla	Big Bend CBC, Inc.	76.7	71.2	69.8	73.4
Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	71.7	68.4	63.4	68.6
Flagler, Putnam, Volusia St. Johns	Community Partnership for Children, Inc.	69.9	79.0	75.0	76.6
Duval, Nassau	Family Support Services of North Florida, Inc.	82.6	75.1	74.8	76.4
Clay	Kids First of Florida, Inc.	73.8	70.1	68.2	65.1
Alachua, Baker, Bradford, Gilchrist, Levy, Union Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families	69.0	76.9	63.3	78.0
Brevard	Brevard Family Partnership	79.2	72.9	70.1	79.4
Orange, Osceola	Embrace Families	79.8	75.1	81.3	62.5
Seminole	Embrace Families	75.7	88.2	67.7	65.6
Hardee, Highlands, Polk	Heartland For Children	76.2	74.1	78.1	76.1
Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	74.0	71.8	76.4	78.6
Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	68.7	72.6	72.3	73.4

Pasco, Pinellas	Eckerd Community Alternatives	76.2	77.2	73.8	78.7
Hillsborough	Eckerd Community Alternatives	73.1	73.5	71.4	74.3
DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	75.0	77.8	77.9	76.5
Broward	ChildNet, Inc.	72.0	74.7	69.4	71.7
Palm Beach	ChildNet, Inc.	70.4	73.1	64.8	71.3
Indian River, Martin, Okeechobee, St. Lucie	Communities Connected for Kids	74.5	70.9	64.0	54.8
Miami-Dade, Monroe	Our Kids of Miami-Dade/Monroe, Inc.	80.6	80.8	82.8	75.9
	Statewide	74.7	74.6	72.0	72.8

Overall, the proportion of licensed foster families statewide that were active after 12 months slightly decreased over time form 74.7% in SFY 14-15 to 72.8% in SFY 17-18 (see Figure 9).

Figure 9. Proportion of Licensed Foster Families that Were Active after 12 Months statewide

The proportion of newly recruited licensed foster families. This measure examined the subset of foster families who were recruited for the first time during a specific fiscal year in relation to the number of children served. The number of foster families who were recruited for the first time during a specific fiscal year was examined for SFY 14-15, SFY 15-16, and SFY 16-17. This number was not available for SFY 17-18.

Table 9

Proportion of Newly Recruited Licensed Foster Families during a Specific Fiscal Year (N = 32,354)

Counties in Circuit	Lead Agencies	SFY 14-15	SFY 15-16	SFY 16-17
		%	%	%
Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Washington, Wakulla	Big Bend CBC, Inc.	3.7	5.7	4.1
Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	5.3	4.5	5.1
Flagler, Putnam, Volusia St. Johns	Community Partnership for Children, Inc.	2.5	2.7	3.6
Duval, Nassau	Family Support Services of North Florida, Inc.	7.1	7.9	9.1
Clay	Kids First of Florida, Inc.	6.9	13.8	8.2
Alachua, Baker, Bradford, Gilchrist, Levy, Union Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families	4.4	3.8	3.2
Brevard	Brevard Family Partnership	3.5	6.8	5.9
Orange, Osceola	Embrace Families	2.6	4.3	3.9
Seminole	Embrace Families	4.0	2.7	3.7
Hardee, Highlands, Polk	Heartland For Children	2.8	2.7	2.4
Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	2.6	3.1	4.6
Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	6.7	5.8	5.8
Pasco, Pinellas	Eckerd Community Alternatives	3.1	3.1	3.5
Hillsborough	Eckerd Community Alternatives	3.5	5.1	6.4
DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	2.8	1.7	4.8
Broward	ChildNet, Inc.	9.1	7.6	7.1
Palm Beach	ChildNet, Inc.	6.8	6.1	6.1
Indian River, Martin, Okeechobee, St. Lucie	Communities Connected for Kids	6.3	6.5	7.2
Miami-Dade, Monroe	Our Kids of Miami-Dade/Monroe, Inc.	3.7	4.0	4.5
	Statewide	4.4	4.6	5.1

Table 9 shows the proportion of newly recruited foster families in relation to the number of children served in out-of-home care. As indicated in Table 9, the proportion of newly recruited foster families ranges from 2.5% to 9.1% in SFY 14-15; from 1.7 to 13.8 in SFY 15-16, and from 2.1% to 9.1% in SFY 16-17.

In SFY 14-15 ChildNet-Broward had the highest proportion of newly recruited foster homes (9.1%). In contrast, Community Partnership for Children had the lowest proportion of newly recruited foster homes (2.5%). In SFY 15-16, Sarasota YMCA/Safe Children Coalition had the lowest proportion of new foster homes and Kids First of Florida had the highest (13.8%). Finally, in SFY 16-17, Family Support Services of North Florida had the highest proportion of newly recruited foster families (9.1%) and Heartland for Children had the lowest (2.4%). Overall, the proportion of newly recruited foster families increased over time by 0.7% from 4.4% in SFY 14-15 to 5.1% SFY 16-17.

Discussion

Overall, longitudinal trends for permanency indicators revealed a steady trend. Although there is a trend of a declining proportion of children who achieved timely permanency including reunification, the adoption rates remained high and steady over time. Thus, it appears that compared to the years preceding the implementation of the Demonstration extension, a much higher proportion of children achieved permanency via adoption and lower proportion of children achieved permanency because of reunification or placement with relatives (Vargo et al., 2012). It appears that decline in reunification rates and permanency achieved through reunification is due to the expedited timelines instituted by federal and state law. Achieving permanency through reunification requires extensive collaboration with other agencies, the courts, as well as extra time. At the national level, administrators reported relief by staff, as timelines provided a rationale for terminating a parent's rights and seeking a permanency option other than reunification for children whose parents are not able to resolve issues that brought the child into care US DHHS, 2001).

An examination of safety indicators showed that the proportion of children who continue to stay safe remained stable over time. Specifically, there is a significant decrease in the number of verified child maltreatment cases per 1,000 child population over time and this reduction was almost 3% (Vargo et al., April, 2016). Although no significant differences were found, there is a trend indicating improved performance statewide on the rate of child maltreatment during foster care placement (Vargo et al., October, 2016) and on the proportion of children who did not experience verified maltreatment after either in-home or out-of-home services were terminated (Armstrong et al., April, 2018). Re-entry into out-of-home care

remained stable over time and approximately 91% of children did NOT reenter out-of-home care across the Demonstration extension years.

When the effects of child and family characteristics on outcome indicators were examined, results showed that child age, physical health and behavioral problems, parental substance abuse, and history of domestic violence played an important role in predicting child outcomes. Specifically, children with physical health and behavioral problems or children who came from families with substance abuse issues were less likely to achieve permanency and less likely to be reunified. Children whose parents had domestic violence issues were more likely to achieve permanency or reunification but they were less likely to be adopted and more likely to reenter out-of-home care. Presence of child behavioral problems is associated with multiple adverse outcomes including safety and permanency.

Findings also indicated considerable variability over time in the proportions of licensed foster families that were active after 12 months and the proportion of newly licensed foster families. Examination of statewide rates over time suggested that proportion of licensed foster families that were active after 12 months and the proportion of newly licensed foster families remained stable.

Although there have been demonstrated areas of improvement in ensuring child safety, permanency, and well-being there remains room for further progress. These include additional attention to children with behavioral problems, and possibly provision of evidence-based services and interventions for families with substance abuse and domestic violence issues.

It is important to note a few limitations in conducting this outcome analysis. First, the study design did not include a comparison group (e.g., counties where the extension of the Demonstration project was not implemented), because the Demonstration was implemented statewide. Because a comparison group was not available, longitudinal comparison was performed using entry or exit cohorts. No time by group interaction was examined. Second, due to data limitations, predictor variables were limited to child demographic characteristics, presence of child physical health problems, and only two family characteristics: (a) presence of domestic violence in the family and (b) parental substance abuse. Finally, the findings do not account for the effects of the lead agency characteristics or characteristics of the Circuits.

The Outcome Study: Child and Family Well-Being

As part of their quality assurance program, the Department utilizes the federally-establish guidelines to conduct ongoing case reviews in accordance with the Child and Family Services Reviews (CFSR) process (U.S. Department of Health and Human Services, 2014). The constructs of child and family well-being have been examined according to the applicable

CFSR outcomes and performance items. These outcome and performance items focus on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, mental health needs.

Key Research Questions

The hypothesis of the child and family well-being outcome analysis was that there would be an improvement in the physical, mental health, developmental, and educational well-being outcomes for children and their families. The key research questions pertaining to this hypothesis are below.

1. Did the agency make concerted efforts to assess the needs of and provide services to children, parents, and foster parents to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family?
2. Did the agency make concerted efforts to involve the parents and children (if developmentally appropriate) in the case planning process on an ongoing basis?
3. Were the frequency and quality of visits between caseworkers and children sufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals?
4. Were the frequency and quality of visits between caseworkers and the mothers and fathers of the children sufficient to ensure the safety, permanency, and well-being of the children and promote achievement of case goals?
5. Did the agency make concerted efforts to assess children's educational needs, and appropriately address identified needs in case planning and case management activities?
6. Did the agency address the physical health needs of children, including dental health needs?
7. Did the agency address the mental/behavioral health needs of children?

Data Sources and Data Collection

In SFY 15-16, Florida transitioned from quality of practice case reviews and quality service reviews, adopting use of the Child and Family Services Reviews (CFSR) into Florida's continuous quality improvement reports (CQI), which reflect federally-established guidelines to conduct ongoing case reviews (U.S. Department of Health and Human Services, 2014). Through these CFSRs, CBCs review cases to ascertain the quality of child welfare practices relevant to the safety, permanency, and well-being of children. Florida's CQI Child and Family Well-Being Outcomes 1, 2, and 3 are rated as Substantially Achieved (SA), Partially Achieved

(PA), or Not Achieved (NA); accompanying performance items are rated as either a strength or an area needing improvement. Performance item ratings are used to calculate a summated rating of the performance items addressing each outcome. The CFSR Onsite Review Instrument and Instructions (USDHHS, 2014) include details regarding the review process. Table 10 below shows the child well-being outcomes and performance items that have been reviewed for this report. The data utilized for this report were derived from the Online Monitoring System of FL CQI reviews.

Table 10

CFSR Well-Being Outcomes and Performance Items

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

Data Analysis

The following results show the number of cases reviewed that have been rated as substantially achieved for well-being outcomes and performance items rated as a strength. Results presented below represent finalized CFSR data from FL CQI case file reviews submitted on or before October 01, 2018 for the period under review (PUR) start year (July of 2014) through January of 2018, and CFSR data presented throughout the Demonstration evaluation. It is important to remember that the PUR is 12 months prior to review of the case.

To assess for significant differences between baseline data and that obtained through ongoing review, Wilcoxon matched-pairs signed-rank test was used. This is a non-parametric statistic used to compare ratings when the samples are not independent. This was the most appropriate test because ongoing review ratings include data reported at baseline. Significant differences are only assessed for statewide ratings.

Results

Appendix J shows tables (Tables J1 through J23) with the performance and well-being Items from baseline (data pulled from the FL CQI case reviews online system on September 30, 2016) to final ongoing review (data pulled from the FL CQI case reviews online system on October 01, 2018). The tables show the total number of cases, number of applicable cases, and percentage of cases rated as a strength for baseline and each ongoing review that was completed by the evaluation team.

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

As shown in Figure 10, ongoing review shows the percentage of cases rated as a strength statewide improved during ongoing review for in-home cases from 60% at baseline to 62% at the final ongoing review period. At the state-level, the changes from baseline to ongoing were not found to be statistically significant. At the Circuit-level for in-home cases, the percentage of cases rated as a strength improved over time with marked improvement[6] for Circuits 13 and 19. Circuit 12 also showed increases over time, but not marked improvement. Circuit 5 had a marked decline[7] over time. Circuits 1, 2, and 17 showed declines in the percentage of cases rated as a strength over time, but not marked decline. For foster care cases (Figure 11), ongoing review of FL CQI case review findings shows the percentage of cases rated as a strength statewide declined during ongoing review for foster care cases from 67% at baseline to 65% at the final ongoing review period. The changes from baseline to final ongoing review were not found to be statistically significant. At the Circuit-level for foster care cases, the percentage of cases rated as a strength showed marked decline for Circuits 5 and 11.

[6] For the purposes of the final report a marked improvement over time refers to an increase of at least 10% from baseline to final ongoing review for the percentage of cases rated as a strength, and consistent increases from baseline to prior ongoing review periods.

[7] For the purposes of the final report a marked decline over time refers to a decrease of at least 10% from baseline to final ongoing review for the percentage of cases rated as a strength, and consistent decreases from baseline to prior ongoing review periods.

Figure 10. Performance Item 12: Needs and Services of Child, Parents, and Foster Parents (In-Home Cases)

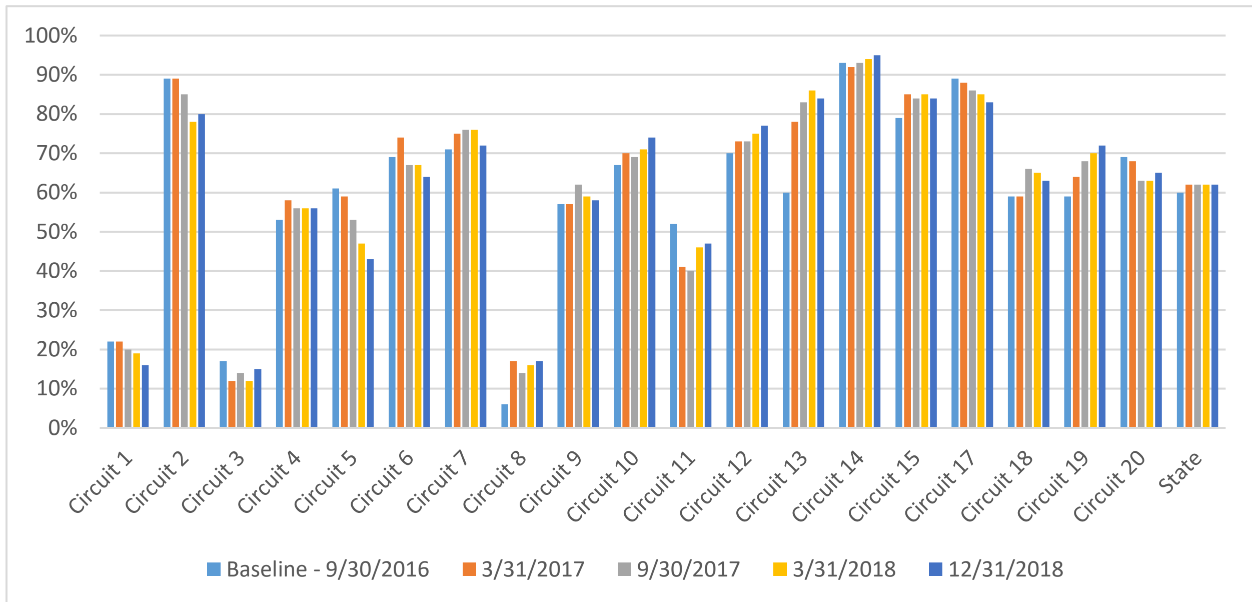
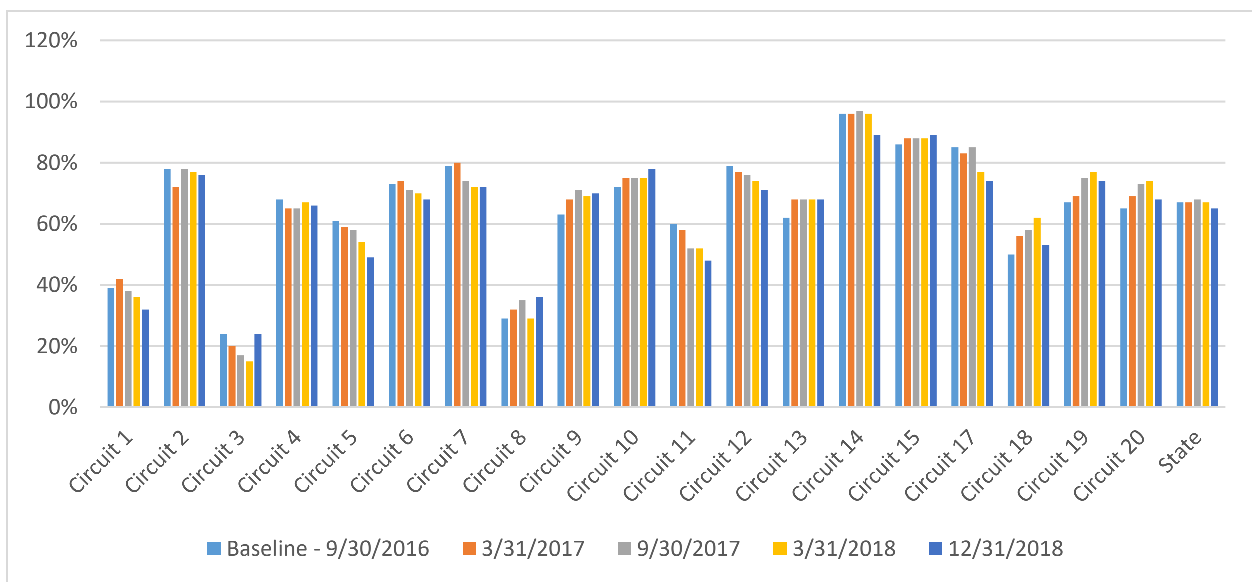


Figure 11. Performance Item 12: Needs and Services of Child, Parents, and Foster Parents (Foster Care Cases)



Performance item 12A. For sub-item 12A, the state increased slightly in the percentage of cases rated as a strength for addressing the child's needs from baseline (83% for in-home and 87% for foster care) to final ongoing review (85% for in-home and 88% for foster care) for both in-home and foster care cases (See Figures 12 and 13). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home

cases, the percentage of cases rated as a strength improved over time with marked improvement for Circuits 3, 8 and 13. Circuits 7 and 12 also showed increases over time, but not with marked improvement. For foster care cases, the percentage of cases rated as a strength showed marked improvements for Circuits 3 and 8 over time. Circuits 10 and 15 also showed increases over time, but not with marked improvement. Circuits 12, 17, and 18 showed declines over time.

Figure 12. Performance Item 12A: Needs Assessment and Services to Child (In-Home Cases)

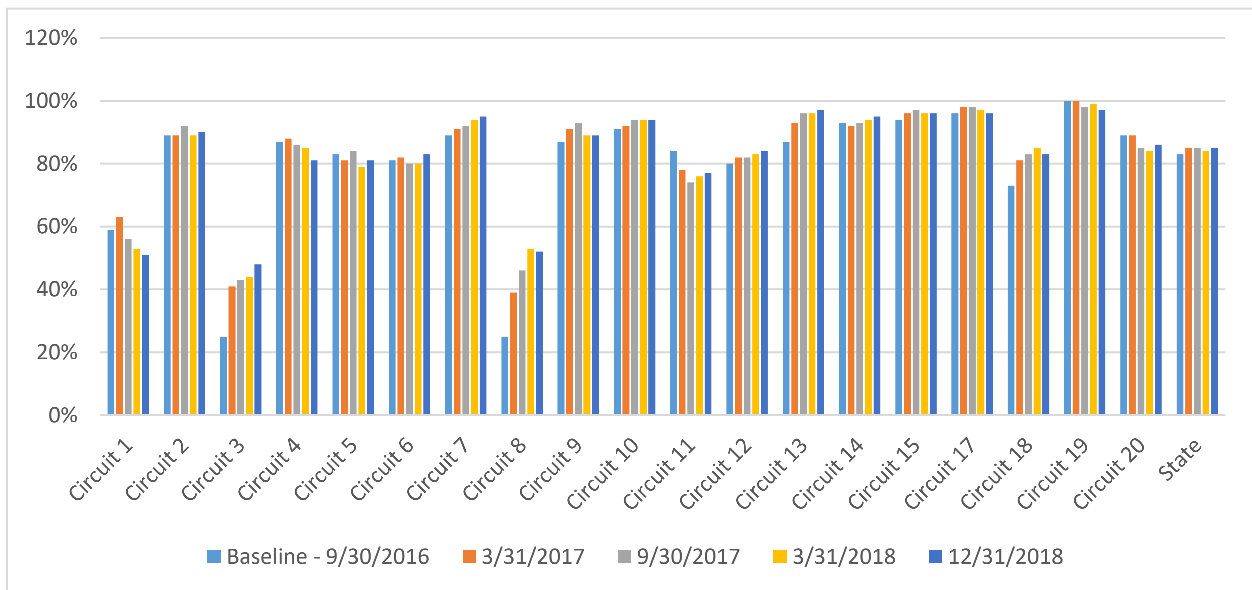
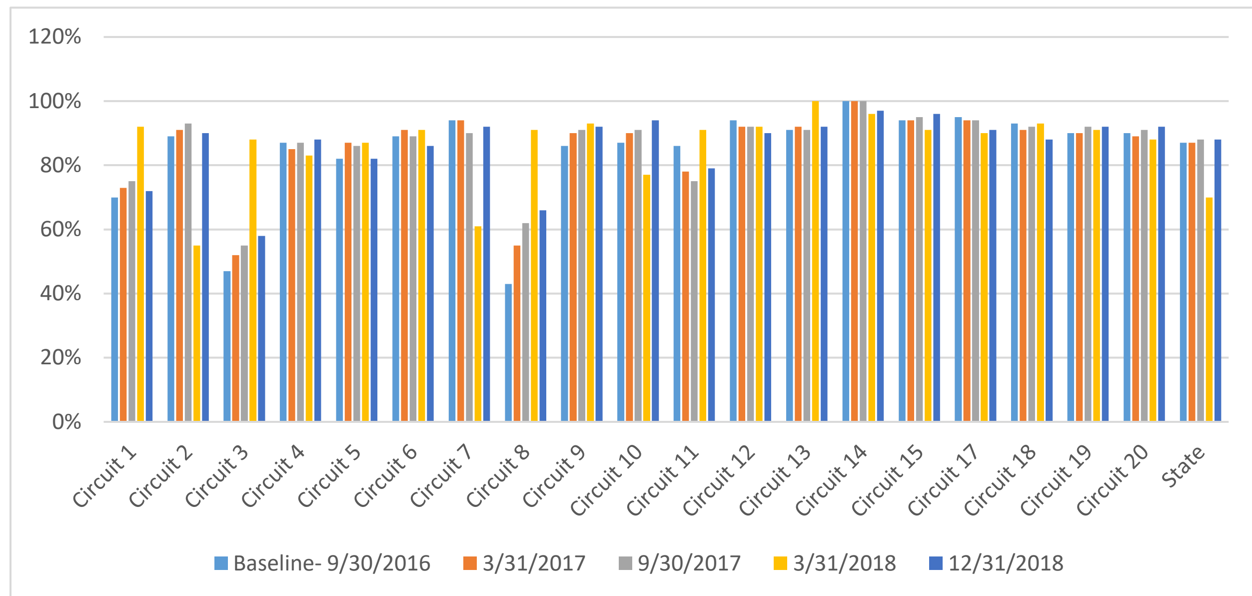


Figure 13. Performance Item 12A: Needs Assessment and Services to Child (Foster Care Cases)



Performance item 12B. For sub-item 12B, the State declined in the percentage of cases rated as a strength for addressing the parent's needs from baseline (66%) to final ongoing review (66%) for in-home cases (See Figure 14). The State decreased from 70% at baseline to 69% at final ongoing review for foster care cases. At the state-level, the changes from baseline to ongoing were not found to be statistically significant for both in-home and foster care cases. For in-home cases, the percentage of cases rated as a strength improved over time with marked improvement for Circuits 8, 13, and 19. Circuit 14 remained consistent over time with 100% of cases rated as a strength. Circuit 5 had a marked decline in the percentage of cases rated as a strength over time. For foster care cases (Figure 15), Circuits 5, and 11 had marked declines in the percentage of cases rated as a strength over time. Circuits 18 and 19 had marked improvements in the percentage of cases rated as a strength over time.

Figure 14. Performance Item 12B: Needs Assessment and Services to Parents (In-Home Cases)

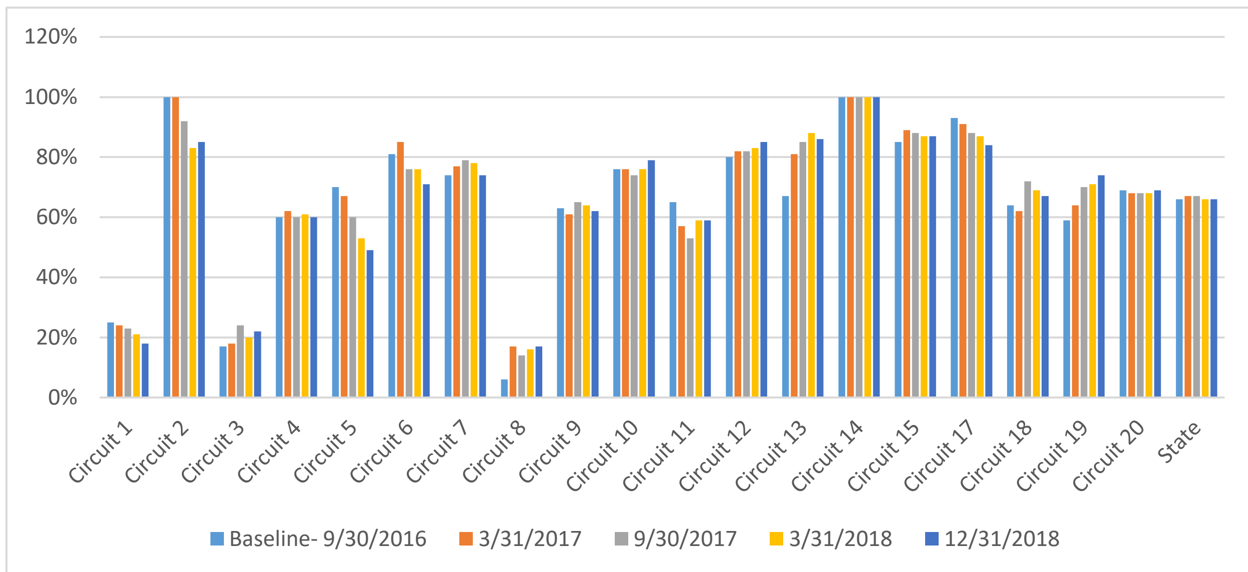
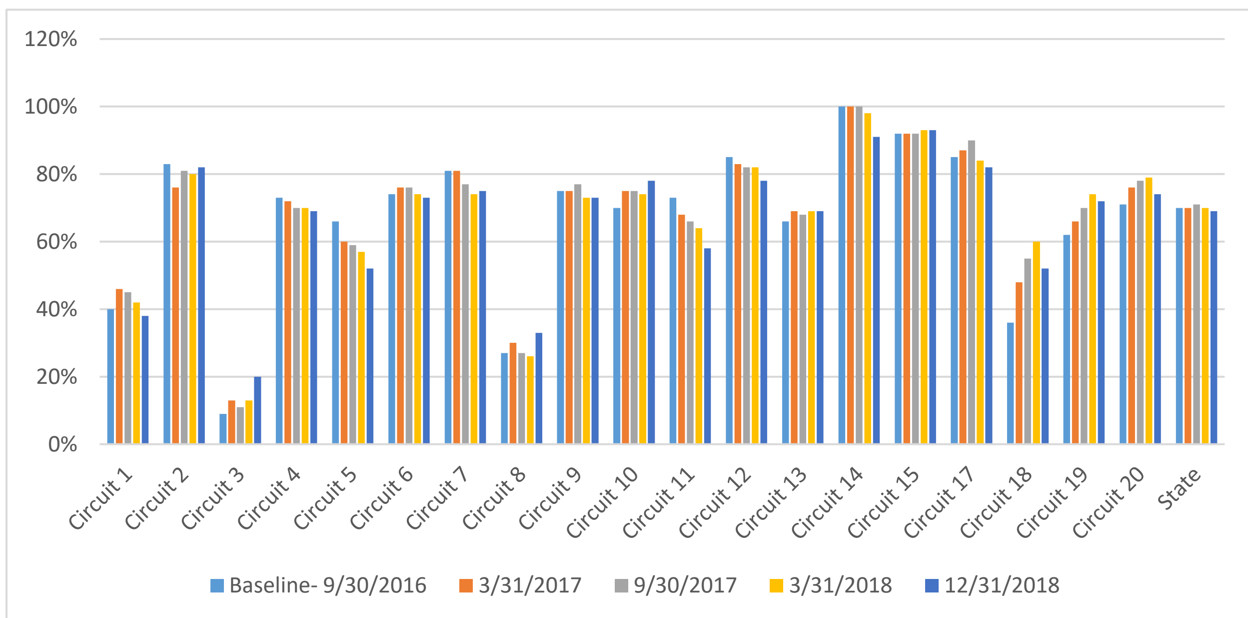


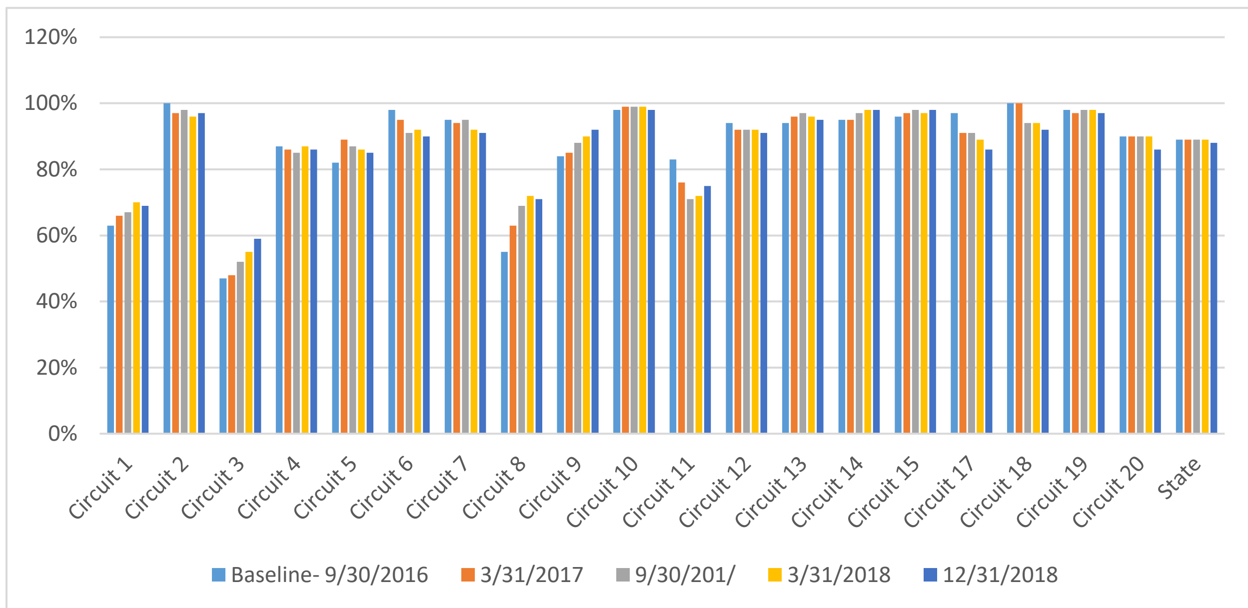
Figure 15. Performance Item 12B: Needs Assessment and Services to Parents (Foster Care Cases)



Performance item 12C. For sub-item 12C, the State decreased in the percentage of cases rated as a strength for addressing the needs of foster parents from baseline (89%) to final ongoing review (88%) (See Figure 16). This performance item is not applicable for in-home cases. At the state-level, the changes from baseline to ongoing were not found to be

statistically significant. Circuits 3 and 8 showed marked improvement over time. Circuit 17 showed marked decline in the percentage of cases rated as a strength over time. Circuits 5 and 9 showed improvements over time, but not marked improvements. Circuits 6 and 11 showed declines over time, but not marked declines.

Figure 16. Performance Item 12C: Needs Assessment and Services to Foster Parents/Caregivers (Foster Care Cases)



Performance item 13. This item pertains to efforts made to involve the parents and children (if developmentally appropriate) in case planning processes. The percentage of cases rated as a strength statewide declined slightly from baseline (60%) to final ongoing review (59%) for in-home cases and remained consistent from baseline (66%) to final ongoing review (66%) for foster care cases (See Figures 17 and 18). At the state-level, the changes from baseline to ongoing were not statistically significant for both in-home and foster care cases. For in-home cases, Circuit 8 showed marked improvement over time for the percentage of cases rated as a strength. Circuit 17 had marked declines in the percentage of cases rated as a strength over time. For foster care cases, Circuits 8 and 10 increased over time, but not with marked improvement.

Figure 17. Performance Item 13: Child and Family Involvement in Case Planning (In-Home Cases)

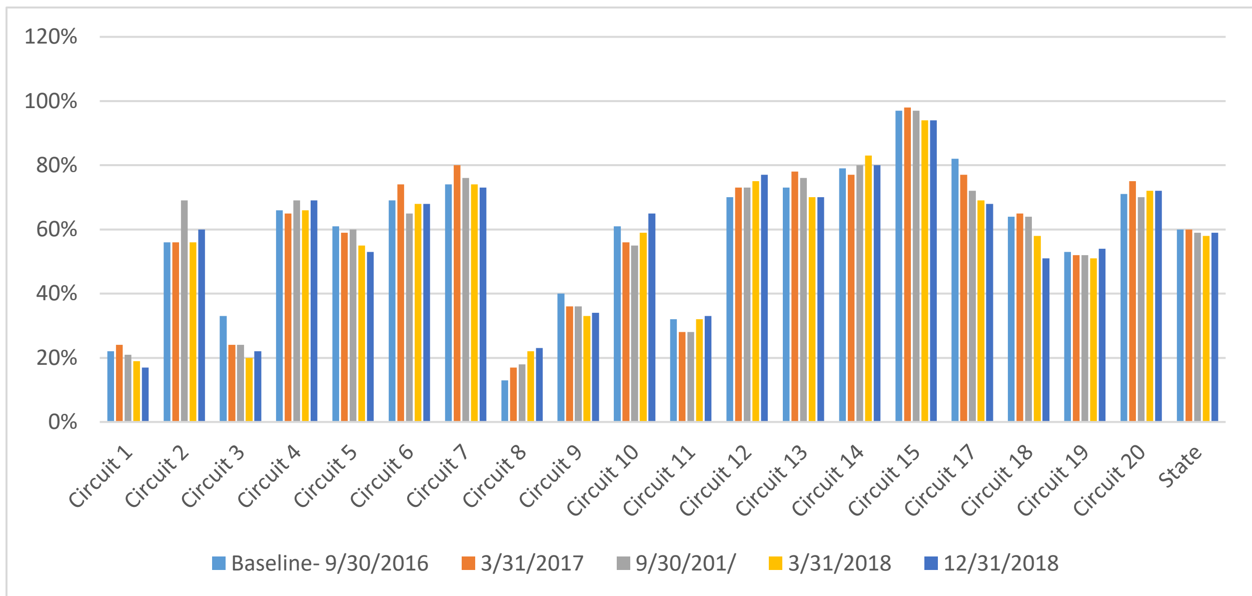
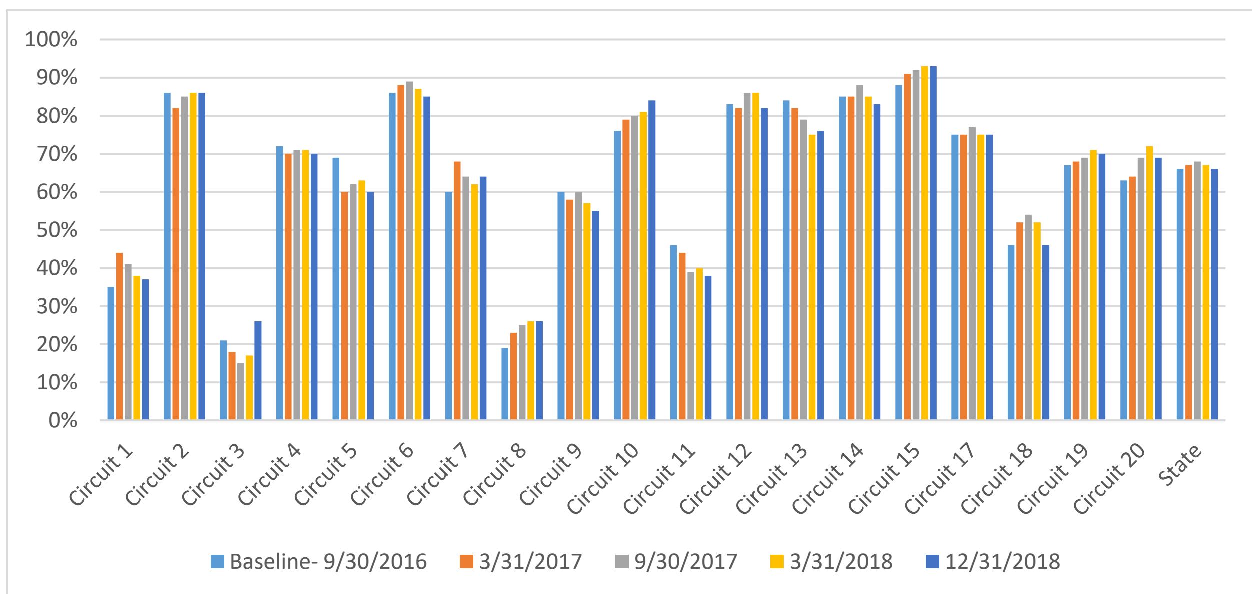


Figure 18. Performance Item 13: Child and Family Involvement in Case Planning (Foster Care Cases)



Performance item 14. This performance item considers the sufficient frequency and quality of visits between caseworkers and children to promote achievement of case goals in ensuring the safety, permanency, and well-being of the child. Final ongoing review shows the percentage of cases rated as a strength statewide increased slightly from baseline (59%) to final

ongoing review (60%) for in-home cases (Figure 19), and decreased from baseline (69%) to final ongoing review (68%) for foster care cases (Figure 20). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuits 8 and 19 showed marked improvement over time. Circuits 14 and 17 showed marked decline over time. For foster care cases, Circuit 1 showed marked improvements over time. Circuits 14 and 18 showed marked declines over time for the percentage of cases rated as a strength.

Figure 19. Performance Item 14: Case Worker Visits with Child (In-Home Cases)

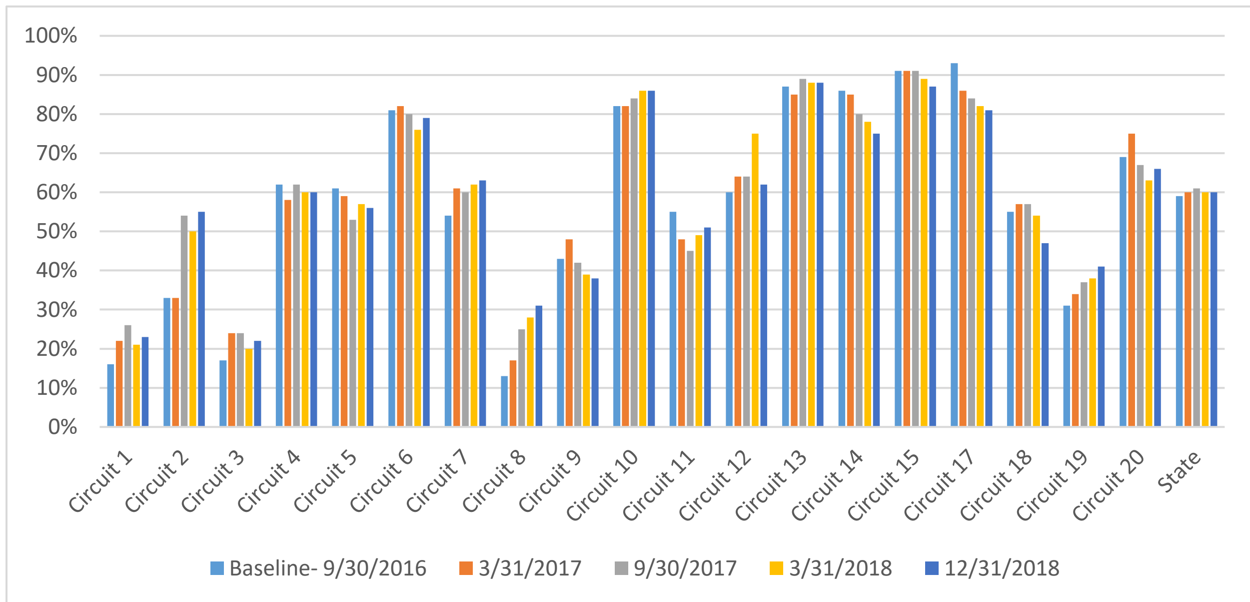
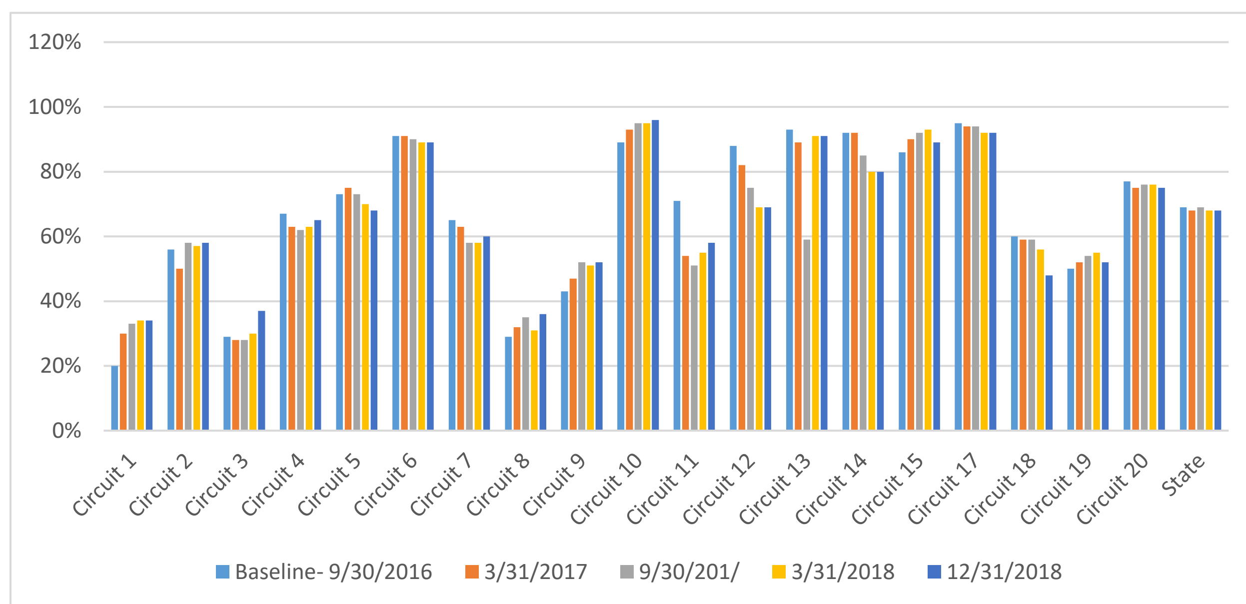


Figure 20. Performance Item 14: Case Worker Visits with Child (Foster Care Cases)



Performance item 15. This performance item considers the sufficient frequency and quality of visits between caseworkers and children's parents to promote achievement of case goals in ensuring child safety, permanency, and well-being. Final ongoing review shows the percentage of cases rated as a strength statewide increased slightly from baseline (44%) to final ongoing review (47%) for in-home cases (Figure 21) and increased from baseline (36%) to final ongoing review (38%) for foster care cases (Figure 22). At the state-level, the changes from baseline to ongoing were not found to be statistically significant for both in-home and foster acre cases. For in-home cases, Circuits 4, 15, and 19 showed marked improvements over time. Circuit 18 showed marked declines over time. For foster care cases, Circuits 17, 18, and 19 showed marked improvements over time. Circuit 12 showed a marked decline over time.

Figure 21. Performance Item 15: Case Worker Visits with Parents (In-Home Cases)

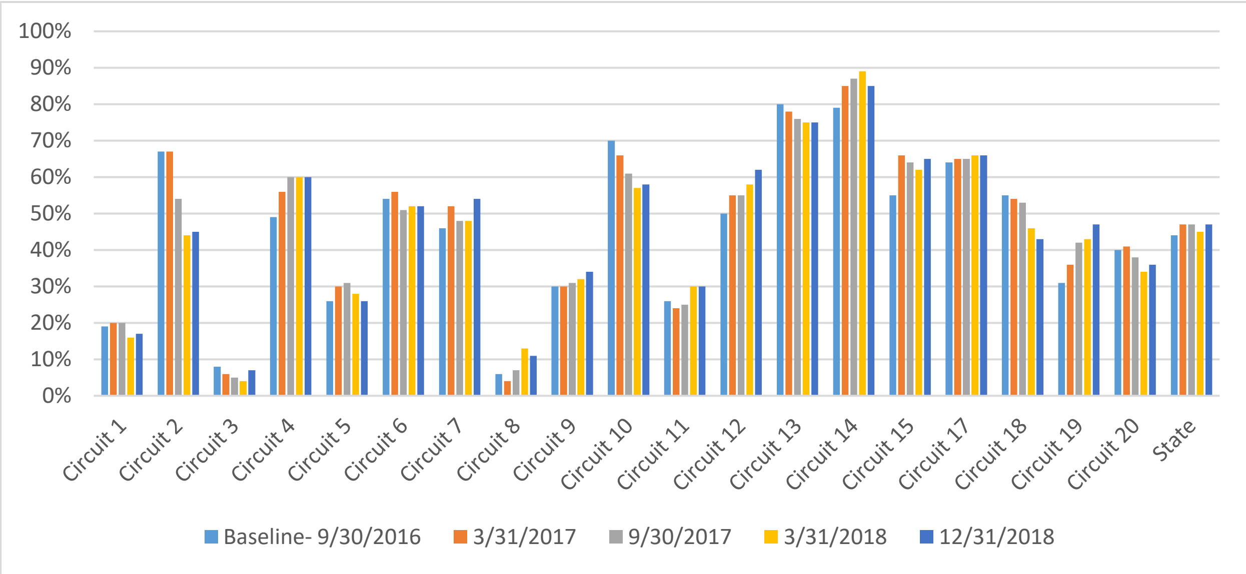
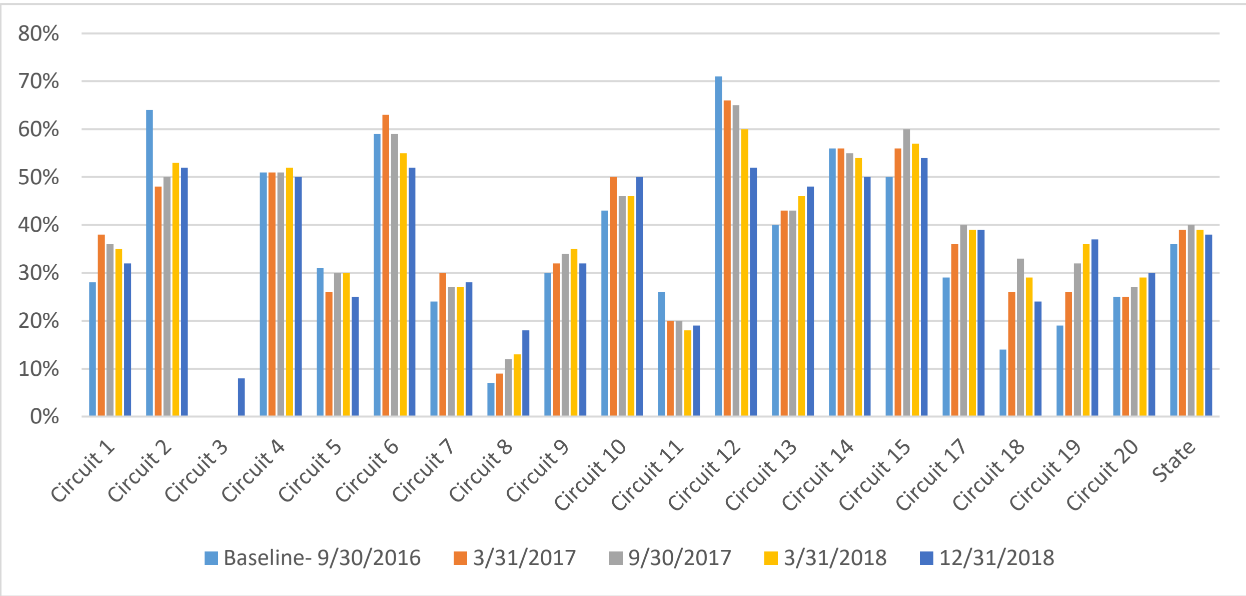


Figure 22. Performance Item 15: Case Worker Visits with Parents (Foster Care Cases)



Well-Being outcome 1 ratings. Figures 23 and 24 detail ratings for this outcome pertaining to families having the enhanced capacity to provide for their children's needs. The ratings shown are a compilation of the ratings for performance items 12 through 15. The State increased slightly for the percentage of cases rated as a strength from baseline (45%) to final ongoing review (46%) for in-home cases and remained consistent for the percentage of cases rated as a strength from baseline (53%) to final ongoing review (53%) for foster care cases. At the state-level, the changes from baseline to ongoing were not statistically significant for both in-

home and foster care cases. Circuits 10 and 13 showed marked improvements over time for in-home cases. Circuits 8 and 15 remained consistent in the percentage of cases rated as a strength for in-home cases. Circuit 10 showed marked improvement over time for the percentage of cases rated as a strength for foster care cases. Circuit 5 showed marked decline for the percentage of cases rated as a strength over time for foster care cases.

Figure 23. Well-Being Outcome 1: Family's Enhanced Capacity to Provide for Children's Needs (In-Home Cases)

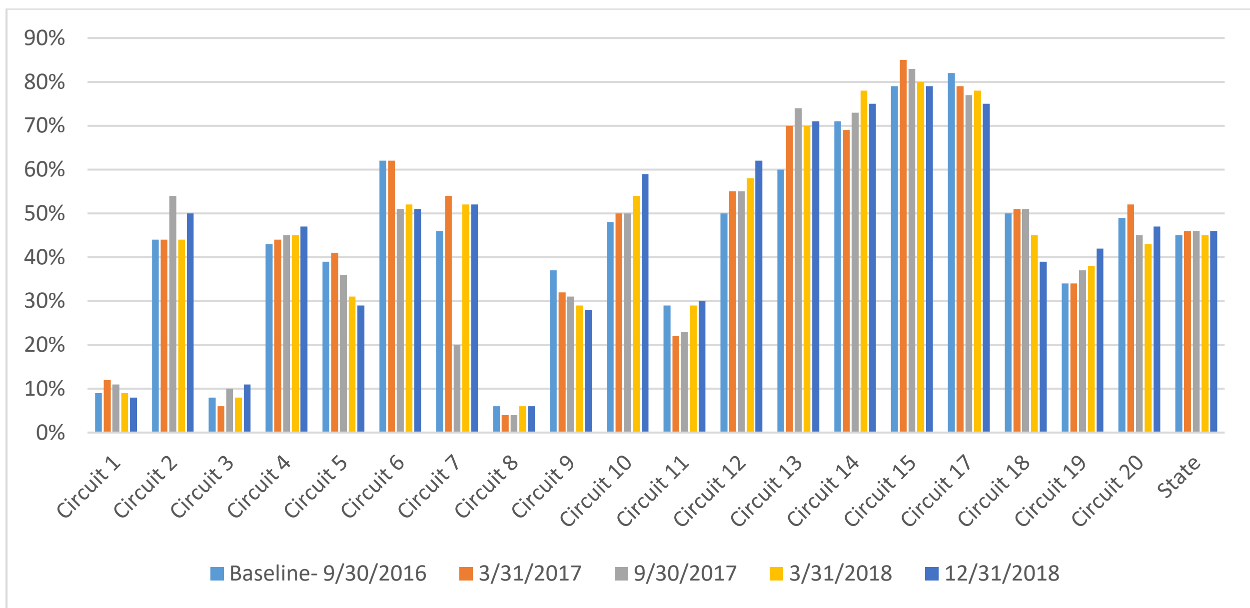
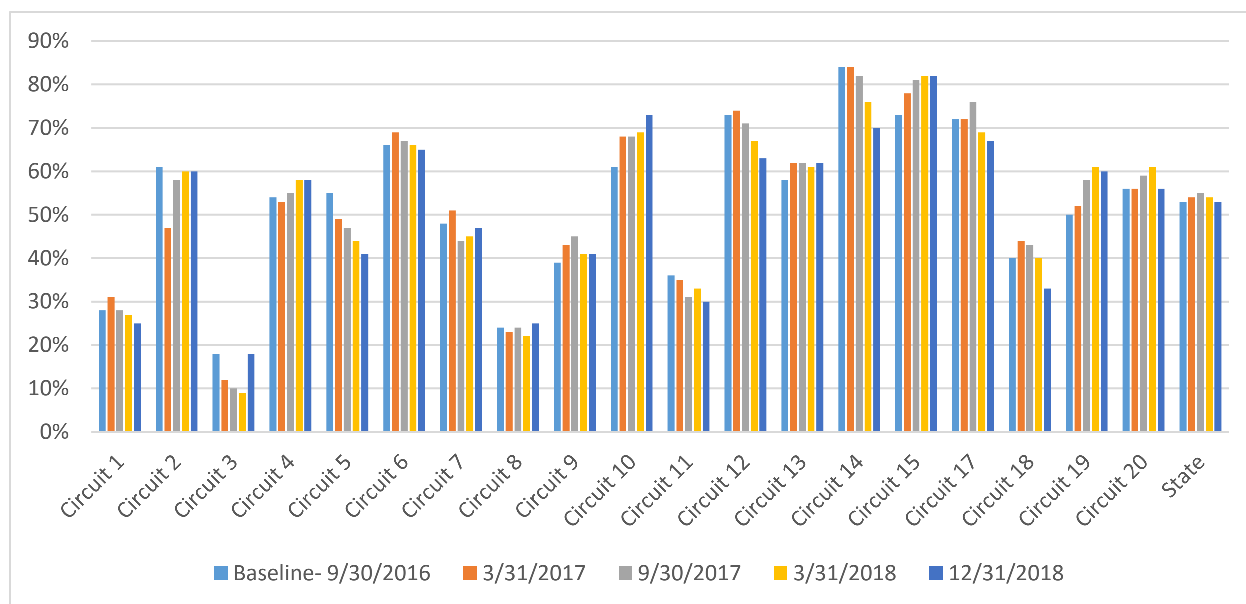


Figure 24. Well-Being Outcome 1: Family's Enhanced Capacity to Provide for Children's Needs (Foster Care Cases)



CFSR well-being outcome 2 ratings. The second well-being outcome pertains to receipt of appropriate services to meet the educational needs of children. Only one performance item encompasses this outcome (Performance item 16) which evaluates efforts made to assess children's educational needs and appropriately address those needs. Only the results of Well-Being Outcome 2 will be shown due to the fact that the data from Performance Item 16 mirrors the data for Well-Being Outcome 2. Also, due to the few number of applicable in-home cases at the circuit level, caution should be taken when interpreting results for in-home cases.

Figures 25 and 26 detail ratings for this outcome pertaining to receipt of appropriate services to meet the educational needs of children. The State increased slightly in the percentage of cases rated as a strength from baseline (64% for in-home and 81% for foster care) to final ongoing review (66% for in-home and 82% for foster care) for both in-home and foster care cases. At the state-level, the changes from baseline to ongoing were not be statistically significant for both in-home and foster care cases. For in-home cases, Circuits 1, 10, 15, and 18 showed marked improvements over time for the percentage of cases rated as a strength. Circuit 14 had no applicable cases for review over time. For foster care cases, Circuits 1, 3, and 20 showed marked improvements over time for the percentage of cases rated as a strength.

Figure 25. Well-Being Outcome 2: Appropriate Services to Meet Children's Educational Needs (In-Home Cases)

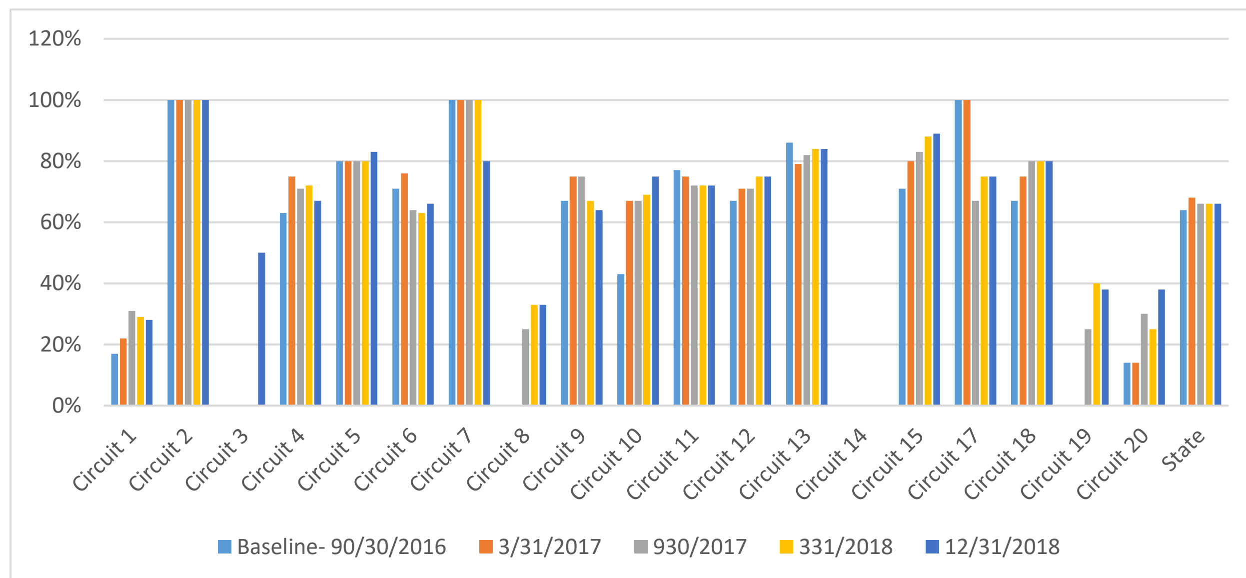
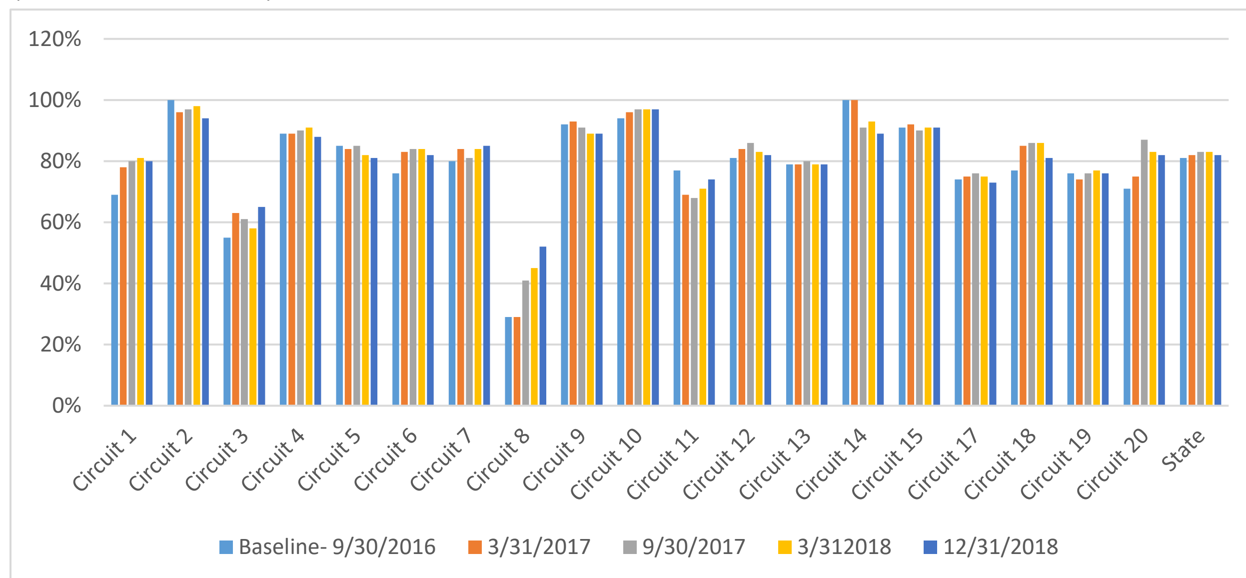


Figure 26. Well-Being Outcome 2: Appropriate Services to Meet Children's Educational Needs (Foster Care Cases)



Performance item 17. The third well-being outcome pertains to receipt of adequate services to meet the physical and mental health needs of children. Results of the performance items for this outcome are shown in Figures 27 and 28. Again, due to the few number of applicable in-home cases at the circuit level, caution should be taken when interpreting results for in-home cases.

This performance item addresses accurate assessment and receipt of appropriate services for the physical health needs of children. This item also addresses children's dental health needs. Final ongoing review shows the percentage of cases rated as a strength statewide remained consistent at 64% for in-home cases from baseline to final ongoing review and increased slightly from 77% at baseline to 78% at final ongoing review for foster care cases (See Figures 27 and 28). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuits 2 and 3 remained consistent over time with 100% of applicable cases rated as a strength. Circuit 14 had no applicable cases for review over time. Circuit 5 showed marked improvement over time, and Circuit 11 showed marked decline over time. For foster care cases, Circuit 20 showed marked improvement over time.

Figure 27. Performance Item 17: Physical Health of the Child (In-Home Cases)

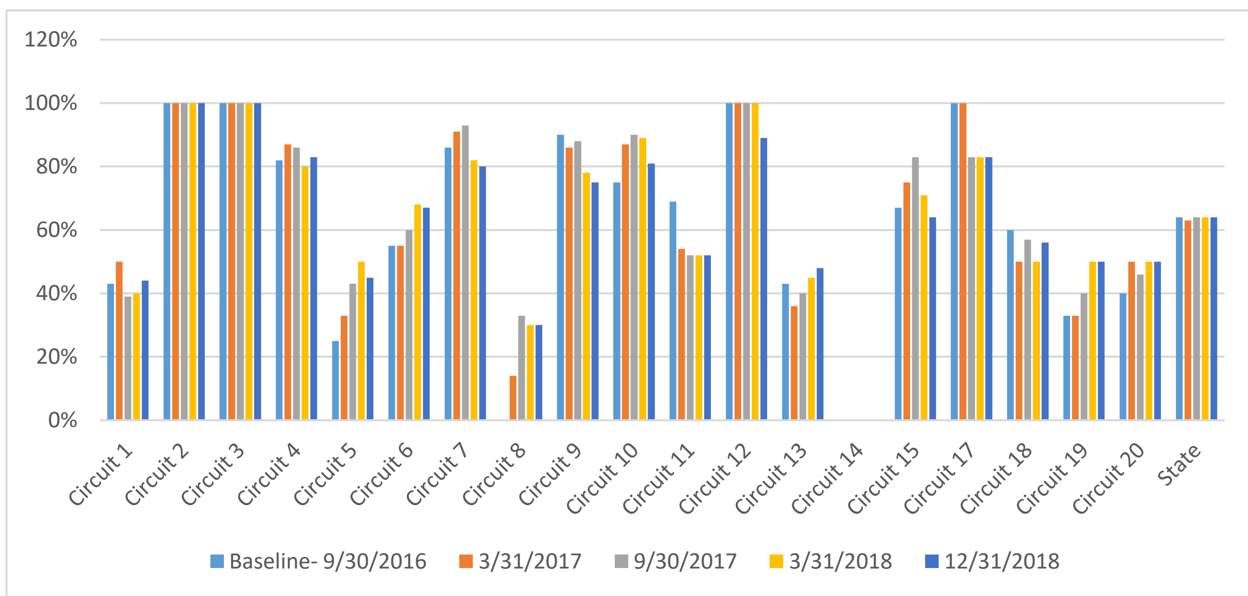
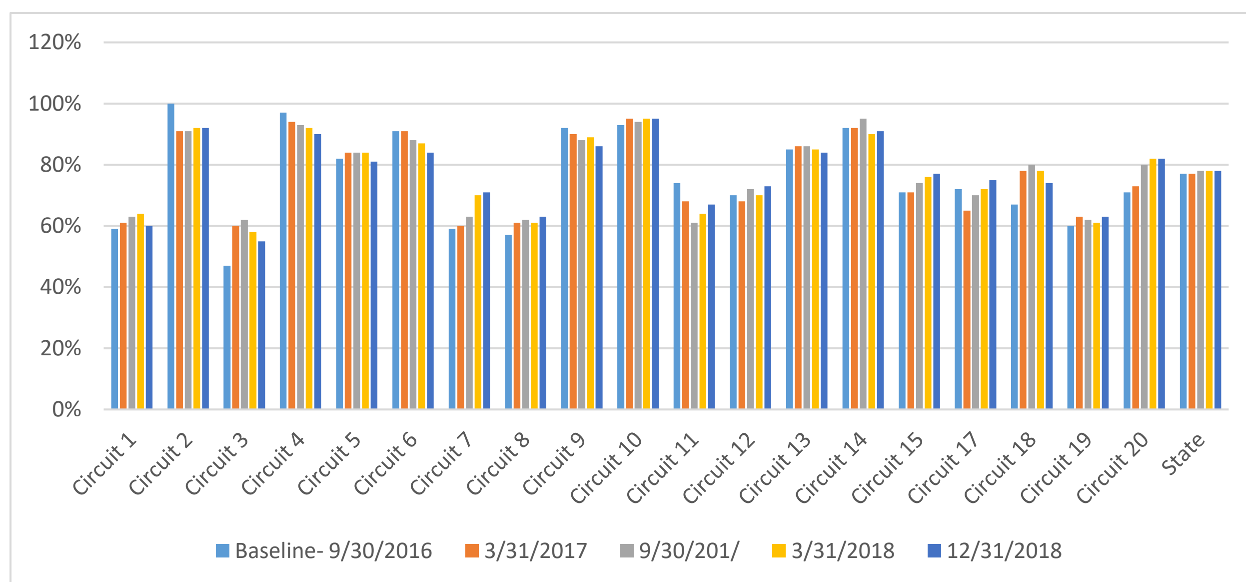


Figure 28. Performance Item 17: Physical Health of the Child (Foster Care Cases)



Performance item 18. This performance item addresses accurate assessment and receipt of appropriate services for the mental and behavioral health needs of children. Final ongoing review shows the percentage of cases rated as a strength statewide decreased for in-home cases from baseline (71%) to final during ongoing review (67%) and increased slightly from baseline (73%) to final ongoing review (74%) for foster care cases (See Figures 29 and 30). At the state-level, the changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuit 19 showed marked improvement over time. Circuits 3, 12, and 14 remained consistent over time with 100% of applicable cases rated as a strength. For foster care cases, Circuits 7 and 10 showed marked improvements over time. Circuits 5, 11, and 18 showed marked declines over time.

Figure 29. Performance Item 18: Mental/ Behavioral Health of the Child (In-Home Cases)

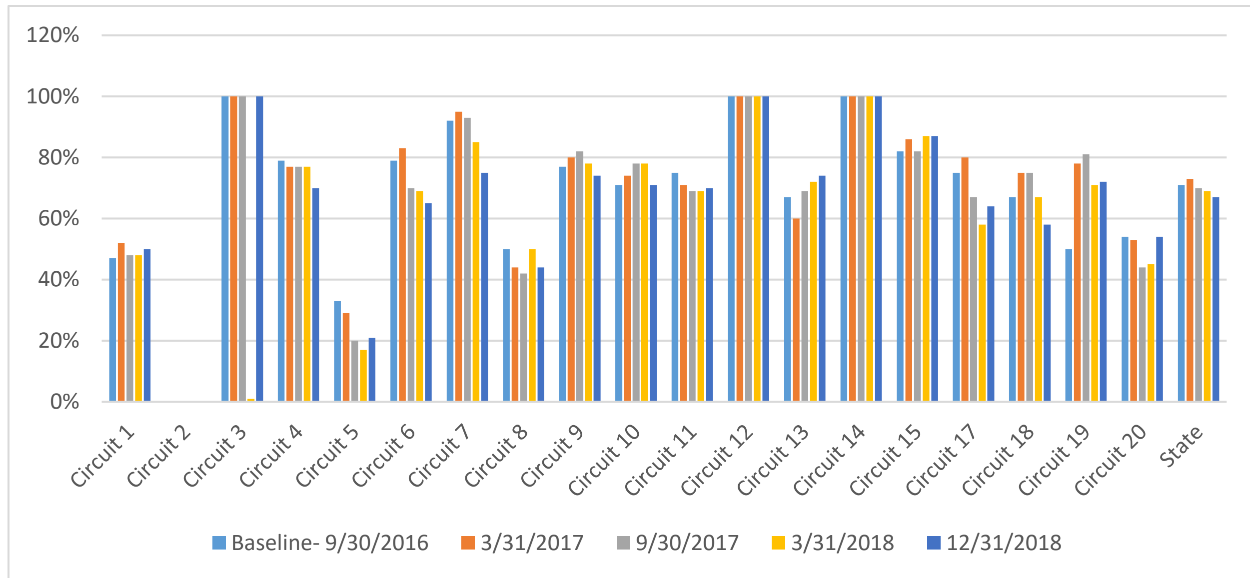
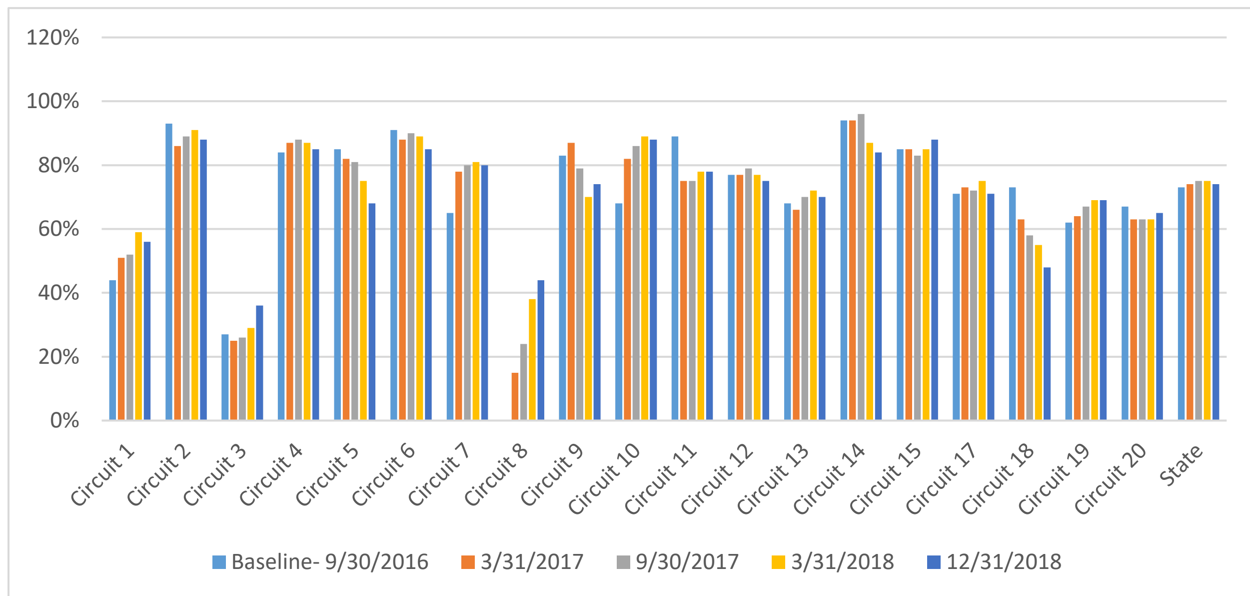


Figure 30. Performance Item 18: Mental/ Behavioral Health of the Child (Foster Care Cases)



Well-Being outcome 3 ratings. CFSR Well-Being Outcome 3 pertains to receipt of adequate services to meet the physical and mental health needs of children. Caution should be taken when interpreting the results for in-home cases due to the low number of applicable cases (for example, four Circuits have n's less than 10 applicable cases) for many circuits. Final ongoing review shows the percentage of cases rated as a strength statewide decreased for in-home cases (65% at baseline to 63% at final ongoing review) and foster care cases (70% from baseline to 69% at final ongoing review) (See Figures 31 and 32). At the state-level, the

changes from baseline to ongoing were not found to be statistically significant. For in-home cases, Circuits 8 and 19 showed marked improvements over time. Circuit 11 showed marked decline over time. Circuits 2, 3, and 14 remained consistent over time with 100% of applicable cases rated as a strength. For foster care cases, Circuit 3 showed marked improvement over time. Circuit 11 showed marked decline over time.

Figure 31. Well-Being Outcome 3: Appropriate Services to Meet Children's Health Needs (In-Home Cases)

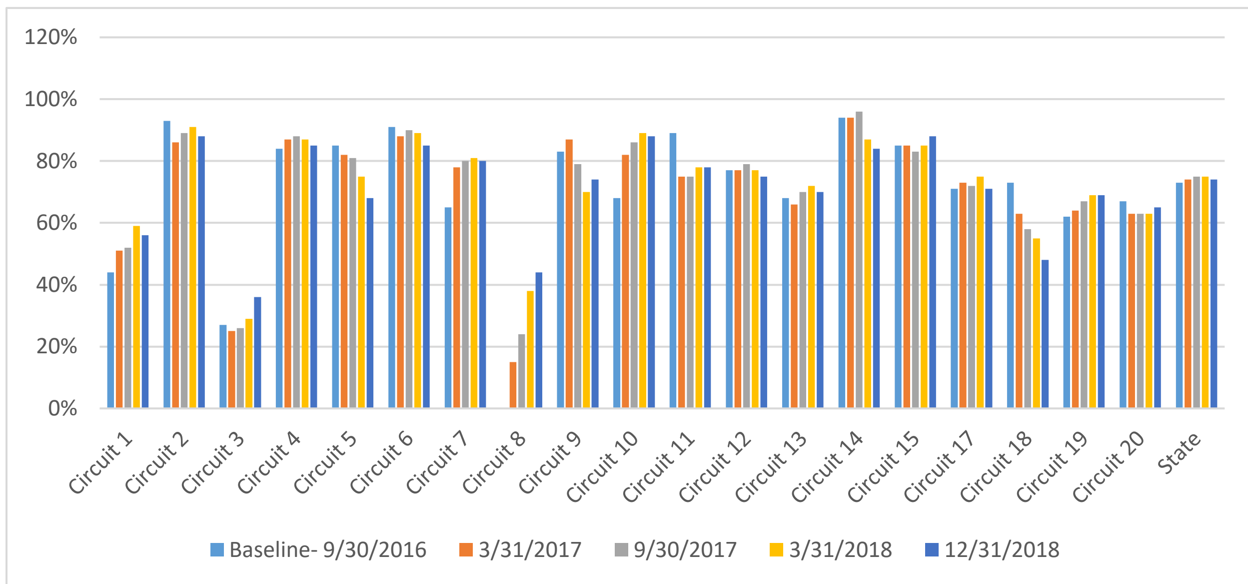
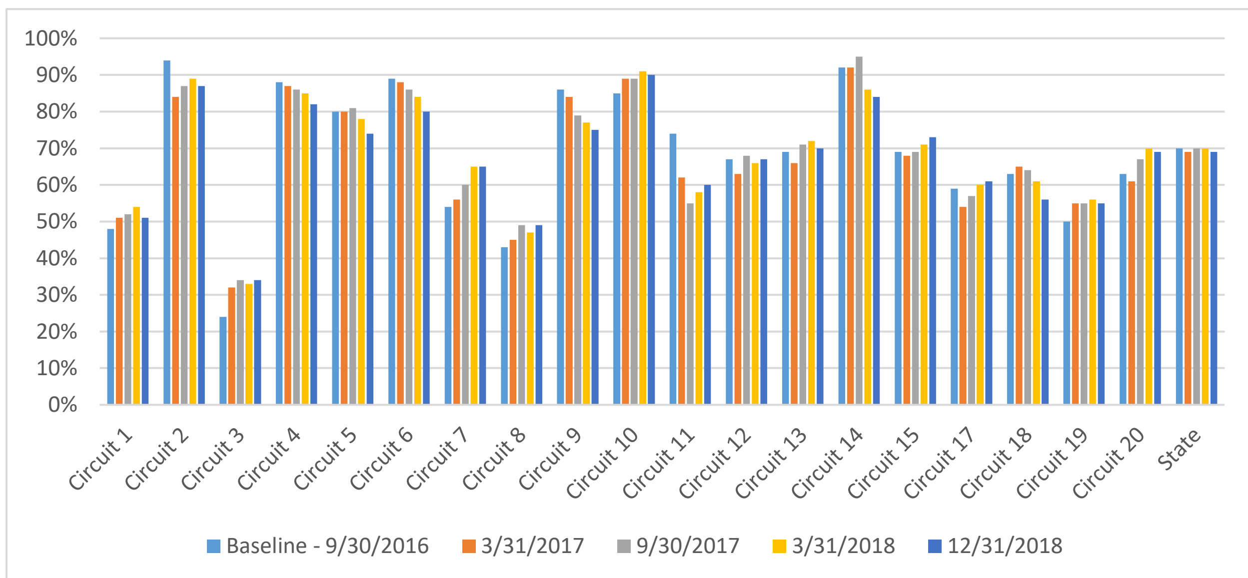


Figure 32. Well-Being Outcome 3: Appropriate Services to Meet Children's Health Needs (Foster Care Cases)



Discussion

At the state-level for both in-home and foster care cases from baseline to final ongoing review the changes were not statistically significant. For in-home cases Circuits 8 and 19 showed improvements over time across most performance and well-being outcome items. Circuit 5 showed declines over time across most performance and well-being outcome items. For foster care cases, Circuit 3 showed improvements over time across most performance and well-being outcome items. Circuit 5, 11, and 12 showed declines over time across most performance and well-being outcome items. In previous evaluation reports, evaluation team members have reported on the quality improvement measures discussed at a quarterly QA managers' meeting attended by QA managers throughout the child welfare system. The QA managers' meetings typically follow an agenda where CFSR and PIP items/cases are reviewed and discussed. The meetings also review any initiatives and activities conducted in the DCF regions that will increase performance on CFSR performance items and well-being outcomes. The most recent QA managers call occurred on 2/21/2019 and the next call is scheduled for 3/21/2019. During the call Items that the State struggle on were addressed. Examples of best practices for reviewing those items on cases were reviewed.

The Cost Study

The cost analysis was divided into two sections. First, the cost analysis for the Evaluation Report examined the relationship between the Demonstration implementation and changes in the use of child welfare funding sources. Second, the evaluation used a unique data source to examine child-level costs for children served by the child welfare system. Detailed research questions are provided and analyzed in each section of the cost study.

Key Research Questions Part One

1. Was the Demonstration implementation associated with a substitution from out-of-home expenditures to in-home prevention/early intervention/diversion expenditures using IV-E funding?
2. How has the Demonstration implementation impacted the use of other child welfare funding such as TANF and State funds?
3. Is the increased flexibility of the Demonstration associated with a reduction in administrative costs?
4. Was the Demonstration implementation cost-effective? What services were most cost-effective?

Data Sources and Data Collection

Data for the cost analysis was provided by the Florida DCF Office of Revenue Management. Cost data were available from SFY 03-04 through SFY 15-16. The length of the time frame allowed the analysis to have a true 'pre' Demonstration period. While the focus of the evaluation is the Demonstration extension, there was a Demonstration Project already in place during the time-period prior to the implementation of the Demonstration extension. The inclusion of data from SFY 04-05 and SFY 05-06 enables comparison of a three time-periods: pre-Demonstration (SFY 03-04 through SFY 05-06), during the initial Demonstration (SFY 06-07 through SFY 12-13), and during the Demonstration extension (SFY 13-14 through SFY 14-15).

Data Analysis

The analysis began with an assessment of time series data costs from SFY 04-05 through SFY 15-16. Costs are compared for each of the three time-periods: pre-Demonstration (SFY 03-04 through SFY 05-06), during the initial Demonstration (SFY 06-07 through SFY 12-13), and during the Demonstration extension (SFY 13-14 through SFY 15-16). The evaluation also compared costs by funding source, comparing a year prior to the Demonstration with a year during the Demonstration extension. As such, changes in expenditures are the result of both the Demonstration and the demonstration extension. The cost effectiveness analysis was limited by available outcome data to a comparison of a time during the Demonstration with a time-period during the demonstration extension.

Results Part One

Research question one. *Was the Demonstration implementation associated with a substitution from out-of-home expenditures to in-home prevention/early intervention/diversion expenditures using IV-E funding?* Trends in the numbers of children receiving out-of-home (including independent living services for young adults ages 18 and older), in-home, and adoption services, and the costs for those services were examined. Three time-periods are compared: pre-Demonstration (SFY 03-04 through SFY 05-06), during the initial Demonstration (SFY 06-07 through SFY 12-13), and during the Demonstration extension (SFY 13-14 through SFY 15-16).

Changes in costs over time are reported in Table 11. The comparisons were between a pre-Demonstration period (SFY 04-05 through SFY 05-06), the initial Demonstration (SFY 06-07 through 12-13), and the Demonstration extension (SFY 13-14 through SFY 15-16). Expenditures are reported for adoption services (services associated with the adoption, e.g., legal), adoptions (maintenance adoption subsidies), case management, independent living, licensed care (e.g., foster or group), and prevention (in-home) services. Expenditures for

adoption services have increased over time. Expenditures for adoptions have increased from $102 million per pre-Demonstration year, to $156 million per year during the initial Demonstration, and $196 million per year during the Demonstration extension. Expenditures for case management were lower during the initial Demonstration ($264 million) than pre-Demonstration ($270 million) but increased during the Demonstration extension to a level greater than pre-Demonstration ($301 million). Expenditures for independent living nearly doubled during the initial Demonstration (from $17.6 million to $34.5 million) but declined during the Demonstration extension ($28.6 million). Spending during the Demonstration extension remained greater than spending prior to the initial Demonstration. Similarly, expenditures for licensed foster care increased during the initial Demonstration (from $134 million to $165 million) but declined during the Demonstration extension ($148 million). Expenditures for front-end prevention services (e.g., family support services) have increased from $16.8 million per pre-Demonstration year, to $39.6 million per year during the initial Demonstration, and $52.3 million per year during the Demonstration extension. Other prevention services, which are primarily allocated in-home case management and administrative expenses, declined during the original Demonstration (from $188 million to $149 million), and remained below the levels prior to the Demonstration during the Demonstration extension ($148 million).

Table 11

Annual Costs by Service: Pre versus Post

Service	Pre-Demonstration	Initial Demonstration	Demonstration Extension
Adoption services	$ 4,170,780	$ 20,318,018	$ 23,432,805
Adoptions (includes alloc admin)	$ 102,321,233	$ 156,982,437	$ 196,179,797
Case Management	$ 270,299,581	$ 264,926,061	$ 301,042,311
Independent Living	$ 17,675,986	$ 34,574,707	$ 28,635,381
Licensed Care	$ 154,939,869	$ 164,041,998	$ 151,854,992
Front-end Prevention Services	$ 16,813,030	$ 39,648,052	$ 52,321,056
Other Prevention Services (includes alloc case management and admin)	$ 188,194,486	$ 149,358,378	$ 148,238,084

Note. Data Source: DCF Office of Revenue Management, Run date: 09-18-2017.

Statistical significance was assessed through a regression analysis. The *p* values for the Chi square statistics are in Table 12. Changes in adoption services (p<.0001) and

adoptions (p=0032 and p=.0041) are sufficient to be considered statistically significant. However, changes in case management, licensed care, and prevention services are not sufficient to be statistically significant. Changes in independent living expenditures changed significantly between the pre-Demonstration and original Demonstration (p=.0060) but change between the pre-Demonstration and the Demonstration extension did not meet the $p<.05$ criteria.

Table 12

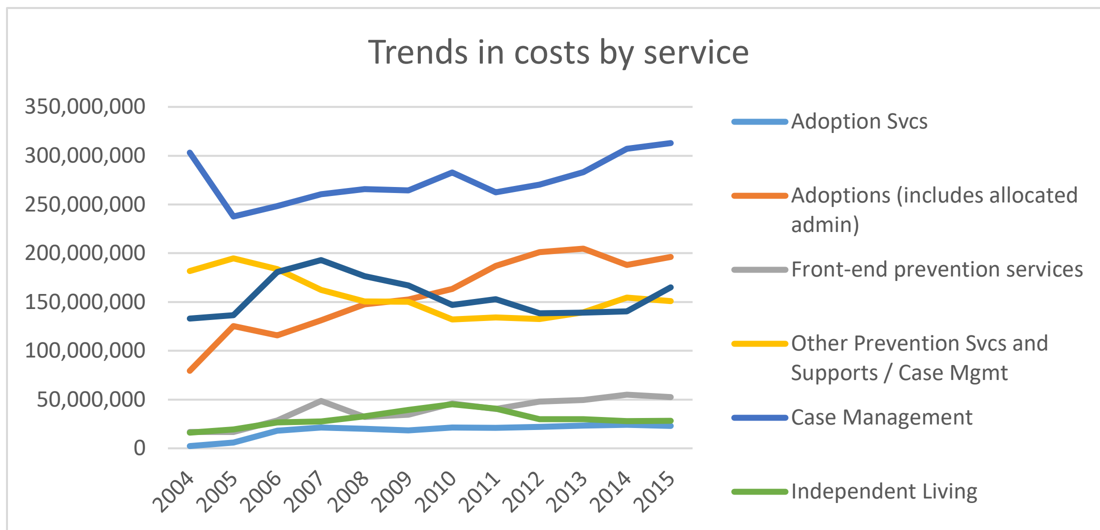
Statistical Significance of Changes in Costs

	p values		
Service	**Pre-Demonstration**	**Initial Demonstration**	**Demonstration Extension**
Adoption services	--	<.0001	<.0001
Adoptions (includes alloc admin)	--	0.0320	0.0041
Case Management	--	0.7337	0.1117
Independent Living	--	0.0060	0.0723
Licensed Care	--	0.0597	0.4237
Front-end Prevention Services	--	0.0022	0.0003
Other Prevention Services	--	0.0153	0.0244

Note. Data Source: DCF Office of Revenue Management, Run date: 09-18-2017.

The trends in expenditures are illustrated in Figure 33. Expenditures for adoptions increased through the initial Demonstration and stabilized during the Demonstration extension. Expenditures for case management services increased throughout the initial Demonstration and continued to increase during the Demonstration extension. Expenditures for licensed care declined during the initial Demonstration but increased during the Demonstration extension. Expenditures for independent living services have not shown any clear trends. Expenditures for front-end prevention services have trended upward, while expenditures for other prevention services have trended downward.

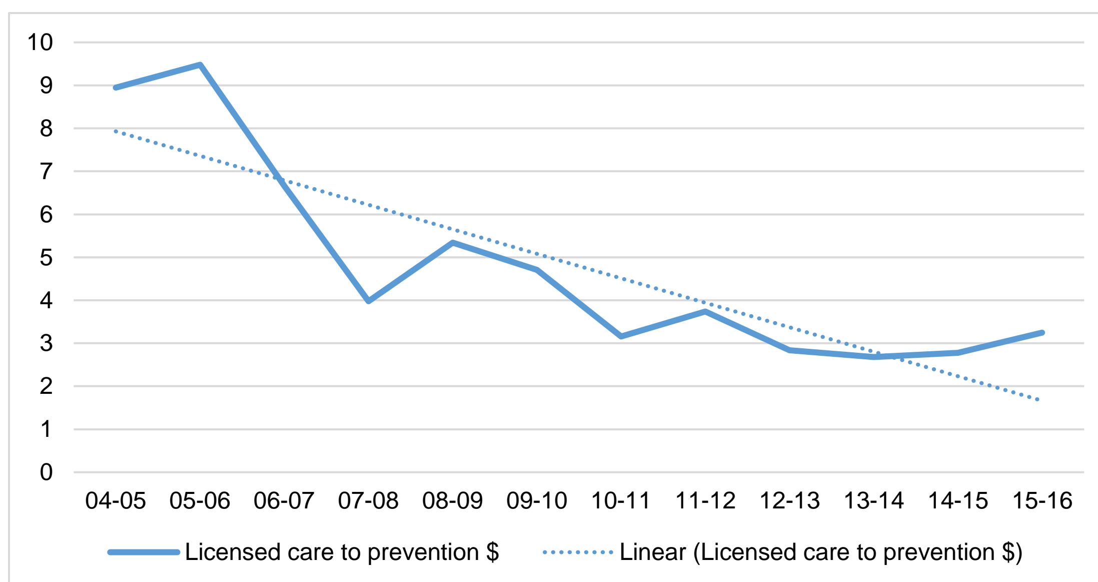
Figure 33. Trends in Costs by Service



Note. Data Source: DCF Office of Revenue Management, Run date: 09-18-2017.

Ratio of licensed care to prevention costs. Figure 34 contains the ratio of costs for licensed care to costs for prevention services. The IV-E Demonstration was expected to provide greater emphasis on in-home child welfare services, avoiding the need for some children to be removed from their home. Prior to the original Demonstration (SFY 04-05 and 05-06), the ratio was between 9 and 10. In other words, expenditures for licensed care were 9-10 times larger than for prevention services. The ratio declined with the implementation of the Demonstration reaching 4.0 in SFY 07-08. The ratio remained in the 4-5 range until SFY 10-11 when the ratio fell below 4. The ratio remained near 3.0 since SFY 12-13.

Figure 34. Ratio of licensed care to front-end prevention service expenditures



Note. Data Source: DCF Office of Revenue Management, Run date: 03-29-2018.

Research question two. *How has the Demonstration implementation impacted the use of other child welfare funding such as TANF and State funds?* Florida's Demonstration provides a pre-determined amount of federal funding for foster care. The Demonstration Terms and Conditions required that savings resulting from the Demonstration be used for the further provision of child welfare services; this clause is also referred to as "maintenance of effort." Using data from the DCF Office of Revenue Management, the evaluation compared planned expenditures for SFY 14-15 to actual FFY 04-05 expenditures by funding source (see Table 13). The FFY 04-05 expenditures are prior to the implementation of the original Demonstration. Thus, the differences represent a cumulative effect of the original Florida IV-E Demonstration and the Demonstration extension.

State Independent Living expenditures (beyond match requirement; row 8) increased from $514,660 in FFY 04-05 to $19,250,167 in SFY 14-15. Expenditures for adoption services increased dramatically from both federal and state funding sources (rows 21 and 22). State funding for Prevention, Intervention, and In-Home Supports (row 10) increased from $27,540,388 in FFY 04-05 to $68,926,694 in SFY 14-15.

Table 13

Title IV-E Base Year Level of Effort Worksheet

		Federal	State	Federal	State
Row	**Fund Source**	**Expenditures - October 1, 2004 through September 30, 2005**	**Expenditures - October 1, 2004 through September 30, 2005**	**Planned Expenditures SFY2014-15 for IVE-IVB Services**	**Planned Expenditures SFY2014-15 for IVE-IVB Services**
1	IV-E Foster Care Maintenance	50,754,233	33,163,382	0	13,879,389
2	IV-E Foster Care Administration w/o SACWIS	83,178,110	83,178,099	167,983,114	92,147,138
4	Title IV-B, Part 1	15,655,725	11,347,611	13,160,237	4,324,739
5	Title IV-B, Part 2	14,228,992	1,315,263	14,869,367	370,812
6	Chafee IL Match	7,889,242	3,547,100	5,979,489	1,494,873
7	Education and Training Voucher	3,521,171	603,723	2,396,966	599,242
8	State Independent Living Beyond Match Requirement	0	514,660	0	19,250,167
9	State Funded Maintenance Payments - Non IV-E	0	36,136,640	0	18,496,569
10	Prevention, Intervention, In-Home Supports State Funded - Non TANF	0	27,640,388	0	65,199,151
11	Medicaid Administration - Child Welfare	1,265,398	1,265,398	1,240,988	1,240,988
12	State Access and Visitation - Child Welfare	404,817	0	498,271	0
13	Promoting Safe and Stable Families - Marriage Grants	534,747	0	0	0
14	Child Abuse Prevention and Treatment	769,651	0	1,101,921	0
15	Community Based Child Abuse Prevention - Family Resource and Support	1,454,155	363,538	1,409,513	352,378
16	TANF MOE - Child Welfare	0	42,394,833	0	88,403,998
17	TANF Federal - Child Welfare	96,501,978	0	56,642,709	0
18	SSBG Funded Child Welfare Federal	15,859,779	0	9,003,108	0
19	SSBG II Funded Child Welfare Federal	41,216,118	0	41,305,125	0

20	Other State Funded Title IV-B-or IV-E Equivalents	0	55,069,533	0	35,560,129
21	TANF/State Funded Adoption Assistance Non-Title IV-E	7,662,366	9,761,620	16,037,534	30,581,895
22	Title IV-E Adoption Assistance Subsidy Payments	37,056,174	24,959,079	67,734,753	49,882,503
23	Total	377,952,656	331,260,867	399,363,095	421,783,971
24	Adjustment arising from factors other than Demonstration** beyond control of the State (1)	(4,136,818)	(941,023)	(40,602,145)	0
25	Adjusted Requirement	373,815,838	330,319,844	358,760,950	421,783,971
	Funding Requirement		704,135,682	76,409,239	780,544,921

Note. Represents Federal Award adjustments since the base year that are out of the control of the Department. For the SFY 14-15 Federal column, the $40 million adjustment represents the annual Federal increases to the Title IV-E Demonstration since its implementation through SFY 13-14. These increases cannot be used to meet the State's "Savings" requirement pursuant to Section 2.2(l) of the Title IV-E Demonstration Terms and Conditions contract.
Note. Training costs will be reimbursable separately in addition to the amount of the capped allocation, therefore, training costs are not included in SFY 14-15 and have been removed from the base year.
Note. The effect of CS/SB 1036-Extended Foster Care to State funds in SFY 14-15 have been applied to Foster Care Room and Board and Maintenance Adoption Subsidies based on the fiscal analysis. The estimated effect was also adjusted in the base year for the same amount.
Note. Data Source: DCF Office of Financial Management, Date: September 2015.

In calculating FFY 04-05 and SFY 14-15 planned expenditures, two sets of adjustments were made. The base year requirement was reduced for reductions in federal funds (and associated state matching funds) that are unrelated to the Demonstration. In addition, the amount of planned SFY 14-15 federal funds included an adjustment for the annual increase that is part of the pre-determined federal funding. This adjustment prevented a reduction in state commitment due to increased federal funds. In other words, the State's funding level for child welfare services cannot be reduced because of the annual federal funding increase. When adjusted for reductions in federal funds (and associated state match) unrelated to the Demonstration, the base year funding requirement was $704,135,682. Planned expenditures for SFY 14-15, after adjustment for Demonstration related increases, are $780,544,921. This difference of $76,409,239 indicates that the State of Florida exceeded the maintenance of effort level (as measured by expenditures) that existed prior to the original Demonstration, assuming all planned expenditures are actually incurred.

Research question three. *Is the increased flexibility of the Demonstration associated with a reduction in administrative costs?* The Terms and Conditions included an expectation that administrative costs would be reduced. As discussed in Vargo et al. (2012), the flexibility of

the IV-E Demonstration enabled CBC lead agencies to simplify administrative processes and thus reduce administrative costs. Available data did not enable precise calculation of changes in administrative costs due to the Demonstration in Vargo et al (2012) or in this evaluation report. However, administrative savings would be expected to increase as the duration of the Demonstration increased, and lead agencies became more familiar with new reporting and budgeting requirements. In addition, stakeholders reported the transition to the Demonstration extension to be seamless (Armstrong et al, 2016) suggesting that the Demonstration extension continued the reduction in administrative burden achieved during the original demonstration.

Research question four. *Was the Demonstration implementation cost-effective? What services were most cost-effective?* A cost-effectiveness analysis examined the relationships between expenditures on specific types of services (out-of-home care, prevention services, and adoption subsidies) and outcomes across circuits. Instead of focusing on nominal dollars, the analysis examined the share of total expenditures spent on out-of-home care, prevention services, and adoption subsidies. The flexibility provided by the Demonstration was designed to enable lead agencies to shift resources to services that best fit the needs of families and youth. For example, being able to provide more in-home services may enable some children and youth to remain in the home and not require out-of-home care. The goal was not to save money, but to shift resources between types of services in order to improve outcomes.

The analysis examined changes in outcomes and expenditures for each circuit between pre- and post-implementation of the Demonstration extension. The goal was to determine whether there is a relationship between changes in expenditure patterns and changes in outcomes across circuits.

A total of eleven outcomes reported in prior Demonstration evaluation semi-annual progress reports were assessed. Expenditure data for each CBC were provided by the DCF Office of Financial Management. Specifically, total expenditures for specific service categories were reported by fiscal year (SFY 11-12 through SFY 15-16). Categories included dependency case management (OCA DCM00), prevention services for families not currently dependent (OCA PVS00), maintenance adoption subsidies from IV-E funds (OCA WR001), licensed foster care (OCA LCFH0), and licensed residential group home care (OCA LCRGE). The three service categories associated with out-of-home care (dependency case management, licensed foster care, and licensed residential group care) are combined into a single out-of-home service category. Proportions are used instead of nominal dollars because the number of families and youth served varies considerably across circuits.

The results in Table 14 report the changes in expenditures and outcomes between the pre- and post-Demonstration. Among the expenditure categories, there has been an increasing trend among the proportion of expenditures spent on adoption subsidies in 18 of the 20 circuits. There has been an increasing trend in prevention and out-of-home expenditures in expenditures in 7 of the 20 circuits. The findings for prevention services indicate that 12 circuits had an increase in the proportion of expenditures for prevention between the pre- and post-extension periods. Among the outcome variables, the analysis of pre-post changes also shows a decreasing trend in the maltreatment rate, as well as permanency through reunification or placement in permanent guardianship. In addition, there was an increasing trend in length of stay and the proportion of children and youth that received in-home services who entered out-of-home care within 12 months. Some of these changes are viewed as positive (e.g., decreasing maltreatment rate), while others merit further investigation (e.g., the trend in youth who receive in-home services who enter out-of-home care within 12 months).

Table 14

Changes Between Pre- and Post-Extension Periods - Number of Circuits with Increased and Decreased Expenditures and Child Outcomes

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

Note. Data are from the Fall 2015 (Phase 3), Spring 2016 (Phase 4), and Fall 2016 (Phase 5) Semi-Annual Evaluation reports. Retrieved January 15, 2017.

The final set of results examines the relationships between changes in expenditure shares and outcomes. The circuits are sorted into groups based on spending patterns. For example, 8 Circuits had an increasing share of expenditures spent on prevention and adoption services and a decreasing percentage on out-of-home services. Another 3 had an increase in the adoption share and a decrease in prevention and out-of-home services, while 4 circuits saw an increase in out-of-home and adoption and a decrease in prevention. Three circuits had an increase in all three spending categories; presumably accompanied by a decrease in other expenditures. Finally, there was one circuit that had a decline in all three expenditure categories, and one that had an increase in prevention and a decrease in out-of-home and adoption.

For each expenditure group, the average change in each of the outcomes was computed. The results, presented in Table 15, are used to determine if there are any patterns between changes in expenditures and outcomes. The change in the proportion of children and youth in foster care who were abused was positive among circuits than had an increase in the out-of-home share of expenditures but tended to be negative in circuits that had a decline in the out-of-home proportion of expenditures.

Table 15

Changes in Outcomes by Spending Groups

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

Note. Data are from the Fall 2015 (Phase 3), Spring 2016 (Phase 4), and Fall 2016 (Phase 5) Semi-Annual Evaluation reports. Retrieved January 15, 2017. Outcome values reflect percentage point changes except for length of stay and months active, where the changes reflect a change in mean value.

Discussion Part One

This section of the cost study examined the trends in the numbers of children receiving out-of-home (including independent living services for young adults ages 18 and older), in-home, and adoption services, and the costs for those services. The analysis used data that covered a pre-Demonstration period, the initial Demonstration, and the Demonstration extension. Compared to the pre-Demonstration period, costs for adoption services, adoptions, and front-end prevention services increased. Costs for licensed care declined during the initial Demonstration but increased during the Demonstration extension. The Demonstration was expected to increase the use of prevention services resulting in a reduction in the use of out-of-home care. Indeed, front-end prevention services (family support services) have increased during the initial Demonstration and the Demonstration extension. The number of children in out-of-home care was lower in the initial Demonstration and Demonstration extension compared to the pre-Demonstration period. Consistent with one of the goals of the Demonstration, the ratio of expenditures for licensed foster care to expenditures for front-end prevention services has trended downward over time.

There was a minimal relationship between changes in spending patterns and changes in outcomes. Only the rate of abuse in foster care appeared to have a relationship with spending patterns. Circuits that shifted resources from out-of-home care had lower average maltreatment rates while the child was in foster care compared to circuits that increased the share of expenditures spent on out-of-home services. Other outcomes showed no clear relationship with changes in expenditures. However, due to the statewide implementation of the Demonstration extension, the cost effectiveness analysis lacked an appropriate comparison group.

Overall, the State and Lead Agencies face challenges as the IV-E Demonstrations come to an end. The flexibility provided by the Demonstration extension has allowed lead agencies to continue to shift resources to where they are most needed. In addition, the long duration of the IV-E Demonstration program suggests that such flexibility has become ingrained in the way lead agencies operate.

Part Two: FSFN Child-level Cost Data

The analysis in this section of the cost study examined child-level cost data reported by lead agencies through the Florida Safe Families Network (FSFN). Child-level data on costs are available from SFY 13-14 onward, and an analysis in this report examines child characteristics for children with the highest costs. In addition, Medicaid-funded services costs and Substance Abuse and Mental Health (SAMH) costs are compared for high cost and lower cost children. Given the high cost for children that have complex needs, the question becomes whether new

programs could be developed that use the flexibility provided in the Demonstration to provide parents with the needed support to maintain the child in the home. For example, if children who have high child welfare costs also have high Medicaid costs, a potential intervention could provide an integrated and intensive support and treatment framework and remain cost-effective.

Research often studies individuals with the highest costs to determine whether there are ways that high cost children differ from other children served. Most research on high cost users (sometimes referred to as super utilizers) focuses on health care costs, however similar questions regarding high cost children may be important for child welfare services as well. From a policy perspective, the question would be whether there are modifiable characteristics of children that interventions influence to improve outcomes for these children. For example, child alcohol and drug problems, or child behavior problems may be modifiable factors that influence child outcomes. From a fiscal perspective, a small proportion of children account for a significant proportion of costs. It is important to understand whether steps can be taken to reduce costs for these children (without diminishing outcomes).

Key Research Questions Part Two

1. What child/family characteristics were associated with having high costs (defined as costs in the top decile)?
2. How did permanency outcomes differ for high cost children?
3. What were the Medicaid and SAMH expenditures and services received by high cost children compared to lower cost children?
4. Were Medicaid and SAMH expenditures for outpatient services in the first 90 days of child welfare services associated with the likelihood of having high costs?

Data

FSFN data. FSFN data provided information on child age, race (Asian, White, Black; in some cases multiple categories were selected and in some cases none were selected), and gender, as well as substance abuse for parent/child, domestic violence, reasons for removal and other household characteristics. In addition, there was information on child outcomes (reunification, guardianship, adoption, remained in out-of-home care, or aged out of the child welfare system).

FSFN cost data. In addition to examining aggregate data, child level data were available from SFY 13-14 through SFY 16-17 (although data from May and June 2017 were incomplete). The data included child identifiers (DCF child ID, social security number, name, and date of birth), fiscal agency (typically the lead agency), service batch, service type and payment. Service batch is a broad service category (e.g., out-of-home care), while service type

is a detailed descriptor of the service. There were two primary limitations with these data. First, the data were limited to a time-period after implementation of the Demonstration extension. Thus, the status of children during the Demonstration extension can be examined, but it is not possible to determine whether the Demonstration extension had an effect on high cost children. Second, the data did not include dependency case management or prevention services. Thus, it did not provide a complete picture of the expenditures on each child.

Medicaid data. Medicaid claims and encounter data included all fee-for-service claims and encounters from the Statewide Medicaid Managed Care (SMMC) program. In 2014, most Medicaid recipients were transitioned to the SMMC program that became responsible for both physical and behavioral health care. In addition, a specialty SMMC plan (Sunshine Health Child Welfare Specialty Plan) was created that focuses on providing services to children and youth in the child welfare system. Children in the child welfare system are enrolled in either a standard managed care plan or the specialty plan. Medicaid data provided information on each service received by children and youth. Data were available on the dates of service, diagnoses, and expenditures for each service. Expenditures denoted the amount paid to the provider of service by the Medicaid program (when the child was enrolled in the fee-for-service program) or to the managed care organization (when the child was enrolled in a SMMC plan). Services were classified as physical or behavioral health based on the primary diagnosis on the claim or encounter.

Research question three examined health care utilization from SFY 13-14 through SFY 16-17. Research question four was limited to health care utilization in the first 90 days of child welfare service. The limited time frame was used for two reasons. First, it was important that children receive needed services promptly when entering the child welfare system. Second, children in the child welfare system for several years are likely to use more health care services simply because they are in the system longer; differences in health care service use would merely reflect the longer time in the child welfare system.

SAMHIS data. The Substance Abuse and Mental Health Information System (SAMHIS) provided data for substance abuse and mental health services paid through the State's SAMH program. Information included the dates of service, diagnosis, and expenditures for each substance abuse or mental health service. Similar to the Medicaid analysis, research question three examined services from SFY 13-14 through 16-17. Research question four was limited to outpatient services received in the first 90 days of child welfare services.

Results Part Two

Research question one. *What child/family characteristics were associated with having high costs (defined as costs in the top decile)?* In order to examine child characteristics, a cohort of children removed from the home in SFY 13-14 was examined. Children in the top decile of costs were classified as high cost to focus on youth with the highest costs. Total costs were computed for each child in the SFY 13-14 cohort through SFY 16-17. Thus, total costs include the costs during the out-of-home stay that began in SFY 13-14. In addition, for children who were discharged from the SFY 13-14 out-of-home stay but had subsequent re-entry into out-of-home care, the total costs included the costs from the subsequent out-of-home care as well. Children at the 90th percentile had costs of $51,628. Children with costs above $51,628 were classified as high cost, while children below $51,628 were classified as lower cost.

Child and household characteristics for high and lower cost children are provided in Table 16. Children in the top decile of costs had average costs of $93,170 compared to $9,810 for the other 90% of children. Thus, among children with total costs above $51,628, the average cost was $93,170. Children with high costs were older with an average age of 12.3 years compared to 5.6 years for other children. Children who were Black were more likely to be in the high cost group compared to Whites. Thirty-eight percent of the lower cost group was Black compared to 48.8% of the high cost group. Interestingly, parental drug abuse and domestic violence in the household were associated with a lower probability of being in the high cost group. Over 40% of the low cost group involved parental substance abuse compared to 17.4% of the high cost group. Children in the high cost group were more likely to be the victims of sexual abuse or an absence of care (e.g., due to parent incarceration, death, abandonment of child, or relinquishment of custody). Children in the high cost group were also more likely to have reported behavioral problems (14.3% versus 3.5%).

Table 16

Child Characteristics

	Lower cost (n=7,983)	**High cost (n=887)**
	%/mean	**%/mean**
Total cost	9,810	93,170
Males	50.2%	51.5%
Age	5.6	12.3
White	66.8%	54.6%
Black	37.6%	48.8%
Physical health problems	0.8%	3.0%

Single parent - Female	52.3%	51.8%
Single parent - male	4.0%	9.8%
Two parent family	44.3%	40.4%
Reasons for service		
Parental substance abuse	44.1%	17.4%
Domestic violence	15.0%	6.5%
Sexual abuse	3.6%	8.2%
Physical abuse	14.4%	16.0%
Neglect	42.3%	43.1%
Absence of care	23.8%	42.5%
Child behavioral problems	3.5%	14.3%
Threatened harm	1.2%	1.2%

Note. Data Source: DCF Office of Child Welfare and DCF Office of CBC/ME Financial Accountability, Run date: 03-29-2018.

Table 17 compares the types and duration of placements for high cost children compared to other children. The number of days in each placement type were computed from the removal date in SFY 13-14 through 16-17. High cost children spent much more time in residential settings and spent much less time with relatives. Other differences (e.g., RTC level of care, corrections) also point towards greater complexity of needs for high cost youth.

Table 17

Placements

	Lower cost (n=7,983)	**High cost (n=887)**
	Mean	**Mean**
Days in foster care - non-relative	235.6	180.6
Days in RTC	1.7	23.3
Days in correctional	4.4	34.8
Days in licensed care	0.5	23.7
Days in non-relative care	62.9	28.7
Days in relative care	201.3	50.5
Days in residential	23.8	345.1
Days in independent living	0.0	0.0

Note. Data Source: DCF Office of Child Welfare and DCF Office of CBC/ME Financial Accountability, Run date: 03-29-2018.

Research question two. *How did permanency outcomes differ for high cost children?* Child outcomes are provided in Table 18. Children in the high cost group had very different outcomes than other children. Discharge from out-of-home care was less likely for children in

the high cost group. In particular, reunification with the parents and adoption were less likely. Reunification occurred for 29.7% of children in the lower cost group, compared to 15.3% of the high cost group. Adoption was the outcome in 37.1% of cases in the lower cost group compared to 8.5% of the high cost cases. Rates of guardianship were also lower for children in the high cost group (4.5% versus 13.0%). A higher percentage of children in the high cost group aged out of the child welfare system (17.2% versus 2.8%). The lower likelihood of achieving permanency for high cost children led to longer lengths of stay and higher costs.

Table 18

Child Welfare Outcomes

	Lower cost		**High cost**	
Number of children discharged	6,665		409	
Number of children in sample	7,983		887	
% discharged	83.5%		50.6%	
Permanency time (in months)	22.0		35.8	
	% of discharged	**% of all youth**	**% of discharged**	**% of all youth**
Adoption	44.4%	37.1%	18.3%	8.5%
Age of majority/child turned 18/emancipation	3.5%	2.9%	38.1%	17.5%
Death of child	0.0%	0.0%	0.2%	0.1%
Guardianship	15.6%	13.0%	9.8%	4.5%
Living with other relatives	0.1%	0.1%	0.0%	0.0%
Reunification	35.6%	29.7%	33.3%	15.3%
Transfer to another agency	0.8%	0.7%	0.2%	0.1%

Note. Data Source: DCF Office of Child Welfare and DCF Office of CBC/ME Financial Accountability, Run date: 03-29-2018.

Research question three. *What were the Medicaid and SAMH expenditures and services received by high cost children compared to lower cost children?* Medicaid-funded service use is reported in Table 19. The mean and median expenditures are reported for high cost and lower cost children and by service type. The distinction between high and lower cost children continued to be based solely on child welfare costs (i.e., Medicaid and SAMH costs are not used to determine high cost cases). Nearly all youth in the SFY 13-14 out-of-home cohort used some Medicaid-funded services between SFY 13-14 and 16-17. Average Medicaid costs for the 876 high cost children that used Medicaid-funded services were $39,902 compared to $17,102 for the 7,983 lower cost children that used Medicaid services. A higher percentage of high cost youth received Medicaid-funded out-of-home care (e.g., Statewide Inpatient

Psychiatric Program, SIPP; Specialized Therapeutic Foster Care, STFC; or Specialized Therapeutic Group Homes, STGH). Twenty percent of high cost children received Medicaid-funded out-of-home services while 7.9% of lower cost children received Medicaid out-of-home services. In addition to being more likely to use specific services, high cost children also had higher Medicaid costs for most services. Notable differences include Medicaid-funded out-of-home care ($65,920 versus $41,256) and outpatient services ($12,388 versus $7,040).

Table 19

Medicaid-Funded Service Use

	Lower cost (n=7,983)			High cost (n=887)		
	# Children	**Mean**	**Median**	**# Children**	**Mean**	**Median**
Children that used any service	7,874	17,102	5,570	876	39,902	17,091
Assessment	5,883	558	462	835	832	700
Crisis care	64	185	128	12	179	159
Developmental disability care	706	226	196	33	77	27
Emergency room	6,045	884	537	762	1,747	874
Inpatient	2,526	15,713	3,901	450	17,457	6,156
Other	37	2,597	1,800	21	5,400	3,848
Out of home	632	41,256	26,365	182	65,920	47,127
Outpatient	7,811	7,040	3,142	876	12,388	8,543
Targeted case management	2,403	1,672	624	367	5,020	1,968
Treatment planning	4,060	246	194	759	346	291

Note. Data Source: DCF Office of Child Welfare, DCF Office of CBC/ME Financial Accountability, and Agency for Health Care Administration. Run date: 03-29-2018.

SAMH-funded service use is reported by SAMH cost center in Table 20. Fewer youth in the SFY 13-14 out-of-home cohort used some SAMH-funded services between SFY 13-14 and 16-17. Average SAMH costs for high cost children were $2,453 compared to $1,855 for lower cost children. A higher percentage of high cost youth received crisis support/emergency services and residential services, although neither was utilized by a large number of children.

Table 20

SAMH Funded Service Use

	Lower cost (n=7,983)			High cost (n=887)		
	N	Mean	Median	N	Mean	Median
Children that used any service	1,416	1,855	402	431	2,453	702
Assessment	220	428	86	90	189	172
Case management	597	480	148	151	647	316
Crisis support/emergency	279	559	98	149	1,178	310
In-home and on-site services	171	1,284	513	32	1,622	772
Intervention	285	658	329	116	372	202
Medical services	195	1,647	739	70	1,240	942
Outpatient	628	535	262	193	591	264
Residential level 1	70	13,009	5,919	33	12,557	7,309
Substance abuse detox	35	1,687	842	18	1,379	1,025
Tx Alt for Safe Cities (TASC)	103	458	200	43	696	247
Non-contract services	31	258	50	22	95	50

Note. Data Source: DCF Office of Child Welfare, DCF Office of CBC/ME Financial Accountability, and DCF Substance Abuse and Mental Health. Run date: 03-29-2018.

Research question four. *Were Medicaid and SAMH expenditures for outpatient services in the first 90 days of child welfare services associated with the likelihood of having high costs (defined as costs in the top quartile for this research question)?* In order to examine the effects of Medicaid-funded outpatient service use on an outcome, it was crucial to examine children that were at similar risk of the outcome. Children that use more services tend to have more need, and are at greater risk for a poor outcome (in this analysis, the poor outcome would be a high cost case). A statistical approach (propensity score matching) was used to estimate the risk that a child entering the child welfare system will become a high cost case over the next four years.

Propensity score matching (PSM) attempts to match people in the high cost and lower cost groups that have similar characteristics (e.g., demographic, alcohol and drug abuse, and reasons for removal in Table 16). In other words, based on characteristics observed at the start of child welfare services, matched children would have a similar probability of having a high cost case. The evaluation team examined whether the provision of outpatient services was associated with better outcomes for children that had similar likelihood of a poor outcome.

Medicaid outpatient services. Table 21 contains the data examining the effect of outpatient service use on youth that had similar probabilities of becoming a high cost case. The four columns represent the predicted probability of becoming a high-cost case based on characteristics observed at the start of child welfare services. Children in the outpatient

services groups one, two, and three have the lowest predicted probability of becoming a high cost case, while child in the fourth group have the highest probability. The table rows represent the outpatient services received by children in the first 90 days of child welfare services. Children in the first group received the fewest outpatient services while children in the top group received the most services.

In general, as expected children that use more outpatient services in the first 90 days of child welfare services have the highest probability of becoming a high cost case. This finding holds even for children that have a similar probability of becoming a high cost case. However, the finding that is most relevant to this analysis is that the relationship is not monotonic (i.e., there is not always a positive relationship between outpatient services and having a high cost case). When compared to the group with the fewest outpatient services, children in the second fewest outpatient services had a lower probability of having a high cost case. In other words, compared to the children with the fewest outpatient services, the provision of slightly more outpatient health care services in the first 90 days of child welfare services was associated with a lower probability of the child becoming a high cost child welfare case. For children in columns 2 and 3, the probability of becoming a high cost case continued to fall as more outpatient services were provided, and only began to increase for children receiving the most outpatient services. These results suggest that children receiving very few outpatient services may benefit from an increase in services.

Table 21

Probability of Becoming a High-Cost Case as a Function of Outpatient Services During First 90-Days in Child Welfare Service

	Predicted Probability of becoming a High-Cost Case							
Outpatient Services Groups	**1 (<9.1%)**		**2 (9.1-16.8%)**		**3 (16.8-37.6%)**		**4 (>37.6%)**	
	Children	%	Children	%	Children	%	Children	%
<$2	230	4.8%	236	13.1 %	168	21.4 %	172	45.9 %
2-201	273	3.7%	344	9.3%	324	20.1 %	265	42.3 %
201-873	552	4.9%	565	9.0%	463	14.5 %	432	50.7 %
873-2814	516	4.8%	472	10.6 %	507	19.7 %	516	57.8 %
2814-6429	254	9.4%	253	22.5 %	360	30.0 %	340	64.7 %
>6429	168	16.1 %	199	32.7 %	178	47.2 %	259	87.6 %

Note. Data Source: DCF Office of Child Welfare, DCF Office of CBC/ME Financial Accountability, and Agency for Health Care Administration. Run date: 09-25-2018.

SAMH-funded outpatient services. Once again, in order to examine the effects of outpatient service use on an outcome, children that have a similar risk of the outcome must be compared. A new model was estimated for users of SAMH services because, unlike the Medicaid analysis, all children that use SAMH services have a mental health or substance abuse diagnosis. A new propensity score matching model was estimated for children that used SAMH services.

Table 22 contains the data examining the effect of SAMH outpatient service use on youth that had similar probabilities of becoming a high cost case. The four columns represent the predicted probability of becoming a high-cost case based on characteristics observed at the start of child welfare services. Table 21 presented the predicted probabilities used to divide the sample into quartiles. The table rows represent the SAMH outpatient services received by children in the first 90 days of child welfare services. The findings reported in Table 20 were used to divide the sample into four groups based on the expenditures for outpatient services. Four groups were used for SAMH services, compared to six for Medicaid-funded services, due to the smaller sample size for the SAMH analysis.

The results were less clear for SAMH-funded outpatient services than for Medicaid-funded services. In general, as expected children that use more outpatient services have the highest probability of becoming a high cost case. This finding holds even for children that have a similar probability of having a high cost case. However, the finding that is most relevant to this

analysis is that the relationship is not monotonic. Children in groups 2, 3, and 4 (i.e., the groups where youth had at least a 29.7% likelihood of having a high cost case), youth receiving the fewest outpatient services had a higher likelihood of actually becoming a high cost case than youth with a slightly higher amount of outpatient services. In other words, the provision of more outpatient health care services in the first 90 days of child welfare services was associated with a lower probability of the child becoming a high cost child welfare case. For children in group 1 (i.e., children with less than a 29.7% likelihood of becoming a high cost case), the association between outpatient services and the probability of becoming a high cost case was quite different. Children with the highest level of outpatient services (>$637) in the first 90 days of child welfare services, were least likely to become a high cost case. Despite the unexpected results for group 1, overall these results suggest that children receiving relatively few outpatient services may benefit from an increase in services.

Table 22

Probability of Becoming a High-Cost Case as a Function of Outpatient Services During First 90-Days in Child Welfare Service

	Predicted Probability of becoming a High-Cost Case							
Outpatient Services Group	**1 (<29.7%)**		**2 (29.7-52.9%)**		**3 (52.9%-69.0%)**		**4 (>69.0%)**	
	Children	%	Children	%	Children	%	Children	%
<450	133	16.5%	128	40.6%	126	69.0%	119	75.6%
450-533	39	25.6%	40	35.0%	40	62.5%	48	68.8%
533-637	79	21.5%	86	41.9%	87	64.3%	85	69.4%
>637	74	6.8%	75	42.7%	100	64.0%	86	74.4%

Note. Data Source: DCF Office of Child Welfare, DCF Office of Substance Abuse and Mental Health, and DCF Office of CBC/ME Financial Accountability, Run date: 09-25-2018.

Discussion Part Two

This evaluation examined child-level data on costs as reported by fiscal agencies and examined the relationship between specific child and parent characteristics and the likelihood of a child being a high cost case. High cost children require a disproportionate share of resources. The implementation of evidence-based practices designed to reduce the intensity and duration of child welfare services may reduce costs while also improving child outcomes. Overall, a high cost child tends to be older, Black, more likely to be a victim of sexual abuse and/or neglect, with parents that were more likely to abandon the child or be unable to provide care. However,

parental substance abuse or domestic violence in the household is less common. Such children are more likely to have very severe behavioral problems perhaps reflecting the severity of the maltreatment and/or the severity of the child's mental health problems.

Children that had high child welfare costs also tended to have high Medicaid costs. This finding reinforces the idea that cross-system children, who receive services from multiple public sector agencies, should be emphasized in research efforts. The combined public sector costs are substantial for youth with complex behavioral health needs, and efforts are necessary to ensure that these youth receive the most appropriate treatment.

The results in this report also indicate that some children may benefit from additional outpatient services, particularly early on in their involvement with child welfare services. Most children have medical or behavioral health needs when entering the child welfare system and entering the child welfare system can be a traumatic event unto itself. Thus, all children require some Medicaid and/or SAMH services when starting child welfare services. The prompt provision of services may increase the likelihood that a child achieve permanency either through reunification, guardianship, or when necessary, adoption. Given the high costs to the child welfare and Medicaid programs, such an intervention could provide needed support and treatment and remain cost-effective.

Sub-Study One: Cross-System Services and Costs

Children involved in the child welfare system often receive services that are funded through state Medicaid programs and other funding sources and are at-risk for juvenile justice involvement. Appropriate and effective services provided through the child welfare system have the ability to effect services and expenditures with other public sector systems. It is important to examine how changes in the child welfare services provided to children also affect service use and costs for other public sector systems. Specific public sector systems examined in this sub-study included Medicaid, State general revenue expenditures for behavioral health services, Juvenile Justice, and Baker Act (involuntary examinations).

The sub-study was divided into three sections. In the first section, Medicaid enrollment and claims/encounter data for children that received out-of-home services were analyzed as were services funded through State Substance Abuse and Mental Health (SAMH) funding sources. In addition, rates of involuntary examinations and juvenile justice encounters were examined for children in out-of-home care. The second section examined Medicaid and SAMH funded services for children receiving in-home child welfare services. Finally, the third section examined three questions related to predicting health care needs, determinants of permanency, and determinants of child juvenile justice placements and involuntary examinations.

Section 1. Medicaid and SAMH service use among children receiving out-of-home child welfare services

Background

A number of studies have examined Medicaid-funded health care services received by children and youth in the foster care system. Medicaid-funded services are appropriate for analysis because the vast majority of children and youth in the foster care system are enrolled in the Medicaid program. Children and youth in the foster care system tend to use much higher levels of both physical and mental health services than other children (CMHS and CSAT, 2013; Gen, Sommers, & Cohen, 2005; Halfon, Berkowitz, & Klee, 1992; Harman, Childs, Kelly, & Kelleher, 2000; Takayama, Bergman, & Connell, 1994). Harman et al., (2000) found that youth in the foster care system have expenditures similar to children eligible for Medicaid due to disability, and much greater than children eligible due to Temporary Assistance for Needy Families (TANF). Unlike previous literature, this sub-study does not compare children and youth in foster care with other children. It has been well established that children and youth in the foster care system use more services than other children.

Children and youth in the foster care system are often physically and/or emotionally abused, and frequently have unmet physical and mental health needs when entering out-of-

home care (Thompson, Lindsey, English, Hawlet, Lambert, & Browne, 2007). This might imply that children and youth were not receiving adequate treatment prior to their entry into out-of-home care. The goal was to determine the degree to which health care expenditures changed between the year before entering out-of-home care and the year after entering out-of-home care. While not a perfect measure, it should give some understanding of the extent of unmet need of children and youth entering out-of-home care, and enable examination of factors associated with greater unmet need.

Key Research Questions Section One

1. What proportion of children who received out-of-home child welfare services were Medicaid enrolled?
2. How many children who received out-of-home child welfare services used Medicaid-funded services? What were the average expenditures for each child that used services?
3. What types of Medicaid-funded services did children use? What were the average expenditures for each service category?
4. How many children received SAMH-funded services? What were the average expenditures for each child that used services? What types of SAMH-funded services did children receive?
5. How many children had involuntary examinations or juvenile justice encounters in the year before and after entering out-of-home care?

Data Sources

The sample was identified from the Statewide Automated Child Welfare Information System (SACWIS), which in Florida is the Florida Safe Families Network (FSFN). Subjects were children and youth, ages 0-18, who were removed from their home by child protective agencies in the state of Florida. Some of the analysis used children removed from the home between July 1st, 2011 and June 30th, 2013, while some of the analysis was able to add another year of data to include children removed from the home between July 1st, 2011 and June 30th, 2014. The analysis using SFY 11-12 through 13-14 only included the youth's first entry into out-of-home care during this time frame. Including additional removals makes it challenging to examine time periods before and after removal. While restricting the data to the first removal in the time frame reduces such concerns, some children were likely to have had out-of-home care episodes prior to the time frame examined.

For children in each cohort all Medicaid enrollment and claims/encounter data were extracted for the 12 months before and after removal. In addition, all events from the Substance

Abuse and Mental Health Information System (SAMHIS) were extracted where Medicaid was not listed as the funding source. Baker Act data were extracted based on youth Social Security Number. Juvenile justice (DJJ) encounters were extracted based on Social Security Number as well. However, nearly 30% of DJJ data have missing Social Security Numbers. In these situations, cases were considered matches if the first name, last name, and date of birth matched. All encounters were included with a valid offense date in the year prior to or after entering out-of-home care.

Results Section One

Research question one. *What proportion of children who received out-of-home child welfare services were Medicaid enrolled?* There were 45,879 removals during SFY 11-12 through SFY 13-14, with 42,851 (93.4%) having Medicaid enrollment in the 12 months after removal. Interestingly the vast majority of children (93%) were also Medicaid enrolled in the year prior to removal. Children averaged 288 days of Medicaid enrollment in the year prior to removal. This finding suggests that most children were Medicaid eligible due to other factors (e.g., family income below poverty level).

Research question two. *How many children who received out-of-home child welfare services used Medicaid-funded services? What were the average expenditures for each child that used services?* Table 23 examines service use and expenditures from several perspectives. The first set of statistics examine average utilization across all children in the sample. The middle section examines average use among users of services. The discussion below focuses on expenditures with patterns for units and days also reported. Units reflect the definition for CPT procedure codes. Thus, a single behavioral health office visit might include 3 or 4 units of service (with each unit denoting a 15-minute office visit). Days of service are also somewhat challenging for outpatient claims that span several days; it is unclear whether services are provided on each day or not. Both units and days of service are useful for examining patterns over time, but care should be taken when looking across services or looking at absolute numbers of units or days.

A number of results are noteworthy. First, conclusions regarding total expenditures depend on the perspective of the comparison. Children averaged $3,805 in total Medicaid expenditures in the year prior to removal compared to $4,881 in the year after removal. Thus, it would appear that expenditures increased after removal. However, this simply reflects the much lower penetration rates in the year prior to removal. Only 63.7% (n=27,319) of children used any Medicaid services in the year prior to removal compared to 96.7% of children in the year after removal. When looking only at children that received services, the average

expenditures were $5,971 in the year prior to removal and $5,049 in the year after removal. It can be concluded that more children received services in the year after removal, and that among users, average expenditures declined in the year after removal.

Utilization of specific services was also examined. Services were classified as physical health inpatient, physical health outpatient, behavioral health inpatient, and behavioral health outpatient. Services were classified based on the primary diagnosis for the claim/encounter and the service type listed on the claim/encounter. Physical health inpatient utilization declined in the year after removal. The average physical health inpatient expenditures declined from $2,382 to $984 among all children, and from $3,738 to $1,108 among all users of Medicaid services. The $3,738 average for physical health inpatient services among users of Medicaid services comprised nearly 63% of the $5,971 total expenditures on the children.

In an effort to examine why inpatient services declined, we examined the diagnoses reported in the inpatient claims for children that had an inpatient stay in the year prior to entering out-of-home care (the results are not included in the table). There seemed to be several groups of children. There were children that were hospitalized and their hospital record indicated maltreatment, others had diagnoses consistent with injuries without diagnosis of maltreatment in the claim/encounter, others had typical physical health problems (e.g., asthma) that necessitated hospitalization. Finally, another important group stemmed from the fact that it is not uncommon for children to enter out-of-home care in their first year of life. Thus, the inpatient stay in the year before removal was due to their birth. The use of inpatient services still declined after entering out-of-home care when inpatient stays in the pre-period that were associated with births were excluded, however, the decline was less dramatic. For the purposes of this sub-study, such children were included while recognizing that expenditures associated with births are an important component of the high physical health costs in the year prior to out-of-home care.

The use of outpatient services increased in the year after removal. Per child behavioral health outpatient expenditures increased from $353 to $1,768 among all children and from $555 to $1,829 among all users of Medicaid services. Thus, despite overall expenditures declining among users of services in the year after removal, the focus of treatment shifted considerably; presumably towards a more therapeutic emphasis.

Table 23

Medicaid Expenditures by Service Category

	Year Prior to Removal		Year After to Removal	
		Mean		**Mean**
All Children with Medicaid Enrollment (n=42,876)				
Total Expenditures		$ 3,805.04		$ 4,881.70
Physical Health Inpatient				
Units		2.18		0.91
Days		2.03		0.97
Expenditures		$ 2,382.02		$ 984.60
Physical Health Outpatient				
Units		36.42		71.28
Days		14.00		26.77
Expenditures		$ 875.06		$ 1,868.93
Behavioral Health Inpatient				
Units		0.34		0.52
Days		0.35		0.91
Expenditures		$ 194.18		$ 259.71
Behavioral Health Outpatient				
Units		17.80		71.08
Days		10.83		43.18
Expenditures		$ 353.78		$ 1,768.46
Use of Any Medicaid Service	n=27,319	63.7%	n=41,449	96.7%
Total Expenditures		$5,971.85		$ 5,049.76
Physical Health Inpatient				
Units		3.42		0.94
Days		3.19		1.00
Expenditures		$ 3,738.48		$ 1,018.49
Physical Health Outpatient				
Units		57.17		73.74
Days		21.98		27.70
Expenditures		$ 1,373.38		$ 1,933.27
Behavioral Health Inpatient				
Units		0.54		0.53
Days		0.56		0.94
Expenditures		$ 304.75		$ 268.65
Behavioral Health Outpatient				
Units		27.94		73.53
Days		17.00		44.67
Expenditures		$ 555.24		$ 1,829.35

Note. Data Sources: SFY 11-12 through 13-14 Florida Safe Families Network (FSFN), Medicaid enrollment and claims/encounter data, and Florida Substance Abuse and Mental Health Information System (SAMHIS).
Note. Data accessed January 25, 2016.

Research question three. *What types of Medicaid-funded services did children use? What were the average expenditures for each service category?* Table 24 examines service use and expenditures. Units reflect the definition for Current Procedural Terminology (CPT) procedure codes as defined by the American Medical Association. Thus, a single behavioral health office visit might include three or four units of service (with each unit denoting a 15-

minute office visit). It can be difficult to compare units across services because a single unit of service can have different meanings for different services. For example, an inpatient day (which is one unit of service) is likely to be associated with more intensive services and costs, more than a 45-minute (3 units of service) behavioral therapy session.

A number of results were noteworthy. First, the use of most services increased in the year after removal with the exception of physical health inpatient stays. Notable increases for physical health services included expenditures for crisis care (e.g., emergency room) and physical health outpatient services (from $12.9 million to $34.0 million).

Behavioral health service use increased more dramatically in the year after entering out-of-home care. For example, assessment services increased from $.3 million to $20.5 million, outpatient services from $2.9 million to $21.7 million, Specialized Therapeutic Foster Care (STFC) services from $84,594 to $14.8 million, Therapeutic Group Homes (TGH) from $.6 million to $3.1 million, targeted case management from $1.3 million to $5.0 million, and treatment planning from $.2 million to $1.4 million. Overall, behavioral health expenditures increased from $14.7 million to $81.7 million in the year after entering out-of-home care.

The increase in service utilization was expected. Children living in homes where maltreatment was occurring were unlikely to receive the care they needed. Thus, we anticipated a great deal of unmet need when children entered out-of-home care. In addition, despite being maltreated, being removed from their home can be a traumatic event for some children and youth, leading to the need for additional services to help cope with the adjustment (Chipungu & Bent-Goodley, 2004).

Table 24

Medicaid Services in Year Before and After Entering Out-of-Home Care: Children Entering Out-of-Home Care in SFY 11-12 – SFY 14-15 (n=32,898)

	Medicaid					
	Year Prior to Removal			**Year After Out-of-Home Entry**		
	Children	Paid	Units	Children	Paid	Units
Physical Health						
Anesthesia	1,000	697,229	165,775	2,593	797,063	280,786
Crisis Care	8,316	2,490,037	26,574	13,221	4,517,790	47,166
Developmental Disability Care	229	46,856	8,842	1,391	212,738	7,882
Home Health	58	2,037,111	86,344	156	4,745,372	216,510
Inpatient	6,412	111,657,762	151,882	4,375	43,231,350	71,773
Laboratory	9,971	643,292	151,990	18,200	1,434,174	218,219
Outpatient	18,257	12,937,649	605,504	27,478	34,044,711	1,538,528
Radiology	5,619	899,965	26,456	9,546	1,869,017	38,240
Transportation	961	247,214	43,861	968	177,116	3,787

Total Physical Health		$133,005,885	1,273,159		$93,935,472	2,440,339
Behavioral Health						
Assessment	1,983	322,965	5,053	27,623	20,553,051	657,177
Crisis Care	423	156,850	979	666	397,548	1,625
Developmental Disability Care	221	39,726	3,199	2,104	369,035	12,035
Inpatient	491	2,679,312	5,884	676	3,983,073	8,330
Laboratory	544	45,264	7,091	1,166	120,061	14,163
Outpatient	3,541	2,953,695	187,861	15,154	21,714,536	1,192,797
Rehabilitation	44	74,869	7,912	124	294,696	32,244
Residential	12	679,546	1,659	14	690,258	1,687
SIPP	117	6,143,940	15,073	164	8,869,191	21,830
STFC	8	84,594	924	1,240	14,847,453	220,755
Targeted Case Management	1,533	1,309,292	100,848	7,523	5,997,821	523,443
TGH	19	697,528	3,874	116	3,157,392	17,440
Treatment Planning	1,502	186,673	2,373	10,045	1,413,653	17,739
Total Behavioral Health		$14,704,921	341,747		$81,732,245	2,720,270

Note. Data Source: FSFN, Run date: 01-08-2015; Medicaid, Run date: 10-07-2016

Research question four. *How many children received SAMH-funded services? What were the average expenditures for each child that used services? What types of SAMH-funded services did children receive?* SAMH funded services received by children before and after entering out-of-home care are reported in Table 25. SAMH funding of services was far smaller than Medicaid. This was not surprising since most children entering out-of-home care were Medicaid eligible, and the vast majority of children were also Medicaid enrolled in the year prior to removal. The vast majority of behavioral health care expenditures were for outpatient services. Among behavioral health services in the year prior to out-of-home care, outpatient services, targeted case management, and Therapeutic Group Home care were the top three services in terms of expenditures. Such services in the prior year may indicate prior involvement with the child welfare system. In the year after removal, the same three services continued to have the highest expenditures. The service category with the next highest level of expenditures, assessment services, had a doubling of expenditures from $109,547 to $214,215 between the year before and year after entering out-of-home care. Expenditures for behavioral health outpatient services and targeted case management services also had notable increases in the year after the child entered out-of-home care.

Table 25

SAMH Services in Year Before and After Entering Out-of-Home Care: Children Entering Out-of-Home Care in SFY 11-12 – SFY 14-15 (n=32,898)

	SAMH					
	Year Prior to Removal			**Year After Out-of-Home Entry**		
	Children	Paid	Units	Children	Paid	Units
Physical Health						
Crisis Care	-	186	-	12	734	18
Inpatient	-	820	-	-	-	-
Outpatient	337	173,912	2,983	539	237,111	3,411
Transportation	-	-	-	-	67	-
Total Physical Health		$199,848	3,185		$302,531	3,854
Behavioral Health						
Assessment	523	109,547	1,186	1,229	214,245	2,301
Crisis Care	82	11,713	266	68	6,789	167
Inpatient	-	2,495	-	-	66,536	206
Outpatient	679	820,152	5,902	1,329	1,061,610	10,306
Rehabilitation	14	9,931	166	19	3,865	63
Residential	61	118,557	600	71	139,522	09
SIPP	17	15,530	294	13	23,763	77
STFC	-	-	-	10	25,974	282
Targeted Case Management	378	362,196	5,836	1,263	504,864	8,072
TGH	36	306,044	1,800	42	329,058	2,280
Treatment Planning	198	34,525	360	428	60,923	656
Total Behavioral Health		$1,838,866	17,198		$2,497,655	25,807

Note. Data Source: FSFN, Run date: 01-08-2015; SAMHIS, Run date: 10-07-2016.

Research question five. *How many children had involuntary examinations or juvenile justice encounters in the year before and after entering out-of-home care?* Table 26 examines rates of Baker Act initiations. Ninety-seven percent of the 32,898 children did not have a Baker Act initiation in the year before or after entry into out-of-home care. There were 373 children that had a Baker Act only in the year prior to their removal and 410 that had a Baker Act only in the year after their removal. Finally, 224 children had Baker Act initiations in both the year before and year after entering out-of-home care.

Table 26

Baker Act Examinations

	Year After Out-of-Home Entry				
	No Baker Act		**One or More Baker Acts**		
Year Before Out-of-Home Entry	Children	%	Children	%	***Total***
No Baker Act	31,891	97.0%	410	1.2%	32,301
One or More Baker Acts	373	1.1%	224	0.7%	597
Total	32,264	98.1%	634	1.9%	32,898

Note. Data Source: FSFN, Run date: 01-08-2015; Baker Act Initiation data, Run date: 10-07-2016

Rates of juvenile justice encounters are provided in Table 27. Over 96% of the 32,898 children did not have a juvenile justice encounter in the year before or after entry into out-of-home care. There were 457 children that had a justice encounter only in the year prior to their removal and 416 that had a justice encounter only in the year after their removal. Finally, 405 children had a juvenile justice encounter in both the year before and year after entering out-of-home care.

Table 27

Juvenile Justice Indicators

	Year After Out-of-Home Entry				
	No Juvenile Justice Encounters		**One or More Justice Encounters**		
Year Before Out-of-Home Entry	Children	%	Children	%	***Total***
No Juvenile Justice Encounters	31,620	96.5%	416	1.2%	32,036
One or More Justice Encounters	457	1.4%	405	1.2%	862
Total	32,077	97.6%	821	2.4%	32,898

Note. Data Source: FSFN, Run date: 01-08-2015; DJJ event data, Run date: 10-07-2016

Section 2. Medicaid and SAMH service use among children receiving in-home child welfare services

Many children involved with the child welfare system are not removed from their families; instead children are receiving services in their homes and communities. Families whose children remain in the home after a maltreatment investigation typically have substantial service needs (U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, 2013). In-home child welfare services play an important role in children's safety, permanency, and well-being.

The receipt of in-home services indicates the child remained in the home and was not placed in relative or non-relative foster care. In-home child welfare services might be offered to families if a maltreatment allegation is substantiated but the child is deemed safe, when allegations are substantiated and the child is deemed unsafe but removal is not deemed necessary, if the child is being reunified but the family continues to need services, and in some cases when the maltreatment allegation is not substantiated but the family needs services. The trauma and negative outcomes associated with a child's removal from his or her family highlights the importance of having effective in-home services to stabilize and strengthen the family to prevent the need for out-of-home care. Indeed, one of the primary goals of

Demonstration projects nationwide is to provide greater resources for States to increase the likelihood of a child being able to remain in the home, and to decrease the use of or length of stay in out-of-home services.

Research findings emphasize the reasons for a greater focus on services received by children remaining in the home. Children receiving in-home services have physical, developmental, and mental health needs that are similar to children in out-of-home care (Leslie, Gordon, Memeken, et al., 2005). Similarly, children remaining in the home were just as likely to score in the clinical range of the Child Behavior Checklist, but were less likely to receive mental health services (Burns, Phillips, Wagner, et al., 2004). Thus, given a similar level of child need, lead agencies and case managers should work with parents/caregivers to ensure that children remaining in-home are getting the services they need to address physical and behavioral health needs.

The State has used the flexibility of the Demonstration to increase funding for preventive in-home services (e.g., Armstrong, Vargo, Cruz et al., 2017). However, IV-E funds are only one source of funds for services needed by children and families. An optimal in-home services program would ensure that both children and parents access available services to minimize the needs for out-of-home placement. Such services include those funded by IV-E and other child welfare funding sources, but also include physical and behavioral health services available through Medicaid and Substance Abuse and Mental Health (SAMH) programs. Children have high rates of mental health problems and medical needs. The purpose of this section of the sub-study was to look at children and youth who receive child welfare in-home services and examine their health care utilization before and during in-home child welfare services. Medicaid and SAMH data were used to determine the health care services received, and whether the receipt of child welfare in-home services affected health care service use.

Key Research Questions Section Two

1. What proportion of children who received in-home child welfare services were Medicaid enrolled?
2. How many children who received in-home child welfare services used Medicaid-funded services? What were the average expenditures for each child that used services?
3. Did Medicaid-funded service use decline as the child spent more time in child welfare?
4. What types of Medicaid-funded services did children use? What were the average expenditures for each service category?

5. How many children received SAMH-funded services? What were the average expenditures for each child that used services? What types of SAMH-funded services did children receive?
6. Were expenditures for Medicaid-funded services affected by the reason the child received in-home child welfare services? Children receiving in-home child welfare services due to medical neglect should see an increase in physical health services, while children with potential trauma due to sexual abuse should see an increase in behavioral health services.

Data

Subjects were children and youth, ages 0-18, who received in-home child welfare services from July 1st, 2015 to June 30th, 2016. Because the goal is to examine the use of health care services, a minimum duration for in-home services was set to 31 days. Given the lags that often occur in receiving treatment, children receiving child welfare in-home services for less than a month may not have the opportunity to access health care resources before the end of in-home services.

FSFN data was the source of demographic variables (age, race, ethnicity, gender), as well as the date the child started in-home services and the reason the children received in-home services. Reasons for entering in-home services included abandonment, alcohol abuse by child, alcohol abuse by parent, caregiver unable to care for child, child behavior problems, child disability, domestic violence in the household, drug abuse by child, drug abuse by parent, emotional abuse or neglect, inadequate housing, inadequate supervision, medical neglect, parents incarcerated, physical neglect, relinquishment of custody, requested services, or sexual abuse. Several reasons for services, including abandonment, parental incarceration, parental death, and relinquishment of custody may seem inconsistent with the child remaining in the home. This likely reflects a more inclusive concept of family and the role of extended family. As noted by Landsman (2015), the distinction between keeping children at home and keeping children with family is not always clear. In other words, the receipt of in-home services does not necessarily indicate the children remained in the same home, as they move to live with another parent or family members.

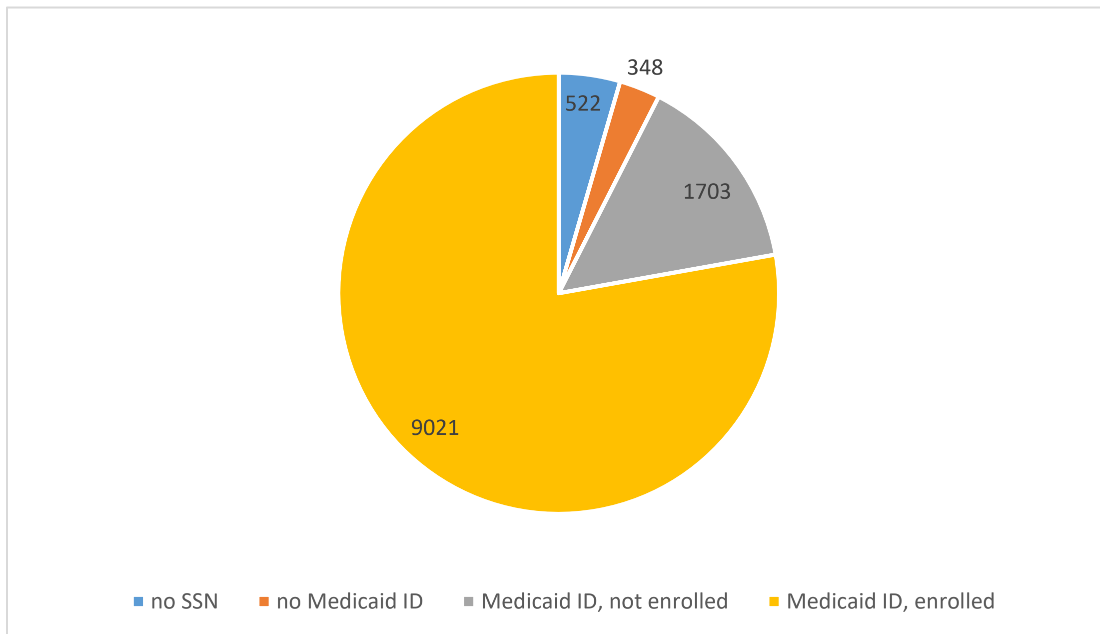
Medicaid claims and encounter data included all fee-for-service claims, and encounters from the Statewide Medicaid Managed Care (SMMC) program. Health care utilization was examined in the year prior to starting in-home services and during the time the child received in-home services. The duration of child welfare in-home services can be more or less than one year. The Substance Abuse and Mental Health Information System (SAMHIS) provides data for

substance abuse and mental health services paid through the State's SAMH program. Information included the dates of service, diagnosis, and expenditures for each substance abuse or mental health service.

Results Section Three

Research question one. *What proportion of children who received in-home child welfare services were Medicaid enrolled?* Figure 35 provides a summary of the steps taken to determine Medicaid enrollment during in-home child welfare services. Of the 11,594 children that received in-home child welfare services, 522 did not have a valid Social Security Number (SSN) reported in FSFN and were not matched to Medicaid data. Of the 11,072 children with valid SSNs, 81.5% (n=9,021) of children were enrolled in the Medicaid program during in-home child welfare services, while 18.5% (n=2,051) of children were not.

Figure 35. Matching between FSFN and Medicaid (n = 11,594)



Research question two. *How many children who received in-home child welfare services used Medicaid-funded services? What were the average expenditures for each child that uses services?* There were 7,659 children that used Medicaid-funded physical and behavioral health services in the year prior to starting in-home child welfare services. That represents 66% of the 11,594 children in the sample and 85% of children who were Medicaid enrolled during child welfare services. The use of a before period enables determination of whether Medicaid service use increased, decreased, or remained the same after the child

began child welfare services. There were 7,428 children who received Medicaid-funded services during in-home child welfare services. That represents 64% of all children in the sample, and 82% of Medicaid enrolled children.

Table 28 contains the proportion of children that used Medicaid-funded services as well as the distribution of monthly expenditures. In order to account for differing exposure times, services were examined for the same time before and during in-home services. For children that received in-home services for less than a year, the length of the pre-period was reduced to match the time in in-home services. For children that received in-home services for more than a year, the length of the during-period was reduced to one year. In this way, the analysis compared Medicaid services for each child received in the same number of days before and during child welfare services. More children received Medicaid-funded services during child welfare in-home services than before the start of child welfare in-home services. In addition, the distribution of expenditures suggests that among children that received Medicaid-funded services, most children received more services during in-home child welfare services than before. For example, the median expenditures were $61 per month prior to the start of in-home services and $87 per month during in-home services.

Table 28

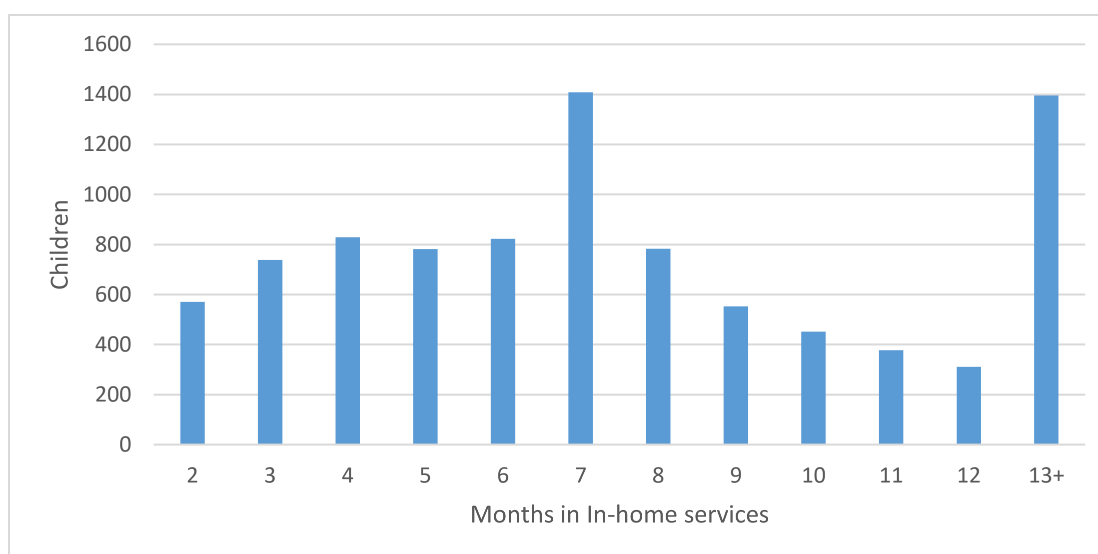
Medicaid Service Use among Children Receiving Child Welfare In-home Services: The Distribution of Monthly Expenditures with Equal pre- and during Time Periods

	Users of Medicaid services	% of all youth children	% of Medicaid enrolled	Distribution of monthly expenditures for users of services (percentile)				
				10th	25th	50th	75th	90th
Before	6,957	60.0%	77.1%	6	17	61	196	820
During	7,394	63.8%	82.0%	11	31	87	211	509

Note. Data sources: SFY 15/16 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 3/15/2018

Research question three. *Did service use decline as the child spent more time in child welfare?* This research question was answered in two steps. First, Figure 36 provides a simple chart to highlight the duration of in-home services. All children received in-home services for at least 31 days because 30 days or more of in-home services was required to be in the sample. Treatment lasted between 1 and 2 months for 571 children. The largest spike was in the seventh month when 1,408 children left in-home services. There were 1,396 children who received in-home services for more than one year.

Figure 36. Duration of In-Home Services



Note. Data sources: SFY 15/16 Florida Safe Families Network. Date retrieved from FMHI data servers; 3/15/2018

Second, to examine how expenditures changed over time, an individual fixed-effects model, sometimes referred to as a within-person model, was estimated. Separate observations were created for each month that the child received in-home services. The dependent variable was the Medicaid expenditures during that month. The independent variables were the month in in-home services (ranging from 1 to 28), and dummy variables for each child in the data. The analysis also explored whether the effect of time was linear by including a variable denoting months squared. This regression approach controlled for variation in service use across children and focused on the change in expenditures for each child over time. The results are in Table 29; specification #1 indicates that expenditures declined by about $9 per month; although the coefficient was not significant at the $p<.05$ level. While the coefficient may seem small, the median expenditure during in-home services was $89. Specification #2 suggests that the decline was non-linear where there was a steeper decline during the early months with the decline moderating as months passed.

Such a decline may be appropriate. At the start of in-home services, children may need assessments, treatment planning, and both physical and behavioral health treatment to address on-going issues. The question was whether the decline in Medicaid-funded services was medically warranted due to an improvement in the child's condition, or whether it reflected time limits imposed by a managed care organization, or some other non-medical reason. This analysis of administrative data cannot answer this question.

Table 29

Regression Results: Expenditures and Time in In-Home Services

	Specification #1			Specification #2		
	Coef	Std err	p value	Coef	Std err	p value
Intercept	240.9	1629.9	.910	357.9	1631.1	0.826
Month	-9.3	7.5	0.215	-40.4	19.0	0.034
Month squared	--			1.9	1.0	0.076
Individual fixed effects	Yes			Yes		
R squared	0.339			0.340		

Note. Data sources: SFY 15/16 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 3/15/2018

Research question four. *What types of services did children use? What were the average expenditures for each service category?* Table 30 contains the mean and median expenditures by type of service. In order to compare the pre- and during periods, the pre- and during periods were set to be of equal duration for each child. Three services, outpatient, inpatient, and emergency room, were divided into physical health and mental health services based on the primary diagnosis. Inpatient stays that encompassed the child's birth were placed in a separate category due to the large number of children and high average expenditure. Fewer children used physical health inpatient services during child welfare in-home services than before child welfare services began, while the use of physical and behavioral health outpatient services, targeted case management, and treatment planning services all increased. However, emergency room visits for physical health reasons also increased. It is also worth noting that, unlike children entering out-of-home care, most children who received child welfare in-home services did not receive behavioral health assessments. Behavioral health assessments are only required when children receive out-of-home child welfare services.

Table 30

Mean and Median Monthly Expenditures by Medicaid Service

Service	Before In-home Services			During In-home Services		
	Number of children	Mean ($)	Median ($)	Number of children	Mean ($)	Median ($)
Assessment	1,801	60	36	2,151	34	10
Developmental Disability Care	130	22	16	143	35	20
ER - BH	90	34	16	70	95	18
ER - PH	2,716	48	21	3,032	69	36
Inpatient - BH	140	1,030	249	123	1,172	363
Inpatient – PH	646	2,378	393	402	2053	493
Inpatient - Birth	783	12,441	509	--		
Out of Home	57	1,604	887	15	2137	413
Outpatient - BH	6,072	135	22	6,539	184	36
Outpatient - PH	1,753	119	29	2,611	171	66
Targeted Case Management	451	77	21	695	114	29
Treatment Planning	764	11	8	1,449	28	14

Note. Data sources: SFY 15/16 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 3/15/2018

Research question five. *How many children received SAMH-funded services? What were the average expenditures for each child that used services?* This analysis examined service use paid by the Substance Abuse and Mental Health system in Florida. The FSFN file with child identifiers was matched to SAMHIS service data based on Social Security Numbers. Children do not enroll in the SAMH program like Medicaid. Rather data were available only for children who receive services through the system.

Table 31 contains the proportion of children that received SAMH services, as well as the distribution of monthly expenditures for users of services. Less than 3% of children that received in-home child welfare services used SAMH funded services. Even among users, the distribution suggests that most children did not receive a sizable number of services. The Medicaid program appears to provide the vast majority of behavioral health services to children receiving in-home child welfare services. For example, over 6,000 children received Medicaid behavioral health outpatient services, well in excess of the number of children that received any SAMH funded service.

Table 31

Users of SAMH Services and the Distribution of Monthly Expenditures

	Users of SAMH services	% of all children	Distribution for users of services				
			10th	25th	50th	75th	90th
Before	331	2.9%	2	6	12	35	101
During	277	2.4%	2	5	14	45	160

Note. Data sources: SFY 15/16 Florida Safe Families Network, and Florida Substance Abuse and Mental Health Information System. Date retrieved from FMHI data servers; 3/15/2018

Table 32 contains the utilization of specific SAMH funded services. Services are reported by SAMHIS cost center with some cost centers combined due to small sample sizes. The most notable services provided through SAMH were case management and outpatient services. However, the 105 children that received case management services prior to in-home services represented less than 1% of the sample. A similarly low percentage received outpatient services.

Table 32

Mean and Median Expenditures by SAMH Cost Center

	Before			During		
Cost Center	N	Mean	Median	N	Mean	Median
Assessment	45	93	7	33	13	6
Case Management	105	38	11	91	30	8
Crisis Support/Emergency	54	32	5	23	25	9
In-Home & On-Site Services	28	37	29	17	91	39
Intervention	55	56	20	43	71	22
Medical Services	17	44	31	11	22	15
Non-Contractual Services	<10	40	14	<10	23	16
Outpatient	131	13	7	141	32	12
Residential/Detox	<10	773	408	<10	627	544
TASC (Tx Alt for Safe Cities)	<10	13	5	<10	53	10

Note. Data sources: SFY 15/16 Florida Safe Families Network, and Florida Substance Abuse and Mental Health Information System. Date retrieved from FMHI data servers; 3/15/2018

Research question six. *Was the reason the child received in-home child welfare services associated with expenditures for Medicaid-funded services?* Research question five examined whether there was a relationship between the reason for in-home child welfare services and the receipt of Medicaid services. Given the declining Medicaid service use over the duration of in-home services time, two different time frames were considered; the first six months of in-home services and the duration of in-home services. A linear regression was

estimated where the dependent variable was the average monthly expenditures for the child during in-home services. The independent variables included demographic variables (age gender, race, and ethnicity), the reason for in-home child welfare services (abandonment, alcohol abuse by child, alcohol abuse by parent, caregiver unable to care for child, child behavior problems, child disability, domestic violence in the household, drug abuse by child, drug abuse by parent, emotional abuse or neglect, inadequate housing, inadequate supervision, medical neglect, parents incarcerated, physical neglect, relinquishment of custody, requested services, or sexual abuse), average monthly expenditures in the year prior to in-home services beginning, the length of time receiving in-home services, whether the child was born in the prior year, and an interaction between being a prior year birth and prior year expenditures. In order to achieve a parsimonious model, a stepwise approach was utilized that only retained coefficients significant at the $p<.05$ level. Distinguishing newborns was important because of the high prior year expenditures and the expectation that expenditures remained elevated for some period. The interaction between prior year birth and prior expenditures accounted for the fact that the relationship between prior year and current expenditures may differ for newborns compared to other children.

The regression results are in Table 33. The results were very similar for the first six months of in-home services, and for the duration of in-home services. The first noteworthy result was that none of the reasons for in-home services were significantly associated with Medicaid expenditures for the child during in-home services. It was expected that children who received in-home services due to medical neglect would have increased physical health services, while children with sexual abuse histories required behavioral health services. However, no reason was significantly associated with average monthly expenditures during in-home services. It is worth noting that this analysis is limited to services provided to children. A relationship may exist for services provided to parents. For example, child welfare involvement due to parental substance abuse would be expected to affect substance abuse services received by parents. Prior year expenditures were positively associated with Medicaid expenditures during in-home services. Time in care was negatively associated with monthly Medicaid expenditures. This reflects the decline in service use over time, leading to lower average monthly expenditures. Newborns had higher expenditures while in in-home services. However, as expected, the relationship between prior monthly expenditures and expenditures while receiving in-home services was weaker.

Table 33

Regression Results

	First Six Months			Duration of In-Home Services		
	Coef	Std err	p value	Coef	Std err	p value
Intercept	193.30	37.96	<.0001	144.50	38.61	0.0002
Prior year expenditures	0.58	0.03	<.0001	0.71	0.03	<.0001
Time in-home care	-0.68	0.14	<.0001	-0.41	0.14	0.0032
Prior year birth	420.41	59.00	<.0001	426.05	60.01	<.0001
Prior year expenditures*Prior year birth	-0.37	0.03	<.0001	-0.46	0.03	<.0001
R squared	0.0637			0.0814		

Note. Data sources: SFY 15/16 Florida Safe Families Network, and Florida Medicaid Enrollment, claims, and encounter data. Date retrieved from FMHI data servers; 3/15/2018

Section 3. Health care service utilization among children and youth in the child welfare system

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

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

The second purpose was to examine whether physical and behavioral health care needs are associated with the likelihood of the child being in a permanent placement. In order to better understand the extent to which permanency is being achieved in a timely way for children

and youth placed in out-of-home care, this section focuses on levels of health care utilization and its association with permanency outcomes including reunification with original caregivers, placement or guardianship with relatives or non-relatives, and adoption.

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

Key Research Questions Section Three

1. Can a model be developed to predict which children and youth will have a substantial increase in health care service utilization after starting out-of-home child welfare services?
2. Are physical and behavioral health care needs associated with the likelihood of achieving permanency?
3. Is the receipt of behavioral health services while in out-of-home care associated with reductions in the number of placements, and a lower likelihood of placement in correctional facilities?

Data

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

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

entering out-of-home care who were at least one year old at removal averaged 319 days of Medicaid coverage in the year prior to removal. Thus, Medicaid funded services are likely to represent a substantial portion of healthcare received by children and youth in the year prior to entering out-of-home care.

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

FSFN data was the source of demographic variables (age, race, gender), as well as the date the child entered out-of-home care and the reason the children and youth entered out-of-home care. Examples of out-of-home care placements include foster homes, group care homes, residential care, licensed kinship care, and approved relative and non-relative placements. Reasons for entering out-of-home care include abuse, neglect, threatened harm, and care unavailable. Abuse includes physical abuse, sexual abuse, or emotional abuse. Neglect consists of both physical neglect, such as being withheld appropriate access to food and water, and medical neglect, such as denial of access to necessary healthcare services. Threatened harm is composed of prospective physical abuse, prospective sexual abuse, and prospective emotional abuse. In these cases, children and youth were threatened with harm, but no abuse had yet occurred. Care unavailable includes cases where the caregiver is incarcerated or upon caregiver death. The lack of a caregiver is not technically considered maltreatment but requires action by the Department of Children and Families.

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

A number of additional variables were utilized. First, there was a dichotomous variable denoting whether there was proof of domestic violence in the home. In addition, assessments were made concerning whether there was inadequate supervision, poor housing, or whether

caregivers voluntarily give up custody (abandonment, relinquish custody, adoption dissolution). Finally, a variable was available in the FSFN system denoting if the child had extremely severe emotional and/or behavioral problems; in other words, very severe behavioral problems that are well above the criteria for severe emotional disturbance (SED).

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

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

Annualized expenditures = Expenditures/Proportion of year

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

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

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

$Expend_{it}$ represents health expenditures on children *i* in the year after entering out-of-home care, and $Expend_{i,t-1}$ denotes expenditures in the year prior to out-of-home care. Separate models were estimated for physical health service expenditures, mental health service expenditures, and total expenditures. *Demog* denotes demographic variables (age, race, gender). *Maltreat* includes child welfare variables denoting the reasons for removal and other descriptors of the parental household (whether there was sexual abuse, physical abuse, emotional abuse, medical neglect, physical neglect, other neglect, threatened harm, a caregiver unavailable, domestic violence, parental substance abuse, child substance abuse, poor housing, and inadequate supervision). *Diagnosis* includes 21 diagnostic categories denoting physical and mental health diagnoses received in the year prior to removal. Eighteen diagnostic categories are typical ICD-9 groupings (e.g., mental disorders, diseases of the respiratory system) and contain numerous diseases/diagnoses in each category. A diagnostic group denoting a diagnosis consistent with child maltreatment was also included. Child maltreatment was defined based on the following ICD-9 codes: child maltreatment syndrome (995.5), adult maltreatment ages 15+ (995.80-995.85), effects of hunger and thirst (994.2-994.3), child abuse by a perpetrator (E967), criminal neglect (E968.4), and evaluation for suspected abuse and neglect (V71.81). A diagnostic group indicated a designation of very severe emotional and behavioral problems in the FSFN data, while another group denoted a claim and/or encounter for a well-child visit (V20.2). To achieve a parsimonious model, coefficients were required to be significant at the $p<.05$ level to be retained in the model.

Results Section Three (research question one)

Regression results are provided in Table 34. Separate regressions were estimated for physical health expenditures, behavioral health expenditures, and total expenditures. Physical health expenditures in the year following removal were associated with expenditures in the prior year. Factors associated with sizable effects on expenditures included the presence of extremely severe behavioral problems ($1,901), neoplasms/cancers ($2,841), endocrine disorders ($3,151), nervous system disorders ($5,681), diseases of the circulatory system ($5,118), congenital anomalies ($6,592), and a diagnosis indicative of maltreatment ($1,212). A finding of medical neglect was also associated with greater service use in the year after removal ($2,904). All factors with sizable coefficients were fairly rare conditions with the finding of medical neglect (3.1%) being most prevalent. Several additional factors were associated with

modest increases in physical health expenditures (e.g., diagnosis of a mental health condition), and several factors were associated with modestly lower expenditures in the following year.

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

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

Table 34

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

	Physical Health (PH) Expenditures			Behavioral Health (BH) Expenditures			Total Expenditures		
	Coef	**Std error**	**p value**	**Coef**	**Std error**	**p value**	**Coef**	**Std error**	**p value**
Intercept	1767	107	<.0001	459	82	<.0001	2320	139	<.0001
Age	-71	10	<.0001	134	6	<.0001	68	12	<.0001
Female				178	57	0.0019			
PH prior year expenditures	0.07	0.00	<.0001						
BH prior year expenditures				0.22	0.01	<.0001			
Total prior year expenditures							0.10	0.00	<.0001
Extremely severe behavioral health problems	1901	267	<.0001	4347	174	<.0001	6658	328	<.0001
Diagnosis in prior year									
Infectious diseases				-250	98	0.011	-434	190	0.0224
Neoplasms/cancers	2841	683	<.0001				2242	833	0.0071
Endocrine and metabolic diseases	3151	300	<.0001				3101	367	<.0001
Diseases of the blood	1529	332	<.0001				1426	406	0.0004
Mental disorders	321	108	0.003	1634	70	<.0001	2254	133	<.0001
Diseases of the nervous system	5681	342	<.0001				5508	417	<.0001
Diseases of the sense organs	-399	128	0.0018				-380	169	0.0249
Diseases of the circulatory system	5118	429	<.0001	960	268	0.0003	5956	525	<.0001
Diseases of the respiratory system				-194	76	0.0112	-386	157	0.0136
Digestive disorders	1009	185	<.0001				984	228	<.0001
Genitourinary system	724	222	0.0011	291	143	0.0413	1041	275	0.0002
Complications of pregnancy				-1914	433	<.0001	-1992	827	0.0159
Skin and subcutaneous diseases	683	225	0.0024						
Musculoskeletal system				-431	149	0.004			
Congenital anomalies	6592	357	<.0001				6140	435	<.0001
Ill-defined conditions									
Injury and poisoning				412	96	<.0001	824	176	<.0001
Diagnosis indicative of maltreatment	1212	368	0.001				1235	450	0.006
Child Welfare Variables									
Physical abuse				547	84	<.0001	452	160	0.0047
Sex abuse				761	147	<.0001	1028	279	0.0002
Unspecified neglect				268	79	0.0006			
Medical neglect	2904	255	<.0001	475	163	0.0035	3169	311	<.0001
Physical neglect									
Threat of harm									

Caregiver unavailable	-402	126	0.0014	-214	82	0.0087	-650	155	<.0001
Domestic violence	-432	123	0.0004	-170	79	0.0314	-560	150	0.0002
Parental substance abuse	-306	91	0.0008	-388	62	<.0001	-761	116	<.0001
Inadequate supervision	-270	120	0.0248						
Observations	34987			34987			34987		
Log likelihood	-371316			-346568			-376024		
AIC	742677			693174			752090.6		

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

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

Proportional hazards models were used to examine the time until achieving permanency. While the logistic regressions required placements within 12 months (or 24 months for adoption) after removal, the proportional hazards models utilized the time until permanency regardless of whether it occurred in the first 12 months. Observations for children and youth who did not achieve a permanent placement were considered censored. The independent variables were the same as the logistic regressions.

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

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

Results Section Three (research question two)

Changes in service utilization, based on whether the child or youth used services, between the year before removal and the year after removal from the home are reported in Table 35. As noted above, children and youth that used physical health inpatient, behavioral health inpatient, and physical health outpatient services were considered to have health care needs. Because most children and youth used physical health outpatient services, children are identified as having health care needs if they used more than the median number of services. Based on these criteria, service use was examined in the year before and year after removal. For example, 3.6% of children and youth have behavioral health outpatient services only in the year prior to removal (Use-No use), 38.6% only in the year after removal (No use-Use), 11.3% in both years (Use-Use) or 46.6% in neither year (No use-No use).

The pattern differed considerably for inpatient and outpatient services. Eleven percent of children and youth had a physical health inpatient stay in the year prior to removal (8.6% only in the year before removal and 1.7% in both the year before removal and year after removal). Among physical health outpatient services, more than 28% were above the median in both periods. Another 21.8% were below the median before removal from the home but above the median after removal. Among behavioral health outpatient services, 38.6% of children and youth did not use services before removal but did after removal. Once again, this suggests there was either unmet need for behavioral health services before the child was removed from the home, or that the trauma of removal resulted in a need for services. Fifty-three percent of children and youth in the sample received behavioral health outpatient services in the study period (38.6% only after removal, 3.6% only before removal, and 11.3% both before and after removal). However, there is a distinct difference between the pre- and post-periods. Only 15% of children and youth received behavioral health outpatient services in the year prior to removal

(3.6% + 11.3%). Fifty percent of children and youth received behavioral health outpatient services after removal (38.6%+11.3%).

Table 35

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

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

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

Logistic regression results examining how changes in health care utilization are associated with child welfare outcomes are reported in Table 36. Adoption (OR=1.78, CI: 1.45-2.17) was more likely among children and youth with physical health inpatient use in both periods while reunification (OR=0.60, CI: 0.50-0.72) and guardianship (OR=0.55, CI: 0.41-0.75) were less likely. Children and youth with physical health inpatient use in the post period but not in the prior year were also more likely to be adopted (OR=1.76 CI: 1.48-2.10), but less likely to be reunified with caregivers (OR=0.53, CI: 0.46-0.61) or placed with guardians (OR=0.71, CI:

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

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

Table 36

Changes in Health Care Service Use and Child Welfare Outcomes

	Permanency			Adoption			Reunification			Guardianship		
	OR	95% CI		OR	95% CI		OR	95% CI		OR	95% CI	
Health Care Service Use/Need												
PH Inpatient												
Use-Use	0.83	0.70	0.97	1.78	1.45	2.17	0.60	0.50	0.72	0.55	0.41	0.75
Use-No use	0.85	0.78	0.91	1.37	1.23	1.52	0.79	0.73	0.86	0.68	0.60	0.78
No use-Use	0.70	0.62	0.80	1.76	1.48	2.10	0.53	0.46	0.61	0.71	0.58	0.89
PH Outpatient												
High use-High use	0.87	0.83	0.92	1.49	1.35	1.64	0.73	0.69	0.78	1.06	0.98	1.15
High use-Low use	1.00	0.94	1.06	1.27	1.14	1.41	0.87	0.82	0.93	1.19	1.09	1.29
Low use-High use	0.77	0.73	0.82	1.12	1.01	1.24	0.81	0.77	0.86	0.86	0.79	0.94
BH Inpatient												
Use-Use	0.33	0.19	0.59	0.15	0.02	1.06	0.71	0.42	1.20	0.15	0.04	0.63
Use-No use	0.57	0.44	0.75	0.32	0.14	0.72	0.99	0.74	1.31	0.40	0.24	0.68
No use-Use	0.48	0.36	0.63	0.34	0.16	0.73	0.62	0.49	0.80	0.24	0.14	0.41
BH Outpatient												
Use-Use	0.54	0.50	0.58	0.98	0.86	1.12	0.52	0.48	0.56	0.70	0.63	0.78
Use-No use	1.15	1.04	1.28	1.21	1.03	1.43	1.19	1.07	1.33	0.96	0.83	1.12
No use-Use	0.55	0.52	0.57	1.05	0.97	1.13	0.50	0.48	0.52	0.73	0.68	0.78
Age	0.99	0.99	0.99	0.95	0.94	0.95	1.00	0.99	1.00	1.05	1.04	1.05
White	0.99	0.91	1.07	0.96	0.84	1.11	0.91	0.84	0.99	1.26	1.11	1.42
Black	0.97	0.89	1.05	0.77	0.68	0.89	1.04	0.96	1.13	1.08	0.95	1.21
Female	0.99	0.95	1.03	1.11	1.04	1.19	0.93	0.89	0.97	1.04	0.98	1.10
Reason for Removal												
Abuse	1.08	1.01	1.15	0.64	0.57	0.72	1.83	1.71	1.95	0.47	0.43	0.52
Neglect	0.95	0.91	1.00	0.77	0.71	0.84	1.30	1.23	1.37	0.71	0.66	0.76
Other	1.01	0.94	1.09	1.09	0.97	1.23	1.05	0.97	1.14	0.88	0.79	0.98
Observations	42782			42782			42782			42782		
Likelihood ratio	1344.9		<.0001	975.2		<.0001	1939.7		<.0001	782.5		<.0001

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

Table 37 contains the proportional hazards results for the time until permanency. As noted earlier, children did not have to achieve permanency within 12 months for this outcome. The first specification examines service use in the year prior to removal. Behavioral health inpatient and outpatient service use were associated with a longer time until achieving permanency. Physical health service use was not associated with the time to permanency. The second specification examined the role of changes in service use. While levels of physical health care in the prior period were not associated with permanency, changes in physical health care use were significantly associated with outcomes. Children and youth with physical health inpatient use in both the pre- and/or post-period or use only in the year after removal had a longer time until permanency. Children and youth with high physical health outpatient care in both the pre- and post-periods or only the year after removal had a longer time until permanency. Use of behavioral health inpatient services in either the pre- or post-period or both periods was associated with a longer time until permanency. The results for behavioral health outpatient use were inconsistent. Children and youth with behavioral health outpatient use in both the year before and year after removal (Use-Use), or only in the year after removal (No use-Use), had a *longer* time until permanency. Children and youth with behavioral health outpatient use only in the year before removal (Use-No use) had a *shorter* time until permanency; although this result was only marginally significant (*p*=.08).

Table 37

Proportional Hazard Results

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

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

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

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

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

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

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

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

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

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

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

Results Section Three (research question three)

The results of multiple linear regression analysis are presented in Table 38. The average number of placements for all children and youth was 2.48 (*SD* = 3.10). Among child demographic characteristics, child age, or African American race/ethnicity were significantly associated with the number of placements. In particular, older youth and African American children were more likely to have greater number of placements.

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

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

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

placements. Presumably, assessments enabled children to be matched with needed services, and repeat assessments would determine whether such services were effective at reducing symptoms. Overall, results indicated that 13% of the variance in placement stability was explained by the examined predictor variables.

Table 38

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

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

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

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

Table 39 presents findings from logistic regression analysis examining whether the child had a correctional placement (as reported in FSFN). The FSFN placement file reports all child placements including licensed foster care, relative care, residential care, and correctional placements. The sample was limited to children ages 10 and above since correctional placement is very rare at younger ages. Two percent of youth had a correctional placement

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

Table 39

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

Risk Factors	**β**	**Wald $\chi^2_{(1)}$**	**OR**	**95% CI**
Child Age	0.24	50.69**	1.28	[1.19, 1.36]
Child Gender	0.78	30.60**	2.19	[1.66, 2.89]
Child Race[a]				
White	0.24	0.73	1.27	[0.74, 2.18]
Black	0.46	2.8	1.58	[0.92, 2.70]
Hispanic	-0.38	0.94	0.69	[0.32, 1.47]
Caregiver Loss	0.34	6.01*	1.41	[1.07, 1.86]
History of Child Maltreatment[b]				
Sexual abuse	-0.29	0.8	0.75	[0.40, 1.41]
Physical abuse	-0.4	3.04	0.67	[0.43, 1.05]
Neglect	-0.13	0.57	0.88	[0.63, 1.23]
Physical Health Problems	-0.41	8.24**	0.66	[0.50, 0.88]
Mental Health Diagnoses				
Adjustment reaction disorder	-0.02	0.01	0.98	[0.70, 1.38]
Conduct disorder	0.87	20.73**	2.39	[1.64, 3.47]

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

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

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

Discussion

Cross-system service use among children receiving out-of-home child welfare services. There are a number of interesting results that emerged. The vast majority of youth that were enrolled in the Medicaid program after removal from the home were also enrolled prior to removal. However, service penetration was much higher after removal from the home. The pattern of service use also differed before and after removal. Physical health inpatient services were more common before removal. Behavioral health outpatient services were much more common after removal from the home. Behavioral health services are likely crucial to future youth outcomes due to the trauma associated with maltreatment.

Cross-system service use among children receiving in-home child welfare services. Findings suggested that the majority of children that receive in-home child welfare services are Medicaid enrolled and used Medicaid-funded services. SAMH was not a substantive funding source for these children. More children used Medicaid funded services after in-home child welfare services began, although use declined over the duration of in-home child welfare services. More specifically, there was increased use of physical and behavioral

health outpatient services, targeted case management, and treatment planning services. Medicaid-funded service use was not associated with the reason for in-home child welfare services. This was a surprising result given that one of the reasons for in-home services is medical neglect.

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

There are several practical policy implications from this study. First, we know that children and youth enter out-of-home care with considerable health care needs. However, there is often a lag between when a child or youth enters out-of-home care and when an assessment occurs. Such delays can cause exacerbation of problems during such a crucial time for the children and youth. Models that can predict which children and youth will have the greatest unmet need could help triage children and youth such that youth with the highest anticipated need can be connected to needed services promptly. For example, youth who have extreme severe emotional and/or behavioral problems, suffer from medical neglect, or suffer from neoplasms, endocrine disorders, circulatory disorders, nervous system disorders, or congenital anomalies are likely to have significant health care needs. A type of risk score could be easily computed, such that those children and youth with the highest score would be expected to have the highest need. Second, the model predictions can provide additional information for case managers to use when establishing treatment plans for children and youth.

Permanency. Children and youth with physical or behavioral health problems are less likely to achieve permanency. Children and youth with physical health needs are more likely to be adopted, but youth with behavioral health needs are less likely to be adopted. Reunification is less likely when the child or youth has substantial physical health needs and is less likely when the youth has behavioral health needs although the results are not as clear as some

measures of need were not significantly associated with reunification. Guardianship is less likely when the child or youth had physical or behavioral health inpatient use. Guardianship is also less likely when the child or youth had behavioral health needs addressed through outpatient services. Greater attention should be paid to the question of why these children and youth are less likely to achieve permanency. For example, are the services received by children and youth ineffective? Do the children and youth need more intensive services? What else could be done to help these children and youth achieve a successful outcome?

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

The study measured health care need using health care service utilization. Clearly, some degree of unmet need is likely to remain. Approximately 50-60% of foster children and youth have behavioral problems (Burns et al., 2004; Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998). Fifty-three percent of children and youth in our sample received behavioral health services in the study period. Thus, overall utilization rates are consistent with prior research using direct measures of behavior.

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

Limitations. This analysis only examined Medicaid and SAMH funded services. Consequently, it may not include all services received by youth. Youth may also receive services funded by lead agencies. In addition, the analysis is very descriptive. Given the Demonstration was implemented statewide, the development and testing of specific hypotheses is challenging. The secondary data analysis design implicitly holds several limitations. First, as

always, administrative data are likely to be imperfect. For example, reliable reporting of social security numbers in both FSFN and Medicaid records was assumed when compiling complete data for each subject. However, neither department/agency uses social security numbers as a primary identifier (DCF has a client ID, while Medicaid has its own identifier). Errors and incomplete information may have resulted in missed matches. Second, while the focus of the analysis of expenditures was on how parents can limit health care, all children and youth in the child welfare system are enrolled in a Medicaid managed care plan that has its own gatekeeping protocols. In addition, children and youth could have switched Medicaid managed care plans when removed from the home, and thus changes in service use may reflect differences in service authorizations across plans. Third, the analysis of permanency outcomes measured health care need based on service use. As a result, the measure of need is imperfect and subject to some degree of error. However, the overall prevalence rates are consistent with prior research. Finally, the analysis of placements examines services after entering out-of-home care. There is the potential for reverse causation (i.e., the number of placements may influence the number of services received). In addition, the number of placements is only a proxy for the child's trajectory. For example, a youth that requires residential treatment when they entered out-of-home care, then was stepped down to a therapeutic group home, and then to a foster home may be on a very different path than a youth who began in a foster home and then progressed to more intensive treatment over time.

Sub-Study 2: Services and Outcomes for 'Safe but High Risk' Families

Placement in out-of-home care may provide children with physical safety, but the abrupt and indefinite nature of placement may also have deleterious effects. Studies have shown that children placed in out-of-home care experience a wide variety of adverse outcomes ranging from physical and mental health problems, substance use, and issues related to poor academic performance (Cheng & Lo, 2011; Goldman et al., 2003; Fussell, & Evans, 2009). It is generally agreed that out-of-home placement should occur only when the child's safety is at significant risk. Thus, child protection workers should consider first all efforts directed to keep children in the care of their families while addressing immediate safety or risk concerns. The decision-making process is complicated for child welfare professionals because they are not always able to predict whether the course they choose for a given child is the best one (Pinto, & Maia, 2013).

To ensure that children whose safety is at risk are correctly identified and that their families receive the proper services, the Florida Department of Children and Families (DCF) initiated a multi-year effort to develop and implement the child welfare practice model (DCF, 2014). The practice model dictates that all families whose children are assessed as safe but at high or very-high risk for future maltreatment are to be offered voluntary family support services that target the building of family protective factors to improve the long-term safety of children in the home. One expectation of the Demonstration extension was that these services would incorporate a broader array of service options, and increased utilization of evidence-based practices, to better meet the needs of families compared to the voluntary services available prior to the extension. It was also expected that through the implementation of the child welfare practice model, improved efforts to effectively engage families in these voluntary services would result in greater service engagement and adherence, and ultimately better outcomes for these families.

Key Research Questions

Outcomes Analysis

1. What is the number and proportion of children who were the subject of a subsequent report of maltreatment within 12 months after the initial maltreatment report for cases in the intervention group as compared to the matched comparison group?
2. What is the number and proportion of children that experience verified maltreatment within 12 months after the initial maltreatment report for cases in the intervention group as compared to the matched comparison group?

3. What is the number and proportion of children that had an in-home dependency case opened within 12 months after the initial maltreatment report for cases in the intervention group as compared to the matched comparison group?
4. What is the number and proportion of children that had an out-of-home dependency case opened within 12 months after the initial maltreatment report for cases in the intervention group as compared to the matched comparison group?

Services and Practice Analysis

1. To what extent have lead agencies established an array of effective family support services to meet the needs of high risk families?
2. What factors facilitated successful engagement of families in family support services (e.g. families choose to participate in services, follow up on referrals, and complete the recommended services)?

Methods

This sub-study examined child welfare practice, services, and safety outcomes for families who received family support services. A matched comparison group was used to assess whether outcomes were improved for children whose families received family support service interventions.

Outcomes analysis. To examine the effect of the child welfare practice model, particularly with regard to the provision of voluntary services, two groups of cases were compared in relation to several outcomes. Two groups were identified: (a) the intervention group, that is the group of children assessed under the child welfare practice model, and (b) the comparison group, that is, those children who were assessed prior to the implementation of the child welfare practice model. The intervention group was identified based on the following characteristics: (a) children who were assessed under the child welfare practice model July 1, 2016 and July 1, 2017; (b) who were deemed safe to remain at home, yet are at a high or very high risk of future maltreatment in accordance with the child welfare practice model. A matched comparison group included similar cases with the dates for maltreatment reports between July 1, 2011 and July 1, 2012. Voluntary services were offered to all families in both groups.

Matching cases between the intervention and comparison groups was accomplished using the propensity scoring method (Rosenbaum & Rubin, 1984). This technique allows for equating group differences simultaneously on multiple variables by reducing all relevant characteristics to a single composite score (Rubin, 1997). Cases for the comparison group were selected by matching on child demographic characteristics and variables that differentiate between groups (e.g., maltreatment type). The cases were matched using the nearest neighbor

technique, wherein cases for the comparison group were selected based on propensity scores that are closest to propensity scores of the cases in the intervention group (Dehejia & Wahba, 2002).

There were 2,859 cases that met the criteria and were included in the intervention group. There were 28,681 cases available for selection for the comparison group. After selecting the matched cases, the comparison group consisted of 2,632 cases. The average age for this sample was almost 8 years (*M* = 7.99; *SD* = 5.01) ranging from birth to 18 years. As shown in Table 40, both groups consisted of 50% males. A majority (66%) for both the intervention and the comparison groups of children were Caucasian, 23% were African-American, approximately 2% were Hispanic, and the remaining 9% were from other racial or ethnic groups. A substantial proportion (47% for the intervention group and 44% for the comparison group) of these youth had parents with substance abuse problems, and approximately 30% of the youth came from families with domestic violence histories.

The most prevalent type of maltreatment among study cases was neglect (51%) followed by physical abuse (55% for the intervention group and 54% for the comparison group), physical abuse (19% for the intervention group and 13% for the comparison group) and sexual abuse (3%). Approximately one percent of children experienced a caregiver loss due to death, incarceration, long-term hospitalization, or abandonment.

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

Table 40

Characteristics of Children in the Intervention and the Comparison Groups

	Intervention Group (N = 2,859)	**Comparison Group (N = 2,632)**
Child Characteristics		
Gender (Male)	50.5%	51.1%
African American	23.6%	25.2%
Hispanic	2.6%	2.5%
Caucasian	64.3%	64.2%
Age		
	M = 7.99 (*SD* = 5.07)	*M* = 7.4961 (*SD* = 5.01)
Maltreatment Types		
Sexual abuse	2.8%	2.7%
Physical abuse	19.0%	13.4%
Neglect	51.5%	50.5%
Threatened Harm	3.5%	5.4%
Parental substance abuse	46.7%	43.8%

Domestic violence	32.8%	29.4%
Caregiver loss	1.2%	1.2%

Services and practice analysis. This component of the sub-study explored in greater depth the services and practices provided to families with children categorized as safe but at high risk for future maltreatment. Methods employed included a set of case file reviews and focus groups with family support service providers. The analysis was designed to be exploratory in nature to provide more context for understanding what factors may impact the effectiveness of voluntary family support services.

Case file review. The evaluation team reviewed case files for a sample of cases that received family support services following the implementation of the child welfare practice model. A lead agency was selected for the case file reviews based on the number of cases that met the intervention criteria. These criteria were cases in which 1) the child(ren) was determined to be safe but at high or very high risk for future maltreatment according to the CPI safety and risk assessments, and 2) the family received family support services, as indicated by a designation of partial or completed services in FSFN's family support services module. Eckerd Community Alternatives (Circuit 6) had the greatest number of cases that met these criteria (n = 1,584), and was selected for the review.

A case file review protocol was developed to capture data from the files (see Appendix K), and included a combination of closed- and open-ended response items to gather a variety of data about each case. The case file reviews were completed in December of 2017. The selected lead agency had two contracted family support service providers, both of whom were included in the file reviews. An important distinction was that one provider only made hard copy case files available for the review, while the other provider offered access to FSFN in addition to hard copy case files. As a result, the amount of information available for the file reviews varied between the two providers.

Cases that met the intervention criteria were identified through FSFN. A sample of nine randomly selected cases were included in the analysis. The number of children involved in the cases reviewed ranged from two to five, with a median of three children per case. The children ranged in age from younger than one year to 17 years. The mean age of the youngest child in the household was 2.8 years, while the mean age of the oldest child in the household was 12.1 years. Eight of the nine families had at least one child under the age of five. Just under half (n = 4) of the cases were a single-parent household headed by the biological mother. A third of the cases (n = 3) were two-parent households composed of both biological parents, while one case was a two-parent household comprised of the biological mother and her current spouse

(the children's step-father). The final case was a relative caregiver who had legally adopted the children in her care. Just under half of the caregivers (n = 4) were in their mid-to-late 20s (ages 25-29), a third (n = 3) were in their 30s, and two were over the age of 40.

Descriptive statistics were produced using SPSS for data that were appropriate for quantitative analysis (e.g. frequencies, means, and medians). This included information about the family composition, abuse allegations, safety and risk determinations, and various components of case practice that were assessed using a binary Yes/No checklist. Open-coding was performed on qualitative data to identify key themes and patterns emerging from the data. Analysis further entailed looking at how different pieces of data within a case file related to one another; for example, did the services provided to the family align with the needs identified in the family assessment?

Focus groups. To further explore practices and services associated with the provision of family support services, focus groups were conducted with the providers for three lead agencies: Families First Network (FFN), Family Support Services of North Florida (FSSNF), and ChildNet. These focus groups occurred in conjunction with another contracted study that USF is conducting to evaluate community-based child abuse prevention programs throughout Florida. A focus group guide was developed to facilitate the focus group sessions (see Appendix L), which included questions about the purpose of family support services, the needs of families that receive these services, strategies that are used to engage families and perceived barriers to engagement, the types of services provided, and the successes and challenges of service provision.

Eight focus groups were conducted from June to November of 2018 across the three lead agencies and included a total of 41 participants. Voluntary informed consent was obtained from participants at the beginning of each session. The focus groups were audio-recorded with permission from the participants. The audio files were then transcribed into a Word document for analysis. Transcripts were coded using a grounded theory approach to identify emergent themes and concepts from the data.

The sample included in the focus groups consisted primarily of front-line staff with direct service roles (n = 29), but also included supervisors and program directors (n = 12). Participants were predominantly female (n = 36). The sample was ethnically diverse, with approximately 49% of participants self-identified as white (n = 20), about 29% self-identified as black or African American (n = 12), and 17% self-identified as Hispanic or Latino (n = 7). On average, participants had been employed in their current position for a little over two years (M = 30.75 months).

Results

Outcomes Analysis

Child maltreatment re-reporting. The proportion of children who were reported as being maltreated and were reported again within 6 months of the previous child maltreatment report was calculated for comparison group entry cohort SFY 11-12 and the intervention group entry cohort SFY 16-17. Initial reports and subsequent reports were included regardless of the results of the child protection investigations. Approximately 33% (33.1%) of children in the intervention group and approximately 14% (13.5%) children in the comparison group experienced a subsequent child maltreatment report. The results of chi-square analysis indicated that there is a statistically significant difference, χ^2 (1, N = 5,491) = 292.09, $p < .05$.

Recurrence of maltreatment. Recurrence of maltreatment was defined as a second incident of verified maltreatment within 6 months of a child's first verified maltreatment incident. Only children with "verified" maltreatment (i.e., when the protective investigation resulted in a verified finding of abuse, neglect, or threatened harm) were included in the analysis. The first and second episodes of maltreatment were selected based on the received dates of child maltreatment reports.

Approximately 1% (1.2%) of children in the intervention group and 4.2% of children in the comparison group experienced recurrence of maltreatment. The results of chi-square analysis indicated that there was a significantly higher proportion of children with recurrence of maltreatment in the comparison group than in the intervention group, χ^2 (1, N = 5,491) = 46.55, $p < .05$.

Placement in out-of-home care. The proportions of children who did not enter out-of-home care after initial child maltreatment report within 12 months were calculated for the SFY 11-12 (i.e., comparison group) and SFY 16-17 (intervention group). The proportion of children who entered out-of-home care within 12 months was higher for the comparison group – 22% than for the intervention group – 5.1%. The results of chi-square analysis indicated that there was a statistically significant difference between the two groups (χ^2 (1, N = 5,491) = 338.26, $p <$ .05).

Re-entry into out-of-home care. For the purposes of this sub-study re-entry was defined as all children who entered out-of-home care, were discharged during a given fiscal year and subsequently reentered within 12 months of initial removal. There were 1.6% of children in the comparison group who reentered out-of-home care after discharge. The proportion of children who reentered out-of-home care in the intervention group was smaller –

0.3%. Results of chi-square analysis indicated that there was a statistically significant difference between the two groups (χ^2 (1, N = 5,491) = 26.30, p < .05).

Services and Practice Analysis

Case file review. Most cases included in the review contained multiple abuse allegations, and all but one case had at least one substantiated allegation. The most common allegations included environmental hazards, inadequate supervision, domestic violence, substance abuse, and parental mental health problems (see Table 41). Additionally, trouble meeting basic needs (e.g. food, clothing, and housing due to poverty) and uncontrolled child mental health problems were significant identified needs on several cases. For the majority of cases, the children were determined to be safe but high or very high risk, and thus appropriate for family support services. On three cases, however, the CPI assessment in the file indicated that children were determined to be unsafe, although the information included in the family assessments did not necessarily support such conclusions. For example, one case had no substantiated allegations, but the children were still determined to be ‘unsafe’ by the CPI. On another case, the CPI concluded that “domestic violence in the home poses threat to child safety,” but the information gathered by the CPI indicated that the father was threatening to harm himself and no one else, and the children were not present when the incident occurred. These findings indicate some inconsistencies with the child welfare practice model, since families with a determination of ‘unsafe’ are not eligible for family support services and should always be provided with mandatory child welfare services, and since the information included in the assessments did not appear to support some of the safety determinations. Furthermore, the findings were inconsistent with the data that was pulled from FSFN, since inclusion criteria used to select the cases were limited to families that were assessed as safe but high or very high risk. Thus, it appeared that in some cases the assessment results entered into FSFN by caseworkers did not align with the assessments in the case files.

Table 41

Child Abuse and Neglect Allegations and Findings from Investigation (n = 9)

Allegation	Substantiated (# cases)	Unsubstantiated (# cases)	Total # Cases
Environmental hazard	2	1	3
Inadequate supervision	1	2	3
Threatened harm to child	1	1	2
Medical neglect	0	1	1
Sexual abuse	0	1	1
Domestic violence	1	2	3
Substance abuse	3	0	3

Parental mental health	0	3	3
Child mental health	0	2	2
Basic needs	0	2	2

With regard to family assessment, three of the cases reviewed did not have an initial Family Functional Assessment (FFA) in the file, although it is entirely possible that the FFA was completed and simply was absent from the hard copy case management files that were reviewed. All but one of the cases had at least one updated family assessment competed by the case manager in the file, although for two of the cases it was not the official Department FFA, but a different assessment used by the case management agency. Of the six cases that had an FFA-initial on file, most (n = 5) indicated that interviews were completed with the mother, with additional relatives and/or adult household members, and with other collaterals (such as school personnel, doctors, neighbors, etc.). Two-thirds of these cases (n = 4) indicated that interviews were completed with at least some of the children. Some children were too young to interview, but in some cases children who were old enough were not interviewed. Only two cases indicated that interviews were completed with the biological fathers. Although the biological fathers did not live in the same household as the children in several cases, the FFA in the files provided no indication of whether or not these fathers had any involvement with their children or whether any attempts were made to contact them. Additional sources of information noted in the files for completing the FFA included police reports, prior abuse reports and/or child welfare cases, observations of the family, and medical records. For all six cases, the FFA-initial included an assessment of the caregivers' protective capacities, safety, risk, and the family's needs. On the other hand, they did not all include an assessment of the family's strengths or the family's perspective of their needs and strengths. These findings are summarized in Table 42.

Table 42

Areas Addressed by the Initial Family Functional Assessment (n = 6)

Key Elements Assessed	Proportion of Cases
Caregivers'/parents' capacity to protect and nurture the children.	100%
Observations of interactions between the children and household members.	83.3%
Whether the children can live safely in the current home or placement.	100%
Factors that may place the children's safety at risk.	100%
As assessment of the family's strengths and resources.	66.7%

An assessment of the family's needs that hinder providing a safe and stable home.	100%
The family's perspective of their needs and strengths.	33.3%

After being referred for family support services, the duration of cases ranged from as little as one month up to five months, with the median service duration being about three months. The majority (n = 6) of cases were staffed roughly every two weeks, with two cases that were staffed weekly and one case that was staffed less frequently (roughly once per month). Case documentation indicated that for most cases (n = 7) the caregivers participated in the staffings at least some of the time, with three cases indicating consistent family participation in staffings. The same seven cases also included documentation of the inclusion of family voice and perspectives during staffings, such as asking family members to report their perceived needs, services they would like to receive, and how they feel about the services they have received. All nine cases showed evidence that family needs and the identification of services to address those needs were discussed during staffings, as documented in case staffing notes. Some staffing notes also indicated discussion of family strengths, but needs were more often the focus.

The services provided to families varied depending on their particular needs, but frequently included services such as individual and/or family counseling, parenting and life skills education, psychoeducation regarding children's mental/behavioral health needs, and assistance with basic needs such as daycare and affordable housing. All cases included referrals to formal services, which generally (though not always) matched the identified family needs. On the other hand, fewer cases incorporated the use of informal supports, although some cases did make use of these. Examples included referring a caregiver to a local parent support group and engaging local relatives in the family care plan.

In a few cases, there appeared to be services provided that did not match the family's needs, such as one case in which the parents were referred to substance abuse services despite the fact that the substance abuse allegations were unsubstantiated. Another example was a case in which the primary need identified was for safe and stable housing, but the services provided were counseling and parenting skills. There were a few cases in which some of the family's identified needs appeared to be unmet by the services provided, although it is possible that families were connected to other resources not formally documented in the case files. For the majority of cases (n = 7), most or all of the family's identified needs appeared to be addressed by the services provided.

Aspects of case practice that were more difficult to assess from the case files were case managers' contact and engagement with families and responsiveness to family needs over the life of the case. Most of the case files did not contain actual documentation of case manager home visits or contact with the family, however, the staffing reports noted the frequency with which the case manager was expected to conduct visits. All cases indicated a minimum of weekly visits; several cases specified at least two visits per week and one case indicated contact from the case manager or another support worker up to four times per week. Information about the substance of those visits, however, was not documented in the files. Strategies used by either case managers or CPIs to engage families were also unclear and largely undocumented in the case files. Two cases noted the use of family team meetings to engage the family in service planning and identification of needs and strengths, but otherwise there was limited information about engagement processes. One case file explicitly noted the mother's limited engagement, but efforts to increase her engagement were not documented.

The majority of cases (n = 6) contained some indicators of ways in which case managers were responsive to family concerns and new or changing needs, as evidenced by the case manager's documentation of concerns expressed by the family or the identification of new needs arising over the course of the case and follow-up with service referrals. Most often, these issues were documented in the case staffing reports. For example, a staffing report for one case described how the mother expressed some concerns over new problematic behaviors that one of her children was exhibiting. According to the notes, the case manager discussed the concerns with the mother and was able to suggest some behavior management strategies as well as providing a referral for psychoeducation services. On another case, a staffing report noted that the mother had a mental health breakdown one day and called the case manager, who was able to de-escalate the situation over the phone and referred the mother to a nearby mental health receiving facility. The case manager then met with the mother the following day to implement a safety plan.

Additional strengths evidenced in these cases were that all the families appeared to have participated in the recommended services and many families expressed satisfaction with the services they received according to family surveys included in the files. All files indicated that the families cooperated with services, and case closure was based on the family's progress and observed behavior changes for all but one case, which was discharged because the family moved to a different county. In this case, the case manager provided a list of resources for the family's new residence. On the other hand, some of the challenges that could be identified in the files included lack of transportation for some families, limited ability for some families to

participate in case staffings (either due to scheduling conflicts or transportation issues), and the difficulty of managing serious mental and behavioral health problems of children.

Focus groups. Findings from the focus groups provided further insight into aspects of frontline practice that were not easily assessed through the case file reviews. Findings reported here draw from preliminary analyses completed for the Community-based Child Abuse Prevention Evaluation (Rohrer, et al., 2018, 2019). During focus group sessions, family support service workers shared their perspectives regarding the following: the purpose of family support services, eligibility criteria and characteristics of families served, strategies used to effectively engage families in services, the types of services provided and any specific program models used, and successes and challenges related to the provision of family support services.

Purpose of family support services. Participants described the purpose of these services primarily in terms of preventing future maltreatment and removal of children from the home. Other key concepts relayed during focus groups included helping families become self-sufficient, strengthening or empowering families, building parenting capacities, and ending generational cycles of abuse. A number of participants spoke about using their interactions with clients to address the underlying reasons for the family's most recent maltreatment incident, "Not just putting a Band-Aid on the situation, but to really engage with the family intensively. Get to know them. Really find out what the root cause, you know, of the incident that happened." Overall, participants across focus groups described the purpose of these services in terms of strengthening families and connecting them to resources that would prevent the need for more intensive DCF intervention in the future.

Eligibility and family characteristics. Across the participating agencies, it was reported that family support service providers received referrals from DCF for families where children were assessed as safe but at high or very high risk for future maltreatment. One lead agency was only serving families that met this high/very high risk criteria. The other two lead agencies indicated that they could also serve moderate or lower risk families, and one agency accepted referrals from other community partners, such as schools or law enforcement, in addition to receiving referrals from DCF. At a minimum, programs were required to serve high/very high risk families.

Focus group participants regularly cited domestic violence, substance abuse, mental health problems, hazardous home conditions, homelessness, and inadequate supervision of children as common risk factors that the families they serve experienced. Some also noted generational involvement with the child welfare system. As one participant expressed, "Some of the parents we work with, they were children of the system." Another respondent added that

they often worked with "parents that are dealing with their issues from their childhood that they never resolved. And now they're parents, and now they're passing this on to their children." Another commonly reported need among families entailed caring for children with psychological, developmental, or physical health issues. As one respondent explained, "A lot of the kids are disabled. And… they have a laundry list of medical issues and the parents aren't taking them to their appointments."

Poverty and a lack of community resources were reported to be significant burdens among families, especially in rural communities. Families particularly struggled with a lack of adequate public transit and affordable housing. Participants also cited that lack of awareness or inaccessibility of community resources were common problems for families. Participants stated that many parents needed access to mental health and substance abuse programs, financial assistance with housing and utilities, daycare, respite care, and reliable access to public transportation. Many parents also needed assistance with maintaining a safe home environment and developing formal and informal support networks.

Family engagement. Participants were asked about the strategies they use to engage families in these services, and the challenges or barriers they encounter in their efforts to engage families. Several themes emerged in response to these questions. The first was reluctance among families who feel they do not need services or no longer want to be involved with DCF. Participants explained that overcoming the negative experiences a family has had with DCF was often their most significant struggle. Families were regularly found to be resentful and/or fearful of child welfare system workers. Parents feared having their children removed from the home and feared having their privacy invaded by friends, family, or community members. One participant summarized the overwhelmingly negative view families have of the child welfare system, stating, "They don't believe in the system, so they don't want to do services, or they say the system is against them, so they don't want to do services." This resistance was especially prominent among families who had been involved with DCF multiple times. As one participant expressed, "A lot of our families, they're generationally involved with the department and they grew up with services being in the home and so, if they've never worked with [family support services] before, they have a jaded outlook of things."

To address this reluctance, program staff frequently had to reassure their clients that, "We're not DCF." Numerous respondents noted that distancing themselves from the formal child welfare system helped alleviate fears among families. They explained to families that they were not investigators and were not there to remove children from the home; that their program was different from other programs and investigations a client was previously involved in; that

they were there to provide services, such as daycare, housing, or transportation; that their services could help a family improve their functioning; that the agency's engagement could help a family prevent future involvement by DCF; and that a family's willingness to complete services would help their case in any future investigations. Educating clients about the services the agency could offer was often necessary because families were usually unaware of the nature of the provider or its services. Participants also tried to build rapport with clients by agreeing with their perceptions and offering a solution, "You can either keep viewing this as negative or I can try and help you so you don't ever have to deal with this again and make it a positive experience for [you]." Respondents also reported that families were responsive to empathy, respect, and positivity. Many workers noted existing strengths within the family and emphasized possible successes during their first home visits, which often motivated families to accept services.

Some participants indicated that they used a client's fear or ignorance of the child welfare system to encourage engagement. As one respondent put it, "We were told to not say 'voluntary.'" Another explained that when families were being resistant, they contacted the CPI, who then persuaded a family to comply with services, "They'll accept the parenting because [of] the CPI, they feel like… some fear, you know, pressure." In one focus group, workers sometimes met with families as a team to urge participation,

> I think that's wonderful, having two or even three of us. Because I know that peer pressure usually helps. So, us being as a group going in and talking to them, I think it helps sway them to want to engage in services.

Another challenge to engagement that was reported by participants was the referral process itself. Referrals were generally received after the CPI had finished their investigation. Among some families, the result was that services were viewed as an unnecessary additional burden, "Nine times out of ten they're automatically in defense mode, like, 'No, why do I have to? …My investigation is closed, I did everything I was supposed to do.'" Additionally, one focus group explained that CPIs did not reliably inform families that family support workers would be approaching them after an investigation ended, "We get pushback from that because they're like, 'No one told us that you all were coming,' and so you have to calm some of them down." For other families, agency involvement came too late,

> Some of the families that we've not gotten engaged with past the initial contact, they have said to us that because we are waiting to accept these referrals at the end of the investigations, at that point they don't need our help anymore, they needed it at the beginning of the investigations. And so when we get out there later on, they don't want to work with us anymore.

Across focus groups, there was consensus that it would be most beneficial for families in need if family support services were engaged earlier in the case while the investigation was still ongoing. This would allow workers to initiate services while families are in crisis and more likely to feel a need for help. Furthermore, some families were reportedly resentful or mistrustful of child welfare authority figures. These feelings stemmed from negative experiences with more coercive CPIs and repeated involvement in the child welfare system. To address these issues, participants focused on fostering autonomy and developing partnerships with families. One respondent explained, “We make it clear that we’re there to partner with them, we’re not there to tell them what to do. Everything that they do is their choice and what they choose to work on, their goals.” Thus, participants emphasized empowering families to make decisions about their services.

Another theme discussed by participants involved issues with maintaining contact and keeping scheduled appointments with families. Many participants had difficulty maintaining contact with clients, which presented issues before and after families accepted services. Several families had members in the household that did not want involvement, although these members were not always part of the family or recipients of services. “Sometimes if they’re staying with someone, that person they’re staying with don’t want you in their house,” a respondent explained. Furthermore, some families had conflicting schedules (e.g. between the parents and children), which often became more erratic during school breaks. Some families declined services due to the time commitment presented, indicating that they were unwilling to participate for several months. Other families continuously scheduled and rescheduled meetings until the end of the engagement period.

In some cases, families that initially accepted services eventually asked to close out earlier than expected, usually because they either received a specific requested service or believed they reached their conclusion early. A respondent explained,

> They start meeting their own needs and they’ve built that confidence, then they’re just like, ‘alright cool, I’m done, bye.’ And we’re like, ‘wait we have to finish the process out and transition’…keeping through the whole process can be tough.

A loss of contact, in which a client no longer answered the phone or relocated without notice, was not typical but had happened to several participants.

In response to these issues, participants explained that they made their own schedule more flexible, were willing to meet clients at home or at school, communicated with families through phone, text, and face-to-face meetings, and consistently reminded clients of their appointments. Participants also used meetings to manage expectations, such as the timeline of

involvement or the time and effort needed for tasks. Families were encouraged to share what obligations they had so that family support workers could schedule meetings more flexibly.

The final theme related to the topic of family engagement was working with families who have serious behavioral or psychological issues. Some families were found to be difficult to engage because of the severity of these problems, such as highly aggressive behavior. Others reportedly had unaddressed mental health or substance abuse issues that prevented them from accepting their need for services or being able to fully engage in services. One respondent described, “Sometimes they come to us high risk and they don’t even know they have a problem. Like, they don’t recognize that their substance misuse is actually an addiction and it’s affecting [them].” Other families expressed feelings of hopelessness due to repeated involvement with DCF. Many participants cited low self-esteem among parents as a common barrier to help-seeking behavior, an issue that becomes particularly relevant when setting up goals and listing strengths.

Some participants reported that they offer immediate assistance to gain the family’s trust and interest in services. For example, one participant regularly offered and fulfilled a service to a family immediately, such as providing clothes. Other participants explained that persistence was key to addressing these issues. “You can tell they’re trying to put you away and once you don’t give up, and you just stay there through it, they’re like, okay you really do care,” a respondent explained. Participants worked with parents to raise their self-esteem, which included strategies such as listing strengths that they saw in the family, acknowledging small positive changes in behavior, reviewing accomplishments, and rewarding clients for successfully completing tasks. Some providers also found that using peer support was critical to breaking clients out of denial and encouraging them to learn,

> When you get them into any kind of group setting, group work is powerful because it allows you to move them through the stages of change to me at a faster pace than, you know, just sitting there with them.

As these responses illustrate, a variety of methods were utilized by staff to engage families in services, and while not always effective, respondents found these approaches to be successful with many of the families they served.

Service provision. Family support service programs were found to provide a wide array of services, which included services that agencies provided directly as well as services that they referred families to in the community. Across agencies, a similar process was reported that entailed providing a comprehensive assessment of the family’s strengths and needs, which incorporated the family’s input, and connecting the family to an array of services based on their

particular needs. The most commonly reported services included case management, mental health services, budgeting courses, parenting courses, employment assistance, and transportation assistance. Other services reported by some but not all agencies included anger management, substance abuse services, domestic violence services, legal advocacy, behavior modification courses, and peer support groups. Respondents also reported that they frequently assist families in applying for various social services such as day care, disability assistance, food stamps, and housing assistance. A variety of evidence-based parenting programs were reported by participants, including the Nurturing Parenting Program, the Incredible Years Program, Effective Black Parenting, and Common Sense Parenting. Evidence-based practices for service coordination were also reported, including the Wraparound model and Integrated Practice Teams.

Strengths and successes. Participants had mixed views about the effectiveness of family support services, though a majority were positive. Participants perceived that families who benefitted the most from services were those who were the most engaged. They viewed the strengths of their programs as providing families with much needed services, allowing for supervision within the home, and giving families, but particularly parents, an outlet to discuss and address stressors. Reportedly, through their involvement with services, clients became aware of resources in the community and learned how to access them. This prevented significant financial disasters, such as homelessness, from occurring, which gave families an opportunity to improve their lives and functioning. One participant stated that these services enabled families to achieve their main goal, which was to prevent the removal of children from the home. With many families that were generationally involved in the child welfare system, family support services also gave caregivers an understanding of how they could parent differently. In several focus groups, furthermore, participants described low rates of subsequent abuse or maltreatment reports as evidence of their programs' successes.

Several participants described the use of family support services as an improvement upon previous voluntary services. Several positive remarks were made about the increased flexibility given to workers under their current model. When describing old models, one participant stated, "To realize how flexible this [program] is, not having seen how awful it was in the past… I was to the point seriously where [I thought] I don't feel effective." Another strength noted in one focus groups was a focus on "quality services rather than quantity."

Challenges. One of the primary challenges reported by participants concerned the difficulties agencies faced in providing adequate resources to families. A lack of community resources was a serious and widespread problem across communities. Participants explained

that they could not address many of their families' needs, sometimes for extended periods of time. This issue was particularly salient among rural communities,

> Housing is a lot harder to find up there, things like that. Jobs are a lot harder to find up there so it can take longer, where here in [city] we can probably get you into housing within three months. Up there you'll go to waitlist for nine months and hopefully get into something.

A lack of affordable housing, reliable transportation, and affordable daycare were some of the most commonly reported challenges. An inability to meet basic needs caused other issues with family functioning, even among families who were engaged in services. One participant described how a lack of extended supervised care delayed a client's ability to receive mental health services, "Cause they're like, 'If I Baker Act, where are my kids going to go?' Well you're right. They're going nowhere." On that same note, it was reported that some families struggled during school breaks because they were unable to access supervised activities, such as camps, for their children. Access to these activities could be limited either due to the family's financial situation or lack of available activities within the local community. As a result, children were often left at home unsupervised.

As described previously, there were also challenges with regard to the delay in receiving referrals from DCF. In nearly every group, participants wanted the timeline of intervention to be changed so that family support workers could become involved several days, if not weeks, before an investigation was completed. In fact, respondents from one agency indicated that per the practice model, they should be receiving referrals much earlier, within the first 15 to 30 days of the investigation, but reported that this rarely happened. Participants stated that receiving referrals sooner would give them more time to gain the family's trust and enhance engagement. It would also allow them to offer services in the midst of a crisis and would benefit families whose issues might become more severe with waiting, such as those with impending evictions or unpaid bills.

Discussion

Overall, findings based on previous cohort of children who were assessed using the new child welfare practice model (see Vargo et al., October 2017) and based on the current (i.e., SFY 2016-17) cohort indicated that children in the intervention group (i.e., who were assessed using the new child welfare practice model) had better outcomes compared to children in the comparison group (i.e., those who were assessed using standard practice). Specifically, children in the intervention group had a lower rate of recurrence of maltreatment, lower rate on entry in out-of-home care, and lower re-entry rate.

Findings from the services and practice analysis indicate that families who received voluntary family support services were connected to a variety of services and supports to address their needs and build their protective factors. Although a small proportion of the case files that were reviewed appeared to be inappropriate for voluntary services (e.g. children were identified as unsafe) or provided services that did not address the family's primary needs, the majority of cases reflected appropriate service provision and individualized case planning based on the family's identified needs and strengths.

Strengths of family support services identified during focus groups with providers were that these programs provided families with much needed services, allowed for supervision within the home, gave families an outlet to discuss and address stressors, and increased awareness of resources in the community and how to access them. In several focus groups, furthermore, participants described low rates of subsequent abuse or maltreatment reports as evidence of their programs' successes. Several participants described the use of family support services as an improvement upon previous voluntary services, and also emphasized a focus on providing quality services, rather than focusing on the quantity of services.

On the other hand, challenges that were identified during focus groups included inadequate community resources to meet the needs of families, especially affordable housing, transportation, and daycare, and delayed service initiation as a result of referrals being sent after CPI complete their investigations. Based on these findings, one recommendation is for DCF to modify the current guidelines to allow and encourage CPI to send referrals for family support services earlier in the case (e.g. within one to two weeks of case initiation) so that providers can begin engaging and working with families sooner.

Limitations. One of the primary limitations of this research was the quasi-experimental design. Cases were not randomly assigned to the intervention or comparison groups. Hence, there may have been other characteristics of these cases that contributed to the differences in outcomes. Second, the intervention was conducted in different environments (i.e., different counties, different lead agencies). Thus, it was not possible to disentangle effects due the intervention from those due to the local factors. Finally, only safety outcomes were examined. Another limitation concerns the case file reviews. Originally, the intent was to compare a set of cases that received family support services under the child welfare practice model (intervention group) with a set of cases that received voluntary services prior to the implementation of the child welfare practice model (comparison group) to examine the impact that these practice changes have had on family engagement, service provision, and participation in voluntary services. There were some unexpected challenges that required an alteration to this approach,

in that the evaluation team was unable to draw a comparison group as initially proposed.[8] As a result, the team was only able to review a set of cases that met the intervention group criteria, and therefore only a descriptive analysis of family support services under the current child welfare practice model could be provided.

Additionally, the findings presented here are limited in that they present the perspectives of family support service providers, but not the perspectives of families. The original evaluation proposal included interviewing families who received these services to gather their perceptions and compare these with the perceptions of providers. These interviews could not be completed for this report due to delays in initiating data collection for the sub-study. However, families are currently being recruited to participate in interviews as part of the Community-Based Child Abuse Prevention Evaluation mentioned previously, and their perspectives will be examined as part of this ongoing research endeavor.

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[8] A comparison group was drawn using FSFN, however, the lead agency reported that they could not find the cases that matched the FSFN numbers provided. After multiple attempts to re-draw the sample with the same results, the evaluation team asked the lead agency if they could draw a sample from their files using the comparison group criteria, but the agency reported that it was unable to do so. At this point, the decision was made to abandon the inclusion of a comparison group for the case file reviews.

Summary, Policy Implications and Recommendations, and Lessons Learned

Summary

Research methodology. The primary goal of the implementation analysis was to describe implementation of the Demonstration Project, to track changes, and to identify lessons learned. Interview data were gathered from child welfare stakeholders in Florida from January of 2015 through March of 2019. The interviews were coded using a qualitative data analysis software (Atlas.ti 6.2), and an interrater reliability process was completed by evaluation team members at each phase of the evaluation.

The purpose of the services and practice analysis was to assess progress in expanding the service array under the Demonstration extension. This includes implementation of evidence-based practices and programs, changes in practice to improve processes for identification of child and family needs, connections to appropriate services, and enhanced use of in-home services to increase successful family preservation and reunification. A service array survey, an evidence-based practice (EBP) survey (Wraparound and Nurturing Parenting), follow-up interviews regarding the two evidence-based practices, and focus groups with case managers and CPIs were conducted by evaluation team members.

Several key outcomes related to child safety, timely permanency, and well-being were hypothesized to improve over time and were assessed in the outcomes study. Permanency outcomes examined included the proportion of children who achieved permanency within 12 months of removal, the proportion of children who were either reunified or placed with relatives within 12 months of removal, and the proportion of children with finalized adoptions. Safety outcomes examined were the proportion of children who did not re-enter out-of-home care within 12 months of their most recent discharge from out-of-home care and the proportion of all children who did not experience maltreatment within six months of case closure. Resource family outcomes that were examined were the number and proportion of licensed foster families that were active at the end of a specific fiscal year and have remained in an active status for at least 12 months and the proportion of newly recruited licensed foster families during a specific fiscal year. The hypothesis of the child and family well-being outcome analysis was that there would be an improvement in the physical, mental health, developmental, and educational well-being outcomes for children and their families. CFSR outcomes and performance items were examined over time.

The cost analysis was divided into two sections. First, the cost analysis for the examined the relationship between the Demonstration implementation and changes in the use

of child welfare funding sources. Second, the cost study examined child-level cost data reported by lead agencies through the Florida Safe Families Network (FSFN).

A sub-study specific to the cost analysis was divided into three sections. The first section analyzed Medicaid enrollment and claims/encounter data for children that received out-of-home services, as well as, services funded through State Substance Abuse and Mental Health (SAMH) funding sources. The second section examined Medicaid and SAMH funded services for children receiving in-home child welfare services. Finally, the third section examined three questions related to predicting health care needs, determinants of permanency, and determinants of child juvenile justice placements and involuntary examinations.

Sub-study examined child welfare practice, services, and safety outcomes for families who received family support services through an outcomes analysis and a services and practice analysis of two groups (pre- child welfare practice model implementation and post- child welfare practice model implementation). Secondary data from FSFN were utilized for the outcomes analysis. Case file reviews and focus groups were conducted for the services and practice analysis.

Results.

Process study. In summary, the qualitative evaluation methods (interviews and focus groups) resulted in similar findings that indicated that child welfare serving entities practices were in line with the goals of the Demonstration. Stakeholders (CBC Leadership, CMO Leadership, Judges and Magistrates, CPI supervisors, CPIs, and case managers) across the child welfare system struggled with the implementation of the child welfare practice model. Stakeholders perceived that there were inconsistencies with the fidelity to the child welfare practice model, the implementation of the child welfare practice model inadvertently created more pressure for frontline staff to complete assessments in a timely manner, and it was perceived that the in-depth nature of the assessments created an increase in children entering out-of-home care. Frontline staff turnover, availability of resources, funding, poverty, and housing were challenges to effectively serving families reported across child welfare stakeholders. Despite these challenges, it was predominantly reported that each child welfare serving entity maintained positive relationships with one another. Examples of the positive relationships included regularly scheduled meetings, co-located staff, and co-located entities. Despite the challenges in the availability of services, stakeholders consistently reported that there were increases in the amount of services and types of services that were available to families. Stakeholders reported that the Demonstration was an integral and essential aspect of Florida’s child welfare system and the efforts to keep children safely in the home.

Findings related to the service array identified a variety of services provided throughout the state. A significant strength identified through the evaluation was that there is a wide array of evidence-based practices that have been implemented in various parts of the state. The data were most complete with regard to family support services and safety management services, and indicate that lead agencies provided a variety of services to prevent families from formally entering the child welfare system and to help children remain safely in their home. Expansion of these services has been one of the primary focuses under the Demonstration extension.

Outcome study. Overall, longitudinal trends for permanency indicators revealed a steady trend. There is a trend of a declining proportion of children who achieved timely permanency including reunification, the adoption rates remained high and steady over time. An examination of safety indicators showed that the proportion of children who continue to stay safe remained stable over time. Re-entry into out-of-home care remained stable over time and approximately 91% of children did not re-enter out-of-home care across the Demonstration extension years. When the effects of child and family characteristics on outcome indicators were examined, results showed that child age, physical health and behavioral problems, parental substance abuse, and history of domestic violence played an important role in predicting child outcomes. Findings also indicated considerable variability over time in the proportions of licensed foster families that were active after 12 months and the proportion of newly licensed foster families. Examination of statewide rates over time suggested that proportion of licensed foster families that were active after 12 months and the proportion of newly licensed foster families remained stable.

The child and family well-being analysis of CFSR outcomes and performance items showed that there were no statistically significant changes at the state level over time. However, for in-home cases Circuits 8 and 19 showed improvements over time across most performance and well-being outcome items. Circuit 5 showed declines over time across most performance and well-being outcome items. For foster care cases, Circuit 3 showed improvements over time across most performance and well-being outcome items. Circuit 5, 11, and 12 showed declines over time across most performance and well-being outcome items.

Cost Study. Findings indicated that front-end prevention services (family support services) increased during the initial Demonstration and the Demonstration extension. The number of children in out-of-home care was lower in the initial Demonstration and Demonstration extension compared to the pre-Demonstration period. Consistent with one of the goals of the Demonstration, the ratio of expenditures for licensed foster care to expenditures for front-end prevention services has trended downward over time. There was a minimal

relationship between changes in spending patterns and changes in outcomes. Only the rate of abuse in foster care appeared to have a relationship with spending patterns. Circuits that shifted resources from out-of-home care had lower average maltreatment rates while the child was in foster care compared to circuits that increased the share of expenditures spent on out-of-home services.

Findings also indicated that children with high cost cases required a disproportionate share of resources. Overall, children with high cost cases tend to be older, Black, more likely to be a victim of sexual abuse and/or neglect, with parents that were more likely to abandon the child or be unable to provide care. However, parental substance abuse or domestic violence in the household was less common. Such children were more likely to have very severe behavioral problems. Children that had high child welfare costs also tended to have high Medicaid costs.

Sub-Study one. A number of interesting results emerged from sub-study one. The vast majority of youth who were enrolled in the Medicaid program after removal from the home were also enrolled prior to removal. However, service penetration was much higher after removal from the home. Physical health inpatient services were more common before removal. Behavioral health outpatient services were much more common after removal from the home. Findings also suggested that the majority of children who receive in-home child welfare services are Medicaid enrolled and used Medicaid-funded services. More children used Medicaid funded services after in-home child welfare services began, although use declined over the duration of in-home child welfare services. Medicaid-funded service use was not associated with the reason for in-home child welfare services.

Service use prior to removal was associated with service use after removal. When controlling for service use prior to removal, a number of factors were associated with expenditures in the year after removal. Mental health disorders were associated with higher unmet need, as were several less common physical health diagnostic groups. Victims of sexual abuse, physical abuse, and/or medical neglect also had greater unmet need when entering out-of-home care. Children and youth with physical or behavioral health problems were less likely to achieve permanency. Children and youth with physical health needs were more likely to be adopted, but youth with behavioral health needs were less likely to be adopted. Reunification was less likely when the child or youth had substantial physical health needs and was less likely when the youth had behavioral health needs although the results were not as clear as some measures of need were not significantly associated with reunification. Guardianship was less likely when the child or youth had physical or behavioral health inpatient use. Guardianship was

also less likely when the child or youth had behavioral health needs addressed through outpatient services. Children and youth who had behavioral health outpatient use in the prior year but not in the year after removal were more likely to be reunified.

Findings indicated that age corresponds to the likelihood of placement in a correctional facility in such a way that being one year older increases the odds of placement by 28%. Males were over two times more likely to be placed in a correctional facility. Loss of a caregiver increased the odds of placement by 41% but history of child maltreatment was not related to involvement with the justice system. Among mental health disorders, alcohol and drug disorders, conduct disorder, and bipolar disorder were the strongest predictors of placement in a correctional facility, with conduct disorder related to 2.39 times increased odds of being placed. Youth who were diagnosed with either bipolar disorder or alcohol and drug disorders were 2.3-2.7 times more likely to be placed in a correctional facility compared to youth who did not have a mental health diagnosis. The presence of physical health problems was negatively associated with justice system involvement. Youth with physical health problems were approximately 34% less likely to be placed in a correctional facility. Findings also indicated that caregiver loss and presence of mental health disorders predicted undesirable outcomes, such as greater number of out-of-home placements and placement in a correctional facility.

Sub-Study two. Overall, findings indicated that children in the intervention group (i.e., who were assessed using the child welfare practice model implemented during the Demonstration extension period) had better outcomes compared to children in the comparison group (i.e., those who were assessed using standard practice). Specifically, children in the intervention group had a lower rate of recurrence of maltreatment, lower rate on entry in out-of-home care, and lower re-entry rate.

Findings from the services and practice analysis indicate that families who received voluntary family support services were connected to a variety of services and supports to address their needs and build their protective factors. Although a small proportion of the case files that were reviewed appeared to be inappropriate for voluntary services or provided services that did not address the family's primary needs.

Strengths of family support services identified during focus groups with providers were that these programs provided families with much needed services, allowed for supervision within the home, gave families an outlet to discuss and address stressors, and increased awareness of resources in the community and how to access them. In several focus groups, furthermore, participants described low rates of subsequent abuse or maltreatment reports as evidence of their programs' successes. Several participants described the use of family support

services as an improvement upon previous voluntary services, and also emphasized a focus on providing quality services, rather than focusing on the quantity of services. On the other hand, challenges that were identified during focus groups included inadequate community resources to meet the needs of families, especially affordable housing, transportation, and childcare, and delayed service initiation as a result of referrals being sent after CPI complete their investigations.

Policy Implications and Recommendations

1. Advocate for an increase in funding for frontline staff and support staff for frontline workers. This refers to both salary increases and an increase in funding to hire more staff
2. Develop funding strategies to fill current service gaps at the community-level (particularly safety management services, affordable housing, childcare, and substance abuse treatment) and expand the availability of providers who offer in-home services
3. Reinforce requirements for CBC lead agencies and their contracted providers to measure and track fidelity to evidence-based practices and programs that they are using
4. Ensure that CBC contracts with service providers include language requiring the evaluation and demonstration of service effectiveness and requirements for assessing and reporting client outcomes to the child welfare agency/case manager
5. Reinforce standardized processes and expectations for collaborative casework between CPIs and case managers that are in place, such as joint home visits and family assessments during the transition from investigation to case management
6. Engage CBC lead agencies identified in the evaluation that have developed and implemented effective in-home service programs and approaches to provide mentoring and implementation assistance to other lead agencies
7. Expand funding for family support services so that low and moderate risk families can also participate (some but not all lead agencies have done this; requires expanded funding)
8. Utilize models (such as the model developed in Sub-study One of this evaluation) that can predict which children and youth will have the greatest unmet need in order to help triage children and youth such that youth with the highest anticipated need can be connected to needed services promptly
9. There is a need for increased efforts to provide outpatient mental health services and especially underscore the need for regular comprehensive mental health assessments

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

Evaluation Lessons Learned

A key lesson learned from the implementation of this evaluation was the ability to understand and navigate the child welfare system. Evaluation team members actively attended DCF held meetings, conferences, and trainings. This helped the evaluation team gather observation data and understand the best way to gather data. For example, an understanding of the rigorous schedule of child welfare stakeholders helped evaluation team members plan recruitment and data collection accordingly. A positive relationship with our DCF partners was also key in the success of this evaluation. The DCF partners provided the secondary data and assisted with figuring out an anomalies in the data, recruiting participants, providing contact information. The DCF evaluation partners actively utilized evaluation finding in daily operations and provided the evaluation team with any current internal assessments the Department was conducting.

Link to Evaluation Reports

Below is the link where all FL Title IV-E Demonstration Evaluation reports can be found: http://centerforchildwelfare.fmhi.usf.edu/IVEReport.shtml

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Appendix A: Implementation Analysis Interview Protocols

CBC and DCF Leadership Interview Protocol

1. What are your views regarding how the IV-E Demonstration extension has impacted the Department and/or lead agencies (e.g., changes to the service array, changes in cost allocations and spending, etc.)
2. One of the expectations with the IV-E Demonstration was that fewer children would need to enter out-of-home care. Have you seen this trend in your local system? What impact has it had on your organization and staff (e.g., providers, case managers, supervisors)?
3. Are there any ways in which your lead agency has uniquely adapted the flexibility that came with the IV-E Demonstration to your local system's and community's needs? Please explain.
4. Please discuss any relevant asset mapping or needs assessments that were done in conjunction with the Demonstration extension, or to facilitate service system changes desired as the result of Demonstration extension.
5. Please discuss how the implementation process for the IV-E Demonstration extension is proceeding thus far regarding:
    - staff structure,
    - changes in policy or procedure,
    - administrative oversight,
    - problem resolution, and
    - funding committed.
6. What adaptations have your agency, providers, CPIs and staff made to increase attention to Family Support and Safety Management Services in relation to what the iv-e Demonstration allows? Have you been able to shift resources for this purpose since Demonstration implementation?
7. Please discuss any salient issues regarding staffing and training to carry out the IV-E Demonstration extension (e.g., experience, education and characteristics of staff). How many and which staff are focused on IV-E Demonstration implementation?
8. Another expectation of the IV-E Demonstration is that changes in practice (e.g., implementation of the state service delivery model) would lead to improved outcomes for children. Have you been able to change practice as the result of the IV-E Demonstration? And if so, has it had an impact on child safety, permanency or well-being? How so?

9. What has been the role of the courts in the IV-E Demonstration extension period? Has it changed since the Demonstration was renewed? What about child welfare legal services? Please describe, including any examples of efforts to jointly plan and communicate between the Court and DCF, or the Court and lead agencies, or lead agencies and child welfare legal services.
10. What are some of the other reform efforts (besides the IV-E Demonstration) that your agency is a part of or you are aware of that impact the work that you do for children and families?
11. Whether your work is done at the policy or practice level, what are some of the current social, economic and political issues that most often impact the work that you do for children and families?

Judges and Magistrates Interview Protocol

The Florida Mental Health Institute of the University of South Florida is under contract with the Florida Department of Children and Families to evaluate the implementation of Florida's IV-E Demonstration extension. The purpose of this interview is to collect information about how the Florida IV-E Demonstration extension was implemented in your area and how the IV-E Demonstration is changing the child welfare and judicial system.

1. Please describe your role in the child welfare system and how long you have been in this role.
2. What is your area of specialization or what types of cases do you normally preside over
3. Have you changed the way you make removal, reunification, or permanency decisions since the IV-E Demonstration was implemented? Please explain and elaborate on any changes.
4. What are your views regarding how the IV-E Demonstration extension has impacted child welfare practices (e.g., requests for removals, service array, and engagement with parents)?
5. In your opinion, how can judges and magistrates help families overcome barriers or challenges within the child welfare system?
6. Please describe any efforts to jointly plan and communicate between the Court, child welfare legal services, child protective investigators and lead agencies.
7. What, if any, are the issues with respect to coordination of responsibilities and functions of Child Protective Investigators, the Court, and Lead Agency case managers?
8. What do you see as the strengths of the current child welfare system?

9. What do you see as the barriers or challenges of the current child welfare system?
10. Is there any additional information you would like to share regarding implementation of Florida's IV-E Demonstration or the Community-Based Care system in Florida?

Case Management Organization Leadership Interview Protocol

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

CBC Leadership Interview Protocol

Thank you for taking the time to participate in this interview. We are going to begin by asking a few questions regarding the array of services available to families served by your agency. Specifically Family Support Services, Safety Management services, Treatment services, and Child Well-Being services.

The definitions for these service types are:

Family Support Services - Voluntary supportive family services to prevent future child maltreatment among at-risk families.

Safety Management Services – Safety services actions, tasks, activities, and other imposed situations that may be formal or informal and provided by professionals and non-professionals for the purpose of managing or controlling impending danger threats and documented in a safety plan. Safety service must be capable of having an immediate effect, must be immediately available, must always be accessible, and must be sufficient to control impending danger.

Treatment Services – Specific, usually formal, services/interventions to achieve fundamental change in functioning and behavior associated with the reason that the child is unsafe.

Child Well-Being Services – Specific, usually formal, services/interventions utilized to assure the child's physical, emotional, developmental, and educational needs are addressed. The assessment of the child strengths and needs indicators is used to systematically identify critical child well-being needs that should be the focus of thoughtful, case plan interventions.

1. Which Family Support Services have you found to be the most successful for the families served by your CBC? (Follow up: Are these services evidence-based or promising practices, how do you know they are implemented with fidelity?)
2. Which Safety Management services have you found to be the most successful for the families served by your CBC? (Follow up: Are you using both formal and informal Safety Management Services and if formal, are they available for use by the case managers?)
3. Which Treatment services have you found to be the most successful for parents and caregivers served by your CBC?
4. Which Child Well-Being services such as educational, physical health, dental health, and behavioral health have you found to be the most successful for children served by your CBC?
5. The Children's Bureau is interested in learning more about CBCs use of Rapid Safety Feedback reviews. Please tell us how the Rapid Safety Feedback reviews have improved practice for your CBC? Are you able to provide an example?

6. We would now like to transition into discussing the end of IV-E Demonstrations. We would like to gain your thoughts and perceptions on how your CBC will continue child welfare work when the Demonstration ends.
7. What are some new innovative programs or services that have been introduced by your CBC (or Case Management Organizations providing case management services for your area) because of the Demonstration? (capacity and funds invested)
8. What, if any, current services and supports available to prevent removals are at risk of being reduced or eliminated post Demonstration?
9. What revenue sources are projected post Demonstration by your CBC to support continuation/expansion of: in-home services, if any? Prevention (primary, secondary, or tertiary) services?

CPI Supervisor Interview Protocol

1. How would you describe your role in the child welfare system?
2. How would you describe your relationship with other child welfare serving entities? (CMOs, CBC, Judiciary)
3. How are decisions made about whether a child can remain safely in the home or if a case requires a removal?
4. What do you think are the greatest challenges or barriers for families involved in a child welfare investigation?
5. To the best of your knowledge, what services are available for families that CPIs can refer to?
6. What adaptations have CPIs and staff made to increase attention to Family Support and Safety Management Services?
7. What are some of the current social, economic and political issues that most often impact your work with children and families?
8. What would you like to see change about the current child welfare system?

Appendix B: Implementation Analysis Informed Consent

Verbal Informed Consent to Participate in Research Involving Minimal Risk
Information to Consider Before Taking Part in this Research Study
Pro # __5830146300____

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

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

The person who is in charge of this research study is Mary I. Armstrong, Ph.D. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. Other research team members include Amy Vargo, Areana Cruz, Svetlana Yampolskaya, Melissa Johnson, John Robst, and Monica Landers.
The research will be conducted at Child welfare agencies and stakeholder offices in Florida.
This research is being sponsored by The Department of Children and Families.

Purpose of the study

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

Why are you being asked to take part?
We are asking you to take part in this research study because you work in or are affiliated with a child welfare agency, or have been identified as having knowledge about certain aspects of Florida's Title IV-E Waiver and Community-Based Care.

Study Procedures:

If you take part in this study, you will be asked to give us your opinions through an interview that will take about 30-90 minutes to complete. The interview will be tape-recorded (with your permission) to make sure our notes are correct.

Total Number of Participants

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

Alternatives / Voluntary Participation / Withdrawal

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

Benefits

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

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

Risks or Discomfort

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

Compensation

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

Costs

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

Privacy and Confidentiality

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

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

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

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

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

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

Consent to Take Part in this Research Study

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

Appendix C: Implementation Analysis Code Lists

CBC and DCF Leadership Code List

Leadership

Leadership Involvement – discussion of ways leaders at various levels of DCF have been included in the waiver planning and implementation process

Consistency in leadership – either consistency or changes in leadership of DCF or lead agencies

Vision/Values – discussion of the extent to which there is a vision for change among leadership, staff and stakeholders

Environment

Contextual Variables

Poverty

Housing

Employment – regarding clients seeking jobs or the current job market that may influence turnover rates for case workers or CPIs

Domestic Violence

Substance abuse

Mental health

Juvenile justice system

Unaccompanied minors

Human trafficking

Other reform efforts – Coinciding reform efforts to the IV-E Waiver other than the Florida Practice Model

Staff Support – the extent to which there is support and buy-in for the Waiver among DCF front-line staff (e.g. CPS workers, caseworkers, and supervisors), including issues pertaining to personal beliefs and values; and, the process to change laws to better support child welfare practice goals/goals of the IV-E Waiver

Political Support – discussion of the political environment and extent to which political support and buy-in for the Waiver exists, including issues pertaining to personal beliefs and values as well as support for funding

Community Support – discussion of the broader social environment and extent to which there is support and buy-in among the general community (e.g. community providers/organizations, advocacy groups, and families), including issues pertaining to personal beliefs and values

DCF Climate – discussion of aspects of the organizational climate at DCF, e.g. issues such as trust and respect between leadership and front-line staff, the extent to which there is an environment that supports teamwork and problem solving, etc. either within DCF or between DCF and lead agencies

Internal Communication – discussion of communication processes within DCF

External Communication – discussion of communication processes with system partners outside DCF; discussion of the extent to which system partners (e.g. judges, GALs, providers, etc.) work together as a system, including joint planning with system partners; discussion of issues in working/interacting with external stakeholders (e.g. judges, GALs, etc.) that impact child welfare practice

Service Array/Resources – discussion of community resources currently in place, and/or service/resource needs

Media – influence of either news media or social media on child welfare activities

Spikes in Out-of-Home Care Population – influxes in children coming into foster care

Organizational Capacity/Infrastructure

Policies & Procedures – discussion of the extent to which policies and procedures are aligned with the Waiver goals, changes/revisions that have been made to align policies and procedures, or changes that are still needed in order to align them

Training – discussion of training that has been provided to prepare staff/stakeholders to implement the waiver, and additional/on-going training needs

Technical Assistance – discussion of technical assistance that has been provided to help with waiver implementation, and additional/on-going technical assistance needs

Caseworker Skills – discussion of the extent to which caseworkers have the necessary knowledge and skills, and skill-building that is still needed; turnover issues

Family engagement – discussion of issues pertaining to how or what extent or what problems exist in the current system regarding family engagement

CPS Practice – changes in CPS practice; turnover issues

Florida Practice Model – discussion of the Model, including strengths and challenges related to its use

Assessment – discussion of child or family/parents assessment process

Supervision – discussion of supervision processes, including coaching, mentoring, etc. and what supervision is needed to support successful implementation

Quality Improvement Processes – discussion of the use of data to inform decision-making and identify areas for practice improvement, and processes for the development of improvement plans based on the data
Oversight & Monitoring – discussion of processes for the collection and review of data, but without a clear connection to implementation of practice improvement processes
Funding – discussion of how services are funded, strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.
FSFN – discussion of Florida's SACWIS system, including strengths and challenges related to its use.
Removal Decisions – changes in how the decision is made to place a child out of home
Judiciary – ways in which the waiver has impacted/affected/changed practice of judges
GALs – ways in which the waiver has impacted/affected/changed practice of GALs
Child Welfare Legal Services – ways in which the Waiver has impacted/affected/changed practice of CWLS
Waiver Impact
Family engagement – how the Waiver has impacted the extent to which and what methods are used to engage families
Caseworker Practice – ways in which the waiver has impacted/affected/changed practice of caseworkers
Supervisory Practice – ways in which the waiver has impacted/affected/changed practice of supervisors
Family Well-being – ways in which the waiver has impacted family outcomes (e.g. strengthening families, increasing access to resources, increasing self-sufficiency, etc.)
Child Safety/Well-being – ways in which the waiver has impacted child safety and well-being outcomes
Services – changes in the availability/accessibility of services since implementation
Organizational – ways in which the waiver has impacted the organizational environment/processes
Client Characteristics – ways in which the waiver has impacted the characteristics of families served by the child welfare/foster care system
Morale – ways in which the waiver has impacted morale among DCF staff/leadership
Removal Decisions – how the IV-E Waiver has impacted changes in how the decision is made to place a child out of home

Funding – how the Waiver has impacted funding and funding flexibility such as strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.

Conclusion

Recommendations – any specific recommendations that are made about how to improve waiver implementation

Lessons – any discussion of lessons learned about implementation

Judges and Magistrates Code List

INTRO

Role of the Individual- leadership role in the Circuit, State or National; type of cases the judge or magistrate presides over

IMPACT

Role of the Court: Role of the court and court personnel in child welfare cases since Waiver implementation

Judicial Leadership – discussion of ways judicial leaders have been included in the waiver planning and implementation process

Vision/Values – discussion of the extent to which there is a vision for change among judicial leadership, staff and stakeholders

GALs – ways in which the Waiver has impacted/affected/changed practice of GALs

Child Welfare Legal Services – ways in which the Waiver has impacted/affected/changed practice of CWLS

Policies & Procedures – discussion of the extent to which judicial policies and procedures are aligned with the Waiver goals, changes/revisions that have been made to align policies and procedures, or changes that are still needed in order to align them

Training – discussion of training that has been provided to prepare judicial staff/stakeholders to implement the waiver, and additional/on-going training needs

Quality Improvement Processes – discussion of the use of data to inform decision-making and identify areas for practice improvement, and processes for the development of improvement plans based on the data

CPS Practice – judge and magistrate perception of changes in CPS practice; turnover issues

Supervisory Practice – judge and magistrate perception of ways in which the waiver has impacted/affected/changed practice of supervisors

Caseworker Practice – judge and magistrate perception of ways in which the waiver has impacted/affected/changed practice of caseworkers

Family engagement – judge and magistrate perception of how the Waiver has impacted the extent to which and what methods are used to engage families

Family Well-being – ways in which the waiver has impacted family outcomes (e.g. strengthening families, increasing access to resources, increasing self-sufficiency, etc.)

Child Safety/Well-being – ways in which the waiver has impacted child safety and well-being outcomes

Service Array/ Resources – discussion of or changes in the availability/accessibility/need of services since implementation

Organizational – ways in which the waiver has impacted the organizational environment/processes

Removal/Permanency/Reunification Decisions – how the IV-E Waiver has impacted changes in how the decision is made to place a child out of home, achieve permanency, and/or reunify a child

Funding – how the Waiver has impacted funding and funding flexibility such as strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.

JOINT EFFORTS TO PLAN AND IMPLEMENT THE WAIVER

Political Support – discussion of the political environment and extent to which political support and buy-in for the Waiver exists, including issues pertaining to personal beliefs and values as well as support for funding

Community Support – discussion of the broader social environment and extent to which there is support and buy-in among the general community (e.g. community providers/organizations, advocacy groups, and families), including issues pertaining to personal beliefs and values

External Communication / Collaboration – discussion of communication and collaboration processes with system partners outside of the judicial system; discussion of the extent to which system partners (e.g. Community-Based Care Agencies, DCF, and community partners, etc.) work together as a system, including joint planning with system partners; discussion of issues in working/interacting with external stakeholders (e.g. judges, GALs, etc.) that impact child welfare practice

CONCLUSION

Recommendations – any specific recommendations that are made about how to improve waiver implementation

Case Management Organization Leadership Code List

Environment

Contextual Variables

Poverty

Housing

Employment – regarding clients seeking jobs or the current job market that may influence turnover rates for case workers or CPIs

Domestic Violence

Substance abuse

Mental health

Juvenile justice system

APD youth

Unaccompanied minors

Human trafficking

Other reform efforts – Coinciding reform efforts to the IV-E Waiver other than the Florida Practice Model

Staff Support – the extent to which there is support and buy-in for the Waiver among DCF front-line staff (e.g. CPS workers, caseworkers, and supervisors), including issues pertaining to personal beliefs and values; and, the process to change laws to better support child welfare practice goals/goals of the IV-E Waiver

Shared Accountability – the extent to which there is a sense of shared accountability for Waiver outcomes among leadership, staff and stakeholders

Political Support – discussion of the political environment and extent to which political support and buy-in for the Waiver exists, including issues pertaining to personal beliefs and values as well as support for funding; legislature support

External Communication – discussion of collaboration and communication processes with system partners; discussion of the extent to which system partners (e.g. judges, GALs, providers, etc.) work together as a system, including joint planning with system partners; discussion of issues in working/interacting with external stakeholders (e.g. judges, GALs, etc.) that impact child welfare practice; Does not include CBCs, DCF, or CMOs

Climate – discussion of aspects of the organizational climate, e.g. issues such as communication (between DCF, CBCs, and CMOs), trust, and respect between leadership and front-line staff, the extent to which there is an environment that supports teamwork and problem solving, etc.; morale

Services/Resources – discussion of community resources currently in place, and/or service/resource needs, including any asset mapping or strategic planning processes around gaps in the service array

Media – influence of either news media or social media on child welfare activities

Child Welfare System and Infrastructure

Policies & Procedures – discussion of the extent to which policies and procedures are aligned with the Waiver goals, changes/revisions that have been made to align policies and procedures, or changes that are still needed in order to align them; child safety and well-being

Caseworker Skills – discussion of the extent to which caseworkers have the necessary knowledge and skills, and skill-building that is still needed

Family engagement – discussion of issues pertaining to how or what extent or what problems exist in the current system regarding family engagement

CPI Practice – changes in CPI practice

Supervision – discussion of supervision processes, including coaching, mentoring, etc. and what supervision is needed to support successful implementation

Quality Improvement Processes – discussion of the use of data to inform decision-making and identify areas for practice improvement, and processes for the development of improvement plans based on the data

Oversight & Monitoring – discussion of processes for the collection and review of data, but without a clear connection to implementation of practice improvement processes

Funding – discussion of how services are funded, strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.

Judiciary – changes in the practice of judges

GALs – changes in the practice of GALs

Child Welfare Legal Services – changes in the practice of CWLS

Caseload Size- Discussion of the caseload size for caseworkers

Waiver Impact

Caseworker Practice – ways in which the Waiver has impacted/affected/changed practice of caseworkers

Family Well-being – ways in which the waiver has impacted family outcomes (e.g. strengthening families, increasing access to resources, increasing self-sufficiency, etc.)

Child Safety, Well-being, and Permanency – ways in which the waiver has impacted child safety, well-being, and permanency outcomes

Service Array – changes in the availability/accessibility of services since implementation
Client Characteristics – ways in which the waiver has impacted the characteristics of families served by the child welfare/foster care system
Removal Decisions – how the IV-E Waiver has impacted changes in how the decision is made to place a child out of home
Funding – how the Waiver has impacted funding and funding flexibility such as strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.
Mitigating Factors – Factors that affect the impact of the IV-E Waiver such as, the FL practice model, turnover, spikes in out-of-home care, and removal decisions
Conclusion
Recommendations – any specific recommendations that are made about how to improve waiver implementation
Lessons – any discussion of lessons learned about implementation

CBC Leadership Code List

Practice and Service Array: service array resulting from, at least in part, implementation of Florida's IV-E Waiver, including review processes that are in place for child welfare cases
(FSS) Family Support Services- examples and descriptions of successful services
(FSSEBP) Family Support Services—evidence-based practices; examples and descriptions of successful services
(FSSPP) Family Support Services---promising practices; examples and descriptions of successful services
(FSSFID) Family Support Service Fidelity—issues measuring and/or achieving fidelity
(SMS) Safety Management Services- examples and descriptions of successful services
(ISMS) Informal Safety Management Services- examples and descriptions of successful services
(FSMS) Formal Safety Management Services- examples and descriptions of successful services
(TS) Treatment Services - examples and descriptions of successful services
(CWBS) Child Well-Being Services- examples and descriptions of successful services
(CWBSGAPS) Child Well-Being Service Gaps- any indications of gaps in child well-being services
(RSFR) Rapid Safety Feedback Reviews – Implementation and success of RSFRs

Impact: relevant impacts of the IV-E Waiver, or potential lack thereof in the future

(INNOVSERV) Innovative services - created as a result of Florida's IV-E Waiver flexible funding

(CAP) Capacity – increases or decreases in service capacity as a result of Florida's IV-E Waiver ending

(PREVSERV) Services/supports that prevent removals – created or enhanced as a result of Florida's IV-E Waiver

(ALTREV) Revenue sources to sustain changes without Waiver funding

(ALTREV-TCM) Discussion of pursuing targeted case management as a way augment funding

(WAIVEND) Impact of Waiver ending on the current child welfare system in Florida

(WAIVEND-MITFACT) Mitigating factors/context regarding how each lead agency's child welfare system might be impacted by the ending of Florida's IV-E Waiver (e.g., Florida's allocation formula)

CPI Supervisor Code List

Role – Supervisor's discussion of how they see their role within the child welfare system

Child Welfare Interagency Relationships – Discussion regarding the interagency relationships of child welfare serving entities (CMOs, CBCs, Judiciary)

Removal Decision Processes – Discussion regarding the processes regarding removal decisions, in-home safety plans, and other safety/risk decisions

Challenges/ Barriers for Child Welfare Involved Families – Discussion regarding the challenges or barriers for families involved in child welfare investigations

Availability of Services – Discussion regarding the availability of services for families involved in the child welfare system

CPI Referrals – Discussion of services and resources that CPIs can refer to

Family Support and Safety Management Services – Discussion regarding any adaptations made by CPIs and staff to increase attention to Family Support and Safety Management Services

Issues that Impact Child Welfare Work – Discussions regarding social, economic, and political issues that impact work with families

Recommendations for Change – Discussion regarding changes that would like to be seen in the child welfare system

Decision Rules for Coding

- Don't double code, except for policy recommendations OR in cases where there are coinciding events where in there is a precursor and antecedent (e.g., funding cuts and reductions in services, OR media and removals)
- If things come up that are directly stated as lessons learned and recommendations, please directly code as such. If an important issue comes up that lends itself to our making a recommendation or summarizing a lesson learned, please double code to the relevant topic and lessons learned or recommendations.
- Don't code the actual protocol question in isolation or with the data, unless the data does not actually answer that question
- Don't code things as Impact unless they have actually happened (e.g., hopes for impact might go under vision or goals)

Don't make a new global code for strengths/facilitators and barriers/challenges; please insert these two codes as needed at a third level underneath each topic

Appendix D: Service Array Survey

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

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

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

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

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

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

- ❍ Yes
- ❍ No

Please indicate which CBC Lead Agency you represent.

- ❍ Families First Network
- ❍ Big Bend CBC, Inc.
- ❍ Partnership for Strong Families
- ❍ Kids First of Florida, Inc.
- ❍ Family Support Services of North Florida, Inc.
- ❍ St. Johns County Board of Commissioners
- ❍ Community Partnership for Children, Inc.
- ❍ Partnership for Strong Families
- ❍ Kids Central, Inc.
- ❍ CBC of Central Florida
- ❍ Heartland for Children
- ❍ Brevard Family Partnership
- ❍ Eckerd Community Alternatives
- ❍ Sarasota Family YMCA, Inc.

- Children's Network of Southwest Florida
- ChildNet Inc.
- Devereux Families Inc.
- Our Kids of Miami-Dade/Monroe, Inc.

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

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

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

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

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

Section 1: Family Support Services

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

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

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

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

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

Section 2: Safety Management Services

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

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

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

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

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

Section 3: Treatment Services

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

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

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

Section 4: Child Well-being Services

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

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

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

Section 5: Provider Contracts

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

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

❍ Yes

❍ No

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

❍ Yes

❍ No

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

❍ Yes

❍ No

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

❍ Yes

❍ No

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

❍ Yes

❍ No

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

❍ Yes

❍ No

Appendix E: Evidence-Based Practice Survey

Q1 Thank you for taking the time to answer a few questions about your agency's service array. The purpose of this survey is to learn about the use of some particular Evidence Based Practices in Florida's Child Welfare System. Your participation in this survey is voluntary and will take no more than 5-10 minutes. We greatly appreciate your response.

Q2 Please indicate which CBC Lead Agency you represent.

▼ Families First Network (1) ... Our Kids of Miami-Dade/Monroe, Inc. (19)

Q3 Does your agency currently include Wraparound services as part of your child welfare service array?

- ❍ Yes (1)
- ❍ No (2)

Skip To: Q9 If Does your agency currently include Wraparound services as part of your child welfare service array? = No

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Q4 Which of the following best characterizes the stage you (or your contracted provider) are currently at with the implementation of Wraparound?

- ❍ Pre-implementation: planning, training, and preparation (1)
- ❍ Early implementation: training and practice implementation began within the last 6 months (2)
- ❍ Moderate implementation: At least 6-12 months of practice implementation, with roughly 50% of staff consistently practicing (3)
- ❍ Full implementation/maintenance: More than 50% of staff have been consistently practicing with fidelity to the model for more than 12 months (4)

Q5 How is this service being used? Please mark all service categories that apply.

- ☐ Family Support Service (1)
- ☐ Safety Management Service (2)
- ☐ Treatment Service (3)
- ☐ Child Well-being Service (4)

Q6 Do you (or your contracted provider) currently measure practice fidelity to the Wraparound model?

- ❍ Yes (1)
- ❍ No (2)

Skip To: Q8 If Do you (or your contracted provider) currently measure practice fidelity to the Wraparound model? = No

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Q7 How do you measure fidelity? Please identify what measures or protocols you use.

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Q8 Would you be interested in participating in a fidelity assessment as part of a study examining Wraparound implementation throughout the state of Florida? There is no obligation to

participate if you answer yes; a member of our study team will follow up with more information about the study so that you can make an informed decision.

- ❍ Yes (1)
- ❍ No (2)

Q9 Does your agency currently include the Nurturing Parenting Program (NPP) as part of your child welfare service array?

- ❍ Yes (1)
- ❍ No (2)

Skip To: End of Survey If Does your agency currently include the Nurturing Parenting Program (NPP) as part of your child we... = No

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Q10 Which of the following best characterizes the stage you (or your contracted provider) are currently at with the implementation of Nurturing Parenting Program?

- ❍ Pre-implementation: planning, training, and preparation (1)
- ❍ Early implementation: training and practice implementation began within the last 6 months (2)
- ❍ Moderate implementation: At least 6-12 months of practice implementation, with roughly 50% of staff consistently practicing (3)
- ❍ Full implementation/maintenance: More than 50% of staff have been consistently practicing with fidelity to the model for more than 12 months (4)

Q11 How is this service being used? Please mark all service categories that apply.

- ☐ Family Support Service (1)
- ☐ Safety Management Service (2)
- ☐ Treatment Service (3)
- ☐ Child Well-being Service (4)

Q12 Do you (or your contracted provider) currently measure practice fidelity to the Nurturing Parenting model?

- ❍ Yes (1)
- ❍ No (2)

Skip To: Q14 If Do you (or your contracted provider) currently measure practice fidelity to the Nurturing Parenti... = No

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Q13 How do you measure fidelity? Please identify what measures or protocols you use.

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Q14 Would you be interested in participating in a fidelity assessment as part of a study examining Wraparound implementation throughout the state of Florida? There is no obligation to participate if you answer yes; a member of our study team will follow up with more information about the study so that you can make an informed decision.

- ❍ Yes (1)
- ❍ No (2)

Appendix F: Case Manager and CPI Focus Group Protocols

Case Manager Focus Group Interview Guide

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

1. In your opinion, what is the primary purpose of the child welfare system? What is your role?
2. What do you think are the greatest challenges or barriers for families involved in the child welfare system? (e.g. in caring for their children, in completing their case plan, in making sustainable changes to improve their personal and family functioning)
    - How do you support and encourage the families on your caseload?
3. How do you define child safety?
    - How do you assess whether or not a child is safe?
    - What are the challenges to assessing safety?
    - What practices or processes have been implemented to improve safety assessment?
4. How do you identify and assess a family's needs?
    - How are families engaged in this process? (Probe: parents, children, others)
    - What are the processes for connecting clients to appropriate services based on their identified needs?
    - How do you assess a family's progress and changes over time (e.g. behavior change)?
5. What is the process when a case transitions from CPI to case management?
    - What are the strengths or challenges of this process?
    - What is your relationship like with CPI?

6. How does practice differ between in-home and out-of-home cases?
7. What are your primary concerns about keeping children in the home when there is substantiated abuse or neglect?
    - What could be done to alleviate these concerns?
8. What do you think are the benefits of keeping children in the home while working with families?
    - What services are available to support family preservation and prevent child removals? In your opinion, how effective are these services? What are the challenges?
9. For out-of-home cases, how are decisions made about reunification and when a child can be returned home?
    - What factors, indicators or evidence inform these decisions?
    - What services are available to promote and support timely and successful reunification?
    - What factors may present barriers to reunification?
10. To the best of your knowledge, how would you describe the availability of services for families involved with the child welfare system in your community?
    - To what extent are adequate services available to meet the various needs of families and children?
    - How effective are the available services? (Use of evidence-based practices?)
    - What are the current barriers/gaps in the service array?
11. What things support you in doing your job well? What things make it difficult for you to do your job?
12. What do you like most about your job? What do you like least or find most challenging?
13. What would you like to see change about the current child welfare system?

CPI Focus Group Interview Guide

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

and we want to know what you think could be done to improve the system in your community and throughout the state of Florida.

1. In your opinion, what is the primary purpose of the child welfare system? What is your role?
2. What do you think are the greatest challenges or barriers for families involved in the child welfare system? (e.g. in caring for their children, in completing their case plan, in making sustainable changes to improve their personal and family functioning)
    - How do you support and encourage the families on your caseload?
3. How do you define child safety?
    - How do you assess whether or not a child is safe?
    - What are the challenges to assessing safety?
    - What practices or processes have been implemented to improve safety assessment?
4. How do you identify and assess a family's needs and strengths?
    - How are families engaged in this process? (Probe: parents, children, others)
    - What are the processes for connecting clients to appropriate services based on their identified needs?
5. How are decisions made about whether a child can remain in the home while you work with the family to address safety concerns?
    - What factors, indicators and/or evidence inform these decisions?
    - Under what circumstances can an in-home safety plan be effectively implemented?
    - What circumstances warrant the removal of the child?
    - What strategies are used to prevent out-of-home placement?
6. What are your primary concerns about keeping children in the home when there is substantiated abuse or neglect?
    - What could be done to alleviate these concerns?
7. What do you think are the benefits of keeping children in the home while working with families?
    - What services are available to support family preservation and prevent child removals? In your opinion, how effective are these services? What are the challenges?

8. To the best of your knowledge, how would you describe the availability of services for families involved with the child welfare system in your community?
    - To what extent are adequate services available to meet the various needs of families and children?
    - How effective are the available services? (Use of evidence-based practices?)
    - What are the current barriers/gaps in the service array?
9. What is the process when a case transitions from CPI to case management?
    - What are the strengths or challenges of this process?
    - What is your relationship like with the CBC lead agency and case management agencies?
10. What things support you in doing your job well? What things make it difficult for you to do your job?
11. What do you like most about your job? What do you like least or find most challenging?

What would you like to see change about the current child welfare system?

Appendix G: Code List for Caseworker Focus Group Analysis

Ability to address family issues
Accountability
Administrators
Advocate
Affordable housing
Amount of time and tasks
Assessment
Basic needs
Bureaucracy
Burnout
Case expectations
Case transfer
Child behavior
Child safety
Child well-being
Coercive
Compensation
Conditions of return
Coordination
CPI-CM relations
Data requests
Economic needs
Emotionally demanding
Encouragement
Engagement strategies
Evidence-based/data-driven
Family preservation
Family support workers
Family supports
Family team conferencing
Financial support for families
Flexibility
Funding
Generational CW involvement
High caseloads
In-home benefits
In-home concerns
In-home practice
Lack of family buy-in
Lack support system
Length of services
Maintain family connections
Motivation
OOH practice
Out of county
Partnership
Perceptions of CW
Permanency
Placements
Preserve family
Punitive
Purpose
Rapport
Reactive
Referrals
Reunification barriers
Reunification process
Reunification services
Rewarding
Safety plans
Service array
Service availability
Service effectiveness
Service intensity
Service links
Strengthen families
Substance abuse
Supervisors
Support staff
Teamwork
Technology
Transportation
Turnover
Working with families

Appendix H: Measures

Measure 1

The number and proportion of all children exiting out-of-home care for permanency reasons within 12 months of the latest removal.

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Only children who were in out-of-home care for at least eight (8) days were included in the calculation of this measure. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved permanency. Permanency is defined as discharge from out-of-home care to a permanent home for the following reasons as indicated in FSFN: (a) reunification, that is the return of a child who has been removed to the removal parent or other primary caretaker, (b) permanent guardianship (i.e., long-term custody or guardianship) with a relative or non-relative, (c) adoption finalized, that is when the Court enters the verbal order finalizing the adoption, and (d) case dismissed by the court.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.[9] Because every child was followed for 12 months, this measure is identical to a percent where the numerator is the number of children who exited out-of-home care for permanency reasons within 12 months after entry. The denominator is all children who entered and stayed for at least 8 days in out-of-home care at any time during a specific fiscal year.

Measure 2

The number and proportion of children who were reunified (i.e., returned to their parent or primary caregiver) within 12 months of the latest removal.

[9] Event history analysis is a statistical procedure that allows for analyzing data collected over time as well as for utilizing information about cases where the event of interest did not occur during data collection (e.g., children who did not exit out-of-home care during the 12-month period). This technique allows for calculation of the probability of an event occurring at different time points, such as in 12 months after out-of-home care entry (Allison, 1984). This technique was chosen over a percent because (a) it represents the state of art for analyzing longitudinal data, (b) it allows to efficiently dealing with complex data, and (c) it allows estimating the probability of an event to occur beyond the study period.

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Only children who were in out-of-home care for at least eight (8) days were included in the calculation of this measure. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker. Reunification is identified based on one of the reasons for discharge as indicated in FSFN.

Measure 3

The number and proportion of children with finalized adoptions (i.e., the date of the Court's verbal order finalizing the adoption) within 24 months of the latest removal.

This measure is based on entry cohort. An entry cohort is defined as all children who were placed into out-of-home care during a given fiscal year and had 'adoption' in their case plans as their primary goal. Placement in out-of-home care is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Children were followed for 24 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and were adopted. Adoption finalized is defined as discharge from out-of-home care for adoption reason as indicated in FSFN and is the date of the Court's verbal order finalizing the adoption.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis.[1] Because every child was followed for 24 months, this measure is identical to a percent where the numerator is the number of children who exited out-of-home care for the reason of adoption within 24 months after entry. The denominator is all children who entered out-of-home care at any time during a specific fiscal year and whose primary treatment goal was adoption.

Measure 4

The number and proportion of children who did NOT reenter out-of-home care within 12 months of their most recent discharge from out-of-home care for permanency reasons.

This measure is based on exit cohort. An exit cohort is as the children who “left” out-of-home care during a certain time period. Specifically, an exit cohort is defined as all children who exited out-of-home care for permanency reasons during a given fiscal year and it is based on the date the child was discharged from out-of-home care as indicated by a *Discharge Date* in FSFN. Children will be followed for 12 months from the date of discharge from out- of-home care for permanency reasons to determine whether they are subsequently placed in out-of-home care as indicated by a new *Removal Date* in FSFN.

This measure is expressed as a percent generated by Life Tables, which is a type of Event History Analysis. Because every child will have 12 months follow-up data, this measure is identical to a percent where the numerator is the number of children who did NOT enter out-of-home care within 12 months after exit for permanency reasons only. Only children who exited out-of-home care for reasons of permanency will be included in the calculation of the measure. The denominator is all children who had a Discharge Date in FSFN during a specified fiscal year (i.e., exit cohorts) and who were discharged for permanency reasons. The measure is based on children who exited their first episode of out-of-home care.

Measure 5

The number and proportion of licensed foster families that were active at the end of a specific fiscal year and have remained in an active status for at least 12 months.

This measure is a percent. The numerator is all licensed foster families were active at the end of a specific fiscal year and have remained in an active status for at least 12 months. The denominator is all licensed foster families that were active at the end of a specific fiscal year.

Measure 6

Proportion of newly recruited licensed foster families during a specific fiscal year.

This measure is a percent. The numerator is all licensed foster families that received licenses during a specific fiscal year. The denominator is the number of children served in out-of-home care during a specific fiscal year.

Appendix I: Results of Statistical Analyses

Table I1

Factors Associated with Exit from Out-of-Home Care for Permanency Reasons within 12 Months of the Latest Removal in the State of Florida (SFYs 2011-2012 through 2016-2017)

	Children Entering Out-of-Home Care (*N* = 99,127)		
	β	$\chi^2_{(1)}$	**OR**
Child age	0.01	276.46*	1.01
Child gender	- 0.01	0.02	0.99
Race			
White	- 0.02	0.85	0.98
African American	- 0.01	0.02	0.99
Asian	0.20	7.70*	1.22
Physical health problems	- 0.20	31.07*	0.82
Single female family structure	- 0.05	26.29*	0.95
Single male family structure	- 0.12	17.45*	0.89
Parental substance abuse	- 0.07	41.47*	0.93
Domestic violence	0.13	102.96*	1.14
Child Behavioral problems	- 0.33	104.27*	0.72
Cohort	- 0.16	3138.73*	0.85

Note. *$p < .05$.

Table I2

Results of Cox Regression. Factors Associated with Reunification within 12 Months of the Latest Removal in the State of Florida by Cohort (SFYs 2011-2012 through 2016-2017)

	Children Entering Out-of-Home Care (*N* = 66,066)		
	β	$\chi^2_{(1)}$	**OR**
Child age	0.02	440.054*	1.01
Child gender	0.01	0.01	1.00
Race			
White	- 0.05	6.26*	0.95
African American	- 0.02	1.16	0.98
Asian	0.19	7.60*	1.21
Physical health problems	-0.40	134.45*	0.67
Single female family structure	- 0.07	45.33*	0.93
Single male family structure	- 0.13	6.59*	0.94
Parental substance abuse	- 0.13	154.32*	0.88
Domestic violence	0.19	210.19*	1.21
Child Behavioral problems	- 0.14	23.05*	0.87
Cohort	0.05	250.26*	1.05

Note. *$p < .05$.

Table I3

Results of Cox Regression. Factors Associated With Adoption Finalized within 24 Months of the Latest Removal in the State of Florida (SFYs 2011-2012 through 2016-2017)

	Children Entering Out-of-Home Care (*N* = 15,948)		
	β	$\chi^2_{(1)}$	**OR**
Child age	0.02	48.81*	1.02
Child gender	- 0.04	1.84	0.96
Race			
White	- 0.11	3.64	0.89
African American	- 0.07	1.45	0.93
Asian	0.07	0.07	1.07
Physical health problems	0.81	208.80*	2.25
Single female family structure	- 0.01	0.09	0.99
Single male family structure	- 0.11	1.99	0.89
Parental substance abuse	- 0.03	0.72	0.98
Domestic violence	- 0.14	8.05*	0.87
Child behavioral problems	- 0.23	5.61*	0.80
Cohort	0.17	257.68*	1.19

Note. **p* < .001.

Table I4

Results of Cox Regression. Factors Associated with Re-entry Into Out-of-Home Care within 12 Months of the Discharge in the State of Florida (SFYs 2011-2012 through 2016-2017)

	Children Entering Out-of-Home Care (*N* = 58,868)		
	β	$\chi^2_{(1)}$	**OR**
Age	0.01	13.81*	1.01
Child gender	0.06	6.55*	1.06
Race			
White	0.23	26.76*	1.26
African American	0.25	33.08*	1.28
Asian	0.19	1.10	1.21
Physical health problems	-0.83	124.48*	0.44
Single female family structure	0.02	0.80	1.02
Single male family structure	- 0.01	0.02	0.99
Parental substance abuse	- 0.09	14.73*	0.91
Domestic violence	0.04	2.47	1.04
Child Behavioral Problems	0.21	15.29*	1.23
Cohort	- 0.09	185.13*	0.91

Note. **p* < .05.

Appendix J: CFSR Tables Baseline through Each Ongoing Review

Table J1

Performance Item 12: Needs and Services of Child, Parents, and Foster Parents (In-Home Cases)

In-Home Cases										
	N	% Strength Baseline 9/30/2016	N	% Strength on 3/31/17	N	% Strength on 9/30/2017	N	% Strength on 331/2018	N	% Strength on 12/31/2018
C1	32	22% (n=7)	49	22% (n=11)	61	20% (n=12)	75	19% (n=14)	87	16% (n=14)
C 2	9	89% (n=8)	9	89% (n=8)	13	85% (n=11)	18	78% (n=14)	20	80% (n=16)
C 3	12	17% (n=2)	17	12% (n=2)	21	14% (n=3)	25	12% (n=3)	27	15% (n=4)
C 4	47	53% (n=25)	66	58% (n=38)	86	56% (n=48)	104	56% (n=58)	126	56% (n=71)
C 5	23	61% (n=14)	27	59% (n=16)	45	53% (n=24)	58	47% (n=27)	70	43% (n=30)
C 6	26	69% (n=18)	39	74% (n=29)	55	67% (n=37)	66	67% (n=44)	77	64% (n=49)
C 7	35	71% (n=25)	56	75% (n=42)	75	76% (n=57)	90	76% (n=68)	120	72% (n=86)
C 8	16	6% (n=1)	23	17% (n=4)	28	14% (n=4)	32	16% (n=5)	35	17% (n=6)
C 9	30	57% (n=17)	44	57% (n=25)	55	62% (n=34)	66	59% (n=39)	74	58% (n=43)
C 10	33	67% (n=22)	50	70% (n=35)	62	69% (n=43)	70	71% (n=50)	86	74% (n=64)
C 11	31	52% (n=16)	46	41% (n=19)	53	40% (n=21)	63	46% (n=29)	70	47% (n=33)
C 12	10	70% (n=7)	11	73% (n=8)	11	73% (n=8)	12	75% (n=9)	13	77% (n=10)
C 13	15	60% (n=9)	27	78% (n=21)	46	83% (n=38)	57	86% (n=49)	69	84% (n=58)
C 14	14	93% (n=13)	13	92% (n=12)	15	93% (n=14)	18	94% (n=17)	20	95% (n=19)
C 15	33	79% (n=26)	47	85% (n=40)	58	84% (n=49)	71	85% (n=60)	82	84% (n=69)
C 17	28	89% (n=25)	43	88% (n=38)	57	86% (n=49)	67	85% (n=57)	77	83% (n=64)
C 18	22	59% (n=13)	37	59% (n=22)	53	66% (n=35)	65	65% (n=42)	76	63% (n=48)
C 19	32	59% (n=19)	44	64% (n=28)	60	68% (n=41)	69	70% (n=48)	78	72% (n=56)
C 20	35	69% (n=24)	44	68% (n=30)	60	63% (n=38)	82	63% (n=52)	101	65% (n=66)
State	485	60% (n=292)	693	62% (n=429)	916	62% (n=567)	1110	62% (n=686)	1311	62% (n=807)

Table J2

Performance Item 12: Needs and Services of Child, Parents, and Foster Parents (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	46	39% (n=19)	67	42% (n=28)	88	38% (n=33)	107	36% (n=38)	127	32% (n=41)
C 2	18	78% (n=14)	32	72% (n=23)	45	78% (n=35)	53	77% (n=41)	62	76% (n=47)
C 3	17	24% (n=4)	25	20% (n=5)	29	17% (n=5)	33	15% (n=5)	38	24% (n=9)
C 4	78	68% (n=53)	116	65% (n=75)	146	65% (n=95)	179	67% (n=120)	205	66% (n=136)
C 5	49	61% (n=30)	75	59% (n=44)	99	58% (n=57)	117	54% (n=63)	136	49% (n=67)
C 6	44	73% (n=32)	65	74% (n=48)	91	71% (n=65)	110	70% (n=77)	132	68% (n=90)
C 7	63	79% (n=50)	89	80% (n=71)	115	74% (n=85)	145	72% (n=104)	172	72% (n=124)
C 8	21	29% (n=6)	31	32% (n=10)	37	35% (n=13)	51	29% (n=15)	59	36% (n=21)
C 9	49	63% (n=31)	68	68% (n=46)	97	71% (n=69)	128	69% (n=88)	155	70% (n=109)
C 10	46	72% (n=33)	73	75% (n=55)	93	75% (n=70)	110	75% (n=83)	138	78% (n=108)
C 11	42	60% (n=25)	69	58% (n=40)	83	52% (n=43)	99	52% (n=51)	118	48% (n=57)
C 12	33	79% (n=26)	65	77% (n=50)	99	76% (n=75)	121	74% (n=89)	145	71% (n=103)
C 13	55	62% (n=34)	74	68% (n=50)	99	68% (n=67)	116	68% (n=79)	132	68% (n=90)
C 14	25	96% (n=24)	25	96% (n=24)	39	97% (n=38)	51	96% (n=49)	64	89% (n=57)
C 15	51	86% (n=44)	72	88% (n=63)	98	88% (n=86)	112	88% (n=99)	138	89% (n=123)
C 17	39	85% (n=33)	65	83% (n=54)	86	85% (n=73)	101	77% (n=78)	119	74% (n=88)
C 18	30	50% (n=15)	54	56% (n=30)	74	58% (n=43)	104	62% (n=64)	135	53% (n=71)
C 19	48	67% (n=32)	67	69% (n=46)	91	75% (n=68)	106	77% (n=82)	121	74% (n= 90)
C 20	52	65% (n=34)	64	69% (n=44)	91	73% (n=66)	119	74% (n=88)	153	68% (n=104)
State	806	67% (n=538)	1196	67% (n=806)	1601	68% (n=1087)	1963	67% (n=1314)	2350	65% (n=1536)

Table J3

Performance Item 12A: Needs Assessment and Services to Child (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	32	59% (n=19)	49	63% (n=31)	61	56% (n=34)	75	53% (n=40)	87	51% (n=44)
C 2	9	89% (n=8)	9	89% (n=8)	13	92% (n=12)	18	89% (n=16)	20	90% (n=18)
C 3	12	25% (n=3)	17	41% (n=7)	21	43% (n=9)	25	44% (n=11)	27	48% (n=13)
C 4	47	87% (n=41)	66	88% (n=58)	86	86% (n=74)	104	85% (n=88)	126	81% (n=102)
C 5	23	83% (n=19)	27	81% (n=22)	45	84% (n=38)	58	79% (n=46)	70	81% (n=57)
C 6	26	81% (n=21)	39	82% (n=32)	55	80% (n=44)	66	80% (n=53)	77	83% (n=64)
C 7	35	89% (n=31)	56	91% (n=51)	75	92% (n=69)	90	94% (n=85)	120	95% (n=114)
C 8	16	25% (n=4)	23	39% (n=9)	28	46% (n=13)	32	53% (n=17)	35	52% (n=19)
C 9	30	87% (n=26)	44	91% (n=40)	55	93% (n=51)	66	89% (n=59)	74	89% (n=66)
C 10	33	91% (n=30)	50	92% (n=46)	62	94% (n=58)	70	94% (n=66)	86	94% (n=81)
C 11	31	84% (n=26)	46	78% (n=36)	53	74% (n=39)	63	76% (n=48)	70	77% (n=54)
C 12	10	80% (n=8)	11	82% (n=9)	11	82% (n=9)	12	83% (n=10)	13	84% (n=11)
C 13	15	87% (n=13)	27	93% (n=25)	46	96% (n=44)	57	96% (n=55)	69	97% (n=67)
C 14	14	93% (n=13)	13	92% (n=12)	15	93% (n=14)	18	94% (n=17)	20	95% (n=19)
C 15	33	94% (n=31)	47	96% (n=45)	58	97% (n=56)	71	96% (n=68)	82	96% (n=79)
C 17	28	96% (n=27)	43	98% (n=42)	57	98% (n=56)	67	97% (n=65)	77	96% (n=74)
C 18	22	73% (n=16)	37	81% (n=30)	53	83% (n=44)	65	85% (n=55)	76	83% (n=63)
C 19	32	100% (n=32)	44	100% (n=44)	60	98% (n=59)	69	99% (n=68)	78	97% (n=76)
C 20	35	89% (n=31)	44	89% (n=39)	60	85% (n=51)	82	84% (n=69)	101	86% (n=87)
State	485	83% (n=401)	693	85% (n=587)	916	85% (n=775)	1110	84% (n=937)	1311	85% (n=1109)

Table J4

Performance Item 12A: Needs Assessment and Services to Child (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	46	70% (n=32)	67	73% (n=49)	88	75% (n=66)	107	70% (n=75)	127	72% (n=92)
C 2	18	89% (n=16)	32	91% (n=29)	45	93% (n=42)	53	92% (n=49)	62	90% (n=56)
C 3	17	47% (n=8)	25	52% (n=13)	29	55% (n=16)	33	55% (n=18)	38	58% (n=22)
C 4	78	87% (n=68)	116	85% (n=99)	146	87% (n=127)	179	88% (n=157)	205	88% (n=181)
C 5	49	82% (n=40)	75	87% (n=65)	99	86% (n=85)	117	54% (n=63)	136	82% (n=112)
C 6	44	89% (n=39)	65	91% (n=59)	91	89% (n=81)	110	87% (n=96)	132	86% (n=114)
C 7	63	94% (n=59)	89	94% (n=84)	115	90% (n=104)	145	91% (n=)132	172	92% (n=159)
C 8	21	43% (n=9)	31	55% (n=17)	37	62% (n=23)	51	61% (n=31)	59	66% (n=39)
C 9	49	86% (n=42)	68	90% (n=61)	97	91% (n=88)	128	91% (n=117)	155	92% (n=143)
C 10	46	87% (n=40)	73	90% (n=66)	93	91% (n=85)	110	93% (n=102)	138	94% (n=130)
C 11	42	86% (n=36)	69	78% (n=54)	83	75% (n=62)	99	77% (n=76)	118	79% (n=93)
C 12	33	94% (n=31)	65	92% (n=60)	99	92% (n=91)	121	91% (n=110)	145	90% (n=131)
C 13	55	91% (n=50)	74	92% (n=68)	99	91% (n=90)	116	92% (n=107)	132	92% (n=122)
C 14	25	100% (n=25)	25	100% (n=25)	39	100% (n=39)	51	100% (n=51)	64	97% (n=62)
C 15	51	94% (n=48)	72	94% (n=68)	98	95% (n=93)	112	96% (n=107)	138	96% (n=133)
C 17	39	95% (n=37)	65	94% (n=61)	86	94% (n=81)	101	91% (n=92)	119	91% (n=108)
C 18	30	93% (n=28)	54	91% (n=49)	74	92% (n=68)	104	90% (n=94)	135	88% (n=119)
C 19	48	90% (n=43)	67	90% (n=60)	91	92% (n=84)	106	93% (n=99)	121	92% (n=111)
C 20	52	90% (n=47)	64	89% (n=57)	91	91% (n=83)	119	91% (n=108)	153	92% (n=140)
State	806	87% (n=698)	1196	87% (n=1044)	1601	88% (n=1409)	1963	88% (n=1719)	2350	88% (n=2068)

Table J5

Performance Item 12B: Needs Assessment and Services to Parents (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	32	25% (n=8)	49	24% (n=12)	61	23% (n=14)	75	21% (n=16)	87	18% (n=16)
C 2	9	100% (n=9)	9	100% (n=9)	13	92% (n=12)	18	83% (n=15)	20	85% (n=17)
C 3	12	17% (n=2)	17	18% (n=3)	21	24% (n=5)	25	20% (n=5)	27	22% (n=6)
C 4	47	60% (n=28)	66	62% (n=41)	86	60% (n=52)	104	61% (n=63)	126	60% (n=76)
C 5	23	70% (n=16)	27	67% (n=18)	45	60% (n=27)	58	53% (n=31)	70	49% (n=34)
C 6	26	81% (n=21)	39	85% (n=33)	55	76% (n=42)	66	76% (n=50)	77	71% (n=55)
C 7	35	74% (n=26)	56	77% (n=43)	75	79% (n=59)	90	78% (n=70)	120	74% (n=89)
C 8	16	6% (n=1)	23	17% (n=4)	28	14% (n=4)	32	16% (n=5)	35	17% (n=6)
C 9	30	63% (n=19)	44	61% (n=27)	55	65% (n=36)	66	64% (n=42)	74	62% (n=46)
C 10	33	76% (n=25)	50	76% (n=38)	62	74% (n=46)	70	76% (n=53)	86	79% (n=68)
C 11	31	65% (n=20)	46	57% (n=26)	53	53% (n=28)	63	59% (n=37)	70	59% (n=41)
C 12	10	80% (n=8)	11	82% (n=9)	11	82% (n=9)	12	83% (n=10)	13	85% (n=11)
C 13	15	67% (n=10)	27	81% (n=22)	46	85% (n=39)	57	88% (n=50)	69	86% (n=59)
C 14	14	100% (n=14)	13	100% (n=13)	15	100% (n=15)	18	100% (n=18)	20	100% (n=20)
C 15	33	85% (n=28)	47	89% (n=42)	58	88% (n=51)	71	87% (n=62)	82	87% (n=71)
C 17	28	93% (n=26)	43	91% (n=39)	57	88% (n=50)	67	87% (n=58)	77	84% (n=65)
C 18	22	64% (n=14)	37	62% (n=23)	53	72% (n=38)	65	69% (n=45)	76	67% (n=51)
C 19	32	59% (n=19)	44	64% (n=28)	60	70% (n=42)	69	71% (n=49)	78	74% (n=58)
C 20	35	69% (n=24)	44	68% (n=30)	60	68% (n=41)	82	68% (n=56)	101	69% (n=70)
State	485	66% (n=319)	693	67% (n=461)	916	67% (n=612)	1110	66% (n=737)	1311	66% (n=861)

Table J6

Performance Item 12B: Needs Assessment and Services to Parents (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	35	40% (n=14)	52	46% (n=24)	71	45% (n=32)	85	42% (n=36)	101	38% (n=38)
C 2	12	83% (n=10)	25	76% (n=19)	37	81% (n=30)	41	80% (n=33)	50	82% (n=41)
C 3	11	9% (n=1)	16	13% (n=2)	19	11% (n=2)	23	13% (n=3)	25	20% (n=5)
C 4	64	73% (n=47)	96	72% (n=69)	111	70% (n=78)	137	70% (n=96)	155	69% (n=107)
C 5	29	66% (n=19)	52	60% (n=31)	68	59% (n=40)	82	57% (n=47)	99	52% (n=51)
C 6	35	74% (n=26)	54	76% (n=41)	78	76% (n=59)	95	74% (n=70)	112	73% (n=82)
C 7	57	81% (n=46)	80	81% (n=65)	103	77% (n=79)	129	74% (n=95)	153	75% (n=115)
C 8	15	27% (n=4)	23	30% (n=7)	26	27% (n=7)	39	26% (n=10)	46	33% (n=15)
C 9	44	75% (n=33)	59	75% (n=44)	81	77% (n=62)	110	73% (n=80)	133	73% (n=97)
C 10	37	70% (n=26)	60	75% (n=45)	76	75% (n=57)	90	74% (n=67)	112	78% (n=87)
C 11	37	73% (n=27)	53	68% (n=36)	65	66% (n=43)	77	64% (n=49)	95	58% (n=55)
C 12	26	85% (n=22)	47	83% (n=39)	74	82% (n=61)	95	82% (n=78)	113	78% (n=88)
C 13	44	66% (n=29)	58	69% (n=40)	79	68% (n=54)	93	69% (n=64)	108	69% (n=75)
C 14	17	100% (n=17)	17	100% (n=17)	30	100% (n=30)	42	98% (n=41)	55	91% (n=50)
C 15	39	92% (n=36)	51	92% (n=47)	74	92% (n=68)	85	93% (n=79)	108	93% (n=100)
C 17	27	85% (n=23)	45	87% (n=39)	61	90% (n=55)	74	84% (n=62)	90	82% (n=74)
C 18	22	36% (n=8)	42	48% (n=20)	58	55% (n=32)	83	60% (n=50)	110	52% (n=57)
C 19	42	62% (n=26)	58	66% (n=38)	74	70% (n=52)	88	74% (n=65)	100	72% (n=72)
C 20	45	71% (n=32)	54	76% (n=41)	77	78% (n=60)	101	79% (n=80)	129	74% (n=96)
State	638	70% (n=446)	942	70% (n=664)	1263	71% (n=902)	1570	70% (n=1106)	1895	69% (n=1306)

Table J7

Performance Item 12C: Needs Assessment and Services to Foster Parents/Caregivers (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	46	63% (n=29)	65	66% (n=43)	86	67% (n=58)	105	70% (n=73)	125	69% (n=86)
C 2	17	100% (n=17)	31	97% (n=30)	44	98% (n=43)	51	96% (n=49)	59	97% (n=57)
C 3	17	47% (n=8)	25	48% (n=12)	29	52% (n=15)	33	55% (n=18)	37	59% (n=22)
C 4	78	87% (n=68)	113	86% (n=97)	143	85% (n=121)	175	87% (n=152)	200	86% (n=172)
C 5	47	82% (n=41)	70	89% (n=62)	93	87% (n=81)	111	86% (n=95)	130	85% (n=111)
C 6	43	98% (n=42)	63	95% (n=60)	88	91% (n=80)	107	92% (n=98)	128	90% (n=115)
C 7	61	95% (n=58)	87	94% (n=82)	112	95% (n=106)	142	92% (n=131)	169	91% (n=153)
C 8	20	55% (n=11)	30	63% (n=19)	36	69% (n=25)	50	72% (n=36)	58	71% (n=43)
C 9	44	84% (n=37)	61	85% (n=52)	88	88% (n=77)	118	90% (n=106)	142	92% (n=130)
C 10	43	98% (n=42)	68	99% (n=67)	87	99% (n=86)	103	99% (n=102)	128	98% (n=126)
C 11	41	83% (n=34)	68	76% (n=52)	82	71% (n=58)	97	72% (n=70)	116	75% (n=87)
C 12	32	94% (n=30)	62	92% (n=57)	92	92% (n=85)	113	92% (n=104)	135	91% (n=123)
C 13	53	94% (n=50)	69	96% (n=66)	92	97% (n=89)	109	96% (n=105)	125	95% (n=119)
C 14	22	95% (n=21)	22	95% (n=21)	35	97% (n=34)	46	98% (n=45)	59	98% (n=58)
C 15	46	96% (n=44)	66	97% (n=64)	91	98% (n=89)	104	97% (n=101)	129	98% (n=126)
C 17	35	97% (n=34)	58	91% (n=53)	76	91% (n=69)	90	89% (n=80)	107	86% (n=92)
C 18	28	100% (n=28)	52	100% (n=52)	72	94% (n=68)	102	94% (n=96)	131	92% (n=120)
C 19	43	98% (n=42)	61	97% (n=59)	85	98% (n=83)	99	98% (n=97)	111	97% (n=108)
C 20	51	90% (n=46)	62	90% (n=56)	87	90% (n=78)	115	90% (n=103)	148	86% (n=127)
State	766	89% (n=682)	1133	89% (n=1004)	1519	89% (n=1346)	1871	89% (n=1662)	2238	88% (n=1976)

Table J8

Performance Item 13: Child and Family Involvement in Case Planning (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	32	22% (n=7)	49	24% (n=12)	61	21% (n=13)	75	19% (n=14)	87	17% (n=15)
C 2	9	56% (n=5)	9	56% (n=5)	13	69% (n=9)	18	56% (n=10)	20	60% (n=12)
C 3	12	33% (n=4)	17	24% (n=4)	21	24% (n=5)	25	20% (n=5)	27	22% (n=6)
C 4	47	66% (n=31)	66	65% (n=43)	86	69% (n=59)	104	66% (n=69)	126	69% (n=87)
C 5	23	61% (n=14)	27	59% (n=16)	45	60% (n=27)	58	55% (n=32)	70	53% (n=37)
C 6	26	69% (n=18)	39	74% (n=29)	55	65% (n=36)	66	68% (n=45)	77	68% (n=52)
C 7	35	74% (n=26)	56	80% (n=45)	75	76% (n=57)	90	74% (n=67)	120	73% (n=88)
C 8	16	12.5% (n=2)	23	17% (n=4)	28	18% (n=5)	32	22% (n=7)	35	23% (n=8)
C 9	30	40% (n=12)	44	36% (n=16)	55	36% (n=20)	66	33% (n=22)	74	34% (n=25)
C 10	33	61% (n=20)	50	56% (n=28)	62	55% (n=34)	70	59% (n=41)	86	65% (n=56)
C 11	31	32% (n=10)	46	28% (n=13)	53	28% (n=15)	63	32% (n=20)	70	33% (n=23)
C 12	10	70% (n=7)	11	73% (n=8)	11	73% (n=8)	12	75% (n=9)	13	77% (n=10)
C 13	15	73% (n=11)	27	78% (n=21)	46	76% (n=35)	57	70% (n=40)	69	70% (n=48)
C 14	14	79% (n=11)	13	77% (n=10)	15	80% (n=12)	18	83% (n=15)	20	80% (n=16)
C 15	33	97% (n=32)	47	98% (n=46)	58	97% (n=56)	71	94% (n=67)	82	94% (n=77)
C 17	28	82% (n=23)	43	77% (n=33)	57	72% (n=41)	67	69% (n=46)	77	68% (n=52)
C 18	22	64% (n=14)	37	65% (n=24)	53	64% (n=34)	65	58% (n=38)	76	51% (n=39)
C 19	32	53% (n=17)	44	52% (n=23)	60	52% (n=31)	69	51% (n=35)	78	54% (n=42)
C 20	35	71% (n=25)	44	75% (n=33)	60	70% (n=42)	82	72% (n=59)	101	72% (n=73)
State	485	60% (n=290)	693	60% (n=414)	916	59% (n=541)	1110	58% (n=643)	1311	59% (n=768)

Table J9

Performance Item 13: Child and Family Involvement in Case Planning (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	43	35% (n=15)	62	44% (n=27)	82	41% (n=34)	100	38% (n=38)	119	37% (n=44)
C 2	14	86% (n=12)	28	82% (n=23)	41	85% (n=35)	49	86% (n=42)	57	86% (n=49)
C 3	14	21% (n=3)	22	18% (n=4)	26	15% (n=4)	30	17% (n=5)	35	26% (n=9)
C 4	75	72% (n=54)	113	70% (n=79)	139	71% (n=98)	169	71% (n=120)	188	70% (n=131)
C 5	35	69% (n=24)	58	60% (n=35)	77	62% (n=48)	95	63% (n=60)	114	60% (n=68)
C 6	36	86% (n=31)	56	88% (n=49)	81	89% (n=72)	99	87% (n=86)	117	85% (n=99)
C 7	60	60% (n=36)	85	68% (n=58)	110	64% (n=70)	138	62% (n=86)	163	64% (n=104)
C 8	16	19% (n=3)	26	23% (n=6)	32	25% (n=8)	46	26% (n=12)	53	26% (n=14)
C 9	48	60% (n=29)	65	58% (n=38)	90	60% (n=54)	120	57% (n=68)	146	55% (n=80)
C 10	42	76% (n=32)	67	79% (n=53)	85	80% (n=68)	100	81% (n=81)	126	84% (n=106)
C 11	39	46% (n=18)	61	44% (n=27)	74	39% (n=29)	89	40% (n=36)	107	38% (n=41)
C 12	29	83% (n=24)	57	82% (n=47)	87	86% (n=75)	109	86% (n=94)	130	82% (n=107)
C 13	51	84% (n=43)	65	82% (n=53)	89	79% (n=70)	106	75% (n=80)	122	76% (n=93)
C 14	20	85% (n=17)	20	85% (n=17)	34	88% (n=30)	46	85% (n=39)	59	83% (n=49)
C 15	48	87.5% (n=42)	68	91% (n=62)	93	92% (n=86)	106	93% (n=99)	131	93% (n=122)
C 17	32	75% (n=24)	56	75% (n=42)	75	77% (n=58)	89	75% (n=67)	106	75% (n=80)
C 18	28	46% (n=13)	50	52% (n=26)	70	54% (n=38)	99	52% (n=51)	129	46% (n=59)
C 19	48	67% (n=32)	65	68% (n=44)	87	69% (n=60)	101	71% (n=72)	116	70% (n=81)
C 20	49	63% (n=31)	61	64% (n=39)	87	69% (n=60)	113	72% (n=81)	146	69% (n=101)
State	727	66% (n=483)	1085	67% (n=729)	1460	68% (n=998)	1805	67% (n=1218)	2165	66% (n=1438)

Table J10

Performance Item 14: Case Worker Visits with Child (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	32	16% (n=5)	49	22% (n=11)	61	26% (n=16)	75	21% (n=16)	87	23% (n=20)
C 2	9	33% (n=3)	9	33% (n=3)	13	54% (n=7)	18	50% (n=9)	20	55% (n=11)
C 3	12	17% (n=2)	17	24% (n=4)	21	24% (n=5)	25	20% (n=5)	27	22% (n=6)
C 4	47	62% (n=29)	66	58% (n=38)	86	62% (n=53)	104	60% (n=62)	126	60% (n=76)
C 5	23	61% (n=14)	27	59% (n=16)	45	53% (n=24)	58	57% (n=33)	70	56% (n=39)
C 6	26	81% (n=21)	39	82% (n=32)	55	80% (n=44)	66	76% (n=50)	77	79% (n=61)
C 7	35	54% (n=19)	56	61% (n=34)	75	60% (n=45)	90	62% (n=56)	120	63% (n=76)
C 8	16	12.5% (n=2)	23	17% (n=4)	28	25% (n=7)	32	28% (n=9)	35	31% (n=11)
C 9	30	43% (n=13)	44	48% (n=21)	55	42% (n=23)	66	39% (n=26)	74	38% (n=28)
C 10	33	82% (n=27)	50	82% (n=41)	62	84% (n=52)	70	86% (n=60)	86	86% (n=74)
C 11	31	55% (n=17)	46	48% (n=22)	53	45% (n=24)	63	49% (n=31)	70	51% (n=36)
C 12	10	60% (n=6)	11	64% (n=7)	11	64% (n=7)	12	75% (n=9)	13	62% (n=8)
C 13	15	87% (n=13)	27	85% (n=23)	46	89% (n=41)	57	88% (n=50)	69	88% (n=61)
C 14	14	86% (n=12)	13	85% (n=11)	15	80% (n=12)	18	78% (n=14)	20	75% (n=15)
C 15	33	91% (n=30)	47	91% (n=43)	58	91% (n=53)	71	89% (n=63)	82	87% (n=71)
C 17	28	93% (n=26)	43	86% (n=37)	57	84% (n=48)	67	82% (n=55)	77	81% (n=62)
C 18	22	55% (n=12)	37	57% (n=21)	53	57% (n=30)	65	54% (n=35)	76	47% (n=36)
C 19	32	31% (n=10)	44	34% (n=15)	60	37% (n=22)	69	38% (n=26)	78	41% (n=32)
C 20	35	69% (n=24)	44	75% (n=33)	60	67% (n=40)	82	63% (n=52)	101	66% (n=67)
State	485	59% (n=287)	693	60% (n=417)	916	61% (n=555)	1110	60% (n=661)	1311	60% (n=792)

Table J11

Performance Item 14: Case Worker Visits with Child (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	46	20% (n=9)	67	30% (n=20)	88	33% (n=29)	107	34% (n=36)	127	34% (n=43)
C 2	18	56% (n=10)	32	50% (n=16)	45	58% (n=26)	53	57% (n=30)	62	58% (n=36)
C 3	17	29% (n=5)	25	28% (n=7)	29	28% (n=8)	33	30% (n=10)	38	37% (n=14)
C 4	78	67% (n=52)	116	63% (n=73)	146	62% (n=91)	179	63% (n=112)	205	65% (n=133)
C 5	49	73% (n=36)	75	75% (n=56)	99	73% (n=72)	117	70% (n=82)	136	68% (n=93)
C 6	44	91% (n=40)	65	91% (n=59)	91	90% (n=82)	110	89% (n=98)	132	89% (n=117)
C 7	63	65% (n=41)	89	63% (n=56)	115	58% (n=67)	145	58% (n=84)	172	60% (n=104)
C 8	21	29% (n=6)	31	32% (n=10)	37	35% (n=13)	51	31% (n=16)	59	36% (n=21)
C 9	49	43% (n=21)	68	47% (n=32)	97	52% (n=50)	128	51% (n=65)	155	52% (n=81)
C 10	46	89% (n=41)	73	93% (n=68)	93	95% (n=88)	110	95% (n=104)	138	96% (n=132)
C 11	42	71% (n=30)	69	54% (n=37)	83	51% (n=42)	99	55% (n=54)	118	58% (n=68)
C 12	33	88% (n=29)	65	82% (n=53)	99	75% (n=74)	121	69% (n=84)	145	69% (n=100)
C 13	55	93% (n=51)	74	89% (n=66)	99	89% (n=88)	116	91% (n=105)	132	91% (n=120)
C 14	25	92% (n=23)	25	92% (n=23)	39	85% (n=33)	51	80% (n=41)	64	80% (n=51)
C 15	51	86% (n=44)	72	90% (n=65)	98	92% (n=90)	112	93% (n=104)	138	89% (n=123)
C 17	39	95% (n=37)	65	94% (n=61)	86	94% (n=81)	101	92% (n=93)	119	92% (n=110)
C 18	30	60% (n=18)	54	59% (n=32)	74	59% (n=44)	104	56% (n=58)	135	48% (n=65)
C 19	48	50% (n=24)	67	52% (n=35)	91	54% (n=49)	106	55% (n=58)	121	52% (n=63)
C 20	52	77% (n=40)	64	75% (n=48)	91	76% (n=69)	119	76% (n=91)	153	75% (n=115)
State	806	69% (n=557)	1196	68% (n=817)	1601	69% (n=1097)	1963	68% (n=1326)	2350	68% (n=1590)

Table J12

Performance Item 15: Case Worker Visits with Parents (In-Home Cases)

In-Home Cases										
	N	% Strength Baseline	N	% Strength on 3/31/17	N	% Strength on 9/15/17	N	% Strength on 3/19/18	N	% Strength on 10/1/18
C1	32	19% (n=6)	49	20% (n=10)	61	20% (n=12)	75	16% (n=12)	87	17% (n=15)
C 2	9	67% (n=6)	9	67% (n=6)	13	54% (n=7)	18	44% (n=8)	20	45% (n=9)
C 3	12	8% (n=1)	17	6% (n=1)	21	5% (n=1)	25	4% (n=1)	27	7% (n=2)
C 4	47	49% (n=23)	66	56% (n=37)	86	60% (n=52)	104	60% (n=62)	126	60% (n=76)
C 5	23	26% (n=6)	27	30% (n=8)	45	31% (n=14)	58	28% (n=16)	70	26% (n=18)
C 6	26	54% (n=14)	39	56% (n=22)	55	51% (n=28)	66	52% (n=34)	77	52% (n=40)
C 7	35	46% (n=16)	56	52% (n=29)	75	48% (n=36)	90	48% (n=43)	120	54% (n=65)
C 8	16	6% (n=1)	23	4% (n=1)	28	7% (n=2)	32	13% (n=4)	35	11% (n=4)
C 9	30	30% (n=9)	44	30% (n=13)	55	31% (n=17)	66	32% (n=21)	74	34% (n=25)
C 10	33	70% (n=23)	50	66% (n=33)	62	61% (n=38)	70	57% (n=40)	86	58% (n=50)
C 11	31	26% (n=8)	46	24% (n=11)	53	25% (n=13)	63	30% (n=19)	70	30% (n=21)
C 12	10	50% (n=5)	11	55% (n=6)	11	55% (n=6)	12	58% (n=7)	13	62% (n=8)
C 13	15	80% (n=12)	27	78% (n=21)	46	76% (n=35)	57	75% (n=43)	69	75% (n=52)
C 14	14	79% (n=11)	13	85% (n=11)	15	87% (n=13)	18	89% (n=16)	20	85% (n=17)
C 15	33	55% (n=18)	47	66% (n=31)	58	64% (n=37)	71	62% (n=44)	82	65% (n=53)
C 17	28	64% (n=18)	43	65% (n=28)	57	65% (n=37)	67	66% (n=44)	77	66% (n=51)
C 18	22	55% (n=12)	37	54% (n=20)	53	53% (n=28)	65	46% (n=30)	76	43% (n=33)
C 19	32	31% (n=10)	44	36% (n=16)	60	42% (n=25)	69	43% (n=30)	78	47% (n=37)
C 20	35	40% (n=14)	44	41% (n=18)	60	38% (n=23)	82	34% (n=28)	101	36% (n=36)
State	485	44% (n=214)	693	47% (n=323)	916	47% (n=426)	1110	45% (n=504)	1311	47% (n=614)

Table J13

Performance Item 15: Case Worker Visits with Parents (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	36	28% (n=10)	53	38% (n=20)	72	36% (n=26)	86	35% (n=30)	102	32% (n=33)
C 2	11	64% (n=7)	23	48% (n=11)	34	50% (n=17)	38	53% (n=20)	46	52% (n=24)
C 3	11	0% (n=0)	16	0% (n=0)	19	0% (n=0)	23	0% (n=0)	25	8% (n=2)
C 4	63	51% (n=32)	94	51% (n=48)	114	51% (n=58)	140	52% (n=73)	159	50% (n=80)
C 5	26	31% (n=8)	46	26% (n=12)	63	30% (n=19)	74	30% (n=22)	91	25% (n=23)
C 6	32	59% (n=19)	51	63% (n=32)	75	59% (n=44)	92	55% (n=51)	109	52% (n=57)
C 7	55	24% (n=13)	76	30% (n=23)	97	27% (n=26)	123	27% (n=33)	147	28% (n=41)
C 8	14	7% (n=1)	22	9% (n=2)	25	12% (n=3)	38	13% (n=5)	45	18% (n=8)
C 9	43	30% (n=13)	57	32% (n=18)	79	34% (n=27)	107	35% (n=37)	130	32% (n=42)
C 10	37	43% (n=16)	60	50% (n=30)	76	46% (n=35)	91	46% (n=42)	113	50% (n=56)
C 11	38	26% (n=10)	54	20% (n=11)	65	20% (n=13)	76	18% (n=14)	94	19% (n=18)
C 12	24	71% (n=17)	44	66% (n=29)	71	65% (n=46)	92	60% (n=55)	111	52% (n=58)
C 13	45	40% (n=18)	58	43% (n=25)	79	43% (n=34)	93	46% (n=42)	108	48% (n=52)
C 14	16	56% (n=9)	16	56% (n=9)	29	55% (n=16)	41	54% (n=22)	54	50% (n=27)
C 15	38	50% (n=19)	50	56% (n=28)	72	60% (n=43)	83	57% (n=47)	104	54% (n=56)
C 17	24	29% (n=7)	42	36% (n=15)	58	40% (n=23)	71	39% (n=28)	87	39% (n=34)
C 18	22	14% (n=3)	42	26% (n=11)	58	33% (n=19)	83	29% (n=24)	111	24% (n=27)
C 19	42	19% (n=8)	58	26% (n=15)	74	32% (n=24)	88	36% (n=32)	101	37% (n=37)
C 20	44	25% (n=11)	52	25% (n=13)	74	27% (n=20)	97	29% (n=28)	125	30% (n=37)
State	621	36% (n=221)	914	39% (n=352)	1235	40% (n=493)	1537	39% (n=605)	1863	38% (n=712)

Table J14

Well-Being Outcome 1: Family's Enhanced Capacity to Provide for Children's Needs (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	32	9% (n=3)	49	12% (n=6)	61	11% (n=7)	75	9% (n=7)	87	8% (n=7)
C 2	9	44% (n=4)	9	44% (n=4)	13	54% (n=7)	18	44% (n=8)	20	50% (n=10)
C 3	12	8% (n=1)	17	6% (n=1)	21	10% (n=2)	25	8% (n=2)	27	11% (n=3)
C 4	47	43% (n=20)	66	44% (n=29)	86	45% (n=39)	104	45% (n=47)	126	47% (n=59)
C 5	23	39% (n=9)	27	41% (n=11)	45	36% (n=16)	58	31% (n=18)	70	29% (n=20)
C 6	26	62% (n=16)	39	62% (n=24)	55	51% (n=28)	66	52% (n=34)	77	51% (n=39)
C 7	35	46% (n=16)	56	54% (n=30)	75	52% (n=39)	90	52% (n=47)	120	52% (n=62)
C 8	16	6% (n=1)	23	4% (n=1)	28	4% (n=1)	32	6% (n=2)	35	6% (n=2)
C 9	30	37% (n=11)	44	32% (n=14)	55	31% (n=17)	66	29% (n=19)	74	28% (n=21)
C 10	33	48% (n=16)	50	50% (n=25)	62	50% (n=31)	70	54% (n=38)	86	59% (n=51)
C 11	31	29% (n=9)	46	22% (n=10)	53	23% (n=12)	63	29% (n=18)	70	30% (n=21)
C 12	10	50% (n=5)	11	55% (n=6)	11	55% (n=6)	12	58% (n=7)	13	62% (n=8)
C 13	15	60% (n=9)	27	70% (n=19)	46	74% (n=34)	57	70% (n=40)	69	71% (n=49)
C 14	14	71% (n=10)	13	69% (n=9)	15	73% (n=11)	18	78% (n=14)	20	75% (n=15)
C 15	33	79% (n=26)	47	85% (n=40)	58	83% (n=48)	71	80% (n=57)	82	79% (n=65)
C 17	28	82% (n=23)	43	79% (n=34)	57	77% (n=44)	67	78% (n=52)	77	75% (n=58)
C 18	22	50% (n=11)	37	51% (n=19)	53	51% (n=27)	65	45% (n=29)	76	39% (n=30)
C 19	32	34% (n=11)	44	34% (n=15)	60	37% (n=22)	69	38% (n=26)	78	42% (n=3)
C 20	35	49% (n=17)	44	52% (n=23)	60	45% (n=27)	82	43% (n=35)	101	47% (n=47)
State	485	45% (n=219)	693	46% (n=321)	916	46% (n=419)	1110	45% (n=501)	1311	46% (n=601)

Table J15

Well-Being Outcome 1: Family's Enhanced Capacity to Provide for Children's Needs (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	46	28% (n=13)	67	31% (n=21)	88	28% (n=25)	107	27% (n=29)	127	25% (n=32)
C 2	18	61% (n=11)	32	47% (n=15)	45	58% (n=26)	53	60% (n=32)	62	60% (n=37)
C 3	17	18% (n=3)	25	12% (n=3)	29	10% (n=3)	33	9% (n=3)	38	18% (n=7)
C 4	78	54% (n=42)	116	53% (n=62)	146	55% (n=81)	179	58% (n=104)*	205	58% (n=118)
C 5	49	55% (n=27)	75	49% (n=37)	99	47% (n=47)	117	44% (n=52)	136	41% (n=56)
C 6	44	66% (n=29)	65	69% (n=45)	91	67% (n=61)	110	66% (n=73)	132	65% (n=86)
C 7	63	48% (n=30)	89	51% (n=45)	115	44% (n=51)	145	45% (n=65)	172	47% (n=80)
C 8	21	24% (n=5)	31	23% (n=7)	37	24% (n=9)	51	22% (n=11)	59	25% (n=15)
C 9	49	39% (n=19)	68	43% (n=29)	97	45% (n=44)	128	41% (n=52)	155	41% (n=64)
C 10	46	61% (n=28)	73	68% (n=50)	93	68% (n=63)	110	69% (n=76)	138	73% (n=101)
C 11	42	36% (n=15)	69	35% (n=24)	83	31% (n=26)	99	33% (n=33)	118	30% (n=35)
C 12	33	73% (n=24)	65	74% (n=48)	99	71% (n=70)	121	67% (n=81)	145	63% (n=91)
C 13	55	58% (n=32)	74	62% (n=46)	99	62% (n=61)	116	61% (n=71)	132	62% (n=82)
C 14	25	84% (n=21)	25	84% (n=21)	39	82% (n=32)	51	76% (n=39)	64	70% (n=45)
C 15	51	73% (n=37)	72	78% (n=56)	98	81% (n=79)	112	82% (n=92)	138	82% (n=113)
C 17	39	72% (n=28)	65	72% (n=47)	86	76% (n=65)	101	69% (n=70)	119	67% (n=80)
C 18	30	40% (n=12)	54	44% (n=24)	74	43% (n=32)	104	40% (n=42)	135	33% (n=45)
C 19	48	50% (n=24)	67	52% (n=35)	91	58% (n=53)	106	61% (n=65)	121	60% (n=72)
C 20	52	56% (n=29)	64	56% (n=36)	91	59% (n=54)	119	61% (n=73)	153	56% (n=86)
State	806	53% (n=429)	1196	54% (n=651)	1601	55% (n=883)	1963	54% (n=1064)	2350	53% (n=1246)

Table J16

Well-Being Outcome 2: Appropriate Services to Meet Children's Educational Needs (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	6	17% (n=1)	9	22% (n=2)	13	31% (n=4)	17	29% (n=5)	18	28% (n=5)
C 2	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)
C 3	--	--	--	--	--	--	--	--	2	50% (n=1)
C 4	8	62.5% (n=5)	12	75% (n=9)	14	71% (n=10)	18	72% (n=13)	24	67% (n=16)
C 5	5	80% (n=4)	5	80% (n=4)	5	80% (n=4)	5	80% (n=4)	6	83% (n=5)
C 6	14	71% (n=10)	17	76% (n=13)	25	64% (n=16)	27	63% (n=17)	29	66% (n=19)
C 7	3	100% (n=3)	3	100% (n=3)	4	100% (n=4)	4	100% (n=4)	5	80% (n=4)
C 8	2	0% (n=0)	2	0% (n=0)	4	25% (n=1)	6	33% (n=2)	6	33% (n=2)
C 9	3	67% (n=2)	4	75% (n=3)	4	75% (n=3)	9	67% (n=6)	11	64% (n=7)
C 10	7	43% (n=3)	12	67% (n=8)	12	67% (n=8)	13	69% (n=9)	16	75% (n=12)
C 11	22	77% (n=17)	36	75% (n=27)	39	72% (n=28)	39	72% (n=28)	39	72% (n=28)
C 12	6	67% (n=4)	7	71% (n=5)	7	71% (n=5)	8	75% (n=6)	8	75% (n=6)
C 13	7	86% (n=6)	14	79% (n=11)	17	82% (n=14)	19	84% (n=16)	19	84% (n=16)
C 14	--	--	--	--	--	--	--	--	--	--
C 15	7	71% (n=5)	10	80% (n=8)	12	83% (n=10)	17	88% (n=15)	19	89% (n=17)
C 17	1	100% (n=1)	1	100% (n=1)	3	67% (n=2)	4	75% (n=3)	4	75% (n=3)
C 18	3	67% (n=2)	4	75% (n=3)	5	80% (n=4)	5	80% (n=4)	5	80% (n=4)
C 19	2	0% (n=0)	2	0% (n=0)	4	25% (n=1)	5	40% (n=2)	8	38% (n=3)
C 20	7	14% (n=1)	7	14% (n=1)	10	30% (n=3)	12	25% (n=3)	16	38% (n=5)
State	107	64% (n=68)	149	68% (n=102)	182	66% (n=121)	213	66% (n=141)	239	66% (n=158)

Table J17

Well-Being Outcome 2: Appropriate Services to Meet Children's Educational Needs (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	36	69% (n=25)	51	78% (n=40)	64	80% (n=51)	78	81% (n=63)	95	80% (n=76)
C 2	16	100% (n=16)	28	96% (n=27)	36	97% (n=35)	43	98% (n=42)	49	94% (n=46)
C 3	11	55% (n=6)	19	63% (n=12)	23	61% (n=14)	26	58% (n=15)	31	65% (n=20)
C 4	61	89% (n=54)	94	89% (n=84)	118	90% (n=106)	142	91% (n=129)	163	88% (n=143)
C 5	39	85% (n=33)	55	84% (n=46)	73	85% (n=62)	90	82% (n=74)	109	81% (n=88)
C 6	33	76% (n=25)	46	83% (n=38)	69	84% (n=58)	81	84% (n=68)	94	82% (n=77)
C 7	45	80% (n=36)	68	84% (n=57)	91	81% (n=74)	115	84% (n=97)	134	85% (n=114)
C 8	14	29% (n=4)	21	29% (n=6)	27	41% (n=11)	40	45% (n=18)	46	52% (n=24)
C 9	38	92% (n=35)	57	93% (n=53)	77	91% (n=70)	106	89% (n=94)	129	89% (n=115)
C 10	35	94% (n=33)	57	96% (n=55)	76	97% (n=74)	90	97% (n=87)	111	97% (n=108)
C 11	35	77% (n=27)	62	69% (n=43)	75	68% (n=51)	91	71% (n=65)	104	74% (n=77)
C 12	26	81% (n=21)	55	84% (n=46)	83	86% (n=71)	102	83% (n=85)	118	82% (n=97)
C 13	47	79% (n=37)	63	79% (n=50)	79	80% (n=63)	92	79% (n=73)	104	79% (n=82)
C 14	22	100% (n=22)	22	100% (n=22)	35	91% (n=32)	44	93% (n=41)	54	89% (n=48)
C 15	44	91% (n=40)	60	92% (n=55)	81	90% (n=73)	91	91% (n=83)	113	91% (n=103)
C 17	38	74% (n=28)	54	75% (n=48)	85	76% (n=65)	100	75% (n=75)	112	73% (n=82)
C 18	26	77% (n=20)	47	85% (n=40)	64	86% (n=55)	88	86% (n=76)	109	81% (n=88)
C 19	41	76% (n=31)	54	74% (n=40)	74	76% (n=56)	82	77% (n=63)	95	76% (n=72)
C 20	42	71% (n=30)	52	75% (n=39)	72	81% (n=58)	92	83% (n=76)	118	82% (n=97)
State	649	81% (n=523)	975	82% (n=801)	1302	83% (n=1079)	1593	83% (n=1324)	1888	82% (n=1557)

Table J18

Performance Item 17: Physical Health of the Child (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	7	43% (n=3)	12	50% (n=6)	18	39% (n=7)	25	40% (n=10)	32	44% (n=14)
C 2	1	100% (n=1)	1	100% (n=1)	2	100% (n=2)	2	100% (n=2)	3	100% (n=3)
C 3	1	100% (n=1)	1	100% (n=1)	1	100% (n=1)	1	100% (n=1)	2	100% (n=2)
C 4	11	82% (n=9)	15	87% (n=13)	21	86% (n=18)	25	80% (n=20)	30	83% (n=25)
C 5	4	25% (n=1)	6	33% (n=2)	7	43% (n=3)	10	50% (n=5)	11	45% (n=5)
C 6	20	55% (n=11)	22	55% (n=12)	25	60% (n=15)	31	68% (n=21)	33	67% (n=22)
C 7	7	86% (n=6)	11	91% (n=10)	14	93% (n=13)	17	82% (n=14)	20	80% (n=16)
C 8	6	0% (n=0)	7	14% (n=1)	9	33% (n=3)	10	30% (n=3)	10	30% (n=3)
C 9	10	90% (n=9)	14	86% (n=12)	16	88% (n=14)	18	78% (n=14)	20	75% (n=15)
C 10	8	75% (n=6)	15	87% (n=13)	21	90% (n=19)	27	89% (n=24)	37	81% (n=30)
C 11	26	69% (n=18)	41	54% (n=22)	42	52% (n=22)	42	52% (n=22)	42	52% (n=22)
C 12	6	100% (n=6)	7	100% (n=7)	7	100% (n=7)	8	100% (n=8)	9	89% (n=8)
C 13	7	43% (n=3)	14	36% (n=5)	20	40% (n=8)	22	45% (n=10)	23	48% (n=11)
C 14	--	--	--	--	--	--	--	--	--	--
C 15	3	67% (n=2)	4	75% (n=3)	6	83% (n=5)	7	71% (n=5)	11	64% (n=7)
C 17	1	100% (n=1)	2	100% (n=2)	6	83% (n=5)	6	83% (n=5)	6	83% (n=5)
C 18	5	60% (n=3)	6	50% (n=3)	7	57% (n=4)	8	50% (n=4)	9	56% (n=5)
C 19	3	33% (n=1)	3	33% (n=1)	5	40% (n=2)	6	50% (n=3)	10	50% (n=5)
C 20	5	40% (n=2)	6	50% (n=3)	13	46% (n=6)	14	50% (n=7)	16	50% (n=8)
State	132	64% (n=84)	188	63% (n=118)	241	64% (n=155)	280	64% (n=179)	325	64% (n=207)

Table J19

Performance Item 17: Physical Health of the Child (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	46	59% (n=27)	67	61% (n=41)	88	63% (n=55)	107	64% (n=68)	127	60% (n=76)
C 2	18	100% (n=18)	32	91% (n=29)	45	91% (n=41)	53	92% (n=49)	62	92% (n=57)
C 3	17	47% (n=8)	25	60% (n=15)	29	62% (n=18)	33	58% (n=19)	38	55% (n=21)
C 4	78	97% (n=76)	116	94% (n=109)	146	93% (n=136)	179	92% (n=164)	205	90% (n=184)
C 5	49	82% (n=40)	75	84% (n=63)	99	84% (n=83)	117	84% (n=98)	136	81% (n=110)
C 6	44	91% (n=40)	65	91% (n=59)	91	88% (n=80)	110	87% (n=96)	132	84% (n=111)
C 7	63	59% (n=37)	89	60% (n=53)	115	63% (n=73)	145	70% (n=101)	172	71% (n=122)
C 8	21	57% (n=12)	31	61% (n=19)	37	62% (n=23)	51	61% (n=31)	59	63% (n=37)
C 9	49	92% (n=45)	68	90% (n=61)	97	88% (n=85)	106	89% (n=94)	155	86% (n=134)
C 10	46	93% (n=43)	73	95% (n=69)	93	94% (n=87)	110	95% (n=104)	138	95% (n=131)
C 11	42	74% (n=31)	69	68% (n=47)	83	61% (n=51)	99	64% (n=63)	118	67% (n=79)
C 12	33	70% (n=23)	65	68% (n=44)	99	72% (n=71)	121	70% (n=85)	145	73% (n=106)
C 13	55	85% (n=47)	74	86% (n=64)	99	86% (n=85)	116	85% (n=99)	132	84% (n=111)
C 14	25	92% (n=23)	25	92% (n=23)	39	95% (n=37)	51	90% (n=46)	64	91% (n=58)
C 15	51	71% (n=36)	72	71% (n=51)	98	74% (n=73)	112	76% (n=85)	138	77% (n=106)
C 17	39	72% (n=28)	65	65% (n=42)	86	70% (n=60)	101	72% (n=73)	119	75% (n=89)
C 18	30	67% (n=20)	54	78% (n=42)	74	80% (n=59)	104	78% (n=81)	135	74% (n=100)
C 19	48	60% (n=29)	67	63% (n=42)	91	62% (n=56)	106	61% (n=65)	121	63% (n=76)
C 20	52	71% (n=37)	64	73% (n=47)	91	80% (n=73)	119	82% (n=98)	153	82% (n=126)
State	806	77% (n=620)	1196	77% (n=920)	1601	78% (n=1247)	1963	78% (n=1540)	2350	78% (n=1835)

Table J20

Performance Item 18: Mental/ Behavioral Health of the Child (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	17	47% (n=8)	22	52% (n=12)	33	48% (n=16)	42	48% (n=20)	50	50% (n=25)
C 2	0	---	0	---	0	---	0	---	-	---
C 3	1	100% (n=1)	2	100% (n=2)	3	100% (n=3)	4	100% (n=4)	4	100% (n=4)
C 4	19	79% (n=15)	26	77% (n=20)	31	77% (n=24)	39	77% (n=30)	50	70% (n=35)
C 5	6	33% (n=2)	7	29% (n=2)	10	20% (n=2)	12	17% (n=2)	14	21% (n=3)
C 6	14	79% (n=11)	18	83% (n=15)	27	70% (n=19)	32	69% (n=22)	37	65% (n=24)
C 7	12	92% (n=11)	19	95% (n=18)	29	93% (n=27)	40	85% (n=34)	55	75% (n=41)
C 8	6	50% (n=3)	9	44% (n=4)	12	42% (n=5)	14	50% (n=7)	16	44% (n=7)
C 9	13	77% (n=10)	20	80% (n=16)	22	82% (n=18)	27	78% (n=21)	31	74% (n=23)
C 10	14	71% (n=10)	19	74% (n=14)	23	78% (n=18)	23	78% (n=18)	28	71% (n=20)
C 11	20	75% (n=15)	31	71% (n=22)	35	69% (n=24)	36	69% (n=25)	37	70% (n=26)
C 12	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)	4	100% (n=4)	4	100% (n=4)
C 13	6	67% (n=4)	10	60% (n=6)	16	69% (n=11)	18	72% (n=13)	19	74% (n=14)
C 14	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)
C 15	17	82% (n=14)	22	86% (n=19)	28	82% (n=23)	39	87% (n=34)	47	87% (n=41)
C 17	4	75% (n=3)	5	80% (n=4)	9	67% (n=6)	12	58% (n=7)	14	64% (n=9)
C 18	6	67% (n=4)	8	75% (n=6)	8	75% (n=6)	9	67% (n=6)	12	58% (n=7)
C 19	4	50% (n=2)	9	78% (n=7)	16	81% (n=13)	21	71% (n=15)	25	72% (n=18)
C 20	13	54% (n=7)	17	53% (n=9)	27	44% (n=12)	33	45% (n=15)	41	54% (n=22)
State	178	71% (n=126)	251	73% (n=182)	335	70% (n=233)	408	69% (n=280)	487	67% (n=326)

Table J21

Performance Item 18: Mental/ Behavioral Health of the Child (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	27	44% (n=12)	37	51% (n=19)	44	52% (n=23)	54	59% (n=32)	64	56% (n=36)
C 2	14	93% (n=13)	21	86% (n=18)	28	89% (n=25)	32	91% (n=29)	34	88% (n=30)
C 3	11	27% (n=3)	16	25% (n=4)	19	26% (n=5)	21	29% (n=6)	25	36% (n=9)
C 4	45	84% (n=38)	69	87% (n=60)	88	88% (n=77)	112	87% (n=97)	129	85% (n=110)
C 5	20	85% (n=17)	33	82% (n=27)	43	81% (n=35)	55	75% (n=41)	136	68% (n=45)
C 6	22	91% (n=20)	33	88% (n=29)	51	90% (n=46)	61	89% (n=54)	74	85% (n=63)
C 7	31	65% (n=20)	51	78% (n=40)	71	80% (n=57)	89	81% (n=72)	105	80% (n=84)
C 8	8	0% (n=0)	13	15% (n=2)	17	24% (n=4)	29	38% (n=11)	34	44% (n=15)
C 9	23	83% (n=19)	38	87% (n=33)	48	79% (n=38)	64	70% (n=45)	82	74% (n=61)
C 10	22	68% (n=15)	38	82% (n=31)	51	86% (n=44)	62	89% (n=55)	80	88% (n=70)
C 11	28	89% (n=25)	53	75% (n=40)	59	75% (n=44)	73	78% (n=57)	85	78% (n=66)
C 12	22	77% (n=17)	43	77% (n=33)	58	79% (n=46)	65	77% (n=50)	76	75% (n=57)
C 13	37	68% (n=25)	53	66% (n=35)	60	70% (n=42)	68	72% (n=49)	74	70% (n=52)
C 14	17	94% (n=16)	17	94% (n=16)	23	96% (n=22)	30	87% (n=26)	38	84% (n=32)
C 15	33	85% (n=28)	48	85% (n=41)	64	83% (n=53)	73	85% (n=62)	89	88% (n=78)
C 17	28	71% (n=20)	48	73% (n=35)	65	72% (n=47)	75	75% (n=56)	81	71% (n=61)
C 18	15	73% (n=11)	27	63% (n=17)	36	58% (n=21)	51	55% (n=28)	66	48% (n=32)
C 19	34	62% (n=21)	42	64% (n=27)	54	67% (n=36)	62	69% (n=43)	75	69% (n=52)
C 20	27	67% (n=18)	35	63% (n=22)	46	63% (n=29)	60	63% (n=38)	80	65% (n=52)
State	464	73% (n=338)	715	74% (n=529)	926	75% (n=695)	1137	75% (n=852)	1363	74% (n=1006)

Table J22

Well-Being Outcome 3: Appropriate Services to Meet Children's Health Needs (In-Home Cases)

In-Home Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	21	48% (n=10)	30	53% (n=16)	41	46% (n=19)	52	42% (n=22)	62	44% (n=27)
C 2	1	100% (n=1)	1	100% (n=1)	2	100% (n=2)	2	100% (n=2)	3	100% (n=3)
C 3	2	100% (n=2)	3	100% (n=3)	4	100% (n=4)	5	100% (n=5)	6	100% (n=6)
C 4	25	80% (n=20)	35	80% (n=28)	44	80% (n=35)	54	76% (n=41)	68	72% (n=49)
C 5	8	25% (n=2)	10	20% (n=2)	14	21% (n=3)	19	26% (n=5)	21	29% (n=6)
C 6	24	58% (n=14)	30	63% (n=19)	40	60% (n=24)	47	62% (n=29)	54	59% (n=32)
C 7	15	87% (n=13)	26	92% (n=24)	37	92% (n=34)	51	82% (n=42)	68	75% (n=51)
C 8	10	20% (n=2)	14	29% (n=4)	18	33% (n=6)	20	35% (n=7)	22	32% (n=7)
C 9	18	83% (n=15)	28	82% (n=23)	32	84% (n=27)	37	78% (n=29)	42	76% (n=32)
C 10	19	68% (n=13)	29	76% (n=22)	36	81% (n=29)	42	81% (n=34)	54	74% (n=40)
C 11	29	59% (n=17)	44	48% (n=21)	49	47% (n=23)	50	48% (n=24)	51	49% (n=25)
C 12	6	100% (n=6)	7	100% (n=7)	7	100% (n=7)	8	100% (n=8)	9	89% (n=8)
C 13	8	50% (n=4)	15	40% (n=6)	24	46% (n=11)	27	52% (n=14)	29	55% (n=16)
C 14	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)	3	100% (n=3)
C 15	17	82% (n=14)	22	86% (n=19)	29	83% (n=24)	40	85% (n=34)	49	82% (n=40)
C 17	5	80% (n=4)	7	86% (n=6)	13	77% (n=10)	16	69% (n=11)	18	72% (n=13)
C 18	9	56% (n=5)	11	55% (n=6)	12	58% (n=7)	14	50% (n=7)	17	47% (n=8)
C 19	6	50% (n=3)	11	73% (n=8)	18	72% (n=13)	23	65% (n=15)	29	63% (n=19)
C 20	16	50% (n=8)	21	52% (n=11)	33	48% (n=16)	40	50% (n=20)	50	56% (n=28)
State	243	65% (n=157)	348	66% (n=230)	457	65% (n=298)	551	64% (n=353)	656	63% (n=414)

Table J23

Well-Being Outcome 3: Appropriate Services to Meet Children's Health Needs (Foster Care Cases)

Foster Care Cases										
	N	**% Strength Baseline 9/30/2016**	**N**	**% Strength on 3/31/17**	**N**	**% Strength on 9/30/2017**	**N**	**% Strength on 331/2018**	**N**	**% Strength on 12/31/2018**
C1	46	48% (n=22)	67	51% (n=34)	88	52% (n=46)	107	54% (n=58)	127	51% (n=65)
C 2	18	94% (n=17)	32	84% (n=27)	45	87% (n=39)	53	89% (n=47)	62	87% (n=54)
C 3	17	24% (n=4)	25	32% (n=8)	29	34% (n=10)	33	33% (n=11)	38	34% (n=13)
C 4	78	88% (n=69)	116	87% (n=101)	146	86% (n=126)	179	85% (n=152)	205	82% (n=169)
C 5	49	80% (n=39)	75	80% (n=60)	99	81% (n=80)	117	78% (n=91)	136	74% (n=101)
C 6	44	89% (n=39)	65	88% (n=57)	91	86% (n=78)	110	84% (n=92)	132	80% (n=106)
C 7	63	54% (n=34)	89	56% (n=50)	115	60% (n=69)	145	65% (n=94)	172	65% (n=112)
C 8	21	43% (n=9)	31	45% (n=14)	37	49% (n=18)	51	47% (n=24)	59	49% (n=29)
C 9	49	86% (n=42)	68	84% (n=57)	97	79% (n=77)	128	77% (n=98)	155	75% (n=117)
C 10	46	85% (n=39)	73	89% (n=65)	93	89% (n=83)	110	91% (n=100)	138	90% (n=124)
C 11	42	74% (n=31)	69	62% (n=43)	83	55% (n=46)	99	58% (n=57)	118	60% (n=71)
C 12	33	67% (n=22)	65	63% (n=41)	99	68% (n=67)	121	66% (n=80)	145	67% (n=97)
C 13	55	69% (n=38)	74	66% (n=49)	99	71% (n=70)	116	72% (n=83)	132	70% (n=93)
C 14	25	92% (n=23)	25	92% (n=23)	39	95% (n=37)	51	86% (n=44)	64	84% (n=54)
C 15	51	69% (n=35)	72	68% (n=49)	98	69% (n=68)	112	71% (n=80)	138	73% (n=101)
C 17	39	59% (n=23)	65	54% (n=35)	86	57% (n=49)	101	60% (n=61)	119	61% (n=73)
C 18	30	63% (n=19)	54	65% (n=35)	74	64% (n=47)	104	61% (n=63)	135	56% (n=76)
C 19	48	50% (n=24)	67	55% (n=37)	91	55% (n=50)	106	56% (n=59)	121	55% (n=67)
C 20	52	63% (n=33)	64	61% (n=39)	91	67% (n=61)	119	70% (n=83)	153	69% (n=106)
State	806	70% (n=562)	1196	69% (n=824)	1601	70% (n=1122)	1963	70% (n=1378)	2350	69% (n=1629)

Appendix K: Case File Review Protocol

Date of Case Review ______ / _____ / ______ FSFN ID# ________________________________

Reviewed by: ____

Part 1: Investigation	
1. Date case open to investigation: _____ / ______ / ______ 2. Assigned CPI: ______________________________	
3. Gender of Child(ren) in family: Child 1: ☐Female ☐Male Child 2: ☐Female ☐Male Child 3: ☐Female ☐Male Child 4: ☐Female ☐Male Child 5: ☐Female ☐Male	4. Birthdates of Child(ren): Child 1: _____ / ______ / ______ Child 2: _____ / ______ / ______ Child 3: _____ / ______ / ______ Child 4: _____ / ______ / ______ Child 5: _____ / ______ / ______
5. Adults in household in relation to children: Adult 1: ___________________________ Adult 2: ___________________________ Adult 3: ___________________________ Adult 4: ___________________________	6. Birthdates of adults: Adult 1: _____ / ______ / ______ Adult 2: _____ / ______ / ______ Adult 3: _____ / ______ / ______ Adult 4: _____ / ______ / ______

7. Maltreatment allegations and findings from investigation:

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

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

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

Individual	Included?	If yes, how were they engaged? If no, provide any available information as to why not.
Mother/ female legal guardian	☐Y ☐N	
Father/ male legal guardian	☐Y ☐N	
Children	☐Y ☐N	
Other household members (please identify):	☐Y ☐N	
Other relatives/ extended family outside the household (please identify):	☐Y ☐N	
Other non-relative collaterals (e.g. neighbors, friends, school, health providers, etc. Please identify):	☐Y ☐N	

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

10. Did the family assessment contain the following elements:

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

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

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

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

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

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

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

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

11. What are the identified family strengths?

12. What are the identified family needs?

13. What were the safety and risk determinations?

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

14. Describe any strategies or practices evidenced in the file that were used to obtain family buy-in and encourage family engagement in services:
15. Any additional notes related to the investigation/ initial assessment process:
Part 2: Case Management
1. Date case open to FSS: ____ / _____ / _____ 2. Assigned CM: ______________________________
3. If applicable, were updated family assessments completed to reflect current and relevant information impacting the child(ren)'s level of risk? ☐Y ☐N ☐N/A Date(s) of subsequent assessments: ___ /___ / ____ ___ /___ / ____ ___ /___ / ____ ___ /___ / ____ Is there evidence that the family was engaged in the ongoing assessment process? ☐Y ☐N Explain/describe: Was each updated assessment signed and approved by the CM supervisor? ☐Y ☐N ☐N/A
4. Additional notes related to family assessment:

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

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

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

Staffing type: ____ Date: ___ / ____ / ____

Who attended:

Staffing type: ____ Date: ___ / ____ / ____

Who attended:

Staffing type: ____ Date: ___ / ____ / ____

Who attended:

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

Explain/describe:

8. Is there evidence that the voice of the family was considered during the staffing/service planning process? ☐Y ☐N Explain/describe:
9. Were the needs and strengths of the family as identified through the assessment process discussed in the staffings/family meetings? ☐Y ☐N Explain:
10. Were formal services and informal supports identified that match the needs and strengths of the family? ☐Y ☐N List the identified services and supports:
11. Is there evidence of follow up by the CM on service recommendations, referrals, service receipt, and any challenges encountered by the family? ☐Y ☐N Explain/describe:
12. Is there evidence that the CM communicates with the family regarding their services and progress on a regular basis (e.g. at least every 30 days) ☐Y ☐N Explain/describe, including frequency of face-to-face and other contacts:

13. Is there evidence that the CM follows up with concerns expressed, questions asked, or additional needs identified by the family during home visits or other contacts? ☐Y ☐N Explain/describe:
14. Describe any strategies or practices evidenced in the file that were used to encourage family engagement in services:
15. Identify strengths of the case management process as evidenced in the file.
16. Identify challenges of the case management process as evidenced in the file.
17. Date case closed: ____/____/____ Summary/description of family progress and reason for case closure:

Appendix L: Sub-Study Two Focus Group Questions

Family Support Services

Focus Group Guide

1. How would you describe the purpose/objective of Family Support Services (FSS)?
2. Tell me about your role on FSS cases. What are your typical tasks and responsibilities?
3. How are families referred to your agency for these services? What are the eligibility criteria for families to receive these services? What role, if any, do you have in assessing a family's eligibility?
4. Tell me about the types of cases that are typically referred for FSS. (e.g. What kinds of allegations or family risk factors do you typically see on these cases? Family characteristics? Needs?)
5. Given the voluntary nature of these services, what strategies do you use to engage families? What other factors facilitate family engagement in FSS?
6. What factors hinder or present barriers to family engagement in FSS? How do you address the barriers to family engagement? (e.g. What do you do if a family is reluctant or resistant towards engaging in services?)
7. How are families involved in identifying their needs and strengths? How are family strengths incorporated in the family's service plan?
8. What kinds of services are provided to these families? Are there particular program models or evidence based practices that you use? Do you provide all the services in house or do you refer families out to any other providers?
9. How frequently do you have contact (in person, telephone) with the families on your caseload? What do you do on a typical home visit or appointment?
10. What processes are used to assess a family's progress towards desired goals and outcomes? How are decisions made about when to close a case?
11. What procedures are in place for ensuring the quality of services provided and assessing the effectiveness of the program?
12. In your experience, how effective do you think FSS are in reducing risk and preventing future child maltreatment? Please explain.
13. What do you think are the strengths and challenges to FSS as provided by your agency? What services or programs do you feel are most beneficial to families?
14. Do you have any recommendations about how Family Support Services might be improved?