Phase 4- Florida Title IV-E Demonstration Evaluation Semi-Annual Progress Report (04/2016-09/2016)

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Executive Summary

Background

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

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

As specifically required by the Terms and Conditions under which the Demonstration extension was granted (October 1, 2013 through September 30, 2018), this evaluation seeks to determine, under the expanded array of services made possible by the flexible use of Title IV-E funds, the extent to which the State was able to:

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

The Terms and Conditions of the Demonstration require a process, outcome, and cost analyses. Primary data was collected for this semi-annual report via interviews and focus groups with judges, general magistrates, and child protection investigators. Secondary data analysis was performed with extracts from the Florida Safe Families Network (FSFN, Florida's

statewide SACWIS system), Florida Continuous Quality Improvement (CQI)[1], Florida Medicaid, Substance Abuse and Mental Health Information System (SAMHIS), and Department of Juvenile Justice (DJJ).

Findings

Implementation analysis. The primary goal of the implementation analysis is to describe implementation of the Title IV-E Demonstration Project (the Demonstration), to track changes, and to identify lessons learned that might benefit continued implementation of the Demonstration. Judges and magistrates were interviewed for this semi-annual report regarding their role in the child welfare system, the impact the Demonstration has had on their work, and training and joint planning efforts. Judges and magistrates 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. Generally, respondents indicated that the Demonstration had not had an impact on the judicial decisions they made because these decisions remained grounded in Florida statute and testimony presented. 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 is on safety and family engagement rather than risk.

Interviewees were asked whether they had received training or informational materials related to Florida's IV-E Demonstration. The consensus was that most judges and magistrates are not familiar with the Demonstration. Specific to the current sample, only 3 of 14 interviewees had knowledge of the Demonstration prior to their interview. . One recommendation was that there could be periodic communication for court-related personnel on 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.

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

Services and practice analysis. The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. This component also assesses changes in practice to improve processes for the identification of child and family needs and facilitation of connections to appropriate services, including enhanced use of in-home services to increase successful family preservation and reunification. For the current report, key findings are presented from a set of child protective investigator focus groups. The focus groups explore CPI perspectives regarding the array of services available to child welfare involved families, procedures for assessing child and family needs and connecting families to appropriate services, and practices that promote effective family engagement.

Findings indicate that CPIs have a strongly child-centered approach, viewing child safety and well-being as their primary concerns, but also expressing a preference for family preservation. Removing children was considered a last resort, and is determined by a joint decision-making process involving the CPI, supervisor, administrators, and Children's Legal Services. While CPIs generally prefer not to remove children, they expressed concerns about what they perceived to be insufficient safety plans and the reliability of families and collaterals to uphold them.

Additional challenges include poor staff retention, understaffing, and burnout within the CPI offices. Primary supports, on the other hand, were reported to be supervisors and co-workers, with CPIs emphasizing the importance of teamwork. Overall, these findings suggest several factors that impact removal decisions and the use of in-home services: the lack of trust in safety plans and limited availability of services are particularly likely to contribute to a CPI's decision to remove a child rather than trying an in-home intervention. It is critical for communities to increase the array of in-home services in order to maintain more children safely in the home.

Child safety and resource family analysis. The outcome analysis for this report tracks changes in several successive fiscal years (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, and SFY 15-16 for some measures) during which potential foster parents were recruited and licensed. Additionally, changes in the abuse rate for children who were in licensed foster care over the course of four years (i.e., SFY 11-12, SFY 12-13, SFY 13-14, and SFY 14-15) were examined. All indicators were calculated at the circuit and state levels, and cohorts were constructed based on a state fiscal year. The data sources for the quantitative measures used in this component of the report were data abstracts taken from the Florida Safe Families Network (FSFN).

Overall, there is limited variability in the rate of child maltreatment during foster care placement for the State of Florida over time. The average rate for the State of Florida ranged from 2.4% in SFY 11-12 to 2.1% in SFY 14-15. Although no significant difference was found, there is a trend indicating improved performance statewide on the examined indicator.

Likewise, there is limited variability over time in the proportions of new licensed foster families that have been recruited during a specific state fiscal year and remained in an active status for at least 12 months in the State of Florida. For example, in SFY 11-12 the proportions of new licensed foster families that remained in an active status for at least 12 months was 73.3%. It then dropped slightly to 70.2% in SFY 12-13, followed by an increase of 3% for the following year. Results of Chi-square test indicated no significant difference between average proportions of newly recruited foster families statewide that were in an active status for at least 12 months across fiscal years.

Child and family well-being analysis. The constructs of child and family well-being were examined per the applicable Florida CQI items. These outcomes focus on improving the capacity of families to address their child's needs; and providing services to children related to their educational, physical, and mental health needs. Overall, the findings for this report indicate that Circuits 2, 10, 14, 15, and 17 consistently obtained strength ratings for the relevant performance items. Circuits 1, 3, and 8, however, appear to be less effective in the quality of child welfare practices relevant to the safety, permanency, and well-being of children. Further, the performance item related to enhancement of a family's capacity to provide for the needs of their children is an area of concern statewide with just 53% of foster care cases and 45% of in-home cases being rated as substantially achieved**.** Concentrated efforts to improve the frequency and quality of case workers visits with parents would improve scores for this outcome. Generally, ratings for in-home and foster cases were similar at both the circuit-level and state-level but a greater percentage of foster care cases scored as a strength compared to in-home cases.

Cost analysis. This report examined trends in overall costs for the SFY 11-12 through SFY 15-16 time period. Expenditures have increased for most CBCs over these years. However, the increases have not been across all services. In general, the clearest finding is that CBCs are placing a greater emphasis on adoption services over time. Other services have seen varying patterns of change across CBCs. Another important finding is that the levels of expenditures and proportions differ considerably across CBCs. While levels may vary due to a number of factors, most importantly number of youth served, additional analysis of the variability

across CBCs is warranted to determine if the service mix provided by CBCs is associated with differences in youth outcomes.

Sub-study: cross-system services and costs. The analysis examined trends in health service use and costs for youth served by the child welfare system. In addition, Baker Act initiations and juvenile justice encounters were examined before and after entering out-of-home care. A cohort analysis was conducted that followed youth who were removed from the home at different points in time to examine how services, costs, and outcomes in other public-sector systems vary depending on whether the youth entered the child welfare system before or after implementation of the Demonstration extension.

Findings show that youth received many more behavioral health services after entering out-of-home care than in the prior year. Youth also received many more physical health services after entering out-of-home care with the exception of inpatient services. Service utilization patterns have changed over time for physical health care, with a greater reliance on a combination of crisis care and outpatient follow-up when compared to inpatient hospital treatment. Behavioral health service use has also increased over time.

In conclusion, stakeholders remain heavily involved in their local child welfare systems, although in this second five year period of the Demonstration, judges and magistrates are not as familiar with the Demonstration. CPIs have maintained a very child-centered focus with the dual understanding that family preservation is a goal, tempered with ongoing concern that safety plans be adequate enough, and upheld by all accountable. Rates of child maltreatment have decreased slightly during the Demonstration extension, and there has been limited variability over time in the proportions of new licensed foster families that have been recruited during a specific state fiscal year and remained in an active status for at least 12 months in the State of Florida. Expenditure patterns varied by lead agency over time, but an increased focus on adoption services was more uniformly seen across the Demonstration period. Finally, behavioral and physical health service use increased after entering out-of-home care.

Next steps for the semi-annual progress report to follow include, but are not limited to, interviews with the CEOs of case management organizations contracted by lead agencies, a comprehensive analysis of the combined case management and child protective investigator focus groups, administration of a service array survey statewide to lead agencies and front-line staff, identification of two evidence-based practices to include in a fidelity assessment, continued examination of indicators related to the recruitment and retention of the resource families, longitudinal analyses and comparisons of successive annual cohorts of children on critical safety indicators, an assessment of trends in Florida CQI reviews and progress towards

achieving national standards for these outcomes at both the circuit-level and the state-level, a more detailed analysis of the expenditure data inclusive of how expenditures vary across CBCs based on the characteristics of youth served by the CBCs, and examination of differences across time and across circuits regarding the relationship between youth characteristics and service use to determine how much of the changes over time and across circuits can be explained by differences in youth characteristics. Finally, the relationship between service use patterns will be examined as well as whether changes in service use are associated with outcomes.

Introduction

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

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

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

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

Evaluation Plan

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

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

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

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

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

Demonstration project. The cost analysis examines the relationship between Demonstration implementation and changes in the use of child welfare funding sources

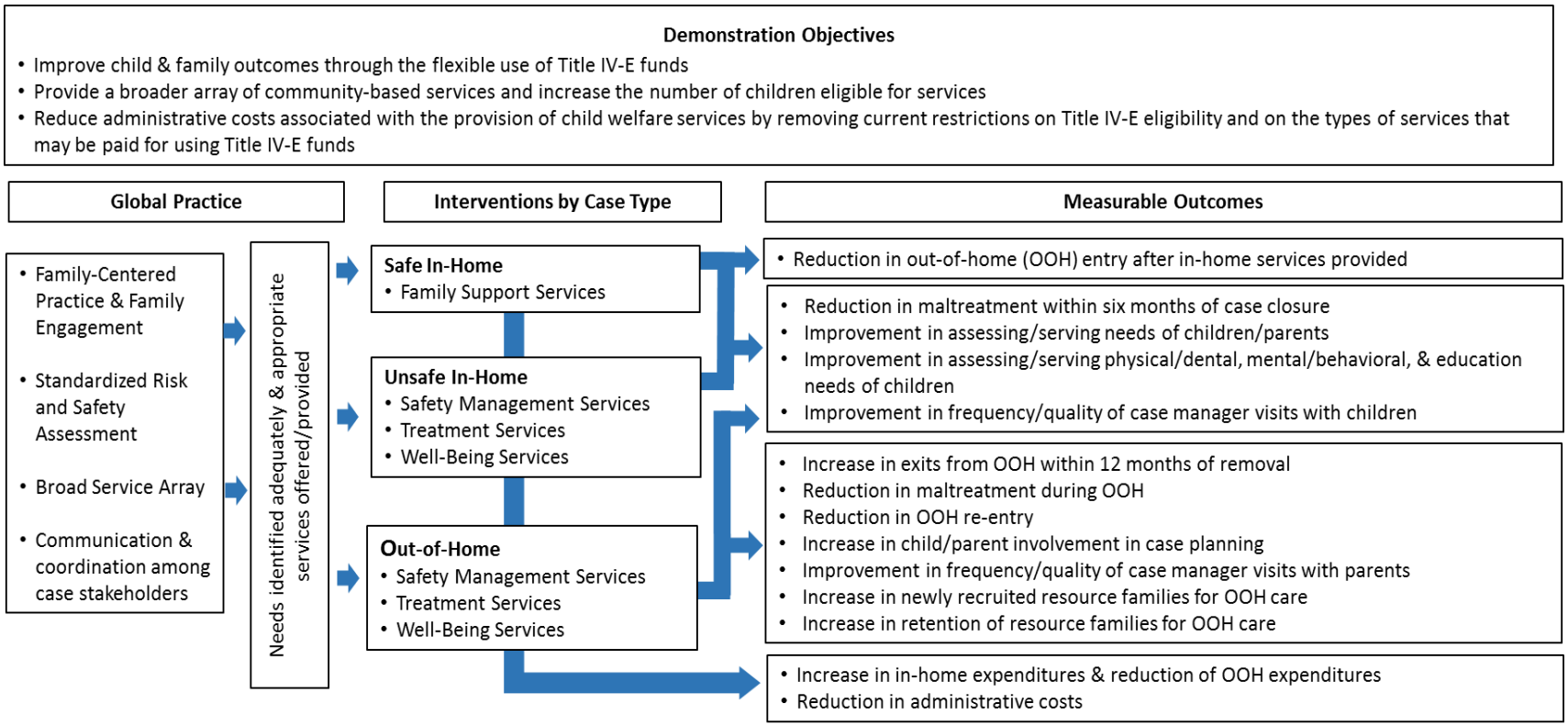
The first sub-study, reported on in the current progress report, employs a cost analysis. It is important to examine how changes in the child welfare services provided to youth also affect service use and costs for other public sector systems. Specific public-sector systems that are examined are Medicaid,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

The second sub-study (not yet initiated) will examine and compare child welfare practice, services, and several safety outcomes for two groups of children: (a) children who are deemed safe to remain at home, yet are at a high or very high risk of future maltreatment in accordance with the child welfare practice model (intervention group) and are offered voluntary Family Support Services, and (b) a matched comparison group of similar cases during the two federal fiscal years immediately preceding the extension of the Demonstration (FFYs 11-12, 12-13), where the children remained in the home and families were offered voluntary prevention services.

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

This semi-annual report includes the results from stakeholder interviews with members of Florida's judicial system (implementation analysis), results from focus groups conducted with Child Protective Investigators (services and practice analysis), findings related to child safety, resource families, and well-being indicators (outcome analysis), a cost analysis, and partial findings from the first sub-study on trends in service use and costs.

Figure 1. IV-E Demonstration Project Evaluation Logic Model



Definitions:

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

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

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

Process Analysis

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

Implementation Analysis

The goal of the implementation analysis is to identify and describe implementation of the Demonstration extension within the domains of individual roles, Demonstration impact, collaboration and communication efforts, and recommendations acquired throughout the process. This semi-annual report includes methods for data collection and data analysis including a coding scheme, and findings from a set of key stakeholder interviews conducted during the reporting period of April 2016 through October 2016.

Methods. Fourteen semi-structured stakeholder interviews were conducted via telephone with relevant stakeholders in Florida's judicial system in order to assess how the Demonstration extension has impacted the child welfare and judicial systems (see Appendix A for interview protocol). The interviews focused on the interviewee's role within the child welfare system and the Demonstration's impacts on permanency/reunification/removal decisions, child welfare practice, and communication/collaboration efforts.

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).

Data analysis. Interview data were coded using four overarching domains that provide a framework for conceptualizing systems change: individual role, Demonstration impact, joint collaboration and communication efforts, and recommendations acquired throughout the process. 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. Three team members who did the data analysis, participated in an interrater reliability process that achieved an inter-rater reliability score of 72%. 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 list). This progress

report includes the most commonly found patterns and themes from the current set of interviews.

Findings.

***Role of the individual*.** Interviews were conducted with four general magistrates and ten judges across ten circuits in Florida. In order for interviewees to be included in data collection, they had to have seen dependency cases within the past six months.

The majority of General Magistrates interviewed had been in their positions for greater than 5 years (time in position ranged from 15 months to 10 years), and focused solely on dependency cases. General Magistrates typically received cases as referrals from dependency judges after a case's disposition for matters such as judicial reviews, motions for reunification, modifications of placement, and expansions of visitation. Magistrates did not typically discuss additional roles during the interview, however one mentioned meeting with case managers to help them be prepared for the courtroom.

The majority of judges had 12 or more years' experience as a judge (time on the bench ranging from 18 months to 28 years). Judges for the most part had lengthy periods of focus on dependency cases, indicative of a strong interest in child welfare cases and not reflective of the general population of dependency judges in Florida who may cycle on and off the bench per election terms. There was variance amongst the judges interviewed based on how their circuit was organized, in terms of whether they focused solely on dependency or also heard juvenile delinquency cases or cross over cases (e.g., where a family sees one judge under Florida's Unified Court Model, although factors in their case may have to do with domestic violence or dissolution of marriage/family law). Another factor influencing a judge's docket was population. Judges from more rural areas were less likely to only hear dependency cases, while higher population areas normally had a handful of judges who only heard dependency.

Judges interviewed often maintained advisory positions within the community, state and sometimes at the national level. Judges were active in their Community Alliances, coordination meetings with the Department of Juvenile Justice (DJJ), Unified Family Court, the trauma informed court initiative, and additional methods of convening child welfare stakeholders.

***Demonstration impact*.**

Role of the court. Judges and magistrates saw themselves as having two primary roles. The first role was to ensure that everyone was doing what they were supposed to be doing, from the parents to the case managers. One respondent stated, "I think the biggest thing is to hold everyone accountable, whether it be DCF or [the] guardian to make sure everyone's doing what they're [supposed to be] doing." The other role judges and magistrates saw themselves as

having, was to be actively involved in child welfare policy and practice discussions outside the courtroom. One respondent stated:

> I don't think you can just apply law to facts and grant or deny orders, or rubberstamp case plans and things such as that. I think we recognize that it just doesn't work that way and the judiciary has to take a leadership role in things such as federal finance reform…I think we understand that there are many, many aspects of this system that are complicated, that the judiciary doesn't get involved in, doesn't take a leadership role in, doesn't learn about, that the system, you know, that we're doing a disservice to ourselves, and to the system as a whole.

Judges across three circuits reported utilizing a Unified Family Court model that included Early Childhood Court, Therapeutic Courts, and Dependency Drug Court. Interviewees highlighted that these court models have been very successful, because they provide "continuity in handling cases" and utilize a team approach. One interviewee spoke to the direct benefits of Therapeutic Courts:

> One of the best parts about our Therapeutic Courts is the frequency that we're able to see these parents and these families. I think by really helping them and taking a therapeutic approach to these cases, and really looking at these cases through a trauma lens, that we're really able to address their specific needs instead of giving them cookie cutter case plan tasks.

Judicial leadership. The rotation system for judges was reported as a significant drawback to effective understanding of child welfare practices among the judiciary. "When you're rotated out of the jurisdiction you cannot develop the expertise that you need in a short period of time, plus there's no continuity in the handling of the cases at all, but also understanding the practice and policies." However, there are judges and magistrates across circuits that have been able to maintain a position as a dependency judge or magistrate for an extended period of time. Judges and magistrates that have an extended tenure in dependency reported more active involvement in child welfare related practices. One interviewee stated:

> There's a core of juvenile judges who have stayed in the system by choice, and do care, and do train, and do interact with other judges, and we have a monthly juvenile judges' conference call where we just talk [about] a hot topic or something.

Removal/permanency/reunification decisions. One of the questions that was asked during the interview is whether Florida's Title IV-E Waiver Demonstration Project has an impact on judicial decisions to remove a child, achieve permanency, and/or reunify a child with his/her family. This section summarizes the interviewees' responses to this question including a

distinction between judicial decisions and the judicial process. Impacts of the Demonstration on the judicial process that are discussed include access to a broader array of services including safety management services, a change in vision that emphasizes keeping families together, and an emphasis on safety rather than risk.

Ten of the 14 respondents directly addressed this question; and their response was that the Demonstration has not had an impact on the judicial decisions that they make. 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. The consensus of the interviewees was that their role is to follow the law "objectively and appropriately without regard to other considerations." As one respondent explained:

> There are many represented interests in a dependency case, and so I rely on due process of law. I rely on the evidence and the recommendations provided by the dependency case managers, child protective investigators, the placement people who provide evidence, especially the Guardians ad Litem and the professional witnesses like psychologists, psychiatrists, and therapists. So, I'm guided by the statutory standards and the recommendations made by the people who are responsible for gathering the facts of the cases.

Another respondent discussed the importance of giving everyone involved in a case the opportunity to be heard: "I do whatever I can to give everyone involved a chance to be heard…I try to hear as much as possible when making a determination. And I actively participate as well. I ask questions myself."

However, six interviewees also noted that although the Demonstration has not affected judicial decisions, the Demonstration has impacted the judicial process:

> So my major decisions, remove or don't remove, adjudicate or don't adjudicate, terminate parental rights or don't terminate parental rights, honestly I don't think have been affected by the Waiver. How we do business throughout that process and what we do for and with the family has dramatically changed.

The most common impact on the judicial process noted by respondents is the additional resources and services that case managers and child protective investigators can access for families: "There are many cases that we never see that would've been removals in years' past because they're able to do services in the home and safety management." Regarding resources, one important factor is an expectation by court personnel that as a result of the Demonstration, case managers can find services for families when they are needed. "Now I'm

finding that they're putting services in place that have meaning and we may have an open case without a removal…and that's a good thing." Specific types of services noted that are now available include in-home parenting services, clinical services for the child, in home reunification teams that are able to assess the parental readiness and child safety, day care services, substance abuse services, psychological evaluations. Another comment was that the Demonstration's funding flexibility means having resources to pay for utilities, move in costs for new apartments, and helping parents to furnish apartments: "That's one of the reasons we get permanency much faster, because we've gotten to them faster and they can provide them more intensively."

In addition to resource availability, other factors were mentioned that affect the process of removal decisions. One factor noted by several respondents is a change in vision and values so that the focus now is trying to keep families together, and even if children are removed, to make efforts to reunify the family. "It's a change in mindset, it's a change in approach, [and] it's a change in execution."

One respondent explained that the emphasis now is on safety rather than risk. "Rather than removing a child because of risk factors, our consideration is whether we can safely allow the child to remain in/be returned to the home, and under what circumstances." Another interviewee noted that the use of in-home safety plans in the child welfare practice model is a strategy that allows children to remain safely at home. Another factor identified related to this change in vision and values that was noted is changes in the efforts to engage and work with families. Finally, respondents noted their participation in local and regional workgroups such as the Safe Reduction Workgroup that are addressing this goal.

Family engagement/family well-being. Judges and magistrates across circuits commonly reported that there has been an increase in efforts to engage parents and families since Demonstration implementation. One respondent stated: "I don't know if necessarily as a result of [the Demonstration], but I do think [there has] been a [family engagement] change, a shift, not that we didn't do it before, but I think that's a definite focus of what we're trying to accomplish." Commonly reported activities include holding frequent court hearings that allow parents an opportunity to be heard, ensuring access to services, addressing barriers and challenges in court, and making sure parents are fully informed about what is happening. One interviewee mentioned:

> I think the main thing a judge can do is to let them know that you care and that you're going to give them an opportunity to be heard…And then just be prepared and be aware

> of all the potential helpful resources that are available and make sure they're aware of that.

Judge and magistrate respondents agreed that the primary focus today is to keep families together, and as a result there has been an increase in understanding how to best meet the needs of a family. One respondent stated:

> I think despite the monstrous size of our system, and the many layers of bureaucratic stuff that we deal with, that nonetheless we do a much better job of touch, I mean literally touching families. You know going into their homes, getting them where they need to be. Being more creative…We aren't as quick to remove kids or not reunify kids just because of those sorts of systemic barriers that families face.

Service array/resources. Another issue that was discussed with respondents was the impact of the Demonstration on access to and availability of services and resources for families. Both strengths and challenges regarding the service array were noted in the interviews.

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. The perception of some interviewees was that specific types of services (i.e., in-home parenting services, clinical services for the child, in home reunifications teams that are able to assess the parental readiness and child safety, day care services, substance abuse services) are more available now as a result of the Demonstration. As one interviewee commented: "Parents get services faster. I mean significantly faster." Another respondent with similar views also noted that even when services are available, sometimes parents do not take advantage of these resources. The Demonstration's increased flexibility regarding how IV-E funds can be used was described as: "It allows us to think outside the box. It allows us to use some creativity…..It allows us to be much more individualized in our provision of services to families." Various respondents offered specific examples from their communities: selection of a new provider with needed skills and expertise, payment of psychological assessments for parents, and the use of prevention services. Finally, a respondent noted that the funding flexibility has allowed their circuit to introduce evidence-based practices such as parent-child psychotherapy to the child welfare system of care.

Respondents also identified gaps in needed services. 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. Two respondents discussed the importance of frequent contact between a child and parent after removal in order to maintain the bond between parent and child. Both

respondents noted the importance of visitation centers and the quality of the visitation that takes place. A related challenge is finding appropriate services for specific problems, such as services for parents with low IQs who are caring for a medically complex child, intergenerational domestic violence and substance abuse, parents with dual diagnoses of mental health and substance use including inpatient substance abuse with a mental health component.

Caseworker practice. Judges and magistrates described caseworker practice with two primary themes, service engagement and turnover issues. Interviewees recognized that services are being provided to families prior to court involvement. One stakeholder acknowledged that the most severe cases are the ones that are coming into court, "cases that require a lot of oversight." Another judiciary respondent echoed this sentiment by stating: "They [case management] stepped up in a number of instances and said you know, 'We'll take the case earlier than we should. We're not going to sit here and say that's your responsibility don't give it to us.'"

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. One respondent stated: "It just seems the caseloads are exorbitant for the worker sometimes. I'm amazed at how prepared they are for court given their caseload. So, I would say they need to have more manpower to work with these families." Turnover among licensed mental health counselors and therapists was also mentioned as a challenge. One interviewee commented that the turnover problem will continue until we can permanently increase salary levels. A final related issue is that due to case management turnover, "supervisors become supervisors in a crisis and are not trained to be supervisors."

CPS practice. Judges and magistrates unanimously reported that child protective investigators had an inherent passion for child welfare work. "I do know that by and large the vast majority of the ones that I've met with in court, their hearts are in the right place; they're genuinely in this for the welfare and safety of children," stated one interviewee. Judges and magistrates reported turnover, lack of resources, and vicarious traumatization as obstacles to the effective practice of child protective services. One respondent stated:

> It really takes a very particular person and personality to be able to do this, day in and day out. And we learn about compassion fatigue, and vicarious trauma, and those are real things, and you have to be very dedicated, and very experienced to be able to deal with the issues that we see on a daily basis. And, unfortunately, turnover is very high because either they're completely overwhelmed with the amount of work because we

have so many kids in care, or they get to the point of burnout…That really affects the outcome of cases when there isn't consistency.

Funding. "I find virtually no problem in funding now." Respondents identified both positive impacts of the Demonstration on funding as well as ongoing challenges regarding funding levels and adequacy. In addition to the strengths identified earlier (better service access, the capacity to offer more individualized services, and the use of Evidence-Based Practices), a few respondents noted that their understanding is that the Demonstration has expanded the use of preventive and pre-court services. However, these respondents noted that it is unclear "how effective this has been." Other respondents noted that without the funding flexibility of the Demonstration, more children would be removed from their families. Despite the funding flexibility offered by the Demonstration, some interviewees identified ongoing funding challenges including restrictions on access to quality therapeutic services: "Why do our children have to see people who only take Medicaid, whom you would never take your own children to?" Another interviewee commented that the overall funding limitations in children's services are problematic because the system is unable to retain clinicians who are credentialed and qualified to offer best practice interventions such as eye movement behavioral therapy and child-parent psychotherapy.

Policies and procedures/quality improvement. A few respondents addressed these topics and highlighted gains that have taken place in policies, quality improvement methods and data access. Regarding policy, one positive change noted is the efforts that are being made to engage parents earlier and getting them started with their case plan. One challenge, despite this policy shift, is that during the engagement phase sometimes delays happen in getting services initiated: "The process to make a referral, and request funds, and get somebody started really just can take way too long." Once again, the need for more frequent visitation after removal was noted, and its relationship with faster reunification.

Two respondents noted strengths in the area of quality improvement. The first strength identified is more use of science and research findings in decision making about policy direction including a better understand of child development and the importance of what happens to a child in the early childhood phase, the use of evidence based practices in the child welfare system such as child parent psychotherapy with older children. The importance of university partnerships was also mentioned: "It is very important in my opinion that every child welfare system has clinical partners and university partners, so we can share information and do the best that we can in terms of research and evaluation as well." The second strength is better access to and use of data related to evaluating services and understanding whether services

are making a difference for children and their families. A related request is to conduct longitudinal studies so that families can be followed over time to understand whether long-term positive outcomes are achieved.

Training. Interviewees were asked whether they had received training or informational materials related to Florida's IV-E Demonstration. The consensus was that most judges and magistrates are not familiar with the Demonstration: "There just seems to be a lack of understanding about what the Wavier is, and maybe that's important, maybe it's not, but there maybe could be a little more education on that." Specifically, only 3 of 14 stakeholders interviewed for this component knew about the Demonstration prior to being interviewed. One recommendation made by interviewees, was that there could be training for court-related personnel on the Demonstration at the Child Protection Summit.

***Joint efforts*.**

External communication/collaboration. Judges and magistrates reported many different ways in which they jointly plan and communicate with other stakeholders involved in the child welfare system. The collaborative efforts ranged from dependency court improvement meetings, informal open communication, participation in trainings (with the CBCs and different agencies), "brown bags", Safe Reduction Workgroups, quarterly meetings, a statewide court improvement panel, Community Alliances, informal meetings with key stakeholders, list serve emails for data sharing, providers that come in and do trainings and information sessions, workgroups aided by Casey Family Program, and attending the DCF Child Protection Summit. The most commonly reported types of communication and collaboration were court improvement meetings, Safe Reduction Workgroups, and "brown bag" meetings. Court improvement meetings were the most common collaboration effort reported. Both judges and magistrates reported attending these meetings regularly.

The use of Safe Reduction Workgroups was reported by three different circuits. The primary goal of these workgroups is to safely reduce the number of children in care. Stakeholders that comprise the Safe Reduction Workgroups include DCF, the lead agency or agencies, representatives from case management agencies, child welfare leaders, children's legal services attorneys, parent attorneys, court personnel, and child protective investigators. The workgroups were reported to have been successful in identifying goals to work towards either as a collaborative group or in subgroups. Two circuits reported starting the workgroups with help from the Casey Family Program.

At least two circuits reported having "brown bags" which were described as meetings with stakeholders to discuss what is working and what is not working. The meetings also serve

to keep communication lines open, ensure stakeholders are moving in the same direction, and to assure that concerns are addressed. One respondent described what a typical "brown bag" meeting entailed: "Every 90 days we have a brown bag…where I have all the stakeholders come in and meet…And we go through and talk about what's working or not, what they're seeing as far as the mechanics of the day-to-day operation."

Political support. Interviewees described how political support had an impact on child welfare practice. The perception of some of the interviewees was that there was not enough local autonomy and that some Florida statutes needed to be altered. Respondents did not give specifics on what statutes they perceived needed changing. In regards to local autonomy, one respondent stated:

> The understanding that every community is different needs to be recognized by Tallahassee. And the lack of bringing in quality services is a problem, the political ramifications of getting rid of bad services in the community that might have served the Child Welfare community in that certain area for decades, to finally say to them, you haven't been effective' And they've had these positions based on politics.

One respondent noted that state policies sometimes are focused on number targets rather than what is best for children and families.

***Recommendations for child welfare system improvement*.** 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, frequency of visitation, accessibility and availability of services, case manager retention, and funding.

Mental health services. The only area that respondents overlapped on was a need for a more diverse array of mental health services and better quality mental health services. This was specific to parents, families, and children who have mental health needs. "We have a lot of parents with some serious mental health issues and I don't know that we have the support for them that we should have", stated an interviewee. Another clarified that more detailed attention should be paid to the nature of specific therapeutic interventions for parent/child therapy, therapy for the child, parents, or family, and finding the right fit to the family's circumstances and individual diagnoses. Intensity of therapeutic interventions was also mentioned as an area

needing improvement in the direction of increased intensity where needed. Another interviewee approached the mental health issue from a long term perspective:

> We have a crisis model and crisis hospitalization, but we really lack team resources and long term housing for people with serious mental illnesses. It would be a giant help to the whole court system, and to the dependency population disproportionately.

In-patient psychiatric treatment for parents outside of the criminal justice system was cited as another area in need of funding.

Prevention services. Prevention of child abuse, both primary and tertiary, was mentioned. "We need to drill down younger into the community, prior even to getting referrals", articulated one interviewee. Reference was made to the research study that found reading at grade level by third or fourth grade was the strongest predictor of positive long term outcomes for children, and that reading at this level was strongly tied to exposure to vocabulary on a regular basis from 0 to 3 years of age. A suggestion was made that the child welfare system direct prevention funds to going into 4C daycares (Community Coordinated Care for Children[2]) to provide higher level verbal contact with children, as well as making sure at risk children were at reading level by the fourth grade. It was believed that this type of primary prevention might eliminate the majority of truancy and child abuse issues judges see, and significantly improve high school graduation rates. An interviewee explained: "I really think we're trying to, you know, close the barn door after all the horses have run away by the way we operate our dependency system." Acting sooner at the first or second referral to DCF, rather than subsequent to repeat referrals, was also seen as a way of preventing more severe situations.

> You know, those kids are clearly in an environment where they are being mentally and emotionally harmed. I mean...if you've got 15 dependency referrals, something isn't right in that family, and if you don't fix it, you're going to have a broken kid, and they're going to have broken kids when they grow up.

Investigations. The context in which abuse is reported and training for investigators were each mentioned by an interviewee. One respondent discussed the different cultural constraints that come into play when stakeholders make the decision about whether or not to report perceived child abuse or neglect. Second, an interviewee heralded the work of investigators, acknowledging that they did an excellent job of identifying "real world problems," but also suggested that for those investigators who were not from a law enforcement background, legal training regarding what areas of child abuse and neglect have legal

[2] The Community Coordinated Care for Children program in Florida partners with certain daycare providers to offer financial assistance to families, with a focus on healthy child growth and development.

repercussions might prove beneficial. An interviewee explained: “That's one area of concern, that maybe they don't simply know exactly what to look for. This isn't just a conversation they’re having with potential people. They need to be aware of real legal issues”.

Timing of services. Areas of concern regarding timing of services were length of time between the sheltering of a child and assignment of a case manager, length of time needed for a CBC to perform rapid home studies and backgrounds for those seeking placement of children, wait times for children to receive medical and mental health services, and timely reports from Comprehensive Behavioral Health Assessments. Judges and magistrates attributed the longer wait times to a lack of funding for services and a lack of funding to pay for more case managers.

Family engagement. Following on the heels of getting parents started in services sooner was also engaging parents in their case plan. Specific ideas on how to do this were not offered, but a lack of engagement, particularly early on in a case was noted by interviewees.

Increased visitation. Another area of concern were situations where a CBC was not able to facilitate court ordered visitations for a parent. An interviewee stressed: “They [the CBCs] need better capability of following through with court orders, so that whenever we ask them to complete something it actually gets finished.” An interviewee shared a recent example where the parents said in court that they had not seen their children for three weeks despite there being a court order, and the Department/CBC admitted they had not been able to coordinate because of the distance between the parents and where the children were fostered. “It's an untenable situation. I mean, the parents have got to see the children, they're required to see the children, and the Department can't make that happen. It's a real issue.”

Another interviewee stressed that along with frequency of visitation needing improvement, so too does the quality of visitation need to be improved. “The visitation centers are bursting at the seams not just from dependency cases, but also from family law cases that are not dependency related,” shared an interviewee. It was suggested that CBCs allocate additional resources and additional staff to supervise visits safely, either in their facility or out in public. “I think they used to have staff that were designated to transport and to supervise visits, and due to budgetary reasons, I don’t believe those exist very often anymore,” an interviewee clarified. It was also noted more generally that if DCF and the lead agencies can find a way to build capacity around more frequent visitation that reunification would happen in many cases at a faster pace.

Accessibility and availability of services. Transportation was noted as a consistent barrier to accessing services, particularly mental health. One interviewee noted that in rural areas, parents often have neither driver’s licenses nor access to cars or other means of

transportation. This is especially problematic when service providers are located only in cities that are far distances from where parents live. Batterer's intervention and domestic violence training were also recognized as being difficult to access.

> I see a lot of domestic cases and the nearest batterer's intervention is I think 60 miles away…if you've got somebody that's working and you're expecting them to go work and then have to drive an hour for a batterer's intervention and then have to do that on a regular basis for a 26-week period, that's asking an awful lot and to me, it's a real barrier.

A suggestion was made that a mobile intervention be developed, so that batterer's intervention and domestic violence training would be offered once a week in each county, and the unit would rotate each day in terms of which county they were serving in a general area.

Case manager retention. It was acknowledged that generally, there is simply not enough incentive for case managers to both be attracted to the job and to stay at the job for a longer period of time, and that the field is in need of both more "boots on the ground" but also higher retention rates. Funding for higher pay to case managers and more case managers to achieve lower caseloads was requested. "The Court is impeded in effectively hearing cases because of the revolving door of case managers in each and every case," stressed an interviewee.

Funding. Priorities for increased funding included children's medical and mental health treatment services, licensed beds that are appropriate for children with medical and mental health issues, higher pay for case managers, and capacity to facilitate more frequent visitation.

Summary. In conclusion, judges and magistrates interviewed for this semi-annual report 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. Generally, 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.

Next Steps. In the next phase of the Demonstration implementation analysis, interviews will take place with a random sample of CEOs from case management organizations contracted by lead agencies. In the Interim Evaluation Report (Armstrong, et al., 2016), it was reported that

the next phase of the implementation analysis would focus on a set of interviews with CPIs and CPI supervisors. After discussion and review, it was concluded that interviews with CPI stakeholders was not appropriate at this time, because evaluation team members recently conducted focus groups with these stakeholders.

Services and Practice Analysis

The purpose of the services and practice analysis component is to assess progress in expanding the service array under the Demonstration, including the implementation of evidence-based practices and programs. This component also assesses changes in practice to improve processes for the identification of child and family needs and facilitation of connections to appropriate services, including enhanced use of in-home services to increase successful family preservation and reunification. For the current report, key findings are presented from a set of child protective investigator focus groups conducted in various areas of the state. The focus groups explore CPI perspectives regarding the array of services available to child welfare involved families, procedures for assessing child and family needs and connecting families to appropriate services, and practices that promote effective family engagement. A full, detailed analysis that brings together findings from the completed case management focus groups (summarized in the previous semi-annual report) and child protective investigator focus groups is forthcoming in the next semi-annual progress report.

Methods. Focus groups were conducted with child protective investigators during July 2016 in the same five circuits where the case management focus groups were previously completed (Vargo, et al., 2016). As described in previous reports (Vargo, et al., 2016 and Armstrong, et al. 2016), these sites were selected using a stratified random sampling process based on child removal rates (as reported in the CBC Lead Agency Trends and Comparisons Report, June 26, 2015). Circuits were stratified into three categories: low removal rates (less than five removals per 100 investigations), moderate removal rates (five to six removals per 100 investigations), and high removal rates (greater than six removals per 100 investigations). Next, two circuits were randomly selected from each category using a random number generator. While this process 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 same five circuits were included for the child protective focus groups, which were as follows: Circuit 4, Circuit 19, Circuit 12, Circuit 11, and Circuit 15.

Contact information for the Regional Managers of each selected circuit was obtained from DCF, and each was 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. Regional Managers were given the option of having either one or two focus groups completed for their circuit, depending on their preference. All but one circuit opted to have two focus groups. In four out of the five circuits, child protective investigations were handled entirely by DCF, while one circuit was split between one county that had DCF child protective investigations and one county in which the Sheriff's office conducted the investigations. For this circuit, one focus group was conducted with DCF investigators and a separate focus group was conducted with the Sheriff's office investigators. Focus groups varied in size from as few as four to as many as 12 participants. Focus group participants were primarily child protective investigators, but a couple focus groups included supervisors as well.

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

Findings. Focus group questions were centered on practices and perceptions of child protective investigators (CPIs) relating to their role, how family needs are identified, the availability of services in the community, and challenges to the current child welfare system. Prevalent themes that emerged from the CPI focus groups are organized as follows: purpose of the child welfare system, assessments, safety determinations, service array, challenges, and supports. Key findings related to each of these themes are described.

Purpose. Focus group respondents across circuits unanimously stated that child safety and well-being are the primary purposes of the child welfare system, and within the system, investigators described themselves as the first responders in determining child safety. One respondent, for example, described the responsibility of a CPI: "To ensure the safety and well-being of children, to link families with services that would ensure the safety and well-being of children, as well, as making [families] more [self] sufficient." Educating families about what

services are available, as well as becoming a confidant for parents were also reported as roles that CPIs hold, but an emphasis on safety was always first and foremost.

Assessments. Child protective investigators reported a number of ways in which they identify and assess a family's needs, and how they asses change over time. The methods reported included active listening, engaging the parent(s), speaking with collaterals (school, neighbors, external family members, and friends), looking at prior criminal history, looking at prior abuse reports with DCF, reaching out to prior CPIs, and job experience. Respondents shared that the child welfare practice model has enabled them to be less incident-driven in their assessments and focus more on how the family is functioning. The child welfare practice model allows CPIs to assess if there are underlying issues that need to be addressed that might have been missed in an incident-driven investigative approach. The assessment methods described above are utilized by CPIs to complete the Family Functioning Assessment (FFA) in FSFN.

CPIs also identified a lack of expertise to make quality assessments, specifically when it came to assessing an individual's mental health. In the words of one participant: "There's always been substance abuse, but the mental health component along with the substance abuse, our investigators don't have those initials after their names to make that quality assessment." Another challenge in making quality assessments reported was cases that involved young children who could not speak for themselves. Furthermore, the amount of time required to complete the FFA along with the limited timeframe CPIs have to complete it was reported to be a challenge, particularly since most circuits expressed that they were experiencing higher than recommended CPI caseloads.

Assessing a family's progress and change over time was reported as difficult for CPIs because they are only involved with a family for up to 60 days. However, respondents mentioned that change tends to happen if the family expresses a willingness to engage in services and if there are no recurring reports after the case closes. CPIs also reported that occasionally a caseworker or family will contact them to provide an update on how the family is progressing. For the most part, however, assessing change was not considered to be part of the CPI's role.

Safety determination. Focus group members were asked how decisions were made about whether a child can remain safely in the home. CPIs reported that there are a set of safety questions that must be answered in order to determine if a child can remain safely in the home. CPIs answer questions such as: Is there present danger, can the danger threat be controlled (i.e. through a safety plan), what are the parent's protective capacities, what is the family's cooperation level, and is there a safety manager (i.e. a non-offending family member or

professional who can ensure the safety of the child) available? The answers to the safety questions help determine whether an in-home safety plan can be implemented.

Challenges to safety plan implementation and maintenance were reported. CPIs felt that safety plans were promissory in their nature (i.e. they are based upon a promise by the parents to comply) and that it was difficult to monitor compliance. One respondent stated: "I mean with safety plans, if I have to come up with a safety plan, like if I have to start gathering family members, start calling people to come and do this: they weren't doing it anyway, what makes you think they're going to do it now?" This and other similar responses indicate a degree of distrust and skepticism towards families, which make CPIs hesitant to try in-home service interventions. CPIs also reported that when a removal occurs after more than one "failed" safety plan, they often get reprimanded in court for not taking action sooner, or conversely, the court may question the reasoning for removal after so much time has passed.

Despite the frustrations and concerns expressed regarding the use of safety plans, the majority of CPIs reported that the removal of children should be a last resort option. Respondents cited that removals place children with unfamiliar faces or areas, foster home placements are not always stable, and removals may traumatize children just as much or more than the abuse or neglect they are experiencing at home. CPIs reported that when children see the DCF badges/shirts they often express fear, because they think they will be taken away from their parent or siblings, as the following CPI narrative suggests:

> I've had kids cry and they've never seen me and they'll see my shirt, they know who I am, they'll start crying like bawling saying 'I want to be with my mom. Are you here to take me? Please don't take me away from my mom.' And I'm here because the child had shoes that were too dirty or the hands were too dirty. But the child just loves to play outside. So now you've caused this child to have a traumatic effect when it wasn't even needed.

Across circuits it was reported that the decision to remove was a joint decision between at least the CPI, their supervisor and someone from Children's Legal Services (CLS). A number of participants expressed the perception that ultimately the decision is driven by CLS and whether or not there is legal sufficiency to remove. Furthermore, there were considerable frustrations expressed over a perceived diminishing of CPI power in removal decisions; whereas it was reported that in the past they had the authority to make removal decisions on their own, they no longer are able to do so, and this was a source of contention.

Service array. Access to services and the availability of services were discussed at length among focus group members. Transportation, daycare, autism spectrum services,

psychiatrists, and affordable housing/housing assistance were noted as services that were needed but unavailable to families across circuits. CPIs in all circuits reported challenges with service providers, but some participants also did state that there were services that met and exceeded their expectations. The most commonly mentioned challenges were time lapses between a service referral and service initiation, insurance coverage, and service providers not understanding the child welfare system.

First, CPIs described how they would make a referral and providers often had wait lists for weeks, allowing families time to change their minds about cooperating. Long waitlists for services could also mean the difference between being able to implement an in-home safety plan and needing to remove a child, since immediate services may be crucial to ensuring the child's safety. CPIs also expressed frustration when they would refer a family to needed services and the service provider would disregard the CPI's recommendation.

Next, CPIs reported being uninformed about insurance issues until after they had closed a case. The most common insurance issues were providers not accepting a family's insurance and the insurance company not covering the cost of the recommended amount of services. Families without private insurance and who do not qualify for public insurance, either due to their income level or immigration status, also presented a considerable challenge. Sliding scale fees offered by providers were often too expensive for the families involved in the child welfare system.

Finally, CPIs noted that service providers would advertise offering services for high risk families, and then turn down families that were classified as high risk because they were either "too high risk" or "not high risk enough." Additionally, it was reported that providers are unaware of how the child welfare system operates:

> The agencies [are] going to have to understand more of the child welfare, and where we're coming from, and what our recommendations are. Because we work from a certain standard, Chapter 39. They're going to need to know what we're dealing with, and what our requirements are, because other than that, there's a major disconnect, because kids are still going to be unsafe.

Lack of provider understanding of the child welfare system was a cause of ongoing frustration, since it resulted in families receiving different and contradicting messages from service providers that do not align with the goals or requirements of the child welfare system.

Challenges. Turnover, lack of system cohesion, and the types of cases the hotline accepts were all reported as significant challenges to a CPI's ability to effectively do their job. It was perceived that investigations, case management, service providers, and the legal system

are often not on the same page. This similar sentiment was expressed in the case management focus groups. One respondent articulated this point by saying that the process is not black and white:

> It's not black and white, and it depends on who you talk to. Like, I just had a removal from case management that a couple months ago I wouldn't have removed, but they yelled at me and they were like, well, that's present danger, because they violated a court order. Now I'm going to court after removing. The attorneys told me that's not enough, that's not showing a danger threat, even though they violated a court order.

As this narrative indicates, different stakeholders involved in a case view the same set of information about a family's situation in very different ways and may draw different conclusions about the appropriate action to take. This can be challenging for CPIs to negotiate when they are presented with conflicting opinions from various stakeholders.

CPIs also expressed that there was a lack of efficient education regarding mandated reporting. For example, investigators reported that school system personnel would not properly handle children that misbehaved in school. School personnel would often request that the parent come pick the child up from school, and when the parent punished the child in front of school personnel, they would call in a report of abuse. Another source of frustration for CPIs was service providers who call in reports for the same reasons that the families were originally referred to services. As one participant expressed: "When the kid goes to see a counselor, or a parent goes to see a counselor, why do [the counselors] pick up the phone and make a call? They're there for a reason, and that's to get some help."

Investigators described turnover as one of the most burdensome aspects of their job. They attributed turnover issues to a lack of passion for this type of work, employee burnout, and unrealistic expectations. CPIs recognized that it "takes a special type of person to do this job." From their perspective, child protection employment is not a job that is taken just for a paycheck; those that enter this field do so because of their passion for child safety and working with families. "It's really, it's not a job, it's a calling. It's something that is within you. People that stay have a burning desire," one CPI explained. Unrealistic expectations were described as the timeframe demands for task completions while being understaffed, and the pressures of not accruing too much overtime. The unrealistic expectations then lead to burnout.

CPIs also mentioned that there is more turnover than there are new hires. They reported that when an employee quits it creates a ripple effect of burden. CPIs that stay are left to take on the cases of the employee that quit along with new cases coming in. Some circuits reported being understaffed by at least 30 CPIs.

In addition, CPIs reported that the hotline makes their job more difficult than it needs to be. CPIs gave examples of the hotline accepting reports from parents calling in reports on one another for custody battle reasons, reports where there is no child victim, and incidents that occurred in the past (no present danger) and being marked as immediate. This takes up a significant amount of time for the investigators when they could be devoting their efforts to more complex and legitimate cases. This discussion further led CPIs to explain the process of completing a full FFA for cases they felt they should not have received in the first place. As one CPI described: "The FFA just causes way too much work. It really is, and it's ridiculous when there are no indicators of any abuse or neglect, and the family's fine, you still have to do that whole thing." It was expressed that a briefer assessment should be allowed for those cases in which the allegations are not verified by the investigator, since it produces a substantial burden to complete a full FFA on a case that does not go to court.

Supports. CPIs reported two primary aspects of their job that are the most supportive, encouraging supervisors and a supportive team. CPIs explained that: "When you don't have the support of a good supervisor, it makes you or it breaks you." Supportive supervisors were described as supervisors that enable open communication, offer assistance if they can, and those that do not try to micromanage. Most focus group members reported a positive relationship with their supervisors.

CPIs reported that teamwork is one of the most positive aspects of the job. "We rely on each other a lot. You know, experienced workers pass information on. And the new workers coming out of training, they bring with them a gamut of information, as far as, the system." Other aspects of teamwork were described as CPIs coming together to help with interviewing large families and CPIs "tag-teaming" on cases (e.g. one co-worker will help another with a severe case if they have a case that is not severe). Having access to the school system information and other resources were also disclosed as helpful for CPIs.

Summary. The findings presented in this section highlight key themes emerging from a set of focus groups with Child Protective Investigators across five circuits. The focus groups were designed to elicit CPI perceptions regarding their role, the needs of system involved families, critical components of child welfare practice, and current strengths and challenges of the child welfare system in Florida. The findings indicate that CPIs have a strongly child-centered approach, viewing child safety and well-being as their primary concerns, but also expressing a preference for family preservation. Removing children was considered a last resort, and is determined by a joint decision-making process involving the CPI, supervisor, administrators, and Children's Legal Services. While CPIs generally prefer not to remove

children, they expressed considerable concerns about what they perceived to be insufficient safety plans and the reliability of families and collaterals to uphold them.

CPIs utilize a variety of methods to provide a holistic and comprehensive assessment of a family's needs in order to identify service interventions and make safety determinations. It was emphasized that the current assessment process is less incident-driven than in the past and geared more towards assessing the family's functioning. The amount of time and effort it takes to complete these assessments, however, presents a considerable challenge for CPIs given their current caseloads. A lack of sufficient services or excessive waitlists for available services were also reported as a significant challenge across circuits, with the most commonly reported service needs being housing, transportation, daycare, and psychiatric services. Furthermore, there was a sense that providers and other external agencies do not understand child welfare and that there is a lack of shared understanding across agencies, described here as a lack of system cohesion.

Additional challenges include poor worker retention, understaffing, and burnout within the CPI offices. Primary supports, on the other hand, were reported to be supervisors and co-workers, with CPIs emphasizing the importance of teamwork. Overall, these findings suggest several factors that impact removal decisions and the use of in-home services: the lack of trust in safety plans and insufficient availability of services are particularly likely to contribute to a CPI's decision to remove a child rather than trying an in-home intervention. It is critical for communities to increase the array of in-home services in order to maintain more children safely in the home.

Next Steps. A detailed, comprehensive analysis of the combined case management and child protective investigator focus groups is currently in process and will be provided in the next semi-annual progress report. Also for the next reporting period, the service array survey will be administered throughout the state. The proposed plan includes two distinct surveys, one for CBC lead agencies and one for front-line staff, which will be administered using a web-based survey program. The current timeline is to complete this data collection by the end of February 2017, in order to present the results in the next semi-annual report. Additionally, a final decision will be made in the next few months about which evidence-based practices will be selected for the fidelity assessment component.

Outcome Analysis

Safety and Resource Family Indicators

The IV-E Waiver legislation was developed as a fiscal mechanism that provides greater flexibility to child welfare agencies in developing services and prevention efforts including

prevention of entry into out-of-home care (James Bell Associates, 2015). Although removing children from their homes is utilized as a last resort, out-of-home placement is sometimes required to ensure the child's safety (USDHHS, 2015). When out-of-home care is utilized, child safety while in out-of-home care becomes even more important to avoid re-victimization or further abuse. In this context foster parents become important partners in ensuring child safety and well-being because a substantial proportion (48% nationwide) of children are placed in foster care (Kids Counts, 2011). An assumption of foster care is that the child is moving to a secure location and residing in a safer place compared to the home where the abuse or neglect occurred. However, recruitment of foster parents who are able to provide a nurturing environment can be challenging. Therefore, it is important to examine whether sufficient numbers of foster parents are recruited, whether these parents are retained, and whether children remain safe with these families. Specific indicators were developed and calculated to address these research questions. 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

Methods. The outcome analysis for this report tracks changes in several successive fiscal years (SFY 11-12, SFY 12-13, SFY 13-14, SFY 14-15, and SFY 15-16 for some measures) during which potential foster parents were recruited and licensed. Additionally, changes in the abuse rate for children who were in licensed foster care over the course of four years (i.e., SFY 11-12, SFY 12-13, SFY 13-14, and SFY 14-15) were examined. Data provided by the Department include "the listing of children in foster care during the selected report period." All indicators were calculated at the circuit and state levels, and cohorts were constructed based on a state fiscal year. The following indicators were examined:

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

Sources of data. The data source for the quantitative measures used in this component of the report are data abstracts taken from the Florida Safe Families Network (FSFN).

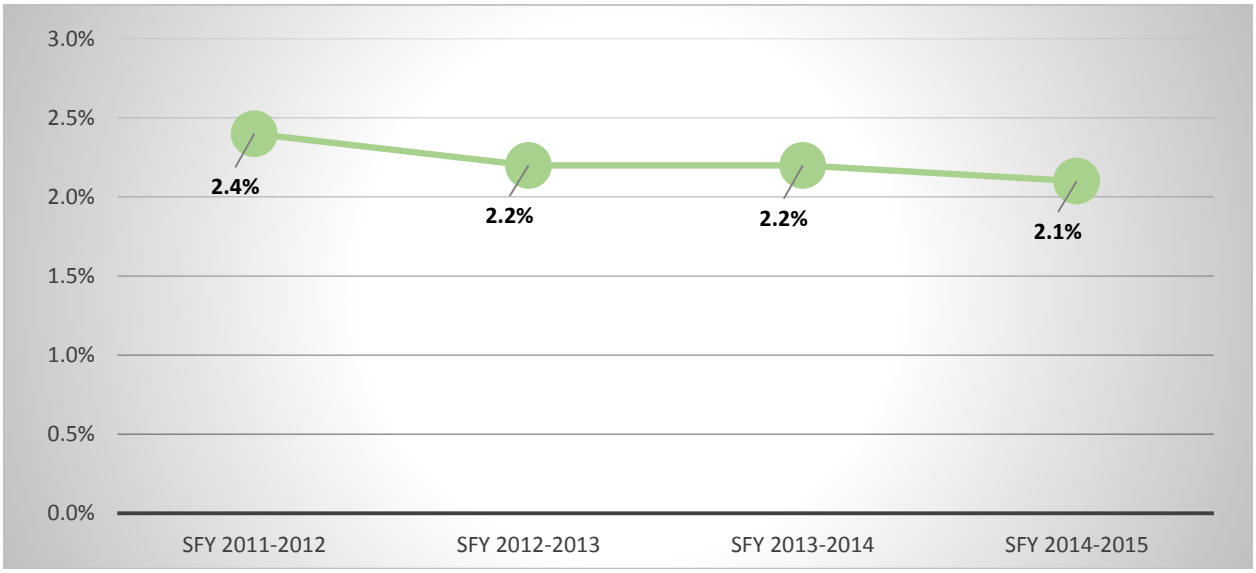
Data Analysis. Statistical analyses consisted of analysis of variance (ANOVA) and chi-square test. All analyses were conducted using SPSS software.

Findings.

Abuse during foster care by fiscal year. This report provides the rate of verified maltreatment reports during the youth's time in foster care (see description of the measure in

Appendix A, Measure 1[3]). Overall, the statewide rate of abuse in licensed foster care through the four-year period between SFY 11-12 and SFY 14-15 is less than 5% (see Figure 2). 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 (see Figure 2 and Appendix F, Table F1).

Figure 2. Rate of Verified Child Maltreatment Reports During Foster Care in the State of Florida by Cohort

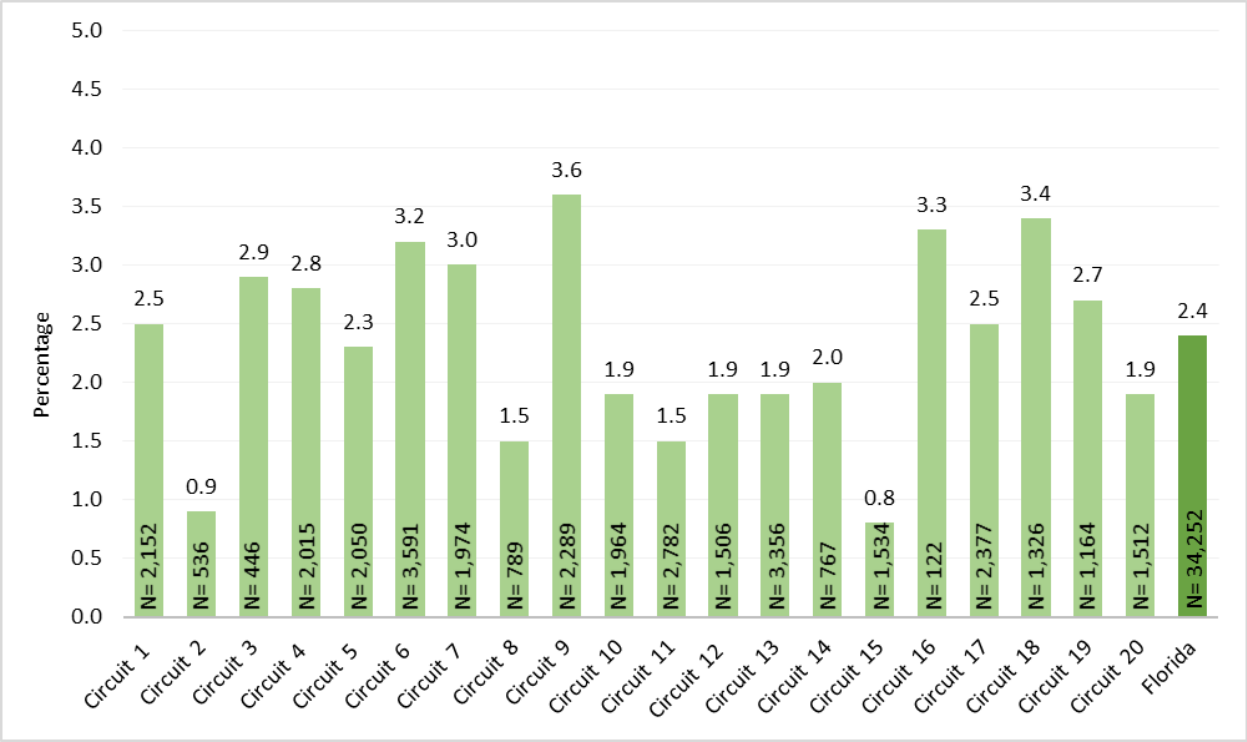


Note. Data Source: FSFN, Run Date: 10-03-2016

As shown in Figure 3 during SFY 11-12, Circuit 9 had the highest rate of child maltreatment while in licensed foster care (3.5%). Circuit 15 had the lowest rate of child maltreatment during services (0.8%). The average rate of child maltreatment while in licensed foster care in SFY 11- 12 for the State was 2.4%.

[3] The Department calculated this measure.

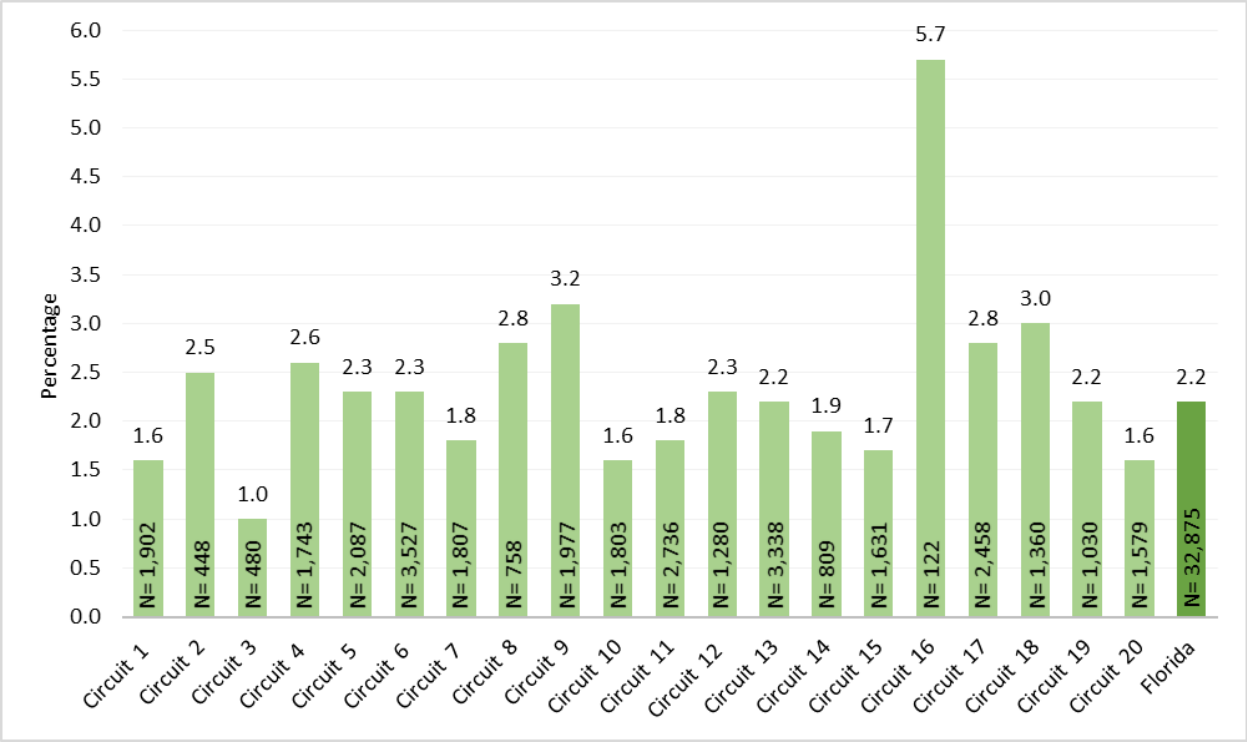
Figure 3. Rate of Verified Child Maltreatment Reports During Foster Care in the State of Florida by Circuit in SFY 11-12



Note. Data Source: FSFN, Run Date: 10-03-2016

During SFY 12-13, Circuit 16 had the highest (5.7%) and Circuit 3 had the lowest (1%) rate of child maltreatment for children in licensed foster care. The average rate of child maltreatment statewide for children in licensed foster care in SFY 12-13 was 2.2% (see Figure 4).

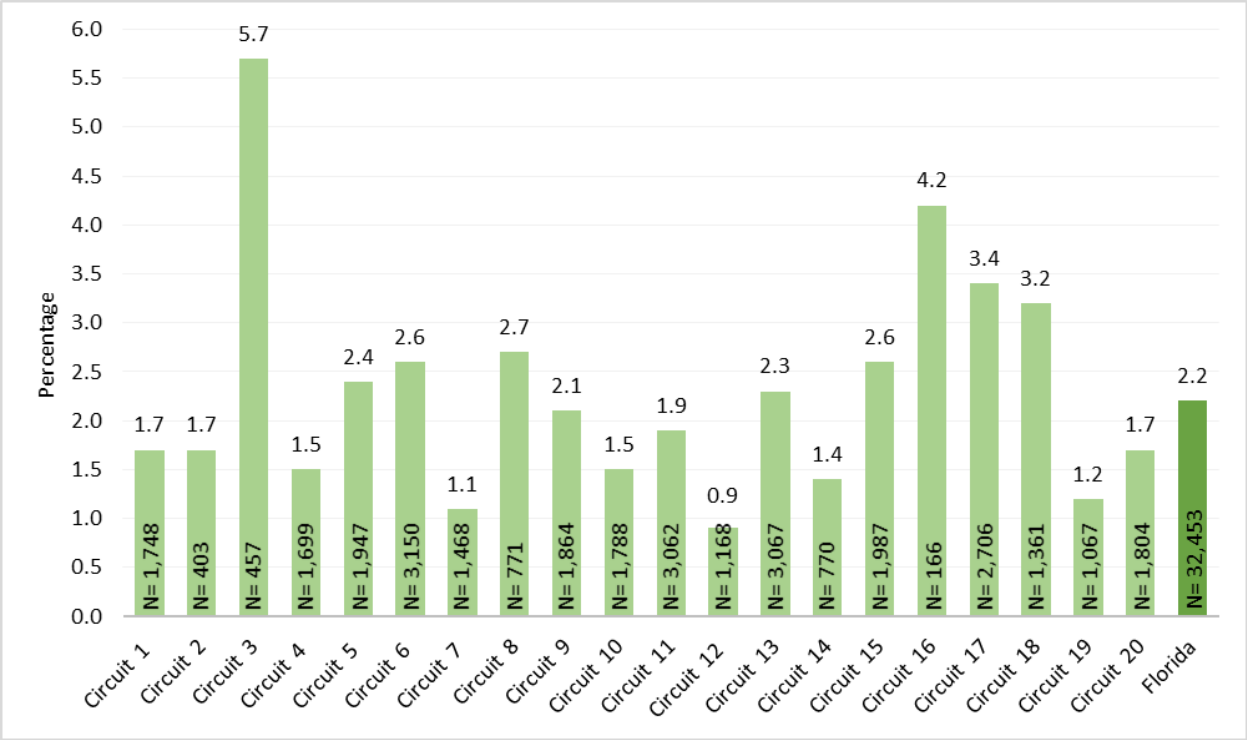
Figure 4. Rate of Verified Child Maltreatment Reports During Foster Care in the State of Florida by Circuit in SFY 12-13



Note. Data Source: FSFN, Run Date: 10-03-2016

In SFY 13-14, Circuit 3 had the highest rate of child abuse or neglect experienced by children in licensed foster care (5.7%), and Circuit 12 had the lowest rate of child maltreatment for children in licensed foster care (1%). The average rate of child maltreatment for children in licensed foster care statewide in SFY 13-14 was 2.2% (see Figure 5).

Figure 5. Rate of Verified Child Maltreatment Reports During Foster Care in the State of Florida by Circuit in SFY 13-14

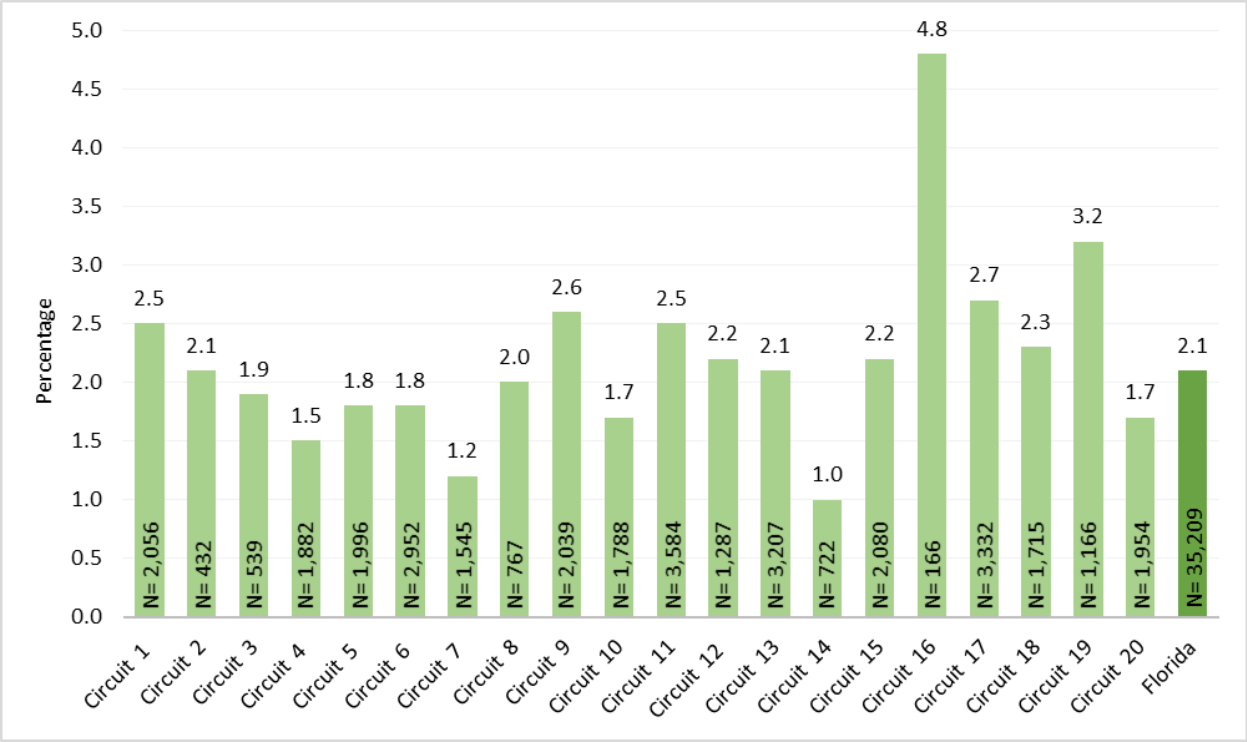


Note. Data Source: FSFN, Run Date: 10-03-2016

Circuit 16 had the highest rate of child maltreatment during services (4.8%) in SFY 14-15, and Circuits 7 and 14 had the lowest rate of child maltreatment during services (1.1% and 1%, respectively). The average statewide rate of child maltreatment during services in SFY 14-15 was 2.1% (see Figure 6).[4]

[4] The Department calculated this measure

Figure 6. Rate of Verified Child Maltreatment Reports in the State of Florida by Circuit in SFY 14-15



Note. Data Source: FSFN, Run Date: 10-03-2016

The number and proportion of new licensed foster families that were recruited during a specific fiscal year and have remained in an active status for at least 12 months. This measure examined the subset of foster families who were recruited for the first time during a specific fiscal year and remained in an active status for at least 12 months. The proportions of foster families who were recruited for the first time during a specific fiscal year and remained in an active status for at least 12 months were calculated for SFY 11-12, SFY 12-13, SFY 13-14, and SFY 14-15. Data on new licensed foster families who remained in active status was not available for SFY 15-16. The proportions of new licensed families that have remained in an active status for at least 12 months were calculated based on data from FSFN.

As shown in Table 1, in SFY 11-12 Circuit 10 (Heartland for Children) had the highest proportion (92.9%) of foster families who remained in an active status for at least 12 months after recruitment. In SFY 12-13 Circuit 17 (ChildNet Broward) had the highest proportion (89.0%) of foster families who remained in an active status for at least 12 months after recruitment. In SFY 13-14 Circuit 19 (Devereux Community Based Care) had the highest proportion (94.4%) of foster families who remained in an active status for at least 12 months

after recruitment. In SFY 14-15 Circuit 7 (Heartland for Children) had 85.4% of newly recruited foster families that remained in an active status for at least 12 months.

Table 1[5]

The Proportion of New Licensed Foster Families that were Recruited During a Specific Fiscal Year and have Remained in an Active Status for at least 12 Months

Circuit	**Counties in Circuit**	**Lead Agencies**	**SFY 11-12**	**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
			%	%	%	%
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	78.1	71.2	75.6	77.6
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.*	53.1	61.0	65.1	82.4
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families*	70.3	81.8	81.6	81.1
Circuit 4	Clay, Duval, Nassau	Kids First of Florida, Inc. Family Support Services of North Florida, Inc.	66.5	80.2	84.0	77.9
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	87.9	69.4	69.8	69.2
Circuit 6	Pasco, Pinellas	Eckerd Community Alternatives	71.4	63.6	67.3	64.8
Circuit 7	St. Johns, Flagler, Putnam, Volusia	St. Johns County Board of Commissioners*** Community Partnership for Children, Inc.	66.9	70.8	71.7	85.4
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families*	70.3	81.8	81.6	81.1
Circuit 9	Orange, Osceola	CBC of Central Florida	84.5	87.2	83.6	61.5
Circuit 10	Hardee, Highlands, Polk	Heartland For Children	92.9	65.9	83.7	76.7

[5] In collaboration with the Department, we are currently examining the reasons for a substantial variability across the lead agencies.

Circuit	Counties in Circuit	Lead Agencies	SFY 11-12	SFY 12-13	SFY 13-14	SFY 14-15
Circuit 11	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.*	64.6	38.1	63.6	40.5
Circuit 12	DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	72.6	53.8	90.0	83.9
Circuit 13	Hillsborough	Eckerd Community Alternatives	59.4	61.5	47.8	60.7
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.*	53.1	61.0	65.1	82.4
Circuit 15	Palm Beach	ChildNet, Inc.	57.0	70.0	72.7	75.0
Circuit 16	Monroe	Our Kids of Miami-Dade/Monroe, Inc.*	64.6	38.1	63.6	40.5
Circuit 17	Broward	ChildNet, Inc.	90.6	89.0	73.9	66.1
Circuit 18	Seminole, Brevard	CBC of Central Florida** Brevard Family Partnership**	92.1	67.4	72.7	72.3
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC	83.3	88.0	94.4	84.6
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	73.2	86.9	79.8	60.7
State of Florida			73.3	70.2	73.5	70.0

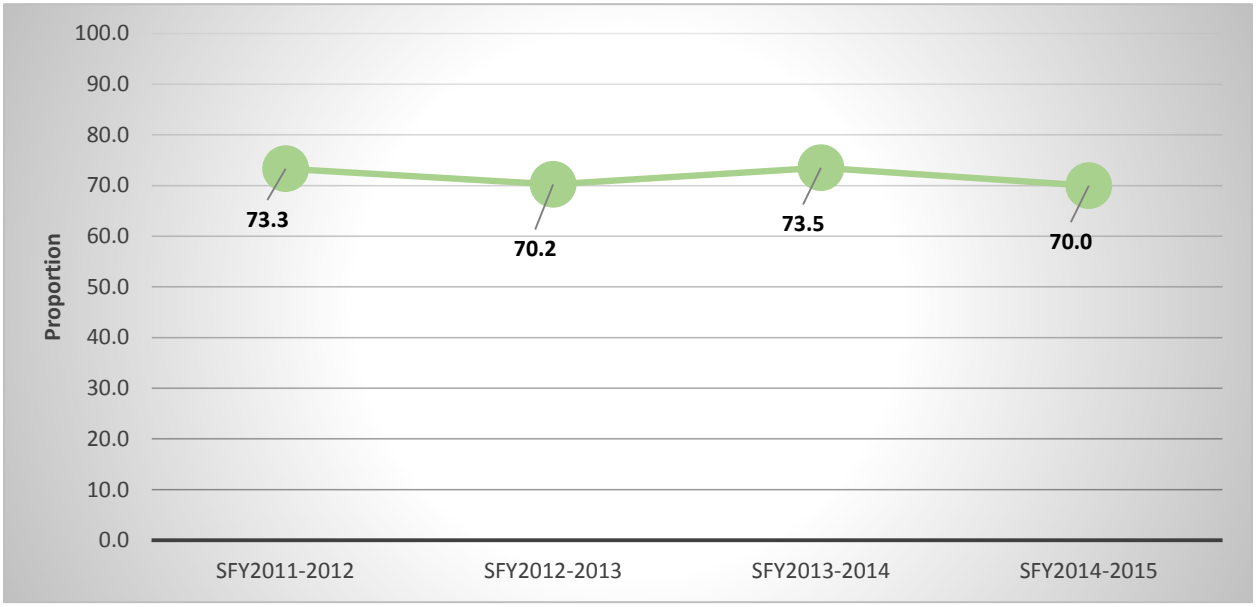
Note. * Because this lead agency serves two circuits, the same proportion of recruited families that remained in an active status for at least 12 months was reported in each circuit.
**The average for the circuit was estimated based on the proportion for each agency.
*** No information was available for this lead agency/Circuit.
Note. Data Source: FSFN, Run Date: 10-24-2016

Big Bend CBC had the lowest proportions of foster families who remained in an active status for at least 12 months during SFY 11-12 (53.1%). During SFY 12-13, and SFY 14-15, Our Kids of Miami-Dade/Monroe had the lowest proportions of foster families who remained in an active status for at least 12 months (38.1% and 40.5%, respectively). Circuit 13 (Eckerd Community Alternatives) was reported to have the lowest proportions of foster families who remained in an active status for at least 12 months during SFY 13-14 (47.8%).

The average proportion of newly recruited foster families that were in an active status for at least 12 months for the state of Florida was 73.3% in SFY 11-12; 70.2% in SFY 12-13; 73.5%

in SFY 13-14, and 70% in SFY 14-15 (see Figure 7). Results of Chi-square test indicated no significant difference between average proportions of newly recruited foster families statewide that were in an active status for at least 12 months across fiscal years (see Appendix F, Table F2).

Figure 7. The Proportions of New Licensed Foster Families that Have Been Recruited and Remained in Active Status for at Least 12 Months in the State of Florida by State Fiscal Year



Note. Data Source: FSFN, Run Date: 10-24-2016

The average number of months that licensed foster families remain in an active status. Table 2 shows the average time (i.e., average number of months) of maintaining an active status for foster families for each circuit. As indicated in Table 2, the average number of months that foster families maintained their active status does not vary much by fiscal year or by circuit. The longest time period (12 months) that foster families maintained their active status was observed for Circuit 18 (Community Based Care of Central Florida-Seminole and Brevard Family Partnership) in SFY 12-13. The shortest time period (8 months) foster families maintained their active status was observed for Circuit 13 (Eckerd Community Alternatives - Hillsborough) in SFY 12-13.

Table 2

The Average Number of Months Licensed Foster Families Remained in an Active Status by State Fiscal Year

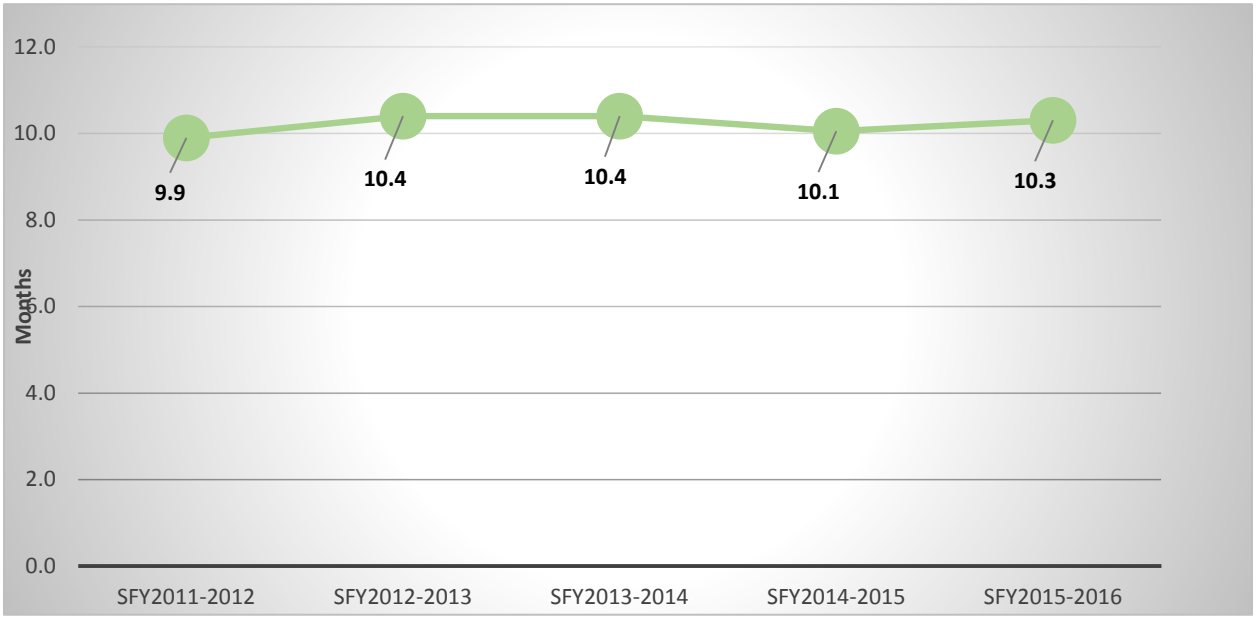
Circuit	Counties in Circuit	Lead Agencies	SFY 11-12	SFY 12-13	SFY 13-14	SFY 14-15	SFY 15-16
Circuit 1	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network	11	11	11	10	12
Circuit 2	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.*	9	10	10	10	10
Circuit 3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families*	9	10	10	11	10
Circuit 4	Clay, Duval, Nassau	Kids First of Florida, Inc. Family Support Services of North Florida, Inc.	9	10	11	10	10
Circuit 5	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.	11	11	10	11	11
Circuit 6	Pasco, Pinellas	Eckerd Community Alternatives	9	10	9	10	10
Circuit 7	St. Johns, Flagler, Putnam, Volusia	St. Johns County Board of Commissioners Community Partnership for Children, Inc.	----	----	----	----	----
Circuit 8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families*	9	10	10	11	10
Circuit 9	Orange, Osceola	CBC of Central Florida	11	12	12	11	11
Circuit 10	Hardee, Highlands, Polk	Heartland For Children	11	12	12	11	11
Circuit 11	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.*	10	11	10	10	12

Circuit	Counties in Circuit	Lead Agencies	SFY 11-12	SFY 12-13	SFY 13-14	SFY 14-15	SFY 15-16
Circuit 12	DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.	9	9	10	10	9
Circuit 13	Hillsborough	Eckerd Community Alternatives	9	8	9	9	8
Circuit 14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.*	9	10	10	10	10
Circuit 15	Palm Beach	ChildNet, Inc.	9	9	11	10	10
Circuit 16	Monroe	Our Kids of Miami-Dade/Monroe, Inc.*	10	11	10	10	12
Circuit 17	Broward	ChildNet, Inc.	11	10	10	10	9
Circuit 18	Seminole, Brevard	CBC of Central Florida** Brevard Family Partnership**	11	13	12	11	11
Circuit 19	Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC	10	10	12	11	12
Circuit 20	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida	10	10	9	9	10
State of Florida			9.9	10.4	10.4	10.1	10.3

Note. *This agency serves two circuits; the average number of months for the agency was reported in each circuit. **The average number of months for the circuit was estimated based on the average number of months reported by each agency.
Note. Data Source: FSFN, Run Date: 10-24-2016

The average number of months licensed foster families remained in an active status in the state of Florida was 9.9% in SFY 11-12, 10.4% in SFY 12-13 and SFY 13-14, 10.1% in SFY 14-15, and 10.3% in SFY 15-16 (see Figure 8). The results of analysis of variance (ANOVA) indicated that there is no significant difference in the average number of months foster families maintained their active status statewide over time (see Appendix F, Table F3).

Figure 8. The Average Number of Months Licensed Foster Families Remained in Active Status in the State of Florida by State Fiscal Year



Note. Data Source: FSFN, Run Date: 10-24-2016

Summary. Overall, there is limited variability in the rate of child maltreatment during foster care placement for the State of Florida over time. The average rate for the State of Florida ranged from 2.4% in SFY 11-12 to 2.1% in SFY 14-15. Although no significant difference was found, there is a trend indicating improved performance statewide on the examined indicator. Specifically, there is a slight decrease in the number of verified child maltreatment reports received during foster care placement over time.

Likewise, there is limited variability over time in the proportions of new licensed foster families that have been recruited during a specific state fiscal year and remained in an active status for at least 12 months in the State of Florida. For example, in SFY 11-12 the proportions of new licensed foster families that remained in an active status for at least 12 months was 73.3%. It then dropped to 70.2% in SFY 12-13 and then increased by 3% the following year. The average rate for the last three fiscal years for the State of Florida was 71.23%.

Limitations. 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 IV-E Demonstration project was not implemented), because the Demonstration was implemented statewide. Because a comparison group was not available, only longitudinal comparison was feasible. Second, no time by group interaction was examined. Finally, the

findings do not account for the effects of child or family socio-demographic characteristics, any of the lead agency characteristics, or characteristics of the circuits.

Next Steps. The next IV-E Waiver progress report will continue to examine indicators related to the recruitment and retention of the resource families. Specifically, the outcomes section will include an indicator reflecting the number of new licensed foster families recruited each year in relation to the lead agency size. Changes over time will be also assessed. In addition, longitudinal analyses and comparisons of successive annual cohorts of children on critical safety indicators will be conducted. Finally**,** in the next semi-annual progress report, this analysis will be extended to another state fiscal year (SFY 15-16) to further assess trends and changes in performance indicators.

Child and Family Well-Being

In SFY 15-16, Florida transitioned from quality of practice case reviews and quality service reviews, adopting use of the 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.

Key questions. Table 3 below presents the key questions relevant to child and family well-being and their alignment with CFSR performance items. Specifically, these questions focus on an agency's assessment of needs and provision of appropriate services to children and families, involvement of children and families in case planning, case managers' visitation with children and parents, and addressing the physical/dental health, mental/behavioral health, and educational needs of children.

Table 3

Child & Family Well-Being Outcomes: Hypothesis and Evaluation Questions

Well-Being Hypothesis
There will be improvement in the physical, mental health, developmental and educational well-being outcomes for children and their families.
Well-Being Outcome Evaluation Questions
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. The constructs of child and family well-being are examined according to the applicable CFSR outcomes and performance items shown in Table 4. These focus on improving the capacity of families to address their children's needs; and providing services to children related to their educational, physical, and mental health needs. Florida CQI Child and Family Well-Being Outcomes 1, 2, and 3 are rated as Substantially Achieved (SA), Partially Achieved (PA), or Not Achieved (NA); accompanying 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) includes details regarding the review process.

Table 4

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

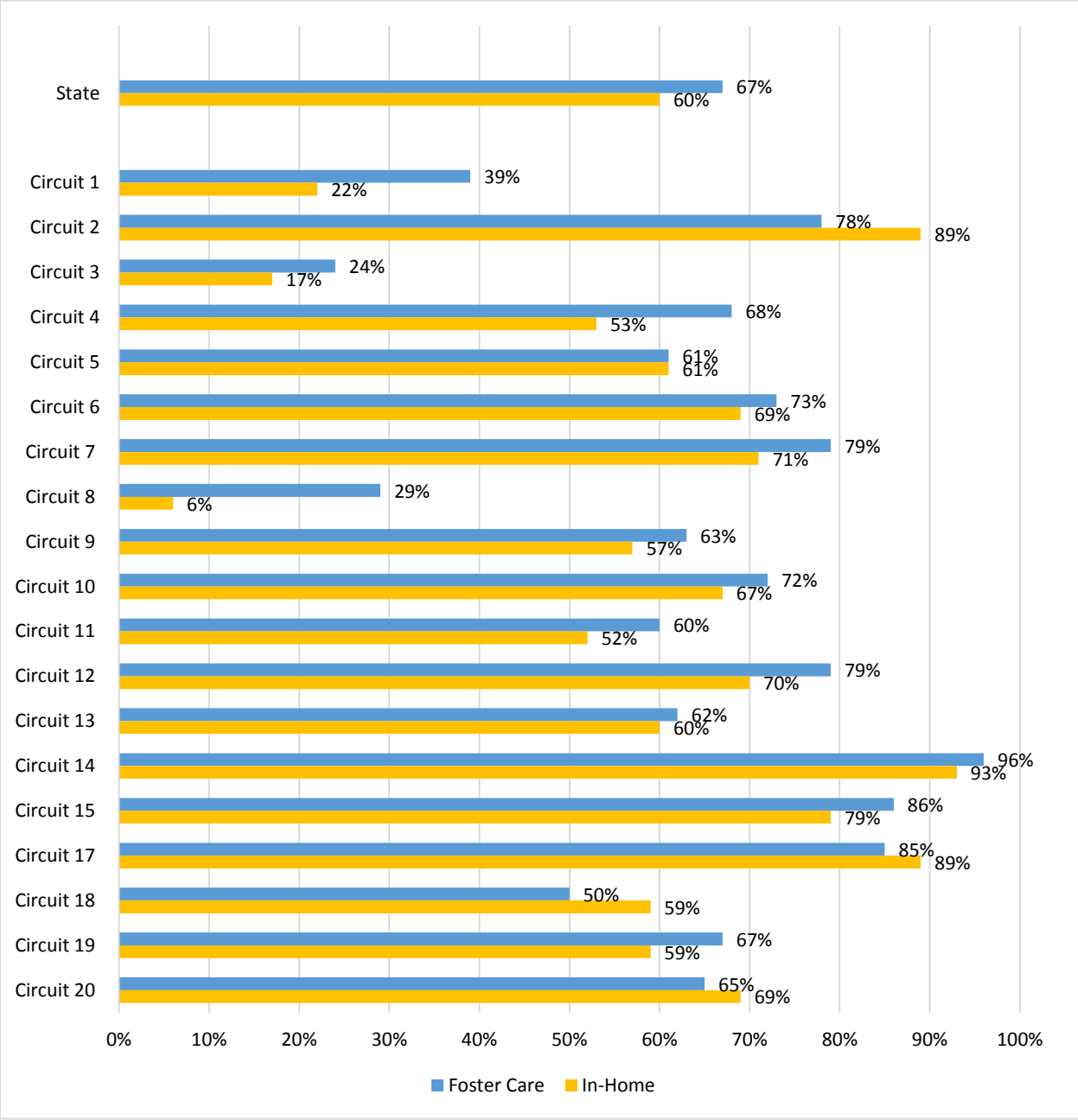
Data analysis. The results below disaggregate outcome and performance item ratings by circuit. However, these data are derived from a live dataset in that cases are reviewed on an ongoing bases. For this reason, the number of applicable cases and accompanying ratings shown below are not final. Results reported below represent completed and finalized Florida CQI data submitted between SFY 15-16 and September 30, 2016 using the federal On-Line Monitoring System (OMS). Further, as Quality Assurance staff continue to familiarize themselves with use of the CFSR tool for case reviews, inter-rater reliability will be improved and the reported findings will be based on their consistent understanding on what the tool is measuring. In addition, the period under review (PUR) for SFY 15-16, is 12 months prior to review of the case. For instance, the PUR for the first quarter of SFY 15-16, is the first quarter of the previous fiscal year. Data for the PUR for SFY 15-16 and Quarter 1 of SFY 16-17 are aggregated and detailed in this report. Circuit 16 (Monroe County) has been omitted from this analysis due to insufficient data; only one case review was completed as of the date the CFSR data were pulled.

Findings.

CFSR well-being outcome 1. The first well-being outcome pertains to enhancement of the family's capacity to provide for the needs of their children. Four performance items (12-15) encompass the first well-being outcome.

Performance item 12. This item pertains to the assessment of needs and the provision of appropriate services for children, parents, and foster parents. Three sub-items are aggregated for this item: needs assessment and services to children, needs assessment and services to parents, and needs assessment and services to foster parents. As shown in Figure 9, statewide, 60% of in-home cases and 67% of foster care cases reviewed were rated as a strength. Although the percentage of cases rated as a strength was similar for both in-home and foster care cases for most circuits, with the exception of a few circuits, a greater percentage of foster care cases were rated as a strength. A substantial number of both in-home and foster care cases were rated as a strength for Circuits 2, 14, 15, and 17. For some circuits (Circuits 1, 3, and 8) a greater percentage of cases, both in-home and foster care cases, were rated as needing improvement.

Figure 9. Needs and Services of Children, Parents, and Foster Parents: Strength Ratings

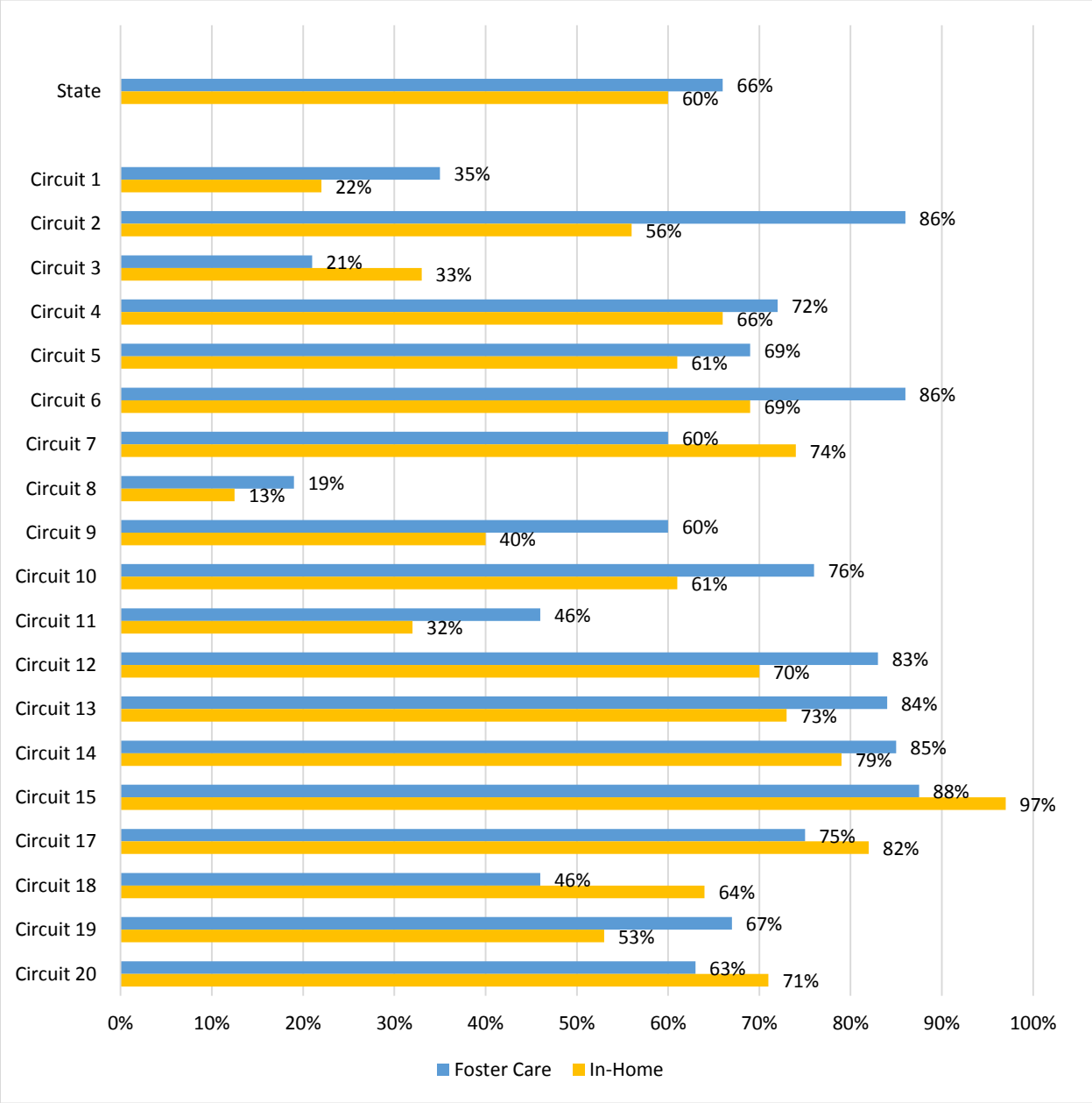


Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

Performance item 13. This item pertains to efforts made to involve the parents and children (if developmentally appropriate) in case planning processes. Statewide, 60% of in-home cases and 66% of foster care cases reviewed were rated as a strength, as shown in Figure 10. Again, although the percentage of cases rated as a strength was similar for both in-home and foster care cases for most circuits, a greater percentage of foster care cases were

rated as a strength, with the exception of a few circuits. At least 75% of both in-home and foster care cases were rated as a strength for Circuits 14, 15, and 17. For some circuits (Circuits 1, 3, 8, and 11) a greater percentage of cases, both in-home and foster care cases, were rated as needing improvement in efforts to involve the parents and children in case planning processes.

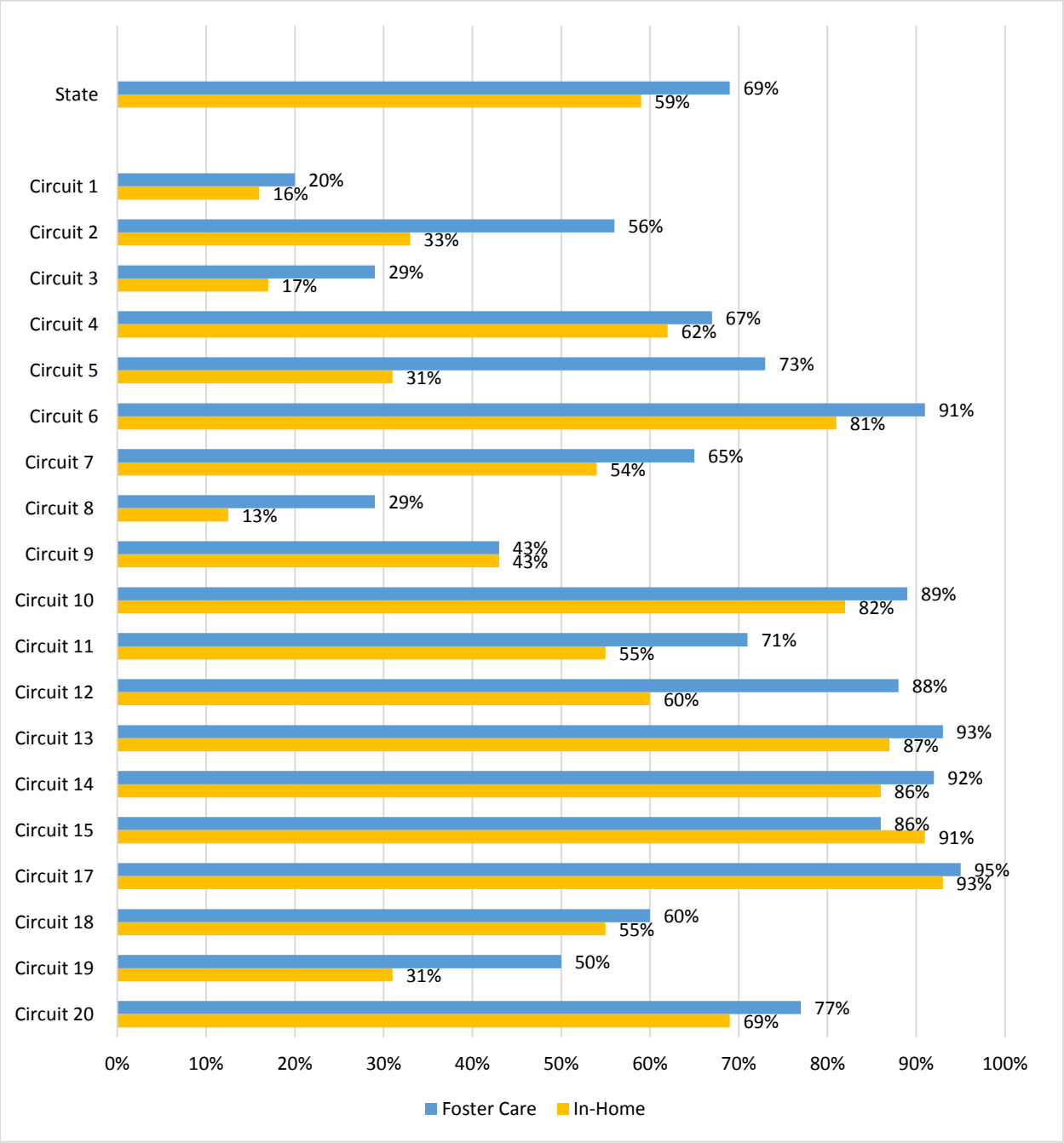
Figure 10. Child and Family Involvement in Case Planning: Strength Ratings



Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

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. As depicted in Figure 11, 59% of in-home cases reviewed and 69% of foster care cases reviewed were rated as a strength statewide. A large majority of circuits showed slightly greater percentages of foster care cases rated as a strength compared to in-home cases. Circuits 6, 13, 14, 15, and 17 had a substantial number of both in-home and foster care cases rated as a strength in the frequency and quality of caseworkers' visits with children. Circuits 1, 3, and 8 showed a markedly greater percentage of cases rated as needed improvement for this item.

Figure 11. Case Worker Visits with Child: Strength Ratings

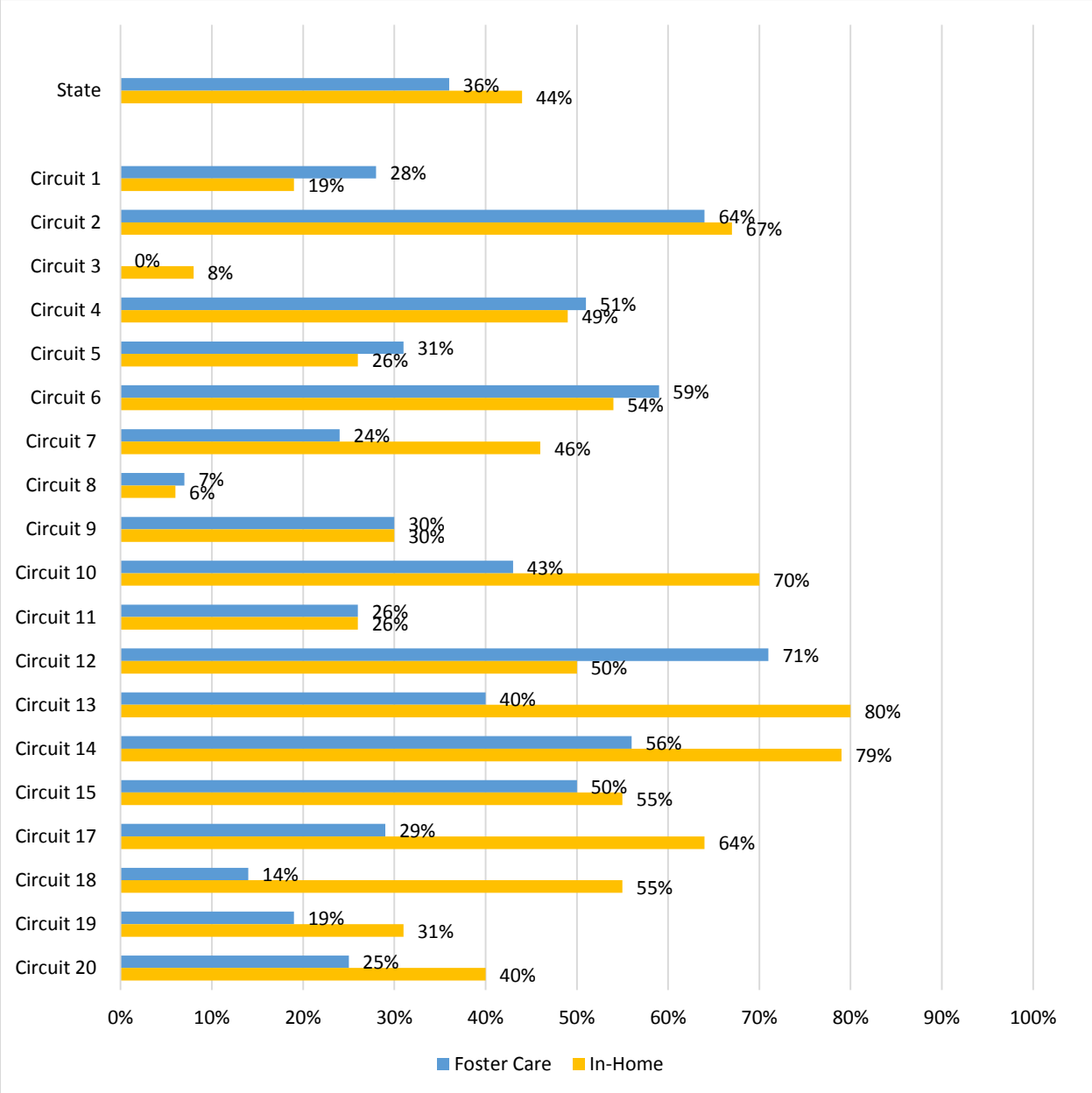


Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

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. As shown in Figure 12, statewide, 44% of in-home cases and 36% of foster care cases reviewed were rated as a strength.

Statewide, a greater percentage of cases were rated as needing improvement in the frequency and quality of caseworkers' visits with children's parents. At the circuit level, a greater percentage of in-home cases were rated as a strength compared to foster care cases. Also, for most circuits, a greater percentage of cases, both in-home and foster care cases, were rated as needing improvement than as a strength.

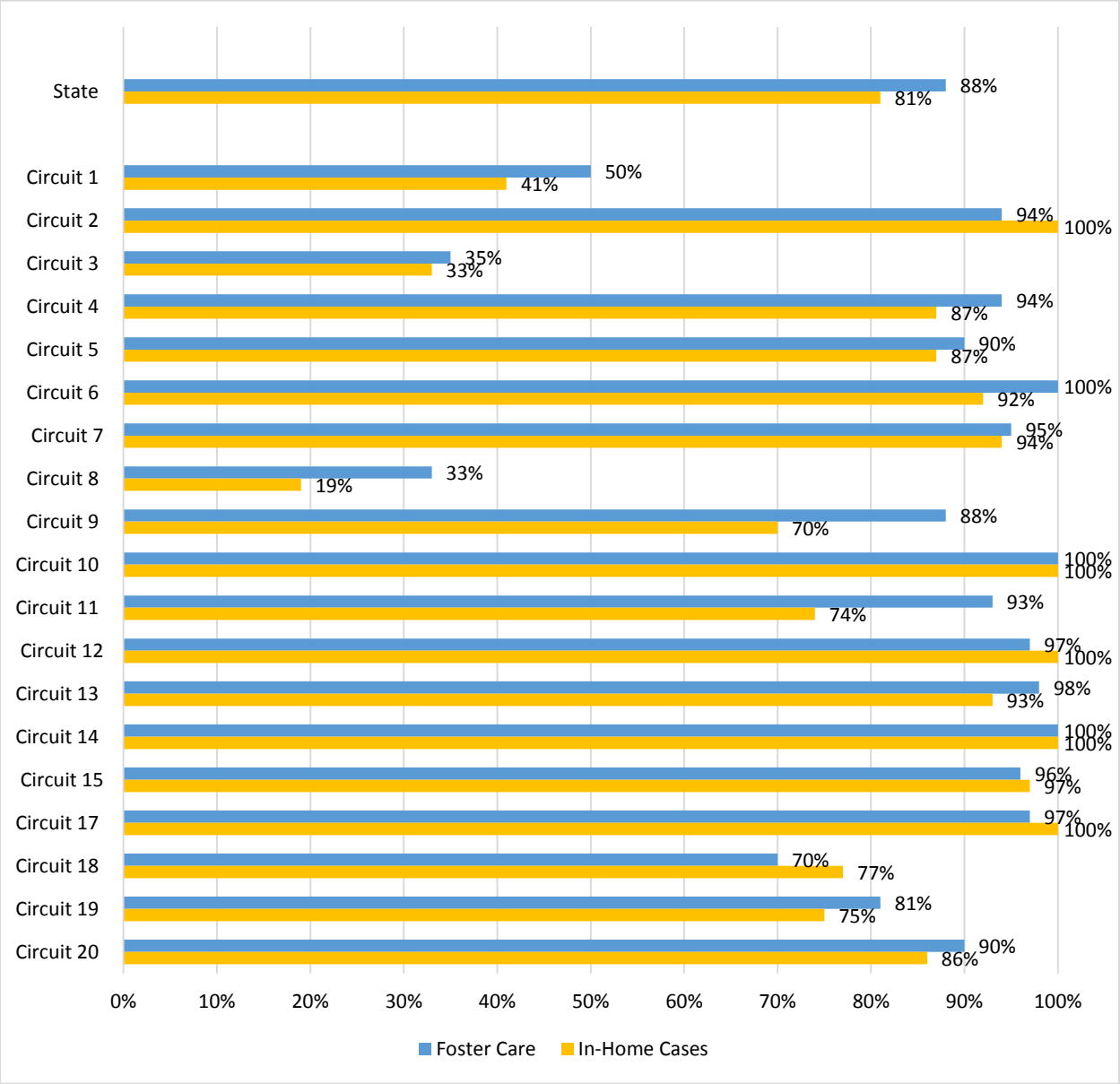
Figure 12. Case Worker Visits with Parents: Strength Ratings



Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

Well-Being outcome 1 ratings. Figure 13 details ratings for this outcome pertaining to families having the enhanced capacity to provide for their children's needs. The ratings shown are a compilation of the ratings for performance items 12 through 15. Of the in-home cases reviewed statewide, 81% met the standards of substantial achievement or partial achievement. The standard for this outcome was not achieved for 19% of in-home cases reviewed. Of foster care cases statewide, 88% met the standards of substantial or partial achievement, and the standard for families having the enhanced capacity to provide for their children's needs was not achieved in 12% of foster care cases. Substantial conformity is defined as a rating substantial achievement for at least 95% of cases reviewed. Circuits 2,10, 12, 14, 15, and 17 were in substantial conformity for in-home cases, and Circuits 6, 7, 10, 12, 13, 14, 15, and 16 met this standard for foster care cases.

Figure 13. Well-Being Outcome 1: Substantial and Partial Achievement Ratings*

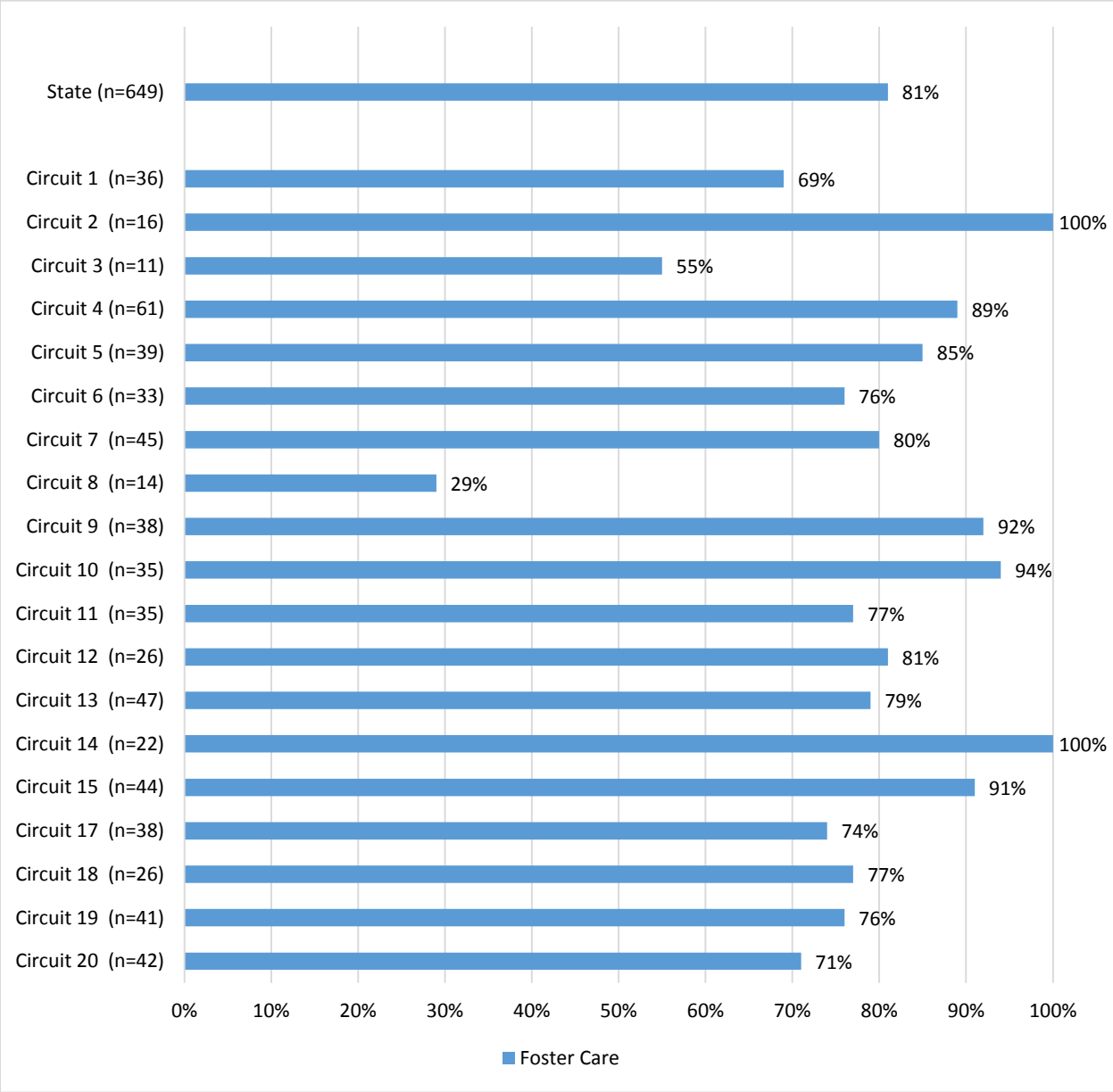


Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016
Note. * Substantially achieved is defined by Performance Item 12 being rated as a Strength and only one of Performance Items 13, 14, and 15 being rated as an Area Needing Improvement. Partially achieved is defined by (1) Performance Item 12 being rated as an Area Needing Improvement and at least one other Performance Item rated as a Strength or (2) Performance Item 12 being rated as a Strength but at least of Performance Items 13, 14, and 15 being rated as an Areas Needing Improvement.

CFSR well-being outcome 2. The second well-being outcome pertains to receipt of appropriate services to meet the educational needs of children. One performance item encompasses this outcome.

Performance item 16. This performance item evaluates efforts made to assess children's educational needs and appropriately address those needs. Due to the few number of applicable in-home cases at the circuit level, the figure below shows only foster care cases. Data pertaining to in-home cases for Performance Item 16 are presented in Appendix G (see Table G6). As shown in Figure 14, 81% of foster care cases reviewed were rated as a strength for this item. For in-home cases, 64% were rated as a strength (not shown in figure). Overwhelmingly, at the circuit level, there was a greater percentage of cases rated as a strength in efforts to assess and address children's educational needs. At least 75% of foster care cases were rated as a strength for 14 circuits and in two circuits (Circuits 2 and 14) 100% of cases were rated as a strength. A substantial percentage of cases were rated as needing improvement under this item for Circuit 8.

Figure 14. Educational Needs of the Child: Strength Ratings for Foster Care Cases

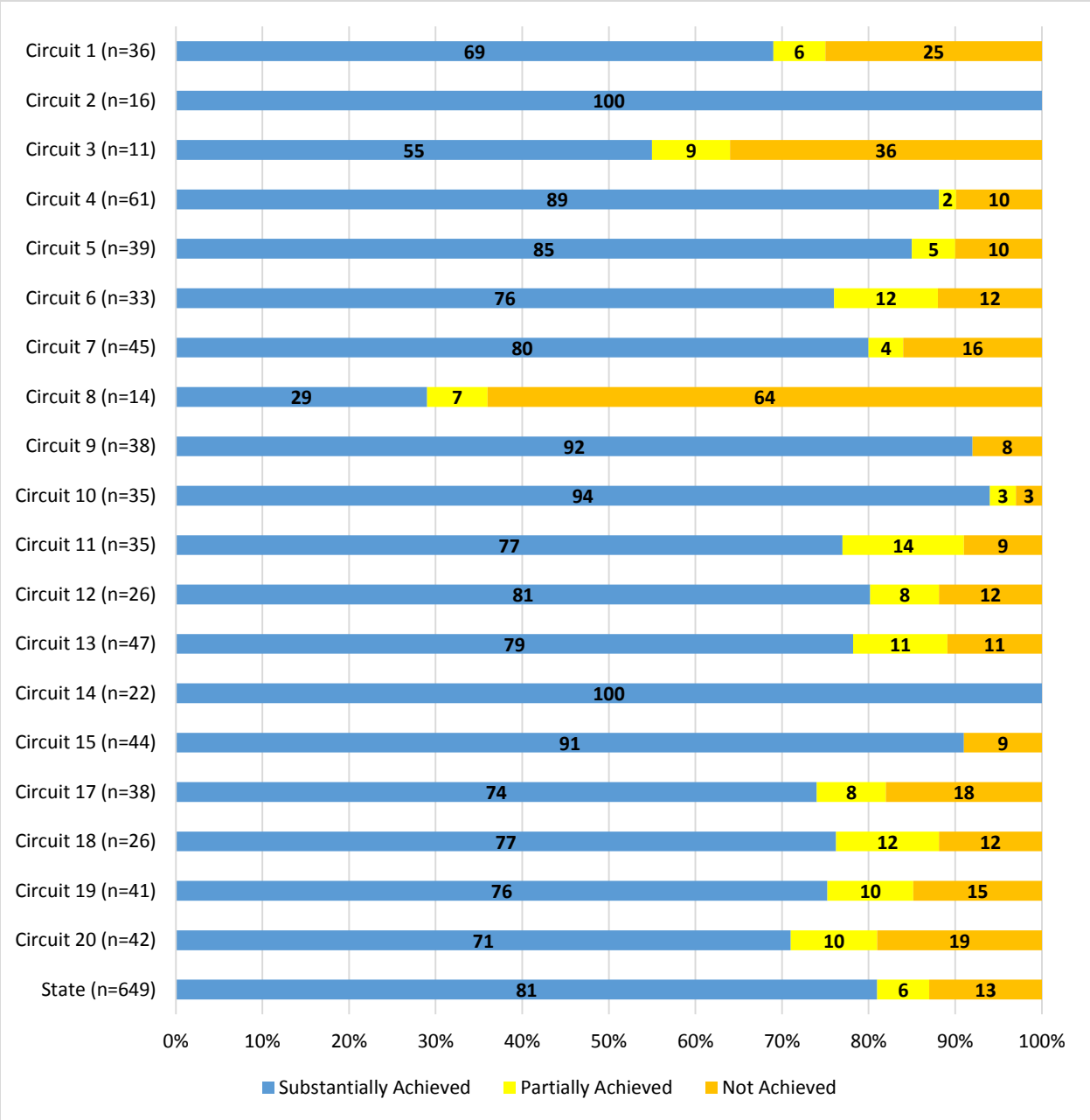


Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

Well-Being outcome 2 ratings. CFSR Well-Being Outcome 2 pertains to receipt of adequate services to meet the educational needs of children. Figure 15 shows ratings for Well-Being Outcome 2 for foster care cases only. Due to the few number of applicable in-home cases at the circuit level, they were not presented in this figure. See Appendix G for data pertaining to in-home cases (see Table G7). As shown in Figure 15, of the foster care cases reviewed statewide, 81% met the standards of substantial achievement in adequately servicing the educational needs of children. An additional 6% of cases reviewed were in partial

achievement for this outcome. Circuits 2 and 14 were in substantial conformity with greater than 95% of cases being rated as substantially achieved. In Circuit 8, the large majority of cases, 64%, were rated as not achieved.

Figure 15. Well-Being Outcome 2 Achievement Ratings

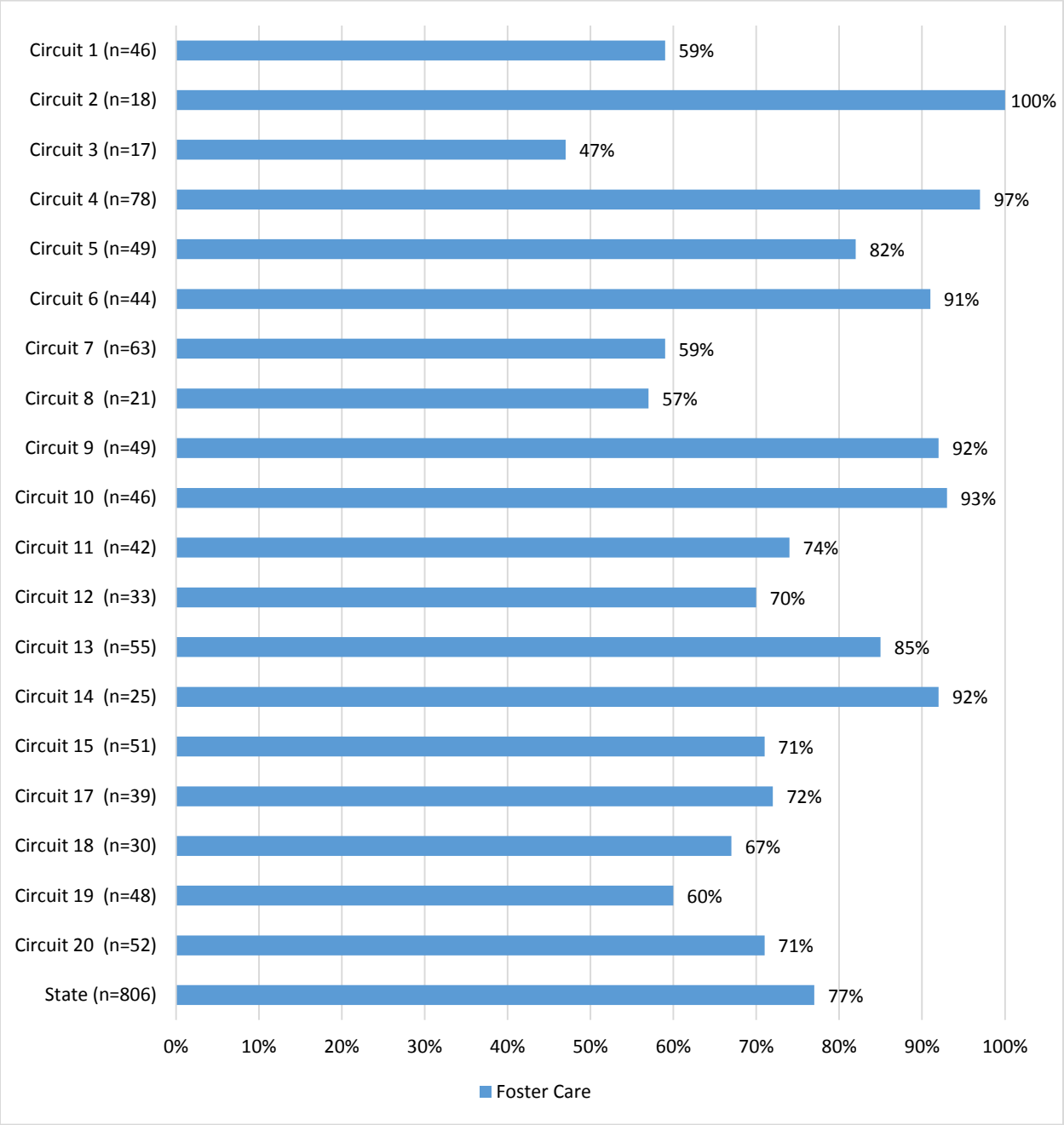


Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

CFSR well-being outcome 3. The third well-being outcome pertains to receipt of adequate services to meet the physical and mental health needs of children. Results of the performance items for this outcome are shown in Figures 16 and 17. Due to the few number of applicable in-home cases at the circuit level, the figures below depict only foster care cases. Data pertaining to in-home cases for Performance Items 17 and 18 and, subsequently, Well-Being Outcome 3, are presented in Appendix G (see Tables G8, G9, and G10).

Performance item 17. This performance item addresses accurate assessment and receipt of appropriate services of the physical health needs of children. This item also addresses children's dental health needs. As shown in Figure 16, 77% of foster care cases reviewed were rated as a strength for this item. For applicable in-home cases, 64% were rated as a strength (not shown in figure). At the circuit level, there was a greater percentage of cases rated as a strength in efforts to assess and address children's physical health needs compared to cases rated as needing improvement. At least 75% of foster care cases were rated as a strength for Circuits 2, 4, 5, 6, 9, 10, 13, and 14, and 100% of cases were rated as a strength for Circuit 2. For Circuit 3, a greater percentage of foster care cases were rated as needing improvement in assessing and serving the physical and dental health needs of children.

Figure 16. Physical Health of the Child: Strength Ratings for Foster Care Cases

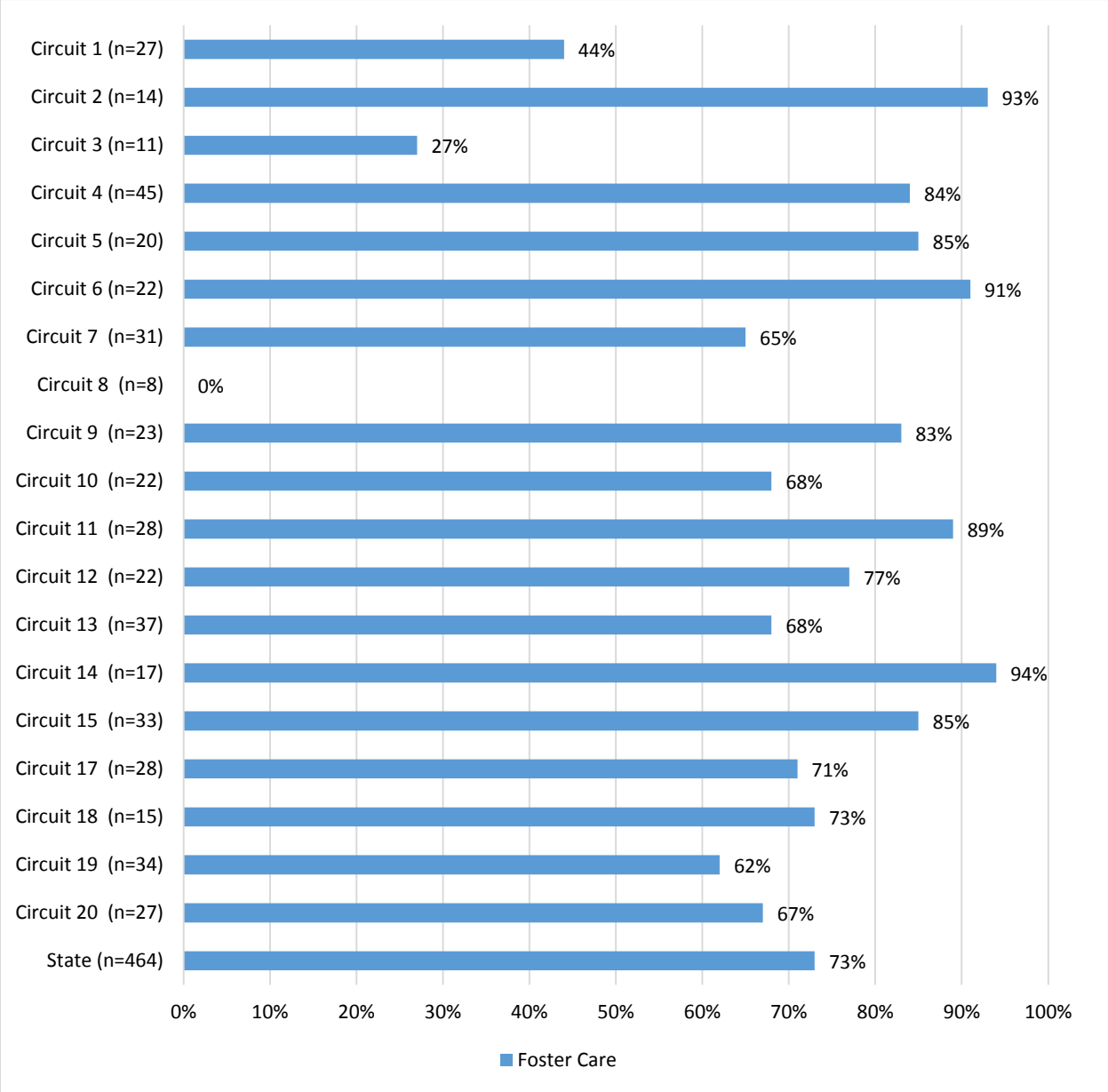


Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

Performance item 18. This performance item addresses accurate assessment and receipt of appropriate services for the mental and behavioral health needs of children. Figure 17 shows 73% of foster care cases reviewed were rated as a strength for this item. Further, 71% of applicable in-home cases were rated as a strength (not shown in figure; see Appendix G, Table G9). Largely, at the circuit level, there was a greater percentage of cases rated as a

strength in efforts to assess and address children's mental and behavioral health needs than cases rated as needing improvement. For Circuit 1, 3, and 8 a greater percentage of foster care cases were rated as needing improvement in this area. In Circuit 8, 100% of foster care cases were rated as an area in need of improvement. At least 75% of foster care cases were rated as a strength for Circuits 2, 4, 5, 6, 9, 11, 12, 14, and 15.

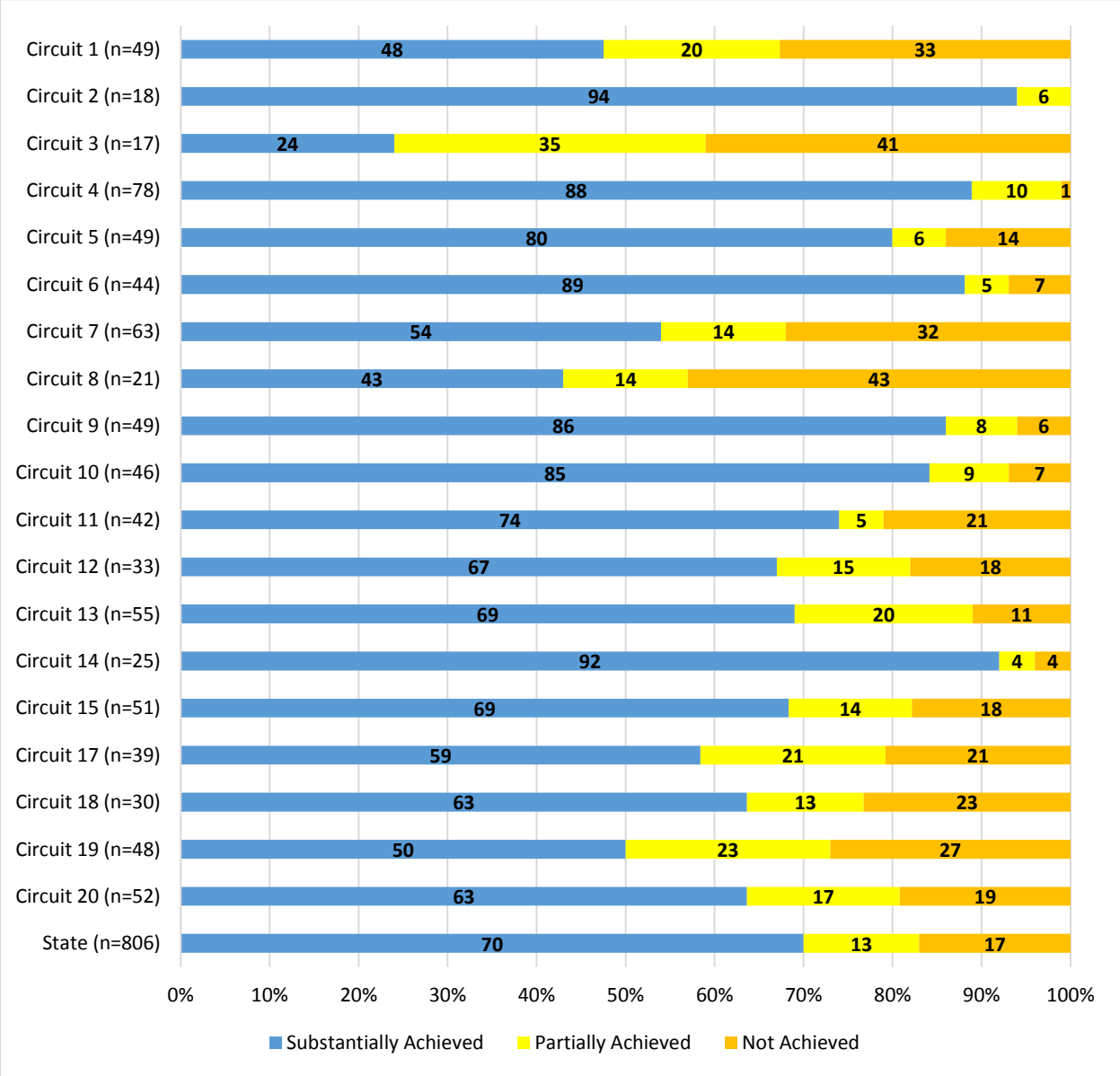
Figure 17. Mental/ Behavioral Health of the Child: Strength Ratings for Foster Care Cases



Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

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. Figure 18 shows ratings for Well-Being Outcome 3 for foster care cases only. As shown, 70% of foster care cases reviewed statewide met the standards of substantial achievement in adequately servicing the physical and mental health needs of children. An additional 13% of cases reviewed were in partial achievement of this outcome. For some circuits, (Circuits 2, 4 and 14) greater than 95% of cases being rated as substantially or partially achieved.

Figure 18. Well-Being Outcome 3 Achievement Ratings



Note. Data source: CFSR Online Monitoring System; Date: 9-30-2016

Summary. Overall, Circuits 2, 10, 14, 15, and 17 most notably, stand out as consistently obtaining strength ratings for the relevant performance items. Circuits 1, 3, and 8, however, appear to be less effective in the quality of child welfare practices relevant to the safety, permanency, and well-being of children. Further, the performance item related to enhancement of a family's capacity to provide for the needs of their children, Well-being Outcome 1, is an area of concern with just 53% of foster care cases and 45% of in-home cases being rated as substantially achieved**.** Concentrated efforts to improve the frequency and quality of case workers visits with parents, focusing on family engagement, would improve scores for this outcome. Generally, ratings for in-home and foster cases were similar at both the circuit-level and state-level but a greater percentage of foster care cases scored as a strength compared to in-home cases. The only exception was with Performance Item 15 related to case workers visit with parents. Subsequent reports for the upcoming state fiscal years will allow for the assessment of trends in CFSRs and progress towards achieving national standards for these outcomes at both the circuit level and the state level.

Next Steps. Previous reports regarding well-being outcomes have aggregated outcomes for in-home cases and foster care cases. Disaggregated findings used in this and future reports may help to better represent well-being outcomes and allow for comparisons to be made for in-home and foster care cases. For this reason, the Florida CQI data presented in this report will now serve as a baseline assessment. Subsequent reports will compare the most recent CQI data with the data shown in this report.

Cost Analysis

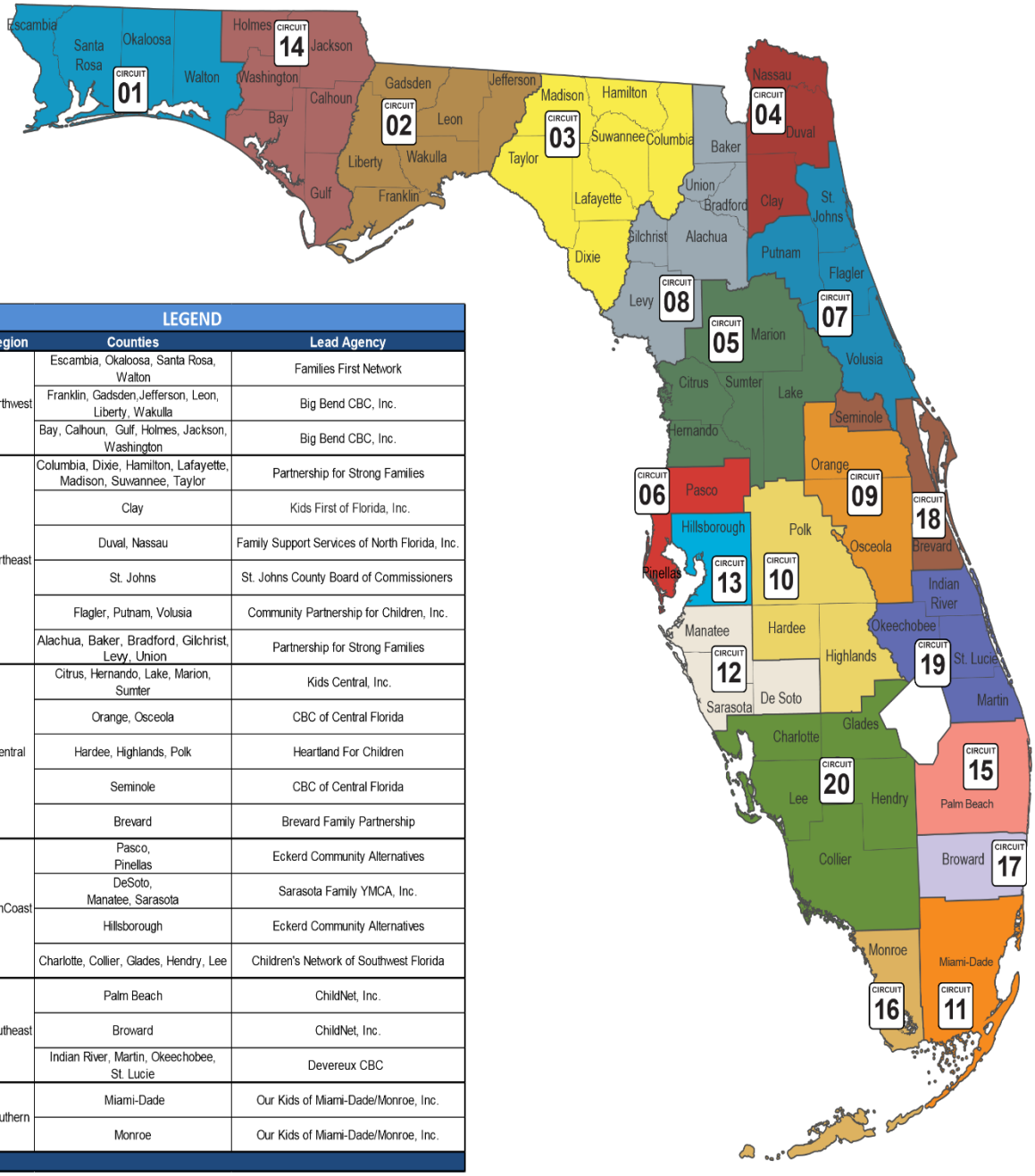
The IV-E Waiver Demonstration was designed to be cost neutral. However, the Demonstration can have important implications for the services provided. During Florida's first five year Demonstration period the Demonstration resulted in a notable shift in expenditures from out of-home services to in-home services. The flexibility provided by the Demonstration gave opportunities to provide more services while the youth were still in the home in hopes of preventing removals. The current analysis seeks to examine whether such trends have continued under the Demonstration extension, and whether the revised Terms and Conditions of the Demonstration extension have led to further changes in the distribution of services. Thus, the analysis compared a pre-Demonstration extension period with a post-Demonstration extension period. There was a IV-E Demonstration in place during the 'pre' period. Consequently, the analysis in this report focused on the 'marginal' effect of the Demonstration extension by comparing the last two years of the original Demonstration period (SFYs 11-12 and 12-13) to the extended Demonstration period (SFYs 13-14 through 15-16).

Methods

Data for each CBC were provided by the Department. Specifically, total expenditures for numerous service categories were reported by year (SFY 11-12 – 15-16). For two CBCs, Eckerd and ChildNet, data was available for each circuit that they serve. For two other CBCs, Big Bend and OurKids, data was not provided at the circuit level. Thus, data for Big Bend includes Circuits 2 and 14, while data for Our Kids include Circuits 11 and 16. Data were reported using the greatest available detail. Figure 19 maps Community-Based Care lead agencies to the circuits that they serve.

Service expenditures were provided based on Other Cost Accumulator (OCA) codes. Trends in overall expenditures were examined, as were expenditures in specific OCA categories. 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). In particular, the analysis determined whether there was a change in expenditures between the two years immediately preceding the Demonstration extension and the three years during the Demonstration extension period. In addition, the study examined the trends in the percentage of total expenditures spent on specific services.

Figure 19. DCF Circuit Map

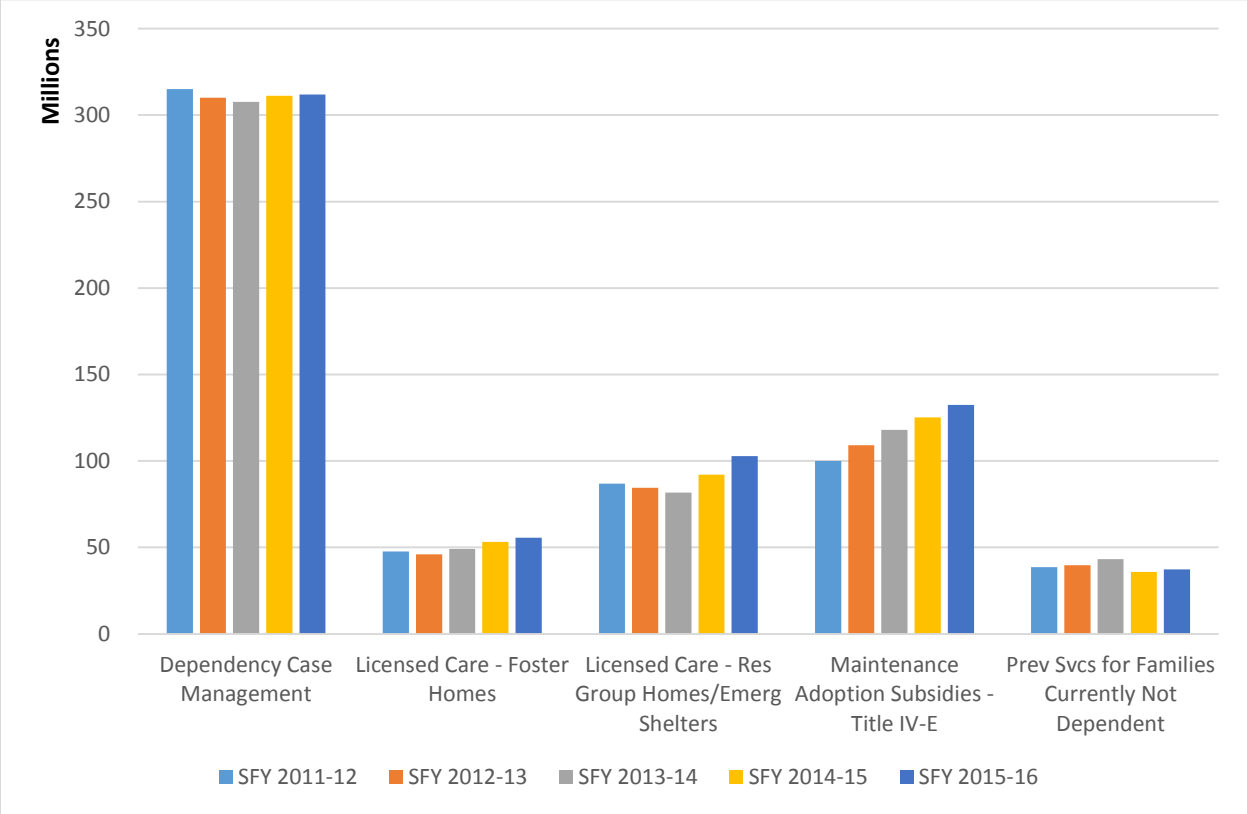


LEGEND				
Circuit		Region	Counties	Lead Agency
	1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network
	2		Franklin, Gadsden,Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.
	14		Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.
	3	Northeast	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families
	4		Clay	Kids First of Florida, Inc.
	4		Duval, Nassau	Family Support Services of North Florida, Inc.
	7		St. Johns	St. Johns County Board of Commissioners
	7		Flagler, Putnam, Volusia	Community Partnership for Children, Inc.
	8		Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families
	5	Central	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.
	9		Orange, Osceola	CBC of Central Florida
	10		Hardee, Highlands, Polk	Heartland For Children
	18		Seminole	CBC of Central Florida
	18		Brevard	Brevard Family Partnership
	6	SunCoast	Pasco, Pinellas	Eckerd Community Alternatives
	12		DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.
	13		Hillsborough	Eckerd Community Alternatives
	20		Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida
	15	Southeast	Palm Beach	ChildNet, Inc.
	17		Broward	ChildNet, Inc.
	19		Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC
	11	Southern	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.
	16		Monroe	Our Kids of Miami-Dade/Monroe, Inc.

Findings

Figure 20 examines total expenditures for specific service categories in each of the five years (SFY 11-12 through SFY 15-16). Maintenance adoption subsidies (IV-E funded) were the only service category with a clear upward trend in expenditures. A simple trend line indicated that maintenance adoption subsidies (IV-E funded) increased a statistically significant $8 million per year (p=.0002). Expenditures were $86.8 million in SFY 11-12 and have increased in each year with expenditures of $132.5 million in SFY 15-16. Other service categories were relatively stable over time, although there were increases in licensed care (foster family care and residential/group care) since the implementation of the Demonstration extension. For example, expenditures for foster family care increased from $46.0 million in SFY 12-13 (the year prior to the implementation of the Demonstration extension) to $55.6 million in SFY 15-16. Similarly, expenditures for residential/group care increased from $84.5 million to $102.7 million.

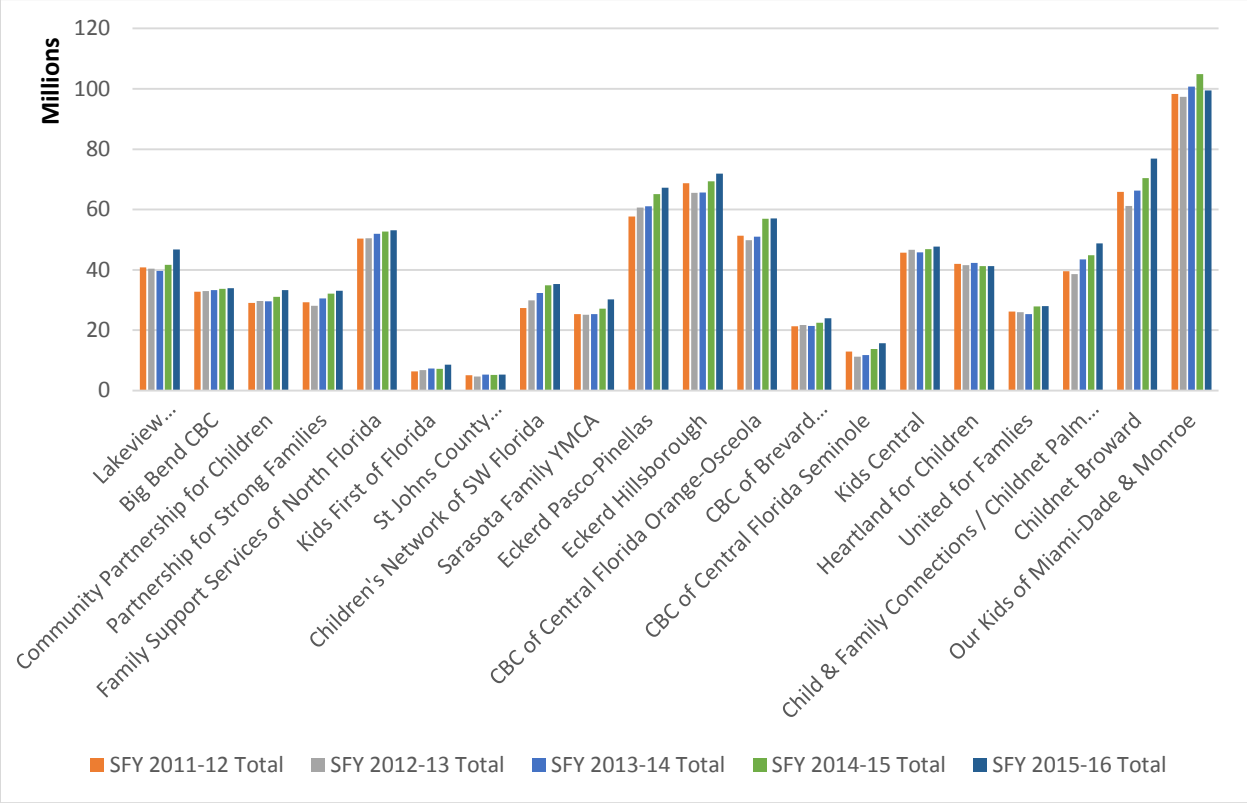
Figure 20. Expenditures for Specific Services by Year



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 21 presents total expenditures reported by each CBC for each of the five years. Total expenditures varied considerably across CBCs. Such differences were expected given the different number of children and youth served by each CBC. Several CBCs had expenditures increase in each of the five years. All but one CBC (St. Johns County) reported an increase in expenditures between SFY 11-12 and SFY 15-16.

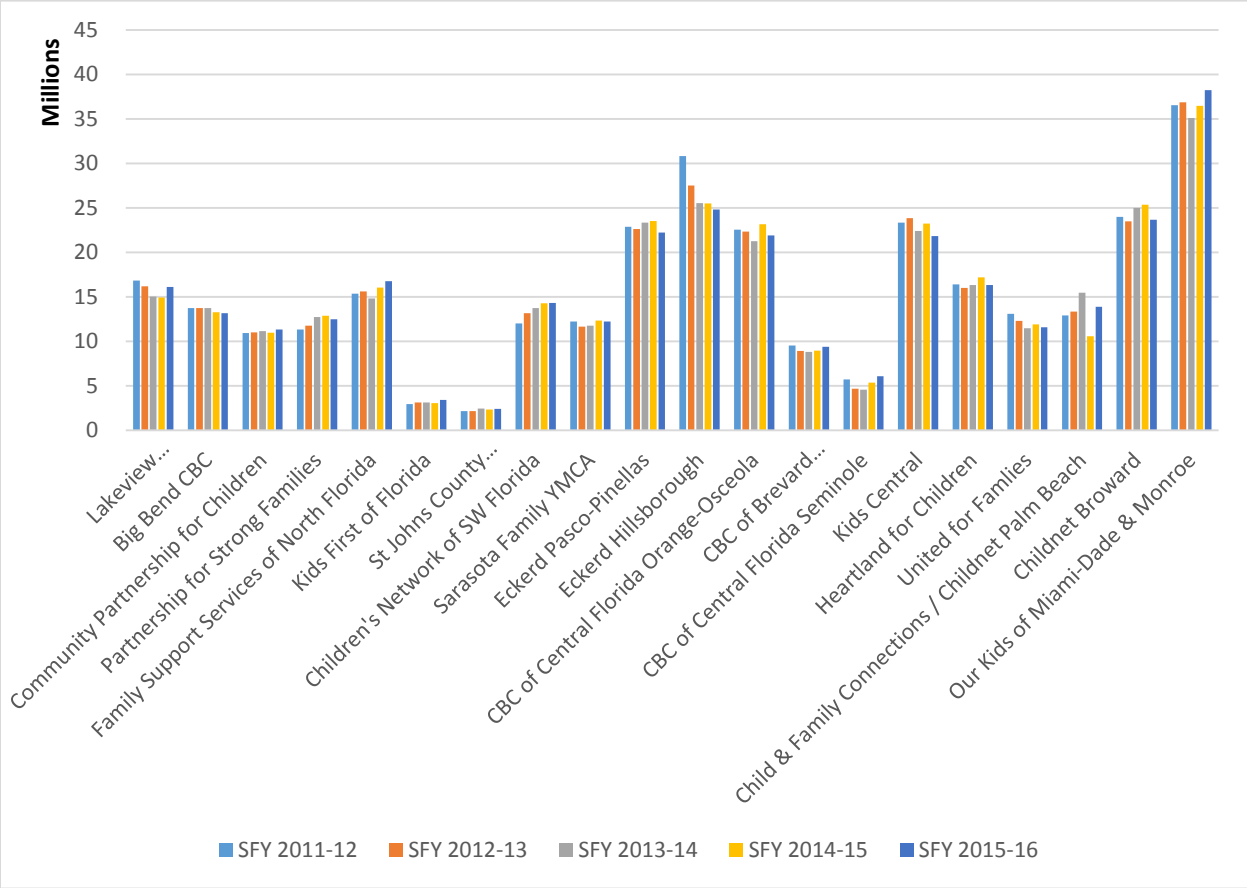
Figure 21. Total Expenditures by CBC by State Fiscal Year



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 22 examines expenditures for dependency case management services. As noted in Figure 20, there was no clear overall trend in dependency case management expenditures over the five years. The results for CBCs were consistent with the lack of a clear trend. Some CBCs had an increase in dependency case management services, while others had a decline in expenditures, and some exhibited no clear trend.

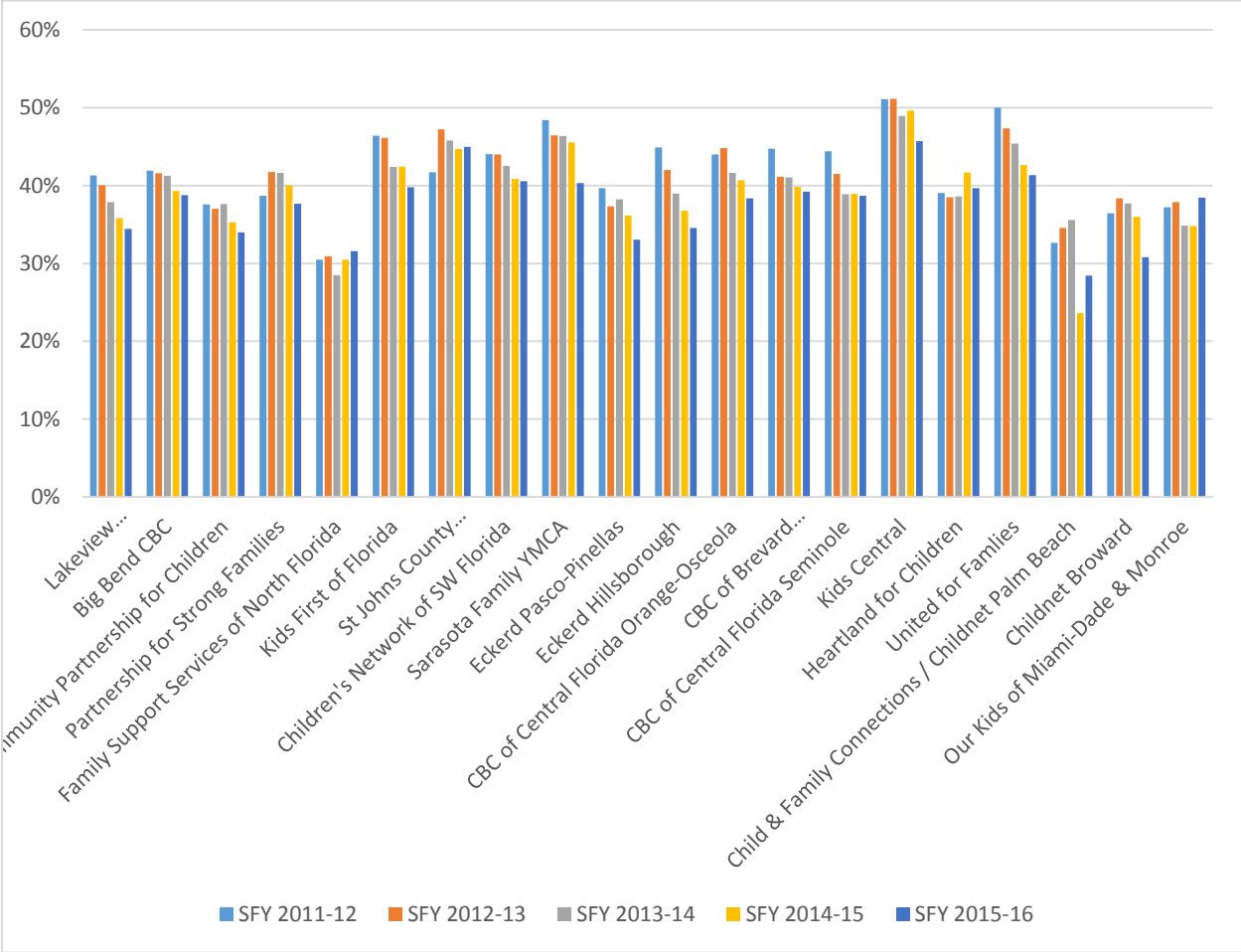
Figure 22. Expenditures on Dependency Case Management Services



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 23 examines expenditures for dependency case management services as a percentage of total expenditures. Dependency case management expenditures made up a considerable portion of total expenditures. However, the results suggest that over time dependency case management services were comprising a smaller proportion of total expenditures. In particular, the percentage for SFY 15-16 was the lowest of the five years for 14 of the 20 observations. Thus, while there was not a clear conclusion regarding trends in dependency case management expenditures, the implementation of the Demonstration extension was associated with a decline in dependency case management services as a percentage of total expenditures.

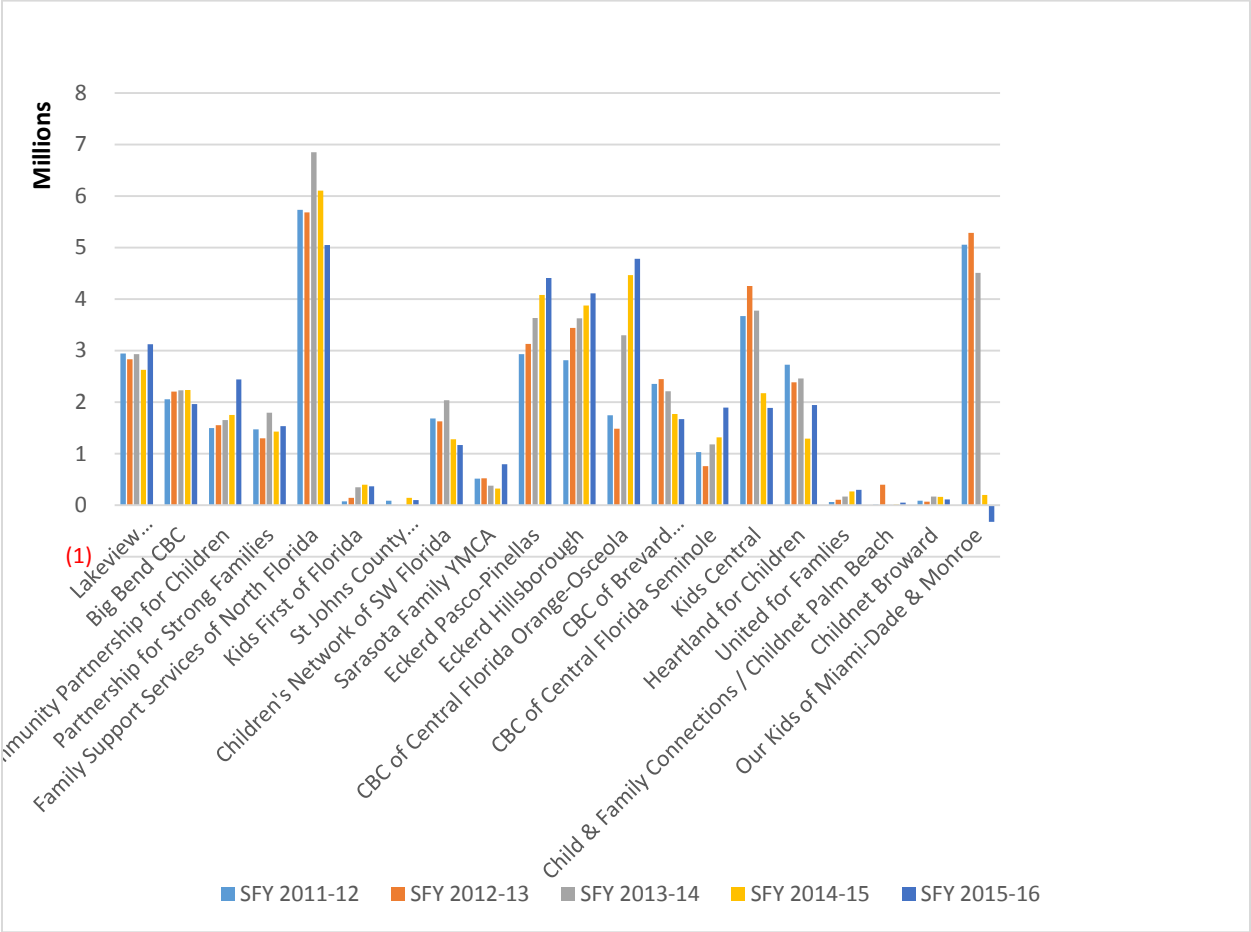
Figure 23. Dependency Case Management Expenditures as a % of Total Expenditures



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 24 examines expenditures for prevention services for families that are not currently dependent. Figure 20 did not show a clear statewide trend over time. Figure 24 illustrates some interesting differences across CBCs. Several CBCs had dramatic increases in reported prevention services, while others had dramatic declines. In particular, one CBC (OurKids) reported expenditures less than zero in SFY 15-16. In addition, most of the changes occurred after the implementation of the Demonstration extension. Given that the Demonstration placed an emphasis on prevention services, the next semi-annual progress report will investigate these changes in more detail.

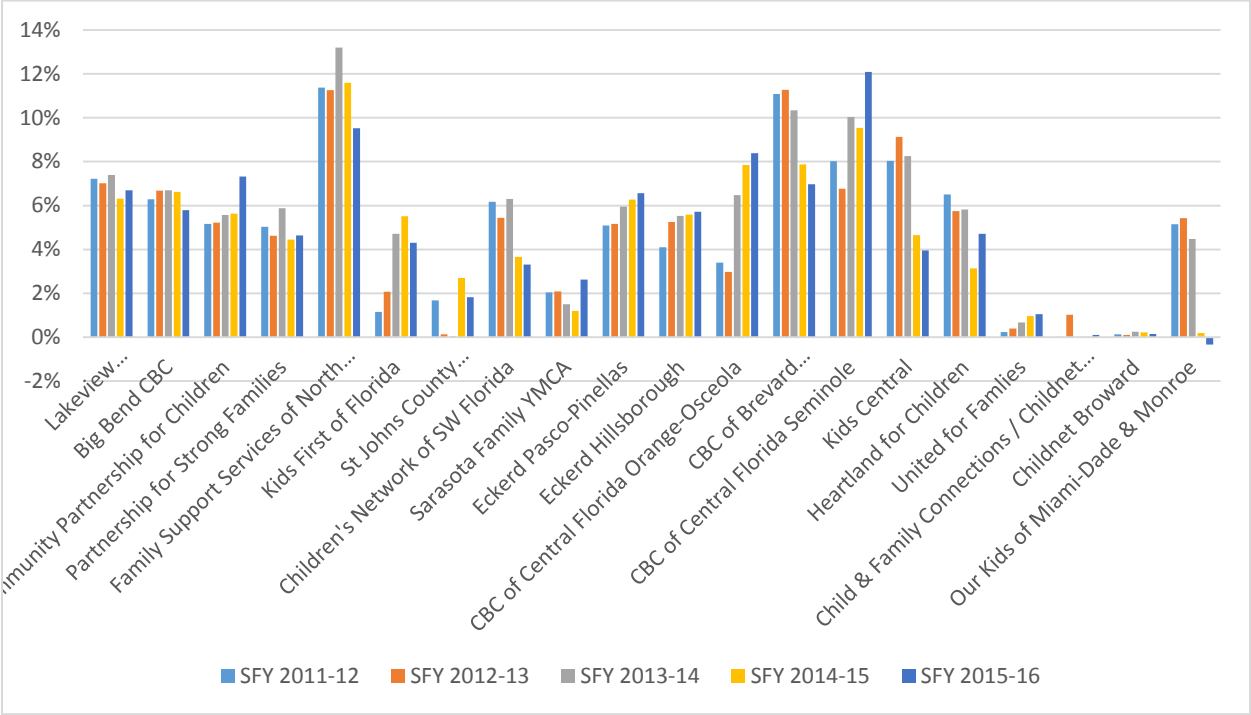
Figure 24. Expenditures for Prevention Services



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 25 examines prevention services expenditures as a percentage of total expenditures. The percentage of total expenditures spent on prevention services varied considerably across CBCs. Some agencies spent about 10% of their total expenditures on prevention services, while others spent less than 2%. Similar to the findings for expenditures on prevention services, there was no clear trend in the proportion of expenditures spent on preventions services. The proportion trended upward for some CBCs, but downward for others.

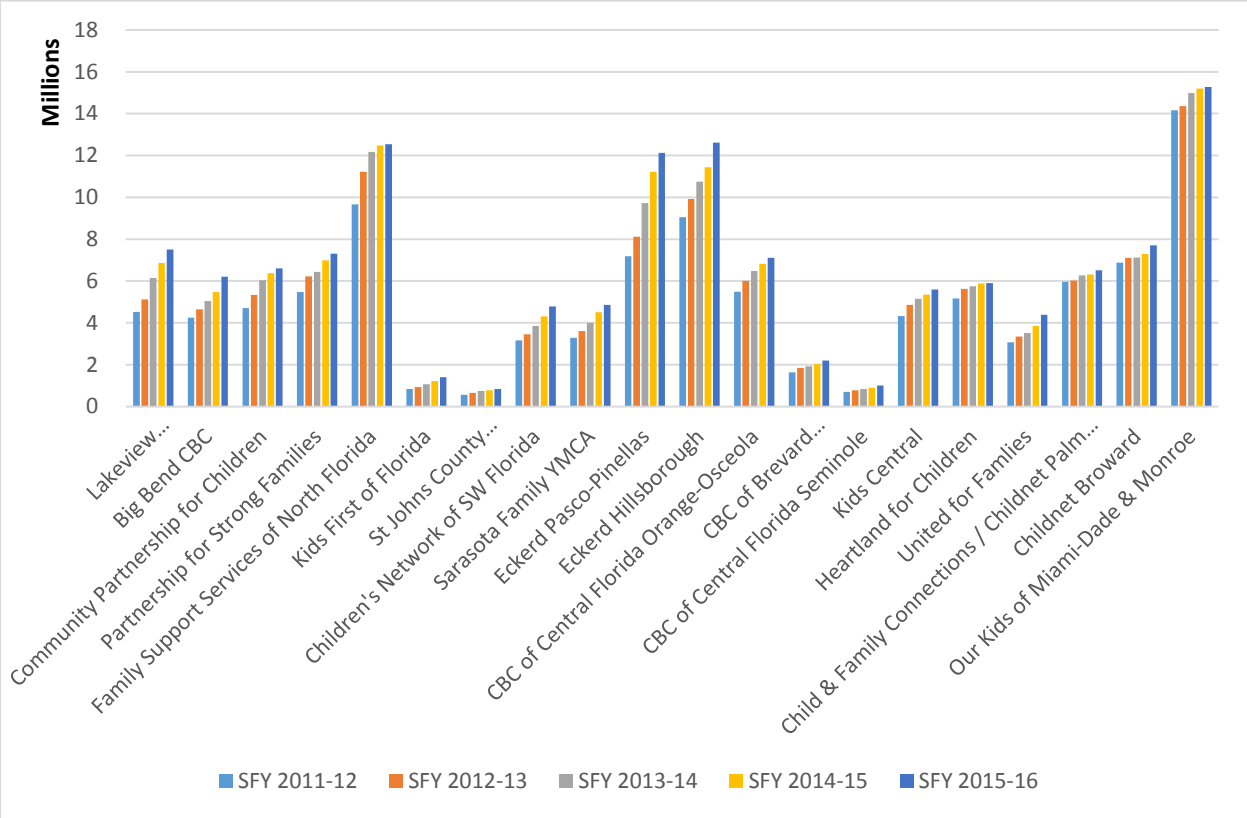
Figure 25. Prevention Services as a % of Total Expenditures



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 26 contains expenditures for Maintenance Adoption Subsidies funded by IV-E. Figure 20 showed a clear, statewide upward trend in Maintenance Adoption Subsidies funded by IV-E. This upward trend is evident for each CBC as well. Perhaps the clearest finding in the analysis was the increased emphasis on adoption that occurred between SFY 11-12 and SFY 15-16.

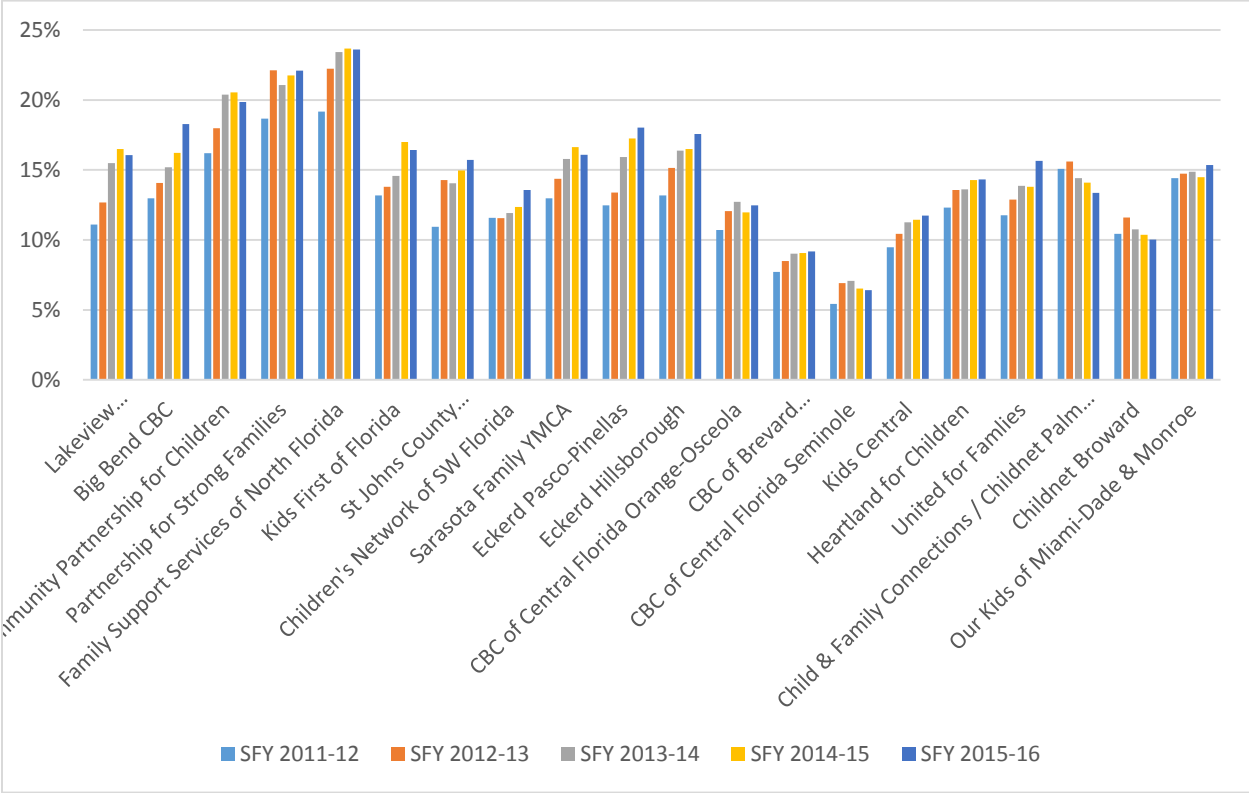
Figure 26. Expenditures for Maintenance Adoption Subsidies IV-E



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 27 contains Maintenance Adoption Subsidies (MAS IV-E) expenditures funded by IV-E as a percentage of total expenditures. Similar to the trend for MAS IV-E expenditures, the proportion was trending upward for most CBCs. Thus, once again, the results indicate that CBCs were placing greater emphasis on adoption services. While the proportion was trending upward, there remained considerable differences in the percentages across CBCs. In some cases, CBCs were spending over 20% of total expenditures on MAS IV-E services while in other cases the percentages were less than 10%.

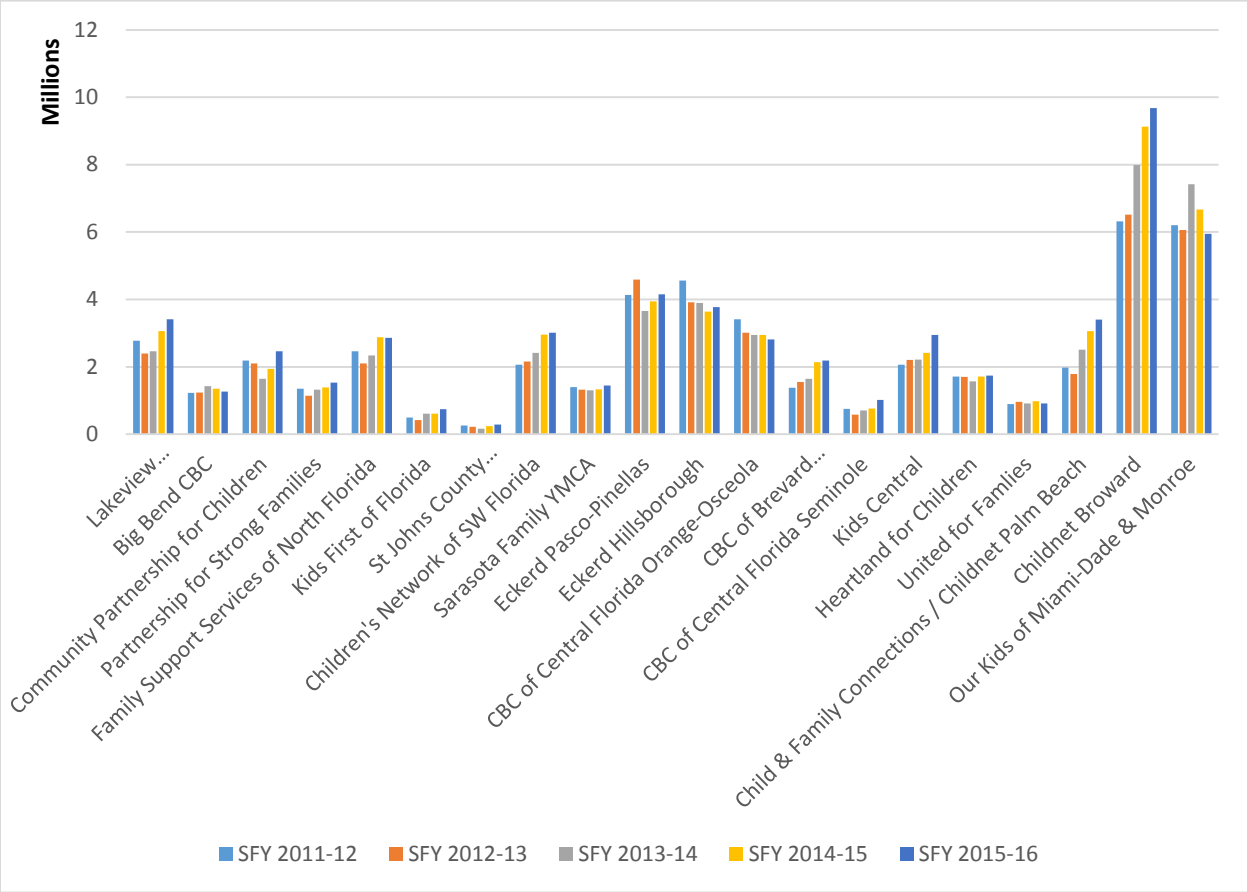
Figure 27. Maintenance Adoption Subsidies as a % of Total Expenditures



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 28 presents annual expenditures for licensed foster care services provided by each CBC. Overall trends in Figure 20 indicated an increase in licensed foster care expenditures since the implementation of the Demonstration extension. However, trends differed considerably across CBCs. Several CBCs saw increased licensed foster care expenditures. But others had no clear trend and some had declines in licensed foster care expenditures over time.

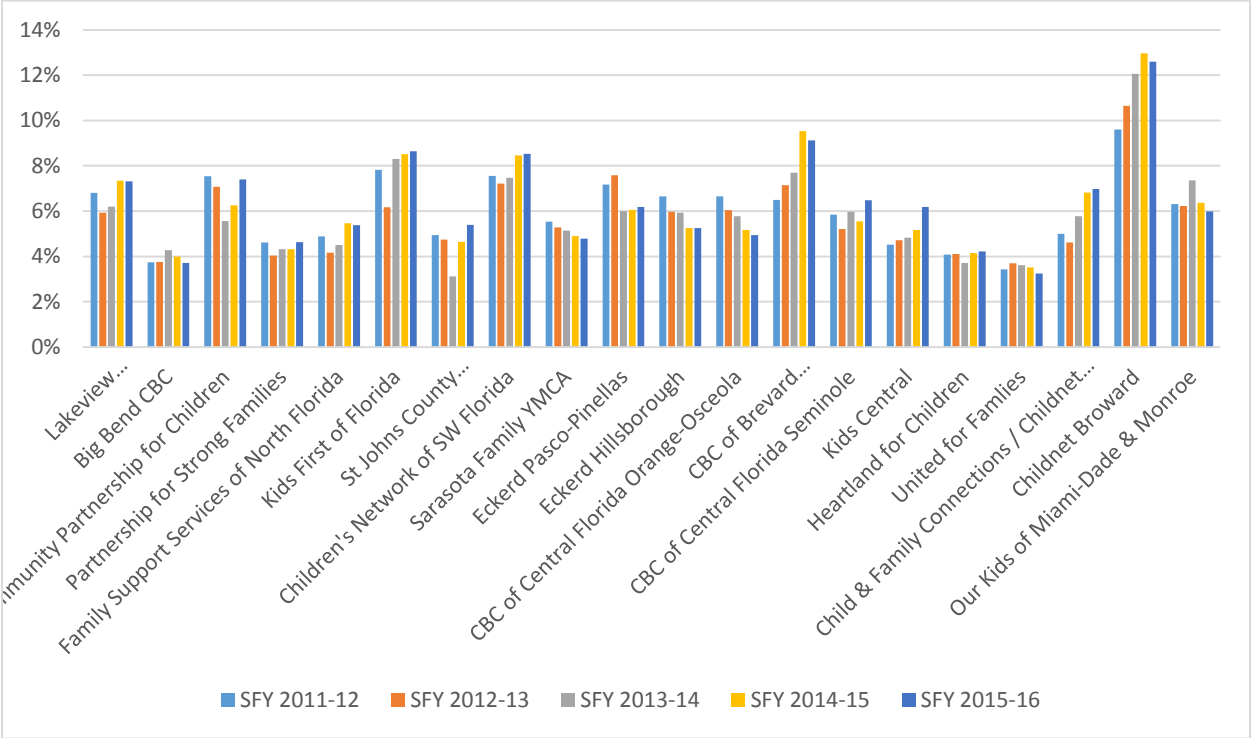
Figure 28. Expenditures for Licensed Foster Care



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 29 presents annual licensed foster care expenditures as a percentage of total expenditures by each CBC. Similar to the findings for licensed foster care expenditures, there was no clear trend in the proportion of expenditures spent on licensed foster care services. The percentages increased over time in some cases, while they declined in other cases.

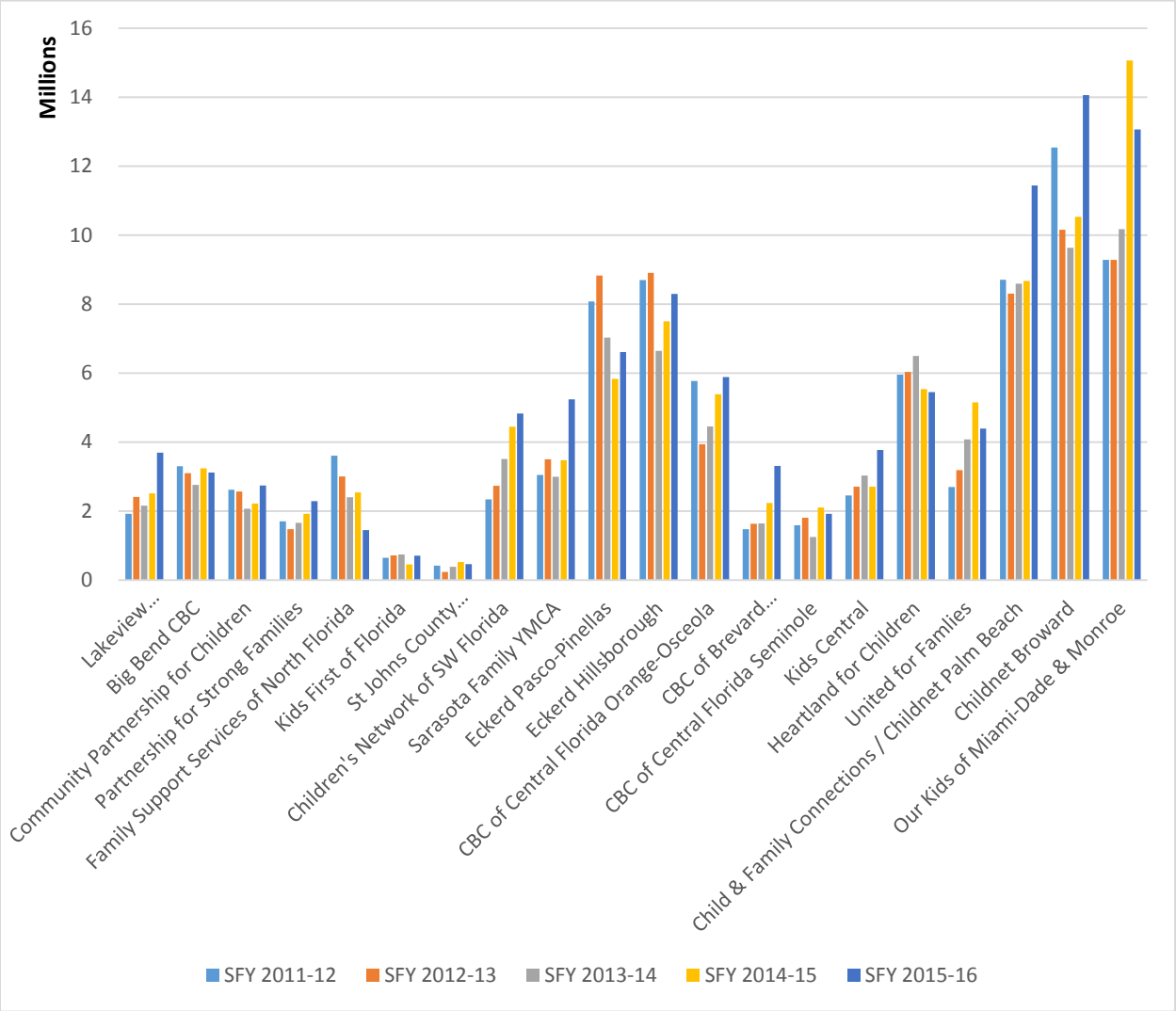
Figure 29. Licensed Foster Care Expenditures as a % of Total Expenditures



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 30 presents annual expenditures for licensed residential care services provided by each CBC. Overall trends in Figure 20 indicated an increase in licensed residential care expenditures since the implementation of the Demonstration extension. However, trends differed considerably across CBCs. Several CBCs had increased licensed foster care expenditures. But others have shown no clear trend and some have even seen declines in licensed foster care expenditures over time. With one exception (ChildNet Broward) the percentages were fairly stable across CBCs with most being around 6-8%.

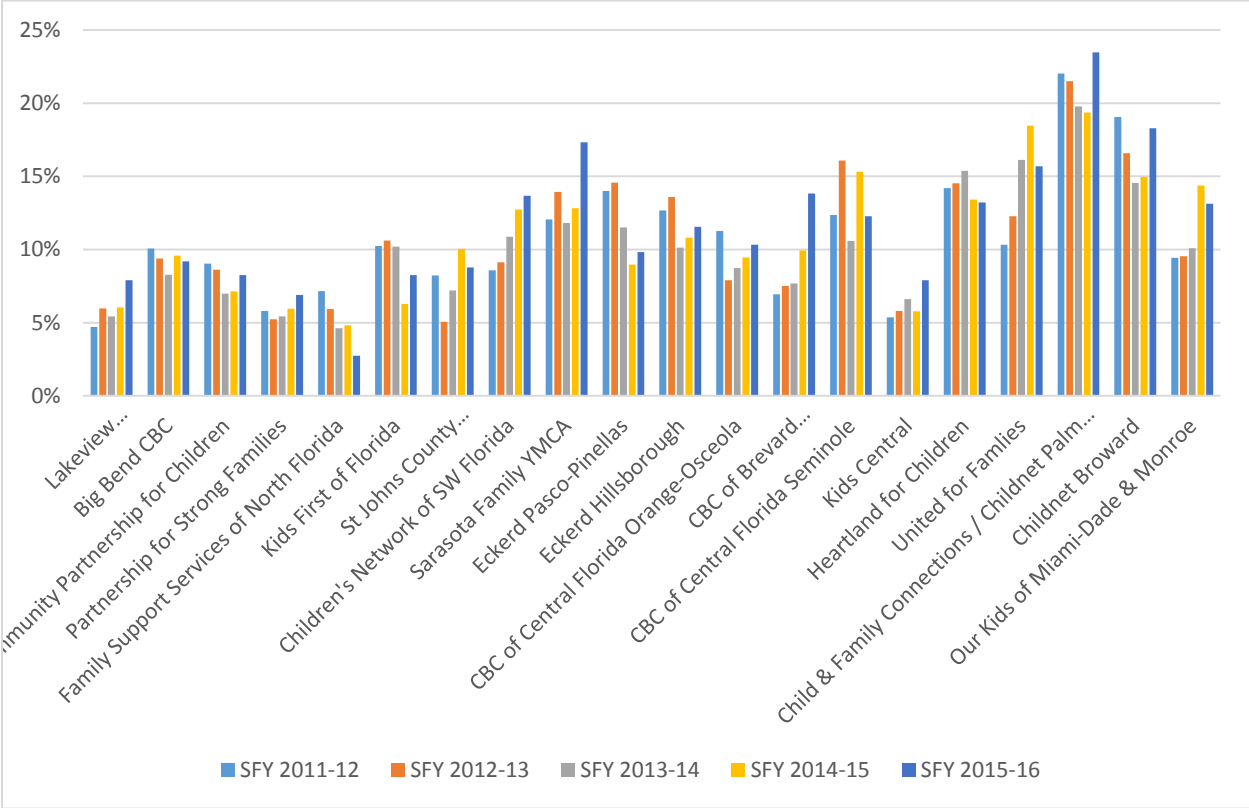
Figure 30. Expenditures for Licensed Group Care/Emergency Shelters



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Figure 31 presents annual licensed residential care expenditures as a percentage of total expenditures provided by each CBC. Once again there was no clear trend across the CBCs. The use of residential group care varied across CBCs. Residential care expenditures approached or exceeded 20% in some CBCs, while many were below 10% of total expenditures.

Figure 31. Licensed Residential Care Expenditures as a % of Total Expenditures



Note. Data Source: DCF Office of Revenue Management, Run date: 10-03-2016.

Summary. This cost analysis examined trends in overall costs for the SFY 11-12 through SFY 15-16 time period. Expenditures have increased for most CBCs over these years. However, the increases have not been across all services. In general, the clearest finding is that CBCs are placing a greater emphasis on adoption services over time. Other services have seen varying patterns of change across CBCs. Another important finding is that the levels of expenditures and proportions differ considerably across CBCs. While levels may vary due to a number of factors, most importantly number of youth served, additional analysis of the variability across CBCs is warranted to determine if the service mix provided by CBCs is associated with differences in youth outcomes.

There are two primary limitations to this analysis. First, as noted earlier, the analysis compared a pre-Demonstration extension period with a post-Demonstration extension period. However, there was a IV-E Demonstration in place during the 'pre' period. Consequently, the study can only draw conclusions regarding the marginal effect of the Demonstration extension, not the overall IV-E Waiver Demonstration. Second, the Demonstration extension includes the entire State. Thus, there is no comparison group. Consequently, it is difficult to distinguish between effects of the Demonstration extension and simple time trends.

Next Steps. Upcoming analysis for the next semi-annual report will include a more detailed analysis of the expenditure data. This will include statistical tests to more rigorously examine whether trends achieve statistical significance. In addition, the next report will examine how expenditures vary across CBCs based on the characteristics of youth served by the CBCs. Finally, aggregated expenditure data starting in SFY 04-05 was recently received. Analysis of these data will provide information on patterns across a time period that includes a pre-Demonstration period, an (original) Demonstration period, and a Demonstration extension period. This will provide a clearer picture of the overall effects of the IV-E Waiver.

Sub-Study: Cross-System Services and Costs

Youth in the child welfare system receive physical and behavioral health care services 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 youth also affect service use and costs for other public sector systems. Specific public sector systems that will be examined in this sub-study include Medicaid, Juvenile Justice, and Baker Act initiations (involuntary examinations). The analysis examines trends in health service use and costs for youth served by the child welfare system. In addition, Baker Act initiations and juvenile justice encounters were examined before and after entering out-of-home care. A cohort analysis was conducted that followed youth who were removed from the home at different points in time to examine how services, costs, and outcomes in other public-sector systems vary depending on whether the youth entered the child welfare system before or after implementation of the Demonstration extension. As such, there is no explicit comparison group.

A number of studies have examined health care services received by youth in the foster care system. Youth in the foster care system tend to use much higher levels of both physical and mental health services than other youth (CMHS and CSAT, 2013; Gen, Sommers, & Cohen, 2005; Halfon, Berkowitz, & Klee, 1992; Harman, Childs, Kelly, & Kelleher, 2000; Takayama, Bergman, & Connell, 1994). Youth in the foster care system are often physically and/or emotionally abused and thus frequently have unmet physical and mental health needs when entering out-of-home care (Thompson, Lindsey, English, Hawlet, Lambert, & Browne, 2007).

Prior Demonstration evaluation reports used three years of data to examine expenditures for physical and behavioral health services received by the youth in the year before entering out-of-home care and the year after entering out-of-home care. Average expenditures were greater in the year after removal than in the year prior to removal. However, this difference varied across broad service groups. Physical health inpatient utilization declined in the year after removal, and the use of outpatient services increased in the year after removal. The utilization of behavioral and physical health outpatient services increased in the year after removal. Thus, the focus of treatment post removal shifted considerably; presumably towards a more therapeutic emphasis.

The sub-study will be completed in stages based on the availability of data. In this report, Medicaid enrollment and claims/encounter data for youth that received out-of-home

services were analyzed as were services funded through State Substance Abuse and Mental Health (SAMH) funding sources. The analysis was refined to examine more detailed service categories and to compare service use before and after the implementation of the demonstration extension. In addition, rates of involuntary examinations and juvenile justice encounters were examined for youth in out-of-home care. This report only examined youth that were removed from the home. Youth that only received in-home services will be examined in a future report.

Methods

Enrollment and service use data was examined for four cohorts. The cohorts contain all youth, ages 0-18, removed from the home during SFY 11-12 through SFY 14-15. Identifiers for youth were from FSFN. In order to develop a cleaner study sample, we 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 youth are likely to have had out-of-home care prior to the time frame we examined. For youth in each cohort all Medicaid enrollment and claims/encounter data were extracted for the 12 months before and after removal. Enrollment data are maintained by the Agency for Health Care Administration (AHCA). Claims and encounter data include all fee-for-service claims, Prepaid Mental Health Plan encounters, HMO encounters, and encounters from the Statewide Medicaid Managed Care (SMMC) program. 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. It is important to note that the Baker Act data only report that an involuntarily examination was initiated. The data contain no information on the outcome of the examination. 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 cases, cases were considered to be 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.

Findings

Table 5 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).

The decline in inpatient utilization was consistent with findings from prior evaluation reports (Vargo et al., 2016). In an effort to examine this issue in more detail, we examined the diagnoses reported in the inpatient claims for youth 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 youth. There were youth 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 youth 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 if this sub-study, such youth 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.

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.

Some youth appear to have received out-of-home services (STFC and TGH) prior to their removal. There were two likely explanations: First, the data was limited to the child's or youth's first removal in our time frame (SFY 11-12 through SFY 14-15). The child or youth might have been in out-of-home care prior to this time frame and thus received related services in the prior year. Second, this analysis relies on accurate reporting by many different entities.

Dates, particularly in encounter data submitted by health plans to the Agency for Health Care Administration were likely to have some data entry errors. Thus, a few dates were likely incorrect and placed the service in the wrong period.

The increase in service utilization was expected. Youth living in homes where maltreatment is occurring were unlikely to receive the care they needed. Thus, we anticipated a great deal of unmet need when youth 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 5

Medicaid Services in Year Before and After Entering Out-of-Home Care

Youth 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**		
	Youth	**Paid**	**Units**	**Youth**	**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
	Medicaid					
	Year Prior to Removal			**Year After Out-of-Home Entry**		
	Youth	**Paid**	**Units**	**Youth**	**Paid**	**Units**
Behavioral Health						
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

SAMH funded services received by youth before and after entering out-of-home care are reported in Table 6. SAMH funding of services was far smaller than Medicaid. This was not surprising since all youth entering out-of-home care were Medicaid eligible, and the vast majority of youth were also Medicaid enrolled in the year prior to removal. The vast majority of physical 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. 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 youth entered out-of-home care.

Table 6

SAMH Services in Year Before and After Entering Out-of-Home Care

Youth 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**		
	Youth	**Paid**	**Units**	**Youth**	**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
	SAMH					
	Year Prior to Removal			**Year After Out-of-Home Entry**		
	Youth	**Paid**	**Units**	**Youth**	**Paid**	**Units**
Behavioral Health						
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.

Table 7 examines rates of Baker Act initiations. Ninety-seven percent of the 32,898 youth did not have a Baker Act initiation in the year before or after entry into out-of-home care. There were 373 youth 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 youth had Baker Act initiations in both the year before and year after entering out-of-home care.

Table 7
Baker Act Examinations

	Year After Out-of-Home Entry				
	No Baker Act		One or More Baker Acts		
Year Before Out-of-Home Entry	Youth	%	Youth	%	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 8. Over 96% of the 32,898 youth did not have a juvenile justice encounter in the year before or after entry into out-of-home care. There were 457 youth 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 youth had a juvenile justice encounter in both the year before and year after entering out-of-home care.

Table 8

Juvenile Justice Indicators

	Year After Out-of-Home Entry				
	No Juvenile Justice Encounters		One or More Justice Encounters		
Year Before Out-of-Home Entry	Youth	%	Youth	%	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

Table 9 contains data on how Medicaid expenditures have changed after implementation of the Demonstration extension. Thus, changes in expenditures pre- and post-extension were examined for the year prior to removal, as well as for the year after the youth entered out-of-home care. For the purposes of this sub-study, youth were assigned to the pre- and post-extension period based on when they entered out-of-homecare (an alternative would have been to assign them based on the Medicaid-funded service date). Thus, youth who entered out-of-home care in SFY 11-12 and SFY 12-13 were considered to be in the pre-extension period and youth who entered out-of-home care in SFY 13-14 and SFY 14-15 to be in the post-extension period. SAMH funded services were not included in this analysis. SAMH data were only available through SFY 14-15 limiting the ability to examine services after the youth entered out-of-home care. Given that the Medicaid program funds the vast majority of services, the findings should not be affected by this exclusion.

There were some important changes in the way services were provided pre- and post-the Demonstration extension. For physical health services provided in the year prior to entering out-of-home care, inpatient services declined over time from $57.1 million to $54.5 million. At the same time, crisis care increased from $.7 million to $1.7 million and outpatient services increased from $5.9 million to $7.0 million. In the year after removal from the home, we also had a decline in inpatient use over time from $22.4 million to $20.8 million. Crisis care increased from $1.5 million to $2.9 million and outpatient services increased from $15.5 million to $18.5 million.

It is challenging to attribute reasons to the changing patterns of expenditures. We saw similar patterns of changes in services pre- and post-Demonstration extension for both the year before entering out-of-home care and the year after entering out-of-home care. Thus, the patterns were unlikely to be associated with the Demonstration extension since services received prior to entering out-of-home care are unlikely to be substantially influenced by the Demonstration. One possible explanation is the introduction of the Statewide Medicaid Managed Care program (SMMC). The SMMC transitioned almost all Medicaid enrollees to managed care and was introduced early in the post-extension period. Many youth received physical health care coverage through the Medicaid fee-for-service program prior to the SMMC. The gatekeeper system associated with managed care plans may have reduced inpatient utilization, and led to an increase in a combination of crisis care and outpatient follow-up. Future work will examine whether the changes in patterns of care were associated with changes in child welfare outcomes.

Among behavioral health services in the year prior to entering out-of-home care, there was a general increase in service utilization over time. Utilization of inpatient (from $1.1 million to $1.6 million), outpatient ($1.3 million to $1.6 million), and SIPP services (from $2.7 million to $3.4 million) all increased over time. Differences are much greater in the year after entering out-of-home care. Provision of inpatient (from $1.3 million to $2.6 million), SIPP (from $4.0 to $4.8 million), and STFC (from $6.9 million to $7.9 million) all increased over time. However, utilization of assessment (from $10.9 million to $9.6 million) and targeted case management (from $3.2 million to $2.8 million) have declined over time. Overall, utilization of behavioral health services increased over time in both the year before removal and the year after removal.

Once again, it is challenging to determine why patterns of spending have changed. Unlike physical health care, Medicaid enrollees have received behavioral health services from managed care plans for many years. Prior to SMMC implementation, behavioral health services were carved-out and provided through Prepaid Mental Health Plans (PMHPs). After implementation of the SMMC, youth in out-of-home care received both physical and behavioral health services through a Medicaid SMMC Specialty Plan specifically designed for youth in the child welfare system. Changes in service use may reflect the substantial changes in the Medicaid program, may reflect the different business models used by different health plans in the PMHP and SMMC programs, or may reflect changes in the youth being served over time. The next semi-annual report will assess what factors were associated with changes in expenditures over time.

Table 9

Changes in Expenditures by Service: Pre-Extension versus Post-Extension

Medicaid Only - Youth Entering Out-of-Home Care in SFY 11-12 – SFY 14-15 (n=32,898)

	Pre-Demonstration Extension		**Post Demonstration Extension**		**Change**		
	Youth	**Expendit-ures**	**Youth**	**Expendit-ures**	**Δ Youth**	**Δ Expendit-ures**	**% Change**
Physical Health							
Year Before Out-of-Home Care							
Anesthesia	426	328,820	574	368,409	148	39,589	12.0%
Crisis Care	3,052	766,425	5,265	1,723,612	2,213	957,187	124.9%
Develop-mental Disability Care	116	35,286	113	11,570	(3)	(23,716)	-67.2%
Home Health	29	1,045,393	29	992,384	-	(53,008)	-5.1%
Inpatient	2,460	57,108,750	3,952	54,549,012	1,492	(2,559,738)	-4.5%
Laboratory	3,981	259,519	5,991	383,773	2,010	124,254	47.9%
Outpatient	7,563	5,921,508	10,696	7,016,141	3,133	1,094,633	18.5%
Radiology	2,181	335,987	3,438	563,978	1,257	227,990	67.9%
Transport-ation	389	65,518	572	181,696	183	116,178	177.3%
						($76,630)	-0.1%
Year after Out-of-Home Entry							
Anesthesia	1,207	346,130	1,386	450,933	179	104,803	30.3%
Crisis Care	5,311	1,558,320	7,913	2,959,471	2,602	1,401,151	89.9%
Develop-mental Disability Care	644	89,997	747	122,741	103	32,744	36.4%
Home Health	68	2,056,969	88	2,688,402	20	631,433	30.7%
Inpatient	1,920	22,429,801	2,455	20,801,449	535	(1,628,352)	-7.3%
Laboratory	7,772	621,391	10,428	812,783	2,656	191,392	30.8%
Outpatient	11,888	15,507,774	15,590	18,536,937	3,702	3,029,163	19.5%
Radiology	4,080	765,611	5,466	1,103,406	1,386	337,795	44.1%
Transport-ation	443	89,447	525	87,669	82	(1,777)	-2.0%
						$4,098,352	9.4%
Behavioral Health							

Year Before Out-of-Home Care							
Assessment	936	157,056	1,047	165,909	111	8,852	5.6%
Crisis Care	157	76,548	266	80,303	109	3,755	4.9%
	Pre-Demonstration Extension		**Post Demonstration Extension**		**Change**		
	Youth	**Expendit-ures**	**Youth**	**Expendit-ures**	**Δ Youth**	**Δ Expendit-ures**	**% Change**
Behavioral Health							
Year Before Out-of-Home Care							
Develop-mental Disability	106	17,772	115	21,954	9	4,182	23.5%
Inpatient	198	1,122,871	293	1,556,440	95	433,569	38.6%
Outpatient	1,578	1,352,416	1,963	1,601,279	385	248,863	18.4%
Rehabilit-ation	17	37,235	27	37,635	10	400	1.1%
Residential	4	241,976	8	437,570	4	195,594	80.8%
SIPP	44	2,729,132	73	3,414,808	29	685,676	25.1%
STFC	7	77,610	1	6,984	(6)	(70,626)	-91.0%
Targeted Case Manage-ment	745	601,881	788	707,411	43	105,530	17.5%
TGH	7	249,480	12	448,048	5	198,568	79.6%
Treatment Planning	700	90,721	802	95,952	102	5,230	5.8%
						$1,819,595	26.9%
Year after Out-of-Home Entry							
Assessment	13,899	10,894,690	13,724	9,658,361	(175)	(1,236,329)	-11.3%
Crisis Care	346	295,940	320	101,608	(26)	(194,332)	-65.7%
Develop-mental Disability	1,065	195,262	1,039	173,773	(26)	(21,488)	-11.0%
Inpatient	284	1,333,986	392	2,649,087	108	1,315,101	98.6%
Outpatient	7,211	10,595,856	7,943	11,118,680	732	522,825	4.9%
Rehabilit-ation	51	118,053	73	176,643	22	58,590	49.6%
Residential	8	452,690	6	237,568	(2)	(215,122)	-47.5%
SIPP	70	4,048,088	94	4,821,103	24	773,015	19.1%
STFC	604	6,591,446	636	7,896,007	32	944,561	13.6%
Targeted Case Manage-ment	3,709	3,183,691	3,814	2,814,130	105	(369,561)	-11.6%
TGH	51	1,426,711	65	1,730,680	14	303,969	21.3%
Treatment Planning	4,855	685,702	5,190	727,951	335	42,249	6.2%

						$1,923,478	4.8%

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

Summary. There are a number of interesting results that emerged from this sub-study. Youth received many more behavioral health services after entering out-of-home care than in the prior year. Youth also received many more physical health services with the exception of inpatient services. Service utilization patterns have changed over time for physical health care, with a greater reliance on a combination of crisis care and outpatient follow-up when compared to inpatient treatment. Behavioral health service use has increased over time.

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

Summary

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

Implementation Analysis

The goal of the implementation analysis is to identify and describe implementation of the Demonstration within the domains of individual roles, Demonstration impact, joint collaboration and communication efforts, and recommendations acquired throughout the process. This report includes findings from a set of key stakeholder interviews conducted with judges and magistrates in order to assess how the Demonstration extension has impacted the child welfare and judicial systems. The interviews focused on the interviewee's role within the child welfare system and the Demonstration's impacts on permanency, reunification, and removal decisions; child welfare practice; and communication and collaboration efforts with the child welfare system.

One important finding was the distinction between judicial decisions and judicial processes, and whether they are impacted by the Demonstration. Generally, respondents indicated that the Demonstration had not had an impact on the judicial decisions they made because these decisions are derived from Florida statutes; and are based on the testimony presented in court. 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. A global change in vision and values also was mentioned such that the Court's focus now is trying to keep families together, and on safety and family engagement rather than mitigating risk.

Strengths that were identified regarding the service array 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.

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 familiar with the Demonstration and have not received training regarding 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. 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 call for increased focus on and resources for additional services to treat mental health issues.

Services and Practice Analysis

One purpose of the services and practice analysis component is to assess changes in practice to improve processes for the identification of child and family needs and facilitation of connections to appropriate services, including enhanced use of in-home services to increase successful family preservation and reunification. For the current report, key findings are presented from a set of nine child protective investigator focus groups conducted in various areas of the State.

The findings indicate that CPIs have a strong child-centered approach, viewing child safety and well-being as their primary concerns, but also expressing a preference for family preservation. CPIs utilize a variety of methods to provide a holistic and comprehensive assessment of a family's needs in order to identify service interventions and make safety determinations. The amount of time and effort it takes to complete these assessments, however, presents a considerable challenge for CPIs given their current caseloads. A lack of sufficient services or excessive waitlists for available services were also reported as a significant challenge across circuits, with the most commonly reported service needs being housing, transportation, daycare, and psychiatric services. Additional challenges include poor worker retention, understaffing, and burnout within the CPI offices. Primary supports, on the other hand, were reported to be supervisors and co-workers, with CPIs emphasizing the importance of teamwork. Overall, these findings suggest several factors that impact removal

decisions and the use of in-home services: the lack of trust in safety plans and insufficient availability of services are particularly likely to contribute to a CPI's decision to remove a child rather than trying an in-home intervention.

The Annual Progress and Service Reports (APSRs) submitted by the DCF Regions in April 2016 identify a number of strategies to support child protective investigations. In April 2015, the Southeast Region identified four positions as certified Critical Child Safety Practice Experts (CCSPE's). In April 2016 these positions transitioned to a Decision Support Team model. This model supports upfront collaboration and decision making when making initial determinations with regards to present danger and appropriate safety planning. The CCSPE's are then involved through various junctures throughout the investigation, providing ongoing consultation and support. Intervention/Safety Services reported by Devereux CBC include the Boys Town Rapid Response In-Home Family Services which provide child protective investigators with a safe alternative to removing a child from home by providing safety management support services to the family. The program seeks to meet the needs of the highest-risk families without further traumatizing children by removing them from home. Broward County Sheriff's Office (BSO) has a collaboration with Henderson Behavioral Health, Inc. which provides both mental health and substance abuse professionals' onsite at BSO daily. This affords CPI's to seek immediate consultation and service activation as warranted. The substance abuse program, Family Engagement Program (FEP), uses multiple peer specialists onsite at BSO to engage referred clients to substance abuse evaluations and follow up for assisting in initiating the outcome treatment recommended from the evaluations.

Outcome Analysis: Safety and Resource Family Indicators

This component of the outcome analysis tracked changes in several successive fiscal years in the abuse rate for children who were in licensed foster care, the proportion of new licensed foster families that were recruited and remained in active status for at least 12 months, and the average number of months that licensed foster families remain in an active status.

Findings indicate that there is limited variability in the rate of child maltreatment during foster care placement for the State of Florida over time. The average rate for the State of Florida ranged from 2.4% in SFY 11-12 to 2.1% in SFY 14-15. Although no significant difference was found, there is a trend indicating improved performance statewide. Specifically, there is a slight decrease in the number of verified child maltreatment reports received during foster care placement over time.

There also is limited variability over time in the proportions of new licensed foster families that have been recruited during a specific state fiscal year and remained in an active

status for at least 12 months in the State of Florida. For example, in SFY 11-12 the proportions of new licensed foster families that remained in an active status for at least 12 months was 73.3%, it dropped slightly to 70.2% in SFY 12-13, and then it increased by 3% for the following year. Results of Chi-square test indicated no significant difference between average proportions of newly recruited foster families statewide that were in an active status for at least 12 months across fiscal years.

The APSRs identify several CBC strategies to increase successful foster family recruitment. All, but two, lead agencies report their participation in the Quality Parenting Initiative (QPI) that is designed to strengthen foster families. Devereux CBC has expanded from one to four providers agencies focused on the local recruitment of foster homes. All four agencies have adopted a modernized curriculum, Partnership in Parenting, which incorporates principles of QPI and research around trauma informed care. Families First of North Florida has workgroups that are addressing the issues of foster family recruitment for teens and for children who have experienced placement instability. Our Kids has adopted Together Facing the Challenge, an evidenced-based model designed to assist foster parents who works with children with difficult behaviors. Foster parents are trained in the model and provided with follow up coaching.

Outcome Analysis: Child and Family Well-Being

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

Overall, the findings for this report indicate that Circuits 2, 10, 14, 15, and 17 consistently obtained strength ratings for the relevant performance items. Circuits 1, 3, and 8, however, appear to be less effective in the quality of child welfare practices relevant to the safety, permanency, and well-being of children. Further, the performance item related to enhancement of a family's capacity to provide for the needs of their children is an area of concern statewide with just 53% of foster care cases and 45% of in-home cases being rated as substantially achieved**.** Concentrated efforts to improve ongoing efforts to engage the family and the frequency and quality of case workers visits with parents would improve scores for this

outcome. Generally, ratings for in-home and foster cases were similar at both the circuit level and state level but a greater percentage of foster care cases scored as a strength compared to in-home cases. Subsequent reports for the upcoming state fiscal years will allow for the assessment of trends in Florida CQI reviews and progress towards achieving national standards for these outcomes at both the circuit level and the state level.

Cost Analysis

During Florida's first five year Demonstration period the Demonstration resulted in a notable shift in expenditures from out of-home services to in-home services. The flexibility provided by the Demonstration gave opportunities to provide more services while the youth were still in the home in hopes of preventing removals. The current report examined whether such trends have continued under the Demonstration extension, and whether the revised Terms and Conditions of the Demonstration extension have led to further changes in the distribution of services.

This report examined trends in overall costs for the SFY 11-12 through SFY 15-16 time period. Expenditures have increased for most CBCs over these years. However, the increases have not been across all services. In general, the clearest finding is that CBCs are placing a greater emphasis on adoption services over time. Other services have seen varying patterns of change across CBCs. Another important finding is that the levels of expenditures and proportions differ considerably across CBCs. While levels may vary due to a number of factors, most importantly number of youth served, additional analysis of the variability across CBCs is warranted to determine if the service mix provided by CBCs is associated with differences in youth outcomes.

Sub-Study on Cross-System Services and Costs

Finally, this semi-annual progress report includes updated findings on the sub-study related to cross-system services and costs. In this report, Medicaid enrollment and claims/encounter data for youth that received out-of-home services were analyzed, as were services funded through State Substance Abuse and Mental Health (SAMH) funding sources. The analysis was refined to examine more detailed service categories and to compare service use before and after the implementation of the demonstration extension. In addition, rates of involuntary examinations and juvenile justice encounters were examined for youth in out-of-home care.

There are a number of interesting results that emerged from this sub-study. Youth received many more behavioral health services after entering out-of-home care than in the prior year. Youth also received many more physical health services with the exception of inpatient

services. Service utilization patterns have changed over time for physical health care, with a greater reliance on a combination of crisis care and outpatient follow-up when compared to inpatient treatment. Behavioral health service use has increased over time.

Lessons Learned and Next Steps

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

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

For the services and practice analysis component, a detailed, comprehensive analysis of the combined case management and child protective investigator focus groups is currently in process and will be provided in the next semi-annual progress report. Also for the next reporting period, the service array survey will be administered throughout the State. The proposed plan includes two distinct surveys, one for CBC lead agencies and one for front-line staff, which will be administered using a web-based survey program. The current timeline is to complete this data collection by the end of February 2017, in order to present the results in the next semi-annual report. Finally, a decision will be made in over the next few months regarding which evidence-based practices will be selected for the fidelity assessment component.

For the programmatic outcomes related to child safety and permanency, the next IV-E Demonstration semi-annual report will continue to examine indicators related to the recruitment and retention of the resource families. Specifically, the outcomes section will include an indicator reflecting the number of new licensed foster families recruited each year in relation to the lead agency size. Changes over time will be also assessed. In addition, longitudinal analyses and comparisons of successive annual cohorts of children on critical safety indicators will be conducted. Finally**,** in the next semi-annual progress report, this analysis will be extended to another state fiscal year (SFY 15-16) to further assess trends and changes in performance indicators.

Regarding the child and family well-being outcomes, this is the first report that has disaggregated results from the ongoing Child and Family Service Reviews will be updated in each semi-annual progress report at the circuit level and statewide. Disaggregated findings may help to better represent well-being outcomes and allow for comparisons to be made for in-home and foster care cases. For this reason, CFSR data presented in this report will now serve as a baseline assessment. Subsequent reports will compare the most recent CFSR data with the data shown in this report.

Upcoming analysis for the cost analysis component will include a more detailed analysis of the expenditure data. This will include statistical tests to more rigorously examine whether trends achieve statistical significance. In addition, the next report will examine how expenditures vary across CBCs based on the characteristics of youth served by the CBCs. Finally, aggregated expenditure data starting in SFY 04-05 was recently received. Analysis of these data will provide information on patterns across a time period that includes a pre-Demonstration period, an (original) Demonstration period, and a Demonstration extension period. This will provide a clearer picture of the overall effects of the IV-E Waiver.

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

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Appendix A

Interview protocol

Judges and Magistrates

The Florida Mental Health Institute of the University of South Florida is under contract with the Florida Department of Children and Families to evaluate the implementation of Florida's IV-E Waiver extension. The purpose of this interview is to collect information about how the Florida IV-E Waiver extension was implemented in your area and how the IV-E Waiver 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.
    - What is your area of specialization or what types of cases do you normally preside over
2) Have you changed the way you make removal, reunification, or permanency decisions since the IV-E Waiver was implemented? Please explain and elaborate on any changes.
3) What are your views regarding how the IV-E Waiver extension has impacted child welfare practices (e.g., requests for removals, service array, and engagement with parents)?
4) In your opinion, how can judges and magistrates help families overcome barriers or challenges within the child welfare system?
5) Please describe any efforts to jointly plan and communicate between the Court, child welfare legal services, child protective investigators and lead agencies.
    - 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?
6) What do you see as the strengths of the current child welfare system?
7) What do you see as the barriers or challenges of the current child welfare system?
8) Is there any additional information you would like to share regarding implementation of Florida's IV-E Waiver or the Community-Based Care system in Florida?

Appendix B

Verbal Informed Consent

Verbal Informed Consent to Participate in Research Involving Minimal Risk

Information to Consider Before Taking Part in this Research Study

Pro # __5830146300____

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

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

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

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

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

Purpose of the study

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

Why are you being asked to take part?

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

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

Study Procedures:

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

Total Number of Participants:

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

Alternatives / Voluntary Participation / Withdrawal:

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

Benefits:

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

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

Risks or Discomfort:

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

Compensation:

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

Costs:

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

Privacy and Confidentiality:

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

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

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

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

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

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

Consent to Take Part in this Research Study

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

Appendix C

Florida Judge and Magistrate Code List

(First draft 07/14/16)

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

Decision Rules for Coding

1. 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)
2. 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.
3. Don’t code the actual protocol question in isolation or with the data, unless the data does not actually answer that question
4. Don’t code things as Impact unless they have actually happened (e.g., hopes for impact might go under vision or goals)
5. 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
Focus Group Interview Guide

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

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

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

Appendix E
Measures

Measure 1: Rate of Abuse or Neglect per Day While in Foster Care

This measure is a percent. The numerator is all children in foster care for at least twenty-four (24) hours during the report period where the removal episode had an overall length of stay of at least eight (8) days. If a child had multiple removal episodes during the report period, the days in foster care for all such removal episodes which meet this criteria are included in the denominator. If a child has no active placements in foster care during the report period, they are excluded from the denominator. Any days in foster care after the child turns eighteen (18) year of age are excluded from this measure (i.e., the child's removal episode is considered to have ended as of the end of the day immediately prior to their 18th birthday). The denominator is the total number of reports with at least one verified maltreatment for all children in the denominator where the report received date was both in the report period and during the child's time in foster care; was prior to the child's eighteenth (18th) birthday; and, did not occur during the first seven (7) days of the child's removal episode.

Resource Family Outcomes

Measure 2 The number and proportion of new licensed foster families that have remained in an active status for at least 12 months during a specific fiscal year.

This measure is a percent. The numerator is all foster families who received licenses for the first time during a specific fiscal year and have remained in an active status for at least 12 months. The denominator is all new families that received their licenses for the first time during a specific fiscal year.

Measure 3. The average number of months licensed foster families remain in an active status. This measure is based on entry cohort. An entry cohort is defined as all foster families that were licensed on the 30th of June of each year. This measure is presented in number of months between the 30th of June of each year and the date when a family no longer has an active status. All foster families licensed on the 30th of June of each year were followed for 12 months. If a family retained their licenses on the 30th of June of the following year, the number of months this family remained in an active status is 12. If a family renew its license within 90 days, it should be considered an ongoing 'active status.'

Appendix F

Results of Statistical Analyses

Table F1

Results of ANOVA Test. Number of Verified Child Abuse or Neglect Reports During Services in the State of Florida by State Fiscal Year Cohort: (State Fiscal Years 2011 through 2014-2015)

Cohort	Average number of verified reports	*N* = 45,025	
		F	*df*
SFY 11-12	0.02	1.51	3
SFY 12-13	0.02		
SFY 13-14	0.02		
SFY14-15	0.02		

Note. *$p < .05$.

Table F2

Results of Chi-Square Test. The number and proportion of new licensed foster families that have remained in an active status for at least 12 months (State Fiscal Years 2011-2012 through 2014-2015)

Fiscal year	Proportion of Foster Families Remain in Active Status	*N* = 84	
		X^2	*df*
SFY 11-12	73.3	240.00	234
SFY 12-13	70.2		
SFY 13-14	73.5		
SFY14-15	70.0		

Note. *$p < .05$.

Table F3

Results of ANOVA Test. The Average Number of Months Licensed Foster Families Remained in Active Status. (State Fiscal Years 2011-2012 through 2015-2016)

State Fiscal Year	Average number of *New Licensed Foster Families*	*N* = 100	
		F	*df*
SFY 11-12	9.9	0.87	4
SFY 12-13	10.4		
SFY 13-14	10.4		
SFY14-15	10.1		
SFY15-16	10.3		

Note. *$p < .05$.

Appendix G

CFSR Ratings for Performance Items 12-18 and Well-Being Outcomes 1-3

Table G1

Performance Item 12: Needs and Services of Child, Parents, and Foster Parents

	In-Home Cases			Out-of-Home Cases		
	Cases	Strength	ANI	Cases	Strength	ANI
Circuit 1	32	22% (n=7)	78% (n=25)	46	39% (n=19)	61% (n=28)
Circuit 2	9	89% (n=8)	11% (n=1)	18	78% (n=14)	22% (n=4)
Circuit 3	12	17% (n=2)	83% (n=10)	17	24% (n=4)	76% (n=13)
Circuit 4	47	53% (n=25)	47% (n=22)	78	68% (n=53)	32% (n=25)
Circuit 5	23	61% (n=14)	39% (n=9)	49	61% (n=30)	39% (n=19)
Circuit 6	26	69% (n=18)	31% (n=8)	44	73% (n=32)	27% (n=12)
Circuit 7	35	71% (n=25)	29% (n=10)	63	79% (n=50)	21% (n=13)
Circuit 8	16	6% (n=1)	94% (n=15)	21	29% (n=6)	71% (n=15)
Circuit 9	30	57% (n=17)	43% (n=13)	49	63% (n=31)	37% (n=18)
Circuit 10	33	67% (n=22)	33% (n=11)	46	72% (n=33)	28% (n=13)
Circuit 11	31	52% (n=16)	48% (n=15)	42	60% (n=25)	40% (n=17)
Circuit 12	10	70% (n=7)	30% (n=3)	33	79% (n=26)	21% (n=7)
Circuit 13	15	60% (n=9)	40% (n=6)	55	62% (n=34)	38% (n=21)
Circuit 14	14	93% (n=13)	7% (n=1)	25	96% (n=24)	4% (n=1)
Circuit 15	33	79% (n=26)	21% (n=7)	51	86% (n=44)	14% (n=7)
Circuit 16	1	100% (n=1)	0% (n=0)	---	---	---
Circuit 17	28	89% (n=25)	11% (n=3)	39	85% (n=33)	15% (n=6)
Circuit 18	22	59% (n=13)	41% (n=9)	30	50% (n=15)	50% (n=15)
Circuit 19	32	59% (n=19)	41% (n=13)	48	67% (n=32)	33% (n=16)
Circuit 20	35	69% (n=24)	31% (n=11)	52	65% (n=34)	35% (n=18)
State	485	60% (n=292)	40% (n=193)	806	67% (n=538)	33% (n=268)

Note: Figures may not total to 100% due to rounding.
ANI: Area Needing Improvement

Table G2

Performance Item 13: Child and Family Involvement in Case Planning

	In-Home Cases			Out-of-Home Cases		
	Cases	Strength		Cases	Strength	ANI
Circuit 1	32	22% (n=7)	78% (n=25)	43	35% (n=15)	65% (n=28)
Circuit 2	9	56% (n=5)	44% (n=4)	14	86% (n=12)	14% (n=2)
Circuit 3	12	33% (n=4)	67% (n=8)	14	21% (n=3)	79% (n=11)
Circuit 4	47	66% (n=31)	34% (n=16)	75	72% (n=54)	28% (n=21)
Circuit 5	23	61% (n=14)	39% (n=9)	35	69% (n=24)	31% (n=11)
Circuit 6	26	69% (n=18)	31% (n=8)	36	86% (n=31)	14% (n=5)
Circuit 7	35	74% (n=26)	26% (n=9)	60	60% (n=36)	40% (n=24)
Circuit 8	16	12.5% (n=2)	87.5% (n=14)	16	19% (n=3)	81% (n=13)
Circuit 9	30	40% (n=12)	60% (n=18)	48	60% (n=29)	40% (n=19)
Circuit 10	33	61% (n=20)	39% (n=13)	42	76% (n=32)	24% (n=10)
Circuit 11	31	32% (n=10)	68% (n=21)	39	46% (n=18)	54% (n=21)
Circuit 12	10	70% (n=7)	30% (n=3)	29	83% (n=24)	17% (n=5)
Circuit 13	15	73% (n=11)	27% (n=4)	51	84% (n=43)	16% (n=8)
Circuit 14	14	79% (n=11)	21% (n=3)	20	85% (n=17)	15% (n=3)
Circuit 15	33	97% (n=32)	3% (n=1)	48	87.5% (n=42)	12.5% (n=6)
Circuit 16	1	100% (n=1)	0% (n=0)	---	---	---
Circuit 17	28	82% (n=23)	18% (n=5)	32	75% (n=24)	25% (n=8)
Circuit 18	22	64% (n=14)	36% (n=8)	28	46% (n=13)	54% (n=15)
Circuit 19	32	53% (n=17)	47% (n=15)	48	67% (n=32)	33% (n=16)
Circuit 20	35	71% (n=25)	29% (n=10)	49	63% (n=31)	37% (n=18)
State	485	60% (n=290)	40% (n=195)	727	66% (n=483)	34% (n=244)

Note: Figures may not total to 100% due to rounding.
ANI: Area Needing Improvement

Table G3

Performance Item 14: Case Worker Visits with Child

	In-Home Cases			Out-of-Home Cases		
	Cases	Strength	ANI	Cases	Strength	ANI
Circuit 1	32	16% (n=5)	84% (n=27)	46	20% (n=9)	80% (n=37)
Circuit 2	9	33% (n=3)	67% (n=6)	18	56% (n=10)	44% (n=8)
Circuit 3	12	17% (n=2)	83% (n=10)	17	29% (n=5)	71% (n=12)
Circuit 4	47	62% (n=29)	38% (n=18)	78	67% (n=52)	33% (n=26)
Circuit 5	23	61% (n=14)	39% (n=9)	49	73% (n=36)	27% (n=13)
Circuit 6	26	81% (n=21)	19% (n=5)	44	91% (n=40)	9% (n=4)
Circuit 7	35	54% (n=19)	46% (n=16)	63	65% (n=41)	35% (n=22)
Circuit 8	16	12.5% (n=2)	87.5% (n=14)	21	29% (n=6)	71% (n=15)
Circuit 9	30	43% (n=13)	57% (n=17)	49	43% (n=21)	57% (n=28)
Circuit 10	33	82% (n=27)	18% (n=6)	46	89% (n=41)	11% (n=5)
Circuit 11	31	55% (n=17)	45% (n=14)	42	71% (n=30)	29% (n=12)
Circuit 12	10	60% (n=6)	40% (n=4)	33	88% (n=29)	12% (n=4)
Circuit 13	15	87% (n=13)	13% (n=2)	55	93% (n=51)	7% (n=4)
Circuit 14	14	86% (n=12)	14% (n=2)	25	92% (n=23)	8% (n=2)
Circuit 15	33	91% (n=30)	9% (n=3)	51	86% (n=44)	14% (n=7)
Circuit 16	1	100% (n=1)	0% (n=0)	---	---	---
Circuit 17	28	93% (n=26)	7% (n=2)	39	95% (n=37)	5% (n=2)
Circuit 18	22	55% (n=12)	45% (n=10)	30	60% (n=18)	40% (n=12)
Circuit 19	32	31% (n=10)	69% (n=22)	48	50% (n=24)	50% (n=24)
Circuit 20	35	69% (n=24)	31% (n=11)	52	77% (n=40)	23% (n=12)
State	485	59% (n=287)	41% (n=198)	806	69% (n=557)	31% (n=249)

Note: Figures may not total to 100% due to rounding.
ANI: Area Needing Improvement

Table G4

Performance Item 15: Case Worker Visits with Parents

	In-Home Cases			Out-of-Home Cases		
	Cases	Strength	ANI	Cases	Strength	ANI
Circuit 1	32	19% (n=6)	81% (n=26)	36	28% (n=10)	72% (n=26)
Circuit 2	9	67% (n=6)	33% (n=3)	11	64% (n=7)	36% (n=4)
Circuit 3	12	8% (n=1)	92% (n=11)	11	0% (n=0)	100% (n=11)
Circuit 4	47	49% (n=23)	51% (n=24)	63	51% (n=32)	49% (n=31)
Circuit 5	23	26% (n=6)	74% (n=17)	26	31% (n=8)	69% (n=18)
Circuit 6	26	54% (n=14)	46% (n=12)	32	59% (n=19)	41% (n=13)
Circuit 7	35	46% (n=16)	54% (n=19)	55	24% (n=13)	76% (n=42)
Circuit 8	16	6% (n=1)	94% (n=15)	14	7% (n=1)	93% (n=13)
Circuit 9	30	30% (n=9)	70% (n=21)	43	30% (n=13)	70% (n=30)
Circuit 10	33	70% (n=23)	30% (n=10)	37	43% (n=16)	57% (n=21)
Circuit 11	31	26% (n=8)	74% (n=23)	38	26% (n=10)	74% (n=28)
Circuit 12	10	50% (n=5)	50% (n=5)	24	71% (n=17)	29% (n=7)
Circuit 13	15	80% (n=12)	20% (n=3)	45	40% (n=18)	60% (n=27)
Circuit 14	14	79% (n=11)	21% (n=3)	16	56% (n=9)	44% (n=7)
Circuit 15	33	55% (n=18)	45% (n=15)	38	50% (n=19)	50% (n=19)
Circuit 16	1	100% (n=1)	0% (n=0)	---	---	---
Circuit 17	28	64% (n=18)	36% (n=10)	24	29% (n=7)	71% (n=17)
Circuit 18	22	55% (n=12)	45% (n=10)	22	14% (n=3)	86% (n=19)
Circuit 19	32	31% (n=10)	69% (n=22)	42	19% (n=8)	81% (n=34)
Circuit 20	35	40% (n=14)	60% (n=21)	44	25% (n=11)	75% (n=33)
State	485	44% (n=214)	56% (n=271)	621	36% (n=221)	64% (n=400)

Note: Figures may not total to 100% due to rounding.
ANI: Area Needing Improvement

Table G5

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

	In-Home Cases				Out-of-Home Cases			
	N	SA	PA	NACH	N	SA	PA	NACH
C1	32	9% (n=3)	31% (n=10)	59% (n=19)	46	28% (n=13)	22% (n=10)	50% (n=23)
C 2	9	44% (n=4)	56% (n=5)	0% (n=0)	18	61% (n=11)	33% (n=6)	6% (n=1)
C 3	12	8% (n=1)	25% (n=3)	67% (n=8)	17	18% (n=3)	18% (n=3)	65% (n=11)
C 4	47	43% (n=20)	45% (n=21)	13% (n=6)	78	54% (n=42)	40% (n=31)	6% (n=5)
C 5	23	39% (n=9)	48% (n=11)	13% (n=3)	49	55% (n=27)	35% (n=17)	10% (n=5)
C 6	26	62% (n=16)	31% (n=8)	8% (n=2)	44	66% (n=29)	34% (n=15)	0% (n=0)
C 7	35	46% (n=16)	49% (n=17)	6% (n=2)	63	48% (n=30)	48% (n=30)	5% (n=3)
C 8	16	6% (n=1)	12.5% (n=2)	81% (n=13)	21	24% (n=5)	10% (n=2)	67% (n=14)
C 9	30	37% (n=11)	33% (n=10)	30% (n=9)	49	39% (n=19)	49% (n=24)	12% (n=6)
C 10	33	48% (n=16)	52% (n=17)	0% (n=0)	46	61% (n=28)	39% (n=18)	0% (n=0)
C 11	31	29% (n=9)	45% (n=14)	26% (n=8)	42	36% (n=15)	57% (n=24)	7% (n=3)
C 12	10	50% (n=5)	50% (n=5)	0% (n=0)	33	73% (n=24)	24% (n=8)	3% (n=1)
C 13	15	60% (n=9)	33% (n=5)	7% (n=1)	55	58% (n=32)	40% (n=22)	2% (n=1)
C 14	14	71% (n=10)	29% (n=4)	0% (n=0)	25	84% (n=21)	16% (n=4)	0% (n=0)
C 15	33	79% (n=26)	18% (n=6)	3% (n=1)	51	73% (n=37)	24% (n=12)	4% (n=2)
C 16	1	100% (n=1)	0% (n=0)	0% (n=0)	---	---	---	---
C 17	28	82% (n=23)	18% (n=5)	0% (n=0)	39	72% (n=28)	26% (n=10)	3% (n=1)
C 18	22	50% (n=11)	27% (n=6)	23% (n=5)	30	40% (n=12)	30% (n=9)	30% (n=9)
C 19	32	34% (n=11)	41% (n=13)	25% (n=8)	48	50% (n=24)	31% (n=15)	19% (n=9)
C 20	35	49% (n=17)	37% (n=13)	14% (n=5)	52	56% (n=29)	35% (n=18)	10% (n=5)
State	485	45% (n=219)	36% (n=176)	19% (n=90)	806	53% (n=429)	34% (n=278)	12% (n=99)

Note: Figures may not total to 100% due to rounding.
SA- Substantially Achieved; PA- Partially Achieved; NACH- Not Achieved

Table G6

Performance Item 16: Educational Needs of the Child

	In-Home Cases			Out-of-Home Cases		
	Cases	Strength	ANI	Cases	Strength	ANI
Circuit 1	6	17% (n=1)	83% (n=5)	36	69% (n=25)	31% (n=11)
Circuit 2	3	100% (n=3)	0% (n=0)	16	100% (n=16)	0% (n=0)
Circuit 3	0	0% (n=0)	0% (n=0)	11	55% (n=6)	45% (n=5)
Circuit 4	8	62.5% (n=5)	37.5% (n=3)	61	89% (n=54)	11% (n=7)
Circuit 5	5	80% (n=4)	20% (n=1)	39	85% (n=33)	15% (n=6)
Circuit 6	14	71% (n=10)	29% (n=4)	33	76% (n=25)	24% (n=8)
Circuit 7	3	100% (n=3)	0% (n=0)	45	80% (n=36)	20% (n=9)
Circuit 8	2	0% (n=0)	100% (n=2)	14	29% (n=4)	71% (n=10)
Circuit 9	3	67% (n=2)	33% (n=1)	38	92% (n=35)	8% (n=3)
Circuit 10	7	43% (n=3)	57% (n=4)	35	94% (n=33)	6% (n=2)
Circuit 11	22	77% (n=17)	23% (n=5)	35	77% (n=27)	23% (n=8)
Circuit 12	6	67% (n=4)	33% (n=2)	26	81% (n=21)	19% (n=5)
Circuit 13	7	86% (n=6)	14% (n=1)	47	79% (n=37)	21% (n=10)
Circuit 14	0	0% (n=0)	0% (n=0)	22	100% (n=22)	0% (n=0)
Circuit 15	7	71% (n=5)	29% (n=2)	44	91% (n=40)	9% (n=4)
Circuit 16	1	100% (n=1)	0% (n=0)	---	---	---
Circuit 17	1	100% (n=1)	0% (n=0)	38	74% (n=28)	26% (n=10)
Circuit 18	3	67% (n=2)	33% (n=1)	26	77% (n=20)	23% (n=6)
Circuit 19	2	0% (n=0)	100% (n=2)	41	76% (n=31)	24% (n=10)
Circuit 20	7	14% (n=1)	86% (n=6)	42	71% (n=30)	29% (n=12)
State	107	64% (n=68)	36% (n=39)	649	81% (n=523)	19% (n=126)

Note: Figures may not total to 100% due to rounding.
ANI: Area Needing Improvement

Table G7

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

	In-Home Cases				Out-of-Home Cases			
	N	SA	PA	NACH	N	SA	PA	NACH
C1	6	17% (n=1)	17% (n=1)	67% (n=4)	36	69% (n=25)	6% (n=2)	25% (n=9)
C 2	3	100% (n=3)	0% (n=0)	0% (n=0)	16	100% (n=16)	0% (n=0)	0% (n=0)
C 3	0	0% (n=0)	0% (n=0)	0% (n=0)	11	55% (n=6)	9% (n=1)	36% (n=4)
C 4	8	62.5% (n=5)	12.5% (n=1)	25% (n=2)	61	89% (n=54)	2% (n=1)	10% (n=6)
C 5	5	80% (n=4)	0% (n=0)	20% (n=1)	39	85% (n=33)	5% (n=2)	10% (n=4)
C 6	14	71% (n=10)	7% (n=1)	21% (n=3)	33	76% (n=25)	12% (n=4)	12% (n=4)
C 7	3	100% (n=3)	0% (n=0)	0% (n=0)	45	80% (n=36)	4% (n=2)	16% (n=7)
C 8	2	0% (n=0)	0% (n=0)	100% (n=2)	14	29% (n=4)	7% (n=1)	64% (n=9)
C 9	3	67% (n=2)	33% (n=1)	0% (n=0)	38	92% (n=35)	0% (n=0)	8% (n=3)
C 10	7	43% (n=3)	29% (n=2)	29% (n=2)	35	94% (n=33)	3% (n=1)	3% (n=1)
C 11	22	77% (n=17)	9% (n=2)	14% (n=3)	35	77% (n=27)	14% (n=5)	9% (n=3)
C 12	6	67% (n=4)	17% (n=1)	17% (n=1)	26	81% (n=21)	8% (n=2)	12% (n=3)
C 13	7	86% (n=6)	14% (n=1)	0% (n=0)	47	79% (n=37)	11% (n=5)	11% (n=5)
C 14	0	0% (n=0)	0% (n=0)	0% (n=0)	22	100% (n=22)	0% (n=0)	0% (n=0)
C 15	7	71% (n=5)	14% (n=1)	14% (n=1)	44	91% (n=40)	0% (n=0)	9% (n=4)
C 16	1	100% (n=1)	0% (n=0)	0% (n=0)	---	---	---	---
C 17	1	100% (n=1)	0% (n=0)	0% (n=0)	38	74% (n=28)	8% (n=3)	18% (n=7)
C 18	3	67% (n=2)	0% (n=0)	33% (n=1)	26	77% (n=20)	12% (n=3)	12% (n=3)
C 19	2	0% (n=0)	0% (n=0)	100% (n=2)	41	76% (n=31)	10% (n=4)	15% (n=6)
C 20	7	14% (n=1)	43% (n=3)	43% (n=3)	42	71% (n=30)	10% (n=4)	19% (n=8)
State	107	64% (n=68)	13% (n=14)	23% (n=25)	649	81% (n=523)	6% (n=40)	13% (n=86)

Note: Figures may not total to 100% due to rounding.
SA- Substantially Achieved; PA- Partially Achieved; NACH- Not Achieved

Table G8

Performance Item 17: Physical Health of the Child

	In-Home Cases			Out-of-Home Cases		
	Cases	Strength	ANI	Cases	Strength	ANI
Circuit 1	7	43% (n=3)	57% (n=4)	46	59% (n=27)	41% (n=19)
Circuit 2	1	100% (n=1)	0% (n=0)	18	100% (n=18)	0% (n=0)
Circuit 3	1	100% (n=1)	0% (n=0)	17	47% (n=8)	53% (n=9)
Circuit 4	11	82% (n=9)	18% (n=2)	78	97% (n=76)	3% (n=2)
Circuit 5	4	25% (n=1)	75% (n=3)	49	82% (n=40)	18% (n=9)
Circuit 6	20	55% (n=11)	45% (n=9)	44	91% (n=40)	9% (n=4)
Circuit 7	7	86% (n=6)	14% (n=1)	63	59% (n=37)	41% (n=26)
Circuit 8	6	0% (n=0)	100% (n=6)	21	57% (n=12)	43% (n=9)
Circuit 9	10	90% (n=9)	10% (n=1)	49	92% (n=45)	8% (n=4)
Circuit 10	8	75% (n=6)	25% (n=2)	46	93% (n=43)	7% (n=3)
Circuit 11	26	69% (n=18)	31% (n=8)	42	74% (n=31)	26% (n=11)
Circuit 12	6	100% (n=6)	0% (n=0)	33	70% (n=23)	30% (n=10)
Circuit 13	7	43% (n=3)	57% (n=4)	55	85% (n=47)	15% (n=8)
Circuit 14	0	0% (n=0)	0% (n=0)	25	92% (n=23)	8% (n=2)
Circuit 15	3	67% (n=2)	33% (n=1)	51	71% (n=36)	29% (n=15)
Circuit 16	1	100% (n=1)	0% (n=0)	---	---	---
Circuit 17	1	100% (n=1)	0% (n=0)	39	72% (n=28)	28% (n=11)
Circuit 18	5	60% (n=3)	40% (n=2)	30	67% (n=20)	33% (n=10)
Circuit 19	3	33% (n=1)	67% (n=2)	48	60% (n=29)	40% (n=19)
Circuit 20	5	40% (n=2)	60% (n=3)	52	71% (n=37)	29% (n=15)
State	132	64% (n=84)	36% (n=48)	806	77% (n=620)	23% (n=186)

Note: Figures may not total to 100% due to rounding.
ANI: Area Needing Improvement

Table G9

Performance Item 18: Mental/ Behavioral Health of the Child

	In-Home Cases			Out-of-Home Cases		
	Cases	Strength	ANI	Cases	Strength	ANI
Circuit 1	17	47% (n=8)	53% (n=9)	27	44% (n=12)	56% (n=15)
Circuit 2	0	0% (n=0)	0% (n=0)	14	93% (n=13)	7% (n=1)
Circuit 3	1	100% (n=1)	0% (n=0)	11	27% (n=3)	73% (n=8)
Circuit 4	19	79% (n=15)	21% (n=4)	45	84% (n=38)	16% (n=7)
Circuit 5	6	33% (n=2)	67% (n=4)	20	85% (n=17)	15% (n=3)
Circuit 6	14	79% (n=11)	21% (n=3)	22	91% (n=20)	9% (n=2)
Circuit 7	12	92% (n=11)	8% (n=1)	31	65% (n=20)	35% (n=11)
Circuit 8	6	50% (n=3)	50% (n=3)	8	0% (n=0)	100% (n=8)
Circuit 9	13	77% (n=10)	23% (n=3)	23	83% (n=19)	17% (n=4)
Circuit 10	14	71% (n=10)	29% (n=4)	22	68% (n=15)	32% (n=7)
Circuit 11	20	75% (n=15)	25% (n=5)	28	89% (n=25)	11% (n=3)
Circuit 12	3	100% (n=3)	0% (n=0)	22	77% (n=17)	23% (n=5)
Circuit 13	6	67% (n=4)	33% (n=2)	37	68% (n=25)	32% (n=12)
Circuit 14	3	100% (n=3)	0% (n=0)	17	94% (n=16)	6% (n=1)
Circuit 15	17	82% (n=14)	18% (n=3)	33	85% (n=28)	15% (n=5)
Circuit 16	0	0% (n=0)	0% (n=0)	---	---	---
Circuit 17	4	75% (n=3)	25% (n=1)	28	71% (n=20)	29% (n=8)
Circuit 18	6	67% (n=4)	33% (n=2)	15	73% (n=11)	27% (n=4)
Circuit 19	4	50% (n=2)	50% (n=2)	34	62% (n=21)	38% (n=13)
Circuit 20	13	54% (n=7)	46% (n=6)	27	67% (n=18)	33% (n=9)
State	178	71% (n=126)	29% (n=52)	464	73% (n=338)	27% (n=126)

Note: Figures may not total to 100% due to rounding.
ANI: Area Needing Improvement

Table G10

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

	In-Home Cases				Out-of-Home Cases			
	N	SA	PA	NACH	N	SA	PA	NACH
C1	21	48% (n=10)	0% (n=0)	52% (n=11)	46	48% (n=22)	20% (n=9)	33% (n=15)
C 2	1	100% (n=1)	0% (n=0)	0% (n=0)	18	94% (n=17)	6% (n=1)	0% (n=0)
C 3	2	100% (n=2)	0% (n=0)	0% (n=0)	17	24% (n=4)	35% (n=6)	41% (n=7)
C 4	25	80% (n=20)	0% (n=0)	20% (n=5)	78	88% (n=69)	10% (n=8)	1% (n=1)
C 5	8	25% (n=2)	0% (n=0)	75% (n=6)	49	80% (n=39)	6% (n=3)	14% (n=7)
C 6	24	58% (n=14)	8% (n=2)	33% (n=8)	44	89% (n=39)	5% (n=2)	7% (n=3)
C 7	15	87% (n=13)	7% (n=1)	7% (n=1)	63	54% (n=34)	14% (n=9)	32% (n=20)
C 8	10	20% (n=2)	10% (n=1)	70% (n=7)	21	43% (n=9)	14% (n=3)	43% (n=9)
C 9	18	83% (n=15)	0% (n=0)	17% (n=3)	49	86% (n=42)	8% (n=4)	6% (n=3)
C 10	19	68% (n=13)	0% (n=0)	32% (n=6)	46	85% (n=39)	9% (n=4)	7% (n=3)
C 11	29	59% (n=17)	28% (n=8)	14% (n=4)	42	74% (n=31)	5% (n=2)	21% (n=9)
C 12	6	100% (n=6)	0% (n=0)	0% (n=0)	33	67% (n=22)	15% (n=5)	18% (n=6)
C 13	8	50% (n=4)	25% (n=2)	25% (n=2)	55	69% (n=38)	20% (n=11)	11% (n=6)
C 14	3	100% (n=3)	0% (n=0)	0% (n=0)	25	92% (n=23)	4% (n=1)	4% (n=1)
C 15	17	82% (n=14)	0% (n=0)	18% (n=3)	51	69% (n=35)	14% (n=7)	18% (n=9)
C 16	1	100% (n=1)	0% (n=0)	0% (n=0)	---	---	---	---
C 17	5	80% (n=4)	0% (n=0)	20% (n=1)	39	59% (n=23)	21% (n=8)	21% (n=8)
C 18	9	56% (n=5)	11% (n=1)	33% (n=3)	30	63% (n=19)	13% (n=4)	23% (n=7)
C 19	6	50% (n=3)	0% (n=0)	50% (n=3)	48	50% (n=24)	23% (n=11)	27% (n=13)
C 20	16	50% (n=8)	6% (n=1)	44% (n=7)	52	63% (n=33)	17% (n=9)	19% (n=10)
State	243	65% (n=157)	7% (n=16)	29% (n=70)	806	70% (n=562)	13% (n=107)	17% (n=137)

Note: Figures may not total to 100% due to rounding.
SA- Substantially Achieved; PA- Partially Achieved; NACH- Not Achieved