Shifting Resources in Child Welfare to *Achieve Better Outcomes* for Children and Families

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Introduction

The field of child welfare has made substantial improvements in helping more families parent their children in safe ways, and consequently Commissioner Bryan Samuels of the Administration on Children, Youth, and Families and others have called for the narrative about child welfare to change. Child welfare agencies are helping to prevent children from entering foster care and to exit from care to a permanent home more quickly – with a substantial number of children achieving permanency through return home and adoption rather than by aging out of care.[1] However, while some types of child maltreatment and rates of children in foster care have decreased, many jurisdictions are still trying to address the following:

- As compared to all children entering foster care, a significant number of infants and young children are entering care.[2]
- Over 40% of youth are entering foster care from family situations with one or more of the following characteristics: ineffective treatments for youth with challenging behaviors, parent substance abuse, youth emotional and behavioral disorders including the emotional effects of trauma, and aggressive, inappropriate or otherwise anti-social youth behaviors (which might also necessitate juvenile justice-involvement).[3]
- Rates of substantiated and unsubstantiated child maltreatment re-referrals remain high at 5% or more in some communities.[4]
- On average, 13% of children re-enter foster care within 12 months of reunification.[5]
- Over 1 in 5 (22%) of the youth currently in foster care have been in care for over three years without achieving legal permanency.[6]
- Too few of the youth involved with child welfare who have diagnosed emotional and behavioral disorders are receiving effective treatment.[7]
- Some youth in foster care lack strong and vital relationships with non-paid/non-professional adults and the ability to form those relationships. This presents a barrier to achieving legal permanency.[8]
- States have the option to serve young adults age 19-21 who have been in foster care, but many of the standard practices in child welfare are not designed to help that population – and certainly are not geared to helping young adults build positive social, career-building, and employment networks.

Despite these challenges, system reform strategies in the areas of practice, administration, and policy have changed the conditions for maltreated children and have accelerated permanency planning, thereby safely reducing the number of children in foster care.[9] Cost-savings resulting from foster care reductions and other program reforms need to be reinvested in high-quality and proven services for the parents and children who need services – whether in- or out-of-home, especially in times of fiscal constraint.[10] Yet the restrictions on certain funds challenge child welfare agencies to leverage their resources in a different way. So, how do we free up funds to address the issues listed above? How can child welfare agencies pay for innovations and interventions with known effectiveness to improve community, family, and child outcomes?

We need to reduce our investments in program areas and services that are less effective in helping children and their families

We need to reduce our investments in program areas and services that are less effective in helping children and their families (i.e., de-scaling).This does not diminish the challenges associated with implementing and sustaining evidence-based practices (e.g., building program infrastructure, maximizing utility for specific populations and training costs, and maintaining program fidelity) and the reality that some interventions might be effective with certain populations and not others.[11] *Thus this research brief describes how reinvestment is being used in other fields and applied in child welfare. It identifies program areas that could be scaled back to free up funds for more effective strategies to improve outcomes for children and families. Exemplars from states that have made these reforms to support the accomplishment of organizational priorities and achieve more positive child welfare outcomes are highlighted.*

Examples of Re-Investment in Non-Child-Welfare Fields

Reinvesting in Business

For-profit businesses shift their mix of products or services to meet changing times and customer needs.[12] The related resource-shifting involves moving from ineffective products or services to increased investment in other key services, staff capacity, and other aspects of organizational capacity. Reinvestment occurs in government agencies, professional groups, service agencies, and communities, as well as in for-profit businesses as all of these organizations seek to increase accountability and achieve maximum results with unchanging or decreased resources. Change may take the form of finding greater efficiencies in business operations, and scaling back or eliminating services, procedures, or worker activities that are not as effective, so that more effective strategies can be initiated or increased.

Modifying Resource Allocations in Health Care

Another example is the movement to encourage health care providers, payers, and consumers to shift from ineffective to more effective prevention and treatment strategies. The Congressional Budget Office has estimated that up to one-third of the over $2 trillion that the U.S. now spends annually on health care in the U.S. goes for unneeded medical services.[13] Consider these observations compiled by Kelley of Thomson Reuters:[14]

> *Estimates suggest that as much as $700 billion a year in healthcare costs do not improve health outcomes. They occur because we pay for more care rather than better care. We need to be moving towards a system in which doctors and hospitals have incentives to provide the care that makes you better, rather than the care that just results in more tests and more days in [the] hospital."* — Peter Orszag, director of the White House Office of Management and Budget, May 2009 interview with National Public Radio.

The potential over-utilization of less than effective clinical practices and the potential under-utilization of effective clinical practices not only result in less than optimal care but also fragmented, inefficient, and unsustainable resource allocation.

According to Jack Wennberg of Dartmouth's Center for the Evaluative Clinical Sciences, *"…up to one-third of the over $2 trillion that we now spend annually on healthcare is squandered on unnecessary hospitalizations; unneeded and often redundant tests; unproven treatments; over-priced, cutting-edge drugs; devices no better than the less expensive products they replaced; and end-of-life care that brings neither comfort care nor cure."*[15]

The American Board of Internal Medicine Foundation has teamed up with nine specialty medical groups and Consumer Reports to identify five common tests, procedures, or treatments in each specialty area (45 total) that are overused in many situations. The goal is to provide payers and consumers with new information about how health care dollars can be invested more wisely.[16] Indeed, this is an international issue for the health care community:

The potential over-utilization of less than effective clinical practices and the potential under-utilization of effective clinical practices not only result in less than optimal care but also fragmented, inefficient, and unsustainable resource allocation. Systemic approaches to disinvestment will improve equity, efficiency, quality and safety of care, as well as sustainability of resource allocation.[17]

Similarly, investment in ineffective services year after year is a frustration voiced by many child welfare administrators and policy leaders. The remedy is akin to changing a tire on a moving vehicle; and, to make it even more challenging, maximizing the impact of services requires a coordinated effort from child mental health, health care, and other agencies working in concert with child welfare leaders. But Title IV-E waivers and other strategies described below can help achieve these reforms, and a large amount of federal, state, and county funds are being invested in these programs.[18]

Examples of Reinvestment in Child Welfare

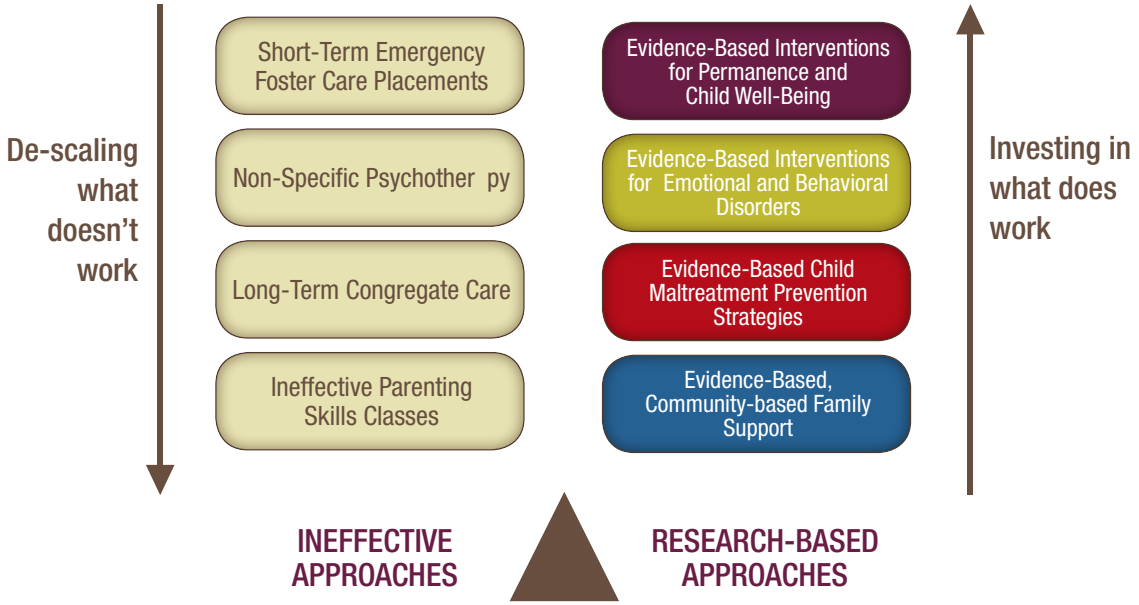
Overview

States, counties, and tribes are adjusting their investments in child welfare through different policy and program reforms. For example, by implementing restorative justice (Circle Sentencing)[19] and Signs of Safety,[20] Yellow Medicine County in Minnesota reduced spending on foster care placements from over $635,000 in 2002 to $70,000 in 2009. These child welfare leaders established an agreement with their county board to re-invest some of these savings in family group decision-making, specialized parent support services, and increased staff training and coaching. Much of the success the county realized was due to the expansion of the restorative justice program. The agency also made a commitment to extensive staff learning opportunities in the Signs of Safety approach.

The agency has also supported staff to share that approach with other counties by becoming a practice leader in this area. The dollar savings from fewer out-of-home placements made this training and consultation activity possible.[21]

This de-scaling and reinvestment framework is shown in Figure 1, and examples are provided in the sections that follow. The next section describes how some aspects of group care are being changed to free up funds for reinvestment.

Shifting Resources to Support What Works



Investing savings to bridge from ineffective to effective practices

Source: Adapted from Samuels, B. (2012). *Looking to the future: An agenda for the Children's Bureau's next 100 years.* Presentation to 18th National Conference on Child Abuse and Neglect, Washington, DC, April 18, 2012.

Long-Term Congregate Care Placements

Youth placed in group care comprise about 15% of all youth in out-of-home care in the United States. Specifically, as of September 30, 2010, 408,425 youth were in out-of-home care, with 25,066 (6%) placed in group homes and 36,607 (9%) placed in other congregate care settings (e.g., residential treatment centers).[22]

While group homes and residential treatment centers can be a key part of the child welfare continuum of services, they have been challenged to better define their intervention models and the youth they are best suited to serve: to "right-size" the length of stay, to involve family members more extensively in treatment, to help youth learn skills for managing their emotions and behaviors in order to function well in the community, to help youth achieve permanency, and to conduct more rigorous evaluation studies.[23] The need for these reforms is underscored by data demonstrating the pitfalls of congregate care stays in excess of nine months.[24] The group care field has responded by improving many aspects of intervention design, implementation, staff development, and evaluation.[25] Most group care agencies are concerned about length of stay, stepping youth down in levels of care, and providing more effective independent living services in ways that help youth succeed back in the community.[26]

The group care field has responded by improving many aspects of intervention design, implementation, staff development, and evaluation.

A large number of states are trying to target those children who will benefit most from group care (and which ones won't) and to cut back the average length of stay through better assessment, use of more evidence-based treatments, more aggressive permanency planning, increased family engagement, and other innovations.

For example, the California legislature authorized a multi-year pilot demonstration project to transform the state's current system of long-term, congregate care into a system of residentially based services (RBS) that will reduce the length of time in group care and improve permanency outcomes for youth. The overarching goals of the RBS framework are permanency, well-being, and safety for youth whose complex needs require intensive therapeutic interventions and comprehensive services to help them reunify or reconnect with family members.

These goals will be accomplished by combining short-term, intensive, residential treatment interventions with community-based services aimed at reconnecting children with their families and communities. RBS hopes to accomplish these improved outcomes without increasing costs by producing savings from reduced lengths of stay in high-cost group care to offset increased up-front costs.[27] RBS is currently being implemented and evaluated in Los Angeles, Sacramento, San Bernardino, and San Francisco Counties.

Successful group care reform efforts are also occurring in many other jurisdictions, including New York City, Maine, Louisiana, Texas, and Virginia.[28,29] For example, the Travis County Child Protective Services Reintegration Project evaluation in Austin, Texas, found that by providing the right intensity and duration of wraparound services and other supports, including dedicated staffing, reunification can be achieved for youth with complex mental and behavioral needs, thereby saving costs to the child welfare agency over time.[30] Another success story from Virginia is presented below.

Virginia Refines Group Care Approaches to Invest in Other Program Areas[31]

Nearly one-third of the children in Virginia's foster care system were in congregate care facilities until 2007, when a reform-minded leader (the Commonwealth's First Lady Anne Holton) stepped forward to insist on change. The Annie E. Casey Foundation and its partners in Virginia – a locally administered system with 126 offices – sought to use three levers of change, two in concert with each other. First and second, they chose to target the state's finance system while adding performance management strategies to improve its frontline practice. Third, they sought to involve a wide variety of stakeholders in crafting reform strategies. In January 2008, the group's findings and recommendations were presented to key stakeholders, including the full House Appropriations Committee of Virginia's General Assembly. In his biennial budget, Governor Tim Kaine proposed and advocated for a child welfare reform package. Despite a state deficit of $1 billion, the package passed the Assembly in March. Key components included:

- $1.8 million over two years to recruit, train, and support foster and adoptive families
- A 23-percent increase over two years for foster care and adoption subsidies
- $800,000 for the training of foster care and adoption caseworkers
- A new state-local funding formula with incentives for community-based placements

The state-local financing change was especially significant in Virginia's locally administered child welfare system. The formula increased state match funding for community-based services and decreased state match funding for residential and group-home placements. The first phase was implemented in July 2008; the second phase had two parts and began in January 2009. As legislative work proceeded, the Council on Reform (CORE) was created to serve as the steering committee for statewide efforts to improve child welfare. CORE included 100 volunteer representatives from the Commonwealth's departments of social services, mental-health, and comprehensive services. It also included representatives from provider and parent organizations. Thirteen localities now sit on CORE and are committed to developing and implementing reform; these localities include the Commonwealth's largest local child welfare agencies and represent nearly 50 percent of children in care.

The City of Richmond was selected as the first pilot site for reforming front-line practice. The first order of business was implementing team decision making (TDM) for all children for whom a step-down from congregate care was being considered. TDM is a facilitated meeting of professionals and clients that focuses on a key placement decision, such as moving a teen to a family-based placement. For the pilot, three court mediators were loaned to the local child welfare office to be trained as TDM facilitators.

The results in Richmond were immediate. The court mediators held 250 TDMs in five months, resulting in a 30-percent decrease in the number of Richmond youth in congregate care. Birth families, never before included in meetings related to their children, were central

participants in the TDMs. Statewide results were equally impressive. By March 2009:

- 1,399 children were in congregate care, down from 1,922 in 2007, a 27-percent decrease.
- The 14 CORE localities saw a 14-percent drop in the overall foster care population while statewide the numbers dropped 11 percent.
- Family-based placements increased 9 percent in CORE localities and 5 percent statewide.
- Discharges to permanent families were up 14 percent in CORE localities and 5 percent statewide.[32]

Parenting Classes

Some parents served by child welfare are experiencing difficulties in nurturing and providing appropriate kinds of discipline for their children. Timely instruction and coaching can substantially help these parents. But public child welfare agency leaders and researchers are concerned about the huge amount of funds spent on parenting classes for two major reasons. First, some CPS workers do not have the time or expertise to carefully assess what aspects of parenting are endangering children, and which parents could most benefit from parenting education. Consequently, generic parenting classes have become a de facto part of the service plan when a more specific parent coaching or safety plan would not only be less burdensome to the parents, but more effective and likely, less expensive – especially when the time of parents, travel expenses, and child care expenses are included in the cost calculations. Second, curricula for many parenting skills classes are untested and have no supporting manuals; in addition, many have been found to be ineffective.[33]

Many parenting classes are essentially a generic intervention aimed at delivering psycho-educational content to the average parent, and they do not account for the needs, skills, and challenges faced by many of the parents who are involved with the child welfare system. For example, many of these parents experience symptoms of trauma themselves. The extent to which trauma interferes with cognitive processing and interpersonal interactions is well demonstrated, but it has not been considered in the development of parenting class materials. In short, some classes are useful primarily for the certificate of completion provided to parents, as an emblem of their willingness to comply with requests of the child welfare agency, but little more. Resources, such as that provided by the United Nations Office on Drugs and Crime, can provide child welfare planners with current information about effective parenting/family skills programs.[34]

Given the widespread use of parenting education programs with little documented effectiveness, there is ample opportunity to scale back less effective and unneeded parent skill-building approaches to free up funds to invest in more tailored and effective models. Some jurisdictions have been doing just this. For example, agencies in California, Maine, Massachusetts, and Minnesota are more carefully assessing parenting skill gaps or needs using a variety of safety-

oriented risk assessment approaches to CPS practice.[35] In addition, agency staff and judges are recommending participation in more effective parent skill-building programs (*e.g., Familias Unidas, Incredible Years, Nurturing Parenting Program (NPP), Parent Child Interaction Therapy [PCIT], Triple P, Parent Management Training [PMT], and Parenting Wisely*), which are ultimately more likely to be cost-effective – given the early cost savings analyses completed for *NPP* and *Triple P*.

In addition, child welfare agencies in New York, Washington, and other states are implementing the *Incredible Years*. Louisiana recently implemented the *Nurturing Parenting Program* statewide after a thorough review of evidence regarding different parenting education models, with very good success and at a reasonable cost. Some of their results are presented below.

Louisiana Scales up the Nurturing Parenting Program (NPP) to Improve Services

Louisiana state child welfare leaders were not satisfied with the results from the investments they were making in parenting programs, so they chose to shift resources to pay for a program with more research evidence of effectiveness. The NPP for Infants, Toddlers, and Preschoolers is a parenting education program designed to prevent maltreatment by developing positive parenting skills for caregivers of young children.[36] The program was delivered statewide in Louisiana between 2005 and 2008 to parents referred by child welfare to parenting education, with the goal of preventing repeat maltreatment, preventing out-of-home care, and for some families, facilitating reunification. The Office of Community Services contracted with nine community-based providers to provide NPP, with Prevent Child Abuse Louisiana assisting with training and technical assistance.

An evaluation demonstrated that increased program attendance was associated with significant reductions in substantiated incidences and re-reports of child maltreatment. Specifically, caregivers who attended the average number of group or home sessions (18) of the NPP had a 35-percent lower likelihood of a substantiated maltreatment incident within two years of program participation compared to participants attending only three sessions (the bottom decile), controlling for other characteristics of caregivers that might be associated with participation or likelihood of repeat maltreatment. Program costs and benefits (cost savings) were calculated using program, workforce, and administrative data. The benefit-cost ratio of 0.87 demonstrates that the NPP approaches cost neutrality in a short time, without consideration of long-term benefits or benefits to other systems.[37]

Short-Term Emergency Foster Care Placements[38]

While not much is known about the demographic profiles of short-stayers in many local, county, and state jurisdictions, there is reason to wonder whether the decision to place children in out-of-

home care is warranted in some cases. Children may have been placed in out-of-home care due to the arrest of a parent or a parent's mental health episode, or due to their own unmet physical health, mental health, or educational needs.[39] Nationally, there has been a sizable reduction in brief placements (e.g., 34% of children exiting care stayed 0-6 months in fiscal year 2003 compared with 28% in fiscal year 2010).[40] However, this issue of short-stayers remains a concern for many states.[41] A case example from New Mexico is included below, and Michigan recently passed special legislation to more closely regulate emergency placements.[42]

Since foster care is not generally designed for two- or three-day placements, many child welfare agencies use receiving homes, shelters, or assessment centers for children in unplanned, short-term placements.

While estimates of the number of short-stayers in the U.S. exist, it is not possible to describe them due to the dearth of research analyzing their demographic characteristics, the specific circumstances leading to their removal, the roles of different professionals, and the relative availability of local services in the community. Nevertheless, evidence from the placement change literature suggests that short-term placements may induce emotional and behavioral problems in children because of separation from family and dislocation from resources, services, schools, and places of familiarity and comfort.[43]

Since foster care is not generally designed for two- or three-day placements, many child welfare agencies use receiving homes, shelters, or assessment centers for children in unplanned, short-term placements. Better placement decisions and more effective emergency interventions are warranted – decisions and interventions that not only ensure child safety but also avoid disruptive, traumatic, and expensive removals. The cost to the child and family has not been well documented, although all indications are that the trauma and disruption of family functioning, combined with the relatively low impact of the intervention/removal itself, are significant drivers for downstream costs to child and family well-being and child welfare.

States are using one or more of the following evidence-based approaches to prevent unnecessary out-of home-placements, and some of these might be adapted to help prevent emergency placements:

- Alternative or differential response systems to provide family support so children are not removed from their homes and placed in foster care.[44]
- Mobile response services. In New Jersey, for example, these services helped keep between 90 to 94 percent of children referred for emergency services in their homes while achieving two important goals: (1) connecting the family with needed and sustainable services; and (2) de-escalating the crisis at hand by fundamentally changing the family's response pattern to crises.[45]

- Homemaker services. Parent aides who go to a family's home to provide child supervision, cleaning, and other services on an emergency basis.
- Family-based services such as *Family Connections, Functional Family Therapy (FFT), Homebuilders, Multi-systemic Treatment (MST), Parent-Child Interaction Therapy (PCIT), and Triple P Positive Parenting Program*, which offer intensive counseling, education, and supportive services.[46] For example, New Jersey child welfare leaders saw a significant decline in out-of-home requests and attributed it to the availability of the MST program.[47]
- Home-visiting services such as *Healthy Families New York, Nurse-Family Partnership, and SafeCare*.
- Informal care systems such as informal faith-based foster care programs.[48]

New Mexico Reduces Unnecessary Short-Term Placements by Passing Legislation to Improve CPS/Law Enforcement Coordination

In 2009, then New Mexico Governor Bill Richardson signed into effect significant revisions to the state's Children's Code. Due to these revisions, law enforcement agencies are now required to contact New Mexico Children, Youth and Families Department (CYFD) to conduct an on-site safety assessment to determine whether taking a child into immediate custody is necessary (with some exceptions such as medical emergencies). In addition, when a child is taken into custody by law enforcement, CYFD is not compelled to place that child in out-of-home care and may release the child to his or her parents or legal guardians. The new legislation, which became law on July 1, 2009, further specifies that CYFD shall release the child unless custody "is appropriate or has been ordered by the court." The reform, while promising, is relatively new, and no results have yet been published about the impact of the law and CYFD joint trainings involving CYFD staff and law enforcement officers.[49]

Unspecified Mental Health Therapy Using Unproven Interventions

The field of psychotherapy has documented that generic psychotherapy is not effective.[50] Consequently, the field is moving more toward treatment interventions with demonstrable effects for the children and families served by child welfare.

As the number of studies about the effectiveness of mental health services with children and parents involved in child welfare grows (including alumni from foster care), evidence is being assembled about the ineffectiveness of conventional unspecified therapy where no particular treatment approach is employed, including long-term treatment provided on a weekly or bi-weekly basis – often accompanied by a high turnover rate among the therapists for a specific child.[51] For example,

Weisz examined the mean effect sizes of unspecified psychotherapy treatments compared to control conditions (typically no-treatment controls). The mean effect size is less than zero, meaning that the unspecified treatments did not outperform the no-treatment controls.[52]

In addition, a recent meta-analysis of general psychotherapy studies focused on children who were randomly assigned to an evidence-based treatment (mainly behaviorally oriented or multi-system approaches) or to some form of usual clinical care. The mean effect size was .30, indicating that in those studies the average improvement of evidence-based treatments over usual care fell about midway between a small and medium effect, by Cohen's effect size standards, showcasing their value.[53] Some child welfare agencies and the mental health treatment organizations with which they work are improving assessment of mental health conditions of youth in care and the services provided to help them heal. State and county agencies are examining the mental health approaches with evidence of effectiveness, and those that are suitable for the emotional and behavioral disorders and sub-disorder conditions that are most prevalent for families involved in child welfare.[54] Maine's use of a combination of evidence-based approaches tailored to the needs of the child and family is described below.

Maine Implements Child Steps to Improve Therapist Training and Mental Health Treatment Outcomes

The State of Maine was concerned about maximizing the value of their investments in mental health therapist training and services. The Maine Office of Child and Family Services, working in collaboration with Casey Family Programs, was selected by the Youth Mental Health Network[55] as one of two sites for a groundbreaking implementation study to improve the quality of mental health services for youth. The Maine site focused on youth involved with the child welfare system. The Youth Mental Health Network is a multi-year (now decade-long) collaboration of leading mental health experts including psychotherapy researchers, organizational and qualitative researchers, policy makers, and family representatives. The Network has documented and studied several types of challenges in improving mental health care for youth in community clinics. Based on this research, the Network has developed a multi-component model that includes an integrative, modular form of evidence-based psychotherapy together with a web-based clinical information system that guides treatment planning and clinician decision-making. The entire model, derived from the Network's Child Systems and Treatment Projects, is called *Child STEPs*.

The Surgeon General's Office and the Institute of Medicine have both underscored the urgent need to give youth and their families access to forms of psychotherapy whose effectiveness has been tested scientifically. Solid research evidence supports specific, separate treatment strategies for four of the most common and important mental health problems in youth: anxiety, post-traumatic stress, depression, and conduct problems. Dissemination of these separate treatments in community mental health systems, however,

has proved difficult. The Network worked for several years to develop and test a treatment approach that simultaneously addresses each of these four problems in youth age 7-13. The result of this work – *Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems* (MATCH)[56] – can be flexibly tailored to meet the needs of individual youth and families with any one or any combination of these four problems, using a single integrated treatment approach. MATCH follows an innovative modular design,[57] and it has been found to produce outcomes superior to both usual clinical care and standard evidence-based treatments, in a recently published randomized effectiveness trial.[58]

National studies have documented the high prevalence of mental health needs in youth who are involved in the child welfare system; these needs interfere with core child welfare goals of permanency and increased well being. While the pace of dissemination of evidence-based psychotherapies for youth in general has been disturbingly slow, the pace has been even slower for youth involved in child welfare. There is an urgent need to develop improved treatment approaches in support of better permanency and well-being outcomes for this population. Research into the changes in the mental health functioning outcomes of these children, including those involved in child welfare, will be published in late 2012.

Community-Based Family Support Services

With the exception of the *Promoting School-Community-University Partnerships to Enhance Resilience (PROSPER)* model[59] and the *Communities That Care (CTC)* strategy,[60] research evidence about community-based family support strategies is scant. However, community-based family support strategies have much potential for success when there is a long-term commitment to the community; integration of clinical and community support services; and when they are holistic, integrated, comprehensive, and culturally relevant.

For example, the Center for Family Life in Brooklyn is a long-standing family support approach that takes into account the impact of the community on the family and vice versa, and includes activities that are fun and normalizing, such as arts and other recreational activities. In addition, more evidence-based approaches to preventing the recurrence of specific types of child maltreatment are needed, such as *Healthy Families America, Nurse-Family Partnerships, Parent-Child Interaction Therapy,* and *Triple P*.[61]

Financing and Implementation Strategies

Program Re-Investments Using Title IV-E Waiver Funding

Beginning in 1994, states could obtain five-year waivers for flexible use of Title IV-E foster care maintenance and administrative funds. States have used these flexible funds for an array of

programs and services, including subsidized guardianship, flexible funding to local agencies, child welfare managed care, substance abuse services, intensive preventive services, and tribal administration of federal child welfare funds, among others. The IV-E waiver program was intended to generate new knowledge about alternatives to foster care placement.[62]

Waivers were recently re-authorized by Congress, and reinvestment strategies have been highlighted by recent waiver demonstration projects, in the current Federal Waiver Call for Applications, and the associated Information Memo.[63] Waivers can be a key financing strategy for supporting demonstration projects and applying these principles of reinvestment.

Facilitating the Process of Reinvestment

When engaging in re-investment activities, jurisdiction leaders recommend that careful attention be paid to these challenges and tasks:

- Select desired child welfare outcomes around which there is consensus among key stakeholders. This can be the starting point for the creation of a more comprehensive child welfare strategy that includes community partners and focuses on the priority outcomes.
- Begin with the shared interest of key stakeholders in improving the social and emotional well-being of youth known to the child welfare system. Often, different state agencies (including health, mental health, Medicaid, and education) are already making investments to address well-being. For example, states such as Georgia, Ohio, and Colorado are improving permanency planning services for older youth in foster care.
- Use agency data in a timely way to refine approaches to achieving the desired outcomes. How do agency leaders determine what needs improvement and what needs replacement? What kinds of family and youth profiles help inform planning? For example, Illinois identified distinct clusters of youth in foster care to better determine what sets of interventions might best meet their needs.[64]
- Choose carefully among multiple evidence-based practice options. Consider implementation and service delivery costs in relation to benefits; considering only one or the other does not tell the full story. Timing is important as well. A program may be expensive but it may be preferred if it has better outcomes and/or outcomes that persist farther into the future (e.g., Nurse Family Partnership).[65] What other partners need to be engaged for effective service delivery, such as education, employment, housing, mental health, substance abuse treatment, and vocational rehabilitation? For example, Juvenile Court Judge Cindy Lederman has been a powerful advocate for evidence-based and trauma-informed care in Miami-Dade County; which has led to the redirection of resources and the development of a specialized court for families with children 0 to 3 years of age.[66]
- Consider applications to different populations. Can the new set of interventions be suitable for certain ethnic groups and immigrant or other special communities?[67] Will these interventions be implemented in both rural and urban settings?

- Have courageous conversations about the gaps in capacity or capability that might be present in the current system. This includes managing relationships with contract providers and helping them with capacity-building: identifying, training, and retaining staff to implement these practices. For example, New York City closely compared performance indicators for agencies providing foster care services; this helped leaders determine which agencies to coach (so their practices could improve) and which to stop funding.
- Identify what resources are needed to "de-scale" and "retool." Seek creative financing approaches such as agency reinvestment of savings in states[68] and social impact bonds.[69] Reinvestment also requires considering carefully the complex issues of how to reward good agency performance with carefully designed performance-oriented contracting and monitoring approaches.

- Manage services during the interim period while moving from one service delivery model to a new one. This is akin to fixing a moving train – for example, such as when some of the current child welfare staff in states like Florida, Illinois and Kansas assumed a stronger services monitoring role while greater privatization of certain services was being implemented.

- Communicate clearly. How can the change process be made simple enough for the maximum number of people to understand it? Target your messages to key audiences – public citizens, agency leaders, supervisors, and line staff. For example, in Los Angeles, child welfare and mental health agencies developed a social marketing approach to share key information about a planned set of group care reforms. This resulted in the timely launch of the Residentially-Based Services Initiative.[70]

- Upgrade performance measurement. Creating an evaluation process to measure both the implementation and effectiveness of the evidence-based practices (EBPs) is a challenge. Frequently, the quality, fidelity, and outcomes of new intervention approaches cannot be measured well with existing management information systems. What kinds of affordable upgrades are most important and feasible to make or is development of an additional performance monitoring data base warranted? Information systems, fidelity to the model, case worker fatigue, and community provider buy-in are significant concerns for child welfare planners when EBP implementation is considered. Increasingly, field-tested resources are available that can ameliorate many of these concerns.[71]

Introducing fidelity measures, which take into account the additional workload and orientation of caseworkers during the implementation phase, is a necessary step in ensuring that services sustain positive effects. Oklahoma implemented SafeCare statewide, and found that staff retention and fidelity to the model were strong when consultation was used as the vehicle for fidelity monitoring.[72]

The issues of how to de-scale and re-invest resources to implement more evidence-based programs are complicated, and this section highlights only a fraction of the issues involved in this process. Fortunately, growing attention is being paid to implementation science, performance monitoring,

and related fiscal dimensions by the Institute of Medicine (IOM), National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Administration (SAMHSA), and the Administration for Children, Youth and Families (ACYF).

Conclusions

Meaningful change requires mutually agreed-upon outcomes across government entities, business, and faith-based and other community sectors. Taking responsibility for child and family well-being and implementing policies across social service and governmental entities that incentivize positive measurable change for children and families are necessary ingredients for transformation. Policies should require measuring and improving outcomes as well as a more integrated community response. Innovations in public administration and community development are beginning to highlight the need for this kind of reform.[73]

This research brief has focused on how certain child welfare program or service areas could be examined for phase-out, de-scaling, right-sizing, or decreasing investments so that funds can be re-invested in more evidence-based interventions. The examples presented in this brief are by no means an exhaustive list of the strategies that should be examined for their effectiveness (or lack thereof). The field also needs more evidence-based interventions from which to choose.[74] Additional research using a variety of evaluation designs is also needed to more firmly establish the effectiveness of the emerging and promising interventions listed on the evidence-based registries and clearinghouses.

Endnotes

1. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2010). *Child welfare outcomes 2006-2009: Report to Congress.* http://www.acf.hhs.gov/programs/cb/pubs/cwo06-09/cwo06-09.pdf#page=51.

2. See AFCARS and other reports: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report18.htm; http://www.chapinhall.org/research/brief/who-are-infants-out-home-care; Klein, S. (2011). Building the evidence-base regarding infants/toddlers in the child welfare system. *Children and Youth Services Review, 33,* 1333-1336.

3. AFCARS FY 2010 data obtained from Data Advocacy Services, Casey Family Programs, April 5, 2012.

4. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). *Child maltreatment 2010,* p. 56 http://www.acf.hhs.gov/programs/cb/pubs/cm10/index.htm

5. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2010). *Child welfare outcomes 2006-2009: Report to Congress,* p. 6.39 http://www.acf.hhs.gov/programs/cb/pubs/cwo06-09/cwo06-09.pdf#page=51.

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www.casey.org/resources/publications/NeedForFinanceReform.htm. For a state-by-state analysis of prevention services funding streams and services, see DeVooght, K., Fletcher, M., Gavin, B., McCoy-Roth, M. (2012). *The 2011 Casey Family Programs state prevention policy survey: A patchwork of policies and programs to prevent child maltreatment.* Washington, DC: Child Trends. http://www.childwelfarepolicy.org/tools/assets/files/2011-CFP-Prevention-Survey.pdf

11. For discussions on the challenges of implementing evidence-based practices, see:

    - Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).
    - Huey, S. J., & Polo, A. (2008). Evidence-based psychosocial treatments for ethnic minority youth. J*ournal of Clinical Child & Adolescent Psychology, 37*(1), 262-301.
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13. Kelley, R. R. (2009). *Where can $700 billion in waste be cut annually from the U.S. healthcare system?* Washington, DC: Healthcare Analytics, Thomson Reuters. http://www.factsforhealthcare.com/whitepaper/HealthcareWaste.pdf

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19. For more information about restorative justice and circle sentencing, see http://www.doc.state.mn.us/rj/publications/circle.htm

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32. Virginia Department of Social Services administrative data, 2007-2009, as cited in The Annie E. Casey Foundation. (2010). *Rightsizing congregate care: A powerful first step in transforming child welfare systems,* pp.7-8. www.aecf.org.

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35. See the Signs of Safety Web site for a wide range of books, reports, and videos: http://www.signsofsafety.net/ For California materials, see http://208.86.2.45/sop/112158ReachingOut.pdf; Munro, E. (2002). *Effective child protection.* London, UK: Sage.

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- Note that because family group conferences are often not possible to organize on an emergency basis, this way of engaging extended families and other support systems to develop safety plans and prevent out-of-home placement is less relevant to emergency short-term placements.

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    A number of organizations, including various branches of the federal government and the Annie E. Casey Foundation, have been cataloging effective interventions. See, for example, the following databases:
    - Blueprints for Violence Prevention, a project of the Center for the Study and Prevention of Violence at the University of Colorado (http://www.colorado.edu/cspv/blueprints)
    - National Child Traumatic Stress Network (NCTSN; www.nctsn.org)
    - OJJDP Model Programs Guide (http://www.ojjdp.gov/mpg/)

- OJJDP Children Exposed to Violence Evidence-Based Guide (http://www.safestartcenter.org/pdf/Evidence-Based-Practices-Matrix_2011.pdf)
- SAMHSA National Registry of Evidence-Based Programs and Practices (NREP; http://nrepp.samhsa.gov/)
- U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) (http://www.acf.hhs.gov/programs/opre/other_resrch/home_visiting/index.html)

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61. For more information about the following evidence-based child maltreatment prevention programs, see the California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/) and the following websites:

    - *Healthy Families America:* http://www.healthyfamiliesamerica.org/home/index.shtml
    - *Nurse-Family Partnership:* http://www.nccfc.org/nursefamilypartnership.cfm
    - *Parent Child Interaction Therapy (PCIT):* http://pcit.phhp.ufl.edu/efficacy.htm or http://pcit.phhp.ufl.edu/
    - *Triple-P Positive Parent Partnership:* www.triplep.net

62. For summaries of past state or county waiver strategies, see: http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2011/flexible.pdf

63. The Title IV-E Waiver RFP announcement and guidance can be found on the ACF Web site at http://www.acf.hhs.gov/programs/cb/

64. Weiner, D. A. (2011). *Understanding youth in long-term foster care.* Presentation for the Illinois Department of Children and Family Services Champaign-Urbana, IL: Illinois Department of Children and Family Services.

65. Chamberlain, P., et al. (2011). A strategy for assessing costs of implementing new practices in the child welfare system: Adapting the English cost calculator in the United States. *Administration and Policy in Mental Health, 38*(1), 24-31.

66. Falconer, M. K., DiLorenzo, P., Lederman, C. S., Pecora, P.J., & Thompson, C. K. (in press.) Family-centered practice in Florida: Family court actions and perceptions. *Juvenile and Family Court Journal*; Lederman, C. S. (2012). Using science to make healing decisions in juvenile courts. In *CW 360 - Using a Developmental Approach in Child Welfare Practice, Winter,* p. 26. http://www.cehd.umn.edu/ssw/cascw/attributes/PDF/publications/CW360-CEED_Winter2012.pdf

67. See:
    - Chibnall, S., Dutch, N., Jones-Harden, B. Brown, A., Gourgine, R., Smith, J., Boone, A., & Snyder, S. (2003). *Children of color in the child welfare system: Perspectives from the child welfare community.* Washington, DC: U.S. Department of Health and Human Services Administration for Children, Youth and Families, Children's Bureau.
    - Huey, S. J. & Polo, A. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 262-301.
    - Webb, M. B., Dowd, K., Jones-Harden, B., Landsverk, J., & Testa, M. (Eds.) (2010). *Child welfare and child well-being: New perspectives from the National Survey of Child and Adolescent Well-Being.* New York: Oxford University Press.

68. Many states have passed laws allowing reinvestment of program savings back into child welfare. For example, Washington State enacted HB 2263 in 2012 to create a child and family reinvestment account in the state treasury, to be funded with savings resulting from reductions in foster care caseloads and per capita costs. Funds from the account may only be used to safely reduce entries into foster care, increase reunifications, achieve permanency for children unable to be reunified, and improve outcomes for youth who age out of foster care. The Department of Social and Health Services is required to develop a methodology for calculating the savings to be deposited into the reinvestment account. The methodology must incorporate the relevant requirements of any Title IV-E demonstration waiver granted to the state. The methodology must be submitted to the Governor and legislature by December 1, 2012, and, if approved, shall be used to calculate savings for transfer into the reinvestment account, beginning in fiscal year

2014. The reinvestment account and reinvestment methodology terminate on June 30, 2018. For other state examples, see: Casey Family Programs. (2011). *Authority to reinvest savings from foster care: The top 20 states*. Seattle, WA: Author.

Also see: http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Session%20Law%202012/2263-S.SL.pdf

69. See:

- Dugger, R. & Litan, R. (2012). *Early childhood "pay-for-success" social impact finance: A PKSE bond example to increase school readiness and reduce special education costs.* (A Report of the Kauffman Foundation – ReadyNation Working Group on Early Childhood Finance Innovation). Webinar discussion draft paper, March, 2012. Kansas City, MO: Kauffman Foundation, p. 3. http://www.readynation.org/uploads//20120404_KauffmanReadyNationPKSEReport.pdf
- Another practical resource is the following paper: Aarons, G. A., Hurlburt, M., & McCue Horwitz, S. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*, 4-23. Here planners will find tools for evaluating readiness and determining fit within existing structures, and a particularly helpful discussion of the various funding mechanisms available to planners for implementation and sustainability.

70. Los Angeles County. (2010). *Los Angeles County "Open Doors" - Residentially Based Services Demonstration Project (RBS)*. Los Angeles: Department of Children and Family Services.

71. Information systems may not be an issue since the vast majority of EBPs have ready-built data collection systems, which are designed to either interface with typical operating systems or, in most cases, run from a desktop using readily available and easy-to-use programs like Microsoft Access.

72. Aarons, G. A., Sommerfeld, D. H., Hecht, D. B., Silovsky, J. F., & Chaffin, M. J. (2009). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: Evidence for a protective effect. *Journal of Consulting and Clinical Psychology, 77*(2), 270-280.

73. Bourgon, J. (2011). *A new synthesis of public administration.* Montreal, Quebec: McGill Queen's University Press; Bowie, P. (2011). *Getting to scale: The elusive goal. Magnolia Place Community Initiative.* Seattle, WA: Casey Family Programs.

74. See Pecora, P. J., Sanders, D., Wilson, D., English, D., Puckett, A., & Rudlang-Perman, K. (2012). *Addressing common forms of child maltreatment: Intervention strategies and gaps in our knowledge base.* (Research brief.) Seattle, WA: Casey Family Programs. www.casey.org.

shifting resources

Casey Family Programs is the nation's largest operating foundation whose work is focused on safely reducing the need for foster care and building communities of hope for all of America's children and families. We work in partnership with child welfare systems, families and communities across the nation to prevent child abuse and neglect and to find safe, permanent and loving families for all children. We believe every child deserves a family of their own and a community of hope.

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