Health and Human Services Committee
LR 37 Hearing – September 28, 2011
Omaha, Nebraska

Good morning, Senator Campbell and members of the Health and Human Services Committee. My name is Camas Diaz (C-A-M-A-S D-I-A-Z). I am an Administrator with Families Matter in the 19 counties that comprise the Eastern and Southeast Service Areas. I am the Administrator responsible for the Initial Assessment teams and the Abuse/Neglect ongoing teams in both of these service areas. These are activities that have been, and will continue to be, responsibilities of the Department. Prior to this position, I was the Administrator responsible for all Children and Family Service teams in the Eastern Service area. I have been employed with DHHS since 2000, when I began as a Case Manager.

Today I'll provide some updated information and address several topics requested by the Committee, primarily about the data used and gathered by the Department and the Lead Contractors.

The Eastern and Southeast Service Areas have gone through substantial changes in the last 24 months. Since April 16, 2010, The Eastern Service Area has temporarily provided direct case management to 1/3 of the ESA families which were originally served by Visinet, Inc. These families will soon be transitioning to the Nebraska Families Collaborative, NFC, for case management. The majority of families impacted by this change will be transitioned to NFC by Oct. 15, 2011. Any of these families that are likely to close before the end of December 2011, will remain with DHHS for case manager continuity. Upon case closure these families will transfer to NFC for Aftercare services. The complete transition to NFC will be completed by December 31, 2011. For the past twelve months, the Eastern Service Area has operationally been managing two systems, one system delivering case management as in previous years and another system performing oversight of the NFC/KVC case management contracts. These dual roles have caused role confusion within staff, families, providers and the Court system.

As we move to a system where DHHS monitors case management, it has been necessary to evaluate our current outcome monitoring system, including the data reports and access to information that helps drive decisions and planning. Moving from providing direct case management to contract oversight of case management requires restructuring and a change in staff culture and accountability systems. This is still in progress as we learn from other states, national consultants and our own experiences.

In the Eastern and Southeast Service Areas, DHHS has a category of staff titled Child and Family Outcome Monitors (aka CFOM's). The CFOM staff are responsible for collecting the data necessary to monitor the Lead Contractors. These functions include the review and approval functions of case planning, placement changes, court report recommendations, and case closure. DHHS also continues to maintain review and approval of those functions that restrict an OJS youth's liberties, including detention, secure transport and revocation of parole. The

function of the CFOM has been adjusted over time as we learn more effective and efficient ways to do this work.

An example of one recent adjustment occurred on September 1st, 2011, when we co-located several CFOM's within the offices of NFC and KVC. We have also assigned one DHHS CFOM to each Court room in the Southeast and Eastern service areas. While the co-located and Court-assigned CFOM adjustment is only in its first month, we have already seen positive results. The co-located CFOM is able to immediately review court reports and request any revisions necessary, and do this face-to-face with the Lead Contractor staff. This activity is much more efficient when done face-to-face versus through email communication. The Court-assigned CFOM attends every hearing and is able to report back concerns, positive experiences, legal issues that surfaced during the hearing and problem-solve Court-related issues. Because the CFOMs are in court each day, they are also able to participate in conversations with the Court and legal parties on a daily basis. The co-located and Court-assigned CFOM's also collect data related to timeliness of court report completion, the quality of the Court report and ensure that Court reports are submitted to all legal parties prior to the hearing.

In addition to the co-located and Court-assigned CFOM's, DHHS also has teams of CFOM staff who perform random sample reviews on specific data outcomes. These reviews are aggregated and analyzed to provide feedback to both DHHS and the Lead Contractors regarding outcomes. As you may know, all states must participate in periodic Federal Child and Family Services Review, or CFSR. The CFSR is completed by using a standard case review tool that focuses on 23 items, all related to Safety, Permanency and Well-Being. This information can be found on Handout #1. Our Review CFOM's have been trained on the CFSR and are responsible for completing our internal CFSR review of a specific number of families each month. This data is also then aggregated and analyzed for trends, areas of strength and areas of weakness.

Research indicates that there is a strong correlation to improved child safety, permanency and well-being with frequent and consistent contact between the case manager and the child. DHHS is able to aggregate and analyze data regarding frequency of monthly contacts. This data can be drilled down to individual case managers within NFC, KVC and DHHS. In addition, our Review CFOMs also complete random samples on monthly contact narratives to assess for both the quality and quantity of documentation and visitation. Our CFOM and Quality Assurance teams also conduct quality and quantity reviews on Court Report Timeliness, Family Team Meetings, Home Studies, and Placement Stability.

Our system of oversight is still evolving, but as you can see we are making improvements each day. We have also been consulting with Casey Family Programs as well as reviewing how other states have structured their oversight role. We are also reviewing our current organizational structure to determine how best to organize both resources and expertise. We are committed to ensuring that we have a solid Continuous Quality Improvement system that collects the right data, analyzes the data and uses the data to make system improvements which improve the lives of the children and famlies we serve.

Our current case management database is called NFOCUS, which has been our data system since 1998. NFOCUS is the statewide database for child protection data, Economic Assistance data as well as data from the Division of Developmental Disabilities. Having this data from various programs combined into one system allows the user to access information about any of those services a family may be receiving. This provides a more efficient and comprehensive view of the family situation than using separate data systems.

The Lead Contractors, NFC and KVC, as well as the Foster Care Review Board, have access to the NFOCUS system, with certain limitations built in to protect the privacy of the families involved in other DHHS programs. NFC and KVC are required to enter certain case management related information into NFOCUS. NFOCUS generates data reports that range from individual worker performance on key areas to system-wide performance on aggregate federal outcomes.

I will add that NFC and KVC also maintain independent data systems based on their unique business and operational needs, separate from NFOCUS. These data management systems allow NFC and KVC to track information important for their operations, such as their referral information, claims data and a variety of other management-related data and reports.

In addition to the individual performance outcomes that are reported through NFOCUS, DHHS is required to submit a number of federal reports regarding specific data. I have included this information at the request of the Committee. These federal reports include the AFCARS (Adoption and Foster Care Analysis and Reporting System) data sets which are submitted semi-annually; a description of these can be found on Handout #2; the NCANDS (National Child Abuse and Neglect Data System) data sets which are submitted annually, found on Handout #3; the NYTD (National Youth in Transition Database) data which is submitted semi-annually, see Handout #4; and the IV-B Caseworker visit data which is submitted annually, found on Handout #5.

The integrity of our data improves each week as we work with NFC and KVC to ensure that we are defining hundreds of pieces of data in the same way. Reconciling the NFOCUS data with the data collected by the NFC and KVC systems is challenging and involves work each week by all three agencies. This is important because NFC and KVC maintain the "official" family file for all review and case management purposes, while DHHS maintains a CFOM file and legal information on each family. The co-located DHHS CFOM is the conduit for any hard copy information that is shared between DHHS and NFC/KVC. Specific requests for assistance from DHHS can also be directed to a single email address that has been established solely for time sensitive requests. This single point email is also utilized for requests for background checks and child care authorizations, both functions that DHHS has retained.

The Foster Care Review Board coordinates their regular family reviews directly with NFC and KVC. The Foster Care Review Board provides notice to NFC and KVC of those families to be reviewed. This allows NFC and KVC sufficient time to prepare the files to be reviewed. Reviews occur both on-site of hard copy information as well as through NFCOCUS documentation.

The Division of Child and Family Services is developing a plan to guide our work and priorities into the future. This planning will be a statewide effort focusing on those areas that we believe will have the greatest impact on our efforts to ensure that children are safe. We are working with consultants from the Casey Family Programs who have great expertise in Child Welfare. Our foundational outcomes are to make sure that children and neighborhoods are safe; that children are connected to caring adults; and that children have the tools they need to lead productive lives. The next step will involve sharing this plan with our statewide stakeholders in order to enhance the plan and assist us with developing both local and statewide strategies to accomplish the identified priorities and outcomes.

Thank you for your time this morning and for inviting me. I appreciate the opportunity to share information with you about this important work. I'm excited for the future and for the improvements we are making to better serve Nebraska's children and families. I am happy to answer any questions you may have.

Department of Health & Human Services
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LR-37 Testimony, Omaha, NE September 28, 2011
Handout #1: CFSR Outcomes and Systemic Factors, and Associated Items and Data Indicators

During a Child and Family Services Review (CFSR), the review team assesses the State's substantial conformity with the following:

- Seven outcomes in the domains of safety, permanency, and child and family well-being
- Seven systemic factors that affect outcomes for children and families

To measure a State's substantial achievement of the outcomes, the review team assesses items (onsite review) or items and data indicators (onsite review and Statewide Assessment). To measure substantial achievement of the systemic factors, the review team assesses items to determine whether the systemic factors are in place and functioning satisfactorily.

The items and/or data indicators associated with the outcomes and systemic factors are listed below.

Outcomes

Safety

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

- Timeliness of initiating investigations of reports of child maltreatment (Item 1)
- Repeat maltreatment (Item 2)
- Absence of recurrence of maltreatment (data indicator)
- Absence of maltreatment of children in foster care (data indicator)

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.

- Services to family to protect child(ren) in home and prevent removal or re-entry into foster care (Item 3)
- Risk assessment and safety management (Item 4)

Permanency

Permanency Outcome 1: Children have permanency and stability in their living situations.

- Foster care re-entries (Item 5)
- Stability of foster care placement (Item 6)
- Permanency goal for child (Item 7)

- Reunification, guardianship, or permanent placement with relatives (Item 8)
- Adoption (Item 9)
- Other planned permanent living arrangement (Item 10)
- Timeliness and permanency of reunifications (Permanency Composite 1)
- Timeliness of adoptions (Permanency Composite 2)
- Achieving permanency for children in foster care (Permanency Composite 3)
- Placement stability (Permanency Composite 4)

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.

- Proximity of foster care placement (Item 11)
- Placement with siblings (Item 12)
- Visiting with parents and siblings in foster care (Item 13)
- Preserving connections (Item 14)
- Relative placement (Item 15)
- Relationship of child in care with parents (Item 16)

Child and Family Well-Being

Child and Family Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.

- Needs and services of child, parents, and foster parents (Item 17)
- Child and family involvement in case planning (Item 18)
- Caseworker visits with child (Item 19)
- Caseworker visits with parent(s) (Item 20)

Child and Family Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.

- Educational needs of the child (Item 21)

Child and Family Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

- Physical health of the child (Item 22)
- Mental/behavioral health of the child (Item 23)

Systemic Factors

Statewide Information System

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

Case Review System

- The State provides a process that ensures that each child has a written case plan to be developed jointly with the child's parent(s) that includes the required provisions. (Item 25)

- The State provides a process for the periodic review of the status of each child, no less frequently than once every 6 months, either by a court or by administrative review. (Item 26)
- The State provides a process that ensures that each child in foster care under the supervision of the State has a permanency hearing in a qualified court or administrative body no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter. (Item 27)
- The State provides a process for termination of parental rights proceedings in accordance with the provisions of the Adoption and Safe Families Act. (Item 28)
- The State provides a process for foster parents, pre-adoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be heard in, any review or hearing held with respect to the child. (Item 29)

Quality Assurance System

- The State has developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of the children. (Item 30)
- The State is operating an identifiable quality assurance system that is in place in the jurisdictions where the services included in the Child and Family Services Plan (CFSP) are provided, evaluates the quality of services, identifies strengths and needs of the service delivery system, provides relevant reports, and evaluates program improvement measures implemented. (Item 31)

Staff and Provider Training

- The State is operating a staff development and training program that supports the goals and objectives in the CFSP, addresses services provided under titles IV-B and IV-E, and provides initial training for all staff who deliver these services. (Item 32)
- The State provides for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP. (Item 33)
- The State provides training for current or prospective foster parents, adoptive parents, and staff of State licensed or approved facilities that care for children receiving foster care or adoption assistance under title IV-E that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children. (Item 34)

Service Array and Resource Development

- The State has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency. (Item 35)
- The services in item 35 are accessible to families and children in all political jurisdictions covered in the State's CFSP. (Item 36)
- The services in item 35 can be individualized to meet the unique needs of children and families served by the agency. (Item 37)
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Agency Responsiveness to the Community

- In implementing the provisions of the CFSP, the State engages in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP. (Item 38)
- The agency develops, in consultation with these representatives, Annual Progress and Services Reports pursuant to the CFSP. (Item 39)
- The State's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population. (Item 40)

F ster and Adoptive Parent Licensing, Recruitment, and Retention

- The State has implemented standards for foster family homes and child care institutions that are reasonably in accord with recommended national standards. (Item 41)
- The standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-E or IV-B funds. (Item 42)
- The State complies with Federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children. (Item 43)
- The State has in place a process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed. (Item 44)
- The State has in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children. (Item 45)

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Handout #2: Adoption and Foster Care Analysis and Reporting System (AFCARS)

AFCARS was created, in part, due to concerns raised about the lack of national information available on children in foster care, their families, foster care settings and adopted children. In 1986, Congress amended title IV-E of the Social Security Act by adding section 479, which requires the Federal government to institute a foster care and adoption collection system. In response to the law, requirements for States to report adoption and foster care data to a Federal system (known as AFCARS) were implemented under Federal regulations at 45 CFR 1355.40. AFCARS collects case level information on all children in foster care for whom the State child welfare agency has responsibility for placement, care or supervision and on children who are adopted under the auspices of the State's public welfare agency.

The data includes basic demographic information on children, parents, foster parents, and adoptive parents; removal dates; number of removals; placement settings; numbers of placement settings; discharge date; discharge reason and funding sources.

AFCARS is submitted semi-annually. The report periods cover October 1 to March 31 (due by May 15th) and April 1 to September 30 (due by November 14th).

AFCARS is subjected to required edit checks for the following:

- Timely submission of the data files
- Timeliness of data entry for certain data elements
- Whether the data meets a 90% level of tolerance for missing data and internal data consistency

AFCARS data is specifically used in the following:

- Adoption Incentive Programs
- Child Welfare Outcome Reports
- Child and Family Services Reviews (CFSR)
- CFSR Data Indicators for Reunification, Adoption, Permanency and Placement Stability
- Title IV-E Eligibility Reviews
- Allotment of funds in the Chafee Foster Care Independence Program (CFCIP)

Additionally, AFCARS is used by the Administration of Children and Families (ACF):

- Responding to Congressional requests for current data on children in foster care or those who have been adopted

- Responding to questions and requests from other Federal departments and agencies, including the General Accounting Office (GAO), the Office of Management and Budget (OMB), the DHHS Office of Inspector General (OIG), national advocacy organizations, States, and other interested organizations
- Short and long term budget projections
- Trend analysis and short and long term planning
- Targeting areas for greater or potential assistance efforts for discretionary service grants, research and evaluation and regulatory change
- Determining and assessing outcomes for children and families

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Handout #3: NCANDS SUMMARY

NCANDS (National Child Abuse and Neglect Data System) is an electronic report that is submitted annually by each state. The file provides the information below for all Child Abuse and Neglect reports (AKA Intake Reports) where the allegation finding was entered during the report period.

The Federal Report Period is October 1 through September 30 of the following year. States are to submit the report electronically by January 31st following the end of the report period. The report includes the following information

I. **REPORT DATA** - This is general information about the report and provides dates and an identifying number for each report and child combination. A record is created for each child and report number combination. There are total of eleven (11) fields.

II. **CHILD DATA** – This section has thirteen (13) fields that provides demographics for the child victims to include; DOB, Gender, race and Ethnicity

III. **MALTREATMENT DATA** – This section has nine (9) fields that provides information about the abuse types identified in the allegation and the findings for each of those abuse types using the highest level of severity (Substantiated or Unfounded)

IV. **CHILD RISK FACTOR DATA** – This section has nine (9) fields that identify specific characteristics for a child victim. Examples are Alcohol Abuse, Drug Abuse and other disabilities.

V. **CAREGIVER RISK FACTORS DATA** - This section has nine (9) fields that identify specific characteristics for the child victim's caregiver. Examples are Alcohol Abuse, Drug Abuse and other disabilities or financial issues.

VI. **SERVICES DATA** – This section has 30 fields that identifies if a child victim received any of the 30 services identified to include legal support and services after the report date and prior to the allegation finding was entered.

VII. **STAFF DATA** – This is only two fields that identifies the worker and supervisor for the intake report

VIII. **PERPETRATOR DATA -** This section has fifty-seven (57) fields that provides demographics for the perpetrators to include; DOB, Gender, race and Ethnicity. This provides this information for up to 3 perpetrators and also includes a reference to the maltreatment they were responsible for that references back to the Maltreatment data section.

IX. **ADDITIONAL FIELDS** - This section includes two (2) fields to include the AFCARS ID so that the report can be cross references to the states AFCARs file and the incident date for the allegation(s) being reported in the record

The information included in the NCANDs file is used for the States Children Family Service Review and is used to calculate the following:

I. **RECURRENCE OF MALTREATMENT** – If a child victim allegation was substantiated and the report was received in the first six months of the report period then it is checked to see if the child victim is a victim in a subsequent report that is received within six months of the original report. This is considered recurrence of maltreatment.

II. **ABUSED IN FOSTER CARE** – If the perpetrator for a substantiated allegation is a foster parent then it is considered that the child victim was abused in Foster Care.

Additional information that is derived from the NCANDS file includes the average time to complete an investigation. This is determined by comparing the Investigation Start Date (Date Child Victim is contacted) to the date the report was received (Intake Receive Date). This information is captured in the Report Data section of the NCANDS file.

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Handout #4: National Youth in Transition Database Summary

NYTD (National Youth in Transition Database) is an electronic report that is submitted semi-annually by each state. The files are submitted by May 15th and November 15th to report the information below.

The Federal Report Periods are October 1 through March 31 (Submitted by May 15) and April 1 through September 30 (Submitted by November 15). States are to submit the report electronically by the end of the report period. The report includes the following information

- **BASELINE** - For Youth that turned 17 years old in Foster Care
  - Demographics about the youth to include DOB and race
  - Indicator if they completed a 21 question survey within 45 days of their 17th Birth date
  - The answers the youth submitted/selected for the survey
- **FOLLOW-UP** For youth that participated in the baseline survey successfully
  - Demographics about the youth to include DOB and race
  - Indicator if they completed a 21 question survey within 45 days of their 17th Birth date
  - The answers the youth submitted/selected for the survey
- **SERVED POPULATION -** Any youth that received an Independent Living Service during the report period
  - Demographics about the youth to include DOB and race
  - Indicator of a Yes or No if the youth received the service listed. There are 14 Service categories.
  - The Highest Education level completed by the youth

The baseline survey population is selected every three years starting on October 1, 2010 through September 30, 2011. Youth that submit the baseline survey on time and successfully are required to answer the survey questions again every two years up until the year of their 21st birth date (Once at age 19 and once at age 21).

Currently NYTD is not used for any Federal reports like the CFSR but it does have potential to be included in a similar review. This has been incorporated into the states IV-B plan.

Department of Health & Human Services
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Handout #5: IV-B Caseworker Visits

Background: In passing the Child and Family Services Improvement Act of 2006 (P.L. 109-288), Congress noted in its findings that "...CFSRs also found a strong correlation between frequent caseworker visits with children and positive outcomes for these children, such as timely adherence of permanency and other indicators of child wellbeing." P.L. 109-288 was signed into law on September 28, 2006 and included both requirements and funding for caseworker visits in title IV-B of the Social Security Act (the Act).

In accordance with Sections 424(e) (1) and (e) (2) of the Social Security Act (the Act), States must, beginning with Fiscal Year (FY) 2007, provide data on the percentage of children in foster care under the responsibility of the State who were visited on a monthly basis by the caseworker responsible for the case of the child; and the percentage of visits that occurred in the residence of the child.

The goal of this statutory provision is to achieve at least a 90 percent threshold of children in foster care being visited monthly by their caseworker and ensure that the majority of the visits will be in the child's residence by October 1, 2011.

Failure to meet this goal results in a reduction of federal funds.

This data is reported by federal fiscal year (October to September) and is due by October 31st.

PERFORMANCE STANDARDS AND IMPLEMENTATION SCHEDULE
DHHS-FAMILIES MATTER
KVC Behavioral Healthcare
July 11, 2011

Contract performance is measured through outcomes. When outcomes are not met, contractors are required to develop Performance Program Improvement Plans and demonstrate improved performance. Failure to improve on said outcomes may result in contract termination. Performance measurement focused on child and family outcomes is critical in ensuring our efficiency and effectiveness in serving the children and families of Nebraska.

The f llowing Performance Standards are an addition to the existing Outcome Measures identified in the Operations Manual, Section 13-1 to 13-24 (see attachment).

Performance Standards:

Outcome: KVC will assist DHHS in increasing the number of families who are able to safely meet the needs of their children without the formal system involvement of DHHS-CFS and/ r the Juvenile Court System.

Strategy:

KVC will implement the Initial Response Unit (IRU) in the Southeast Service Area (SESA) and continue to provide IRU service in the Eastern Service Area (ESA).

- Measurement: Total number of accepted Initial Assessment (IA)'s in the SESA with an IRU response (numerator)/Total number of accepted IA's in the SESA (denominator).
- Measurement: Total number of accepted IA's in the ESA with an IRU response (numerator)/Total number of accepted IA's in the ESA (denominator).
- Data Collection Tool: IRU Data Collection Worksheet
- Timeframe: Implementation of SESA IRU - July 2011
  Quarterly report of aggregate data to DHHS:
  Q1 - July, Aug, Sept = Due Oct 31
  Q2 - Oct, Nov, Dec = Due Jan 31
  Q3 - Jan, Feb, Mar = Due Apr 30
  Q4 - Apr, May June = Due July 30

Outcome: Planning for families will involve families.

Strategy:

KVC will annually complete the Family Centered Practice Rating Tool to assess family inclusion.

- Measurement: Completion of Family Centered Practice Tool by June 30, 2012.
- Data Collection Tool: The Rhode Island Coalition for Family Support and Involvement *Family-Centered Practice Tool* (see attachment).
- Timeframe: Quarterly report to include implementation plan, implementation results (to include plan to address needs identified).
  Quarterly report to DHHS:
  Q1 - July, Aug, Sept = Due Oct 31
  Q2 - Oct, Nov, Dec = Due Jan 31
  Q3 - Jan, Feb, Mar = Due Apr 30
  Q4 - Apr, May June = Due July 30

Strategy:

KVC will facilitate Family Team Meetings one time each month for all court involved families.

- Measurement: Review of NFOCUS documentation
- Data Collection Tool: QA Tool developed by DHHS. DHHS will track exceptions to this include last minute cancellations by families, no-shows, and other DHHS approved extenuating circumstances. Timeframe: Monthly random sample review to begin August 2011

Strategy:

KVC will ensure that at least one family member participates in each Family Team Meeting.

- Measurement: Review of NFOCUS documentation
- Data Collection Tool: QA Tool developed by DHHS. Family Team Meetings are to be face to face, DHHS will grant exceptions for extenuating circumstances e.g. parent incarcerated, out-of-state residence or distance.
- Timeframe: Monthly random sample to begin August 2011

Outcome: Increase the number of youth who are able to achieve timely permanency to best support their individual needs.

Strategy:

KVC will actively work with the Regional Behavioral Health Authorities to develop a mutually agreed upon documented process that results in youth with a behavioral health disorder receiving a Transition Plan. Transition Planning must begin at least 3 months prior to the youth's 19th birthday.

- Measurement: Review of meeting minutes until documented process is completed. DHHS will then QA Transition Plans documented in NFOCUS.
- Data Collection Tool: Meeting minutes until Transition Plans are documented in NFOCUS.
- Timeframe: Quarterly report to include all meeting minutes to DHHS:
  Q1 - July, Aug, Sept = Due Oct 31
  Q2 - Oct, Nov, Dec = Due Jan 31
  Q3 - Jan, Feb, Mar = Due Apr 30
  Q4 - Apr, May June = Due July 30

Strategy:

KVC will ensure uniform and consistent utilization of Structured Decision Making assessments and tools throughout the KVC ESA cases and SESA.

- Measurement: To be determined by KVC
- Data Collection Tool: Quality Assurance report
- Timeframe: Quarterly Report to DHHS
  Quarterly report to DHHS:
  Q1 - July, Aug, Sept = Due Oct 31
  Q2 - Oct, Nov, Dec = Due Jan 31
  Q3 - Jan, Feb, Mar = Due Apr 30
  Q4 - Apr, May June = Due July 30

Additional expectations to enhance outcome attainment:

1) KVC to partner with DHHS to facilitate discussions with the Court, Chief Justice, Law Enforcement, etc. to address system barriers and challenges that impede successful attainment of desired outcomes.
2) DHHS to implement Structured Decision Making through contract with the Children's Resource Center. Model adaption to begin July 2011, training to begin September 2011, all DHHS staff trained December 31, 2011.
3) KVC to continue participation in advisory and stakeholder committee meetings as requested by DHHS.
4) KVC to continue to provide aftercare services to both court and non court involved families
5) KVC to continue to recruit and retain foster care families to meet the unique, diverse and individualized needs of children served.

LR 37 TESTIMONY OUTLINE

Alicia B. Henderson
Chief Deputy/Juvenile Division
Lancaster County Attorney's Office

CHILDREN ARE NOT NUMBERS:

1. Removals of Children in Lancaster County in September
2. These Children deserve the Best we can give them
3. Are We Giving them the Best we Can?

KVC:

Top Three Observations:

1. Lack of basic training and understanding of safety and risk
    a. Teen runaway
    b. Four young children
2. Failure to Provide include Pertinent Information to Court and Parties
    a. Teen victim
    b. Baby at Risk
3. Caseworker Turnover and High Caseloads
    a. Toddler and Newborn at Risk

Other Significant Concerns:

1. Not knowing whereabouts of wards
    a. Baby and mother AWOL
2. Child getting kidnapped during a supervised visitation
    a. Where was the worker?
    b. Why had the visits moved back to the mother's home without notification to parties?

CHILD WELFARE SYSTEM IN NEBRASKA:

Pressure to "Reduce the Number of State Wards" is most likely placing children in harm's way:

1. Child Exposed to Marijuana
2. Toddler who was harmed because no removal was done.
3. Out of Home Safety Plans in Non-Court cases

Why does the Legal Guardian of the child know only what is in the court report?

1. CFOM responsibilities

RECOMMENDATIONS FOR THOSE CHARGED WITH MAKING POLICY DECISIONS:

1. Scrutinize the Numbers
    a. Who are State Wards in other States?
        i. Conduct a Study
            1. Do other states include OJS youth in their numbers?
            2. Do other states make children state wards when they are placed with family?
            3. Do other states have ways to get services for youth and families without making them wards of the state?
    b. Are you being provided with comparable data?
        i. Time frames should not change
    c. Are the private agencies and HHS reporting data in the same way?
        i. Placement stability data
2. Compare the Outcomes
    a. Eastern and Southeastern Service areas have private agencies
    b. Northern, Central and Western do not
    c. Where are the better outcomes?
3. Compare Data on Child Deaths due to Abuse/Neglect
    a. Where does Nebraska stand?

COMMENDATIONS:

To whom it may concern:

I have included the letters we wrote in March and early April regarding our foster children. We have no agenda but only wish that all foster children receive the care and love they deserve. The current system has many gaps and holes, and while staffed with some great people and some others who seem to be working off another agenda, we feel that it can and should be improved for the sake of the children and the community.

I appreciate you taking the time to read this and sharing with whoever you feel can impact positive change. If you would like to discuss this letter or if my wife or I can be of any service in trying to impact change feel free to contact us.

Curtis and Amy Harrington
402-659-4427, 402-689-9948

This letter was typed March seventh and sent to NFC, state workers, county attorney, GAL and his supervisor. Discussions were held with all but the County Attorney who never responded.
I am typing this email from a very frustrated and disappointed place. My wife and I have been foster parents for over 10 years. We both serve as volunteers in several different roles in the human services field regarding foster parents. I have a master's degree in counseling and my wife has a master's of social work. We both have worked for over 15 years each in the human services field. We have excellent skills and education and experience. We advocate relentlessly for the rights of biological parents and the children placed in our care. We have a biological son and a daughter we adopted from the foster care system. We are not a permanent option for our current placements. All of that brings us to the place we are currently. Helpless, frustrated, disappointed, and terrified for our current placements.

We currently have two different court cases impacting the three foster children we have in our home. These cases have been mishandled and mismanaged in a horrific manner. We have spoken to people involved in the case at all different levels and cannot seem to find any acceptable and appropriate resolution and satisfaction. Everyone states that they are doing their job and doing everything that they can and they don't want this or that to happen but no one is stepping up and taking a stand demanding that the right thing be done for these children. This is the motivation for this email.

I want to take a moment here to clarify some things. We have always taken one placement at a time and had them until they went home or achieved permanency. We took a little girl in March. We had her until she went home in September. In August we were told that she would be leaving in less than two weeks. We took our next placement trusting in this information. It took six weeks for her to go home and we had both kids and that was fine. In December we took the little girl's sibling while paternity was established. Two weeks later we got the little girl back following dad's arrest and a determination that she was not receiving current and consistent care at the home of her dad's mother. Hence where we are now.

Case A is the case of a 13 month old boy. He has been in our home since August of this year. End of June or early July, he was voluntarily placed in care by his mother due to having no permanent home and income to provide for his needs. He came to our home in August after it was deemed that the current home which he had been in, his mom's foster home until she aged out of the system, was inappropriate for him to get reunified with his mother. We were told he had significant medical issues and concerns for his development were long but it was agreed at the time he came to us that the home he was leaving would be an adoptive placement for our little guy if his mother did not get him back. A court hearing was scheduled in September that we attended. Adjudication did not occur as an agreement was made that if mom could resolve her issues she would get her son back. At this time we had a great department case manager and a horrible service coordinator. It was determined during this time the previous foster parent was no longer a placement option and we were told that she had her license taken away.

The little guy came to our house with some serious attachment issues. We had to work very hard to soothe him and address his issues. Developmentally he was behind but within the age appropriate range and we have worked very hard to help him. I am pleased to say that developmentally he is doing very well. Emotionally he still has some serious issues that we have attempted to address. As foster parents my wife has been able to stay home with our daughter and our placements so he has not been placed in day care. His daily needs and demands for attention and affection would prevent him from being successful in a day care setting. We have not placed him in respite placement. He has spent time with my mother in law for respite for our family when we left the state one time which helps with his adjustment. He has become very emotionally dependent on my wife and I. We have attended all of the scheduled team meetings. The one in September didn't take place. The one in October led to a significant conflict between biological mom and the service coordinator. Fortunately the DHHS worker was there to prevent that from escalating. For the November meeting, we were uninvited due to concerns of mom's volatility. December's meeting did not occur because mom had a seasonal job and was unable to schedule. During the month of December, mom who was supposed to have 4-5 visits a week, she had 4 or less. She stated her schedule had changed and the visit provider was unable to accommodate her visits. The provider stated that they had tried to get ahold of mom and she was not responsive. We addressed this issue with the service coordinator who was not responsive to us. We finally pushed for resolution and invited the service coordinator and her supervisor and the GAL to attend a meeting at our home. The supervisor and the GAL attended. We were able to address our concerns. We stated that we were concerned that the case had not been adjudicated. Additionally a court hearing was upcoming at the end of March and that our little guy continued to have serious attachment issues. We were able to use these individuals and mobilize services for our little guy. We asked to have this brought to court for adjudication. We asked for a bonding assessment to see if he and his mother, who is again pregnant with an April due date, were bonded. Our little guy is unable to self soothe. He does not sleep through the night. He is very anxious and clingy. He does not venture out of the sight of my wife or me. He is a very stressful and demanding young man who stresses my wife and me with his issues. We are competent, experienced parents, educated, trained, self-confident and supported individuals that he challenges to the point that we have to take turns to get through the day and the night. We have asked for a fetal alcohol evaluation but cannot get one unless mom reports she drank while pregnant. We have asked for work with attachment issues but have been told that until he is in a permanent home that is not appropriate. We have asked for a developmental assessment but have been told that since he does well in our home he is not appropriate. We have succeeded in getting a sleep disorder appointment with a child psychologist who has done an excellent job in the two appointments we have had. He still does not sleep through the night and we are at a critical step to addressing this issue and the process is on hold while we see if this little man goes back to his mother in less than 48 hours.

The court hearing we had heard about for the end of March was upcoming. We wanted to know what would happen. What everyone was recommending. We asked our new service coordinator who spoke with the supervisor who was at our house in January what would happen. We were told that no one would recommend that the little guy go home. The previous service coordinator at the team meeting in January had

stated that mom had a job and an apartment and would probably get him back. There was no team meeting in February since this worker left and was being replaced. We brought up concerns of a man living in the house where visits were taking place. Had he been through a back ground check? We felt these were all issues that we would like addressed prior to the court hearing at the end of March. Our Service coordinator's supervisor who has done an excellent job contacted court to find out the time and was informed by the bailiff that there was not court at the end of the month but instead it was in two days, a check hearing to review sending our little guy home. This supervisor immediately sent out an email notifying all parties. The GAL responded that the previous court order stated that if no one came in prior to the end of March that the case would be closed. The GAL had not received notice of the court hearing and was not in support of the little guy going home and would speak to the county attorney. I saw him today and he confidently informed me that he felt the little guy would not go home. That within the next 36 hours an affidavit would be filed that would leave this young man in care. Who is to file this affidavit? On what grounds would there be a case against mom who has housing approved for visits and has a job? He did not have these answers.

We have a young man with intense needs and emotional issues that potentially faces an immediate move to the home of his mother who has only done supervised visits since August and missed most of the visits in December and visits are not occurring this week due to a change in her work schedule. Going home without transition or support or court involvement could have significant impact on this young man. To a mom who at the team meeting in January stated that all of the concerns my wife and I have were the result of her son being taken from her and he never had these issues when he lived with her, at less than six months old.

Court is Thursday morning. I do not know what will happen. Maybe my concerns are way off base and I should have more faith in the system and the GAL. But what if my concerns are accurate and the system sends this little guy home and mom is not prepared and he is not prepared and mom does not have the support and skills she needs to be 8 months pregnant with an anxious, needy, attention seeking child with attachments issues?

There was no court that Thursday morning. The case was not dropped at that time. We spent the next three weeks pursuing someone to file an affidavit, knowing the whole time that they had no one who could testify to anything the mother had done. We were told that the Service coordinator was looking to file to have the baby mom delivered in April removed. We were told the whole time not to worry, he would not go home, also the other baby would be born and the kids would be placed together in an adoptive foster home. A referral was made for an adoptive home. The last day of the month we were told an affidavit was filed and there was a court hearing for the end of April. The day of court in April a decision was made that mom had agreed to voluntarily let the little guy remain in care and she could take her newborn home.

My wife and I developed and pushed for a strong transition for our placement to meet his needs. Mom was on maternity leave. We provided a significant amount of the transportation. Mom got her son home on May 26th. We remained involved in the case and continued to provide respite and support for mom. She was

receiving family support. Several weeks after he was home mom called and said she got a job with her mom 2-3 hours from Omaha, still in NE. We contacted the service coordinator who said she would work with the county mom went to get her services. End of June mom leaves and the only people who have had contact with her are the foster parents. We have seen the mom and the children and have continued to support them. We will be going up to see their place in the next few weeks. There is no after care or traditional support for this family. We hope and pray that it works out for all, but what if it doesn't?

Case B has similar concerns but for different issues. Our little 19 month old has been moved eight times. At three weeks she was placed in foster care. At about three months she went to her father's. She was there for five months. She came back into care and was placed at our home. She was with us for 6 months. She went back to dad's for a week and was back in care for a week. She then went home for 6 weeks with dad at dad's home with his mother. Dad was arrested and she spent two weeks with multiple care givers before returning to our house 3 months ago. She is a resilient and beautiful little girl that in spite of all of these moves has done tremendously well.

She was removed from her mother's care due to violence with dad's sister and the mother using a knife to threaten the little girl's life. She was removed from dad's house the first time due to domestic violence between mom and dad. Mom refused to testify and the criminal case was dropped. From July until August there were concerns of domestic violence but no charges or police calls. She was returned home in September. She was removed a week later due to allegations that could not support a removal due to Dad having an excellent attorney and the affidavit not being thorough or accurate enough. Dad got his little girl back. He continued to use us as informal supports. Dad did a very nice job parenting his daughter. She seemed happy and was clean and well dressed. He used us for weekend respite and contacted my wife to address health issues and concerns for his daughter. We had no issues with him having her except his violent history and his relationship with the mother. End of November he was arrested for stabbing his sister's boyfriend after domestic violence between his sister and her boyfriend. He has pleaded no contest to this charge. He has been detained since that time and will be sentenced in May and may receive probation and time served. The only thing he has been adjudicated on in juvenile court is being in jail and not being able to provide for his daughter. His attorney was able to prepare for the dad to get visits unsupervised when he is out of jail. Dad's attorney and the judge have both done exactly what they have needed to do to represent the law and the client. I do not fault them for the job they have done and the decisions that they have made with the information and rules that they are under. The service coordinator and her supervisor have written excellent affidavits to address concerns they have regarding dad and his history of violence. The county attorney addressed none of these issues and agreed to a plea on the dad regarding dad being in jail for now, without addressing any other issues for this man as a parent. No

concern or attention paid to the fact that if dad gets out, while the affidavit has a great deal of concern for the safety and dad's violent past, none of this has been adjudicated on. So dad gets out, goes back in to the house with his mother and gets a job, he gets the little girl back? With the only thing ordered at court was a parenting class while in jail or four months after he gets out.

Dad was sentenced to 6-8 years in prison. He is eligible for a parole hearing in November of this year. He has not been adjudicated on anything for his 8 month old son. There was an adjudication set for June but the county attorney did not get him brought back. There is an adjudication scheduled but at this time they are looking at starting visits with dad for when he gets out in November. He has never seen his son.

The mother's side of this case is even more concerning. After terroristic threats and the knife incident, Labor Day weekend of 2009, the little girl enters care when mom is arrested on felony charges. Mom is in jail until February or March, prior to our involvement. She becomes pregnant. There is a domestic violence issue and the police are called and dad gets arrested. The little girl comes into our care. Dad goes to jail until July when he gets out and continues his relationship with the mother, who refused to testify at district court regarding the domestic violence. Mom has had services and visits and family support work since March of 2010. She has not had her district court charges addressed. She reports that the county attorney was on maternity leave and returned to have 8 murder cases and will not address her charges. Who knows how much or what is true. What we know is mom has not had these issues addressed. Mom has gone back and forth from cooperative with services to combative. Her son was born early December. She was encouraged to place him in voluntary care while she worked to get a house and a job. She does not have a house but has had consistent employment for months. She believes when she gets her house she will get her kids back.

In January she was involuntarily committed to a mental health facility after threatening suicide 4 different times. In February a team meeting was cut short after mom became argumentative and confrontational. After we left the meeting we have been informed that mom threatened to kill the family support worker. Visits were put on hold for a few days while the situation was evaluated. Until today mom had never been adjudicated on for her mental health issues.

Over 18 months her daughter has been in care. The issues that led to her daughter in care have not changed. Nothing has been filed to address terminating parental rights. It has been discussed getting a reasonable efforts finding and ending visits. It is discussed and then never comes up in court or makes its way into the recommendations. Various reasons have been told to us for this. One is that the county attorney won't file on only one parent. That since she was in dad's care that this does not count against moms 15 out of 22 months and that she is only at 10 of 18. That moms time in jail does not count against

her. That now there is a new baby and they do not have the time needed on mom for him so why terminate on the sister.

Our placements little brother was born and voluntarily placed in our home by his mother in early December directly from the hospital. He has regular visits with his mother. They are in the process of addressing paternity for this little guy so that he can be included on dad's petition for being in prison. He was adjudicated on for mom's mental health issues today. We assume that he is now starting a completely new process with mom. The case is set for review on both kids for six months.

Mom has had visits consistently since April, prior to that they were inconsistent. We have a new visit worker who looks to start the Family Support over for the sake of making sure a reasonable efforts finding is not brought against them.

An 1184 hearing was held regarding this case. We attended and expressed our views. The only result we heard was that they recommended the kids be moved to an adoptive home.

Additionally, we have been informed that he does not have Medicaid due to some error when the case transferred from voluntary to a detention status. This fact combined with the inability to get treatment authorization is a major concern for us. His assigned case manager is aware and fixing but what happens in between if he needs medical care?

We are with an excellent agency and feel that we are very supported and they want the same things that we want. We believe that our case is managed by the better of the two local lead agencies. We have a great deal of people in the case who feel we are on point with our concerns, but yet we have grave concerns.

I have composed a list of concerns/ breakdowns in the system/ Families Matter that we have seen in the foster care system as foster parents and volunteers in the foster care arena

- Visits with three new workers in the same week for one young man who has attachment issues
- Unable to provide visits in the evening due to a change in mom's work
- Visit workers who do not know proper car seats based on size age and weight or installation of said car seats.
- No identified/consistent state worker
- New guardian ad litems. Our new one is the same for both cases and he has been very professional and supportive and has had great contact with us and the service coordinators.
- No affidavit, or someone to write one who has been with the case

- Services not willing to address needs that are very important and are seriously impacting this young man's life
- Case A- Losing a HHS employee who was excellent and did a great job
- Case A-Having a Service coordinator who was inappropriate and not professional
- Case B- Losing a HHS worker who provided nothing substantial to the case
- Case B- An excellent Service Coordinator who did a great job for the children
- Both cases- No identifiable HHS employee
- County attorney who will not write a strong petition and press for substantive charges to put teeth in the court to get parents to change for the benefit of the kids
- GALs who do not visit with their children
- Foster parents who do it only for the payment
- Foster parents who do it only for adoption
- Foster parents willing to adopt children but the state not willing to provide Medicaid and a subsidy
- Foster parent homes with no current home study
- Parents not able to access services they need to provide for their children, counseling, drug treatment,
- Long waits for Psychological and psychiatric evaluations
- Housing not available for parents
- Lack of support for foster parents
- Failure to identify paternity for children in the system on intake
- Foster Placements made with inaccurate or incomplete information provided to the families and the workers placing the kids
- Redundancy in services between the foster parent reports, the foster care specialists, the service coordinator, HHS employee, Family Support Workers, Visitation workers, therapists, family support network people, GALs, CASAs. All identifying concerns and issues. But the change was made to eliminate the bueraracy, instead it increased and provides the opportunity to shift responsibility and blame others for the kids falling thru the cracks.
- Another issue, we were at Children's hospital with our thirteen month old foster boy on a Tuesday afternoon at 2PM. The hospital called his assigned worker for permission to treat, she was unavailable. The lady placing the call spoke with someone and asked to speak to the worker's supervisor and was told that the supervisor was in a meeting. She asked to speak with any supervisor and was told that none were available. The hospital employee informed us that for several days in a row they have called and been unable to get authorizations to treat. They treated without authorization since it was not an emergency; no one at DHHS knew it was not an emergency.
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My goals for this are not to change the course of the two cases and the three kids that we have in our home. My goal is to be sure that people are aware that these kids are all exposed to significant risk and their young fragile lives are being protected by a system that has serious flaws, and while no one wants bad things to happen to young kids, they all are doing their jobs, getting paid, saying the system is broke and does not work because other people are not doing their jobs, and sending these and many other children into situations that could have significant and life changing impacts on young lives that might not show themselves for years.

Who will accept responsibility for these children if something dreadful happened?

A young girl with 9 different care giver changes before 19 months, facing a move back to her dad and separation from her younger sibling by the age of 21 months after no visits for over 6 months. What will her life look like in 12, 15, 18 years?

A young man who has serious attachment issues and a young mom who does not understand these issues and has no support. Facing a move and breaking the longest attachment he has in his life without transition to go to a home where four weeks later his sibling arrives and adds stress and anxiety to him and his mother. A mother who has not expressed or exhibited any interest in cooperating with services while the child is in care, hoping she cooperates with these same people after the court case is closed. What does this Child look like at 12, 15, 18?

"I did my best but the system is broke" will not comfort me for these children or others like them if I do nothing or allow others to not accept responsibility for their role in a "broke" system.

I hope and pray for the best, and have done everything that I think I can to help these children. I want to think and believe that they are going to a better place, and hope that my concerns are wrong and unfounded. But at the same time, I am concerned about their immediate safety and their long term mental health and attachments and adjustments. My wife and I will do our best to stay involved, but have major concerns. Maybe we cannot help these kids, maybe they don't need more help, but hopefully this letter gets to people who can do more for these children and also other children like them that may need help.

I am not interested in saying that one thing or another is the cause or the reason the system is not working. The system was broke before privatization and it remains broke after. It has been going on

long enough that transition is not an acceptable excuse while they work the bugs out. It is beyond all of that blaming and not accepting responsibility. DHHS has a role. Lead agencies have a role. Contractors have a role. Parents have a role. Foster parents have a role. The court has a role. County attorneys have a role. Judges have a role. GALs and parent attorneys have a role. The state and the communities have a role. The problem is big enough that everyone can and should take responsibility in the problem and more importantly in the solution.

I want to take the opportunity to thank you for taking the time to read this letter. I realize I am not the best writer, and grammar is not a strength, but I believe that my points and passion for these kids and the other kids is so important, something had to be said even if it is said badly and with poor grammar.

Sincerely,

Curtis L Harrington
Amy L Harrington

Health and Human Services Committee
Testimony on LR 37
September 28, 2011

Presented By
Karen Authier, LCSW, LMHP
Executive Director
Nebraska Children's Home Society

My name is Karen Authier and I am Executive Director of Nebraska Children's Home Society (NCHS). I also am Vice President of the Children and Family Coalition of Nebraska (CAFCON) and have worked in many roles as a professional and as an advocate for over 40 years. I want to thank the Committee for the invitation to provide testimony on the Nebraska child welfare reform initiative and for the Committee's leadership in assessing the impact of that initiative and developing recommendations for the future of Nebraska's at risk children. NCHS has been in the role of subcontractor with the original 5 lead agencies and currently is a subcontractor with the remaining 2 lead agencies. As a subcontractor, NCHS provides foster care, in home services for children and families, and relinquishment counseling. In addition to our work as a subcontractor with lead agencies, NCHS provides other services statewide, including pregnancy, parenting and adoption services; post adoption services; prevention programming for teens and operates a Children and Family Center.

To put the current reform effort in perspective, I find it useful to reflect on the past in addition to surveying the present. When the state was very young, there was no state child welfare system. There were only private charities and county governments that had legal responsibility and limited funds for care of abused, neglected and abandoned children. Since 1893 Nebraska Children's Home has been a statewide resource for children who needed temporary or permanent homes and families. Privatization is not new. What has changed is the shifting framework of state statutes and regulations, legal decisions, federal funding and regulations, as well as new research and "best practices" that shape the environment in which we carry out our work. Now we are adjusting to a new way of doing our work with lead agencies as intermediaries between the Department of Health and Human Services and private agencies as subcontractors.

I will share with you my observations regarding the reform effort as it relates to lead agencies, issues we are facing and recommendations for the future:

Lead agencies. I believe that NCHS has a solid and productive working relationship with both Nebraska Families Collaborative (NFC) and KVC and I serve on the NFC Community Advisory Board. Nevertheless, all entities involved in the reform have experienced disappointment and frustration in our shared effort to meet the needs of Nebraska's children and families. The following are some general, as well as specific observations:

1. Shared challenges. While there have been some midcourse corrections, both remaining lead agencies have struggled to respond to an ambitious time line for implementation, changing expectations from the Department that did not match funding allocations, responsibility for outcomes without the authority for case management decisions that

impact those outcomes, lack of "upfront" work with the judicial system, and simultaneous tightening of authorizations for Medicaid services that families need. Lead agency staff often lack experience in child welfare that becomes evident in poor decision making, lack of information about resources in the community and lack of credibility in court. In addition to inexperience, high turnover of case management staff means that caseloads are high; many workers lack knowledge about the children and families for whom they are responsible; and there is no opportunity for a relationship to develop between the worker and the child.

With a short timeframe for start up, lead agencies did not have adequate infrastructure in place to handle payments for work done by subcontractors and at one point NCHS accounts receivables were six to nine months in arrears. Of course, when Visinet closed its doors, we received only 70¢ on the dollar in payment. However, both KVC and NFC have implemented changes and are now timely in their payments, as is the Department, which still has responsibility for 1/3 of the cases in the Eastern Service Area. It is important to point out that NCHS and other private providers continued to pay our foster parents and staff even when we did not receive timely reimbursement from the lead agencies.

2. Lead agency as direct service provider. While both NFC and KVC faced similar challenges in "launching their ships," KVC's situation seems more complicated because it made the decision to become a direct service provider in Nebraska, as well as assume the role of lead agency. Start-up of its own foster care, mental health and in home services may have distracted KVC from its work as lead agency and resulted in less attention to reasonable caseloads, responsiveness to subcontractors, and clarity in organizational structure. In addition, KVC's role as direct service provider presents a potential for conflict of interest in decision making regarding management and utilization of services.

3. Optimism regarding lead agency leadership. There are some signs for optimism. NFC is working on transitioning the remaining 1/3 of the children from the Department to NFC. I have been encouraged by reports from my that there is planning underway that should reduce the chaos that occurred in November of 2010 when the children initially were transitioned from the Department to lead agencies without adequate planning. NFC and KVC both have shown interest in tapping into the expertise of subcontract agencies to improve outcomes for children.

Issues we are facing. Although I remain optimistic that there is commitment to the goals and vision for system improvement, I would like to highlight a few issues that need to be considered:

1. Role of subcontractors. Subcontractors provide the bulk of the services in the child welfare reform yet are virtually nonexistent in the design of the reform. NCHS and other subcontractors have picked up the slack when lead agencies dropped the ball. We are often the people with the strongest relationship and the most complete grasp of the needs of the child and family, but may have little input into planning. Our information regarding specific children and family issues is not necessarily communicated to the

courts. We are left "holding the bag" when a lead agency does not fulfill its responsibility or becomes insolvent. While team meetings should provide opportunity for collaboration and planning with families, lead agencies, subcontractors and others who are involved, there is inconsistency in the scheduling and effectiveness.

2. Relationship between child welfare service needs and Medicaid. Outcomes in the child welfare system often depend on access to Medicaid treatment services. Changes in criteria for accessing behavioral health services and dwindling options within the service array are variables that impact achievement of the goal of improving outcomes for children in the system or at risk for coming into the system. Unless there is leadership in addressing these issues across Division lines in the Department of Health and Human Services, lead agencies and subcontractors will be stymied in implementing appropriate service and treatment plans. When Medicaid does not authorize services, costs either shift to lead agencies or appropriate services are not provided.

3. Cost shifting to subcontractors. Prior to the reform initiative, the state provided funding for clothing vouchers and authorized payment for some assessments and intervention services not covered by Medicaid. The lead agencies do not provide equivalent services, assessments or supplements for children, biological parents and foster parents. While NCHS has always used funds from donors to provide additional benefits such as summer camps, prom dresses, athletic fees, etc. for children in our foster care program, we now use our own funds to provide gift cards for clothing and other necessities that used to be paid by the state. There has been attention to the fact that foster parent retention has become a problem. In fact our foster care program has tripled in size, but I believe the expansion is directly related to the additional, non-reimbursed support we provide to children in our program.

Recommendations. It is difficult to distil my thoughts into a few recommendations, but I believe the following concepts are important:

1. Look forward, not backward. While it is important to review the history and the current challenges of the reform, it is more important to look to the future and focus on quality, desired outcomes and accountability. There may be disagreement regarding the wisdom of some of the decisions that have been made, but as the saying goes, "Once you're a pickle, you can't go back to being a cucumber." The upheaval that would occur from reversal of the decision to privatize would further disrupt the lives of children. We need to put children at the center of our thinking, agree on a plan, and fix what needs to be fixed.

2. Focus on quality and results, not speed. Last week heading east from Lexington, on the I-80 there was a slowdown in traffic ahead, flashing lights of emergency vehicles, and cars and trucks off the road. Was stepping on the gas a first reaction? No. Seeing all the signs of problems in the roadway, it was necessary to slow down and consider the options. We do have the option to slow down and consider the options. As a statewide organization, NCHS sometimes pilots programs in one location and then determines what would be need to be changed to take the program statewide. It is my opinion that the

state should put plans on hold for resuming privatization in the 3 service areas that have reverted to the public model of service delivery. In those areas the public agency can be held accountable to the same requirements set for the lead agencies until a reasonable plan is in place that covers the entire state.

3. Focus on the well-being of children as well as numbers. Numbers are important and goals and objectives must be measurable. However, there is a temptation to focus purely on numbers that do not tell the whole story and are virtually useless in capturing the happiness or grief of a child. To use a quote from Rowena Young, Director of the Skoll Center for Social Entrepreneurship, "The risk with any metric is that people will come to see it as a description of reality, rather than a tool for a conversation about that reality." For example, the often cited numbers of children in foster care in Nebraska are important. However, when those numbers are compared with those of other states there is usually no explanation that numbers of children in care in Nebraska include children in the juvenile justice system. Nebraska is one of only 4 states that include those children in their numbers. It is important to develop measures of success that capture the well-being as well as the status of children. There is discussion of performance based contracting that has merit. However, performance based contracting that focuses only on numbers creates the same pitfalls as the current plan.

Thank you for this opportunity to present my opinions regarding the reform initiative. Sometimes it seems like we have been pushing a heavy ball uphill for a long time, but the alternative is to let the ball roll backwards over the children we serve.

voices for children
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September 28, 2011

To: Members of the Health and Human Services Committee

From: Carolyn D. Rooker, Executive Director

RE: Improving Nebraska's Child Welfare and Juvenile Services System

Voices for Children in Nebraska is grateful to the Health and Human Services Committee for their leadership in child welfare and juvenile services reform. We appreciate the opportunity to share our perspective and vision of what reform should look like going forward.

Since 2009, Nebraska has been struggling to reform its child welfare and juvenile services systems. This reform has focused primarily on privatizing service delivery and case management as a way to improve care to children and families. We know reform hasn't succeeded:

- Nebraska has lost services;
- Children, families and employees have gone through huge periods of transition and uncertainty; and
- Nebraska has not seen substantial improvement in its child welfare measures.

From Voices for Children's perspective, the primary challenge associated with reform has been its lack of focus on children and families. While we are not opposed to privatization, Nebraska was foolish to think that handing an under-funded broken system to the private sector, without focusing on fixing its flaws in a meaningful way, would have a significant impact.

There are four major steps that can make a significant impact on our child welfare and juvenile services system:

1. **Invest in prevention and family preservation services.**
2. **Improve and develop a more complete structure of juvenile services.**
3. **Provide clear structures of accountability and oversight.**
4. **Ensure an experienced and knowledgeable leader heads the reform.**

Attached to this letter, you will find a more complete description of these recommendations.

In the coming months, we as Nebraskans have a responsibility to focus child welfare debate on creating a child- and family-centered system. What is best for children and families is best for all of us. We look forward to working the committee, DHHS, and other stakeholders to chart a positive course forward.

voices for children IN NEBRASKA

September 2011

Building a Better Child Welfare System for Nebraska

For a long time in Nebraska our child welfare system hasn't served kids and families the way we want it to. Our "house" hasn't been in order for some time. The child welfare system as we currently know it is much like a home in need of repair.

We've been trying to fix it, but haven't quite gotten it right. We tried to paint over flaws instead of addressing the structural problems In the past, we didn't have a good plan or foundation of services or the accountability, oversight and leadership needed at the top.

So, how do we rebuild our state's child welfare "house" to better serve children and families?

It's time to roll up our sleeves and start working together to build the system that our children and families deserve.

It won't be easy, but we've outlined a few key places where the impact on the system will be greatest.

A Strong Foundation

Prevention and Family Preservation Services

All of Nebraska's children deserve to grow up in a safe, loving environment that meets their developmental needs. Families are a crucial part of this process, but sometimes they need supports and services to help keep their children safe. Providing prevention services to families is an essential component of a child-centered system, which works to make sure kids never experience maltreatment.

Nationally, the number of child victims of abuse and neglect has decreased substantially since 1990 due in large part to an emphasis on prevention. The story in Nebraska is different: numbers of child victims of abuse and neglect have risen since 2000 to over 5,000 a year, almost the same level as that in 1990.

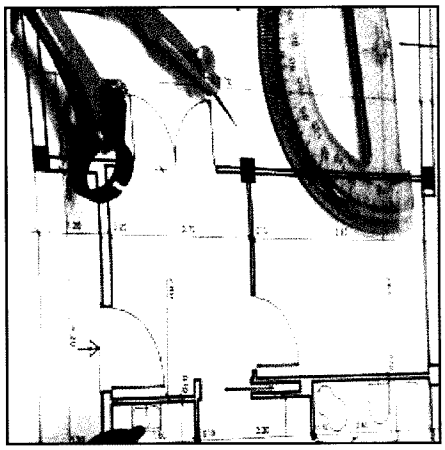
Family preservation or "in-home" services are another essential component of a truly child-centered system. Children love their families, and being removed from them even in cases where abuse or neglect has occurred, can be traumatic. Everyone benefits when services can simultaneously keep children safe and keep families together. Nebraska's rate of children being removed from their homes has been more than twice the national average since 2000. We must invest in and develop a clear system of in-home services that keep children safe and out of out-of-home care if we want our child welfare system to improve.

A Well-Designed Floor Plan

A Complete Array of Juvenile Services

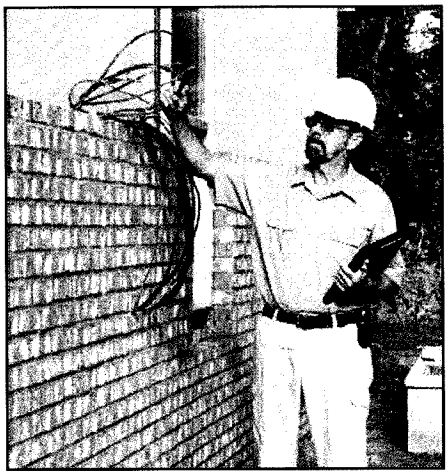
Nebraska's child welfare system also includes children involved in the juvenile justice system. The Division of Children and Family Services is responsible for children who have been made wards of the state through the Office of Juvenile Services (OJS). As of June 2011, about 22% of Nebraska's wards were OJS wards. Building a successful system will require an intentional look at the services we offer these children and their families while they are wards of the state. It will also require Nebraska to develop juvenile and behavioral health services that make wardship unnecessary for a greater number of children.

Nationally and in Nebraska, juvenile services have been provided in out-of-home environments that are often unnecessarily restrictive, expensive, and do not meet the needs of the children they serve. Youth are usually better served in their communities, where they can strengthen family bonds and stay in school. Community services and alternatives to detention need to be developed across Nebraska, especially in rural areas, to make it possible for youth to stay in their homes and communities.



Code Enforcement

Oversight and Accountability



In order for a system to work well, there need to be clear checks and balances and performance oversight, both internally and externally. DHHS must develop a clear data system that measures how children and families are doing and invest in data analysts to help with planning and system improvement going forward. DHHS should strengthen internal oversight of finances related to child welfare and better track where dollars come from and how they are spent.

External oversight is also necessary. The Legislature has an important role to play in designating where dollars go and how they are spent. Budgeting procedures need to be modified to allow this to occur. As Nebraska begins to serve more children in their homes, independent oversight of these non-court involved services, similar to what the Foster Care Review Board currently does for children in out-of-home care, must also be developed.

An Experienced General Contractor

Leadership and Collaboration

Reforming a broken system is not an easy job, and we need a leader who understands how to work collaboratively with the many branches of government, departments, agencies, and stakeholders who have a role to play in child welfare. As the agency responsible for child welfare reform, DHHS needs experienced leadership that has a proven track record of success with system reform and is committed to building a system that puts children and families first.

TESTIMONY FOR LR37 – HEALTH & HUMAN SERVICES COMMITTEE - NEBRASKA LEGISLATIVE HEARING SEPTEMBER 28, 2011 - OMAHA PUBLIC SCHOOLS – TEACHER ADMINSTRATION BUILDING - OMAHA

Good morning Senator Campbell and members of the Health & Human Services Committee. My name is Melanie Williams-Smotherman (W-i-l-l-i-a-m-s hyphen S-m-o-t-h-e-r-m-a-n).

I am co-founder and executive director of the Family Advocacy Movement, which is a grassroots collaborative made up of families, advocates, and professionals who call for more competent and accountable child welfare laws, policies and practices.

The majority of our member families – some of whom are here today - have been unnecessarily harmed by the very system that so many other testifiers have described as lacking transparency, oversight, and competent case management. Even State Auditor Mike Foley presented troubling commentary when he not only expressed great frustration over the apparent attempt by DHHS to avoid oversight by his office, he even suggested possible statutory violations.

We complain about these same things, too – only we aren't just talking about financial mismanagement, we're talking about the destruction of families, the loss of children, and the trampling of civil liberties.

You have heard desperate families cry out for help – requesting better review and more independent oversight with their cases. As attorney Jon Braaten told you three weeks ago, there is extreme dysfunction. I think he used the term "embarrassing." For families it's devastating. We see deliberate harm through negligence, retaliation, abuses of power, denials of due process, the lack of representation by so many of the hand-picked court-appointed attorneys and the so-called "therapists" who are hired by the department to offer their titles in support of DHHS case plans and make it all appear for court as though there are the proper professional checks and balances. We've seen for ourselves and heard even more about the covering up of foster care abuses,

Make no mistake, the Nebraska Department of Health & Human Services runs the show, with massive resources and well-appointed attorneys, along with the collaboration – some have said collusion – of county attorneys and too many guardians ad litem who often make no effort to even meet the

children they are paid to represent. Easy money. And what of juvenile court judges who choose a handful of Facebook friends that include the very people working against the family over whose case the judge presides?

In this regard, it doesn't really matter whether the department or a private agency does the grunt work of case management and service-coordination, except for the concern over even more circular finger-pointing and even less public transparency and accountability.

By the way, families don't consider most of what is forced upon them to be "services." They are obstacles presented and managed as punitive measures, as barriers to reunification, as tools to destabilize families and cause parents, and couples and children to fail.

Two public testifiers with us today are former caseworkers who have chosen to speak publicly about how some of this happens. One has already publicly exposed how she quit the department when she was instructed to commit perjury in court against a family. We also are visited by a couple brave licensed mental health practitioners from North Platte, Lincoln and Omaha, who wish to share what they observe from their professional perspectives.

The broken system that families experience daily is no accident. It's not simply due to innocent causes or exceptional circumatances, like overcrowded caseloads. We know workers are overloaded with cases, because that a direct side-effect of taking too many children from their homes. It's due to the department crudely sweeping up everyone and keeping them trapped – even the innocent – by the bureaucracy's standardized checkboxes and forms with meaningless copied-and-pasted text that is only there because statute requires it to be there.

And the same mechanism that tramples the rights of the innocent and not-so-guilty, also misses the much rarer, but devastating cases of real abuse – as with Michael Belitz. And those are the children the public believes we are paying the department to protect.

(One of the materials within the packet I handed out before my testimony includes official statistics made available by DHHS each year showing that the increase in reports and calls about alleged child abuse or neglect is not the number we should be looking at. That number is influenced by public DHHS campaigns and legal requirements of mandatory reporting for any inkling of something potentially wrong. And with the economy, the poor are

getting poorer. Nebraska has written poverty into its neglect laws, and ever more families are vulnerable to being unjustly and unnecessarily caught up in the terror of juvenile court and unhelpful intrusion by state officials.

What we need to be looking at is the number of cases eventually deemed UNsubstantiated – that would be thousands – a whopping 75 percent of all cases investigated - that are innocent, but have had their children traumatized, and their family lives disrupted with impunity. The excuse of erring on the side of caution doesn't fly when caution only hints at suspicions of harm but forced separations of innocent children from their families is a guaranteed harm – which is done in Nebraska at one of the very highest rates in the country.

And after children torn away from everyone they know and love, they are forced into compliance, so as not to offend their foster parents and cause trouble for the caseworkers. They are labeled as bi-polar, ADHD, ODD, RAD – any one of those impossible to prove or disprove diagnoses by a practitioner who will do **anything** to nurture the DHHS relationship. The those children are treated to dangerous psychotropic drugs – we've seen as early as six here in Douglas County, but it may even be sooner.

And finally, we get to face even more disappointment from the supposed last line of checks and balances by way of the Foster Care Review Board and the State Ombudsman's Office – each which have shown families and advocates a darker side that the public doesn't readily see.

System abuses occur all the way until the time when a family has been nearly broken - sometimes made homeless and jobless, and too often these cases end by finally reaching that arbitrary statutory minimum of 15 months for when a family can be "referred" to the county attorney for legal termination of parental rights to prevent a child from "floundering" in the system he should never have been pulled into in the first place.

After the state effectively uses the laws to permanently sever the rights of parents to children, child welfare officials have been granted the authority to snatch any **future** children – without cause or need to provide proof of harm or reasonable efforts for reunification – simply because our legislature has written that horrific option into statute.

I am convinced that these fundamental issues will continue to be the real reasons why the system has failed. The governor says he intends to keep

privatizing, because he doesn't want to return to "the failures of the past," as though privatization is the magic bullet. But that's tired rhetoric to push another agenda. Because if we are failing in the present and plans to privatize cause failures in the future, then all we get is a child welfare version of the Christmas Carol.

Our recommendations for helping along true reform:

1. Change the financial incentives. There have long been clear conflicts of interest created by the federal government through the Title IV-E funding stream, which – until just a few days ago, was only made available to states for taking children into foster care. Now states are free to apply for flexible waivers from that requirement – which translates into about $18 million that now can be used – in greater part than ever before - for PRESERVING FAMILIES by funding prevention, supporting more competent investigations and oversight protections, and offering wraparound services for families where such services would make the difference between foster care or home. (I have more information on this that I've included in your packet of materials).

Another recommendation is to stop presuming that the department knows families and children better than the families and children. Stop assuming that the families who make up the system deserve to be there, because most don't. Build into statute the requirements for more transparency, independent oversight processes, and fundamental civil liberties protections, and provide some sort of restitution for the irreparable harms that come to children and families from violating them – just as the legislature passed those wrongly imprisoned.

And finally, when we appreciate the inherent value of families and their irreplaceable relationships with their children, we may take the time to see who is really getting caught up in this run-away system.

We aim to dispel distortions of fact, and the worn-out myth that we have a child abuse epidemic in our state.

As Richard Wexler of the National Coalition for Child Protection Reform said during his visit in Nebraska two years ago, "Either Nebraska is the cesspool of parenting, or the state unnecessarily traumatizes too many children in the name of keeping them safe. For the amount wasted by DHHS

on juvenile court and foster care for most cases that either do not pose imminent risk of harm to their children or because Nebraska confuses poverty with neglect, we could pile all that money up and set it on fire. At least then it would keep a poor family warm in the winter and save a child from becoming a state-made orphan and thrust into the uncertain fate of foster care.

TABLE 1 -1 CHILD ABUSE AND NEGLECT REPORTS BY COUNTY CALENDAR YEAR 2009

County	Total Calls	Abuse/Neglect Calls		Reports Assessed or In Process of Assessment		Substantiated Reports		Unfounded Reports		Unable to Locate		In Process of Assessment	
Jefferson	65	65	100.0%	46	70.8%	12	26.1%	33	71.7%	1	2.2%	0	0.0%
Johnson	38	38	100.0%	32	84.2%	3	9.4%	28	87.5%	1	3.1%	0	0.0%
Kearney	65	65	100.0%	40	61.5%	10	25.0%	28	70.0%	0	0.0%	2	3.1%
Keith	106	96	90.6%	69	71.9%	8	11.6%	60	87.0%	1	1.4%	0	0.0%
Keya Paha	1	1	100.0%	1	100.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%
Kimball	39	39	100.0%	32	82.1%	3	9.4%	27	84.4%	2	6.3%	0	0.0%
Knox	145	126	86.9%	97	77.0%	25	25.8%	47	48.5%	2	2.1%	23	18.3%
Lancaster	4,102	3,749	91.4%	2,672	71.3%	886	33.2%	1576	59.0%	129	4.8%	81	2.2%
Lincoln	1,526	1,407	92.2%	616	43.8%	86	14.0%	515	83.6%	8	1.3%	7	0.5%
Logan	11	11	100.0%	7	63.6%	0	0.0%	7	100.0%	0	0.0%	0	0.0%
Loup	2	2	100.0%	2	100.0%	0	0.0%	2	100.0%	0	0.0%	0	0.0%
Madison	938	688	73.3%	305	44.3%	48	15.7%	236	77.4%	4	1.3%	17	2.5%
McPherson	1	1	100.0%	1	100.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%
Merrick	43	43	100.0%	30	69.8%	4	13.3%	25	83.3%	1	3.3%	0	0.0%
Morrill	59	57	96.6%	41	71.9%	7	17.1%	32	78.0%	1	2.4%	1	1.8%
Nance	40	40	100.0%	32	80.0%	6	18.8%	22	68.8%	2	6.3%	2	5.0%
Nemaha	55	55	100.0%	40	72.7%	7	17.5%	33	82.5%	0	0.0%	0	0.0%
Nuckolls	32	32	100.0%	22	68.8%	1	4.5%	18	81.8%	0	0.0%	3	9.4%
Otoe	192	169	88.0%	130	76.9%	38	29.2%	90	69.2%	2	1.5%	0	0.0%
Pawnee	12	12	100.0%	9	75.0%	3	33.3%	5	55.6%	0	0.0%	1	8.3%
Perkins	16	16	100.0%	9	56.3%	0	0.0%	9	100.0%	0	0.0%	0	0.0%
Phelps	58	58	100.0%	41	70.7%	8	19.5%	33	80.5%	0	0.0%	0	0.0%
Pierce	68	60	88.2%	48	80.0%	8	16.7%	37	77.1%	2	4.2%	1	1.7%
Platte	327	293	89.6%	211	72.0%	36	17.1%	160	75.8%	6	2.8%	9	3.1%
Polk	41	41	100.0%	28	68.3%	11	39.3%	15	53.6%	0	0.0%	2	4.9%
Red Willow	138	121	87.7%	95	78.5%	8	8.4%	86	90.5%	0	0.0%	1	0.8%
Richardson	89	89	100.0%	67	75.3%	13	19.4%	53	79.1%	0	0.0%	1	1.1%
Rock	5	5	100.0%	5	100.0%	0	0.0%	5	100.0%	0	0.0%	0	0.0%
Saline	132	123	93.2%	81	65.9%	27	33.3%	52	64.2%	0	0.0%	2	1.6%
Sarpy	1,114	1,057	94.9%	770	72.8%	235	30.5%	506	65.7%	12	1.6%	17	1.6%
Saunders	167	161	96.4%	114	70.8%	34	29.8%	79	69.3%	1	0.9%	0	0.0%
Scotts Bluff	722	686	95.0%	546	79.6%	135	24.7%	393	72.0%	2	0.4%	16	2.3%
Seward	181	169	93.4%	121	71.6%	26	21.5%	85	70.2%	8	6.6%	2	1.2%
Sheridan	39	39	100.0%	31	79.5%	1	3.2%	26	83.9%	2	6.5%	2	5.1%
Sherman	33	33	100.0%	21	63.6%	7	33.3%	14	66.7%	0	0.0%	0	0.0%
Stanton	20	20	100.0%	16	80.0%	2	12.5%	13	81.3%	0	0.0%	1	5.0%
Thayer	46	42	91.3%	22	52.4%	2	9.1%	18	81.8%	0	0.0%	2	4.8%
Thomas	2	2	100.0%	2	100.0%	2	100.0%	0	0.0%	0	0.0%	0	0.0%
Thurston	132	112	84.8%	69	61.6%	15	21.7%	11	15.9%	0	0.0%	43	38.4%
Valley	23	23	100.0%	17	73.9%	4	23.5%	12	70.6%	0	0.0%	1	4.3%
Washington	121	115	95.0%	80	69.6%	13	16.3%	63	78.8%	0	0.0%	4	3.5%
Wayne	31	31	100.0%	25	80.6%	5	20.0%	18	72.0%	1	4.0%	1	3.2%
Webster	27	27	100.0%	20	74.1%	1	5.0%	14	70.0%	0	0.0%	5	18.5%
Wheeler	5	5	100.0%	4	80.0%	1	25.0%	3	75.0%	0	0.0%	0	0.0%
York	241	227	94.2%	151	66.5%	42	27.8%	101	66.9%	2	1.3%	6	2.6%
Total	30,309	25,106	82.8%	14,039	55.9%	3,520	25.1%	9,522	67.8%	334	2.4%	663	2.6%

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CHILD WELFARE WAIVERS: THE STAKES FOR YOUR STATE

A state-by-state breakdown of the amount of federal foster care money that could be used for better alternatives if your state gets a child welfare waiver.

By Richard Wexler, NCCPR Executive Director, September 28, 2011

In September, 2011, Congress restored the authority of the Department of Health and Human Services to issue "waivers" from rules that limit the way states can spend federal aid under a program called Title IV-E. That authority had expired in 2006. When the legislation is signed by President Obama, HHS will have the authority to issue ten child welfare waivers per year for the next five years.

Nationwide, states are expected to receive roughly $7 billion in IV-E funds in 2012. Of that total, about $2.5 billion goes to services related to adoption. These funds are not affected by waivers.

Most of the rest, about $4.2 billion, is eligible for waiver. Without a waiver, this money can be spent only on foster care. In addition, the foster care funding is an open-ended entitlement. That is, for every eligible child, a state is reimbursed for anywhere from half to, in some years, 83 percent of the cost of holding that child in foster care, with poorer states receiving a higher reimbursement rate. [1] (The percentage received by your state is the same percentage it receives for its expenditures under the Medicaid program. That percentage can vary from year to year and even quarter to quarter. Rates for 2011 can be found on the last page of this document.)[2]

In contrast, in 2009, the most recent year for which data are available, states were given only about $527 million to spend on prevention, family preservation and family reunification under another federal program, known as Title IV-B. And, in fact, the states spent only about $331 million of that money on services to keep families together. Much of the rest was diverted into child abuse investigations and other child protective services activities. Some even was funneled into foster care.[3]

So for every federal dollar a state spends on prevention and family preservation under title IV-B, it spends, on average nearly13 federal dollars on foster care, and another seven federal dollars on adoption through Title IV-E. (See the methodology section below for a full discussion of this estimate.)

This skewed system creates a perverse incentive. Although safe, proven alternatives to foster care cost less in total dollars, it sometimes may cost a state or a county less to throw a child into foster care.

THE POTENTIAL OF WAIVERS

Waivers come in a variety of shapes and sizes. Some are quite limited; a state may want to experiment with only a small part of its IV-E funds and target them to a narrow purpose. But big, bold waivers have the most potential to improve the lives of vulnerable children. Under these waivers a state agrees to take its entire share of that $4.2 billion as a

flat grant. The waivers usually last for five years. The state gets whatever it was expected to get under the entitlement, plus an adjustment for inflation. The state then gets the right to use the money not only for foster care but also for safe, proven alternatives to foster care, as well as for adoption.

There are several other advantages.

Under the current entitlement program, if a state reduces needless foster care it gets less federal IV-E money. Under a waiver, if a state reduces needless foster care it gets to keep the savings, as long as those savings are plowed back into child welfare. In addition, waivers come with a "maintenance of effort" requirement. That means the state must agree not to use the federal money to replace existing state spending. In other words, budget-cutting state legislators, who normally might see child welfare as a tempting target, have to keep their hands off, or see their state lose all of its Title IV-E foster care money as well.

That's the carrot. The stick is that if a state rushes to tear apart more families after a waiver is in effect, it doesn't get any more federal aid for those placements – it has to pick up the tab for additional placements entirely with state or, in some cases, local funds.

That, too, is an advantage. It helps put the brakes on foster-care panics, sharp, sudden spikes in needless removals of children by child protective services agencies reacting to a high-profile tragedy on the front page of a major newspaper, or demagogic grandstanding by politicians. The urge to harm children while protecting oneself by adopting a "take the child and run" approach is tempered when top officials and political leaders know that their state or local government will have to pick up the entire tab.

The waivers also come with another important requirement: States must arrange for independent evaluations – something which, of course, does not exist in any meaningful way, under the *status-quo*.

THE FLORIDA EXPERIENCE

All of these advantages have been seen in Florida, the one state bold enough to accept one of these large-scale waivers when they were briefly offered to the states in 2006. Michigan initially accepted such a waiver, but changed its mind at the last minute. (Smaller-scale waivers were available for the previous decade.)

Thanks to the waiver, Florida can take about $140 million a year in IV-E foster care funds and use it for better options as well. The results:

• *Less needless foster care:* From 2006, the last year before waiver began, through 2010, the number of children in foster care on any given day was reduced by 35 percent. The number of children taken from their parents over the course of a year also was cut by 35 percent.

No slash-and-burn budget cuts. When the Florida Legislature considered slashing the state child welfare budget, lawmakers were reminded that such cuts would mean the end of federal IV-E funding. The legislators backed off.

• *No foster-care panic.* When one reckless journalist for a major newspaper tried to exploit the horrifying death of a child and near death her brother to try to reverse the state's family preservation reforms and return to a take-the-child-and-run approach (something she tried to do even though the children were taken from their birth parents only to be horribly abused allegedly by their *adoptive* parents) the child welfare agency refused to cave into the pressure.

And most important of all:

• ***Children are safer.*** The independent evaluations[4] of Florida's waiver concluded that child safety improved. That's not surprising. With fewer needless removals workers had more time to find children in real danger.

Indeed, the transformation in Florida was so remarkable that it was the subject of a major story in *The New York Times*.[5] There's more about the Florida waiver in this post to the *NCCPR Child Welfare Blog.*

METHODOLOGY, CAUTIONS AND CAVEATS

The charts that follow are a guide to how much your state is likely to be able to spend flexibly if your state applies for and receives a waiver from Title IV-E foster care funding restrictions. That figure is compared to the amount your state actually spends now in federal dollars under the Title IV-B program.

The first chart provides just that information, the second breaks down child welfare spending in more detail.

That first chart uses the higher of two estimates concerning each state's Title IV-E foster care expenditures – an estimate for 2012 based on President Obama's budget proposal. The lower figure is the actual amount states will spend in 2011.

Why is the higher figure closer to the mark? Because IV-E is an entitlement program, and most of the spending increase, though not all, is built into the entitlement formula. So while the total is likely to be closer to the 2012 figure, it may fall somewhere between that figure and the 2011 figure. For most states, there is not a great deal of difference.

Although Title IV-B involves a lot less money it's more complicated and requires a bit more explanation.

Title IV-B commonly is referred to as the federal funding stream for prevention and family preservation. But that's only partially true. Unfortunately, a lot of Title IV-B money legally can be diverted to other purposes, and it is.

Title IV-B has two major components, the Promoting Safe and Stable Families part (PSSF) and the Child Welfare Services part.

States are required to spend 90 percent of their PSSF funds on family support, family preservation, family reunification and adoption promotion and support. States are required to spend no less than 20 percent of their PSSF funds on any one category.

This means that, as a practical matter, roughly 25 percent of all PSSF money is off-limits to family preservation, family reunification and prevention. So while states received $336 million in PSSF money in 2009, only about $252 million was available for keeping families together.

The other program, called Child Welfare Services, has almost no strings attached. States spent nearly $275 million in these funds in 2009 and all of it *could* have been used for keeping families together if states wanted to do it.

But states diverted a huge part of their limited CWS funds into child protective services – things like child abuse investigations and related work. Though this is shameful, it's entirely legal. Some funding even was diverted into foster care maintenance payments. (Some of the money diverted to foster care may have been for a morally legitimate reason as well. It may have been used to help grandparents and other relatives providing kinship foster care. When such relatives can't meet what often are page after page of hypertechnical foster-parent licensing requirements, the case usually isn't eligible for reimbursement under Title IV-E.)

The diverted funds are listed in the second chart.

As a result, as noted above, while we estimate states could have spent $527 million on safe, proven alternatives to foster care under Title IV-B in 2009, they actually spent only $331 million.

Other caveats:

• The IV-E data in the charts are for 2011 and 2012, but for IV-B the most recent figures we could get are for 2009. However, funds under Title IV-B are not an entitlement, so the total doesn't usually change much from year to year.

• Even if a state gets a waiver, not all of the money listed in the IV-E columns in the charts could be used for alternatives to foster care. Although NCCPR believes far too many children are in foster care, there are some children for whom it is genuinely necessary, so states still will have to use some of this money for foster care.

• Titles IV-B and IV-E are not the only federal programs that can be used to fund child welfare. Temporary Assistance for Needy Families (TANF), Medicaid, and the Social Services Block Grant also can be used. But Medicaid funds largely services for children already in foster care, and using the other two funding streams means taking money from other programs helping impoverished families. (Indeed, the use of TANF as a child welfare

slush fund is a scandal in itself, as is discussed in our overview of child welfare finance issues.)[6] For a good discussion of these other funding streams and how they can be used, see this analysis from ChildTrends.[7]

So the best source of federal funding for prevention and family preservation, by far, is the huge amount now spent on foster care.

• The impact of waivers may be different in the 13 states in which individual counties run child welfare systems. The interplay of federal and state financial incentives may change the calculus concerning whether a waiver would work for a given county. But waivers already have been implemented successfully in some counties in Ohio and California.

CHARTS BEGIN ON THE FOLLOWING PAGE, AFTER THE ENDNOTES

NOTES:

[1] All data concerning Title IV-E in both the narrative and the chart are from U.S. Department of Health and Human Services, Administration for Children and Families, *Justification of Estimates for Appropriations Committees: Foster Care and Permanency*. Undated, 2011. Available online at http://www.acf.hhs.gov/programs/olab/budget/2012/cj/PFCP.pdf

[2] U.S. Department of Health and Human Services, Administration for Children and Families, *Program Instruction*, Log #ACYF-CB-PI-10-12, September 17, 2010. Available online at http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/PIonIncreasedFMAPratesfortitleIV-E.pdf

3. NCCPR estimates concerning Title IV-B, and all figures in the charts concerning Title IV-B are based on data in, Emilie Stoltzfus, *Child Welfare: Funding for Child and Family Services Authorized Under Title IV-B of the Social Security Act,* (Washington DC: Congressional Research Service) June 13, 2011.

[3] M.I. Armstrong, et. al., *Florida's IV-E Waiver Demonstration Project, Evaluation Brief #2* (University of South Florida, College of Behavioral and Community Sciences,) January, 2010. Available online at http://centerforchildwelfare.fmhi.usf.edu/kb/LegislativeMandatedRpts/CBC%20Brief2January2010.pdf

[4] Erik Eckholm, "Florida Shifts Child Welfare System's Focus to Saving Families," *The New York Times*, July 24, 2009. Available online at http://www.nytimes.com/2009/07/25/us/25florida.html?_r=2&ref=us

[5]National Coalition for Child Protection Reform, *You Get What You Pay For: Real Reform Means Ending the Foster Care Entitlement* (Alexandria, VA: 2010). Available online at http://www.nccpr.org/reports/finance.pdf

[6]Kerry DeVooght, et. al., *Federal, State, and Local Spending to Address Child Abuse and Neglect in SFY 2006* (Washington, DC: ChildTrends) December, 2008. Available online at http://www.childtrends.org/Files/Child_Trends-2009_02_17_FR_CWFinancePaper.pdf

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CHART 1: THE BASICS

State	Here are the federal funds your state actually spent on prevention, family preservation and family reunification under Title IV-B in 2009	This is an estimate of the total amount of additional federal aid that could be used for prevention and family preservation (as well as foster care) if your state got a waiver in 2012
Alabama	$5,686,000	$34,264,001
Alaska	$779,000	12,911,911
Arizona	$4,611,000	83,061,619
Arkansas	$5,758,000	36,173,624
California	$35,907,000	1,168,911,586
Colorado	$2,340,000	59,196,099
Connecticut	$1,727,000	59,437,294
Delaware	$778,000	3,475,659
District of Columbia	$1,083,000	20,992,247
Florida	$19,236,000	149,856,473
Georgia	$13,210,000	81,357,107
Hawaii	$1,930,000	18,296,601
Idaho	$2,393,000	9,580,399
Illinois	$22,806,000	205,758,474
Indiana	$4,260,000	94,487,529
Iowa	$2,137,000	24,140,284
Kansas	$4,044,000	22,218,976
Kentucky	$3,936,000	47,229,911
Louisiana	$6,637,000	46,496,368
Maine	$1,073,000	13,204,429
Maryland	$4,995,000	85,803,910
Massachusetts	$3,604,000	51,969,303
Michigan	$13,155,000	85,693,340
Minnesota	$4,108,000	49,463,199
Mississippi	$3,726,000	10,261,932
Missouri	$15,751,000	55,842,944
Montana	$624,000	10,035,225
Nebraska	$1,278,000	18,985,949
Nevada	$2,655,000	28,557,864
New Hampshire	$615,000	14,434,566
New Jersey	$5,892,000	78,294,654
New Mexico	$2,353,000	22,283,193
New York	$15,885,000	395,830,255
North Carolina	$10,091,000	74,500,670
North Dakota	$688,000	10,255,336
Ohio	$8,774,000	196,805,342
Oklahoma	$3,548,000	36,573,811
Oregon	$4,196,000	90,974,665
Pennsylvania	$8,047,000	131,773,943
Rhode Island	$1,228,000	14,385,021
South Carolina	$5,928,000	34,007,614
South Dakota	$514,000	5,241,873
Tennessee	$13,288,000	39,677,414
Texas	$29,106,000	221,833,436
Utah	$3,430,000	17,492,157
Vermont	$336,000	10,768,697
Virginia	$4,167,000	65,945,221
Washington	$6,561,000	90,419,589
West Virginia	$1,785,000	32,099,592
Wisconsin	$6,856,000	49,022,872
Wyoming	$208,000	2,715,822
TOTAL:	$331,422,000	4,223,000,000

CHART 2: THE DETAILS

TITLE IV-E FOSTER CARE TITLE IV-B CHILD WELFARE FUNDING, 2009

State	This is the minimum in funds now limited to foster care that your state also could use for prevention and family preservation if your state got a waiver	This is the maximum in funds now limited to foster care that your state also could use for prevention and family preservation if your state got a waiver	Promoting Safe and Stable families funds to be used for family support, family preservation, reunification and adoption	Child Welfare Services	TOTAL available for various child welfare servicves	Actually spent on prevention or family preservation	Diverted to child protective services	Diverted to foster care	Other, including adoption
	2011 actual	*2012 projected*							
Alabama	$31,439,878	**$34,264,001**	$7,108,000	$4,829,000	$11,937,000	**$5,686,000**	$1,766,000	$1,201,000	$3,284,000
Alaska	11,847,679	**12,911,911**	$693,000	$294,000	$987,000	**$779,000**	$0	$0	$208,000
Arizona	76,215,477	**83,061,619**	$7,683,000	$5,944,000	$13,627,000	**$4,611,000**	$5,349,000	$0	$3,667,000
Arkansas	33,192,105	**36,173,624**	$4,644,000	$3,154,000	$7,798,000	**$5,758,000**	$788,000	$0	$1,252,000
California	1,072,567,036	**1,168,911,586**	$33,895,000	$32,523,000	$66,418,000	**$35,907,000**	$20,343,000	$0	$10,168,000
Colorado	54,317,011	**59,196,099**	$3,310,000	$3,650,000	$6,960,000	**$2,340,000**	$0	$3,500,000	$1,120,000
Connecticut	54,538,326	**59,437,294**	$2,141,000	$2,419,000	$4,560,000	**$1,727,000**	$48,000	$1,984,000	$801,000
Delaware	3,189,187	**3,475,659**	$858,000	$802,000	$1,660,000	**$778,000**	$564,000	$0	$318,000
District of Columbia	19,262,014	**20,992,247**	$1,082,000	$327,000	$1,409,000	**$1,083,000**	$109,000	$0	$217,000
Florida	137,504,936	**149,856,473**	$14,481,000	$15,348,000	$29,829,000	**$19,236,000**	$4,365,000	$0	$6,228,000
Georgia	74,651,455	**81,357,107**	$12,447,000	$9,797,000	$22,244,000	**$13,210,000**	$3,483,000	$1,486,000	$4,065,000
Hawaii	16,788,551	**18,296,601**	$966,000	$1,157,000	$2,123,000	**$1,930,000**	$0	$0	$193,000
Idaho	8,790,759	**9,580,399**	$1,217,000	$1,749,000	$2,966,000	**$2,393,000**	$0	$318,000	$255,000
Illinois	188,799,356	**205,758,474**	$15,191,000	$11,109,000	$26,300,000	**$22,806,000**	$0	$0	$3,494,000
Indiana	86,699,635	**94,487,529**	$7,101,000	$6,331,000	$13,432,000	**$4,260,000**	$3,595,000	$0	$5,577,000
Iowa	22,150,583	**24,140,284**	$2,650,000	$2,461,000	$5,111,000	**$2,137,000**	$192,000	$1,092,000	$1,690,000
Kansas	20,387,634	**22,218,976**	$2,245,000	$2,783,000	$5,028,000	**$4,044,000**	$0	$0	$984,000
Kentucky	43,337,106	**47,229,911**	$6,398,000	$4,297,000	$10,695,000	**$3,936,000**	$2,815,000	$1,052,000	$2,892,000
Louisiana	42,664,023	**46,496,368**	$8,522,000	$4,727,000	$13,249,000	**$6,637,000**	$2,067,000	$1,301,000	$3,244,000
Maine	12,116,087	**13,204,429**	$1,527,000	$1,176,000	$2,703,000	**$1,073,000**	$212,000	$0	$1,418,000
Maryland	78,731,742	**85,803,910**	$3,737,000	$4,303,000	$8,040,000	**$4,995,000**	$1,549,000	$0	$1,496,000
Massachusetts	47,685,866	**51,969,303**	$4,737,000	$4,182,000	$8,919,000	**$3,604,000**	$3,772,000	$0	$1,543,000
Michigan	78,630,285	**85,693,340**	$13,174,000	$9,117,000	$22,291,000	**$13,155,000**	$35,000	$2,169,000	$6,932,000
Minnesota	45,386,321	**49,463,199**	$3,379,000	$4,301,000	$7,680,000	**$4,108,000**	$2,454,000	$256,000	$862,000
Mississippi	9,416,118	**10,261,932**	$5,322,000	$3,522,000	$8,844,000	**$3,726,000**	$1,372,000	$424,000	$3,322,000
Missouri	51,240,232	**55,842,944**	$10,544,000	$5,660,000	$16,204,000	**$15,751,000**	$0	$0	$453,000
Montana	9,208,097	**10,035,225**	$925,000	$713,000	$1,638,000	**$624,000**	$713,000	$0	$301,000
Nebraska	17,421,081	**18,985,949**	$1,545,000	$1,752,000	$3,297,000	**$1,278,000**	$197,000	$1,183,000	$639,000
Nevada	26,204,055	**28,557,864**	$1,533,000	$2,399,000	$3,932,000	**$2,655,000**	$0	$0	$1,277,000
New Hampshire	13,244,833	**14,434,566**	$625,000	$1,076,000	$1,701,000	**$615,000**	$20,000	$425,000	$641,000
New Jersey	71,841,417	**78,294,654**	$5,107,000	$5,772,000	$10,879,000	**$5,892,000**	$2,373,000	$0	$2,614,000
New Mexico	20,446,557	**22,283,193**	$3,267,000	$1,664,000	$4,931,000	**$2,353,000**	$439,000	$455,000	$1,684,000
New York	363,204,956	**395,830,255**	$19,086,000	$14,344,000	$33,430,000	**$15,885,000**	$13,344,000	$0	$4,201,000
North Carolina	68,360,143	**74,500,670**	$10,970,000	$8,878,000	$19,848,000	**$10,091,000**	$1,343,000	$0	$8,414,000
North Dakota	9,410,066	**10,255,336**	$517,000	$570,000	$1,087,000	**$688,000**	$0	$0	$399,000
Ohio	180,584,164	**196,805,342**	$12,679,000	$10,678,000	$23,357,000	**$8,774,000**	$6,035,000	$225,000	$8,323,000
Oklahoma	33,559,308	**36,573,811**	$5,242,000	$1,762,000	$7,004,000	**$3,548,000**	$359,000	$340,000	$2,757,000
Oregon	83,476,310	**90,974,665**	$4,733,000	$3,335,000	$8,068,000	**$4,196,000**	$1,000,000	$0	$2,872,000
Pennsylvania	120,912,812	**131,773,943**	$12,328,000	$10,495,000	$22,823,000	**$8,047,000**	$0	$5,456,000	$9,320,000
Rhode Island	13,199,372	**14,385,021**	$934,000	$954,000	$1,888,000	**$1,228,000**	$0	$0	$660,000
South Carolina	31,204,623	**34,007,614**	$6,529,000	$4,604,000	$11,133,000	**$5,928,000**	$588,000	$951,000	$3,666,000
South Dakota	4,809,825	**5,241,873**	$756,000	$569,000	$1,325,000	**$514,000**	$123,000	$61,000	$627,000
Tennessee	36,407,104	**39,677,414**	$9,951,000	$5,920,000	$15,871,000	**$13,288,000**	$0	$0	$2,583,000
Texas	203,549,381	**221,833,436**	$35,971,000	$25,294,000	$61,265,000	**$29,106,000**	$18,596,000	$0	$13,563,000
Utah	16,050,411	**17,492,157**	$1,771,000	$3,495,000	$5,266,000	**$3,430,000**	$981,000	$0	$855,000
Vermont	9,881,114	**10,768,697**	$481,000	$590,000	$1,071,000	**$336,000**	$590,000	$0	$145,000
Virginia	60,509,855	**65,945,221**	$6,110,000	$6,412,000	$12,522,000	**$4,167,000**	$5,771,000	$0	$2,584,000
Washington	82,966,985	**90,419,589**	$5,614,000	$5,468,000	$11,082,000	**$6,561,000**	$2,734,000	$0	$1,787,000
West Virginia	29,453,865	**32,099,592**	$2,760,000	$1,823,000	$4,583,000	**$1,785,000**	$1,640,000	$0	$1,158,000
Wisconsin	44,982,287	**49,022,872**	$4,925,000	$4,920,000	$9,845,000	**$6,856,000**	$1,150,000	$0	$1,839,000
Wyoming	2,491,977	**2,715,822**	$307,000	$467,000	$774,000	**$208,000**	$0	$270,000	$296,000
TOTAL	**3,874,930,000**	**4,223,000,000**	**$335,971,000**	**$274,847,000**	**$610,818,000**	**$331,422,000**	**$112,876,000**	**$24,150,000**	**$142,370,000**

For data sources, see the endnotes on page 5.

TO: Members of the Health & Human Services Committee (Senator Kathy Campbell, Senator Dave Bloomfield, Senator Tanya Cook, Senator Mike Gloor, Senator Gwen Howard, Senator Bob Krist, Senator Norman Wallman)

FROM: Beverly Eby, 905 Prairie Lane, Beatrice, Nebraska 68310

DATE: Wednesday, September 28, 2011

Dear Senators,

I am a survivor of 9/11. No not that 9/11; I am a survivor of Lancaster County JV07 911.

The horror our family had to endure at the hands of the Lincoln Police Department, Lancaster County Attorney's Office, Lancaster County Juvenile Court, and the Nebraska Department of Health and Human Services is one that will haunt me for the rest of my life. That experience was life changing.

When law enforcement comes in and physically removes a 4 month old baby and a three year old child from their home, and you as a parent, grandparent, and an uncle become the false targets of a child abuse case, it is almost more than one can bear. It was bad enough when the baby – my great nephew - was diagnosed with Shaken Baby Syndrome. But to victimize our innocent family when there is still a daycare provider/baby sitter in Lincoln who is most likely guilty of abusing my nephew and other children in her care is unconscionable. I have come to terms with the reality that she "got away with it," but I will never get over what the state did to my family.

I must say even though that day – the day they removed the children from their homes - was traumatic for us, there was another experience that was even more traumatic.

My husband and I – great uncle and great aunt - became the temporary foster parents for the two boys. Approximately three weeks after they placed the children with us in Beatrice, they came to our home one morning as I was getting ready to take one of our vehicles in to be serviced. However, before I got out the door, the doorbell rang at 9:00 a.m..

On my doorstep were two young girls from DHHS who informed me that they had come to pick up the three year old child to be "interrogated by the Lincoln Police Department" (their words/not mine).

We had never seen these girls before this day and they produced NO paperwork explaining what was happening. No one had called to inform us that any of this would be happening that day. They would not let any of us go along with Noah - including the lady from Pathfinders who had been supervising the daily visits that my niece was allowed to spend with her two boys. So Noah knew no one.

The women said they would be back by noon, however they did not show back up until after 2:00 p.m.. We weren't even given the courtesy of a telephone call from these "professionals" saying they were going to be late – which was just par for the course.

We never were allowed to view the tape of this "police interrogation." There was never any tape introduced during court proceedings. I have to ask, "Does this tape even exist, and why can't we see it?" Can we see it?

We have no idea what they did to this 3-year-old child for FIVE hours. (We got a look into what it must have felt like for the Jews who were separated from loved ones by the Nazis during World War II – also uncertain of what was happening and powerless to stop it). NO ONE was there to protect Noah's rights—not even Hazell Rodriguez - his court-appointed guardian ad litem. Of course NOT ONCE during our 14 months of hell did Ms. Rodriguez even once "personally" visit these boys (her clients). This seems very wrong, doesn't it? That should be looked into.

When a family has been done a horrible wrong, you must wonder how many others they have hurt in the same ways. We are now finding out there are many others out there like our family. When you've written countless letters to those whom you think may be able to help you, and you get NO encouragement that these matters will be looked into and changes made, then a person has no other choice but to "go public" and speak out to any and all who will listen.

How can you allow another innocent family to have to go through this experience?

I wrote one letter in particular to Kerry Winterer, CEO of the Nebraska Department of Health & Human Services, regarding a "supervisor" (not the caseworker) who lied under oath in Lancaster County Juvenile Court. I provided documented proof (a court transcript and information obtained from the State Auditor's office) to show that this occurred, and I was told by Winterer, "I am not able to discuss what OR IF any actions will be taken in regard to this supervisor providing inaccurate testimony to the court."

I was more expecting something that is so blatantly illegal to be taken more seriously. I guess it's okay for DHHS workers to lie in court and not be held at all accountable. Perhaps these are the ones who actually get promoted?

But after the past two weeks while we've watched headlines unfold story after story of this lack of accountability by DHHS, I can understand where these caseworkers and supervisers might get the idea that it is ok to lie on the job.

When even Governor Heineman gets caught lying to the public - saying he didn't get a copy of the audit (before it was released to the public) that Mike Foley just completed on the Nebraska Department of Health & Human Services – why wouldn't others learn from that?

Mike Foley has done the citizens of the state of Nebraska a huge favor by exposing DHSS for just how they mishandle matters. So if the guy at the top (the governor) can deceive constituents and the legislature whenever it's convenient for him to do it, then it must be acceptable

official behavior for those state employees who are wanting the public to believe they are "so concerned" about our children.

In closing, I have to say I'm even disappointed in our state senators who were in office on February 5, 2009.
I wrote a nine page, typewritten letter and sent that to each and every one in the legislature. I only received back two replies.

I don't think it is asking too much to simply acknowledge that the correspondence was received in your office (and I would have considered anything on top of that would be pure cream).

I would like to publicly thank Senator Deb Fischer and Senator Galen Hadley (they are the only two Senators who gave me any kind of an acknowledgement/reply to my letter). All of you on this committee were also senators at that time, except for Senator Dave Bloomfield and Senator Bob Krist (if my information is correct), so you should have received my letter appealing to you to take note.

Personally taking care of my nephews was the EASIEST PART of this whole ordeal. Even for a 55-year-old who became a first-time "mom" during that period.

Putting up with what the "system" forced us to do was the hardest part. It's time for major changes, and you are the only people who are in a position to do this for innocent children and families in Nebraska – which are the VAST majority. We – the majority of good people who love our children – need your help to protect us from these unjust treatments and unnecessary traumas.

THANK YOU FOR YOUR TIME. If you have any questions regarding this letter, please contact me. There are many other stories I could share regarding this nightmare that our family lived through.

Sincerely,

Beverly Eby
905 Prairie Lane
Beatrice, Nebraska 68310

LR 37 – Exhibit 11
9-28-11

NEBRASKA ASSOCIATION OF PUBLIC EMPLOYEES

September 28th, 2011

Re: LR 37 – Child Welfare

Dear Senator Campbell and Members of the Committee:

My name is Julie Dake Abel. I am the Executive Director of NAPE/AFSCME Local 61. We are the union that represents the majority of state employees, including the Child Welfare workers, those that are left anyway, that work for DHHS to care for our children. I appreciate the opportunity to testify here today and thank you for exercising your oversight responsibilities on this matter, by virtue of LR 37.

First off, NAPE/AFSCME must thank State Auditor Mike Foley and his office for the impressive comprehensiveness of his audit of this matter. His thoroughness has brought to light most of what the union and state employees already suspected was happening with DHHS. That brings us to "what do we do now"?

We understand that you as Legislators have approached this undertaking with much reservation, with some of you fearing that you are micromanaging. You are not. You are expected by our Constitution to do just what you are doing and we know that you are devoting hours of your lives to ascertaining how bad a situation Nebraska finds itself in and what you can do about it. Too that end, NAPE/AFSCME Local 61 has directed me to convey to you observations and recommendations from those citizens that have been entrusted this sacred trust only to see it stripped from them for a profiteering enterprises - based not on science or research but on hollow political rhetoric that now has metastasized into wholesale dysfunctionality.

The state already has qualified child care specialists and has already invested over $12,500 per Child Welfare employee. That investment ensured that every employee that worked for the State in the Child Welfare system had the training and expertise to care for the children. Now, unfortunately, they have now thrown away that investment and expertise.

We are now to a point that statutory changes need to occur that provide checks and balances that could prevent the type of ignorant decisions by DHHS that created this fiasco. Coming on the heels of the tragedies that occurred with the Beatrice State Development Center, we see a definite pattern of mismanagement and dangerous actions that deserve Nebraskans vigilant oversight and demand that this misguided venture be undone. DHHS cannot contract away their responsibility. The state, not private contractors have the responsibility to protect the citizens and the taxpayers.

We have several exhibits that we would like to be included into the public record.

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First, a copy of Article IV, Section 19 of the Nebraska Constitution mandating that you exercise 'general management, control and government' of the services that Nebraska has instituted for child welfare over the past decades of work.

Second, is a report from the State of Texas that compares both of the 'poster children' for privatization Florida and Kansas and the problems they found and lessons they've learned? We have sent this via email to all of you and wish for you to at least read the executive summary which we believe you will find consistent with what you have been hearing in meetings with your constituents as you have traveled around the State.

Based on all that is happening in the system, we offer these recommendations for your consideration:

First, as a result of this experience we believe it is time for the Legislature to clearly define what can and can not be contracted out for profit. There needs to be a line drawn in statute that recognizes the certain essential governmental services that are core responsibilities can't be contracted out. The following language is a start on that effort.

I. – Nebraska Constitution – Article 4, Section 19

It shall be the policy of the State of Nebraska that certain governmental services are so intimately related to the public interest as to mandate performance by government employees and the Department of Administrative Services is prohibited from entering into contracts that would privatize essential governmental responsibilities that would transfer official responsibility to government contractors. Essential governmental services are those services where Nebraska has a legal responsibility for the care of the individual citizen.

II. - LB 980

Second, existing statutes regulating the responsibility of the Departments to do a cost benefit analysis have proven inadequate. The Department of Administrative Services perverted the statutory requirements that this Legislature enacted by creating a justification study after the decision to privatize had already been made. The worse feature of this debacle was the total disconnect by DAS of the valued of the human infrastructure that had be built over decades. However, we believe that statute is a good one and can be improved in the best interest of the citizen of the State with the additional changes that were contained in Legislative Bill 980 introduced in 2010 and prioritized by Senator Wallman.

III. Appropriations

Finally, we are pleased to see that you have your performance audit staff reviewing this situation and we recommend that the Appropriations Committee not expend tax payer money to finance the continuation of a failed venture. Actually, this provides the most direct and clear cut method to change course. The Legislature appropriates money. The Legislature chooses. It is time that the Legislature chooses to fund the appropriate delivery of child welfare services consistent with the responsibility that we have as a State set forth in our statutes.

I would like to thank this committee, in particular Senator Campbell, for allowing me to testify today, and for so many of you, such as Senator Howard who realize how incredibly urgent it is to act upon this mess that we now have. It is a crucial undertaking in making sure the children are properly cared for and that appropriate oversight is occurring. Thank you.

Sincerely,

Julie Dake Abel

Julie Dake Abel
Executive Director
NAPE/AFSCME Local 61
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IV-19. State institutions; management, control, and government; determination by Legislature.

The general management, control and government of all state charitable, mental, reformatory, and penal institutions shall be vested as determined by the Legislature.

Source: Neb. Const. art. V, sec. 19 (1875); Amended 1912, Laws 1911, c. 225, sec. 1, p. 677; Amended 1920, Constitutional Convention, 1919-1920, No. 13; Transferred by Constitutional Convention, 1919-1920, art. IV, sec. 19; Amended 1958, Laws 1957, c. 216, sec. 1, p. 753.

Annotations

The statutes which give the Court of Industrial Relations jurisdiction over public employees are not unconstitutional. American Fed. of S., C. & M. Emp. v. Department of Public Institutions, 195 Neb. 253, 237 N.W.2d 841 (1976).

Under former law, members of the Board of Control were constituted a separate class as to salaries. State ex rel. Day v. Hall, 129 Neb. 699, 262 N.W. 850 (1935); State ex rel. Taylor v. Hall, 129 Neb. 669, 262 N.W. 835 (1935).

Constitutional amendment purporting to exclude schools of deaf and blind from jurisdiction of Board of Control was ineffective for failure to comply with constitutional requirements. State ex rel. Hall v. Cline, 118 Neb. 150, 224 N.W. 6 (1929).

LR 37 – Exhibit 13
9-28-11

Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate

CPPP
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The Center for Public Policy Priorities is a 501(c)(3) nonpartisan, nonprofit research organization committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. We pursue our mission through independent research, policy analysis and development, public education, advocacy, coalition building, and technical assistance.

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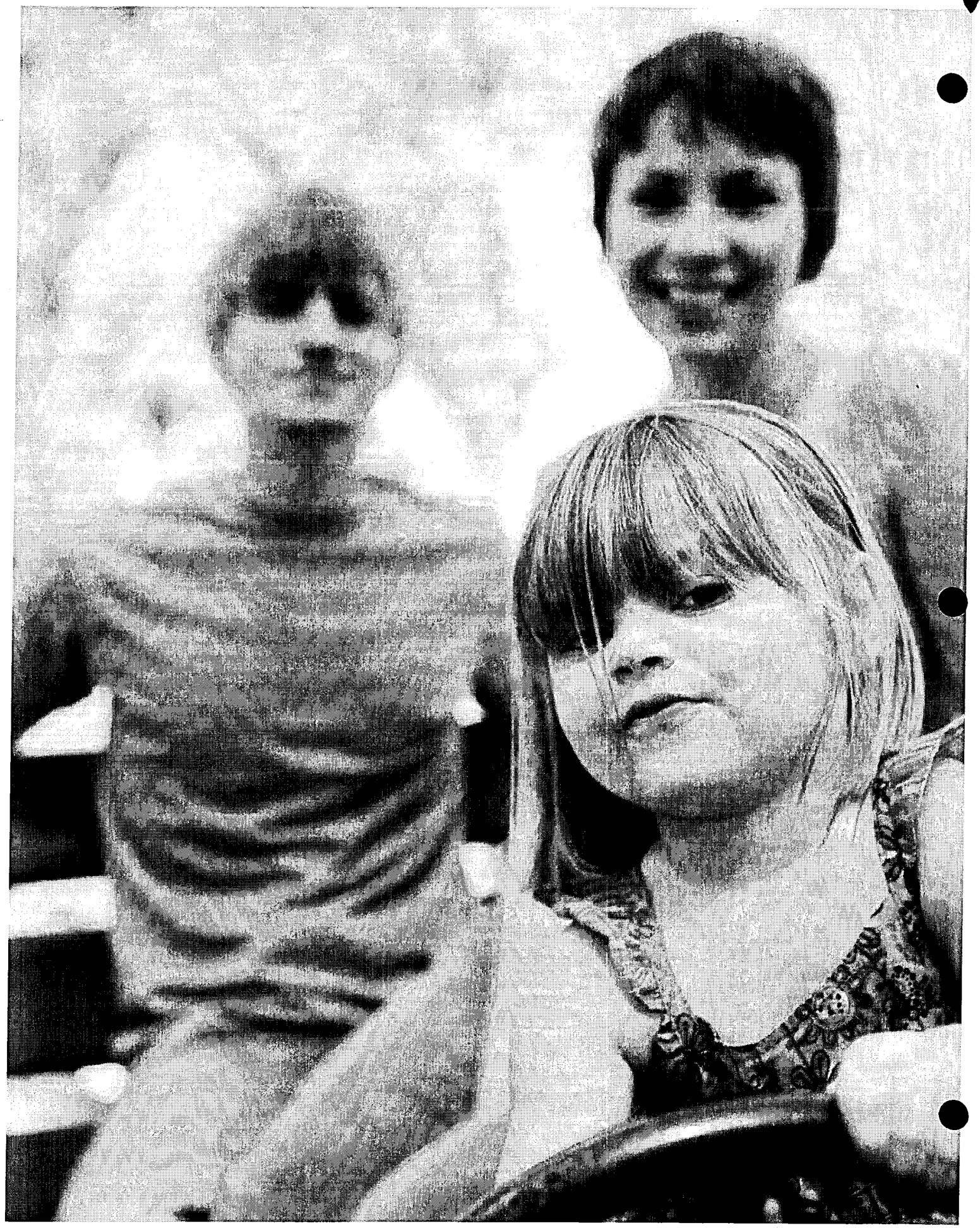
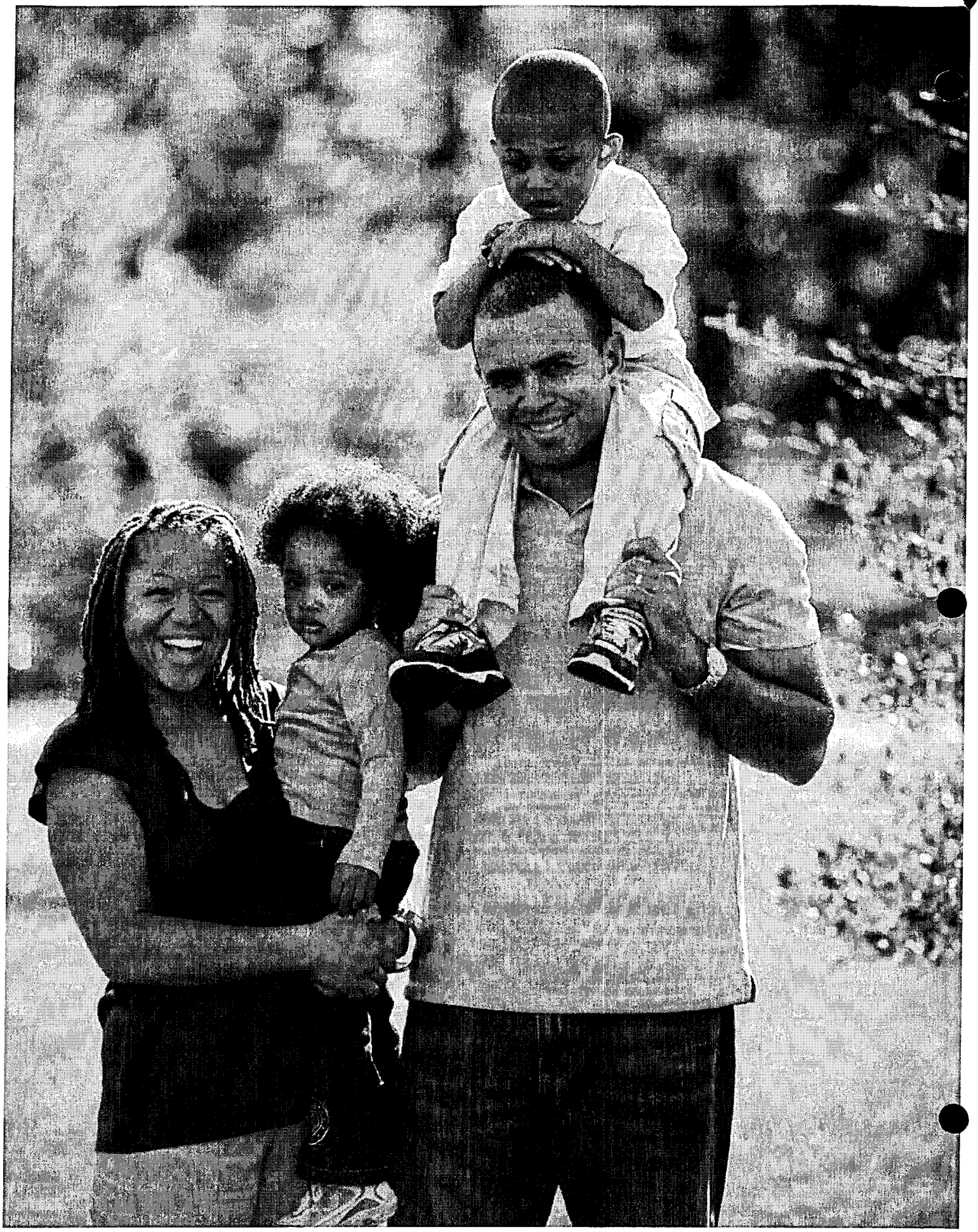
**Ms. Roper left the center on March 31, 2008.*

This report is underwritten in part through funding by Casey Family Programs, whose mission is to provide and improve—and ultimately to prevent the need for—foster care. Established by UPS Founder Jim Casey in 1966, the foundation provides direct services and promotes advances in child welfare practice and policy. To learn more, visit www.casey.org. The opinions expressed in this report are those of the Center for Public Policy Priorities and do not necessarily reflect the views of Casey Family Programs.

Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate



Contents



Foreword

After the Texas Legislature adjourned in 2003 and before it convened in 2005, the Texas child welfare system went through a crisis. Throughout the state, communities were shocked by news reports of abused and neglected children, some in situations known to the state and others not. The circumstances of these children engendered three legislative reports, a report by the state comptroller, and a report by the Texas Health and Human Services Commission, ordered by the governor.

In response, in 2005, the Legislature increased funding for Child Protective Services and enacted Senate Bill 6, a major legislative change in direction. Senate Bill 6 mandated that all Child Protective Services after the investigation phase be outsourced to private providers by 2011. Between 2005 and 2007, however, implementation stalled, and in 2007, the Legislature again changed direction. Senate Bill 758 repealed the mandate to privatize, instead calling for a pilot of privatization with 5% of the cases.

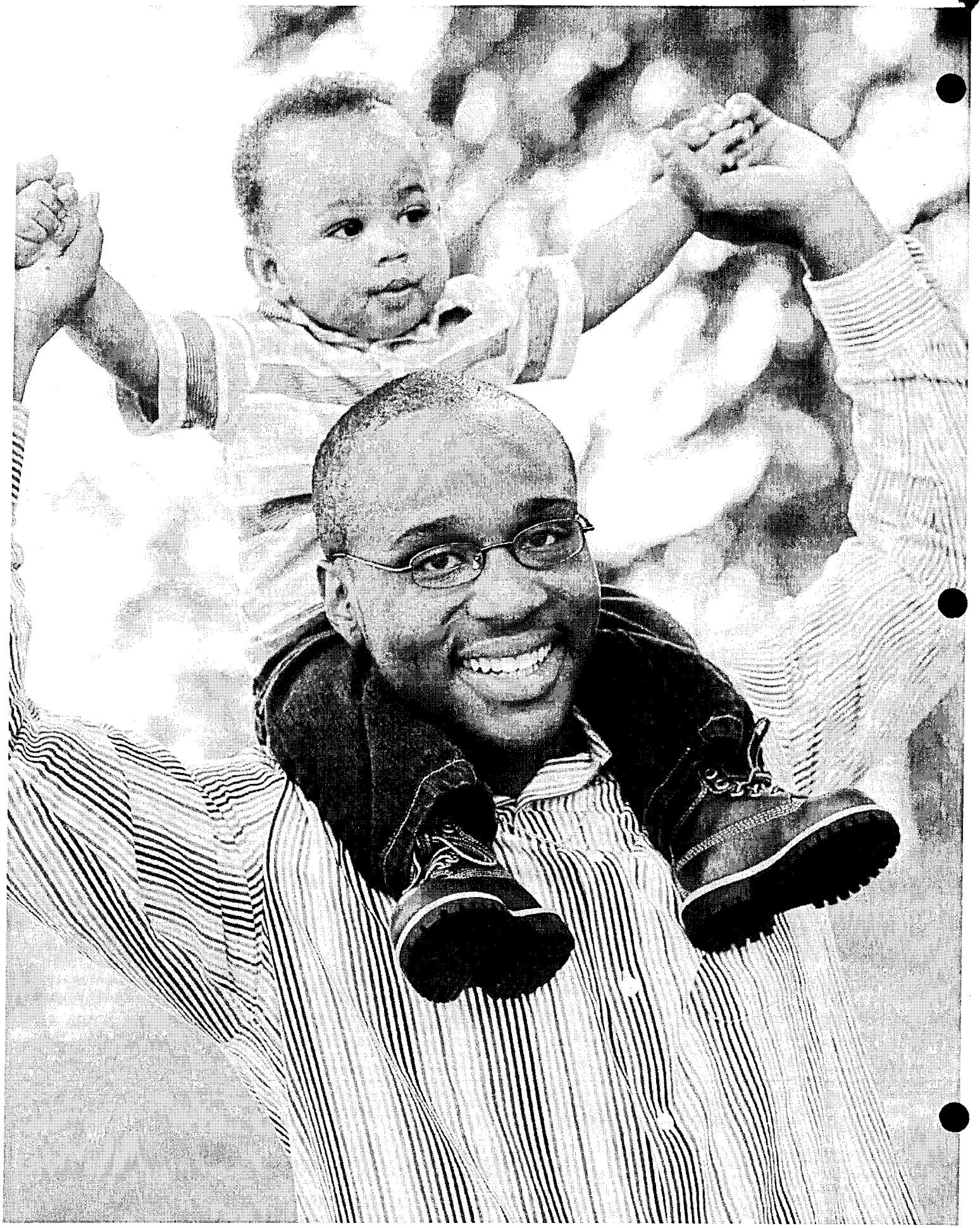
The child welfare community in Texas is small, and child advocates and service providers have long worked together to improve services to children and families. The debate over privatization, however, has divided customary allies into opposing camps.

After the Legislature adjourned in 2007, CPPP decided to step back and give the question of privatization a fresh look based upon careful research and analysis. Casey Family Programs agreed to fund our study of the experiences in Kansas and Florida, the two states that have most completely privatized.

Protecting children and strengthening families is difficult, complicated work. Doing it well requires successfully engaging the entire community—both the public and private sectors. In this report, we explore the issues raised by how a state draws the line between public and private responsibility, and we make specific policy recommendations.

Regardless of the exact contours of the line between public and private, public officials, private providers, and child advocates must work together if we hope to meet the needs of Texas children and families. Our analysis and recommendations are offered in the hope of finding a way to move forward together.

F. Scott McCown
Executive Director



Executive Summary

Child Protective Services (CPS) works to keep vulnerable children safe and to strengthen at-risk families. It is a critical piece of our state's public infrastructure. A strong child protection system ensures that all children are protected from abuse and neglect, giving them the opportunity to thrive and grow into responsible and productive adults. By doing so, CPS fosters healthy families and communities, the building blocks of a vibrant society.

CPS can be thought of like a rescue boat patrolling the ocean for signs of families in distress. Its job is to find sinking boats and either help the family quickly plug the hole, or, if that is not possible, pull the children aboard the state's boat. The more rescue boats available to patrol the waters, the more families can be assisted and children protected.

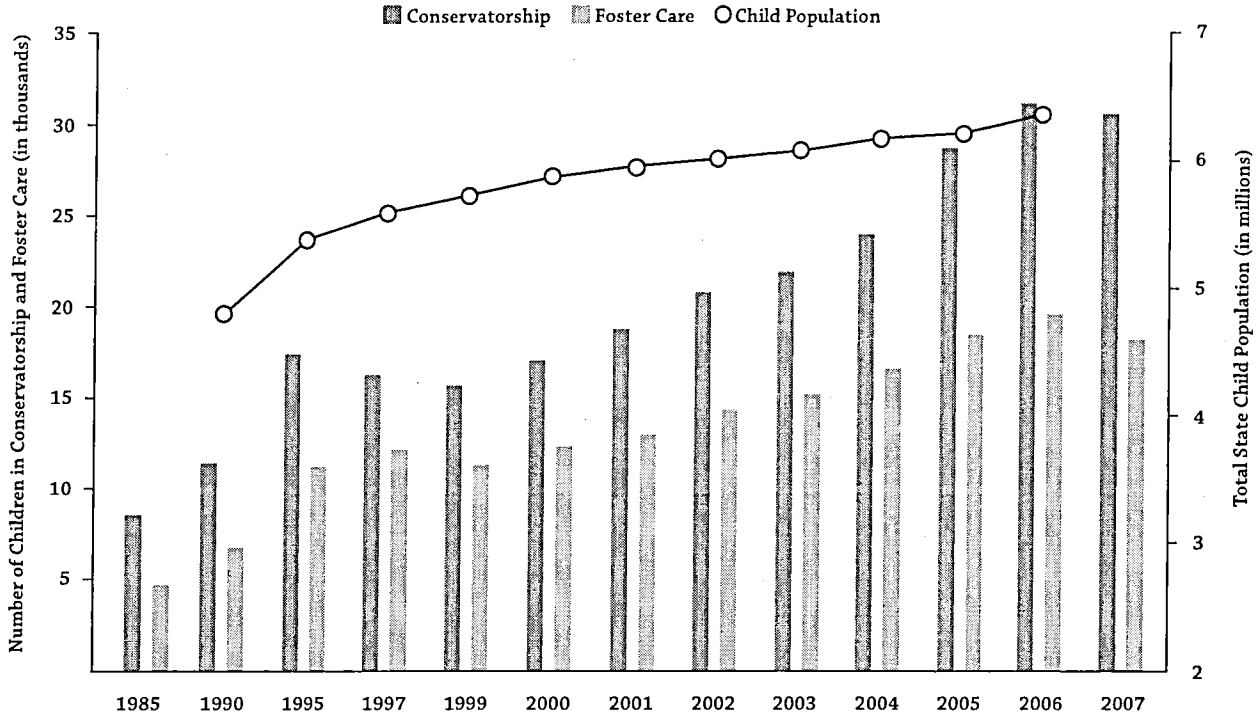
Over the last decade, the Texas Legislature has expanded the CPS fleet. As a result, CPS has improved its investigations and made progress in achieving better outcomes for families and children. For example, in just the last two years, CPS has reduced the removal of children from their homes by 9.2%, and increased "kinship" placements—the placement of children with family members by 11.2%.[1] CPS has also worked aggressively to move more children into permanent adoptive homes; in 2006, the federal government honored Texas with the largest award among the states for increasing the number of children adopted from foster care.

Despite these successes, the challenges CPS faces appear unending. The total number of Texas children has grown rapidly over the last decade, with an increase in the number of children who are at significant risk for abuse and neglect. About 23% of Texas children live in poverty, and 10% live in extreme poverty (meaning in families with incomes below 50% of the federal poverty level). This has resulted in a significant increase in the number of children coming into the state's care each year.

Even though funding for child protection has increased significantly over the last decade, CPS remains grossly underfunded. In 2004, the most recent year for which national comparisons are available, the state spent 58% less per child on child protection (prevention, services, and foster care) than the U.S. average—low enough to rank Texas 47th nationally.[2]

With inadequate funding, CPS struggles to both patrol the open water and tend to the children on the state's boat, juggling one crisis after another. These struggles have obscured the very good work that CPS has done over the last decade, such as increasing the use of kinship homes and speeding adoptions. These struggles have also contributed to negative public perception of the system and have undermined public confidence in the system's ability to protect vulnerable children.

Children in State Conservatorship and Foster Care on the Last Day of the Fiscal Year



Source: DFPS

Understandably, legislative frustration is high as well. Each session, the Legislature puts more money into CPS only to be told in the next session that it was not enough. In part, this is because the Legislature has taken a piecemeal approach to strengthening CPS.

Out of frustration and the desire to improve outcomes for children and families, the Legislature has searched for new models of service delivery. Leaning philosophically toward private sector solutions, and seeing experiments with the privatization of child protection in other states, the Legislature has considered outsourcing major child protection tasks to private providers. In 2005, the Legislature passed Senate Bill 6, mandating the privatization of case management and all state foster care and adoption services by 2011.

Private providers have always played a significant role in the delivery of child welfare services—both providing services to children in the state's care as well as delivering prevention services to families considered at risk. Undeniably, private providers have made important contributions to the child protection system in Texas. Working locally, these organizations often develop relationships and coordinate community resources more effectively and rapidly than CPS.

However, the Legislature's decision to privatize so much, so fast, and to outsource the case management functions traditionally performed by public employees, caused much concern in the child welfare community. In 2007, responding to these concerns, the failed privatization efforts in other areas of Texas state government,[3] and the cost of privatization, the Legislature passed Senate Bill 758, which converted the plan to privatize case management into a pilot program and dropped the plan to privatize all foster care and adoption services.

Despite these changes, privatization of child protection continues to generate significant interest and debate in Texas. Some observers argue that privatization will increase the quality and efficiency of child protective services, while others raise doubts. Still others contend that the primary question is not whether but how privatization should be accomplished. Unfortunately, much of this debate fails to

Case Management versus Care Coordination

Case management is a planning and decisionmaking function. A case manager develops a plan about how to proceed in compliance with the law and in the best interest of the children, and then pursues that plan, including prosecuting the legal case necessary to implement the plan. Subject to a judge's approval, a case manager has the final say in placement decisions, treatment decisions, and legal decisions. Case management is linked to but different from the *delivery of services* to children and families. While case management in Texas is done solely by public employees, CPS contracts with private providers to provide most services to children and families—for example, foster care for children or substance abuse treatment for parents. As part of caring for a child, a foster care network or residential treatment center will provide *care coordination* and may make care or treatment recommendations to a case manager: However, this function is distinct from *case management* in that the service provider does not have overall responsibility for planning and decisionmaking and does not prosecute the legal case.

distinguish between privatizing the primary function of government—to set policy and make decisions in applying that policy—and the secondary function of government—to provide services.

This paper focuses on this distinction. We analyze the different outcomes and risks associated with privatizing CPS case management, which is a primary function of government, and privatizing the delivery of services, a secondary function. In the latter, if done right, privatization has the potential to improve the quality of government services. In the former, however, privatization breaks the critical link between democracy and the most fundamental government decisions, putting the objective of child protection—to keep children out of harm's way—seriously at risk.

Our analysis looks particularly at the experiences of Kansas, Florida, and Texas. We recommend maintaining case management as a public function, limiting the role of private providers to the delivery of services to children and families, and exploring greater use of performance-based incentives when contracting for these services. While we support expanding the use of private providers in the provision of foster care and adoption services, we recommend that states move slowly, with adequate budgets, and always placing the needs of children and families first.

ISSUES AND RECOMMENDATIONS

Privatization is not a panacea for the problems facing our child protection system.

In states that have substantially privatized child protection, these efforts have produced mixed results, and no state has completely or even substantially eradicated problems within its system. First and foremost, privatization has failed to solve the main problems plaguing the child welfare system—high caseworker turnover, heavy caseloads, and inadequate resources for services to families.

Texas' public system performs as well as or better on key child and family outcomes as privatized systems, despite spending less per child.

In 2007, we made site visits to Kansas and Florida, the two states that have privatized child protection to the greatest extent. We conducted interviews with lawyers, judges, service providers, community-based care agencies, state agency staff, and the guardians *ad litem* appointed to represent the best interests of the children in foster care. We analyzed the outcomes of these privatization efforts and found that Texas' public system continues to do as well as or better on important outcomes as the privatized systems. In Florida, although child welfare costs substantially increased, privatization did not show improvement across all outcomes for children, particularly children's safety outcomes.

Privatization makes it harder for states to set policy and respond effectively to changing needs.

States must retain enough control over the child protection "purse" to be able to shift course when needed and remain responsive to the Legislature. Above all, states should not outsource so much that they lose the expertise or flexibility to judge between policies (i.e., decide which services work

best for children and families) or to target limited public resources to the areas with the greatest need.

The claim that outsourcing creates a powerful lobby for child welfare funding should be treated with skepticism and caution.
Consider the case of Medicaid and the Children's Health Insurance Program (CHIP). Even though doctors and hospitals are powerful advocates for health care, their clout has not yielded adequate reimbursement rates in these public programs, and health advocates are involved in a perennial fight for funding. States with inadequate taxation and therefore revenue, like Texas, should be particularly wary of the claim that the more powerful the lobby, the better social services will compete against other budget priorities. When there is no money available to spend, even a powerful lobby can't produce adequate spending.

In a recent example, in April 2008, the Florida legislature asked child welfare administrators to cut tens of millions of dollars from safety-net programs for vulnerable children in response to the economic slowdown. Lawmakers are considering these cuts despite studies showing that child abuse and neglect rise during periods of economic hardship.[4]

Furthermore, to the extent that lobbying can affect budgeting, caution is warranted. Government contractors can easily become like a "military-industrial" complex that skews budget priorities in the wrong direction. Much like prisons compete with parole and probation for whatever dollars are available, foster care and adoption services compete with prevention and community services. A powerful lobby can undermine effective budgeting and the setting of appropriate policy priorities.

When expanding the use of private providers in the foster care and adoption process, states should proceed slowly, with adequate resources, always placing the needs of children and families first.
Private providers have a long history in the delivery of foster care and adoption services to children and families. They currently manage 81% of Texas foster and adoptive homes, and do 44% of adoptions, while CPS manages 18% of the foster and adoptive homes and does 56% of adoptions.[5] To ensure that this fragile system is not damaged, adjustments in the role of the private sector must be done carefully. States must consider the capacity of private providers to expand, have a careful transition plan that limits disruptions in services to children already in the state's care, and be able to step in quickly in the event that private providers are unable to meet the terms of their contracts. States also must consider whether they have the resources to pay for privatization, which may improve the quality of services, but cost more.

A state should avoid completely dismantling its public foster care and adoption infrastructure, for several reasons. First, public units increase market competition. CPS foster and adoption services themselves compete with the cost and quality of private providers. Second, by retaining public units, the state avoids being at the mercy of private providers—if the state can't strike a deal with private providers, it can expand public capacity. Third, by being in the business of providing services, the state develops and maintains expertise that is useful in both contracting and regulating private providers.

Finally, states must also include stakeholders in the planning process both to benefit from their perspective as well as to win their support.

What makes a public function inherently "governmental in nature"?

"Security contractors perform many vital functions, but in Iraq they are also undertaking roles of military significance outside the military chain of command. And that is asking for big trouble."

–*National Review Online* commenting on the Blackwater, U.S.A. investigation

Federal guidelines define "governmental in nature" as a function that is "so intimately related to the public interest as to mandate performance by government employees," and prohibit privatization of these functions because it would involve an "unacceptable transfer of official responsibility to government contractors." The use of private military contractors in Iraq offers a compelling lesson on the dangers of outsourcing an inherently governmental function.[6]

Case management involves the impartial application of public laws and policy to individual families and should be done by public employees supervised by public officials.
While a CPS investigator makes an initial determination of abuse or neglect, once a child comes into foster care, an ongoing case manager must continue to assess these issues, gather additional information, and prosecute the legal case to a final conclusion. As such, case management involves making decisions that affect people's rights—whether abuse has occurred, whether to take a child from a parent, and whether to place the child with a relative or in foster care. These are inherently governmental decisions that require the impartial application of public laws and policy to individual families. These decisions should be made by public employees who themselves are responsible to high-ranking public officials who are in turn accountable for their actions and legally obligated to protect the rights of citizens.

Case management functions should not be performed by private agencies with a financial conflict of interest.
Though private providers may be committed to making decisions that are in the best interest of children and families, the financial interests of private companies—whether for profit or not for profit—can and often do influence these decisions. Indeed, the very justification for privatization is that financial incentives influence behavior. Concern about the bottom line is troublesome in a system that makes fundamental decisions about families, including life and death decisions about children.

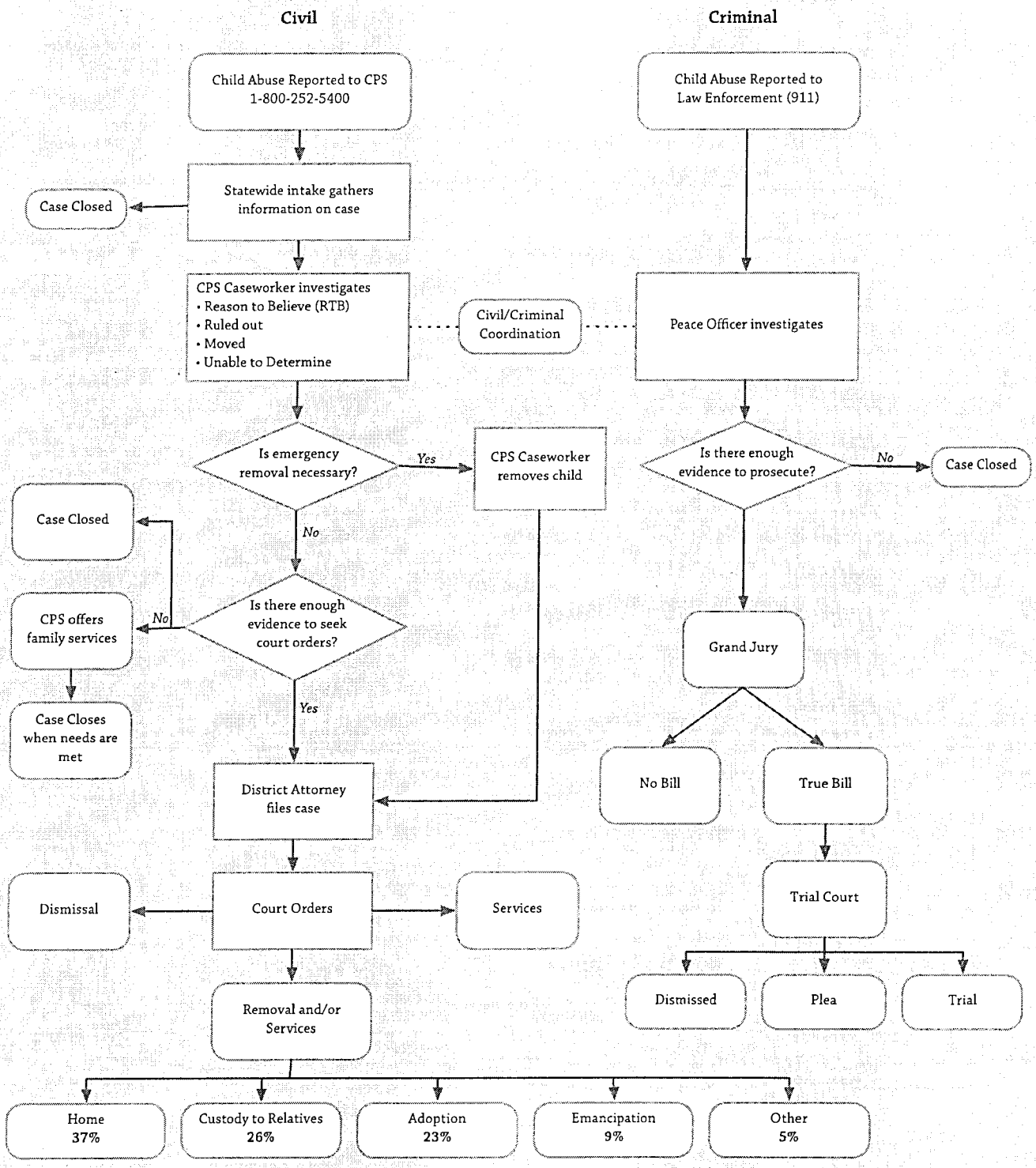
Performance-based contracting, if done right, may improve service delivery; however, it is less effective when used to improve case management.
Performance-based contracting has proven effective at improving child welfare outcomes under specific conditions: States must have the resources and expertise to craft contracts in a way that stimulates competition, be able to develop appropriate and measurable performance outcomes, and have the capacity to manage and enforce contracts.

Research has consistently shown that the most important predictor of success is the ability to articulate clear goals and outcomes. For this reason, using performance-based incentives is not as effective or appropriate in case management. Case management requires workers to balance competing priorities—such as the safety of the children with the desire to keep families intact—that can result in conflicting outcome measures. If the goal is a singular good, such as increased high school graduation rates, then it can be stated and measured. If the goal requires balancing conflicting goals, then it is not easily measured. For example, asking a district attorney to have a high conviction rate is something that it easy to measure. However, it is not the same as asking a district attorney to convict the guilty and not the innocent, something that is virtually impossible to measure.

Privatization leads to the loss of Child Protective Services' greatest asset—its workforce—which undermines the long-term goal of improving CPS.
The difficulty of recruiting and training qualified staff is a major challenge facing CPS. In fiscal 2007, the average turnover rate for CPS caseworkers in Texas was 34%.[7] High turnover affects staff performance, lowers employee morale, and reduces the quality of services to the children and families served by CPS. Given the importance of a trained and dedicated workforce, many of the recent CPS reforms have been directed at attracting and retaining high-quality staff.

Privatization will only undermine this effort. Contrary to the claims of private providers, CPS caseworkers are not likely to join the private provider workforce if their jobs are privatized. The Texas Department of Family and Protective Services (of which CPS is a division) attributes caseworker turnover to a variety of reasons, primarily the heavy workload and limited compensation. Neither of these circumstances is likely to improve in a privately run system, and could actually worsen. CPS faces trouble recruiting and retaining qualified staff now, even with the generous benefits and retirement package given to state employees: It is highly unlikely that private providers will do any better, given that they are likely to pay less and offer fewer benefits.

The Texas Child Protection System



NOTE: Data are for children who exited DFPS legal responsibility in fiscal 2006.

The Functions of the Child Welfare System

Understanding the issues raised by how the line is drawn between public and private responsibility for child welfare requires some basic familiarity with how child protection works.

Child Protective Services' (CPS) work can be divided broadly into four functions: 1) investigations; 2) case management, which includes decisionmaking, coordination, and legal casework; 3) services to children and families; and 4) foster care and adoptive home recruitment, training, and management. On the opposite page is a decision tree outlining the process CPS follows as it investigates and responds to an allegation of child maltreatment. It is easier to explain the functions by discussing them in reverse order.

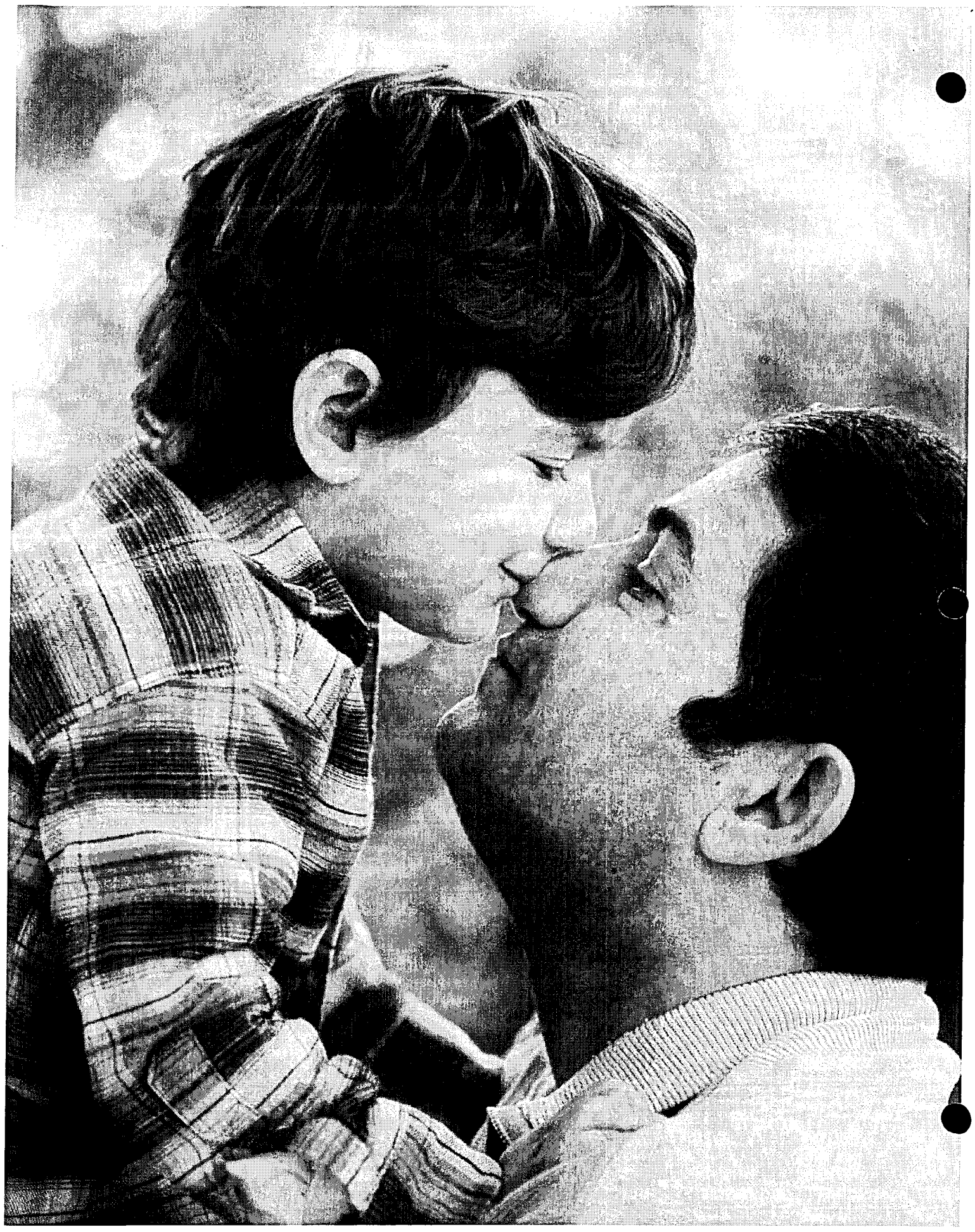
Foster care and adoption services (also called substitute care services): Foster care services is recruiting, training, and supervising foster homes for children. Adoption services is recruiting and training adoptive parents, plus providing assistance to the home during the waiting period before the adoption is completed. Texas has a public and private system of foster placements, using a combination of emergency shelters, foster family homes, foster group homes, and residential care facilities. These services are often called substitute care services as they are the services provided to children when state care has been substituted for parental care.

Services to children and families: CPS uses private providers for most services to children and families, such as substance abuse treatment, parenting classes, and therapy. CPS will either ask parents to voluntarily pursue help through community resources, or CPS will seek a court order requiring parents to participate in services. If the parent cannot afford the services and no free community services are available, CPS will offer services through private providers with whom it contracts.

Case management: Case management means the provision of case management services to a child for whom the state has been appointed temporary or permanent managing conservator. It includes placement decisions, treatment decisions, reunification decisions, and the legal court work leading to permanency for a child, including pursuing a case for termination of parental rights.

Investigations: Most commonly, someone who suspects child abuse or neglect calls the state hotline and makes a report. CPS must respond to reports of immediate danger within 24 hours and other reports within three days. A CPS investigator talks to the child, family, and others to determine if child maltreatment has occurred. The CPS investigator must also determine how to respond: 1) refer the family to community resources; 2) seek a court order for the family to participate in services; or 3) remove the child for placement with a relative or in foster care. CPS investigators make complex decisions about families, including whether children should be removed to ensure their safety. CPS investigators coordinate legal cases with the prosecutor and represent the state in court.

Research suggests that the characteristics associated with successful privatization initiatives are easier to achieve when privatizing the delivery of services and harder to do when privatizing case management, which involves making and applying policy. In the following sections, we explore this distinction between privatizing case management, which involves primary government decisionmaking, and privatizing the delivery of foster care and adoption services, a secondary function of government.



The National Context

THE ORIGINS OF CHILD WELFARE PRIVATIZATION

Nonprofit agencies have always played a role in the delivery of child welfare services. The first significant growth in government contracting for the delivery of child welfare and other social services occurred in the 1960s as a result of changes to the Social Security Act that allowed federal funding to be used to fund social services by private, nonprofit agencies. This development was part of the Great Society's War on Poverty—the federal government wanted to increase spending on mental health, health care, and social services and purchased services from nonprofits as one way to achieve that public policy goal. By the mid-1970s, what is now known as privatization had become common practice in the delivery of child and family welfare services. The enactment of the Adoption Assistance and Child Welfare Act of 1980 unleashed a second wave of privately provided child welfare services, as additional federal funding became available.[8]

During the Reagan Administration, a philosophical shift occurred at the federal level away from the public commitment to anti-poverty efforts that characterized the Great Society programs and toward individual and private sector solutions. This shift, combined with cuts in federal funding for social services, set the stage for a third wave of growth in child welfare privatization. In contrast to the growth in privatization that occurred in the 1960s and 70s, this growth wave was motivated by the goals of government downsizing, deregulation, and cost containment.[9]

These fiscal and regulatory concerns continue to be factors in today's privatization initiatives. However, since the mid-1990s the privatization of child welfare has been increasingly focused on the purported ability of private providers to improve the quality of services and outcomes for children and families, achieve greater flexibility and opportunities for innovation, and improve the efficiency of service delivery.[10]

The privatization of social services in general, and of child welfare services in particular, has sparked great debate. Proponents and critics argue over the degree to which privatization can produce better outcomes for children and families, the ability of the government to reap the benefits of competition, and the appropriate role for private providers in the delivery of child welfare services. Others take the position that the important question is not whether, but how to privatize child welfare services. In this section, we summarize these basic positions.

ARGUMENTS FOR AND AGAINST PRIVATIZATION OF CHILD WELFARE

Proponents of privatization argue that private providers have the capacity to deliver higher quality, more efficient

services at a lower cost. At the heart of this argument is the belief that expanding privatization and curtailing the government's role in social service delivery is the essence of open competition and greater efficiency. Greater efficiency, in turn, leads to better quality and cost savings.

Proponents cite numerous examples of the successful delivery of social services by private providers, including alcohol and drug abuse treatment, employment and training for welfare recipients, adoption services, and housing projects. They also argue that private providers are not bogged down by bureaucracy, thus giving them greater flexibility and allowing more innovation. They portray government as an "alienating megastructure" whose role should be limited to empowering community groups to "mediate" between government and individuals.[11] They portray private providers as better advocates for children and families because they are local, better at building relationships, and have the trust of the community.

One of the most commonly cited reasons for outsourcing is that it will increase competition, thereby improving quality and lowering cost. However, critics argue that the very nature of child welfare makes privatization risky and inappropriate. They contend that, in many cases, "no meaningful opportunity exists to create the competition that lies at the heart of a privatized approach."[12] These limits on competition undermine the state's ability to reap the benefits of competition and achieve any cost savings.

Critics point out that no competitive market exists for case management in the child welfare system. States that decide to outsource this function are essentially buying a service that no company now sells. States would have to recruit companies into the business. These companies would have to make a huge investment to enter the market, including hiring, training, and supervising staff; investing in technology; and many other steps, creating significant start-up costs. The few companies able to respond to a contract offer would in essence assume monopoly or oligopoly market power. This may account in part for the dramatic increase in costs in those states that have privatized.

Any competition effectively ends upon the signing of a contract. Because of the cost and disruption of awarding a contract and the significant start-up costs involved in transferring responsibilities to the contractor, contracts are likely to run for many years, eliminating any competition for long periods of time.

Because bidders lack existing capacity to offer case management services, selecting a contractor requires the state to speculate. If awarding a contract is influenced by the amount of the bid, then bidders may underestimate the cost of providing the services in order to win the contract. Later, when it is clear that the bid was too low to do the job, the state faces a difficult decision: pay the contractor more or let services suffer. Because there isn't a market with many potential contractors, the state will have no other choices. The disruption, cost, and risk of moving to a new contractor, if one were available, or rebuilding the public system leaves the state with little practical choice but to stay with the original contractor even if the company has performed poorly or is demanding a higher price.

Those skeptical about the benefits of competition also argue that "efficiency," when it is achievable, often comes at the cost of quality. For example, the more time a social worker spends with a client, generally speaking, the better the results. Privatization forces a trade-off between efficiency and quality, with the desire for cost savings undermining the goal of improving quality and outcomes. In particular, critics raise the concern that the focus on costs inevitably leads to "creaming"— providing services to the clients who are easiest to serve, and leaving the more difficult cases to the government to serve or leaving them unserved—a risk shown to be greatest when clients are vulnerable or at a high risk.

Finally, some critics of child welfare privatization have raised concerns about the impact that the "blurring of the distinction between public and private" functions has on the rights and interests of the children and families in the system.[13] A primary concern is whether the provider's commitment to high quality will persist when faced with the prospect of diminished financial returns. Critics also raise the important question of the extent to which private agencies have legal duties to their clients.[14] Some critics even question whether privatizing an inherently governmental function like case management is constitutional, given that private agencies, unlike government, are neither politically accountable nor obligated to protect citizens' rights.[15]

The research on privatization suggests that the key factor in predicting success is whether there is "clear accountability for results, clear criteria for performance, and clear public objectives."[16] Debate over how rather than whether to privatize generally focuses on three principles: Can the contractor be easily replaced (or, is the government able to easily intervene when things go wrong), can the tasks be easily delineated and measured, and is the result more important than the process?[17] Experts emphasize the need for the state to retain enough control over the system to be able to make policy, shift course, and allocate resources to the areas with the greatest need. They also emphasize the importance of contract monitoring, oversight, and enforcement, for even a well-designed privatization effort won't yield positive outcomes if the government does not possess the skills or spend the resources needed to hold contractors accountable for their performance.[18] Unsophisticated management information systems, limited auditing capacity, and a lack of skilled contract managers—all common challenges for public welfare agencies—also have the potential to undermine meaningful accountability in the contracting for child welfare services.

CONTRACTING FOR RESULTS

Child welfare agencies are increasingly exploring the use of performance-based contracts that focus on the quality of outcomes, rather than the quality of effort. These arrangements generally involve financing arrangements that align payment with outcomes and give private providers greater flexibility and autonomy in determining how funds are used, while at the same time shifting financial risk to private agencies.

In a performance-based contract, the daily rates for care and fixed fees for services are replaced with payments that are conditioned on a provider meeting specific performance goals; typically, penalties are imposed if a provider fails to meet these standards. A performance-based model shifts some risks to the private provider, such as if more children come into care than projected, or the cost of providing the services exceeds projections. The different financing models being used across the country include capitation, capped allocations, and case rates.[19]

"The ... very dynamics that support successful privatization of social services may be the most difficult to achieve."

Freundlich and Gerstenzang (2003)

Regardless of which financing option it chooses, a state must structure its rates carefully. If they are too low, children and families won't get the help they need. If the rates are structured wrong, incentives or disincentives can negatively affect services. For example, children may be "pushed through the system" to minimize costs or avoid penalties. This could result in a child being returned home, and subsequently reabused, because of how a state contract allocates financial risk.

Performance-based contracting has proven effective at improving child welfare outcomes under specific conditions: States must have the resources and expertise to craft contracts in a way that stimulates competition, be

Financing Models[20]

Capitation pays a fixed rate for each child in a general population—for example, in a geographic area. The financial risk is shifted from the state to the service provider. For example, if more children were removed from their homes than forecast, the service provider might lose money.

Capped allocation also pays a fixed rate per child for each child, but for a more limited population instead of for a general service population—for example, all children removed from their homes by CPS in Harris County that come into state conservatorship. The financial risk is still shifted from the state to the service provider.

Case rates pay per child but regardless of the services offered. This too shifts the risk to the service provider. For example, if a drug-abuse epidemic hit a community, resulting in drug-exposed babies with very high medical needs, the provider would have to meet those needs on a case rate set before the epidemic.

able to develop appropriate and measurable performance outcomes, and have the capacity to manage and enforce contracts. Since payment is tied to predetermined outcomes, the government must be able to define these outcomes in a realistic and meaningful way.

Several studies of social services privatization have shown that this is very difficult to do in the area of child welfare. A 1997 study by the General Accounting Office (GAO)[21] found that state agencies lack the experience needed to develop contracts that contain specific programs results, largely because the "complexity of tasks" makes it hard to specify the scope of work. GAO pointed out that it is particularly difficult to balance the competing priorities associated with child welfare—such as the safety of the child with the desire to keep families intact—without unintended negative consequences.[22] Researchers also urge caution when using performance-based incentives in child welfare contracting, because the product—the "changes in human conditions"—is so hard to measure.[23]

"Crafting money consequences to go with performance is tricky business.... We should not implement pay for performance (or other rewards or penalty policies) before we know what good performance is."

Marc Friedman, The Finance Project

Child welfare agencies also provide many different services to address many different problems—often with inconsistent objectives. This can make it difficult for states to choose which results they want to specify in their contracts.[24] The Alliance for Redesigning Government's analysis of performance measurement in child welfare found that focusing on one set of goals can have negative repercussions on others. For example, an emphasis on reduced admissions into foster care can increase a child's length of stay in care, while an emphasis on reducing the length of stay can increase reentry rates.[25]

Federal Findings on the Use of Performance-Based Incentives[26]

In its report to Congress on the use of performance-based incentives in child welfare contracts, the U.S. Department of Health and Human Services' Children's Bureau identified three major areas of concern:

- In designing performance-based contracts, which services should be targeted? How can the contract design take into account distortions that occur when one part of the system is emphasized at the expense of the other?
- How can a performance-based system be designed to increase accountability and improve performance without unintentionally punishing children and families when contractors fail to perform well?
- It can take time to measure the impact of financing changes on children and families. States need to adopt a "thoughtful, staged process" that permits assessment of the impact on children, families, and service systems.

Comparing Texas to Kansas and Florida

The privatization of child welfare services, including case management, is on the rise, with over half the states experimenting with some form of privatization. In 2003, the Child Welfare League of America identified 39 privatization initiatives in 25 states.[27] By 2006, the number of states experimenting with privatization had increased to 29. Kansas and Florida are the only states that have totally privatized child welfare services, and several more states are considering statewide privatization. Some states have totally privatized their child welfare systems in specific regions of the state.[28]

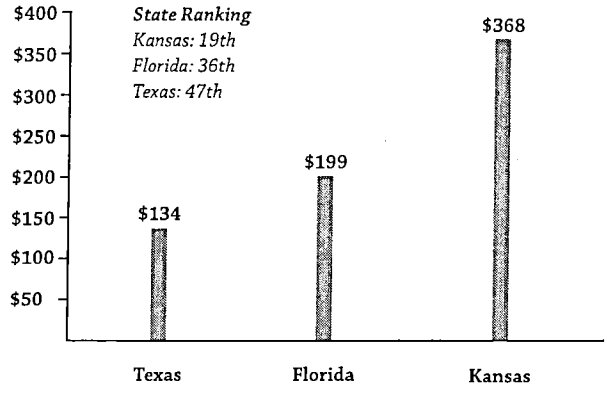
In states that have substantially privatized child protection, these efforts have produced mixed results, and no state has completely or even substantially eradicated problems within its system. First and foremost, privatization has failed to solve the main problem plaguing the child welfare system—high caseworker turnover, heavy caseloads, and inadequate resources for services to families.

According to a study by the National Quality Improvement Center on the Privatization of Child Welfare Services, 44 states are not currently privatizing case management functions or have made only limited privatization efforts. Of the 29 states that have experimented with some degree of privatization, nine states have cancelled their contracts, primarily because the private provider failed to produce the expected outcomes for children and families.[29]

Privatization has failed to solve the main problems plaguing the child welfare system—high caseworker turnover, heavy caseloads, and inadequate resources for services to families. As a result, 9 of the 29 states that have experimented with some degree of privatization have cancelled their contracts and resumed responsibility for those functions.

In 2007, we made site visits to Florida and Kansas to evaluate their experiences with child welfare privatization. We conducted interviews with lawyers, judges, service providers, community-based care agencies, state agency staff, and the guardians *ad litem* appointed to represent the best interests of the children in foster care. We analyzed the outcomes of these privatization efforts and found that Texas' public system continues to do as well as or better on many outcomes as the privatized systems.

State Spending per Child on Child Welfare in the General Population, 2005



Source: Urban Institute's analysis of data provided by the U.S. Department of Health and Human Services.

In Florida, although child welfare costs substantially increased, outcomes for children varied across the state, particularly safety outcomes. Moreover, Texas spends significantly less per child than both states. In 2004, Texas spent 32% less per child in the general population than Florida. Kansas greatly outspent both states, spending over two and a half times more per child in the general population than Texas and 84% more than Florida.

KANSAS

Kansas' Decision to Privatize

Before privatizing, the Kansas Department of Social and Rehabilitation Services (SRS) was responsible for investigations, case management, family preservation services, and most substitute care services. The state had contracts with child placing agencies to verify foster homes, as well as some contracts to provide residential placements.

In 1989, a class action lawsuit brought by the American Civil Liberties Union (ACLU) Children's Rights Project on behalf of Kansas children initiated a push for child welfare reform.[30] The lawsuit claimed that the Kansas child welfare system lacked adequate placements for children entering foster care and violated Title IV-E of the Social Security Act, the federal Child Abuse Prevention and Treatment Act (CAPTA), the Federal Due Process Clause, the Kansas Code for Care of Children, and the Kansas Constitution. At the time, the Kansas system had several serious deficiencies, including the highest rate of recidivism in the country. Too often, children reunified with their parents after placement in foster care returned to the system.

The lawsuit was settled in 1993, mandating significant reforms, including increasing the number of foster placements. The settlement included a consent decree mandating annual reviews of SRS' performance, which the agency failed five years in a row.[31] Frustrated, Kansas turned to privatization in the hopes that private providers could fix the problems plaguing its child welfare system and help the state comply with the lawsuit.[32] The four guiding principles of Kansas' privatization effort were:

- Private providers should be required to meet clearly defined program goals,
- Quality and cost-effectiveness could be achieved through competition,
- A single case manager should oversee services to children, and
- Services should be equally available across the state.[33]

Summary of Kansas Findings

- A lack of data about the public system makes it difficult to compare outcomes before and after privatization.
- Privatization of Kansas' child welfare system happened too quickly with too little input from stakeholders, causing disruptions in services to children and families.
- Kansas' privatized system continues to struggle with many of the same problems that plagued its publicly run system.
- Kansas' child welfare costs have increased substantially since privatization, making it difficult to determine whether improvements in the system are attributable to privatization or simply the result of increased funding.
- Texas' public child welfare system compares favorably to Kansas' privatized system on several key outcomes, even though Texas spends significantly less overall and less per child.

The Kansas Privatization Model

Kansas privatized each component of its system incrementally over the course of three years. The state chose a lead agency model, selecting nonprofit providers to provide case management, family preservation services, adoption services, and foster care and group home care services. In 1996, family preservation services were contracted to five private agencies, and adoption services were contracted to a single statewide vendor, Lutheran Social Services. In 1997, foster care and group home care services were contracted to three agencies. As of 2007, post-investigation responsibilities have been privatized in almost all 105 counties in the state. Currently, six lead agencies have contracts covering five regions in Kansas.[34]

Based on a managed care approach to child welfare, the three major features of the Kansas privatization model were:

- Designation of lead agencies on a regional basis for family preservation and foster care services and on a statewide basis for adoption services (later contracts amended this designation; contractors now handle the gamut of services);
- Performance-based contracting, under which private contractors would be held to certain specified performance measures; and
- Use of a case rate to cover the costs of all services needed by a child or family while being served through the family preservation, foster care, and adoption programs.[35]

As it did before privatization, Kansas receives legal custody of the children who enter foster care, but now its only contact with children and families occurs when providing prevention services and during investigations of child abuse and neglect. Initially, the state maintained oversight of case management; however, in the most recent contracts this oversight role has been transferred to private providers. After the child abuse or neglect investigation is complete, private agencies take over. In sum, private agencies have assumed responsibility for both the delivery of services to, and the day-to-day decisions about, the children and families in their care.

Kansas made the mistake of privatizing too rapidly and without input from the key stakeholders in the child welfare system. As a result, the first round of contracts, awarded beginning in 1996, created a chaotic environment for children, parents, service providers, and community advocates.

The state also underestimated the cost of privatization. In the first wave of contracts, Kansas established a set "capitated" fee, reimbursing its contractors between $13,000 and $15,000 per child receiving family preservation services, in foster care, or successfully adopted. Many experts voiced the concern that this reimbursement rate was insufficient. Kansas used "best-guess" data to structure the contracts, and guessed wrong. The providers could not afford to provide sufficient, quality services within that reimbursement rate, and one contractor, United Lutheran Youthville, was bankrupted.

Fortunately, the initial contracts were short in length, enabling Kansas to reprocure the services in 2000. At that time, the agency restructured the contracts to reimburse its vendors based on the number of children served each month. The state also revised its outcome measures and performance goals.

Analyzing the Impact of Privatization on Kansas' Child Welfare System

Our ability to compare the outcomes achieved by Kansas' private providers to the performance of its public system is limited, given that the state did not collect sufficient data on these measures before privatizing. (In fact, one of the commonly cited benefits of privatization in Kansas is that the state now collects better data.) Our analysis of performance in Kansas' child welfare system over time is based on the outcome measures reviewed in the federal Child and Family Services Review (CFSR) and data collected by the state for fiscal years 2005 and 2006. We supplement these data with information gathered during a site visit in 2007, at which time we interviewed stakeholders such as lawyers, judges, service providers, community-based organizations, state agency staff, and the guardians *ad litem* appointed to represent the children in Kansas' foster care system. Our comparison of the Kansas and Texas child welfare systems uses state agency-collected data from the most recent fiscal years available for both states.

Stakeholders' Perspectives

The stakeholders we interviewed in Kansas expressed mixed feelings about the benefits of privatizing Kan-

sas' child welfare system. None felt that privatization had cured the major problems within the child welfare system, with more than one respondent warning that "privatization is not a panacea." Among those who voiced more concern than praise, many seemed resigned to having a privatized system, mostly because of the difficult transition and the fear that "going back" would be too disruptive. The opinions of the people we interviewed are summarized below:[36]

The reported benefits of privatization

- **Kansas collects better data than before privatization.**
  Kansas now collects data not only on safety and permanency outcomes, but also on other issues affecting children in its child welfare system, including outcomes relating to maintaining family connections, meeting educational needs, timeliness of permanency hearings, and developing appropriate permanency goals to meet the needs of children.

- **Performance-based contracting has the potential to improve outcomes.**
  The use of performance-based contracting sets high standards for private contractors and provides a structure for holding providers accountable. According to one source, "benchmarks are common sense and expectations are clear." Also, contractors or outcomes may be changed or modified if the contractor does not meet performance goals.

- **Privatization has increased funding for child welfare.**
  The Kansas Legislature appropriates significantly more funds for its child welfare system than before privatizing. Some attributed the increase to the influence of private providers, who can lobby for increased funding, something that state agencies are prohibited from doing.

- **Private providers work better with the community.**
  Child welfare is community-based rather than state-run, which enables local providers to build stronger relationships with community partners.

- **Privatization has led to improvements in family preservation and adoptions.**
  Private providers offer family preservation services 24 hours a day, seven days a week and have speeded up the pace of adoptions. Most children in out-of-home care live in family-like settings rather than residential treatment centers or more restrictive placements. A high percent of stakeholders report that services under the privatized system have enhanced the ability of families to meet the needs of the children in their care.[37]

Concerns about Kansas' privatized system

- **Caseworker turnover is high.**
  Fewer SRS employees than anticipated went to work for private providers when the state privatized its child welfare system. One source reported that turnover among private provider staff is "concerning." Another stated that because they "can't keep up with the caseworker changeover, [they] don't even keep caseworker information in files anymore."

- **Services, especially in rural areas, are still inadequate.**
  Privatization may have reduced the array of services because of the limited number of subcontractors. This problem is particularly acute in rural areas where the lack of providers in close proximity to families already poses serious barriers to meeting the needs of children and families in the child welfare system.

- **Pressure to reduce costs is threatening the quality of services.**
  Several people expressed the concern that contractors' efforts to control costs have come at the expense of children. For example, certain providers of family services are paid the same rate by the state for all therapy services. Now, instead of using licensed therapists, the contractor uses social workers as therapists, which is insufficient to help severely abused children. Others questioned the notion that privatization had increased competition or improved quality, because so few organizations have the expertise needed to compete.

- **Privatization has added another layer to the child welfare bureaucracy, diverting money from services.**
  The lead agencies have become a middle man that didn't exist in the public system. Before privatization, Kansas contracted with providers directly. Under the lead agency model, scarce dollars are diverted to pay the middle man's administrative costs.

- **The high turnover in contractors has been disruptive.**
  The transitioning of contracts to new providers has caused disruptions or delays in services for children and families, who may lose therapists, counselors,

"With more major service providers competing for a limited workforce, continuity of service to the family is challenging. As a predominantly rural state, the needs for a diverse and skilled workforce must be addressed on a broader scale."

–SRS Statewide Assessment Instrument for Second Round CFSR

caseworkers, and foster parents in the process. In one region, at least three different providers had contracts over an 11-year period.

- **Contractors are territorial, which negatively affects services to children and families.**
  When families move from one region of the state to another, they often switch contractors, which has led to disputes about payment for services between contractors. According to one source, competition among contractors hampers information-sharing about best practices that could improve child welfare services.
- **Some providers have demonstrated a lack of understanding of child welfare laws and the role of the courts.**
  Some sources complained that private providers often don't understand all of the requirements of federal and state child welfare laws, in particular the standards for reasonable efforts and the importance of permanency planning.
- **Privatization has led to confusion about who is ultimately responsible for the children in the conservatorship of the state.**
  Though the state retains legal custody of children in foster care, the private providers make decisions about their care, including recommendations to the court regarding whether they should return home. The lack of clarity over who is responsible for these children has undermined outcomes for some children in the child welfare system.

The Cost of Privatization

Kansas spends significantly more on child welfare than it did before privatizing, yet has failed to achieve comparable gains in the overall performance of the system. From 1996 to 2004, the latest year for which data are available, Kansas' overall child welfare spending increased 41% after adjusting for inflation.

Given the increase in spending, it is impossible to say whether the reported improvements in the areas of family preservation and adoptions are the result of private providers outperforming the public system in these areas, or whether the same gains could have been achieved by a better funded public system.

COMPARING TEXAS TO KANSAS USING STATE DATA

Texas and Kansas collect a wide range of data to assess the performance of their child welfare systems. We can only compare performance on those outcomes for which the same type of data are collected and measured in each state. Both states collect comparable permanency and safety outcome data for internal state evaluation purposes and because these data were required for the first round of the federal Child and Family Services Review (CFSR), authorized by Congress in 1994. In this section we compare the data gathered by Texas and Kansas in fiscal years 2005 and 2006. The data represent statewide averages for each outcome. Later, we use the results of the first-round CFSR and state data collected in preparation for the second-round CFSR to compare performance in Kansas, Florida, and Texas.

Kansas	1996	2004	Percent Increase
Total child welfare spending (in 2004 dollars)	$182.1 million	$257.8 million	41%
Spending per child in the general population	$265	$368	39%

Source: Urban Institute and U.S. Census Bureau.

The data show that Texas' public system performs as well as or better than Kansas' fully privatized system on key permanency and safety outcomes.

Permanency is defined as leaving substitute care through reunification, relative placement, or adoption—in essence, leaving the legal responsibility of the state.[38] One of child protection's core goals is to get children into placements that best meet their needs as quickly as possible to avoid moving them repeatedly, which is very disruptive for children. Permanency outcomes are measured by looking at the family reunification rate within 12 months of entry into foster care, the number of children with two or fewer placements who have been in care 12 months or less, and the adoption rate within 24 months of a child being removed from the home.

When comparing Texas' public system to Kansas' fully privatized system during fiscal 2005 and 2006, Texas does better than Kansas on all permanency outcomes.

Another goal of any child welfare system is preventing children from being further abused or neglected. Safety outcomes are measured by looking at the incidence of maltreatment of children in foster care, repeat maltreatment, and recidivism. Texas performed better than Kansas in 2005 and almost as well as Kansas in 2006 on the first outcome, slightly worse on the second in 2006, and better on the third in 2005 and 2006.

FLORIDA

The Florida Privatization Model

In Florida, all post-investigation responsibilities have been privatized. The Department of Children and Family Services (DCF) retains legal custody of children who enter foster care, but its only contact with children and families occurs during investigations of child abuse and neglect and through contracting oversight of private agencies. After the child abuse or neglect investigation is complete, private agencies take over. Private agencies make all decisions regarding these children and their families and provide them with any necessary services. Florida uses the lead agency model. Eighteen lead agencies have 22 contracts covering all 67 counties in Florida.[59] Most of these lead agencies are private, community-based organizations; though two are local government agencies. Lead agencies are responsible for planning, administering, and delivering services in accordance with state and federal laws; and coordinat-

Permanency Outcome	Texas 2005	Kansas 2005	Texas 2006	Kansas 2006	Kansas Standard[39]
Percent of children with two or fewer placements who have been in care 12 months or less	76.2%[40]	70.4%	76.4%[41]	72.5%	86.7%[42]
Percent of children reunified with family within 12 months of entry into foster care	63.5%[43]	45.1%	61.4%[44]	54%	76.2%[45]
Percent of children adopted within 24 months of removal	52.2%[46]	22.2%	53.5%[47]	29%	32%[48]

Safety Outcome	Texas 2005	Kansas 2005	Texas 2006	Kansas 2006	Kansas Standard
Percent of children in care who did not experience a confirmed incident of maltreatment while in foster care	99.4%[49]	98.2%[50]	99.2%[51]	99.8%	99.4%[52]
Child victims with repeat maltreatment—a confirmed allegation of maltreatment within the prior six months	4.4%[53]	Data unavailable	4.4%[54]	3.8%	< 6.1%[55]
Percent of children reentering foster care within 12 months of discharge from a previous episode of foster care	2.1%[56]	3.5%	2.9%[57]	5.5	< 8.6%[58]

Summary of Florida Findings

- Privatization of Florida's child welfare system yielded mixed results, with improved outcomes in some areas, but deterioration in others.
- Overall, Florida's system still struggles with many of the same problems that led the state to seek privatization.
- Even though child welfare spending has increased substantially since privatization, outcomes have not substantially improved across the board.
- It is difficult to ascertain whether the limited improvements in the Florida system are attributable to privatization or simply the result of increased funding.
- The current state-run Texas child welfare system compares favorably to Florida's completely privatized system, even though Texas spends significantly less overall and less per child.

ing with other local public or private agencies that offer services for clients.[60]

The objectives of Florida's privatization effort included:

- Improving the safety and well-being of children,
- Creating community ownership around child welfare issues,
- Shifting the responsibility for direct services in child welfare from DCF to newly created lead agencies,
- Creating a more integrated and comprehensive child protective service system, and
- Gaining the flexibility to manage available resources.[61]

DCF developed the following outcome measures to evaluate its contractors' performance: 1) Serving a greater number of children, 2) moving children to permanency more quickly, 3) ensuring greater stability in out-of-home placements, and 4) guaranteeing low occurrences of reabuse and reentry into the system.

A Word About the Data

Our analysis of Florida's system before and after privatization compares data from fiscal year 1999 with the most recent fiscal year available.[62] For comparison of the Florida and Texas child welfare systems, our analysis uses data from the most recent fiscal years available for both states. We note any discrepancies in the states' data in an accompanying reference note.

Performance on Key Outcome Measures Related to the Safety and Well-being of Children

Some of Florida's lead agencies have performed better on certain outcome measures than Florida's public system.[63] Overall, however, privatization has produced mixed results—both when assessing the state average for all lead agencies as well as when looking at individual lead agency performance. In fiscal 2006, no lead agency performed at or above the state average across all safety and permanency outcomes. [64] Half of the lead agencies performed at or above the state average across permanency indicators, and only 30% performed at or above the state average across safety indicators.[65]

Permanency for Florida children has improved, but the rates of reentry and reabuse have increased.

The percentage of Florida children exiting foster care within 12 months has increased. In fiscal 1999, only 30% of those who entered foster care exited within twelve months. In comparison, 54% of Florida children who entered foster care during fiscal 2004 exited within a 12-month period.[66] Further, the percentage of children remaining in foster care longer than 12 months decreased from 76% in fiscal 1999 to 61% in fiscal 2005,[67]

"The Sarasota YMCA runs the best-funded foster care program in the state and has been heralded as a pioneer in the state. But state records show the YMCA still struggles with some of the same problems that caused Florida to privatize its foster care in the first place."

–"YMCA-run foster care struggling,"
Sarasota Herald-Tribune, June 25, 2006

and the number of children adopted from foster care increased from 4.72% to 8.75%.[68]

The percentage of Florida children who were reunified with their families within 12 months of removal also increased, from 44% in fiscal 1999 to 70% in fiscal 2005. However, this was below the state goal of 76%.[69]

Unfortunately, while children exited care more quickly, a higher percentage of children experienced reabuse and reentered foster care after family reunification.[70] During the transition to statewide privatization, there was a gradual increase in the percentage of children who experienced reabuse within six months of a previous abuse report. Since 2000, private providers have failed to reach the statewide goal that 7% or less of children experience reabuse; the percentage of children reabused reached 11% in fiscal 2005.[71]

Private providers also haven't met the statewide goal that no more than 9% of children reenter foster care. Only two of 16 lead agencies met the statewide goal of 9% in fiscal 2004.[72] Of children reunified in fiscal 2004, 12% subsequently reentered foster care within a 12-month period.[73] In fiscal 2005, children in the case management of three lead agencies reentered foster care at rates of 16% and 17% in fiscal 2005.[74] In fiscal 2006, 12.4% of children, on average, reentered foster care within a 12-month period.[75]

One study conducted over 2005-2006 found that children who were reunified were four times more likely to reenter foster care than children who were discharged from out-of-home care for other reasons, such as relative placement and adoption.[76] Some attribute this phenomenon to reuniting families too quickly. Another possibility is that families may not have received sufficient services to resolve the problems that led to foster care placement, in particular substance abuse problems.

Some evaluations of Florida's lead agencies identify other reasons. One study found a correlation between reentry and the number of counties served by the lead agency; the more counties in the lead agency's service area, the greater the likelihood that children reentered foster care.[77] The level of lead agency funding was also associated with outcomes for children—lower expenditures per child increased the likelihood of reentry and decreased the chance that children receiving out-of-home services would leave out-of-home care.[78] A recent evaluation of lead agencies found that those that were more successful at reducing the length of stay in out-of-home care also had higher rates of reentry.[79]

Foster care capacity has improved, but children still move around a lot.

Though the number of foster care "beds" has increased with privatization, and fewer foster homes are over capacity,[80] this may be the result of increased funding rather than an outcome of privatization (we discuss the funding variable in more detail below). At the same time, the stability of Florida foster care placements has declined since the transition to private providers. One of child protection's core goals is to have children in placements that best meet their needs as quickly as possible to avoid moving them repeatedly. Since 2000, the percentage of children with three or more placements within the first 12 months has more than doubled.[81] In fiscal 2006, the average percentage of children statewide with three or more placements within the first 12 months was 18.8%.[82]

Caseworker Turnover Remains High

Although the caseloads of child welfare workers in Florida are limited by the Legislature, caseworker salaries and workloads vary statewide. The lead agencies in Florida's privatized system offer lower caseworker starting salaries than other entry-level professional positions, and the benefits are not as comprehensive.[83] Depending on the lead agency, caseloads for fiscal 2005 ranged from 16 to 38, with a statewide average of 24 children per caseworker.[84]

Turnover and vacancy rates for Florida caseworkers remain high. Although the statewide average for vacancy rates was 9% during fiscal 2005, some lead agencies had vacancy rates as high as 22%.[85] Most notably, the statewide average turnover rate in fiscal 2005 was 31%—with some lead agencies experiencing turnover rates as high as 63%.[86] In 2005, lead agency starting salaries for caseworkers were almost always lower than those of the state.[87]

Contract Oversight is Inadequate

As Florida transitioned to a privatized child welfare system, DCF shifted its role from service provider to service purchaser. As a result, its oversight responsibilities increased. By December 2005, the 20 lead agencies under

Florida[91]	1999	2006	Percent Increase
Total child welfare spending (in 2006 dollars)	$536.0 million	$1,009.7 million	88%
Number of children and youth served	45,150	46,833	3.7%

contract with DCF had 500 subcontracts, including 64 subcontracts with case management organizations.[88] The Florida child welfare system became highly decentralized, with each of the 20 lead agencies operating a "mini-agency" within its region.

Even though DCF no longer handles the cases, it still has legal responsibility for children in its foster care system. Because of this responsibility, it must oversee the handling of these cases. DCF has faced numerous challenges in monitoring contracts with private providers. According to one 2006 study, even seven years after the transition to a privately run system, the "department continues to lack sufficient processes and systems to effectively oversee the community-based system."[89]

Even more troubling, DCF continues to give *more* oversight responsibility to its lead agencies, despite having determined that many lead agencies have not adequately met their current monitoring responsibilities. The study warned that "transferring additional oversight duties to these entities will increase risks unless [DCF] ensures that the lead agencies have the capability and willingness to fully meet this responsibility."[90]

Improved Outcomes May be the Result of Increased Funding

Florida's child welfare spending increased significantly during its transition to a privatized system. After adjusting for inflation, spending increased 88% between fiscal 1999 and fiscal 2006, although the number of children and youth served increased only 4%.

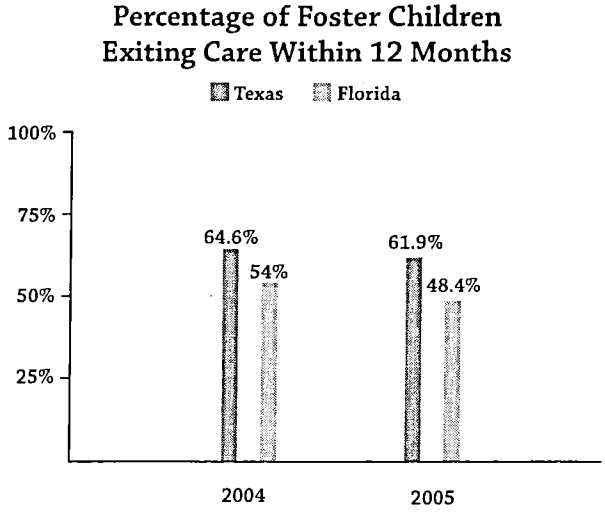
This raises the question of whether the improvements that have occurred in certain outcomes is the result of private providers outperforming the public system in these areas, or whether outcomes would have improved in a better funded public system. Given that Florida's privatized system has not substantially improved its child welfare outcomes across the board, one thing is clear—privatization has cost Florida more to do very much the same thing as its public system was doing.

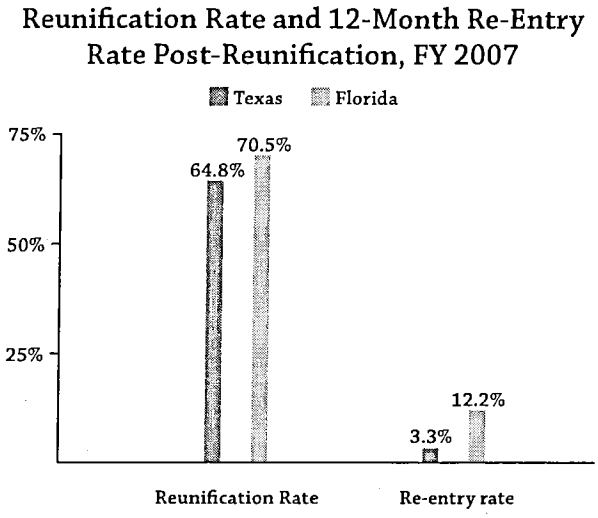
A COMPARISON OF TEXAS AND FLORIDA USING STATE DATA

Like Texas and Kansas, Florida collects a wide range of data to assess the performance of its child welfare system. We can only compare performance on those outcomes for which the same type of data are collected by the states. Both Florida and Texas collect comparable permanency and safety outcome data for internal state evaluation purposes and because these data were required for the first round of the federal Child and Family Services Review (CFSR). In this section we compare statewide data gathered by Texas and Florida in fiscal years 2004, 2005, 2006, and 2007. Later, we use the results of the first-round CFSR and state data collected in preparation for the second-round CFSR to compare performance in Kansas, Florida, and Texas.

Texas' public system performs better than Florida's fully privatized system on several key permanency and placement outcomes.

When comparing Texas's public system to Florida's fully privatized system, Texas compares favorably to Florida in both permanency and placement outcomes. Permanency outcomes are measured by looking at the family reunification rate, the reabuse rate, and the adoption rate within 12 months of a child being removed from the





home. Placement outcomes are measured by looking at the number of placements in a 12-month period.[92]

- Texas had a higher percentage of children exiting foster care[93] within 12 months than Florida in both fiscal 2004 and fiscal 2005.[94]
- The percentage of Florida children remaining in foster care longer than 12 months was 61% in fiscal 2005, compared to 50.2% in Texas during the same period.[95]
- Though Florida had a higher reunification rate, meaning the percentage of children who returned home within 12 months of removal, in both fiscal 2005 and 2006, Texas was more successful at reunifying families, meaning that Texas had a lower percentage of children returning to care within 12 months of reunification. In fiscal 2007, 70.5% of Florida children and 64.8% of Texas children who returned home were reunified with their families within 12 months.[96] Although a higher percentage of Florida children than Texas children who returned home did so within one year during fiscal 2007, Florida had a higher percentage of children who reentered care within 12 months of reunification—12.2% vs. Texas' 3.3%.[97]
- In fiscal 2005 and fiscal 2006, Texas had a lower percentage of children reabused within six months of a prior referral—4.4% compared to 11% in Florida[99] In fiscal 2007, this figure dropped to 4.0% in Texas.[100]
- Texas also had a higher rate of adoption in fiscal 2004—13.1% compared to 8.8% in Florida.[101]
- The percentage of Texas children with no more than two placements within twelve months of removal was 76.2% in fiscal 2005 and 76.4% in fiscal 2006.[102] In Florida, the percentage was 81.2% in both years.[103] In Texas, this rose to 77.3% during fiscal 2007;[104] it dropped to 80.3% in Florida.[105]

THE CHILD AND FAMILY SERVICES REVIEW—HOW DO THE STATES COMPARE?

The Children's Bureau of the U.S. Department of Health and Human Services developed the Child and Family Services Review (CFSR) to set standards for state child welfare agencies and to ensure that state practices conform to federal child welfare requirements. These standards include specific outcome measures in the areas of safety, permanency, and child well-being as well as the systemic factors ("critical systems") that affect those outcomes.

The Children's Bureau conducts the CFSR at regular intervals to assess the performance of state child welfare agencies, track outcomes for children and families in each state, and assist states in enhancing their capacity to improve outcomes for children and families in the child welfare system. The CFSR uses data from 1) an assessment conducted by the state's child welfare agency, 2) the State Data Profile prepared by the Children's Bureau, 3) reviews of a pre-determined number of cases from three counties in the state, and 4) interviews or focus groups with state and local stakeholders to evaluate processes and outcomes for children and families in the child welfare system.

Results from the First Child and Family Services Review

The Children's Bureau conducted the first round of CFSR reviews in Kansas and Florida in 2001, after Kansas had completed its transition to a privatized system and midway through Florida's privatization. Texas completed its first round in 2002. No state was in "substantial conformity" with all CFSR outcomes, which means that no state passed the first-round CFSR. Our comparison of the states' performance during the first-round CFSR is based on the final reports prepared for each state by the Children's Bureau.

Comparison of Critical Systems

During the first CFSR, the Children's Bureau reviewed seven critical systems (both internal and external) that

CFSR National Indicators of Child Welfare Outcomes: Systemic Factors—First-Round CFSR[106]

	Florida	Kansas	Texas
Statewide Information System	✓	✓	✓
Case Review System		✓	✓
Quality Assurance System	✓	✓	✓
Child Welfare Staff and Foster & Adoptive Parent Training	✓		✓
Array of Services		✓	✓
Agency Responsive to the Community	✓	✓	✓
Foster & Adoptive Parent Recruitment/ Retention	✓	✓	✓
Total	5	6	7

Note: A ✓ indicates that the system was rated as "substantially conforming" to federal requirements.

affect child welfare outcomes. Compared to Kansas and Florida, Texas better adhered to federal standards by having more critical systems in place.

Conformance with National Child Welfare Outcomes

The first round CFSR included seven outcome measures in the areas of safety, permanency, and child well-being. Texas and Kansas achieved substantial conformity with two of the outcomes, while Florida met one.[107]

Results from the Second CFSR

The Children's Bureau made numerous changes to the second-round CFSR based on lessons learned during the first round and in response to feedback from the child welfare community. As a result of these changes, a state's performance in the second round of the CFSR is not directly comparable to its performance in the first round, particularly with regard to comparisons of percentages.

At publication of this report, only 14 states had completed the second-round CFSR, and only eight had received a final report. Of the three states included in this report, Kansas is the only state to have completed its second-round review and received a final report. Therefore, it is impossible to compare performance across these states until the Children's Bureau has issued the final reports for Florida and Texas. It is worth noting, however, that of the eight states that have received a final report, none had passed the CFSR. To pass the CFSR, a state must be in substantial conformity with all child welfare outcomes and systemic factors.

The final results from Kansas' review are mixed. Kansas substantially conformed to four of the seven systemic

First-Round CFSR: State Conformance with National Child Welfare Outcomes

Outcome	Texas	Florida	Kansas
Safety 1: Children are, first and foremost, protected from abuse and neglect			
Safety 2. Children are safely maintained in their homes whenever possible and appropriate	✓		✓
Permanency 1: Children have permanency and stability in their living situations			
Permanency 2. The Continuity of Family Relationships and Connections is Preserved for Children	✓	✓	
Well-Being 1: Families Have Enhanced Capacity to Provide for their Children's Needs			
Well-Being 2: Children Receive Appropriate Services to Meet their Educational Needs			✓
Well-Being 3: Children Received Adequate Services to Meet their Physical and Mental Health Needs			
Total Outcomes in Substantial Conformity	2	1	2

Note: A ✓ indicates that the state met the national standard for that outcome.

factors, but did not achieve substantial conformity with any of the seven child welfare outcomes. However, the Children's Bureau did commend the state for its performance in the following areas:

- The absence of maltreatment recurrence and the absence of maltreatment of children in foster care,
- Permanency for children in foster care for extended time periods,
- Children are first and foremost protected from abuse and neglect,
- Children receive services to meet their educational needs, and
- The continuity of family relationships and connections is preserved.

But, the CFSR also identified the following areas in which improvements are needed in Kansas to achieve better outcomes for children and families:

- Failure to consistently provide children with permanency and stability in their living situations,
- Poor timeliness and permanency of reunification,
- Poor timeliness of adoption, and
- A lack of placement stability.

These results suggest that, even years after privatization, Kansas is still coping with the problems facing all the states.

CONCLUSION

As our comparison of child welfare outcomes in Kansas and Florida with Texas demonstrates, privatization has not led to better overall performance or universally improved outcomes for children and families in Kansas' and Florida's child welfare systems. Privatization has also cost more money and created additional layers of bureaucracy. Though both Kansas and Florida have improved outcomes for children and families in certain areas, given the increased spending under privatization it is possible that a better funded public system might have made the same—or potentially greater—gains. The data simply do not support a case for child welfare privatization. Yet, in the legislative debates in Texas in 2005, the available data were given almost no attention. In the next section, we discuss the privatization debate in Texas in 2005 and 2007 and where Texas stands now.

Texas Context

TEXAS' CHILD WELFARE SYSTEM

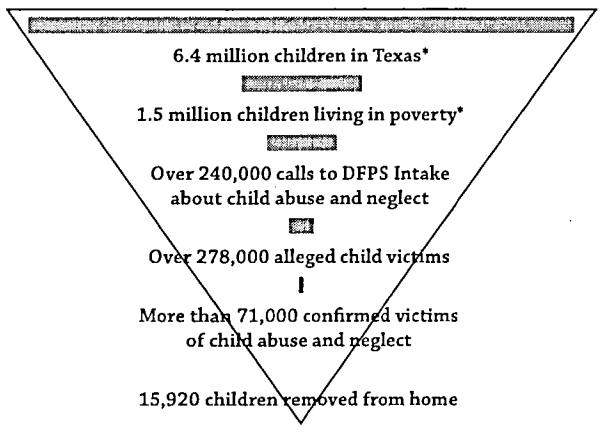
Texas' child welfare system is almost a $1 billion annual operation. In fiscal 2007, Texas' Child Protective Services (CPS) division employed 7,046 staff and served over 407,100 children, including almost 29,000 children in substitute care. [108]

Despite having a model law and regulatory framework, Texas has always faced numerous challenges in its child protection system. Some of these challenges are inevitable. Throughout history, beliefs about the state's responsibility to protect children have bumped up against commonly held ideas about parental rights. Competing views on when the state has the right to intervene can make it difficult to achieve consensus or to strike the right balance in policy decisions. This also affects public perceptions about how well or poorly a state administers its child protection system: when a child is removed from the home, somebody will always cry foul; when a child is harmed by a parent, agency inaction is criticized.

External factors are also responsible for the difficulties states face in ensuring good outcomes for the children in their care. To a great extent, what happens to children and families in the system is not solely a function of CPS. Abused and neglected children generally require a wide range of services, such as mental health counseling, which require extensive coordination across agencies and in communities to ensure good outcomes.

The lack of public resources for child protection is the greatest problem facing the system, undermining Texas' efforts to improve outcomes for children and families. The effects of underfunding are reflected throughout the child protection system. Workloads for front-end staff are still among the highest in the nation—in fact, more than twice the national average.[109] Caseworker turnover is high, foster homes and residential treatment centers are too few, and resources are inadequate to serve families.

Texas Child Protection System, 2007



*Estimated

Even though funding for child protection has increased significantly over the last decade, CPS remains grossly underfunded compared to other states. In 2004, the most recent year for which national comparisons are available, the state spent $837 million on child protection (prevention, services, and foster care), for an average of $134 per Texas child. This is 58% lower than the U.S. average of $319 per child—low enough to rank Texas 47th nationally. In fiscal 2007, Texas spent $978 million on child protection.[110]

CPS Staff Costs Fiscal 2007

CPS Staff Costs	**$376.5 million**
Total Staff (Full-Time Equivalents)	7,046.2
Direct Delivery Total Staff	6,631.3
Caseworkers	
Investigation	1,664.4
Family-Based Safety Services	540.8
Conservatorship	1,173.5
Other Workers	355.7
Supervisors	754.0
Program Directors/Administrators	114.4
Clerical	801.7
Other Direct Delivery Staff	619.6

Fiscal 2007 Other Expenditures

Total:	**$601.8 million**
Purchased Services	$85.0 million
Counseling/Evaluation/Testing	
Homemaker Services	
Parent/Community Groups	
Post-Adoption Services Program	
Day Care Services	
Foster Care Payments	$388.6 million
Adoption Subsidy Payments	$125.6 million
Federally Funded Special Projects	$2.6 million

RECENT STEPS TO STRENGTHEN CPS

In 2005, the Legislature responded to a sharp increase in child abuse-related deaths by adding roughly $250 million over two years to CPS investigations. Senate Bill 6 mandated that the Texas Department of Family and Protective Services hire more investigative caseworkers and take steps to improve the quality of investigations, provide training and additional resources to caseworkers, and strengthen links to law enforcement. Senate Bill 6 also included provisions related to improving medical care for foster children, expanding kinship care, services for youth transitioning out of foster care, and prevention and early intervention services. As a result, CPS improved its investigations, lowered the caseloads of investigators, and made progress towards better addressing the immediate problems of children and families.

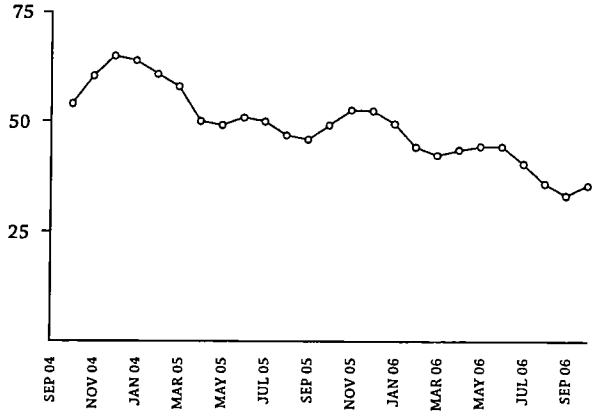
A spate of child deaths in foster homes after the passage of Senate Bill 6 prompted the Legislature to enact reforms in 2007 designed to improve outcomes for children *after* they were removed from their homes. Again, the Legislature increased funding for CPS with a renewed emphasis on foster care.

Though these funding increases and reforms have helped, CPS still struggles. To truly make a difference in the lives of children, the state must better fund child

CPS Adoption Award

Last year, the U.S. Department of Health and Human Services awarded Texas $4.1 million for increasing the number of children adopted from foster care. Texas earned a higher award than any other state.

Texas CPS Average Daily Investigation Caseload September 2004 - September 2006



Source: DFPS

protection. Texas still ranks below the national average in spending per child for child protection, and our caseloads remain among the highest in the nation. For example, while the caseloads of investigators have dropped from the mid-70s to the mid-20s, national best-practice standards call for investigative caseloads between 12 and 15 per caseworker.

PRIVATIZING CHILD PROTECTION IN TEXAS

In 2005, Senate Bill 6 included a plan to privatize, directing the Texas Department of Family and Protective Services (DFPS) to completely privatize case management and substitute care services throughout the state by 2011, with the first region to be privatized by the end of 2007. Texas did not consider privatizing investigations, and private agencies have not asked to take over investigations.

Senate Bill 6 required an independent administrator rather than a lead agency. Most states that have privatized use a lead agency model. The essential difference between an independent administrator and a lead agency is that a lead agency both administers the contract and provides services, using subcontracts to provide those services the lead agency does not offer. An independent administrator, on the other hand, is like a general contractor who provides no services, but rather selects and works through subcontractors.

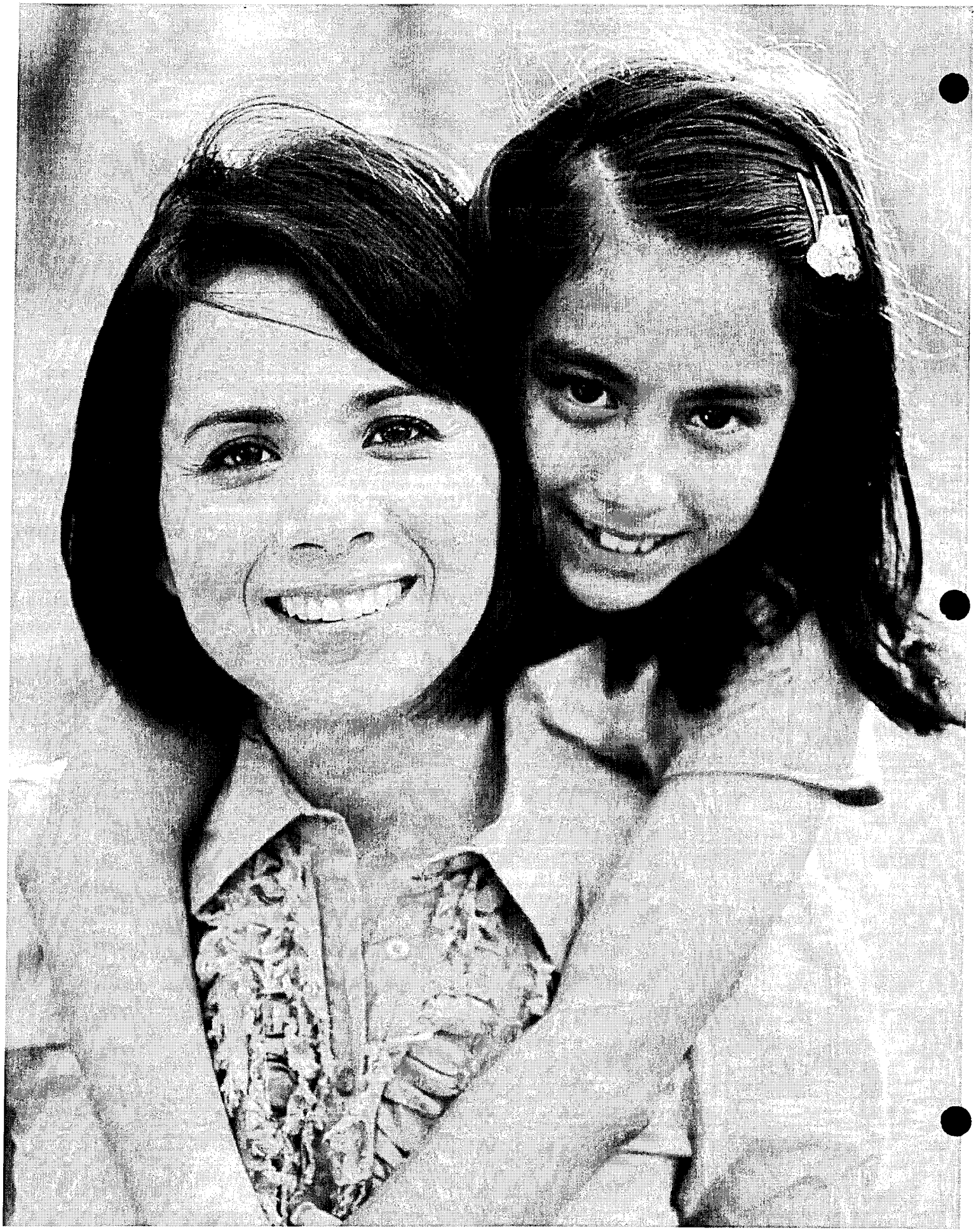
The state chose Region 8, which includes San Antonio, to begin privatization. DFPS released a Request for Proposals (RFP) for an independent administrator. Two proposals were submitted in response to the RFP. At that point, however, due to various difficulties, DFPS suspended the process to await further legislative guidance.

Between 2005 and 2007, Texas experienced one of the biggest privatization disasters in the state's history. In 2005, the Texas Health and Human and Human Services Commission awarded an $899 million contract to Accenture to take over development, operation, and partial staffing of a new system for enrolling families in public benefits.[111] The new system was marked by technical difficulties, staffing problems, and backlogs in application processing. Tens of thousands of needy families were wrongly denied benefits in just the first four months of a two-county pilot. Despite the promise of more than half a billion dollars in savings, Texas didn't save a penny in administrative costs, and was forced to hire 1,000 state staff to prevent further disruptions in services to clients. In March 2007, the state cancelled the contract.

It was in the midst of this debacle that the Legislature revisited privatization of Child Protective Services. The decision in 2005 to privatize so much, so fast, and to outsource the case management functions traditionally performed by public employees had sparked much debate. Then, several child deaths and injuries in private foster care networks and the difficulties encountered in contracting for an Independent Administrator led to increased skepticism about the wisdom and affordability of privatization, prompting the Legislature in 2007 to pass Senate Bill 758, scaling back CPS privatization considerably.

Senate Bill 758 dropped the plan to privatize all substitute care services, instead directing DFPS to develop a CPS improvement plan focused on increasing foster care capacity, with a continued emphasis on kinship care; improving the monitoring of placements; and providing more services for youth in care and those transitioning out of foster care. Senate Bill 758 also mandated that DFPS test the concept of privatizing case management in a pilot involving 5% of the CPS conservatorship caseload statewide, either by focusing on certain geographical areas or certain child populations. This is a prudent approach that will give future Legislatures the opportunity to evaluate the pilot and decide whether privatizing case management is advantageous.

In the next section, we discuss the issues related to privatizing foster care and adoption services; then in the following section, we discuss the issues related to privatizing case management.



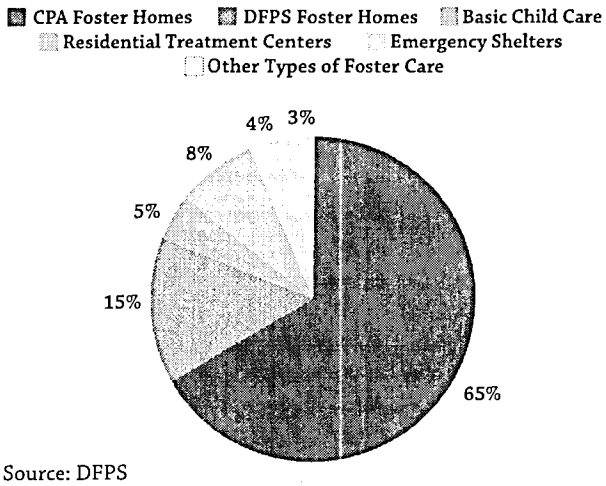
Privatizing Foster Care and Adoption Services

When a state outsources substitute care services, it contracts for recruiting, training, and monitoring foster and adoptive homes and completing adoptions. While we support the plan in Texas to evaluate expanding the involvement of private providers in the provision of foster care and adoption services, we recommend that states move slowly, with adequate budgets, and always placing the needs of children and families first. This section discusses the impact that rapid privatization of substitute care would have on children and families in the child protection system, the cost of privatization, and the importance of retaining a qualified state workforce.[112]

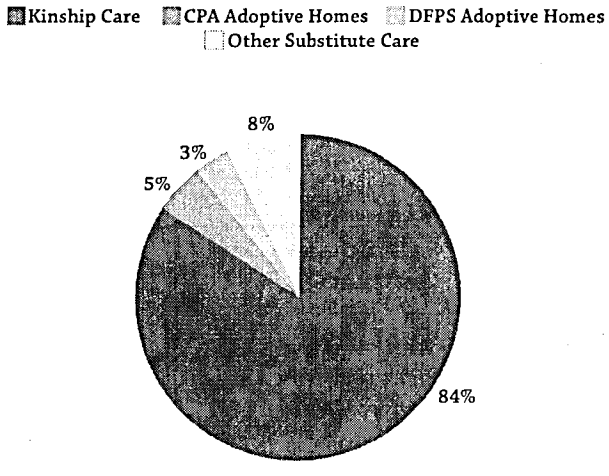
TEXAS' SUBSTITUTE CARE SYSTEM: A PUBLIC AND PRIVATE PARTNERSHIP

Texas has a public and private system of foster care placements, which includes a combination of emergency shelters, foster family homes, foster group homes, and residential care facilities. Child Protective Services (CPS) contracts with private agencies to care for roughly 80% of the children in foster care, including most emergency shelters and residential care facilities. CPS operates foster homes to care for the other 20% of the children. CPS has Foster and Adoption Units that recruit, train,

Children in State-Paid Foster Care



Children in Substitute Care



Source: DFPS

and supervise individuals who open their homes and serve as foster parents. These foster parents are not state employees, but private individuals. Private Child Placing Agencies (CPAs) also recruit, train, and supervise foster homes. Typically, CPAs are nonprofit organizations that provide foster care. CPS also contracts with private agencies to provide adoption services, while maintaining CPS adoption units that also provide these services.

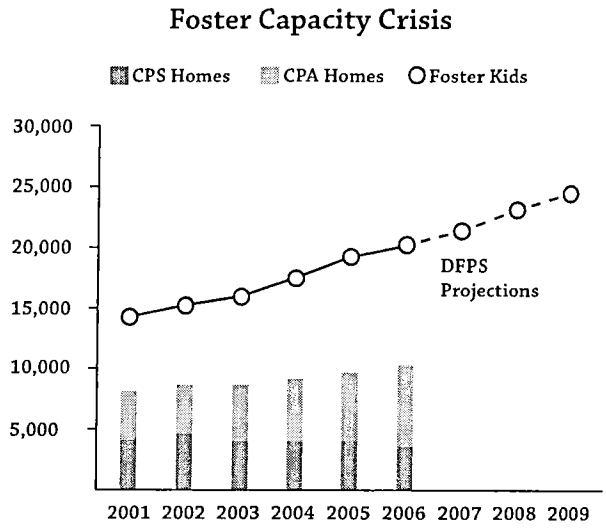
THE IMPACT OF RAPID PRIVATIZATION ON TEXAS' CAPACITY CRISIS

From 2001 to 2006, the number of children entering foster care increased by 45.3%. During the same time period, the number of foster homes grew only 26.4%, leading to crowded homes and inappropriate placements. Texas' capacity problem isn't new, but the growth in the problem is alarming. The very uncertainty about whether the Legislature wants CPS to build capacity or wants it to privatize foster care has stalled CPS' efforts to build capacity, exacerbating the crisis. An analysis of this crisis with recommendations for capacity building is the subject of another CPPP policy paper.[113] In this paper, we only examine the impact that privatization would have on our capacity crisis.

Private providers cannot build needed capacity at the basic rate

CPA and CPS homes serve different populations. CPS homes tend to be "basic" foster family homes, which provide foster care for children who function at a relatively high level. In contrast, CPA homes tend to be specialized, providing therapeutic foster care to children who have greater medical and behavioral challenges. Historically, CPAs have been less willing to provide basic foster care because the rate does not cover costs.

Cost studies show that basic and moderate rates cover about 80% of a CPA's cost, while specialized and intense rates cover closer to 100% of a CPA's cost.[114] If the state were successful in transitioning all its basic homes to CPAs, it would either be a massive cost shift to private providers, or the state would have to substantially increase rates. Even though private providers do provide some basic care now, it is unrealistic to think that private providers could or would sustain such a large cost shift.



Source: DFPS

Asking private providers to care for thousands of more children at 80% of cost may well result in private providers pushing children to higher levels of care. While some might express indignation at such a suggestion, ironically, the entire premise of privatization is that the state can structure financial incentives to improve performance. Conversely, of course, the state can structure financial incentives that diminish performance. Not only does this cost the state more, it hurts children, particularly by diminishing their prospects for adoption because they have been labeled more troubled.

Rapid privatization would make our adoption capacity crisis worse

Because of policy changes at the federal and state level, CPS has worked aggressively to move more children into permanent adoptive homes. One of its tactics has been to encourage foster parents to adopt. Consequently, even as CPS has added new homes, its total number of foster homes has dwindled as foster parents adopt and leave the system. This accounts in part for the declining number of CPS homes noted in the graph above.

Even with this effort, Texas has an adoption capacity crisis. In 2007, over 5,800 children were available for adoption, but had no adoptive placement.[115] Children are not waiting for lack of effort. The number of adoptions has grown each year, but it has not kept pace with the growth in the number of children available for adoption. Just as with foster care, rapid privatization will exacer-

Service Level	Daily Rate to Child Placing Agency	Minimum to Foster Family
Basic	$38.59	$21.44
Moderate	$70.22	$37.52
Specialized	$93.54	$48.24
Intense	$171.53	$85.76

Source: DFPS 24-Hour Residential Child Care Rates, FY 2008-2009

bate this capacity crisis, as the state dismantles its public workforce. The impact will be very significant because CPS does far more adoptions than private providers do. In fiscal 2007, CPS did 56.4% of all adoptions (2,267), while private providers did only 43.6% (1,756).[116]

MITIGATING THE RISKS

CPS' core mission is safety and permanency for each child. Providing a strong network of foster and adoptive parents has always been a major CPS function. Any attempt to privatize these functions must be undertaken with care to avoid disruptions in care for children and the loss of valuable expertise for CPS.

Indeed, a major disadvantage to rapid privatization is that it would cause terrible disruptions to children. If a CPS foster home is unable or unwilling to transfer to a private provider, a child will lose his or her home. Even if foster parents are willing to move from CPS to private providers, private providers will have different managers, therapists, and doctors, disrupting the continuity of care to children. A mandate to privatize within a set period of time would have tragic consequences for children.

Privatization also disrupts the CPS workforce. During the transition to a privatized system, instead of recruiting and training new homes, the state workforce will be looking and leaving for new jobs. The state experienced this same sort of disruption when it tried to privatize eligibility determination and enrollment for public benefits. There is even less margin for error in CPS where children's lives are at stake.

The state can mitigate these risks with careful planning, adequate funding, and realistic timelines. First and foremost, the state must consider the capacity of private providers to expand. The next step is to develop a staged transition plan that limits disruptions in services to children already in the state's care and preserves the state's ability to intervene in the event that private providers are unable to meet the terms of their contracts. A pilot approach also would enable the state to determine which financial incentives produce the best outcomes.

The state must also do a thorough cost-benefit analysis to determine whether privatization is worth it, and whether the Legislature will commit the resources to pay for it. Privatization may well improve the quality of services, but cost more. Regardless of whether privatization costs more or less, the Legislature must be willing to fund the surge in the workforce that will be necessary to build foster care capacity in preparation for privatization. Finally, states must also include stakeholders in the planning process—lack of support from the judiciary or other advocates involved in the child protection system will undermine the work done by the private providers.

Privatizing Case Management

The privatization of case management means turning over both the day-to-day and long-term decisionmaking regarding children and their families to private entities. For example, a private entity would speak for the state on whether 1) a child should be placed with a relative, 2) a child should be returned to a parent, 3) the parents' parental rights should be terminated, or 4) a child should remain in foster care until aging out of the child protection system. In other words, it involves outsourcing critical decisions about the lives of children and parents to private companies.

Outsourcing case management decisions is entirely different from outsourcing the delivery of services to children and families once they are in the system or even the coordination of those services. Take for example, the provision of family-based supportive services. Private providers in Texas do or have the potential to do this extremely well because they often work in and have ties to the community. Private providers also make decisions about the type of services being provided to a child or family, which is called "care coordination." However, providing this kind of service or making this kind of decision is very different from making a decision that affects a family's legal rights, such as whether to return a child home after abuse has occurred. When providing a service, if done right, privatization has the potential to improve outcomes. With case management, however, privatization breaks the critical link between state responsibility and child protection.

HOW DOES CASE MANAGEMENT WORK NOW?

After a CPS investigator conducts an investigation, one of three things happens: CPS closes the case, works with the family informally, or takes the family to court. CPS takes the family to court: 1) If it determines that a court order is needed to ensure that the family participates in services; or 2) to obtain a court order to remove a child from the home to ensure safety. If the case moves beyond the investigation stage, a CPS caseworker takes over from the CPS investigator. This caseworker refers the family to community services or to CPS-contracted services. The caseworker monitors progress and makes decisions about the case. If CPS takes a case to court, this caseworker makes recommendations to the court pursuant to state policy.

WHAT DOES IT MEAN TO PRIVATIZE CASE MANAGEMENT?

In 2004, the Texas Health and Human Services Commission (HHSC) recommended that the state outsource some, but not all, case management services to the private sector. When CPS determines that it will work with

the family without removing the child (whether it does so informally or through a court order), HHSC recommended that CPS retain this work. Once a judge places a child in the legal conservatorship (custody) of the state, however, HHSC proposed that the state contract with a private entity to serve as an "independent administrator" (IA) to provide case management, including taking over the legal case, providing services to the family, and caring for the child. The IA would operate under a "performance-based contract," meaning that the contract would have certain performance standards such as X% of children reunited with their families within Y days.

An independent administrator would have functioned just like CPS. The IA would have contracted with a subcontractor or several subcontractors to 1) place the child in a home, 2) provide services to the child, and 3) provide services to the family. The independent administrator would have made decisions regarding the future of the child, including whether to recommend to the court that the child be adopted or placed with relatives or returned to a parent. The IA would have had caseworkers (like CPS caseworkers) who would have used contracts (like CPS caseworkers use contracts) to obtain services from other private providers. Those private providers would also have had "case managers" who would have overseen whatever it was the private provider was to do, for example, placement services or family services. The IA would not have been allowed to provide services because of the conflict of interest between making decisions and making money from those decisions.

This plan raised a host of issues and concerns: 1) It required the state to abdicate its legal authority and control over placement decisions; 2) it was difficult, if not impossible, to measure performance, because there were no agreed-to norms *in the aggregate*; 3) it would have created conflicts of interest and strained limited resources; 4) it would have reduced the ability of the state to set policy priorities and target resources to the areas in greatest need; and 5) it would have led to the loss of Child Protective Services' greatest asset—its workforce.

ABDICATING CONTROL

Senate Bill 6 prohibited the state from doing case management and assigned this authority to a private Child Placing Agency (CPA) selected by an independent administrator (IA).[117] At the same time, the state assured the public and the Legislature that the Department of Family and Protective Services (DFPS) would "continue to manage the overall service plan for the child and family and make recommendations to the court." This apparent contradiction raised two questions. How would DFPS retain control over the decisions made by the private contractor regarding a child in the care of the state? Would private providers have a *voice* in decisionmaking, or would they be *assuming responsibility* for legal decisions?

Such questions are particularly troublesome in a system that makes fundamental decisions about families, including life and death decisions about children. The final decision to terminate a parent's rights and place a child for adoption should be made by a public employee who is both politically accountable for his actions and legally obligated to protect the rights of citizens. Case management involves making decisions that affect people's rights—whether abuse has occurred, whether to take a child from a parent, or whether to place the child with a relative or in foster care. These are inherently governmental decisions that require the impartial application of public laws and policy to individual families. These decisions should be made by public officials who are responsible to the public and subject to legislative and executive branch control.[118]

By its express terms, Senate Bill 6 preserved the state's legal rights against third persons such as parents, but it gave contractors total control over the case management decisions affecting children and families. Though the state would be able to "indirectly" affect how case management was done through contract requirements and licensing regulations, it would relinquish its authority to make actual decisions in individual cases. In essence, private providers would be empowered by the state but not controlled by the state.

However, contracting and licensing controls offer inadequate protections in individual cases. For one, failing to do what is best for an individual child and family does not necessarily rise to the level of a contract violation. Moreover, Senate Bill 6 prohibited the state from doing case management in individual cases; thus, any assessment of contract performance would be in the aggregate, not on an individual child or family basis. Though the

Defining Case Management

In every case, to achieve a good outcome, there must be one person responsible for planning and processing the case to make sure that the case moves forward and that the outcome is in the best interest of the child(ren). This job goes under the name "case management," but it is composed of many tasks, which broadly include:

- The development and revision of the case plan;
- Oversight of the coordination and monitoring of services needed by the child and family; and
- Prosecuting the legal case, including preparing court reports, attending judicial hearings and permanency hearings, testifying about the permanency plan for the child, and ensuring that the child is progressing toward permanency within state and federal mandates.

Case management is distinct from the care coordination role played by service providers, such as a residential treatment center, in which the provider coordinates and monitors the services being provided to a child or family but does not have any legal or decisionmaking authority over what ultimately happens to that child or family.

state might be able to increase its control over providers through licensing, licensing relates to violations of law and regulations, not to case management decisions about what is best for an individual child and family.

Senate Bill 6 also did not provide the resources for contract monitoring or licensing enforcement that were necessary for the state to oversee privatized case management. In a system where the case management function is public, there are two layers of administration (state and contractors/subcontractors). A privatized system, in contrast, has three (state, independent administrator, contractors/subcontractors). Even with privatization, the state must maintain oversight of each case and monitor contract performance and outcomes. Across the country, in those states that have privatized, public sector administrative costs continue to grow for this very reason. Even if Texas had allocated enough additional funds for contract oversight and licensing (which it did not), this is not the best use of the limited pot of money available for child protection, especially when privatization has not consistently improved child and family outcomes.[119] In other states that have privatized, private agencies struggle with the same issues that public agencies do such as obtaining adequate services, reducing caseloads, and reducing turnover. This raises the question of whether additional funding alone would be enough to produce better child welfare outcomes.

CONFLICT OF INTEREST

Privatizing case management creates a conflict of interest. Though private providers may be committed to making decisions that are in the best interest of children and families, the financial interests of private companies—whether for profit or not for profit—will inevitably conflict with what is best for an individual family, leading to decisions that a public entity would not have made.

Senate Bill 6 recognized this "conflict of interest" by proposing an independent administrator (IA) who could not provide direct services. While an independent administrator model might minimize the conflict, it does not resolve the conflict. The IA would have no caseworkers of its own. Indeed, under Senate Bill 6, the IA could not do

Children in the foster care system deserve an advocate who can look out for their interests without regard for the bottom line of their employer. As one teenage foster youth explained, "I feel like the people in charge of your house work for the [foster] parents, and CPS caseworkers work for us."

Tonya, teenage foster youth, speaking at the CPPP Texas Youth and Alumni Leadership Summit, Austin, Texas, November 10-12, 2006

case management. Only the Child Placing Agency with care of the child could do case management.

Moreover, the IA model is not well thought out. It defeats one of the primary goals of privatization, which is supposedly to better coordinate case management. More important, such an approach invites disaster. For example, consider a hypothetical case with a mother and three children. The oldest child needs residential treatment. The middle child needs a basic foster home. The youngest child is a drug-addicted newborn who needs a habilitative home. Assume no one agency has all three homes, which is the most likely scenario. Consequently, three different agencies take the children. In addition, the mother needs drug treatment. Plus, a father about to get out of prison needs parenting classes and job training. Who does the case management for this family?

The independent administrator does not do the case management. It only selects the agency that will pick the actual placements. If all three agencies are going to do their own case management, then disagreement about the best course of action for the family will invariably result. One agency may argue that the children should go home; another agency may argue they should be united in the basic foster home; the third agency may advocate for adoption. Or, each agency could propose a different plan for each child. What about the mother and the father? Are the agencies with care of the children really the best able to determine the services needed by the mother and father, or assess whether the parents have made satisfactory progress for the children to go home?

Private providers have suggested that privatization of case management means that one agency with one caseworker who best knows the children will be in charge of making appropriate placements and moving the case to a rapid conclusion. In reality, as the hypothetical case above illustrates, no one person, indeed, no one agency will be providing all services. If case management is privatized, services will still be provided by multiple agencies employing multiple people. Inevitably, under either a public or private system, a single point person must coordinate services, process information, and make decisions.

However it works, private providers have an inherent conflict of interest when it comes to case management. They earn money under a payment system of incentives, disincentives, and risk-shifting that may lead them even unconsciously to make decisions that are not in the best interest of a particular child or family. They may also be guided by a mission that is in conflict with the best interest of a particular child or family, such as being philosophically opposed to residential treatment or family reunification. Nonprofits are no different. Setting aside the question of whether nonprofit providers have the capacity or access to capital to undertake case management privatization, nonprofits may also have a mission that conflicts with the goals established by the state.[120] Moreover, they are not immune from financial or program abuses, as the state has learned through its experience with charter schools.

MEASURING PERFORMANCE

Supporters of privatization in Texas claim that children would move through the system faster if providers operated under performance-based contacts awarded through competitive bids instead of open enrollment contracts. Of course, nothing prevents the state from using performance-based contracts or competitive bidding in a public case management system. These are not advantages that flow from outsourcing case management but from writing performance-based contracts and using competitive bidding. Further, as explained above, privatization may actually decrease accountability and performance if the state does not provide individual case oversight or adequately monitor contracts and subcontracts.

The more important question, however, is whether performance-based incentives are even appropriate in the area of case management. Under privatized case management, the state must define the performance standards that private providers have to meet. As noted above, states must be able to articulate clear goals and outcomes in order to evaluate success. However, this is both difficult and risky to do with case management decisions. For one, the goals are difficult to state and measure. Case management decisions require workers to balance competing priorities—such as the safety of the child with the desire to keep families intact—that can result in conflicting outcome measures, or the targeting of certain services or children at the expense of others. If the goal is a singular good, such as increased high school graduation rates, then it can be stated and measured. If the goal requires balancing conflicting goals, then it is difficult to state and

The focus on kinship care and CPS' success with family-group decisionmaking helped increase relative placements by 30% between 2005 and 2007.

measure. For example, asking a district attorney to have a high conviction rate is something that it easy to measure. However, it is not the same as asking a district attorney to convict the guilty and not the innocent, something that is virtually impossible to measure.

In case management, there are no agreed-to norms regarding what is best for children and families *in the aggregate*. To decide which goals are most desirable, the state would need to make an essentially arbitrary choice about which results are the "best" results and which services are more important than others. For example, what percentage of children should be returned to the home after being removed due to child abuse? Is relative care better than a foster home? While it is possible to make these judgments in an *individual* family's case, the state can't know what is *best* or *achievable* in the aggregate, because there are no existing outcomes measures or data to support this assessment.

Finally, it is very difficult to allocate risk in a manner that increases accountability and improves performance without unintentionally punishing children and families when contractors fail to perform well. For example, if a particular area of the state is hit with a methamphetamine epidemic, leading to a sudden rise in the number of high-need infants needing specialized foster care, then the contractor must respond by putting more of its resources into that area—or let those babies suffer. If the contractor does respond, and fails to meet performance targets as a result, the contractor loses money. At that point, all of the children needing services in the area suffer.

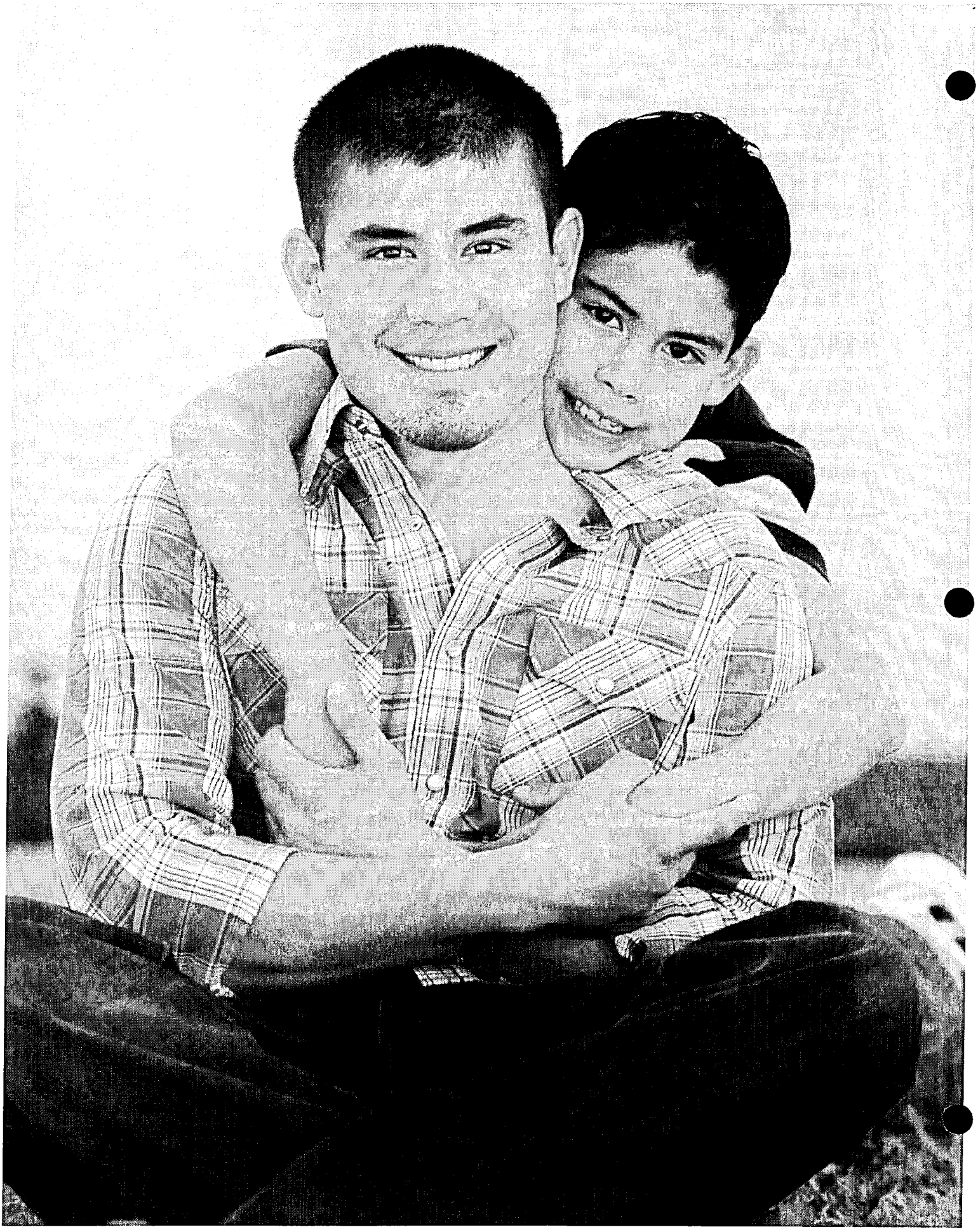
SETTING POLICY PRIORITIES AND TARGETING RESOURCES

Proponents of privatization argue that private providers are more flexible, innovative, and responsive to local needs. At the same time, privatization makes it harder for the states to judge different policies (i.e., decide which services work best for fragile children and families) or target limited public resources to the areas with the greatest need. Privatization also diminishes the state's responsiveness to the democratic process and the will of the Legislature. In part, this is because privatization ties up limited public funds in contracts, making it hard for the state to change course or reallocate its resources. It is also because the state loses expertise when it privatizes. For example, in 2005 the Legislature told DFPS to focus more of its efforts on family group decisionmaking. The state responded, increasing the number of kinship placements dramatically in a short period of time. This might not have been possible in a privatized system, if the terms of the contract dictated a different approach or the state did not have the expertise to make the change.

Privatization adds a "filter" between the democratic process and decisionmaking that impedes a state's ability to set policy priorities. Contractors are independent entities. They have missions, priorities, and interests outside of the goals established in their contracts. They are responsible to their boards of directors and—in the case of a for-profit corporation—their shareholders. Their own interests may conflict with the policies determined by the state to be the best way to produce good outcomes for clients.

For example, an effort to increase adoptions might be resisted by providers, because it could mean losing a foster home, which is an important business asset. Or, a private provider may push to keep a child in a foster home because the foster parents want to adopt and the private agency is paid for every adoption consummated, even though the biological parents have reduced the risk of abuse and neglect and it is in the child's best interest to be reunified with the parents. In a worst-case scenario, the contractor might use its influence to lobby not for those policies or services proven to be in the best interest of children, but for those that offer the greatest benefit to the company.

In sum, privatization leads to a loss of control over the details. States must retain enough control over the child protection "purse" to be able to shift course when needed and remain responsive to the democratic process and the Legislature.



Next Steps for Texas

CONTINUING DEBATE

Texas has long relied upon private providers for essential child welfare services and will continue to do so. In the future, the state will probably seek more performance-based contracts. As the state pushes to hold private providers more accountable for performance, private providers will in turn push for more authority. Some private providers seek an increased role in child welfare regardless of the nature of contracting. Undoubtedly, the state will continue to search for the optimal way to draw the line between public and private responsibility.

We know that privatization is more likely to succeed when:

- The state and providers are able to agree to clearly articulated goals and objectives;
- The state provides sufficient funding to achieve these goals;
- Contracts include specific, measurable outcomes and other performance criteria; and
- The state has the capacity to monitor progress toward meeting these goals.

We know that privatization is more likely to fail when:

- There are insufficient resources to achieve the expected outcomes;
- Financial models do not take into account actual costs;
- The state has limited capacity to monitor and evaluate contractor performance;
- There is confusion over the roles and responsibilities of public and private agencies;
- There is difficulty building new capacity;
- Outcomes are poorly defined or are simply the wrong ones;
- There is difficulty recruiting and training staff;
- There is a lack of understanding of legal issues; and
- There has been limited stakeholder involvement.[121]

Given what we know about privatization, where do we go from here?

FOSTER AND ADOPTION SERVICES

At the time Senate Bill 758 was adopted in 2007, it was clear that Texas needed more foster and adoptive homes and needed to complete adoptions more quickly. Since the end of the legislative session, the state's need for more homes has become even more urgent.[122] The core work presently done by private providers is foster and adoption services, and private providers can play an important role in building capacity.

While Senate Bill 758 reverses the mandate to outsource all foster and adoption services, it does require the Department of Family and Protective Services (DFPS) to conduct a needs assessment and use private providers when doing so will improve services to children and

families. DFPS has contracted for a needs assessment that will be completed shortly.[123] Based upon that needs assessment, DFPS should ask private providers through a Request for Information how they would build capacity in a way that would improve services.

The major barrier to private providers building new capacity is financial. Currently through the state's open enrollment contracting system, private providers are reimbursed on a daily rate as capacity is used. This presents two problems. First, the state does not allow advance funding for private providers to increase their capacity. Second, the daily rate does not provide for private providers to recoup the investment required to build capacity. Once the state has determined its capacity needs, it should develop a plan to contract with providers to build specific capacity and to either provide some development funding or guarantee payment for utilization or both.

CASE MANAGEMENT

Senate Bill 758 tasks the Texas Department of Family and Protective Services (DFPS) with developing a pilot project for outsourcing case management in 5% of cases.[124] The legislation was designed to maximize the Legislature's control over the experiment, strengthen the state's bargaining position, and enable the state to maintain its public workforce while evaluating the effectiveness of privatized case management. This approach will allow the state to resolve the many difficult legal and practical questions discussed in this paper before deciding whether to proceed with statewide outsourcing of case management.[125]

However, the Legislature did not appropriate any funds for the pilot. Consequently, DFPS has announced that it will use the time until the 2009 legislative session for planning. The first step is to seek suggestions from stakeholders and others about how to proceed. Then, DFPS plans to draft a proposal for contracting for case management. That proposal would be presented to the Legislature in January 2009.[126]

As far as it goes, DFPS has laid out a good way to proceed. We recommend, however, that the process be more clearly divided into two parts. First, DFPS should release a general Request For Information that would allow providers across the state to suggest plans for outsourcing 5% of the cases, including their rationale for serving either certain geographical areas or certain child populations. After evaluating the providers' ideas, DFPS should ask for specific Requests For Proposals (RFP) for its preferred approach.

This RFP should be based upon the services needed and the outcomes desired. The RFP that DFPS developed to begin outsourcing in Region 8 under Senate Bill 6 was highly prescriptive. In other words, the RFP required specific processes. The value of performance-based contracting, however, is that it focuses on outcomes, not processes, allowing for flexibility and innovation.

In any outsourcing project, what will be done by the public agency and what will be done by the private provider must be clear. Senate Bill 758 carefully delineates the role of each, defining case management, but distinguishing it from conservatorship services. DFPS will continue to provide conservatorship services, which includes "services provided directly by the department that the department considers necessary to ensure federal financial participation and compliance with state law requirements, including initial placement of a child and approval of all subsequent placements of a child, approval of the child and family case plan, and any other action the department considers necessary to ensure the safety and well-being of a child."[127]

PLANNING, IMPLEMENTATION, AND EVALUATION

In addition to the specific approaches outlined above, we offer the following recommendations to the Department of Family and Protective Services (DFPS) for planning, implementing, and evaluating these initiatives.[128]

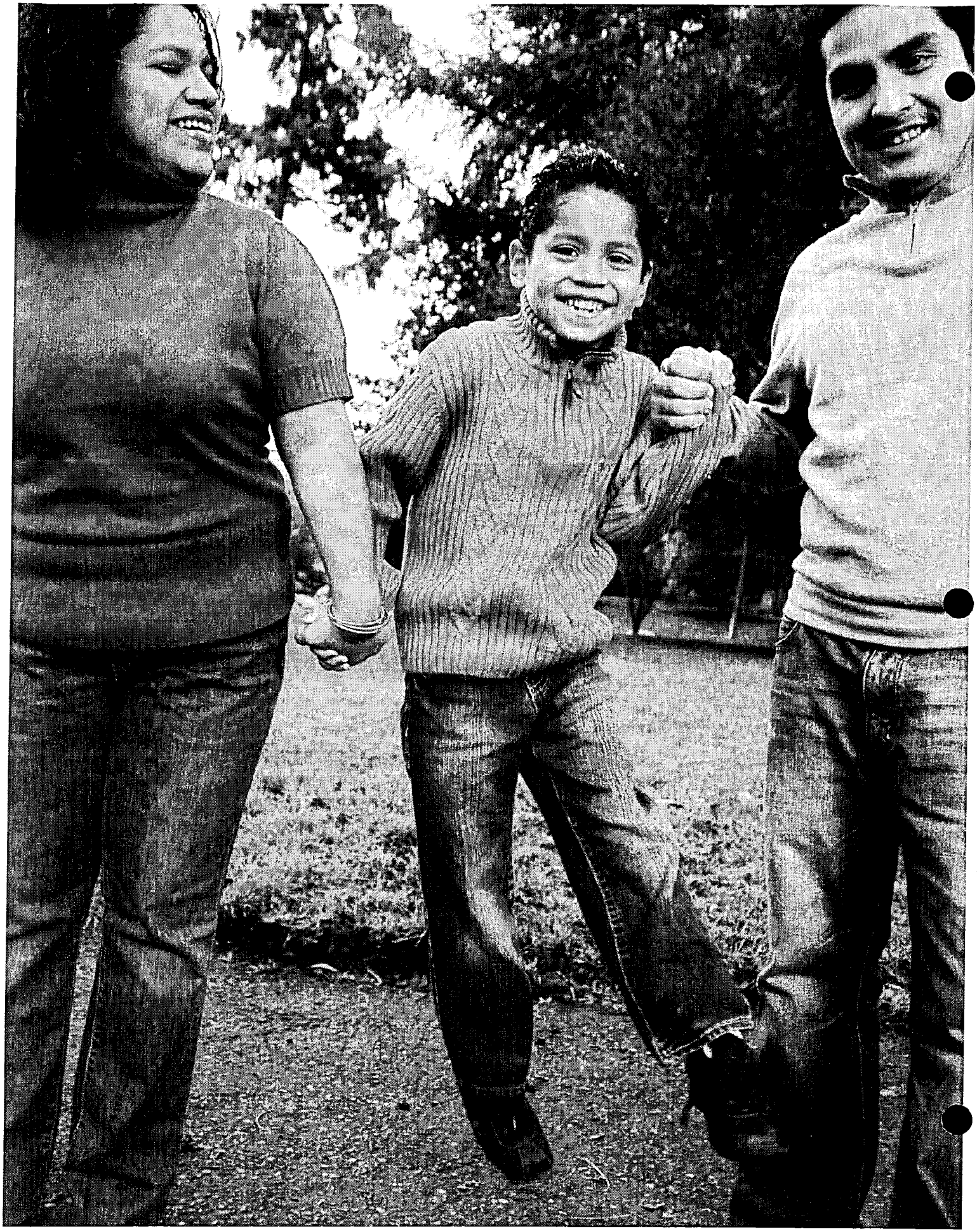
DFPS should employ a broad-based planning process that actively engages all relevant stakeholders in an ongoing dialogue. In collaboration with these stakeholders, DFPS should strive to reach consensus on the vision, goals, and structure for the initiative; assess community and provider readiness; use sound data to develop the service model and fiscal approach; secure the commitment of the financial, technological, and human resources necessary to support implementation; and delineate the roles and responsibilities of the public and private agencies.

DFPS also should take steps to ensure that legislators' and the public's expectations for privatization are aligned with the goals established for each initiative.

The transition of cases from the public to the private sector should take into account the needs of children and families and the readiness of private agencies. DFPS should ensure ongoing consumer involvement throughout the implementation phase. The department should provide technical assistance and training to private agencies on their contractual and legal responsibilities, in the development and implementation of appropriate information systems, and in preparing private agency caseworkers to assume their new service responsibilities. DFPS should also provide ongoing technical assistance and training to its staff as they assume their new monitoring responsibilities.

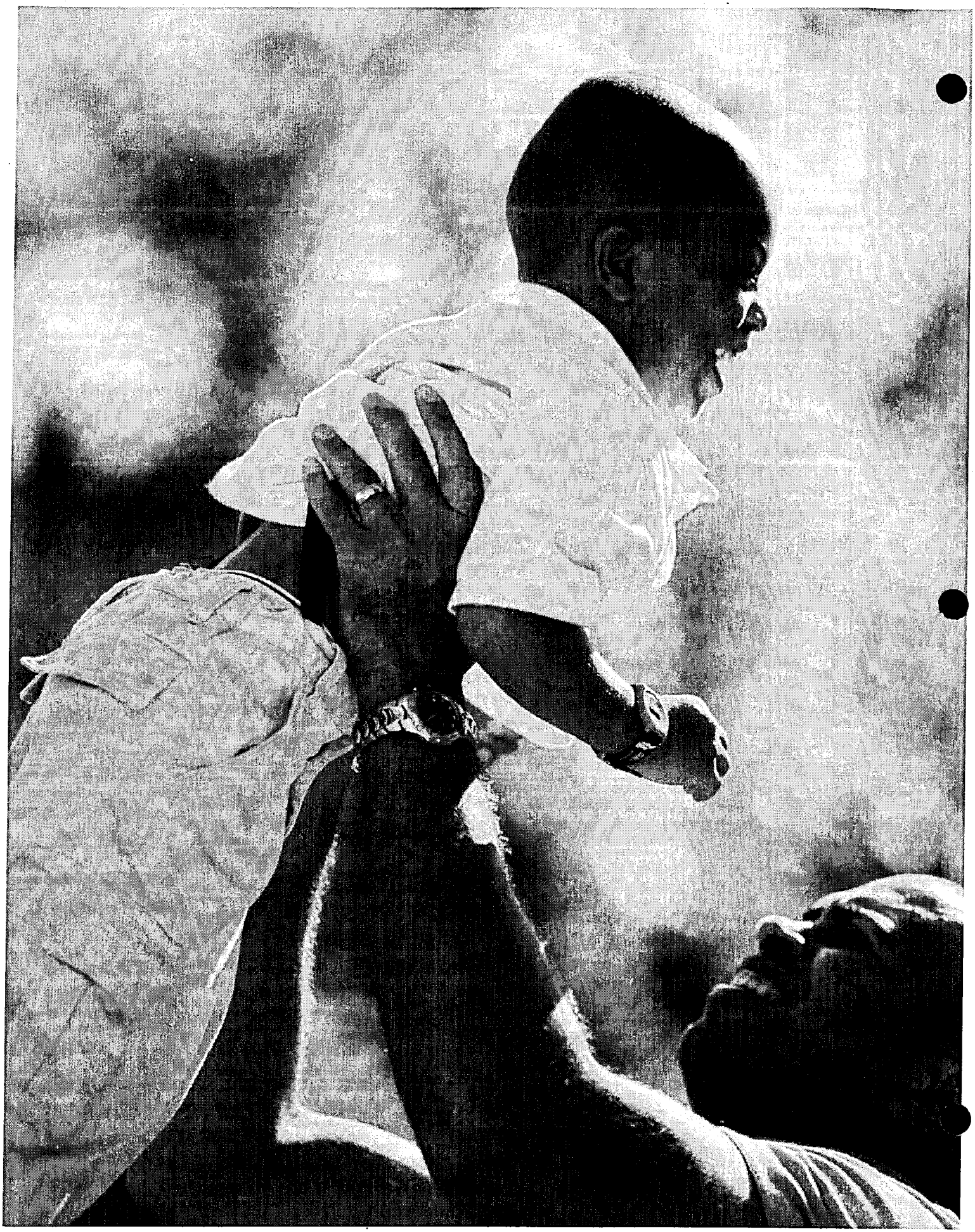
DFPS must develop accountability systems with clear, meaningful performance standards that are focused on outcomes, and monitoring systems for ensuring these standards are being met. The department also must ensure that both public and private agencies have the information systems technology necessary to permit the timely exchange of service, outcome, and cost data, including the ability to share information across different government agencies.

Finally, as with any pilot project, DFPS should develop an evaluation instrument that will enable it to assess the overall success of privatization, identify what worked and what didn't, and make recommendations to future Legislatures for expanding, halting, or modifying these initiatives.



Summary of Recommendations

- Maintain case management as a public function and limit the role of private providers to the delivery of services to children and families.
- When appropriate, explore greater use of performance-based incentives when contracting for child welfare services.
- Before privatizing, conduct a thorough cost-benefit analysis to determine the cost of privatization and whether policymakers are willing to commit the resources to pay for it. A surge in the workforce will be necessary initially to build the capacity of private providers in preparation for privatization.
- Include stakeholders in the planning process—lack of support from the judiciary or other advocates involved in the child protection system will undermine the work done by the private providers.
- Avoid disruptions in services to children and families by moving slowly, with adequate budgets, and always placing the needs of children and families first. States should not impose a mandate to privatize within a set period of time, which could have tragic consequences for children.
- Conduct a pilot first before significantly expanding the role of private providers in the child welfare system. Pilots are beneficial because they allow states to determine which financial incentives produce the best outcomes; maximize state control over the experiment; strengthen states' bargaining positions; and enable states to maintain their public workforces while evaluating the effectiveness of privatization.
- Ensure that contracts include specific, measurable, and agreed to outcomes and performance measures and devote sufficient staffing and financial resources to monitor progress toward meeting these goals.



Endnotes

[1] Texas Department of Family and Protective Services, 2006 and 2007 Data Books.

[2] "The Cost of Protecting Vulnerable Children V: Understanding State Variation in Child Welfare Financing," The Urban Institute, May 24, 2006.

[3] In March 2007, the state terminated its $899 million contract with Accenture to develop and administer the eligibility and enrollment system for public benefits.

[4] "Hard times put kids at risk, as well as programs to serve them," Carol Marbin Miller, *The Miami Herald*, April 17, 2008.

[5] Texas Department of Family and Protective Services, 2007 Data Book, pages 47 and 54.

[6] "Mercenaries vs. Counterinsurgency," Mario Loyola, *National Review Online*, September 26, 2007; and Office of Federal Procurement Policy Letter 92-1, Inherently Governmental Functions, September 23, 1992.

[7] Rider 13 report, Texas Department of Family and Protective Services.

[8] Rosenthal (2000), in Freundlich, Madelyn, and Gerstenzang, Sarah. (2003). *An Assessment of the Privatization of Child Welfare Services*. Washington DC: Child Welfare League of America, Inc.

[9] Ibid.

[10] Freundlich & Gerstenzang. (2003).

[11] Berger and Neuhaus, p. 11 (1977), in Freundlich & Gerstenzang. (2003).

[12] Freundlich & Gerstenzang, p. 5.

[13] Morgan & England (1988) in Freundlich & Gerstenzang. (2003).

[14] Moe (1987) in Freundlich & Gerstenzang. (2003).

[15] Sullivan (1987) in Freundlich & Gerstenzang. (2003).

[16] Nightingale, Demetra Smith & Nancy M. Pindus, "Privatization of Public Social Services, A Background Paper," Urban Institute, October 15, 1997.

[17] Donahue (1989) in Freundlich & Gerstenzang. (2003).

[18] Kettl (1993), in Freundlich & Gerstenzang. (2003).

[19] We do not evaluate these different financing options in this paper, except to point out that no evidence has been found that any model (capitation, capped allocation, case rate, or the various forms of risk sharing) has resulted in cost savings. For a good review of the different financing models of child welfare privatization, see McCullough, C. (2005). *Child Welfare Privatization: Synthesis of Research and Framework for Decision-Makers*; Freundlich & Gerstenzang. (2003); and the National Quality Improvement Center on the Privatization of Child Welfare Services, 2006.

[20] Mark Friedman, "A Guide to Developing and Using Performance Measures in Results-based Budgeting," Prepared for The Finance Project, May 1997.

[21] The General Accounting Office was renamed the Government Accountability Office in 2004.

[22] U.S. General Accounting Office (1997) in Freundlich & Gerstenzang. (2003).

[23] Friedman, May 1997.

[24] Alliance for Redesigning Government (1996) in Freundlich & Gerstenzang. (2003).

[25] Usher, C.L., Gibbs, D., Wildfire, J. (1999) in Freundlich & Gerstenzang. (2003).

[26] U.S. Department of Health and Human Services, Children's Bureau, *Report to Congress*, 1996.

[27] The 2003 study was the last such national survey conducted by the Child Welfare League of America.

[28] See the National Quality Improvement Center on the Privatization of Child Welfare Services at http://www.uky.edu/SocialWork/qicpcw/.

[29] "National Needs Assessment and Knowledge Gaps Analysis Findings," National Quality Improvement Center on the Privatization of Child Welfare Services, University of Kentucky College of Social Work, September 2006.

[30] See Sheila A. v. Finney, Sheila A. v. Haden, and J.D.B. v. Barton), 253 Kan. 793, 861 P.2d 120 (Kan. 1993); 259 Kan. 549, 913 P.2d 181 (Kan. 1996).

[31] For further commentary, see the National Center for Youth Law at http://www.youthlaw.org/publications/fc_docket/alpha/sheilaavwhiteman/.

[32] In 2002, the parties agreed to replace the settlement agreement with internal monitoring from SRS' Quality Assurance Unit.

[33] Freundlich & Gertstenzang, p. 40.

[34] Kansas Department of Social and Rehabilitation Services.

[35] Freundlich & Gerstenzang, p. 40.

[36] See Freundlich & Gerstenzang for further discussion of improvements to the Kansas child welfare system and lessons learned from its transition issues.

[37] Kansas Department of Social and Rehabilitation Services, Outcomes for 2007 Business Plan.

[38] Texas Department of Family and Protective Services, 2004 Data Book, p. 81.

[39] According to Freundlich and Gerstenzang, two permanency standards were also not met from 1998 to 2004: 1) children exiting foster care for reunification in less than 12 months; and 2) children in foster care less than 12 months will have less than two moves.

[40] Texas Department of Family and Protective Services, 2005 Data Book, p. 87.

[41] Texas Department of Family and Protective Service, 2006 Data Book, p. 80.

[42] Kansas Department of Social and Rehabilitation Services, Outcomes for 2007 Business Plan. Outcome entitled percent of children in out of home [care] less than 12 months will have two or fewer placements.

[43] Texas Department of Family and Protective Services 2005 Data Book, p. 87. In Texas, this is with DFPS legal custody terminated.

[44] Texas Department of Family and Protective Services 2006 Data Book, p. 80.

[45] Kansas Department of Social and Rehabilitation Services Outcomes for 2007 Business Plan. Outcome entitled percent of children released from custody for reasons of reunification will be released from custody within twelve months of removal into care.

[46] Texas Department of Family and Protective Services, 2005 Data Book, p. 87.

[47] Texas Department of Family and Protective Services, 2006 Data Book, p. 80.

[48] Kansas Department of Social and Rehabilitation Services, Outcomes for 2007 Business Plan. Outcome entitled percent of children released from custody for reasons of adoption will be released from custody within 24 months of removal into care.

[49] Texas Department of Family and Protective Services, 2005 Data Book, p. 87.

[50] Kansas Department of Social and Rehabilitation Services, Children and Family Services, Outcome Performance Across Time, October 18, 2005, p. 2.1. See http://www.srskansas.org/CFS/datareports.html.

[51] Texas Department of Family and Protective Services, 2006 Data Book, p. 80.

[52] Kansas Department of Social and Rehabilitation Services, Outcomes for 2007 Business Plan. Outcome is entitled percentage of children who remain safe in out-of-home placement.

[53] Texas Department of Family and Protective Services, 2005 Data Book, p. 87. The Texas data refer to children in any stage of care.

[54] Texas Department of Family and Protective Services, 2006 Data Book, p. 80. The Texas data refer to children in any stage of care.

[55] Kansas Department of Social and Rehabilitation Services, Outcomes for 2007 Business Plan. Outcome entitled percent of children who experienced a substantiated abuse or neglect incident do not experience recurrent maltreatment within six months of the previous incident. The threshold for this standard is set at 93.9% of children who experience a substantiated abuse or neglect incident do not experience recurrent maltreatment with six months of the previous incident. The 2006 % equaled 96.2%. For purposes of comparison, these numbers were inverted.

[56] Texas Department of Family and Protective Services, 2005 Data Book, p. 87.

[57] Texas Department of Family and Protective Services, 2006 Data Book, p. 80.

[58] Kansas Department of Social and Rehabilitation Services, Outcomes for 2007 Business Plan. Outcome entitled percent of children will not reenter custody. In Kansas performance-based contracts, the threshold is set at 91.4% of children will not reenter custody. In 2005 and 2006, 96.5% and 94.5%, respectively, of children exiting foster care did not reenter out of home placements.

These figures were inverted for comparison with Texas data.

[59] Community-Based Care Lead Agencies and Contract Managers Contacts, Florida Department of Children and Families, February 2008.

[60] "Child Welfare System Performance Mixed in First Year of Statewide Community-Based Care," Office of Program Policy Analysis & Government Accountability, an office of the Florida Legislature (OPPAGA), Report No. 06-50, June 2006, p. 1.

[61] "Evaluation of the Florida Department of Children and Families Community-Based Care Initiative in Manatee, Sarasota, Pinellas, and Pasco Counties," Final Report on Fiscal Year 2001-2002, University of South Florida, Louis de la Parte Florida Mental Health Institute, June 2002, p. ix.

[62] Florida data often use the term fiscal year, followed by the calendar year during which the fiscal year commenced and the calendar year during which the fiscal period ended. For purposes of this analysis, the fiscal year noted is the calendar year during which the Florida fiscal year ended.

[63] "Ensuring the Long-Term Success of Florida's Community-Based Child Welfare System," Florida Tax Watch, March 2006, p. 3.

[64] Safety indicators included recurrence of maltreatment and reentry into out-of-home care. Permanency indicators included proportion of children exiting out-of-home care (within 12 months and within 12 months into permanency) and length of stay of out-of-home care.

[65] "Report to the Legislature: Evaluation of the Department of Children and Families Community-Based Care Initiative, Fiscal Year 2005-2006," University of South Florida, January 2007, p. vii.

[66] OPPAGA June 2006, p. 5.

[67] OPPAGA June 2006, p. 5 and Appendix D, Table D-2, p. 19.

[68] See National Data Analysis System, Child Welfare League of America at http://ndas.cwla.org/data_stats/data_trends.asp. The rate of adoption was calculated by dividing the number of adoptions consummated by the total number of children in out-of-home care during the fiscal year.

[69] OPPAGA June 2006, p. 5, and Appendix D, Table D-1, p.19, and Florida DCF Child Welfare Annual Statistical Data Tables Fiscal Year 2004-2005, DCF, October 2005, p. 214.

[70] OPPAGA June 2006, pp. 6-7.

[71] Florida Department of Children and Families Child Welfare Annual Statistical Data Tables Fiscal Year 2004-2005, October 2005, p 82.

[72] OPPAGA, June 2006, p. 7.

[73] Ibid.

[74] OPPAGA June 2006, p.8.

[75] Florida Department of Children and Families, Business Plan Fiscal Year 2006-07, November 30, 2006, p. 6.

[76] "Community-Based Care White Paper for State Fiscal Year 2005-2006," University of South Florida June 2006,, p. 80.

[77] OPPAGA June 2006, Appendix E, p. 21.

[78] "Community-Based Care White Paper for State Fiscal Year 2005-2006," University of South Florida June 2006, p. 80.

[79] USF, January 2007, p. 27.

[80] OPPAGA June 2006, p. 10.

[81] OPPAGA June 2006, p. 8.

[82] Florida Department of Children and Families, Business Plan Fiscal Year 2006-07, November 30, 2006, p. 6.

[83] OPPAGA June 2006, pp. 12-13.

[84] OPPAGA, June 2006, Appendix F, Table F-1, p. 22.

[85] Ibid.

[86] OPPAGA, June 2006, Appendix F, Table F-3, p. 23.

[87] Ibid.

[88] "Additional Improvements Are Needed as DCF Redesigns its Lead Agency Oversight Systems," OPPAGA, Report No. 06-05, January 2006, pp.1-2.

[89] OPPAGA, January 2006, p. 3.

[90] OPPAGA , January 2006, p. 12.

[91] OPPAGA, June 2006, p. 3, Florida DCF Quick Facts, January 2008, pp. 19, 23.

[92] Texas Department of Family and Protective Services 2004 Data Book, p. 81.

[93] This number may be misleading as the Texas Department of Family and Protective Services collects data regarding the number of children achieving permanency during a fiscal year. There may be some children who exited this system without achieving permanency that are not accounted for.

[94] OPPAGA June 2006, p. 5, "Report to the Legislature: Evaluation of the Department of Children and Families Community-Based Care Initiative, Fiscal Year 2005-2006," University of South Florida, p. 20, January 2007; and DFPS 2005 Data Book, p. 89.

[95] OPPAGA June 2006, p. 5 and Appendix D, Table D-2, p. 19; and Texas Department of Family and Protective Services.

[96] Texas Department of Family and Protective Services 2007 Data Book, p. 56; Florida Department of Children and Families Child

Protection and Permanency Performance Dashboard for state fiscal year to date based on data schedule July 1, 2006 through June 30, 2007.

[97] Texas Department of Family and Protective Services 2007 Data Book, p. 56. Florida Department of Children and Families Quick Facts, p. 4, January 29, 2008.

[98] Florida Department of Children and Families Child Welfare Annual Statistical Data Tables Fiscal Year 2004-2005, October 2005, p. 214; Texas Department of Family and Protective Services 2005 Data Book, p. 87; Florida DCF Quick Facts, Florida Department of Children and Families, January 2007, p. 4; Florida Department of Children and Families, Business Plan Fiscal Year 2006-07, November 30, 2006, p.6; and DFPS 2006 Data Book, p. 80.

[99] OPPAGA, p.7, June 2006; Texas Department of Family and Protective Services 2005 Data Book, p. 87; Florida Department of Children and Families Child Protection and Permanency Performance Dashboard for state fiscal year to date based on data schedule July 1, 2005 through June 30, 2006; and Texas Department of Family and Protective Services 2006 Data Book, p. 80.

[100] Texas Department of Family and Protective Services 2007 Data Book, p. 56. A comparable figure for Florida fiscal 2007 is not yet available through report.

[101] See National Data Analysis System, Child Welfare League of America at http://ndas.cwla.org/data_stats/data_trends.asp. The rate of adoption was calculated by dividing the number of adoptions consummated by the total number of children in out-of-home care during the fiscal year.

[102] DFPS 2005 Data Book, p. 87, and Texas Department of Family and Protective Services 2006 Data Book, p. 80.

[103] OPPAGA June 2006, Appendix D, Table D-4, p. 20, and Florida Department of Children and Families Quick Facts, January 2007, p. 4.

[104] Texas Department of Family and Protective Services 2007 Data Book, p. 56.

[105] Florida Department of Children and Families Quick Facts, January 29, 2008, p. 4.

[106] Children's Bureau CFSR Summary of Key Findings, Fiscal Years 2001 and 2002.

[107] Children's Bureau CFSR "Key Findings Report: Florida Department of Children and Families," April 23, 2002; Children's Bureau CFSR "Key Findings Report: Kansas Department of Social and Rehabilitative Services Child and Family Policy Division," September 17, 2001; and Children's Bureau "CFSR Key Findings Report: Texas Department of Protective and Regulatory Services," August 23, 2002.

[108] Texas Department of Family and Protective Services, 2007 Data Book, p. 25. The unique number of children served includes children in completed investigations, family based safety services, conservatorship, substitute care, and preparation for adult living services.

[109] "The Cost of Protecting Vulnerable Children V: Understanding State Variation in Child Welfare Financing," The Urban Institute, May 24, 2006.

[110] Texas Department of Family and Protective Services, 2007 Data Book, pp. 25-6.

[111] "Updating and Outsourcing Enrollment in Public Benefits: The Texas Experience," CPPP, November 2006.

[112] "Privatization of State Foster Care and Adoption Services: An Idea Whose Time Has Come or a Disaster in the Making?" CPPP, April 3, 2007; and "Creating Foster Care Capacity for Abused and Neglected Children," CPPP, January 2008.

[113] "Creating Foster Care Capacity for Abused and Neglected Children," CPPP, January 2008.

[114] Texas Department of Family and Protective Services Cost Study Data provided to the Legislature in 2005.

[115] Texas Department of Family and Protective Services Fiscal Year 2007 Data.

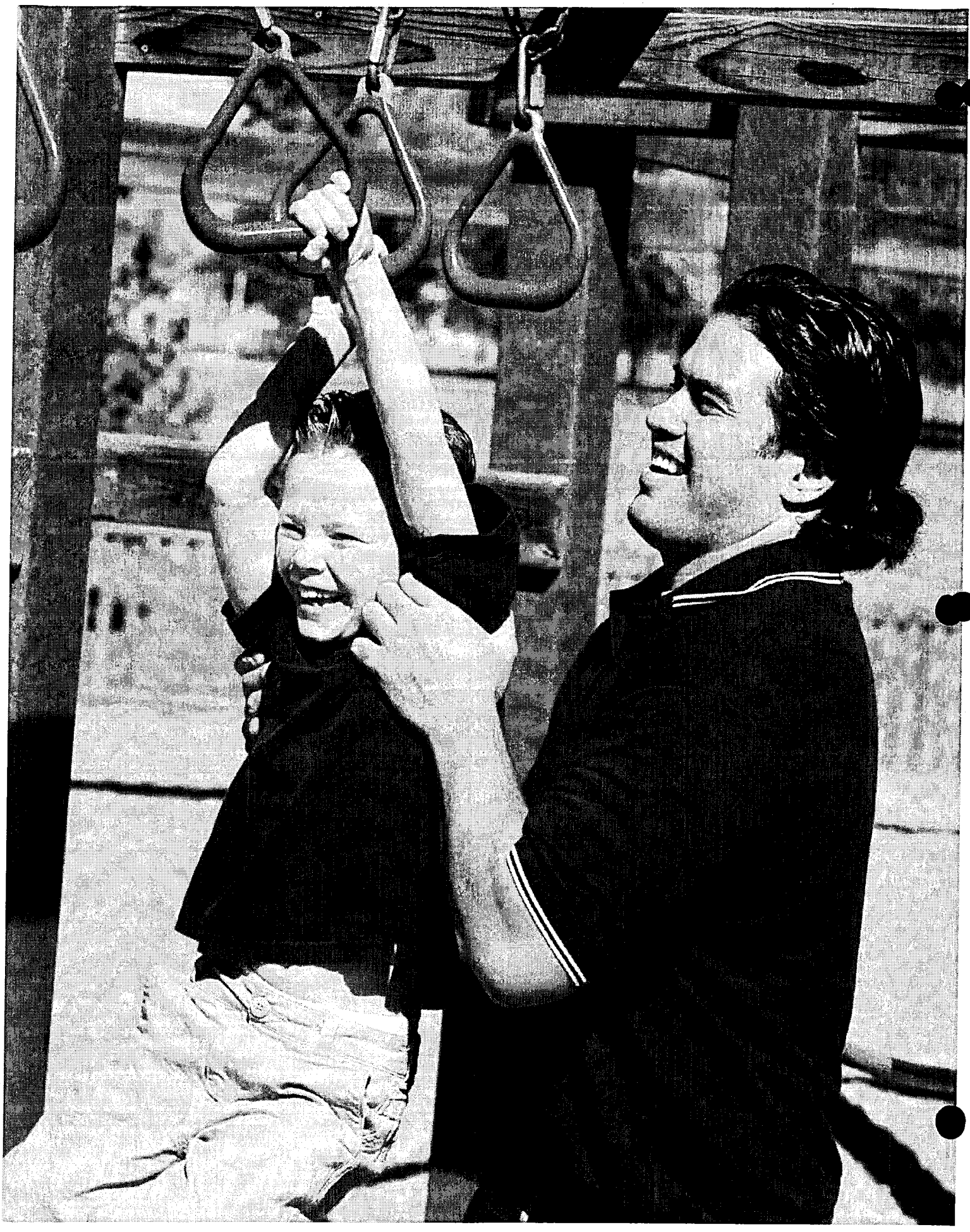
[116] Texas Department of Family and Protective Services 2007 Data Book, p. 54.

[117] Under Texas' plan the independent administrator would procure substitute care services (foster homes and residential treatment centers) and case management services from private agencies. When a child entered the care of the state, the independent administrator would assign the child to an agency, not a home; the agency would then manage the case from that point. The independent administrator would not do case management.

[118] The plan to privatize case management raised constitutional questions as well. Under the Texas constitution, power is divided among the legislative, executive, and judicial departments. Privatizing case management violates the constitutional principle of separation of powers. Taking case management away from state executive officers and allocating it to private companies violates the separation of powers by interfering with the executive's exercising of its power. An analogy may be helpful here. Under the constitution, the attorney general has the power to issue advisory opinions on legal questions. Suppose that the Legislature thought that the attorney general was giving bad advice. Then suppose the Legislature decided to require the attorney general to hire private lawyers to answer all questions and prohibited the attorney general from answering any questions. The Legislature would not be exercising the attorney general's power, but it would nonetheless be violating the separation of powers because the Legislature would be interfering in the exercise of the executive branch's power. See generally *Texas Boll Weevil Eradication Foundation, Inc. v. Lewellen*, 952 S.W.2d 454 (Tex. 1997) (discussing unconstitutional delegation of legislative power to private corporation).

[119] Senate Bill 6 added only 184 additional staff for procurement, evaluation, monitoring, and other oversight activities and 63 new licensing staff. This addition was far short of what is needed, particularly given the increased outsourcing of all foster and adoption services also mandated by SB 6.

[120] Senate Bill 6 gave the department the option to contract with for-profit providers knowing that they would be likely to have better access to sufficient capital to undertake such a massive project.
[121] Privatization Position Paper, Casey Family Programs, August 2007.
[122] "Creating Foster Care Capacity for Abused and Neglected Children," CPPP, January 2008.
[123] SB 758 Implementation Plan, Texas Department of Family and Protective Services, December 31, 2007, p. 15.
[124] Relevant sections of SB 758 were codified in Texas Family Code Section 264.106.
[125] "Privatization of State Foster Care and Adoption Services: An Idea Whose Time Has Come or a Disaster in the Making?" CPPP, April 2007.
[126] SB 758 Implementation Plan, p. 21.
[127] Texas Family Code, § 264.106(a)(5).
[128] These recommendations are based on the approaches developed in Casey Family Programs' Privatization Position Paper.



Glossary

CAPITATION A financial model in which private providers are paid a fixed rate for each child in a general population, such as a geographic area.

CAPPED ALLOCATION A financial model in which private providers are paid a fixed rate for each child in a limited population, such as all children removed from their homes in a particular county that come into state conservatorship.

CASE COORDINATION The coordination and monitoring of services provided to a child or family, excluding legal or ultimate decisionmaking authority.

CASE MANAGEMENT The planning and decisionmaking by a case manager of placement decisions, treatment decisions, reunification decisions, and the legal court work leading to permanency for a child.

CASE RATES A financial model in which private providers are paid for each child, regardless of the services offered.

CHILD AND FAMILY SERVICES REVIEW (CFSR) A review administered to states by the Children's Bureau of the U.S. Department of Health and Human Services developed to ensure that state practices conform to federal child welfare requirements. These standards include specific child welfare outcomes in the areas of safety, permanency, and child well-being, as well as the systemic factors that affect those outcomes.

CONSERVATORSHIP Texas uses the term "conservatorship" for what in other states is called guardianship. "Conservatorship" is when a court appoints a person, the state, or an authorized agency to be legally responsible for a child.

CHILD PLACING AGENCIES (CPAS) Private agencies that recruit, train, and supervise foster homes.

FOSTER CARE The temporary placement of children outside their homes into licensed and subsidized placements due to abuse, neglect, or dependency. Foster care is a subset of substitute care.

INDEPENDENT ADMINISTRATOR A model for privatizing child protection in which the independent administrator acts like a general contractor and selects, coordinates, and works through subcontractors. The independent administrator does not provide any actual services itself.

KINSHIP CARE The placement of a child with a family member other than a parent.

LEAD AGENCY A model for privatizing child protection in which the lead agency both administers the contract

and provides services, using subcontracts to provide the services that the lead agency does not offer.

OPEN ENROLLMENT CONTRACT A contract that is open to any potential provider who establishes through acceptable means (such as licensure or certification) that it meets all provider service standards and agrees to all terms and conditions set forth in the contract, including the established rates.

PERFORMANCE-BASED CONTRACT A contract that involves financing arrangements that align payment with the quality of specified outcomes. This generally gives private providers greater flexibility in determining how funds are used and shifts the financial risk to the private providers.

PERMANENCY A process in which a child leaves the legal responsibility of the state, usually by leaving substitute care through reunification, relative placement, or adoption.

SERVICES "Conservatorship services" are "services provided directly by the department that the department considers necessary to ensure federal financial participation and compliance with state law requirements, including initial placement of a child and approval of all subsequent placements of a child, approval of the child and family case plan, and any other action the department considers necessary to ensure the safety and well-being of a child."
"Substitute care services" are "services provided by a substitute care provider to or for a child in the temporary or permanent managing conservatorship of the department or for the child's placement, including the recruitment, training, and management of foster and adoptive homes by a child-placing agency."

STATE-PAID CARE Foster care placements paid for by the state including foster family homes, basic child care, emergency shelters, foster group homes, and residential care facilities.

SUBSTITUTE CARE The placement of a child who is in the conservatorship of the state or authorized agency in care outside the child's home.

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Media Coverage

Miami Herald, "Hard Times Put Kids at Risk, as wells as Programs to Serve Them," Gary Fineout & Mary Ellen Klas, April 17, 2008

The Florida Legislature asked child-welfare administrators to cut tens of millions of dollars from safety-net programs for vulnerable children at a time when kids may be at greater risk due to the economic slowdown.

Herald Tribune, "YMCA entangled in unorthodox land deal," Michael Braga, Bob Mahlburg, August 12, 2007

"Sarasota attorney and Sarasota Family YMCA board member David Band sold half a run-down office building on land tainted by groundwater pollution to the YMCA for $830,000 and donated the other half to the nonprofit as an $830,000 gift that could save Band and his partners at least $200,000 on their tax bills. The same day, the YMCA made a quick profit by selling the entire building for $1.3 million, receiving $300,000 in cash, while providing the buyers with a $1 million interest-only loan. Band and his partners benefited by transferring the risk of the loan to the YMCA, leaving the Y exposed to losses if the new owners cannot meet their obligations."

Miami Herald, "Study: Foster Care System Flawed," Carol Marbin Miller, August 7, 2007

A comprehensive review, conducted by the Chapin Hall Center for Children of the University of Chicago on privatized foster care services in Miami-Dade, Broward, and Monroe counties, found that South Florida children in foster care are not receiving the support and care they should be – from regular immunizations, preventive dental care, and counseling, to being bounced between foster homes because "caregivers become frustrated over a lack of support from child-welfare agencies." The Chapin Hall report involved the review of 90 foster children's files – 45 from ChildNet and 45 from Our Kids.

St. Petersburg Times, "Child Protection in Florida Falters," Editorial, August 7, 2007

"State Dept. of Children and Families Secretary Bob Butterworth calls that no one will escape the review of child-protection services at the Sarasota Family YMCA. Over the past decade the YMCA grew into a $91-million-a-year state-funded business, and signs show of its faltering. The agency's financial priorities have become murkier, as well. Butterworth: 'Everything is on the table. Our system, if not broken, is in desperate need of serious repair.'"

Florida Times-Union, "State to Review Sarasota YMCA", Carol Marbin Miller, August 4, 2007

Sarasota Family YMCA has been "the target of recent criticism because it receives among the highest per-child funding for private foster agencies statewide but is among the worst at caring for children, according to state records. Cracks in Florida's child welfare system were revealed after the disappearance case of 2-year- old Courtney Clark and systemic problems were found with the Sarasota YMCA and poor oversight by the DCF. The review of the Sarasota Family YMCA is the latest in an ongoing state effort to root out problems that occurred in the Courtney Clark case. The girl's mother took her from foster care in September. But the caseworker, employed by a Sarasota YMCA subcontractor, did not report her missing to law enforcement for four months."

Tampa Tribune, "Panel Will Look At Ways To Improve Child Welfare Statewide," Sherri Ackerman, August 4, 2007

"A top state official launched a new task force Friday with a primary goal: Make the state's child welfare system work better. Butterworth created the panel June 18, four days after authorities located a toddler who went missing from Florida's foster care system for nine months.

"The Child Protection Task Force convened for its first meeting at Stetson University College of Law in Tampa to discuss ways to make DCF the gold standard in child welfare and to help craft child protection legislation. Among those changes, Butterworth wants the panel to look at rewriting laws that allow DCF more authority over community-based agencies providing local foster care and adoption services for the state."

Associated Press State and Local Wire, "Fla. State contractor defends actions in missing girl case," unlisted, June 19, 2007

"The company responsible for monitoring a missing 2-year-old in foster care said it was working hard to locate her, despite criticism it did not immediately call local police."

Orlando Sentinel, "DCF will investigate how toddler could 'disappear under the radar,'" Adrian G. Uribarri, June 19, 2007

"The Florida DCF is investigating why a 2-year-old girl in state foster care wasn't reported missing for almost four months."

Miami Herald, "DCF chief blasts ChildNet boss," Erika Bolstad, April 25, 2007

"Florida's top child welfare official said Tuesday that problems at Broward's private foster care agency were the fault of the group's now-fired CEO.

"Even before allegations of theft, fraud and doctored invoices surfaced this month, ChildNet lacked accountability, and former CEO Peter Balitsaris had a dysfunctional relationship with state child welfare managers, said DCF Secretary Bob Butterworth."

Miami Herald, "ChildNet told to fix troubling problems," Erika Bolstad, April 24, 2007

"As many as 20 employees of Broward's private foster care agency may have had invalid or suspended driver's licenses, or had such shoddy driving records that they shouldn't have been driving children, according to findings released Monday by the Department of Children & Families."

Miami Herald, "The Miami Herald Fred Grimm column: Thieves add new dimension to foster care," Fred Grimm, April 17, 2007

"The key phrase was 'once again.' In 1996, shameful treatment of foster children was the same old news. But the scandal that exploded last week out of ChildNet, a private vendor hired to manage foster care cases in Broward County, introduced a new element in the old story—petty criminality. ChildNet workers ripped off Christmas presents. In an inside job, they stole donated presents and $8,000 worth of Wal-Mart gift cards meant for foster kids from ChildNet offices in Fort Lauderdale."

Newsday, "Protests over privatizing: Suffolk looking for private contractor, but union says work can be done by Child Protective Services," Rick Brand, March 2, 2007

"Suffolk welfare officials are seeking a private contractor to provide a wide range of new preventive services, sparking complaints from union officials who say the work has been done by caseworkers from Child Protective Services. Social services officials say no county jobs will be replaced, and the county is only following the model of programs in New York City and Nassau that aim to help families without the stigma of involvement by Child Protective Services, which also investigates abuse and neglect complaints."

Newsday, "Outsourcing on the Rise," March 1, 2007

"While critics question the outsourcing of social work, which often deals with delicate family situations, other child welfare advocates say the plans work well over time and have proven cost-effective. But the Child Welfare League of America has been skeptical of aspects of the practice. In a 2003 report, the Washington-based advocacy group criticized Kansas for doing the changeover too quickly and faulted inadequate communication between contracted agencies and government, as well as delayed payments to contracted agencies. But over time the problems were resolved, the report said."

Youth Law Center, "Victory for Florida Foster Children" Nov. 9, 2006

"State Circuit Judge Janet Ferris has issued a permanent order on behalf of foster children in the Florida Panhandle area in a lawsuit against the Florida Department of Children and Families (DCF) that alleged that foster children were being forced to live in an unlicensed DCF office conference room. The order, known as a writ of mandamus, directs DCF and its private contract agencies to obey Florida state law and only use licensed facilities for the emergency placement of children removed from their homes."

Bonita Daily News, "Child Welfare to appoint new board of directors," Deirdre Conner, October 8, 2006

(This article is an update to all the information from Deirdre's previous article on Sept. 26)

"The fired board members from Children's Network, previously under Camelot, plan to pursue the new contract, which begins March 25. As a new nonprofit agency they call The Children's Network Inc., fundraising has already begun, and if they lose the bid, they plan to use the cash to build a group home for teens transitioning out of foster care."

Naples Daily News, "After Major Shuffle, DCF eliminates $100M deal with Children's Network," Deirdre Conner, September 26, 2006

"The state Department of Children and Families has terminated a private company's $23.5 million yearly contract for child welfare services. The move came just weeks after the parent company of the Children's Network of Southwest Florida dismissed its local board of directors and fired its chief executive. Ousted board members cried foul, saying Camelot Community Care Inc. was curbing local control to protect a for-profit company. Camelot said the Children's Network was endangering children with its plan to quickly cancel sub-contracts and bring all social workers in-house."

Youth Law Center, "Partial Settlement in Florida Shelter Care Lawsuit," August 9, 2006

"Youth Law Center announces the partial settlement of Susan C. et al. v. Department of Children and Family Services, et al., our case in Tallahassee, Florida, regarding the practice of DCF and its private contractor to make foster children live in a DCF conference room for days, and sometimes weeks, upon end. The private contractor, Big Bend Community Based Care, entered into a settlement with plaintiffs on August 7, 2006, that states, among other things, that they will set a policy prohibiting overnight stays in offices, conference rooms, or other unlicensed placements in the DCF District over which it manages foster care services. The settlement does not affect ongoing litigation against the State of Florida, but YLC and local counsel hope that the state will make a similar agreement soon."

Herald Tribune, "YMCA–run foster care struggling," Todd Ruger, June 25, 2006

"State reviews and reports show YMCA's foster care program is lagging behind other agencies on key measures of child safety during the fiscal year 2004. It was among the worst agencies for the number of foster children who re-enter the system less than a year after they leave it, and also scored poorly for the number of times a child is bounced from home to home. YMCA executives shrug off the report, saying their agency instead looks to semiannual evaluations by the state to see how it's doing."

South Florida Sun-Sentinel, "Report shows increase in abuse since privatization of state child-welfare system," Josh Hafenbrack, June 25, 2006

"Florida's switch to a privatized child-welfare system has been followed by increased instances of abuse and more children shuffled among foster homes, a state audit has found.

"The number of Florida children who are abused multiple times has steadily increased since the state started shifting its child-welfare system to private hands in 1999, according to a report released this month by the Legislature's investigative arm, the Office of Program and Policy Analysis & Government Accountability."

Youth Law Center, "Class Action Lawsuit Filed on Behalf of North Florida Foster Children," April 4, 2006

"A class action lawsuit filed in Florida state court today charges the Department of Children and Family Services ("DCF") and a private contract foster care agency, Big Bend Community Based Care, Inc., with failing to find appropriate and licensed foster placements for abused and neglected children. Specifically, DCF and Big Bend are accused of forcing foster children to sleep night after night in a conference room in a DCF building at 3019 Jackson Bluff Road in Tallahassee."

Kansas City Star, "Foster-Care Providers are offered incentives," Laura Bauer, March 14, 2005

"Nine years after private contractors took over, Kansas' foster-care system is twice as expensive and still struggling to move children into permanent homes at a faster pace. So in an attempt to improve a system that in 1996 pioneered private child welfare, the state is raising the stakes for contractors. Starting in July, the state will pay them more money during the first six months a child is in foster care. But that money will be cut more than two-thirds if a child lingers in the system longer than a year. The idea is to cut the average time a child is in the system, which is 23 months, roughly what it was before Kansas privatized services."

Miami Herald, "FBI targets child care agency," Carol Marbin Miller, Date not given

"Two private investigators hired to look into irregularities at ChildNet allege the privately run child welfare agency responsible for various illegal activities."

Herald Tribune, "Sarasota YMCA under review," Bob Mahlburg, Date not given

(This article discusses the same story of the Sarasota YMCA under investigation by the DCF.)

"DCF Regional Director Nick Cox said past examinations had focused on the YMCA's problems with specific children. 'This is more of an overall review of the agency,' Cox said."

Center for Public Policy Priorities

LEGISLATURE OF NEBRASKA

ONE HUNDRED FIRST LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 980

Introduced by Wallman, 30; Conrad, 46; Haar, 21; Karpisek, 32; Mello, 5; White, 8.

Read first time January 19, 2010

Committee: Government, Military and Veterans Affairs

A BILL

FOR AN ACT relating to state government; to amend sections 73-301, 73-302, 73-303, 73-304, 73-305, 73-306, 73-307, and 81-154.01, Reissue Revised Statutes of Nebraska; to name an act; to define terms; to change provisions relating to contracts for personal services; to provide requirements for privatization contracts; to harmonize provisions; to provide an operative date; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

Section 1. This section, sections 73-301 to 73-307, and sections 2 and 8 of this act shall be known and may be cited as the State Personal Services Contract Act.

Sec. 2. For purposes of the State Personal Services Contract Act:

(1) Contract for personal services means an agreement by a contractor to provide human labor but does not mean a contract to supply only goods or personal property. The term includes contracts with private service providers, consultants, and independent service contractors, except as provided in section 73-307;

(2) Director means the Director of Administrative Services;

(3) Privatization contract means a contract for personal services by which a person other than a state employee contracts with a state agency to provide human labor valued at fifty thousand dollars or more annually if the human labor is the same or substantially similar to and in lieu of such labor provided, in whole or in part, by permanent, classified state employees and if the contract would result in a reduction in force of at least one permanent, classified state employee position in the state agency or the elimination of a vacant permanent, classified state employee position in the state agency; and

(4) State agency means an agency of the state other than the University of Nebraska, the Nebraska state colleges, and any

other board, commission, or agency established by the Constitution of Nebraska.

Sec. 3. Section 73-301, Reissue Revised Statutes of Nebraska, is amended to read:

73-301 (1) The ~~Director of Administrative Services~~ director shall review and approve or disapprove any contract for personal services between a private entity and ~~any~~ a state agency~~,~~ ~~other than (1) the University of Nebraska, (2) the Nebraska state colleges, and (3) any other board, commission, or agency established by the Constitution of Nebraska,~~ if, on the effective date of the contract, the personal services are performed by permanent state employees of the agency and will be replaced by services performed by the private entity or if the contract is a privatization contract. ~~The contract~~

(2) Each contract subject to approval by the director shall be subject to the public bidding procedures established in sections 81-145 to 81-162 except in emergencies approved by the Governor.

~~For purposes of this section, contract for personal services means an agreement by a contractor to provide human labor but does not mean a contract to supply only goods or personal property. The term includes contracts with private service providers, consultants, and independent service contractors.~~

Sec. 4. Section 73-302, Reissue Revised Statutes of Nebraska, is amended to read:

73-302 (1) A state agency that seeks to enter into a contract ~~described in section 73-301~~ for personal services with a private entity shall submit the following information to the ~~Director of Administrative Services:~~ director:

(a) The proposed contract;~~,~~

(b) ~~a~~ A review of the long-term actual cost savings;~~,~~

(c) ~~the~~ The measurable goals for improving the quality of the service;~~,~~ and

(d) ~~an~~ An assessment of the feasibility of alternatives within the agency to contracting for performance of the service.

(2) In calculating the cost savings under subsection (1) of this section, the state agency shall project, for twelve months and for sixty months, the following:

(a) Direct costs, including salary and fringe benefits;

(b) Indirect overhead costs which shall include only those costs that can be attributed solely to the work in question and that would not exist if the work were not performed by state employees. Indirect overhead costs shall include the pro rata share of existing administrative salaries and benefits, rents, equipment costs, utilities, and materials;

(c) Any continuing or transitional costs that are directly associated with contracting for the work, including unemployment compensation and the cost of transitional services; and

(d) Additional costs of performance of the work by state

employees, including the salaries and benefits of additional staff performing inspection, supervision, and monitoring duties and the cost of additional space, equipment, and materials needed to perform the services.

Sec. 5. Section 73-303, Reissue Revised Statutes of Nebraska, is amended to read:

73-303 A state agency that seeks to enter into a contract ~~described in section 73-301~~ for personal services shall also submit to the ~~Director of Administrative Services~~ director a formal plan of assistance to the state employees of such state agency who will be displaced by such contract. The plan shall include, but need not be limited to, the following provisions:

(1) Efforts by the state agency to place displaced employees in vacant positions in that agency or another state agency;

(2) Provisions in the contract for personal services, if feasible, for the hiring of displaced employees by the contractor; and

(3) Demonstration by the state agency that it has taken formal and positive steps in considering alternatives to such contract, including reorganization, reevaluation of service, and reevaluation of performance.

Sec. 6. Section 73-304, Reissue Revised Statutes of Nebraska, is amended to read:

73-304 The ~~Director of Administrative Services~~ director

may approve a proposed contract for personal services if:

(1) The potential economic advantage of contracting is not outweighed by the public's interest in having the particular services performed directly by the state agency;

(2) The contract does not adversely affect the state's affirmative action efforts;

(3) The contract will include adequate control mechanisms to insure that the services are provided pursuant to the terms of the contract; and

(4) The private entity is fairly compensating its employees.

Sec. 7. Section 73-305, Reissue Revised Statutes of Nebraska, is amended to read:

73-305 The ~~Director of Administrative Services~~ director shall, within forty-five days after receipt of the information described in sections 73-302 and 73-303 from the state agency, prepare a report detailing why the proposed contract for personal services was approved or disapproved. The report shall be delivered to the chairperson of the Appropriations Committee of the Legislature and the Legislative Fiscal Analyst.

Sec. 8. The director shall not approve a privatization contract unless all of the following requirements are satisfied:

(1) Thirty-five days prior to the beginning of any open bidding process, the state agency shall provide written notice to the collective-bargaining agent of the intent to seek to

enter a privatization contract. During such thirty-five-day period, the collective-bargaining agent shall have the opportunity to discuss alternatives to contracting. Such alternatives may include amendments to the contract if mutually agreed upon by the parties. Notices regarding the bid opportunity may not be issued during such thirty-five-day period. The continuation of discussions beyond the end of such thirty-five-day period shall not delay the issuance of notices;

(2) The proposed privatization contract is projected to result in overall cost savings to the state of at least ten percent above the projected cost of having the services provided by state employees covered under the State Employees Collective Bargaining Act; and

(3)(a) When comparing the cost of having a service provided by state employees covered under the State Employees Collective Bargaining Act to the cost of having the service provided by a contractor, the expected costs of having services provided by state employees covered under the State Employees Collective Bargaining Act and obtaining the service through a contractor should be compared over the life of the contract. One-time costs associated with having services provided by a contractor rather than state employees covered under the State Employees Collective Bargaining Act, such as the expected cost of leave pay-outs for separating employees, unemployment compensation, and the cost of meeting the state's obligation, if any, to continue

health insurance benefits, shall be spread over the expected life of the contract.

(b) For purposes of this subdivision, the basic cost of services by a contractor includes:

(i) The bid price or maximum acceptable bid identified by the state agency; and

(ii) Any additional costs to be incurred by the state agency for inspection, facilities, reimbursable expenses, supervision, training, and materials, but only to the extent that these costs exceed the costs the state agency could expect to incur for inspection, facilities, reimbursable expenses, and materials if the services were provided by state employees covered under the State Employees Collective Bargaining Act.

(c) For purposes of this subdivision, the basic cost for services provided by a state employee covered under the State Employees Collective Bargaining Act includes:

(i) Wages, benefits, and training;

(ii) The cost of supervision and facilities, but only to the extent that these costs exceed the costs the state agency could expect to incur for supervision or facilities if the services were provided by a contractor; and

(iii) The estimated cost of obtaining goods when the comparison is with the cost of a contract that includes both goods and services.

(d) Possible reductions in the cost of obtaining

services from state employees covered under the State Employees Collective Bargaining Act that require concessions shall not be considered unless proposed in writing by the certified collective-bargaining agent and mutually agreed to by the state and the collective-bargaining agent.

Sec. 9. Section 73-306, Reissue Revised Statutes of Nebraska, is amended to read:

73-306 The Department of Administrative Services shall adopt and promulgate rules and regulations to carry out ~~sections 73-301 to 73-305.~~ the State Personal Services Contract Act. Such rules and regulations shall apply to the ~~Director of Administrative Services~~ director in carrying out his or her duties pursuant to ~~such sections.~~ the act.

Sec. 10. Section 73-307, Reissue Revised Statutes of Nebraska, is amended to read:

73-307 ~~Sections 73-301 to 73-306~~ The State Personal Services Contract Act shall not apply to the Nebraska Consultants' Competitive Negotiation Act.

~~Sections 73-301 to 73-306~~ The State Personal Services Contract Act shall not be construed to apply to renewals of contracts for personal services already approved pursuant to or not subject to ~~such sections,~~ the act, to amendments to such contracts, or to renewals of such amendments unless the amendments would directly cause or result in the replacement by the private entity of additional permanent state employees or positions greater than

the replacement caused by the original contract.

Sec. 11. Section 81-154.01, Reissue Revised Statutes of Nebraska, is amended to read:

81-154.01 The materiel division shall make available copies of current purchase agreements and standard specifications to the University of Nebraska. The University of Nebraska may utilize such purchase agreements if it determines that it would be to its advantage to do so. The materiel division may utilize purchase agreements entered into by the University of Nebraska upon a finding by the materiel administrator that the use of such agreements would be in the best interests of the state. For purposes of this section, purchase agreements do not include contracts for personal services subject to ~~sections 73-301 to 73-307.~~ the State Personal Services Contract Act.

Sec. 12. This act becomes operative on July 1, 2011.

Sec. 13. Original sections 73-301, 73-302, 73-303, 73-304, 73-305, 73-306, 73-307, and 81-154.01, Reissue Revised Statutes of Nebraska, are repealed.

Nebraska Health and Human Services Committee's LR 37 Investigation and Hearing

Testimony of the Nebraska Psychological Association
Omaha, Nebraska on September 28, 2011

Testimony by:
Theodore J. DeLaet, Ph.D., Director of Professional Affairs

Chairwoman Campbell and members of the Health and Human Services Legislative Committee:

Good morning! My name is Dr. Ted DeLaet. I am a psychologist in a full time private practice in Omaha. As the Director of Professional Affairs for the Nebraska Psychological Association (NPA) I am the authorized spokesperson for the association regarding LR 37. On behalf of the over 300 licensed doctoral level psychologists in Nebraska I thank you for the opportunity to testify in today's hearing. I have organized my testimony in compliance with Senator Campbell's August 2, 2011 letter. In addition to my verbal testimony, additional information is included in the printed handouts I have prepared.

The top three issues experienced with lead agencies.

1. **Lack of direction and oversight from the Nebraska Department of Health and Human Services (DHHS) that has resulted in inconsistent goals, strategies, and service utilization. These shortages threaten the integrity of the current behavioral health system in Nebraska.**

   It appears that the rush to privatization by DHHS did not adequately identify the interface between case management services and treatment services before developing financially at risk contracts for the lead agencies. I have had direct dealings as a psychologist in private practice with Boys and Girls Home, Visinet, Nebraska Families Collaborative, and KVC Behavioral Health. Two of these four are now bankrupt, an indication of poor planning by both DHHS and the lead agencies. As you are aware, a third lead agency also bankrupted during the first year of privatization. I have attached a copy of a public document of the over $2.5 million owed providers on the Boys and Girls Home contract and you will see I am owed over $1000 and have been for the past year.

   Due to radical and ever-changing utilization management and "medical necessity" changes, many of Nebraska's current behavioral health providers have had their referrals reduced in excess of 50% since July 2011. As a result, they are at risk of going out of business. Additionally, psychologists across Nebraska to include myself have experienced radical reductions in the "medical necessity" of psychological testing and the overall role of psychologists within the system since July 2011. This is illustrated in the elimination of psychologists as a competent provider to determine the necessity for the new PRTF level of care. There is no regulatory or evidence-based basis for this action. NPA is of the opinion that the behavioral health treatment needs of the youth and families and Nebraska did not change during that time frame, just the treatment options available to them has changed!

Further evidence of the ever-changing nature of what the vision and strategies to deliver Child Welfare services is found in the number and frequency of Medicaid rule and regulation changes. I have received notification e-mails from DHHS of four changes since Thursday, September 22, 2011 and one more notification of possible future changes. How can anyone understand and comply with an ever-changing system?

On a corresponding point, DHHS did not adequately identify its network needs (e.g., the types and numbers of services needed that lead agencies needed to secure as a precondition of being awarded an at risk contract. I was never contacted by any of the lead agencies regarding participation in their network prior to the awarding of the contract and have had no contact from them to become a network provider. Upon knowledge of the awarding of lead agency contracts this testifier initiated contact with NFC, Visinet, and KVC about becoming a network or preferred provider with them. I have been told on multiple occasions that there is no interest on their part for me to become a preferred provider. I concluded there is no valid identification of network needs nor is there an effective credentialing process to identify competent and expert providers within their networks. As Nebraska is identified as a Federally Designated Shortage area in 89 of 93 counties, it would seem we need all competent and willing behavioral health providers to meet the needs of the youth and families involved in the child welfare system and not be reducing the number of providers.

2. **There is significant cost shifting across DHHS funding streams, not reduction of overall case cost to DHHS.**

   The issues of cost shifting from primarily Medicaid to other funding streams such as Child Welfare, Office of Juvenile Services, Developmental Disabilities, or the lead agencies is highly problematic. Delays in access to service for youth and families in addition to increases in non-billable administrative time to providers in dealing with approvals for services have resulted.

3. **Lack of effective utilization of evidence-based research and practice guidelines for behavioral health assessment, diagnosis, and treatment services across the system and including the lead agencies.**

   I have attached a copy of the American Psychological Association's 2005 policy on evidence-based practice and also provider checklist. NPA has noted a lack of application or selective application of evidence-based strategies. As a result, the evidence-based assessment strategies for such high risk and high expense diagnoses as Bipolar Disorder and Attention Deficit Hyperactivity Disorder have not been implemented or have been prohibited. There is also significant misapplication of evidence-based research toward the treatment of youth with behavioral disorders. Another significant implication of this issue is the awarding or steerage of clients to certain providers by lead agencies who provide certain "evidence-based" services and using this basis as a reason to not refer to other providers. Neither DHHS nor any of the lead agencies has demonstrated any leadership or opportunities to train behavioral health providers in emerging evidence-based diagnostic or treatment strategies. Available research has identified misdiagnosis

has resulted in ineffective treatment outcomes, unhappy clients and consumers, overall cost increases, and increased negative outcomes such as involvement with the juvenile court system and/or expulsion from school. We can do much better with this.

The top three issues facing them where currently lead agencies no longer exist.

1. **In Omaha, the other lead agencies and DHHS have absorbed the cases previously held by the now bankrupt lead agencies. Statewide, concerns exist over network development and service availability.**

2. **Using myself as an example, the providers being owed money from the bankrupted lead agencies need to be paid.**

   An examination of the attached list of debts owed to providers from the Boys and Girls Home lead agency contract demonstrates the financial impact on providers. As a small businessman, I cannot afford to provide uncompensated services or to have significant delays in payment for me to pay my creditors.

3. **Even though lead agencies have certain geographic or case load responsibilities, assurance that there is appropriate access to services in underserved areas.**

   In areas of the State that are underserved, are there sufficient access to services and providers in other parts of the State. As most psychologists and psychiatrists are in the Omaha and Lincoln area, are there sufficient relationships and network developed to assure appropriate and timely access to providers.

What recommendations does NPA have regarding child welfare in the future?

1. NPA requests that DHHS and the legislature assure the appropriate roles of psychologists as meaningful and valued behavioral health providers in the emerging Child Welfare System. Our profession and the research generated have value to offer. We continue to communicate our desire to partner and participate in evolving the Nebraska Child Welfare with others.
2. NPA suggests that certain immediate actions be taken to correct identified problems and to set time-limited strategies in place to address other issues. We are not supportive of throwing the identified issues into yet another "overhaul" of the system.
3. NPA is supportive of the recommendations developed by the Nebraska Behavioral Health Coalition regarding immediate actions that can be taken by DHHS. These include:
   a. Magellen Behavioral Health should apply the medical necessity criteria in effect before July 1, 2011.
   b. The application process used for access to the PRTF and other out-of-home levels of care before July 1, 2011 should be re-instated. This would include allowing psychologists to sign/determine medical necessity for such services. Psychiatrists will continue their practice of certifying admission to the level of care at admission.

4. Take steps to assure a true partnership between DHHS, its managed care contracting entities, and providers to address the current problems and to forge a mutual vision of the future of Nebraska Child Welfare services. This would allow for the determination and teamwork required for all behavioral health professionals in Nebraska to better meet the needs of our youth and families.
5. Establish an oversight committee comprised of professional association membership to review and participate in application of evidence-based research relevant to Child Welfare services. This is needed to assure that all relevant research is being considered and applied. This committee could then be a facilitative vehicle to communicate with their members to create a common vision and assist in developing continuing education/competency development for their respective association membership. DHHS has a current "Best Practices" website that was established in 2005 that appears to not be updated or utilized to reflect Child Welfare matters.
6. Review the process and procedure by which DHHS determines, communicates, and trains providers regarding Medicaid and other changes. Several hundred (measured in excess of 500) rule and regulation changes in the past four years. This writer alone has received three Medicaid rule changes and one proposed rule change e-mails from DHHS since Thursday, September 22, 2011. It is virtually impossible for providers to keep up with the changes and the frequent, sometimes multiple times daily, release of changes appears reactive and poorly planned.
7. Establish an oversight mechanism for rate setting that assures fairness across providers of the various levels of care.
8. Review the contracts DHHS has with its various managed care entities, especially with respect to network development requirements and competencies of providers. DHHS and each entity should be open in disclosure of open and closed provider networks, credentialing procedures, and network needs (e.g., types and volumes of providers and services). DHHS should have primary responsibility for assuring there is adequate network and competent providers for all identified services and treatments.
9. Establish a mechanism for establishing clarity of medical necessity decisions vs. case management decisions. These boundaries appear vague and inconsistent at this time.

In Summary: NPA and its member psychologists stand at the ready to assist DHHS, the legislature, and the Governor in determining the needed changes and evolution of the Child Welfare System. The current lack of partnership and trust is disappointing and in need of prompt attention. Psychologists currently feel disenfranchised and are concerned about actions taken that threaten not only psychologists but the behavioral health system in general. We see significant opportunities for improvement and the need for appropriate, evidence-based, decision making. Psychologists are trained as scientific practitioners and have a wealth of appropriate research to assist in making important decisions. We remain committed to advocating for the needs of the youth and families we serve. We endorse the concept of TEAM: Together Everyone Accomplishes More. We are confident that if we work together effectively, appropriate and cost-effective solutions can be determined for these important issues.

I have attached a copy of the provider training chart for behavioral health providers, the American Psychological Association Policy statement on Evidence-Based Practice in

Psychology (EBPP), an EBPP Checklist for Psychologists, a copy of the Dismantling the System of Care developed by Voices for Children in Nebraska to provide further background of the points and issues raised in this document.

Thank you for consideration of this input. Thank you for the service and leadership you provide through your role as lawmakers in the State of Nebraska. Please feel free to contact NPA if the association or I can be of further assistance to you.

Attachments

Nebraska Health and Human Services Committee's LR 37 Investigation and Hearing

Supplement to the Testimony of the Nebraska Psychological Association
Omaha, Nebraska on September 28, 2011

Testimony by:
Theodore J. DeLaet, Ph.D., Director of Professional Affairs

ELABORATION ON KEY CONCERNS:

1. **Due to decisions already made, the current system of behavioral health delivery is in risk of collapse!** As detailed by such reports from the Nebraska Behavioral Health Coalition, of which I am NPA's representative, and the Nebraska Appleseed Center for Law in the Public Interest, due to changes in utilization practices authorized by DHHS, many behavioral health providers are operating at capacities below levels required to stay in business. As Nebraska has long had a shortage of services and providers, it doesn't make sense for current quality providers to have to close their doors at this critical time. Nebraska is a Federally Designated Shortage Area in 89 of our 93 counties. Compounded by recent rate reductions, there is elevated risk for more services to go out of business. The changes implemented so far also reveal a lack of awareness of the smooth and seamless transition to services or the partnering with providers to alter or develop services to better meet the needs of the youth and families involved in the Child Welfare system. Based on feedback from psychologists in Omaha and across the State of Nebraska, it appears the criteria and interpretation of criteria of who belongs where and what services are needs have changed multiple times without apparent reason. The current criteria appear to be based on methods to "exclude" the youth or family from services, rather than to "include" them. This has contributed to current numbers of an over 50% decline in admissions for residential applications since July 2011. Half-full facilities will not be able to stay in business!

   It has long been a mutual goal between DHHS and providers to have all youth treated in the least restrictive treatment environment and to provide successful treatment and services. It has also been a mutual goal to reduce recidivism or relapse, thereby reducing overall cost to the State. The significant reduction in the levels of care available to providers, youth, and family is alarming and of concern, especially in the absence of valid information of a "case flow" of a family/youth from entry into the system until discharge. As DHHS has implemented many changes,

2. **The current system appears to be targeted toward short-term cost reduction and cost shifting, typical managed care strategies, at the risk of elevated long-term costs and poor outcomes.** NPA advocates that the legislature and DHHS adopt a "case rate" approach to understanding the true costs of the Child Welfare system. Studies of managed care practices nationally over the past 30 years has revealed a tendency for government officials and managed care companies to focus on short-term goals over long-term goals. Examples of this include cost cutting for purposes of re-election and/or cost-cutting for purposes of gaining bonuses for managed care executives and profit for the managed care companies. There may be short-term cost savings but these are not sustained over time and typically result in elevated total case cost. If a family comes into

the Child Welfare system, the goal should not be to determine whether they can be discharged within a specific period of time or for a limited cost. The goal, as previously documented by DHHS is the "Right service at the right time in the right amount". NPA would offer that goal should be amended to add "by the right provider".

Personal experiences of this writer and other psychologists about the use of psychological testing and other general assessment strategies appear focused on cost reduction and not on evidence-based research regarding appropriate diagnosis, treatment planning, or level of care determination. As demonstrated in the groundbreaking research about 20 years ago by psychologist Marsha Linehan, Ph.D. regarding the treatment effectiveness of Dialectical Behavior Therapy (DBT), she was able to demonstrate simultaneous success in clinical, customer satisfaction, and case cost reduction outcomes. High likelihood diagnostic groups such as youth with Attention Deficit Hyperactivity Disorder (ADHD) and Bipolar Disorder (e.g., Manic-Depressive Disorder) have documented missed diagnostic rates of 50% or higher. The use of evidence-based assessment protocols that include psychological assessment designed to improve the diagnostic accuracy for these disorders have been eliminated and/or denied and are not part of the current strategy or plan in the implemented Child Welfare and Medicaid changes. We need to spend money wisely for the appropriate diagnostic and treatment planning services for the purposes of more efficient and successful treatment. In cooperation with effective and appropriate case management services, then DHHS can achieve its stated goals of keeping more children in their homes, reducing the length of time youth and families are involved "in the system(s)", and reducing overall case rates spent to meet the family's needs.

The cost shifting to Child Welfare funds and State Dollars by recent changes in DHHS policy from Medicaid dollars is not going to save either case rate or even on an annual basis. Youth with Developmental Disabilities have also been impacted by these changes with eligibility determination, service access, and funding all being adversely impacted by the implemented changes.

Further evidence of the problems with the current system and risk of collapse of the current system of care is found in the September 2011 Nebraska Supreme Court opinion that strengthens the juvenile court's authority to enforce orders that the court determines are in the children's best interests. This case arose over the lack of consensus over how to best meet the needs of children and families.

3. **The role of psychologists and the services they provide to Child Welfare recipients has been reduced. Reimbursement for psychological services has also been lowered in a disproportionate share relative to other behavioral health services.** Psychologists and psychiatrists comprise the two categories of doctoral level behavioral health providers in Nebraska. There is a statewide shortage of each profession across the State. The role of psychologists in the emerging Child Welfare system is being reduced. As primary evidence of this reduction is the elimination of the capacity of psychologists to make medical necessity decisions for the new PRTF and the requirement that only a psychiatrist can make such a determination. Psychologists have been able to make such determinations since the implementation of Medicaid managed care in 1995. To date, the

quality of clinical judgment exercised by psychologists has not been a problem and the change to remove them is unnecessary and contributes to delays in accessing service due to creating extra administrative steps and delays in accessing a psychiatrist. This is a problem in both urban and rural areas. DHHS has repeatedly stated that federal guidelines are triggering some of these changes. Proof of such guidelines and the interpretation of them has not been offered by DHHS to date.

Attached is chart demonstrating training differences for the various behavioral health professionals licensed by DHHS. As many of the Child Welfare, Medicaid, Developmental Disabilities, and Office of Juvenile Services cases are complex with multiple co-occurring disorders and issues, the appropriate and evidence-based use of diagnostic, treatment planning, and treatment delivery. Psychologists have significant training in diagnosis (to include the use of psychological testing), treatment planning, and effective treatments over non-doctoral providers. As a 25 year part-time faculty member in the University of Nebraska at Omaha's Counseling Program, I can attest to the training and competency differences. While all licensed behavioral health providers have value and are sorely needed, not all provider categories have the same skills set. This writer has been instructed by the Medicaid office that Licensed Mental Health Practitioners (masters level providers) should complete a pre-treatment assessment to determine if psychological assessment or other psychological services are needed. This is not a cost effective or appropriate use of services. LMHPs do not have sufficient training in the scope of or use of psychological testing to determine the potential benefits of psychological testing on any particular case. Let me be clear that NPA is lobbying for psychological testing of all or even most of Child Welfare recipients.

Research is clear that psychological testing has advantages and a role in the emerging Child Welfare system for the following reasons:

- The use of a psychological test battery provides an empirically based set of data that allows for **more precise measurement of individual characteristics** than is usually obtained from interviews alone.
- The use of multiple tests that comprise a test battery **allows for cross checking of hypotheses.** This increases diagnostic and treatment planning accuracy.
- The evaluator is able to gather a wide range of information to facilitate an understanding of the youth, the parent(s), and the family system and to provide a comparison against a group of peers
- Use of a psychological test battery is the **generation of data from a large number of personality, cognitive, emotional, or other dimensions simultaneously.**
- Test batteries tend to be **inclusive and cover a range of functioning domains, many of which may have been overlooked during less formal evaluation procedures.**
- Psychological testing provides for **standardized administration and scoring procedures.**

- Standardization may also reduce legal and ethical problems because it **minimizes the prospects that unintended bias** may adversely affect the client and/or the evaluator's interpretation of the client's responses.

In addition to clinical uses of psychological testing, there are also valuable and reliable forensic risk assessments for such matters as child protection, adolescent sex offender risk, parenting risk, etc. These types of assessments require specialized training and are of significant use for case managers, probation, and the juvenile courts.

While the DHHS announced reductions in provider payments implemented July 1, 2011 were 2.5%, the actual reductions to the most frequently used psychological services codes was 5.8%, more than double the announced changes. This include the use of CPT codes 90801, 90846, and 96101. There is no logical reason for a disproportionate reduction in reimbursement to some providers or services over others, therefore casting trust and oversight doubt on DHHS.

In summary, Nebraska psychologists have specialized training of value to the youth and families involved in the Child Welfare system in addition to DHHS and the juvenile courts. Reducing our role and scope of services at this critical time is not evidence-based and is not cost-effective. The role of psychologists in the emerging health delivery system can be demonstrated to be cost-effective and having significant value, not an expensive and/or unnecessary service.

— Supervised behavioral health clinical training, graduate level, included in blue color years.

PROVIDER TRAINING IN BEHAVIORAL HEALTH

Undergraduate - Number of Years					
Discipline	**Psychologist**	**Psychiatrist**	**Licensed Mental Health Practitioner (LMHP)**	**Licensed Alcohol and Drug Counselor (LADC)**	**Gambling Counselor**
Year 1	4 year Undergraduate Bachelor's (BA/BS)	4 year Undergraduate Bachelor's (BA/BS)	4 year Undergraduate Bachelor's (BA/BS)	270 hrs. substance abuse relevant courses	255 hrs. gambling relevant courses
Year 2				300 hrs supervised training in "12 core functions"	300 hrs. training in core functions
Year 3				3,000 to 6,000 hrs paid supervised experience	3,000 hrs. paid supervised experience
Year 4					

Graduate - Number of Years				
Discipline	**Psychologist**	**Psychiatrist**	**LMHP**	**LADC/Gambling**
Year 1	Scientific & Clinical Coursework	General Medical Science Courses	Graduate Program	
Year 2	Research Coursework Clinical Practicum	General Medical Science Courses	Graduate Program **Master's Degree**	
Year 3	**Master's Degree** Clinical Practicum Coursework	Clerkships	Supervised clinical experience	
Year 4	Advanced Scientific & Clinical Courses & Practicum/Research	Electives **M.D. Awarded**	Supervised clinical experience **LIMHP**	
Year 5	Specialized Courses Research Clinical Practicum	Psychiatric Residency		
Year 6	Internship	Psychiatric Residency		
Year 7	Completion of Dissertation and Supervised Clinical Experience	Psychiatric Residency		
Year 8	**Doctoral Degree Awarded** One year Post-Doctoral Supervised Clinical Experience	Psychiatric Residency **Board Eligible**		

American Psychological Association Statement

Policy Statement on Evidence-Based Practice in Psychology[1]

The following statement was approved as policy of the American Psychological Association (APA) by the APA Council of Representatives during its August, 2005 meeting.

Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.[2] This definition of EBPP closely parallels the definition of evidence-based practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values." The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.

Best Research Evidence

Best research evidence refers to scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields. A sizeable body of evidence drawn from a variety of research designs and methodologies attests to the effectiveness of psychological practices. Generally, evidence derived from clinically relevant research on psychological practices should be based on systematic reviews, reasonable effect sizes, statistical and clinical significance, and a body of supporting evidence. The validity of conclusions from research on interventions is based on a general progression from clinical observation through systematic reviews of randomized clinical trials, while also recognizing gaps and limitations in the existing literature and its applicability to the specific case at hand (APA, 2002). Health policy and practice are also informed by research using a variety of methods in such areas as public health, epidemiology, human development, social relations, and neuroscience.

Researchers and practitioners should join together to ensure that the research available on psychological practice is both clinically relevant and internally valid. It is important not to assume that interventions that have not yet been studied in controlled trials are ineffective. However, widely used psychological practices as well as innovations

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[1] An expanded discussion of the issues raised in this policy statement including the rationale and references supporting it may be found in the Report of the Presidential Task Force on Evidence-Based Practice available online at http://www.apa.org/practice/ebpreport.pdf.

[2] To be consistent with discussions of evidence-based practice in other areas of health care, we use the term *patient* to refer to the child, adolescent, adult, older adult, couple, family, group, organization, community, or other populations receiving psychological services. However, we recognize that in many situations there are important and valid reasons for using such terms as *client, consumer* or *person* in place of *patient* to describe the recipients of services.

developed in the field or laboratory should be rigorously evaluated and barriers to conducting this research should be identified and addressed.

Clinical Expertise

Psychologists' clinical expertise encompasses a number of competencies that promote positive therapeutic outcomes. These competencies include a) conducting assessments and developing diagnostic judgments, systematic case formulations, and treatment plans; b) making clinical decisions, implementing treatments, and monitoring patient progress; c) possessing and using interpersonal expertise, including the formation of therapeutic alliances; d) continuing to self-reflect and acquire professional skills; e) evaluating and using research evidence in both basic and applied psychological science; f) understanding the influence of individual, cultural, and contextual differences on treatment; g) seeking available resources (e.g., consultation, adjunctive or alternative services) as needed; and h) having a cogent rationale for clinical strategies. Expertise develops from clinical and scientific training, theoretical understanding, experience, self-reflection, knowledge of current research, and continuing education and training.

Clinical expertise is used to integrate the best research evidence with clinical data (e.g., information about the patient obtained over the course of treatment) in the context of the patient's characteristics and preferences to deliver services that have a high probability of achieving the goals of treatment. Integral to clinical expertise is an awareness of the limits of one's knowledge and skills and attention to the heuristics and biases—both cognitive and affective—that can affect clinical judgment. Moreover, psychologists understand how their own characteristics, values, and context interact with those of the patient.

Patients' Characteristics, Values, and Context

Psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences. Many patient characteristics, such as functional status, readiness to change, and level of social support, are known to be related to therapeutic outcomes. Other important patient characteristics to consider in forming and maintaining a treatment relationship and in implementing specific interventions include a) variations in presenting problems or disorders, etiology, concurrent symptoms or syndromes, and behavior; b) chronological age, developmental status, developmental history, and life stage; c) sociocultural and familial factors (e.g., gender, gender identity, ethnicity, race, social class, religion, disability status, family structure, and sexual orientation); d) environmental context (e.g., institutional racism, health care disparities) and stressors (e.g., unemployment, major life events); and e) personal preferences, values, and preferences related to treatment (e.g., goals, beliefs, worldviews, and treatment expectations). Some effective treatments involve interventions directed toward others in the patient's environment, such as parents, teachers, and caregivers. A central goal of EBPP is to maximize patient choice among effective alternative interventions.

Clinical Implications

Clinical decisions should be made in collaboration with the patient, based on the best clinically relevant evidence, and with consideration for the probable costs, benefits, and available resources and options.[3] It is the treating psychologist who makes the ultimate judgment regarding a particular intervention or treatment plan. The involvement of an active, informed patient is generally crucial to the success of psychological services. Treatment decisions should never be made by untrained persons unfamiliar with the specifics of the case.

The treating psychologist determines the applicability of research conclusions to a particular patient. Individual patients may require decisions and interventions not directly addressed by the available research. The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential to EBPP.

APA encourages the development of health care policies that reflect this view of evidence-based psychological practice.

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[3] For some patients (e.g., children and youth), the referral, choice of therapist and treatment, and decision to end treatment are most often made by others (e.g., parents) rather than by the individual who is the target of treatment. This means that the integration of evidence and practice in such cases is likely to involve information sharing and decision-making in concert with others.

PRACTITIONER RESOURCE

EBPP Checklist for Psychologists

Do you follow these effective practices?

Evidence-based practice in psychology (EBPP) is the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences.

The checklist below is part of the online continuing education (CE) course from the APA Practice Organization (APAPO) entitled, "Evidence-Based Practice in Psychology," available at **Practice Central**. Visit **apapracticecentral.org** to access this and other CE courses from APAPO.

EBPP Effective Practices Checklist

BEST RESEARCH EVIDENCE

Is it based on ...

- Systematic reviews?
- Reasonable effect sizes?
- Statistical and clinical significance?
- A body of supporting evidence?

PATIENT CHARACTERISTICS

Are you responsive to your patients' ...

- Functional status?
- Readiness to change?
- Level of social support?
- Variations in presenting problems or disorders, etiology, concurrent symptoms or syndromes and behavior?
- Chronological age, developmental status, developmental history and life stage?
- Sociocultural and familial factors?
- Environmental context and stressors?
- Personal preferences, values and preferences related to treatment?

CLINICAL EXPERTISE

Do you ...

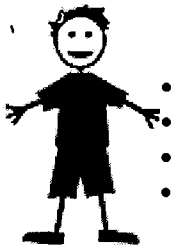
- Conduct assessments to assign diagnoses and develop systematic case formulations and treatment plans?
- Have a rationale for clinical decisions?
- Systematically implement treatment strategies?
- Monitor patient progress?
- Possess and use interpersonal expertise, including the formation of therapeutic alliances?
- Continue to self-reflect and acquire professional skills?
- Evaluate and use research evidence from both basic and applied psychological science?
- Understand the influence of individual, cultural and contextual differences on treatment?
- Seek available resources?

PSYCHOLOGIST'S ACTIONS

Do you ...

- Ask about current and past functioning, risk and safety, presenting concerns, patients' life context?
- Acquire patient information and relevant clinical and research evidence regarding presenting concerns, relevant treatment options and other psychological contributors?
- Appraise your current knowledge and need for new knowledge?
- Apply proposed intervention strategies coordinated with other providers, if appropriate?
- Analyze individual progress and the effectiveness of your services?
- Adjust your approach based on your analysis?

Overarching question: Do you collect outcomes data to determine if you provide high-quality care?



Johnny's Journey

- 12 yr old ward of the state
- From Lincoln, NE and placed in foster care in Omaha
- Has been working with a therapist in the community to address his impulsive control disorder
- Has recently become highly assaultive toward peers and adults and has started making suicidal statements and threatens to hurt others. His therapist begins the Medicaid application process:

Pre-July 1

Post-July 1

Outpatient therapy by community provider: therapist (LMHP/LCSW), psychologist, or independent therapist (LIMHP), advanced practiced nurse (APRN-BC)

Community provider (therapist, psychologist, independent therapist) completes Magellan application for treatment level of care (PRTF)

Receive verbal consent by legal guardian for application to be submitted

Same day guardian approval and supervising practitioner signature if supervisor is in house.

If application is completed by a therapist, need to get signature from supervising practitioner (psychologist, independent therapist or psychiatrist)

Dependant on DHHS case worker availability to respond. **Minimum 24 hrs**

Need signature by legal guardian for application before submitting

Averaging **6 weeks***

Need signature by psychiatrist for Statement of Need on application before it is submitted

Approval or appeal process by Magellan

72 hrs**

72 hrs**

Placement in PRTF

Average time from beginning application to placement: **3 days**

Average time from beginning application to placement: **Over 6 weeks**

*based on parent reports and that 95% of Nebraskan counties have federally designated shortage areas of psychiatrists
**as per Magellan guidelines

Prepared by Voices for Children in Nebraska using information from area behavioral health providers

voices for children IN NEBRASKA

Dismantling the System of Care

System of Care Pre July 1

- Residential Treatment
- Enhanced Treatment Group Home
- Treatment Group Home
- Treatment Foster Care
- Day Treatment
- Intensive Outpatient Services

Youth are able to step down to appropriate levels of care until they are prepared to return to their communities and participate in intensive outpatient care

"Right Treatment at the Right Time" is based on Managed Care Principles.

System of Care Post July 1

- Psychiatric Residential Treatment Facility

OR

- Therapeutic Group Home

OR

- Professional Resource Family Care*

**Can only be placed in a PRFC if youth is returning to an actively participating family*

Under Medicaid's continued stay criteria, it is noted that there is to be a written, up-to-date discharge plan that outlines the aftercare treatment plan where ***discharge to another residential level of care is not an acceptable goal.***

-Draft Medicaid Medical Necessity

voices for children IN NEBRASKA

Prepared by Voices for Children in Nebraska using information from area behavioral health providers

Unpaid Claims

as of: 09/09/2011, 4:37 PM

Agency	Per Agency Amount Owed	Yes	No	Undecided
Albin, Mark D.	$ 500.00	yes		
Apex Foster Care	$ 19,044.00	yes		
Apex Therapy	$ 7,237.17	yes		
Behavioral Health Specialists	$ 61,086.55			undecided
Beneficial Behavioral Health	$ 18,701.25	yes		
Better Living Counseling Service Inc.	$ 72,325.05		no	
Boys Town / Father Flanagan's Boys Home	$ 225,807.75			undecided
Boys Town National Research Hospital	$ 21,956.38			undecided
Bryan LGH Medical Center	$ 13,041.40	yes		
Building Blocks for Community Enrichment	$ 105,754.32	yes		
Catholic Charities	$ 23,853.00			undecided
Cedars Youth Services, Inc.	$ 8,919.00		no	
Central Mediation Center	$ 8,132.00	yes		
Che, Myhanh Interpreter	$ 175.00	yes		
Child Saving Institute	$ 7,590.00	yes		
Children's Square U.S.A / Child Connect	$ 12,558.00	yes		
Children's Hospital & Medical Center	$ 1,278.00	yes		
Christian Heritage Childrens Homes	$ 118,937.50	yes		
Colorado Boys Ranch	$ 16,263.51	yes		
COMMUNITY ACTION PARTNERSHIP OF WESTERN NEBR	$ 46,339.75			undecided
COMPASS	$ 54,422.94	yes		
Cooper Village	$ 32,309.67			undecided
Counseling and Enrichment Center	$ 83.42	yes		
DeLaet, Theodore, PhD.	$ 1,253.00	yes		
Developmental Services of Nebraska	$ 13,384.50			undecided
Encor Medical Support	$ 1,836.00			undecided
Envision of Norfolk, Inc.	$ 44,242.86	yes		
Epworth Village	$ 157,556.12			undecided
FAMILY RESOURCES, INC	$ 7,874.00	yes		
FAMILY SKILL BUILDING SERVICES	$ 507,448.53	yes		
Gingerbread Playschool Inc.	$ 276.00	yes		
Good Life Counseling & Support, LLC	$ 167,681.86		no	
Grace Children's Home	$ 56,640.00		no	
Great Plains Regional Medical Center	$ 626.25	yes		
HANSON, JUANA I	$ 743.00	yes		
Harvest Haven Group Home, LLC	$ 2,592.00	yes		
Heartland Behavioral Health Services	$ 6,375.60	yes		
Heartland Boys Home, LLC	$ 9,027.00	yes		
Heartland Family Service	$ 208,818.51		no	
Home Health Solutions	$ 1,705.70			undecided
Human Services, Inc.	$ 26,053.53			undecided
Indiana Developmental Training Center of Lafayette	$ 27,398.15	yes		
LanguageLinc Interpretation SE	$ 231.50	yes		

Unpaid Claims

as of: 09/09/2011, 4:37 PM

Agency	Per Agency Amount Owed	Yes	No	Undecided
Mark of Honor Youth Lodge	$ 31,665.00		no	
McConaughy Discovery Center / BSM	$ 616,597.75	yes		
MEADOWS BEHAVIORAL HEALTH, INC.	$ 336.00	yes		
Meidlinger, John	$ 4,695.00		no	
Mercy Medical	$ 1,380.00			undecided
Michaelsen, Rick & Betty	$ 1,242.74	yes		
Mid Plains Center	$ 136,198.00	yes		
Midwest Special Services	$ 26,548.97	yes		
Mosaic - Grand Island & Res. Care	$ 25,620.34	yes		
Nebraska Children's Home Society	$ 1,290.00		no	
Nebraska Foster & Adoptive Parent Association	$ 39,718.83	yes		
Norfolk Group Home	$ 133,851.00	yes		
North Star Services	$ 41,767.34	yes		
NORTHEAST NEBRASKA JUVENILE SERVICES INC	$ 12,495.00	yes		
Nova Therapeutic Community	$ 15,525.00	yes		
Oasis Counseling Intl.	$ 24,770.30	yes		
Occupational Health Services / Columbus Community Hospital	$ 108.50		no	
OGALLALA COUNSELING	$ 455.00	yes		
Omni Behavioral Health	$ 63,735.00			undecided
On Call Employee Health (Urgent Care Center)	$ 1,360.00	yes		
OPTIONS IN PSYCHOLOGY, LLC	$ 640.20	yes		
Owens & Associates	$ 2,425.25			undecided
Panda Transportation	$ 872.10	yes		
Panhandle Mental Health Center	$ 51,761.75			undecided
Pathfinder	$ 166,547.89		no	
Prairie Fields Family Medicine	$ 165.00	yes		
Prince of the Road	$ 118,521.64	yes		
R & A Transport, LLC	$ 2,039.82		no	
Richard H Young Hospital / Good Samaritan Hospital	$ 44,162.30	yes		
South Central Behavioral Health Services	$ 280,155.34	yes		
St. Monica's	$ 10,633.72		no	
The Pines Residential Treatment Centers	$ 20,806.94	yes		
Townsend, Jeanna LMHP	$ 581.00		no	
Tuggle, Donald	$ 1,461.60	yes		
Uta Halee Girls Village	$ 4,314.00			undecided
Villezcas, Raquel	$ 220.00	yes		
Wesley Center Inc. Child Care & Crisis Nursery	$ 17,673.00		no	
WICS Residence for Girls	$ 1,224.00		no	
YES House	$ 4,932.00			undecided
		$ 2,535,297.79	$ 750,842.35	$ 740,436.95

My name is Leslie Byers, Family-Professional with Family-Professional Partnership Solutions. Family Professionals are family members who bring their lived experience, in conjunction with systems training, to help families navigate the system and to learn how to develop skills for self-efficiency and sustainability of safety, permanency, and well-being.

As a family member, my husband and I struggled for years to get access to the proper services for our daughter's mental illness which daily threatened the safety and preservation of my family. Ultimately, we succumbed to the only option available - to relinquish custody of our child for the sole purpose of getting proper care. Today our family is whole but we are not without deep emotional scars from having to relinquish custody.

My family's involvement with the system goes from 1996 - 2002 in which my daughter was in out-of-home care on two occasions. I formally began my work as a Family Professional in 2003. Because of my dual experience and roles (one as family member and one as family professional), I would like to parallel my families experience then compared to the system I have witnessed for families today.

In 2002 families had to relinquish custody to get services and, as a result, became involved with the courts.

In the system of today, I would not have to relinquish custody of my child but rather I could access services through a voluntary/non-court involvement. I'm working with one such family today whose circumstances mirrors mine but these parents have access to services in a voluntary/non-court arrangement. Court involvement for non-criminal issues adds an additional burden, bureaucracy, and cost to the system and demeans good-loving caregivers.

In 2002, when a families case closed they were left with no ongoing support. I remember when the judge pounded the gavel to pronounce that we were, once again, our daughter's legal guardian how afraid I was. It was everything I wanted but I was afraid because it meant we no longer had the support and resources to ensure we wouldn't end up right back in the system.

Today, families have 12 months of aftercare to provide that safety net during a very vulnerable time as families come back together again and re-learn their relationships and roles.

These are two examples of care that is occurring within this new structure. Providing more access to services through a voluntary/non-court involvement relieves the burden, and expense, on the system and providing aftercare enables significant prevention measures that, as a family member and family professional, I believe are components of true reform.

Leslie Byers
9/28/2011

September 28, 2011
LR37 Testimony

Dear Senators of the Health and Human Services Committee,

I am not in agreement with the fact that the Lancaster County juvenile court hearing for my infant child was postponed today in order for the prosecuting attorney (Alicia Henderson) to speak at this meeting in Omaha.

Every day that my newborn baby is separated from me is another day when he is not allowed to bond, and I am not allowed to care of him. This delay also makes my case go on even longer, a practice that is most often beyond a parent's control. It is what is used to justify termination of parental rights – which is what DHHS and Alicia Henderson did to my family.

I feel that my case - starting from 2006 - has not yet been truly heard, and that is because my court-appointed attorney, the Department of Health and Human Services and other State of Nebraska officials have neglected competent investigations and due process. It seems no one cares about the truth. These people have also neglected my children - who have been forced into 11 different foster homes during these past five years.

My oldest daughter, Breia, who is now almost 10, has been molested in state care, and **nothing** has been done about it.

My son, Trevon, resides in an institution in York, Nebraska, separated from his sisters, and the state is giving him a drug that is not supposed to be administered to children under the age of 17. He has been taking this medication since he was 8 years old, and he is now 13.

My children were separated from me - their mother - when they were young, and reunification appeared to never be the plan, even though I was compliant with what they asked. Since the termination of parental rights, they have refused to allow visitations between my children and me, even though my case has been in appeal.

I just gave birth to a beautiful baby boy named Elijah a little over a month ago (on August 16th), and he was immediately taken by DHHS directly from the hospital without cause. The only justification making this possible is the prior TPR for my older three – a terrible injustice in its own right. Since he was taken, I have only allowed to see my newborn son a few times each week, even though I am a nursing mother. And KVC has refused to allow visits in my own home, as I've requested, apparently because the county attorney doesn't want it to happen. The county attorney – Alicia Henderson - and DHHS are expected to argue against the need for "reasonable efforts" for reunification with my baby, even though I have never harmed him, because Nebraska statute allows them to do this! This would break my heart. It would make an orphan of my baby, who I love with all my heart.

Please help me bring my family back together. If I was not a caring mother I would not have asked God for the strength to continue to fight for my family.

Sincerely,
Pamela Myles, Loving mother of Trevon, Breia, Raven, and baby Elijah
Lincoln, Nebraska

Hello – My name is Dana Smith. I am a mother of six beautiful children; five which have been taken from me by the Department of Health & Human Services.

I am a loving, dedicated, and nurturing mother who was always been involved with my children's schooling. However, DHHS never sought to learn about our family's strengths or our special bonds. I have always provided all the essentials for my children, including a nice home. My children were never – at any given moment – placed in an imminent harm situation, nor were they ever in harm's way while in my care.

Have you ever overslept, or been late picking up a child from school, or any sort of event? This very mistake is what set in motion my nightmare, and my children's suffering.

In Douglas County during a day in February 2004, my daughter's school called the emergency contact I had listed on the school forms. I was late, and they needed my daughter to be picked up after school. A family member came and brought my daughter home.

Everything was fine until she saw my car in the driveway, but still could not rouse me from sleep by simply knocking. She called the police for a WELL-BEING check.

When the police arrived, I was startled awake by them banging on all the doors. Rushing to answer and still half-asleep, the police presumed I was on drugs. I wasn't, and they never tested me to determine either way.

They took my daughter, Courtney, and informed me that they were going to pick up my two boys, Jaden and Payton, from daycare, assuming that I was late picking them up, too – which was incorrect. The police didn't ask me – they told me – and I felt as though I had no choice but to comply with their decision.

The police took my children to a shelter, and I was given a ticket for neglect – which was soon dismissed. I was never arrested with anything regarding this situation, yet the department completely shut me out from having contact with my children for the next 30 days. The judge said my appearance in court wasn't necessary, and none of what was happening made sense to me.

Only recently did I learn from the director of Heartland Family Services Children Shelter that in all the cases she has seen, children go home when there are no further criminal charges and the home is found to be safe. SO WHY NOT IN MY OWN CASE? All charges had been dropped, and my children and I lived in a beautiful home, with no imminent safety concerns.

Because the department already had three of my children, they also later took two other children from me. My daughter Grace was taken directly from the hospital

after birth, even though toxicology reports showed no drug use. At the time the state took Grace from me, the department's excuse was that they didn't have the results of the testing, yet; however, later it was proven that they did. They had lied.

The system never allowed Grace and me a chance to bond as mother and newborn. Heartbreakingly, I was only provided 2-hour visits, twice each week, with her. All the while, I was trying to jump through unrealistic hoops to meet the seemingly endless demands of the caseworker – many of the requirements addressing issues not even pertaining to my case.

Nothing ever could be done to satisfy the caseworkers.

For fear of the department, I moved to Iowa to have my fifth child – Hanah. She and I were Iowa residents.

We visited Nebraska to see Hanah's siblings (Courtney, Jaden, and Payton), all who were still state wards, and the department then took Hanah from me, as well.

It didn't matter that we were Iowa residents, or that CPS in Iowa had just told me that I was doing a wonderful job with my 5-month-old baby.

Not even one month had passed from the time the department took Hanah, and the state filed "Termination of Rights" papers on me. This meant that Hanah was only in the Nebraska CPS system for one month, but they moved to sever my rights to all five of my children at once. The state just absorbed her, and I was helpless to stop it.

After the TPR was filed, I was offered a ***Sophie's Choice*** bind:

> The Department would give me an additional six-month reunification plan for my older three children (Courtney, Jaden, and Payton), if I would agree to relinquish my rights to my two babies (Grace and Hanah). That seemed like kidnapping, extortion and blackmail to me, and it was an unconscionable proposal.

From one very human mistake of over-sleeping, the system acted upon stereotypes, assumptions and false accusations. My children and I never stood a chance.

Nebraska Department of Health & Human Services was continually putting up roadblocks - intentionally sabotaging our reunification process. I grew weary and distraught. I suffered from trauma and depression caused by this horrible treatment and the sense that there was nothing I could do to get my children back home.

Some of the most troubling aspects of my experience have included:

- Court-ordered family counseling – but that the department never allowed that with my children and me, yet it *was* allowed with the foster family;

- My education rights for my children were still intact, but the department refused to recognize these rights and kept the children's school location a secret from me, as well as their report card, school functions, etc....

- My medical rights for my children were still intact, but I was not notified of counseling sessions, doctor's appointments, or hospitalizations from their deteriorating emotional well being brought on by the traumas of the state's actions;

- I was not allowed to have the phone contact with my children that had been approved;

- I had reported bruising on my children, and it was ignored by the department;

- I was given back the same public defender that I had already fired (isn't that a conflict of interest?)

- My TPR appeal was improperly filed by public defense attorneys;

- And too much more...

More recently, I have learned that of my original three children who were originally taken, two of them have been inpatient hospitalized. My oldest daughter Courtney went to inpatient, so they could work on her medications. While in the hospital, though, I have been told that she was put on a suicide watch for a week. My younger son Payton has been admitted to inpatient on two different occasions due to "behavior issues," with intense outpatient services needed as follow up. All of this was brought on by the children being removed from their home unnecessarily and forced into the system permanently, rather than returned home, as they should have been. These types of emotional issues were never a problem prior to the state traumatizing my children.

The children were told in the beginning "your mommy is sick" as the reason they could not be at home with me. A visitation worker then told me that at a later time the children were informed, "mommy is not sick any more." Try to put yourself in the mindset of these young children. Can you even imagine what must have gone on in their minds through this? These children are our futures. What the system is doing and has already done to my kids is far more negligent than what I was accused of at any time. It is emotionally abusive and a fundamental violation of their rights and mine to be treated in this manner. Our fundamental rights as a parent are supposed to be protected and preserved.

What has happened to DUE PROCESS and our CONSTITUTIONAL RIGHTS as parents, as children, and as citizens?

To think about all of the intrusive and unwarranted evaluations that the department requested over and over again for "updates" – hoping to prove something that wasn't there. Our state foots that bill, as the system perpetuates itself.

Nothing I could have done would have been enough for the caseworkers, and the department consistently failed to fulfill its own obligations.

Continuous court dates that reiterated the same things – always wanting updated materials, evaluations, etc., was just another way for the department to drag its feet until it could claim that parental rights need terminating to prevent children from languishing in a system they should never have been thrust into in the first place.

Children and families are suffering needlessly. We're human beings. We aren't statistics, we aren't "cases," and we aren't criminals.

This system must change. I worry so much for my children. I long for them. I fight for their return every day, even though I don't know where they are, and I don't know if anything can be done.

Please help them to come home.

I eagerly wait for your response to the above matter. Any ideas, comments or other contact information would be grateful.

Dana Smith

Dana M. Smith
~~608 Nuckolls Street~~ P.O. Box 56
Glenwood, IA 51534
majestic.btrfly7@yahoo.com

IN THE SEPARATE JUVENILE COURT FOR DOUGLAS COUNTY, NEBRASKA

IN THE INTEREST OF

SMITH, COURTNEY
SMITH, JADEN
SMITH, PAYTON

Children under Eighteen Years of Age

Doc. 110 No. 167

PETITION

And Second Supp filed 5/9/
Third Supp. Pet filed 5/4/06
And Let Supp. 5/18/04
Supp. Pet. filed 1/27/05
Sup. Pet filed 2/3/05
and Sup. Pet filed 4/14/06

TO THE HONORABLE, THE JUVENILE COURT OF DOUGLAS COUNTY, NEBRASKA

Comes now Scott J. Ricketts, Deputy County Attorney for Douglas County, Nebraska, and shows to the Court that:

COUNT I

COURTNEY SMITH was born February 28, 1996, JADEN SMITH was born September 21, 1998, PAYTON SMITH was born January 17, 2001, and said children are now living or to be found in Douglas County, Nebraska.

COUNT II

COURTNEY SMITH, JADEN SMITH, PAYTON SMITH come within the meaning of Nebraska Revised Statutes, 1943, Section 43-247 (3a), being under the age of eighteen years, and lacking proper parental care by reason of the faults or habits of DANA SMITH, natural mother of said children, in that:

A. On or about February 23, 2004, Dana Smith failed to pick up Courtney Smith from school.

B. On or about February 23, 2004, Dana Smith failed to pick up Jaden Smith and Payton Smith from day care.

C. Dana Smith has failed to provide necessary care and support for said children.

D. Due to the above allegations, said children are at risk for harm.

Exhibit # 40
Date 3-20-07
Pages

Court Reporter
Janice Broussard

FILED
JUVENILE COURT
DOUGLAS COUNTY, NEBRASKA

FEB 24 2004 11

RUDY J. TESAR
CLERK DISTRICT COURT AND
EX-OFFICIO CLERK OF THE
JUVENILE COURT

OMAHA CITY PROSECUTOR
2 WEST - HALL OF JUSTICE
OMAHA, NEBRASKA 68183

July 15, 2008

DANA M SMITH
608 NUCKOLLS ST.
GLENWOOD, IA 5153H

Dear Madam/Sir:

Re: U01584
CHILD ABUSE/NEGLECT

Your appearance is not required for the court date on the 29th day of March, 2004, at 9:00 A.M., as indicated on your citation.

** After due consideration, we have decided to exercise our discretion and to dismiss the above charge(s). Be advised that this action is not a decision on the merits of your case. It does not establish a precedent nor does it give you an exemption from future tickets. This pertains only to the above listed citation/arrest.

Very truly yours,

City Prosecutor's Office

Date: Wednesday, June 6, 2007 11:57 AM

From: croninlaw@cox.net

To: abiola.ayodele@hhss.ne.gov

Cc: john.baker@hhss.ne.gov

Subject: Dana S.

Dear Abbie,

Dana Smith is the primary reason I have been trying to get ahold of you.

First, she has asked repeatedly to know what school the children attend. She understands that she cannot go to the school when the children are present. However, her parental rights are intact, and under Rule 51 as well as HHS policy, she has every right to get the children's school information, talk with their teachers, etc. Therefore, please advise me as to what school the children are attending.

Second, Dana advises me that the oldest child needs surgery on her mouth, some kind of dental surgery. Why? When? Where? Again, the mother has the right to know this information.

Third, VISITATION remains a huge issue:
1. Why must visits take place at the Visitation Center, especially now that the weather is good?
2. Why are make up visits NOT being scheduled, although requested repeatedly?
3. will you please send me a copy of the Visitation Reports for the past 6 months?
4. Why were the babies NOT brought to the visit last Saturday? If, as Dana reports, it's because they didn't want to go with a stranger, that doesn't cut it.
5. Likewise, although the older kids had something else they wanted to do last Saturday, why could the visit not be rescheduled?
6. Why are there no telephone visits? It is possible to block the senders phone number. Have you even discussed this with the foster parent? (obviously, this quesiton only relates to the older children)

For several months, Dana has been asking that visits be increased, yet the Department or Visinet or the foster parents continue to throw up road blocks. Yes, I KNOW there were "problems in the past", but this sabotaging has been going on since I was assigned to this case.

I understand that the kids are in Lincoln and that adding an extra visit would increase their travel time. Why not arrange for a Lincoln visit by a Lincoln visitation agency that could take place at a neutral location? Transportation could be provided for Dana through Prince of the Road so that she would be the one doing the traveling. Is this an option, and if not, why not?

Dana remains employed and involved with Community Alliance. She is taking her medication faithfully. She has obtained a chemical dependency evaluation and a psychiatric evaluation. She is living with a friend in Council Bluffs and her mail may be sent there: 1116 N. Broadway, Council Bluffs, IA 51501.

I also have a problem with the "double confirmation". Is it true that if the mother confirms 24 hours ahead of time and then confirms the morning of the visit, but is a few minutes late, Visinet will NOT allow the visit to take place? How many consistent visits would have needed to occur before this requirement of double confirmation was dropped.

I would also like to know how many visits have been attended and how many have been missed in the past 6 months. If visits were missed, I want to know who missed them and why. I would appreciate it if you would get that information to me within a week.

In addition, I would especially appreciate copies of the reports (probably older than six months) where Dana allegedly got into the visitation worker's car and refused to leave.

Finally, are the kids in therapy? When you met with the oldest daughter about possible reunification, what exactly did you ask her? What was her response? Did you talk with the boys? Tim Watts is supposed to be talking with them as well. This is critical at this time, and if the Department is sabotaging visitation, it will be very relevant. The question is whether the mother would relinquish her parental rights to the babies in exchange for having a solid 6 month reunification plan for the older children. She has maintained stability and has been compliant with the Court's plan, but in the time I've been on the case, it seems that numerous roadblocks are being thrown up. On the other hand, I realize that I'm viewing this only from the mother's perspective. Do you have any therapy reports addressing the bond or permanency issue?

I know that this is a lot, but this is a serious case. I look forward to hearing from you. PLEASE ADVISE ME AS TO WHETHER THE DEPARTMENT WILL VOLUNTARILY SUBMIT THE REQUESTED REPORTS TO ME. Thanks, Abbie.

Carol Pinard-Cronin
Attorney at Law
300 S. 19th St. Suite 202
Omaha, NE 68102
(402) 341-9929
(402) 341-4045 (fax)
(402) 515-5528 (cell)

Department of Health & Human Services

DHHS

NEBRASKA

Division of Children and Family Services

State of Nebraska
Dave Heineman, Governor

October 26, 2010

Dana M Smith
608 Nuckolls St
Glenwood, IA 51534-1836

Dear Ms.Smith:

You are currently court ordered to provide health insurance coverage to the following dependent(s):

COURTNEY	R	SMITH		02/28/1996
JADEN	C	SMITH		09/21/1998
PAYTON	A	SMITH		01/17/2001

Our records indicate that you may not be currently providing health insurance coverage for these dependent(s) as per **court order #1041722.** If this is correct, please contact your employer to enroll these dependent(s) in your employer offered health insurance plan by **November 9, 2010**.
When the child(ren) are enrolled in the health insurance plan, please work with your employer to complete the proof of compliance form located on the back of this letter and return it to your child support caseworker.

If you are currently providing health care coverage for your child(ren), please complete and return the proof of compliance. This will insure that our records regarding your child support obligation are correct.

When the above requested information is received, your caseworker will update your child support case information to reflect that you have enrolled the child(ren) as per your court ordered obligation.

If you have any questions, please contact the Nebraska Child Support Customer Service Call Center at 1-877-631-9973.

JANINE F. UCCHINO

ATTORNEY AT LAW
2712 South 87th Ave.
OMAHA, NE 68124
PHONE: (402) 934-8406
FAX: (402) 614-5548
janine@jucchino.omhcoxmail.com

January 28, 2008

Mr. Timothy Watts
319 So. 17th Street
#236
Omaha, NE 68102

Ms. April Carlson
NDHHS
1313 Farnam Street
Omaha, NE 68102

RE: In the Interest of Smith/Preston

Dear Mr. Watts and Ms. Carlson,

I have recently met with Dana Smith and her attorney, Carol Pinard-Cronin, and have several concerns arising from that meeting. First, Ms. Smith has been advised that she is not to talk with her children about the court proceeding. It has come to Ms. Smith's attention, through what her children have told her during their visits, that the foster mother of the older three children is telling the children that she will be adopting them. Additionally, it has come to Ms. Smith's attention that her older daughter is also using the last name of the foster family instead of her given name of Courtney Smith. As you are both aware, the termination of Ms. Smith's parental rights is currently on appeal to the Nebraska Court of Appeals. It would seem inappropriate to tell the minor children that they will be adopted by the current foster parent as adoption is certainly not a foregone conclusion in view of the appeal. Additionally, if Ms. Smith is not permitted to discuss the current court proceedings with her children it would seem appropriate to extend the same limitation to the current foster parent.

Secondly, it has also come to Ms. Smith's attention that the older children are also being told that they do not have to listen to Ms. Smith during their visits. The source of this is unknown, however, while visiting with her children, Ms. Smith is clearly able to redirect her children and they should be encouraged to comply with her redirection.

Thirdly, Ms. Smith is requesting the family counseling be provided. It would seem appropriate for Ms. Smith and the children be permitted to have therapeutic support during this difficult and uncertain time.

I would be glad to speak with you regarding Ms. Smith's concerns. Please feel free to contact

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ISSUANCE AND COLLECTION CENTER
PO BOX 80696
LINCOLN, NE 68501-0696

ICC NUMBER - (402)471-6363
TOLL FREE - 1-877-232-0242

Mail Date - 05-03-2011

SMITH, DANA
608 NUCKOOLS ST
GLENWOOD IA 51534-1836

MONTHLY BILLING STATEMENT

ACCOUNT DETAIL

Account Number
87937781

Created
07-23-2004

Billing Date
05-02-2011

Program
Child Care

ACCOUNT SUMMARY

Total Payments from Previous Month	Account Balance	Amount Due
$0.00	$863.62	**$863.62**

NOTE: If this debt is not paid, it may be assigned to a collection agency for collection or legal action may be pursued in a court of law. Also, delinquent debts may be reported to national credit reporting agencies that furnish credit reports on individuals.

Keep this portion for your records.

Detach and include this portion with payment sent to:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ISSUANCE AND COLLECTION CENTER
PO BOX 80696
LINCOLN, NE 68501-0696

Name	Program	Account
SMITH, DANA	CC	87937781
Billing Date 05-02-2011	**Amount Due**	$863.62
	Amount Paid	$

* Make check payable to Department of Health and Human Services
* Include the Account Number on the face of the check

My name is Pauline Williams. I was a Review Specialist for the State Foster Care Review Board for 16+ years and have been the Supervisor for the past two years. I supervise the Eastern area of the state of Nebraska, which includes Douglas and Sarpy County. This includes seven full time review specialists who manage 21 volunteer board meetings monthly. They review approximately 180 children in this area per month.

The Foster Care Review Board reviews and makes recommendations and findings of children who have been placed in out of home care. I would like to provide the committee with information that the FCRB has received through our reviews, GAL/attorneys, providers and foster parents.

I would first like to start with the numbers from the map. In August there were 1,873 children in out-of-home placement in Douglas and Sarpy Counties – 662 of these children have been in care at least once before, 1,044 have had four or more DHHS workers while in out-of-home care, and 864 of the children have been in four or more placements while in out-of-home care.

Top 3 Issues Experienced:

1. Lack Of Stability of Case Management:
   a) There were originally 3 systems of care: NFC, KVC, and Visinet. Each had different roles, definitions, titles, and administrative structures. Service Coordinators (case managers) lacked knowledge of job responsibilities, familiarity with the child welfare and legal system, and were not provided adequate time to assume case responsibilities due to the speed at which cases transferred to the 3 lead agencies. Information regarding the Roles and Responsibilities of DHHS and the Lead Agencies was not disseminated to legal and non-legal parties. During the review of cases and in conversations with case professionals, the confusion regarding who to call or was in charge was apparent. This resulted in delays in resolving issues and/or obtaining services.

   b) This resulted in a high turnover of agency workers who were not prepared to deal with the stress and increased responsibilities of case management. Any change in case management affects a family, the provision of services, and permanency. It also resulted in the loss of history of a case and knowledge regarding progress or the lack thereof. Nationally recognized researchers have found that caseworker stability increases children's well-being and decreases costs. . .[1]

   c) Many experienced case managers within the DHHS system have resigned due to the uncertainty of future employment stability. This has resulted in high case loads for remaining workers who took over the Visinet case load. The change in case

[1] Literature Review of Placement Stability in Child Welfare, University of California, Davis, Center for Human Services, August 2008.

management is also an additional change for the family, often resulting in the loss of case knowledge and delaying permanency.

d) DHHS and Lead Agency workers who resign do not always have the opportunity or time to update the case file in regard to issues and/or corrective action being taken on a case prior to departure from the agency. The file review process for Review Specialists from the Foster Care Review Board has become more difficult due to the lack of documentation located in the file at the time of review. This is being addressed via the development of a File Content Check-list. Documentation is collected and reported back to the agencies on a monthly basis. The amount of documentation in the case file has improved.

2. Placement Issues:
   a) Loss of placements for children at all levels of care. This would include shelter care, foster home, group homes, treatment group home, etc. There are many sibling groups placed in out-of-home care in Douglas County. It is less likely that siblings will be placed together in foster care as fewer homes are available.

      The number of licensed foster homes has decreased due to payment issues, being required to transport children to visits and services at a time when gas is high, and the extra demands this places on their personal families. Per HHS statistics, there were **793** licensed foster homes in Douglas County in November 2009. As of January 2011, there were **628**. In November 2009 there were **148** licensed foster homes in Sarpy County. As of January 2011 there were **126**. It is unclear if the foster homes whose licenses remain current, but are not longer accepting children into their homes, are included in this number. It has become difficult to maintain children in their communities.

   b) Lack of direct oversight of placements. Previously a Resource Development Unit of DHHS existed. Their job was to locate placements for children, as well as monitor the number and mixture of children in the home. NDHHS remains the licensing agency for the State. However, they no longer locate placements for youth assigned to KVC or NFC. Currently NFC, KVC, and HHS may all be subcontracting to the same foster home. It is unclear if information regarding the behaviors and background of other children in the home are being reported to Lead Agencies/HHS at the time of placement.

   c) Delays in updating records and reporting placements. Children removed from a placement may be placed in several foster homes prior to being placed in a permanent foster placement. The interim placements are often listed as "respite care", even though the intent is not to return the children to the initial foster home. The "respite homes" are not counted as placement changes for the child and no placement change

reports are issued to the FCRB's independent tracking system. Thus the number of changes a child experiences is minimized.

3. Legal Issues
   a) State wards are placed in the care and custody of DHHS by the Court. Per the current contracts, DHHS is not required to have contact with the child, placement, or parents. Yet they may be required to make determinations regarding Safety/Risk in the absence of direct information.

   b) Court continuances reported by Judges, Attorneys, and FCRB staff due to reports not presented in a timely manner, parties not showing at hearings, etc. This delays permanency for a child, especially for a Court system that is already overwhelmed.

   c) Increased number of Evidentiary Hearings regarding Lack of Reasonable Efforts. Additional hearings are held for the Court to determine if services – that are accessible to the family – are being provided in a timely manner. Permanency is delayed until a hearing is held and ruling received.

4. Lack of infrastructure of available services and treatment providers to include, but not limited to, family support workers, visitation specialist, and chemical dependency treatment programs. Although a family may be ready for increased visitation, a worker to supervise that contact may not be available. Waitlists for chemical dependency treatment could be 3 -4 months.

Recommendations for child welfare in the future:

PREVENTION:

- There needs to be a statewide network of proven prevention services in place, such as visiting home nurses, that are readily accessible to the public.
- Wrap around services and access to other in-home or day services is also necessary.

OVERSIGHT:

- Fiscal Oversight and in the Provision of Services. DHHS, as custodian of the child, should be aware of concerns before they become safety problems. NDHHS needs to strengthen their oversight of contract providers and increase communication.
- Rebuild placement infrastructures including foster homes, placements for older youth, as well as placements for youth entering Independent Living. Help ensure that youth aging out of the system have a support system in place and are prepared to live independently. Provide support for staff retention.

- Case managers/CFS Specialists have manageable case loads so that they can oversee services and placement for children and families. Caseloads should not exceed 12 families, and preferably be in the range of 8-10 families, as this can still mean responsibility for up to 40 children. Workers need time to authorize and arrange services, to visit with children and families, to keep vital documentation, and to effectively attend court hearings regarding these families.

HHS Office	# in out of home care	# w/ 4 or more placements	# w/ 4 or more DHHS workers
Douglas/Sarpy	1,873	864 (46%)	1,044 (56%)
Statewide	4,230	1,940 (46%)	2,025 (48%)

*These statistics are as of 9/26/11

Commendations:

* The FCRB and ESA have a great working relationship. Vicki Maca, Ronda Newman, and Camas Diaz from DHHS are responsive to the Board. Regular scheduled meetings are occurring. They respond to calls and emails promptly.

* Regular meetings between the FCRB, Sandra Gasca-Gonzalez, President of KVC, and Dave Newell and Treva Haugaard of NFC are occurring in order to gain a better understanding of how the individual agencies function as well as to address systemic issues and concerns as they arise.

* In Juvenile Court, pre-hearing conferences are occurring, pre-treatment assessments are arranged at initial court hearings, and mediation is utilized on a regular basis thus decreasing the time children may need to remain in out-of-home care.

* Recently, NFC has mandated that their FPS attend Foster Care Review Board meetings in order to ensure that the board has the most updated information available to them and to discuss any issues regarding the case.

Thank you for taking the time to hold a hearing regarding the child welfare system. I appreciate being given the opportunity to be heard regarding child welfare issues we face in the eastern service area.

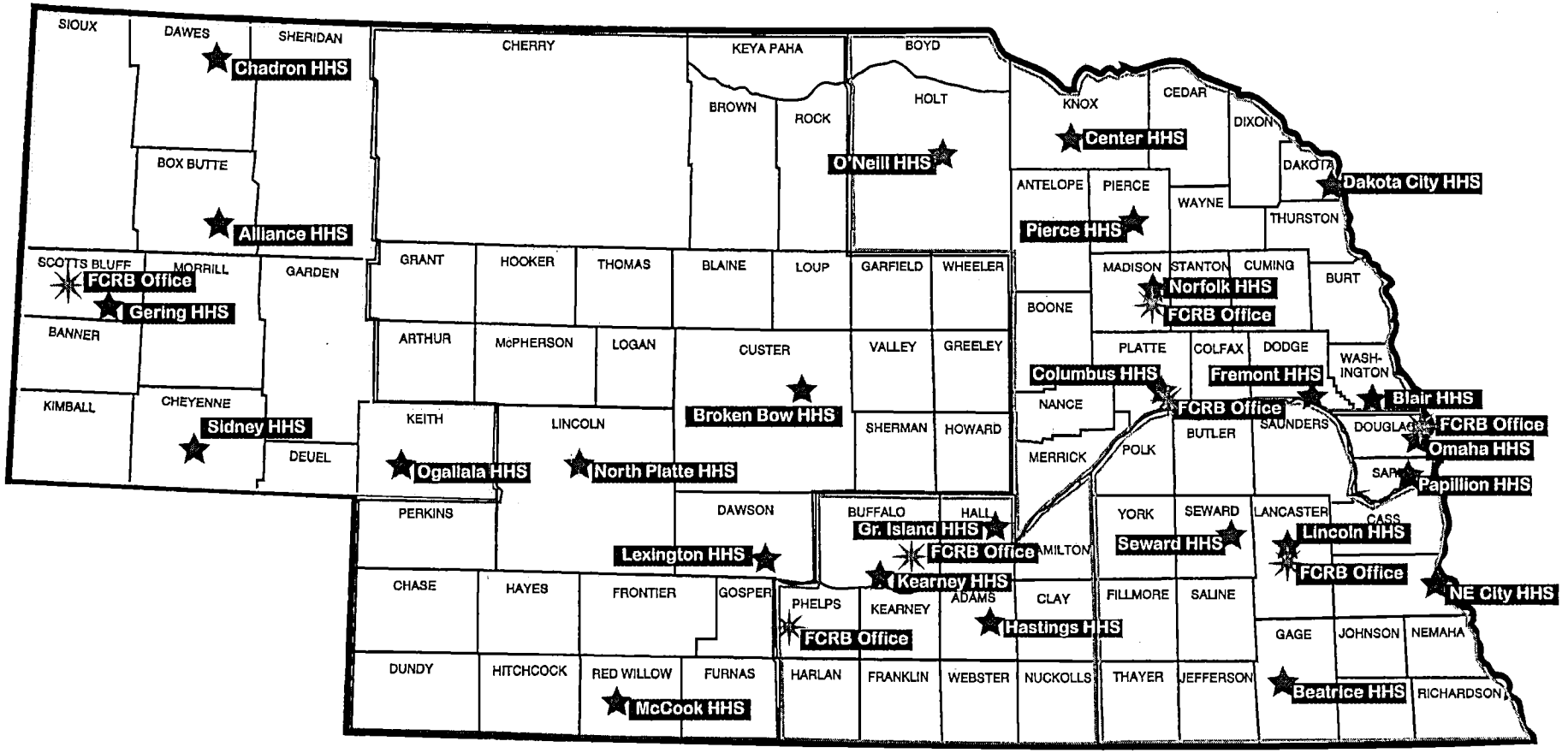
OMAHA/SARPY:

1,873 Total Children

662 Children in Care More Than One Time

1,044 Children have had 4 or More DHHS Workers

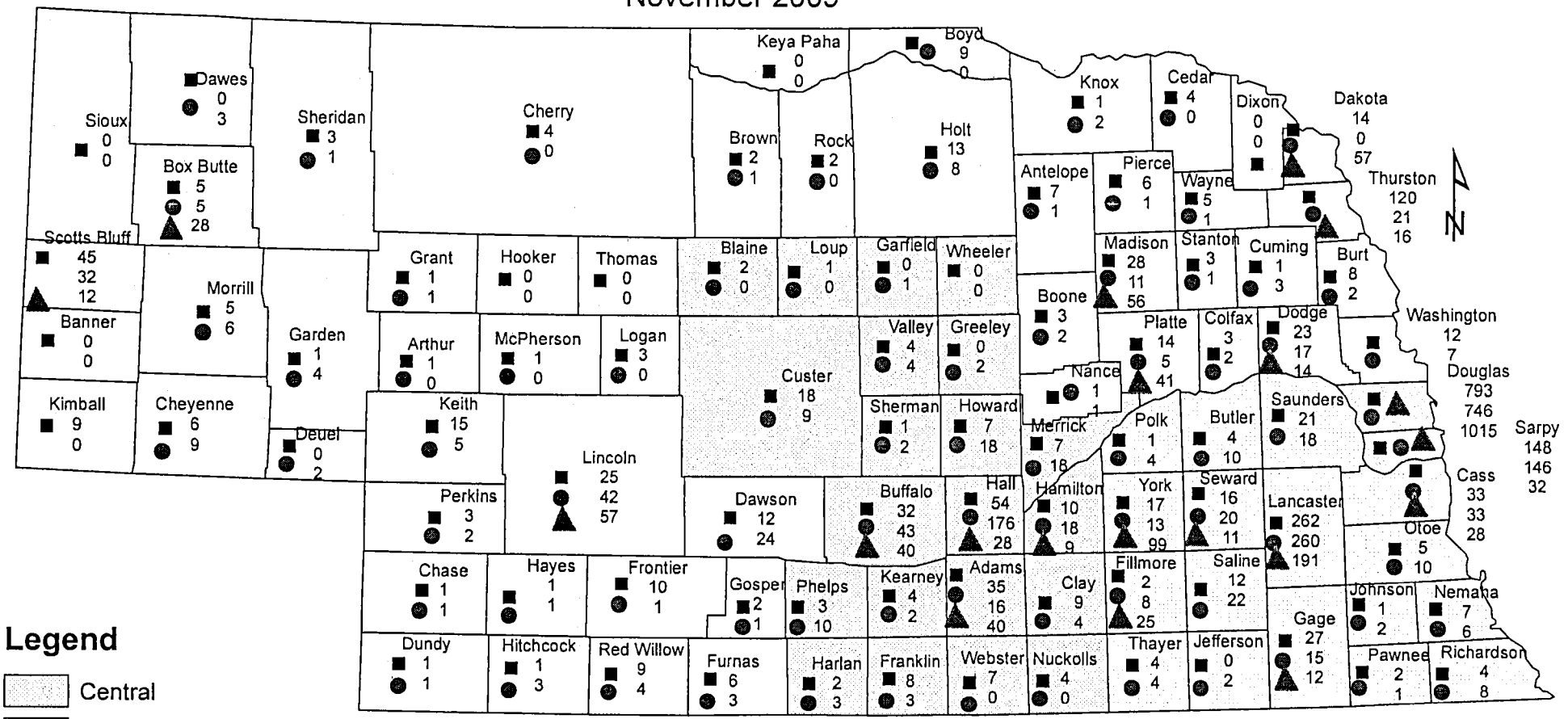
864 Children have had 4 or More Placements



FCRB Tracking System 9/26/11

Licensed Foster Homes, Approved Foster Homes, and Treatment and Non-Treatment Beds by: Service Area

November 2009



Legend

- Central
- Eastern
- Northern
- Southeast
- Western
- ■ Licensed Foster Homes
- Approved Foster Homes
- ▲ Child Caring Beds (Treatment and Non-Treatment)

Note: The average number of beds per license/approved foster homes is 3

	Total	Bed Capacity
Licensed*	2025	6075*
Approved*	1895	5685*
Child Caring	62	1811
Total	3982	13571
Children in Out-of-Home	4373	

Department of Health & Human Services

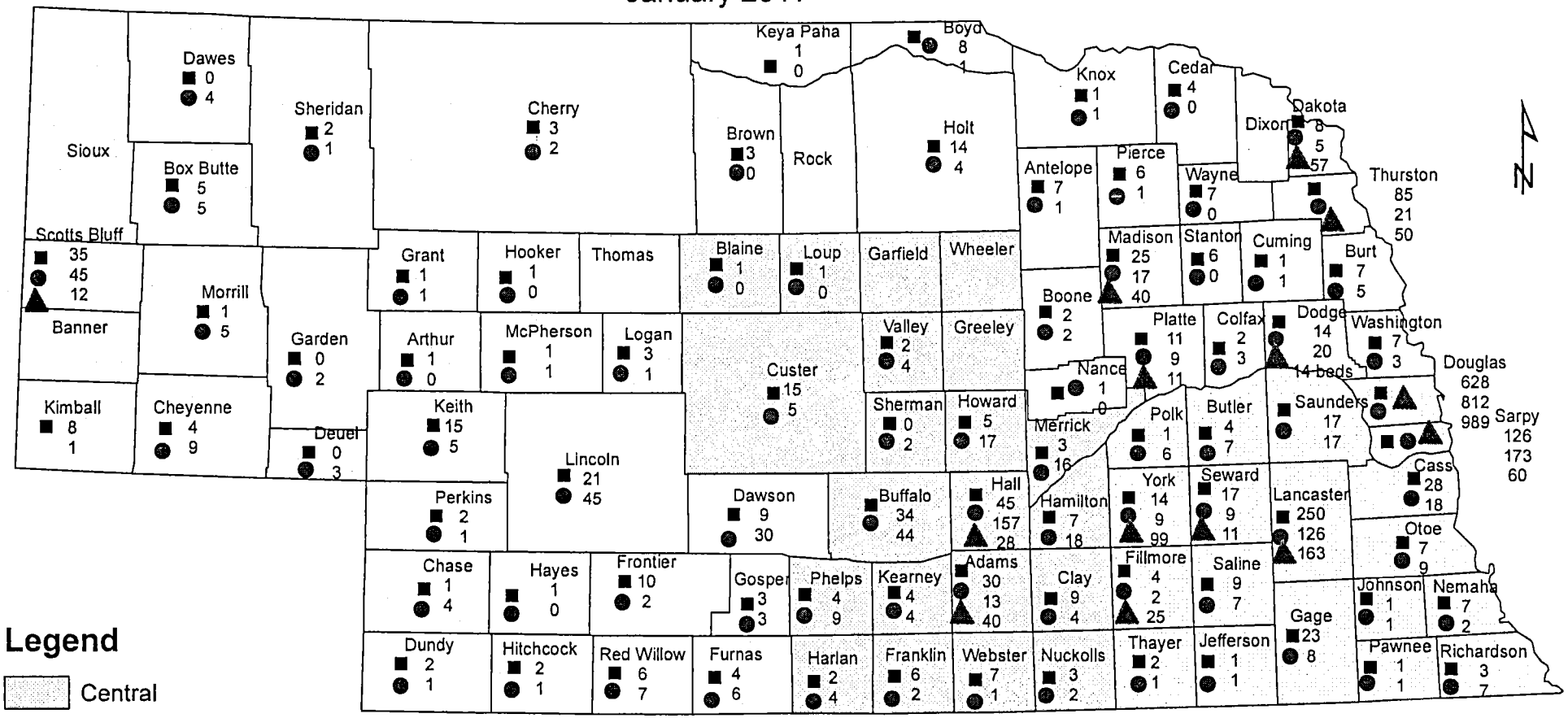
DHHS

NEBRASKA

Geographic Information Systems

Licensed Foster Homes, Approved Foster Homes, and Treatment and Non-Treatment Beds by: Service Area

January 2011



Legend

- Central
- Eastern
- Northern
- Southeast
- Western
- ■ Licensed Foster Homes
- Approved Foster Homes
- ▲ Child Caring Beds (Treatment and Non-Treatment)

	Total	Bed Capacity
Licensed*	1690	5070*
Approved*	1892	5676*
Child Caring	53	1599
Total	3635	12345
Children in Out-of-Home	4118	

Note: The average number of beds per license/approved foster homes is 3

Department of Health & Human Services
DHHS
NEBRASKA
Geographic Information Systems

LR 37 – Exhibit 21
9-28-11

Written Testimony presented to
Health and Human Services Committee
Wednesday, September 28, 2011
By Judy M. Domina, Executive Director Nebraska Family Support Network

Nebraska Family Support Network is a family organization, created by families, staffed by families, working for families. Started in 1991 Nebraska Family Support Network has provided peer mentoring for families for twenty years.

N braska Family Support Network is a provider of peer mentoring for the Lead Agencies. Referrals for peer mentoring services come directly from the Family Permanency Specialist (FPS). The family may request the service or the FPS may recommend the service to the family. The Family Partner uses these guiding principles: engage, encourage, empower, eliminate and evaluate with the families they mentor. Peer mentoring is unique to the service array. Family Partners have experienced the "system". They work as a partner with the family.

Since the full implementation of child welfare / juvenile services reform April 1, 2010 there has been a decline in referrals for peer mentoring services.

Agency	April, 2010	September, 2011	Decrease
KVC	31	3	28
NFC	110	21	89
Visinet / DHHS	12	12	0
TOTAL	153	36	117

Possible reasons for decline:

1. One referral source verses three.
2. ICCU was educated and trained in the value of family voice and peer mentoring.
3. Staff turnover due to constant turmoil within the child welfare / juvenile services.
4. Considered as duplication of services of family support service due to lack of knowledge of peer mentoring verses family support.
5. Lack of direction from DHHS regarding Family Centered Practice.

Nebraska Family Support Network is being underutilized which is having a negative impact on families.

Family Partners Guiding Principles:
ENGAGE, EVALUATE, ELIMINATE, EMPOWER and ENCOURAGE

ENGAGE

Success for the family cannot happen without engagement. NFSN Family Partner uses their professional expertise and life experiences to connect with the family. Family Partners' life experiences enhance their ability to engage and maintain connection through the lengthy process.

Initial Referral:

- The assigned family partner will make an initial contact with the family within 24 – 48 hours of receiving the referral.

EVALUATE: Family Partner assist the family in evaluating the families' strengths, needs and strategies to obtain the families goals and goals outlined by the Family Permanency Specialist upon referral..

Initial Family Plan:

- Family Plan shall be made within 10 – 14 days of referral. Family goals and objectives are to be defined, in support with the family partner, by the family. Family member/s sign-off on the goals and objectives. All activity, and reporting of such activity, with the family must correlate back to the goals and objectives.

ELIMINATE: Family Partners maintain regular contact with both the family and FPS eliminating miscommunication, role modeling appropriate communication, acting as a liason between the family and FPS. Opening communication enhancing knowledge eliminates the family's fear of the unknown, the "system ".

Weekly Expectations:

- Communicate with the family weekly.
- Contact FPS by phone or email bi-weekly.

Monthly Expectations:

- Family Partner will have a minimum one face to face with the family.
- Each family partner will attend a family team meeting; a family team meeting should be held even if a FPS has not scheduled it.
- Family team meeting form must be completed for each team meeting including signatures of all of the attendees, goals revisited, progress.
- Monthly consultations with Program Director between family partner and his/her supervisor will be held.

Supervisory Team Meetings between NFSN and lead agency - TBD

- A specific family partner will be assigned to meet with a supervisor of each agency team

EMPOWER:

The philosophy of NFSN is "Hand up rather than hand out". To put this philosophy into practice the Family Partner first models how to obtain resources when family is in crisis while building trust and meeting immediate needs on a timely basis. That modeling becomes the teaching moment.

- Resourcing for basic needs: food, clothing, utilities, housing.
- Employment.
- Transportation.
- Advocate for information, knowledge and services.

ENCOURAGE: Family Partner is available to give encouragement and support as the family needs it. The Family Partner is a sounding board ready to listen without judgment and assist in processing the thoughts and emotions so they can appropriately communicate to other professional.

- Family Partner will be meeting with Family prior to Family Team meetings and court to listen to the Family, assist in processing and formulating complaints, concerns and needs.
- Family Partner will return phone calls within 24 hours.
- Family Partner will have secondary contact number for assistance when they are not available.

NFSN
Nebraska Family Support Network

Jobs Performed By the Family Partners

Nebraska Family Support Network currently has a Family Partner program providing services to families in Douglas and Sarpy counties. The Family Partners work with families who are referred through the various children's mental/behavioral health systems such as the child welfare. The Family Partners work with families utilizing family-centered practices and wraparound principles. Over the past year, the Family Partners have worked to help families using the five guiding principles: engage, evaluate, eliminate, empower and encourage. Listed are examples of areas the Family Partners have assisted the families:

BASIC NEEDS

Budget

- Assist families with applying for Access Nebraska and following up on their application.
- Help the family create a realistic budget.
- Help the family go through any bills that are not paid and assist them in planning on how they will pay them.
- Provide resources for rental assistance, utility assistance, etc.

Clothing

- Assist families with locating resources for clothing.
- Model and teach the families how to locate clothing resources on their own for future needs.

Food

- Assist families to locate food pantries.
- Teach and Model how to complete applications for food pantries.
- Help families with application process for SNAP.

Housing

- Assist Family with applying at Housing Authority.
- Assist Family with reducing housing costs.
- Assist Family with locating appropriate housing and completing rental application.
- Assist Family with locate furniture and access household items.

Transportation

- Family Partner will transport parents to court, family team meetings and psychological evaluations as needed.
- Assist Family with locate resources for permanent transportation.
- Help families get reinstatement of driver's license.
- Assist the family in locating community resources that can assist with gas needs. (Not always available but can try to locate)
- Help family locate a bus schedule and teach them how to read the bus schedule and ride a bus.
- Assist family in identifying and recruiting informal support to provide transportation to needed appointments

COURT

- Provide support to comply with requirements of the court documents.
- Family Partner will meet with the parent before court to provide support and help ask any questions they may have.
- During court the Family Partner can give a verbal report to the Judge stating how the parent has been progressing with the Peer to Peer Mentoring services.
- Family Partner will meet with parent after court to help them process the hearing, ask any questions they may have, and begin planning for any immediate needs.

EDUCATION SYSTEM

- Assist in scheduling, attending and reviewing IEP meetings.
- Assist with application process for developmental disabilities
- Assist families work with navigating the developmental disabilities program.
- Assist family in locating, applying and completing GED.
- Assist family in locating and applying for college scholarships.

EMPLOYMENT

- Help families locate and apply for jobs.
- Connect with Vocational Rehabilitation.
- Assist families with creating a resume.
- Assist families with completing employment applications.
- Encourage families to follow up on Employment Applications that have been submitted.
- Assist families with locating volunteer opportunities if needed.

FAMILY TEAM MEETINGS

- Facilitate meetings or work as a liaison between professional & families
- To help families effectively communicate their needs & concerns
- Assist the parent and the Family Permanency Specialist (FPS) with arranging the FTM if needed.
- Help the parent create a list of people who are positive informal supports and they want at their FTM.
- Help the parent contact their informal supports to invite them to the FTM.
- Meet with the parent before family team meetings to review what they want to discuss at the meeting and write down a list of topics that are important to them.
- Attend the FTM and support the parent throughout the process.
- Help the parent communicate with the professionals on the team by role modeling before and during the family team meeting.

LEGAL

- Assist the family with accessing legal services.
- Direct the family to their attorney when they have legal questions and assist in communicating these questions if needed.
- Educate the family on the legal process that they are currently navigating.

MEDICAL

- Assist the family with writing out a list of questions they may have in regards to medical treatment before they attend an appointment.
- To go along to provide support at doctor's appointments, etc.
- Assist in locating doctors and applying funding to meet medical needs.
- Assist in locating and applying for funding sources to pay for medications and medical treatment.

PARENTING

- To work on parenting goals (identified by providers and parents themselves).
- Assist in locating needed Parenting Training.

- Assist in applying funding to pay for needed service.
- To help families interact in a positive manner with their children.
- To facilitate conflict resolution within families.
- To work on boundary issues.

TIME MANAGEMENT

- To plan time management by providing planners and teach how they can be most effectively utilized.
- To work with families to plan visitation scheduling.
- To work on house cleanliness.
- Assist family in setting priorities regarding use of time and impact on goals.

TREATMENT

- Assist families in meeting goals related to completing substance abuse treatment.
- Assist in locating substance abuse treatment.
- Assist family in and applying for funding sources to pay for substance abuse treatment
- Attend AA & NA Meetings with families.
- Assist family members with locating a sponsor and encourage them to actively keep in touch with their sponsor.
- To be a Partner in recovery with families.

ONGOING SUPPORT

- To help families outside of any wraparound program develop safety plans for their youth and family.
- To listen and provide an understanding ear.
- To offer resources, information and ideas for success throughout systems.
- To understand the "Rights & Responsibilities" of NHSS-Protection and Safety system.

Alexander Domina Timeline

4-1-2005	Foster Placement (1) with Judy Domina, Grandmother at Scotia, NE.
4-15-2005	Interview at Family Advocacy Center, Kearney, NE for sexual abuse.
4-15-2005	Foster Placement (2) with Rod and Lisa Wilkerson, Hasting, NE.
6-3-2005	Foster Placement (3)with Judy Gunn, Hastings, NE because of licensing issues with the Wilkersons.
6-6-2005	Foster Placement (4) with Judy Domina, Scotia, NE.
12-29-2005	Admitted Lincoln LGH.
1-4-2006	Released from Lincoln LGH to temporary Foster Placement (5) with Mary Patrick, North Loup, NE for temporary care due to Judy Domina health issues.
1-12-2006	Foster Placement (6) with to Judy Domina.
1-19-2006	Place in temporary Foster Placement (7) with Mary Patrick, North Loup, NE due to Judy Domina being hospitalized with pneumonia per doctor's orders.
3-31-2006	Foster Placement (8) with Judy Domina, Scotia, NE.
1-2007	Visinet Intense Family Preservation C-Bar put in place.
2-27-2007	Hospitalized Lincoln LGH.
3-12-2007	Released Lincoln LGH and Foster Placement (9) with Laura and Kevin Hein, York NE with Day treatment at Epworth Village, York, NE.
6-18-2007	Removed from Laura and Kevin Hein home due to abuse report by Epworth Village regarding Heim's. Foster Placement (10) with Bonnie and Bill Hobbs with continued day treatment at Epworth Village, York, NE.
7-10-2007	Admitted Lincoln LGH
7-26-2007	Foster Placement (11) with Taucha Davis, Lincoln, NE with Day Treatment at Epworth Village, York, NE.
9-1-2007	Foster Placement (12) with Jan Kreifels, Lincoln, NE with Day Treatment at Epworth Village, York, NE.
10-8-2007	Foster Placement (13) with Sylvia Hydo, Lincoln, NE with Day Treatment at Epworth Village, York, NE.
4-8-2008	Hospitalized Lincoln LGH.
5-8-2008	Placed at [redacted], Omaha, NE.
4-15-2009	Placed at I Believe In Me Ranch, Kearney, NE.
10-31-2009	Foster Placement (14) Carolyn Marion, Omaha, NE.
12-16-2009	Foster Placement, (15) LaWanda,Ballard Omaha, NE.
2-10-2010	Removed from Omaha Public School for Day Treatment at Behavin .
4-1-2010	April 1, 2010, fully implemented child welfare/juvenile services reform changes.
5-25-2010	Foster Placement (16) with Delores Pollock, Omaha, NE.
10-5-2010	Foster Placement with C-Bar through Omni Behavioral Health (17) with Judy Domina, Elkhorn, NE.
11-29-2010	Started Day School at Boys Town, NE.
12-13-2010	Started Before and After School Care at Children's Respite Care Center.
1-14-2011	Admitted Mercy Hospital, Council Bluffs, IA.
1-19-2011	Dismissed Mercy Hospital to Foster Placement (17) with Judy Domina.
1-24-2011	Admitted to Immanuel Hospital, Omaha NE.
2-2-2011	Admitted to [redacted].

17 Foster Placements with 12 different foster families
21.5 months with Judy Domina
6 Hospitalizations for 73 days total
1 Day Treatment Program / 1 year
2 [redacted] / 19 months
1 Treatment Group Home / 6.5 months

"Shattered Innocence"
The Alexander Domina Story

Alex, and his brother, Zachary, came into their grandmother's custody on April 1, 2005. It was determined that they are both victims of sexual and physical abuse. Parental rights were terminated September 2006. Judy Domina, the grandmother adopted Zachary on Mary 29, 2007. Alex stayed with his grandmother until February 23, 2007. He was removed from her home due to his aggressive behavior and placed in respite care with Donna Lawson in Broken Bow, NE. He was removed from day care in Broken Bow for aggressive behavior and smearing feces' and placed in emergency placement with Cedars in Broken Bow. February 27, 2007 he was placed at Lincoln LGH Medical Center's Child Psychiatric Unit. This was the beginning of a lengthy, traumatic journey for Alex and our family. Alex has been in Epworth, Immanuel Residential Treatment Center, I Believe in Me Ranch, Behaven, eight foster homes and multiple stays at Lincoln LGH Medical Center. During that time Judy Domina, the grandmother, participated in family therapy and had weekly visits with Alex. When he was well enough he would visit in the home for an overnight visit.

Alex turned nine years old on October 5, 2010. All he wanted for his birthday was to come home to Grandma Judy. Grandma Judy picked him up from Behaven on October 5, 2010 and brought him home. Judge Kelly had ruled the previous week that he was to come home and services were to be provided so he could remain in his Grandmother's home and he could be adopted as his brother had been. Services needed in the home are:

1. Respite care for at least one week-end a month so Judy can visit her aging parents in Central Nebraska and maintain her employment.
2. Day Care.
3. Aides to assist Alex with re entering society.
4. Med management.
5. Therapy

Alex had not been attending school since February 2010 when he was removed from Omaha Public School and placed at Behaven. He left school not due to problems at school but because it was more convenient for the foster parent. Alex started school at Boys Town Day School on 11-29-2010. Elkhorn Public School provides transportation from Before and After School care. He started Before and After School Care at Children's Respite Care Center on December 13, 2010 since he could not remain at Behaven if he was not there the entire day.

Since Alex was placed in his Grandmother's home the case management through DHHS has changed three times. There has been one team meeting. The last two case managers have not seen Alex. Respite was provided three times with no respite since November. Omni Behavior Health provides med management, therapy and support workers. Med management meetings with Dr. Schmidt are once a month. These

meetings were scheduled during the day with the family support worker taking Alex to the meetings from day care. There has been no direct contact with the foster mother. Therapy has been held every week with the last therapy session held on January 4, 2010. At this time it was decided that Alex would transfer therapy to Boys Town since he goes to school there. The process was started but due to Alex's increased aggression the therapist at Boys Town did recommended the foster mother work with the Omni therapist and get a higher level of care. Med management meeting was scheduled for January 10, 2010, with Dr. Schmidt. Dr. Schmidt canceled the meeting due to weather conditions. Family support stopped prior to Christmas, one worker was promoted and could not longer work with Alex and the other worker wanted to take Alex from day care and work with him rather than work in the evening due to scheduling conflicts. Alex's guardian ad ileum met with him during therapy on January 4, 2010. She is concerned with his condition and does not think he can be kept safe within a home and requires round the clock care.

The holiday season is a difficult season for Alex. His abuser came into his life at Christmas time. Alex's aggression started to increase in December. His behaviors and aggression increase to the point that he was hospitalized on January 14, 2011. Beds were not available at Immanuel so he was placed at Mercy Hospital in Council Bluffs, IA. At intake Alex told the nurse that he was thinking of killing his grandmother and himself by using a knife. He also reported that he had a "mouth in my brain that tells me to do bad things and if I don't it gets louder". He admitted that he had attempted to hurt the pets in his home, was breaking furniture at home and school. He has nightmares that wake him up and he seeks food and gets into belonging of the others living in his home. He wets the bed and is now urinating on furniture, carpet and in the furnace vents. He needs residential treatment care for his own protection and the protection of others. Dr. Schmidt and the therapist will not recommend this. They are recommending Therapeutic Foster Care. Prior to Alex's release back to his Grandmother's home the guardian ad ileum requested that either Dr. Schmidt or the therapist request residential treatment care. She offered to take the request to the Judge Kelly. They refused. Alex came home on January 19, 2010 with no safety plan, no in home support and no day care. His first night home he was up four times. He attempted to hurt the family cat and urinated on a basket of clean clothing. His grandmother is not able to work or sleep. She worries that she will not be able to keep him safe. She has locked the household knifes in the trunk of the car. What does the future hold for Alex. Boys Town Day School, Children's Respite Care Center, the guardian ad ileum and his grandmother, the people that have day to day contact with Alex think Alex needs residential treatment care. The professionals that could make it happen do not. What does a Grandmother that loves her grandson do? She advocates for her grandson. Alex returned to Immanuel Hospital on 1-24-2011. Alex's guardian ad ileum presented Alex's case to Judge Kelly on 1-24-2011 complete with the time line of his placements detailed charting of his behaviors at Boys Town Day School, Children's Respite and home. Judge Kelly ordered immediate placement at Boys Town Residential Treatment Hospital for the safety of Alex and his grandmother. As of today Alex remains at Boys Town Residential Treatment Hospital. He is responding to treatment. His progress is steady but slow. His grandmother visits him and attends weekly family therapy and monthly treatment meetings. Alex's brother, Zachary joined him at Boys Town Residential Treatment Hospital September 1, 2011. Brothers are together receiving treatment with the goal to return home. The concern is that they will be returned home before treatment is complete without a transition plan in place. Care for these children is not always determined by the professionals that work daily with them. It is decided by Family Preservation Specialist that see them once a month and managed health care that has met or observed them in person.

Respectively submitted by:
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