Maine Children's Services Reform Report

January 2006

Forwarded to Maine Joint Committee on Appropriations and Financial Affairs
Joint Committee on Health and Human Services by Commissioner John R. Nicholas
Presented by Acting Commissioner Brenda M. Harvey

UNIVERSITY OF
SOUTHERN MAINE

This report was designed and published by the Institute for Public Sector Innovation,
Muskie School of Public Service

Design and Layout: Lisa Hinckley

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Executive Summary

Service reform recommendations presented in this report build on the systems change efforts already underway in both DHHS's child welfare and children's behavioral health programs. Notably, the reforms enhance Maine's efforts to support vulnerable children and their families in their homes and communities. In child welfare, practices have shifted to focus on kinship care and placing children as close to their home community as possible thereby preserving vital links with siblings and extended family. The rapid development of Maine's children's behavioral health system has led to a strong array of child-centered, family focused supportive services also aimed at treating children in their home community. Both disciplines have committed to principles, which include strengths-based and inclusive practices aimed at involving families and surrogate families in the planning and delivery of services.

This report contains some 22 recommendations which further the Department's systems redesign to support better outcomes for vulnerable Maine children and their families. Both the experience of other states and professional literature has been used in formulating the policy recommendations included here. It is the combination of this information along with the commitment and vast experience of the stakeholders, which makes these recommendations more likely to exist beyond just the paper they are written on.

Background

During the 122nd Legislative session, two separate initiatives directed the Department to convene workgroups to provide recommendations regarding children's service system reforms. LD #863, initiated by

children's services providers, directed the Department to convene a workgroup to look at service design for children with mental health needs and complex, multi-system needs. Concurrently, proposed budget initiatives led the Joint Committee on Appropriations and Financial Affairs and the Joint Committee on Health and Human Services to require DHHS to convene a broad working group to "advise the commissioner on the children's mental health services and child welfare systems." PL2005c. 12 (Section JJJJ-2). The Committee stipulated that reforms should address, at a minimum, service delivery structures, financing of these services, quality assurance, and quality improvement strategies. Subsequently, the Department constructed the Children's Services Reform Steering Committee and the process described here to accomplish both charges.

This report is not intended to be a detailed workplan for implementing policy. Rather it is an attempt to capture the rich dialogue that occurred in workgroups and at the Steering Committee as members responded to the charges presented to them. Diverse representation in the workgroups contributed to analysis from multiple perspectives as the members tackled the enormous task before them. The resulting recommendations are broad in nature but supported by rationale, general strategies, enhancers and barriers, timelines, and resources. This report has multiple uses: building a common agenda around priorities for Maine's system of care for children; informing the legislative process and public policy development; and educating service providers, government staff, the legal community and the general public about important reform work in Maine's children's services. Lastly, this report serves as the formal record of the process and results of the Children's Services Reform Steering Committee and workgroups.

How the Work was Conducted

Beginning March 2005 and continuing through December, the Steering Committee met regularly to review and discuss the work conducted by the workgroups they established. During this time, many stakeholders (82) demonstrated commitment and dedication throughout a process designed to enhance service delivery for children and families across the state.

The Children's Services Reform effort was guided by a diverse 28 member Steering Committee consisting of youth, family members, community and advocacy leaders, service providers, and Department staff. Membership of the Steering Committee included representatives from each of the statewide provider, parent, and advocacy groups representing services to children and families. The Steering Committee developed and agreed to a set of guiding principles, vision, purpose and working agreements, which were used to comprehensively unify the significant interests of many stakeholders. Chaired by Deputy Commissioner, Brenda M. Harvey, the Steering Committee was established in March 2005 and met monthly for a total of nine meetings. To complete its task, the Steering Committee organized itself into five workgroups that focused on key issues related to the budget and reform initiatives. Specifically:

- Reforming Treatment
- Reforming Residential Services
- Reforming Community Intervention Programs and Home-Based Care
- Integrating Case Management
- Full Case - Full Court

In addition to the original five workgroups, another task group was

added at the request of a Steering Committee member. The charge of this task group was to survey Maine foster parents regarding their ideas, suggestions and input in reforming services for children served by DHHS. This sixth group was chaired by a foster parent in order to reach more deeply into the foster parent provider community to elicit input regarding reform efforts. Their report is contained in the full report of the Children's Service Reform Committee.

Charge to Workgroups

Reforming Treatment:

The purpose of this group is to reform our current overlapping system of care into one system of behavioral health treatment for all children. This will include:

- Use of a uniform assessment tool that address the presenting needs of the child and family,
- Use of evidence or best practice models,
- Development of outcomes to be assessed and tools to measure them,
- Management of the system of care through authorization and utilization review,
- Examination of existing treatment foster care rate system

Reforming Residential Services:

The focus of this workgroup is to specifically examine the use of residential (congregate care) for children and youth in BCFS custody. This will include:

- Developing discharge criteria and expected outcomes, which minimize time for children in restricted environments
- Examination and analysis of types of treatment services being provided in residential care

- Analysis of current bed capacity- where they are located and types/levels of service being provided
- Projection of future bed capacity – where and what type of service will be needed

Reforming Community Intervention Programs and Home-based Care:

The purpose of this workgroup is to develop recommendations to support families, prevent removing children from their home communities and assure safe and timely reunification. This will include:

- Program development options such as family preservation

Integrating Case Management:

The charge of this workgroup is to study and recommend how behavioral health case management services and child welfare case management services can best be successfully integrated to improve outcomes for families and children when they are served by both systems. This will include:

- Rate setting- fee for service vs. cost-based
- Relationship of case management to crisis follow up and hospitalization
- How case management fits with proposed idea of navigators and Integrated Service Team Leaders

Full Case – Full Court:

The focus of this workgroup is to develop recommendations, which support permanency outcomes for children while keeping them connected to their home communities. This will include:

- Exploring alternatives to Full Case - Full Court which meet the same needs

- Minimizing duplication of services/professionals giving confusing direction to families
- Determining systems for reimbursement

Findings

Maine's existing service delivery system is a mix of entitlement, categorical and demonstration programs. Privatization of service delivery with inconsistent accountability often means that families and children receive different services from different providers in different parts of the state. The current system of care translates into disparate programs providing little continuity of care as children transition from one program to another as they age or their needs change.

Reforming these systems will take time and an ongoing coordinated effort between the provider community, state government, the legal community, advocates and family members. This report contains a set of recommendations including research-based rationale, broad strategies and practical action steps to move toward an improved system of care for Maine's children and families.

The following key elements emerged as major themes during the ten-months work of the Steering Committee. These three major themes are central to the findings and recommendations for system improvement:

- The Right Services at the Right Time
- Streamlining Services
- Increasing Support to Keep Children in their Homes and Communities

The Right Services at the Right Time

With an increased emphasis on outcomes, this shift in services is a profound one. Moving from a process-driven system to one that measures outcomes at individual, program and system levels requires significant changes in policy and practice. Additionally, using a conceptual framework of Evidence-based Practices, Promising Practices, and Emerging practices, Maine is just beginning to re-tool children's services. Several of the Recommendations contained in this report support this paradigm shift while acknowledging the challenges and benefits of doing so. Bringing new Evidence-based Practices to Maine means building capacity to deliver them with fidelity and the ability to measure the effects. As Maine embarks on this change, we will continually be challenged to do business in a different way.

Managing the services and system is a theme that stretched across many of the discussions of several workgroups. The Steering Committee endorses DHHS's efforts to better manage the services but it is the architecture of the management structure and services that will take careful attention for the future.

Streamlining Services

The creation of the new DHHS, and more specifically the Office of Child and Family Services, is an unprecedented opportunity to create a seamless system of care for vulnerable children and their families. Numerous recommendations point to policy and practice changes that will likely yield more consistent approaches to services, particularly where families are served by multiple programs. Integrating case management services promises better access to resources and information. Aligning administrative requirements can be more efficient for DHHS and contracted providers. This work needs on-going coordination between the Office of Integrated Access and

Support and the Office of Integrated Services.

Increasing Support to Keep Children and Youth in Their Homes and Communities

Maine has a strong foundation of services and support for children and families. These workgroup recommendations serve to strengthen the array that will help keep children in their homes and communities. In particular, an emphasis on building supports to keep children out of deep-end services for lengthy stays dovetails with the policy directions already established in the children's system of care. These strategies hold significant promise for decreasing expenditures while improving outcomes for children. Redirecting savings can strengthen the array and capacity of supports.

Recommendations Directly Linked to Budget Initiatives

The following are brief descriptions of the recommendations forwarded by the workgroups and intended to serve as a quick reference to the report. The complete recommendations can be found on the identified pages:

1. **Evidence-Based Practice (EBP)**
   Increase the use of EBP by programs and clinicians when appropriate to the particular services provided and populations served. (Page 21)

2. **Managing a Children's System of Care**
   Develop and implement a system for managing the availability and utilization of children's mental/behavioral health and child welfare services. (Page 30)

3. **Outcome Measurement**
   Establish standardized outcome measures for individual children and their families using national assessment tools and benchmarks whenever possible; Develop information systems for reporting, analysis and communication of outcome results to ensure continuous quality improvement. (Page 36)

4. **Treatment Foster Care Rates**
   Expand the Level of Care system to include assessment of children in unlicensed homes and to conduct permanency focused review for placements likely to exceed 12 months; Maintain the current five levels of care and the current rate structure. (Page 41)

5. **Screening and Assessment**
   Identify and recommend a screening tool that would be voluntarily used by a broad range of disciplines to determine if an asymptomatic child with MaineCare coverage might have a disorder or functional impairment meriting further investigation.

   Children in the custody of the child welfare system or children who are at risk of out of home placement or have been placed in out of home treatment will have a broad based assessment able to determine functional needs and diagnostic concerns. (Page 45)

6. **Prevention and Intervention**
   Ensure that an efficient and effective continuum of support services exists, targeted to the needs of all Maine families with identified issues of child abuse and neglect, in order to support families to reduce risk, prevent removing children from their home communities and assure safe and timely reunification. (Page 61)

7. **Home-based Services**
   Have a strong intensive family preservation service in place to prevent child removal whenever possible. (Page 68)

8. **Unified Practice Model**
   Office of Child and Family Services should develop unified practice guidelines based on values and principles upon which Child Welfare, Children's Behavioral Health Services and Early Childhood Services conduct their work. (Page 84)

9. **Support of Practice Model**
   Develop policies, rules, regulations, contracts and working agreements that support unified practice guidelines. (Page 91)

10. **Quality Assurance**
    DHHS should align quality assurance for case management to assure fidelity to practice guidelines as well as monitor implementation and outcomes of services provided. (Page 96)

11. **Transitions and Teaming**
    Office of Child and Family Services should enable efficient and effective transitions and teaming among case management services for which it has direct or oversight responsibility, while eliminating any unnecessary duplication of case management with any one family. (Page 101)

12. **Residential Care Program Standards**
    Develop and implement a comprehensive set of program standards for all children's residential care facilities that are based on family-centered group care principles and practices. Standards will be consistent with and reflected in licensing rules and/or

performance based contracts and a comprehensive utilization review system. (Page 114)

13. **Unified Utilization Review Process**
    Office of Child and Family Services establish and manage a unified utilization review process for all children's residential services placements including a single point of entry for prior authorization, tracking and coordinating care from admission through discharge for all children receiving services through Child Welfare and Children's Behavioral Health. (Page 120)

14. **Analysis of current and projected needs**
    Office of Child and Family Services will utilize an analysis of current and projected needs for residential services to plan for future resource allocation. (Page 126)

15. **Managed Care System for Treatment Foster Care**
    Design and implement a managed care system for treatment foster care to increase the likelihood of achieving treatment outcomes in a timely fashion, provide the right services for the right amount of time and reduce the amount of time for children to achieve permanency. (Page 153)

16. **Relative/Kinship Placement**
    Increase the placements of youth into relative's/kinship homes by contracting with private agencies to provide help in meeting the standards to qualify for licensure and to provide support in acquiring and keeping the resources necessary to ensure a successful placement. (Page 162)

Recommendations Not Linked Directly to Budget Initiatives

17. **Youth in out-of-home placements**
    Establish a protocol specifying that when a youth is in a placement apart from family, he/she will be involved in all aspects of planning for his/her future as developmentally appropriate. (Page 170)

18. **Crisis Response Strategy**
    Initiate a pro-active policy level Crisis Response Strategy designed to ensure a coordinated response to high profile incidents and to avert crisis driven policy changes. (Page 174)

19. **Development and Management of a Targeted Case Management Workforce**
    Office of Child and Family Services adopt current healthcare industry practice to ensure the development and management of a sufficient targeted case management workforce with consistent minimum qualifications and core competencies aligned with the practice guidelines. (Page 180)

20. **Resolve Outstanding Issues of Confidentiality**
    Resolve outstanding issues of confidentiality in order to expedite referral and delivery of appropriate services and ensure that the process of sharing client information guarantees consumer rights to choice and informed consent. (Page 186)

21. **Multi-dimensional Treatment for Therapeutic Foster Care**
    Adopt and implement the evidence-based multi-dimensional

treatment foster care model designed by Patricia Chamberlain. (Page 192)

22. Steering Committee Reconvene

Reconvene in one to assess progress on recommendations outlined in this report.

Minority Reports are included for the record and can be found in the Minority Reports section of the report on page 201.

Commissioner Nicholas, although completing his tenure on January 13, 2006, has authorized forwarding all the recommendations listed above. The Minority Reports are included in the interest of having a complete record of the Steering Committee's work and will inform continued work on transforming the children's system of care undertaken by DHHS.

The implementation of this ambitious reform agenda will challenge all parties involved. Critical to the success of these reforms is strong and dedicated leadership and solid partnerships between schools, juvenile justice programs, social service programs, public and private non-profit entities, the legal community, advocacy groups, youth and family members. We acknowledge that this system change is both complex and critical. Maine's children and families are worth our best efforts.

Children Services Reform Introduction

Service reform recommendations presented in this report build on the systems change efforts already underway in both DHHS's child welfare and children's behavioral health programs. Notably, the reforms enhance Maine's efforts to support vulnerable children in their homes and communities. In child welfare, practices have shifted to focus on kinship care and placing children as close to their home community as possible thereby preserving vital links with siblings and extended family. The rapid development of Maine's children's behavioral health system has led to a strong array of child-centered, family focused supportive services also aimed at treating children in their home community. Both disciplines have committed to principles, which include strengths-based and inclusive practices aimed at involving families and surrogate families in the planning and delivery of services.

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During the 122nd Legislative session, two separate initiatives directed the Department to convene workgroups to provide recommendations regarding children's service system reforms. LD #863, initiated by children's services providers, directed the Department to convene a workgroup to look at service design for children with mental health

needs and complex, multi-system needs. Concurrently, proposed budget initiatives led the Joint Committee on Appropriations and Financial Affairs and the Joint Committee on Health and Human Services to require DHHS to convene a broad working group to "advise the commissioner on the children's mental health services and child welfare systems." PL2005c. 12 (Section JJJJ-2). The Committee stipulated that reforms should address, at a minimum, service delivery structures, financing of these services, quality assurance, and quality improvement strategies. Subsequently, the Department constructed the Children's Services Reform Steering Committee and the process described in this report in order to accomplish both charges.

This report is not intended to be a detailed workplan for implementing policy. Rather it is an attempt to capture the rich dialogue that occurred in workgroups and at the Steering Committee as members responded to the charges presented to them. Diverse representation in the workgroups contributed to analysis from multiple perspectives as the members tackled the enormous task before them. The resulting recommendations are broad in nature but supported by rationale, general strategies, enhancers and barriers, time lines and resources. This report has multiple uses: building a common agenda around priorities for Maine's system of care for children; informing the legislative process and public policy development; and educating service providers, government staff, the legal community and the general public about important reform work in Maine's children's services. Lastly this report serves as the formal record of the process and results of the Children's Services Reform Steering Committee and workgroups.

Committee's Background and Work

To accomplish the charge, the Department of Health and Human Services established a process beginning in March 2005 and lasting

through December 2005 when the Steering Committee issued its recommendations. During this time, many stakeholders (82) demonstrated commitment and dedication throughout a process designed to enhance service delivery for children and families across the state.

The Children's Services Reform effort was guided by a diverse 28 member Steering Committee consisting of youth, family members, community and advocacy leaders, service providers, and Department staff. Membership of the Steering Committee included representatives from each of the statewide provider, parent, and advocacy groups representing services to children and families. The Steering Committee developed and agreed to a set of guiding principles, vision, purpose and working agreements, which were used to comprehensively unify the significant interests of many stakeholders. Chaired by Deputy Commissioner Brenda M. Harvey, the Steering Committee was established in March 2005 and met monthly for a total of 9 meetings. To complete its task, the Steering Committee organized itself into five workgroups that focused on key issues related to the budget initiatives. Specifically:

- Reforming Treatment
- Reforming Residential Services
- Reforming Community Intervention Programs and Home-Based Care
- Integrating Case Management
- Full Case - Full Court

Each of the workgroups was co-chaired by a Department and non-Department representative (see Recommendations for full membership list). The workgroups operated from a common

set of expectations that included using evidence-based or best practice models to inform and guide recommendations; working within existing resources and identifying cost reductions; and maintaining focus on the specific charge given to each workgroup. Communication between the workgroups and the Steering Committee occurred regularly throughout the process.

In a thoughtful and inclusive manner, several workgroups reached beyond their own membership to gather even broader input for debate and analysis. Notable examples are Integrated Case Management & Reforming Residential Services workgroup's efforts to reach out to a larger number of families who have received services from DHHS programs. In addition, the Foster Parent Input group surveyed all licensed foster parents to gather their perspectives.

Both Steering Committee and workgroup meetings were colored by an atmosphere of suspicion among members. Questions persisted throughout the process about the legitimacy of the effort. Numerous discussions took place trying to answer such questions as "What decisions has DHHS leadership already made regarding these policies?"; "Were workgroups given enough information to make informed decisions?"; Was DHHS leadership only committed to recommendations that would further their own agenda?"; "Was this effort really only window dressing?" Despite this considerable lack of trust, workgroup and Steering Committee meetings were characterized by high attendance and vigorous participation and discussion over the relevancy and alignment of the recommendations. As a whole, the group was passionate about reforming children's services and the resulting recommendations show a remarkable consistency in direction, if not in every detail.

Charge to Workgroups

Reforming Treatment:

The purpose of this group is to reform our current overlapping system of care into one system of behavioral health treatment for all children. This will include:

- Use of a uniform assessment tool that address the presenting needs of the child and family,
- Use of evidence or best practice models,
- Development of outcomes to be assessed and tools to measure them,
- Management of the system of care through authorization and utilization review,
- Examination of existing treatment foster care rate system.

Reforming Residential Services:

The focus of this workgroup is to specifically examine the use of Residential (congregate care) for children and youth in BCFS custody. This will include:

- Developing discharge criteria and expected outcomes, which minimize time for children in restricted environments,
- Examination and analysis of types of treatment services being provided in Residential care,
- Analysis of current bed capacity- where they are located and types/levels of service being provided,
- Projection of future bed capacity – where and what type of service will be needed.

Reforming Community Intervention Programs and Home-based Care:

The purpose of this workgroup is to develop recommendations to support families, prevent removing children from their home communities and assure safe and timely reunification. This will include:

- Program development options such as family preservation.

Integrating Case Management:

The charge of this workgroup is to study and recommend how behavioral health case management services and child welfare case management services can best be successfully integrated to improve outcomes for families and children when they are served by both systems. This will include:

- Rate setting- fee for service vs. cost-based,
- Relationship of case management to crisis follow up and hospitalization,
- How case management fits with proposed idea of navigators and Integrated Service Team Leaders.

Full Case – Full Court:

The focus of this workgroup is to develop recommendations, which support permanency outcomes for children while keeping them connected to their home communities. This will include:

- Exploring alternatives to Full Case - Full Court which meet the same needs,
- Minimizing duplication of services/professionals giving confusing direction to families,
- Determining systems for reimbursement.

Membership for each of the workgroups was based on a set of criteria that included knowledge in the content area, commitment to the proposition of reforming children's services, ability to be team players, open-mindedness and ability to contribute to the larger shared goals of the organization. Membership was geographically dispersed statewide and included representation from all major stakeholders. Department staff were included, while a majority of the membership was external stakeholders.

Decisions made by the Steering Committee and each of the workgroups were based on a consensus model. In the event that the Committee or workgroups could not reach an agreement by this method, they were provided the option to state their opinion or recommendation via a minority report.

Workgroups set their own meeting schedules with regular progress reports to the Steering Committee. All meetings were recorded and minutes were posted on a web-site, created specifically for this project, with full public access. The five workgroups engaged in months of intense and detailed research, deliberations, and planning on their assigned topics. Workgroup recommendations followed a similar template with supporting research, rationale, cost savings, broad strategies and major activities. Each workgroup produced a set of recommendations that are the result of a thoughtful and facilitated consensus building process.

Foster Parent Survey

In addition to the original five workgroups, another task group was added at the request of a Steering Committee member. The charge of this task group was to survey Maine foster parents regarding their ideas, suggestions, and input in reforming services for children served

by DHHS. During the first session of the 122nd legislature, foster parents voiced concerns about policies which lowered payments for goods and services. This sixth group was chaired by a foster parent in order to reach more deeply into the foster parent provider community to elicit input regarding reform efforts. A small group of stakeholders designed a survey instrument to capture data from the foster parent population. Research staff from the Muskie School provided assistance in survey design and analysis. The results of that survey are included in this report (see page 219).

Youth Involvement

The Steering Committee felt strongly that youth's participation, perspectives, and recommendations should be an integral part of the reform work. Each workgroup invited a youth representative to join and there was youth representation on the Steering Committee. During the life of this work it be came more evident how critical it was to hear directly from a broader perspective of youth who receive services. A Youth Forum was held in September with the express purpose of having youth and young adults share their experiences and perceptions about the systems and suggested reforms. Workgroups were invited to submit questions to groups of youth who participated in facilitated discussions. These discussions were formed around the five major topics of the workgroups. The Forum provided valuable insight and information for reforms (see page 261 for Summary Youth Conference Part II).

Major Themes Reflected in the Steering Committee Recommendations

The following key elements emerged as major themes during the 10 months work of the Steering Committee. The three major themes are central to the findings and recommendations for system

improvement:

- The Right Services at the Right Time
- Streamlining Services
- Increasing Support to Keep Children in their Homes and Communities

Each of these themes is discussed in more detail on the following pages.

The Right Services at the Right Time

With an increased emphasis on outcomes, this shift in services is a profound one. Moving from a process-driven system to one that measures outcomes at individual, program, and system levels requires significant changes in policy and practice. Additionally, using a conceptual framework of Evidence-based Practices, Promising Practices and Emerging practices, Maine is just beginning to re-tool children's services. Several of the Recommendations contained in this report support this paradigm shift while acknowledging the challenges and benefits of doing so. Bringing new Evidence-based Practices to Maine means building capacity to deliver them with fidelity and the ability to measure the effects. As Maine embarks on this change, we will continually be challenged to do business in a different way.

Managing the services and system is a theme that stretched across many of the discussions of several workgroups. The Steering Committee endorses DHHS's efforts to better manage the services but it is the architecture of the management structure and services, that will take careful attention for the future.

Streamlining Services

The creation of the new DHHS, and more specifically the Office of Child and Family Services, is an unprecedented opportunity to create a seamless system of care for vulnerable children and their families. Numerous recommendations point to policy and practice changes that will likely yield more consistent approaches to services, particularly where families are served by multiple programs. Integrating case management services promises better access to resources and information. Aligning administrative requirements can be more efficient for DHHS and contracted providers. This work needs ongoing coordination between the Office of Integrated Access and Support and the Office of Integrated Services.

Increasing Support to Keep Children and Youth in Their Homes and Communities

Maine has a strong foundation of services and support for children and families. These workgroup recommendations serve to strengthen the array that will help keep children in their homes and communities. In particular, an emphasis on building supports to keep children out of deep-end services for lengthy stays dovetails with the policy directions already established in the children's system of care. These strategies hold significant promise for decreasing expenditures while improving outcomes for children. Redirecting savings can strengthen the array and capacity of supports.

Workgroup members acknowledge that re-tooling more traditional services while maintaining an adequate array of services will be challenging. In fact, the implementation of many of the recommendations is complicated by the need to maintain current service levels especially for youth who are transitioning out of the system. Critical success factors include strong and dedicated

leadership as well as respectful and solid partnerships among the stakeholder groups. The work of system reform is complex and difficult but Maine's children and families are worth our best efforts. Maine has the opportunity to learn from other state's mistakes and successes and should take full advantage of technical assistance in this regard.

Finally, the Steering Committee recommends that it reconvene in one year to assess progress on the recommendations outlined in this report. Commissioner Nicholas, although completing his tenure on January 13, 2006, has authorized forwarding all the recommendations found in sections 1 and 2 of this report. The Minority Reports are included in the interest of having a complete record of the Steering Committee's work and will inform continued work on transforming the children's system of care undertaken by DHHS.

Steering Committee Members

Name	Representing
Chris Beerits	Office of Child and Family Services
Jim Beougher	Office of Child and Family Services
Susan Boudreau	MADAR Maine Alliance for DHHS Accountability and Reform
Penthea Burns	Youth Leadership Advisory Team
Mary Callahan	Adoptive Parent
Meg Callaway	Foster Family Treatment Association
Andy Cook, MD	Office of Child and Family Services
Dean Crocker	Children's Ombudsman
Dan Despard	Office of Child and Family Services
Pat Ende	Office of the Governor
Sean Faircloth	Maine State Legislature Representative
Bob Glidden	Maine State Employees Association
Richard Farnsworth	Maine Association for Community Service Providers
Danelle Hanson	Youth Leadership Advisory Team
Brenda Harvey	DHHS Commissioner's Office
Lucky Hollander	DHHS Commissioner's Office
Bette Hoxie	Adoptive and Foster Families of Maine
Paul LeCompte	Home Counselors
Marvin McBreairty	Foster Parent
Ken Olsen	Maine Association of Mental Health Services
Sheryl Peavey	DHHS/Bureau of Health - Early Childhood
Joan Smyrski	Office of Child and Family Services
Janice Stuver, AAG	Office of the Attorney General
Mike Tarpinian	Maine Association of Mental Health Services
Steve Tuck	Maine Association of Group Home Providers
Mary Wegrzyn	Community Intervention Programs Representative
Nadine Edris	Muskie School of Public Service
Leslie Rozeff	Muskie School of Public Service

Original Budget Initiative and Workgroup Recommendation Crosswalk

Original Budget Initiative	Workgroups that addressed policy issue	Recommendations Moved Forward
Caseload reduction (reduction of number of children in care by achieving permanency)	1. Full Case/Full Court 2. Reforming Residential Services	1a. Managed Care for TFC 2. Establish and manage a unified utilization review process
Phase-in reductions of treatment foster care rates (reducing # of levels from 5 to 3)	1. Reforming Treatment	1. Treatment Foster Care Rates
Increase Title IV-E claims through kinship care (New unlicensed kinship placements will receive $10/day vs the $16.50 currently being paid. If kin pursue and are licensed, will receive Level of Care rates (minimum of $16.50/day) and state can draw down Federal IV-E $ for licensed homes)	1. Full Case/Full Court	1. Relative/Kinship
Child welfare and behavioral health case management when both systems are involved and they intersect	1. Reforming Residential Services 2. Reforming Treatment 3. Integrating Case Management	1a. Program Standards 1b. Current and projected needs 2a. Managing a system of care 2b. Outcome measurement 2c. Screening and Assessment 3a. Unified Practice Model 3b. Support of Practice Model 3c. Transitions and teaming

Original Budget Initiative	Workgroups that addressed policy issue	Recommendations Moved Forward
Utilization review	1. Reforming Residential Services 2. Reforming Treatment	1. Establish and manage a unified utilization review process 2. Managing a system of care
Reduce reliance on CIPs for assessment	1. Community Intervention and Home-based Services	1. Prevention and Intervention
Eliminate Section 37 and fold into Section 65, M and N	1. Community Intervention and Home-based Services	1. Home-based Services
Contract for full case, full court services using performance based contracting	1. Full Case-Full Court	1. The Full Case-Full Court approach was not endorsed by the workgroup nor recommended by the Steering Committee

Recommendations Moved Forward by the Department of Health and Human Services: Directly Related to Budget Initiatives

Reforming Treatment Recommendations

- Evidence-Based Practice
- Managing a Children's System of Care
- Outcome Measurement
- Treatment Foster Care Rates
- Screening and Assessment

Reforming Treatment Workgroup Members

Name	Representing
Andy Cook, MD Co-chair	Office of Child and Family Services
Ken Olson, Co-chair	KidsPeace of New England
Dallas Adams	Sweetser
Jeanette Andonian	USM School of Social Work
Bart Beattie	Providence of Maine
Susan Boudreau	MADAR
	Maine Alliance for DHHS Accountability and Reform
Cheryl Davis	Kennebec Valley Medical Health Center
Penny Dineen	Office of Child and Family Services
Danelle Hanson	Youth Leadership Advisory Team
Diane Kindler	Casey Family Services
Gloria Melnick	Youth Alternatives
Leslie Mulhearn	MidCoast Mental Health Center
Natali Plourde	KidsPeace of New England / AFFM
Mark Rains, Ph.D.	MaineGeneral Medical Center
Sue Righthand, Ph.D.	Consulting Psychologist
Joann Schladale	Resources for Resolving Violence
Carol Tiernan	Crisis and Counseling Center, Inc.
Lindsey Tweed, MD	Anchor/Maine Medical Center
Wayne Walker	Community Health and Counseling Services
Maggie Vishneau, Staff	Muskie School of Public Service
Marty Zanghi, Staff	Muskie School of Public Service

Introduction

The Reforming Treatment Workgroup (RTWG) met to address the challenge of informing ourselves of the issues and developing recommendations regarding five important areas relevant to the development, implementation, management and sustenance of a comprehensive system of care for children in Maine.

The RTWG put in countless hours of personal time, in addition to 24 hours of workgroup time and travel over five months of meetings. Experts from each of the following topics took it upon themselves to: a) collect and distribute resources on the topics, b) lead discussion of the relevant articles, and c) write the recommendations and rewrite them multiple times after group input and discussion.

The five topic areas reviewed were as follows:

- Evidence Based Practice
- Management of the System of Care
- Outcome Measurement
- Treatment Foster Care Rates
- Screening and Assessment

Though the recommendations for each topic can be considered alone, the workgroup felt that our recommendations should be considered together as there is a cumulative benefit in implementing all the recommendations.

These recommendations should apply to all stakeholders involved in the Children's System of Mental Health Care. Accountability, responsibility and efforts to achieve the best possible care within the state budget must be everyone's responsibility.

Finally, in order to do an adequate fiscal analysis, one must look at total health and other social service costs (child protective, education, and juvenile justice) costs. For example, cutting outpatient services will likely result in an increase in hospitalizations. To lower costs in just one part of the system, while not analyzing costs across all child serving systems is penny wise and pound foolish.

Recommendation 1

Evidence Based Practice

Upon examination of Evidence Based Practice (EBP), the workgroup finds that EBP implementation is a complex process that involves strategic planning with short, medium and long-term goals and objectives. The workgroup agrees that increased use of EBP in Maine would be beneficial in serving the needs of children. It is also vital that approaches to the adoption of EBP are handled with attention to and respect for the treatment and services currently provided across the state that may be effective. Furthermore, it is important to note that in spite of important gains, EBP research is in an early developmental phase. Applying practices that have been found to be effective in one area to other service systems and populations must be done with caution and its effectiveness evaluated in the new context. Our reviews of EBP lead us to conclude that a statewide effort to implement practices supported by evidence is needed. We recognize that successful implementation requires a major commitment from the State of Maine. To this end, we offer the following recommendations.

- EBP and outcome studies are inextricably related and should be addressed simultaneously to ensure the desired goals are achieved. Increasing the use of EBP in Maine will require an infrastructure to support on-going data collection to develop a broader indigenized evidence base for our practices (tailored to the particular characteristics and needs of Maine children and families).
- Programs and clinicians should adopt practices that are supported by the highest level of evidence available, appropriate to the particular services they provide and the populations they serve.

- EBP should be developed for the prevention of risks and negative outcomes and for the promotion of health, protective factors, and resiliency.
- Emphasis on family engagement and participation are a key to effective implementation of all services.

As articulated by Burns, Hoagwood, & Mrazek, (1999), "The effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when and why families or caregivers are engaged in the delivery of care" (page 238).

There is some evidence to suggest that clinicians who have developed competence and confidence with EBP are more likely to be sensitive to client-practitioner relationship issues and nuances of intervention that lead to enhanced effectiveness. The therapeutic relationship between practitioners and clients/families has been linked to effective treatment (Miller, Hubble & Duncan, 1999), thus it should be considered an essential ingredient for quality care and successful outcomes.

- EBP implementation in Maine will require the creation of a standing committee of stakeholders to review and assess EBP (representatives from client families and consumer organizations, MaineCare, DHHS, contract agencies, educational and professional training institutions and programs, credentialing bodies, and other relevant participants). See "Broad Strategies" on page 27 for a detailed description of the recommended roles and activities of this group.
- Professional licensing boards can be urged to support EBP competency by requiring CEU content on EBP for individuals to maintain practice licenses.

- Regulatory bodies should include assessment of EBP implementation as part of a state funded agencies' licensure renewal process.
- Professional training programs can be strongly urged to infuse EBP in curriculae (e.g., psychiatry, psychology, social work, counseling, nursing, etc.).
- DHHS should consider financial and other incentives to encourage the adoption of EBP, such as funding them at a level that enables fidelity to the EBP, and utilizing outcome evaluation and accountability requirements as incentives for adopting EBP.
- While implementation of EBP across state children's services is a process that will take time and planning, the use of EBP should be encouraged, supported, and initiated promptly. Many programs have been collecting data on effectiveness (e.g., case management, crisis, and in-home support services) and plans are in place for this to continue and expand to include other services. Services that seem useful but have little to no evidence to support them will need to generate data to demonstrate effectiveness to justify continued practice. While some practitioners may believe on a tacit level that quality work is done, data collection is needed to document evidence of effectiveness.

Rationale

- Outcome assessment is important because EBP are only a means, not an end in themselves.
- EBP are specific to populations, problems, and cultures. A practice may actually lose its evidence base if generalized too far. EBP are defined along a continuum of evidence (See Appendix for EBP Definitions).
- EBP are preferred methods of treatment.
- Use of EBP increases successful outcomes.

- Use of EBP may curtail the total costs of health care by increasing treatment effectiveness and decreasing length of stay and use of higher cost treatments.
- EBP are linked to improved quality of care.
- The most expensive treatment is ineffective treatment.

Specific Changes

Current Status	Proposed Changes
	As noted above in the recommendations, multiple changes are in order, namely related to the development of an adequate infrastructure and the creation of a standing committee of stakeholders working together to support the implementation of EBP across the state.

Resources

Currently, the literature on EBP is proliferating nationally and data exists to support the use of particular treatments and services with particular populations. We also know that, within the state, efforts have been underway to examine EBP for use in particular programs and data collection for some programs has been institutionalized. This national and state research provides rich resources for EBP implementation, and it should be utilized in the planning for and development of EBP. We have well-established programs in Maine to apply EBP, (some that are planfully and knowingly using EBP and others whose practices may be unknowingly supported by evidence) to gather data to expand the evidence base for current practices, and

to increase the development of new and innovative EBP applications.

Barriers

- Implementation of EBP may have associated training costs and higher levels of staffing.
- Statewide adoption of EBP requires a paradigm shift that will challenge all system of care stakeholders to examine current practices and policies, assess what is working and what is not, and to make changes accordingly.
- Training, supervision, and measurement of fidelity require a reallocation of resources to support successful implementation of EBP.
- Current reimbursement practices favor non-EBP; Non-EBP earn the same reimbursement.
- Current policy mandates may impede EBP implementation processes.
- Hamilton (2005) noted that professionals' misperceptions of EBP can undermine their interest and investment in acquiring the knowledge and skills for evidence-based approaches. Thus, as part of EBP implementation, it is important to understand and deal openly with skepticism and common apprehensions to mitigate potential interference with adopting EBP. As an example, the original goal of using scientific evidence to influence the selection of mental health treatments was to empower practitioners and consumers to find and use more effective treatments. Many practitioners and consumers fear, however, that the evidence based practice movement will be used to limit treatment options.
- The evidence base regarding the effective treatment of children is not nearly as extensive as we would like it to be. It is important to recognize that there are many questions about the effective treatment of children for which there is not yet evidence to guide

us.

- Consideration of limiting treatment options to effective interventions should be counterbalanced by the need to identify, develop, and evaluate promising, culturally competent, and ecologically valid interventions for under served populations (whom may not be well-served by existing EBP).
- Statistical significance (evidence-base) is necessary, but not sufficient to produce clinical significance.
- EBP research could be vulnerable to placebo or expectancy effects, depending on the comparison groups, research design, and fidelity checks.
- Some providers may be anxious about and resistant to new modalities of treatment.

Enhancers

- Long-term cost effectiveness of EBP may outweigh initial expenditures (possible examples: decrease in the necessity and cost of residential treatment, decreased hospitalization use and length of stay, reduced use of emergency resources when intensive support is provided, decreased staff turnover rates, etc.).
- Making a paradigm shift to EBP may result in revitalized and improved services, increased job satisfaction among practitioners, and family and professional empowerment.
- Collaborative activities that utilize stakeholder strengths and assets are essential for the successful adoption and acceptance of EBP. Collaborative approaches break down barriers that can impede service provision and build bridges among all levels of systems of care. Effectively approaching the process of integrating EBP as standards for service provision will be accomplished through collaborative partnerships and participation of all stakeholders, rather than using policy

mandates in a "top down", authoritative manner. Strategies for involving multiple stakeholders in an integral way and harnessing their contributions need to be developed (Burns, et al, 1999).

- "Demystify" EBP through providing information, support, competent supervision, and education for direct service providers to improve understanding of what EBP really means.
- EBP are tied closely to quality improvement as agencies take steps to move in the direction of adopting EBP.
- Support infrastructure of supervision, accountability, and networking.

Broad Strategies

As noted in recommendation 3, EBP implementation in Maine will require the creation of a standing committee of stakeholders to review and assess EBP (representatives from client families and consumer organizations, MaineCare, DHHS, contract agencies, educational and professional training institutions and programs, credentialing bodies, and other relevant participants). This group will serve a facilitation role by networking and collaborating with agencies and programs to accomplish the following:

- Establishing short, medium and long-term goals for strategic implementation planning.
- Create a clearinghouse for information and disseminating information and current state and national research findings, and to collect and distribute information about evidence based practices including but not limited to the following topics: (1) with what populations the practice has been studied (with attention to cultural relevance and adaptability); (2) best methods of learning the practice; (3) best methods of measuring and ensuring fidelity; (4) study and recommend incentives for adoption of EBP that have been successful in other locations and examining promising

processes for EBP implementation in other states (e.g., Florida "What works" initiative");

- Provide consultation and technical support to direct service providers working to institute EBP and collect pertinent data;
- Recommend training on EBP and facilitating access to training and supervision resources;
- Encourage local and state representatives, including family stakeholders, to attend national child and family services conferences to stay abreast of state-of-the-art EBP and to network with others who are implementing EBP in other locations (Examples: attending or presenting at annual conferences sponsored by Georgetown Center for Child and Human Development, Portland State University Research and Training Center for Family Support and Children's Mental Health, University of South Florida Research and Training Center for Children's Mental Health, Federation of Families for Children's Mental Health, etc.);
- Provide connection with national consumer/parent organizations such as the Federation of Families for Children's Mental Health and the National Alliance for the Mentally Ill;
- Identify potential local and national grant funding sources (for training initiatives, outcome research, evaluation and monitoring, program development, etc.).

Cost Reduction

It is expected that initial costs may increase as an infrastructure to support EBP is developed and implemented. It is also expected that successful implementation may lead to long-term cost reduction. There is support for this position as long as total health care costs are included.

Major Activities Time Line

The time line for implementation of EBP cannot be addressed at this time because it is dependent on the development of the infrastructure and supports necessary to move forward.

Appendix

1 Adapted from: Saunders B., Berliner L., Hanson R. (2004). Child Physical and Sexual Abuse: Guidelines for Treatment (revised report April 26, 2004). Charleston, SC: National Crime Victims Research & Treatment Center. http://www.musc.edu/cvc/guide1.htm

Recommendation 2

Managing a Children's System of Care

Common Assumptions

A system of care is a broad array of effective services and supports for children and adolescents with behavioral health disorders and their families that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery, management, and policy levels. (Pires, S.A. (2002) *Building Systems of Care: A Primer*)

Effective systems of care are built on three core values[1] that must be shared by administrators and direct service providers. These values assert that the system of care should be:

- Child centered and family focused, with the needs of the child and family dictating the types and mix of services provided;
- Community based, with the locus of services as well as management and decision making responsibility resting at the community level;
- Culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the population they serve.

These values are then guided into practice by 10 principles[1]:

- Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical,

1 Adapted from National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development

emotional, social, and educational needs.

- Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
- Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
- The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
- Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
- Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
- Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
- Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
- The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
- Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive

and responsive to cultural differences and special needs.

These values and principles become the foundation of a community service delivery system that is thoughtfully planned, managed and operated to ensure positive outcomes for all vulnerable children and their families.

Recommendations

- A system for managing the availability and utilization of children's mental/behavioral health and child welfare services should be developed and implemented:
    a. This system should include a level of care system that accounts for all levels and types of services;
    b. Each level of care/type of service should have known and overt admission/assessment/screening criteria for entering and moving between levels of care/service types;
    c. Each level of care/service type should also have associated expected treatment outcomes;
- The system should manage more restrictive, higher cost services at a higher priority than lesser restrictive, lower cost services. These higher services include but are not limited to in- and out-of-state inpatient and residential services and group homes;
- Decision making authority should kept at the child/family and provider level;
- Prior Authorization for each level of care/service type should occur;
- Utilization Review at given intervals of service delivery should occur;
- Prior authorization and utilization review should be conducted indiscriminately between children receiving services from the child welfare and mental/behavioral health;

- Outcome studies should be conducted on this management system focusing on its efficacy in improving children's mental health and its efficiency in resource utilization;
- The management system must include an appeal process that involves family and provider input;
- Savings realized from managing higher cost more restrictive services should be cycled back into the children's mental/behavioral health system to improve the accessibility to and quality of lower cost early intervention/prevention home and community based services;
- The management system should encourage the use of evidence-based practices as outlined in prior recommendations;
- The management system should encourage service outcome measures as outlined in prior recommendations;
- Administrative procedures and regulations should be kept to a minimum to ensure that they do not overburden providers or increase administrative costs;
- Real cost centers for service types should be developed without cost shifting from adult services to children's services;
- Current licensing, accreditation, and managed care standards and regulations should be reviewed and revised to result in lower administrative and operational hurdles and costs for provider agencies;
- Qualifications for provider agency direct line staff should be reviewed and streamlined to facilitate movement between levels of care/service types.

Resources

- DHHS has an established Levels of Care system for managing the foster care system that can provide information and insights for the development of a management system for children's mental/

behavioral health system.

- DHHS has contracted with a Beacon Health Strategies, a managed care company, to aid in the development and implementation of a system for managing children's mental/behavioral health services.

Barriers

- The management system could be used to limit necessary child welfare and mental/behavioral health services;
- The management system could discourage the provision of necessary early intervention/prevention home and community based services resulting in escalating mental/behavioral health issues requiring higher cost and more restrictive services;
- The management system could require over regulation and burdensome administrative procedures to the state and provider agencies.
- Current licensing, accreditation, and managed care standards and regulations are not uniform and result in redundant, cumbersome and costly administrative and operational hurdles
- Providers are currently overburdened with the administrative changes with and financial costs of the MaineCare billing system.

Enhancers

- Maine has developed a strong foundation of service types and provider agencies that provide early intervention/prevention home and community based services as well as higher end inpatient and residential services to Maine's children and families.
- DHHS has experience conducting prior authorization and utilization review for in- and out-of-state residential and group home services as well as Assertive Community Treatment (ACT) services.

- DHHS has experience conducting utilization review for Section 37 Home-based Services.

Broad Strategies

- DHHS should explore, develop, and implement a system to manage of behavioral health care, looking to maximize the benefits. This should be done with consumers actively involved in the process
- Input should be solicited from providers to minimize the disruption and maximize the benefit.

Cost Reduction

- It is expected that the effective development and implementation of a system for managing Maine's mental/behavioral health services could result in a more efficient utilization of such services translating into substantial overall cost reductions.
- It is expected that an increase in the allocation of funding for lower-cost preventative home and community based services would result in a reduction in need for higher cost out-of-home services resulting in overall cost.

Recommendation 3

Outcome Measurement

Recommendations, Strategies, and Activities

This set of recommendations focuses on measuring the outcomes of individual children and their families. System-wide outcomes (e.g., length of waiting lists, number of children institutionalized) are also very important, but they are not covered here.

- The Office of Child and Family Services of DHHS focus on three outcome domains: safety, permanency, and well-being.
- All children in DHHS custody will be assessed periodically for safety, mental health needs, and permanency;
- The same outcome measures should be used for all children receiving mental health services whenever this is appropriate. Separate measures will need to be used for children who have specific needs or who are being treated in specific settings: examples include children with developmental disabilities or children in residential treatment.
- Outcome measures should measure the strengths of children and their families as well as their challenges.
- DHHS should use national assessment tools and benchmarks whenever possible in analyzing outcome data statewide and when reporting outcome data back to provider agencies. DHHS could then, for instance, compare the outcomes for the children's public mental health system as a whole to the outcomes achieved in other states; provider agencies could compare themselves to other agencies in Maine and in other states; etc.
- DHHS should develop the necessary information systems to make reporting, analysis, and communication of outcome results as easy as possible.
- DHHS should provide technical assistance to provider agencies

to help them better use outcome data in their continuous quality improvement (CQI) process. This assistance would include use of the measures in a reliable and valid manner, efficient methods of data entry and management, and effective methods of analyzing data in a CQI process. Ohio is one state that has provided extensive technical assistance of this type to local agencies; the Ohio Department of Mental Health's Outcomes Home page can be viewed at www.mh.state.oh.us/oper/outcomes/outcomes.index.

- Outcome data must be fed back in timely manner and a useful format in order for it to be useful to agencies, clinicians, and families.
- Use of outcome data in an open and effective manner will require that providers and clinicians are not penalized for reporting poor outcomes initially. Using limited outcome data for reimbursement or contract renewal decisions, for instance, may greatly inhibit the effective use of outcome data for CQI purposes. Agencies and clinicians should, however, be held accountable for using outcome data as part of an effective CQI process.
- Decisions about reimbursement or contract renewal should never be based exclusively on outcome data.
- Changes in outcome measurement imposed from the top down will likely evoke resistance and not be effective. Improvement of Maine's system for measuring outcomes will require a collaborative effort of all major stakeholders. A workgroup with representatives of all major stakeholders should be convened for the purpose of planning an outcomes management system and overseeing its implementation. It may be that this workgroup should be joined together with the workgroup on implementation of evidence based practices; both of these initiatives are efforts to improve the quality of mental health care for children.

- Effective use of outcome data in an agency's CQI process should be a requirement for agency recertification.
- Measurement of outcomes of mental health services is a field that continues to progress; we must stay aware of the development of new instruments. Instruments currently being developed, for instance, do a much better job of eliciting information directly from parents and children

Rationale

- Continuous Quality Improvement (CQI) is a well accepted method for improving the quality of any organization's work.
- Use of outcome data in a CQI process will improve the quality and efficacy of services provided by DHHS.
- Outcome data can inform CQI processes at several levels: DHHS, provider agencies, individual clinicians, and individual families (consumers). DHHS can use outcome data to evaluate and improve the effectiveness of the children's mental health system as a whole, as well as individual program initiatives (e.g., assertive community treatment, case management, in-home behavioral services). Provider agencies can evaluate/improve the effectiveness of their agency as a whole, individual programs, or individual clinicians. Individual clinicians can use outcome data to help learn why some of the children they are treating are improving more and others less. Individual families can use outcome data to evaluate and improve the progress they are making.

Barriers and Concerns

- No outcome measure is perfect; any outcome measure will capture only a portion of the mental health progress of a child.
- If concrete rewards (reimbursement, contract renewal) are tied

closely to initial outcome measures, agencies and clinicians may be encouraged to focus only on the portion of the child's mental health that is being measured.
- Providers may fear that outcome measurement will be used against them, instead of as a tool to help CQI.
- Providers already cope with a large number of regulatory requirements. This runs the risk of being seen as yet another piece of paper work.
- DHHS computer system is not yet sufficiently developed to enable an efficient outcome measurement system.

Resources and Enhancers

- DHHS, provider agencies, clinicians, and advocacy groups all agree that outcome measurement is a key component of quality improvement.
- DHHS and many children's mental health providers already have experience with a nationally recognized outcome measure (CAFAS).

Broad Strategies

- DHHS work with key stakeholders to identify key outcomes to be measured.
- DHHS work with other states and managed care organizations to obtain a system that can:
    - Support a clinically comprehensive outcome measurement system
    - Allow provider web access to the system (to enter data and access reports)
    - Create timely and relevant clinical reports
    - Create timely and relevant reports on the system outcomes
- Further explore Systems Integration Grants to support this

paradigm change in the delivery of mental health services

- Explore support from private insurers and managed care organizations.
- Explore purchase of existing Information Services, rather than jury rigging a system that we know is marginally capable.

Cost Reduction

The most expensive treatment is treatment that is ineffective. Outcome measurement will not lead to an immediate reduction in the cost of mental health treatment. Outcome measurement and an associated CQI process will, however, lead to an improvement in the quality and effectiveness of mental health services; this improvement will lead to a reduction in more costly forms of care (hospitalization, residential treatment, and overall medical health care costs) and a reduction in the chronicity of children's mental health problems. There also will be reductions, or at least cost neutrality in the total costs of health care, education and corrections.

Major Activity Time Line

This really depends on:

- Developing a strong political will,
- Creating opportunities that allow an initial expense while creating long term savings and continuous quality improvements.

Recommendation 4

Treatment Foster Care Rates

Recommendations

- Maintain the current use of five levels of care.
- Maintain the current rate structure for foster home payments.
- Increase efforts to implement concurrent planning and work directly with the family in cases where this will assist in timely permanency for the child. This effort will lower overall costs.
- A level of care assessment should be completed for children placed in unlicensed homes. Although the level will not affect the payment rate to the home, it will provide important clinical information and may help in defining clinical and support services needed for the child and family.
- OCFS should track levels in unlicensed homes separately from licensed homes.
- OCFS should continue to assess the need and recruit placement resources to meet these needs (foster homes) by geographic region allowing children to live in their home communities.
- Assess methods to increase collaboration between DHHS and provider agencies to assure the most efficient use of resources.
- All foster care should be time limited to placements of no more than 12 months. The Levels of Care system should be expanded to also conduct permanency-focused reviews for placements likely to exceed 12 months. Further, the Levels of Care Assessment Team should review progress towards permanency goals and document permanency recommendations for all cases under review.
- Convene a stakeholders' group with a purpose of comparing TFC Evidence-based Models with current Maine Program Standards

for Treatment Foster Care. Revise current standards to adopt evidence based practices wherever possible.

Rationale

Deciding when children are ready to move out of foster care and when new families are ready to take them in is a complex process. Children do not have to be "cured" in foster care in order to move on to greater permanency. They do need to be able to live in a family setting and the family to which they are heading needs to be prepared to care for the child they are getting. Foster parents can be enormously helpful in the transition process.

The current Levels of Care system performs a prior approval and utilization review function for children in foster care to assist in the implementation of the above statement. With universal assessment of children in care, this same system can be expanded for all children in care. The expansion can incorporate additional reviews for children who have not likely to achieve a permanency plan after 12 months.

Specific Changes

Current Status	Proposed Changes
Assessments for children placed in licensed foster homes	Assessments for all children in custody of DHHS regardless of placement option
Level of Care system primarily determines payment level.	Level of Care system functions as case management as well as determining payment levels.
Permanency reviews conducted within DHHS districts	Permanency reviews conducted by Levels of Care system

Existing Resources

- The LOC system provides a structured method for determining treatment levels.
- Level of Care system determines rates through assessments.

Attainable Resources

- Continuation of existing function
- Continuation of current levels and rates.
- Complete assessments for all children in care through Levels of Care system.

Barriers

- There is a risk that children will remain in treatment foster care too long if the goal of stability is given more emphasis than the goal of permanency.
- Many foster parents have received lowered rates with the implementation of the LOC. They all have had reductions in the clothing allowance. The reductions have created a level of discouragement and distrust in the system.
- Payment to foster parents is higher than other states. An exact analysis is difficult due to differing definitions used by states.
- Recent reductions in rates through the levels of care system has hurt foster parents. Greater reductions could jeopardize the foster parent base in the state.

Enhancers

- Treatment foster care is a valuable transitional service and concurrent planning for permanency must be part of each child's experience in treatment foster care.
- Foster parents play a primary role as a provider of treatment

services not a recipient of services.

- Foster parents have higher expectations in team involvement (sometimes weekly), paperwork, accountability and implementation of treatment plans.
- There has been a strong tradition of collaboration at between DHHS and providers at the policy, agency and case level.
- The LOC provides a structured method for determining treatment levels.

Broad Strategies

OFCS in collaboration with provider agencies and other stakeholders should assess the feasibility of expanding Levels of Care functions.

Cost Reduction

Cost reduction may be obtained by fewer children in care and shorter lengths of stay in treatment foster care. There would not be a cost reduction based on the number of levels or the payments per level.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

Short Term

- Monitor total costs of all Levels of foster care and length of stay in higher levels of care
- Completion of feasibility study. Implement pilot project. Maintain existing Levels of Care system and payment rates.

Medium Term

- Implementation of universal assessments and expanded prior approval and utilization reviews.

Recommendation 5

Screening and Assessment

Charged with the task of recommending reforms that reduce duplication, increase effectiveness of early intervention, and develop one system of behavioral health treatment for children, the Reforming Treatment Workgroup explored the process, tools, and issues associated with uniform screening and assessment.

Definitions

Screening is the process by which a large number of asymptomatic individuals are tested for the possible presence of a particular trait (emotional or behavioral problems for example)

Assessment tools assist practitioners to determine with greater certainty the nature of impairment, the nature of the condition, strengths that can be incorporated into a service plan, and/or whether the child identified in the screen could benefit, or has benefited, from the intervention (diagnostic and functional assessment tools, or level of care assessment tools)

Common Assumptions Regarding Screening and Assessments

- Proper screening should accurately identify the need, or lack of need, for more comprehensive behavioral health assessment.
- Reliable, valid and consistent screening can improve early identification and enhance the prevention of more advanced and difficult to treat problems.
- A screening process in a single system should make use of existing screening processes (such as EPSDT, CDS, Head Start,

etc.) and should, whenever possible, minimize duplication and support consistency in the selection and use of screening tools.

- All screening and assessment processes should reflect fundamental values of respect for the child and family.
- Assessment for behavioral health treatment should include the full range of life domains – e.g. Strengths, Concerns, Family Functioning, School Functioning, Drug and Alcohol, Community Functioning, and Responses to Services (Service History).

Common Concerns Regarding Screening and Assessments

- Increased initial costs
- Potential for "pathologizing" normal child/adolescent developmental issues/events
- What will happen if this process identifies a large unmet need for early intervention/treatment?
- Clients fear becoming "involved" with the "system"
- There is a potential in identifying minor problems that might result in unnecessary labeling, stigmatization, and unnecessary psychotherapeutic or medical treatment.

Screening Recommendations

With regards to screening, the work group recommends that DHHS:

- Develop a list of screening tools currently used by state agencies in Maine (EPSDT, CDS, BCFS) – consider other tools for inclusion on the list. Wherever possible develop consistency and uniformity in the screening tools used.
- Identify and recommend a screening tool that could be used by primary care physicians, educators, law enforcement staff, public health nurses, etc. to determine if an apparently asymptomatic MaineCare child might have a disorder or functional impairment

that merits further investigation. This would not be mandated but highly recommended for all children receiving MaineCare benefits.

Rationale

The purpose of broad screening is to identify children and families in need of service who currently "fall through the cracks" and do not receive services until their level of symptomatology can no longer be ignored. Screening would allow earlier identification and treatment, with long term decreased costs and morbidity.

Specific Changes

Current Status	Proposed Changes
There is currently no screening tool that has been selected and recommended by DHHS for use with MaineCare Children	Providers educated about its use
	Providers trained as to where to refer for further assessment if the screening was positive
	DHHS would have to support the expansion and development of early intervention and treatment resources to meet the initial increase in need

Existing Resources

There are currently a wide range of screenings and assessments that are done with MaineCare Children (CDS, Public Health, EPSDT, etc.). Most of the screening/assessment is done with children 6 or under.

Attainable Resources

Appropriate Screening for older children is indicated as well. Current Screening should be reviewed to assess where there are gaps and where there are duplications. Wherever possible and clinically indicated there should be designation of a common screening tool.

Barriers

- Initial increase in referral, with associated costs, particularly for early prevention services.
- Intrusiveness: There was concern expressed that parents and other advocate groups (e.g. Church of Scientology) might object to "testing" and labeling of children. The work group felt that a broad screen would only indicate if there might be a problem, and then parental consent would be sought if further assessment was indicated. There is precedent for this in the routine screening primary care physicians and schools currently do.

Enhancer

- Primary Care Physicians contacted were very interested and supportive of DHHS recommending a standard screening tool for mental health concerns (such as the Pediatric Symptom Checklist (PSC))

Broad Strategies

- There would need to be a public education campaign re:
    - Screening
    - Resources for further assessment and
    - Appropriate intervention strategies.

Cost Reduction

There would be an initial cost increase and then a long term cost reduction or cost neutrality.

Major Activities Time Line

- Determine how EPSDT fits with this initiative, both in terms of screening and funding
- Assess and Review all current tools used – 6 months
- Identify the screening tool(s) - 6 months
- Resolve which children would be screened – 6 months
- Resolve who would administer the tool(s) – 6 months
- Resolve who would read or interpret the results of the assessment
- Resolve how to track the results of the tool in a data system
- Pilot the use of the tool in a couple of locales and then - 1 year
- Gradually implement state wide – 2 years

Assessment Recommendations:

Children for whom child welfare provides care, or children who are 1) at risk of out of home placement or; 2) have been placed in out of home treatment, shall have a broad based assessment, that is strength and needs based, family centered (where appropriate), and considers all the domains relevant to the child's growth and development. This tool should be able to assess the level of care needs, functional assessment (both adaptive and maladaptive) and areas of diagnostic concern. Examples of possible tools are Child and Adolescent Level of Care Utilization Screen (CALOCUS), Child and Adolescent Functional Assessment Scale (CAFAS), Child and Adolescent Needs and Strengths (CANS) scale, Child Behavior Checklist (CBCL).

Rationale

- Children receiving care from Child Welfare, or MaineCare children who are at risk of out of home placement or have been placed in out of home treatment, are at high risk of having a moderate to severe diagnosable mental health problem, which may require treatment. The assessment tools would provide guidance in terms of the specific strengths and diagnoses that would be critical to service planning, and determination of the type of treatment indicated.
- Earlier identification and treatment of this high risk group should decrease overall length of treatment, lower morbidity, and decrease the use of high cost services such as residential treatment and hospitalization. In addition accessing appropriate treatment early could decrease multiple foster placements, with their consequent harmful consequences on children already traumatized.

Specific Changes

Current Status	Proposed Changes
Currently children referred to Child Welfare in central Maine are assessed by the Pediatric Rapid Evaluation Program (PREP). Other children coming into the care of Child Welfare and at risk for out of home placement do not routinely have a comprehensive assessment. If there is one, it is more likely to be a clinical assessment rather than one using a standardized assessment scale.	This proposed change would require all children in these two high risk groups to all have a comprehensive assessment using a standard assessment tool(s).

Existing Resources

In addition to the PREP program, many of the children in this at risk group have current evaluations. What would be required with this recommendation is to standardize what assessment is done.

Attainable Resources

DHHS would have to ensure that providers are trained and able to interpret the test results. Most of the suggested testing could be administered by office staff together with parents and their children. Analysis of the testing can be done by computer.

Barriers

- Resistance to using a standard tool
- Training providers how to interpret the tool
- Tracking assessments results (develop common information system)

Enhancers

- Simplification of complex current system with multiple areas of duplication and gaps

Broad Strategies

- Require through contracting
- Extend PREP pilot beyond central Maine and to high needs children and families served by Children's Behavioral Health Services.

Cost Reduction

There would be an initial cost increase or it would be cost neutral, and then a long term cost reduction or cost neutrality with earlier

intervention and decrease in use of high cost services.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

Short Term

- Determine how EPSDT fits with this initiative, both in terms of assessment and funding
- Assess and Review all current tools used
- Identify the screening tool(s)
- Resolve who would administer the tool(s)
- Resolve who would read or interpret the results of the assessment
- Resolve how to track the results of the tool in a data system
- Pilot the use of the tool in a couple of locales and then
- Gradually implement statewide

Appendix A : Evidence-Based Practice Definitions

A variety of EBP definitions are documented in the literature, and many templates describing the continuum of evidence are available. To describe generally, at the highest end of the EBP continuum, practices are consistently well supported by evidence with multiple, controlled, randomized outcome studies. While some of these well-established practices exist, given that EBP research is in an early stage of development, more practices fall in a mid-range or lower end of the continuum. In the mid-range of the continuum are practices that are supported by some studies demonstrating treatment success, and they may be widely accepted based on clinical knowledge of effectiveness with particular populations, but further research is needed to build or extend the evidence base. At the lower end of the spectrum are those practices that are not supported with sufficient evidence or simply have not been studied. Further, practices that are potentially harmful or concerning are at the bottom of the continuum are should not be used. Table 1 on the following page is a more detailed view of the levels of evidence that are generally described here, and a few examples are provided.

Appendix B:

Table 2: Examples of Evidence-Based Practices for Trauma and Child Abuse[1]

Source	Well Supported Efficacious	Supported, Probably Efficacious	Supported and Acceptable	Promising and Acceptable	Novel and Experimental	Concerning
Child PTSD (ISTSS) International Society for Traumatic Stress Studies	Cognitive Behavioral Therapy (CBT)	EMDR	EMDR	Dynamic Family Group Art		
Child PTSD (NCTSN) National Child Traumatic Stress Network www.nctsnet.org	Trauma-Focused CTB Child Parent Therapy for Family Violence	Abuse-Focused CBT CBIT in Schools PICT ARC	Real-Life Heros Trauma Systems Therapy	Trauma-adaptive recovery group, education and therapy	Modified DBT with DD children Biofeedback Assisted Reduction of PTSD Symptoms	
Child Abuse (OVC)						Holding Therapy

EMDR - Eye movement Directed Recall (previously EM Desensitization and Reprocessing)

CBITS - Cognitive Behavioral Intervention for Trauma in Schools

PCIT - Parent Child Interaction Therapy

ARC - Attachment, Self-Regulation, and Competence: A common-sense framework for intervention with complexly traumatized youth

1 Adapted from: Saunders B., Berliner L., Hanson R. (2004). Child Physical and Sexual Abuse: Guidelines for Treatment (revised report April 26, 2004). Charleston, SC: National Crime Victims Research & Treatment Center. http://www.musc.edu/cvc/guide1.htm

Appendix C: Definitions of Treatment Foster Care (TFC) and Levels of Care (LOC)

Treatment foster care is defined as foster care provided to children with serious medical, behavioral and/or mental health problems with prescribed goals and objectives for care and/or amelioration of such problems, provided in specialized homes with treatment and in-home supports provided by a licensed child placing agency, under contract for such services with the state. (State of Maine Program Standards for Treatment Foster Care in Maine).

Levels of Care (LOC) is a system used to assess children in care to establish a level of care based on the child's social, behavioral, educational, community and emotional functioning. All children placed in licensed foster homes are assessed and the results are used to determine payment level to the foster parent and to ascertain if the child qualifies for placement in a treatment foster home. Those in care are assessed yearly after the first level is determined. LOC also functions as a system of prior approval for treatment foster care and utilization review for maintenance of established levels and matching service levels.

Foster parents in the treatment foster care system are required to maintain a specialized license. The license contains more extensive experience and education requirements, higher yearly training requirements and fewer total placements than family foster homes.

Reforming Community Intervention Programs and Home-Based Services Recommendations

- Prevention and Intervention
- Home-based Services

Reforming Community Intervention Programs and Home-Based Care Workgroup Members

Name	Representing
Joan Smyrski, Co-chair	Office of Child and Family Services
Mary Wegrzyn, Co-chair	Families United
Connie Allen	MADAR Maine Alliance for DHHS Accountability and Reform
Penthea Burns	Muskie School of Public Service
Joan Churchill	Community Concepts
Chris Davis	Richardson Hollow
Margaret Degon	Maine Parent Federation
Lynn Duby	Youth and Family Services, Inc.
Richard Farnsworth	Woodfords Family Service
Isabel Garcia	Former Youth in Care
Mary Haynes-Rodgers	Providence Service Corp of Maine
Lucky Hollander	DHHS, Commissioner's Office
Paul Le Compte	Home Counselors, Inc.
Robert Rogers	Youth and Family Services, Inc.
Francis Sweeney	Office of Child and Family Services
Kim Tousignant	MADAR Maine Alliance for DHHS Accountability and Reform
Annelisa Schneider, Staff	Muskie School of Public Service
Vickie Fisher, Staff	Muskie School of Public Service

Introduction

The Community Intervention Programs (CIP) and Home-based Services Workgroup met twelve times between June 1 and November 22, 2005. CIP providers, home-based providers, other mental health and community service providers, DHHS representatives, Steering Committee members, parents, and youth were represented in this group. Meeting size varied between 12 and 21 attendees, with a core group of ten in consistent attendance.

From the beginning, the Workgroup Chairs set a tone of respectful open dialogue and honest discussion, which was helpful since members came to the table with many questions about the Children Services Reform (CSR) process. Many expressed ongoing concerns about such issues as "a hidden agenda" on the part of the Department, distrust of DHHS due to the Governor's January budget process, and frustration during planning sessions due to non-availability of the Section M/N Rules. It is not an exaggeration to describe the feeling in the room during many discussions as extremely skeptical of DHHS and its plans for moving forward.

Although meetings were contentious at times, members did an admirable job of regularly revisiting agreed upon guidelines for working together as they considered the Steering Committee's charge: *to develop recommendations to support families, prevent removing children from their home communities and assure safe and timely reunification. This will include: Program development options such as family preservation.*

Early on in the process members identified and agreed upon a set of critical components for a children's services system of care, listed on page 73. Despite ongoing differences of approach and varying levels of trust among members, the group came to agreement rather quickly

around and held fast to a set of principles throughout the CSR process. (See Appendix A.)

The group looked at a number of evidence-based and values-based best practice models and felt particularly aligned with The Child Welfare League of America's Standards of Excellence for Services to Strengthen and Preserve Families with Children, which closely mirrored the identified critical components. Therefore, the group agreed to adopt the framework of the CWLA standards.

The Workgroup submitted four recommendations: Youth Voice, Prevention and Intervention, Crisis Response Strategy, and Home-based Services.

Some specificity was lost in the recommendations as the group struggled with and compromised on language and approach to services. Although the process was challenging, the good news is that this diverse group did continue to work together - talking, negotiating, scheduling extra meetings, sending documents back and forth - and was able to come to consensus on many key points in the four recommendations.

Almost to a person, workgroup members expressed willingness to be available on an ongoing basis to continue to inform the process of determining and designing the most effective services for families and children.

Recommendation 1

Prevention and Intervention

Maine shall ensure that an efficient and effective continuum of support services exists, targeted to the needs of all Maine families with identified issues of child abuse and neglect, in order to support families to reduce risk, prevent removing children from their home communities, and assure safe and timely reunification.

Specific Recommendations:

- DHHS will assure that there is continuing quality assurance and ongoing review of data that results in strategies for quality improvement developed in partnership with providers.
- Community Intervention Programs continue to provide stabilization services to low and moderate risk cases.
- Community Intervention Programs continue to provide stabilization services to high risk cases referred by the Department, when this level of stabilization is warranted.
- Community Intervention Programs or similar programs select service models which are flexible and tailored to the individual characteristics of the communities they serve, provided they meet the outcome measurements established by the Department. We support Department efforts to utilize outcome measures to evaluate program success and develop a research base.
- Community Intervention programs can begin to accept Department referrals for reunification cases, when this level of stabilization is warranted.
- We considered the assumption that there would be a savings

in the Community Intervention Program funds due to less volume and did not conclude that there would be a surplus. We recommend that DHHS and a stakeholder group analyze recent historical data and projected volume levels to determine whether or not there will be excess funds, in terms of the Department's goals to define standardized procedures for CPS workers to consistently refer all appropriate cases, emphasize reunification, and reduce foster care and residential care placement.

- We recommend that savings realized in other parts of the child welfare system be reinvested in the continuum of community based prevention and intervention services, based on a gap analysis using the CWLA standards. The Department can prioritize services based on the gap analysis, need and service capacity.

Rationale

Each year, thousands of Maine children living in low, moderate and high conditions of child abuse and neglect are brought to the attention of the child welfare system. Maine law mandates that every reasonable effort be made to maintain family permanency by engaging parents to improve these conditions. This requires that the public child welfare system assertively partner with and consistently utilize Maine's community-based child welfare system. This system, based on the Child Welfare League of America's (CWLA) Standards of Excellence to Preserve and Strengthen Families and Children is cost effective, efficient and effective in reducing child abuse and neglect. Providing family preservation services to all Maine children living in conditions of child abuse and neglect will reduce the escalation of risk, reduce foster care placement, and increase the likelihood of maintaining children safely in their homes.

Maine did not meet the 2003 Federal Safety Review Standard for family preservation. A key finding of the Child and Family Services case reviews was that Bureau of Child and Family Services (BCFS) is not consistent in providing appropriate services to families to protect children in the home and prevent their removal, and is not consistently effective in reducing the risk of harm to children.

Maine policymakers have clearly demonstrated a historic and current commitment to prevention and intervention services to reduce child risk and maintain family stability through its funding of Community Intervention Programs, home visitation, and other community-based services.

Current research and practice data affirms that risk reduction services to children living in families with low/moderate and high risk child abuse and neglect issues are effective and cost effective (See Appendix B: Literature Search).

Program/Practice Issues

- The Child Welfare system needs access to services tailored to stabilize child risk, prevent child removal and assure effective reunification.
- Child Welfare League of America's (CWLA) Standards of Excellence to Strengthen and Preserve Families with Children 2003 clearly identifies what an effective continuum of services should look like:
    - Early intervention via "Family Resource, Support and Education Services"
    - Targeted child abuse and neglect intervention via "Family Centered Casework Services"
    - Intensive family preservation services via "Intensive

Family Centered Crisis Services"

- Maine should clearly state its policy that every effort should be made to keep families together unless the child(ren) is in jeopardy.
- DHHS needs to have standardized/uniform criteria for determining eligibility for program stability services that are appropriate for the child/family.
- Not all high-risk families should stay together.
- Clarification is needed on whether Title IV Refunds are available for family preservation and/or family reunification services.

Resources

Maine has many of the CWLA recommended services in place, including:

- Home visitation, parenting education (part of CWLA's Family Resource, Support, and Education Services)
- Community Intervention (similar to CWLA's Family Centered Casework Services)
- Section 37 (similar to CWLA's Intensive Family Centered Crisis Services), as well as services funded through MaineCare Sections G
- Successful pilots such as "Community Partnerships" in southern Maine

Barriers

- Section 37 services will be phased out after July 1, 2006.
- If services were targeted only to high risk families, children with low and moderate risks would not have stability services, contrary to public policy.
- DHHS has historically had a difficult time effectively monitoring compliance to new policies and procedures across regions.
- MaineCare regulations.

- Categorical funding streams.
- Consideration of one standardized intervention may not meet needs of all children:
    - Assumes a homogeneous population
    - Not strengths-based
    - Level of care determined by program, not family need
    - Assumes homogeneous environment in which to provide services:
        - Maine's rural/urban/small community requires attention to subculture, socio-economic issues
        - Not best practice
        - Out of sync with wraparound principles of family voice and choice and tailored services

Enhancers

- Co-mingling of resources may provide more flexibility of service provision and less reliance on MaineCare.
- Generic funding with graduated support system could allow for more flexibility and less dependency on MaineCare funding.
- Emphasis on keeping families together is significantly more cost-effective for the State:
    - Services to prevent removal are much less costly than foster care and residential care.
    - Services to prevent removal can become a critical component of the child welfare system.
- Community providers are more cost effective than public child welfare workers:
    - Low/moderate risk assessment and services by public child protective workers should be reviewed from an economic standpoint to ensure cost efficiency before transitioning completely from CIPs to CPS.

Cost Reduction

- Prevention/intervention services based on level of care are less costly than one standard intervention.
- Prevention services keep families out of more costly systems of foster care, residential care, residential treatment, incarceration.
- Long term cost benefits (avoidance of high-cost services e.g. incarceration).
- Reentry and recidivism are reduced as families are empowered.
- Better utilization of existing funds may result in short-term savings.
- More support earlier on means less costly support over long haul.

Broad Strategies

- Department will ensure adherence to standardized CIP referral mechanisms in its updated policies and procedures to ensure families are consistently and appropriately referred to CIPs for risk reduction/stability services.
- Any redirection of funds to high-risk families will be spent on a variety of services that are:
    - Family-centered
    - Strengths-based
    - Preventative: focused on preventing removal
    - Reflective of a consistent statewide approach
    - Individualized level of care
    - Designed to retain flexibility at the local/community level and to incorporate family voice and choice
- A system will be developed to enable Child Welfare management and staff to educate themselves about all services available to benefit children and families, so that services are non-duplicative and tailored to the needs of the population.

Major Activities Time Line

Short Term:

- CPS/CIP management team review CPS policies to ensure adequate policies and procedures exist for standardized, mandatory referral to CIP, Home-based, etc.
- CPS Program Improvement Plan (PIP) Workgroup be charged with ensuring new policies and procedures are followed across regions using data management system.

Medium Term:

- CPS/CIP/other stakeholder work group to develop plan to address any gaps in services that would benefit from family preservation and reunification.
- CPS data management system enhanced to incorporate outcome and process oriented management data.

Appendix

Appendix A: Literature Search, page 75.

Recommendation 2

Home-based Services

Maine should have a strong intensive family preservation service in place to prevent child removal whenever possible.

Rationale

Maine's Home-based Mental Health Services (Section 37) is projected to be phased out effective July 1, 2006, and to be transitioned into the new Section M. Maine needs a service for families at the higher end of family complexity* to prevent child removal and to increase the likelihood of successful reunification.

A considered phase out of Section 37 would allow the CIP and Home-based Services Workgroup to reconvene once Section M is made public to continue its discussion and assessment of these issues. The recommended one year timeframe would be used to evaluate practice changes and identify if there are any unintended consequences resulting from the implementation of the new treatment services (Sections 65 M and N).

*Families at the higher end of complexity are those in which there are multiple issues contributing to instability, such as poverty, child abuse, domestic violence, substance abuse, inadequate housing and employment, in addition to mental health. Families with high complexity require advanced worker skills and a continuum of step-down services.

Specific Change

Current Status	Proposed Change
Scheduled phase-out of Section 37 services on July 1, 2006, which serves solely those children who are at imminent risk of removal from their homes.	Establishment of a year's timeframe between the start-up of the redesigned services and the phase-out of Section 37 in MaineCare.

Program/Practice Issues

Section 37 / Home-based Services is currently designed to serve only those children at imminent risk of removal from their families. If the program is eliminated, these families will be served under the (not yet initiated) Section 65 M service. Access to Section 65 M services is expected to be through central enrollment.

- High-needs children currently receiving services under Section 37 are adequately being served - no studies have been shown to prove otherwise. Phasing out Section 37 leaves these children at risk, to be served under an untested new service.
- The MaineCare regulations for Section 37 include a highly relevant crisis-service component: clinical input is available until 11:00 pm on weekdays, and available on weekends. Section 65 M regulations are not expected to provide this service component.

Resources

Child Welfare League of America's Standards to Strengthen and Preserve Families identify the Section 37-type model as the Family Centered Crisis Service for families with imminent risk of child removal. Section 37 model is presently in place but will be phased out by July 1, 2006.

Existing Resources

- Intensive family preservation services currently exist under Section 37, and have a 25 year track record.
- Step-down services currently exist under Section 65G: these need to be tweaked and tightened (however, there is not a consensus that they need to be eliminated).

Barriers

Department's decision to eliminate Section 37 and replace it with Section M and N, for which there may be limited step-down services. Section 37 providers were not party to the development of the new services and are concerned about the implication of these changes.

Based on discussions in the workgroup, DHHS and some providers have different perspectives on the potential cost savings for services to children at imminent risk of removal, that could be realized by the phase-out of Section 37 into the new redesigned treatment services. Providers anticipate it would be revenue neutral, because a service will still be provided; DHHS anticipates a cost savings primarily because Section M will be managed.

Enhancers

By having a redesigned service, the goal is that all children will receive services that are strengths-based, in-home, coordinated by a team, and built on best practices and evidence-based practices.

Broad Strategies

- When the new rules become public, reconvene the CIP and Home-based Services Workgroup (or a similar stakeholder group) to discuss and assess Sections 65M and N:
    - Discussion should include:

- Service models
- Staffing
- Reimbursement
- Eligibility
- Case complexity
- Child welfare / social services issues

- Compile and evaluate outcome data from Section 37 providers (from before and after Regulations change in 2002).
- Seek additional input from Section 37 providers.
- Request analysis of Dirigo monthly eligibility guidelines:
    - Suggestion: consider quarterly rather than monthly assessments to realize savings.

Cost Reduction

- While there is a lack of agreement regarding whether there is a cost savings at all in the proposed changes in Section 37, the Department will assure that the subcommittee will reconvene and conduct a full review with all parties at the table before we make a specific recommendation that addresses this issue.

Major Activities Time Line

Short Term

- Establishment of the recommended year's time frame by the Legislature.
- Proposed Sections 65 M and N rules distributed.
- CIP and Home-based Services Workgroup reconvened to discuss and assess.

Medium Term:

- Evaluate Sections 65 M and N.

Long Term:

- Establish codified Q/A protocol for evaluating impact of rules change.

Appendix A: CIP and Home-based Service Workgroup System of Care Critical Components

Family-Centered and Strengths-Based

- Individualized approach
- No decision about the family without the family
- Removal of children is a last resort
- Removal shouldn't be linked to poverty
- When working with families, ask what they need
- Build family resiliency
- Make parent education and support resources available to screened-out families

Community-Based

- Include natural supports
- Balance between consistent statewide approach and maintaining flexibility and creativity at the community level
- Identify available community resources and bridges to those resources

User-Friendly

- Continuum of care includes prevention, intervention, and treatment services that are flexible and family-centered
- Flexibility to select from a menu of services to meet family needs
- Clear and consistent standards for screening
- Consumer needs drive funding
- Timely access to services
- Services available to all throughout child welfare system
- Low risk and moderate families served (with or without Maine Care)

- Case management to include planning for families reentering the system

Evidence-Based

- Explore evidence-based practice and promising practice in other states
- Department support for development of Maine evidence-based practice through identification of promising practice in local programs

Preventative

- Early intervention to assess needs and identify appropriate services available
- Financial support for families to avert crises (e.g., lack of medical care, housing or childcare) and encourage financial independence
- Economic development at the community level to combat poverty

Appendix B: Literature Search

Current research and practice literature affirms that risk reduction services to children living in families with low/ moderate and high risk child abuse and neglect issues are effective and cost effective. Some excerpts:

- The National Clearinghouse on Child Abuse and Neglect 2003 report "Research to Practice: Reducing Re-Referral in Unsubstantiated Child Protective Services Cases" includes the following Practice Recommendations:
  1. Assess risk more effectively
  2. Provide services to at-risk families in unsubstantiated cases
  3. Employ an alternative response model, like the Community Intervention Program.

  One of the report's conclusions: "One study compared the outcomes of family preservation services (brief, intensive, in-home services provided to families at greatest perceived risk for foster care placement) with what the researchers referred to as "family-centered services" (less intensive, in-home services provided, over several months, to families at lower risk for out-of-home placement) and foster care (out-of-home services). In that study, family-centered services and foster care were found to reduce the risk of re-referral significantly. Family preservation services were found to be associated with a greater likelihood of re-referral involving eventual out-of-home placement. It is important to note, however, that family preservation services were designed to provide intensive short-term services to families at imminent risk of having a child removed. Caseworkers providing family preservation services, who are with a family so frequently, may be more likely to identify risk factors too great to permit the child to remain safely in the home. In this case, re-referral may

actually indicate a higher, not lower, level of protection for the children."
http://nccanch.acf.hhs.gov/pubs/focus/researchtopractice/.

- The Casey Family Program's 2003 report on its "Initiative to Prevent the Need for Foster Care by Helping Parents Strengthen Families" maintains that:
  1. Poverty is the primary cause of family instability
  2. Whenever possible, birth parents and extended families should raise children
  3. Keeping families together is far more cost-effective than supporting youth once they are in foster care.

  http://www.casey.org/NR/rdonlyres/680CAF37-5B7D-433B-9B88-5509011A7086/115/casey_hope_in_the_face_of_adversity.pdf,

- Maine did not have the funding to conduct a formal evaluation of providing stabilization services to low and moderate risk situations, but the State of Minnesota did. Minnesota's November 2004 "Alternative Response Evaluation" report found that "child safety was not compromised by the Alternative Response to child protection. No evidence was found that this approach led to a decrease in the safety of children. On the contrary, there was evidence that the safety status of children improved during cases in which Alternative Response was used and that this was related to increased service provision." http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_001627.hcsp.

- The National Clearinghouse for Child Abuse and Neglect Information "Child Neglect Demonstration Projects: A

Synthesis of Lessons Learned," published in 2004. The study found reductions in foster care placement and CPS referrals in the 10 demonstration projects serving families "considered to be at very high risk for neglect, most families referred by CPS." The report also states "A family empowerment approach, with an emphasis on fostering positive relationships between staff and caregivers, was found to be key," along with offering "a combination of in-home and outside (support) services." http://nccanch.acf.hhs.gov/pubs/candemo/index.cfm.

- Dr. Lawrence Ricci, Director of Spurwink Child Abuse Program, has an article in emedicine.com (2005) that states: "Early detection of at-risk families and appropriate intervention may prevent future abuse. Likewise, identification of children with less severe physical abuse—with aggressive intervention—may prevent more severe subsequent injuries or death." He states as a prognosis: "Without appropriate social service and mental health intervention, child abuse is usually a recurrent and sometimes escalating problem." http://www.emedicine.com/emerg/topic368.htm.

- Excerpts of the 2003 "Issues in Risk Assessment in Child Protection Services: A White Paper," from North American Resource Center for Child Welfare, Center for Child Welfare Policy, Columbus, Ohio:
  - "Formal risk assessment is a single technology with the limited purpose of estimating, with acceptable accuracy, which children in our communities are most likely to be maltreated" (page 27).
  - "The unique role of formal risk assessment in the larger context of child protection is to classify families accurately into groups, based on their likelihood of future maltreatment,

thereby enabling agencies to target the most extensive services to the children and families who most need them. Formal risk assessment is only one component in a larger, more comprehensive process of family-centered casework which incorporates activities of engagement, individualized assessment, ongoing case planning, service delivery, and reassessment throughout the life of the case" (page 19).

- Actuarial based assessment versus "consensus" risk assessment (page 21).

http://www.nccd-crc.org/crc/pubs/ra_issues_whitepaper_2003.pdf

- Actuarial-based risk assessment is discussed in "The Improvement of Child Protective Services with Structured Decision Making: The CRC Model," National Council on Crime and Delinquency, 1999. The California study used structured risk assessment to place families in low, moderate, high and very high categories (random sample of 2,800 families, page 13). At 24 month follow-up:
  - 60% of very high risk had a re-referral
  - 48% of high risk had a re-referral
  - 46% of the total low and moderate risk families had a re-referral (27.5% of moderate and 18.5% of low risk)

The actuarial based risk assessment does categorize children and families by need. However, this data definitely shows the need to provide stabilization services to low, moderate and high risk families in order to stabilize the family circumstances.
http://www.nccd-crc.org/crc/pubs/crc_sdm_book.pdf

Integrating Case Management Recommendations

- Unified Practice Model
- Support of Practice Model
- Quality Assurance
- Transitions and Teaming

Integrating Case Management Workgroup Members

Name	Representing
Chris Beerits, Co-chair	Office of Child and Family Services
Dean Crocker, Co-chair	Maine Children's Alliance
Lisa Burgess	Sweetser
Catherine Charette	Community Health & Counseling Services
Joan Churchill	Community Concepts
Sharon Kelly	Office of Child and Family Services
Kari LeBranche	Youth Leadership Advisory Team
Trish Niederowski	Wings for Children and Families
Sheryl Peavey	DHHS, Bureau of Health
Deb Schaedler	Office of Child and Family Services
Ron Taglienti	Office of Child and Family Services
Maureen Baker, Staff	Muskie School of Public Service
Erica Hansen King, Staff	Muskie School of Public Service

Children's Services Case Management within DHHS-Office of Child & Family Services

Core Case Management Functions

- Engagement
- Assessment
- Teaming
- Planning (DC, transition, support, etc.)
- Interventing / Implementation
- Coordination
- Advocacy
- Monitoring
- Evaluation

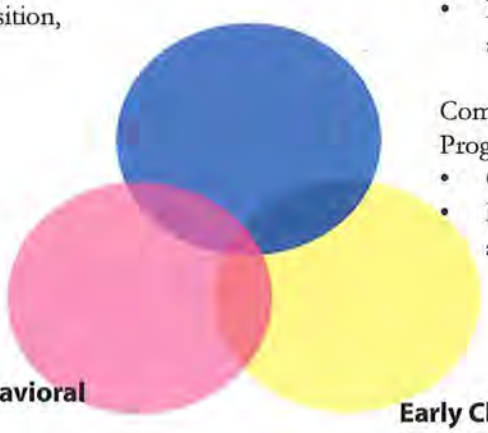
Child Welfare

Reason for Referral / Eligibility

- Investigate reports of abuse or neglect
- MaineCare (if applicable)

Community Intervention Programs (CIP)

- Contract with DHHS
- MaineCare (if applicable)



Children's Behavioral Health

Reason for Referral / Eligibility

- Age 0-21
- Axis I or II diagnosis

  or
- At risk for disability or delay
- MaineCare

Early Childhood Services Reason for Referral / Eligibility

Home Visiting

- First time parent
- Teen parent (under 22)
- MaineCare (if eligible)

Early Head Start

- Income
- Age of child (0-3 years)

Head Start

- Income
- Age of child (3-5 years)

Introduction

The Integrating Case Management (ICM) workgroup was charged with making recommendations for the integration of child welfare and children's behavioral health case management services. We have identified several areas in which policy and procedure must be developed or revised in order to integrate these systems. Our recommendations are organized under the following policy areas:

1. The Office of Child and Family Services (OCFS) should develop unified practice guidelines based on shared values and principles upon which Child Welfare, Children's Behavioral Health Services, and Early Childhood Services conduct their work.
2. DHHS should develop policies, rules, regulations, contracts, and working agreements that support the unified practice guidelines.
3. OCFS should align quality assurance for case management to monitor implementation and outcomes of services provided to assure fidelity to the unified practice guidelines.
4. OCFS should enable efficient and effective transition among case management services for which it has direct or oversight responsibility, while eliminating any unnecessary duplication of case management with any one family.
5. OCFS should adopt current healthcare industry practice to ensure the development and management of a sufficient Targeted Case Management workforce with consistent minimum qualifications and core competencies aligned with the practice guidelines
6. DHHS should resolve outstanding issues of confidentiality in order to expedite referral and delivery of appropriate services, and ensure that the process of sharing client information guarantees consumer rights to choice and to informed consent.

The Integrating Case Management Workgroup recognizes that the

charge to the group was specific to the needs of integrating case management services within the Office of Children and Families, but would like to acknowledge that there are other systems and providers that offer targeted case management services to children and families within the OCFS system and integration with those systems is equally important. The ICM Workgroup has created these recommendations with the current available information relative to this charge. Future forthcoming changes for DHHS management, such as utilization review and other initiatives to manage care, will likely impact implementation planning for the recommendations of this work group.

Additionally, the ICM Workgroup is aware that there are a number of states the nation — Utah, Vermont, Colorado, Wisconsin, New Jersey, Oregon, just to name a few — that have adopted an integrated approach to case management based on a policy level model or set of unifying principles that drive the funding, practice, and evaluation of the case outcomes. The National Governors Association's Center for Best Practices (Enhancing the Capacity for Cross Systems Innovation, 2004), CMHS's Promising Practices series (1999, 2000, and 20001), the Bazelon Center (Mix and Match, 2003) and the Annie E. Casey Foundation (Building Support for Innovation Inside Child Welfare Agencies, 1999), along with the Chapin Hill Center for Children, the National Technical Assistance Center for Children's Mental Health, and the Danforth Foundation (Policymakers' Program series, 1998) and Building Systems of Care: A Primer (2002) by Shelia Pires, all speak to the need to have a unified set of principles and or practice model from which all integrated services can successfully flow. It is the intent of the ICM Workgroup that all of this work can serve as the starting point for realizing a number of the strategies presented within these recommendations.

Recommendation 1

Unified Practice Model

The Office of Child and Family Services (OCFS) should develop unified practice guidelines based on shared values and principles upon which Child Welfare, Children's Behavioral Health Services, and Early Childhood Services conduct their work.

Rationale

Currently there are multiple models for case management being utilized by systems under the Office of Child and Family Services. With the use of multiple models come differences in language, structures, process, policy, and protocols across systems that often work with the same families and children. These differences create challenges to teaming and service integration. By collaboratively developing unified practice guidelines for case management that will be used by all systems within the Office of Child and Family Services, teaming across systems will be improved. A shared structure and practice will help communication across systems and will support the creation of one comprehensive plan with integrated components for each family, rather than multiple plans. In order to articulate the thinking of the ICM Workgroup in support of this recommendation, the group would like to emphasize the following points:

- In order to forge a new identity in our current case management system, we must be willing to relinquish some components of our old separate identities. If we are going to be truly integrated as an Office of Children and Families, rather than a collection of separate, disconnected programs, then some amount of change and transformation is inevitable.
- Although there are a number of existing practice models in

disciplines currently that share some common principles on paper, there has been little to no opportunity to come together across systems to dialogue about what those principles look like in implementation.

- An inclusive process of creating unified practice guidelines across systems would be helpful in bringing about such a dialogue and greater understanding of other case management systems and their values.
- Unified practice guidelines will create an overarching model within which all quality assurance, quality improvement, training, supervision, and support can be aligned across OCFS.

Specific Changes

Current Status	Proposed Change
• Currently, each system has its own language and model for the provision of case management services. • There are four existing models for the provision of case management services in Child Welfare, Children's Behavioral Health, Head Start, and Community Intervention Programs.	• Shared practice and teaming guidelines: a) to develop consistent language, practice and norms for teaming b) to ground the work and direct the service of case management across systems c) to create a foundation for a shared structure and process to engage with families.

Resources

- Children's Behavioral Health Services currently uses the Wraparound Process and has developed a training curriculum for this process, to which all systems may have access.
- Child Welfare has successfully piloted an inclusive process to

develop a new practice model. This process and product can be utilized as a resource.

- Child Welfare has also incorporated Family Team Meetings as an important means to implement their practice model.
- Some Community Intervention Programs are currently using the practice model from the Child Welfare League of America.
- Maine's Children's Cabinet has established Principles and Benchmarks for Collaborative Service Planning through a Letter of Agreement among all departments of state government serving children.
- A comprehensive array of cross systems training (Introductory, Advanced Skills, Facilitation and Train-the-Trainer) has been developed with funds from the Children's Cabinet for an Integrated Case Management Project in Maine. This could be modified to incorporate and support unified practice guidelines.

Barriers

- During the transition time, staff may begin to experience an identity crisis. This often accompanies the beginning stages of collaboration.
- Staff may be hesitant to fully embrace new way of working that is different from how they have done things in the past.
- Competing priorities and initiatives that occupy existing staff time will challenge new development. There may be differing and conflicting perspectives on the work of case management, how staff see families and think case management should be used as an intervention. Some changes may challenge current expectations of some families.

Enhancer

- An inclusive, collaborative process to develop the unified

practice guidelines will support the creation of a product that can be embraced by each system.

- Unified practice guidelines will provide/promote a more comprehensive and holistic view of the child and family across systems.
- The former Bureaus of Child and Family Services and Children's Behavioral Health have already done a lot of internal work.
- The Maine Association of Mental Health Services has also crafted recommendations for a community-based system that has many similarities.
- The Children's Cabinet has endorsed unified practice guidelines across systems that should be incorporated.[1]
- This change is in alignment with many parent and family organizations (e.g. Maine Parent Federation's federal grant funded LINK project) that have already developed similar recommendations.

Broad Strategies

- As soon as possible, create an interdisciplinary work group to identify commonalities and conflicts in beliefs and planning processes, as a foundation for developing the unified practice guidelines based on existing resources. Unit managers in all DHHS organizational units must be directed to catalogue all projects and grants potentially able to be used as resources for work on a unified practice guidelines or whose goals and objectives conflict in some way, the objective being to ensure resources are aligned or inconsistencies reduced.
- There are currently a number of existing and new training programs on case management principles that must be modified to reflect the

1 Children's Cabinet Letter of Agreement on Integrated Delivery of Services to Families ratified in June of 2004 and the Children's Cabinet's Principles and Benchmarks for Collaborative Service Planning also adopted at the same time. Additionally, in Maine there has been a great deal of work done that supports the development of unified model including, A Matrix of Case Management Models within the new DHHS completed in the spring of 2005, Toward A Single Coherent Vision (Eileen Griffin, Muskie School, 2002), and The ICM Initiative Assessment Report (RA Spence, Muskie School, 2000), each of which catalogues some aspect of where Maine is presently and what needs to happen to move towards a unified set of practice principles.

unified practice guidelines. The work around these programs must be inclusive of public and private agencies as well as families. Integrated case management begins with integrated policy and planning and the efforts of all initiatives must be coordinated with present or emerging strategies in the Office of Children and Families. Therefore, we recommend that a work group of stakeholders be convened to review and revise existing initiatives and trainings to ensure that all ongoing and new initiatives are consistent with the unified practice guidelines.

- Develop practice guidelines for Office of Child and Family Services relying on both the successful process piloted by Child Welfare and the work of Children's Behavioral Health Services (Wraparound Process). The practice guidelines must:
    1. Support clear responsibilities and roles for all team members, including all public and private agencies and families;
    2. Make clear what the public-private partnership should look like,
    3. Clarify the roles of both in helping the family develop their plan.
- The development and implementation of the unified practice guidelines must be consistent statewide and should incorporate the values and principles identified in the Collaborative Service Planning Models matrix work that was done two years ago (and includes Family and Systems Teams, Wraparound, and Family Team Meetings).
- Develop a forum, such as an advisory committee, for engaging parents, families, and youth in the development of the unified practice guidelines. Family/parent/ youth organizations should be included early, often, and upfront to guide the development and implementation of the unified practice guidelines so that

the voices of the children and families are heard and considered. This is consistent with the values and principles of the above models/processes.

- Ensure that there is regular record review and that documentation consistently reflects the new unified practice guidelines. If strengths-based practice is part of the guidelines, then identification and application of the strengths should be apparent in the plan and other supporting documentation. If the unified practice guidelines are successfully implemented, families should understand what they have a right to expect from case management, whether involved with one system or multiple systems. As an internal part of an evolving Quality Assurance system, the review process should evaluate and measure:
    1. Statewide consistency with the unified practice guidelines.
    2. Consumer input for both process and outcome.
    3. Uniformity across regions.
    4. Information to management regarding the degree to which clear responsibilities and roles for all team members are in place.[2]

Cost Reduction

Because there must be an initial investment to integrate case management within the Office of Child and Family Services, a reduction in funding to public and private Targeted Case Management cannot be realized at this time. There may be added costs as state and private agencies modify existing administrative systems able to support the new practice guidelines. For example,

2 In terms of strategies for a unified practice model, Maine could review work done over the past seven years in the British Columbia ICM practice implementation as it is grounded in the ministry's philosophical shift in case work practice that includes foundational principles for how all work with families will happen, and there is an extensive evaluation report that reflects high family satisfaction as well as improved case work practice and case outcomes.

existing forms, staff development plans and procedures, and finance systems will need revision in order to implement new policies for cost allocation.

Cost reduction will be realized over time due to increased system efficiency and effectiveness and in proved outcomes. Given research evidence (McKeown, 2000) that social support and client hopefulness have a significant influence on client outcomes, it is reasonable to expect that collaborative work will improve the prognosis for successful outcomes for more Maine families. Cost reductions in years two, three and four will come from:

1. Better coordinated and focused work.
2. Reduced duplication in case management services.
3. More competent staff working in evidence based models.
4. Shortened periods of service through better practice and utilization review.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

Within the first nine months, the unified practice guidelines must be developed through a collaborative and facilitated process, which includes both public and private stakeholders, which draws on existing resources. Staff should be dedicated to coordinate this process, which should build on the successful process that Child Welfare piloted in 2005. This inclusive process will support the Office of Children and Families in forging a new identity as a more unified and integrated office, rather than a host of different programs and disciplines coexisting under one administrative structure.

Recommendation 2

Support of Practice Model

DHHS should develop policies, rules, regulations, contracts, and working agreements that support the unified practice guidelines.

Rationale

Rules, contracts, and working agreements must give staff specific guidance and expectations in various situations, to ensure that work is carried out consistently, to ensure that overlaps in case management have clear rules to avoid duplication and to assure service collaboration. There is a current lack of written protocols across child welfare, children's behavioral health, and early childhood services to clarify how staff should collaborate across systems. For example: non-agency contracted providers for DHHS do not meet the same standards for licensing as a licensed mental health agency.

Specific Changes

Current Status	Proposed Change
Outdated, non-existent, or incomplete working agreements among Office of Child and Family Services case management programs.	Complete, clear working agreements such as MOU's across all Office of Child and Family Services case management programs and families.

Current Status	Proposed Change
Unilateral or non-existent policies. For example there is no policy, procedure or job description to which community case managers can use to understand how DHHS regional management staff are expected to resolve complex case situations (like payment for out of home placements).	Uniform or complimentary policies and practices developed and driven by Office of Child and Family Services and families that are enforced through contracts and consistent with unified practice guidelines. This will lead to uniformity and consistency across the state and within programs.
Agency autonomy.	Clearly written policies that delineate expectations for service and the role of the Targeted Case Management and program managers within DHHS. This is important to identify.

Resources

- Child Welfare Practice Model
- Wraparound Process and existing curriculum
- Child Welfare League of America Practice Model (used by some Community Intervention Programs)
- Collaborative Service Planning Model-Maine Children's Cabinet
- Family/Parent Organizations
- Child Development Services
- Juvenile Justice Detention Alternatives Program (JDAP) and Risk Reduction Program (JRRP)
- National models that can provide examples for development of

policy, protocol, and procedures [1]

Barriers

- Agencies and Department Divisions will resist giving up their autonomy
- Capacity issues relative to staff time

Broad Strategies

- Standardized policies, rules and regulations for all private and public systems must be developed regarding:
    - Timely and coordinated access to services
    - Timely and coordinated Department response to reportable events.
- There are licensing, contractual, and other requirements that are barriers to families' access to timely services from contract agencies. In support of faster intake and case planning, revisions must be made to these requirements.
- Access by family to Targeted Case Management services should be made available when needed over time. Families should have timely access to care and the ability to be "inactive" for a time and assured timely "reactivation" when needed. There may be differences in the ability of public and private agencies to meet this need.
- Develop a Memorandum of Agreement to define how state agency programs outside DHHS will function as part of integrated teams for children and families.
- Reimbursement policies of DHHS for targeted case management

1 There are a number of models nationally that could serve as examples in terms of actual policies and procedures. The Bazelon Center publication, Mix and Match (2003), discusses the difficulties of bringing integrated systems to scale and has an action step process for implementing integrated services, as well as some successful state examples. Other additional resources include, Kagan, Goffin, Golub, and Pritchard's Toward Systemic Reform: Service Integration for young Children and their Families (1995), and The Community Partnership Practice Model (Community Partnerships for Protecting Children, Spring 2005).

must be consistent across public and private agencies and must ensure that all families from Kittery to Fort Kent receive the same high quality case management service. While some costs may be affected by local geographic and economic factors (like recruitment of staff to rural areas, facilities costs, travel, etc.), principles of reimbursement should not support practice differences but must support quality of care. To the extent the state does support costs associated with different practice models it should be in the context of a plan to test models for adoption by the whole system. There needs to be discussion about quality of care issues and caseload ratios based on quality and availability. The practice guidelines and quality of care need to be reflected in the rate setting process.

- Development of unified practice guidelines, working agreement, policies, licensing and Contractual requirements must assure a process that is inclusive of all stakeholders (families, youth, and all levels of staff).

Cost Reduction

Due to costs of integration of Office of Child and Family Services case management, a reduction in funding to public and private agencies,Targeted Case Management cannot be realized at this time. The annual contracting cycle must be considered in setting time lines in implementing these changes. Thus, savings would not be realized in the coming year, due to the time line.

There will be savings long term, due to increased efficiency, effectiveness, and service provided when needed. Savings and increased consumer satisfaction should begin to be apparent in year three. [2]

2 Cost reductions from the successful integration of case management is dependent on the ability to blend, braid, and or reallocate funding streams at the administrative level which

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

A concurrent process must be employed with the following time line:

Unified Practice Guidelines – 9 months

1. Working agreements – One Year
2. Policies – One year
3. Licensing – One year
4. Contractual and other requirements – One year

would mean that funding is indistinguishable at the point of service delivery and the tracking and accountability for each pot of money is maintained at an administrative level. (Mix and Match, Bazelon Center, 2003)

Recommendation 3

Quality Assurance

To assure fidelity to the practice guidelines, DHHS should align quality assurance for case management to monitor implementation and outcomes of services provided.

Rationale

A unified system of quality assurance and accountability is necessary to support implementation of an integrated services model in the Office of Child and Family Services. An integrated quality assurance and accountability process will more easily identify duplication and other issues affecting team based practice. Managers who have responsibility for assuring fidelity to the unified practice guidelines will have the information needed to do their jobs.

Through a unified system of quality assurance and accountability, the integration of services in OCFS can be more readily achieved, duplication can be more clearly identified and avoided, and teaming across all systems should be improved. Both process and outcome measures are important to ensure success and must be linked. If the process is not based on a comprehensive, accurate assessment of strengths and needs, the interventions in the plan are not likely to be successful. We need a mechanism for families and team members to inform of the degree to which the services they received corresponded to those which we intended to provide. This process, through which we can evaluate their concerns, must be used in all cases to evaluate service integration in the field. Therefore, in order to ensure fidelity to the unified practice guidelines, a unified process evaluation tool must be adopted and administered.

Specific Changes

Current Status	Proposed Change
Separate systems for quality assurance and accountability	Unified, aligned systems of quality assurance and accountability.
Inconsistent, competing, and fragmented orientation and training activities across and within each system	Structures that ensure collaboration and reduce duplication.
At times, Children's Behavioral Health case management continues too long because of systematic barriers to timely re-opening of cases after they have been closed.	Children and families receiving the level, intensity, and duration of services needed.
Thinking you know – relying primarily on anecdotal information.	Specific, measurable goals
	Family-driven care
	Data to show the relationship of process to outcomes.

Resources

- A pilot Process Evaluation Tool has already been developed in Maine and could be utilized for evaluating teams. Remark software could be used to easily scan tools, as well as to generate data reports in a way that requires minimal staff support.
- Quality Assurance unit and MACWIS/Data unit in Child Welfare; Quality Assurance in Children's Behavioral Health.
- Director of Quality Improvement, DHHS

- National QA models for integrated case management [1]

Barrier

- In-house quality assurance resources are currently not integrated or aligned.
- There is not a quality assurance, function or collective database for Early Childhood Services.
- Child Welfare, Children's Behavioral Health and Early Childhood Services are all accountable to various federal agencies for specific data that must be reported as well as for specific quality assurance measures. Therefore they are limited in terms of flexibility to modify data or measures.
- Missions are different, so desired outcomes vary.
- There is no uniform classification/diagnostic system that allows intersystem comparisons of target populations.

Enhancers

- MACWIS for Child Welfare
- Enterprise Information System (EIS) database for Office of Public Health and Children's Behavioral Health Services
- Department of Education is developing a database that produces child specific information, which could potentially profile kids who do well on Maine Educational Achievements and those who do not.

1 Child Trends, ASPE, Chapin Hall, and the Urban Institute have all done work around strengthening program accountability within the context of cross-systems practice and have performance and outcome measures and indicators for integrated service systems that provide examples of how to assure QA across a unified practice model. NGA Center for Best Practice has also done an issue brief on Implementing Results-based Decision making: Advice from the Field (2004) that provides some insights and ideas around cross-agency work and the community's role in achieving results in integrated service delivery. Also, The Power of Outcomes: Strategic Thinking to Improve Results for our Children, Families, and Communities (Cornelius Hogan, 2001) addresses the policy and "big picture" issues around integrating service delivery systems.

Broad Strategies

- Integrate Quality Assurance within OCFS. Integrate the Quality Assurance positions and functions within the Office of Child and Family Services in order to streamline Quality Assurance processes that respond to federal and state mandates through defined standards of quality care.
- Develop and implement process evaluation of Case Management. While the trend may be to move toward managed care and outcome focused systems, federal process mandates (such as Title IV E, Homestead, TANF, etc.) continue to apply to quality assurance review. Therefore, review and modify the many existing process evaluation tools to assess fidelity to unified practice guidelines and develop a protocol for implementation of a new standardized tool. Ensure that the tool is implemented for all child and family teams held through any targeted case management. Institute an ongoing review process to review data generated from the standardized process evaluation tool. Assessment of outcomes/improvements in Case Management should be standardized and ongoing, not just during the implementation phase.
- Develop and Implement Outcome Evaluation of Case Management. Define common success outcome indicators across systems (e.g. avoiding removal, successful reunification, use of kinship/natural supports). Develop outcome evaluation measures and evaluate accordingly.
- Align all agency contracts with unified practice guidelines and new evaluation protocols. Contracts should specify timeliness of service, expectations of process consistent with the unified practice guidelines, and expectations regarding service outcomes.

Cost Reduction

Over time, cost reductions would result from increased system efficiencies as findings from evaluation data are translated into action plans to improve programs. Since OCFS has incompatible data systems that need to be integrated, there is a cost to the system. Long term cost reductions result from better/more effective practice over shorter periods of time and reduction in duplication.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

Align Quality Assurance – 1 year
Process tool – 1 year (concurrent with development of practice guidelines)
Define success outcome measures – 1 year

Recommendation 4

Transitions and Teaming

OCFS should enable efficient and effective transitions and teaming among case management services for which it has direct or oversight responsibility, while eliminating any unnecessary duplication of case management with any one family.

Rationale

Structures must be put in place to ensure that efficient and effective transition occurs and duplication is eliminated. Currently, there is no integrated function to avoid duplication or to ensure efficient and effective service transition for children and families when they are involved with multiple systems. Currently there are virtually no protocols for transferring families between the various Office of Child and Family Services case management programs. This lack of clarity allows service "silos" to continue for a particular family. For example, in one part of the state there is current duplication for 12-26 weeks between Behavioral Health and CIP case management, due to lack of an agreed-upon protocol. The goal is for providers to partner with or refer to other Office of Child & Family Services case managers for families with multiple needs and include them in developing one comprehensive plan with the family, with clearly defined roles and responsibilities for each team member.

Although its effectiveness could be improved, one structure to reduce duplication already exists in the MaineCare billing system. Presently if two providers bill MaineCare for the same service, MaineCare will pay the first bill received and reject other claims. While this is

somewhat effective in discouraging duplication in some instances, it does not provide a structure for communication nor does it prevent duplicative functions from occurring under the different case management services billed under Section 13.

Specific Changes

Current Status	Proposed Change
No mechanism in place to efficiently and effectively transfer a family so that duplication is eliminated.	Protocols and mechanisms in place to facilitate orderly transition and eliminate duplication of service.
No mechanism to ensure communication when transferring a family.	Clarity of roles and responsibilities documented in one plan.
Lack of clarity relative to the roles and responsibilities of other case managers who are working with the same child/family.	One child, one family, one plan to meets the family's need. Multiple agency plans may still be necessary, but the family should experience one shared planning process and have what is for them, one plan.[1]
	In any planning process the individual agency plans will be put on the table to ensure that the plans do not conflict and to make sure they meet the family's needs.

1 The Bazelon Center suggests that: "Successful systems integrate resources behind a common plan for each child and family, to which all the collaborating agencies are committed...each family has one care plan that is coordinated through a single accountable entity but funded with resources from various programs." (Mix and Match, 2003, page 3)

Current Status	Proposed Change
	Memoranda of understanding/ agreement will be developed between departments to support/require integrated plans when clients are shared between departments.

Resources

- Targeted Case Management providers (Child Welfare, CIP, Children's Behavioral Health Case Management, Early Childhood Services, others) recognize the potential value in organized, facilitated transfers and are motivated to develop the necessary protocols.
- Integrating Case Management Work group met with Chris Zukas-Lessard to determine feasibility of modifying existing structures in MaineCare to trigger utilization review function through Bureau of Medical Services when concurrent bills were received from targeted case management providers in different systems with different goals. According to Chris Zukas-Lessard, this would be possible, but not likely attainable for 2-3 years given competing priorities.

Barriers

- Proposal is possible, but due to MaineCare's computer issues, official rule changes regarding MaineCare billings may not be attainable for 2-3 years.

Enhancers

- Proposal is possible.
- MaineCare rules do not preclude integrated assessments and

plans. MaineCare/Medicaid only requires that there be a process for determining that TCM is necessary (including client status), stating what will be done (from the assessment), by what qualified person.

Broad Strategies

- Convene work group of representatives of various Office of Child & Family Services Targeted Case Management programs and private agencies (or extend role of Integrating Case Management Work Group) to develop protocols for efficient and effective transfer of cases, including mechanisms to assure that service/safety plans become part of the new provider's goal plan including utilizing a team concept for developing agreement on initial service plans.
- Develop protocols on transitioning and teaming with families as well as on creating and functioning under a unified child/ family plan, including but not limited to:
    1. Child Protective Services to Community Intervention Program.
    2. Community Intervention to Children's Behavioral Health.
    3. Child Protective Services in Child Welfare to Children's Behavioral Health.
    4. Child Welfare Children's Services to Children's Behavioral Health.
    5. Children's Behavioral Health to Child Protective Services or to Community Intervention Program.
    6. Youth to adult transitioning within the Mental Health/ Mental Retardation population.
    7. Early Childhood Services to Child Welfare or Children's Behavioral Health.
- Develop policies and protocols that allow for multiple case man-

agers of different functions only when there is a clear plan, which differentiates roles and responsibilities.

- Develop protocol that specifies when multiple case managers/ agencies are involved, a meeting must be called with the family and all case managers to define the needs of the family, differentiate the roles and responsibilities of each case manager, and to work with the family to develop their plan. This plan must be documented and disseminated to all team members and the family.
- Office of Child & Family Services must finalize the above protocols and adopt them as official program policies. Staff and public/private agencies must be held accountable for implementing protocols and policies.
- DHHS/OCFS must recognize that the work done by Targeted Case Managers supporting teamwork, integrated assessment, and service planning may become time intensive. To enable essential integration to occur, DHHS must ensure adequate financial support.
- Create a utilization review function that will be triggered by MaineCare when they receive more than one bill under Section 13 for case management. Billing by more than one TCM provider should occur only when the providers certify that they are billing under a unified plan. For example, if Children's Behavioral Health is active with a given child/family and a Community Intervention Program receives a referral and bills for that same family, the Office of MaineCare would trigger a utilization review function for case management on the family. This would require and ensure that caseworkers across systems work collaboratively, documenting their distinctive roles and responsibilities as they develop and implement a unified family plan without duplicating services. To this end, only case management services that are

coordinated and documented in the comprehensive family plan should be billable and acceptable.

- Convene a work group of data information specialists from the Office of Child and Family Services and from Information Technology to explore feasibility of using existing technology to evaluate and monitor areas of targeted case management overlap to ensure a data driven system, rather than one driven by the anecdotal reports of providers and families. This group should determine how to run Child Welfare caseloads, Children's Behavioral Health Services caseloads, and Early Childhood caseloads against each other on a regular basis to evaluate joint involvement and trigger cases for utilization review to avoid duplication of service. This work group must coordinate efforts with the Mental Health Indicators Project. Queries must be extracted from MaineCare to assess where current duplication is most likely and protocols must be developed accordingly. In addition, such data should be given to Systems Integration Directors for regional evaluation and utilization review.

Cost Reduction

A reduction in funding to public and private Targeted Case Management cannot be realized until DHHS successfully implements the strategies outlined above.

When all service providers are orchestrating services together according to an inclusive family plan, there is a strong likelihood that some of the providers can close sooner. The less concurrent case management that you have in a given case, the less State seed is expended. Cost-savings could also include the savings in various other state systems that result from DHHS's use of comprehensive and integrated case planning and management.

Additionally, interagency service delivery systems are "efficient and, if appropriately designed and implemented, can reduce wasted expenditures and improve child outcomes, resulting in significant future savings for many state systems."[1]

Major Activities Time Line:

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

Short term

- 6 months for Data work group. Group may be extended based on its six-month recommendations.
- 1 year for protocol development relative to transitions among case management programs.
- 1 year for protocol when plan is made that needs more than one case manager for implementation
- 1 year for protocol development regarding including all case managers at Family Team meetings to make a plan.

Medium Term

- 2-3 years for billing data feedback.

1 Bazelon Center Issue Brief: Mix and Match: Using Federal Programs to Support Interagency Systems of Care for Children with Mental Health Care Needs, 2003, p. 18 and 19.

It should be noted that in addition to the above brief there are numerous resources that could assist Maine in developing flexible financing to support ICM. Publications reviewed for the CSR work include: (1) The Critical Role of Finance in Creating Comprehensive Support Systems (Orland, Danegger and Foley, 1997) that provides strategies that successfully save money and includes examples of each; (2) The Bazelon Center brief that lays out exactly how to get to blended and or braided funding and provides examples from states (Vermont, Michigan, Wisconsin, NJ, and Indiana) who have done so successfully; (3) Sharing Savings with Multi-disciplinary Teams (Mary O'Brien, 1997) that looks at three types of settings (CW, Multi-Agency, and Medicaid) with various case management structures and how they make flexible funding work to support the integration of services; and (4) Getting to the Bottom Line (Farrow & Bruner, National Center for Service Integration, 1993) that looks at state and community level financing strategies for comprehensive service delivery systems.

Reforming Residential Services Recommendations

- Residential Care Program Standards
- Unified Utilization Review Process
- Analysis of Current and Projected Needs

Reforming Residential Services Workgroup Members

Name	Representing
Dan Despard, Co-chair	Office of Child and Family Services
Steve Tuck, Co-chair	Maine Association of Group Care Providers
Roxanne Carpentier	Former Youth in Care
Neil Colan	Good Will-Hinckley
Nancy Connolly	Department of Education
Deb Gile	CBHS UR Nurse
Roxy Hennings	Department of Corrections
Helen Jones	GEAR Parent Network
Jack Mazzotti, III	Harbor Schools of Maine, Inc.
Mary Melquist	Spurwink
Karen J. M. Mitchell, Esq.	Maine Guardian Ad Litem Institute
Paul Peterson	Sweetser
Nancy Rochat	Turning Point Farm
Frances Ryan	Office of Child and Family Services
Shawn Savage	Catholic Charities
Heather Stephenson	Casey Family Services
Mike Tarpinian	MAMHS, Inc.
Becky Harvey, Staff	Muskie School of Public Service
Leslie Rozeff, Staff	Muskie School of Public Service

Introduction

The Reforming Residential Services workgroup assembled on June 10, 2005 and met ten times before completing its recommendations on November 9, 2005. The workgroup included representation from large and small residential programs, youth, families, the legal community, the DHHS Office of Child and Family Services and DHHS Children's Behavioral Health Services. Comprised of 19 members from across the state, attendance and commitment were high throughout the process.

At the outset, the charge of the Reforming Residential Services workgroup appeared to be the most direct of any of the Children's Services Reform workgroups, since the recommendations were to focus on one component of the larger merged Child Welfare and Children's Behavioral Health systems- the use of residential care for children and youth involved with DHHS. However, challenges for the Reforming Residential Services workgroup arose while the group was forming.

As the group began its work, it became apparent that the larger provider community held skepticism and distrust about the reform process, questioning whether the recommendations of the workgroup would really be acted upon. Provider representatives suggested that while DHHS was undertaking the reform process, they wondered if there was another agenda. They questioned the veracity of the data the Department used, and they questioned whether the Department valued the role of residential care in the array of services. They spoke of being informed of Department decisions rather than being a partner in the planning. Provider representatives spoke of inconsistencies in practice, communications and expectations. They brought forth their historical and current

concerns and were candid about being uncertain whether to invest in the process.

The Department, through its representatives, spoke of the challenges of managing change in a large agency during a merger. They acknowledged that despite an agency commitment to the new direction, not all DHHS staff possessed the commitment or skills necessary to move forward, and they affirmed that practice, communications and expectations were not consistent. They provided context for data that had been cited in reports and during meetings. They spoke of federal outcome measures and of the momentum generated through federal reviews and audits. A defining moment for the group came when the Department representatives acknowledged that finding permanency for children is a shared responsibility, and that the best way to achieve this was in a 'true partnership' with all elements of the system. The DHHS representatives stated their commitment to address inconsistencies in practice, communications and expectations, and to find ways to include the larger provider community in planning.

Once the concerns were named and acknowledged, the atmosphere in which the group worked quickly shifted to one of collaboration. The group developed a written proclamation about the role of residential services in the continuum of care, as well as the shared responsibility among DHHS, service providers and the legal community to promote and achieve safety, permanency, and well-being for those children and youth who must enter foster care. It has yet to be determined how the tenets of this group can be used as the reform process continues.

Together, the group examined demographics, reviewed research and

identified systems issues that impact the use of residential care in Maine. In addition to individual experience and expertise, workgroup members reviewed national best practice models and considered national and state data. All workgroup members were challenged to reflect upon their individual and agency values and practices.

The following three recommendations represent a foundation for future work toward improving the outcomes for children and families who use residential services.

Recommendation 1

Residential Care Program Standards

DHHS develop and implement a comprehensive set of program standards for all children's residential care facilities that are based on family-centered group care principles and practices. These program standards will be consistent with and reflected in licensing rules and/or performance based contracts and a comprehensive utilization review system.

Rationale

Research has shown that programs that engage in family-centered practice in group care/treatment settings show promise of better outcomes for children and families. By working towards optimum family involvement for each child in care/treatment, even when reunification is not possible, agencies using family-centered practice principles have shown that increased family visitation and parental engagement with the program led to a higher rate of completion of treatment, shorter lengths of stay, parental reports of greater positive change in children's externalizing behavior problems over time, and family/school data that were more predictive of maintenance of gains. (Alwon, Cunningham, et al, 2000; Villiotti, 1995; Spence, 2005; CWLA, 2004; Ainsworth, 1991; Knecht and Hargrave, 2002; CWLA, 2003; CT Department of Children and Families 2004; Reitz, 1998; Massachusetts Department of Public Health, 1999; Landsman, Groza, et al, 2001)

Specific Changes

Current Status	Proposed Change
For the most part, children's residential programs in Maine are child-centered.	Children's residential programs in Maine will be family-centered.
Some larger agencies are accredited by different national organizations. If an agency is not nationally accredited, there are no Maine program standards for out of home treatment. The 'Rules for the Licensure of Residential Child Care Facilities' are broad.	Program Standards for all licensed residential child care facilities that incorporate values, principles and indicators of family-centered practice. Agencies adhere to program standards once established.
There are limited performance-based contracts for children's residential services programs.	All children's residential programs will have performance-based contracts.

Existing Resources

- Models for practice standards are available from Child Welfare League of America (CWLA), Council on Accreditation (COA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on the Accreditation of Rehabilitation Facilities (CARF).
- Models for performance-based contracts and outcome measures related to family-centered practices are available from other states.

Attainable Resources

- Children's Behavioral Health Services (CBHS) has funds through MaineCare Section M and N to provide intensive community

based support to children and families as they transition from residential placements to their home communities.

- Office of Child and Family Services (OCFS) has quality assurance and information technology staff who can collate, analyze and report outcome data that is submitted by agencies.

Barriers

- Many persons involved in children's residential services (government, agencies, courts, public at large) are reluctant to embrace family-centered group care practices and principles.
- Best practice models of family-centered group care are still evolving and will require further development.

Enhancers

- Many state workers, families, guardians ad litem, providers, etc. already believe in the family-centered group care philosophy.
- Some agencies already engage in family-centered group care practices and there are pockets of excellence.
- Preliminary research is informative and promising.
- Program Standards would bring the child welfare system in line with CBHS service delivery model of out of home care.
- Recommendation fits with OCFS child welfare practice model and policy revisions.

Broad Strategies

Develop specific program standards that would include practice expectations, process and outcome measures. Work with licensing and contract staff to determine the most effective way to ensure that accountability to the program standards can be accomplished by changing rules or developing performance-based contracts.

Cost Reduction

Changing the system to a model of family-centered children's residential care shows the promise of better outcomes for children and families.

Substantial PNMI savings have already been realized through the reduction in number of children utilizing residential services.

Additional costs will be reduced through:

- Decreased length of stay achieved through practice changes and Utilization Review;
- Having children remain in their home communities;
- Rate setting and capitation methodology.

By reinvesting savings into program development and realigning existing programs to ensure that transition and aftercare services are in place to support children and families upon re-entry into the community, additional savings will be realized as these community based services cost less.

Long term savings will continue to be realized as a comprehensive utilization review system will be in place for prior authorization through discharge. Intensive community based services will be expanded therefore reducing the number of children requiring residential treatment level of services.

Major Activities Time Line

There will be costs associated with the transition to family-centered practice in children's residential services. These costs can be moderated by reinvesting savings, already being realized, into meeting the needs of families to ensure that transition and aftercare services

are in place to support children and families upon re-entry into the community.

Short term: 1-2 years

- Establish and maintain system to track savings achieved by the ongoing reduction of children receiving residential services
- Identify and research costs that will be associated with assisting agencies to move towards family-centered group care practice including training, support and other resources
- Convene a workgroup, including major stakeholders (providers, families, legal community representatives, and DHHS staff) and subject matter experts that would be responsible for coordinating and consolidating information gathered on best practice examples of family-centered group care to develop a comprehensive set of program standards that would include, but not be limited to the following broad areas:
    - Family engagement and involvement in all phases of the child's placement
    - Treatment plan development that is family-centered
    - Program expectations regarding the agency's role in identifying and developing enduring important connections for all children in their programs
    - Integration of children/youth into community-based educational, recreational, and social settings at every opportunity to enhance development of age-appropriate social skills.
- Establish accountability system which consists of the following key elements: program purpose and goals, utilization review, performance measures, a process for valid and reliable data collection and reporting for all contracted providers.
    - Contracted Agency would have responsibility for meeting

and reporting on outcome measures
    - Contracted Agency would have responsibility for ongoing assessment, discharge, transition, and aftercare planning and service delivery
- Reinvest savings into program development and realignment of existing programs to ensure that transition and aftercare services are in place to support children and families upon re-entry into the community.
- OCFS to partner with residential care providers to expand their array of services or help them develop alternative services which would be paid on a fee for service basis and could include:
    - Intensive temporary out of home treatment
    - Crisis and respite care
    - In-home treatment teams
    - Treatment foster care
    - Independent living programs
    - Day treatment/alternative school
- OCFS and Office of MaineCare Services to create a pooled funding system (cost savings are already or will soon be achieved through reduction in numbers of children in residential care, rate setting and capitation methodology) to fund above programs.
- Streamline business processes so that contracting and OMS work more closely with program areas.

Medium term: 2-3 years

- Review and revise licensing rules and/or develop performance-based contracts.
- Provide training, support and necessary resources to agencies as they shift to family centered group care practices.
- Review and revise program standards and outcome measures as needed.

Recommendation 2

Unified Utilization Review Process

The Office of Child and Family Services establish and manage a unified utilization review process for all children's residential services placements. This would include development of a single point of entry for prior authorization, tracking and coordinating care from admission through discharge. Child Welfare will adopt the Children's Behavioral Health Services process, recognizing that some modifications will need to be made as appropriate for the population served by child welfare.

Rationale

Utilization review is the process of determining whether all aspects of a child's care, at every level, are clinically indicated, developmentally appropriate, and appropriately delivered. By establishing a UR process for children's residential services, this will help ensure that placement/treatment is focused on specific needs and that discharge to a lower level of care occurs when those specific needs have been met. (Maine Department of Behavioral and Developmental Services, 2004)

Specific Changes

Current Status	Proposed Change
Uniform admission and discharge criteria do not exist. Each residential program establishes its admission and discharge criteria and policies.	Criteria for admission, continuing stay, and discharge for all children's residential programs will be consistent with the Utilization Review Plan for CBHS. Criteria will be child and family focused, ensure that placement and treatment is focused on specific needs and ensure that a child moves to a lower level of care as soon as possible. By ensuring movement through the continuum of care, beds will be available for those in need of that level of service.
Each child welfare district office has a Residential Review/ Permanency Team, but this is not a strict process. Some residential placements are still occurring without the approval of the Residential Review Team.	OCFS caseworkers will be involved in the review of placements, but the decision will rest with the Utilization Review Team.
Child Welfare caseworkers, at times, underutilize regional placements based on their past experiences. This leads to placements far away from children's home communities.	A unified Utilization Review process that ensures that the clinical care provided is consistent with best practice standards, meets the criteria for Medical Necessity (as defined in statute) and cost effectiveness.

Current Status	Proposed Change
Placements that don't meet the child's needs (too restrictive, not enough structure, inappropriate level of services) result in unplanned discharges, multiple moves and negative impact on child's emotional health.	Thoughtful, thorough matching of child's needs with a program that has the specific services to meet the individual needs and that is located within the home community/region.
Occasionally caseworkers utilize a "blanket/shotgun approach" of sending out multiple referral packets. This is time consuming for multiple agencies to review material and meet with families.	Consistency in the referral, approval, and utilization review process across the state.
Agencies aren't sure who to contact within the Office of Child and Family Services (OCFS) system regarding placement questions (i.e., resource coordinator, Residential Review Team members or caseworker)	Ease of navigation- providers know who to contact
	Continuity of staff- as case moves from the child welfare system to children's behavioral health system, the team members follow the case.
	Ongoing review of treatment needs which allows for move-ment within the system to higher or lower levels of service as needed for stabilization.

Existing Resources

- Children's Behavioral Health Services (CBHS) has a Utilization Review plan and process for Intensive Temporary out of Home Treatment Services (ITOOHTS)
- Provider support- their experience with the CBHS UR is positive

Attainable Resources

- OCFS will explore all existing staff resources to determine how the additional UR staffing needs can be met through reallocation of staff lines

Barriers

- Possible resistance from OCFS caseworkers regarding changes in their authority to authorize residential services and determine placements

Enhancers

- UR system retains team approach and utilizes the existing Family Team Meeting process as venue for input and recommendations

Broad Strategies

Create a utilization review process that focuses on and responds to child and family needs and recognizes individual circumstances. It is the expectation that, in this process, all parties will share a sense of urgency to get the right services in place for the child and family for the right amount of time.

Cost Reduction

It is anticipated that a Utilization Review process will reduce costs for the following reasons:

- More children will be placed at appropriate levels of care, which will ultimately cost less.
- Placements in the child's home community or closest regional opportunity will result in reduced travel costs for caseworkers.
- Utilization Review data from CBHS indicate an average length of stay in residential treatment at 5.5 months which is shorter than current child welfare lengths of stay.

Major Activities Time Line

- Review how current Child and Family Team Process policy fits with existing ITOOHTS Utilization Review process, including clarification of roles, who calls meetings and under what circumstances, etc.
- Redesign the Child Welfare District Residential/Permanency Review Process to ensure it complements the new UR system
- Request that the Legislature expand the Department of Education guidelines for state agency client funding to support children in the foster care system as they transition out of residential care to permanency.
- OCFS to coordinate a process that ensures the Educational Protocol, established for children in foster care, is being consistently followed.
- OCFS to work with Department of Education to ensure that school administrative districts are holding timely Pupil Evaluation Team (PET) meetings each time a child moves into or out of a school. Reinforce Family Team Meeting (FTM) policy to ensure that education staff are included in all FTMs when there are transition issues being discussed.
- OCFS will develop a plan to identify how the additional Utilization Review positions will be funded to support the increase in the number of children that will be reviewed. Plan

will include development of job descriptions which specify title, educational experience necessary, credentials as well as the pay range, location and # of positions needed.

- Develop training for OCFS staff, new UR positions, providers, Guardians ad litem, Judges to ensure a consistent understanding of the utilization review process.
- Establish mentoring plan to ensure that new UR positions share same philosophy and practices statewide that the current CBHS UR nurses operate from.
- Establish policy and procedures as well as a training plan to ensure OCFS placement coordinators, caseworkers and/or supervisors serve in the similar capacity as the CBHS Mental Health Coordinator's (for children in DHHS custody) with regard to a UR process.
- Establish clear definitions for levels of residential services (group home vs. residential treatment center). Utilize recommendations from Group Care Assessment Summary to assist with clearly defined differences in residential program options. ITOOHTS utilizes only facilities with a mental health license while child welfare places children in a range of group care facilities, many of whom do not have mental health licenses yet are still appropriate placement options.
- Activity above done in conjunction with the work of the PNMI group so that fiscal principles are aligned with goals of program areas.

Recommendation 3

Analysis of Current and Projected Needs

OCFS will utilize an analysis of current and projected needs for residential services to plan for future resource allocation.

Rationale

State and local administrators need to be able to determine how much of each type of service is needed within a system of care in order to match need and capacity. This forms the basis for decisions regarding staffing and other resources required. By utilizing a predictive model for out of home care, OCFS can incorporate greater specificity in their planning processes with respect to service capacity and required resources. A predictive model can incorporate projected population changes and factor in certain demographic characteristics that are present within a system at a given time. For example, the State of Maine child welfare system currently has a large percentage of older youth in care. Approximately 40% of the total child welfare population is between the ages of 14-17 and most of these youth are in residential care. As these youth age out of the system, the resource allocation will need to shift accordingly. ((State of New Jersey, 2005; Pires, 1990; MACWIS, 2005; Maine Department of Education, 2004; Maine Bureau of Child and Family Services, 2004; Stuck, Small & Ainsworth, 2000; California Mental Health Directors Association, 2002))

Specific Changes

Current Status	Proposed Change
Individual program development that occurs regionally and is often in response to a perceived need.	Statewide planned service system development that is based on an analysis of regional/district needs and developed in collaboration with providers
Current system which is operating at 70% capacity	A service delivery system with the appropriate number of beds to meet the given need.
Current service clusters (CBHS and Child Welfare) have different ways of identifying placement needs and contracting for those services	A unified system of care which routinely reviews resource needs and has standardized contracting and rate setting procedures
Percentage of children placed in residential care higher than the national average	Achieving target goals which reduce the number of children in residential care and increase the number of children placed with relatives and in family foster homes.
Inability to comprehensively calculate existing out of home care capacity	Utilization of a model to accurately predict resource needs and adjust with the fluid changes in the population being served.
Inconsistent categories of services	System wide resource directory which uses standardized, functional categories of service which are clearly defined

Existing Resources

- Interdepartmental Resource Review Committee
- Director of System Integration positions (to facilitate some of the major activities)
- Extensive data on number of children, geographic location of placements, current levels of services being provided, projected needs
- Predictive model for Out of Home Resource Needs

Attainable Resources

- Accurate, current data regarding the # of beds and where they are located
- Ability to establish factors for a fully developed predictive model

Barriers

- Maintaining a current system while re-tooling the system of care
- There are service gaps throughout the state for specialized programs such as autism or developmental disability/behavioral disorders
- Current system of care and funding structure prevents certain beds from always being accessible when needed. For example, children remain in bridge home or assessment beds beyond the licensed "short term" stay thereby creating a shortage of these types of beds and children being placed either far away from their home community or in a placement which doesn't meet their needs.
- 50% of the existing mortgages held by residential programs are covered by MSHA and there are covenants on transfer of title (e.g., only to another 501 (c) 3 making it difficult for a program to close and sell their property.

Enhancers

- Organizations are motivated to address the occupancy challenges
- Organizations are willing to work with DHHS Interdepartmental Resource Review Committee to explore alternative program/ service delivery options
- DHHS is working with MSHA on the mortgage issue

Broad Strategies

Maintain a collaborative, inclusive process which would include continuation of a workgroup comprised of DHHS staff (central office and regional staff) and providers to establish a comprehensive predictive model of out-of-home care and a system wide resource directory which uses standardized, functional categories of service which are clearly defined.

Cost Reduction

OCFS has established target goals for the following types of out of home placements to be achieved with the next 12-24 months:

	Current	Target	Change
Relative	19.86%	25.00%	5.14%
Family Foster	12.85%	16.00%	3.15%
Therapeautic Foster	27.15%	25.00%	-2.15%
Group Home/ Residential	22.43%	18.00%	-4.43%

The projected savings from the reduction of the usage of 116

residential placements by State agencies (Child Welfare, CBHS, DOC and DOE) would fall between $4.9 to 5.9 million dollars in fiscal year October 2006 to September 2007. See Appendix A, page 132, for more information.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

- Develop accurate master list of all licensed agencies with functional capacity versus licensed bed capacity
- Maintain existing protocol for close-out plans and associated costs (incremental downsizing of population and staff)
- Work with Directors of System Integration to establish plan for regional meetings in each of the 8 districts with the following goals:
    - Bring interdisciplinary groups together (DHHS, DOE, Providers)
    - Collaboratively determine what types of programs and services are needed locally based on data from the predictive model, MACWIS and assessment of current service system
    - Work together to determine the fit between the district needs and capacity and develop strategies for resource allocation.
- Create standardized, functional categories of service which are clearly defined (there are currently 16 categories which do not strictly line up with the licensing rules)
- Identify role for the Directors of System Integration with regard to maintaining the link between services purchased through Central Office and the availability of those services in the regions.
- Maintain the Interdepartmental Resource Review Committee

until such time as an alternative process is established.

- Ensure regular and ongoing review and assessment of the service population and their needs using the predictive model. Revise target goals and resource allocation as necessary.

Appendix A:

The following are some abbreviated examples of the underlying tenets of Family centered group care practices from articles where these principles were taught and implemented: CWLA Trieschman Center Carolina's project, research by Frank Ainsworth, and River Oak Center for Children, Sacramento, CA.

Basic Principles of Family-Centered Group Care Practice

- Placement can be both child-centered and family affirming
- Group care is not necessarily the choice of the last resort
- Children and families are irrevocably linked
- All families have potential
- Family-centered practice promotes family empowerment and builds strengths
- Family-centered practice respects family diversity
- Family-centered practice requires flexible teamwork
- Family-centered practice requires maximum feasible contact.

Adapted from Maluccio, Warsh, & Ine, 1993 and from Ainsworth & Small, 1995

Shifting From Child-Centered to Family-Centered Group Care Provider

	Child Centered Group Care	Family Centered Group Care
Focus	Child Welfare.	Family & child welfare.
Reason for Out-of-home care	Poor Parenting. Parental neglect. Parental abuse.	Family stress environmental and psychological, limited adaptation and coping skills.
Intervention	Protect child by separation from parents. Treat parents and/or remove parental rights.	Protect child as necessary but recognize parents' continuing place in the child's life and accept them as partner's in the child rearing process.
How parents are viewed	Blame them for their inadequacy.	Support parents' efforts to make positive contributions to their child's life.
Child and Youth care tasks	Look after children until they grown up, if necessary.	Teach parents wherever possible how to look after their own children. If not possible, maintain active connections between parent and child throughout period of child's out-of-home care.

Indicators of Family-Centered Practice From the Carolinas Project

- Parents are provided with a handbook or materials, written specifically for them, that outlines relevant agency policies.
- An established, documented grievance procedure is in place for parents who have concerns about their child's care.
- Parents are recognized as full partners in the care of their child with equal input into planning and day-to-day decision making; and diligent efforts are made to insure parents' attendance at and/or participation in all meetings where decisions are made.
- There is a plan for regular and frequent communication between the agency and the parents.
- Visiting and communication between children and their families is open, flexible and restricted as necessary only on a case-by-case basis.
- The agency extends assistance to families for whom a lack of recourses prevents communication or contact.
- The agency provides for family visiting in privacy, in a space conducive to positive family interaction.
- Parents are represented on the Board and/or participate in a formal advisory process in order to provide input into agency policies, practices and program evaluation.
- The agency regularly solicits feedback from its consumers, including clients, family and referral sources.
- The agency works collaboratively with other service providers to families.

Appendix B:

University of Southern Maine, Muskie School of Public Service Residential Care Consumer Survey Fall 2005: Analysis

Context: In Summer 2005, the Residential Service Workgroup surveyed 1000 families that used residential services in the state of Maine between July 15, 2004 and July 14, 2005. There were 60 valid responses received to this survey by the deadline date of 9/23/05. This document summarizes and highlights these responses.

General Demographics: Half of the surveys came from Cumberland (17%), York (12%), Aroostook (10%) and Kennebec (10%). Over half (64%) were filled out by a parent. Over half the children (68%) were 15 or older at the time of their latest placement. A majority (71%) had lived in 1 to 2 places. Roughly half the children had been in residential care for 6 months or less. At the time of the survey, 63% were in residential care and 32% resided with parents. Finally, 58% were in the custody of parents while 25% were in the custody of the state and 8% were now adults. When asked if they were willing to tell their stories, 20 of the 60 respondents said, "yes".

Scaled Responses: The survey included 21 scaled items in which respondents were asked to rate their level of agreement with several statements about residential care services. All of these items were "positively worded", meaning that all represented desirable values and actions on the part of the residential care provider. A score of "1" indicates "greatest agreement", while "7" indicates greatest disagreement. Therefore, lower average scores for each item with less deviation would present the most hopeful results.

Item	Description	Mean	Median	Mode	SD	95% CI	Upper	Lower
R1	My voice is valued	2.6	2	1	2.12	0.54	3.14	2.06
R2	I was made aware of how to raise a concern or file a complaint	3.2	2	1	2.38	0.60	3.80	2.60
R3	I had phone calls and visits with my child immediately following his or her placement	2.5333	1	1	2.35	0.59	3.13	1.94
R4	I have/had adequate phone and visitation contact with my child	1.65	1	1	1.41	0.36	2.01	1.29
R5	Staff's actions show they believe in getting children back with families	2.1167	1	1	1.92	0.49	2.60	1.63
R6	I feel safe to ask questions about my child's care and about the program	1.9667	1	1	1.76	0.44	2.41	1.52
R7	Staff treated my family with respect	1.9167	1	1	1.82	0.46	2.38	1.46
R8	Staff treated my child with respect	1.8667	1	1	1.63	0.41	2.28	1.45
R9	Staff showed sensitivity to our family's culture	1.95	1	1	1.74	0.44	2.39	1.51
R10	Staff helped me see and value my family's strengths	2.75	2	1	2.07	0.52	3.27	2.23
R11	Staff showed they are capable and qualified to deal with my child individual needs/family issues	2.6	2	1	2.14	0.54	3.14	2.06
R12	I was an equal member of the treatment team	2.8333	2	1	2.15	0.54	3.38	2.29
R13	The goals on the transition plan make sense to me	2.5	2	1	2.05	0.52	3.02	1.98
R 14	The length of time my child was in residential care was appropriate	2.5333	2	1	2.20	0.56	3.09	1.98
R15	I am included in the discharge planning for my child	2.0667	1	1	1.81	0.46	2.53	1.61
R16	Being in a residential setting helped my child	1.9333	1	1	1.64	0.41	2.35	1.52

Item	Description	Mean	Median	Mode	SD	95% CI	Upper	Lower
R17	Staff care/cared what happens to my child	1.7667	1	1	1.45	0.37	2.13	1.40
R18	My parenting skills have improved	2.1667	1.5	1	1.89	0.48	2.64	1.69
R19	After discharge, the staff checked to see that the aftercare plans met our needs and helped me with referrals	2.4	1.5	"NA"	2.34	0.59	2.99	1.81
R20	My child's behavior has improved since discharge	2.1333	1	"NA"	2.15	0.54	2.68	1.59
R21	My child is regularly attending school since discharge	1.8333	1	"NA"	2.26	0.57	2.41	1.26

Comments on Scaled items: Most items came out with scores closest to 1 "Strongly Agree" and 2 "Somewhat Agree", as demonstrated by the mode (most common response) for each item. However, some items show a greater diversity of responses, indicating less common agreement. It is also important to note that responses for the last three items clustered strongly around "NA" (no answer) and "Not Sure". Those who did answer these items tended to respond positively. One explanation for this pattern is that not all respondents had a child who had yet been discharged and these questions all address post-discharge planning and results.

One standout item is R2 "I was made aware of how to raise a concern or file a complaint." Response to this item is spread out enough to warrant attention to assuring that this function is fulfilled. Another item with a wide variety of responses is R12 "I was an equal member of the treatment team". A handful of items were closer to averaging a "3" response, giving the impression that parents feel less certain that these values are borne out in practice. Families do, however, seem confident that "Being in a residential setting helped my child" and "Staff care what happens to my child".

Narrative Responses: The survey included 7 open-ended questions designed to encourage free discussion of how staff in residential settings help children and families and how they can improve

their ability to do so. The questions are as follows:

1. What is the most important thing residential services did for your child?
2. What is the most important thing residential services did for your family?
3. How did staff help you during the time your child was coming back into the home?
4. How could staff improve their support of your family?
5. What are some other ways to improve residential services?
6. Please feel free to explain any of the ratings you gave from above:
7. What else would you like us to know?

Taken together, these narratives evidenced some clear themes. These themes included:

Respite: For questions one and two combined, 14 separate comments referenced the value of respite for families and children alike. According to these comments, respite created safety, bonding and healing time for families and increased their ability to respond effectively to other family members.

Behavioral Control: Under question one, 31 comments referenced the value of residential care in teaching or modeling behavior control, including the acquisition of social skills and anger management.

Supervision and Structure: Under question one, 14 of 59 coded comments referred to the importance of providing the child with supervision and/or structure. Under question 2, 7 comments referred again to the importance to the family of knowing the child had a safe, secure, structured environment in which to reside.

Emotional Support: Between questions one and two, 11 comments referred to the support staff members provide the child and 11 referred to the support and encouragement staff provide family members. Comments included "They are there for us", "They gave us hope" and "They were a family to us". One comment referred to the importance of giving the child a "sense of belonging". Under question 3, the willingness of staff to talk a lot during the reunion process and be available afterwards was frequently cited as crucial.

Services: Among the services identified as important to families and children were medical and counseling referrals (including in-home support), reading materials, educational completion (including finding information on programs and setting up PET's), parenting skills guidance and direct suggestions on how to interact with the child. Most frequently mentioned was some form of self-awareness promotion for the family. Two comments on question 2 pointed to inclusion of the family in the treatment process and allowing open communication as crucial elements in service. Under question 3, reunion services cited as useful included longer visits before reunion, calls during home visits the check in, availability by phone, transition planning.

Problems: Question one did not elicit any mention of problems from the child's perspective. Question two included 6 comments expressing the opinion that the residential agency did little to nothing to help the family and 2 indicating uncertainty about whether the agency helped the family. Question two also inspired one respondent to remark that the child's tenure in the facility caused the family to fight more and another to remark the family was deeply hurt by the process. On question 3, a respondent with two children in the system indicated

not enough meetings regarding one of the children, while 6 indicated no help was giving in reunion and 1 responded at length with anger over not knowing what will happen with the child. Under question 4, families repeatedly mention not receiving enough information about what is happening with their child

Suggested Improvements: Families indicated strongly over the course of their answers to questions 4 and 5 (which elicit suggested improvements) that more contact and direction would be extremely helpful. The word "listen" was specifically used 5 times to describe what staff could do. More family therapy also appeared in several comments. It should be noted that 15 of 48 comments on question 4 stated that staff performance was excellent and could not improve.

Some specific suggested improvements were:

- More communication
- More family therapy and greater opportunities to learn parenting skills
- More sibling contact
- A handbook for families
- Weekly group meetings for children after they leave
- Less blame for families
- Information advocate for the child
- DHS to allow for more outside activities/family events—"More normalcy"
- Less staff turnover (better salaries would help) and more staff, smaller staff/child ratio
- Placements closer to home
- More training for staff; make sure staff know parents and are respectful to them
- Better communication/agreement among and with state staff

- Longer program
- Host a family once a month for dinner
- More and better individualized programming
- More help with visits and moves (especially coordinating transportation and more flexibility)
- Better food
- A parent exchange list with phone numbers

Concluding Remarks: The respondents to this survey were clear about that they value and need from residential services a strong connection with the agency and inclusion its process, as well as continuing support after reunion. The responses also show, however, that experience often falls short of this mark. Families are clearly grateful for the assistance they have received through residential services in providing their children with safe, structured environments that teach and model self-awareness and control. Moreover, these services give the families themselves the ability to regroup, heal and strengthen. The single most powerful improvement to this services is, in the opinions reflected here, more and better communication, both written and oral.

In conclusion, respondents offered several items in response to the question "What else would you like us to know?"

Anything Else to Tell Us

- That our kids need to stay in the state. And that parents with kids with disabilities need someone to tell them what is out there, what is available to our children before they become in crisis because it feels like if you don't know – no one tells you. My son is one of the lucky ones - he had a worker at Tri-Co that cared.
- This residential program saved my family!

- The group home claims since my child can do well in group home/small school setting that I could lose funding REGARDLESS of child's inability to function in "real" world. It seems that the program feels that parent involvement is strange. At times I feel they would rather I disappear and my child would become a ward of the state. Therefore, the program wouldn't be questioned by a strong advocate (MOM).
- Spurwink does an outstanding job with autistic children. We did not need family support in that we sought out professional help from other sources.
- Our daughter was adopted @ 18 mos. From the beginning she was tough to parent - we tried every type of therapy (both us & her), multiple drugs always looking for that magic pill that would let us live together as a family. The behavior escalated to the point where safety was a huge issue - the psychiatric hospital said how did we do it so long? Not living with your child is very difficult but which worse?
- I am very grateful for the help.
- The places have never provided a "family therapy" session to help us or the child
- There needs to be more resources that can help parents find residential housing for children. And for agencies to take in consideration how the child is at home compared to Residential
- I've recommended Sweetser to many foster families
- Our stay was Crisis Unit we left after 3 weeks due to a family death. After we left, Mareissa started a new day program else where.
- Staff didn't know me but didn't get up to make sure it was okay for my child to go with me. I wasn't acknowledged. I would not recommend this facility to anybody!
- I think the DHS workers have too heavy a case load, it usually

took 4-5 days to have my son's caseworker call me back when I had a question and she said she would call me after important court date etc. and she never did.

- Care needs to be more needs driven not money driven
- I've recommended Sweetser to several families
- Camden Community School should be replicated elsewhere to assist more students in obtaining their diplomas.
- Maine In-home services are a disaster - ended up in mediation with agency. The system is broke and a total disgrace.
- I am thankful for these services being available, because incarceration was the only other option & not therapeutic.
- I think Phoenix House is wonderful
- Biddeford DHS enabled adults to interfere with foster parenting. They are borderline neglective of treating the family with respect.
- The Phoenix Academy did a wonderful job with my child.
- Our child has not lived at home since July 2004. She has been bounced around between LCYDC & 3 other facilities. It is very discouraging & does not help our teen.
- That peer pressure with teenagers is very hard. Adolescents have a hard time becoming a matured adult.
- There are not many services available and most are reactive not proactive. You have to be in trouble (bad) to get help.
- Keep the focus on the whole family - not just one individual.
- Staff listened to child's complaints and addressed them
- Very disappointed in the care given to the kids that go to the clinic.
- Very helpful and understanding
- My ratings reflect the current program that our child is in - it is an excellent program. If I rated the last program she was in, the scores would be significantly lower.

Appendix C: Role of Residential Services in the Continuum of Care

We have a commitment to preserve and support lifelong family connections for all children. For those children and youth who must enter foster care or residential treatment we believe it is the responsibility of DHHS, service providers and the legal community to promote and achieve safety, permanency and well-being as defined below:

- Safety- means both physical and psychological safety for children, their families and the community. Consideration should be given to how it will be achieved and sustained over time and to the development and implementation of safety plans.
- Permanence- means each child/youth have enduring connections to siblings, extended family members, peers and other significant adults, including birth parents when appropriate. Permanency means having lifelong connections to family history, race, ethnicity, culture, religion and language. It affords the child the rights and benefits of a secure legal and social family status.
- Well-being- means optimal developmental outcomes related to health, mental health, education, vocation, employment/ career, housing, identity, life and relational skills and community engagement will be achieved and sustained over time

We believe that collaborative team planning and decision-making are essential components in an inclusive process for children and families. If a child/youth must come into care:

- A comprehensive, integrated array of services should be available to meet his/her immediate needs
- A child/youth will be placed in a family setting whenever possible
- Agencies will, along with the family team meeting, support and

implement planning for children which takes into consideration safety, permanency and well-being
- Children/youth will be given a voice in decision-making when ever possible

Residential Services play a critical role in the continuum of care and should be utilized when:
- Directed by the Child and Family Team
- There are presenting challenges that the family acknowledges they cannot handle and sufficient community supports cannot remedy
- The Child and Family Team has routinely reviewed the service needs and determined that the residential placement meets specific needs including a treatment component that addresses a permanency plan

Written by the Reforming Residential Treatment Workgroup
July 2005

Appendix D: Projected Savings from the Reduction of 116 Residential Service Beds by October 1, 2006

Variables Used in Calculations	
Residential Services Variables	
FY 05 Total PNMI Rates/Day	$46,720
Number of Homes	146
Days in Year	365
Average PNMI Daily Rate	$320.00
Average PNMI Daily Seed	$108.80
FY 05 Total Room and Board Rates/Day	$6,462
Number of Homes	146
Days in Year	365
Average Room and Board - Daily Rate	$44.26
State Cost for Non-IVE Youth (55%)	$44.26
State Cost for IVE Youth (45%)	$15.05

Estimated Savings					
Type of Savings	Number of Reduce Youth in Group Care	Projected Savings from Less Youth in Group Care at Same Cost	Projected Savings Based on a 4% rise in Mean	Estimated Increase Cost for Children Still in Residential Care at 4% Rise in Mean	Projected Actual Savings Base on 4% Rise in Mean
PNMI Seed (BMS)	116	$4,606,592	$4,790,856	$1,111,936	$3,678,920
R&B (non-IVE)	64	$1,030,683	$1,071,910	$204,198	$867,712
R&B (IVE)	52	$286,717	$298,186	$45,264	$252,921
	Total Savings	$5,923,992	$6,160,951	$1,361,398	$4,799,553

Notes: The projected savings is based on the mean daily cost of to Maine taxpayers for PNMI payments and Room and Board Payments. It should be noted that the Mean is slightly higher than the Median, which would indicate that the average cost is skewed to the higher cost homes. The Mean was chosen since the trend is to close less expensive beds for higher cost treatment beds. It is expected that the Mean cost will rise with the next fiscal year due to this trend. This will result in a higher cost per child, but far less children in the system, so greater savings overall. A 4% increase in the Mean was used based on the 4% increase that occurred between FY 04 and FY 05, due to this trend. Any projection of actual savings also needs to assume increase cost to the children who remain in the program. The projected savings from the reduction of the usage of 116 by State agencies (Child Welfare, CBHS, DOC and DOE) would fall between 4.9 to 5.9 million dollars in FY 10-06 to 9-07.

Source: PNMI Rate Setting Budgets

Developed by Dean Bailey OCFS Residential Program Manager 11-05

Appendix E: Predictive Model for Out of Home Resource Needs in Maine November 8, 2005

The following are percentages for each type of placement:
Changing the target percentages, changes the numbers in the model.

	Current	Target	Change
Relative	19.86%	25.00%	5.14%
Family Foster	12.85%	16.00%	3.15%
Therapeutic Foster	27.15%	25.00%	-2.15%
Group Home/Residential	22.43%	18.00%	-4.43%

Predictive Model for Out of Home Resource Needs in Maine

Starting Values						Starting Values After Targets Applied				Changes to Resources Needed			
	Current Placements									Starting Values-Starting Values After Target			
	A	B	C	D	E	A*Tgt	A*Tgt	A*Tgt	A*Tgt				
Level	Tot Kids in Care	Relative	Fam Foster	Tx Fos	Resid	Relative	Fam Foster	Tx Fos	Resid				
State	2608	518	335	708	585	652	417	652	469	(+134)	(+82)	(-56)	(-116)
District													
1	400	65	50	76	134	100	64	100	72	(+35)	(+14)	(+24)	(-62)
2	444	95	63	106	85	111	71	111	80	(+16)	(+8)	(+5)	(-5)
3	393	93	51	107	81	98	63	98	71	(+5)	(+12)	(-9)	(-10)
4	369	35	43	91	98	92	59	92	66	(+57)	(+16)	(+1)	(-32)
5	288	76	46	90	53	72	46	72	52	(-4)	(+0)	(-18)	(-1)
6	335	77	50	87	65	84	54	84	60	(+7)	(+4)	(-3)	(-5)
7	168	37	24	46	37	42	27	42	30	(+5)	(+3)	(-4)	(-7)
8	211	40	8	105	32	53	34	53	38	(+13)	(+26)	(-52)	(+6)
Totals	***2608***	***518***	***335***	***708***	***585***	***652***	***417***	***652***	***469***	***(+134)***	***(+82)***	***(-56)***	***(-116)***

Predictive Model developed by Muskie School Research Staff

Full Case - Full Court Recommendations

- Managed Care System for Treatment Foster Care
- Relative/Kinship Placement

Full Case - Full Court Workgroup Members

Name	*Representing*
James Beougher, Co-chair	Office of Child and Family Services
Mary Callahan, Co-chair	Adoptive Parent
Meg Callaway	Community Care
Toby Hollander	Guardian Ad Litem
Bette Hoxie	Adoptive and Foster Families of Maine
Nonny Soifer	Maine CASA
Martha Proulx	Office of Child and Family Services
Janice Stuver	Office of the Attorney General
Ann Archibald	Youth Alternatives
Jill Dionne	Community Care
Ed Schnopp	Youth Leadership Advisory Team
Michael Callahan	Youth Representative
Jayme Dennis-Ladd	Office of Child and Family Services
Bob Glidden	Office of Child and Family Services
Lee Hodgin, Staff	Muskie School of Public Service
Nancy Markowitz, Staff	Muskie School of Public Service

Introduction

The Full Case - Full Court (FCFC) workgroup convened for the first time on May 5, 2005 and met on a bi-weekly basis through November 1, 2005. The work group initially consisted of five members, two chairs and two staff from the Muskie School. Over the next five months the group expanded to 16 members and included foster parents and youth.

The charge of the group was to explore the possibility of implementing some form of FCFC in Maine, and to consider its advantages and disadvantages. The group was also asked to consider other alternatives that would meet the goals of increasing permanency for children, save money and reduce duplication of services.

Initially, the group agreed to work toward the development of a FCFC pilot. They also agreed to use the findings from the pilot to decide about expansion of the program statewide. The concept of FCFC was introduced as an approach to therapeutic foster care that would rely on privatization of a part of the child welfare caseworker role. A private agency would assume responsibility of the caseworker role including case management, reunification, court work and adoption. Due to the inability to come to a conclusive determination that FCFC would substantially increase the rate at which children reach permanency, save money, and reduce duplication of services, a decision was made to turn the focus to alternatives.

The group developed a number of alternative recommendations that represent the best effort to meet the charge given to the work group. Three of the recommendations were supported by a majority of group members. These include:

- Relative/ Kinship Placement;
- Managed Care Approach to Therapeutic Foster Care;
- Multi-dimensional Treatment Model for Therapeutic Foster Care.

There were also minority recommendations including:

- Privatization of Adoption Services;
- Performanced Based Contracts: Full Case - Full Court.

Recommendation 1

A Managed System of Care for Treatment Foster Care

Design and implement a managed care system for treatment foster care to increase the likelihood of achieving treatment outcomes in a timely fashion, provide the right services for the right amount of time and reduce the amount of time for children to achieve permanency.

The members voted on whether to move forward with this recommendation. Six were in favor, one opposed and one would be in favor if a conflict/dispute resolution process was included in the recommendation.

Rationale

Since the mid-90s medical and mental health care have been managed in order to reduce costs, improve service, improve cost effectiveness and assure quality services are delivered.

Treatment foster care was originally created to prevent children from entering institutional care and to enable children, who were institutionalized, especially those who were placed outside of Maine, to return to a family setting in Maine. Treatment foster parents are trained and specialize in providing care for children with high needs.

Maine spends thousands of dollars on treatment foster care with too little scrutiny to ensure that services delivered are efficient and effective. A managed care system governing treatment foster care should be designed to increase the likelihood that treatment outcomes

will be met in a timely fashion. Savings would be realized through children and families receiving the right services for the right amount of time. A well designed managed care system would result in its taking less for children to reach permanency.

Specific Changes

Current Status	Proposed Change
Referral for service is based on a mix of treatment and placement needs. Due to a lack of regular foster homes statewide, some children are placed in treatment level homes for lack of another more appropriate resource.	Referral for service (type of home and supportive services to home) based on an independent assessment (separate from provider of services) of treatment need. The assessment is based on an assessment of case data, e.g., presentation of the child and/or family. The entity responsible for the assessment will not be connected with resources responsible for providing treatment. The referral takes into consideration natural support systems such as extended family members.

Current Status	Proposed Change
Team decides what services are available and selects from the menu. Length of service is not predetermined. Funding of service is considered, cost is not considered.	Prior approval from an independent source authorizes a specific number of units of service. The independent approval authority is linked to DHHS or is a part of DHHS with no direct stake in decisions and not subject to legislative pressures. Cost effectiveness is considered and no payment is made for services delivered without the prior authorization.
Treatment milieu is determined by expertise available in the agency.	Treatment milieu is determined by evidence based, cost effective standards based on best practice. Therapeutic foster care is considered a service, within the treatment milieu. Both the independent assessment of the child's treatment needs and the prior authorization would be in place for the child to be place in a therapeutic foster care setting. Structure around fidelity to a model will help in the delivery of consistency of services.

Current Status	Proposed Change
Assessments are reviewed every 90 days.	Treatment is reviewed as units of service are used up and assessed for efficacy. Services continue when child moves into adoption or reunification.
There is no retrospective review of services delivered in complicated or especially costly cases.	Retrospective review of complicated/costly cases.
System is process driven	System is product/outcome driven.
Services determined by resources of the agency. All services are delivered in house (in most but not all agencies.)	Accessible array of services through cooperative agreements among all agencies delivering services. Together, agencies are able to meet the individual needs of children and families by filling in service gaps. Services needed but unavailable in house are delivered by outside sources, for example EMDR. Agencies would be responsible for creating cooperative agreements with services in community.
Service cost determined by agency expense.	Service costs are uniform based on fee schedules.

Current Status	Proposed Change
Paper treatment notes and individual service plans.	An single information management system that is capable of providing cost/ benefit analysis. All record keeping is computerized so it can be analyzed for cost effectiveness. It makes it possible to see what treatment is most effective.
Long term treatment focus.	Brief treatment focus. Treatment is based on the assessment and then assessed within a short period of time. However, if treatment were needed for a specific diagnosis the treatment would be extended. Brief long-term therapy is used for specific diagnoses that repeatedly appear.
Foster care rates are based on the annual Levels of Care assessment of the child.	The Levels of Care system continues to be utilized.
One of the most expensive treatment foster care system in the country.	A state of the art treatment foster care system Maine can afford.
Fair Hearing?	A conflict dispute resolution process is developed and utilized.

How a case tracks through the Managed Care process:

A child/sibling group comes into care [note: all attempts will be

made to place children together, and sibling groups will be treated the same as an individual child below] or a child in placement needs a new placement.

1. The child's caseworker screens the child's needs using school records, medical records, and other available information in the system [is s/he known to CDS, Behavioral Health, etc.?]
2. Based on this preliminary screening for potential special needs, a decision is made to look for a family foster care resource or a treatment resource.
    a. If a family foster care resource is chosen, a review will be conducted in 90 days to determine if the level of care is appropriate. If so, no further reviews are scheduled, but can be requested at any time by the DHHS caseworker.
    b. If the preliminary screening indicates treatment foster care is needed, the child is referred for placement to all available treatment resources (treatment homes) within the criteria for maintaining placement in home community set forth in OCFS policy.
3. When a child enters family foster care, if at 90 day review further supports appear necessary, either services will be wrap-around the child and foster family or the child may be referred for placement to available treatment resources. The child will be maintained in their home community according to criteria set forth in OCFS policy.
    a. If after 90 days it is determined that a treatment placement resource is located and approved, the child is referred to the care manager to authorize a number of sessions for assessment of treatment needs.
    b. If after 90 days the child is assessed as having no treatment needs, the child will receive either level A or level B services and the case will be managed as in 2a., above.

4. If a child is assessed as needing treatment services, a number of units of service of the most cost effective treatment modality will be authorized by the care manager based on the presenting behaviors/special needs, underlying causes, and contributing factors.
5. If the service authorized is available through the contracted treatment agency, it is delivered in house. If not, the provider will refer out for the appropriate service.
6. Once the units of service are consumed, the efficacy of the service is reviewed by the care manager. Treatment is either discontinued or additional units of service are authorized.
7. 4 above continues as long as the child needs the support of treatment foster care services. When treatment is no longer necessary, 6., above.
8. A ceiling amount is set for the expense of the case. Once that ceiling is reached, a utilization review takes place.

Attainable Resources

- Contract or reallocate staff for single point of entry/service authorization-Attainable (insurance companies already have this capability.)
- Single fee schedule.
- Single information management system-attainable (but expensive)
- Training that is uniform for professional staff around the change in focus and how to make that change within the NASW code of professional ethics.
- System becomes truly community based because all resources from every agency are shared.

Unattainable Resources

Team control of product is shifted to an outside source authorizing

services based on evidence based best practice and cost effectiveness. - This may not be attainable.

Barriers

- Agency resistance to change;
- Distrust of DHHS;
- Lack of political will to change;
- This will be very controversial.

Enhancers

- Will save money;
- Can increase community support;
- Will give evidence of what works;
- Will increase customer satisfaction.

Broad Strategies

- The creation of a broad based advisory panel with a similar make up to the steering committee;
- An initial big send off with follow up from a nationally recognized program to address the ethical concerns from professionals;
- A presentation of the proposed change to a joint meeting of the DHHS Committee and the Children's Cabinet;
- State develops an assessment tool that is used for all youth.

Cost Reduction

A cost reduction of 15% is anticipated through the increase in permanency and the reduction in the need for treatment level services.

Major Activities Time Line

Short term 1-2 years:

- Develop criteria for selection and identify advisory committee members to promote and oversee the development of a managed care system for treatment foster care;
- Convene committee;
- Include all stakeholders are identified and represented in the planning process;
- Complete strategic plan;
- Identify assessment tool to be used;
- Develop a uniform rate structure;
- Managed care implementation is phased in.

Medium term 2-3 years:

- Full implementation of managed care;
- Preliminary evaluation results are available.

Long term 4-5 years:

- Full implementation has been underway for two years;
- Evaluation results to date are utilized to improve the process.

Recommendation 2

Relative/ Kinship Placement

Increase the placements of youth into relative's / kinship homes by contracting with private agencies to provide:

- Help in meeting the standards to qualify for licensure by either becoming an adoptive home or a guardian resource (depending on the case goal);
- Support in acquiring and keeping the needed resources to ensure a successful placement.

Rationale

DHHS/OCFS has a clear vision and the mandate to attempt placing children with relatives /kin (Title 22, § 4062[4]). Further, research has shown that children placed with relatives disrupt less and reach permanency sooner. Enabling staff to support relatives with their placement responsibilities, navigating the system and completing the family standards process benefits the children and families we serve.

Private agencies have the expertise in providing supportive services to help stabilize placements and ensure their success. Families served by OCFS would benefit from the agencies experience with these services.

Relatives/ kin are adults that have a legal relationship or emotional relationship due to a significant prior relationship.

Specific Changes

Current Status	Proposed Status
Not routinely providing a menu of supportive services designed to meet the individual needs of the child and relative/ kinship placement resource.	Providing all relative/ kinship placements with services from a contracted agency to ensure their needs are met.
Not providing concentrated services to help the relative/ kinship placement become a licensed or approved resource.	Agency would contact the family within one day of the placement, work collaboratively with the caseworker to asses the child and families needs to ensure the success of the placement.
	Provide in home support to the family as needed.
	Work with the relatives/kin to help them meet the family standards and work toward permanency (reunification, adoption, guardianship).

Existing Resources

- Therapeutic foster care agencies have expertise in working with families to ensure placement success. Their roles could be expanded to work with relative placements;
- Utilization of community resources including community intervention programs (CIP);
- Services and resources exist- they need to be pulled in;
- Adoptive & Foster Families of Maine;
- Family Connections.

Attainable Resources

- Attainable with redistribution of present resources.

Barrier

MaineCare and/or payment, stringency of federal code, PNMI rate- need to pull down other funding stream.

Enhancer

IVE if licensed home, IVB may also be a potential option.

Cost Reduction

It is anticipated that placements in more intensive and expensive programs will decrease as the percentage of placements with relatives/ kinship increases (in relation to the total number of children in care). For every increase of 100 kinship placements we would expect a decrease of 25% in therapeutic placements. This funding could be redirected to the private sector to increase services to relatives/ kin who are providing placements for children in the State's care/custody.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

Short term:

Develop community supports to assist relative/ kinship placements; Fire Marshall standards to be looked at- Can standards be looked at to be more realistic of a family home rather than looking at life safety standards associated with a facility?

Appendix A: Concerns and Feedback from the Foster Family-based Treatment Association in Response to the Managed Care Approach Proposal

- A number of the premises on which this proposal is based are inaccurate.
- A managed care approach would be an overcorrection. Multiple internal and external mechanisms for clinical program and treatment plan reviews are already in place, although they may not be fully utilized.
- Proposed approach adds another layer of bureaucracy, incurring more cost for questionable benefit.
- Substantial improvements may be made in both the quality and utilization of review mechanisms without resorting to a managed care approach, e.g., requiring more substance and uniformity in agency program evaluations, tightening up audit practices, ensuring more DHHS caseworker training and involvement in team meetings.
- Proposed approach would duplicate the work of private agency licensed clinicians who already ensure timely comprehensive assessments and timely reviews and adaptations to treatment plans.
- Simply requiring that a permanency goal be added to every TFC treatment plan would help keep permanency in the forefront, along with other treatment goals that may not necessarily require placement in TFC.
- Providing comprehensive menu of services under one agency when appropriate is efficient and effective. Unbundling services now provided under PNMI risks significantly increasing costs on the board and care side (state costs).
- Comprehensive review of services in complicated and costly cases

is manageable with existing agency and DHHS resources.

- Maine's system is expensive. More effort to control the lengths of stay in TFC will likely save money. Existing resources are sufficient to accomplish this goal. Agencies are now fully informed about - and supportive of - DHHS's shift in policy direction toward shorter stays in care and more timely birth family work.
- Evidence suggests that changes already implemented are working to reduce time in care, e.g., LOC system, agencies' focus on measuring outcomes, promoting more timely birth family work, etc.
- The proposal suggests that clients may remain in non-treatment homes and receive TFC services. Under the current regulations, agencies are not permitted to provide service under these conditions. This may be a model of service DHHS decides to pursue, but it is not TFC.
- LOC already serves as a mechanism for utilization review for placement and could be enriched to provide a comparable review for treatment services.

Recommendations Moved Forward by the Department of Health and Human Services: Not Linked to Budget Initiatives

Community Intervention Programs and Home-Based Services Recommendations

- Youth in Out-of-Home Placements
- Crisis Response Strategy

Recommendation 1

Youth in Out-of-Home Placements

Establish a protocol for engaging youth in placement specifying that when in a placement apart from family, youth will be involved in all aspects of planning for their future, as developmentally appropriate and not to preclude family involvement.

Rationale

The opportunity to be at the center of an authentically collaborative planning process helps youth to develop self-worth and self-confidence, and to have hope for the future.

- When youth are part of a process that respects their need for information and input, they gain a sense of optimism that allows a deeper connection with available supports and resources.
- When their participation is valued, youth are more likely to maintain the energy needed to do the hard work that bridges the divide between setting and achieving goals.
- Inclusion is a powerful motivator for youth, and allows them to practice crucial life skills, such as decision-making, in safe and supportive settings.
- A team approach to developing positive expectations of youth is likely to reduce running away or other avoiding behavior.

In addition to the benefits for youth, the system benefits from embracing the youth perspective, which when positively engaged, is uniquely creative in generating solutions to complex problems.

Specific Changes

Current Status	Proposed Changes
Minimal youth involvement in planning and decision-making regarding out-of-home placements.	Establish a protocol for use by case managers and child advocates that assures that youth will be an integral part of planning for out-of-home placements.

Barrier

Adults' assumption that they know what youth need.

Enhancer

Team of youth available to be utilized in designing the protocol and in training sessions regarding positive use of the protocol.

Broad Strategies

Protocol for engaging youth in placement will address and include:

- All meetings and interactions with youth will be
    - strengths-based
    - solution-focused
    - non-blaming
    - individualized
- Meetings and interactions with youth and family will be culturally competent
- Youth will be part of a process that allows them to:
    - understand the reasons for separation from their family of origin
    - gain resolution of their relationship with the family
    - clarify arrangements for contact with family
- The protocol will be used in conjunction with the Department policy on Family Team Meetings:

- youth will be involved in preparation for team meetings
- youth will be involved in team meetings
- youth-identified best ally/advocate will be included in team meetings
- when reunification is an option, and whenever feasible, parent(s) and
- family will be included in team meetings
- potential placement option(s) will be involved in team meetings

- Youth will be asked:
  - what kind of living situation would be most beneficial
  - to identify professional resources needed to achieve goals set during the planning process
  - to identify family and natural supports needed to make effective use of the plan
- Youth will be included in generating and assessing:
  - available options for placement
  - components that must be in place for reunification
  - expectations and responsibilities of each party involved
- Training will be provided for case managers and child advocates on use of the protocol and will include:
  - strategies for engaging youth in the planning process
  - whenever possible and appropriate, strategies for engaging families in the planning process
  - tools and reporting mechanisms to ensure that the protocol is followed (See Appendix C for suggested reporting tools)
  - guidelines for a culturally competent approach to planning and working with youth

Note from the Workgroup: Strategies identified by Department policy as good for children are also good for families.

Cost Reduction

- Engaging youth more positively may help prevent avoiding and runaway behavior, thereby reducing staff time (particularly overtime) spent on locating and/or moving youth
- For some youth and families, this approach may facilitate the reunification process
- An empowering approach may increase hope and foster a positive outlook for the future, reducing self-harming or problem behavior that leads to more restrictive or longer placements for youth

Major Activities Time Line

Short Term:

- Convene a youth group to help design a protocol, along with guidelines for its use
- Submit protocol to appropriate DHHS Offices for review, revision and development of implementation plan

Medium Term:

- Utilize the protocol to design a presentation by youth to be included in training of case managers and children's advocates
- Develop tools and training that will support case managers and advocates as they implement the spirit and the letter of the protocol

Long Term:

- Develop plan for outcome measurement of the protocol's impact on youth, family and system.

Recommendation 2

Crisis Response Strategy

Initiate a pro-active policy level Crisis Response Strategy designed to ensure a coordinated response to high profile incidents and to avert reactive, crisis-driven policy changes resulting from such incidents.

Rationale

After a high profile incident, it is often the case that various policy bodies initiate investigations and call for sweeping reforms. While the community and the Department should always welcome a sound process of review and accountability, we also need to acknowledge the danger of implementing policy changes in reaction to a specific crisis and the resulting public and media outcry.

Practitioners, providers and policy-makers should recognize that in the aftermath of a crisis, the tendency will be to challenge the status quo: to search for an explanation or remedy by altering current policies whether or not there is evidence that to do so will be in the best interest of children and families. Policy reform should be driven instead by a careful assessment of needs and review of best practice and developed with comprehensive input from all stakeholders.

If our goal is an ongoing evolution of policy and practice leading to best care of children and families, we must acknowledge the profound effect a crisis-driven response to an incident has on those working in the child welfare system. Judgment, good practice and morale are difficult to maintain when the integrity of workers and the system in which they function is continually second-guessed. The

quality of day-to-day work in children's services can be seriously affected by workers' constant fear that, if a child is harmed, managers, policy-makers, and politicians will be quick to make public judgments without fair and careful analysis.

The proposed Crisis Response Strategy would encourage all stakeholders to work together to prevent crisis situations from arising and, when an incident does occur, to deal with it in a coordinated, respectful and effective manner. Although such a protocol could be implemented formally only between the Department and community providers, we would urge the Legislature to make use of it to inform its own response to any future incidents. We expect that an additional benefit to implementation of this protocol would be increased public and legislative confidence in the ability of providers and the Department to provide quality care for children and families.

Specific Changes

Current Status	Proposed Changes
From (current status): Policy "pendulum swings" that: • use an inordinate amount of system time and energy • impact children inappropriately or inadequately • leave providers, Department staff and the public unable to feel confident that the changes provide good care for children and families	Inclusive, considered policy development that encompasses detailed planning by relevant stakeholders.

Existing Resources

Commitment to be clear and planful about policy and practice changes and to communicate directly with community stakeholders.

Attainable Resources

Adequate resources and staffing allocated to this initiative to assure development of a quality protocol and plan for implementation.

Barrier

In response to a specific incident, tendency by some policy-makers and legislators to rush to judgment, assume worst intent, and call for abrupt changes in policy.

Enhancer

A commitment from management to work with all stakeholders to hold the line on panic, judgment and policy changes until a sound analysis of an incident is complete.

Broad Strategies

- Convene a group representative of all stakeholders to create a Crisis Response Strategy
- Systematize a protocol which includes community and Department in a partnership designed to minimize a reactive response to crisis
- Develop steps that would be taken by all parties to assure accountability
- Develop a process for thorough assessment of needs and assets, in order to maximize best use of available resources and avoid duplication
- Create a process for sorting out which issues related to a particular incident are systemic and which are case specific

Cost Reduction

- Emergency responses are expensive: a coordinated approach makes better use of resources
- Sometimes a child receives costly intensive services simply to err on the side of caution: a careful, planned analysis of a case should result in more effectively meeting a child's needs and reducing costs by utilizing intensive services only where really needed
- A comprehensive, agreed upon plan avoids duplication of services and expenditures
- It costs more to provide services to high-risk families than to low and moderate risk families

Major Activities Time Line

Short Term

- Bring all stakeholders to the table to determine criteria against which all crises will be assessed
- Develop Crisis Response Strategy

Medium Term

- Systematize protocol which includes community and Department
- Develop implementation plan for protocol
    - include buy-in from all stakeholders directly involved in child protection
    - urge other stakeholders, including Department Commissioner, committee of jurisdiction (HHS), and Governor's office to work together under Department guidelines and leadership to assure best possible outcome of any investigation
    - develop process for measuring effectiveness and impact of protocol

- Designate parties (individuals and/or committee) responsible for overseeing protocol implementation and quality assurance

Long Term

- Continue to measure and refine protocol in light of any incidents that require its use

Integrating Case Management Recommendations

- Development and Management of Targeted Case Management Workforce
- Resolve Outstanding Issues of Confidentiality

Recommendation 1

Development and Management of a Targeted Case Management Workforce

OCFS should adopt current healthcare industry practice to ensure the development and management of a sufficient TCM workforce with consistent minimum qualifications and core competencies aligned with the practice guidelines.

Rationale

Fragmentation in the field and in training approaches promotes lack of uniformity and collaborative practices. We recognize that there are unique qualifications related to the target populations within each system. However, without shared standards for qualifications, competencies and accountability, it is difficult to deliver consistent case management services or for families to understand what to expect from a case management service.

Specific Changes

Current Status	Proposed Changes
Training for Wraparound is decentralized and varies widely.	Specialized training for different kinds of case management that reflects a common practice, values, and principles.

Current Status	Proposed Changes
Lack of cross systems information and understanding among the programs of Child Welfare, Children's Behavioral Health, Home Visiting and Head Start.	Cross systems knowledge fostered through integrated case management training, thereby enhancing collaboration
Multiple, unlinked training initiatives.	Families involved in the provision of training specific to family-focused, strengths based model of casework.
Only Child Welfare targeted case managers are required to possess a social work license.	Integrated training requirements that promote competencies necessary to meet expectations of an integrated case management system.
Lack of uniform standards for Other Qualified Mental Health Providers (OQMHP) credentialing. Minimum qualifications for OQMHP vary from agency to agency.	Clear and consistent expectations of case management services for providers and families
	Continuity of care
	Uniform credentialing, which travels with the person from agency to agency.

Existing Resources

Training Resources:

Within the State of Maine, training models already exist that can be customized and synthesized for the training of all OCFS case

management staff. Each of these training models is based on strength-based, family focused values and principles. Once the unified practice guidelines are developed, the following resources can be utilized to develop a training program for case managers:

a. Wrap Around training
b. Family Team Meeting training.
c. Family and Systems Teams training.

Qualification Resources:

- A Competency Model for Lead Case Managers in Integrated Case Management, February 2000. (Muskie Institute, USM)
- Children's Targeted Case Management Practice Guidelines, 2nd Edition, Children's Behavioral Health, July 2005.
- Report submitted by the OQMHP subgroup of the "Z" committee of the Children's Mental Health Services Committee of the Maine Association of Mental Health Services in September of 2002. This report offers recommendations on training and certification requirements for Other Qualified Mental Health Professionals (OQMHP) who serve children with mental illness.

Barrier

A higher level of case management may require higher salaries to attract and retain qualified staff.

Enhancer

Maximizing utilization of potential available federal financing under Medicaid and Title IV-E to supplement existing state funding.

Broad Strategies

- Convene a task force that builds on the work of the Maine Association of Mental Health Services Children's Services Committee, adding representation from Child Welfare and Early Childhood Services. Task Force should consult with the human resources systems and make recommendations to ensure that new hires have core competencies for case management and that existing staff acquire them.
- In addition to skill building, philosophy and beliefs must be reinforced through all trainings. Review all existing training programs for MaineCare and state-funded targeted case management to identify common foundational beliefs and underpinnings. Based on this information and input from the task force, make decisions about where staff training could be integrated and where cross systems case management training systems could be implemented. All case management staff and supervisors across the Office of Child and Family Services and their contracted provider agencies will need consistent training about the roles, mandates, responsibilities of other systems and the unified practice guidelines.
- Minimum qualifications for Qualified Mental Health Professional (QMHP) for case management must be standardized and centralized. The certification must be able to travel with the person, rather than stay with the agency. Minimum qualifications are currently contingent upon what services a case manager is delivering and for which agency; thus these vary greatly. At one point, a plan was developed to change the credential requirement to Other Qualified Staff (QS) and the status of this plan must be reexamined. QMHP must be changed and standardized to ensure consistent level of competency for administration of that

credential. Responsible Party: Director, Office of Child and Family Services.

- All practice principles from the unified practice guidelines must be integrated into staff orientation, training, supervision, and performance appraisals. Responsible Party: Director, Office of Child and Family Services.
- Review all existing positions in the context of changed expectations and revise job descriptions accordingly. Responsible Party: Director, Office of Child and Family Services.
- Although this is not a specific recommendation, the workgroup would suggest considering coordinated recruitment by private providers. A number of benefits might accrue from a coordinated effort, including: better matching of individuals to jobs available, more effective recruiting of out of state candidates, decreased costs through coordinated in-state recruiting.

Cost Reduction

Combined, integrated training could reduce training costs. Further cost reduction is possible by increasing efficiency and effectiveness as a result of training. Integrated provision of training could be supported under Title IV-E using the University and/or community college systems' state expenditures as match.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

Convene a task force to address both:

- Qualifications Recommendations - to be submitted within 6 months, and
- Training Recommendations - to be submitted within 12 months

Note: In process of convening, articulate the relationship between this task force and the work group that will be convened by OCFS Director to inventory existing training.

Recommendation 2

Resolve Outstanding Issues of Confidentiality

DHHS should resolve outstanding issues of confidentiality in order to expedite referral and delivery of appropriate services, and ensure that the process of sharing client information guarantees consumer rights to choice and to informed consent.

Rationale

In order for multiple agencies to participate in the development of a joint planning process and integrated plan, issues surrounding electronic and shared access to records must be resolved. Additionally, there are many families (over half of those reported for abuse and neglect) who come to the attention of Child Protective Intake and need help but don't meet criteria for investigation. Currently, these families cannot be referred out for services because there is no authorization to release information. Without this authorization, other divisions of the Office of Children and Families or private agencies cannot be made aware of the need and are therefore unable to do outreach.

Specific Changes

Current Status	Proposed Changes
Each agency having separate release and interpretation of HIPPA guidelines.	Potential for a universal authorization to release information that is legally approved by the Attorney General's Office

Current Status	Proposed Changes
Families having to sign multiple releases for the same agencies, even though they have already authorized this communication to occur.	Family voice and choice ensured.
Families not clear that universal form does not mean universal access.	Child Protective Intake legally empowered to refer to other services those families in need of service for whom CPS and CIP's have no investigative role.

Attainable Resources

Maine Health Information Technology has collected national data about peoples' reactions to sharing confidential health information.

Barriers

- Determining how to ensure that people are able to give informed consent while creating shared access to information is challenging
- Differing federal standards and liability issues make the sharing of information across programs difficult

Enhancers

- There is a great deal of interest nationally to determine how to ensure informed consent within the context of electronic record.
- There is interest in children's mental health and among pediatricians in establishing traveling records.
- Maine Health Access Foundation awarded a grant to Maine Health Information Center to develop a plan for electronic records. This project is exploring possible barriers inherent in such policy implementation relative to law, attitudes and values.

Broad Strategies

- Conduct a study to analyze the group of referrals that come to child protective intake and are screened out as inappropriate. When there are issues that could be addressed by CBH or private contract agencies, explore problems and possible solutions around referring these families to these appropriate services. Responsible Party: Director of Office of Child and Family Services or designee.
- Convene a workgroup inclusive of public and private stakeholders to explore the complex legal and ethical issues surrounding confidentiality including a universal authorization form for release of information. Responsible Party: Attorney General's Office
- Connect with the Maine Health Access Foundation grant-funded project that is working or developing electronic records to improve system ability for coordinating comprehensive medical care. Quality of care, cost savings and privacy are all at issue here. Responsible Party: Commissioner or designee.

Cost Reduction

National interest in electronic records is spurred by two interests. Physicians believe electronic records will improve the quality of care. Federal DHHS believes it will do that and reduce the cost of care. There appears to be considerable research suggesting that better coordinated care is more effective. Therefore, it is reasonable to predict some cost reduction through increased efficiency and effectiveness due to more timely hassle-free access to needed information.

Major Activities Time Line

(short term 1-2 years; medium term 2-3 years; long term 4-5 years)

- Study regarding Child Protective Intake referrals – 3 - 6 months
- Workgroup to explore potential for universal release- 6 months – 1 year
- Connect with MEHA Grant (and other efforts to coordinate care and share health care records) – 2 years.

Full Case - Full Court Recommendation

- Multidimensional Treatment for Treatment Foster Care

Recommendation 1

Multidimensional Treatment Recommendation for Treatment Foster Care

Begin to utilize the multidimensional treatment foster care (MTFC) model developed by Patricia Chamberlain.

The members voted on moving forward with this recommendation. Six voted yes and three abstained. This was the second meeting where this recommendation was discussed and the sense was that more details were needed.

Rationale

MTFC is an evidence based model. MTFC is a comprehensive treatment approach designed to change the trajectory of children's problem behavior by improving their adjustment in family, school, and peer groups. It is an evidence-based model in use in Oregon for over 20 years. It is both effective and cost efficient. It utilizes a behavioral and skill-building approach that emphasizes a child's day-to-day functioning rather than a psychoanalytic approach. Treatment is provided in a family setting where new skills are practiced daily and reinforced.

The core objectives are:

- Establish a supportive relationship between the child and a mentoring adult (not a parent substitute)

- Enforce clear limits and consequences
- Provide close supervision of whereabouts
- Build youth competencies

Research (Chamberlain, Moreland and Reid, 1996) has shown that with the use of the MTFC model there are:

- Fewer placement disruptions
- Fewer foster parents dropping out of providing care
- Fewer child problem behaviors in follow-up

Further research (Fisher, 2004) has shown that there is:

- More successful reunification
- Fewer child behavior problems
- More stable neurobiological outcomes

Specific Changes

MTFC uses a treatment team to provide simultaneous and well-coordinated treatments in multiple settings: home, school and community. Thus the changes would include the following:

Current Status	Proposed Changes
A case manager who coordinates services amongst numerous clinical and outside providers	A team of providers who work closely together to provide co-ordinated services to a child and his/her permanent family

Current Status	Proposed Changes
Clinical providers who may work with various parts of the system but who are not in close and consistent contact with one another	The foster family is the "eyes and ears" of the program and implements a structured yet supportive program in their home. They participate in a weekly, mandatory, treatment planning and support meeting
No clear leader of the clinical team which may lead to clinical and support services that at times work "against" one another	A program supervisor responsible for leading the clinical team and coordinating with outside resources such as a child's school
Optional foster parent support meetings	The aftercare resource or "permanent family" involved in weekly treatment emphasizing behavior management and home visits with crisis back-up

Resources

- A clearly specified staffing model; a dedicated group of foster parents
- Training for staff and foster parents in the MTFC model
- Staff access to appropriate computer resources such as a confidential network to facilitate communication and paperwork/ administrative requirements
- Predictable funding for foster parents: comparable to current funding placements

Barriers

- Clinical services are organized differently than the status quo i.e.

there is 24/7 coverage by MTFC team, co-location of treatment team members, foster home is primary service site
- Recruiting and training foster families
- Making the philosophical shift from individual oriented and group therapies to a parent-mediated model and from a psychoanalytic to a behavioral model
- Making a philosophical shift in which foster parents are seen as "replacement parents" to one in which foster parents are seen as "mentors"

Enhancers

- MTFC research has clarified what it takes to make the program work for severely troubled youth
- Well trained staff and appropriate consultation
- Role stratification: clearly defined roles of each treatment team member have been specified and careful planning is taken to maintain the distinction of these roles. Minimal overlap in roles allows for predictability of treatment and decreased emotionality

Broad Strategies

To implement MTFC there needs to be an enthusiastic staff willing to truly work collaboratively and be available to kids and families 24/7. The staff needs to participate in intensive training designed to clarify role expectations and interventions that are used. Additionally, a group of dedicated foster parents need to be trained to use a behavioral, structured approach with children in their home. To successfully implement this model there needs to be commitment to focus on daily case progress and problem-solving by the entire team. Initially there needs to be weekly consultation from the developers of MTFC to ensure adherence to the model and to monitor the quality of implementation and outcomes.

Cost Reduction

There have been cost-savings studies done on this model for youth who placed in foster care due to criminal activity (Cost Effectiveness Analysis: Washington State Institute for Public Policy, May, 1999):

- Compared to 31 other violence prevention programs and other approaches, MTFC was identified as one of the programs resulting in the greatest savings to taxpayers
- Cost comparisons for treating youth from juvenile justice are approximately 1/3 less than group care
- Net gain to the taxpayer including victim costs that are avoided is $43,661 per youth
- MTFC saved taxpayers $14.07 for every dollar spent

There has also been a study comparing MTFC and hospitalization for youth (Chamberlain & Reid, 1992):

- Youth in MTFC had significantly less days between referral and placement
- Cost of MTFC was ½ cost of hospitalization per month
- Severely emotionally and behaviorally disturbed youth can be safely maintained in a community setting

Major Activities Time Line

- Find staff: 4 - 8 weeks if new staff; 2 - 4 weeks if staff already in positions
- Training staff: Initial training in Oregon is 1 week. This is offered 4 times/year

- Finding foster parents: 3 – 6 months. There may be some current foster parents who are willing to give this model a try. Otherwise, new foster parents will need to be recruited, trained and licensed
- Training foster parents: a 12-hour training that can be done when there is an adequate size group (recommend a minimum of 6 people made up of either couples or single people)
- Arrangements made for consultation: 1-3 weeks

TFC and MTFC: Similarities and Differences

Treatment Foster Care	Multidisciplinary Treatment Foster Care
Requires Specialized Foster Care license through DHHS	Requires Specialized Foster Care license through DHHS
Families work with an agency case manager who coordinates services and provides support as needed	Families work with the MTFC treatment team; services and support are coordinated by the Program Supervisor
Clinical resources available through referral i.e. child may get clinical services through another agency	Clinical resources part of MTFC team i.e. Individual Therapist, Family Therapist, and Life Skills Coach are part of our team
Individualized Service Plans developed for each child in care and plans reviewed on a regular basis	Individualized Service Plans developed for child based on a highly structured, level system that requires Foster Parents to provide close supervision
Foster Parents complete daily logs that record each child's progress towards goals and share these with their Case Manager on a regular basis	Daily phone contact with the Foster Parents to get reports on the child's behavior during the previous 24 hours and to provide support

Treatment Foster Care	Multidisciplinary Treatment Foster Care
Children placed can be 0 – 21 years old	Children can be 0 - 21 years old
Children placed for various time periods depending on permanency planning	Children placed for 6 - 12 months and then return home
Emergency and crisis on-call support through YA community on-call number	24/7 support and back-up directly with MTFC Program Supervisor
Regular Foster Parent Support meetings available	Mandatory, weekly 2-hour Foster Parent Support and Treatment Planning Meeting
Access to planned respite	Access to planned respite
Professional training provided by YA on an annual basis	Professional training provided by YA on an annual basis

Appendix A: Concerns Raised By the Workgroup

- Whether children would stay in the same homes once it was determined they did not need the same level of service provided under MTFC.
- Referenced in an article was 90% permanency rate through this program for children ages 3-6. Go to: www.MTFC.com for information and links.
- Could components of this model be combined with other good components from other models? Treatment fidelity is important under the current view of the Office that evidence-based practices are right for children and families in Maine. Fidelity to the model ensures that a program in Aroostook County is the same as a program in York County. Without research, programs lose legitimacy.
- Regarding the Levels of Care rating needed for a youth to enter this program, it was determined that the level need not be level five. No child would automatically get that level so that they could enter the program. There may be an issue of children receiving the level at entry into care and then when they settle into their new environment they are not seen as having the high level of need they initially presented with. The intent is that children with high needs and their families are able to access this service. Would it be possible to set the rate for these homes outside of the existing Levels of Care structure to $30/day?
- Discussion of the evolution of foster parent rate setting in Maine, including management decisions responding to programmatic needs.
- It was agreed that the best approach to piloting MTFC would be through an RFP, opening it up to all districts. A statistically significant sample size of approximately 200 children for the pilot

across districts would enable program evaluation. Homes for the purpose of providing care under this model would need to be developed. There would need to be a minimum of 8 homes per district

Minority Reports

Full Case - Full Court Recommendations

- Privatization of Adoption Cases
- Family Finders
- Performance-Based Contracts

Recommendation 1

Privatization of Adoption Cases

Privatization of adoption cases by contracting them to private agencies.

The group voted on whether to go forward with this recommendation. Two voted to go forward and five were opposed. This is going forward as a minority recommendation. Concerns expressed by adoption professionals and others appear on pages 226 and 227

Rationale

The transfer of full responsibility of adoption cases to a private agency will reduce caseloads by 30 %; thereby freeing up DHHS caseworkers to focus on children in custody such as upfront preventing removal work for children and families.

This plan will lead to quicker permanency as Department agents will be more able to be actively involved in the reunification process with children and families to improve communication, better facilitate change and decrease the amount of time it takes to get children to permanency.

- This plan will decrease the amount of children in care.
- This plan will increase the quality of care to children and families.
- This plan will reduce the cost of maintaining children in the Department's custody by reducing the amount of time children are in system.

- This will decrease the duplication of services between the foster care agency and the Department as DHHS will be responsible for any and all case management duties involving children in custody prior to a permanency plan of adoption.

Specific Changes

Current Status	Proposed Changes
Treatment foster care agencies currently provide case management and the coordination of their services for children with increased treatment needs that are placed in therapeutic foster homes.	Private agency will remain connected with the child rather than the therapeutic foster home. If the child's placement ends, the child stays with case manager.
Currently a case has multiple caseworkers throughout the life of the system	Agencies will provide case management duties as well as pre and post adoption services to those children with a DHHS permanency plan of adoption only.
The levels of care system is utilized to determine the rate at which foster parents are paid to care for the child	DHHS will provide all case management services to children in their custody with any other permanency plan.
	DHHS will utilize and coordinate therapeutic agency services such as individual therapy, rehabilitation services and family services.

Current Status	Proposed Changes
	Training and collaboration between DHHS staff and agency staff, in order to ensure smoother transition to the adoption program.
	The Department and the agencies will share a common philosophy and utilize a similar practice model. The present DHHS model will be utilized.
	Each family will have one caseworker to reduce the number of transitions children endure in the system.
	This proposal includes outcome-based reimbursement for the therapeutic agencies so measurable goals are more readily achieved.

Existing Resources

- Child Welfare Training Institute
- Skilled Department caseworkers
- Kinship placements
- Foster care and adoptive placements
- Case management duties
- Therapeutic services
- Support groups and support services for foster/kin families
- Foster care agencies
- Recruitment and Retention of foster and adoptive families

Attainable Resources

- All of the above that currently exist
- DHHS liaison for oversight
- Concrete plans from other state successes

Unattainable Resources

Resources are more difficult to identify in rural and remote areas

Barrier

Support of foster families as they currently rely on the therapeutic agencies.

Enhancer

This plan will increase the quality of care for children in DHHS custody. The goal of privatizing adoption cases is to enhance the Department's capacity to provide trained, skilled staff that engage and assist families thus preventing removal, family preservation and permanency.

Broad Strategies

- A strategy is to enhance the fundamentals training and pre service training so the Department staff and foster/kinship parents are better equipped to formulate a team with the birth family that is working towards reunification and permanency planning.
- An enhanced mentor program should be utilized for foster and kin placements to help them understand and facilitate the goals within the practice model
- Increased recruitment and retention efforts for foster and adoptive families

Cost Reduction

The research reviewed does not show a significant cost reduction from privatization alone in other states. The cost reduction would come from:

- A decrease in the amount of time that children are maintained in care
- A decrease in duplication of services.

Recommendation 2

Family Finders

Independent diligent search for parents, kin and/or de facto parents for children currently in care. It is called Family Finders in other states (De Sa, 2005).

This recommendation is put forward by Mary Callahan to supplement the Kinship/ Relative recommendation. This was never discussed by the workgroup.

Rationale

Many children considered to be "languishing" in care actually have people on the outside who are still interested in them. Many of those people have been cut from the child's life due to old department philosophies like "The apple doesn't fall far from the tree."

Mary's example: Grandparents were cut out of my adopted daughter's life because they gave her a comforter for Christmas. The DHHS worker and the GAL agreed it was an insensitive gift for a child who had experienced sexual abuse in her bed, and also an indication that the grandparents did not believe the abuse happened. Now that the child is older, we know two things. The abuse did not happen. And she was devastated when her grandparents disappeared from her life. She assumed they no longer cared about her.

Specific Changes

Current Status	Proposed Changes
	A group would be hired by DHHS to read through files, utilize the Internet, and find these interested parties and determine if they really are safe and if they are still interested. Appropriate reunions would be facilitated by the state and supported.

Existing Resources

Caseworkers themselves might refer cases. Other states that have been very successful with FAMILY FINDERS, like California, New York and Washington, might offer assistance in design.

Enhancers

New philosophies at DHHS.

Cost Reductions

Significant, as many of these children are "languishing" in treatment level foster care or residential settings, very high end, expense-wise. The move to a family would cut that cost significantly, as adoption subsidy or guardianship is much less costly.

As examples of success that could be expected, when the strategy was implemented in Santa Clara California, 36 out of 37 children found permanent homes with family. In Washington State, where it was first developed, 253 out of 288 children considered "troubled" moved in with relatives in the first 6 months the program was in place.

Recommendation 3

Performance-Based Contracts

It is recommended that performance-based contracts for foster care agencies be established, along with full case responsibility, which include full court responsibility.

Rationale

Current contracts based upon a fee-for-child payment can undermine permanency because once the child welfare issues have been resolved and the child is ready for permanency, an agency faces losing revenue unless the child is replaced with a new referral. This dynamic leads to the predictable practice of focusing the work on maintaining kids in care rather than aggressively pursuing permanency.

Other states have created a positive incentive for finding permanency by payment structures that reward it, but also allow for the outliers, children who are particularly difficult to place. The structure also keeps track of re-abuse and negatively reinforces for it, so there wouldn't be an effect opposite of today's structure, where children are returned to dangerous homes or placed in questionable adoptive homes because of the financial incentive to do so.

And, as the agencies will be responsible for the outcome, they must also have more control of the outcome than they have now. Therefore, they would also take on the full case, including the courtroom aspect of the case.

Specific Changes

At first, the contracts would have to make significant investments in activity that would support permanency-additional permanency focused staff positions; resources enabling providers to begin serving children more quickly upon placement; more resources for supporting children returning home to their biological parents; and the flexibility to use administrative funds to support different models of child welfare service provision.

Second, and perhaps most importantly, the contract would realign financial incentives to secure accountability and reinforce the importance of achieving outcomes over maintaining children in care. Agencies would be allowed to use superior performance in moving children to permanency as a way of lowering their caseloads, maintaining their contract level and financially enhancing their program.

Third, private agencies would receive the cases immediately to avoid the child having to move from emergency placement to another placement. Agencies would take siblings and keep them together whenever possible, even when not all are considered treatment level. They would be responsible for the entire case, including courtroom aspects, reunification and/or adoption. In other words, private foster care agencies would go from being specialists in highly troubled foster children to being generalists who deal with any and all children in state custody. This allows for better continuity of care, minimal hand-offs where accuracy is lost and quicker resolution. This also allows the agencies to remain viable, even as few children are taken into care in the state of Maine and Levels of Care removes the label of Treatment Level when inappropriate.

The DHHS role would be primarily in initial placement with the agency, contracting and quality assurance. In Colorado, each agency provides office space for one DHHS worker for day to day consulting, training and oversight.

Attainable Resources

- State of Illinois has utilized this system for the past 5 years and reduced the number of children in care by half (article attached). They have offered to help design a similar system in Maine.

Barriers

- Training in courtroom procedures would be necessary for the agency workers. Foster parents training and expectations would have to change as well. Current workers and foster parents may be resistant to change. Some agencies may be resistant to change.

Enhancers

Some private agencies are already enthusiastic about piloting this new system. The Bureau chief, Jim Beougher, has experience working with performance-based contracts.

Cost Reductions

Cost savings in Illinois were dramatic and could be in Maine as well. They would be achieved primarily by reducing the time children spend in care, thus decreasing the number of children in care at any given time.

Appendix A: Concerns and feedback from adoption professionals and others in response to the Privatization of Adoption

- An attempt to privatize adoption through a limited contract with a private agency within the past 5 years was particularly and demonstrably ineffective in moving child welfare children to permanence.
- No agency has demonstrated the capacity to provide a child welfare service statewide efficiently and effectively.
- State adoption workers stay adoption workers. I believe there is over 200 years total of adoption experience in the state system. This is a resource Maine cannot afford to waste.
- This begins the slippery slope to contracting out all child welfare services in Maine.
- It cannot help but cause delays to permanence. The office director has stated publicly that every handoff causes a delay in progress to permanence and yet he supports this delay for over 500 children.
- This decision would significantly change the covenant the state of Maine has made with children it brings into custody. Maine has decided that when children are brought into custody, that the state is responsible for finding these children a safe place to live; to work with the parents to reduce and correct dangerous living conditions at home so that they can return safely to their parents; and to find permanent homes for children when return home is not safe. The recommendation to privatize adoption would break this covenant for hopes and promises but no guarantees. Maine children deserve better than that.
- The idea that current state adoption staff would be free to work on preventing kids from coming into care and family preservation

work is also false. If the numbers are compared of children with adoption as a goal and the number of children in treatment foster care, they are remarkably similar. Thus it is likely that adoption workers would be used to provide the case management function that would be vacated by the other part of this proposal, that private agency case managers would be eliminated in treatment care. Thus the proposal would really mean that the adoption workers and the agency case managers would effectively change jobs with neither knowing what they are doing. This will delay permanence and end up costing significant Medicaid dollars. It also increases risk for the state. Now if an auditor finds a mistake in the treatment plan, they go to the agency for payback. Under this proposal, the state case manager, and thus HHS would be responsible. The cost implications are very serious.

Appendix B: Notes and Assumptions
Prepared by Mary Callahan, Adoptive Parent

Based on OCFS discussions, I have calculated the comparison of the costs of providing case management services to relative placements vs. children entering care into the current placement types. The calculation assumes the following:

- Due to the availability of case management services for children entering foster care and being placed with a relative, the children would not need access to higher levels of care.
- A percentage of the children placed in relative placement and receiving these case management services would have accessed either residential or therapeutic services.
- Children placed in relative placement and receiving these case management services would have received the average cost of either residential or therapeutic services if they would have been placed in either of those service types.
- These entrants to care would follow the same percentage of level of care needs of the children currently in care. 25% residential 25% therapeutic, 18% relative, and 32% other.
- The cost of providing case management to these children would be set in contract and negotiated at the rate we currently pay for similar services.
- The average cost of the relative placements will be approximately $20.00 a day based on a mix of $10.00, $16.50 and $30.00 rates.
- The current Title IV-E eligible and claimable rate is used in the calculation. (This rate currently represents 40% of all children in foster care that are eligible to receive title IV-E funding.) This percentage is expected to increase in the future.
- All relative placements will be offered this service once the

service becomes available.

Important Notes to accompany any savings calculation based on the availability of this service.

- The calculation is based on 100 relative placements being made and the savings of those 100 placements over a year. The savings is not calculated on a period of time.
- There will be an undetermined amount of MaineCare services cost to be charged to provide these placements to meet the children's medical service needs. Jim estimates that cost as roughly half of the total savings but there is no data from MaineCare in regards to an estimation of cost.
- Savings changes dramatically based on the funding source used to provide the case management service. Both Title IV-E TCM at a 20% federal match rate and MaineCare TCM at a 66% federal match rate are calculated.

Therefore, based on the cost projection attached and the assumptions noted above there can be an expected estimated saving of $400,000 to $600,000 per 100 children per year.

Appendix C: information Prepared by Mary Callahan

		Days of	Required	
Current Therapeutic Payment System (Average)	Rate	Service	Match Rate	Total Cost
Daily Therapeutic PNMI Rate (MaineCare Elig)	$117.00	365	35%	$14,946.75
Daily Room and Board Rate (Title IV-E Elig)	$43.00	365	74%	$11,614.30
General Fund Cost per Child per Year				$26,561.05
Current Residential Payment System (Average)				
Daily Therapeutic PNMI Rate (MaineCare Elig)	$320.00	365	35%	$40,880.00
Daily Room and Board Rate (Title IV-E Elig)	$40.00	365	74%	$10,804.00
General Fund Cost per Child per Year				$51,684.00
Current Intake Rate per 100 Kids Savings Associated with Proposed Change				
25 Therapeutic Placements	$160.00	365	as above	$664,026.25
25 Residential Placements	$360.00	365	as above	$1,292,100.00
18 unlicensed relative placements	$16.50	365	0%	$108,405.00
32 Other Foster Care	$20.00	365	74%	$8,8643.20
Total Cost				$2,073,174.45
Proposed Relative Placement with Services Payment System per Child (Title IV-E Case Management)				
Monthly Case Management Rate (Title IV-E Elig.)	$654.17	12	33%	$6,280.03
Daily Relative Placement Rate (Title IV-E Elig.)	$20.00	365	74%	$5,402.00
General Fund Cost Per Child Per Year				$11,682.03
Savings Associated with Proposed Change Title IV-E TCM				
Increase of 100 relative placements with additional services				$1,168,203.20
Total Savings Policy Change				$904,971.25
Proposed Relative Placement with Services Payment System per Child (MaineCare TCM)				
Monthly TCM Rate	$654.17	12	33%	$2,590.51
Daily Relative Placement Rate (Title IV-E Elig.)	$20.00	365	74%	$5,402.00
General Fund Cost Per Child Per Year				$7,992.51
Savings Associated with Proposed Change MaineCare TCM				
Increase of 100 relative placements with additional services				$799,251.32
Total Savings Policy Change				$1,273,923.13

Foster Parent Survey Results

Children's Services Reform Working Group – Maine DHHS

Workgroup VI – Foster Parents

January 2006

Descriptive Results – A Survey Of Foster Parents

Executive Summary

Submitted To:

Workgroup VI – Chair, Marvin Mcbrearity
Members Of Children's Services Reform Working Group

Prepared By:

Michel Lahti
Tamara Harden
Julia Mason
Jennifer Pratt

Muskie School Of Public Service, University Of Southern Maine

I. Introduction

The following are a select set of initial descriptive results from a survey mailed out in December 2005 to 1, 109 individuals identified as foster parents on a state DHHS mailing list. The survey was designed through a work group process with assistance from University research staff. The survey was anonymous - no identifying information about a respondent was collected. Members of the work group included foster parents, DHHS staff, and a state Legislator. This work group was part of a larger committee responding to a Legislative request to provide advice to the state DHHS on the children's mental health services and child welfare systems. University staff coordinated the mailing of the survey packets and work group members received the completed questionnaires and forwarded them back to the University for data entry and analysis. There was not any additional effort made to contact respondents in order to try to increase a response rate – it was a one time mailing procedure. Of the 1, 109 surveys mailed, one was returned as address unknown and a total of 338 questionnaires were fit for use in the analysis. This results in a response rate of 30%. A full report with item by item responses was forwarded to the work group for their use.

II. Results

A. Respondent Characteristics

- Average age was 47 years old (n=325)
- Gender of Respondents (n=335): 17% MALE 83% FEMALE
- Total Household Income during the last 12 months (n=267): Average - $46, 773.00
- How many adults/parents in the household are Licensed Foster Parents? (n=318)
    - 80% of all respondents indicated that there are two licensed foster parents in the household. 19% indicated that there was just one licensed foster parent in the household.

- Marital Status (n=336):
  - 80% MARRIED
  - 6% SINGLE
  - 4% NEVER MARRIED
  - 7% DIVORCED
  - < 1% SEPARATED
  - 3% WIDOWED

- Respondent Highest Level of Education (n=337):
  - 2% Did Not Complete High School
  - 22% High School Graduate (Diploma or Equivalent, GED)
  - 18% Some College Credit, But Less Than One Year
  - 16% One Year or More of College
  - 10% Associates Degree
  - 22% Bachelors Degree
  - 11% Master's Level Degree or Higher Level

  a. 77% of these respondents have education beyond a high school level. 44% have at least an Associates Degree.

- Both respondent and spouse/partner current licensed Foster Parents (n=325):
  - 86% YES
  - 14% NO, only the RESPONDENT is a licensed Foster Parent

- Average number of years as licensed Foster Parent (n=322): 7 years

- Current Type of Licensed Foster Home (n=334):
  - 67% Therapeutic Foster Home
  - 29% Non-Therapeutic Foster Home
  - 2% Relative Foster Home
  - 2% Other

- Type of Foster Care Service Provided – can select more than one type of service (N=338):
  - FULL TIME PLACEMENTS 84%
  - RESPITE ONLY 24%

- OTHER 11%

- Total Number of Children Cared for to Date (n=295):
  - For all respondents, a total of 4, 763 children
  - For each respondent the average number of children that they have had in care = 16

- Number of Foster Children/Youth in Care Today and Daily Board Rate (n=334):
  - Total Number of Children Reported in Care Today = 430
  - For each respondent, the average number of children in care = 1.
  - The average age of the children in their care = 11 years old with an average daily board rate = $46.15.

- In a Given Week (7 Days) Average/Median Number of Hours of Direct Care Provided to Most Challenging Foster Child/Youth (N=239): 60 Hours Per Week.

- Additional Training / Education Respondent Received During Past 12 Months – beyond the hours that are required for licensure (n=287): Median (average) amount of time spent in additional training in the past year was 20 hours.

B. Ratings Concerning Self/Own Role and Overall Foster Care System

- Type of "Role" as a Foster Parent (n=338):
  - 60% My primary role is as a Nurturer
  - 29% My primary role is as a Professional Provider
  - 7% My primary role is as a Coordinator of Care
  - 4% Other

- Overall Satisfaction with Role as Foster Parent (n=334):
  - 12% NOT AT ALL SATISFIED / DISSATISFIED
  - 83% SATISFIED / COMPLETELY SATISFIED
  - 6% NOT SURE

- The Main Reasons for Choosing to be a Foster Parent (n=334):
  1. We had space, time, and resources and wanted to make a "difference"

2. My life needed meaning; foster care gave me a worthwhile challenge

- 99% of all respondents (n=336) rated their ability to provide care as a Foster Parent as 'Good/Excellent'.
- 56% of all respondents (n=336) rated the job performance of DHHS case workers as 'Good/Excellent', 8% rated the job performance of the State Legislature as 'Good/Excellent', and 6% rated the job performance of the Governor as 'Good/Excellent'.
- Respondents (n=335) rated the following as the top three most effective components of the 'state child welfare system':
  1. DHHS Licensing Professionals
  2. Local Educators in Support of Parents
  3. Local Therapeutic Agencies

  Comments: Three things that the state does that I believe work really well...

  "Specific, constant individual caseworker"
  "MCF (Maine Caring Families) program"
  "Training to prepare foster parents to foster"
  "Team meetings"
  "Visitations with biological parents"
  "Licensing"
  "Meetings-reports-email updates"
  "30 day visits by guardians"
  "Working to reunify biological families"
  "Events to promote foster parents to meet each other"
- The top three components of the 'state child welfare system' that these respondents believe to be least effective are:
  1. Poor Rating of Communication between DHHS Employees, Agencies and Foster Parents.
  2. Poor Rating - Overall Taxpayers Do Not Get a Good "Bang for the Buck" from the State Child Welfare System.
  3. Poor Rating of the Process of Child Intake and Initial Assessment.

  Comments: Three things that the state does that I believe do

not work well at all…

"Supporting foster parents financially"
"Providing respite care"
"Recruiting new foster parents"
"Assuming foster parents are guilty till proven innocent in whatever a child says"
"Keeping to a case plan and length of time in care"
"Transportation and visit supervision"
"Keep decreasing pay and reimbursements"
"Levels of care system"
"Overburdened caseworkers"
"Poor communication from Augusta staff to offices (DHHS), agencies, and foster parents"

- Respondents (n=334) Rated which Groups/Agencies/Individuals they believed are the most effective advocates for foster parents and foster children.
  - Local Therapeutic Agencies – were selected as most effective advocate for both Parents and Children
  - AFFM Advocacy Group – selected as second most effective advocate for Parents
  - DHHS State Agency selected as second most effective advocate for Children

- Overall Rating - Do you think that you have what you need in terms of support from the state child welfare system in order to be effective in your role as a Foster Parent? (n=323)
  - 31% YES
  - 49% NO
  - 20% NOT SURE

C. Perceptions about Level of Daily Board Rates and Levels of Care

- Introduction: DHHS proposed to reform therapeutic board rates such that Level III ($45 per day) would become the maximum rate. The five daily board rates currently are:
  - Level I $16.50 per day
  - Level II $30 per day
  - Level III $45 per day

- Level IV $60 per day
- Level V $75 per day

The suggested reform would result in eliminating Levels IV and V.

- 66% of the respondents (n=326) stated that this would be a negative/major negative effect on their role as a Foster Parent.
- 32% of the respondents stated a Neutral – Neither Positive nor Negative Effect
- Slightly less than 2% stated would be a positive/major positive effect on their role as a Foster Parent.
  - *76% of respondents who stated change would be a negative effect also stated that 'they would seriously consider no longer being a Foster Parent'.*
- 53% of respondents (n=304) do not believe that the current daily board rate they receive now is sufficient.
  - *For those who believe their current daily board rate is insufficient - the average difference in daily board rate between what is received and what is 'needed' is approximately $18.06 per day.*
- 26% of these Foster Parents (n=325) requested in the past year a review of the Level of Care rating for a child in their care, and the majority (88%) were seeking a move up in the level of care rating. A majority (58%) were not satisfied with the process of re-assessment provided by the state DHHS system.

D. Reactions to other Proposed Changes to the Child Welfare System

- The majority of respondents were not aware of the recent proposed changes as described in the survey – Privatization of Services and Elimination of Community Intervention Programs.

E. Final Comments

Due to the large amount of written responses to the opportunity to provide general feedback/comment, only an initial review for broad themes is available for reporting at this time. The four major themes that appear to emerge from the data are:

1. Criticism that the "levels of care" system is flawed and inadequate to meet the needs of the children in care;
2. Lowering rates has created a financial burden on foster families;
3. Caseworker turnover and adequate training for caseworkers needs to be addressed, and
4. Foster Parents are reporting a need for a better balance between the rights of the children and the biological parents.

III. Summary

- Respondent Characteristics: Most (84%) households that are represented in these results have two licensed Foster Care parents. These parents have an average of 7 years of experience in the foster care system and have cared for approximately 4, 763 children – with 430 children in their care today. Most of these Foster Parents are satisfied in their role as a Foster Parent, appear to primarily view themselves as 'Nurturers', and are motivated to be a Foster Parent in order to 'make a difference' for a child. These Foster Parents on average spend about 60 hours per week in direct care for the 'most challenging' child in their care, and they spend on average about 20 hours a year in additional training and education.

- Rating the System: The majority (56%) of respondents rate the job performance of the DHHS state agency caseworker as 'Good/Excellent'. These respondents perceive the most effective components of the system as the work of the DHHS licensing staff, and support they receive from local educators and those who work in the role of Guardian Ad Litem to the youth. These Foster Parents also appear to feel most supported by local therapeutic agencies. Their rating concerning the least effective components of the foster care system focused on poor communication between the state DHHS, foster parents and local agencies, and agreement with a general statement of their belief that 'taxpayers do not get a good bang for the buck' from the

system. Overall, only 31% of the respondents stated "Yes" that they believed that they had what they needed in terms of support to be effective from the state child welfare system.

- Daily Board Rates and Levels of Care: 53% of respondents reported that their current daily board rate was insufficient and on average, suggest that an increase of approximately $18.06 per day would best meet their needs. 66% of respondents stated that it would have a negative effect on them if the maximum daily board rate was $45/day. In terms of Levels of Care, 26% of these respondents have had the experience of seeking a change to the assigned Level of Care rating for the child in their care. The majority (58%) of these respondents were not satisfied with this process.
- Reactions to other Proposed Changes to the System: Most of the respondents were not aware of the proposed changes as described in the survey.
- In response to being able to provide general feedback, the following four issues appear to be most significant:
  - Criticism that the "levels of care" system is flawed and inadequate;
  - Lowering rates has created a financial burden on foster families;
  - Caseworker turnover and adequate training for caseworkers needs to be addressed, and
  - Foster Parents are reporting a need for a better balance between the rights of the children and the biological parents.

Children's Services Reform Working Group – Maine DHHS

Workgroup VI – Foster Parents

January 2006

Descriptive Results – A Survey Of Foster Parents

Submitted To:

Workgroup VI – Chair, Marvin Mcbrearity

Members Of Children's Services Reform Working Group

Prepared By:

Michel Lahti

Tamara Harden

Julia Mason

Jennifer Pratt

Muskie School Of Public Service, University Of Southern Maine

I. Introduction

The following are an initial set of descriptive results from a survey mailed out in December 2005 to 1, 109 individuals identified as foster parents on a state DHHS mailing list. The survey was designed through a work group process with assistance from University research staff. The survey was anonymous - no identifying information about a respondent was collected. Members of the work group included foster parents, DHHS staff, and a state Legislator. This work group was a sub-committee of a larger body that was responding to a Legislative request to provide advice to the state DHHS on the children's mental health services and child welfare systems. The role of University research staff was to provide consultation to the workgroup, assist with data collection procedures, conduct data entry and cleaning, and to conduct descriptive statistical data analysis – providing frequencies and percents for each numeric item, and to provide a limited summary for each open-ended item.

This document presents results item by item. This report does not provide any findings or recommendations based on the results. In addition, there are no inferential analyses presented in this report. This report is submitted back to the Work Group VI for their use. A complete set of results is available from the research staff. In the next couple of months, research staff will prepare another report that will include additional analyses and findings. For more information about this additional analysis, please contact the research staff at the University of Southern Maine; Michel Lahti, Ph.D. or Tamara Harden, Ph.Dc. at the Institute for Public Sector Innovation, the Muskie School, University of Southern Maine, P:207.626.5200.

II. Results

A. Response Rate and Respondent Characteristics

The state DHHS provided research staff with a set of mailing labels addressed to individuals who are listed as licensed foster care providers in Maine. The total number of mailing labels was 1, 109. A packet was prepared that included a cover letter from the Chair of the Work Group VI, Mr. Marvin McBrearity and it was attached to the survey instrument; a blank copy of the instrument is attached to this report. In addition the packet contained a self-addressed, postage paid return envelope addressed to a PO Box set up by the Work Group. University staff coordinated the mailing of the survey packets and Work Group VI members received the completed questionnaires and forwarded them back to the University for data entry and cleaning. There was not any additional effort made to contact respondents in order to try to increase a response rate – it was a one time mailing procedure. Of the 1, 109 surveys mailed, one was returned as address unknown and a total of 338 questionnaires were fit for use in the analysis. This results in a response rate of 30%.

The following information describes the type of respondent. As mentioned earlier, these results are presented by item with the exact wording used in the questionnaire. First a frequency or n = XXX is provided which indicates how many people actually answered that particular question and then a percent is provided. Please note that some percents do not add up to exactly one hundred due to rounding.

1. What is your age? (n=325) Average age was 47 years old

2. What is your gender? (n=335) 17% MALE 83% FEMALE

3. How many people live in your household today full-time; including yourself? (n=325) Average = 4
   a. How many are children/youth between the ages of 0-18? Average = 2
   b. How many are adults, age 19 or older, including yourself? Average = 1.90

4. What is your current Zip Code? (Will be used in later analysis)

5. What was your Total Household Income during the last 12 months? (Include total income of Respondent and spouse or partner if applicable) (n=267) Average - $46, 773.00

6. How many adults/parents in the household are Licensed Foster Parents? (n=318)
   - 80% of all respondents indicated that there are two licensed foster parents in the household.
   - 19% indicated that there was just one licensed foster parent in the household.

   a. What is your marital status? (n=336)
      - 80% MARRIED
      - 6% SINGLE
      - 4% NEVER MARRIED
      - 7% DIVORCED
      - < 1% SEPARATED
      - 3% WIDOWED

7. Are both you and your spouse/partner current licensed Foster Parents? (select one) (n=325)
   - 86% YES
   - 14% NO, only the RESPONDENT is a licensed Foster Parent

- 0% NO, the RESPONDENT and another adult in the household who is not a spouse or partner to the RESPONDENT are licensed Foster Parents.

8. How many years have you been licensed as a Foster Parent? (n=322) Average = 7 years
9. Current Type of Licensed Foster Home (select one): (n=334)
   - 67% Therapeutic Foster Home
   - 29% Non-Therapeutic Foster Home
   - 2% Relative Foster Home
   - 2% Other (please describe): [1]Other types of foster home (total=7 responses):
   - The two most common responses were "Foster-Adoptive" (28.6%) followed by "Respite only" (26.8%).
     - "Foster-Adoptive": 28.5%
     - "Respite only":28.5%
     - "Family Foster home":14.2%
     - "Specialized": 14.2%
     - "Long Term Foster Care": 14.2%

   a. If a Therapeutic Foster Care Home, what local agency do you work with? (print name of agency):

10. The greatest number of respondents worked with Community Health and Counseling Services (CHCS) (26.7%) and Community Care (21%).
    - CHCS: 26.7%
    - Community Care: 21.0%
    - Maine Caring Families: 12.9%

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1 For summaries of open-ended questions, the percents indicate what proportion of those who responded made a certain kind of statement. So for #9 above 'Other', the two most frequent types of responses were 'Respite only' and 'Foster-Adoptive'.

- Kidspeace: 11.9%
- CARE: 4.8%
- Young Alternatives: 4.8%
- FACT: 3.8%
- AMHC: 2.9%
- Catholic Charities: 2.4%
- Choices: 1.9%
- Casey Family Services: 1.9%
- DHHS only: 1.9%
- Woodfords Family Services: 1.4%
- SMART: 1.4%
- OHI: 1.0%

10. What type of Foster Care service do you provide most often? (N=338)

	Yes	No
Full Time Placements	84%	26%
Respite Only	24%	76%
Other	11%	89%

Other types of foster care services provided (total=37):
"Both full-time placements and respite only" (66.7%) and "Pre-adopt" (24.2%) were the most common "other" types of foster care services that were provided.

11. During your whole time as a Foster Parent, how many children have you cared for in your home as a Licensed Foster Parent ? (n=295)
    - For all respondents, a total of 4, 763 children
    - For each respondent the average number of children that they have had in care = 16

12. How many children have you adopted – from the total given n

#11 above: (n=292)

- For all respondents, the total number of children adopted = 230
- For each respondent the average number of children adopted = .79

13. How many foster children/youth are in your care today? (Include children/youth to whom you provide regular, at least on a monthly basis - care). Please indicate the age of each of the children in your care today and that childs' daily board rate: (n=334)
    - Total Number of Children Reported in Care Today = 430
    - For each respondent, the average number of children in care = 1.

The table that follows presents the average age and daily board rate for the first, second, third and fourth child in care in that family.

Age	Current Daily Board Rate
Avg. – 8.34 (n=259)	Avg. $ 45.00
Avg. – 10.13 (n=127)	Avg. - $43.89
Avg. - 13.54 (n=31)	Avg. $43.77
Avg. – 12.00 (n=13)	Avg. - $51.92
TOTALS: The average age of the children in their care = 11 years old with an average daily board rate = $46.15.	

14. Please select which best describes the highest level of education you have completed: (n=337)
    - 2% Did Not Complete High School
    - 22% High School Graduate (Diploma or Equivalent, GED)
    - 18% Some College Credit, But Less Than One Year
    - 16% One Year or More of College
    - 10% Associates Degree

- 22% Bachelors Degree
- 11% Master's Level Degree or Higher Level

77% of these respondents have education beyond a high school level. 44% have at least an Associates Degree.

15. ADDITIONAL TRAINING/EDUCATION: During the past twelve (12) months, please report the total number of direct contact hours that you have spent in an educational / training activity that you believe is directly related to your role as a Foster Parent. This is in addition to the hours that are required for you to keep your license. For example, if you traveled 30 minutes each way to a half day (4 hours) parenting skill building workshop; you would report just 4 hours for the direct contact. (n=287)

    For these respondents, the median (average) amount of time spent in additional training in the past year was 20 hours. The range was from 0 to 200 hours and fifty two respondents reported not spending any additional time in training.

B. Ratings Concerning Self/Own Role and Overall Foster Care System

16. Please select one of the following types of "roles" that best describes you as a Foster Parent: (n=338) (YES Responses):
    - 60% My primary role is as a Nurturer
    - 29% My primary role is as a Professional Provider
    - 7% My primary role is as a Coordinator of Care
    - 4% Other:

Other types of roles as a Foster Parent (total=62):

The two most common responses were "Mother, aka-all of the above and teacher" (66.7%) followed by "Professional parent" (7.4%).

17. Overall, how satisfied are you in your role as a Foster Parent? (select one) (n=334)
    - 2% NOT AT ALL SATISFIED
    - 10% DISSATISFIED
    - 57% SATISFIED
    - 26% COMPLETELY SATISFIED
    - 6% NOT SURE

    - 83% of respondents are 'Satisfied/Completely Satisfied' in their role as Foster Parent.

18. Please select one answer for each statement: (n=336)

		Poor	Fair	Neutral	Good	Excellent	Don't Know
a	Overall, how would you rate your ability to provide good care in your role as a Foster Parent?	0	1%	.3%	23%	76%	.3%
b	Overall, how would you rate the job performance of DHHS local office Case Workers?	8%	18%	16%	40%	16%	2%
c	Overall, how would you rate the job performance of the State Legislature with regard to Maine's Foster Youth?	40%	20%	20%	7%	1%	13%
d	Overall, how would you rate the job performance of the Governor with regard to Maine's Foster Children/Youth?	45%	21%	12%	5%	1%	16%

- 99% rated their ability to provide care as a Foster Parent as 'Good/Excellent'.
- 56% rated the job performance of DHHS case workers as

'Good/Excellent'.

- 8% rated the job performance of the State Legislature as 'Good/Excellent'.
- 6% rated the job performance of the Governor as 'Good/Excellent'.

19. The following is a set of statements specific to the EFFECTIVENESS of different components of the state child welfare system. Based on your experiences, please indicate how much you agree or disagree with each statement: (n=335)

The top three components of the 'state child welfare system' that these respondents believe to be MOST EFFECTIVE are:

1. DHHS Licensing Professionals
2. Local Educators in Support of Parents
3. Local Therapeutic Agencies

The top three components of the 'state child welfare system' that these respondents believe to be LEAST EFFECTIVE are:

1. Poor Rating of Communication between DHHS Employees, Agencies and Foster Parents.
2. Poor Rating - Overall Taxpayers Do Not Get a Good "Bang for the Buck" from the State Child Welfare System.
3. Poor Rating of the Process of Child Intake and Initial Assessment.

		Totally Disagree	Disagree	Neutral	Agree	Totally Agree	DK
a	The professionals at the DHHS Central Office (Augusta) are very effective in their leadership and management.	5%	26%	30%	18%	3%	18%

		Totally Disagree	Disagree	Neutral	Agree	Totally Agree	DK
b	The DHHS professionals involved with Licensing are very effective in their jobs.	3%	9%	20%	48%	18%	2%
c	The DHHS Regional Program Administrators are very effective in their jobs.	3%	13%	31%	23%	5%	25%
d	The DHHS Regional Supervisors are very effective in their jobs.	3%	13%	30%	28%	6%	20%
e	The DHHS Case Workers are very effective in their jobs.	4%	20%	29%	34%	10%	2%
f	The people who serve as Guardian Ad Litems are very effective in their jobs.	12%	18%	21%	32%	15%	4%
g	The local, Therapeutic agencies are very effective in their jobs.	3%	4%	18%	34%	27%	14%
h	The local school system is very supportive of me in my role as a Foster Parent.	3%	10%	11%	29%	34%	14%
i	The state level AFFM organization is very effective.	2%	6%	22%	32%	20%	19%
j	The process of child intake and initial assessment is done very well.	7%	28%	27%	22%	5%	11%
k	The recruitment, training, and orientation prepare Foster Parents to be effective in their new role.	4%	14%	23%	47%	9%	3%
l	Overall taxpayers get a good "bang for the buck" from the state child welfare system.	13%	23%	21%	17%	17%	10%

		Totally Disagree	Disagree	Neutral	Agree	Totally Agree	DK
m	There is very good communication between DHHS employees, agencies and Foster Parents.	12%	30%	22%	27%	6%	2%
n	There is good oversight by DHHS Case Workers concerning the kinds of medications provided to children.	9%	18%	26%	26%	5%	16%
o	The counseling services that the DHHS Case Worker referred us to are very good.	6%	13%	29%	24%	9%	19%
P	Overall, DHHS is effective in how it manages allegations of abuse / neglect as it relates to Foster Family households.	11%	15%	25%	20%	2%	27%
q	Overall, DHHS promotes and supports Foster Parents to connect positively with a child's birth parents/family.	3%	10%	23%	49%	9%	6%
r	Overall, DHHS handles it's authority in child welfare cases very well – fair and balanced.	8%	22%	29%	29%	6%	6%

20. Do you believe that financial resources are being used most effectively in the child welfare system? (select one) (n=331)
    - 9% YES
    - 55% NO
    - 36% NOT SURE

20a. Please explain your answer (n=201):

Two hundred and one respondents explained their answer to question 20. For respondents who answered "YES" on question 20 and explained their answer (n=19), the two most common responses fell into two categories of concern: "Reimbursement issues" (21%) followed by "having supportive caseworkers" (10.5%). For respondents who answered "NO" on question 20 and explained their answer (n=135), the two most common responses fell into two categories of concern: "Reimbursement issues" (38.5%) followed by "administrative issues" (30.4%). For respondents who answered "NOT SURE" on question 20 and explained their answer (n=47), the most common responses fell into three categories of concern: "Reimbursement issues" (19.1%) followed by "administrative issues" (6.4%) and "too much spent on recreation" (6.4%).

21. Please list the top three most effective components of the current state child welfare system. The quotes below were some of the most common types of responses. Three things that the state does that I believe work really well… (n=216)
    - "Specific, constant individual caseworker"
    - "MCF (Maine Caring Families) program"
    - "Training to prepare foster parents to foster"
    - "Team meetings"
    - "Visitations with biological parents"
    - "Licensing"
    - "Meetings-reports-email updates"
    - "30 day visits by guardians"
    - "Working to reunify biological families"
    - "Events to promote foster parents to meet each other"

22. Please list the top three least effective components of the current state child welfare system. Three things that the state does that I

believe do not work well at all… (n=246)

- "Support foster parents financially"
- "Providing respite care"
- "Recruiting new foster parents"
- "Assuming foster parents are guilty till proven innocent in whatever a child says"
- "Keeping to a case plan and time in care"
- "Transportation and visit supervision"
- "Keep decreasing pay and reimbursements"
- "Levels of care system"
- "Overburdened caseworkers"
- "Poor communication from Augusta staff to offices (DHHS), agencies, and foster parents"

23. In a given week (7 days), how many hours of direct care do you provide to your most challenging foster child/youth? Direct care meaning time that you are one to one with this child providing care, managing care and/or coordinating care. (n=239)

    For this group of respondents, the average / median number of hours of direct care per week for their 'most challenging foster child/youth' was 60 hours per week.

    Instructions: For the following questions, please think about your role as a Foster Parent. Consider your experiences in the past year and think about why you have chosen this special role and what rewarding and challenging experiences you have had caring for these children/youth.

24. Please rank the following set of reasons that apply to you as to why you have chosen to be a Foster Parent. In the space provided, rank the reasons that apply to you 1, 2, 3, 4, etc., in order of

importance - 1 being the Most Important and 10 being Least Important. (n=334)

The top three reasons for choosing to be a Foster Parent are:

1. We had space, time, and resources and wanted to make a "difference"
2. My life needed meaning; foster care gave me a worthwhile challenge
3. Other – see summary of responses below

A. Because a relative's child needed a parent Avg. = 8.42
B. Because I had some form of experience with the foster care system when younger Avg. = 8.72
C. To earn additional money for household bills Avg. = 8.14
D. I was experiencing "Empty Nest" Syndrome Avg. = 7.72
E. My life needed meaning; foster care gave me a worthwhile challenge Avg. = 4.98
F. Because someone I know asked me and encouraged me to become a foster parent Avg. = 6.32
G. I became a foster parent in order to be able to adopt children Avg. = 6.80
H. We had space, time, and resources and wanted to make a "difference" Avg. = 2.41
I. As my primary occupation Avg. = 6.81
J. Other (n=107) (respond below) Avg. = 3.88

24. Other:

The two most common themes in the "other" responses were "Making a difference in a child's life and because I enjoy kids" (40.2%) followed by "Kids deserve someone to take care of them" (22.4%).

25. The following are a list of groups/agencies/individuals who

may play an ADVOCACY role in the foster care system. Please rate how effective you think each group is in terms of how they advocate for Foster Parents and then in terms of how they advocate for foster children/youth. Please select one answer for each statement, responses are: (n=334)

The following are the top three groups/agencies/individuals that these respondents believe are effective advocates for FOSTER PARENTS:

1. Local Therapeutic Agencies
2. AFFM Advocacy Group
3. Guardian Ad Litems & Educators

The following are the top three groups/agencies/individuals that these respondents believe are effective advocates for FOSTER CHILDREN/YOUTH:

1. Local Therapeutic Agencies
2. DHHS State Agency
3. Guardian Ad Litems

		Poor	Fair	Neutral	Good	Excellent	DK
A	DHHS State Agency – As an Advocate for Foster Parents	30%	20%	17%	23%	6%	4%
B	DHHS State Agency – As an Advocate for Foster Children/Youth	10%	20%	18%	39%	9%	4%
C	AFFM Advocacy Group – As an Advocate for Foster Parents	3%	7%	15%	34%	21%	19%

		Poor	Fair	Neutral	Good	Excellent	DK
D	Formal State Level Special Interest Advocacy Groups – As an Advocate for Foster Children/Youth	5%	10%	20%	20%	4%	42%
E	Local Therapeutic Agencies – As an Advocate for Foster Parents	5%	7%	11%	29%	33%	16%
F	Local Therapeutic Agencies – As an Advocate for Foster Children/Youth	3%	5%	7%	31%	37%	16%
G	Guardian Ad Litems – As an Advocate for Foster Parents	19%	13%	21%	27%	14%	6%
H	Guardian Ad Litems – As an Advocate for Foster Children/Youth	13%	14%	14%	34%	22%	4%
I	Local Educators – As an Advocate for Foster Parents	12%	12%	22%	29%	12%	14%
J	Local Educators – As an Advocate for Foster Children/Youth	9%	17%	14%	32%	15%	14%

26. In general, how much appreciation do you experience from others outside of your family in terms of your role as a Foster Parent? (select one) (n=333)
    - 7% NONE
    - 53% SOME
    - 40% A GREAT DEAL
    - 1% DO NOT KNOW

27. Overall, when clothing allowances were eliminated by the state Legislature, did that impact your role as a Foster Parent? (select one) (n=324)
    - 54% YES
    - 38% NO
    - 7% NOT SURE

    If YES or NO, please explain your answer (n=237):
    Two hundred thirty-seven respondents explained their answer for question 27. For people who answered "YES" on question 27 (n=148), the two most common responses explaining the answer to question 27 were "More financial burden to the family" (73.6%) followed by "Other" (18.6%). For people who answered "NO" on question 27 and explained their answer (n=73), the two most common responses explaining the answer were "Made it work with the funds available" (46.6%) followed by "does not apply" (19.2%). For people who answered "NOT SURE" on question 27 and explained their answer (n=3) the most common response was "More financial burden to the family" (33.3%).

28. Overall, do you think that you have what you need in terms of support from the state child welfare system in order to be effective in your role as a Foster Parent? (select one) (n=323)
    - 31% YES
    - 49% NO
    - 20% NOT SURE

    If YES or NO, please explain your answer (n=186):

    One hundred eighty-seven respondents explained their answer for question 28. For respondents who answered "YES" on question 28 and explained their answer (n=54), the two most common

responses explaining the answer to question 28 were "Having regular contact/support from caseworker " (38.9%) and "Other" (51.9%). For respondents who answered "NO" on question 28 and explained their answer (n=129), the two most common responses were "Need to pay foster parents more money" (41.8%) followed by "other" (37.6%). For respondents who answered "NOT SURE" on question 28 and explained their answer (n=3), the most common answer was "Need to have regular contact/ support from caseworkers" (66.7%).

29. If you decided to no longer be a Foster Parent, where do you think the children you care for now would go? (select one) (n=273)
    - 34% Another foster home
    - 15% A group home
    - 15% An institution suitable for handling higher needs children
    - 4% Adoption
    - 4% My foster child/children would be apt to run away
    - 2% To stay with kin
    - 9% Not a factor as our home is a respite home
    - 17.2% OTHER:

    Respondents who selected other in question 29 (n=43) said that either "the children would be adopted into their home" (28.1%) or that they "did not currently have a placement" (50%).

30. Do the requirements necessary to hold a "specialized" foster parent therapeutic license impacts negatively on your ability as a Foster Parent in any way? (n=314)
    - 28% YES

- 50% NO
- 20% NOT SURE

If YES or NO, please explain your answer(n=158):

One hundred fifty-eight respondents explained their answer to question 30. For respondents who answered "YES" on question 30 (n=82), the most common response explaining the answer to question 30 was "Training is very educational and necessary" (75.6%) . For respondents that answered "NO" on question 30 and explained their answer (n=66), the most common explanation was "Training is too time consuming" (57.5%). For respondents that answered "NOT SURE" on question 30 and explained their answer (n=10), the most common explanation was " Training is necessary, but very time consuming" (60%).

31. Do you think there should be a limit to the number of foster children/youth that can be placed in any one home? (select one) (n=327)
    - 69% YES
    - 20% NO
    - 11% NOT SURE

If YES or NO, please explain your answer (n=224):

Two hundred twenty-four respondents explained their answer to question 31. For respondents who answered "YES" on question 31 and explained their answer (n=162), the most common responses explaining the answer were "It depends upon the number of kids that the family has in care" (43.8%) and "It depends upon the behavioral issues of the kids in care" (22.8%). For respondents who answered "NO" on question 31 and explained their answer (n=55), the most common

explanations were "It should be decided on a case by case basis and not according to a formula" (32.7%) followed by "Other" (34.5%). For respondents who answered "NOT SURE" on question 31 and explained their answer (n=7), the most common response was "It should be decided on a case by case basis and not according to a formula" (42.9%).

C. Perceptions about Level of Daily Board Rates and Levels of Care

Introduction: DHHS proposed to reform therapeutic board rates such that Level III ($45 per day) would become the maximum rate. The five daily board rates currently are:

Level I	$16.50 per day
Level II	$30 per day
Level III	$45 per day
Level IV	$60 per day
Level V	$75 per day

The suggested reform would result in eliminating Levels IV and V.

32. Rate the overall effect that you think that this would have in your ability to be effective in your role as a Foster Parent. (select one) (n=326)

57%	1	Would be a major negative effect on my role as a Foster Parent
9%	2	
32%	3	Neutral – Neither Positive nor Negative Effect
.3%	4	
1.5%	5	Would be a major positive effect on my role as a Foster Parent

- 66% of the respondents stated that this would be a negative/ major negative effect on their role as a Foster Parent.

- 32% of the respondents stated a Neutral – Neither Positive nor Negative Effect
- Slightly less than 2% stated would be a positive/major positive effect on their role as a Foster Parent.

32a. If you answered that this potential change would have a "negative" effect on your role as a Foster Parent, would it be such that you would seriously consider no longer being a Foster Parent? (n=243)

- 76% YES
- 10% NO
- 14% NOT SURE

33. Do you believe that the current daily board rate that you are receiving now is sufficient? (n=304)

- 47% YES
- 53% NO

If YES or NO, please explain your answer (n=239):

Two hundred thirty nine respondents explained their answer for question 33. For respondents who answered "YES" on question 33 and explained their answer (n=94), the most common explanations for question 33 were related to the children's "behavioral issues" (38.3%) followed by "Other" (30.9%). For respondents who answered "NO" on question 33 and explained their answer (n=145), the most common responses were related to "Money/reimbursement rate/employment" issues (46.9%) followed by "children's behavioral issues" (35.9%).

33a. If you believe that the current daily board rate that you are receiving is insufficient, please indicate in the table below what it should be? Please indicate the age of each child, Current Daily

Board Rate, and Needed Daily Board Rate in the table below: (n=168)

Child	Age	Current Daily Board Rate	Needed Daily Board Rate	Difference in Rates
*Child #1 (n=168)	Avg. -9.67	Avg. - $43.69	Avg. - $60.93	$17.24
Child #2 (n=74)	Avg. – 10.25	Avg. - $44.01	Avg. - $61.3 6	$17.35
Child #3(n=18)	Avg. – 9.88	Avg. - $40.25	Avg. - $56.94	$16.69
Child #4(n=7)	Avg. – 10.20	Avg. - $45.71	Avg. - $66.67	$20.69
TOTALS (n=168)	Avg. = 10 yrs. old	Avg. - $43.42	Avg. - $61.48	$18.06

For this question, the majority of responses are for the first and/or only foster child in care. For these respondents who are reporting on rates associated with this first or only child in the home, the difference in daily board rate between what they are receiving for that child and what they believe they should receive for that child is an additional $17.24 per day.

The last row, Totals, in the table above represents an average calculated for all respondents. This includes respondents with one and or more children in care in their household. For all respondents, the average difference in daily board rate between what is received and what is 'needed' is approximately $18.06 per day.

34. Did you consider no longer being a Foster Parent when the Levels of Care Committee reduced Therapeutic Board rates effective 2004? (n=324)
    - 43% YES
    - 32% NO
    - 25% DOES NOT APPLY, NOT A THERAPEUTIC HOME

If YES or NO, please explain your answer (n=162):
One hundred sixty-two respondents explained their answer to question 34. For respondents who answered "YES" on question 34 and explained their answer (n=96), the most common explanations of question 34 are related to "inadequate reimbursement/ rate level" issues (34.9%) followed by a desire to not "disrupt the children's lives" (15.6%) and "DHHS is disrespectful of the service that foster parents provide to the state" (15.6%). For respondents who answered "NO" on question 34 and explained their answer (n=64), the most common explanations were "Don't know" (29.7%) followed by "Adequate reimbursement rates/ trying to manage with less" (17.2%).

35. From your perspective as a Foster Parent, please indicate below which statement is most like your belief about why changes have been made to the Daily Board rates. Circle the number closest to your belief. (n=295)

Changes Made to Save Money						Changes made - Costs to High
1	2	3	4	5	6	7
64%	10%	6%	10%	4%	3%	3%

For these respondents, 74% believe that changes made to the Daily Board Rate were done to 'save money'. Only 6% believe that changes were done because 'costs too high'. About 20% appear to have a neutral opinion.

36. Have you ever asked for a re-assessment for a child in your care in the past 12 months? (Request for change from one Level of Care to another) (n=325)
    - 26% YES (n=84)
    - 74% NO (n=241)

36a. If YES, was the request to move up or down a Level of Care rating?

- 88% Move up the level of care rating
- 12% Move down the level of care rating

36b. Rate how satisfied you were with the process of re-assessment provided to you by the state DHHS system. (select one)

- 36% Not At All Satisfied
- 22% Dissatisfied
- 30% Satisfied
- 4% Completely Satisfied
- 9% Not Sure

It appears that at least one out of four (26%) of these Foster Parents have requested in the past year a review of the Level of Care rating for a child in their care, and the majority (88%) were seeking a move up in the level of care rating. A majority (58%) were not satisfied with the process of re-assessment provided by the state DHHS system.

37. In your role as a Foster Parent, what do you believe are the most critical types of services or supports that are provided to you by either local therapeutic agencies and or the state child welfare system? Please list the top three most important services / supports:

Ten of the three most important services/supports:

- "Counseling and crisis management"
- "Financial support"
- "Respite"
- "Medical care and costs"
- "Training"

- "Therapy services"
- "Agency caseworker: a buffer between the state and myself"
- "Clothing support"
- "Respecting and listening to what we (Foster Parent) say in team meetings"
- "Helpful efforts towards reunification/visitation with biological families when indicated"

D. Reactions to other Proposed Changes to the Child Welfare System

Privatization Background: DHHS has proposed to reform the foster care system by privatizing most all phases of therapeutic cases to various Agencies. The proposal would assign "full-case/ full-court" duties to agencies but would not include any additional payments to agencies. Agencies would be assigned any given case after initial custody action by the State. The Agency would then handle additional aspects of the case in addition to what they now handle under the current system. Additional duties would include such things as placement of the child, assessment of the child's level of care needed, legal court actions including possible severance of parental rights, kinship care or adoption efforts if the case requires, and final disposition of the child. DHHS would reassign caseworkers who presently work on aspects of cases under the present system to providing full time investigations of new potential cases.

38. How aware are you of this proposed change to the child welfare system? (select one) (n=326)
    - 29% I am very aware of this proposal.
    - 37% I have heard about this but do not really understand it.

- 34% I have not heard about this proposal before now.

39. Based on your experience, do you believe that a privatization effort like that described above would result in improved services for Maine's foster children? (select one) (n=324)
    - 13% YES
    - 44% NO
    - 43% NOT SURE

    Elimination of CIP's - Background: DHHS proposed to eliminate the "Community Intervention Program" (CIP) by privatizing "full-case/full-court" duties to Agencies. The community intervention program was initiated in 1999 whereby DHHS would "sub-let" investigations of alleged problems within a family to private agencies. These were cases judged early on to be not severe; that is, not of imminent danger to children in the particular home. Eliminating CIP's would allow the reassignment of existing DHHS personnel that now manage CIP's and would eliminate the contract costs. Perhaps many of us foster parents have limited or no knowledge of the CIP program, but those of you who are familiar with it are asked to share your thoughts on its past successes and the prospect of its elimination.

40. Are you familiar with Community Intervention Programs (CIP)? (n=321)
    - 21% YES
    - 79% NO

40a. If YES, how aware are you of this proposed change? (select one) (n=163)
    - 22% I am very aware of this proposal.
    - 25% I have heard about this but do not really understand it.

- 53% I have not heard about this proposal before now.

41. Based on your experience, do you believe that eliminating the CIP as described above would result in improved services for Maine's foster children? (select one) (n=279)
    - 6% YES
    - 26% NO
    - 68% NOT SURE

E. Final Comments

42. The following text area is for you to provide us with any additional ideas as to how to improve our Foster Care System. We are especially interested in any ideas that you have that would lead to better services for children and result in cost savings to the state child welfare system. Please share your ideas with us!!

    Due to the large amount of written response to this question, this data is still being analyzed and only an initial review for broad themes is available for reporting at this time. The four major themes that appear to emerge from the data are: (n=233)

    1. Criticism that the "levels of care" system is flawed and inadequate to meet the needs of the children in care;
    2. Lowering rates has created a financial burden on foster families;
    3. Caseworker turnover and adequate training for caseworkers needs to be addressed, and
    4. Foster Parents are reporting a need for a better balance between the rights of the children and the biological parents.

General Appendices Not Related to Recommendations

Appendix A: Summary Youth Conference Part II

(Facilitated youth discussion with the DHHS Children's Services Reform Steering Committee),
September 19, 2005
3-6 pm, August Civic Center

Process Overview

Thirteen youth presently or formerly in the state's child welfare system participated in this facilitated dialogue with steering committee members. There were a total of four groups (Case Management/Full Case Full Court, Residential Services, Treatment Services, Family Preservation and Reunification). Each group had a facilitator with prepared questions and a scribe; there was no set protocol for the scribes to follow. Youth had been identified by the OCFS Life Skills Caseworkers and the Muskie School's Youth Development Programs. Youth were paid a stipend. Their ages ranged from 17-32, with 10 females and 3 males. During the 45 minute sessions, youth were asked to self-select the first topic based on interest and experience, and at the end of the first session, youth moved to the second group that was located in their room (two groups/room). Facilitators sought to accommodate youth to participate in a discussion that had the most relevance to their experiences (e.g. youth who had spent all their time in care in foster families were encouraged not to go to the Residential Services session.) Adults were encouraged to attend the group session that was most relevant to their reform work group (e.g. co-chair of Treatment Services participated in that small group discussion). Adults were encouraged to stay in the same groups in the second session.

Reoccurring Themes

FAMILY AND PERMANENCY

- There seemed to be unanimous agreement among the youth that "every kid needs to live in a family setting." They spoke about the need for family dinners, fewer numbers of kids in family settings, more flexibility, less splitting, more connections and less worry about "liability" (driving cars, sleep overs). Youth also spoke about the importance of relationships with siblings and peers and the damage of being separated from siblings and friends.
    - "DHS could have encouraged relationships with peers. Do things like sleep overs. Stable long time friends that you grow up with and keep in touch with. Recognizing how important friends are. They are like family."

- When asked what "permanency" meant to them, they responded it's when you "treat a child as if they were your own." Youth spoke about the importance of family "someone you love and loves you back, doesn't matter if it's a legal family." Some youth spoke about foster parents being more like parents then "bio" parent. They struggle with the issues of loyalties to "my family." They further expressed a need to "find a permanent adult/ mentor that stays in touch before, during and after foster care, someone outside the system that the youth identifies." Youth encouraged us to think of permanency in terms of parents, extended family, siblings, long time friends and important adults.

SERVICES/TREATMENT

- Most youth reported having family preservation services that were not beneficial or helpful. Some even stated that they don't

recall or know if services were provided. There was a reoccurring theme that they were "removed quickly" and separated from siblings and other extended family members. Youth identified that tangible supports, such as financial assistance would have helped their families. Others expressed a wish that workers had helped their parents be able to parent better, stating that the system needs to let "parents to know that we want you to be able to parent your children - help parents with stressors; help cope."

- Youth generally supported the Family Team Meeting process. They communicated that they felt the model works well, as "youth driven" with "adult/worker input". They appreciated being able to identify who they wanted to attend. One youth thought it was a way to "stay on top of what I was doing, but not in an intrusive way, but a caring way." One youth stated, "I got to pick the location (for the meeting). We met at Subway, can't think of anything I would do differently." Another youth said FTMs should be required, that their service plans be developed and reviewed in FTMs to reduce duplicative meetings. Team meetings should make sense and be understandable to youth. The youth's goals should be the goals of the meeting.

- Youth felt that the case management process could be improved by having a unified approach with just one case plan, and better communication among all, including GAL, staff, caseworker etc. Youth did mention that it would be beneficial for them to have one worker or better coordination between caseworkers for activities, differences and communication.
  - "Different case workers need to work together, when they are at odds with each other it is hard on the youth."
  - "One caseworker should work with youth from the beginning

–one person could stay with the youth through their whole experience."

- When asked about receiving help (treatment) the youth admitted that "forcing is not helpful." There was a quite a bit of agreement among the youth that the "system" over-medicates and that misdiagnosis of youth is a problem that occurs too frequently. However, some youth did mention that medication has been helpful. Counseling when safe and by choice can teach them skills. Getting help from foster family, peers and youth leadership was also helpful. Helpful services are marked by consistency, clear communication, and "unconditional support", those who go above and beyond, choice, trust and follow through. Services and/or treatment that are specifically related to the problem faced by the youth are vital.

- Lastly youth were asked if they felt that their life has improved as a result of the services or treatment they received while in the states care. Youth stated:
  - "life has improved since coming off meds"
  - "Life is better once services stopped."
  - "Positive changes over the past years."
  - "Honest workers who gave me support and choice"
  - "I'm pursuing my education, dreams, hopes, aspirations and helping others."
  - "I would not be alive today, I would not be alive today without the help."

RELATIONSHIPS/CONFIDENTIALITY

- Youth found it challenging to share confidential information with therapist/caseworkers when there is mandated reporting.

For example, they chose to not share when they don't feel safe, because the information they share may get back to those with whom they live. This underlying fear makes the youth lack confidence that they are actually being protected.

- Discussion around relationships varied. Youth stated that it was very hard to form relationships in residential/group home settings and even foster homes and then have those relationships end once the placement was terminated. "Hard when a group home says no contact when you are discharged. How do you stop having a relationship with someone?" Youth also found it difficult to not be allowed to "maintain contact" with other kids once they have left a residential setting.

- The most important thing that child welfare professionals or care providers can do is to build an authentic relationship with the youth. This is affected by more frequent contact and improves case planning for youth. Youth need to know how to reach support people (phone, email, office location). Youth should know what is being documented, have some say about what is being communicated to other providers, and the supervisor needs to be kept up to date.

TRANSITIONS

- Reunification services should start as soon as the youth is removed from the home, should include extended family (aunts, uncles, grandparents), and that the process should be given more of a chance to unfold gradually. Again, youth emphasized that they need to be listened to and actively engaged in the planning process for reunification. One young woman reported that "reunification was a process from 18 years of age until now (age

32)…took a long time before we could talk about experiences or what happened."

- Regarding placements, youth felt that it was very important to consider the "voice" of youth when making placements, giving youth the opportunity to visit, learn and decide. There should be more of a variety to better fit the needs of each individual youth. Proximity of the placement to their communities of origin or proximity to birth families created mixed feelings among the youth. Some youth described the difficulty of living in the same community as their family because of the lack of safety they felt and "always having to be on the look out". Most youth agreed that being in one school setting is beneficial.

- Transitions need to be given more attention particularly when youth are moving to a "less restrictive environment." This youth stated that going "from counting knives to letting you do whatever you want is really hard on kids."

- One youth said "it's helpful to have foster parents close by when you transition to college". One youth spoke about sending college papers to group home staff for feedback.
  - "Not having a relationship with anybody when you leave the group home. On college breaks, campus shut downs. Where does that youth go that doesn't have a comfortable connection with someone? So you can go and stay. You can't ask someone that you just met at college, Can I come stay with you at Christmas? Programs need to have mentors, or identify mentors."
  - Another youth mentioned that once in college, "we need someone to send (us) care packages (calling cards, coffee)."

Appendix B: Foster Parent Input

Submission of workgroup VI write-up for final report to Commissioner 12/30/05

Per authority of "Workgroup VI" meeting in Brewer on 12/29/05; M. McBreairty - chair

Recommendations:

- Reject 2005 budget reform initiatives proposed by DHHS
- Communications within the foster care system must improve
- Perform a line item analysis of OCFS budget
- Eliminate the level I foster care payment rate
- Revise the existing system for dispersal of recreational funds
- Discontinue policy of "punishing foster parents for success"

Foster Parent Input Workgroup Members

Name	Representing
Nancy Price	DHHS Adoption Caseworker, Bangor Office
Marvin McBreairty, Chair	Foster and Adoptive Parent
Charles, "Dusty" Fisher	Maine Legislative House Member
Michael Clendenning	Foster Parent
Lori Noyes	Foster and Adoptive Parent
Michel Lahti	Muskie School of Public Service

Introduction

Workgroup VI was established at the June 2 steering committee meeting due to an initiative request by committee member and foster parent, Marvin McBreairty. Foster parents are arguably the most important members of any foster child's treatment team. Maine is blessed with a dedicated, experienced pool of foster parents. The combined experience level of Maine's foster parents is an extremely impressive and valuable asset to the child welfare system. It seemed prudent to formally solicit their input and after considerable debate, committee chair Brenda Harvey authorized the establishment of workgroup VI to do just that. No other steering committee members volunteered to join workgroup VI, nor was a co-chair assigned by Ms. Harvey.

Workgroup VI began its work by focusing on the direct charge written into law by the Legislature that initiated the overall children's services reform study. This charge is reproduced here for the record: "Sec. JJJJ-2. Children's services reform working group. The Commissioner of Health and Human Services shall convene a broadly representative working group to advise the commissioner on the children's mental health services and child welfare systems. The working group must include representatives of consumers of services and their families, providers of services, advocates, foster parents and the Department of Health and Human Services. The working group must meet at least 4 times to discuss the effective and efficient delivery of services, the needs of consumers, legal requirements for the system, service system redesign and the impact of initiatives authorized by the Legislature or proposed by the department. The commissioner shall provide a report with the recommendations of the working group to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services by January 15,

2006."

Topics and goals to be explored by the foster parent input workgroup included:

- Analysis of DHHS reforms recommended in the early 05 Maine budget process,
  - Elimination of therapeutic foster parent payment levels IV and V, making level III the maximum level,
  - Full privatization, ("Full Case – Full Court"), of therapeutic foster child cases with private agencies, and
  - Elimination of the "Community Intervention Programs", (CIP's), established in 1999.
- Solicitation of ideas to improve the effectiveness and efficiency of the foster care system,
- Solicitation of ideas to identify wastes and ideas for cost savings in the foster care system,
- Exploration of other concepts, such as:
  - Why do people choose to serve as foster parents,
  - Rating the effectiveness of various components of the foster care system,
  - An assessment of foster parent morale and opinions and ideas related to whether the State of Maine is getting a "good bang for its buck".

Through the summer and fall, workgroup VI developed a comprehensive survey with help from Michel Lahti, PhD, of the Muskie School of Public Service. Mr. Lahti has extensive experience in the field of designing and interpreting surveys. The entire Muskie staff has been wonderful help in this mission and workgroup VI would like to thank all involved very much! Workgroup VI also appreciated the active participation of member Mr. Fisher, a Maine

Legislator who has been involved in the welfare of children his entire life as a parent, teacher, and presently as a law maker.

Surveys were sent to all licensed foster homes in Maine, some 1250. To date, 338 responses have been received – over 25% return, and workgroup VI is delighted with this fabulous effort by foster parents! The following recommendations can be considered the collective efforts of hundreds of foster parents and it is hoped that policy makers give them serious consideration.

Please carefully read the following thoughts of one of our respondents. Perhaps this foster parent has captured in words, what many other foster parents are feeling?: "I am "afraid" that people do not visualize the importance of foster care parents. We need so many more. Foster children and foster parents, (in the general community), seem to be looked ill upon. We need more positive promotion on foster care and the incredible work foster parents do. I love the incredible changes our foster child has been able to make in his/her life. He/she's a totally different child than who first came to live with us. I am so proud of her/him! We stuck with it when others wouldn't. (6 placements in 1-1/2 years for her/him) This is due to his/her supportive FOSTER PARENTS. We need your support too." Note: This foster parent is questionably considered "non-therapeutic" by the system as is her foster child. She has been serving Maine as a foster parent a short time and receives a "non-therapeutic level of care" rate for parenting this precious, apparently high needs child. She is unable to work outside the home due to the extreme needs of her foster child. This case can be related to several recommendation outlined below.

A heads up for the Maine Legislature and Governor Baldacci: Our

survey asked, "overall, how would you rate the job performance of the State Legislature, (and the Governor), with regard to Maine's Foster Children/Youth? The results were:

	Poor	Fair	Neutral	Good	Excellent	Don't Know
Legislature	40%	20%	19%	7%	0.3%	14%
Governor	45%	22%	12%	5%	1%	15%

Perhaps one respondent to our survey offers a hint as to why these marks were so low?: "By DHS, the Legislature, and the Governor cutting services and stipends, they are just hurting the children because we can't spend as much time with them that is needed. We need to be their main support system 24/7!"

Recommendation 1

Reject Initiatives proposed by DHHS

Regarding, the elimination of levels IV and V payment rates to therapeutic foster parents: Workgroup VI recommends that this idea be rejected. Therapeutic foster parents suffered up to a 50% payment level cut effective in 2004 due to a previous study group's implementation, ("Level's of Care Committee"). Our survey indicated that 42% of Maine's therapeutic foster parents considered resigning due to the LOC decisions. The system did lose a number of foster parents in 2004 related to the LOC payment cuts.

If the above initiative were implemented, our survey indicated that 77% of therapeutic foster parents would seriously consider resigning with 11% saying no and 13% saying "not sure". Were this initiative implemented, there is no doubt that Maine's foster care system would

suffer long term hardships due to the loss of valuable, experienced foster parents.

Perhaps the following comments by one of our respondents to the survey says it best: "We have parented a very challenging child with reactive attachment disorder for 4-1/2 years now. We did not stop doing foster care at the last cut, ("LEVELS OF CARE" PAY CUT MADE EFFECTIVE IN 2004), as it would have been detrimental to have one more disruption for him/her, (we are placement 13 in 10 years for this child). However, the last cut significantly impacted our ability to meet her/ his needs 24 hours/day as the "stay at home" parent now must work part time. It is very sad to say after 4 years of attachment therapy with her/him, we would not be able to meet his/her needs with more budget cuts. She/he would likely end up institutionalized as he/she would not be willing to do this work with anyone again."

Regarding privatization of therapeutic foster children cases: Workgroup VI recommends that the initiative be rejected. Our survey indicated that this idea was rejected by 45% of respondents with 44% "not sure" and only 12% indicating that it was a good idea.

Another foster parent said, "I don't think you can improve service and cut costs at the same time. If you "privatize" but don't pay agencies more, (Which was the intent of DHHS), they will become overworked and underpaid, like DHS workers. Private agencies will have to hire more staff, resulting in cuts in the budget elsewhere.... probably in stipends and rec funds, etc. I LOVE working with (Agency named), but this is because they don't act like a government agency. The proposed changes would require them to do just that. Every time there's a change – foster parents suffer and we are asked

to serve the best interest of the children and think with our hearts. After 10 years, I feel manipulated....and I am quitting because of it."

Regarding the elimination of CIP's: Workgroup VI recommends that this initiative be rejected. Our survey indicated that this idea was rejected by 26% of respondents with 68% "not sure" and only 6% indicating that it was a good idea.

Rationale

- Our survey revealed that, by far, the most important reasons people choose to be foster parents relate to wanting to accept a meaningful worthwhile challenge, having resources to be a foster parent and wanting to make a "difference", or simply because someone they respected encouraged and asked them to be a foster parent. Therefore, foster parents are not foster parents primarily due to the payments received but most foster parents cannot afford to provide these services on their own or cannot provide these services unless the payments are adequate. Policy makers need to fully realize this and understand that repeated cutting of funding to foster families will result in a serious loss of available foster parents. Funding cuts often necessitate that a foster parent take an outside job, thus compromising time needed to parent a high needs foster child. Some of these children end up in group homes or institutions if foster parents are "forced" to resign. Our survey indicates that a serious loss in the foster parent pool would result if the funding cuts proposed by DHHS during the 05 budget process were implemented.
- The notion of complete privatization of therapeutic cases has potential drawbacks. Foster parents were not sold on the idea and indicated in the survey via a large margin that it should not be done. One potential pitfall of such a notion cited had to do with

the legal phase of cases. An agency working with birth parents could lose credibility and trust with the birth parents if that same agency were known as the entity that would or could progress court proceedings to sever parental rights. Perhaps the existing "good cop/bad cop" system is the best alternative in such a difficult situation.

- Many foster parents that were aware of the CIP program indicated that good results had been gained by it and did not want to see it be eliminated. The flavor of the positive comments had to do largely with the adage, "an ounce of prevention is worth a pound of cure".

Recommendation 2

Communications within the foster care system must improve

When asked to comment in the survey about the statement, "there is very good communication between DHHS employees, agencies and foster parents", 64% disagreed or were neutral while 36% agreed. There is little doubt that DHHS needs to seriously consider its present communications efforts with the idea of initiating improved methods.

Examples cited in the survey results of poor communications included:

- When DHHS proposed to eliminate payment levels IV and V in the 05 budget process, it did not involve foster parents or DHHS staff below the "Augusta upper Staff level" in the process leading up to the initiative. Foster parents were not notified of the initiative until the weekend prior to the Wednesday joint hearing

on the bill! This made attendance difficult and impossible for many foster parents due to the lack of reasonably adequate prior notice. It also made many foster parents feel disrespected to not be notified a reasonable timeframe prior to such a major event.

- Also, related to the above, the notice to foster parents the weekend prior to the Wednesday Legislative hearing did not explain proposed initiatives related to privatization and elimination of CIP's. This showed a lack of understanding and respect for the degree that foster parents are "invested" in the system. Foster parents were also concerned about these other two significant issues and had valuable input at the hearings regarding them after hearing of them via "word of mouth".
- An example of poor communications with regard to the Legislature has to do with the Appropriations Committee eliminating twice/year clothing allowances during its budget deliberations. Foster parents found out about this mostly via word of mouth. It would have been more appropriate if they had been promptly notified by the Legislature as to this significant event with an explanation as to why this action was taken. Even officials at the AFFM office were not notified of this in a timely and thoughtful manner.
- Survey comments indicated that communications are often not effective or consistent from Augusta Staff to all outside DHHS locations and/or contracted agencies. Inconsistencies in actions by various locations and entities cause problems for the system as a whole.
- Effective communications must also involve effective listening. When asked in the survey to list "three least effective components of the current state child welfare system", comments included:
- "Doesn't always tell you enough background on child, (in new placements),

- Hearing foster parents over agency personnel,
- Not listening to team members what is best for the child,
- Not informing foster parents of things they need to know
- Absolutely no communication
- DHHS does not return phone calls; they don't give straight answers to questions asked
- State workers won't listen, (it's a power trip for them)"

Rationale

Effective management of any entity depends on effective communication between members. Management must always take care to communicate effectively, fully, and thoughtfully to ensure maximum results. "Mistakes" or inefficiencies can usually be traced back to a root cause related to those in charge not communicating well to subordinates. The Maine child welfare system is no exception. Morale of all front line workers also depends on effective and skillful communications. A worker needs to know what is expected and needs to be listened to by superiors. If a communication system does not include good listening at all levels, the organization will not be effective in its results.

Resources

The resources for more effective communications are already in place. Trainings and emphasis on good communications skills can be initiated within the present system of resources by "reorganizing" priorities.

Barriers

Barriers will likely include an attitude by some in the system that they already communicate adequately and so no action is needed. Each and everyone who thinks this will be wrong.

Enhancers

A pool of system workers and managers who have skills and potential attitude to improve communications within the system.

Broad Strategies

An organized effort should be initiated with a group of personnel representing a complete cross section of stakeholders, to focus on prioritized efforts to improve communications. Outside location staff and case workers need be involved. The initiative should not come fully from Augusta staff only.

Examples of ideas for improvement are:

- Perform surveys such as initiated by workgroup VI on a regular basis, say yearly or every 2 years. Establish baselines on issues so that improvements or lost progress can be measured and tracked. Each survey can relate to the past one and be improved. More than just foster parents should be included, i.e. DHHS case workers and other front line workers, Agency staff, grown foster children, former foster parents, and others.
- Use the AFFM monthly newsletter more effectively to communicate issues to foster parents. Possibly establish a new "column" wherein DHHS, the Legislature, the Governor, et al communicate to foster parents about current issues to more fully keep them informed of "Augusta actions" and other issues.
- If the above is not practical, perhaps DHHS could establish another periodic newsletter which would include DHHS/ Legislative/Governor communications for distribution to foster parents and other interested entities.
- Include foster parents more fully in deliberations, including letting foster parents have more latitude at public hearings and work

sessions to be able to have adequate time to share valuable, experienced ideas. It is very difficult, for instance, for foster parents to attend working sessions where DHHS staff have unlimited time to voice information while foster parents are not allowed to speak at all. No one in the system knows foster children and their needs as completely as foster parents. If some time were opened up for foster parent, the Legislators and DHHS managers would be able to make more informed decisions using the additional information.

- There is an endless list of particular ideas such as these.

Cost Reduction

No cost increases are anticipated. Cost savings will surely come with added efficiencies and improved morale if communications are more standardized, more complete, more timely, and more effective.

Time Line

This initiative should begin immediately and noticeable improvements should be noticed by end users within 1 year.

Recommendation 3

Perform a line item analysis of OCFS Budget

Workgroup VI asked for authorization to perform a line item review of DHHS's Office of Child and Family Services, (OCFS), budget at the June steering committee meeting but authorization was denied. It is felt that a comprehensive, "fresh" review still would merit serious consideration.

Comments in our survey shared possible savings ideas related to

OCFS budget, such as:

- "Until foster parents are considered professionals, equal to the other pieces of the child welfare system, the State legislature will continue to erode the system. While cost cutting may be necessary, Maine also needs to look at how the Federal dollars are spent."
- "The system seems to lack flexibility. Payments are initiated to a contracted agency for a therapeutic child entering the system. As children get well, needed treatment levels drop, (as needed parenting levels rise). When needed treatment levels drop, are the per diem payments dropped to the agency thus freeing up funds for a different child more in need or for budget savings? This should be looked at as should the entire budget."
- "I feel cuts are made in the wrong places. Shouldn't cut daily board rates. Agencies appear to add another layer of beaurocracy – maybe should look at having more case workers and less agencies."
- "Too much time/money spent defending/supporting birth parents."
- "The system should create a specific treatment plan for birth parents. This should include time limited goals made up of short term – leading to long term goal of reunification. Plan should include measurable objectives and will serve to help the birth parents to be more organized to perform needed functions for their children."
- "Too much money is being used to "rehab" abusive parents. More should be allocated to protect the child."
- "Too much top heavy money being spent. Hire more direct workers or pay foster parents better to retain them."

Rationale

In our survey when asked, "do you believe that financial resources are being used most effectively in the child welfare system?", 54% of respondents said no, 36% said "not sure", and only 9% said yes.

In our survey when asked to comment on the statement, "Overall taxpayers get a good "bang for the buck" from the state child welfare system" 65% of respondents disagreed, were neutral, or didn't know (10%), while 34% agreed. The initiatives proposed by DHHS in the 05 budget process were clearly "budget driven". An analysis of the OCFS budget seemed to be a prudent notion by several survey respondents.

These results support the notion of a review of the OCFS budget.

Resources

It is felt that a team of competent independent people could be found to perform this difficult task. The directive for such an undertaking would have to come from top authority, (the Governor and Legislature), for it to have a chance for reasonably smooth, complete results.

Barriers

Barriers will likely include a resistance from career DHHS personnel to such an invasive oversight study. There will likely to be an attitude of, "we've already done this" or "the legislature has already done this" that will tend to defeat the idea. Some may indicate that the budget is "too complicated" for such a group to be able to analyze it.

All barriers such as those outlined can be overcome with the proper authority and study personnel with well rounded capabilities.

Enhancers

A detailed review of the budget is expected to uncover significant savings and improvements for the system.

Broad Strategies

The budget should be initially broken down into major segments. Each segment could then be studied on a prioritized basis. Possible segments could include:

- Personnel – salaries, wages, fringe benefits/expenses,
- Facilities costs, (with an eye on facilities consolidation),
- Funding sources, (Federal, State, Grants, Private, etc.),
- Contracted Agency costs,
- Health costs including initial assessment, medical, medicines, therapy et al costs,
- Others

Cost Reduction

It is anticipated that considerable cost savings would result from such a study.

Time Line

This initiative should begin immediately by direct initiative of the Governor and/or Legislature.

An appropriate, well rounded study group could be assembled and deliberations begun within 6 months.

A targeted completion timeframe could be 12 months, based on concurrence of the study team.

Recommendation 4

Eliminate the Level I foster care payment rate

The present levels of daily board rate payments to foster parents are as follows:

- Level I, (or A): $16.50/day
- Level II, (or B), $30/day
- Level III, (or C), $45/day
- Level IV, (or D), $60/day
- Level V, (or E), $75/day

Workgroup VI recommends that level I be abolished, making level II, ($30/day) the minimum daily board rate. It can be categorically demonstrated that $16.50/day is inadequate to support the raising of a child today.

Why should the State of Maine expect foster parents to subsidize with their own family finances the raising of the children the system has decided to take from their birth homes? The answer is that the State should not. Foster parents are some of the most compassionate, kindhearted people on earth. Our survey has confirmed that most foster parents are not in it "for the money". On the other hand, the child welfare system is wrong to take advantage of foster parents' inherent kindness to impose on their personal household budgets the expense of raising a foster child.

As a comparison, consider the daily fee paid to "day care" providers which typically is in the area of $25 per day. These facilities also generally receive Federal subsidies to help support meal costs. The children are at the location for daylight hours only, say 8-10 hours at

most. Compare this with a foster child placed in a foster home full time at $16.50/day. Most would conclude that something isn't right with the level I rate.

Other comparisons can be made. Some commonly heard have to do with board rates for pets and the per diem allowance for meals and lodging for Legislators or State employees. All such comparisons serve to support the contention that $16.50/day support for full time foster care services is more than a bargain – it could be characterized as a travesty.

On another subject related to funding for foster parents, there is a portion of foster parents in our system that strongly believe that they should not receive any or much payment for their service. There should be a mechanism put in place that allows these folks to perform their service at no or reduced rates, thus saving funds to reflect as a smaller budget or to utilize these funds for more needy situations. Perhaps a program could and should be initiated similar to the existing adoption subsidy process?

When a foster child is adopted, State adoption subsidy support is negotiated between the adoptive parents, (often foster parents, by the way), and the adoption caseworker. The amount agreed to can be anything from $0/day to $30/day. This support is re-negotiated each year. Sometimes, a family feels that they do not need support for their adopted child, or say only need $10/day support to begin with. Perhaps a couple years later, family finances change, and the same family may negotiate and ask for a $30/day support rate because their financial needs have changed or behaviors have surfaced requiring more expensive treatments for the child.

Some foster parents state that they are "not in it for the money" and/ or others may feel guilty receiving board rates when they believe that their personal financial situation does not need additional support. Why not initiate a program such as above that allows these folks to serve at less or no rates, but allowing them to re-visit this at a later date if things change?

Respondents to our survey were predominately therapeutic foster parents receiving daily board rates at levels IV and V which are considered "therapeutic rates". These foster parents do not have to deal with level I rates obviously. Survey results indicted 67% of respondents were therapeutic, 29% non-therapeutic, with 4% relative or "other". Of non-therapeutic foster parents responding some comments related to this recommendation included:

Question: "Do you believe that the current daily board rate that you are receiving now is sufficient?"

- "No, $16.50 per day is not enough.
- No, I have one very difficult child but she is not considered difficult by current rating system.
- No, only because I feel I still have to work to provide for the children's needs.
- No, with all that kids need this just doesn't cover it.
- No, prices on everything have gone up; fuel, food, clothing, etc.
- No, it is very expensive to raise children! Our child's needs have required me to cut back significantly with outside work. I put her needs before our families' financial future.
- No, foster parents always seem to be the "fall guy".
- No, the daily rate is not enough and now they have taken the clothing allowance."

Rationale

$16.50/day is inadequate funding to support a family raising a child today.

Some children, including newborns, are removed from their birth parents and placed in "strange to them" foster homes, and labeled as "non-therapeutic" which generally means "non special needs" or "low special needs". Many of these children are placed at "level I" care at $16.50/day. Some might say that this is a case of frugal and resourceful action on the part of the State.....is it? Or is it a case of taking unreasonable advantage of the inherent compassion and kindness of foster parents?

Our survey indicated a trend in that many of the infants and very young children placed at the level I rate of $16.50/day are placed with "rookie" foster parents. An example of this was illustrated by one respondent who has been a foster parent for only 1 year. This Mom is parenting three foster children, ages 4 years, 2-1/2 years, and 18 months. All are placed at the $16.50 rate. DHHS has assessed these children as "non-therapeutic", "non-special needs", low needs.....Anyone who has ever been a practicing parent would pretty much have to agree that three children, (4, 2-1/2, & 18 months), are anything but low needs even taken individually! This Mom when asked, "do you believe that the current daily board rate that you are receiving now is sufficient?", answered with a modest understatement. "No, it cost more than $16.50/day to do it the right way." She is so right about this; is placing children at rates below cost the "right way" for the State of Maine to do things?

Consider the comment of the following foster mom, who has been involved for 29 years and has fostered nearly 90 children over the

years, adopting 3. She specializes in newborns but hers is designated a "non-therapeutic" foster home: "I do not believe newborns should be included in normal board rate. (Meaning $16.50/day which is what she receives) We are up every 2 hours around the clock for several months and should be paid accordingly." How can these children be designated, "low needs"?

Since 1960, the US Department of Agriculture has kept data and has estimated the amount of money it takes to raise children. They come out with new figures each year. Please consider some data included in their report "Expenditures on Children by Families, 2004". Check it out for yourself at: www.cnpp.usda.gov/Crc/crc2004.pdf

Here are some points from this report related to this discussion: "For the overall United States, child-rearing expense estimates ranged between $9,840 and $10,900, (annually), for a child in a two-child, married-couple family in the middle-income group. Adjustment factors for number of children in the household are also provided. Results of this study should be of use in developing State child support guidelines and foster care payments as well as in family educational programs."

$9,840/365 = $26.96/day.....$10,900/365 = $29.86/day. These figures represent rearing costs for a typical child in a birth family. Foster children who have been sexually and physically abused, neglected, and otherwise given an abnormal start to life are more difficult and costly on average to rear than the children represented by these figures. Question: Why does not the State of Maine use the USDA's data as a guide in developing minimum foster care payments?

"Children get more expensive to rear as they get older, no matter the family income level", (no big surprise here). This makes it even more inappropriate for DHHS to "re-assess" an older child to a "more well" category and in the process lower the payments to foster parents as a "reward-not" for their good work. (More on this in recommendation #6)

"Data does not include possible expenses after the age of 17 such as college expenses and others",

"As a proportion of total child-rearing expenses, housing accounts for some 33-37%, Food is next at 15-20%, Transportation 12%, and miscellaneous accounts for about 12% and includes things such as personal care items, entertainment, and reading materials" - all items that add up and are not thought of much when thinking of foster parent expenses by those not foster parenting.

For the three income levels cited in the USDA's report, "the expenses for Housing, Food, Transportation, and Miscellaneous alone, (not all expenses incurred), amounts to the following costs to parents: in low income category: $17/day, middle income: $22.75/day, and highest income group: $31.75",

Remember, this data is for "typical children being reared well in their birth families"; no sexual abuse; no physical abuse; no emotional abuse; no missing meals; no neglect.....all of which many of our foster children have experienced thus making them more difficult and expensive to parent,

The USDA data does not include expenditures on children made by people outside the household and by the government. Most children

in birth families get supports from kin beyond the immediate family. Many foster children, (and their foster parents by extension), do not have this added support.

Indirect costs involved in child-rearing by parents, (birth parents or foster parents), including time costs, foregone earnings, and career opportunities are also not included in the data. This seems OK for birth parents but why should the State of Maine and society as a whole expect volunteer foster parents to consider that their time should not be compensated for in a reasonable way?

BOTTOM LINE: LEVEL I FOSTER PARENT PAYMENTS OF $16.50/DAY CANNOT BE JUSTIFIED IT SEEMS. LEVEL II, ($30/DAY), IS MORE IN LINE WITH "REIMBURSEMENT OF ACTUAL EXPENSES" FOR FOSTER PARENTS.

Resources

The existing system for funding foster parents could easily make the adjustment of eliminating level I payments, substituting level II payments.

Barriers

Barriers will likely include:

- A resistance of the system to eliminate this "super bargain" rate.
- Short term, this will add costs to the system.
- There seems to be a predominant attitude of some administrators and policy makers in the system that foster parents are "paid too much" and these people will likely resist this recommendation.
- General resistance, based largely on outmoded feelings, by the Public, Legislature, Governor, and DHHS social servants to the notion that foster parents are foster parents partly, (but

not mainly), for payments received to help them achieve their financially related goals.

Enhancers

Elimination of level I would undoubtedly result in higher morale in the foster parent ranks. Foster parents would likely feel that they are more appreciated and better understood. The service level provided would surely rise and with this rise, better results would benefit the foster children of Maine. Better results will support more productive adults from foster children who would create more in our society.

This notion raises thoughts of the adage, "pay now or pay later".

Broad Strategies

Funding sources would have to be found and allocated by the Legislature.

Cost Reduction

Short term, this will add costs. It is anticipated that long term, the additional costs will reap dividends.

Time Line

No appreciable timeframe is necessary. This recommendation could be implemented in short order.

Recommendation 5

Revise the existing system for dispersal of recreational funds

Workgroup VI recommends that the present system for the

administration of recreational funds to foster children be revised and improved to better affect the intentions of the program. Comments made in survey results clearly indicated that many of the problems outlined below exist in a significant number of foster families.

There has been a longstanding program in the foster care system that promotes the physical and mental development and activities of children. It has a proven track record of accomplishing it's intended purpose to the benefit of Maine's foster children but there are some issues in the system that have been identified as deficient.

A summary of the system in place includes:

- DHHS provides $2/day along with other daily rates paid to Agencies for each therapeutic foster child; this makes some 365 X $2 = $730/year available to promote the recreational activity of foster children,
- Funds must be requested by foster parents,
- Recreational funds are available for "non-therapeutic" foster children by request of the foster parents directly with their DHHS case worker,
- DHHS has a "developing" list of things that have been commonly excluded and included in past proposals, (a partial list follows):

Items Not Allowed under the Recreational Fund:
Pools - Unless Kiddie Wading Pools
Animals
Animal Food
Trampoline
Motorized Equipment - 4 Wheeler, Go-cart (Children in our custody cannot own motorized vehicles)

Food for Children
Motel costs
Airline Tickets
Fence for Foster Parent Yard
Guns
Ammunition
Independent Living Items-class rings, yearbooks, bus passes (these should come from IL funds)
Sun bed tanning hours
Cell phones
Personal care items, such as electric razors, beauty parlor appointments, etc. (should be paid by foster parents as personal care items are part of room & board payment)

Items Allowed under the Recreational Fund:

Life Vest	Doll House
Canoe	Soccer Equipment
Kayak	Craft Equipment
Paddles	Camera and accessories
Hockey Equipment	Punching bag and gloves
Skis and Ski Equipment	Foosball Table
Ski Passes	Air Hockey Table

Snowmobile Outfit (Boots, Suit, Helmet)
Golf Equipment & course fees

Bikes and Helmet	Bowling Equipment
Fishing Equipment	Ice Skates
Fishing License	Roller Blades
Basketball Hoop	Water skis
Basketball	Radio controlled cars
Dance Class	Gymnastics
Dance Outfits	Music Lessons

Music Instruments (Rental or Purchase)

Art Lessons	Art Supplies
Karate Lessons	Karate Equipment & Outfits
Scouting Fees	Camping Equipment
Swimming Lessons	Pool Toys

Fisher Price Playhouse for Back Yard

Swing Set (If Can Be Moved)

Game Boy, Nintendo, Playstation & Games

Television	VCR Player And Tapes
DVD Player And DVDs	Computer
Computer Games	Stereo
Tools	YMCA fees

Horseback Riding Lessons And Equipment

Snowboard And Equipment

Park Passes (Disney World, Sea World, etc. -not local town fairs/carnivals)

Ice Skates	Snow Shoes

Skate Board And Safety Equipment

Outdoor Play Equipment For Younger Children

Issues that have been identified as problematic with the existing system include:

- Some personnel involved in the administration of the funds have not been pro-active in seeing that each child receives the advantages of the program.
- Some involved are not as pro-active as they should be in making the funds known and user friendly to foster parents who must request these funds on behalf of their foster children.
- There is no mandatory accounting system to assure that funds are used to the benefit of children qualified. No routine audits are required or done to assure proper administration.

- Agencies who administer funds for therapeutic foster children automatically receive these funds when receiving contractual payments. To some unknown extent, these dedicated funds are not completely used to benefit development of children as intended. When this happens, funds not utilized directly for children are enveloped into Agency budgets at fiscal year's end. This results in an inappropriate subsidy to the Agency. All children do not receive benefits as the program intends.

Rationale

The rationale for implementing this recommendation to revise the rec fund system is self evident. Dedicated funds, meant for the direct benefit of each of Maine's foster children, should be proactively and consistently administered exactly and completely for that purpose and not used for any other purpose.

Resources

DHHS has all required resources presently to accomplish revisions necessary.

Barriers

Barriers will likely include:

- The natural resistance to change that any workforce tends to have but this should be easily overcome with proper directives and follow up.

Enhancers

Properly utilizing these funds for each of Maine's foster children will result in increased morale of everyone closely involved with children, not to mention the increased morale and development of the children themselves.

Broad Strategies

Appropriate revisions should include:

- A formal revision and establishment of a written procedure for training appropriate personnel and for communicating the program to all involved including staff and foster parents,
- Establishment of a more pro-active atmosphere with procedures so that all involved in the administration of these funds do a complete job of seeing to it that they are utilized to their dedicated purpose in a timely fashion,
- Establishment of a mandatory reporting and audit procedure to quality assure that the system is working as intended. Any discrepancies should be handled and corrected soon after discovery.

Cost Reduction

Costs, after revision efforts, should theoretically remain the same. Efforts needed in affecting the revisions can be absorbed within present staff with a simple prioritizing directive.

Time Line

It would be anticipated that this recommendation could be achieved within 6 months time from the point that it is started.

Recommendation 6

Discontinue policy of "punishing foster parents for success"

Workgroup VI recommends a change in thinking and policy with regard to the reassessment of foster children and the often resulting

actions with regard to foster parent funding.

Foster children are periodically "reassessed" while in State custody to determine how they are progressing. When foster children are judged to be "more well" after some time in the system and in a foster home, often the children are reclassified to a lower "level of care". One of the results is that foster parent daily board rates are reduced, thus "punishing foster parents for success". This resulting action is unparalleled in our society and seems absurd to foster parents.

A comparable action in any other profession would be something like this. The boss calls someone into his office and says to the employee, "Thank you for your good work. It has become more routine and easier for you to do your job so we are reducing your pay by 20% to 45%. If you continue to produce good results, we may lower your pay more later. I couldn't get along without you. Thanks again for your good work. This pay cut is not expected to result in any differences in your performance level, by the way. Thanks again and have a good day! If anyone thinks the above scenario is absurd, you have just a hint of how foster parents feel when this exact scenario is played out time and time again by DHHS and the foster care system.

Consider this comment by a respondent who has been subject to this practice. "I felt it was a slap in my face for all the hard work I had done. The better the children did, the less money I was paid. Doesn't make sense to me."

Another comment was, "Please rethink the levels system by looking at the success of foster parents ability to help children in care to be able to become stable in their environment. To penalize by reducing pay to foster parents that work hard to help kids improve behaviors

and become stable and do better makes no sense to me. The harder I work, the less money I receive to care for foster children. This certainly will not retain or promote anyone to do foster care which is extremely needed. I love doing foster care but have grown concerned with the belief that the State is really not putting the needs of the child on the top of the priority of the State. Please show foster parents the respect they desire for the care they provide to the children they care for. I earn my pay!"

Another respondent when asked, "do you believe that the current daily board rate that you are receiving now is sufficient?, answered: "Yes, but its about to be cut based on last years evaluation of the kids – by someone who doesn't know me or the kids!"

Another says: "No, these children are a lot of work. If you do good job to keep them on track your rate is cut. If the child has to leave, they go back to the way they were when you started with them."

When the reassessment process results in reclassification of a child to a lower "level of care", the foster parent is the only professional involved in the case that takes a pay cut. Workgroup VI contends that in such a scenario, the "level of treatment needed" has, in fact, dropped. What remains the same and, in fact, increases over time is the "level of parenting needed" for the child. Therefore, professionals providing treatment services can back off and savings can be had – these savings can be reflected by a lower budget figure or be used for another child more in need. The foster parents should be properly credited and thanked for their good work, but the foster parents daily board rates should NOT BE DROPPED. If anything, a part of the savings should be used to give the foster parents a reasonable RAISE IN FUNDING as would likely be done

in corporate America when a professional does good work.

There is a distinct difference between the other professionals involved with a case and the professional foster parents under such a scenario. The other professionals merely move on to other subjects/children and continue their good work; the foster parent is expected to continue parenting the same child, (who gets more difficult to parent as he/she gets older, (reference the USDA report), even if he/she is well), for considerably less funding. NONE OF THE OTHER PROFESSIONALS TAKE A PAY CUT.

There is another unfortunate reality related to this practice. In too many cases, foster parents tend to stress negatives about their foster children or are mute about positives for fear of jeopardizing their family income. Can anyone blame them?! These scenarios are unfortunate psychological bummers for all involved, especially the foster child. Foster children hunger for freely given fearless praise for their progress and hard work. This factor alone should be enough for policy makers to adopt recommendation 6.

It is truly difficult enough to parent your own biological children to adulthood; for society to ask foster parents to parent "their" children who have been messed up by their biological homes - to parent those children for a fraction of the rate received when the kids are younger is ludicrous. Foster parents not only expect and plan for foster children to improve, they are the most crucial factor as to why they improve. Foster parents should not be punished and de-moralized as the goal of wellness is approached or accomplished.

Most in the foster care system would consider treatment as all the segments of effort going into the child - some provided by the foster

parents, some by DHHS workers, some by agencies, some by doctors, etc. While it is an important juncture of a child's life in State custody as to when he/she may no longer need some of these services, no one should deny the fact that the child will continue to need skilled PARENTING. This vital service, (parenting), is provided by the foster parent until the system can find a permanent home for the child. The role and need for parenting does not decrease, as does the need for weekly counseling, the need for medications, the need for significant, (time consuming), case management, etc., etc. Therefore, the system should be astute and flexible enough to recognize this; save the $ for others more in need when some of the treatment services are no longer needed for certain children, but also recognize that the parents still need to continue their hard, vital work on a day in/day out basis and therefore should continue to be compensated in the same OR ADDITIONAL manner. TREATMENT GETS EASIER AND LESS EXPENSIVE - PARENTING DOES NOT.

Result if this recommendation is implemented: The child continues to get well, the system saves money for other more urgent uses and the foster parent continues providing services with good morale and fearless testimonials regarding the child's improvements.

Rationale

The rationale for this recommendation is self evident. "Punishing" any segment of the system for good, successful work is not OK.

Resources

Revising the system per the recommendation can be done in short order with resources available.

Barriers

Barriers will likely include:

- Resistance to change by those "running" the system.
- A resistance by Legislators if they see this as adding cost.
- The apparent opinion by some that foster parents are "paid too much".

Enhancers

Adoption of this recommendation would undoubtedly result in higher morale in the foster parent ranks. Foster parents would likely feel that they are more appreciated and their services better understood. The present feelings among many foster parents that, "the system does not understand or appreciate what we do" and that "no one listens to our concerns and needs" would evaporate to a large extent.

The service level of performance would surely rise and with this rise, better results would benefit the foster children of Maine. Better results will facilitate better development of foster children to mature, skilled, productive adults.

Broad Strategies

A decision by policy makers to accept this recommendation is all that is needed. It could be implemented with existing resources.

Cost Reduction

Cost factors should be negligent if the system is flexible enough to fully factor in the decreased need for "treatment services" with resulting funding adjustments downward in the appropriate segments of cases. Full implementation of flexible "case by case" segment review could possible result in significant cost savings.

Time Line

No appreciable timeframe is necessary. This recommendation could be implemented in short order.

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As this report reflects, Maine's initiative to redesign how the work of state government can better serve families draws from a range of state and community experts. In our efforts to not "reinvent the wheel," Maine sought assistance from a number of states and individual programs that have successfully redesigned the delivery of children's services. Thus, in addition to the references listed in this bibliography, Maine researchers contacted multiple states and individual programs to gather best practice and reform information, strategies and tools. Some of those contacts and conversations are referenced directly in the report, while others served as supporting resources for workgroup discussions and may not be directly referenced in the report. We have, wherever possible, acknowledged these contacts and conversations in this bibliography.

This bibliography is organized within broad topic areas that we hope will make it useful not only in support of information referenced in the report, but also as a research tool.

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