Comments on the CFSR Review Process: The Eight Questions[1]

Children and Family Futures

Responses

1. *How could ACF best promote and measure continuous quality improvement in child welfare outcomes and the effective functioning of systems that promote positive outcomes for children and families?*

Here the critical issue in CFSR seems to be the definition of "systems that promote positive outcomes for children and families." The broadest question is what other systems are critical to child welfare outcomes. This goes beyond but is related to Question #4 on stakeholder roles.

In every serious analysis of the driving forces in child welfare—including five national reports—substance abuse is described as a major factor.[2] ACF and SAMHSA have created and funded a National Center on Substance Abuse and Child Welfare in recognition of the bridges that need to be built across the divide between these two fields. The Regional Partnership Grants to 53 coalitions were funded for five years through ACF to achieve stronger links among child welfare, treatment agencies, and dependency courts. CWLA devoted a special issue of *Child Welfare* and many separate articles to the subject. A recent review of the history of ASFA discussed the extent of substance abuse and its impact on ASFA goals.

Yet there is an attitude in some segments of the child welfare field that substance abuse is "just one more factor" in child welfare. While it is an attitude that is increasingly difficult to sustain in view of the facts, the attitude persists. And in a serious logical flaw, this attitude is justified by "the lack of causative proof" that substance abuse has a major effect on abuse and neglect. The logical flaw is that if little effort is made to collect in-depth data on a factor, it is impossible to determine the significance of that factor. And for the most part, supported by federal policy, the child welfare information system does not systematically collect data on the presence of substance abuse as a factor in child abuse and neglect cases. It is not required in the SACWIS, it is not reviewed as a major factor in AFCARS, and it is essentially ignored in the CFSR reviews except for a brief reference in the case reviews. And when it is raised by the states in their statewide assessments, typically it is mentioned in a list of "array of services" gaps. Even with the inconsistencies among states in documenting substance abuse as a reason for removal in AFCARS reporting, large states such as Texas and Florida report alcohol or drug abuse as the reason for removal at 58 and 42 percent, respectively (2007 AFCARS report). The inconsistency

[1] These comments represent the views of Children and Family Futures and are not intended to reflect those of its funders or collaborating partners.

[2] *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy*. Washington, DC: Child Welfare League of America. 1998. *Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers.* Washington, DC: U.S. General Accounting Office. September 1998. *No Safe Haven: Children of Substance-Abusing Parents.* New York: The National Center on Addiction and Substance Abuse at Columbia University. January 1999. *Healing the Whole Family: A Look at Family Care Programs*. Washington, DC: Children's Defense Fund. 1998. *Blending Perspectives and Building Common Ground. A Report to Congress on Substance Abuse and Child Protection.* U.S. Department of Health and Human Services. Washington, D.C.: U.S. Government Printing Office, 1999.

in reporting methodology is underscored by California's reporting that substance abuse accounts for only 4.4 percent of the reasons for children being removed from their homes.
Many studies have also made clear that substance abuse is not an isolated factor that can be assessed in isolation from co-occurring disorders and other problems facing child welfare families, notably mental illness, family violence and trauma, learning disabilities, employment history and economic self-sufficiency, and related factors. Clearly those underlying, associated conditions must be considered in the assessment of systems that promote positive child welfare outcomes.

We would summarize the impact of substance abuse on child welfare, relying on the data that is currently available—for all its shortcomings—as follows:

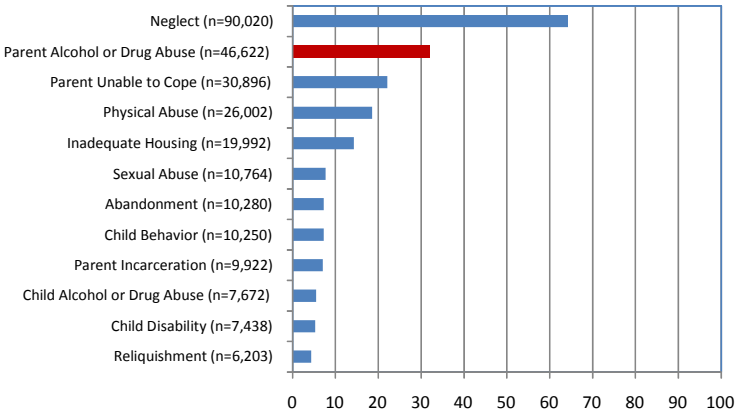
- *A minimum of one-third of the substantiated child welfare caseload is affected by parental substance abuse at a level that front-line workers determine to require treatment in order to improve the odds of positive child welfare outcomes. The sites that do the best job of screening for and assessing parents with substance use disorders report rates well above this level.*
- *A considerably higher rate of cases where children were removed—as much as two-thirds of all cases in some jurisdictions—involved parental substance abuse. The national average of approximately 31% is less relevant than the upward trend line and the fact that the rate is much higher in the states that do the most thorough job of screening these cases. Despite very uneven data from states and localities, substance abuse has an impact on child welfare caseloads that is documented to be increasing over a ten-year period in the highest-cost segment of the caseload—those children who are removed from their families*
- *Improving documentation of prenatal substance exposure suggests that this problem is not declining over a multi-year period, cumulatively affecting more than eleven million children and youth and annually affecting more than 600,000 newborns. These children are known to be at higher risk for eventual entry into the child welfare system.*[3]
- *On the treatment side, the few states that report treatment admissions linked to parental status and numbers of children have documented that (1) a majority of treatment entrants are parents and that (2) parents entering treatment from child welfare and dependency court referrals are able to achieve rates of positive outcomes comparable to those of all clients when referred to effective treatment programs.*
- *Given this data from multiple sites, the evidence strongly refutes the thesis that substance abuse among parents in the child welfare system is over-emphasized, with numerous sites reporting more than one-third of the substantiated cases affected by substance abuse and several sites with well-documented rates double that level.*

If this is true, then the CFSR question is *whether proportionate attention is given to the effects of this set of co-occurring problems on the effective functioning of systems to reach positive outcomes for children in the child welfare system*. To report and review those child welfare outcomes without any attention to their underlying causes seems to us a major omission. The

[3] Barth, Richard P. "Research Outcomes of Prenatal Substance Exposure and the Need to Review Policies and Procedures Regarding Child Abuse Reporting," *Child Welfare* Vol. LXXX No.2, March-April 2001, 275-296.

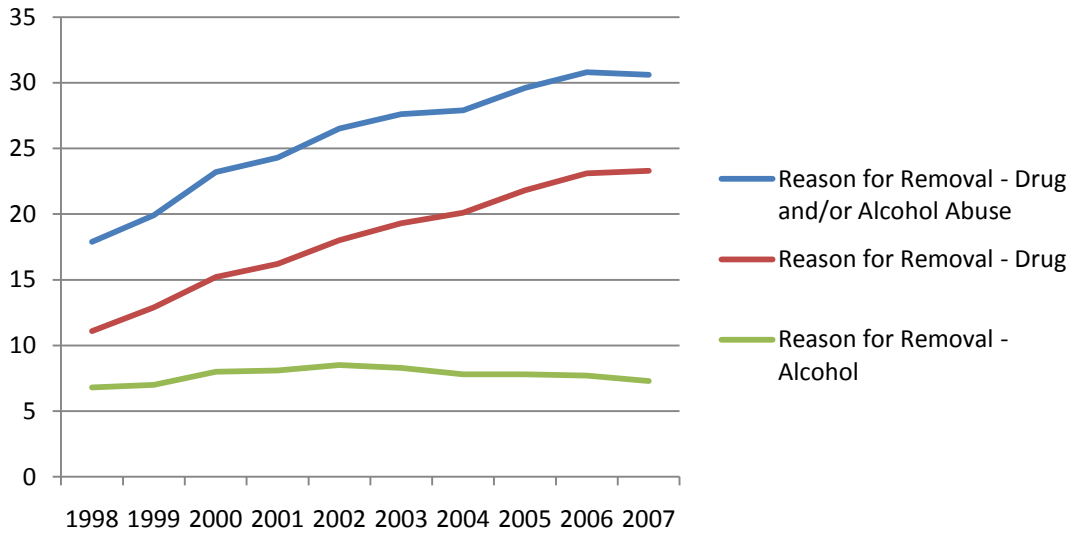
chart below (Figure 1) makes clear that AFCARS reports substance abuse as the second most frequently mentioned factor—and the first, neglect, is often summarized as an artifact of poverty and substance abuse. Figure 2 shows that over time, states are gradually improving their ability to use AFCARS to capture substance abuse prevalence, though at rates well below what many states indicate are the actual figures.

Figure 1: Percent and Number of Children with Terminated Parental Rights by Reason for Removal -- 2007

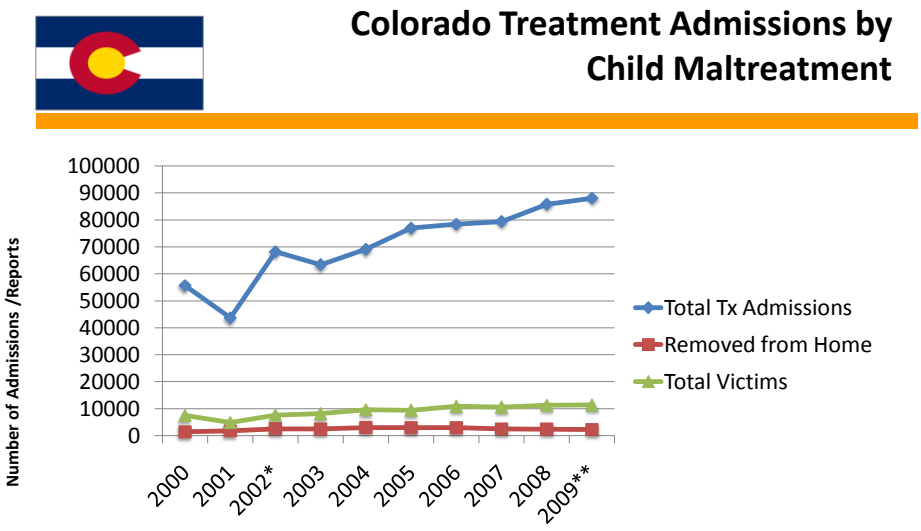


Source: Boles, S. (2010). Unpublished data analysis of the 2007 Adoption and Foster Care Analysis and Reporting System (AFCARS) data set.

Figure 2: Average Drug/Alcohol Abuse as a Removal Factor for all States from 1998-2007 AFACRS data



At the very least, the statewide assessment should require data on the actual prevalence of substance use disorders among families in the child welfare system. The CFSR review process should include an accounting of how many families identified as needing substance abuse services actually receive and complete services. Subsequently, the PIP should require separate sections with strategies on how that gap will be closed. To make this concrete, we often use the attached slide in our presentations to joint meetings of child welfare, treatment agencies, and courts to document the actual availability of treatment slots at levels well beyond those needed for all child welfare families with substance abuse problems that are likely to affect final child welfare outcomes. It is the lack of a priority for child welfare families and the absence of strong linkages across these systems that affects timely access to effective treatment, rather than the actual gap in treatment services in most states.



Office of Applied Studies, SAMHSA Quick Statistics from the Drug and Alcohol Services Information System, Accessed 2/1/11.
U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2009.* Washington, DC: U.S. Government Printing Office, 2009.
* Indicates CFSR Round 1 On-Site Review
** Indicates CFSR Round Two On-Site Review

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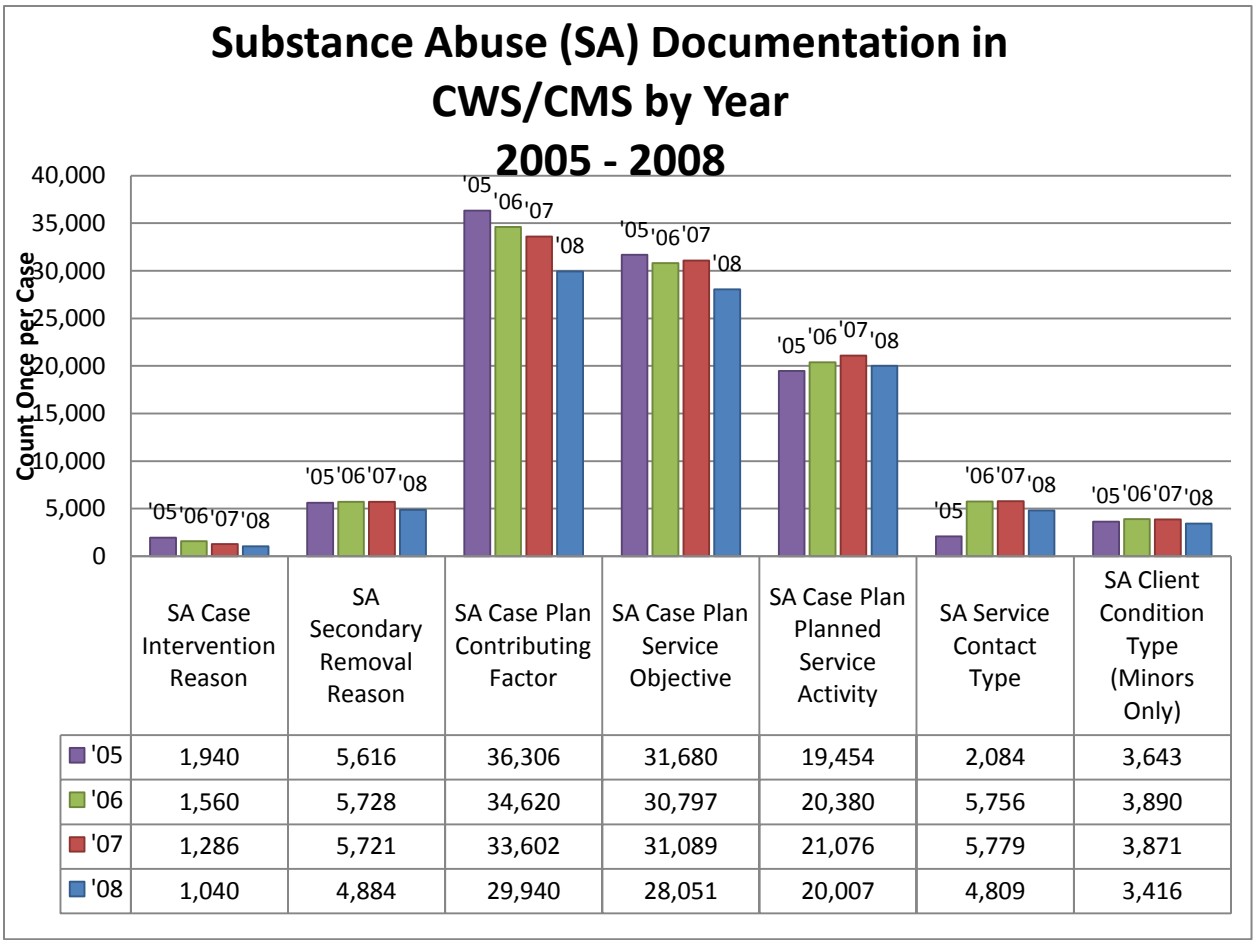
2. *To what extent should data or measures from national child welfare databases (e.g., the Adoption and Foster Care Analysis and Reporting System, the National Child Abuse and Neglect Data System) be used in a Federal monitoring process and what measures are important for State/Tribal/local accountability?*

As noted, AFCARS data, while partial and ranging widely across different states with different methods, shows a clear trend line toward increased reporting on substance abuse as a factor, even though this data is optional and not standardized. Quality review of AFCARs as part of the CFSR should explicitly review the screening and assessment methods that states use to identify and record the presence of substance abuse as a risk factor—and what is done about it. A standardized definition of what case management for substance abuse factors means would ensure that this data would be of considerably higher quality over time.

3. *What role should the child welfare case management information system or systems that States/Tribes/local agencies use for case management or quality assurance purposes play in a Federal monitoring process?*

Some states, such as California, have analyzed their case plans and their SACWIS data to determine the different ways in which substance abuse was recorded as a factor in the case. The attached chart shows an analysis of California SACWIS data from 2005-2008 that reveals the extent of substance abuse as captured in case files; this can be contrasted with reports in AFCARS of 4.4% of removed cases (the lowest rate in the nation) being affected by drugs or alcohol use by parents. The case for using SACWIS as well as AFCARS in CFSR reviews seems very strong in light of this data.



	SA Case Intervention Reason	SA Secondary Removal Reason	SA Case Plan Contributing Factor	SA Case Plan Service Objective	SA Case Plan Planned Service Activity	SA Service Contact Type	SA Client Condition Type (Minors Only)
'05	1,940	5,616	36,306	31,680	19,454	2,084	3,643
'06	1,560	5,728	34,620	30,797	20,380	5,756	3,890
'07	1,286	5,721	33,602	31,089	21,076	5,779	3,871
'08	1,040	4,884	29,940	28,051	20,007	4,809	3,416

Other states, including Florida and California, have tracked treatment admissions from child welfare agencies and dependency courts to determine how the outcomes for these clients compare with other entrants to the treatment system. Collaboration with treatment agencies that provides this kind of data is a critical test of how deeply collaboration goes, and indicates whether cooperative efforts are limited to specially funded, small-scale pilot projects—or range across the entire state government. As the language in Question 1 makes clear, it is the improvement in systems needed to reach child welfare outcomes that is needed.

4. *What roles should State/Tribal/local child welfare agencies play in establishing targets for improvement and monitoring performance towards those targets? What role should other stakeholders, such as courts, clients and other child-serving agencies play?*

On this question, the role of stakeholders should follow from the comments above regarding the prevalence of substance abuse in the child welfare caseload. If treatment agencies at the state level are merely "consulted" in the CFSR process, they are likely to play a far less active role than if they are an active part of the CFSR review process *to the extent that the state can document the effects of those risk factors on child welfare outcomes.*

We recognize the reluctance of states to be held responsible for agencies over which they do not have direct authority. This has led to some proposals that CFSR reviews should require "communications" with other agencies, but not go beyond that to requiring actual collaboration. But along the continuum from communicating with other agencies to being held responsible for their efforts, there is a great deal of middle ground. Simply meeting with other agencies—communicating with them—is minimal. Collaboration and shared outcomes are an optimal result, and go well beyond meetings—they are about accountability and trust. Both take time and leadership and a definite priority on such efforts. It is questionable whether anything less than collaboration and shared outcomes can actually improve access to services and outcomes for families in need of services outside of the direct authority of the child welfare system. In response to the above concern of state child welfare agencies to be held responsible for services outside of the child welfare system, to our knowledge there is no formal requirement or expectation for engagement of state/county substance abuse and mental health agencies either in the CFSR process or in core federal funding provided under Title IV-E, IV-B, and SAMHSA substance abuse and mental health block grants. The recent requirement for the state substance abuse director participation (as evidenced by being a signatory to the application) for the Maternal and Child Health Home Visiting Program is a positive example of what could also be tied to other funding streams as well.

Measures of the capacity of states and localities to move from communication to accountability, including our own Collaborative Capacity Instrument (and an accompanying Collaborative Values Inventory) have been used with dozens of ACF grantees to document the extent of joint efforts by child welfare and its partner agencies in the Regional Partnership Grant sites.[4] The chart below makes clear that there are several interim steps from mere communications toward shared accountability for outcomes. Such measures could be used in the CFSR process to review the extent of collaboration with partner agencies whose efforts are critical to improving child welfare outcomes. This chart was used in a recent ACF-HRSA presentation to home visiting agencies on collaboration efforts in the home visiting program.

[4] These tools are available at www.cffutures.org

The Continuum from Cross-systems Communication to Shared Accountability

Communication	Information Exchange	Shared Information on Client Needs	Referrals	Referrals and followup	Resources	Dedicated resources	Targeted Resources	Accountability
We sent them a memo	We meet a lot and brief each other	We have useful data on statewide service needs of clients we share	We can communicate about shared clients; we have a formal protocol for referrals	We know how we treat each other's referrals and whether they get services	We jointly fund some programs and out-station staff	We set aside slots for their clients; we negotiated specific resources for our clients	We agreed on which clients should be the highest priority and which risk factors are critical	We share responsibility for results and monitor outcomes annually

In addition to emphasizing stakeholders at the state level, the CFSR process would be enhanced by recognizing how much other federal agencies' initiatives could affect state and local collaborative efforts. For example, federal support of early childhood councils in states have provided resources for younger children that could have direct impact on the school readiness of children in the child welfare system—which is central to child well-being, and in which the risk factors in child welfare families directly affect school readiness, school attendance, and academic performance. In Colorado, use of a unique identifier across all early childhood and education programs enables tracking children (including children from the child welfare system if they were given a special code) as they enter and move through school. If the CFSR review process took these innovations into account as they have the potential to positively affect child welfare outcomes, states would be given deserved credit for innovations in other systems that are likely to benefit child welfare clients.

Funding for collaborative efforts in more than 325 family drug courts, which are now supported by three different federal agencies, (ACF/CB, SAMHSA, and DoJ/OJJDP) provides a basis for using the CFSR process to review the relative scale and effectiveness of this innovative method of improving child welfare outcomes. But each agency currently has its own evaluations, its own performance indicators, and its own funding streams. If the CFSR process asked states to identify their efforts to collaborate across these different projects, the impact of FDCs could be compared with other child welfare innovations in their impact on ultimate outcomes.

Similarly, CFSR processes could invite states' responses on the question of how child welfare outcomes are currently or prospectively affected by federal support for home visiting programs,

implementation of the Affordable Care Act, recent parity regulations affecting heath coverage, and support for military families. Such efforts to work on a more fully interagency basis in the CFSR would seem consistent with the White House memorandum on administrative flexibility recently issued to all federal agencies.[5]

Finally, on this question, we would note that the suggestion that "child-serving agencies" should be involved in the CFSR process should be widened to include *family*-serving agencies as well; children live and thrive in families, and the wider perspective is essential.

5. *In what ways should targets and performance goals be informed by and integrated with other Federal child welfare oversight efforts?*

The CAPTA requirements as amended in 2010 include greater attention to substance abuse and prenatal exposure. Greater emphasis on states' reporting their actual counts of both required referrals—prenatally exposed births and 0-2 year-olds in substantiated cases for Part C agency assessments—represent Congressional recognition that these infants and toddlers often need early intervention and oversight from child welfare systems. The lack of any overview of CAPTA counts in state CFSR reports is an omission of one of the most important congressional mandates to pay particular attention to these children and their needs, and such counts should be a formal part of the CFSR process in response to the 2010 CAPTA amendments.

The emphasis on differential/alternative response in the CAPTA amendments of 2010 also raises important questions about how these responses to families' entering the child welfare caseload are assessed in terms of factors outside the child welfare system that affect child welfare outcomes. Very few reviews of Differential Response/Alternative Response efforts include assessment of how often these families have substance abuse and co-occurring disorders—and even fewer assess whether services are provided to these families when they need them. With a minority of cases in the formal child welfare system receiving services that are in the case plan, it seems likely that even fewer of these cases diverted from the child welfare system receive needed services from external agencies. With the national trend of reduced case loads of children in out-of home care, more families are being served in alternative response systems. The CFSR process should review the extent to which these services are provided by a state's DR/AR programs and result in improved outcomes including long-term diversion from out-of-home care. The effectiveness of DR/AR and family preservation services will directly impact other child welfare outcomes such as the recurrence of maltreatment and re-entry into the child welfare system.

6. *What specific strategies, supports, incentives, or penalties are needed to ensure continued quality improvement and achievement of positive outcomes for children and families that are in substantial conformity with Federal child welfare laws?*

Pending expansion of waiver authority for Title IVE programs would provide a major incentive for exemplary efforts to improve outcomes. Waivers are typically justified as a tradeoff between oversight and outcomes, with the premise being that greater flexibility will result in improved

[5] February 28, 2011 WHITE HOUSE MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES "Administrative Flexibility, Lower Costs, and Better Results for State, Local, and Tribal Governments."

outcomes. States should be invited to suggest supplementary outcomes that would affect child welfare outcomes, not just those currently within the CFSR process, including school readiness and attendance, health coverage, and access to substance abuse and mental health services for parents as well as children.

Consideration should also be given to linking CFSR outcomes to the continued funding of collaborative projects such as the Regional Partnership Grants, the Substance-exposed Newborn projects, and special home visiting programs that emphasize supportive services such as substance abuse treatment that are not a major feature of most home visiting programs (see our comments on the home visiting legislation at http://www.cffutures.org/files/presentations/HV_SA_memo.pdf).To the extent that these programs result in support for CFSR outcomes, they should be noted as part of the CFSR review and not simply mentioned in the state's self-assessment. This would give the "array of services" issues more meaning as part of the overall review.

7. *In light of the ability of Tribes to directly operate title IV–E programs through recent changes in the statute, in what ways, if any, should a Federal review process focus on services delivered to Indian children?*

Tribal data should be broken out separately in states where tribal enrollment in child welfare is a significant issue. Continued efforts should be made to provide targeted technical assistance to tribes and to monitor their linkages to state agencies and the results of those links.

8. *Are there examples of other review protocols, either in child welfare or related fields, in which Tribal/State/local governments participate that might inform CB's approach to reviewing child welfare systems?*

The federal interagency process typically excludes review of each agency's own methods of reviewing state performance. This leads to a deepening set of silos, in which cross-silo responses become very rare because the state and local agencies are responding solely to their own funders—despite the growing evidence that those funders' intended outcomes cannot be achieved within their own state agency counterparts. Yet considerable evidence in recent (and earlier) innovative grants suggests that interagency efforts can be effective (some of which was set forth in a recent report by NORC).[6]

Another critical segment of the federal government has sought "services integration" since 1947—the armed forces. Recent analyses suggest that the end state has not yet been reached.[7] But lessons about inter-service review of operations, especially the value of "after-action reports," suggest that more in-depth analysis of projects that sought collaboration would be helpful, especially if they were to include an explicit assessment of whether increased costs of collaboration were justified by the value added in collaborative outcomes.

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[6] Improving Children's Health and Well-being by Integrating Children's Programs, NORC 2011. http://www.firstfocus.net/sites/default/files/Improving%20Children's%20Health%20and%20Well-being%20by%20Integrating%20Children's%20Programs_Final%20Report.pdf

[7] Diane K. Morales and Steve Geary, "Speed Kills: Supply Train Lessons from the War in Iraq." *Harvard Business Review*. November 2003.

Finally, although cost analysis is not a "review protocol" as such, the fact that the CFSR process is almost completely resource-free, to the extent that it requires little information about costs or cost-effectiveness, seems to ignore the dire fiscal situation in which most child welfare agencies find themselves today. A host of child welfare innovations are currently in use by states, but the data on the costs of these innovations are often excluded in evaluations funded extensively by federal grant-making agencies. If the CFSR process invited states to submit data on the costs and cost offsets of their efforts to improve child welfare outcomes, more useful information might result over time on which of those innovations were proving most effective. In tight fiscal climates, such information would seem very useful to child welfare agencies in improving their outcomes, and in sustaining those innovations that prove most cost-effective.

Summary

The more narrowly the CFSR process is restricted to child welfare agencies and outcomes, the more an implicit message seems to be sent: child welfare agencies can achieve their mandated outcomes largely by their own efforts, using their own resources. This message seems inaccurate and ill-timed, given the strain placed on child welfare agencies by recent state and local (and pending federal) budget cuts. A wider role for the data, resources, and involvement of other agencies seems critical, and the CFSR process is one arena in which that could be encouraged. That encouragement requires considerably more attention than it is given in the current CFSR process.