TOWARD AN
ORGANIZED SYSTEM OF CARE
FOR
RHODE ISLAND'S CHILDREN, YOUTH AND FAMILIES

The Report of the

Rhode Island System of Care Task Force

January 2, 2003

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TRANSMITTAL LETTER

Hon. Donald L. Carcieri, Governor-elect
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Providence RI 02903

Hon. William V. Irons, Senate President-elect
State House - Room 317
Providence RI 02903

Hon. William J. Murphy, House Speaker-elect
390 Wakefield Street
West Warwick, RI. 02893

Dear Governor-elect, President-elect and Speaker-elect:

Congratulations to each of you on your successful elections.

With this letter, we send to you the report of the Rhode Island System of Care Task Force and ask for your full support and your strong leadership in moving us closer to an organized system of care for Rhode Island's children, youth and families.

A major impetus for the creation of the System of Care Task Force was the study of the Department of Children, Youth and Families commissioned by the Children's Policy Coalition (CPC) and conducted by the RI Public Expenditure Council (RIPEC) [*A Review of the Department of Children, Youth and Families* prepared by the RI Public Expenditures Council and commissioned by the RI Children's Policy Coalition (January 2001)]. The System of Care Task Force took up where the RIPEC Study ended. Our report culminates nearly 2 years of data gathering, analysis, discussion and consensus building. The members of the System of Care Task Force unanimously endorsed the vision and principles of this report and acknowledged that considerable work needs to yet be accomplished.

This report builds on the strengths of our state's system of care, describes the challenges and outlines a plan to move a currently disorganized and fragmented system of care into an organized system of care. Our recommendations were developed through dialogue and consultation with family members, advocates, elected and appointed officials, judges, expert practitioners and other members of the public who are involved or have an interest in services for children, youth and families.

The work of the Task Force was divided among two data-gathering committees, the Foster Care Committee and the Current Reality Committee, and one design committee, the Ideal System of Care Committee. The former two committees were tasked with collecting data relative to their assigned areas, analyzing that data and forwarding it to the Ideal System of Care Committee. The Ideal System of Care Committee was tasked with using this and other input to present to the Task Force a plan that moved away from the traditional response to child and resource crises (adding more resources through additional funding with no

organized plan) to developing a structure for a new system of care that is family-centered, community-based and in which programs and services are measured against agreed upon outcomes.

The reports and the recommendations of the two planning committees are included as appendices to this document. The vision and structure outlined in the body of the Task Force report is based on the recommendations of the Ideal System of Care Committee. Our vision recognizes that the resource needs identified in the other two committee reports can be effectively addressed only through a true "paradigm shift" which ensures that we move to structures and processes which emphasize community-based prevention, strengthen families and communities and more clearly define the parameters used to determine when a child or youth is placed out-of-home. These details must be used to inform the work of those who are tasked with planning and improving Rhode Island's new System of Care.

As the leaders of the Task Force, we believe it important to point out two critical partners for moving ahead – the judiciary and the provider and advocacy communities.

Rhode Island enjoys a very active and involved Family Court bench which unquestionably seeks to ensure that children and their families are provided with the highest quality of services and supports available. The reality, however, is that the authority for expenditures and the control of those expenditures is extremely diffuse. As long as this diffusion continues, the State will have difficulty focusing on priorities, achieving the best possible outcomes and controlling expenditures. The challenge before us is to more clearly define roles within our system and thereby achieve greater quality, greater accountability and a more cost effective approach to delivering services and supports to children and their families.

Likewise, Rhode Island's provider and advocacy communities are aggressive in providing input and feedback, especially in regard to the functions and practices of DCYF. Two-thirds of DCYF's expenditures flow to private providers. We must continue to include these voices at the table while recognizing that some perspectives represent narrow interests and arriving at consensus for significant and critical improvements can be elusive.

Finally, the Task Force strongly endorsed the Children's Cabinet as the principle body to oversee the implementation of these recommendations. The Cabinet has become a truly effective vehicle for interagency collaboration and systems reform. We encourage you to use the Cabinet as the steering authority for the System of Care Implementation Committee modeled after the successful Welfare Reform and Starting RIght Committees. As described in this report, we see the Department of Children, Youth and Families (DCYF) as the lead agency staffing this committee with additional staffing commitments from each of the other executive departments that have the authority and responsibility for the delivery of health, human and educational services to our children, youth and families.

With strong state-level leadership, we know that the recommendations in this report will be used as a blueprint and catalyst for developing an organized system of care for Rhode Island's children, youth and their families. We seek your support and leadership. We look forward to discussing this with you in further detail.

Sincerely,

Thomas J. Izzo

Senator Thomas J. Izzo

Steven M. Costantino

Representative Steven M. Costantino

Robert L. Carl, Jr.

Robert L. Carl, Jr., Ph.D., Director
Department of Administration

PREFACE

The Rhode Island System of Care Task Force was charged to design a full system of services that will provide effective supports and services to children and their families. Looking beyond the current configuration of services, departments and providers, the Task Force worked to design a system that builds on the strengths of children, youth and families through the most effective use of finite state resources.

This System of Care for our state's children, youth and families is a vision. It is a proclamation of shared goals and a desire for better outcomes. The importance of this vision to our state and its future served to induce all three branches of government into its preparation. Critical to the lives of our most vulnerable citizens, Rhode Island's Legislative, Executive, and Judicial bodies are each charged with distinct governmental functions relative to our children and youth. By participating in this planning process, no branch of government has sacrificed any of its authority, power or obligation. Constitutional checks and balances set the context for this vision and comprise the legal foundation of governmental responsibility which may not unilaterally be abdicated. In this new Rhode Island System of Care, if each and every child and family is to succeed, all three branches of government must be vigilant in fulfilling their distinct roles in the lives of children, youth and families.

Integral to any effort on behalf of children and their families is understanding the role and authority of distinct government bodies.

The Family Court has the statutory authority to oversee and implement all the duties as enumerated within Chapter 1 of Title 14, Chapter 11 of Title 40 and any other statutory charge as outlined within Section 8-10-3 of the Rhode Island General Laws.

The Department of Children, Youth and Families has the statutory authority and responsibility to mobilize the human, physical, and financial resources available to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children, youth and their families to reach their full potential, including prevention, early intervention, outreach, placement, care and treatment, and aftercare programs. The Department is the single authority to establish and provide a diversified and comprehensive program of services for the social well-being and development of children, youth and their families. In furtherance of its purpose, the Department of Children, Youth and Families cooperates and collaborates with the Family Court, other public and private agencies, and the federal government in the development and implementation of comprehensive programs to support children, youth and their families.

The Office of the Child Advocate, created in 1979, is statutorily charged with protecting the rights of children in State care. RIGL § 42-73-7 grants the Office of the Child Advocate the authority to take all possible action, including, but not limited to, public education programs, legislative advocacy and formal legal action, to secure and ensure the legal, civil and special rights of children.

While the Task Force made very effort to design a comprehensive System of Care, recognizes the challenges inherent in the implementation of any systemic change. Further, the Task Force recognizes that a body of law exists, both state and federal, which comprises the underpinnings of child welfare, juvenile justice, and children's behavioral health services. This report, its recommendations, and implementation plan must be viewed within that framework.

EXECUTIVE SUMMARY

This plan for an Organized System of Care for Children, Youth and Families is one that has been evolving for more than two decades. During this span of time, the system has grown -- with each attempt at crafting a better plan to ensure that children and families receive the right services to meet their needs. However, during these past 20 years, the growth has been biased in favor of residential treatment to the detriment of the development of community-based capacity that supports and engages families as partners in the helping process with children. We have not sufficiently invested in prevention or early intervention to identify and meet the needs of children, youth and families. There has been a paucity of data to guide better decision-making.

This plan finally establishes a foundation to act from national research and local knowledge. This report mandates a stronger, more urgent commitment to prevention and early intervention and education and, importantly, places a deep emphasis on ensuring an organized system of coordinated services and care.

Rhode Island's organized System of Care for Children, Youth and Families is built on the strengths of families and communities, the successes of past initiatives, and is responsive to the challenges of the past. It is a system that is operationally feasible, financially realistic and supported by broad consensus. This system is the strategic instrument for moving the State closer to the four outcomes embraced by the Rhode Island Children's Cabinet and other key state and community leaders:

- **All Children Entering School Ready to Learn**
- **All Youth Leaving School Ready to Lead Productive Lives**
- **All Children and Youth Safe in Their Homes, Neighborhoods and Schools**
- **All Children Living in Families that are Self-Sufficient, yet Inter-Dependent**

Within the pages of this document, there are three critical interwoven themes:

- **Family-Centered Practice;**
- **Prevention and Education; and,**
- **Promoting Best Practices.**

The fundamental values at the core of this plan are recognition and support for the role of the family as the primary caregiver for children, and that the optimum interventions for any individual child and their family are those most proximate to home with the full resources of the community made available to that child and family. This Plan also recognizes that "family" includes biological parents, adoptive families, extended kinship networks, legal guardians and temporary fostering families.

The Organized System of Care provides all families and primary care-givers ready access to the resources necessary to meet their child's developmental needs. The system has mechanisms to redirect cost savings from reduced reliance on restrictive and expensive out-of-home placements to community-based prevention and intervention services. Included among these resources are those that meet the basic needs of all children for healthy

development, as well as special resources to meet the unique individual needs of children with disabilities and social, emotional, and behavioral disorders; children who have been abused and/or neglected; youth involved with the juvenile justice system; and, young women, whose unique pathways into the juvenile correction system, and their special strengths and needs, have only recently come into view.

This plan envisions the Rhode Island System of Care as one built on principles of best practice and evidence-based results. Past experience has shown that government and private resources have continued to establish and support programs which show little evidence of positive outcomes for children, youth and families. This in turn has led to inadequate resources available to quality programs and services that provide promising or proven results. For Rhode Island's System of Care to make effective use of finite resources, all components of the system must follow best practice principles and ensure that each child is served in the most integrated and least restrictive setting appropriate.

The strategies laid out in this blueprint for an organized System of Care are focused on ensuring strong structural supports at the state level in order to assist care system development and ongoing quality improvement within communities. There are recommendations for necessary and critical changes to establish effective structural support. Among these recommendations are:

- **Revising the structure and authority of the Children's Cabinet** as the state level body coordinating the funding systems among all Departments providing services to children and families;
- **Enhancing the Children's Cabinet's lead role in forging collaborative relationships with communities** in order to increase the effectiveness of local strategic planning for services for children, youth and families;
- **Increasing the pool of child and family service practitioners**;
- **Focusing on resource maximization strategies** that recognize that the System of Care requires both public and private resources working together to meet the health, social, emotional, behavioral, mental health and educational needs of children and families;
- **Focusing publicly supported services on priority populations**;
- **Developing community-based Comprehensive Care Networks** to ensure continuity of care and services that are accessible and proximate to the communities in which families live;
- **Developing a planning and evaluation capacity within the Department of Children, Youth and Families**, to track and measure services and treatment to ensure that a child is in the most integrated and least restrictive setting appropriate to the child and to evaluate the outcomes of each setting; and
- **Ensuring public accountability.** The improvement of the System of Care will ultimately hinge on our ability to effectively evaluate program performance and system outcomes, and to use these evaluations to improve practices. It is essential for the Children's Cabinet to strengthen mechanisms to collect data consistently across Departments.

Within the chapters of this report, representatives of the Executive, Legislative and Judicial branches of state government; provider organizations; families; advocates; and public policy

stakeholders have collectively and diligently focused their attention toward the development of an organized System of Care. This document sets forth a comprehensive plan that will allow flexibility and growth as the System of Care continues to evolve to address the changing needs and challenges of children and families in the years ahead.

CHAPTER 1: OVERVIEW

The Rhode Island System of Care for Children, Youth and Families envisioned by the RI System of Care Task Force (Task Force) is built on the strengths of families and communities, the successes of past initiatives, and is responsive to the challenges of the past. It is operationally feasible, financially realistic and supported by broad consensus. This system is a strategic instrument for moving the State closer to the four outcomes embraced by the Rhode Island Children's Cabinet and other key state and community leaders:

- All Children Entering School Ready To Learn
- All Youth Leaving School Ready To Lead Productive Lives
- All Children And Youth Safe In Their Homes, Neighborhoods And Schools
- All Children Living In Families That Are Self-Sufficient, yet Interdependent

This organized, ideal system is defined by the themes that follow and implemented through the identified strategies and processes which support these themes.

THEME: FAMILY CENTERED PRACTICE – A FUNDAMENTAL SHIFT IN SERVICE DELIVERY

This system of care supports the role of the family as the primary caregiver for children and recognizes that the optimum interventions for any individual child and their family are the interventions most proximate to home with the full resources of the community made available to that child and family *(see Chapter 3 and Appendices B and D).* It is critical to note that "families" include biological parents, adoptive families, extended kinship networks, legal guardians, temporary foster families and other supportive individuals the youth identifies as family. The broad vision is one in which a substantially greater portion of state resources are allocated to universal and selected prevention or early intervention services. However, the system of care acknowledges that substantial portions of the state's limited resources must be focused to meet the immediate needs of identified priority populations.

THEME: PREVENTION AND EDUCATION

The system's foundation is coordinated by local community members and state staff to ensure that all neighborhoods where families live have strong prevention and educational services and supports for the complex and changing needs of today's children and families. It is a system which provides families and other caregivers ready access to the resources necessary to meet children's developmental needs. The system has mechanisms to redirect cost savings from reduced reliance on restrictive and expensive out-of-home placements to community-based prevention and intervention services while ensuring that access to federal and state entitlements for eligible children and their families cannot be restricted or capped. This is accomplished by shifting service delivery methods for these priority populations from a provider-driven, bed-based methodology to a **culturally competent, family centered, gender specific, community-based methodology that is school-linked**, provides adequate state aid to achieve better outcomes, and integrates state and local agency resources *(see Chapter 2).* Included among these resources are those that meet the basic physical, emotional, developmental and educational needs of all children, as well as special resources to meet the individual needs of children with disabilities and social, emotional, and behavioral

disorders; children who have been abused and/or neglected; youth involved with the juvenile justice system; and system-involved females, whose unique pathways into the system and specialized needs have only recently come into view.

THEME: PROMOTING BEST PRACTICES

The Rhode Island System of Care is built upon and builds on principles of best practice. Too often government and private resources have been used to establish and support programs which often show little evidence of significantly increasing positive outcomes for children, youth, and families. This in turn has led to a significant decrease in the resources available to programs and services that provide promising or excellent results through quality outcomes. In order for Rhode Island's System of Care to make effective use of finite resources, it requires all components of the system to follow best practice principles which ensure that each child is served in the most integrated setting appropriate.

SYSTEM STRATEGY #1 - CHILDREN'S CABINET'S LEAD SYSTEM ROLE

The Children's Cabinet provides the state leadership necessary to assist each community in organizing new or strengthening existing collaborative efforts aimed at increasing the ability of communities to plan strategically to meet the needs of their children, youth and families *(see Chapter 2)*. Emphasis is placed on rewarding community-wide collaboration through the targeting of technical assistance and funding to communities which have collaboratively developed local strategic plans for enhancing prevention programming and identifying community, strengths, risks, and needs in relation to children and their families across the system of care.

SYSTEM STRATEGY #2- COMMUNITY OWNERSHIP SUPPORTED BY STATE AID

In embracing these outcomes, the system is one which recognizes that communities bear the primary responsibility for helping children and families succeed, while ensuring that limited state resources are effectively mobilized to aid communities with this challenge *(see Chapter 2)*. It recognizes that the state bears the primary fiscal responsibility for these services. Built on the concept of **family-centered practice** *(see Appendix B)* **and the principles of the Child and Adolescent Services System Program** *(CASSP; see Appendix D)*, this system recognizes and endorses the belief that the most effective path to success is for communities to take responsibility for - "to own" - all of their children and families, especially those viewed as the most challenging. All facets of the community, especially schools, accept their responsibility in supporting all children and families and ensuring that services are provided either in the community or as proximate to the community as possible. This support is particularly critical when an individual returns from placement outside of the community, including residential programs, psychiatric hospitals, the RI Training School and the Adult Correctional System.

SYSTEM STRATEGY #3 – THE FAMILY COURT AND DCYF: A CRITICAL RELATIONSHIP

In this system, DCYF is the lead agency with the statutory authority[1] and responsibility for developing and managing the system of care and services. DCYF ensures that children, youth, and their families from identified priority populations are provided the care necessary so that these children and youth either remain in their home or are provided a permanent home as quickly as possible within the parameters of effective clinical treatment and public and personal safety. At the same time, the RI Family Court[2] is the branch of government with statutory authority to make determinations regarding state custody of children and youth, permanency issues, and public safety. This system works on the premise that an effective relationship exists between DCYF and the Family Court that emphasizes appropriate health, safety and care issues for children, youth and families.

SYSTEM STRATEGY #4– PROMOTING BEST PRACTICES

The system is geared at all levels to **research based prevention, early intervention, crisis intervention, and family stabilization** in order to provide children and their families the greatest levels of consistency and stability possible. Decisions regarding treatment and services are made on an individual basis according to the strengths, risks, and needs of the family and the best interest of the child with a recognition of available fiscal resources. Methods allow for the blending or collaborative use of various funding streams to benefit the child and family. Each child and family is provided with care that is supported by research and the highest professional standards. Providers are required and supported to deliver services according to nationally recognized standards with evaluation mechanisms in place to monitor outcomes *(see Chapter 7 and Appendix K).*

SYSTEM STRATEGY #5 – INCREASING THE POOL OF CHILD AND FAMILY SERVICE PRACTITIONERS

Mechanisms exist to ensure that there is an appropriate supply of paraprofessional caregivers and licensed professionals at all levels and across all disciplines *(see Chapters 4 and 5 and Appendix J).* The Children's Cabinet works with the Department of Human Services (DHS) as the Medicaid agency to ensure that Medicaid reimbursement rates across state agencies are adequate and consistent to encourage individuals to practice in Rhode Island. The Department of Health, the Department of Elementary and Secondary Education, and the Office of Higher Education lead the Cabinet's efforts to work with institutions of higher education to train and educate these professionals to work in Rhode Island. State agencies and private providers collaborate to develop and implement policies and practices, including career ladders, which enable the recruitment and retention of highly qualified professionals.

SYSTEM STRATEGY #6 – RESOURCE MAXIMIZATION

In this new Rhode Island System of Care, either private or public health insurance covers all children and their families *(see Chapter 4).* Mental health screening for children is a requirement for both Medicaid (EPSDT/SCHIP) and private insurers. When problems are identified, children receive a comprehensive behavioral assessment, evidence-based family centered treatment and effective aftercare services.

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[1]Including RIGL 42-72-5, 42-72-16, 42-72-17, 42-72-18, 42-72-19 and 42-72.1-3.

[2]Including RIGL 8-10-3, 14-1-5, 14-1-11, and 15-7-7.

DCYF works closely with both public and private insurance companies to develop clinical pathways and procedures for cost sharing when necessary. The system of care builds on the success Rhode Island has achieved in maximizing access for children to healthcare. The Department of Human Services (DHS) continues to work with community partners and other state agencies to improve care and services for eligible children and maximize Medicaid reimbursement. Access to Medicaid-reimbursable services for children with special health care needs is enhanced through the expanded use of CEDARR Family Centers and the collaboration of CEDARR Family Centers with DCYF's Care Networks and the LCC structure. The Department of Health (DOH), in collaboration with other state agencies, works with private health care insurers to extend benefits for children with special health care needs to assure access to quality screening, assessment, and all levels of medically necessary care for children.

DCYF STRATEGY #1 - LEAD ROLE WITH PRIORITY POPULATIONS

This system recognizes, embraces, and supports the statutorily defined lead role delegated to the Department of Children, Youth and Families "to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential."[3] DCYF, in collaboration with Children's Cabinet agencies, ensures that a full array of services is available to all children and their families. DCYF focuses its resources on three priority populations, recognizing that a majority of the concentration of these populations are found in Rhode Island's six core cities[4]. These populations are:

- Dependent, neglected or abused children and youth **requiring state intervention to ensure safety;**
- Children and youth who meet clearly defined criteria for Serious Emotional Disturbance or Developmental Disability **and who require publicly supported care and services; and**
- Youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

DCYF STRATEGY #2 – REGIONALLY ADMINISTERED AND INTEGRATED CARE AND CASE MANAGEMENT

DCYF integrates the day-to-day operation of juvenile corrections, children's behavioral health, and child welfare *(see Chapter 3).* Regional Offices coordinate all child welfare[5], behavioral health, and juvenile corrections services through the lens of **family-centered, culturally competent**, gender specific *(see Appendices B, C and L)* practice that is **community-based and school-linked**. DCYF strengthens the authority and responsibility of

[3]RIGL 42-72-5(a)

[4] These are originally identified as Central Falls, Newport, Pawtucket, Providence and Woonsocket in the 2001 Rhode Island KIDS COUNT Factbook. Providence: Rhode Island KIDS COUNT, p. 3. Based on new census data, KIDS Count has recently added West Warwick to their list of core cities.

[5] Child Protective Services, including the child abuse hotline, investigative functions and intake remain Central Office functions

the four Regional Offices and the Rhode Island Training School for Youth (Training School), shifting to these locations day-to-day operational decisions with the requisite budgetary authority and responsibility. This shifts the focus of the Central Office to providing greater administrative support and oversight, technical assistance, and specialized resources to the Regional Directors and their staff. In so doing, DCYF does not seek to replicate new positions in each of the four Regional Offices but seeks rather to re-task existing functions within the Department.

DCYF STRATEGY #3 – COMMUNITY-BASED COMPREHENSIVE CARE NETWORKS

Working in partnership with families and community leaders in their region, Regional Directors lead DCYF's efforts to create Comprehensive Care Networks with lead agencies responsible for the provision and management of an array of services *(see Chapter 2 and Appendices G and H)* with the capacity to meet the needs of targeted populations within their respective region and to assess and monitor whether each child is placed in the most appropriate integrated setting DCYF Central Office, through the Children's Services Research and Planning Center (CSRPC) and additional administrative support resources (i.e., program development, billing and reimbursement systems, utilization review), provides analytical, clinical and other technical support to the Regional Directors and communities to accomplish this task. These Comprehensive Care Networks are DCYF's primary partner with DCYF social caseworkers and probation counselors for delivering direct care services within each region. The Comprehensive Care Networks are responsible for describing specific areas where they integrate with local schools and implementing interagency agreements as described in the Rhode Island Student Investment Initiative.

DCYF STRATEGY #4 - CHILDREN'S SERVICES RESEARCH AND PLANNING CENTER (CSRPC)

DCYF management and decision-making structure is supported by the Children's Services Research and Planning Center (CSRPC) *(see Chapter 2).* This Center reports to DCYF Director, is composed of a small centralized group of DCYF staff and external researchers, and focuses on management planning, research, and evaluation. This group supports the Director, Senior Executive Team, and Regional Directors by completing management, planning, and analysis tasks that continuously assess and improve the care and services within the System of Care delivered by and through DCYF, including the development and implementation of performance measures and strategic plans. These measures include collecting and reviewing data regarding whether each child is in the most integrated setting appropriate and, for each child who is not in such a setting, evaluating whether there is a plan to move each such child to such a setting at a reasonable pace. The Center works in collaboration with other state and private agencies to ensure effective cross-disciplinary planning.

PUBLIC ACCOUNTABILITY PROCESS #1 - OUTCOMES, INDICATORS AND PERFORMANCE MEASURES

Key to the success of the system of care is the ability to effectively evaluate performance and outcomes and to use these evaluations to improve practices *(see Chapter 6 and Appendix K).* The system is accountable through context evaluations, implementation evaluations, and outcome evaluations. The Children's Cabinet establishes system-wide outcomes and key social indicators. DCYF develops performance measures for DCYF and its Care Networks.

The indicators and measures are aligned with and logically linked to the four Children's Cabinet outcomes. The system places high value on the four Children's Cabinet outcomes and routinely measures and reports on key social indicators and individual program performance measures.

PUBLIC ACCOUNTABILITY PROCESS #2 - IMPLEMENTATION TIMELINE

The plan that follows is intended to be implemented over the next five years while ensuring stability for children and families and causing as few disruptions to services as possible *(see Chapter 7).* The success of the system of care is dependent on the ability of all key stakeholders to collaborate. Success is measured in terms of:

- positive changes in outcomes for children and families,
- customer satisfaction, and
- the ability of the system to complete identified tasks and meet prescribed milestones within predetermined time frames.

Stakeholders in the system commit to this collaborative process and identify clear timelines for progress, evaluation, reporting, and adaptation.

CHAPTER 2: COMMUNITY-STATE PREVENTION PARTNERSHIPS/ROLE OF THE CHILDREN'S CABINET

Families and Community and State Leaders clearly recognize the important role prevention services play in the system of care and in supporting children, youth, and families for success. The promotion of emotional and physical health is a key responsibility of the Children's Cabinet in partnership with local communities. The system's foundation is the commitment of local communities and the State to ensuring that all neighborhoods have strong prevention and educational services to support the complex needs of their children and families. The Children's Cabinet provides leadership in regard to the structures and mechanisms by which collaboration among state agencies is explicitly described and implemented, including dedicating personnel and other resources.

The principles of **family-centered,** *(see Appendix B)* **culturally competent** *(see Appendix C)* and gender-specific *(see Appendix N)* practice are embedded values in the system of care's community-based prevention services. The system ensures that families and the multiple cultural, linguistic and religious groups that make up the community are viewed as valuable and equal partners at all levels of development, implementation and service delivery. Built upon CASSP principles *(see Appendix D)*, this system ensures that decisions regarding treatment and care are made on an individual basis according to the strengths, risks, and needs of families and the best interest of the child with a recognition of available fiscal resources and that children and youth are placed in the most integrated setting appropriate.

Rhode Island's System of Care understands the role it plays in promoting the mental health of children as defined by the US Surgeon General[6]. It is a system geared at all levels to the earliest possible intervention, prevention, crisis intervention, and family stabilization in order to provide children with the greatest opportunities to achieve and maintain good mental health. It has the capacity to provide services to all children and families at the level[7,8] of

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[6] "Spanning roughly 20 years, childhood and adolescence are marked by dramatic changes in physical, cognitive, and social-emotional skills and capacities. Mental health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills (Surgeon General's Report, 2000, p.123)".

[7]The MECA study (Methodology for Epidemiology of Mental Disorders in Children and Adolescents) estimated that [nationwide] almost 21 percent of US children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment (Surgeon General's Report, 2000, p.123)". Eleven percent of youth have significant functional impairment. This estimate translates into a total of 4 million youth who suffer from a major mental illness that results in significant impairments at home, at school and with peers and five percent are classified with extreme functional impairment (Surgeon General's Report, 2000, p.124).

[8]The foremost finding in the Surgeon General's report is that [nationwide] most children in need of mental health services do not get them (p. 180). The conclusion that a high proportion of young people with a diagnosable mental disorder do not receive any mental health service at all (Burns, et al., 1995; Leaf et al., 1996) reinforces an earlier report by the US Office of Technology Assessment (1986) which indicated that approximately 70 percent of children and adolescents in need of treatment do not receive mental health services. Only one in five children with a serious emotional disturbance used mental health specialty services although twice as many such children received some form of mental health intervention (Burns et al, 1995). Thus, about 75 to 80 percent fail to receive specialty services, and the majority of these fail to receive any services at all, as reported by their families (Surgeon General's Report, 2000, p180)"

prevention or intervention they need while focusing on supporting and maintaining children and youth in their home or as proximate to their home as possible.

Service needs are identified, developed, and implemented across all three levels of the prevention continuum:

- **Universal Prevention Services:** Evidence-based services designed to be accessible to all children and families regardless of their level of need with the intended outcome of reducing the number of children and families requiring higher levels of services. Examples include wellness educational campaigns, child abuse prevention media campaigns, emotional competency programs with children, out-of-school time programs, general recreational programs, mentoring programs, teen pregnancy prevention programs, drug and alcohol abuse education programs, and domestic violence prevention programs.

- **Selected Prevention Services:** Evidence-based services designed to address factors that hamper the abilities of families to appropriately foster their children's development and ensure that families have access to the resources that are necessary to meet their children's developmental needs. Examples of these include parent education programs, family resource and support programs, counseling, parent aide programs, home visiting programs, wraparound and non-traditional services, therapeutic recreation programs, mentoring programs, school-based health clinics and prevention education for youth, parents and professionals.

- **Indicated Prevention Services:** Evidence-based services designed to address the needs of families and children with special health care needs as well as those exhibiting indicators known to be high predictors for teen pregnancy, early drug and alcohol use and/or abuse, witnesses to or victims of domestic violence, child abuse or neglect, and juvenile delinquency. Examples of these include early intervention services for young children, counseling, parent education programs, parent aid programs, home visiting programs, therapeutic daycare, school-based mental health support teams, wraparound and non-traditional services, teen pregnancy prevention programs, drug and alcohol abuse education programs, in-home services for children with special health care needs, mentoring programs, domestic violence prevention programs, and juvenile hearing boards.

The reality of the current system is very different. Fragmentation of the service delivery system frequently leads to prevention planning and programming being developed and conducted within silos. Multiple funding streams with unaligned priorities from multiple agencies lead to overlap, redundancy, and sometimes competing goals. There is little coordination at the local or state levels in regard to prevention planning and service delivery. The System of Care envisioned by the Task Force remedies this by ensuring that indicated prevention services are targeted and funded locally by DCYF and other state agencies through Care *Networks (see Chapter 3)*. Universal and selected prevention services are coordinated by the Children's Cabinet and local communities with funding from federal, state, and local sources.

COMMUNITY/STATE PARTNERSHIP S RECOMMENDATIONS

In this system, the Executive, Legislative, and Judicial branches of government collaborate to eliminate this fragmentation, shift responsibility for children and families to the community level, and ensure that communities are given the requisite fiscal and technical resources to be able to "take ownership" of their children and families.

In order for the State to support strategic planning and local prevention service delivery, the following recommendations are made:

1. **$ The Children's Cabinet must actively work with families and community leaders to strengthen existing or organize new local, collaborative strategic planning efforts aimed developing, implementing, and measuring the results of strategic plans for enhancing prevention programming and identifying the needs of the their community in relation to children and families across the system of care** *(see Appendix E).*

   Significant progress has been made in the area of developing and supporting collaborative entities in the five core communities through DCYF-administered *Comprehensive Strategy Initiative for Serious, Violent and Chronic Juvenile Offender*. Community planning teams exist in each of the five core cities. These teams are representative of the stakeholders identified above and have successfully completed five-year strategic plans aimed at reducing juvenile violence and delinquency by supporting strong prevention and intervention programming from birth to young adulthood. Each of the *Comprehensive Strategy Planning Teams* are supported by the mayor of their respective city or town.

   With limited financial support from the state for coordination, they have used their coalitions to garner significant federal and state funds to operate youth employment programs, reading readiness programs for school-age children, mentoring programs, domestic violence awareness programs, and other services. The coordinators of these teams have played an integral role in the work of the *Youth Success Cluster* of the Children's Cabinet, a state level collaboration focused on infusing a youth development philosophy within state and local initiatives and programs.

   Other examples of effective local partnerships have been the Local Coordinating Councils for Children's Behavioral Health (LCC's) and the local Substance Abuse Prevention Task Forces. Though it varies from community to community, each of these groups have been highly effective in breaking down the barriers among local agencies and finding ways to cooperatively identify resources to be used to benefit the community as a whole, rather than to build the programs and services of a particular agency.

   The Children's Cabinet must focus attention on identifying with communities such partnerships and on how to build on these partnerships to enhance prevention planning and service delivery.

2. **$ The Children's Cabinet must develop a permanent state staff level subcommittee to develop and coordinate prevention planning among state agencies and ensure that this subcommittee is provided the resources necessary to succeed. This subcommittee will be viewed as the state's key link to communities and will be required to ensure community participation in their deliberations and decision-**

making process. It will be responsible for assisting communities with identifying research-based programs and services, coordinating funding streams, developing program outcomes and measurements, and evaluating the success of state and community efforts in the area of prevention.

Many stakeholders have advocated for a formal mechanism by which families, providers, and advocates can present regular feedback on how the system as a whole and the various sub-components are operating and to gather feedback on ideas to increase the system's effectiveness. The Prevention Planning Subcommittee will serve this purpose. It will also serve as the principal forum for planning and implementing statewide universal and selected prevention initiatives.

In order to implement this recommendation, the Children's Cabinet must review its current committee structure with a focus on merging committees which have similar missions and responsibilities. For example, the Youth Success Cluster, in existence for four years, has been successful at moving forward on issues such as youth employment, reducing juvenile delinquency, and out-of school time programming with a youth development focus. The Children's Cabinet also recently endorsed a new subcommittee, the Statewide Prevention Planning Committee, in response to the State applying for and receiving the State Incentive Grant Award from the Center for Substance Abuse Programs (CSAP) of the US Department of Health and Human Services (DHHS). Rather than attempt to support the work of multiple subcommittees which may often be duplicative, the Cabinet must review them and determine the most effective subcommittee structure for the future.

Given DCYF's designation as the state agency principally responsible for the implementation of the recommendations of this report, it is reasonable that DCYF be called upon to administer prevention planning and implementation for the Children's Cabinet in collaboration with its sister state agencies.

3. **$ The Children's Cabinet agencies, through the Prevention Planning Subcommittee, must review the State's prevention funding streams with the goal of blending funding as permissible under state and federal guidelines and increasing the level of collaboration in regard to funding decision-making.**

There currently exists numerous funding streams managed within multiple departments that are principally and sometimes solely focused on prevention activities. Examples include the Safe and Drug Free Schools Program and the Healthy Kids, Healthy School Program administered by the RI Department of Education (RIDE); child abuse prevention funding administered by DCYF's Children's Trust Fund; underage drinking prevention and the new State Incentive Grant Program administered by the RI Department of Mental Health, Retardation and Hospitals (MHRH); teen pregnancy prevention administered by the RI Department of Health (DOH); and juvenile delinquency prevention administered by the RI Department of Administration's (DOA) RI Justice Commission (RIJC).

Although efforts have been made to increase the level of blending of these funds as permitted by state and federal laws and regulations or to increase the level of collaboration in decision-making processes, much more progress must be made in this area. The Prevention Planning Subcommittee of the Children's Cabinet is an ideal venue for further analysis and the development of a collaborative plan.

4. $ **The Children's Cabinet must develop and implement a plan which provides for greater information sharing and collaborative decision-making among agencies, especially DCYF, DHS, RIDE, MHRH, DOH, the Judicial Branch, DOC, the Attorney General, the Public Defender, and Law Enforcement.**

   The Children's Cabinet recognizes the value of increasing the capacity for information to be shared across agencies in accordance with state and federal laws. The lack of this capacity hampers the State's ability to identify and track service use patterns, arrest and recidivism patterns, service gaps, and other key indicators. The Cabinet has created an interagency workgroup, the KIDSLink Project, to begin to develop such an information sharing plan. This effort must be fully supported by key stakeholders at all levels. This capacity will permit agencies to more effectively communicate with one another, see where services overlap, track recidivism, identify existing gaps, and analyze some of the global budget implications for the children and families served. In developing such an interface, the State must make every effort to protect and ensure the confidentiality of individuals by building in appropriate safeguards.

5. $ **The Children's Cabinet must support a statewide Information and Referral System that is consistent across departments and may be accessed by youth, parents, other supportive adults, and children's services professionals. This system will have up-to-date computerized information on access to and performance of children's prevention and treatment services, related state and federal laws, entitlements, regulations, eligibility, and admissions' processes. Information will be available in several languages, in alternative accessible formats, and be accessible by phone, Internet, and fax.**

   Prevention and treatment programming cannot be utilized effectively if the individuals who need the services do not know about them. This information and referral service will provide children, youth, families, and professionals with the access they need to obtain current information on services, legal rights, and other information.

6. $ **DCYF, RIDE and DHS must immediately implement the agreed upon "Coordinated Children's Services System Regulations" (the "pilot" regulations) while ensuring that access to federal and state entitlements for eligible children and their families cannot be restricted or capped.**

   These regulations, developed as required by RIGL 42-72.7, allow for a process which accomplishes two major goals:

   To improve collaborative planning, comprehensive services, and outcomes for children with complex special needs and their families;

   To establish a new system of service funding that utilizes current state level funding but establishes a funding system that provides for locally determined and family centered decision-making about the best utilization of that funding for locally-based residential treatment services and wraparound services as an alternative to out-of-region or out-of-state residential treatment services for children in the pilot catchment areas of Pawtucket/Central Falls and Washington County.

This funding mechanism provides participating LCC's with blended funding from various state agencies and Local Education Agencies (LEA's) equal to the amount each agency currently invests in an identified child's residential treatment. These funds are designed to provide maximum flexibility to purchase services based on the strengths and needs of children in need of education, care, and treatment and their families and ensure that services to children and youth are provided in the most integrated setting possible.

DCYF, RIDE, DHS, and other state and community stakeholders have collaborated to develop these regulations over the past three years. These regulations address agency responsibilities and coordination and also provide resolution mechanisms. The opportunity to implement these pilot projects dramatically align with the State's commitment to system-wide reform. This implementation process must be monitored and evaluated by the participating departments to inform the development of the Comprehensive Care Networks.

CHAPTER 3: STRENGTHENING DCYF AS A FAMILY CENTERED, REGIONALLY-BASED AGENCY

As previously indicated, DCYF is the state agency responsible for leading this "paradigm-shift" to **a system of care that is family centered, culturally competent, gender specific, and school-linked, and community-driven**. It is DCYF's responsibility to ensure that the limited state fiscal resources available to support and sustain this system are utilized more effectively than in the past with an emphasis on priority populations[9].

This shift recognizes that the current system is too fragmented, inhibiting the growth of a strong community-driven system. Currently, DCYF is expected to provide services to much broader sectors of the population than is realistic. Contracted programs are generally statewide in nature with at best weak links back to the child/youth/family's community. Programs are frequently filled to capacity or above leading to:

- unnecessarily long lengths of stay,
- the placement of children and youth on a night-to-night basis until a permanent placement is made,
- "waiting lists" which frequently lead to children and youth symptoms escalating to a point where psychiatric hospitalization is needed, and
- a dependency on expensive out-of-state purchase of service (POS) placements which often greatly reduce effective family involvement.

It is recognized that DCYF cannot and should not move abruptly to a system which significantly disrupts current practices. Such a sudden change in service delivery methods would have disastrous implications to the quality and quantity of services available for targeted populations. In the short-term, this will require DCYF to continue to contract with individual providers for a specific number of beds or slots. During this transition, DCYF must make prudent use of in-state and out-of-state Purchase of Service providers. However, it is imperative that DCYF continue to move forward with their efforts to create a true "paradigm-shift" to a **family-centered, culturally competent, gender-specific and regionallybased service delivery system**. The full transition must occur in a well-planned, well-coordinated fashion with reasonable haste being balanced by prudent decision-making that is least disruptive to children, youth, and families. During this transition time, DCYF will assess all children with behavioral health needs who are not in their family homes and determine whether each child is in the most integrated setting appropriate. For those children who could be in a more integrated setting, DCYF will move these children at a reasonable pace to the most integrated setting appropriate. In order to accomplish this, DCYF may need to expand or expand funding to existing services or programs and/or create or fund new services or programs to do so.

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[9] Dependent, neglected or abused children and youth **requiring state intervention to ensure safety; c**hildren and youth who meet clearly defined criteria for Serious Emotional Disturbance or Developmental Disability **and who require publicly supported care and services;** and youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

DCYF has made significant inroads over the past five years into moving the agency structure and the service delivery methods to a more family-centered, regionally-based structure. Each of the four family service regions have physically relocated to offices within their respective service areas *(see Appendix F)*. The Local Coordinating Councils' for Children's Behavioral Health (LCC's) have shown significant success in helping families to receive and agencies to provide family-centered, community-based services for many years.[10] The Review Team process for children with high-intensity service needs is being moved into the regions with full community partnership in the design of the Care Management Team (CMT). DCYF has merged individual program contracts with the eight Community Mental Health Centers (CMHC's) into one master contract for each CMHC. A pilot Care Network was implemented for 60 youth in need of residential placement and early results are promising. Placement Solutions, a collaboration between the Providence Center and Communities for People, is providing much needed utilization review capacity for children and youth in out-of-state and in-state placements. Working in conjunction with DCYF's Child By Child Project, the immediate goal of this effort is to move these children and youth back to their home communities with necessary supports as soon as it is clinically appropriate. Finally, Project Hope is working with RI Training School staff, families and their communities to reintegrate children from the Training School directly back into their neighborhoods.

STRENGTHENING DCYF AS A FAMILY CENTERED, REGIONALLY-BASED AGENCY RECOMMENDATIONS

Even with this progress, deeper structural and process changes must be made. To accomplish this, DCYF must be supported by state leaders, advocates, providers, family members and other key stakeholders in their efforts to further uphold an agency that is family centered and regionally-based. To this end, the following recommendations are made:

1. **DCYF must continue to move toward a structure which supports a family centered, community-based, culturally competent, gender-specific and school-linked approach. To effectively manage this structure, DCYF must provide regional directors and juvenile corrections administrators with greater authority to manage staff and resources, including fiscal and program resources.**

   A. $ **Regional Directors and the Training School Superintendent will be provided with concrete regional budgets and the concomitant responsibility and authority for managing these budgets;**

   B. $ **DCYF should expand the use of the Care Network Model** *(see Appendices G and H)* **to ensure that the majority of services to the targeted population groups[11] are provided by regionally-based Comprehensive Care Networks that are contracted through specified lead agencies;**

[10] See Kaufman, J.S., Tebes, J.K., Ross, E. & Grabarek, C. (2000) Project REACH Rhode Island Final Evaluation Report. New Haven, CT: The Consultation Center, Department of Psychiatry, Yale University School of Medicine, the Connecticut Mental Health Center and The Community Consultation Board, Inc.

[11] Dependent, neglected or abused children and youth **requiring state intervention to ensure safety; c**hildren

C. Regional Directors and their staff will be expected to work with Comprehensive Care Network lead agencies, lead agency subcontractors, and other key community stakeholders to ensure that services provided by Regional Staff are family-centered, community-based, culturally competent, gender-specific and linguistically appropriate.

Best practice standards across all three population domains served by DCYF call for social caseworkers, probation counselors, behavioral health practitioners, and other state agency staff to develop linkages and more effective collaborations with families and key stakeholders in the communities they serve. DCYF has developed or assisted communities in developing several initiatives aimed at increasing these linkages and levels of collaboration. These include the *Child and Adolescent Service System Program(CASSP) for Children's Behavioral Health* which functions through the *LCC's*, the *Project Hope* program focused on enhancing transition and aftercare services for youth identified as seriously emotionally disturbed who are transitioning from the Training School, the *Youth New Futures* program which provides services to high-risk youth on probation through an interagency collaborative of providers[12], and the *Safe Streets*[13] program. Strengthening and providing increased supports to the four DCYF Family Service Regions and juvenile corrections administrators will enhance the ability of these locations to work more effectively and collaboratively in the communities they serve.

2. DCYF must continue to develop a family centered practice model and to ensure that older youth without clearly identified families are provided the supports and services they need to succeed.

DCYF has made significant strides in moving the agency to a service delivery model based on the principles of family-centered practice *(see Appendix B).* DCYF is strongly encouraged to continue these efforts internally and with external stakeholders.

The Department has also made significant strides over the past few years in enhancing efforts aimed at preparing older youth for independence and self-sufficiency. Through the Chafee Foster Care and Independence Program, youth who are age 16 or older receive life skills training and preparation for their transition out of care. Additionally, through our legislative initiative, older DCYF involved youth are afforded opportunities for higher education through the Community College of Rhode Island, Rhode Island College and the University of Rhode Island. The Department's policies

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and youth who meet clearly defined criteria for Serious Emotional Disturbance or Developmental Disability **and who require publicly supported care and services;** and youth who are adjudicated as delinquent **and who require probationary supervision or incarceration.**

[12] *Youth New Futures*, funded through DCYF, is a collaboration of Tides Family Services, the John Hope Settlement House and DAWN for Children. This program currently provides services only to youth from Providence and Pawtucket.

[13] *Safe Streets* currently operates only in the city of Providence and is a collaborative effort between DCYF's Division of Juvenile Corrections' Juvenile Probation Units, the Department of Corrections' Adult Probation Office and the Providence Police Department. Juvenile and Adult Probation Counselors, working under the joint supervision of the two state agencies, join with Providence Police officers to provide intensive supervision services to very high-risk young adult offenders ages 16-24. Average caseloads are 15:1.

and procedures relating to Independent Living focus great attention on transition efforts to assist youth in out-of-home placement, ages 16 and above, to become self-sufficient as they prepare for adulthood. This preparation includes departmental staff, family and/or primary caregivers and other individuals involved in the care and treatment of the youth.

However, it is recognized that youth who are aging out of DCYF services often do not have a significant biological family connection and there is a growing awareness that important connections for these youth must be cultivated to assist with their transition from DCYF care. As part of its Family Centered Practice implementation and training, the Department will focus more attention on ways in which youth may be assisted in identifying and making valuable connections to caring individuals who will be an important and necessary support for them ongoing.

3. DCYF must continue to expand efforts toward developing cultural competence among agency staff and vendors.

DCYF has also made significant strides over the past two years in developing within the agency a stronger atmosphere of culturally competent *practice (see Appendix C)*. However, the agency recognizes and understands that there is still much progress to be made and that achieving cultural competency is a journey, not a destination. DCYF is strongly encouraged to continue on this journey.

4. DCYF must continue to expand efforts toward developing gender-specific programs and gender competent staff among agency staff and vendors.

DCYF is beginning to make significant strides in moving the agency to a service delivery model based on the principles of gender-specific programming for females *(See Appendix N)*. The Task Force strongly encourages DCYF to continue these efforts internally and with external stakeholders. While gender-specific programming applies to specialized programming for either gender group, the Department's current focus is on gender-specific programming for females because females' involvement in the juvenile justice system has been increasing and program models and intervention modalities have been geared toward the needs of a predominantly male population. Specifically, in collaboration with the Rhode Island Justice Commission (RIJC), DCYF is working to develop a stronger culture of gender specific practice at the Training School and provide preliminary assessments of contracted programs. DCYF recognizes, however, that cultural change occurs over time and with sustained effort. DCYF has created the *Advisory Committee on Effective Programming for Young Women in Rhode Island* to spearhead this effort. There is still much progress to be made, as well as a need to begin a DCYF-wide initiative to enhance gender competency among internal and external staff and providers and to develop and implement gender-specific programming for females.

5. $ DCYF must provide the Regional Offices and Comprehensive Care Networks with the administrative support services necessary for them to succeed.

An essential management component for the system of care is the capacity within DCYF to effectively support the Regional Offices with their responsibility to administer and manage the Comprehensive Care Networks. This capacity includes expanded **analytic, financial, and information management resources for DCYF.** This administrative support function lies within DCYF Central Office but ensures support to each DCYF region It works most closely with the management, budget, and planning and analysis staff, and incorporates DCYF's utilization review

6. $ DCYF must enhance its research, analysis, and planning capacity to support the system of care through the development of the Children's Services Research and Planning Center (CSRPC).

The Children's Services Research and Planning Center (CSRPC) is composed of a small, centralized group of DCYF staff and external researchers focused on management planning and analysis. This Center works in collaboration with other state agencies to ensure effective interagency planning. This group reports to DCYF Director. Analysts have demonstrated competence in both data analysis and the clear presentation of complex information. They minimally possess masters' degrees in fields such as public administration, business administration, social work, social policy, and evaluation to ensure that they have the proper training to conduct analyses and think creatively about structure and process improvement.

This group supports the Director, Senior Executive Team, and Regional Directors by completing management, planning, and analysis tasks that continuously assess and improve the system of care, including the management of performance measures and strategic plans. The CSRPC coordinates the following activities:

- Analysis of children, youth, and families' service needs by geographic location
- Mapping current capacity and usage by location
- Developing common regional boundaries for all divisions of DCYF including Child Welfare, Children's Behavioral Health, and Juvenile Corrections that are mapped to the CPP's, CMHC's, LCC's, LEA's, Comprehensive Strategy Planning Teams, and other key players
- Developing and managing a strategic planning process for the Department to implement the design recommendations contained in this report
- Developing and managing a set of management performance measures to help DCYF monitor and report on progress against established targets and to provide an early warning system for problems
- Analyzing the existing budget to develop regional budgets which are adjusted so that the areas of the state where the need is greatest are targeted with service dollars and resources
- Developing RFP's and certification standards for regional lead agencies

This internal analytic capacity provides the data necessary to target services and resources, measure outcomes, and lead improvements. These measures include collecting and reviewing data regarding whether each child is in the most integrated setting appropriate and, for each child who is not in such a setting, evaluating whether there is a plan to move each such child to such a setting at a reasonable pace. The CSRPC is the Senior Executive Team's resource for validating information and anecdotal reports and supports their ability to consistently focus on strategic plan implementation and performance indicators in the face of a daily barrage of unanticipated events. This office is invaluable to central office and regional managers alike.

7. DCYF should continue its efforts to reform the RI Training School through the construction of a new facility, the implementation of the Resocialization Model, the implementation of gender-specific programming for females, and the finalization and implementation of a sentencing and sanctioning advisory process for DCYF to provide the Family Court with more individual and specific assessments and recommendations.

Each of these reform components except for the construction of the new facility and the implementation of gender-specific programming were identified as recommendations in the report of the Governor's Task Force on Juvenile Justice Reform[14]. The construction of the new facility is supported by the Governor and the General Assembly provided its' support through the passage of 2001-R-340 Joint Resolution Approving The Financing Of A New Training School For Youth At The Pastore Center In Cranston. DCYF is finalizing work with the National Council on Crime and Delinquency (NCCD) in regard to the development of risk assessment and structured decision-making tools which will allow DCYF to provide more informed recommendations to the Family Court in regard to sentencing decisions. DCYF is also entering into a contract with the Texas Youth Commission in regard to implementing the Resocialization Model at the Training School. The Resocialization Model provides state of the art assessments of strengths, risks, and needs of juvenile offenders with case plans that emphasize personal responsibility, increase freedom in phases based on achieving individualized measurable goals and objectives, holds youthful offenders accountable for their offenses, and requires youth to demonstrate sustained competencies.

Finally, DCYF is collaborating with the RIJC through a contract with Core Associates to assess the level of gender-specific programming for females at the Young Women's Unit and recommend enhancements; develop and implement comprehensive staff training in regard to gender-specific practice; and guide essential program development for female residents

$ State leaders should support the plan provided by DCYF to the Joint Legislative Commission to Study an Enhanced Role for Probation and Parole

[14] Stopping Youth Violence: Rhode Island's Response to the Crisis Facing Our Youth: Final Report, (July 1997). Providence, RI: Department of Children, Youth and Families. See Recommendation 1, Strategy 1 p. 19; Recommendation 1, Strategy 2, p. 20; Recommendation 1, Strategy 3, p. 20; and Recommendation 3, Strategy 1, p. 27; Recommendation 3, Strategy 2, p. 28.

(March 13, 2001; See Appendix I) **which calls for a shift to a community supervision model for juvenile probation, the expansion of community support services, the enhancement of early intervention and transitional services for young women offenders in accordance with empirical research on the unique needs of court-involved females and best practices in gender-specific programming, enhanced recruitment efforts for minority probation counselors, enhanced training requirements for probation staff, and lower caseloads.**

DCYF recognizes that the juvenile probation counselors have much greater opportunity for providing community-based services to youth on probation than do adult probation counselors. DCYF also recognizes that juvenile probation caseloads are much lower than adult probation caseloads[15]. However, best practice standards for juvenile probation call for a shift to non-standard hours, increased community supervision and support, smaller caseloads, and better training (including training on how to work effectively with female clients). DCYF believes that the recommendations submitted *(see Appendix I)* to the Joint Legislative Commission to Study an Enhanced Role for Probation and Parole in March 2001 are necessary for DCYF to make this necessary shift.

9. State leaders must continue to support DCYF in working with community leaders to site new and expand existing residential programs in RI communities.

It is well known that DCYF has historically depended on out-of-state purchase of service residential programs for youth with specialized treatment needs such as sexual offending or non-hospital residential psychiatric and/or behavioral treatment. This practice is of high cost to the state and reduces the ability of DCYF to engage families and the community in treatment and transition processes.

It is imperative that DCYF have the ability to develop and implement residential programs within RI regions if DCYF is to truly move to a family-centered, community-based model. However, DCYF, as do other state agencies, frequently runs into the barrier of "not-in-my-backyard" attitudes from local communities when attempting to site new programs. DCYF response must have the active support of key leaders throughout state government and within local communities when attempting to site new programs in the future.

[15]The highest probation caseloads for juvenile probation counselors may average about 41:1 while the adult probation caseloads can be as high or higher than 300:1.

10. The Director of DCYF and the Chief Judge of the Family Court must continue to forge and maintain an effective, collaborative relationship between the Department and the Court.

Recent progress has been made in this area between the Family Court and DCYF. The Court and DCYF have agreed to create a formalized group comprised of members of each agency to address mutual concerns in a prompt fashion. An agreement has been signed in response to FY 2002 State Budget Article 23 by which DCYF and the Family Court developed an agreement clearly outlining the process to be used in making determinations for children and youth for "high-end" placement. Such collaborations need to continue.

CHAPTER 4: FINANCING THE SYSTEM OF CARE

Financing a comprehensive system of care for children, adolescents, and their families is one of the most complex aspects of system reform. Funding for services for children and families comes from a very broad range of federal, state, local, and private sector sources. In FY 2001 DCYF budget exceeded $200 million and these funds were augmented from a number of other sources including but not limited to public and private insurance, federal government grants and contracts, federal entitlements, state general funds, trust funds or other set-asides, and local revenues.

On a State level, funding and supports were available from DHS in the form of RIte Care capitation, fee for service Medicaid claims, and a variety of supports available under TANF. DHS funding for programs for Families and Children in Medicaid alone exceeded $300 million in FY 2001 and covered 120,000 family members of whom over 80,000 were children. LEAs also were a resource available for this system, particularly in their growing role as Medicaid providers.

In this system of care, DHS and DCYF have a strong partnership. DCYF is responsible for developing programs and services to meet the needs of its priority populations. DHS is the designated single state agency with responsibility and accountability for the Medicaid State Children's Health Insurance (SCHIP) programs. The majority of DCYF children, youth, and families are Medicaid/SCHIP eligible. Therefore, the opportunity exists to strategically leverage DCYF's and DHS's authorities and resources to expand services. DHS is a funder with a voice in program development. The responsibility for funding programs is accompanied by participation in design, development, and measurement of program effectiveness. Likewise, in this system, DHS does not establish programs that directly affect DCYF children and families without DCYF's full and equal participation. These two departments operate as a strategic alliance.

The DHS plays an important role in partnering with DCYF and other state agencies to maximize Medicaid support for eligible children and their families. They continue their work with DCYF in developing opportunities for access to RiteCare coverage and their work with DCYF and other state agencies developing opportunities for increased access to services through programs like CEDARR[16] and the LCC's. In this system, DHS ensures access to the full range of medically necessary prevention and treatment services through contractual language with RIteCare providers. DCYF funds provide non-Medicaid reimbursable services. In the system design, the case rate supports the non-Medicaid reimbursable costs while the Comprehensive Care Networks' lead agencies bill Medicaid for reimbursable services with DCYF providing the State Medicaid share.

For non-insurance government funding, the system creates a "state child and family budget" that includes all non-insurance sources of federal and state revenue, clearly organizes the resources to support the system, and recognizes that entitlement programs cannot be capitated. The Child and Family Budget also reflects Federal grants to communities. The system places an emphasis on attracting federal funds, maximizing federal financial

[16] CEDARR stands for Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation and is a collaborative effort of the following state agencies: DHS, DCYF, RIDE, DOH, and MHRH. DHS administers the CEDARR program.

participation, and creating a comprehensive child and family budget coordinating services across all of these policy domains. These federal funds are augmented by a number of state budget appropriations, themselves scattered across a number of state agencies.

A coordinated and organized system of care requires a deliberate ongoing financial strategy that supports the multiple and changing needs of children, adolescents, and their families, and the changing landscape of service opportunities available within the community of professional practice. The goals of the strategy are to marshal every resource available for the care and treatment of the child and family, private and public, across all funds and programs, to assure access to services and treatment and to use data to inform policy, program, and budgetary decisions within an overall strategy.

The principles of a successful financing strategy include:

- Programs and services within a coordinated system must be designed to support the needs of children and families rather than designed to fit the requirements of funding sources;
- The potential gain of maximizing financing from any single source of revenue must be evaluated in light of its impact on program and service delivery, system design, and accountability, as well as overall financial risk;
- The ongoing success (and therefore funding) of programs and services must be based on the outcomes they produce, rather than the activity they perform;
- Rates of payment must be adequate to create and maintain service capacity and rationalized in terms of the value they provide; incentives must support the long term outcomes desired for the system as a whole; and
- Formal and dynamic partnerships between and among units of state and local government, as well as the provider community, is essential.

Currently, 83,000 Rhode Island children receive Medicaid benefits through a variety of delivery systems. Medicaid funding provides a broad range of health care services to children and their families through DCYF, DHS, DOH, MHRH, and the local education authorities. Medicaid funds comprehensive health insurance for many DCYF children, including behavioral health services, through Rite Care as well as fee for service, and a large number of children "touched" by DCYF services are enrolled. Further, it is clear that Medicaid's value to the system can only be realized if, at a minimum, current eligibility standards are maintained – any change in this public policy reduces resources available for this system change.

At the same time, Medicaid is a broad entitlement program with very stringent requirements governing eligibility service definition, and reimbursement. Limits on utilization, provider participation, or consumer choice are not permitted. This set of standards has clear programmatic and budgetary implications, and may mean that Medicaid funding is not universally attractive. However, it is also clear that Medicaid, particularly in light of the mandate of EPSDT (Early Periodic Screening, Diagnosis, and Treatment), needs to be fully leveraged.

This leverage can be accomplished by Comprehensive Care Networks being sufficiently knowledgeable to be able to refer to and otherwise make use of services available to children throughout the rest of the Medicaid system. In this way, Medicaid-financed services can

"wrap" around services provided by and through Comprehensive Care Networks. Comprehensive Care Networks do not need to control these dollars, but do need to be able to access them.

Similarly, development of one or more case rates can be phased in over time, as data becomes available to support and justify this structure. Case rates are simpler to administer than encounter-based claiming, but need to be designed to provide the same level of data feedback to inform ongoing decision-making.

For any financing strategy to be successful, it must be guided by constant review of clear, accurate, actionable data that describes the operation of the system overall. This data, at minimum, must include caseload (the number of active eligibles), expenditure (both on an individual level, as well as projected for the system as a whole, based on current eligibility and patterns), and outcomes (the result realized in consequence of the expenditure, based on an understanding of the need at the onset of the expenditure).

Rate structure is an essential element of any financing strategy. Rates must be established in a rational fashion that blends considerations of cost, capacity, and outcomes, and then maintained in a disciplined fashion. If we value evidence-based services, they should be reimbursed based on performance. The State should pay the same rates for like services across all programs and departments, but should not pay higher rates than other payors unless a sound rationale that supports the outcomes desired for the system can be articulated. Coordination and cooperation among state departments is critical to address these issues.

Development of funding strategies must be concurrent with system of care design and development, focused on maximizing resources that support the needs of the children. Program and fiscal staff, across departments and agencies, must both be intimately involved in planning and development.

The main financing challenges facing the system are:

- How to design a system of performance risk offset by financial reward;
- How to "transplant" monies invested in the current system to the allocation (sites, practices, and modalities) required by the new system;
- How to do so without sacrificing the current system as it is needed until the new system is fully developed; and
- How to fund this transition in a reasonably controlled way.

Some type of all-encompassing rate(s) that reflect a fully mature system's operation and contribution may be optimal. The development of such a structure would take significant time and in-depth analysis.

In the interim, these challenges can be addressed with an interlocking strategy of "wrap-around" models and incentive rates. Comprehensive Care Networks would be paid one or more "base rates" for common core services provided to all children with whom they would become involved (embedding the costs necessary to provide general administrative supports to the Regional Offices). For the purpose of DCYF Comprehensive Care Networks, the base rate would cover services not otherwise billable to other payors. Services required to support an individual child would be billed over and above the base rate to whatever payor was most appropriate, based on individual circumstances (including but not limited to Medicaid, health

insurers, school systems, and parents): funding for any child is truly individualized, and all funding sources are involved. This is a demanding role for the Comprehensive Care Network entity, but one that can be rewarded with an accompanying set of payment incentives.

FINANCING THE SYSTEM OF CARE RECOMMENDATIONS

1. **DCYF should assure that they will make every effort to ensure that Comprehensive Care Networks are informed by, and incorporate as appropriate, the CEDARR certification standards for those functions that are embedded in the role of the Comprehensive Care Networks. Attention will also be paid to ensuring that appropriate service providers are enrolled as providers in the networks of the RIte Care health plans. The intent of this recommendation is to assure that existing system resources are effectively utilized and to avoid supplantation and duplication of services.**

2. **$ The Children's Cabinet should establish a permanent financing workgroup that complements and supports the Caseload Estimating Conference by examining trend data and projections for children served by all Children's Cabinet agencies.**

   A. **The permanent financing workgroup of the Children's Cabinet makes recommendations to the Cabinet regarding consistent rates of payment for similar services across programs and populations and will address the following:**

      i. **adequacy with respect to cost of service,**

      ii. **incentives to develop needed capacity,**

      iii. **routine updating of rates over time and evaluation in light of the outcomes achieved by each service and program**

      iv. **transitioning of contracts and services to performance-based rates.**

      v. **working with the Department of Human Services, the development of a capacity to routinely assign financial responsibility to private insurance carriers, where they should be the primary payor, including coverage for early intervention services as well as comprehensive mental health and substance abuse treatment for both the covered children and adults.**

      vi. **identification of common outcomes for services affecting children across all departments and programs**

      vii. **serve as a forum for the defining of uniform performance standards regarding service definitions to be recommended for use by state agencies for contractual purposes.**

3. **$ DCYF must engage consultants to assist the agency in accurate expenditure and population projections for financial planning purposes. This must include**

partnering with DHS and other state agencies to proactively estimate caseloads in order to develop realistic budgets and spending plans.

The ability of DCYF to accurately project populations and expenditures is key to the success of DCYF and the system of care to control costs while ensuring access to quality services for target populations. The consultants working with DCYF must be experienced in interpreting historic data and developing utilization and expenditure trends. These consultants study data from both DCYF and from Medicaid and project utilization and expenditures for both sources of funds**.**

4. **$ DHS must work with other state agencies, managed care vendors and their behavioral health subcontractors to develop a reimbursement system that attracts behavioral health providers and increases the number of such providers available through the Medicaid program and other health care insurers. In addition to adequate rates of reimbursement, this effort must also focus on ensuring the availability of financing to support system/capacity building (i.e., training, loan guarantees, community capitalization).**

Feedback from numerous forums include criticism of the reimbursement rates for behavioral healthcare providers through the Medicaid program and other health insurers. This has led to a sharp decline in the number of behavioral health professionals, particularly child and adolescent psychiatrists and licensed social workers, practicing in Rhode Island. Although this must be addressed on several fronts, including the training programs for these professionals, it is extremely important that the DHS lead state agencies and other key stakeholders in an effort to examine reimbursement rates and develop a reimbursement system that provides adequate reimbursement and can be easily adjusted to meet market demands.

5. **The Rhode Island General Assembly recognizes the importance of parity in relation to the coverage by health care insurers for treatment of mental illness and substance abuse[17]. This Task Force fully supports this effort and urges the Departments of Health and Business Regulations to move forward with insurers to ensure full implementation as quickly as possible. Specific attention must be given to the issue of the barriers created by the credentialing processes used by insurers.**

The report of the Surgeon General on Mental Health[18] clearly articulates the need for mental health parity coverage by health insurers. Untreated mental illness in children

[17] RI Public Law 2001-409 An Act Relating To Insurance Coverage For Serious Mental Illness

[18] The foremost finding in the Surgeon General's report is that [nationwide] most children in need of mental health services do not get them (p. 180). The conclusion that a high proportion of young people with a diagnosable mental disorder do not receive any mental health service at all (Burns, et al., 1995; Leaf et al., 1996) reinforces an earlier report by the US Office of Technology Assessment (1986) which indicated that approximately 70 percent of children and adolescents in need of treatment do not receive mental health services. Only one in five children with a serious emotional disturbance used mental health specialty services although twice as many such children received some form of mental health intervention (Burns et al, 1995). Thus, about 75 to 80 percent fail to receive specialty services, and the majority of these fail to receive any services at all, as reported by their families (Surgeon General's Report, 2000, p180)"

and adults is a significant drain on our economy and devastating to individuals and families. Enhancing coverage of mental health and substance abuse in private health insurance programs can only serve to improve the quality of life for our children and families and to support our economy. The State's new mental health parity statute is a first step in this direction. Credentialing issues create barriers in two ways: one, these limit the array of professionals and para-professionals that can practice and get reimbursed; two, the procedures are so arduous and onerous that providers often wait long periods of time to receive approval and bear the burden of the cost of providing services during this waiting period.

6. $ **The DHS must continue its efforts to ensure that all children are covered by health insurance through focusing on further reducing the number of uninsured children in Rhode Island through expanded Medicaid/SCHIP access. To accomplish this, DHS maintains RI Medicaid's current definitions of medically necessary services and assures that all Medicaid primary care providers deliver all EPSDT services. DHS must continue to extend Medicaid benefits to children and adolescents covered by SCHIP. In conjunction with the MHRH, the DHS assures that parents of both Medicaid and SCHIP covered children receive needed mental health and substance abuse treatment.**

The DHS is nationally recognized for expanding access to Medicaid for eligible children. This progressive approach has led to Rhode Island being the top state in regard to the number of children covered by health insurance[19]. Rhode Island's Continuum of Care must continue this effort and support the DHS in expanding access to Medicaid.

7. $ **The DHS, in collaboration with other state agencies, must ensure that Medicaid eligible children receive timely and appropriate assessments throughout their development. The DHS must emphasize that primary care providers use age appropriate screening for child/adolescent mental health and substance abuse problems. The DOH, the DHS, and DCYF must work collaboratively to ensure that children from birth to age three involved with DCYF are referred to Early Intervention programs for screening, assessment, and treatment as needed.**

There is a strong need for timely and quality assessments and evaluations for children and youth at all stages of the developmental continuum. Recent changes in the Early Intervention Program and the development of the CEDARR Family Centers show promise in being able to increase access to these services. State agencies must continue to work together in expanding this access and ensuring that a multi-disciplinary team approach be utilized.

8. **It is important that the system of care include independent local providers** *(see Appendix J)* **who may be able to intervene with children and families before tragedies happen or the children need to be removed from their homes. The Children's Cabinet, through a designated agency or committee, must work with**

[19] According to the Annie E. Casey Foundation's National KIDS COUNT data, only seven percent (7%) of Rhode Island children are uninsured compared to a national average of fifteen percent (15%). 200l KIDS COUNT Data Book Online at http://www.aecf.org/cgi-bin/kc2001.cgi?action=profile&area=Rhode+Island

independent behavioral health providers and third party insurers to ensure the prompt and appropriate reimbursement for services and to ensure access to appropriate mental health services. Prompt and adequate payment from insurers and from the state will help to enhance and maintain a core of such providers. It is also important that subscribers receive appropriate treatment to effectively deal with their issues and not be cut short due to insurance limits.

CHAPTER 5: WORKFORCE DEVELOPMENT

Workforce development is a critical component of the system of care. Workforce development includes but is not limited to:

- Undergraduate/graduate education
- Recruitment
- Pre-service education
- In-service education
- Professional Development
- Retention

The children's' services area has historically lagged nationwide in a meaningful investment into this important area of infrastructure development. The system places a high priority on this investment in human capital. DCYF works closely with the Department of Health, the Office of Higher Education, colleges, universities, and public and private providers to address these important issues.

Rhode Island is fortunate to have well-developed higher education institutions at the associate, baccalaureate, and graduate levels. In this system, DCYF, through the Child Welfare Training Institute, works closely with relevant department chairpersons at these institutions to assure that the curriculum reflects up-to-date evidence-based best practices in the child welfare, mental health, juvenile justice, social work, and substance abuse fields. Appropriate undergraduate curricula are developed to prepare students for the varied functions needed in both the public and private sector children's services field including but not limited to:

- Family Based Care and Family Centered Practice
- Residential services and care
- Case management
- Clinical practice, especially child and family psychologists and child and adolescent psychiatrists
- Supervision
- Wraparound services
- Management and administration

Mechanisms exist to ensure that there is an appropriate supply of paraprofessional caregivers and licensed professionals at all levels, including family service coordinators, licensed social workers, licensed mental health counselors, licensed marriage and family therapists, licensed chemical dependency counselors, licensed child psychologists, and child and adolescent psychiatrists. The Department of Health and the Office of Higher Education lead the Cabinet's efforts to work with institutions of higher education to train and educate these professionals. State agencies and private providers collaborate to develop and implement

policies and practices which enable the recruitment and retention of highly qualified professionals to work in Rhode Island.

Recruitment of qualified candidates is essential for the work of the system of care. DCYF and the community providers combine recruiting efforts on college campuses, job fairs, community center career fairs, etc. to maximize resources as well as to assist potential candidates to distinguish among career choices. Both DCYF and community providers establish minimum educational criteria required for positions and assure that new recruits meet or exceed these requirements.

While individuals may choose to move across the public and private sectors, it is also essential that, for those who desire a position in either sector, professional development plans are in place that enable them to develop professionally and to pursue upward mobility through advanced level training and expanded educational opportunities in each sector.

WORKFORCE DEVELOPMENT RECOMMENDATIONS

1. **The Director of the Child Welfare Training Institute must work closely with other DCYF administrators and community providers to ensure that quality training and support is available to biological parents and kin, foster parents, pre-adoptive and adoptive parents, court appointed special advocates, family service coordinators, and staff who provide care or services to children and their families.**

   Training and support are also essential for the large number of individuals, who, though not employed by the public or private sector make an essential and enormous contribution to the children's services delivery system. This group includes but is not limited to foster parents, court appointed special advocates, public and private agency staff and volunteers, and pre-adoptive and adoptive parents. The Director of the Child Welfare Training Institute and the Institute's staff are responsible for working with public and private agency staff and representatives of all these groups to design and implement appropriate training curricula and on-going support opportunities for these most important participants in the system of care.

2. **The Director of the Child Welfare Training Institute must work closely with other DCYF administrators, other state agencies, professional associations, guilds, community providers and other key stakeholders to ensure that quality training and support is available healthcare professionals providing services in the system of care.**

   Ongoing training and support is key to the development and maintenance of a strong healthcare workforce. The Director of the Child Welfare Institute and Institute staff must work closely with professional associations and guilds to review and make recommendations regarding how current Continuing Education Unit (CEU) requirements could be enhanced to address education regarding the system of care. Similar discussions should be held with universities and colleges in the State regarding their graduate training programs.

3. **The Department of Health, the Department of Elementary and Secondary Education and the Office of Higher Education should collaboratively lead the**

Children's Cabinet's efforts in developing strong relationships with RI's academic community to achieve the following goals:

A. An increase in the quantity and quality of licensed professionals choosing to practice in Rhode Island, especially child and family psychologists, child and adolescent psychiatrists, and licensed social workers, licensed mental health counselors, licensed marriage and family therapists, and licensed chemical dependency counselors;

B. An increase in the quality and quantity of learning opportunities (i.e., internships, residencies, clinical practice experiences) for students at all academic levels;

C. The development of curricula reflective of current best practices in children's services, including children's behavioral health, juvenile justice (including newly developed best practices in gender and culturally competent practice and programming), and child welfare.

4. The Implementation Committee for the System of Care must identify and develop methods to provide ongoing support for pediatric/primary care practitioners, including but not limited to:

A. Examining and revising reimbursement structures by which Health Plans/Insurers reimburse for child and adolescent psychiatric services to ensure that rates support actual service costs;

B. Developing web-based consultation and support for pediatric/primary care practitioners;

C. Considering the creation of a child behavioral health consultation team to provider direct support to pediatric/primary care practitioners in order to increase the capacity of behavioral health care available to children and their families. This team would include child and adolescent psychiatry, nursing and other behavioral health practitioners.

The Task Force recognizes the vital role that pediatric/primary care practitioners play in the screening, the early intervention and the ongoing care and treatment of children with behavioral health disorders. As such, the are an integral part of the system of community-based care. Partnering with higher education, (Brown University School of Medicine, Rhode Island College School of Social Work, and Salve Regina's and University of Rhode Island's Schools of Nursing), the Task Force seeks to establish and maintain ongoing professional development in the area of children's behavioral health for pediatric/primary care practitioners. Given the acknowledged shortage of behavioral health practitioners, the Task Force recognizes the importance of the intentional provision ongoing support from behavioral health practitioners to pediatric/primary care practitioners via web-based and other forms of ongoing consultation.

5. $ Community providers, with appropriate assistance as needed from state agencies, must continue to develop compensation and benefits packages designed to retain workers in the community non-profit sector and reverse the trend of the

non-profit sector serving as the training ground for movement into the public sector.

In order for the system of care to be implemented it is essential to develop and retain a well-trained, well-organized private vendor system that retains workers and develops qualified and experienced supervisors and managers. Effective compensation packages are key to the success of this retention effort. While individuals may choose new positions for growth and increasing or different responsibilities, because of the increasing responsibilities of the private sector in the system of care, it must be an attractive option for both new and experienced workers.

6. **$ The RI Child Welfare Training Institute must work with the academic and provider communities to formalize and expand cross training opportunities between the public and community non-profit sectors at all levels.**

Quality in-service training is essential for quality services to be available to children and families. While there has been in-service cross-training in the past between DCYF and provider agencies these efforts must be formalized and expanded. A core orientation curriculum should be jointly developed so that beginning case managers in the community non-profit sector have the same foundation knowledge, values, and skills as case managers in the public sector. By training staff together, all workers will better understand and appreciate the nuances of each system, the complementing of roles and responsibilities, and the need for teamwork throughout the system. Following the development of a foundation curriculum, advanced level cross-training topics are developed that further solidify the partnership model. Because in many private agencies, training budgets tend to be limited, a pooling of resources and dollars allow for maximizing resources. Multiple training methods must be utilized, including but not limited to computer assisted education and distance learning techniques.

7. **$ DCYF must work with the Department of Administration and labor unions to build in a requirement that all supervisors within DCYF must hold a minimum of a masters' degree in social work or a related field. The number of scholarships available to DCYF staff must be increased to support this requirement.**

High quality supervision is valued in the system of care, thus supervisors are given reasonable worker caseloads; time is budgeted for weekly worker supervision; a system is in place to address worker problems early on; and clear personnel policies identify the supervision, worker evaluation, and progressive discipline plans. Supervision is an important element of each staff person's personal growth and development. It is extremely important that supervisors have the knowledge, skills, and experience needed to provide effective mentoring and supervision to other staff. Individuals with masters' level training have the minimum knowledge necessary to be successful as a supervisor. In implementing this recommendation, attention must be given to providing courses in the community and at times which allow for access by a diverse group of individuals. As well, it is critical that DCYF increase the availability of scholarships to qualified staff for the purposes of pursuing graduate level training. Similarly, supervisors in DCYF provider agencies should be required to have a masters' degree.

8. **DCYF must continue to embrace cultural diversity and cultural competence by**

expanding its efforts to build a culturally diverse and culturally competent workforce internally and within vendor agencies.

Cultural diversity and cultural competency *(See Appendix C)* are essential for the System of Care at all levels. DCYF developed a plan to become an affective multi-cultural organization in response to Recommendation 14 of the Governor's Commission to Study the Placement of Children in Foster and Adoptive Care[20] DCYF will address issues of cultural and ethnic competency and diversity through training to staff and all participants in the children's services delivery system. The Department will consult with the National Technical Assistance Center for Cultural Competence and other national resources to assure that the system provides services and supports that are sensitive to the importance of these issues.

9. DCYF must continue to embrace gender-specific programming and practice by expanding its efforts to build a workforce, internally and with vendor agencies, that is educated about gender issues.

Gender-specific programming *(see Appendix N)* is essential for the system of care at all levels. This requires that administrators and staff internally and within vendor agencies are aware of the unique developmental pathways of males and females, and how their development and unique risk factors affect their responses to certain interventions. As previously mentioned, juvenile corrections programming has been developed to meet the needs of a predominantly male population. As females' involvement in the system increases, there is a critical need to orient programming and practice to their unique, gender-specific needs to maximize program effectiveness and reduce recidivism. In response to the Juvenile Justice and Delinquency Prevention Act's directive to improve programming and practices for females in the juvenile justice system, the Department has begun to educate staff at the Training School and will be providing staff training to a sample of contracted program vendors. It will be essential to expand this effort by accessing trainers and technical assistance providers and by consulting with the Office of Juvenile Justice and Delinquency Prevention Training and Technical Assistance Center.

[20] *Strengthening Partnerships for the Safety and Success of Rhode Island's Children: The Report of the Governor's Commission to Study the Placement of Children in Foster and Adoptive Care, (July 1999).* Providence, Rhode Island: Department of Children, Youth and Families. See Recommendation 14, p. 20.

CHAPTER 6: PERFORMANCE MEASURES AND OUTCOMES

Key to the success of the system is the ability to effectively measure and evaluate system performance and client outcomes for children, youth and families and to use these evaluations to modify and further develop best practices. The system highly values the importance of effective performance and outcome measurement at all levels.

The system of care's culture supports evaluation and employs a comprehensive evaluation strategy including the three components of **context evaluation, implementation evaluation and outcome evaluation** *(see Appendix K).* This provides a sophisticated analysis of how and why programs and services work, for whom they work, and under what circumstances they work. The system of care evaluation component:

- Examines how the system functions within the economic, social, and political environment of its community and setting (context evaluation);
- Supports the planning, set up, and implementation of the system as well as documents the evolution of the system (implementation evaluation); and,
- Assesses the short and long-term results of the system (outcome evaluation).

These three measurements serve as the foundation and guide for the development of performance and outcome recommendations for the system of care. The recommendations themselves are tiered to focus on the need for a higher level system reform that must be maintained within the authority of the Children's Cabinet and to recognize the work necessary at the level of state departments - individually and collectively.

On a direct agency level, there is a recognition that DCYF is accomplishing two distinct goals. One is building system capacity. The second is developing a regionally based network system of care which is specifically designed to address increasing demands and changes in service needs for children and families at varying levels of intensity in a community context.

Moreover, the Children's Cabinet continues its work with RI KIDS Count to develop child indicators to assist the state in achieving the four outcomes adopted by the Cabinet and state agencies. Toward this end, DCYF and other state agencies continue their work in building performance measures and outcomes into service delivery both internally and with providers.

PERFORMANCE MEASURES AND OUTCOMES RECOMMENDATIONS

1. **$ The Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of this plan must include families (parents, kin, foster and adoptive families).**

   It must be recognized that there is a significant cost associated with developing the appropriate infrastructure to accommodate these information requirements, and the State must establish this as a priority investment. Each Department must identify its own financing needs for enhancing the data collection and analysis capability for its own services and population, and the provider community must to do the same. This

data collection and analysis capability must be incorporated into state budget appropriations for the Departments within the Children's Cabinet. An overview of the five year phase-in plan and implementation process lays out the expectations for the critical work that will be necessary to achieve this first recommendation over the five year project period. *(See Appendix K)*

2. $ DCYF must develop and implement a work plan that is geared to measure:

- **progress in system of care development and**
- **the effectiveness of the interventions ascribed to the system.**

The information gathered must also be distributed to identify problems, make adjustments to improve system design and to ensure public accountability.

The Department of Children, Youth and Families has established five goals to guide its system of care capacity development. These broad goals reflect the Department's emphasis on community-based, family-centered services to ensure greater capacity for necessary placements close to the child's home/community. An overview of the workplan for DCYF System of Care Capacity Development and Performance Measures provides a five year approach identifying the key objectives necessary to achieve the goals. *(See Appendix K)*

The priority reform performance measures in the system reform are:

- Eliminate night-to-night placements
- Eliminate medically unnecessary days in psychiatric hospitals
- Reduce out-of-state placements

All of the performance measures, however, identify key data elements being tracked for the Department's operations in promoting continuous quality improvement in Child Welfare, Children's Behavioral Health, Juvenile Corrections, and Independent Living program functions.

3. $ Rhode Island KIDS COUNT should continue to track child abuse and neglect, out-of-home placement, children's mental health, education, and juvenile justice indicators to measure results such as trends in numbers of out-of-state placements and foster care.

The foremost public policy principle for the State is that, unless there is reason for a child to be removed from the home due to abuse or neglect, significant mental or behavioral health needs requiring out-of home care, or juvenile delinquency, **the needs of a child or youth are best met by maintaining them in their home with their family and providing the necessary support services to make this work**. However, when it is necessary to remove a child and place them in out-of- home care, it is the desire of the state that this substitute care be in the setting that is least restrictive and most effectively meets that individual child's needs. In this regard, the data collected by RI KIDS Count will assist the state in measuring what proportion of children and youth are in foster care vs. therapeutic foster care vs. congregate and institutional care. The expectation is for this data to show that a greater proportion of children and youth

are being served in less restrictive settings as opposed to more restrictive settings, especially younger children.

4. **$ DCYF must lead the development of performance measures and outcomes for Comprehensive Care Networks. This will be aimed at measuring both the lead agency itself as well as the performance of subcontracted entities in meeting the needs of children and families served. DCYF will develop utilization management and quality assurance mechanisms which will include family input/participation. These mechanisms will assess the implementation of a consistent standard of practice within the Networks that embodies the principles of the system of care.**

   DCYF will use performance measures previously established in partnership with Yale University for outreach and tracking, foster care, shelter care, and residential programs. These and other standards, such as the CEDARR Family Center Standards, will be used to inform and guide the development and implementation of the development of a Comprehensive Care Network systems' evaluation component to include performance and outcome measures.

CHAPTER 7: IMPLEMENTATION

No plan of action is successful without clear articulation of roles, responsibilities, benchmarks, and time frames. The reorganization of Rhode Island's system of care for children, youth, and their families is no different. Numerous state, community, public, and private stakeholders are involved in each of the recommendations presented. The stakes are high for providers, state agencies, the Judicial Branch, and the Legislature and especially for the children and families served. It is imperative that there is clear designation of who, what, when, where, and how each of these recommendations will be implemented.

IMPLEMENTATION RECOMMENDATIONS

1. **The Task Force recommends the creation of a System of Care Implementation Committee which will temporarily oversee the implementation of the recommendations contained in this report. In carrying out this charge, the Implementation Committee must ensure that they consider how to blend the recommendations of the Task Force's Foster Care and Current Reality Committees (*See Appendices L and M)* into the new System of Care.**

   The Task Force recognizes the role the Children's Cabinet is intended to and has played in strategic planning for policies and services affecting children, youth and families. However, the Task Force realistically understands that in this election year it is unclear as to the future direction of the Cabinet. In order to ensure that a vacuum doesn't occur which tables moving forward on these recommendations, the Task Force believes that the creation of an Implementation Committee is a prudent interim step. This committee should be modeled after the successful Welfare Reform and Starting RIght Implementation committees and contain a broad representation of legislators, executive branch leadership, judicial leadership, families, providers and other key stakeholders.

2. **The Governor must ensure that the Children's Cabinet is provided with the leadership and support necessary for the Cabinet to succeed with its mission of interagency collaboration and planning and oversee the implementation of this plan.**

   A. In order for the Cabinet to be able to effectively meet this and its other responsibilities, the Cabinet must be restructured in a manner which provides a greater depth of staff level involvement and commitment and a greater ability to provide forums for state agencies to work collaboratively on issues that does not interfere with the public's access to the Cabinet.

   B. The Governor and the Cabinet should review the Cabinet's enabling legislation (RIGL 42-72.5) and recommend to the General Assembly changes to which will provide the Cabinet with the direction and flexibility needed to accomplish this restructuring.

The systemic changes called for in this report require strong collaboration between and among state agencies as well as between and among the Executive, Legislative, and Judicial branches of government. The Children's Cabinet provides an existing structure within the Executive Branch to oversee and implement this plan. However, in order to accomplish this responsibility, it is clear that the Cabinet must restructure itself in a manner that provides for greater interagency collaboration as well as greater involvement from the Legislative and Judicial branches of state government. In this restructuring, the Cabinet must identify mechanisms which provide for the creation of interagency staff level work teams for prevention, financing and system management planning, development and implementation. In developing these teams, the Cabinet must consider how to most effectively involve the Legislative and Judicial branches of government, the Offices of the Attorney General and Public Defender, and non-governmental organizations and individuals.

3. **$ DCYF must designate a key staff person who will be responsible for the oversight of the implementation of these recommendations. This individual must have the ability to work with all of the stakeholders involved, be willing and able to keep agencies and individuals within DCYF and from other agencies and stakeholder groups on task.**

Most of the recommendations contained in this report fall on the shoulders of DCYF to implement or to collaborate with other stakeholders to implement. It follows that DCYF be held responsible for overseeing the implementation process. However, it is imperative that the staff person designated be relieved of other duties in order to pay full attention to the goal of changing Rhode Island's System of Care. This is obviously no easy task and will require tremendous time, energy and skills from the Project Manager. This person must be at least temporarily added to the Senior Team for DCYF. This individual reports directly to the Director of DCYF.

4. **The Task Force recognizes the need for a clear implementation timeline but also understands that many details still need to be delineated. The five-year timeline below is intended to serve as a preliminary workplan to be used by the Children's Cabinet and the Implementation Committee. Those groups will need to develop a more concrete timeline as one of their initial actions.**

YEAR ONE

A. Appoint System of Care Implementation Committee members, provide committee with mission and direction.

B. Restructure the Children's Cabinet, including the introduction of any legislation necessary to accomplish this restructuring.

C. Appoint a DCYF Project Manager.

D. Clarify, measure, and affirm DCYF priority populations.

E. Engage and mobilize key stakeholders (legislature, judiciary, community leaders, advocates, families, DCYF staff, providers etc) through mechanisms included but not limited to:

i. **Legislative briefings;**

ii. **Meetings with the Judiciary and their staff;**

iii. **Public Hearings;**

iv. **Meetings with state agency administrators and their staff (DHS, DOH, MHRH, RIDE, etc.);**

v. **Meetings with LEA administrators (superintendents, special education administrators, etc.);**

vi. **Memoranda of understandings between and among all involved parties.**

F. **Establish DCYF Planning, Analysis and Evaluation capacity by identifying DCYF staffing capacity and, as necessary, subcontracting for specific expertise to:**

i. **Determine historical costs;**

ii. **Analyze DCYF and Medicaid expenditures;**

iii. **Conduct provider profiling, needs assessment;**

iv. **Determine which, if any, services will be procured statewide (ex. Juvenile sex offender treatment);**

v. **Establish quality indicators, performance measures, and benchmarks;**

vi. **Facilitate program development;**

vii. **Analyze the feasibility of using a case rate payment mechanism for Comprehensive Care Networks;**

viii. **Begin development of RFP's for Comprehensive Care Networks;**

ix. **Begin to produce reports to be used as a baseline for the evaluation process.**

G. **Establish Children's Cabinet functions and performance measures:**

i. **Review and revise RI statutes and agency regulations as necessary;**

ii. **Begin development of Information and referral system;**

iii. **Establish Community Prevention Partnerships;**

iv. **Develop five year projected Child and Family budget (including federal, state and local funds) to support the implementation of the system of care;**

v. **Develop performance measures for Children's Cabinet functions.**

H. Implement Coordinated Children's Services System Regulations:

i. Operationalize pilot project;

ii. Evaluate project, with ongoing feedback from family members, and use information to inform Lead Agency procurement process and guide the CMT process.

I. DCYF to establish and implement agreements with the Family Court, RIDE, DHS, DOH and MHRH

J. Redesign DCYF Organizational Structure:

i. Restructure DCYF Central Office to support new regional structure;

ii. Establish DCYF Regional structure, staffing patterns, and regional budgets;

iii. Establish DCYF Regional Directors with regional budget authority, reporting requirements.

K. Establish Workforce Development focus:

i. Develop curricula for pre-service and in-service training . Such curricula must include training on family centered practice, cultural competency and gender specific programming;

ii. Support training for public and private provider staff with emphasis on best case management and clinical practices, family centered practice, cultural competency and gender specific programming;

L. DCYF to review substance abuse system with MHRH and determine how to move collaboratively forward;

M. Issue first annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

YEAR 2

A. Implement changes to DCYF Regional Structure.

B. Expand DCYF Planning, Analysis and Evaluation capacity:

i. Review and utilization of reports used for baseline;

ii. Enhance and integrate DCYF and provider MIS systems as necessary.

C. Expand DCYF Workforce Development responsibilities:

i. Charge Child Welfare Training Institute to develop provider fiscal, management, and clinical skills;

ii. Establish on-going required and recommended pre-service and in-service training. This must include training in regard to family centered practice, cultural competency and gender specific

programming.

D. Develop DCYF/Medicaid Provider Capacity:

i. Address provider reimbursement issues;

ii. Develop/expand key services in treatment continuum in partnership with family members.

E. Phase in the transition of youth placed out-of-state to newly developed in-state capacity on fee-for service basis as possible.

F. Develop behavioral health requirements for private insurers:

i. Examine current state statutes (i.e., parity) and regulations;

ii. Amend statutes and/or regulations as needed to assure behavioral health screening, assessment and treatment coverage.

G. Establish DCYF Lead Agency procurement policies through the development of the Care Network RFP Identify vision, mission, roles and responsibilities:

i. Establish appropriate payment mechanism;

ii. Develop fiscal accountability structure for providers;

iii. Establish Lead Agency performance indicators;

iv. Identify incentives/penalties for lead agencies;

v. Bring Regional Lead Agencies on-line.

H. Establish Comprehensive Care Networks:

i. Determine sub-contract requirements and financing arrangements;

ii. Establish sub-contractor quality indicators and performance measures;

iii. Procure lead agency subcontractors.

I. Transition youth in traditionally contracted and POS out-of-home care from current system to comprehensive care network system.

J. Issue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

YEAR 3

A. Adjust payment rate structure (and risk arrangements) as necessary.

B. Continue emphasis on DCYF workforce development, DCYF/Medicaid program development and pre-service and in-service training with a focus on family centered practice, cultural competency and gender specific programming.

C. Continue the transition of youth in traditionally contracted and POS contracted out-of-home care to comprehensive care networks.

D. Continue the design and implement evaluation of Comprehensive Care Networks for out-of-home care.

E. Design and implement evaluation of Comprehensive Care Networks for home and community-based services.

F. Begin longitudinal study of children and youth involved in Comprehensive Care Networks.

G. Issue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

YEAR 4

A. Refine fiscal and management reporting.

B. Continue evaluation of Comprehensive Care Networks for out-of-home services.

C. Transition children and families receiving home and community-based services at point of entry to Comprehensive Care Networks.

D. Continue evaluation of Comprehensive Care Networks for home and community-based services.

E. ssue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

YEAR 5

A. Produce comprehensive system of care evaluation report including but not limited to analyses of access, services utilization, quality and performance measures, and cost-effectiveness.

B. Revise system of care design/implementation based on evaluation findings and recommendations.

C. Issue annual system of care progress report, ensuring that family members and other key stakeholders have adequate input into the report compilation process.

APPENDICES

APPENDIX A: RHODE ISLAND SYSTEM OF CARE TASK FORCE MEMBERS AND COMMITTEE PARTICIPANTS

TASK FORCE MEMBERS

Participant		***Agency***
Hon. Thomas J.	Izzo	Co-Chairman; RI Senate
Hon. Steven M.	Costantino	Co-Chairman; RI House of Representatives
Dr. Robert	Carl	Co-Chairman; Department of Administration
Cathy	Ciano	Parent Support Network
Margaret	Alves	RI Foster Parent Association
Mary	Brinson	Butler Hospital
Elizabeth Burke	Bryant	RI KIDS Count
Laureen	D'Ambra, Esq.	Chairwoman, Current Reality Committee; Office of the Child Advocate
Thomas	DiPaola, Ph.D.	Department of Elementary and Secondary Education
Elizabeth V.	Earls	RI Council of Community Mental Health Organizations
Hon. Gordon D.	Fox	RI House of Representatives
Hon. Aram G.	Garabedian	RI Senate
Clark	Greene	Office of the Governor
William	Guglietta, Esq.	Department of the Attorney General
James	Harris	RI Council of Residential Programs for Children and Youth, Inc.
Calittia	Hartley	Department of Human Services
Jane	Hayward	Department of Human Services
Hon. Jeremiah S.	Jeremiah, Jr.	Chief Judge, RI Family Court
Dennis	Langley	Urban League of Rhode Island
David	Lauterbach	Kent County Mental Health Center
Paul	Lemont	RI League of Cities and Towns
Jay G.	Lindgren, Jr.	Department of Children, Youth and Families
Luisa	Murillo	Chairwoman, Foster Care Committee; Center for Hispanic Policy and Advocacy, Inc.

TASK FORCE MEMBERS (CONTINUED)

Participant		***Agency***
Dennis	Murphy	United Way of Rhode Island
George	Nee	Rhode Island AFL-CIO
A. Kathryn	Power	Chairwoman, Ideal System Committee; Department of Mental Health, Retardation and Hospitals
Br. Michael	Reis	Tides Family Services
Kim	Rose	Office of the Governor
Chief Anthony	Silva	RI Police Chiefs' Association
Dr. Elizabeth	Wheeler	Bradley Hospital

CURRENT REALITY COMMITTEE PARTICIPANTS

Participant		***Agency***
Laureen	D'Ambra, Esq	Chairwoman, Current Reality Committee; Office of the Child Advocate
Br. Michael	Reis	Tides Family Services, Inc.
Lee	Baker	Department of Children, Youth and Families
Raymond	Bandusky	RI Disability Law Center
Thomas	Bohan	Department of Children, Youth and Families
Jennifer	Bowdoin	RI KIDS Count
Mary	Brinson	Butler Hospital
Murray	Brown	Department of Human Services
Hon. Angela	Bucci	Magistrate, Rhode Island Family Court
Mike	Burk	Department of Children, Youth and Families
Michael	Cerullo	Children's Policy Coalition
Erin	Crossman	Rhode Island Family Court
Virginia	da Mota	RI Department of Elementary and Secondary Education
Gail	Dalquist	Placement Solutions
Thomas	DiPaola, Ph.D.	Department of Elementary and Secondary Education
Gail	Dyer	Office of the Child Advocate
Elizabeth	Earls	RI Council of Community Mental Health Organizations
John	Farley	Department of Children, Youth and Families
Deborah	Florio	Department of Human Services
Gregory	Fritz, M.D.	Bradley Hospital
James	Harris	RI Council of Residential Programs for Children and Youth
Calittia	Hartley	Parent
David R.	Heden	Rhode Island Family Court
Berit	Huseby	Office of the Child Advocate
Betsy	Ison	Placement Solutions/Communities for People
Rick	Jacobsen	Department of Human Services

CURRENT REALITY COMMITTEE PARTICIPANTS (CONTINUED)

Participant		***Agency***
David	Lauterbach	Kent Co. Community Mental Health Center
Tricia	Leddy	Department of Human Services
Margaret Holland	McDuff	Family Service, Inc.
Rae	Merliard	Children's Policy Coalition
Sharon	O'Keefe	Office of the Child Advocate
Joan	Obara	Department of Human Services
Mary Anne	Peotrowski	East Bay CASSP
Kim	Rose	Office of the Governor
Carol Spizzirri	Spizzirri	Department of Children, Youth and Families
Charles	Staunton, M.D.	Butler Hospital
John	Young	Department of Human Services

FOSTER CARE COMMITTEE PARTICIPANTS

Participant		***Agency***
Luisa	Murillo	Chairwoman, Foster Care Committee; Center for Hispanic Policy and Advocacy
David	Allenson	Department of Children, Youth and Families
Margaret	Alves	Rhode Island Foster Parent Association
Michelle	Catarino DeJesus	Department of Children, Youth and Families
Paula	Fontaine	Department of Children, Youth and Families
Joel	Gluck	Adoptive Parent
Marie	Masterson	Rhode Island Foster Parent Association
Tom	Ottaviano	Department of Children, Youth and Families
Robin	Perez	Department of Children, Youth and Families
Maureen	Robbins	Department of Children, Youth and Families
Mimi	Romero	Rhode Island Foster Parent Association
David	Small	Family Services, Inc.
Leeann	Sperduti	Department of Children, Youth and Families
Honorable Paul A.	Suttell	Associate Justice, Rhode Island Family Court
Charlene	Zeinowicz	Urban League of Rhode Island

IDEAL SYSTEM OF CARE DESIGN COMMITTEE PARTICIPANTS

Participant		***Agency***
A. Kathryn	Power	Department of Mental Health, Retardation and Hospitals
Margaret	Alves	RI Foster Parent Association
Janet	Anderson, Ed.D.	Department of Children, Youth and Families
C. Lee	Baker	Department of Children, Youth and Families
Jennifer	Bowdoin	RI KIDS COUNT
Mary	Brinson	Butler Hospital
Michael	Burk	Department of Children, Youth and Families
Elizabeth	Burke Bryant	RI KIDS Count
Linda	Carlisle	Consultant
Doreen	Cavanaugh	Heller School, Brandeis University, Consultant
Michael	Cerullo	Private Therapist
Cathy	Ciano	Parent Support Network
Thomas	DiPaola, Ph.D.	Department of Education
Elizabeth	Earls	RI Council of Community Mental Health Organizations
John	Farley	Department of Children, Youth and Families
Hon. Michael B.	Forte	Associate Justice, RI Family Court
Marie	Ganim	RI State Senate, Office of the Majority Leader
William	Guglietta	Department of the Attorney General
Jim	Harris	RI Council of Residential Programs
Calittia	Hartley	Department of Human Services
Jane	Hayward	Department of Human Services
Mitzie	Johnson	Parent Support Network
David	Lauterbach	Kent County Community Mental Health Center
Jay G.	Lindgren, Jr.	Department of Children, Youth and Families
Dennis	Murphy	United Way for Southeastern New England
Michael	Reeves	Harmony Hill School
Kimberly	Rodrigues	RI Council of Residential Programs

IDEAL SYSTEM OF CARE COMMITTEE PARTICIPANTS (CONTINUED)

Participant		***Agency***
Kathleen	Spangler	Department of Mental Health, Retardation and Hospitals
Susan	Stevenson	Children's Mental Health Advisory Council; Providence Center
Elizabeth	Wheeler, M.D.	Bradley Hospital; Children's Policy Coalition

APPENDIX B: PRINCIPLES OF FAMILY CENTERED PRACTICE AS ADOPTED BY THE RI DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

The principles of family centered practice embraced below reflect the Department of Children, Youth and Families investment in developing and maintaining a family centered system of care[21]

- **Recognizing that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate. (This recognizes that "family" may have many interpretations, but maintaining a child(ren)'s connection to his/her family holds significant meaning in their lives).**
  - **"Family includes biological families, foster families, concurrent planning families, adoptive families, extended family relationships, kinship, etc.**
  - **Adolescents involved in the Independent Living Program still have need of a family experience and Family-Centered Principles work at assisting maturing youth to identify valuable connective relationships in their life and to build the inner capacity for developing healthy relationships as they reach adulthood.**
- **Facilitating family/professional collaboration at all levels of well-being**
- **Recognizing and respecting the racial, ethnic, cultural, sexual orientation, special needs and socioeconomic diversity**
- **Recognizing family strengths and individuality and respecting different coping methods**
- **Sharing information between DCYF staff and parents on a continuing basis and in a supportive manner**
- **Facilitating Family-to-family support and networking. (This includes parent support organizations, interactions between concurrent planning families, foster families, adoptive families, biological families and extended family relationships.)**
- **Understanding and incorporating the developmental needs of infants, children and adolescents and their families into service delivery systems**
- **Designing accessible service delivery systems that are flexible, culturally competent and responsive to family needs**

[21] Adapted from Family-Centered Principles found in What is family-centered care? (1990) [brochure] Washington, DC: National Center for Family-Centered Care.

APPENDIX C: DEFINITIONS, CORE VALUES AND STANDARDS OF CULTURAL COMPETENCE FOR RHODE ISLAND'S SYSTEM OF CARE FOR CHILDREN, YOUTH AND THEIR FAMILIES

DEFINITIONS[22]

CULTURE

The thoughts, ideas, behavior patterns, customs, beliefs, values, skills, arts, religions and prejudices of a particular people at a given point in time.

CULTURAL DIVERSITY

The rich mixture of ethnic, racial, religious, national and individual characteristics that colors the landscape of the world in which we live.

CULTURAL COMPETENCE

The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

CULTURAL COMPETENCE CORE VALUES[23]

CULTURAL COMPETENCE IS FOR EVERYONE

Cultural competence is a personal and organizational commitment to learn about one another and how individual culture affects how we act, feel and present ourselves in the work place. The purpose of cultural competence is the sharing of knowledge about all aspects of culture [gender, religion, age, sexuality, education, etc.], not just the racial/ethnic culture of people of color. Cultural competence is an enrichment process, which allows everyone to share and learn. We have to be as willing to share our culture as to learn about another person's.

The vision, mission and goals are the tools the organization can use to create an organizational culture where employees feel comfortable discussing cultural difference and learning about the cultures of other employees and the population served. The organization can also further discussion of diversity by holding events or meetings which encourage people to explore different cultures and have open and honest discussions about difference. Organizations should be willing to allocate resources - money, time , people - to ensure that cultural competence is a priority in the organization.

Each organization has a culture. The communication of the organizational culture should start at the initial interview and continue throughout an employee's time with the organization. While the organization should value difference and be willing to mediate between individual and professional needs of employees, employees should be equally committed to the organizational

[22] Adapted from *Advancing Cultural Competence in Child Welfare Initiative*, Child Welfare League of America, September 1997.

[23] Adapted from *Advancing Cultural Competence in Child Welfare Initiative*, Child Welfare League of America, September 1997.

culture and be willing to make any necessary compromises in order to be successful in the workplace.

CULTURAL COMPETENCE IS INTEGRAL TO BEST PRACTICE

In order to efficiently and effectively carry out all the processes that are encompassed by best practice, i.e., the planning, organization and administration of social work services; establishment of state and local regulations; content training and teaching in schools of social work; inservice training and staff development; board orientation and development; fiscal planning; and community relations; cultural implications should be identified and integrated into all agency operations. The integration of cultural competence in an organization leads to the development of programs, policies and procedures which value and respect employees, the population served, visitors and others who come in contact with the organization.

CULTURAL COMPETENCE IS AN ONGOING PROCESS

Cultural competence is a journey not a destination. As the challenges facing agencies change, organizations will continuously have to evaluate their ability to meet the needs of their external and internal customers [employees and children, youth and families] in a way that is responsive, effective and culturally competent. When agencies face a new challenge, the cultural competence implications should be identified and addressed. The planning process should include discussion of the cultural implications involved in making any changes.

CULTURAL COMPETENCE IS PART OF THE OVERALL ORGANIZATION GOAL OF EXCELLENCE

In today's arena, program structure, policies and procedures can be duplicated, however, the quality with which they are administered will determine how well the customer is served and how satisfied they are with the service provided. The competition for scarce resources will determine which child welfare agencies emerge on top. Excellence will be defined by the way organizations are run internally, how well programs are administered to the population served, the quality of their staff and image of the organization in the community. The "human factor", i.e. how well employees perform their duties, will be the key to achieving and maintaining excellence. Organizations will be able to distinguish themselves in the marketplace based on how adept their staff is at delivering quality products/services to the customer. The quality of the staff will have more influence on the ability of the agency to compete in the marketplace than the services that are provided. Organizations will need to hire /promote employees who are culturally diverse and dedicated to the mission, core values and goals of the organization. Additionally, they should be willing to continuously cultivate their skill set to learn more about their jobs, the population they serve and their fellow employees.

Cultural issues arise in everyday decision-making. Organizational and/or departmental values are the guidelines which should be used when evaluating options and making decisions. By establishing values that emphasize cultural competence, organizations can ensure that employees have the necessary tools to integrate cultural competence into their daily work routine.

CULTURALLY COMPETENT ORGANIZATIONS ARE CUSTOMER DRIVEN

To be successful in today's environment, agencies will need to be customer-driven. What the population served by the agency expects, needs, wants and is willing to tolerate are considerations which have to be entertained by the agency when designing programs, policies and procedures involved in delivering services. It is important for child welfare organizations to encourage feedback from the population served and to actively solicit their feedback and input for modification.

Agencies also have to understand and value both their internal and external customers. How employees are recruited and retained and how well they service and support one another is as

critical to the efficiency of the agency as how well products/services are delivered to children and families. Therefore, organizations have to encourage feedback from within the organization regarding internal policies, procedures and processes as well as those which affect the population served. Staff members should be as concerned about giving assistance to one another as an external customer. Good internal customer service increases efficiency via the timely transmission of information which is ultimately used to service external customers.

CULTURALLY COMPETENT ORGANIZATIONS FOSTER LEADERSHIP THROUGHOUT THE ORGANIZATION

The environment agencies are exposed to today is in constant flux. The formal leaders of the organization face a new set of challenges which require their attention to keep the organization competitive. By sharing the responsibility of running the organization with the staff of the organization, the formal leaders can create more time for long-range planning themselves. By creating opportunities for leadership throughout the organization, among those who do the work, formal leaders are able to get better information about how the organization is running and what modifications are necessary. Effective team building allows the entire staff to have an impact not only on their own work, but on the overall success of the organization. This instills a sense of pride and ownership which result in commitments the organizational goals of excellence, customer service and quality delivery of a quality service.

Fostering leadership on every level of the organization gives all employees the opportunity to take on responsibility and allows them to hone the skills which will allow them to move up within the organization. The organization benefits because employees are being cultivated to be leaders, which gives the organization a pool of qualified candidates when managerial positions are available. Because there is a lower percentage of people of color when looking for higher level positions, this is another way to increase staff diversity while ensuring quality.

STANDARDS FOR CULTURAL COMPETENCE IN PRACTICE[24]

1. ***Ethics and Values:*** Individuals working within all levels of the System of Care function in accordance with the values, ethics and standards of their respective fields, recognizing how personal and professional values may conflict with or accommodate the needs of diverse children, youth and families.

2. ***Self-Awareness:*** Individuals working within all levels of the System of Care seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.

3. ***Cross-Cultural Knowledge:*** Individuals working within all levels of the System of Care have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems and artistic expressions of major client groups they serve.

4. ***Cross-Cultural Skills:*** Individuals working within all levels of the System of Care use appropriate methodological approaches, skills and techniques that reflect their understanding of the role of culture in the helping process.

5. ***Service Delivery:*** Individuals working within all levels of the System of Care are knowledgeable about and skillful in the use of services available in the community and broader society and are able to make appropriate referrals for their diverse children, youth and families.

[24] Adapted from *Standards for Cultural Competence in Social Work Practice*, National Association of Social Workers. Online. Available at http://www.socialworkers.org/pubs/standards/cultural.htm 23 June 2001.

6. ***Empowerment and Advocacy:*** Individuals working within all levels of the System of Care are aware of the effect of policies and programs on diverse client populations, advocating for and with children, youth and families when appropriate.

7. ***Diverse Workforce:*** Individuals working within all levels of the System of Care support and advocate for recruitment, admissions, hiring and retention efforts in programs and agencies that ensure diversity within the system.

8. ***Professional Education:*** Individuals working within all levels of the System of Care advocate for and participate in educational and training programs that help advance cultural competence within the system.

9. ***Language Diversity:*** Individuals working within all levels of the System of Care seek to provide or advocate for the provision of information, referrals and services in the language appropriate to the client, which may include the use of interpreters.

10. ***Cross-Cultural Leadership:*** Individuals working within all levels of the System of Care are able to communicate information about diverse client groups to other professionals.

APPENDIX D: VALUES AND PRINCIPLES FOR THE FAMILY-CENTERED, COMMUNITY-DRIVEN SYSTEM OF CARE FOR RHODE ISLAND[25]

VALUES AND PRINCIPLES FOR THE FAMILY-CENTERED, COMMUNITY-DRIVEN SYSTEM OF CARE FOR RHODE ISLAND

CORE VALUES

1. The system of care is child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care is community based, with the locus of services as well as management and decision making responsibility resting at the community level.
3. The system of care is culturally competent, with agencies, programs and services responsive to the cultural, racial and ethnic differences of the populations you serve.

GUIDING PRINCIPLES

1. Children, youth and their families have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children, youth and their families receive individualized services in accordance with the unique needs and potentials of each child and family and guided by an individualized service plan.
3. Children, youth and their families receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and/or surrogate families of children and youth are full participants in all aspects of the planning and delivery of services unless such involvement is clearly detrimental to the safety of the child.
5. Children, youth and their families receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
6. Children, youth and their families are 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.

[25] Stroul, B.A. & Friedman, R.M. (1986). A system of care for children and youth with severe emotional disturbances. (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, p. 18.

7. Early identification and intervention for children, youth and families in need of support and intervention is promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children, youth and their families are ensured smooth transitions to programs and services in the adult service system as necessary as the youth reaches maturity.
9. The rights of children, youth and their families are protected and effective advocacy efforts for children, youth and their families are promoted.
10. Children, youth and their families receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services are sensitive and responsive to cultural differences and special needs.

APPENDIX E: SERVICE AND PROGRAM COMPONENTS WITHIN RHODE ISLAND'S SYSTEM OF CARE FOR CHILDREN, YOUTH AND FAMILIES

THE PROGRAM AND SERVICE COMPONENTS OF THE SYSTEM OF CARE INCLUDE:

- General and specialized targeted prevention
- Early Intervention
- Quality child care and youth care services
- Educational Services
- Medical and dental services
- Social Skills development
- School-based mental health services
- Comprehensive assessments and evaluation
- Mobile crisis intervention services
- Case Management
- Short-term in-home acute care services (i.e., CIS, CES)
- Outpatient therapy (family, group, and individual)
- Outpatient Substance Abuse services for children, youth and their families
- Child abuse and neglect prevention and investigation
- Therapeutic Recreation
- Therapeutic child care
- Out of School Time programs
- Mentoring
- Day Treatment programs
- Community-based programs and services for juvenile offenders, including:
- Outreach and Tracking
- Day Reporting Centers
- Inter-agency Intensive Supervision programs for high-risk probationers (i.e., *Safe Streets)*
- Out-of-home care:
  - Kinship and foster care
  - Therapeutic foster care
  - Group home care, general and specialized
  - Specialized Residential treatment including residential substance abuse treatment and hospital diversion/stepdown
  - Out-of-home Respite care
  - Acute psychiatric hospitalization
  - Incarceration
  - Residential alternatives to incarceration, including staff secure programs

APPENDIX F: DCYF FAMILY SERVICE REGIONAL OFFICE SERVICE AREAS AS OF APRIL 2001

As of December 2001, the RI Department of Children, Youth and Families is divided into four geographic catchment areas for ongoing child welfare case management purposes. Probation offices overlap have some overlap with these regional offices but do not have direct reporting relationships to Regional Directors, instead reporting through the probation chain-of command. Children's behavioral health cases with ongoing case management needs that have no probation or child welfare involvement are also handled by the Regional Office staff.

The four Regional Offices and communities that lie within their service areas are:

- **Region 1: Providence Region - City of Providence**
- **Region 2: East Bay Region - Newport, East Providence, Barrington, Warren, Bristol, Tiverton, Little Compton, Portsmouth, Middletown, and Jamestown.**
- **Region 3: South County Region - New Shoreham, Narragansett, South Kingstown, North Kingstown, Charlestown, Westerly, Hopkinton, Richmond, Exeter, West Greenwich, East Greenwich, Warwick, West Warwick, and Coventry.**
- **Region 4: Northern Rhode Island - Central Falls, Pawtucket, Woonsocket, Cranston, Johnston, Scituate, Foster, Glocester, Smithfield, North Smithfield, Burrillville, and Lincoln.**

APPENDIX G: COMPREHENSIVE CARE NETWORKS

COMPREHENSIVE CARE NETWORK: FUNCTIONS AND RESPONSIBILITIES OF KEY STAKEHOLDERS

Lead Agency Key Expectations

- Each lead agency holds the primary contract with DCYF for the management and oversight of their respective Comprehensive Care Network.
- Each lead agency is responsible for ensuring the effective delivery of an array of services within their contracted region to all children and families referred by DCYF **and may not refuse services or treatment for these referrals or reject any of these referrals.** Each lead agency will be required to fund specialized services not available within their Comprehensive Care Network through the established case rate.
- Each lead agency is expected to ensure the provision of services as proximate to the child/youths' community as possible, thereby reducing the number of children and youth placed outside of their community and allowing for the child/youth to maintain connection to their local school system.
- Lead agencies may provide no more than twenty-five percent (25% - based on total service dollars for the region) of direct service within their Comprehensive Care Network but may subcontract with lead agencies in other Comprehensive Care Networks for direct service programming.
- Each lead agency may be responsible for receiving funds for network services rendered and for the reimbursement of subcontractors.
- Each lead agency is responsible for measuring the performance of their respective network and the individual subcontractors of that network. The lead agency is also responsible for reporting to DCYF the results of such evaluations.
- Each lead agency holds the primary responsibility for care and case management functions and responsibilities.

Lead Agency Management Functions

- Developing a flexible network of service providers that meet identified needs of the region
- Providing a single point of entry to the service system
- Coordinating services throughout the course of treatment, placement and aftercare
- Working with DCYF case managers and families to develop family and child service plans
- Family conferencing
- Implementing "no reject, no eject" policies
- Implementing standard service definitions and common clinical protocols

- Treatment planning and conducting treatment team meetings with family members and clinicians
- Implementing Continuous Quality improvement
- Collaborating with schools, law enforcement, court, medical providers and others to ensure goals and treatment needs are being met
- As necessary developing, implementing and evaluating written interagency agreements with LEA's.
- Maximizing Medicaid/SCHIP, private insurance and education funding
- Coordinating, reviewing and authorizing direct care providers' claims and bills for clinical and non-clinical services
- Submitting required reports (fiscal, performance, outcomes, etc.) to DCYF
- Comprehensive Care Network budget management
- Providing supports and services not currently funded by the current payment methodology (e.g., class trips, recreation, music lessons, tutoring, other special needs of children and families)

DCYF Regional Office functions

- Overseeing and participating in gate keeping into the comprehensive care networks
- Serving as the primary liaison to the comprehensive care networks
- Case management and clinical conferencing with the comprehensive care networks
- Monitoring day-to-day service utilization, program performance and performance indicators
- Participating in planning and coordinating services among the lead agency, care network providers, DCYF staff, community partners and other parties
- Technical assistance and training
- Participating in service expansion and new service development
- Developing network protocols and procedures
- Conflict resolution
- Regional budget management

DCYF Central Office Functions

- Oversight of the Comprehensive Care Network Initiative
- Establishing gate keeping procedures and arrangements with other state agencies (particularly DHS)
- Planning and developing system enhancements
- Developing blended funding solutions with DHS

- Identifying issues and trends and devising plans with other parties to address those issues and trends
- Participating in service expansion and new service development
- Developing common service taxonomy
- Establishing capacity to better understand Medicaid
- Monitoring outcomes of services
- Establishing reporting requirements
- Providing administrative support services to lead agencies and Regional Offices
- Establishing case rates and other funding mechanisms
- Oversight and monitoring of lead agency contracts in collaboration with Regional Offices

- Reporting to the legislature and administration
- Establishing and maintaining relationships with RIDE, Family Court, DHS, DOH, MHRH and key stakeholders
- Establishing a model for handling grievances and resolving conflicts

Comprehensive Care Network Services

- Preventive services
- Crisis intervention (available 24 hours/day, 7 days/week, 365 days/year)
- Initial assessment
- Specialized assessments (e.g., caretaker safety; sex offender; physical health, mental status and substance abuse screening, etc.)
- Development of family-centered family/child service plans
- Family conferences
- Day treatment and reporting
- Outreach and tracking
- Family respite
- Wrap-around services
- Behavioral health services
- Outpatient/community-based counseling services
- Outpatient substance abuse treatment
- Medication evaluation, management and re-evaluation
- Family support and parent education
- Parent Aides
- Counseling

- Home Visitation Services for Newborns
- Tutoring
- Recreation
- Transportation
- Residential services including:
  - Respite Care
  - Shelter Care
  - Regular Foster Care
  - Specialized and Therapeutic Foster Care
  - Group Homes
  - Staff Secure Residential Group Homes
  - Intensive Residential Treatment
  - Specialty Residential Treatment (i.e., sex offenders, substance abuse)
- Ability to access In-patient Psychiatric hospital services as needed through affiliation agreements with psychiatric hospitals
- Aftercare

APPENDIX H: COMPARISON CHART OF COMPREHENSIVE CARE NETWORKS/CEDARR FAMILY CENTERS/LOCAL COORDINATING COUNCILS

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Geographic Access	Specified Geographic Areas	Statewide, with requirement for local accessibility	Specified Geographic Areas
Target Population	DCYF -defined populations: ❑ delinquents ❑ in custody for abuse/neglect ❑ voluntary due to behavioral health needs requiring state assistance	Families with children with special health care needs, i.e., with condition or risk of condition requiring health or related services of a type or amount beyond that required by children generally.	Families with children at significant risk for or identified as seriously emotionally disturbed.
Presenting Needs	❑ wayward/disobedient ❑ at risk for out-of-home or out-of-community placement	Issues associated with special needs unresolved. May include: ❑ Risk for out-of-home or out-of-community placement ❑ Difficulties within family support system ❑ Need for specialty diagnosis; more information re: condition ❑ Difficulties with current services/services coordination ❑ Information /advocacy about services, resources, programs' various eligibility rules ❑ Problems associated with transitions	Emotional or behavioral challenges that significantly disrupts functioning at home, school or in community

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Family Choice	❑ Legal status - case plan driven ❑ Non-legal status - voluntary participation by families	❑ Participation by families is voluntary. ❑ Families have choice of provider.	Participation by families is voluntary.
Funding	State/Federal funding: ❑ Title XIX, IV-E ❑ Private sources ❑ Grants	State/Federal funding: ❑ Title XIX, XX, XXI ❑ Private sources ❑ Grants	State funds.
Payment Mechanism	Case rate for services.	Fee for service.	DCYF contracts.
Scope of Service	❑ Assessment ❑ Care Planning ❑ Referral ❑ Evaluation ❑ Coordination ❑ Lead agency restricted to providing no more than 25% of direct services within their Care Network	❑ Assessment ❑ Care Planning ❑ Referral ❑ Evaluation ❑ Coordination	❑ Service coordination ❑ Family Support ❑ Information, education, advocacy ❑ Non-traditional wraparound support not covered by other funding sources
Utilization Management Function	❑ State provides utilization management of Lead Agency. ❑ Lead agency is responsible for ensuring that subcontractors meet expectations.	❑ Case based data tracking. ❑ CEDARR Direct Services authorized when included in approved Family Care Plan.	None

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Services Provided	Comprehensive array of services from general outpatient to respite to residential treatment (with affiliation agreements with hospitals for psychiatric hospitalization needs). Includes case management No reject - no eject policy for Lead Agency	❑ Basic services and supports – service identification/referral, special needs resource information, system mapping/navigation, peer support ❑ Initial Family Assessment ❑ Specialty Evaluation; Treatment consultation ❑ Family Care Plan Development; periodic review and revision, service tracking ❑ Crisis Intervention ❑ Direct services to be provided only by "CEDARR Direct Service Providers"	Family Service Coordinators: ❑ meet with families to prepare for case review process ❑ assist in identifying appropriate support for parents in the team meetings ❑ coordinate and schedule team meetings ❑ support and advocate for family needs ❑ maintain documentation ❑ complete data collection requirements for system evaluation ❑ follow-up on team assignments ❑ provide community education and information ➢ The - Coordinated Children's Services System - provides for non-traditional, wraparound services through community planning teams.

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Oversight and Monitoring ➢ Certification/ ➢ Accreditation	➢ System oversight by DCYF ➢ Lead Agency responsible for monitoring service utilization	❑ System oversight - DHS, CEDARR Policy Advisory Committee ❑ Certification by DHS. Oversight and Monitoring ➢ Identification of key program issues ➢ Comprehensive data system/data reports/analyses ➢ Provider compliance w/standards ➢ Service delivery process/outcomes ➢ Site visit compliance reviews	N/A
Contracting	❑ Specific contracting responsibility ❑ Specified timeframe ❑ Limited number	❑ Rolling certification of CEDARR Family Centers by DHS ❑ Certification for any applicant that demonstrates compliance with standards.	Functions contracted by DCYF.

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Data Requirements	To be defined during development process but my include, although not exclusively, the following: ❑ DCYF - RICHIST - ➢ Network referrals ➢ Presenting needs ❑ Network Data Reports - ➢ Systems evaluation ➢ Performance indicators ➢ Outcome data ❑ Child Welfare Performance - YALE ➢ Demographic information ➢ Presenting issues ➢ Service needs/referrals ➢ Educational Need/Performance ❑ Placement Solutions - ➢ Service utilization reports for youth placed in and out of state ➢ Service plans for moving youth from high-end residential to community-based support	CEDARR electronic case coordination system provides consistent management tool and establishes uniform centralized data base. Core data elements in such areas as: ❑ Demographic information ❑ Referral sources, presenting issues, other service system involvement of child/family. ❑ Assessment of Family Care Plan components (identified strengths, needs, goals, objectives, interventions) ❑ Process of care (timelines, completion, referrals, services received) ❑ Service gaps experienced ❑ Outcomes of family care plans	Project Hope Evaluation Data Collection for youth with SED leaving RITS with aftercare support: ❑ Demographic information ❑ Presenting needs ❑ Identified services, referral sources for mental health, social services, educational, operational, recreational, vocational, health and juvenile justice ❑ Barriers to services being delivered ❑ Child and Adolescent Functioning Assessment Scale (CAFAS)

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Collaboration - Required Partners	❑ Networks must develop as many connections and linkages to the community as possible. ❑ All subcontractors required to attend regular team meetings to review any case as necessary and appropriate. ❑ Monthly team meetings with contractors and DCYF case workers allows ability to move children, youth and families flexibly within the network up, down and across treatment levels based on the immediate needs; review standards; cross -agency training; and the collaborative planning of events.	Collaboration/coordination required with: ❑ Families ❑ LEAs ❑ LCCs ❑ Early Intervention ❑ DCYF case workers ❑ Primary physician ❑ DHS ❑ RIte Care health plan, commercial payers ❑ Other community natural supports	The voting membership of Local Coordinating Councils must include broad community representation of at least 19 participants, of which no more than 4 may be employees of the fiscal agent.
Case Management	Provided within Network; DCYF caseworker also responsible.	Not required.	Case management provided by some LCCs, but not all.

	Comprehensive Care Networks	CEDARR Family Centers	LCC's
Care Coordination		Family Care Coordination Assistance- Activities to: ❑ Support initiation of Family Care Plan –assist, help arrange for and coordinate key interventions to meet goals and objectives ❑ Promote development of family empowerment and self advocacy skills Reimbursable service by CEDARR Family Center; level of effort at 4-6 hrs/month Limited to six months duration as start of Family Care Plan; may be renewed based on need/transition.	All LCCs provide care coordination.

APPENDIX I: DCYF RECOMMENDATIONS TO THE JOINT LEGISLATIVE COMMISSION TO STUDY AN ENHANCED ROLE FOR PROBATION AND PAROLE (MARCH 2001)

ADMINISTRATION AND MANAGEMENT

- Enhance services for young women offenders
- Develop standards based on American Probation and Parole Association (APPA) Best Practices
- Establish curriculum for staff training and development
- Implement continuous quality improvement process
- Utilize computer mapping to identify geographic "hotspots" based on probationer and criminal activity

COMMUNITY SUPERVISION

- Study feasibility of one probation counselor for each youth throughout the system
- Re-validate the current risk assessment tool
- Develop comprehensive assessment component
- Develop case profiles
- Establish contact standards
- Establish caseload forecasting model
- Review assignment of offenders to probation caseload
  - transfer policy between probation counselors and DCYF social caseworkers
  - convicted adults in Family Court
  - transition from RI Training School to probation

COMMUNITY SERVICE AND SUPPORT

- Expand community support service system:
  - Outreach and tracking
  - Gang intervention
  - Mentoring
  - Substance abuse counseling
  - Sex offender monitoring and treatment
  - Employment services
  - Family support services
  - Mental health counseling
- Enhance early intervention and transitional services for young women offenders

STAFF RECRUITMENT AND TRAINING

- Formalize current outreach efforts to recruit minority probation counselors
- Negotiate a modified civil service exam
- Develop core staff training curriculum specifically tailored for juvenile probation and parole staff
  - New staff = 120 hours in first year
  - Veteran staff = 40 hours annually

COMMUNITY PARTNERSHIPS AND LINKAGES

- Expand information sharing and collaboration with police departments throughout the state
- Expand *Safe Streets* model to all five (5) core cities
- Expand Day Reporting Centers to all five (5) core cities
- Support the continued development and enhancement of Juvenile Hearing Boards
- Support the expansion of Juvenile Drug Courts and Truancy Courts within agreements outlining roles and responsibilities between DCYF and the Family Court as to case management and service delivery functions

CASELOAD MANAGEMENT

- Achieve target caseloads as follows
  - Probation supervisor to probation counselor: 1:8
  - Probation caseload: 30:1 (Current = 41:1)
  - Parole caseload: 35:1 (Current = 47:1)
  - *Safe Streets* caseload: 15:1 (Current = 17:1)

APPENDIX J: LISTING OF LICENSED AND BOARD CERTIFIED PROFESSIONALS

Licensed Psychiatrist, Board Certified (American Board of Medical Specialties) in Child and Adolescent Psychiatry (M.D.)

Licensed Psychologist (Ph.D./Psy.D.)

Certified Registered Nurse Practitioner (CRNP)

Licensed Independent Clinical Social Worker (LICSW)

Licensed Clinical Social Worker (LCSW)

Licensed Marriage and Family Therapist (LMFT)

Licensed Mental Health Counselor (LMHC)

Licensed Chemical Dependency Counselor

Licensed Practical Nurse (LPN)

Registered Nurse (RN)

Licensed Physician Assistant (PA)

Certified Nursing Assistant (CNA)

APPENDIX K: PERFORMANCE MEASURES AND OUTCOMES FOR THE SYSTEM OF CARE

THREE FORMS OF MEASUREMENT

Context Evaluation

Context evaluation focuses on assessing the needs, assets, and resources of the state and local communities in order to plan relevant and effective interventions within the context of the community. It also identifies the political atmosphere and human services context of the community to increase system design support by community leaders and local organizations.

Implementation Evaluation

Implementation Evaluation addresses a broad array of elements. The purpose of this type of evaluation in Rhode Island's System of Care include:

- Identifying and maximizing strengths in development
- Identifying and minimizing barriers to implementing activities
- Determining if project goals match target population needs
- Assessing whether available resources can sustain project activities
- Measuring performance and perceptions of the staff and children, youth and families
- Documenting systemic change.

Outcome Evaluation

Assessing outcomes employs five levels of measurement:

- Individual child and family outcomes –individualized assessments for a specific client
- Program measures (outcomes of a group of children, youth and families receiving specific services)
- Agency or departmental indicators (results of all children, youth and families served by an agencies services)
- System-wide data (child serving system data from multiple agencies)
- Community population statistics (a description of the wider community demographics)

In the System of Care, the development of the outcome evaluation builds on the work completed to date by state agencies in developing common outcomes to use across the system. This process involves stakeholder participation to determine what outcomes are expected or hoped for and to think through how individual participant/client outcomes connect to specific program or system level outcomes. These outcomes measures:

- Help answer questions about what works, for whom, under what conditions and how to improve program delivery and service
- Determine which implementation activities and contextual factors are supporting or hindering outcomes and overall program effectiveness
- Demonstrate the effectiveness of the system and make the case for its continued funding.

A formative evaluation approach is used integrating evaluation processes into the routine operation of service provision. In the System of Care, evaluations develop useful, accessible findings that bridge the gap between research and practice, informing decision-making and improving service programming. It shifts the focus from outputs to results –from how a program operates to the good it accomplishes[26].

[26] Stroul, 1993/Woodbridge and Huang, 2000.

Performance Measures and Outcomes - Recommendation 1: The Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of this plan must include families (parents, kin, foster and adoptive families.

Overview -

Department(s)	Action Steps – Year 1-2	Indicators - Establish Baseline In Year 1	Data Sources	Performance Measures – Year 2-5	Outcomes - Year 2-5
Within the Children's Cabinet - DCYF DHS RIDE DOH MHRH	❑ Establish MOA for Implementation Team with identified funding resources. ❑ Assign key staff. ❑ Establish implementation milestones and schedule.	❑ **Identify relevant** ❑ **percentage of service** ❑ **utilization for tracking -** ❑ Utilization of prevention services ❑ Utilization of emergency services ❑ Utilization of health plan child/family services ❑ Utilization of HBTS (EPSDT)	❑ DHS - ➢ Rite Care ➢ HBTS (EPSDT) ➢ CEDARRs ➢ Medicaid FFS expenditures ❑ DCYF - RICHIST: children/youth receiving of out-of-home mental health or therapeutic tx services	❑ Data infrastructure operational. ❑ Data elements being shared, trends tracked. ❑ Systems alignment evolving. ❑ Services accessed. ❑ Waiting lists reduced/eliminated.	❑ **Compare with Year 1 - baseline data** ❑ Prevention service capacity - expected increase ❑ Emergency services care- expected decrease ❑ Community-based support - expected increase ❑ Court referrals - expected decrease

Overview (continued)

Department(s)	Action Steps – Year 1-2	Indicators - Establish Baseline In Year 1	Data Sources	Performance Measures – Year 2-5	Outcomes - Year 2-5
	❑ Identify data elements within each Department and create reporting formats and schedule. ❑ Report quarterly. ❑ Establish protocols to address systems' barriers. ❑ Establish action plan(s) for necessary adjustments. ❑ Design Community Prevention Partnerships	❑ Utilization of IEPs ❑ Utilization of community-based support ❑ Utilization of out-of-home placement ❑ Utilization of out-of-district placement ❑ Utilization of psychiatric hospitalization ❑ Utilization of out-of-state placement ❑ Agency/service specific data on community level	❑ DOH – ➢ Early Intervention ❑ RIDE – ➢ IEP Services ➢ Private Special Education Schools ❑ MHRH – ➢ Substance Abuse ➢ Adult MH ➢ DD Services	❑ Service gaps/needs identified and addressed with new service development; targeted capacity enhancement. ❑ Community trends: ➢ school attendance ➢ school performance ➢ school suspensions ➢ expulsion rates ➢ arrests ➢ detention rates ➢ placement out of community rates	❑ Psychiatric hospital care - expected decrease ❑ Out-of-state placements - expected decrease

RECOMMENDATION 1 - Children's Cabinet must develop, implement and fund an evaluation/accountability plan to comprehensively assess the State's effectiveness in implementing the recommendations of this report over the five year phase-in period. The development of the evaluation/accountability plan must include families.

Implementation Process -

Action Steps	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Task Force issues final report including Implementation Plan ❑ Implementation Plan elaborated and refined including: ➢ action steps ➢ responsible parties ➢ timelines ❑ Governor and Assembly designate Children's Cabinet to monitor Implementation Plan. ❑ MOA for Implementation Project with identified funding resources.	**Within 3 months of Report Issuance:** ❑ Children's Cabinet agrees to Implementation Project. ❑ A cost analysis is conducted across Departments to determine current capacity for data collection/analysis and budget needs for a comprehensive MIS infrastructure. ❑ MOA is developed and signed. ❑ Family participation is identified and accommodated. ❑ Project staff are assigned. ❑ Implementation goals are set. ❑ Budget requests are developed for future investment in data management/analysis.	Monitor key indicators for investment shift from high-end service to less restrictive and community-based care.	Monitoring implementation continues with Children's Cabinet.	Implementation and monitoring process ongoing.	Implementation and monitoring process ongoing.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Identify data elements within each Department and create data reports that are needed.	**Within 6 months of Report Issuance:** ❑ Each Department identifies the current set of data files for relevant services. ❑ The necessary programs are written for data exchange and compilation that will allow for comprehensive profile of service delivery and access needs. ❑ Identify the data elements that are necessary, but need to be developed. ❑ Create infrastructure to establish baseline data.	❑ Infrastructure is in place and operational. ❑ Needed data elements are developed within the information systems.	New data elements are reported and tracked as part of overall trend and benchmarking analysis.	Continued refinement of data elements as need is identified.	Continued refinement of data elements as need is identified.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Protocols established to address systems' barriers.	**Within 6 months of Report Issuance**: ❑ Children's Cabinet creates a workgroup of staff attorneys, information systems specialist and program staff to identify existing statutory requirements and authorities within each Department. ❑ Workgroup identifies where the statutory authority assists or impedes implementation and recommends necessary accommodations. ❑ Cabinet determines necessary action to remove systems barriers.	❑ System alignment is assessed and necessary changes are made to facilitate seamless service delivery at state and community level. ❑ Waiting list trends are reported as they relate to service access and delivery performance. ❑ Community-based trends are analyzed for local level performance measure achievements.	Ongoing assessment of systems' coordination and necessary adjustments are made.	Ongoing assessment of systems' coordination and necessary adjustments are made.	Ongoing assessment of systems' coordination and necessary adjustments are made.
❑ Information reported quarterly.	❑ Initial data compilation begins among between Departments within the first six months of project implementation. ❑ Baseline data track is established for all elements collected.	❑ Data elements are tracked regularly for trend analysis. ❑ Indicators in service areas across Departments are analyzed. ❑ Problem areas are identified.	❑ Service utilization and cost trends are analyzed quarterly. ❑ Trends represent service concentration in levels of restrictiveness/ community-based care and prevalent geographic utilization.	Data collection and analysis is ongoing.	Data collection and analysis is ongoing.

Implementation Process (continued)

Action Steps (cont.)	Year 1	Year 2	Year 3	Year 4	Year 5
❑ Action plan(s) for necessary adjustments.	❑ Focus on systems needs. ❑ Focus on service and program needs.	❑ Correction plans are developed as necessary. ❑ Service gaps and capacity needs are identified. ❑ Strategies are devised to address service needs.	❑ Ongoing service development and capacity building is monitored and assessed. ❑ Plans developed for increasing/changing service capacity.	Services increased or changed to meet identified population needs.	❑ Monitoring and adjustments are ongoing. ❑ Children/ families are receiving appropriate services in timely manner.

The Department of Children, Youth and Families - System Enhancement

The Department of Children, Youth and Families represents an integrated System of Care comprised of Child Welfare, Children's Behavioral Health and Juvenile Corrections. The Department's five goals for the System of Care Capacity Development are broad, but inclusive of the Department as a whole, interconnecting with each of the distinct operating divisions. The Divisions function both separately and together to provide a full array of services and programs to meet the needs of children, youth and families.

The performance measures themselves are tailored to the specific operations within the department, as part of the department's overall goals to improve the system capacity.

Performance Measures and Outcomes - Recommendation 2: DCYF must develop and implement a work plan that is geared to measure: (a) progress in continuum of care development and (b) the effectiveness of the interventions ascribed to the system.

The information gathered must also be distributed for public accountability and to identify problems and make adjustments to improve system design.

Performance Measures and Outcomes - Recommendation 2: DCYF must develop and implement a work plan that is geared to measure: (a) progress in continuum of care development and (b) the effectiveness of the interventions ascribed to the system.

The information gathered must also be distributed for public accountability and to identify problems and make adjustments to improve system design.

DCYF System of Care Capacity Development	Year 1	Year 2	Year 3	Year 4	Year 5
Goal 1: Create a community-based, family-centered service system **Goal 2: Establish a continuum of high quality, culturally relevant <u>and gender specific</u> placement resources in proximity to each child's home by expanding and improving Rhode Island in-state system of care** **Goal 3: Promote adoption/guardianship as a permanency option when reunification is not achievable** **Goal 4: Transition all children and youth from public supported care with the supports, skills and competencies in place to ensure stability and permanency.** **Goal 5: Enhance the capacity of employees, foster parents and providers to deliver high quality care to children and families.**	❑ Begin to implement Family-Centered Practice ❑ Implement concurrent planning for children in substitute care ❑ Begin implementation of Care Management Team (CMT) community-based placement mechanism ❑ Increase in-state residential capacity ❑ Continue utilization review management ❑ Establish first Regional-based Network ❑ Enhance opportunities and preparation for older youth leaving state care ❑ Enhance training and support for substitute care providers ❑ Enhance training and support for staff	❑ Phase-in of Family-Centered Practice continues ❑ Increase hospital step-down capacity in-state ❑ Establish CMT in all DCYF Regions ❑ Expand Regional Networks ❑ Monitor concurrent planning activity and adjust as necessary ❑ Continue to identify and implement training and support services	❑ Family-Centered Practice ongoing ❑ Assess and maintain hospital step-down capacity ❑ Assess and modify CMT operation as necessary ❑ Expand Regional Networks ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Family Centered Practice Ongoing ❑ Full array of treatment services available through regionally-based networks – except secure corrections and psychiatric hospitals ❑ Children and families receive appropriate care when needed ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Maintain according to plan ❑ Maintain according to plan ❑ Maintain according to plan ❑ Assess and adjust as necessary

DCYF System of Care Performance Measures	Year 1	Year 2	Year 3	Year 4	Year 5
Reform Priority Measures - ❑ Eliminate night to night ❑ Eliminate medically unnecessary days in psychiatric hospitals ❑ Reduce out-of-state purchase of service (POS) placements	❑ Reduce number of medically unnecessary days ❑ Increase family support services[27] ❑ Night-to-night Placement eliminated	❑ Reduce number of Wayward/Disobedient placements ❑ Eliminate medically unnecessary days	Continue to monitor and adjust system functioning as necessary	Continue to monitor and adjust system functioning as necessary	Continue to monitor and adjust system functioning as necessary

[27] Family Support Services includes parent aide, home visiting for newborns, substance abuse treatment, and mental health treatment for parents

DCYF System of Care Performance Measures (continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Child Welfare - *Safety* ❑ Reduce recurrence of child abuse and/or neglect ❑ Reduce the incidence of child abuse and/or neglect in foster care *Permanency* ❑ Increase permanency for children in foster care ❑ Reduce time to reunification without increasing re-entry ❑ Reduce time in foster care to adoption ❑ Increase placement stability ❑ Reduce placements of young children in group homes or institutions *Well-being* ❑ Educational attainment ❑ Families report improvements in ❑ parent/child interaction ❑ Chafee Foster Care Independence Measures[28] ➢ Improved/satisfactory grades ➢ improved/satisfactory school attendance ➢ Classroom stability improved	❑ Enhance recruitment of foster care and adoptive parents ❑ Reduce number of children/youth free for adoption who are not adopted ❑ Increase annual number of adoptions from state care ❑ Enhance staff competence with regard to preparing children and families for permanency ❑ Reduce number of times children/youth disrupt from placements ❑ Reduce number of children removed from home or foster care placements. ❑ Develop "well-being" data elements.	❑ Increase number foster care providers and therapeutic foster care providers ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Ongoing training ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Begin tracking "well-being" indicators	❑ Continue recruitment and training activities ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary

[28] Chafee Foster Care Independence Program Measures included in Appendix K.

DCYF System of Care Performance Measures (Continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Children's Behavioral Health - ❑ % of children receiving appropriate level of behavioral health service as needed ❑ % of children still not receiving appropriate level of behavioral service as needed ❑ % of children admitted into a psychiatric hospital who remain for 21 days or less ❑ Consumer satisfaction rate for Department funded psychiatric hospital and community-based services	❑ Establish baseline for service needs including extent of waiting lists ❑ Assess and redesign as indicated - outpatient services ❑ Restructure CIS services ❑ Reduce hospital recidivism rates ❑ Assess adequacy of psychiatric hospital stepdown programs ❑ Enhance community-support capacity ❑ Increase provider rates where insufficient	❑ Assess and revise based on performance measures ❑ Implement outpatient services design ❑ Continue enhancement of community-support capacity	❑ Monitor and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary	❑ Assess and adjust as necessary ❑ Assess and adjust as necessary ❑ Assess and adjust as necessary

DCYF System of Care Performance Measures (Continued)	Year 1	Year 2	Year 3	Year 4	Year 5
Juvenile Corrections - ❑ Performance measures covering five broad areas in Security, Order & Safety; Programming; Health; Mental Health; and Justice are included in the National Performance-based standards for Juvenile Corrections of which the RITS is a partner (see Appendix K) ❑ % of adjudicated and detained RITS youth passing GED exams ❑ % of adjudicated RITS youth admitted during the fiscal year after release within the prior 12 months ❑ % of former adjudicated RITS youth who have temporary community assessment revoked	Monitoring of indicators and performance measures continues	Monitoring of indicators and performance measures continues	Assess and adjust as necessary	Assess and adjust as necessary	Assess and adjust as necessary
Provider Performance Measures - Developed in partnership with Yale University - necessary training for data collection ongoing	Data collection and analysis continues - adjustments as necessary	Data collection and analysis continues - adjustments as necessary	Assess and adjust as necessary	Assess and adjust as necessary	Assess and adjust as necessary
Workforce Cultural Competency Performance Measures Quality and Executive Capacity Initiatives	To be developed during first year	Workforce initiatives implementation prioritized and phase-in workplan established.	Workplan implementation continues	Assess and adjust as necessary	Assess and adjust as necessary

Rhode Island DCYF Child Welfare Performance Measures

CES	Early Start	Family Preservation	Outreach and Tracking	Youth Diversionary	Residential, Shelter, Foster Care
# of families reported for abuse or neglect during reporting period					
		For children with goal of home preservation, # of children at home			
		For Children with goal of reunification, # of children reunified			
			# of children who go into out of home placements and # that are planned placements		
			# of children with new charges or adjudication		
# of families with improved/stable parenting skills (North Carolina Assessment Instrument)	# of children assessed w/subtypical development in any area of Ages to Stages				# of children with improved adaptive functioning scores (GAF) (Ages 4 and over)
# of families where the risk of abuse/neglect has decreased/ remained low (North Carolina Assessment Instrument)	# of children who have achieved new developmental milestone (Ages to Stages)				
# of families with changes in each of the domains (North Carolina Assessment Instrument)	# of children with subtypical development in one or more domains who showed improvement in that domain from previous Ages to Stages assessment				

Rhode Island DCYF Child Welfare Performance Measures (continued)

CES	Early Start	Family Preservation	Outreach and Tracking	Youth Diversionary	Residential, Shelter, Foster Care
	# of families showing improvement (Selected Child Well Being Scale				
	# of families with reduction of stress (Parenting Stress Index-Short Form)				
			# of adolescents who received their GED during reporting period		
			# of adolescents who received their HS diploma during reporting period		
			# of children/youth with improved/satisfactory grades		
			# of children/youth with improved/satisfactory school attendance		
			# of children/youth whose classroom stability improved		
			# of children/youth with time out of school (detentions; suspensions; expulsions)		
			# of children/youth with in-school (detentions, suspensions)		

PERFORMANCE-BASED STANDARDS FOR JUVENILE CORRECTION AND DETENTION FACILITIES

I. SECURITY, ORDER AND SAFETY

A. Security

1) Completed and uncompleted escapes, walk-aways and AWOLs per 100 person-days of youth confinement
2) Incidents involving contraband (weapons, drugs and other forms) per 100 pers0n-days of youth confinement

B. Order

1) Major misconduct by youth per 100 person-days of youth confinement
2) Staff involvement in documented misconduct per 100 staff-days of employment
3) Physical restraint use per 100 person-days of youth confinement
4) Mechanical restraint use per 100 person-days of youth confinement
5) Use of isolation and room confinement per 100 person-days of youth confinement
6) Average duration of isolation and room confinement
7) Percent of idle waking hours (i.e., hours when there is no scheduled program or activity

C. Safety

1) Injuries to staff per 100 staff-days of employment and to youths per 100 person-days of youth confinement
2) Suicidal behavior by youth per 100 person-days of youth confinement
3) Percent of days during the assessment period when population exceeded design capacity by 10 percent or more
4) Youths injured during the application of physical, mechanical and chemical restrains per 100 person-days of youth confinement
5) Assaults on youth and staff per 100 person-days of youth confinement
6) Percent of staff and youth who report that they do not fear for their safety

II. PROGRAMMING

A. Improve education and vocational competence

B. Provide an educational program that is tailored to each youth's education level, abilities, problems and special needs and that improve education performance and vocational skills while confined.

1) Youths reading and math scores of admission, every 90 days and at discharge for youths confined more than 90 days

2) Percent of youth who report that they received education while in isolation

C. Provide vigorous programming that is culturally competent and gender specific, that minimizes periods of idle time, that addresses the behavioral problems of confined youth and that promotes healthy life choices.

1) Percent of youth whose records indicate they have received a health assessment

2) Percent of youth whose records indicate they have received a mental health assessment

3) Percent of youth whose records indicate they have received a substance abuse assessment

4) Percent of youth whose records indicate they have received reading and math tests

5) Percent of youth whose records indicate they have received a social skills assessment

6) Percent of youth whose records indicate they have received a vocational assessment

7) Percent of youth whose records indicate they have received a physical fitness assessment

8) Percent of youth confined for more than 60 days whose records include a written individual treatment plan

9) Percent of youth confined for more than 60 days whose records indicate that they received the education programming prescribed by their individual treatment plans

10) Percent of youth confined for more than 60 days whose records indicate that they received the social skills programming prescribed by their individual treatment plans

11) Percent of youth confined for more than 60 days whose records indicate that they received the vocational skills programming prescribed by their individual treatment plans

12) Percent of youth confined for more than 60 days whose individual treatment plans have monthly progress notes

13) Percent of youth continued for more than 1 year whose records include an annual summary of treatment progress

14) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed the health curriculum

15) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed a social skills curriculum.

16) Percent of released youth who were confined for more than 60 days whose records indicate that they have completed a vocational skills curriculum

17) Percent of youth interviewed who report receiving at least one hour of large muscle exercise each day on weekdays and two hours each day on weekends

18) Percent of interviewed youth who report receiving education materials while in isolation

D. Promote continuity in programming and services for youth after they are released

1) Percent of released youth who were confined for more than 60 days whose reintegration plans address the remaining elements of their individual treatment plans

E. Open facility to the community via telephone, visitation and volunteer involvement.

1) Percent of youth who report that policies governing telephone calls are implemented consistently

2) Percent of youth who report that they have placed and/or received telephone calls from a parent or guardian

3) Visitation per 100 person-days of youth confinement

4) Percent of youth getting visits

5) The number of community volunteers providing programming in the facility

6) The number of different programs that engage community volunteers

III. HEALTH AND MENTAL HEALTH

A. Identify youths at time of admission who have acute health problems or crisis mental health situations and following evaluation, ensure delivery of appropriate health or mental health services.

1) Percent of staff completing training in administering the health and mental health intake screening who passed a competency test at the end of the training

2) Percent of youth presented for admission who have a health and mental health intake screening completed in one hour or less

B. Provide health appraisals for all youth not released quickly, as well as behavioral, mental health and substance abuse evaluations where indicated.

1) Percent of youth presented for admission whose health assessments were completed within seven days, or sooner as required by law

2) Percent of youth presented for admission whose health assessments were completed within seven days, or sooner as required by law

3) Percent of youth needing a substance abuse assessment for whom it was completed within 14 days of admission or within 14 days of referral

C. Develop or continue individual treatment plans for each confined youth to respond to health, mental health, substance abuse or behavioral problems.

1) Percent of youth confined for more than 30 days whose records include a written individual treatment plan

2) Percent of youth confined for more than 60 days whose records indicate that they received the health treatment prescribed by their individual treatment plans

3) Percent of youth confined for more than 60 days whose records indicate that they received the mental health treatment prescribed by their individual treatment plans

4) Percent of youth confined for more than 60 days whose records indicate that they received substance abuse treatment prescribed by their individual treatment plans

D. Respond in an appropriate and timely manner to the new and chronic health and mental health problems of youth in confinement.

1) Percent of youth who report receiving at admission written and oral instructions for obtaining health, mental health and substance abuse care.

2) Average duration between when youths filed a sick call request and the time they were seen by health care personnel, qualified counselors or mental health care providers

3) Percentage of youth whose records indicated that they required urgent off-site medical services who received the services in less than an hour

E. Promote continuity of treatment for youth undergoing treatment at the time they leave the facility.

1) Percent of youth undergoing treatment for a chronic or acute illness, injury or medical condition at the time of their release who have arrangements for continuation of treatment in their reintegration plans

2) Percentage of youth undergoing treatment for a mental health problem at the time of their release who have arrangements for continuation of treatment in their reintegration plans

3) Percent of youth undergoing treatment for substance abuse problem at the time of their release who have arrangements for continuation of treatment in their reintegration plans

F. Provide a clean and healthy environment where confined youth are safe and ensured adequate nutrition and exercise.

1) Percent of youth whose records indicate that they have been abused or neglected by staff

2) Injuries to youth from (a) other youth and (b) staff per 100 person-days of youth confinement

3) Incidents of suicidal behavior per 100 person-days of youth confinement

IV. JUSTICE

A. Operate the facility in a manner consistent with applicable regulatory, statutory and case law requirements.

1) Grievances or complaints filed per 100 person-days of youth confinement, or per 100 staff-days of employment

2) The percent of interviewed staff and youth who filed a grievance or complaint who received a hearing

B. Ensure that youth, their custodians and other appropriate parties know their legal rights and how to protect them.

1) Youth understand facility rules and their legal rights

2) youth know how to pursue their legal rights

C. Administer the rules and policies for staff and youth fairly and consistently and offer effective means of redress of grievances or violations of rights.

1) Percent of interviewed youth who believe that grievances are fairly, consistently and effectively redressed.

D. Provide confidential and reasonably prompt communications between youth and their lawyers and to make youth available for legal or administrative proceedings.

1) Percent of youth who report that they have timely and reasonable access to their attorneys when requested

2) Attorney visits per 100 person-days of youth confinement

3) Percent of person-days of confinement during the assessment period attributable to missed hearings or administrative proceedings

John H. Chafee Foster Care Independence Program

Draft Performance Measures

- Performance Measure 1: Increase the percentage of youth who have resources to meet their living expenses.
- Performance Measure 2: Increase the percentage of youth who have a safe & stable place to live.
- Performance Measure 3: Increase the percentage of youth who attain educational (Academic or Vocational) Goals.
- Performance Measure 4: Increase the percentage of youth who have positive personal relationships with adults in the community.
- Performance Measure 5: Increase the percentage of youth who avoid involvement with high risk behaviors.
- Performance Measure 6: Increase the percentage of youth who are able to access needed physical and mental health services.
- Performance Measure 7: Increase the percentage of youth who have or know how to obtain essential documents.

APPENDIX L: REPORT OF THE FOSTER CARE RECRUITMENT AND RETENTION COMMITTEE OF THE RHODE ISLAND SYSTEM OF CARE TASK FORCE (MARCH 2002)

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- ***Training***
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4.) Summary of Recommendations

5.) Appendices: The following appendices are available in hardcopy upon request: Financial Effects of Recommendations; Foster Care Pre-service curriculum; Foster Care Services Organizational Chart; Foster Care Flowchart; Sample Retention Survey

INTRODUCTION

I want to begin by thanking Dr. Robert Carl, Director of the Department of Administration for the opportunity to serve on the Rhode Island System of Care Task Force and to chair the Foster Care Recruitment and Retention Committee. As the Executive Director of CHisPA, the Center for Hispanic and Policy Advocacy, whose mission is **to lead and influence change that improves the quality of life for Latinos in Rhode Island,** this initiative interested me as a challenge in light of the numbers of children of color who are in the DCYF system.

The goals of the Foster Care Recruitment and Retention Committee were: to identify the strategies, strengths, and challenges associated with DCYF's efforts toward increased recruitment of foster families to provide safe, nurturing homes for children in the care of the State. To Enhance tracking, monitoring and support systems to maximize retention of foster parents.

The work of this task force and subcommittee has great implications for the future of our children**.** I want to thank the members of the Foster Care Recruitment and Retention Committee for their commitment to this goal and the overall process, which ensured an analysis of the foster care system and policy recommendations. This report is testament to months of hard work and dedication resulting in data, overview of the foster care system and recommendations that are both practical and realistic.

It is you, the reader, who can ensure that these recommendations are implemented and that collectively we work to continue to improve our system. We welcome your feedback by e-mailing comments to Paula Fontaine at FontaiP@dcyf.state.ri.us by March 9, 2002.

Thank you for your support,

Luisa C. Murillo

Chairwoman,
Foster Care Recruitment and Retention Committee

GOAL STATEMENT:

To identify the strategies, strengths, and challenges associated with DCYF's efforts toward increased recruitment of foster families to provide safe, nurturing homes for children in the care of the State. To Enhance tracking, monitoring and support systems to maximize retention of foster parents.

OVERVIEW OF FOSTER CARE RECRUITMENT, TRAINING, LICENSING AND THE PLACEMENT PROCESS WITHIN DCYF

Recruitment:

Recruitment is done by one individual in the department at this time. This person is responsible for advertising, Public Relations, Information meetings, Community Recruitment, and is the Liaison with The RI Foster Parent Association. This individual responds to all inquiries, processes initial applications, including references, BCI and DCYF clearances. The Department's Recruiter position reports directly to the Chief of Contracts and Standards, Division of Community Resources.

Effective recruitment of Foster Parents is essential to the Safety, Permanency and Well Being of children in the care of The State. The Department needs to increase ability to recruit minority foster parents as well as foster parents who will care for older children.

Pre-Service Training:

In July of 2000, in response to recommendations made by the 1999 Governor's Commission to Study the Placement of Children in Foster and Adoptive Care, the Department consolidated staff who train foster and adoptive families. A second Clinical Training Specialist was added to the staff to train foster parents at that time. A Chief Casework Supervisor was hired in June, 1999 to coordinate these efforts. The restructuring and enhancement of the unit has allowed us to eliminate unnecessary waiting lists for foster parent training. Since January of 2001, training of Foster Parents has been done by two full time Clinical Training Specialists. There have been 8-10 classes held per year, each class being 9 weeks in length. Classes have been held in Providence, North Kingstown and Woonsocket. A Foster Parent co-leads the groups. Foster Parent training staff have been included in a unit composed of staff who recruit, train and provide ongoing support to Visiting Resource and Adoptive Resource Families. These positions report to the Chief of Adoption and Foster Care Preparation and Support in the Division of Child Welfare. As of January, 2001, all foster parents are trained in Concurrent Planning theory and practice. This was also in response to the 1999 Governor's Commission.

In January, 2002, Foster Parent and Adoptive Parent training was consolidated. This will allow for a substantial increase in the numbers of foster parents trained in one year, and will further cut down on waiting periods to begin the training process. Dual training will also enhance the training experience for all families, better preparing them for the issues they may face in the future-e.g., foster families will be better prepared to make the transition to

adoption and lifelong commitment, while adoptive families will be better prepared to deal with issues of visitation or work with birth families in open adoption situations.

Licensing:

Foster Care Licensing is administered by the Licensing Administrator in the Division of Community Resources. There is one Supervisor and 8 Licensing workers. There are two fire inspectors. This unit processes all completed applications received from the Foster Parent recruiter as well as Kinship and Child Specific applications received from Family Services staff. This unit completes the licensing process assuring that licensing requirements have been met, including fire inspection, physician's references, DCYF and criminal clearances, and the writing of a home study.

Placement:

The Placement Unit consists of 3 Workers and a Supervisor who are responsible for the daily requests for placements. These workers maintain a listing of available placements including foster homes, shelter and group homes. As requests for placements come in, placement unit workers attempt to match the children with the best available resource. Workers develop close working relationships with foster families and DCYF line staff. The Placement Unit Supervisor reports to The Chief of Contracts and Standards, Division of Community Resources.

Retention:

In 1998 The Department hired a full time Foster Parent Liaison. This individual responds to Foster Parent concerns and complaints as well as provides mediation services between DCYF staff and Foster Parents. The position has proven successful in improving communication between DCYF and the Foster Parent community as well as preserving placements for children. This position reports to the Chief of Development, Contracts and Standards, in the Division of Community Resources.

Link to Adoption:

Approximately 75-80% of DCYF adoptions occur with foster parents adopting children in their care. Pre-adopt parents are increasingly taking placement of children who are "Legal Risk", thus the need to license these homes as foster placements.

Department staff who are involved with any aspect of foster or adopt services participate in a monthly in house meeting devoted to improving communication and enhancing services to our families who care for our children. This has been a successful process and has improved communication between divisions.

Due to the numbers of Foster Parents who adopt, the need for post adopt education and support is critical. The Department houses an Adoption Services Unit whose job largely entails post adoption service/ resource referral. Although there has been an increase in these workers meeting with families to assess needs and provide direct service and support, there is not sufficient staff in the Adoption Services Unit to meet the possible needs of the 2500 (and

growing) families who currently receive subsidy.

FOSTER PARENT RECRUITMENT

Current

Recruitment activities focus on both the long term process of increasing general public awareness of the role of foster parents and the licensing process and the immediate need for increasing our available pool of qualified foster parents. Towards these goals, the following activities are undertaken: Print Advertising – aimed at reaching both general and targeted populations of prospective foster parents, throughout the state through 33 daily, weekly, monthly, and special interest publications; Radio Advertising; Television Advertising; Recruitment Events – Informational Booths and Presentations; Informational Meetings; Targeted Recruitment Efforts – directed at reaching specific populations, such as minority groups, pediatric nurses, and potential foster parents for specific groups of children, such as developmentally disabled children, medically fragile children, and adolescents with foster parent recruitment materials.

These combined activities resulted in the following outcomes for FY2001: **762** inquiries (applications mailed out); **141** completed applications returned; and **118** applications submitted to Licensing for Assignment/Review,(of whom **25%** were minority applicants: **18%** African American; **7%** Latino.) During the year ending 12/31/00, **178** generic foster homes were licensed; in the 2 ½ year period 1/99 - 6/01, **413** new generic foster homes were licensed.

The Department's recruitment effort is best viewed as a multi-year plan since it will take time for the initial gains to become evident. Both general and targeted recruitment activities are essential to meet our goal. General recruitment will reach a broad range of families interested in the spectrum of children we have available for placement. Targeted recruitment will allow us to direct our appeals to specific groups, including ethnic minorities: African Americans, Latinos, and Southeast Asians; foster parents for special needs children, including drug exposed infants; medically fragile / technologically dependent children; sibling groups; the developmentally disabled, and adolescents.

What conclusive research recruitment exists strongly suggests that the approval of a significant number of quality foster homes results from on-going and diverse activities that maintain a positive awareness of foster care over at least one year's time. It has been noted that individuals think about becoming foster parents for about one full year before they actually contact an agency. Constant exposure, over an extended period of time, to the idea of becoming a foster parent will stimulate thought and result in making an inquiry call.

Responsibilities

Presently, the Department employs one full-time foster parent recruiter. The recruiter is responsible for developing a foster parent recruitment plan including general and targeted recruitment goals; developing print and media advertising campaigns; conducting community education and public awareness activities; responding to foster parent inquiries; processing of submitted foster parent applications and background checks; referral of completed application

packets to Licensing Division for assignment / review; developing, implementing, and monitoring the service contract with the Rhode Island Foster Parents Association.

The goal of foster parent recruitment is to ensure that sufficient numbers of qualified foster families are available to meet the needs of the Department and the children it serves and to allow for careful matching and planned placements which meet the best interests of every child in need of foster care. As approximately 80% of all DCYF children who are adopted are adopted by their foster parents, it is critical that initial foster placements be conducted with consideration to a child's long term needs. For the purpose of this plan, we will concentrate our focus upon the need for generic foster homes.

Public Awareness Campaign

Community education is absolutely essential to recruitment. The public must be educated about foster care, the ever increasing need for capable foster parents, and the important role foster parents play in the child welfare service delivery system. People do not offer to do things they neither recognize or understand. Foster care issues must be brought before the public regularly and repeatedly, and the Department must strive to create and maintain a positive awareness of foster care. The efforts of the Rhode Island Foster Parents Association need to be enlisted in this venture. Additionally, professionally produced public relations materials are critical to a successful campaign. Print, radio, and television advertising play an important role in communicating the need for foster parents for both general and targeted populations

The Department needs to recruit families who are capable and willing to perform the functions that the agency and the job require. To do so, foster care needs to be described accurately in order that each recruited family knows, with reasonable specificity, what foster care is and is not, how the program functions, its strengths and it needs. The challenge is to present foster care in such a way that those families who can best meet the needs of the children in the Department's care are encouraged to come forward and participate in the program. At times a basic message needs to reach as many people as possible, and at other times a smaller group needs to be reached with more detailed and / or specific information. Mass media campaigns will be effective in increasing community awareness of foster care and the need for foster homes, while personal contact, including speaking engagements, informational meetings, and inquiry calls is more effective in helping people decide if foster care is right for them and for reaching target populations. The Rhode Island Foster Parent Association plays an important role in communicating the crucial role of foster parents and the special qualities they need to possess.

Community Involvement

Based on the concept that the responsibility for the welfare of a community's children and families ultimately rests with the community itself, the Department needs to establish on-going contact and partnerships with various public and private constituencies. Such constituencies could provide the Department with additional needed resources, expertise, and credibility in its efforts to recruit and retain quality foster homes, especially those in targeted and geographically specific areas. The Department presently does not have information available regarding the numbers of children who are placed outside of their city or region. Such information is necessary in order to direct recruitment campaigns at targeted communities.

Needs

Discussion in the subcommittee has focused on the following three alternative solutions for building the Department's targeted foster parent recruitment capacity.

- Expanding the Department's internal capacity by hiring one additional foster parent recruiter and one additional foster parent trainer; these staff would need to be bilingual / bicultural individuals with strong connections within the targeted minority communities.

- Utilizing a purchase of service model in which letters of interest would be solicited, resulting in a provider list of agencies interested in providing a package of services consisting of recruitment, home study, and pre-service training of prospective foster families. Agencies would receive a set fee for each family submitted to the Department who meet the criteria for licensing. In this manner, diverse target populations could be reached and the Department's licensing workers would not be further burdened.

- Entering into a contract with one agency for the recruitment, home study, and training services for a set number of families meeting certain characteristics.

General Recruitment

- Contract for the design of professional public relations / recruitment materials in the form of logo; press kits; posters; and newspaper ads; for general and targeted recruitment

- Contract for the production of a radio advertising campaign utilizing one general and one targeted commercial

- Contract for the production of a television advertising campaign utilizing a targeted and general commercial

- Contract for the development of a transit advertising campaign utilizing general and targeted ad copy

- Continue existing print advertising campaign, directed at both general and targeted populations

- Implement a foster parent bonus program as an incentive for foster parents referring prospective foster parents

- Continue / expand existing general and targeted recruitment activities – community events; informational meetings; targeted displays; work place recruitment

- Develop a foster parent recruitment campaign directed at state employees in partnership with state agencies and officials

Targeted Recruitment

Adolescents

- Survey existing foster parents to assess interest in this target population;

- Utilize existing foster parents of adolescents to identify / recruit additional resources
- Develop wraparound services to support adolescent placements;
- Enhance board rate for adolescents;
- Develop support services through RIFPA's Life Skills Program
- Provide specialized training, pre-service and in-service, for foster parents of adolescents
- Encourage relative and child specific foster parents of adolescents to continue service
- Develop targeted advertising described above
- Conduct targeted recruitment activities with staff at high schools, athletic programs; youth programs, churches

Minority Populations (African American, Latino, Southeast Asian)

- Meet with existing minority foster parents to enlist their support / recommendations for targeted recruitment efforts
- Promote the foster parent bonus program to encourage referrals
- Develop partnerships with community agencies / groups representing target populations to expand recruitment opportunities
- Collaborate with media serving target populations to run stories regarding foster parenting
- Develop partnerships with churches to promote foster parenting and assist in recruitment activities
- Develop partnerships with schools and parent groups to assist in recruitment activities and foster parent promotion
- Offer Spanish language foster parent pre-service training classes
- Expand work place recruitment activities to include businesses with large minority populations

Medically Fragile/Developmentally Disabled Children

- Direct targeted recruitment materials to support groups for parents of disabled children, service providers, and professional organizations
- Enlist the assistance of existing specialized foster parents in targeted recruitment efforts

Targeted Geographical Areas

- Forge partnerships with cities / towns with large number of children placed outside of their communities to identify additional foster home resources to keep children within the community or to bring them home.
- Conduct church focused recruitment activities with the goal of licensing one or two families per congregation as part of above
- Conduct school focused recruitment activities with the goal of licensing one or two families per school as part of above
- Conduct work place recruitment activities at businesses with local employees

Additional Recruitment Supports

- Emergency funds for relative foster parents to meet fire / space requirements
- Five year limit on drug conviction charges
- Executive director for RIFPA to focus upon for recruitment / retention activities
- RIFPA's Mentor Program to provide support services to foster parent applicants to increase retention through licensing
- Foster parent support groups through RIFPA

Foster parent retention is the first step in recruitment. It is essential to recognize that recruitment and retention are interrelated and that efforts to recruit qualified foster parents can only be as successful as the agency's ability to retain them. The 413 new generic foster homes licensed from 1/99 - 6/01, a 2 ½ year period, suggests that recruitment alone is not the issue and that the Department needs to significantly increase its efforts in the area of retention if it is to maintain and build upon its current supply of foster homes. It is incumbent upon the agency to work actively to retain foster parents by clearly communicating foster parents' rights and responsibilities, providing foster parents with opportunities to develop the knowledge and skills associated with success, and providing agency services to support foster parents in their roles.

FOSTER PARENT PRE-SERVICE TRAINING

Current:

Foster and adoptive parents play a crucial role in the lives of children and are essential links in the continuum of care that DCYF provides for the children in its care. Family Centered Practice and Concurrent Planning bring new focus and new challenges to our work, asking us to rethink our relationships with the families and children in our care, and also with the resource families - foster, kinship and adoptive - who are caring for the children. The roles of foster and adoptive parents, traditionally viewed as separate and distinct, can now be seen as

overlapping to a great extent. Approximately 70% of the adoptions in our state are foster parent adoptions, and many families who come in exclusively to adopt consider "legal risk" placements and also open adoptions.

Foster families and adoptive families are involved in the care and nurturing of children who have experienced significant loss and trauma, and may also be involved in working with biological parents. These families are some of our most valuable resources, and we, as an agency, have an obligation to nurture and support them. Training is a valuable method of providing this nurturing and support, and of supplying the resource families with the knowledge and "tools" that they will need in working with our children.

Pre-service training for foster and adoptive families, in response to recommendations of the Governor's Commission Report of June, 1999, has expanded and changed over the past two years. Up until 2001, the responsibility for all foster parent training fell on one Clinical Training Specialist. In 2000, the responsibility for foster parent training was moved from Staff Development (now the Child Welfare Institute) to the Adoption Preparation and Support Unit (now the Adoption and Foster Care Preparation and Support Unit). At that time, a second Clinical Training Specialist position was added for the purpose of foster parent training.

Responsibilities:

In the present calendar year, (2001), nine separate sessions of the pre-service core training have been held. The addition of a second foster parent trainer has also made it possible to offer training in two different locations within the state, Providence and North Kingstown. A total of 86 families (138 individuals) have been trained this year. Classes are nine weeks in length and include a range of subjects and a variety of training methods/tools.

The majority of the families that come through training are "new" (generic) foster parents. Some already have children in their homes or are visiting with particular children. These families are identified either as kinship caregivers (relatives) or as child specific placements

Needs:

Planning has been under way to offer dual training for foster and adoptive families. This effort was initiated in January, 2002. Dual training will, we believe, enhance the training experience for all of the families, and better prepare them for the issues they may need to face in the future - e.g., foster families will be better prepared to make the transition to adoption and lifelong commitment, while adoptive families will be better prepared to deal with issues of visitation (in the case of a "legal risk" placement) or work with birth families in open adoption situations.

Dual training will also greatly enhance our ability to provide training. At the present time we have four Clinical Training Specialists (CTS) who do adoption training and two CTS who train foster parents. If all six of the CTS are training joint groups of foster and adoptive families, we will be able to substantially increase the number of foster families trained each year. We will be able to offer training on a more frequent basis, cutting down on the amount of time that families must wait before getting into training.

Optimally, we hope to increase the number of Clinical Training Specialists by the addition of a dedicated trainer for training and retention of foster parents. This position would be dedicated to training minority families and would also be able to undertake bilingual training. This position would also be dedicated to ongoing in-service training such as "Fostering Discipline" and other specialized topics that deal with the issues our children present and meet the needs of our resource providers. Such efforts will hopefully improve the level of care and enhance the ability of the resource families to cope with problems and continue their commitment to the children.

Five years from now, dual training of foster and adoptive parents will be the norm, and by that time we may also be moving in the direction of dual licensure. The number of CTS in this unit would have been increased so that we could meet the needs of both pre-service and ongoing training for resource families. We would also have the staff to be able to better serve the specialized training needs of kinship caregivers, and the minority communities. We would be able to offer on-site baby sitting for resource families who are attending training as well as incentive bonuses for foster parents who attend special in-service training.

There are several other areas where improvement must happen if we are to better ensure "right placements and stability of placements". Worker training must be improved. Workers must be able to work in partnership with resource families, and they must learn the value of this - and how to do it! Post- adoption services must be increased so that placements do not fail while families sit on waiting lists at counseling agencies. Respite services and mentoring services must be expanded and made more available. Recruitment activities must be increased and improved so that placements may be made by actually choosing a home on the basis of suitability, rather than the fact that it is the only slot available.

FOSTER CARE LICENSING

Current:

Foster Care Licensing is a program within the Licensing Division that is executed by the Licensing Administrator. This Division falls within the administration of Community Resources. The Foster Care Program has one Senior Casework Supervisor and eight licensing Social Caseworkers. Two Data Control Clerks provide support for this program. Foster Care relies on it's own fire inspectors to evaluate safety and fire compliance of all foster homes. There are two Fire Inspectors.

Responsibilities:

Foster Care Licensing processes all generic, relative and child-specific applicants. The two points of entry for a referral include the Foster Parent Recruiter (generic) and the Family Service Units (kinship).

A completed application accompanies the applicant's BCI and Child Protective Services background checks. The Federal recommendation regarding criminal background checks is to automatically disqualify an applicant if a felony drug offense occurs within five years of the application. RI, however, had opted to disqualify any applicant with such a drug offense regardless of when this offense occurred. The Department is currently involved in

discussions about amending its regulations to reflect the federal recommendation of the 5 year time frame on felony drug offenses. A number of applicants have had troubled pasts and have been able to successfully complete rehabilitation and turn their lives around.

An approved physician's reference is required on all applicants. A preliminary assessment of the home with the approval signature of a DCYF administrator is required on all kinship care applicants.

Once the referral is accepted, it is assigned to a licensing Social Caseworker for purposes of a home study, and to a fire inspector for a home safety evaluation. Additionally, applicants are instructed to contact a Foster Parent Trainer to register for the pre-service orientation course. All applicants are fingerprinted by local Police Departments. The NCIC results are returned to the Licensing Unit.

Upon successful completion of the licensing criteria, the applicant becomes licensed in the Foster Care Program. Their names and addresses are given to the Placement Unit and the Rhode Island Foster Parent Association. The Placement Unit reviews the records and begins to place foster children into these homes.

License renewals occur annually. The renewal process includes an updated BCI and Child Protective Services check with an updated home study evaluation. Approximately six hundred (600) new foster homes (and re-openings) are processed a year. There are one thousand, one hundred (1,100) licensed providers in the State of Rhode Island at the time of this report. This number includes relative, generic and private agency foster homes.

Needs:

The Senior Casework Supervisor screens and processes all of the incoming referrals and enters these applicants into the computer with the support of the data control clerks. He assigns the prospective provider to a social caseworker whose role is to facilitate the provider's process in complying with all licensing criteria. This Supervisor reviews and approves completed records of all new applicants, as well as examines each yearly renewal record. Together with the Licensing Administrator, he critiques questionable referrals and reviews all indicated child protection investigations against foster parents.

All closings are inspected and approved by the senior casework supervisor. All indicated and unfounded child protection investigations against foster parents are reviewed as well. The senior casework supervisor processes all requests for information regarding foster parents. Additionally, all foster care licensing Social Caseworkers are supervised by him.

Due to the high volume of licenses that are processed on a daily basis and the number of Social Caseworkers that must be supervised, the need for additional support for this supervisor remains a necessity. The optimum solution is to position a social casework supervisor, whose function it is to oversee all of the licensing Social Caseworkers, under the Senior Supervisor's management. Another possible solution is to position a Clinical Social Worker under the oversight of the Senior Supervisor. The Clinical's role would be to screen and process new referrals, review all child protection investigations against foster parents, and to process all requests for information and case closings.

There will need to be further discussion regarding the implementation of the 5 year limitation on drug felonies.

PLACEMENT UNIT

Current :

The Placement Unit currently consists of 1 Case Aid; 2 Social Caseworker IIs; and 1 Principal Resource Specialist; and one temporary secretary. The Principal Resource Specialist is serving in the capacity of unit supervisor, leaving 3 workers in the Unit. There is no bilingual capacity within the unit.

Responsibilities:

The Placement Unit is responsible for the daily coordination of requests for placements of children ages birth through eighteen in DCYF custody. Requests for placements include emergency, respite, planned, short, and long term placements. The Placement Unit staff maintain a daily listing of available "beds" including generic foster homes, shelters, and group homes. As requests for placements come in, the Unit staff attempt to match the children in need of placement with the most appropriate placement available. Efforts are made to place children within their region of residence whenever possible. Emergency shelter placements are routinely reviewed in order to move children along to more appropriate longer term placements. Placement Unit staff develop close working relationships with foster parents and agency staff.

On average, the Placement Unit places 110 **(unduplicated)** children every month; 72 of whom are entering placement for the first time (initial placements) and 38 of whom are subsequent placements. An average of 22 children are placed on any given day, but this number contains duplications over the course of a month, as children change placements or adolescents runaway and return. The available placement openings do not always match up with the demographics of the children needing placement. Certain groups of children are harder than others to find placements for: toddler and preschool boys; developmentally disabled and medically fragile children; and adolescents. Placements able to accommodate teen mothers and babies together and sibling groups are often difficult to find. Efforts are made to place children in culturally and linguistically similar homes whenever possible, but additional African American, Latino, and Southeast Asian foster placements are needed to facilitate this practice.

Needs:

Additional foster home resources, particularly for those "hard to place" groups, are necessary in order to meet the needs of children entering placement. Training for line staff is needed on gathering and communicating the types of child specific information that is critical for matching purposes. Training for line staff is also needed on how to deal with and treat foster parents. Numerous foster placements are disrupted and resources lost due to poor communication.

FOSTER CARE RETENTION

Over approximately a five year period, an alarming decline in the total number of licensed foster homes has been evident. A variety of factors including the increased adoption by foster parents, changes in licensing regulations and other specific reasons for closing have dramatically curtailed retention. Recent data indicate on an annual basis DCYF experienced a net gain of 25% in overall new recruitment vs. closure of existing homes.

A significant number of homes close due to licensing/regulatory action, Child Protective Investigations and various conflict with DCYF concerning case management issues. Many foster parents report problems during their involvement with DCYF and its' staff for a variety of reasons. The impact has had a resounding effect on recruitment efforts due to negative public relations.

The agency is perceived as bureaucratic, unwieldy, insensitive and lacking in a child centered staff who can respond to foster families need for service in a timely fashion. Personal styles of both administration and line staff have been described over a range from "caring to cruel".

Efforts over a three year period have made some positive impact on improving relationships between foster parents and DCYF. These improvements have reduced placement disruption and increased stability and consistency for children in foster care. Significant improvement is also noted between the Rhode Island Foster Parent Association and DCYF in establishing a partnership toward improving the foster care system and supporting and maintaining high quality foster homes.

Solutions:

- Provide increased formal training of new casework staff.
- Require a mandatory Casework Supervisor training for present supervisors around foster parent issues and concerns in an effort to improve relationships.
- Initiate ongoing in service training for all foster parents and re-establish fostering discipline module for homes who require this course.
- Increase utilization of Licensing Unit staff to improve relationships between DCYF staff and foster parents.
- Initiate a redevelopment of resources plan to encourage homes to continue in the program.
- Improve utilization and awareness of the RI FPA mentor program through introduction of new foster parents in pre-service training and new staff in the orientation process. Establish regular meetings with mentors.
- Increase awareness of the Foster Parent Liaison protocol through the Foster Parent Pre-service classes and staff orientation.
- Improve timely conflict resolution through Administrative Hearing process.

- Continue and enhance Communications Committee monthly meetings with foster parents to improve relationships.
- Establish regional chapters of the RIFPA to organize and improve retention and communication.
- Increase awareness of Family Centered Practice initiative.
- Initiate Foster Parent Retention Survey in conjunction with RIFPA to gather data and make necessary modifications to improve retention.
- Re-establish an Executive Director position for RIFPA to ensure coordination of programs and improve retention efforts.

RHODE ISLAND FOSTER PARENTS ASSOCIATION

The Rhode Island Foster Parent Association is located in Warwick, Rhode Island. It was formally incorporated in 1995 with funding received from the Department of Children, Youth and Families. A volunteer board of directors governs the Association.

The mission of the Association is to provide education and other forms of support to families that provide substitute care, and to the community-at-large, in order to further the cause of children who cannot live with their parents. The Rhode Island Foster Parents Association represents approximately 1100 foster families and 2000 foster children in the care of the Department of Children, Youth and Families. All of the programs and activities at the Rhode Island Foster Parents Association have been staffed by one full-time Mentor Program Coordinator and one full-time Life Skills Program Coordinator; one part-time Office Manager, and one part-time Teacher Assistant for Life Skills.

The Rhode Island Foster Parents Association's primary function is to provide support services to foster families through the Mentor Program; provide training and develop independence for teens who are being fazed out of the foster care system through the Life Skills Program; and finally offering limited financial assistance to teens 14 to 21 through our Teen Grant Program who are in foster care whether in foster homes or residential programs. Other programs the RIFPA is responsible for are the monthly Newsletter, Holiday Gift Distribution Program, Web Site, The Annual Town Meeting, and The Foster Parent Appreciation Dinner. The Cribs, Beds, Clothes Oh My Program is exclusively organized and facilitated by the Association through donations.

Mentor Program

The Mentor Program provides twenty-four (24) hour support through the Help Line for all licensed foster parents. In addition, during their first six (6) months of fostering, a newly approved foster parent is matched with a veteran foster parent who is available to provide personal, one on one assistance and share their experiences. It is the strong belief of the Mentor Program that they will be successful in retaining foster parents by offering crucial support during the initial six months when new foster parents are asking questions like "is this child's behavior normal?", "am I capable of providing for the needs of this child?", or "how is

this child going to affect the other children in my home?" The Mentor Program is a service dedicated to new foster parents who may need encouragement and direction in order to fulfill the needs of the foster children in their care. The Mentor Program serves as an avenue for retention. Sharing positive experiences of new foster parents and their Mentor, it also serves as a recruitment resource by foster parents making referrals. The Mentor Program's primary function is providing support services. On average, the Help Line receives 170 calls per month. Seventy newly licensed foster parents are serviced monthly as well as countless other foster families who still call on their former mentors for advice and direction. The Mentor Program and the Help Line are advertised in the monthly RIFPA Newsletter.

Teen Grant Program

The Teen Grant Program was designed to provide funds for activities that would enhance the preparation for independence for youth in DCYF care. It is available for activities that contribute to personal growth, skills building, educational pursuits, sports, and other areas that enhance self-esteem. This program is now available to teens ages 14 through 21, which constitutes a lowering of the age qualification from the previous age of 16. This will encompass a larger number of teens able to access moneys for positive promotions.

Newsletter Program

The RIFPA Newsletter is a monthly publication that provides information regarding the Association and DCYF activities. The Newsletter is distributed to all licensed foster homes as well as DCYF and other agencies upon request. This publication has a mailing list of approximately 1300 foster homes and businesses. The Newsletter is the main source of information received by foster families regarding any news or upcoming events or training. This is a major source of recruitment as well as retention.

Web Site

The web site is a new resource of information that the RIFPA has embarked upon within the last two years. It also provides foster families as well as other interested individuals information regarding the Association and the programs they service. It allows for potential recruitment of foster parents and is a support and informational guide to present foster families and outside organizations.

Life Skills Program

The Life Skills Program provides detailed instructions to DCYF involved teens that reside in out-of-home placements, ages 16 to 21 regarding survival and independence. One full-time coordinator and one part-time teacher assistant as well as two teacher aides staff this program. Life Skills provides transportation to all regions of Rhode Island to teens that are participating in the program. Nightly, nutritious meals are prepared with the teens as well as reinforcing positive cleaning skills. Sixteen weeks of independent living skills ranging from food management, housing, money management, emergency and safety skills, job seeking, and maintaining skills. In addition, there is a $200.00 incentive check upon completion of the program, which is distributed at a graduation ceremony. The graduation features the teens with their invited guests, DCYF staff, and a guest speaker. There are multiple field trips that

offer information pertinent to the students regarding their future. There are also reunions for graduates inviting them to participate in fun activities, share stories over pizza and soda, or get involved in civic organization promoting the need for quality foster homes. These are just a few of the opportunities offered to our graduates of Life Skills.

One-Day Town Meeting

The RIFPA in conjunction with the DCYF implement all facets related to the production of a One-Day Town Meeting between the RIFPA and DCYF including representation from the Child Welfare League of America. This meeting consists of foster parents, DCYF personnel, and an outside facilitator to review, assess, and recognize achievements as well as identify new goals for improving relations between the RIFPA and DCYF. It was designed to identify the weak areas that need to be acknowledged with a definitive plan on how to achieve an amicable solution.

The Appreciation Dinner

The RIFPA is responsible for implementing all necessary activities for the presentation of a foster parent recognition dinner. This would consist of where and when the dinner would take place, invitations to foster families as well as DCYF staff, and state dignitaries. Also, the RIFPA is responsible for securing a guest speaker, recognition awards, entertainment, programs, door prizes, flowers, and other necessary material related to this activity. Any written material must acknowledge the DCYF as the sponsoring agency. Everything related to this activity must have prior approval of the DCYF.

Plans For Expansion for the Rhode Island Foster Parents Association

1. A foster parent survey will be implemented researching information to assist in ways of retaining present foster homes and looking for suggestions from foster parents regarding recruitment of new foster families.

2. Bonus Program is being initiated by the RIFPA to provide an incentive for foster parents to recruit new foster parents by being reimbursed for their referrals. Another form of a bonus program is to have foster parent recruitment parties. These parties will be hosted by a foster parent who will be paid a stipend for hosting the party and be allocated funding for refreshments.

3. The RIFPA would like to sponsor the final foster parent training class at the RIFPA facility to expose prospective foster parents to the various programs and services provided by the RIFPA. It would also serve as an introduction to the Association, which would encourage higher participation in Association related activities. This would allow foster parents the knowledge of the Mentor Program and Life Skills Program, which would serve as a retention mechanism for continued support with their foster children. Knowing that there is that support would encourage foster parents to recruit new foster parents because of the positive experience as well as the support and services provided.

4. Life Skills Open House would be the initial introduction for foster parents, teens, Life Skills staff, and Board Members of the Association to the RIFPA facility. Meeting the staff at the Association and becoming aware of the programs and services available to foster families, foster parents may increase the retention of teens in their homes. Recognizing that many teens find their own foster homes that become licensed, they are a prime resource for recruitment of foster homes. As they are fazed out of the home due to age or higher education, the home may be utilized for another teen rather than closed.

5. Presently the RIFPA is implementing an Enrichment Program, which will provide funding for youth under the age of 14 to pursue an activity that they feel would enhance their confidence and creativity. With this funding available, it would assist the foster parents in contributing less of their own funding in order that the foster child be able to pursue a dream. With less out-of pocket expense, we should be able to recruit and retain more foster families.

6. A Mentor Social would be implemented to allow mentors and mentorees the opportunity to meet quarterly in addition to phoning on a regular basis. This social gathering would form a stronger bond and trust between mentor and mentoree. It would also serve as a future opportunity for a new foster parent to feel confident enough through her own experience to recommend fostering to others.

7. On-site training would provide a central locale within the state to offer training that would be helpful in raising foster children. It would also be collaboration with DCYF and strengthen the relationship between the two organizations that are *both* working for the foster children in hopes of recruiting and retaining good foster parents.

8. Develop a Resource Center of information through books, videos, and any other forms of material that may be helpful to a foster child or foster parent. The resource center would assist foster parents in gaining knowledge about a particular issue that is plaguing the home. Accessing the information may help in retaining the home. The resource center would be located at the RIFPA office.

9. Develop recruitment opportunities for foster parents of adolescents in conjunction with the Life Skills Program. Initiate a support group for teens in foster care ages 13 and up that may be matched with an appropriate Life Skills Graduate to be utilized as Youth Mentors. Work with the Life Skills Coordinator to develop support groups, services, and trainings for foster parents of adolescents and encourage foster parent participation in a parent advisory board or committee.

10. Increase staff to include a full-time Executive Director. With the leadership of the Executive Director in place all of the above goals attainable. With additional funding as well as grant writing, additional ideals can become a reality.

11. The Mentor Coordinator will hire two new mentors who will be minorities.

12. Regional Chapters will be organized and meetings to be held on a regular basis. These meetings will be advertised in the monthly Newsletter with dates, times, and

places. Representatives will report back to the Board with ideas, concerns, and possible solutions. These Regional Chapters could serve as recruitment for prospective foster parents and be helpful in maintaining present foster parents through support.

Resources Needed

In order to achieve the goals for the Association, additional funding in the way of an Executive Director is required. The Executive Director would possess the ability to control, guide, and direct the Association in a professional manner that would enable the organization to be stable, provide a solid foundation for the growth it needs, and prosper with the leadership skills necessary to accomplish its goals with positive results. In order to attain success in recruitment and retention from the Association, the Executive Director will work collaboratively with the DCYF recruiter in regards to a media campaign elaborating on the services and programs of the Association. He/she will work with the Life Skills Coordinator to enhance the recruitment and retention of foster families of teens through their own initiative. Working with the Mentor Coordinator, the Executive Director will advocate for additional support services for new foster families as well as veteran foster families who are experiencing difficulties and are at risk. These additional services may include resources such as literature, videos, or trainings which the Association would like to host with guest speakers.

In conclusion, it is essential that funding for the Executive Director's position be approved. For positive results in recruitment and retention, the Association requires the leadership and direction of an Executive Director. Recruitment and retention of foster parents will either be the problem or the solution if an Executive Director is not in the equation. If any of the pieces of the puzzle are missing, the picture will never be complete.

SUMMARY OF RECOMMENDATIONS

Each of the units/divisions within DCYF who have involvement with Foster Care have delineated the committee's recommendations below. There are also recommendations from the Foster Parent Association and community providers. There has been no consensus reached as to the integration of staff who recruit, train, license and support foster families. It is the recommendation of the committee that DCYF continue to look at the physical placement and administrative reporting of the various units so that continuity of services will be provided both to children and Foster Parents.

The financial effects of the committee's recommendations are delineated in the appendix. Further consideration of the appropriate expense and sustainability will be ongoing in the implementation of the report's recommendations.

Recruitment

Discussion in the subcommittee has focused on the following possibilities for building the Department's foster parent recruitment capacity.

- **Utilize a purchase of service model in which letters of interest would be solicited, resulting in a provider list of agencies interested in providing a package of services consisting of recruitment, home study, and pre-service training of prospective foster families.**

- **Expand the Department's internal capacity for targeted recruitment by hiring one additional foster parent recruiter; this staff member would optimally be a bilingual / bicultural individual with strong connections within the targeted minority communities. This position would also be responsible for other areas of targeted recruitment including adolescents.**

- **Expand work place recruitment activities to include businesses with large minority populations.**

- **Expand current media advertising, initiate new media campaign.**

- **Emergency funds for relative foster parents to meet fire / space requirements**

Training

Dual training for foster and adoptive families has been implemented as of January, 2002. Dual training will greatly enhance our ability to provide training. At the present time we have four Clinical Training Specialists (CTS) who do adoption recruitment and training and two CTS who train foster parents. The supervisory position is currently vacant. If all six of the CTS are training joint groups of foster and adoptive families, we will be able to substantially increase the number of foster families trained each year. We will be able to offer training on a more frequent basis, cutting down on the amount of time that families must wait before getting into training.

Optimally, we hope to increase the number of Clinical Training Specialists by the addition of a dedicated trainer for training and retention of foster parents. This position would be dedicated to training minority families and would also be able to undertake bilingual training. This position would also be dedicated to ongoing in-service training such as "Fostering Discipline" and other specialized topics that deal with the issues our children present and meet the needs of our resource providers. Such efforts will hopefully improve the level of care and enhance the ability of the resource families to cope with problems and continue their commitment to the children.

- **The existing vacancy of Chief Casework Supervisor for Adoption and Foster Care Preparation and Support must be filled. This position is vital to the program's continued growth.**

- **An additional Foster Parent Trainer is recommended. This staff member would optimally be a bilingual / bicultural individual with strong connections within the targeted minority communities.**

- **On-site day care for resource families who are attending training.**

- **Incentive bonuses for foster parents who attend special in-service training.**

- **Worker training must be improved.**

- **Workers must be able to work in partnership with resource families.**

Licensing

The Senior Casework Supervisor screens and processes all of the incoming referrals and enters these applicants into the computer with the support of the data control clerks. He assigns the prospective provider to a social caseworker whose role is to facilitate the provider's process in complying with all licensing criteria. This Supervisor reviews and approves completed records of all new applicants, as well as examines each yearly renewal record. Together with the Licensing Administrator, he critiques questionable referrals and reviews all indicated child protection investigations against foster parents.

All closings are inspected and approved by the senior casework supervisor. All indicated and unfounded child protection investigations against foster parents are reviewed as well. The senior casework supervisor processes all requests for information regarding foster parents. Additionally, all foster care licensing Social Caseworkers are supervised by him.

- **Due to the high volume of licenses that are processed on a daily basis and the number of Social Caseworkers that must be supervised, the need for additional support for this supervisor remains a necessity. The optimum solution is to position a social casework supervisor, whose function it is to oversee all of the licensing Social Caseworkers, under the Senior Supervisor's management.**

- **The Federal recommendation is to automatically disqualify an applicant if a felony drug offense occurs within five years of the application. RI, however, had opted to disqualify any applicant with such a drug offense regardless of when this offense occurred. The Department is currently involved in discussions about amending its regulations to reflect the federal recommendation of the 5 year time frame on felony drug offenses.**

Placement

- **Additional foster home resources, particularly for those "hard to place" groups, are necessary in order to meet the needs of children entering placement.**

- **Placements need to be made by actually choosing a home on the basis of suitability, rather than the fact that it is the only slot available. Training for line staff is needed on gathering and communicating the types of child specific information that is critical for matching purposes. Training for line staff is also needed on how to deal with and treat foster parents. Numerous foster placements are disrupted and resources lost due to poor communication.**

Retention:

Foster parent retention is the first step in recruitment. It is essential to recognize that recruitment and retention are interrelated and that efforts to recruit qualified foster parents can only be as successful as the agency's ability to retain them. The 413 new generic foster homes licensed from 1/99 - 6/01, a 2 ½ year period, suggests that recruitment alone is not the issue and that the Department needs to significantly increase its efforts in the area of retention if it is to maintain and build upon its current supply of foster homes. It is incumbent upon the agency to work actively to retain foster parents by clearly communicating foster parents' rights and responsibilities, providing foster parents with opportunities to develop the knowledge and skills associated with success, and providing agency services to support foster parents in their roles.

Some proposed solutions:

- **Provide increased formal training of new casework staff.**

- **Require a mandatory Casework Supervisor training for present supervisors around foster parent issues and concerns in an effort to improve relationships.**

- **Initiate ongoing in service training for all foster parents and re-establish fostering discipline module for homes who require this course.**

- **Improve utilization and awareness of the RI FPA mentor program through introduction of new foster parents in pre-service training and new staff in the orientation process. Establish regular meetings with mentors.**

- **Increase awareness of the Foster Parent Liaison protocol through the Foster Parent Pre-service classes and staff orientation.**
- **Improve timely conflict resolution through Administration Hearing process.**
- **Continue and enhance Communications Committee monthly meetings with foster parents to improve relationships.**
- **Establish regional chapters of the RIFPA to organize and improve retention and communication.**
- **Increase awareness of Family Centered Practice initiative.**
- **Initiate Foster Parent Retention Survey in conjunction with RIFPA to gather data and make necessary modifications to improve retention.**
- **Respite services must be expanded and made more available.**
- **A rapid response system. This system would be set up to respond to the needs of biological, adoptive, and foster families who are experiencing a non abuse/neglect related crisis during hours when an assigned worker is not generally available.**

RIFPA

In order to achieve the goals for the Association, additional funding in the way of an Executive Director is required. The Executive Director would possess the ability to control, guide, and direct the Association in a professional manner that would enable the organization to be stable, provide a solid foundation for the growth it needs, and prosper with the leadership skills necessary to accomplish its goals with positive results. In order to attain success in recruitment and retention from the Association, the Executive Director will work collaboratively with the DCYF recruiter in regards to a media campaign elaborating on the services and programs of the Association. He/she will work with the Life Skills Coordinator to enhance the recruitment and retention of foster families of teens through their own initiative.

- **Working with the Mentor Coordinator, the Executive Director will advocate for additional support services for new foster families as well as veteran foster families who are experiencing difficulties and are at risk. These additional services may include resources such as literature, videos, or training which the Association would like to host with guest speakers.**

Community Providers

Community agency personnel participated in the subcommittee and contributed to the discussions and recommendations as well. It was noted in several discussions that community agencies were better able to provide the wrap around services to families that were necessary in many situations. Families, whether they are biological, foster or adoptive, need to know who and where to turn when they are in need of information or services. An ideal system of care will not only be able to

direct a family, but have sufficient available services to assist families in providing for their child's needs

APPENDIX M: REPORT OF THE CURRENT REALITY COMMITTEE OF THE RHODE ISLAND SYSTEM OF CARE TASK FORCE (SEPTEMBER 2001)

RHODE ISLAND SYSTEM OF CARE TASK FORCE

REPORT OF THE CURRENT REALITY SUBCOMMITTEE

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Introduction

The Current Reality Subcommittee of DCYF System of Care Task Force was charged with the duty of examining the quality of care available to DCYF-involved children. The subcommittee met at the Office of the Child Advocate on 10 occasions between April and August of 2001. At the outset, the subcommittee identified topics and issues on which to focus its attention. Once an agenda was created, representatives from major state departments were invited to subcommittee meetings to provide information and insight regarding their respective areas of expertise and/or topics of interest. Throughout these meetings, the subcommittee analyzed data, statistics and other relevant information for each agenda topic. The subcommittee adopted specific recommendations at the conclusion of each meeting. Recommendations are summarized in this report for submission to the System of Care Task Force.

It is important to note that the subcommittee acknowledged the need for all professionals working within the system to invariably give due consideration to a number of key factors when developing an overall plan for the ideal system of care. These factors are incorporated by reference within all recommendations made in this report. They are:

- ➢ focus on a family-centered system
- ➢ enhancement of early intervention and prevention efforts
- ➢ cultural sensitivity and diversity awareness
- ➢ the importance of school and community ownership of children
- ➢ system-wide integration, communication and coordination

Respectfully submitted:

Laureen D'Ambra, Esquire
Child Advocate
Current Reality Subcommittee Chairwoman
September 15, 2001

Contracted Programs

Tom Bohan and Carol Spizzirri, representing DCYF, provided expert assistance and information to the subcommittee. The RIPEC report was also consulted, with some data taken directly from the report.

I. Current Reality

A. At the end of calendar year 1999, DCYF reported a caseload of 8,064 children. 42.1% of these children living with parents or relatives, not including kinship foster care; 23.6% living in subsidized adoption; 8.2% living in non-relative foster care; 7.4% living in residential facilities and group homes, of which 134 were living in out-of-state facilities; 6.6% living in kinship care; 2.3% lived at the Training School; 1.6% lived independently or in supervised apartments; 1.4% were "runaways"; 1.4% lived in emergency shelters;1.3% lived in private agency foster care homes; and 0.7% lived in psychiatric hospitals. The remaining 3.4% lived with friends or guardians, lived independently without funding or supervision, lived in non-psychiatric hospitals, pre-adoptive homes, unsubsidized adoptions, prison or substance abuse facilities.

B. In 2000, DCYF reported that 35.1% of children spent one year or less in out-of-home care, 20.5% spent one to 2 years in out-of-home care, and 27.1% spent more than 3 years in out-of-home care. About one in eight children (12.1%) of children in DCYF's caseload at the end of December 1999 had been in care for six years or longer. Males comprised approximately 58.5% of the caseload; 41.5% were female. At this same time period, the race and ethnicity of the caseload was as follows: 57.3% white; 19.7% black, 13.6% Hispanic; 1.9% Asian/pacific Islander; 1.4% Native American; 6.1% other or unknown. Over 50% of the population of children were 12 years of age or older; 30% were children between the ages of 6 and 11; and 20.1% were children under age 6. Almost one-half of the children in care lived in Central Falls, Pawtucket, Providence and Woonsocket.

C. In FY 2001, Federal funds supported 38.6% of DCYF's expenditures; State general revenues accounted for 60.6%. Treatment and support services -- juvenile corrections, psychiatric hospitalization, residential treatment, board and care -- consumed over 62 cents of every dollar provided to DCYF in FY 2001.

D. DCYF contracts with 73 residential treatment programs operated by 26 separate entities. The total number of contracted placements are 810: 114 slots are for children ages 12 and under; 544 are for children ages 13-20; and 152 slots are for specialized foster care for children ages 1-17. Of the total 810, 176 slots are for females, 377 for males, and 257 are coed. (89 additional contracted placement beds will be added by June, 2001, pursuant to the 8/27/01 Second Amended Consent Decree. At least 33 placement beds are dedicated to female adolescents.)

E. Pursuant to a Federal District Court civil action, in August, 2001, DCYF admitted to violating the First Amended Consent Decree of 1989 in that it placed 294 youths in 1310 episodes of night-to-night placement from January 1, 2001 to June

30, 2001. DCYF stated that it will no longer place children committed to it care in night-to-night placement for any number of nights, absent unusual placement emergencies. DCYF will also prepare written policy and protocols requiring administrative approval prior to placing any child night-to-night, and that any child so placed will attend school. DCYF has also agreed, among other things, to increase the number of residential placements for female youth and male youth.

F. The 2001 Rhode Island General Assembly approved in Budget Article 13 increases in the amount of $3.69 per day for foster care and 3.8% for contracted DCYF service providers.

II. Solutions

A. "Prevention" needs to be defined and clarified, and then incorporated into policy and practice for each area of DCYF service delivery and within the system of care network. The State needs to provide more resources and a stronger commitment to primary and secondary prevention programs.

B. Foster care and service provider rates should be increased.

C. Night-to-night should be eliminated by expanding placement options, particularly for adolescent girls. (Second Amended Consent Decree dated 8/27/01 addresses this issue.)

D. DCYF should devote more personnel and resources to yield a concerted, creative effort, including extensive community outreach, to encourage families to come forward to provide foster care and specialized foster care.

E. DCYF should assure an adequate placement continuum of care to accommodate the special and particular needs of children within its care.

F. DCYF Family Service Unit caseworkers should work a more flexible, rotating schedule to be available when their clients most need them: evenings and weekends.

G. DCYF, CASA and the Family Court should closely examine the system of care with respect to the amount of time children spend within the system and without a permanent home. DCYF statistics reveal that nearly 3 in 10 children spend more than 3 years in care and nearly 1 in 8 spend 6 or more years in care. This data contradicts the mandate that "foster care" should only be used as a temporary solution to perilous problems within families. Federal and State law prescribe shorter time periods in which to achieve permanency for children.

H. In-home services available to adolescents need to be more available and expanded statewide to prevent the out-of-home placement. Crisis intervention teams must be readily accessible to meet the needs of youth and their families.

I. Family-Centered Practice and Care Management Teams proposed in DCYF pilot programs should be supported.

J. DCYF professionals should comply with the law mandating at least 20 hours of training per year.

K. To address the problem of night-to-night, DCYF should closely examine the development of a rapid diagnosis/assessment center and/or capacity for adolescents upon their first entry into State care to determine appropriate service plans, including but not limited to crisis intervention and wrap-around services to facilitate family reunification and/or identification of the placement needs of said youth. (Paragraph 11 of Second Amended Consent Decree dated 8/27/01.)

Out-of-State and In-State Purchase-of-Service Placements

Tom Bohan, Carol Spizzirri, representing DCYF, and Betsy Ison and Gail Dalquist, representing Placement Solutions, provided expert assistance and information to the subcommittee.

I. Current Reality

A. As of April 30, 2001, the status regarding POS slots was as follows: 341 children were placed by DCYF in purchase-of-service (POS) beds in approximately 37 residential treatment programs (33 of which were out-of-state programs) and 3 therapeutic foster care programs in Rhode Island. A total of 110 children were placed in one of 4 Rhode Island residential treatment facilities in POS beds at an average per-diem rate of $199.95 per child. A total of 187 children were placed in one of 33 out-of-state residential treatment facilities in POS beds at an average per-diem rate of $258.20 per child. A total of 49 children were placed in one of 3 in-state therapeutic foster care programs at an average per-diem rate of $135.16 per child. On average, these children have been opened to DCYF's Family Service Unit for about 3.25 years. As of June 26, 2001 when there were 349 children in POS beds, 109 were female and 240 were male. A high percentage of DCYF's budget is spent on out-of-state POS placements for a relatively small number of emotionally disturbed children and sexual offenders.

B. DCYF has developed a Care Network under the framework of the family-centered, community-based model, as one method of attempting to return out-of-state children to the State's system of care. Approximately 50 slots have been allocated thus far. There is an RFP for a second "network" to serve 20 children.

II. Solutions

A. If the State were to provide additional in-state placement options for children requiring a high level of care in a residential setting, reliance on out-of-state residential care could be reduced. For example, at least 44 out-of-state purchase-of-service slots are occupied by adolescent male sex offenders because the State lacks treatment options for them in-state.

B. The State should develop a comprehensive plan for returning children placed out-of-state to the State's system of care. The plan should focus on consistency of

treatment and permanency goals, as well as, sufficient planning time for clinical case management coordination throughout the transition process.

C. The State should eliminate unnecessary psychiatric hospital days by adding step-down beds.

D. DCYF should carefully evaluate the operation of the Care Network to date in order to correct problems and make other necessary changes before children become involved with the second Network.

E. DCYF should expand its efforts to target, recruit and identify foster families for adolescents. (Specific requirements are detailed in the Second Amended Consent Decree entered 8/27/01.)

Psychiatric Hospitalization

Dr. Gregory Fritz of Bradley Hospital, and Dr. Charles Staunton of Butler Hospital provided expert assistance and information to the subcommittee.

I. Current Reality

A. The number of children and youth in psychiatric hospitals has continued to increase: Bradley is predicting 950 admissions this year compared to 894 admission the previous year; Butler is experiencing a similar upward trend from the 679 admissions received in 2000. Between January and July of 2001, 122 children have been on a waiting list (ranging from a few hours to 5 days) for psychiatric beds. To a large extent, increased demand is related to fewer treatment opportunities in less restrictive settings. The most common diagnoses given to hospitalized children are: Adjustment Disorder (largely mixed disturbance of mood and conduct); Major Depression, recurrent; Major Depression, single episode; and Post- Traumatic Stress Disorder; Bipolar Disorder.

B. The State has a significant shortage of child psychiatrists. In addition, most do not practice forensic child psychiatry. The majority require fee-for-service payment as insurance reimbursement is reportedly low and the paperwork “onerous.”

C. The State lacks sufficient out-patient services for children and families. This has been attributed to a minimal supply, despite the demand, reflecting inadequate reimbursement rates. Family members wait much too long for necessary services.

D. The State lacks (1) sufficient residential step-down alternatives to psychiatric hospitalization and (2) appropriate aftercare services. These deficiencies have caused some children to be readmitted to the hospital. These problems most affect the adolescent patient population. A significant number of these youth have substance abuse problems and/or pending wayward petitions.

E. Family therapy must meet the specialized needs of the family and be readily available.

F. Both Medicaid and insurance reimbursement rates are too low.

G. Psychiatric care for children and youth in Rhode Island, whether in-patient or out-patient, has been primarily driven by our system of reimbursement for care, rather the individual needs and best interest of the patient.

II. Solutions

A. The State needs to develop alternatives to psychiatric hospitalization that include specialized residential program acute-care beds, therapeutic foster care, CIS out-patient services, and family therapy.

B. The State needs to closely examine reimbursement rates and payment methods for child psychiatrists.

C. The State Department of Business Regulations should review whether insurance companies are shouldering their share of the payment burden for psychiatric hospital costs and out-patient services.

D. All mental health out-patient services need to be improved. Insurance companies need to endorse family therapy. Family therapy is a highly effective and powerful medium which demands highly qualified practitioners. Family therapy could be more readily available via financial incentive policies and realistic reimbursement rates adopted by insurance companies.

E. To help shorten the total length of time children remain hospitalized, a comprehensive, multidisciplinary review of their discharge plan and likely date of discharge should occur upon admission.

F. EPSDT should be utilized as a potential alternative to psychiatric hospitalization, or upon discharge, as a way to transition youth from the hospital to gradual step-down service plans.

Outpatient Psychiatric, Mental Health and Substance Abuse Services

Elizabeth Earls, Executive Director of the Rhode Island Council of Community Mental Health Organizations, Inc., and Dave Lauderbach, Executive Director of Kent County Mental Health Center, Inc., provided expert assistance and information to the subcommittee.

I. Current Reality

A. Troubled and emotionally disturbed girls and boys of all ages, races and ethnic backgrounds, and socio-economic status, make-up the population of children requiring a comprehensive and easily accessed system of outpatient mental health and substance abuse treatment. Most of these children live with their birth or adoptive families; however, many must temporarily live in substitute foster care, group homes, residential facilities, correctional facilities and hospitals. Some have access to private insurance coverage, others receive Medicaid or are uninsured. The population of children requiring mental health services on a short- or long-

term basis may come to the attention of DCYF and the Family Court in a variety of ways, including via voluntary placement agreements, or petitions alleging dependency, neglect, abuse, waywardness or delinquency.

Service providers throughout the State consistently agree that demand for treatment far outstrips supply, and that the treatment provided does not always meet the particular needs of children and their families. Furthermore, preventive treatment, which is provided in a variety of venues, is insufficient and uncoordinated. When communities and school systems identify troubled children, some do not make reasonable efforts to assist and treat them within the community, rather they turn to DCYF and the Family Court to assume responsibility for their children. Furthermore, a clear "big picture" view of State-wide publicly and privately available services and how they are accessed is not currently available to all those working within the child welfare system. Consequently, gaps in knowledge and confusion hinder the delivery of appropriate services in a timely fashion.

B. The Rhode Island Council of Community Mental Health Organizations, Inc., is the primary provider of DCYF-funded mental health services for DCYF-involved children and their families. Council members are: Community Counseling Center, Inc.; East Bay Mental Health Center, Inc.; Kent County Mental Health Center, Inc.; Mental Health Services of Cranston, Johnston, and Northwestern Rhode Island, Inc.; Newport County Community Mental Health Center, Inc.; NRI Community Services; The Providence Center; Riverwood Mental Health Services, Inc.; and South Shore Mental Health Services, Inc.

C. A number of Children's Intensive Services (CIS) programs exist in the State to provide preventive treatment for emotionally disturbed children qualifying for Medicaid or without insurance. The goal of CIS programs is to maintain children of all ages in their homes by providing an intensive level of services for children at risk for psychiatric hospitalization or in acute crisis. Services are delivered on a 24/7 schedule, usually consisting of 2 to 2.5 hours per week for a 6-month period. Approximately 10% of clients are serviced beyond the 6-month period. Services include therapy, consultation, case management, medical management, outreach, parent education. CIS services both home-based and out-patient, do not include sufficient targeted training groups for parents and peer counseling for children and youth. CIS does not provide respite care. There is a waitlist for CIS programs State-wide.

D. The State lacks an adequate supply of home-based services post-CIS; i.e., a step-down program to deliver less intensive in-home services -- 1 to 2 hours per week for variable time periods. Consequently, about 35% of clients require re-enrollment in a CIS program after having been discharged from CIS. Some chronically, mentally ill children may need services indefinitely.

E. The State contracts with various programs to provide youth diversionary, outreach and tracking, early intervention, comprehensive emergency, and family preservation services on an outpatient basis. Mental health and/or substance abuse treatment is a component within many of these programs.

F. Various State departments operate programs aimed at helping children with mental health and substance abuse problems. For example, MHRH provides an adolescent substance abuse program, and DHS administers CEDARR, EPSDT, and Rite Care.

G. The State lacks sufficient mental health and substance abuse treatment providers who can deliver direct services to bilingual clients, while also focusing on incorporating an awareness of cultural issues and differences into individual treatment plans.

H. The State lacks a sufficient supply and continuum of mental health treatment options for children and their families post-adoption.

I. The State has a significant shortage of child psychiatrists. In addition, most do not practice forensic child psychiatry. The majority require fee-for-service, vastly diminishing their accessibility to most families.

J. Pursuant to a contract with DCYF, beginning in January, 2001, Placement Solutions started to review out-of-state and purchase-of-service placements for the purpose of providing recommendations and oversight for the transition of children from out-of-state care to in-state care solely from a clinical perspective. Focus to date has been on establishing standards for "level of care" criteria, with attention to time frames and specific services necessary for a successful family-centered transition.

II. Solutions

A. The mental health and substance abuse treatment system can be better coordinated throughout the State. Computer technology should be used to organize, streamline and process data, and to manage an information system that is current and easily accessed. A program of public education should be developed and implemented to help fill gaps in knowledge and information among professionals and others regarding the needs of and services for emotionally disturbed children and substance-abusing youth. This educational program should also include information about funding and payment options and procedures, as well as, the impact of the mental health parity law.

B. Individual communities and schools must truly own their children. This must be committed to both the early identification of family-related problems and the timely provision of specifically tailored community-based services to prevent disruption of the family and the physical and psychological exit of children from the community and school.

C. CIS and less intensive programs, outreach and tracking, and other outpatient mental health and substance abuse treatment options should be available to all children who need this service.

D. Cultural sensitivity and the communication needs of non-English-speaking families should be addressed within the context of continuing education training

programs and workshops for public and private employees servicing diverse populations within the State. In addition, special circumstances, including sibling-related issues within the system of care, sexual orientation of children or their parents, kinship care, adoption, AIDS, should be appropriately addressed within the context of initial and continuing training, and staff supervision. Toward that end, the Child Welfare Institute should ensure a diverse staff capable of assisting DCYF and community-based providers to address cross-cultural views of family roles, discipline, and other parenting issues. (Recommendations in *The Governor's Commission to Study Children in Foster Care and Adoption Report* concerning cultural sensitivity should continue to be implemented.)

E. Crisis intervention services must be available on demand. Out-patient psychiatric, individual counseling services and diagnostic assessment must be readily available, accessible and affordable to meet the needs of individuals and families. Waiting lists must be eliminated.

CASSP and Wrap-around Services

I. Current Reality

A. CASSP is a family-centered service system to assist families at risk. It adopts a holistic approach toward treating the family, one that stresses the importance of accurate assessment of symptoms to identify the most effective path toward problem resolution. As a family-centered model, it is designed to create one comprehensive resource system and to fill in gaps that a more fragmented service plan might expose. A vital component of CASSP is the importance placed on wrap-around services. Wrap-around refers to a service approach that focuses on identifying what children and families need, building on their strengths and creating treatment plans that are individualized, comprehensive and flexible. Wrap-around requires that service providers, especially those responsible for case management, recognize that one problem within the family and among family members is usually affected by others; thus services in their totality must address multiple issues. Effective wrap-around services are based in the community closest to the child's home, and incorporate open and frequent communication among service providers (as well as with clients) so that they work in concert with one another. Roles are clearly defined and tasks are well-coordinated. Progress toward achieving goals is closely monitored and necessary changes in the plan are made to reflect the ongoing evaluation of each family member's progress. Rhode Island's CASSP system is effective; however, implementation of the wrap-around model is hindered by a lack of sufficient resources and financial commitment. DCYF has recently hired two coordinators to implement a family-centered system of care model that will hopefully expand and facilitate the type of planning currently done by CASSP.

II. Solution

A. The CASSP system of care should be a model for expansion within the State. More than lip service must be paid to the notion that an effective system of care is family-focused. The State must devote sufficient resources to wrap-around

services if it hopes to comply with State law and ASFA regarding the mandate to prevent the unnecessary or premature removal of children from their families to achieve genuine permanency. Similarly, wrap-around services will help DCYF to implement reunification plans for children temporarily separated from their families.

Medicaid Services (RIte Care, EPSDT, CEDARR)

The following DHS representatives provided expert assistance and information to the subcommittee: John Young, Richard Jacobsen, Joan Obara, Murray Brown and Trisha Leddy.

I. Current Reality

A. RIte Care is Medicaid's managed care insurance program for families on the Family Independence Program and eligible uninsured pregnant women, parents, and children up to age 19. Eligibility is based on family income and size. The program provides recipients with comprehensive health care through participating health plans. In FY 2000, nearly two-thirds of the more than 95,000 family members participating in RIte Care were children. Under RIte Care, access to prenatal care and maternal health in Rhode Island has improved. The average monthly cost per member was $159, which includes various wrap-around services. For children with special health care needs, the cost was significantly higher ($991 average per month) to provide home and community-based services. In FY 2000, an average of 5,437 children per month receiving Title IV-E services were enrolled in Medicaid, with a noted increase in spending on behavioral health services. Of DCYF-involved children receiving Title IV-E services covered by Medicaid, 52 percent were in substitute care (foster care) and 48 percent were in subsidized adoption. Children in DCYF care accounted for $79.8 million in a combination of State and Federal funds under the Medicaid program. In early FY 2001, foster children began voluntary enrollment in RIte Care health plans, taking advantage of a more coordinated system of health care among DCYF, health care providers, health plans and DHS. From 1997 to 1999, 4.8 percent of the State's low-income children under 19 years of age were without health insurance; however, all children in foster care are enrolled in a government-funded health care program. Incarcerated, sentenced children are not Medicaid eligible.

B. The Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) Family Centers were created in FY 2000 to help improve care for children with special health care needs. It is a project that provides a family-centered, comprehensive source of information, clinical expertise, connection to community supports and assistance to aid families in meeting the previously unmet needs of Medicaid-enrolled children with special health care needs, i.e., physical, developmental and mental disabilities. The CEDARR Initiative reflects a major commitment and level of coordination from DCYF and DHS, in collaboration with the Department of Health, the Department of Education, and the Department of Mental Health, Retardation and Hospitals.

The CEDARR Initiative has lead to a collaborative effort among DHS, RIDE and the LEAs to examine the level of services provided to these children in schools,

and to expand the level of federal reimbursement available for mandated school-based special education and health activities. Thus, LEAs may now claim reimbursement for the preparation of IEPs for Medicaid-eligible special education students.

The goal of the CEDARR Initiative is to serve 10,000 eligible clients. Service delivery began in April 2001.

C. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services. In addition, the Social Security Act requires that any medically necessary health care service be provided to an EPSDT recipient even if the service is not available under the State' Medicaid plan.

The EPSDT program can cover certain services provided via CEDARR, on a case-by-case basis.

II. Solutions

A. Subsequent to the Supreme Court's decision in *Olmstead v. L.C.*, the State should re-evaluate the length of time children with disabilities spend in institutional settings and the efforts made to place children with disabilities in the least restrictive, most family-like setting possible.

B. Once available data is analyzed, the State should continue to examine improvement strategies to include DCYF and health plan providers in order to negotiate non-acute contracted days for service with all relevant agencies, institutions, departments, and private and/or public funders that will best meet the needs of DCYF population.

C. To assure both the provision of appropriate health care and the maximization of Juvenile Justice funding, the State should explore Medicaid services for adjudicated youth and detained, non-adjudicated youth.

D. The State should explore the following recommendations to address the funding problem often associated with the psychiatric hospitalization of DCYF children:

1. To have a third-party liability assessment at the time of admission;

2. To have a review of the discharge date and plan at the time of admission;

3. To require that private insurance be exhausted (and/or denied) with family and community providers before relevant Medicaid is determined and financial responsibility is transferred;

4. To have the State pay only what the private insurers would have to pay for in-patient psychiatric hospital days (The State should not pay higher rates than insurance carriers for the same service.);

5. To use EPSDT as a means to transition youth from psychiatric hospitalization to a gradual step-down program or an alternative to psychiatric hospitalization;

6. To examine RIte Care eligible children with a serious mental illness who have been carved out of RIte Care to determine how medical benefits can be better coordinated and utilized.

E. Regarding CIS, expand it and allow for a more flexible, long-term program; build up other parts of the system of care; expand prevention services (such as CES); expand Family Support Services; and explore Medicaid eligibility to fund expanded services.

Education Issues

Virginia daMota, representing the Rhode Island Department of Education, provided expert assistance and information to the subcommittee.

I. Current Reality

A. When children first enter DCYF placement system of care, the Family Court inquires as to whether DCYF should be appointed Educational Guardian of the child. The Family Court has authority to make this appointment and to determine the residency of the parents for purposes of allowing school districts to bill the responsible district for the education costs expended for children in shelters, group homes and other facilities. DCYF is responsible for assuring that children are enrolled in appropriate educational programs immediately upon entering substitute care. In order to help facilitate a smooth transition from one system of school to another, DCYF provides the school with the child's "Intrastate Educational Identification Card."

1. Family visitation plans and counseling appointments arranged by DCYF do not always accommodate a child's school day and commitment to school-related activities.

2. Shelter and group home providers often report that they experience resistance and unnecessary bureaucratic demands from schools when enrolling DCYF-involved youth.

3. When children experience multiple and/or frequent moves from one placement to another, their academic progress is interrupted and gaps in their education develop. It is common among youth who spend a significant amount of time roaming around the placement system to be 2 or 3 years behind their peers in their education; many leave the system without a high school diploma. Too many youth do not pursue an advanced degree.

4. When children are forced to endure the night-to-night placement system, their education is in abeyance. This has had a disproportionate impact on adolescent girls, who are more highly represented among the night-to-night

population than boys. (The Second Amended Consent Decree entered 8/27/01 addresses this issue.)

B. DCYF-involved children with special education needs are entitled to appropriate educational services under IDEA. When children with disabilities do not have a parent or guardian able to act on educational matters for them, DCYF caseworkers refer children to the Educational Surrogate Parent Program, operated by the Office of the Child Advocate and supported by RIDE. The Program appoints professional Educational Surrogates to assure that children have appropriate evaluations and IEPs, are educated in the least restrictive setting possible, and to the extent possible, are placed with children who do not have disabilities. Approximately 1200 children, including many youth at the Training School, are represented annually by Educational Surrogates. The Program provides consistent and zealous representation of children who require educational advocacy. Approximately 1000 of these children are deemed "high need."

C. Children placed by DCYF in a residential facility and who attend the facility-operated school have their educational expenses incorporated in the total placement cost paid by DCYF to that facility (these facilities include ACE, Alternatives, Cam E-Hun-Tee, Ocean Tides and the Rhode Island Training School for Youth). The Rhode Island Training School has and continues to experience significant and frequent problems with their educational program, especially for girls.

D. Barriers exist for youth transitioning from the Training School to schools within the community.

E. The school suspension rate for DCYF-involved youth, especially black males, appears to be higher than it is for other populations of children.

F. System-wide coordination between schools and community-based programs is lacking. Outreach and Tracking, such as the TIDES Program, are Medicaid eligible; yet the State has not fully explored alternative funding sources for additional community-based services which would work closely with schools.

G. The Parent Support Network (PSN) and the Rhode Island Parent Information Network (RIPIN) provide education, referral, support and advocacy services to parents on a variety of education-related issuess.

III. Solutions

A. The process for school enrollment of DCYF-involved children, and the delays that often accompany the process, need to be addressed through the promulgation of regulations and/or the passage of legislation by the General Assembly with input from DCYF, RIDE and local school districts. Further, when children are physically placed outside their existing school district once an academic year has begun, they should be allowed to complete school in the home district for at least the remainder of the year if it is in their best interest to do so.

B. DCYF, via the RFP process, should require vendors to cooperate with CASSP. The Department should encourage the formation of a bridge between school districts and community organizations. Financial incentives and/or CASSP and respite services could be offered.

C. To address barriers for youth transitioning from the Training School to community-based schools, Project Hope should be implemented system-wide as a model for all school districts.

D. The legislature and DCYF should closely examine racial bias in the schools and the suspension rate of DCYF-involved children. In-school vs. in-home suspensions should be the subject of an in-depth discussion among all interested parties.

E. To reduce disruptions in a child's education, the State should examine the use of Mental Health Centers for diagnostic assessments and pre-screening evaluations. Before managed care, these assessments and pre-screenings helped reduce reliance on psychiatric hospitalization for children. This initiative could encourage the use of a network of services for children within the community, rather than withdrawing them from the community and their school.

Juvenile Justice: Probation, Diversion and Community-Based Services

Mike Burk, representing DCYF, Brother Michael Reis, Executive Director of Tides, and David Heden, representing the Family Court, provided expert assistance and information to the subcommittee. Data reviewed included the 1997 JJTF Report and Family Court juvenile statistical reports.

I. Current Reality

A. Family Court juvenile statistics show that during the year 2000, a total of 8,672 offenses were committed by youth within the State, broken-down as follows: violent crime-492; assaults-1,013; property crimes-2,606; motor vehicle violations-515; status offenses-1,093; truancy-461; weapon offenses-205; drug/alcohol-927; disorderly conduct-1,016; miscellaneous-344. The five core cities – Providence, Central Falls/Pawtucket, Newport, West Warwick, Woonsocket – yield most of the juvenile-related problems. A high percentage of the total number of offenses – 24.45 % -- were committed by youth residing in Providence. In addition, there were 1,280 violations of probation, 29.30 % of which were committed by Providence youth.

B. Each of the five core cities has developed a comprehensive prevention strategy to mobilize and coordinate all community-based resources. However, cities lack funding sources to fully implement the plans and they often compete for scarce resources.

C. Funds have been approved for a new juvenile corrections facility. This facility, among other things, is meant to provide better supervision of and programming for incarcerated youth.

D. Project Hope is operational in 4 catchmen areas. It consists of graduated sanctions and goal-based sentencing, with developmental assistance from the National Center on Crime and Delinquency. It has enhanced DCYF's capacity to deliver mental health, substance abuse and other medical treatment, via Lifespan, for the population served.

E. The Office of the Attorney General is leading efforts to pass legislation related to gun ownership.

F. "Safe Streets" is a Providence-based collaborative program among DCYF, the Providence Police Department, the Adult Correctional Institution, Adult and Juvenile Probation.

G. Misbehaving children move too quickly from their communities to the State system of care, i.e., the Training School or DCYF's care and supervision, in order to access services but often without considering the severity of the offense and the circumstances of each child. Local communities have too few community-based interventions and/or sanction options to address the problems these children pose.

H. After-school programming exists in all Providence middle schools for at-risk youth up to age 15.

I. Tides Family Services reaches many troubled youth via its Outreach and Tracking programs in Pawtucket/Central Falls and West Warwick. It has begun to expand programming into Providence. Nevertheless, there is a lack of outreach and tracking, and diversion programs

J. The Truancy Court has dealt with approximately 200 children, only 12 of which have been referred to DCYF.

II. Solutions

A. "Safe Streets" should be expanded to other cities and communities. Outreach and Tracking programs should be expanded throughout the State, especially in Newport and Woonsocket.

B. DCYF and other appropriate agencies and departments should assure that reasonable, effective and creative efforts are made to address the behavior of troubled youth within their own communities. Thus, DCYF should assure a system of graduated sanctions correlated to the severity of youths' unacceptable behavior. The subcommittee strongly supports the conclusions and recommendations of the Governor's Task Force on Juvenile Justice Reform (see JJTF Report, Executive Summary, dated July 1997), particularly recommendations 1 through 11.

C. DCYF should increase and improve its ability to conduct research for multiple reasons, including the need to utilize research-based data to more effectively plan on a short- and long-term basis.

D. After-school programs should be expanded. They should provide an array services, including tutoring and help for children with disabilities.

E. Individual schools should be accountable for addressing the particular needs of their enrolled children in order to help them succeed beginning with kindergarten and continuing through high-school. Truancy and school-failure are the gateways to juvenile waywardness and delinquency. Therefore, genuine efforts should be made by all school personnel to prevent truancy and school failure by closely monitoring the status of at-risk children and bringing together a myriad of service providers and family members to communicate about and plan for these children as soon as signs of trouble are identified.

F. School-based outreach to children with problems should be better organized, more consistent and individualized in order to respond to the specific problems of children and their families. In addition, schools should enter into partnerships with other community-based service providers to assure coordination, cooperation and communication regarding what is best for that community's children.

G. Cultural sensitivity must be a major component in school and community-based plans to serve children and their families.

H. Colleges and universities within the State with formal teacher-training programs should incorporate within their education curriculum for future teachers relevant information about and exposure to communities with high concentrations of families that are poor, bilingual and/or racially diverse. The Central Falls Professional Development School, a joint venture with Rhode Island College, was noted as a potential model for cultivating awareness of issues germane to inner-city school children among prospective teachers.

I. Youth transitioning from out-of-state placement or the Training School should be encouraged and allowed to integrate into the community and local school district. Community service providers and leaders should rally behind these youth.

J. Early intervention services to meet the needs of families, particularly those with elementary- and middle-school-aged children, should adopt policies and procedures that emphasize the importance of collaboration with other service providers and schools.

K. The Truancy Court model that has been successful in several communities should be expanded as a state-wide initiative to meet the individual needs of children. It should operate in alliance with RIDE, DCYF, Family Court, local school districts, community service providers and families.

L. All State RFP contracts should encourage service providers to cooperate with schools and community organizations, and to develop partnerships and collaborative agreements as necessary.

M. The Rhode Island Department of Education (RIDE) has identified approximately 19 alternative education programs within the State that lacked regulatory

oversight. Other recently identified problems include a shortage of qualified teachers and too many teachers with emergency certification. Oversight efforts should be tightened to avoid similar problems in the future.

Legal Services

Legal agencies provided information via a Survey submitted to them from the subcommittee.

I. Current Reality

A. Court Appointed Special Advocate (CASA), under the auspices of the Family Court. A state-wide system of attorney Guardian *ad litems* who work with social caseworkers and volunteers to represent individual children involved with DCYF by advocating a course of action that is in their best interest.

1. Population served: approximately 3,000 children up to age 21.

2. Eligibility: all children for whom a child protective petition, alleging parental dependency, neglect or abuse, are filed in the Family Court.

3. Staffing: 11 attorneys, 1 project manager, 5 social caseworkers, 1 volunteer recruiter, 1 volunteer coordinator, 2 data entry aides.

4. Annual budget: $1,472,680, 12.55 % of Family Court budget.

5. System of care problems: night-to-night placement; lack of step-down placements from hospitalization; shortage of foster homes, particularly therapeutic foster homes; separation of sibling groups; disruptions in education; lack of in-state residential facilities; lack of aftercare from the Training School; too many youth "age-out" of the system ill-prepared for independence; more specialized training for DCYF workers on adoption-related issues.

B. Office of the Child Advocate (OCA): advocates for particular children whose legal, civil and special rights in DCYF system and/or Family Court proceedings are not being met. In addition, the Office advocates for a group of individuals as an identifiable class where system change for an entire class is necessary.

1. Population served: children in the care of DCYF.

2. Eligibility: Children under the care of DCYF or matters relating to DCYF, including child care, foster care, residential programs, group home, mental health services for children and the Training School.

3. Staffing: Attorneys, social workers, educational advocates and clerical workers.

4. Annual budget: $865,000: $523,165 state funds; $342,703 federal contract with RIDE and Medicaid monies; $23,000 VOCA grant.

5. System of care problems: lack of continuum of care within the placement system and lack of placement prevention efforts and resources.

C. RI Disability Law Center:

1. Population served: Free legal assistance to adults, youth and children with disabilities.

2. Eligibility: Callers requesting legal assistance are referred to one of two intake advocates.

3. Staffing: Director, 2 attorneys, 2 legal advocates, 2 intake advocates, finance/office director, 1 secretary/receptionist.

4. Annual budget: $1,000,000, DHHS, DOE, and Social Security.

5. System of care problems: lack of continuum of mental health care, with emphasis on community treatment options.

D. Office of the Public Defender:

1. Population served: Legal services to parents and juveniles with matters before the Family Court who meet financial criteria.

2. Staffing: 4 attorneys in the Parental Rights Unit and 5 attorneys in the Juvenile Unit.

3. Funding from the State of Rhode Island.

4. System of care problems: lack of placements of all types for children.

II. Solutions

A. Continuing education and training on a variety of topics needs to be provided to attorneys working within the system of care to help them stay abreast of the latest research and data regarding issues germane to child welfare, and exemplary standards of child welfare legal and social work practice. New attorneys should be provided with experienced mentors.

B. Attorneys working within the system of care should adapt to positive changes in law, policy and practice within the system (for example, the concept of Concurrent Planning), rather than adopt a cynical view from the outset.

APPENDIX N: GENDER-SPECIFIC PROGRAMMING FOR FEMALES ALONG RHODE ISLAND'S SYSTEM OF CARE

DEFINITION: GENDER-SPECIFIC PROGRAMMING

Gender-specific programs are ones that intentionally allow gender identity and development to affect and guide program design and service delivery. Gender-specific programming specifically refers to unique program models and services that address the specific needs of a targeted gender group. An essential ingredient is the fostering of positive gender identity development (Maniglia, R. and The Peters Group).

DEFINITION: GENDER-SPECIFIC PROGRAMMING FOR FEMALES

Gender-specific programs for females are comprehensive, providing services along a continuum of care. Programs are designed to recognize the risks and dangers females face because of gender, especially a history of abuse or other forms of victimization. They encourage resiliency factors and life skills that help girls make a positive transition to womanhood and prevent future delinquency. (Office of Juvenile Justice and Delinquency Prevention, 1998)

RATIONALE

While gender-specific programming applies to specialized programming for either males or females, there is currently a national focus on gender-specific programming for females because females' involvement in the system, particularly the court system, has been escalating at unprecedented rates and program models and intervention modalities have been geared toward the needs of a predominantly male population. This is a circumstance that requires an immediate systemic response, however it does not negate the possibility of exploring optimal programming modalities for males in the future.

Until recently, research on patterns of delinquency and recidivism within the juvenile justice system was conducted mostly on males, and research on the etiology and the treatment needs of juvenile offenders focused solely on males as well (Odem & Schlossman, 1991; Chesney-Lind, 1986; 1989; Shelden, 1998). Though juvenile delinquency has been viewed historically as a "male problem," statistics on juvenile delinquency reveal that rates of female delinquency are on the rise (Greene, Peters, & Associates, 1998) and that young girls are becoming court-involved at greater, unprecedented rates. Between 1992 and 1996 juvenile female delinquency increased 25% nationally while juvenile male delinquency remained steady. Recent studies reveal that there is a significant lack of program options tailored to meet the unique needs of a female population.

REVIEW OF IMPORTANT RESEARCH FINDINGS

In order to develop and implement effective programs for at-risk females and female offenders, policymakers, administrators, managers, staff, and community providers and advocates must be familiar with a core body of well-documented research regarding:

1. Female psychosocial development (including the impacts of socialization, girls' relational orientation, and girls' unique decision-making processes and motivators), and
2. Unique factors that place young women at risk of involvement in the child welfare and juvenile justice systems, as well as their unique pathways into such systems

Female Psychosocial Development

Research has evinced developmental differences in males and females and distinct variations in the way they see and understand the world. Cutting-edge scholarship regarding female development has revealed that females have a relational orientation to the world and focus on connection with others. Armed with a more detailed and accurate picture of how females develop, new research is replacing outdated studies that came to wrongful conclusions about female moral, psychological, and social development (Caplan & Caplan, Gilligan, C., Jordan). Research continues to show the negative aspects of socialization and their particular effects on girls and young women. Socially determined gender roles and male/female stereotypes can be limiting and damaging, and objectification, abuse, harassment, and extensive family responsibilities are now being understood as major themes in the lives of girls and women (Chesney-Lind, 1997, OJJDP 1998). Programming must incorporate these themes so that girls and young women can learn how to deal effectively with the issues that impact their lives and choices and services can effectively reach this population.

Female Risk Factors for System-Involvement

Abuse and Exploitation

Girls and young women are sexually abused almost three times more often than boys (Sedlack & Broadhurst, 1996). Girls and young women who have been sexually abused are more likely to have high stress, depressive symptoms, and low self-esteem. The prevalence of abuse in the lives of girls and young women points to the need for services that directly address issues of victimization and survival.

"The abuse and exploitation of young girls should be viewed as a major and pervasive public health threat and a primary precursor to involvement in the criminal justice system" (OJP Coordination Group on Women, 1998). "Girls need access to a continuum of placement options in which their safety can be ensured while they address the issues that brought them into the system and receive the services they will need to leave it (OJP Coordination Group on Women, 1998)." Such options should be non-punitive.

- 8 million, or 1 out of every 4 girls are sexually abused before the age of 18 (CWF, various national statistics)
- Girls are much more likely than boys to be victims of sexual abuse, especially family-related abuse (Chesney-Lind and Sheldon)
- The incidence of physical and sexual abuse and/or exploitation among court-involved girls vary from a low of 40% to a high of 73% and as high as 95-100% of girls in residential and training school facilities) (Chesney-Lind and Sheldon)
- Abuse is the primary cause of running away from home, a status offense that is often a girls' first involvement with the juvenile justice system
- Sexually abused runaways are more likely to engage in delinquent activities (e.g. substance abuse, theft, and prostitution) (Chesney-Lind and Sheldon)
- Most girls seek help from the consequences rather than the causes of abuse (Chesney-Lind, 1995)
- Studies confirm that abused children are at high risk for subsequent involvement in delinquency and violent behavior (Widom, 1992; Thornberry, 1994)

Substance Abuse

Another important risk factor for females is substance abuse. Recent studies have revealed that girls and women have different substance abuse patterns and motivations for substance use than their male counterparts. In the realm of corrections, it is now known that drug abuse is a greater problem for female offenders than for male offenders. The American Correctional Association found that girls have higher rates of substance abuse and addiction - 60% of girls in state training schools in the juvenile justice system need substance abuse treatment at intake and over half of those are multiply addicted (American Correctional Association, 1990). Researchers and practitioners who work with girls and women are beginning to acknowledge the relationship between trauma and substance abuse and a number of studies have found a correlation between chemical dependency and physical and/or sexual abuse, especially among females. In many cases, substance abuse among many at-risk and court-involved girls is effectively numbs the pain from past and/or continuing abuse.

- Studies indicate that at-risk girls indicate that drugs allow them to escape emotional pain from abuse
- Over time, drug usage can become a problem or cause other problems such as addiction and the attendant behavior necessary to attain drugs by any possible means, including criminal activities
- A national survey of female juvenile offenders in training schools discovered that the typical female juvenile offender "started using alcohol or drugs between the ages of 12 and 15 (ACA, 1990). 64% used alcohol at least once or twice a week. Of the 59% who used cocaine, 47% did so on a daily basis. Of the 78% who used marijuana, 47% did so on a daily basis (ACA, 1990)

- There is a long known link between drug use and sexual activity (Bergsmann, 1994).

Teen Pregnancy and Parenthood

Teenage pregnancy and parenthood is also a "major delinquency risk factor" for female juvenile offenders and teenage girls in general (OJP Coordination Group on Women, 1998). Many females who enter the court system are pregnant or are mothers, and the system lacks program options to meet their needs (The Peters Group, 1998).

- In 1995, teenage girls represented a third of all unmarried mothers in the country (Adams, et al. 1995)
- Girls often trade sex for love (Chassler, 1997)
- Research indicates that girls get pregnant "to feel needed and/or loved unconditionally", to have "someone to love and care for and call [their] own"; to keep a boyfriend, to obtain love and popularity, and to escape from an abusive living situation (Chassler, 1997).
- Most female juvenile offenders see pregnancy as a response to past sexual victimization (Chassler, 1997).

Low or Damaged Self-esteem

Low self-esteem is another major risk factor for girls' system-involvement. The breakdown of girls' families and emotional, physical, and sexual abuse cause feelings of profound rejection.

- The majority of female juvenile offenders are victims of severely dysfunctional families and have suffered from neglect and violence and are often emotionally distressed and have limited or no self-respect (OJP Coordination Group on Women, 1998).
- Self-reported data show that more than half of young women in training schools have attempted suicide and 64% of them have tried more than once (ACA).
- Feelings of poor self-esteem are mirrored in the larger society among teenage girls as evidenced by a growing body of research in this area (Chesney-Lind and Shelden)

Truancy and School Dropout

Truancy is a major precursor to court-involvement for girls. Indeed, many girls first enter the court system for truancy and other status offenses (The Peters Group, 1998; Chesney-Lind; Chesney-Lind & Shelden).

- The typical female juvenile offender is a high school dropout (The Peters Group)
- In 1990, the American Correctional Association found that 27% of girls dropped out of school because of pregnancy and 20% left school to be full-time mothers (ACA)
- In a national study of girls in training schools, 65% had completed only 1 to 3 years of high school and had not received a general equivalency diploma (GED). Of these

girls, 36% did not return to any type of school after leaving the training school (ACA).

- When girls leave school, they are less likely to return. This is related to their relational orientation to the world and their damaged self-esteem. Girls who leave school feel marginalized and lose essential connections with peers and staff. They also feel unprepared and fear failure upon return.

Lack of Appropriate Intervention and Re-victimization by the Court and Child Welfare Systems

There is a lack of appropriate prevention and intervention programs for girls (The Peters Group, 1998; OJJDP). Because of this, girls who enter the system often do not get essential needs met. The pervasive lack of information on girls' unique pathways into the system and unique needs often translates into their behaviors being viewed and responded to in isolation. Girls' abuse and trauma histories are often unknown and thus ignored. Ultimately, girls return to the court system repeatedly and move from program to program, in a system designed to meet the needs of a mostly male population. The structure of many programs does not allow for essential gender-specific programming components. Finally, research also indicates that females tend to be punished more severely than their male counterparts, and are often detained or placed in secure settings for protective reasons.

- In a 1996 study of incarcerated women in California, Connecticut, and Florida, a significant proportion of women reported that they had been in trouble as girls and yet little or nothing had been done to help them.
- Nearly half of the women had been suspended from school, more than half ran away from home, often to escape abuse.
- Nearly 30% began as status offenders
- Most reported having experienced one or more forms of abuse

Assumptions of Gender-specific Programming for Females

(Adapted from Maniglia, R.)

- Gender-specific programming does not exist simply because a program has an all-female (or all-male) clientele.
- Gender-specific programming does not exist simply because a program has been in the girl-serving (or boy-serving) business for a long time.
- Girls have different aspects to their development than boys, so services and interventions need to be different.
- Equality is not about providing the same opportunities for girls and boys, but about providing opportunities that mean the same to girls and boys.

- Good gender-specific services begin with good services (e.g. safety and security, well trained, responsive staff, ongoing evaluation of program policies and components, supportive administration).

Principles of Gender-specific Programming for Females

(not a complete list)

1. Gender-based programming, or, space that is physically and emotionally safe and separate from male programming space
2. Opportunities for girls to discuss their lives and personal strengths and challenges without the distraction or demands for attention of male youth
3. Education about women's health, including female development and sexuality
4. Mentors who share experiences that resonate with the realities of girls' lives and who exemplify survival and growth
5. Opportunities for girls to understand women's history and girls' roles in shaping history
6. Opportunities for girls to understand their culture and appreciate and respect the cultures of others
7. Opportunities to learn how to develop and maintain healthy relationships
8. Opportunities for empowerment and self growth beyond the experience of victimization
9. Psychotherapeutic opportunities and mental health treatment
10. Access to female staff members
11. Single-sex programming and recreational opportunities (in co-educational programs)
12. Adequate funding for providing comprehensive programming across the continuum of care

The concept of gender-specific programming is grounded in sound theoretical and practical research on female development and the unique risk profile shared by girls and women, particularly those that are court-involved. Gender-specific programming strengthens the foundation of programs and services for court-involved girls. To meet the specific needs of girls and young women and provide them with best practice services, a gender-specific model of treatment and intervention is critical.

Implementing Gender-specific Programming for Girls in the Rhode Island Juvenile Justice System

Historically, the overall number of girls and young women involved with the juvenile justice system across the nation has been small compared to that of boys and young men. Because girls and young women have not dominated the system in raw numbers, program

options have not been tailored to correspond to their needs as a subgroup, and both locally and nationally there is a paucity of program options tailored to meet their unique needs. Without programming and services that are attentive to their risk profile, girls and young women will continue to enter and re-enter the court system at alarming rates.

The Federal Mandate to Implement Gender-specific Programming for Females

In recent years, the rising numbers of girls and young women entering and re-entering the court system has stimulated national concern regarding the availability of services for females and the effectiveness of programs serving females. During the 1992 Reauthorization of the Juvenile Justice and Delinquency Prevention Act of 1974, Congress paid close attention to the concerns brought by researchers and youth-serving professionals in which they expressed and identified a necessity to address the gender-specific needs of girls and young women. This was accomplished through Congress' references to and emphasis on importance of equity and gender-specific services throughout the Reauthorization legislation. The final Act outlined three specific areas in which states were required to respond and take action. It required each state to:

- Conduct an analysis of gender-specific services for the prevention and treatment of juvenile delinquency, including the types of such services available and the need for such services for females;
- Develop a plan for providing needed gender-specific services for the prevention and treatment of juvenile delinquency; and
- Provide assurance that youth in the juvenile justice system are treated equitably on the basis of gender, race, family income, and mentally, emotionally, or physically handicapping conditions.

These provisions recognized the Act's previous failure to deal with gender bias in a meaningful way and provided the impetus for states to begin to look more closely at the girls and young women moving through their juvenile justice systems. Several states, including Rhode Island, have begun to proactively address these issues within their juvenile justice systems.

New research and national best practices have provided a foundation of knowledge that is allowing researchers, practitioners, administrators, and policy makers to understand the utility of effective service delivery for girls in the context of goals to reduce court-involvement and recidivism. Research has shown that girls in the juvenile justice system are more likely than boys to be victims of abuse, to enter the system with status offenses, and be sanctioned to programs that serve more serious, male offenders. Since girls exhibit specific behaviors that are unique to their gender, they require different interventions, sanctions and services. The majority of juvenile justice providers nationwide lack the skills, tools, and resources necessary to be effective in providing a framework for girls to be successful in changing negative behaviors.

Strengthening Services for Girls and Young Women Along the Continuum of Care

The concept of gender-specific programming is grounded in sound theoretical and practical research on female development and the unique risk profile shared by girls and

women. The principles of gender-specific programming should exist at the core of service delivery in juvenile corrections, foster care, behavioral and mental health, and substance abuse intervention and treatment. Gender-specific programming will strengthen the foundation of services for girls and young women throughout the continuum of care. The systemic change that has begun to take place in the juvenile justice must be replicated in other systems. To meet the specific needs of girls and young women and provide them with best practice services in their communities, a gender-specific model of treatment and intervention is critical. In conjunction with the juvenile justice system, other human welfare, protection, and rehabilitative systems have the opportunity to join efforts and resources to build a veritable and nationally recognized gender-specific service delivery network that provides quality care for all youth receiving state services.