New York State
Office of
Children & Family
Services

Report to the Legislature
Quality Enhancement Fund

State Fiscal Year 2004-05

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Governor Pataki's Child Welfare Financing structure promotes safety, well-being and permanency for children, with the following three components:

1. 65 percent/35 percent State/local funding for all child welfare services except foster care services after applying available Federal funds;
2. A Foster Care Block Grant capping State reimbursement to social services districts for foster care services to the annual amounts appropriated; and
3. A Quality Enhancement Fund administered by the Office of Children and Family Services to increase the availability and quality of children and family services programs.

Chapters 53 and 83 of the Laws of 2002, the Child Welfare Financing law, require that OCFS submit a report to the Governor and the Legislature annually that describes the disbursements from the Quality Enhancement Fund and the status of the projects financed by the fund.

With regard to the Quality Enhancement Fund, the enacted 04-05 State budget called upon the Office of Children and Family Services (OCFS) to "conduct activities to increase the availability and/or quality of children and family services programs which may include, but not be limited to, staff recruitment, retention and training activities, research projects to test innovative models for service delivery which may include areas such as health, mental health and substance abuse services." In addition, such activities may be conducted without competitive bid or request for proposal. The enacted 04-05 budget appropriated $1.9 million in Temporary Assistance to Needy Families (TANF) funds for these purposes beginning in State Fiscal Year 2003-2004.

OCFS applied the following selection criteria for funding proposals from the allocation for the Quality Enhancement Fund:

- Programs must meet one or more of the TANF goals and serve families with incomes up to 200 percent of the Federal poverty level;
- Programs must be outcome based;
- Programs must produce outcomes and spend the money timely;
- Programs must have the proper level of technology support to be evaluated; and
- Programs must build on already existing infrastructure.

Based on those criteria, the Office selected the following areas for investment of Quality Enhancement funds:

1. Care Coordination for children in foster care
2. Support for the Child and Family Services Review Program Improvement Plan
3. Mentoring for youth transitioning from foster care
4. Evaluation of the impact of the child welfare financing structure

The above stated criteria are intended to address Federal TANF priorities Number 1 -- providing assistance to needy families so that children may be cared for in their own homes or in the homes of relatives -- and Number 3 - preventing or reducing the incidence of out-of-wedlock pregnancies. In addition, income eligibility is determined in any program providing direct services to youth.

> **TANF Priority 1 –** "Provides assistance to needy families so that children may be cared for in their own homes or in homes of relatives." Care coordination, permanency mediation, local program improvement plan activities directed toward support for families to promote permanency, and mentoring all will enhance the child welfare system's ability to reduce the length of stay in care and expedite return home. This is the intended result that will be achieved by facilitating comprehensive assessments, improving local district and agency practice in the areas of services provision, case management, and discharge planning. The evaluation will inform OCFS and its stakeholders of the impact of these efforts.
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> **TANF Priority 3 –** "Prevents or reduces the incidence of out-of-wedlock pregnancies." It is through the establishment of ongoing, comprehensive care and education around family planning and reproductive health care services, and health care monitoring, that care coordination will reduce the number of out-of-wedlock pregnancies. In addition, the program improvement plan activities that improve overall case planning and case management and services, support for families and caretakers and the mentoring of adolescents leaving foster care are designed to reduce risk of out-of-wedlock pregnancy and assist young people to successfully transition to their families and communities. Again, the evaluation will provide essential information about the impact of these efforts.

1. CARE COORDINATION:

Children in foster care have significantly more mental health and physical health needs compared to the general population. Care coordination plays a vital role in enabling each child to receive necessary medical, developmental, mental health, dental and substance abuse services in the specified time frames while in foster care; gaining the foster family's and birth family's support of the medical plan for the child; and facilitating the appropriate sharing of information among professionals involved in the child's care. Care coordination is designed to create a locus of responsibility for individual health care coordination by developing and implementing a comprehensive medical treatment plan that integrates and updates all known physical health, mental health, developmental and substance abuse needs.

Coordinated health care supports the case manager's ability to address the safety, well-being and permanency outcomes for children in foster care. The health care coordinator integrates and manages health care information to share with the child welfare case manager, who retains the ultimate authority for case management for the child and family. To support timely achievement of well-being and permanency, it is necessary to identify health needs within the initial weeks of placement so that accurate assessments and treatment plans may be developed

and implemented. These treatment plans must be developed with input and support from both the foster family and birth family to enable continuance of care upon discharge.

The following five outcomes have been identified by OCFS as key indicators in measuring the success of care coordination. OCFS is working with each project to develop the benchmarks and intended change.

1. Increase the stabilization of placement by reducing the number of movements while in care.
2. Increase the participation of birth families in health care visits/service plan reviews.
3. Complete and document the following five child assessments within the first 30-45 days of care: physical health, mental health, development, dental, and substance abuse assessment.
4. Complete a treatment plan for each child that is integrated with the permanency plan.
5. Provide pregnancy prevention education sessions to the target population.

OCFS also anticipates the following: improved access to needed health services; improved coordination of needed health services; decreased duplication of services; improved documentation and communication of health needs and services; and improved continuity of care, resulting in improved compliance with Federal and State foster care and Medical Assistance regulations.

The following agencies participated in this initiative in 2004-05.

AGENCY	REGION	AMOUNT
Children & Adolescent Treatment Services	Erie	$ 150,000
Kinship Family & Youth Services	Southern Tier	$ 85,214
House of Good Shepherd	Oneida County/North Country	$ 125,000
Abbott House	Hudson Valley/New York City	$ 196,475
Catholic Guardian Society	New York City	$ 130,000
Green Chimneys	New York City	$ 85,000
Episcopal Social Services	New York City	$ 100,000
St. Vincent's Services	New York City	$ 150,000
Total:		**$1,021,689**

Through the assessments and the early identification of health care needs, care coordination teams are able to facilitate appropriate treatment and increase stabilization of placement. Eligibility assessments (200 percent of poverty) are conducted for all participating children. It is the expectation that the care coordination teams are developing health treatment plans for each child and integrating them with the family and child's services plan.

The model of care coordination varies depending upon several factors. These include: organizational structure, needs of children, involvement of Local Department of Social Services (LDSS), whether the provision of health care is community based or centrally based, and whether or not the agency operates with a Medical Assistance per diem.

Lessons Learned:

- Qualifications of care coordinator: It has become apparent through discussions with the agencies that to complete the function of the care coordinator, staff must be experienced and skilled in the health and child welfare issues. It is clear that care coordinators must have access to medical personnel to successfully meet the challenges of the children being served through the Care Coordination project.
- Discrete function: Care coordination includes a discrete set of activities (see below). OCFS will determine if these activities must be completed as a discrete function performed by an identified individual, or whether the functions could be spread out over existing casework/health staff.

Functions and Responsibilities of Care Coordination:

- Obtain as much past health information as possible concerning the child and the child's family.
- Establish a medical file to include all relevant medical information, past and ongoing. This medical file is separate and apart from the medical record. The medical file shall be obtained, organized and maintained by the health care coordination team.
- Written consents for routine medical treatment as well as specialty care must be obtained and a copy placed in the medical file and shared with primary care practitioner.
- Consents for the release of previous medical records must also be obtained.
- Assist child welfare staff to find an appropriate home for children with complex health and developmental needs.
- Establish a Medical Home for all children in care.
- Oversee completion of medical, mental health, developmental, dental and substance abuse assessments and necessary and appropriate follow-up evaluations.
- Arrange for and/or provide pregnancy prevention educational classes.
- Monitor the management of identified health conditions and chronic illnesses.
- Monitor routine preventive medical and dental care.
- Monitor periodic reassessments for child's mental health, developmental and substance abuse needs.

- Communicate the results of assessments and on-going medical care with primary care provider, case manager and other medical personnel as indicated as well as both biological and foster parents, as appropriate.
- Review all available health information for completeness, identification of health problems, updating the problem list, recommendations for further assessments, treatment, appropriateness of ongoing services and alternative treatment options.
- Coordinate treatment planning meetings with child, parents, family members and all potential service providers.
- Participate in service plan reviews.
- Assist with the release of health and developmental information.
- Compile health and developmental information for use by agency personnel in routine court hearings.
- Train or identify resources to train LDSS, voluntary agency staff and foster families caring for children with complex health needs.
- Assist LDSS to identify primary care provider upon discharge from care and review the availability of ongoing medical insurance coverage.
- Arrange for the transfer of medical information to new primary care provider when child is transferred among agencies or discharged from care.
- Communicate with schools regarding the medical needs of children.
- Provide ongoing education to agency staff regarding appropriate medical services.
- Provide ongoing education to medical personnel regarding the unique medical needs and mandates of foster care children, including issues surrounding consent and confidentiality.

Care Coordination Evaluation:

To document the process, outcomes, and impacts associated with care coordination, OCFS is in the process of implementing a multi-faceted evaluation plan. Included within this plan are a multi-site process evaluation and a single-site random assignment experimental design. The process evaluation activities are also currently underway at each participating site. Each program maintains an ongoing record of each child served by care coordination, their health-related needs and issues, and service receipt. Information on the activities and services directly provided by the care coordinators, including contact with health professionals, foster and biological parents, is also recorded on a case-by-case basis.

The experimental component of the evaluation examines the impact of care coordination services on foster care children's access to a variety of health and pregnancy prevention related services and explores the potential long-term effects of care coordination services on key indicators of child permanency (e.g., number and length of out-of-home placements). To date, 160 children receiving foster care services from Abbott House have been randomly assigned to

one of two study groups -- a treatment group that receives care coordination services or a control group that receives traditional agency services.

Information on the health care needs, service utilization patterns, and foster care experiences of children involved in the experimental component is currently being gathered. Whether care coordination services lead to positive change in identified outcomes will be determined by comparing the data gathered on the treatment and control groups.

Number and Characteristics of Children Receiving Care Coordination:

Databases from all nine agencies initially funded through Quality Enhancement Funds indicate that a total of 731 foster care children received care coordination services. Over half (53%) of the children served by care coordination were male. Most were minorities, with Blacks making up 51 percent and Hispanics 17 percent of the children receiving care coordination. Children served by care coordination programs tended to be older—61 percent were 10 or older at time of entry into care coordination. Over half (61%) of the children served resided in a foster boarding home-- either regular or therapeutic -- when assigned to care coordination.

Sample children also differed in admission status. Slightly more than half (56%) of the children served by care coordination were "Under Care" youth, meaning that they had been in out-of-home care for 31 days or more when they began receiving care coordination services. The remaining youth were "New Admissions" to both foster care and care coordination services. For these children, enrollment in care coordination occurred within 30 days of their placement into foster care. Eight of the nine participating agencies provided services to both Under Care and New Admission youth.

Characteristics of Children Receiving Care Coordination Services: March 2003 – December 2004

Characteristic	Percent
Sex	
Male	53
Female	47
Race/Ethnicity	
White, Non-Hispanic	25
Black, Non-Hispanic	51
Hispanic	17
Other	7
Age at Entry into Care Coordination	
0-2 years	16
3-4 years	6
5-9 years	17
10-14 years	29
15 years or older	32
Placement Level at Entry into Care Coordination	
Approved Relative Home	8
Foster Boarding Home	49
Therapeutic Foster Boarding Home	14
Group Home	6
Institutional Placement	23
Admission Status	
Under Care (already in care)	56
New Admission	44

Children's Health:

Data on children's health-related problems, initial assessments, and service receipt was derived from the evaluation databases of the 8 funded agencies.

- Consistent with previous research on foster care children, preliminary examination of the health data indicates that 87 percent of children who received a minimum of 45 days of care coordination services had multiple health-related needs.
- As shown below, 82 percent of care coordination recipients had a mental health, developmental and/or substance abuse-related problem. Common mental health problems included: attention deficient/hyperactivity disorder, depression, post-traumatic stress disorder, and oppositional defiant disorder. Developmental problems noted most often included: speech/language, fine motor and gross motor delays.

- Over 70 percent of children receiving care coordination (70%) experienced a medical problem or issue during placement, with asthma, allergies, visual impairments and dermatological problems being the most frequently identified areas of medical need.
- Approximately one-third of all care coordination recipients (30%) were children of a substance abuser (30%).

Health-Related Problems and Issues Among Children with 45+ Days of Care Coordination Receipt

Problem	Percent
Medical	70
Dental	19
Mental Health	68
Developmental	26
Substance Abuse	35
Mental Health, Developmental or Substance Abuse	82
More than one health-related problem or issue	87

Completion and Timeliness of Initial Assessments:

Preliminary examination of the services data for these children suggests that children in care coordination receive a wide range of health-related services that may lead to better health outcomes and facilitate permanency. A primary aim of care coordination is to ensure that foster care children receive timely initial assessments of their current functioning and needs in five core areas: physical, dental, mental health, developmental, and substance abuse. Consistent with stated goals, agency databases indicate that the majority of children who receive care coordination services also receive age-appropriate initial assessments. Of sample participants with 45-plus days in care coordination, 96 percent had an initial physical assessment completed. Completion rates were similarly high for initial dental (86%) and mental health (84%) assessments. Initial developmental (78%) and substance abuse (69%) assessments occurred less frequently but were received by over two-thirds of care coordination recipients in the targeted age range.

Moreover, preliminary analyses suggest that care coordination may decrease the amount of time that elapses between placement into foster care and initial assessments. Although most of the children in the current sample received initial assessments at some point during their stay in foster care, children differed in when these assessments were completed. "New Admission" children had considerably higher rates of timeliness for each assessment type than did their Under Care counterparts. These results suggest that having care coordination services in place at the time of

placement into foster care increases the likelihood that initial assessment services will be carried out within the state-recommended time frames.

Service Receipt

Increasing access to needed health care services is another stated goal of care coordination services. At the time of the present report, agency service data was not sufficiently complete to permit a meaningful comparison of service needs to service receipt.

Approximately 63 percent of care coordination children attended a well childcare visit during the study period examined, and just over half (57%) received medical treatment for an acute, chronic or emergency condition. Routine preventive dental care was also received by about half (56%) of care coordination youth, while 12 percent of sample youth received treatment for orthodontic and/or acute dental needs. Mental Health services were provided to 66 percent of care coordination youth. Individual therapy sessions and medication management services were the most common mental health services provided. Developmental services including speech, occupational and physical therapy were received by 23 percent of care coordination youth. An additional 24 percent received school-related educational services, such as educational assessment, Individualized Education Program (IEP) development and tutoring. Substance abuse services were received least often by sample youth, with only 10 percent of care coordination youth receiving therapeutic, educational or other services.

In addition to identification and service delivery improvement efforts, it is hoped that the provision of care coordination services will improve both documentation and communication practices. Consistent with these objectives, activity records maintained by the care coordinators employed at each participating site indicate that the vast majority of care coordination recipients receive these types of services from their care coordinator. Care coordinators reported participating in the following activities in over 80 percent of their cases: updating child's medical file; obtaining information from collaterals; contact with professional providers, foster parents, or biological parents regarding child's needs and progress; and advocating for child's needs and rights.

2. OCFS CHILD AND FAMILY SERVICES REVIEW (CFSR) PROGRAM IMPROVEMENT PLAN (PIP):

The Federal Administration for Children and Families (ACF) conducted a review of the delivery of child welfare services in every state during 2001 through 2004. The review looks at the state's achievement of outcomes in the areas of child safety, permanency, and well-being using the results of each state's self-assessment, performance on six ACF-established national standard data measures, an on-site review of 50 cases, and stakeholder interviews. This Child and Family Services Review (CFSR) process was conducted in New York State during 2001. ACF issued a "Final Report of the Child and Family Services Review in New York State" in January 2002. The report required that New York State, like all states, develop a Program Improvement Plan to address those areas in which the State was not in substantial conformity with Federal expectations.

While the findings from the CFSR pointed to a need for improvement in several areas, they most clearly demonstrated the need to discharge children from foster care to safe, permanent homes more quickly. The State, local districts, and voluntary agencies must implement strategies that will

decrease the length of time children spend in foster care. New York must demonstrate improvement in these areas by the time ACF returns to conduct the second CFSR review, or there is the potential for fiscal sanctions. Most importantly, reductions in the lengths of stay for children in foster care are necessary so that children grow up in safe, permanent homes and not in foster care. Improvements in these areas were well underway prior to the CFSR process, but the CFSR provides another opportunity to heighten efforts in this regard.

A portion of the Quality Enhancement Fund is being used to help local social services districts implement the CFSR PIP.

2a. PERMANENCY MEDIATION PROJECTS:

	$ 401,375	1 program serving Brooklyn, Bronx and Manhattan in New York City
	$ 75,000	1 program serving Monroe County
	$ 75,000	1 program serving Westchester and Rockland Counties
Total:	$ 551,375	

As the co-sponsor of the permanency mediation programs, the New York State Office of Court Administration (OCA) provides funding to four other programs serving five additional counties.

Child Welfare Permanency Mediation is a promising strategy that may improve the outcomes of children in foster care by reducing the length of stay in such care, reunifying families safely and sooner, or -- where that is not possible -- achieving permanency sooner for the child through adoption or guardianship. It supports progress towards meeting the TANF goal of providing assistance to eligible needy families so that children may be cared for in their own homes or in homes of relatives. The program improvement plan activities that improve overall case planning, case management and services promote the TANF goal of preventing or reducing the incidence of out-of-wedlock pregnancies. Other states have shown significant cost benefit results by instituting this program.

Permanency Mediation is a process that involves all stakeholders: the family (including the child as circumstances warrant), the caseworkers, service providers, foster parents, law guardians, attorneys for all parties, and a neutral mediator. The mediator's role is to help identify issues, clarify perceptions and explore alternatives for a mutually acceptable outcome. It can be done at any stage of the child welfare case and often can obviate the need for protracted litigation in the courts. Because it is non-adversarial, parents are more engaged and empowered in reaching decisions about their families. It is also a mechanism that provides more useful information to the courts and assists with service plan development.

Through joint funding with the Office of Alternative Dispute Resolution (ADR) of the Office of Court Administration and the Permanent Judicial Commission on Justice for Children, OCFS has participated in funding Child Welfare Permanency Mediation programs. In the first year, seven counties participated: Albany, Chemung, Monroe, New York City (Brooklyn and Manhattan), Oneida and Westchester. In Year 2, the New York City program expanded to the Bronx, the Westchester program expanded to Rockland County, and a new agency serving Erie and Niagara counties came under the permanency mediation umbrella.

Despite splitting the contracts between the two state agencies, the overall permanency mediation project is still viewed by all participants as a collaborative project between OCFS and OCA. In keeping with a unified collaborative structure, the programs have been jointly trained by OCFS and OCA and are using the same reporting requirements regardless of contract source. On November 9, 2004, all programs attended a joint OCFS-OCA workshop about developing a continuous improvement plan that includes specific performance targets and activities they will undertake to achieve those numeric goals. The continuous improvement model was chosen by OCFS and OCA as the appropriate method for tracking program progress because it accommodates the unique features of each program, while still requiring accountability and demonstrated progress towards quantifiable goals. Each site requires its own continuous improvement plan as the sites are in different stages of program development, even if it is the same contractor working in two or more counties. In other words, a new program site is not expected to be conducting as many mediations as a program that hired staff more than a year ago. Detailed performance targets allow a realistic vision of how many families the program will be serving a year when the program is fully operational. The continuous improvement plan specifies the actions that the staff will take over the coming year. These measurable activities will be assessed and revised as needed to produce satisfactory progress toward reaching the target number of families to be served by permanency mediation.

New York City Family Court Child Permanency Mediation Project, Kings, New York, and Bronx Counties:

Organization: Society for the Prevention for Cruelty to Children (SPCC) and the New York City Family Court

> The permanency mediation program implemented a strategic plan to systematically increase appropriate referrals that entails 6 stakeholder meetings annually in both Brooklyn and New York counties, 9 stakeholder meetings in the Bronx, a total of 26 presentations to stakeholder groups annually, 28 meetings with judges annually, and courtroom consultation once a week in Brooklyn, twice a week in New York, and five times a week in the Bronx. Although their protocol identified the permanency stage as the initial target, they have received referrals at almost all stages of the legal process, with the exception of cases that are pre-fact finding.

Child Permanency Mediation Program, Monroe County

Organization: The Center for Dispute Settlement, Inc.

> The permanency mediation program is operating in Monroe County, and staff is implementing its plan to engage and educate key stakeholder groups and other interested parties in Monroe County. They are also developing a systematic plan to measure interest and willingness of prospective key stakeholders to implement a permanency mediation program in the seven other counties in the UCS Seventh Judicial District. As they anticipate adding three counties over the second and third year, the program has been working to increase by six the number of certified and experienced permanency mediators. Cases may be accepted at any stage of child welfare proceedings.

Child Permanency Mediation Program, Westchester and Rockland Counties

Organization: Dispute Resolution Center

The permanency mediation program is operating in Westchester and Rockland counties, and staff met with interested groups of stakeholders in Orange and Putnam counties to expand the services to families in these counties. Staff increased from one part-time coordinator to two part-time coordinators. The program has a roster of 10 permanency mediators with various levels of experience and training. Steps are being taken to evaluate all mediators' skills. The Program Coordinator is now targeting underutilized referral sources such as DSS, the County Attorney's Office, Law Guardians, and CASA in Westchester and the court in Rockland. Staff also attends court at least once per month in each county to increase visibility and promote referrals.

Child Permanency Mediation Program, Erie and Niagara Counties

Organization: Catholic Charities

Catholic Charities had been operating a child permanency mediation program since 2000 in Erie County, when it received a grant from the OISHEI Foundation. Their program received more than 80 referrals each year in 2001, 2002, and 2003. In 2003, it had 86 referrals and conducted 52 mediations, but referrals dropped precipitously the next year and just 23 referrals were received and only 16 mediations were held in 2004. Now OCA has allowed Catholic Charities to raise the visibility of permanency mediation with the Erie County Permanency Coordinating Committee stakeholders, the Erie County Family Court Liaison, and DSS and to re-energize the program.

Niagara County DSS and Family Court wanted to bring permanency mediation to their county and agreed to collaborate with Catholic Charities to implement this promising practice. The OCA contract for these two programs began on July 1, 2004. Each county has its own performance plan and performance targets because the programs are in different stages of development. Each program needs its own stakeholders group and needs to educate and work with a different set of attorneys, caseworkers, judges, and service providers. Since the Erie County program already has experienced child welfare mediators, it is focusing its efforts on understanding and correcting the drop-off in referrals through focus groups with caseworkers, and through increasing outreach and marketing to attorneys, foster parents, and court personnel to increase appropriate referrals to the mediation program. The Niagara County program spent considerable effort in its first year to educate stakeholders and develop the program, including recruiting and training three permanency mediators.

There are no limitations regarding the types of cases that can be referred to mediation.

Child Permanency Mediation, Albany County

Organization: Mediation Matters

The first dozen cases referred to the Albany mediation program by the Chief Judge were intentionally among the Court's most difficult and protracted cases. Consequently, these cases had unusually high numbers of mediation sessions per case, and may not be typical of the kinds of families that the program will serve in the future. The program carried out important administrative tasks, such as developing an intake form that contains all the information needed for the evaluation database, and revising the confidentiality and agreement-to-mediate forms. They planned to hold at least five continuing education seminars for the permanency mediator trainers annually, meet more regularly with the Family Court Judge, conduct a training session for all Department of Children, Youth and Families (DCYF) caseworkers, and continue to hold steering committee meetings to review performance goals.

Child Permanency Mediation Program, Chemung County

Organization: Community Dispute Resolution Center (CDRC)

This program is operational and currently has enough trained permanency mediators (4 on staff, 4 volunteer), so it is focusing on increasing the number of referrals to the program as well as broadening the sources of referrals. It also developed a protocol for handling cases with Chemung County DSS Children and Family Services staff to help overcome scheduling problems. Meetings have been held with Chemung County DSS staff and several Family Court judges, as well as discussions with Schuyler County DSS about expanding permanency mediation to Schuyler County. The director of the Law Guardian Office is working with program staff to provide education and information to other attorneys involved in permanency cases.

Sexual abuse cases are not accepted.

Child Permanency Mediation Program, Oneida County

Organization: Peacemaker Program, Inc.

The permanency mediation program had been working only with the Model Family Court in Utica. As the model court has expanded to the Rome Family Court, permanency mediation services will be available to families using the Rome Family Court. The mediation coordinator has been attending model court bi-weekly to accept referrals, and to schedule mediation right then while all parties are present. This practice has had the advantage of getting cases to the first mediation session more quickly (3-4 weeks), alleviates the need to make multiple phone calls to coordinate a date among all participants, and provides an opportunity for parties to speak immediately with the coordinator about the mediation process. The stakeholders group continues to meet quarterly, and holds at least two presentations on mediation for court and social services staff

each year. The program is working on recruiting 3-4 experienced family court mediators to become trained permanency mediators.

Permanency Mediation Evaluation

The Bureau of Evaluation and Research (BER) within OCFS is in the process of evaluating the seven child permanency mediation programs sponsored by OCFS and the Office of Court Administration. Included within the current evaluation plan are a multi-site process evaluation, a client satisfaction study, and a quasi-experimental impact study. This section of the report summarizes each evaluation component and provides a preliminary look at study findings for those areas in which initial data are available.

◆ Multi-Site Process Evaluation Study

The process study is intended to provide a descriptive overview of child permanency mediation services, and involves each of the pilot sites participating in the child permanency mediation project.

Table 1
New York State Child Permanency Mediation Pilot Project Sites

Agency	Counties Served
Catholic Charities	Erie, Niagara
Center For Dispute Settlement	Monroe
Community Dispute Resolution Center	Chemung
Dispute Resolution Center	Rockland, Westchester
Mediation Matters	Albany
New York City Family Court & The New York Society for the Prevention of Cruelty to Children	Kings, New York
Peacemaker Program	Oneida

The purpose of the process study is twofold: 1) to document the service model developed and implemented at each pilot site and 2) to assess the extent to which the models implemented are consistent with the overall intent and concept of child permanency mediation. Key areas addressed by the process study include: referral procedures, staffing and training protocols, service provision practices (e.g., the number and type of cases served; the number, length, and focus of mediation sessions held), involvement of the parties to the mediation (e.g., child, biological parent, foster parent, caseworker, attorney, service provider), and mediation outcomes (e.g., whether a verbal or written agreement was reached).

Information on each of these key areas is recorded on a case-by-case basis using an ACCESS database system specifically created for the current evaluation project by BER and the Office of Alternative Dispute Resolution staff. Agencies submit their databases to BER on a monthly basis. BER staff review each submission for missing and/or inconsistent data entries and provide

program staff with feedback on the quality and comprehensiveness of their data collection efforts.

As depicted in Table 2, a total of 172 referrals, representing 163 families, had been made to child permanency mediation services by January of 2005. One hundred and forty-two or approximately 83 percent of these referrals met agency eligibility guidelines and resulted in an initial mediation session being held. The most common reasons for referrals not leading to an initial mediation session were refusal by one or more of the parties and failure to attend. Of those cases that began mediation, 110 or approximately three-quarters (77%) completed mediation. The most frequently listed reasons for not completing mediation included party withdrawal from the mediation process and the presence of unamenable issues. Agreements were reached in 88 (62%) of the cases that began the mediation process.

Table 2
Child Permanency Cases Served and Associated Mediation Outcomes by Agency

Case Status	Agency							Total
	Catholic Charities	Center for Dispute Settlement	Community Dispute Resolution Center	Dispute Resolution Center	Mediation Matters	New York Society For the Prevention of Cruelty to Children	Peace-maker Program	
Referred	20	11	5	12	20	67	38	172
Mediated	14	11	4	12	15	60	26	142
Completed Mediation	6	11	4	10	11	50	18	110
Agreement Reached	5	5	3	9	9	42	15	88

◆ Client Satisfaction Study

The client satisfaction study uses survey and individual interview methods to assess mediation participants' perceptions of the mediation process and its impact on case outcomes.

Client satisfaction surveys are voluntary and are distributed by agency personnel to all individuals who attend at least one mediation session. Biological parents, foster parents, and extended family members receive a survey designed to measure the extent to which they feel respected, heard, and involved in decision-making processes. Professional parties (e.g., caseworkers, legal representatives, service providers) receive a survey designed to assess the extent to which mediation services influenced their ability to work with the family, their communication with other professionals, and other professional duties. In addition, all parties answer questions regarding their impression of the mediation process and their overall satisfaction with mediation services.

As of January 2005, client satisfaction surveys had been completed by 78 non-professional parties (e.g., parent, foster parent, extended family members) and 132 professionals. As illustrated in Table 3, the majority of respondents reported favorable perceptions of the mediation process and were satisfied with their mediation experience.

Table 3
Participant Satisfaction with Child Permanency Mediation Services

Statement	Percent Satisfied	
	Non-Professional Parties	Professional Parties
I got the chance to talk about the things I wanted to talk about.	96	98
Mediation helped me to consider new ways of thinking about the issues discussed.	80	71
Overall I was satisfied with the mediation process.	89	89

In addition, interviews with professional parties who have participated in multiple mediation cases will focus on documenting professional parties' overall impressions of the mediation process and any benefits and/or drawbacks associated with its use.

◆ Impact Study

Impact studies examine whether specified interventions are an effective means of promoting stated program goals below. Goals associated with child permanency mediation programs focus on expediting the obtainment of safe, permanent living situations for children involved with the child welfare system.

- Increased parental involvement in and compliance with case plans
- Decreased placements into foster care
- Increased stability of foster care placements
- Reduced length of time between foster care entry and permanent placement
- Decreased rate of reentry into foster care

In order to determine whether permanency mediation achieves these goals, it is necessary to compare cases that go through the mediation process with a control group consisting of similarly situated cases that are processed using the traditional family court method. An impact study can be conducted once service capacity of participating pilot sites has reached sufficient levels to permit the identification and formation of reasonably sized study groups, and OCFS is

planning to conduct such a study. Information on the immediate results of the mediation, such as whether an agreement was reached and the nature of the negotiated settlement, will be available earlier, as part of the process study.

2b. LOCAL PIP IMPLEMENTATION/NEW YORK CITY COURT DIVERSION:

A portion of the Quality Enhancement Fund ($100,000) is being used in New York City for a court diversion project. This project is a collaborative effort among the Administration for Children's Services, Legal Aid Society, the Office of Court Administration, and The Center for Family Representation. The Court Diversion Initiative provides intensive children and family services on the front end of cases, to determine whether a family can engage in services and a child can safely remain or return home. This initiative also utilizes alternative dispute resolution as a means to divert court involvement or achieve early settlement of Article 10 (child abuse and neglect) proceedings.

Total: $100,000

3. FOSTER CARE TRANSITIONING - YOUTH MENTORING QUALITY ENHANCEMENT PROGRAM:

The investment of $165,000 in mentoring is consistent with OCFS's commitment to long-term, broad-based strategies to build community supports for children, youth and families that focus on youth development and asset-based solutions. The mentoring of adolescents leaving foster care is designed to support the TANF goals of preventing or reducing risk of out-of-wedlock pregnancy and assisting eligible young people to successfully transition to their families and communities. Programs modeled after the Big Brothers / Big Sisters of America (BBBSA) programs help high-risk youth to build attachments to pro-social others, commit to socially appropriate goals, and become involved in conventional activities. Research indicates that youth who achieve these three core skills engage in less high-risk behavior and more pro-social behavior.

In August 2003, OCFS contracted with the Big Brothers/Big Sisters of NYC to provide mentors for 100 youth in custody of the NYC Administration for Children Services, ages12-20, who were discharged from placement to a biological parent, to a relative, or to independent living.

The program targets youth who are returning to one of the five high-risk neighborhoods that generate the majority of Foster Care placements in NYC: Bedford Stuyvesant; Brownsville; East New York in Brooklyn; Central Harlem; and East Harlem in Manhattan. These five locations are ACS's Neighborhood Network boroughs that contract with organizations to provide mentoring and case coordination programs to improve outcomes for youth. The desired outcomes of this mentoring initiative are consistent with the New York State Child and Family Services Review Program Improvement Plan and OCFS's goal to provide permanency for adolescents and to prevent out-of-wedlock pregnancy. Over 250 youth were matched with mentors.

Total: $165,000

4. EVALUATION OF CHILD WELFARE FINANCING INITIATIVE:

The Child Welfare Financing legislation requires that OCFS submit a preliminary report on the implementation of the child welfare financing provisions. The final report must include "information regarding service delivery trends under the financing structure…and…innovative

models of service provision to be considered for replication." Quality Enhancement funds will be applied to a portion of the costs of the evaluation. In SFY 2004-05, $61,936 in Quality Enhancement funds and $11,409 in unexpended SFY 2002-03 Quality Enhancement funds were applied to the evaluation.

The evaluation is examining the implementation of -- and outcomes resulting from -- the Child Welfare Financing initiative, including changes in service delivery patterns and progress toward achieving key child welfare outcomes. Additionally, the evaluation will include an assessment of the effectiveness of the program models funded through the Quality Enhancement Fund.

The evaluation will assess the success of the Child Welfare Financing initiative in achieving the following outcomes:

- Reduce the rate of recurrence of child abuse and neglect.
- Decrease the incidence of child abuse and neglect in foster care.
- Reduce the rate of out-of-home placement.
- Increase the stability of foster care placements.
- Reduce the length of time from entry into foster care until reunification or adoption.
- Decrease the rate at which children who are reunified with their families reenter foster care.

The evaluation will also explore the implementation and impacts of the programs receiving funding from the Quality Enhancement Fund. Depending on the objectives of the program and the nature of the intervention, the evaluation will analyze the effects of the program on one or more of the outcomes listed above as well as other relevant outcomes, such as continuity of health care services for children in foster care and increasing parental involvement and compliance with case plans.

The assessment of the Quality Enhancement Fund programs will require a different approach than the assessment of the overall Child Welfare Financing initiative. The evaluation designs for these components of the evaluation are discussed separately below.

Evaluation Design for Overall Child Welfare Financing Initiative: The performance of the local districts on the six outcomes specified above is being tracked on a semi-annual basis as part of the Performance Improvement Plan for the Child and Family Services Review. The same outcome measures will be used for the Child Welfare Financing evaluation. Because of the nearly simultaneous implementation of Child Welfare Financing and the PIP, however, it will be impossible to determine how much improvement in performance is attributed to Child Welfare Financing and how much is due to the PIP. Consequently, it will be critical to gauge the success of Child Welfare Financing in meeting the intermediate goals through which we expect improved outcomes for children and families to be achieved.

Interviews and focus groups with key informants in the local districts, i.e., Commissioners, Directors of Services, Fiscal Administrators, and other administrative staff, are being conducted. A series of focus groups will be held with local district administrators at New York Public Welfare Association conferences to obtain the perspectives of a broad spectrum of counties. The

insights gained from these focus groups will inform the development of topic guides for in-depth interviews with key informants in a sample of districts. The sample will include New York City and nine counties varying in size, geographical location, and the characteristics of their service delivery systems. Focusing on a small sample of districts will permit a detailed exploration of how Child Welfare Financing was implemented in each district, the contextual factors that facilitated or impeded implementation, and the strategies employed to achieve the desired outcomes.

Evaluation Design for Quality Enhancement Fund Programs: The evaluation of the mentoring program will be conducted by Big Brothers/Big Sisters, which is responsible for administering the program. OCFS's Bureau of Evaluation and Research will evaluate the Care Coordination and Permanency Mediation programs. These evaluations are described earlier in this report.

Total: $61,936

CONCLUSION:

The three key components of Child Welfare Financing provide a fiscal structure designed to redirect resources from out-of-home placements of children to maintaining them safely and appropriately in their homes wherever possible. Uncapped services funding facilitates the expansion of the services necessary to prevent placement, expedite the return home of foster children, and avert the re-placement of children in foster care. The Foster Care Block Grant provides a financial incentive for districts to reduce unnecessary days in foster care and, when placement is unavoidable, to keep foster children in their own communities rather than distant institutions. The final and equally critical component, the Quality Enhancement Fund, enables OCFS to invest in innovative programs that have been proven to, or have significant potential to, accomplish the goal of enhancing the safety, well-being, and permanency of vulnerable children.

OCFS continues to strategically invest Quality Enhancement funds in program development and evaluation of services and interventions that promise to yield positive outcomes for families and children. These investments are made at all points on the continuum of children and family services. The approach is consistent with OCFS's commitment to providing outcome-focused and evidence-based services.

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Visit our website at:
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For information on the Abandoned Infant Protection Act, call:
1-866-505-SAFE

To report child abuse and/or neglect, call:
1-800-342-3720

For child care and adoption information, call:
1-800-345-KIDS

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