

**FAMILY PRESERVATION AND FAMILY
SUPPORT (FP/FS) SERVICES
IMPLEMENTATION STUDY**

INTERIM REPORT

Volume I
Synthesis Report

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*James Bell Associates
Arlington, VA*

**FAMILY PRESERVATION AND FAMILY
SUPPORT (FP/FS) SERVICES
IMPLEMENTATION STUDY**

INTERIM REPORT

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Submitted To:
Helen Howerton, Project Officer
Administration for Children and Families
U.S. Department of Health and Human Services

Submitted By:
James Bell Associates
2111 Wilson Boulevard, Suite 1120
Arlington, VA 22201
Telephone: (703) 528-3230
FAX: (703) 243-3017

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ALABAMA--

Rebecca Peaton
Clara Price
Sandy Arthur

Hale County

Richard Rhone

Houston County

Linda O'Connell

ARIZONA--

Anna Arnold

Phoenix

Mike Davison
Lydia Carbone

Winslow

Sandy Haggard
Deanna Webb

CALIFORNIA--

Carlos Ramos
Carol Camarrillo

Fresno County

Jeffrey Stover

Los Angeles County

Bruce Rubenstein
Nancy Herrera

Santa Clara County

Zonia Sandoval Waldon
Jodie Harris

COLORADO--

Charles Perez

Denver

Mary McNeil-Jones
Sharon Vesely

San Luis Valley

Betty Goulden

FLORIDA--

Carol McNally

Broward County

Teresa Herrero

Pasco and Pinellas Counties

Ann Doyle

GEORGIA--

Doris Walker

Atlanta/Bibb County

Chatham County

Carla Rogg
Jeanette Myer
(Care Solutions, Inc.)

MISSOURI--

Anna Stone
Vince Geremia

Jackson County/Kansas City

Tim Decker

St. Louis

Veronica Banks

TEXAS--

Beverly Booker

Dallas/Ft. Worth

Truman Thomas
Jillian Elliott

San Antonio

Mary Flanagan
Julie Leake

VERMONT--

Cynthia Walcott

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Shirlee Lively
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JBA Staff

James Bell
Karl Ensign
Robert Geen
Jill Hensley
Emily Lawrence
Elizabeth Lee
Karin Malm
Maria Parisi

Westat Staff

Ronna Cook
Susan Berkowitz
Frances Gragg

Consultants

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Child Welfare and Mental Health Division
Children's Defense Fund

Nilofer Ahsan, State Policy Analyst
Family Resource Coalition of America

Richard Barth, Director
Family Welfare Research Group
University of California at Berkeley

Gordon Berlin, Executive Vice President
Manpower Demonstration Research Corp.

Kathleen Feely, Associate Director
Annie E. Casey Foundation

Ron Haskins, Human Resources Counsel
Committee on Ways and Means

Ivory L. Johnson, Deputy Director
County of San Diego Health and Human
Services Agency
Home Visiting Strategic Initiative

Dana Jones, Executive Director
Southern Maryland Tri-County CAC

Judith Jones, Director
National Center for Children in Poverty

Sheila B. Kamerman, Professor
Columbia University School of Social Work

Elba Montalvo, Executive Director
Committee for Hispanic Children & Families

Susan Notkin, Director
Program for Children
Edna McConnell Clark Foundation

Theodora Ooms, Executive Director
Elena Cohen
Family Impact Seminar

Betsey Rosenbaum, Director
Children and Family Services
American Public Human Services Assoc.

Barbara Solomon, Dean
University of Southern California

Anna Stone, Principal Assistant
Vince Geremina, Program Coordinator,
Family Preservation Services
Missouri Department of Social Services

Ying-Ying T. Yuan, Vice President
Walter R. McDonald & Associates, Inc.

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Project Director

**FAMILY PRESERVATION AND FAMILY SUPPORT (FP/FS)
SERVICES IMPLEMENTATION STUDY
EXECUTIVE SUMMARY**

The 1993 Family Preservation and Family Support (FP/FS) legislation (title IV-B, subpart 2 of the Social Security Act) authorized nearly \$1 billion over five years in new federal funding for services to strengthen and support families' efforts to provide a safe and nurturing environment for their children. FP/FS funds were to be administered at the federal level by the Administration on Children, Youth and Families and at the state level by the child welfare agency responsible for administering child welfare services funds under title IV-B, subpart 1.¹

In September 1994, the Administration for Children and Families (ACF) awarded a five-year contract to James Bell Associates (JBA) to conduct the "Family Preservation and Family Support Services Implementation Study." The purpose of this study is to evaluate how states and communities implemented the legislation, the ways in which implementation altered the pre-existing service delivery system, and the effects on service delivery. This interim report is based on: (1) A review of the FP/FS applications, state plans and 1996 plan updates submitted by each of the 50 states; (2) site visits to 10 states conducted between November 1995 and July 1996; and, (3) site visits to 20 communities between September 1996 and June 1997.

Throughout the study activities to date, it became evident that there was no single story of FP/FS implementation – each state and locality's implementation effort reflected their unique history of family preservation and support services, problems and issues facing their child welfare system, and their unique strategy toward decentralizing decision-making authority for government programs. The degree of flexibility provided to states and localities by the federal government promoted the diversity observed in this study.

Consistent with federal expectations, FP/FS funds have been used to launch new community-based programs and encourage broad-based participation in the planning and service delivery process. Many sites developed innovative and promising approaches to service

¹With the passage of the Adoption and Safe Families Act of 1997, several important changes were made to the FP/FS program. These included: reauthorizing the program through FY 01; adding two service categories to be funded (time-limited family reunification programs and adoption promotion and support services); and renaming the program "Promoting Safe and Stable Families".

delivery. They provided comprehensive services, bridged existing gaps in service delivery, maximized the use of available resources, attracted other funding sources, involved consumers in the service delivery process, supported safe and nurturing environments for children whose parents were transitioning from welfare to work, and reduced tensions between public institutions (especially child welfare agencies) and the communities these agencies serve.

In 1994 and early 1995, when states were engaged in FP/FS planning, several factors slowed FP/FS implementation. States noted the following federal issues: proposals before Congress calling for a child welfare block grant; the shut down of the federal government; delays in issuing final program regulations; and anticipated welfare reform legislation. Other factors at the state and local levels further delayed the start of service delivery. These included changes in the political structures; the challenge of establishing new collaborative planning bodies; and desire to further decentralize decision-making authority to counties and communities.

As a result, most programs in the 10 case study states had just begun operations at the time of the site visits in 1996-97. Since the programs were still in their infancy, it was too soon to accurately describe detailed program operations or draw conclusions about the results they might achieve. Nevertheless, there was sufficient information to examine the lessons learned to date, explore areas where further federal guidance and support would be beneficial and identify promising service delivery program designs. Despite the unique nature of each state and locality's approach to FP/FS implementation, some common issues in planning, management and service delivery emerged. These issues are described below.²

A. Planning

Most states took advantage of the opportunity afforded under the federal legislation to emphasize planning efforts, spending up to \$1 million of their first-year federal funds on these activities without having to allocate state matching dollars. States enthusiastically followed federal guidance in many aspects of the planning process, including: non-supplantation of

²Detailed information on innovative practices can be found throughout the report and in Volume II, State and Local Case Study Summaries.

funds, collaboration, needs assessment, consumer involvement, and approaches to decision making.

1. Non-Supplantation of Funds

As required in the legislation, FP/FS funds do not appear to have supplanted pre-existing monies for family preservation and support programs. States created new programs, replicated promising program models in new geographic areas, and added new and more comprehensive service components to existing program models.

2. Collaboration

Most states made considerable efforts to implement a broad-based collaborative planning process. Both state and local collaborative planning bodies were formed. These planning bodies were comprised of representatives from other human service agencies, including health, mental health, substance abuse treatment, public assistance, domestic violence, education, developmental disabilities, and juvenile justice. Membership included both public and private service providers, as well as advocates, academics and consumers. Furthermore, some states, such as Arizona and Texas, required service providers interested in applying for FP/FS funds to join together to develop more comprehensive and collaborative service delivery projects.

3. Needs Assessment

States followed federal guidance and engaged in a variety of formal and informal needs assessment efforts. States conducted surveys, held focus groups, examined existing statistical data and conducted public hearings. However, the success of the needs assessments varies depending upon the criteria used to judge their effect.

- **Needs assessment as a catalyst:** The assessments often engaged a broad array of stakeholders and encouraged them to review the problems facing children and their families. The assessments also prompted stakeholders to examine existing resources and consider ways to use them effectively. In this regard, state needs assessment efforts were largely successful.
- **Needs assessment as a targeting tool:** Acknowledging that funds were limited, some states used needs assessment data to target funds to specific counties (or communities). Some states used existing data on such measures as poverty,

abuse/neglect rates and teen pregnancy rates to select counties and communities that had the greatest need for additional services.

- **Needs assessment as a technical planning tool:** One weakness in the planning process in many states was that needs assessment data were seldom used to establish program priorities and determine which program models might best address the most pressing gaps in the existing service delivery system. It appears that a lack of time (some planning decisions were made prior to needs assessment completion), and the effects of other contextual factors played a greater role in making these funding and service delivery decisions. In this regard, needs assessment efforts were less useful than they might have been.

4. Consumer Involvement

Most state and local planning groups included consumers in the planning process, often securing input from consumers through focus groups and public hearings. Although states and localities made considerable efforts to appoint consumers to the planning bodies, several states noted that their early efforts had not been as successful as they had hoped. Two issues pertaining to consumer involvement emerged:

- **Definition of a consumer:** While planning groups typically sought to include parents in the process, there was a tendency for consumer participation to be limited to parents who were active in civic affairs (e.g., a PTA president) or who were experienced advocates (e.g., parents of children with disabilities). Few planning groups focused on involving parents who had received public assistance or services from the child welfare agency, had substance abuse problems or were teenage parents. One notable example of efforts to reach a more diverse consumer population occurred in Phoenix, Arizona, where a member of the planning group visited local unemployment and public assistance offices and talked with individuals in the waiting rooms about their service needs.
- **Efforts to attract consumers:** Planning groups attempted to attract consumers primarily by providing child care and transportation services. Despite these efforts, non-traditional consumers typically came to only one or two meetings and then dropped out. Whether or not consumers attend all meetings may be less important than their active participation at critical junctures in the planning process. For example, in Broward County, Florida, special efforts were made to include residents in reviewing provider proposals to establish service programs in their neighborhood.

Although child care and transportation assistance may be important, it appears equally important to create a welcoming environment for families by: educating other members of the group to be sensitive to cultural differences and non-

judgmental about issues facing consumers (e.g., substance abuse); helping consumers understand technical and bureaucratic terminology; keeping in contact with consumers between scheduled meetings; and bringing them up-to-date when meetings are missed.

5. Locus of Decision Making

Although most states formed collaborative planning bodies, there was considerable variation in the composition of the planning groups and the extent of their role in the decision-making process. In turn, these differences affected the nature of the decisions reached as a result of the planning process.

Three decision-making models were identified in the case studies: **state child welfare agency model** in which the child welfare agency (with some input from other stakeholders) made at least one key decision concerning the use of FP/FS funds; **state-level collaborative body model** in which decisions were made by the entire planning body; and **local jurisdiction model** under which the state delegated planning authority to a local agency or planning body.

The type of decision-making model used affected the following:

- **Allocation of significant funds for FP and FS programs:** States employing the child welfare agency decision model set aside funds for both FP and FS programs. While they involved other stakeholders in the decision-making process (especially as it related to family support programs), these states had a clear vision of the types of programs they wished to develop. In contrast, stakeholders who were most knowledgeable about family support programs tended to predominate on the collaborative planning bodies. Often child welfare administrators or front-line staff did not participate actively in this process. As a result, the collaborative planning bodies allocated relatively fewer dollars for intensive family services or reunification programs targeted to the child welfare population.
- **Geographic allocation of funds:** States that delegated authority to the local level divided their FP/FS funds proportionately among all districts or counties. In contrast, states using the child welfare agency decision model targeted funds to selected counties. Some of the sites using state-level collaborative bodies also targeted funds.
- **Size of service delivery projects:** Funding allocations for programs were also affected by the size and diversity of the planning bodies. Large, diverse planning groups tended to achieve consensus by "giving everyone something." This resulted in numerous projects with few resources to achieve the often far-reaching goals that were established.

B. Linking Plans to Service Delivery

Several activities necessary to support and enhance service delivery were undertaken. These include program financing, monitoring and training.

1. Financing

The federal government recognized that FP/FS funds alone would be insufficient to address the range of needs experienced by children and families. One expected outcome of collaboration was that it would lead to agencies and programs blending funding streams or jointly funding programs. Although several positive examples of blended and joint funding were noted, collaboration in the planning process did not necessarily lead to blended or joint funding. Stakeholders in several states noted the need to continue working on efforts in this area.

Successful examples of blended or collaborative funding at the state level include both Missouri and West Virginia. Both states blended FP/FS monies with other federal and state funds to create a larger and more flexible pool of funds to support locally-determined service delivery programs.

At the program level, some FP/FS programs were successful in attracting funds from other sources, gaining access to other agencies' facilities, and having staff from other programs outstationed at their centers. This proved especially true for programs that received sizeable FP/FS grants (i.e., over \$300,000). Programs receiving small grants (under \$50,000) appeared less able to generate the level of interest necessary to attract support from other sources.

One example of collaborative funding at the local level is the Family Service Center in Houston County, Alabama. The site received an initial \$50,000 FP/FS planning grant and \$305,000 in FP/FS funds in 1995. In addition, the Center received \$100,000 from a local foundation to support a child care center; the school district provided a building, and funds from the Community Development Block Grant were utilized for renovation and facilities operations. Other program funds originated from the Governor's High Risk Youth program, the Alabama Civil Justice Foundation, and the United Way. State and federal education funds were used to provide adult education classes. The city government paid for the building's maintenance and utilities.

2. Monitoring

Federal guidance requested that states identify outcome objectives for families and children, select measures and benchmarks, and monitor progress toward these objectives.

- **Establishing measurable objectives:** States encountered considerable difficulties in establishing measures that were realistic and appropriate for the service delivery efforts funded. Many states had plans to use aggregate data available through existing management information systems. However, the size of most programs made it unrealistic to expect that programs serving a small number of families could dramatically affect statewide or even countywide rates of foster care, teenage pregnancy or high school graduation. States acknowledged problems in this area and the need for assistance.
- **Monitoring:** Some of the planning groups retained a role as an oversight committee once implementation began; however, in this capacity they met on a limited basis and focused almost exclusively on allocation of the next year's FP/FS funds. To more adequately monitor existing programs, collaborative oversight bodies needed staff assigned to periodically review programs, collect program data, analyze and interpret findings, and report to the oversight group on a regular basis. Although a few states specifically charged staff with these functions (e.g., Arizona and Florida), most did not. While a portion of each state's FP/FS allocation was allotted for planning and service delivery, only 10 percent could be used for administrative purposes. States varied considerably as to whether they considered management and monitoring to be administrative costs. Without sufficient funds designated for this purpose, states did not appear to invest in creating management and monitoring structures.

3. Training in the Principles of Family-Centered Practice

Federal guidance to states stressed the importance of developing service strategies that operationalized the principles of family-centered practice: services should address the needs of the entire family; there is an emphasis on assessing family strengths; families are actively involved in developing service plans; services are flexible, accessible, and coordinated; and there is respect for community and cultural strengths. Although stakeholders believed that their programs were based on the principles of family-centered practice, some stakeholders did not appear to fully understand these principles or know how to operationalize them. Additional training is needed in this area for stakeholders at all levels in the implementation process.

C. Service Delivery Design

Although federal legislation defined both "family preservation" and "family support" programs, the programs reviewed in the case studies did not fall neatly under the labels provided in the legislation. The FP/FS legislation required states to spend a significant amount of funds on both family preservation and family support programs (defined in federal guidance as at least 25 percent of funds in each category or a justification if fewer dollars were allocated). Analysis of the national data indicated that approximately 64 percent of FY 96 funds were used for family support; however, an examination of the application of these terms to specific programs suggests that the actual allocation of funds to family support programs is even greater. In several instances, programs identified as family preservation programs served families who were unknown to the child welfare agency. While these families often had serious problems, child abuse and neglect was not typically an issue.

In order to more accurately distinguish among the major program models identified through the case studies, a more detailed classification was developed for this study that reflects the variety found in the 36 major FP/FS programs reviewed. As shown in Exhibit A, programs are divided into four major categories: in-home service delivery programs; center-based programs; networks; and mini-grant programs.

Within each of these categories, many promising and innovative programs were established. Examples include:

- **Family Continuity Program, Pinellas County, Florida (In-home service delivery):** This program provides intensive family preservation services for mothers who are part of a welfare reform demonstration and who have had some involvement with the child welfare agency. In addition, staff from this program act as advisors and provide technical assistance to some of the community-based family support programs in their district.
- **Caring Communities, St. Louis, Missouri (School-based center):** This school-based family center provides a comprehensive continuum of services that range from broadly based community-level prevention efforts, cultural and recreational activities, and tutoring and after-school programs, through more targeted assessments of child and family needs, drug counseling, case management and intensive family services.

Exhibit A
Classification of FP/FS Program Models

Program Category	Subcategories/Description
<p>1. In-Home Service Delivery Programs</p>	<p>Intensive Family Services: Includes programs traditionally considered family preservation. Programs primarily serve families known to the child welfare system, and are intended to prevent foster care placement or facilitate reunification when placement has occurred. Staff typically have master's or bachelor's degrees in social work. Workers have small caseloads and may visit families several times per week. Services are typically of limited duration (4 weeks to 12 weeks, although some may serve families for 6 months).</p> <p>Parent Training Programs: Typically intended for teen parents or new mothers with other risk factors. Like intensive family service programs, most are professionally staffed. Most use a formal assessment and protocol that determines the frequency of visits and the duration of service. Typically, home visits occur less frequently than they do in intensive family services programs, but often continue for a longer period of time (e.g., up to three years).</p> <p>Case Management Programs: Unlike the other home-based service programs, these serve a broader target population. Although programs tend to be situated in communities with high rates of poverty and other risk factors, any family in the targeted community can access services. Programs are often staffed by individuals who reside in the community. Frequency of services varies considerably, and there is typically no limit on service duration. Services focus on resolving a specific conflict or emergency. Services are of a brief duration, although a family may return for services when other problems arise.</p>
<p>2. Center-Based Programs</p>	<p>School-Based Centers: Mostly targeted to children with behavior or learning problems, although the array of services available are intended to meet the needs of both children and their caregivers. Programs tend to rely on professional staff and include a formal assessment process. Nature and intensity of services vary.</p> <p>Community-Based Centers: Typically accessible to all members of a targeted community. Varies considerably as to the type of services provided and the staff employed. While some centers have a central intake and assessment component, others do not.</p>
<p>3. Networks</p>	<p>Collaborative entities encompassing multiple service providers -- "centers without walls." Although programs vary in terms of target populations and services provided, they represent a common approach to service delivery fostered by FP/FS. FP/FS funds are used to strengthen the relationships among existing service providers, adding case management services and improving referrals among providers.</p>
<p>4. Mini-Grant Programs</p>	<p>Programs award small grants to several community-based service providers. Services funded vary considerably, but most are intended to provide primary prevention services and expand community involvement in service delivery. Programs are intended to attract new community-based service delivery providers to the process and often have simplified administrative and procurement procedures.</p>

- **The Healthy Grandparents Program, Atlanta, Georgia (Network):** This program represents an example of the formation of an inter-disciplinary network of health, social work, education and law professionals, as well as students and volunteers, who provide multi-disciplinary services to both relative caregivers and the children in their care. Services are provided both in the home and at various other locations. They include health screenings for caregivers and children, parent training, legal services, tutoring, counseling and support groups.
- **Youth and Family Impact Center, Dallas, Texas (Community-based center):** This center-based program serves children ages 4 through 19 who have been identified by the school, child welfare or juvenile services as needing additional services. A staff of five case managers and a supervisor work with children and youth assessing both child and family needs, establishing a service plan, conducting home visits, arranging services and providing transportation to services, as well as monitoring and tracking their progress. Through agreements with approximately 20 public and private sector providers, the Center offers psychological testing, individual and family counseling, tutoring, mentoring programs, a parent involvement program, access to a food bank, and cultural and recreational activities. Typically, services are provided at the Center, and service providers meet quarterly to discuss specific cases and generally maintain a collaborative relationship.
- **Great Start, San Antonio, Texas (In-home services-parent training):** This in-home services program provides parent training to new mothers screened to be at especially high risk of abuse/neglect. Mothers who have given birth (at an area hospital with the largest number of publicly-assisted births) are assessed for life stressors and parenting skills. With their consent, the two screeners contact one-of-three participating social service agencies who provide home visiting until the child is at least three years of age: Avance, which serves the area's poorest Hispanic neighborhoods; Child Abuse Prevention Services, a licensed Healthy Families America provider that specializes in assisting abused teens and pregnant and parenting teens; and Family Services Association, an established social service agency.

D. Next Steps

In addition to the many innovative and promising approaches to planning and service delivery, states and localities also noted several issues and challenges that need be addressed as their programs mature. These include:

- **Child welfare agency involvement:** Historically, child welfare agencies and community-based family support programs rarely interacted. Federal guidance on FP/FS attempted to facilitate a greater degree of collaboration among stakeholders who had not traditionally worked together. This has proved to a challenging goal that has not yet been achieved. Child welfare staff in some localities appeared largely unaware of the family support programs that were

developed with FP/FS funds. Linkages between child welfare and family support programs in some communities appear weak and a sense of distrust persists between the child welfare agency and other programs.

- **Centralized intake and comprehensive assessment at family centers:** Some family centers established a centralized unit that was responsible for intake and assessment functions, while others chose not to do so. Centers that had such units practiced the principles of family-centered practice by emphasizing family strengths in their assessment process, ensuring that families were involved in developing their service plan and providing only those services that a family wanted to receive. In contrast, several centers believed that centralized intake and assessment activities were contrary to the principles of family-centered practice. They did not want to be perceived as intrusive or judgmental by asking questions that might not relate to the reasons a family contacted a center, or that might be perceived as requiring families to accept services that they did not want. However, centers without centralized intake and assessment units may miss the opportunity to comprehensively explore and address family needs.
- **The role of case managers and family advocates:** Though program planners defined these positions as brokers of community services needed by families, some case managers or advocates focused on directly providing services. Further, some of these staff expressed distrust of public agencies and were reluctant to make referrals. While the case management and family advocate positions were intended to provide a bridge between communities and public agencies, in some instances they appeared to reinforce client fears of public agencies.
- **Influence of welfare reform:** Virtually all of the family centers offered some support for family members who were seeking their GED. However for some, welfare reform issues such as adult education and job training were their paramount concern. The question should not be whether FP/FS should support welfare reform, but how it can do this most appropriately. Programs that support families' abilities to provide for the safety and healthy development of their children as they transition from welfare to work are consistent with the goals of FP/FS. Given the limited amount of FP/FS funds, programs need to work with TANF (Temporary Assistance to Needy Families) agencies to provide family services that enhance and complement the education and work-related programs funded through TANF and other job training programs. Use of FP/FS funds largely as a supplemental funding source for education and training does not appear to reflect the definitions of FP and FS services provided in the legislation.

The description of the planning and early implementation of FP/FS, and the identification of issues requiring future attention, point in a common direction. Collectively, they suggest the focus of FP/FS to date has been on establishing broad-based preventive services programs that are accessible to a diverse population within a community. The types of programs funded

appear to reflect trends toward devolving program design and implementation to the community level and increasing community ownership of human services programs. Also, the limited amount of FP/FS funds available may have encouraged the development of less costly (and therefore less intensive programs) than those targeted toward families already facing problems of abuse and neglect.³

As the administrators of the FP/FS funds, this is an appropriate time for state child welfare agencies to examine the balance between the service delivery approaches funded and the needs of the target populations served. It is also important to review the realism of some program objectives in light of the funds allotted, to consider the optimal relationship between welfare reform and FP/FS funds, and to examine approaches which provide comprehensive, family-centered assessments of needs and linkages to appropriate services.

FP/FS implementation takes place within a complex and dynamic context. There are inherent tensions among the various factors that influence FP/FS implementation and limited resources create considerable challenges for states in meeting the diverse needs of children and their families. However, given the flexibility provided in the legislation, there is also the potential to resolve, or at least lessen, the effects of competing influences. Some programs have demonstrated this ability. Using these examples as a basis for providing technical assistance, along with improved oversight and monitoring efforts, will aid the future development of FP/FS programs.

³As mentioned earlier, the legislation including the provisions reauthorizing FP/FS (the Adoption and Safe Families Act of 1997) expands the service categories to be funded to include family reunification programs and adoption promotion and support services. States' response to the new legislation will be documented in upcoming site visits.

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CHAPTER I INTRODUCTION

The 1993 Family Preservation and Support (FP/FS) legislation (title IV-B, subpart 2 of the Social Security Act) authorized \$1 billion in new federal funding over five years for services to strengthen and support families' efforts to provide a safe and nurturing environment for their children. The intent of the legislation was to provide funds for developing programs in two areas:

- (1) *Family Preservation* -- largely intended to serve families known to child welfare agencies and at risk of having children placed in foster care; and
- (2) *Family Support* -- largely intended to serve all families in a community, but focused especially on families with risk factors that may lead to abuse and neglect or other negative behaviors (e.g., substance abuse, teen pregnancy).

The purpose of this study is to provide a national picture of how states and communities implemented the FP/FS legislation. This involves understanding how states used FP/FS funds to implement new or expanded programs, the consistency of implementation with federal legislation and guidance, the array of new programs funded, and the nature and extent of changes in local service delivery that occurred.

A. FP/FS Legislation

The Family Preservation and Family Support provisions of P.L. 103-66, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), represented the most significant piece of child welfare legislation since the passage of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). In many ways, the 1993 legislation picked up where P.L. 96-272 left off.¹ While the 1980 legislation required states to make "reasonable efforts" to prevent foster care placement, OBRA 1993 actually provided funds for them to do so. Moreover, the intent of a separate FP/FS entitlement program was to ensure that funds be used only for services to

¹With the passage of the Adoption and Safe Families Act of 1997, several important changes were made to the FP/FS program. These included: reauthorizing the program through FY 01; adding two service categories to be funded (time-limited family reunification programs and adoption promotion and support services); and renaming the program "Promoting Safe and Stable Families."

strengthen families and not for other functions, such as child abuse and neglect investigation and foster care placement.

Legislative enactment of the FP/FS provisions resulted from a decade of Congressional attention and action. Throughout the 1980s, Congress held hearings that examined implementation of P.L. 96-272. By the late 1980s, legislative proposals providing funding for the development of family preservation services were introduced on a yearly basis in the House Ways and Means Subcommittee on Human Resources. Beginning in 1990, the issue also received attention in the Senate Finance Committee.

Concurrently, models of family support programs were gaining increasing acceptance, primarily on a state and community level, through the advocacy of several organizations. Broadly defined, family support models sought to encourage and support the healthy development of children and families. Although community programs may be targeted to high-risk families, typically they are available to all who wish to use them.

In 1993, a unique opportunity was created to establish funding for both family preservation and family support. To build a continuum of services for all families, the legislation required states to develop and fund both types of programs. Although state child welfare agencies were charged with overall program administration, they were expected to encourage and fund community-based organizations to deliver family support services. The legislation's definitions of family preservation and family support are shown in Exhibit I-1.

B. Evaluation of the FP/FS Legislation

As part of the legislation, the U.S. Department of Health Human Services (HHS) was authorized to set aside funds for "evaluation of State programs funded under... [the legislation] and any other Federal, State or local program, regardless of whether federally assisted, that is designed to achieve the same purposes..." (OBRA, 1993, Subpart 2 Section 430 [d] [1] [B]).

In support of this, HHS funded three separate projects in September, 1994:

- **Family Preservation and Family Support Services (FP/FS) Implementation Study** awarded to James Bell Associates by the Administration for Children and Families (ACF);
- **National Evaluation of Family Preservation Services** awarded to Westat, Inc. by the Assistant Secretary for Planning and Evaluation (ASPE); and

Exhibit I-1
Family Preservation and Family Support Definitions
in P.L. 103-66

<i>Family Preservation Services</i>	<i>Family Support Services</i>
<ul style="list-style-type: none"> • Services for children and families designed to help families (including adoptive and extended families) at risk or in crisis, including: • Services designed to help children <ul style="list-style-type: none"> -- where appropriate, return to families from which they have been removed; or -- be placed for adoption, with a legal guardian or in some other planned, permanent living arrangement; • Preplacement prevention services programs, such as intensive family preservation programs, designed to help children at risk of foster care placement remain with their families; • Service programs designed to provide follow-up care to families to whom a child has been returned after a foster care placement; • Respite care of children to provide temporary relief for parents and other caregivers (including foster parents); and • Services designed to improve parenting skills (by reinforcing parents' confidence in their strengths, and helping them to identify where improvement is needed and to obtain assistance in improving those skills) with respect to matters such as child development, family budgeting, coping with stress, health and nutrition. 	<ul style="list-style-type: none"> • Community-based services to promote the well-being of children and families designed to increase the strength and stability of families (including adoptive, foster and extended families) to increase parents' confidence and competence in their parenting abilities, to afford children a stable and supportive family environment, and otherwise to enhance child development, including (as noted in the conference report): • Services designed to improve parenting skills; • Respite care for children to provide temporary relief for parents and other caregivers; • Structured activities involving parents and children to strengthen parent-child relationships; • Drop-in centers to afford families opportunities for informal interaction with other families and with program staff; • Information and referral services to afford families access to other community services, including child care, health care, nutrition programs, adult education and literacy programs, and counseling and mentoring services; and • Early developmental screening of children to access the needs of such children, and assistance to families in securing specific services to meet these needs.

- **National Evaluation of Family Support Programs** awarded to Abt Associates, Inc. by the Administration on Children, Youth and Families (ACYF).

Consistent with the evaluation plan HHS developed for the FP/FS legislation, the three projects are designed to be complementary. Although each focuses on a different aspect, taken together they represent a comprehensive examination of the programs authorized under the legislation. The first study -- the subject of this report -- is a process analysis of the legislation's implementation and is intended to provide feedback to HHS, Congress, states and localities on the implementation process, the types of programs developed and the barriers encountered. These findings may be used to guide future legislation, federal requirements, and technical assistance and support to states. The latter two research projects are outcome evaluations of specific models, one focusing on family preservation, and the other on family support. They were separated from the implementation study and from each other for several reasons:

- **Program Maturity:** Outcome evaluations yield more useful information when conducted on mature program models rather than new programs such as those just initiated with FP/FS funds.
- **Programmatic Differences:** Family preservation and family support programs target different populations and have different service-delivery approaches. Thus, they may require different evaluation designs and measures of success.
- **Different Evaluation Histories:** Outcome evaluation methods have been established for family preservation programs but not for family support programs. The history of family preservation program evaluations provides a more consistent structure for conducting a national evaluation. The majority of family support programs are community-based efforts that do not readily lend themselves to traditional outcome evaluations.

Ultimately, findings from the three studies will be synthesized to address questions concerning the effect of the legislation on achieving outcomes for children and families. Since interim findings are not yet available from the outcome-based studies, this report presents interim findings solely from the FP/FS Implementation Study.

C. Study Approach

1. Description of the Study

The purpose of the FP/FS Implementation Study is to provide a national picture of how states and communities implemented the FP/FS legislation. The study is being conducted over a five-year period (September 1994 -- June 1999) and is composed of two major components:

- **Analysis of 50 State Reports.** In June 1994, each state submitted an application to ACYF outlining their planning efforts. By September 1995, states submitted a State Plan that described the results of their first-year planning process, indicated their objectives, and explained how funds in the remaining years would be used to meet these objectives. In subsequent years, states were to submit Annual Progress and Services Reports (APSRs) indicating the progress made toward achieving their goals.

To date, this study has produced four reports. Respectively, these reports have synthesized the applications, State Plans, and 1996 and 1997 APSRs submitted by states. A similar report will be prepared utilizing the 1998 APSRs.

- **In-Depth Case Studies:** Ten states were selected for in-depth study, and approximately two local jurisdictions² were selected in each state to examine local-level implementation of the state plans.³ A list of states and counties within each state is presented in Exhibit I-2.

In Year 2 of the study (July 1995 -- June 1996), site visits were made to each state to discuss its planning process and the State Plans developed.

In Year 3 (July 1996 -- June 1997), parallel visits were made to each of 20 localities selected in conjunction with the states.

In Years 4 and 5, additional site visits will be conducted at both the state and local levels to update the status of FP/FS implementation. The visits will include discussions with front-line staff and consumers in order to understand the ways in which FP/FS implementation has affected the service-delivery system and families who received services.

²Broadly defined as a service planning area (e.g., county, district, region).

³California and Vermont provide the two exceptions. Three counties were chosen for study in California, and one district was chosen in Vermont.

Exhibit I-2

**Family Preservation and Family Support (FP/FS)
Implementation Study Sites**

State	Counties/Regions
Alabama	Houston County (Dothan) Hale County
Arizona	Phoenix (Sunnyslope Neighborhood) Winslow
California	Fresno County Los Angeles County Santa Clara County (San Jose)
Colorado	Denver (Five Points/Curtis Park Neighborhood) San Luis Valley (Five-County Region)
Florida	Broward County (Ft. Lauderdale) Pinellas and Pasco Counties (St. Petersburg)
Georgia	Atlanta area Chatham County (Savannah)
Missouri	Jackson County (Kansas City) St. Louis (City)
Texas	Dallas/Fort Worth Region San Antonio Region
Vermont	Lamoille Valley Region
West Virginia	Fayette County Cabell/Wayne Counties

Exhibit I-3
State Versus County Administration, Family Preservation Program History,
Population Size and Percentage of Children in Poverty for the Case Study States

STATE	STATE VS. COUNTY ADMINISTERED	FAMILY PRESERVATION PROGRAM HISTORY	CHILD POPULATION SIZE ⁴		CHILD POVERTY RATES ⁵	
			# CHILDREN (1994)	STATE RANK (CHILD POP.) 1994	% CHILDREN IN POVERTY (1992)	STATE RANK (CHILDREN IN POVERTY)
ALABAMA	County	State model; not statewide	1,080,000	22	23.6%	39
ARIZONA	State	Various models available in most districts	1,139,000	23	22.0%	36
CALIFORNIA	County	Various models; county determined	8,677,000	1	22.7%	37
COLORADO	State	Various models; county determined	970,000	26	16.3%	21
FLORIDA	State	Two state models; available in most counties	3,262,000	4	24.4%	43
GEORGIA	County	County determined; various models	1,893,000	11	23.9%	40
MISSOURI	State	Statewide model	1,379,000	16	19.5%	30
TEXAS	State	State/local models; not statewide	5,301,000	2	24.2%	42
VERMONT	State	Various models; available statewide	146,000	49	13.5%	8
WEST VIRGINIA	State	State guidelines; various models, not statewide	429,000	35	27.9%	48
U.S. AVERAGE			68,018,000 (total)	--	20.6%	--

⁴From Statistical Abstract of the United States: 1995, 115th edition, by U.S. Bureau of the Census, 1995, Washington, D.C. States are ranked from largest child population (1-California) to smallest (49-Vermont).

⁵From 1996 Kids Count Data Book. States Profiles of Child Well-Being, by The Annie E. Casey Foundation, 1995, Baltimore, MD. States are ranked from lowest child poverty rate (8-Vermont) to highest (48-West Virginia).

2. Case Study Site Selection

States were purposively selected to provide diversity within each of the following dimensions: demographic information, child poverty rates, and contextual factors including state vs. county administration of child welfare services, family preservation and family support program history, and previous program collaboration and reform efforts. Exhibit I-3 presents some of these dimensions for the selected states and shows their wide variation. In addition, input on site selection was secured from both the ACYF Regional Offices and the study's Advisory Panel (see Appendix A).

Local programs were selected with the assistance of state officials. States were asked to identify localities that had made considerable progress implementing their FP/FS programs. Although this information was taken into account, final site selection provided a diverse picture of the types of programs implemented across all states. Therefore, both urban and rural programs were selected. Variation in the planning and decision-making processes, and different types of models for both family preservation and family support also were considered in the final selection.

3. Data Collection

a. State Case Studies

Topical interview guides were developed to facilitate discussions with a range of stakeholders involved in FP/FS implementation at the state level. At a minimum, stakeholders included:

- Child welfare directors and program managers;
- Coordinators for FP/FS;
- Representatives of public and private agencies involved in the planning process;
- Managers of existing family preservation and support programs;
- Individuals involved in the needs assessment process; and
- Those responsible for data management and/or evaluation of FP/FS efforts.

Appendix B contains a list of key persons interviewed in each state.

The guides were designed to elicit information on the topics identified in the study's conceptual framework (discussed in Section D of this chapter) and related research questions. Site visits were conducted by two-person teams for up to four days at each site. In addition

to the interviews, available written documents (e.g., program descriptions, needs assessment findings, request for proposals for FP/FS) were reviewed. Summaries of the state site visits are provided in Volume II to this report.

b. Community Case Studies

A similar process was followed for the county/community case studies. Interview guides were developed to guide information collection with the following stakeholders: (1) local child welfare directors and program managers; (2) local FP/FS coordinators; (3) members of a planning and oversight group; (4) FP and FS program directors; (5) FP and FS program staff; (6) child welfare agency front-line staff; (7) consumers involved in program management; and (8) individuals responsible for training, evaluation and management information systems.

A list of key persons interviewed in each community appears in Appendix B. All site visits were conducted by two-person teams who spent up to five days on site. Available documents were reviewed before each site visit; additional studies and reports obtained on site were examined as well. Follow-up telephone discussions were conducted as needed. Summaries of the community case studies appear in Volume II.

4. Limitations

Some problems were encountered in collecting and analyzing data from both the 50 state plans and the case study sites. The reader should be aware of these issues in interpreting the study findings.

a. Fifty-State Analysis

Three limitations were noted in the annual review of state documents. These were:

- **Incomplete Information:** Some states, particularly those that delegated FP/FS to their counties, did not provide complete information on objectives, measures of progress, funding, and/or types of programs funded. Wherever findings from state documents are presented, the actual number of states providing information is noted.
- **Different Definitions:** States' definitions of family preservation and family support varied widely. Data were synthesized based on the terminology used by each state.
- **Varying Stages of Implementation:** It is important to note that states were in various stages of implementation when each of the planning documents were

due to the federal government. The information collected provides a snapshot of implementation at that time. Since the implementation process is a dynamic one, that information may become quickly outdated.

As a consequence, the synthesis is useful for identifying broad trends and categories of service provision but does not provide detailed and completely timely information on individual state programs.

b. In-Depth Case Studies

As discussed earlier, the case study component of the study permitted a more in-depth view of the implementation process from the perspectives of a variety of stakeholders. Detailed information was gathered on not only how and what was implemented, but why states and communities made the choices that they did. Nevertheless, some caution should be exercised in reviewing case study findings as well. First, information on state and local planning efforts was gathered well after many of these activities occurred. As such, the recollections of various stakeholders were occasionally incomplete or inconsistent with one another.

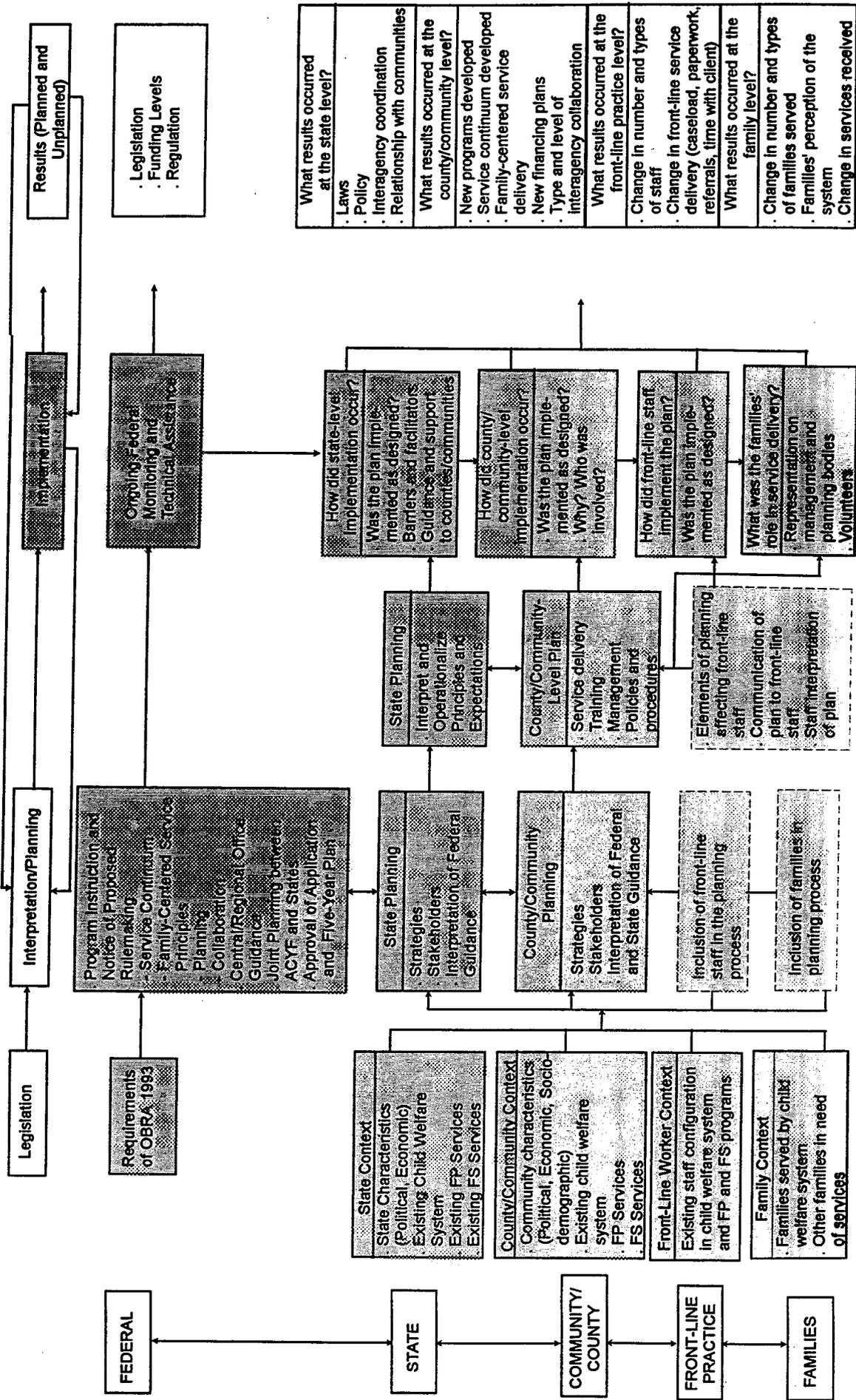
Second, although stakeholders from the states and communities participating in this study were extremely cooperative and forthcoming, a few with whom we requested interviews were unavailable. Typically, these were individuals who were members of planning or oversight bodies that did not appear to play an active role in the FP/FS process. It is possible that they held different views of the implementation process.

Third, although the case study information is more complete and tracks implementation from its onset until the time of the site visit, here too, the dynamic and complex nature of implementation may have an effect. Again, certain information may be dated as of the time of the site visit.

D. Conceptual Framework

A conceptual framework of the FP/FS implementation process was developed to guide the synthesis and analysis of information collected through the state and local case studies. The framework is shown in Exhibit I-4.

Exhibit I-4: Conceptual Framework



The conceptual framework serves as a road map specifying the key parameters to examine. It highlights those aspects of implementation expected to be the most critical to answering the central study questions and indicates expected relationships among individual study components.

The shaded areas of the framework represent the areas addressed in this report. At the time of the site visits to the selected localities, most programs were in their infancy (some had been in operation less than six months). Program results cannot adequately be evaluated until the study's final data collection is completed.

As depicted in Exhibit I-4, the dimensions of the conceptual framework reflect two key premises:

- (1) *The processes and changes associated with implementation must be sampled at several distinct, yet inter-connected levels of stakeholders. (These levels are represented in the figure's left-hand column; their interaction is indicated by arrows pointing up and down.)***
- (2) *Implementation can be viewed as occurring in phases over time. However, because it is an ongoing and hopefully self-correcting process, what happens in one phase, in turn, feeds back to prior phases. (This interaction is identified in the exhibit's top row by the feedback loops linking different phases of the process.)***

Each premise is discussed below.

1. Stakeholder Levels

a. Federal Level

The framework begins with passage of the FP/FS legislation. Through the issuance of the Program Instruction and Notice of Proposed Rulemaking (NPRM), ACYF interpreted the legislation and provided guidance to states in the development of their five-year state plans.

ACYF Central and Regional Offices also developed a joint planning process to provide ongoing assistance to states to develop and implement their plans. In addition, other national organizations (such as the American Public Human Services Association, The Annie E. Casey Foundation and The Center on Budget and Policy Priorities) coalesced to provide assistance to regional offices that worked closely with states to help develop their plans.

b. State Level

The second level of FP/FS program implementation is especially pivotal. States interpreted federal principles and guidance in relation to their own needs and created appropriately tailored state plans. States also translated between the federal level and the local communities where front-line service delivery occurred. State agencies established the parameters for county/community level implementation.

c. County/Community Level

The third level encompasses counties or other relevant jurisdictions. Traditionally, child welfare services are delivered at the county level in most states. However, the legislation emphasized involvement of community-based organizations in the implementation process. Thus, both county- and community-level stakeholders were required to be included in the process.

Typically counties (or other local jurisdictions) were provided discretion in designing and implementing FP/FS programs within general parameters set by the states. States varied in the amount and type of discretion they permitted counties. In turn, individual counties varied in the degree to which they further decentralized planning and service delivery at the community level.

d. Front-Line Practice Level

Although front-line staff and supervisors are part of the local child welfare system and FP/FS programs, they are depicted in the framework as a distinct level. Analyses of public programs often point to major differences between program managers' expectations about program operations and the ways in which staff actually implement programs.

e. Family Level

Although families are typically viewed as passive recipients of service, FP/FS legislation and guidance reflected a different perspective on families. Specifically, families were expected to participate in the planning process, play a role in implementation, and be partners in the service-delivery process.

2. Implementation Phases

The second key principle of the conceptual framework (that implementation occurs in phases over time, is ongoing and therefore influenced by feedback mechanisms) is represented across the top of Exhibit I-4.

a. Legislative Phase

As discussed earlier, the FP/FS provisions provided general definitions for both family preservation and family support. States were expected to develop programs in both areas.

b. Interpretation/Planning Phase

The Program Instructions and a Notice of Proposed Rulemaking (NPRM) issued by ACYF stated federal expectations and parameters for developing the state applications and five-year plans. These documents formed the basis for the Interpretation/Planning Phase, in which the states interpreted federal guidance and developed an implementation plan. This process was paralleled, in turn, at the community level. Within this phase, state and local contextual factors influenced the nature of the planning process and the FP/FS plan itself.

c. Implementation Phase

As shown in Exhibit I-4, the third phase of the conceptual framework involves examining the concrete processes through which implementation occurs. It examines how the plans are operationalized and whether or not implementation is consistent with the original plan. This is not to suggest that changes from an initial plan are inherently negative. As implementation occurs, changes to specific elements of a plan may be necessary to ensure that larger goals are met. Most of the implementation efforts are expected to occur at the county/community level. However, state-level changes to policies and procedures to support implementation at the county/community level will be noted. The role of front-line staff and families in shaping local implementation also will be examined.

d. Results Phase

The fourth phase, not covered in this report, will involve planned and unplanned changes in the service-delivery system.

In sum, the conceptual framework enables a systematic comparison to be made across states and communities, allowing the analysis to transcend specific site and program variations. Higher level questions about overall program implementation and whether or not the intent of the FP/FS legislation is being implemented can be addressed. It also identifies common barriers and facilitating factors experienced by states and communities.

E. Organization of the Report

This report reflects the findings of both the annual review of the 50 state plans and the case studies of selected sites. Since the case studies provided greater depth in understanding the implementation process, they were relied on more heavily than the findings from the 50-state plan analyses. Where appropriate, information from the 50 states is presented first and is then followed by more detailed information based on the case studies.

The findings of the report are presented by the major components of the conceptual framework. Chapter II discusses the federal and state contexts in which FP/FS implementation occurred. Chapter III discusses the planning process, the results of the process and its influence on implementation. Chapter IV presents a discussion of system support efforts, management, financing and training. In Chapter V, a detailed description of the major types of family preservation and family support programs funded by FP/FS is provided. At the time of the site visits many of the programs were in their infancy. Therefore, program descriptions in this chapter provide information on program design and the earliest stages of implementation. Further detail on program implementation will be presented in the study's final report. Chapter VI provides a summary of the key study findings and conclusions. Volume II to this report contains summaries of the 10 state case studies and the 20 local case studies.

CHAPTER II

HISTORY AND CONTEXT

The FP/FS legislation represented a major commitment of federal funds for preserving families and ensuring the safety and well-being of children. It is important to note, however, that FP/FS did not represent an entirely new array of service-delivery programs. Instead, it provided additional resources and guidance for an existing (but often limited) array of programs and services that could be considered FP or FS. FP/FS funds were to be used flexibly, especially to fill existing gaps in service delivery. Numerous contextual factors influenced the decisions made about how best to use FP/FS (state and local) funds to meet the needs of children and families. As will become apparent throughout this report, there is no single story of FP/FS implementation to date -- the planning process and resulting service-delivery systems varied both by state and by community.

The purpose of this chapter is to review the historical and contextual factors that influenced FP/FS implementation in states and localities and to provide a framework for understanding how the implementation process unfolded. This chapter begins by providing a brief history of family preservation and family support programs, followed by a discussion of contextual factors.

A. History

FP/FS legislation combined funding for what traditionally had been two different types of programs. FP and FS programs are rooted in different histories, have been funded by different sources, and serve different populations. While the FP/FS legislation links the administration of both FP and FS funds to the child welfare agency, the range of experience child welfare agencies brought to these programs is quite varied. Although family preservation is typically viewed as a service within the child welfare service-delivery system, family support programs are not. Conversely, many of the stakeholders participating in the planning process represented disciplines (e.g., Mental Retardation/Developmental Disabilities) or consumer groups (e.g., community-based organizations) more familiar with family support than with intensive family preservation programs that serve families already known to the child welfare agency.

Although FP and FS have different origins, there is no single definition of an FP or FS program. Instead, each is an umbrella term that encompasses its own set of program models. A brief review of the evolution of these program characteristics is provided below.

1. Family Preservation Programs

Family preservation and home-based service programs have been in existence since the 1970s. Generally, these programs provide short-term, intensive, in-home services for high-risk families to prevent foster care placement. At the national level, both the federal government and foundations have provided support for these programs. In 1978, the Children's Bureau established the National Clearinghouse on Home-Based Services. In 1985, the Edna McConnell Clark Foundation assisted and tracked implementation of family preservation in eight states (Michigan, Missouri, Iowa, Tennessee, Kentucky, New York, New Jersey and Connecticut) (Rossi, 1991).⁶

Two of the earliest models that gained widespread acceptance were the FAMILIES program begun in Iowa and the Homebuilders program begun in Tacoma, Washington. Both were developed in 1974 and shared common features including small caseloads (i.e., 2-4 cases per worker), short service duration (4-8 weeks), 24-hour and 7-day-a-week access to caseworkers, and in-home service provision. Over time, other states adapted and modified the early program models. Changes focused on: increasing caseload size, extending service duration, teaming a social worker with a parent aide, and limiting a family's access to their caseworker during non-working hours. In essence, newer programs often provided less intensive services than the earlier models.

In a review of family preservation programs conducted as part of the National Evaluation of Family Preservation Services, child welfare administrators in 26 states were contacted and asked to provide information on their programs. Administrators were not supplied with strict definitions, allowing them to define the term "family preservation" as they saw fit. The authors of the report noted:

It was not a simple task to define the parameters of the family preservation programs included in this review. Many respondents focused on describing a single program model for intensive family preservation programs established by

⁶As of 1992, the National Governor's Association noted that family preservation services were available in 30 states and that 17 of these programs were statewide.

the child welfare agency in the state. However, some also included models that were operated by other agencies such as mental health and juvenile justice. Others described funding mechanisms for purchasing a range of services that may assist in placement prevention. Still others described managed care programs for severely emotionally disturbed children that use multi-disciplinary teams to prevent placement, reunify families, or arrange for placement in the least restrictive setting (Westat, Inc., 1995, p. 16).

Despite the apparent proliferation of family preservation programs, the review also noted the following:

- **Lack of Statewide Programs:** Although many states had developed family preservation models, few had services available through all local child welfare offices.
- **Number of Children Receiving Services:** Relative to the number of children who enter foster care each year, the number of children receiving family preservation services is small. For instance, Washington State's Homebuilders program served approximately 50 families per month during 1994. In comparison, approximately 500 children were placed in foster care each month within the state. Caseloads reported by counties show a similar relation. In 1994, 78 families received family preservation services in Contra Costa County, California while the comparable number of foster care cases that were opened in the same time period totaled 589. In Suffolk County, New York, 100 families received family preservation services while 453 entered foster care in 1994.
- **Nature of Reunification Services:** Although many intensive placement prevention programs also served foster care children who were being returned home, these efforts were relatively small. While administrators often referred to these efforts as "reunification programs," in most instances the decision to reunify had already been made, and the services provided might more accurately be termed "aftercare services." In fact, the program review identified only 13 programs in the 26 states contacted that provided any services prior to the child's return home.

2. Family Support Programs

Family support programs are even more difficult to define than family preservation programs. Historically, their origins can be traced to the settlement houses of the 19th century. Located in poor neighborhoods with immigrant populations, settlement houses provided a range of services to help families adjust to life in the United States. Classes in parenting were offered along with English language lessons. Food and other items were available to families in need. Moreover, settlement houses became gathering places for people living in the neighborhood.

They provided opportunities for families to meet one another, discuss common issues and become active in demanding that government be responsive to the concerns of their community.

Historically, another major type of family support program targeted new or young mothers with children under three years of age. These programs focused on teaching infant care and early childhood development and on helping mothers meet children's developmental needs. Today, programs that follow a settlement house model or target families with young children represent only two types of family support programs. Other types of programs now include office-based programs, school-based programs and community-based centers. They are likely to employ professional staff as well as members of the community. They serve children of all ages and families with varying types and degrees of need. As noted in the National Evaluation of Family Support Programs:

Beginning as grass-roots efforts to serve families in ways that recognize individual strengths and respond to individual needs, family support programs have coalesced into a movement that influences most aspects of human services delivery. As a result, there are literally thousands of programs across the country, in schools, hospitals and community agencies... established by the family support movement (Abt Associates, 1995, p. 1).

In their review of existing family support programs, the study's authors developed a typology of 10 models of family support programs, which are presented in Exhibit II-1.

3. Comparison of Family Preservation and Family Support Programs

Although they developed separately, today the lines between family preservation and family support programs can be vague. Over time, family preservation programs expanded to include less intensive service delivery models providing services to families not at imminent risk of foster care placement. Conversely, some family support programs now include more intensive services than those in the early settlement house models. Specifically, home-visiting programs typically come under the family support umbrella.

**Exhibit II-1
Working Typology of Family Support Programs⁷**

1. Comprehensive community family support programs.
2. Situation-specific family support programs.
3. School readiness/achievement family support programs.
4. Family literacy family support programs.
5. Economic self-sufficiency family support programs.
6. Special needs family support programs.
7. Infant and child health and development family support programs.
8. Child abuse and neglect prevention family support programs.
9. Substance abuse family support programs.
10. Wellness family support programs.

In some ways the home-visiting programs fill a place on a service continuum between family preservation programs and family centers. Although home-visiting programs are less intensive and typically of longer duration than family preservation programs, generally they have an explicitly defined service model that is implemented by professional staff or paraprofessionals with specialized training. Apart from these programs, the typical differences between family preservation and family support programs along key dimensions are shown in Exhibit II-2.

Despite their differences, both types of programs have similar underlying philosophies and principles, typically referred to as family-centered principles. These include:

- Comprehensive assessment of all family members' needs;
- Voluntary service participation;
- An emphasis on identifying and building upon family strengths rather than focusing on deficiencies or problems; and
- Active involvement by family members in determining their goals and services and in meeting their goals.

⁷From Children's Bureau Conference Presentation by Abt Associates, Washington, DC., 1995.

**Exhibit II-2
Comparison of Family Preservation and Family Support Programs**

	Family Preservation	Family Support
Goals	Prevent foster care placement and re-allegation of abuse/neglect; improve family functioning.	Varied; may include FP goals, but also may address goals related to basic needs, education, employment and health.
Nature of Service	Treatment.	Prevention.
Target Population	Children at imminent or high risk of placement served by the child welfare or other agency with placement authority.	May be: (1) all families in a community (typically one with a high poverty rate); or (2) a "high-risk" population (e.g. pregnant and parenting teens, children with school problems).
Referral sources	Child welfare agencies, other public agencies, mental health, juvenile justice.	Self-referral, community organizations (hospital, school, church or public agencies).
Funding sources	Mostly public funds--state child welfare funds, federal title IV-B, Medicaid.	Local funds, foundations, charitable organizations. Public funds tend to come from education and public health agencies.
Length of Service	Typically short-term (4-12 weeks) but usually service period is defined in advance.	<u>Home-Visiting Programs</u> : various lengths; 6 months to 5 years; often not pre-determined. <u>Center-Based Programs</u> : no fixed length. Families determine utilization.
Staff Characteristics	Bachelor's or master's level social work-related degree. May be teamed with a paraprofessional.	<u>Home-Visiting Programs</u> : generally utilize professional staff (social workers, teachers, nurses). <u>Center-Based Programs</u> : are staffed with community members, paraprofessionals, volunteers.
Types of Service	Largely therapeutic intervention and addressing concrete needs (e.g., home repair). Some referral for other services.	Varied services include parent training, counseling, employment training, health care, child care, recreation, support groups.
Setting	Home-based.	Some home-based, some community- or school-based centers.

The type and extent of existing FP/FS-type programs influenced the way states used the new FP/FS funds. For example, Missouri already had a statewide family preservation program in place. Florida and Colorado had recently authorized considerable amounts of state funding for family preservation programs. FP/FS program history, however, was only one of several factors affecting FP/FS implementation.

The absence of widely-available family preservation and family support services did not necessarily influence states' implementation of FP/FS in a uniform manner. For instance, neither Texas nor West Virginia had statewide, child welfare-funded family preservation programs, yet each took a different path in utilizing its FP/FS funds. West Virginia chose to use its funds to develop local networks that would determine the types of programs and services that consumers felt were needed in their community.

West Virginia

Although the state child welfare agency in West Virginia had developed policies and guidance on family preservation services, it did not typically fund programs. Instead, private agencies developed family preservation programs and billed Medicaid for eligible families referred to them by local child welfare offices. Prior to FP/FS, a Governor's Cabinet supported the development of Family Resource Networks (FRNs). In turn, the FRNs were responsible for developing communities' capacities to address their own needs and develop needed programs. West Virginia used its FP/FS funds to further these efforts.

In contrast, Texas divided its monies to fund both a statewide uniform, intensive family preservation system delivered by public agencies and awarded a number of community-based family support grants to collaboratives of private non-profit agencies.

Texas

Although some state and local monies had been used to develop individual family preservation programs in some of the state's larger counties, there was no statewide family preservation system operating at the time FP/FS funds became available. Generally, funding for children and family services in Texas was low and the need for family support programs existed as well. Texas developed a statewide family preservation model using a large percentage of its first- and second-year funds to establish family preservation units within each regional child welfare agency. The state also funded collaborative family support programs through a competitive bid process. As the state's FP/FS allocation increased each year, Texas increased the proportion of funds allocated for family support, while leaving the amount of funding dedicated to FP largely unchanged.

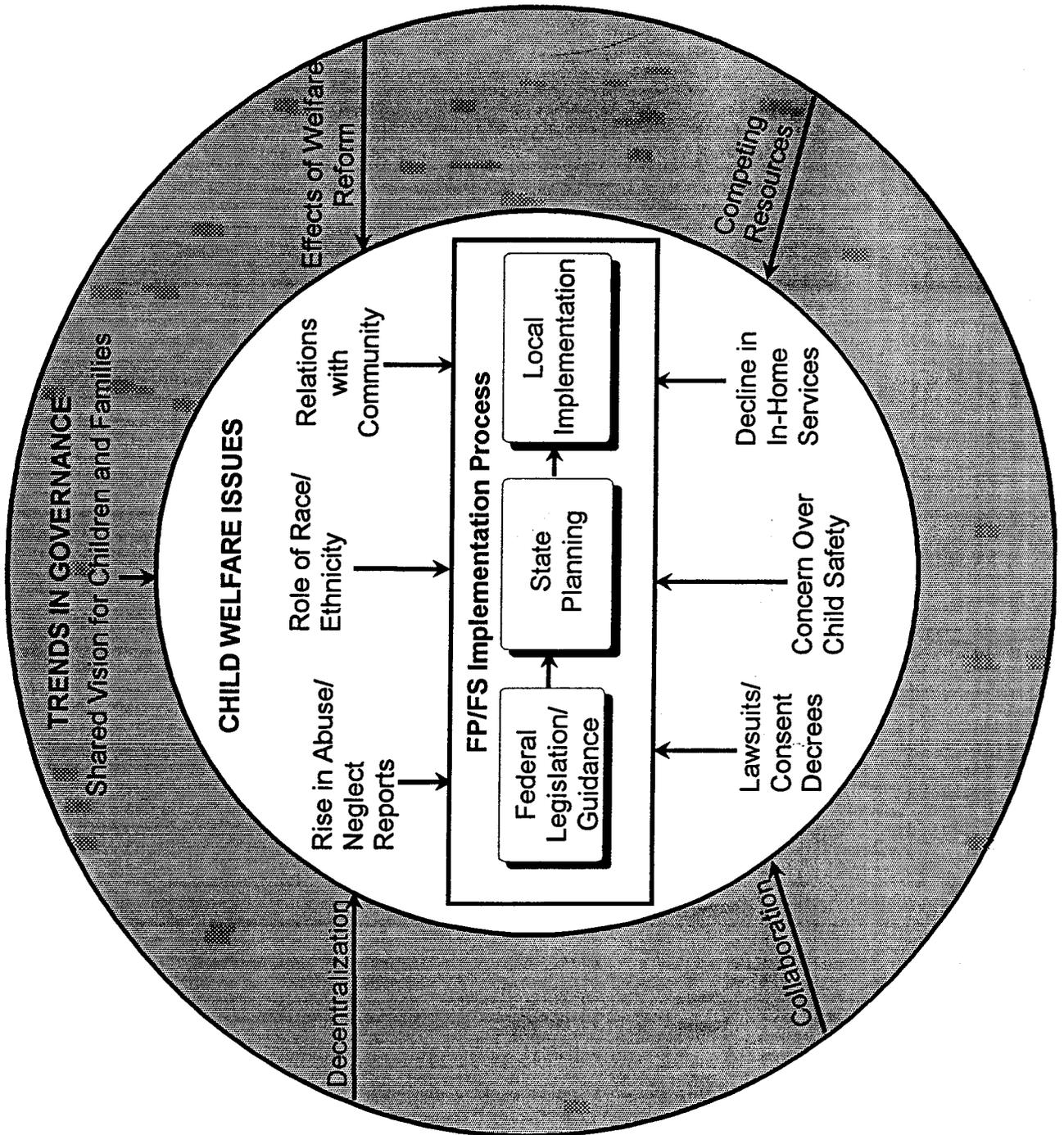
In each state the existing array of services influenced, but did not completely account for, decisions made on the use of FP/FS funds. Contextual issues further shaped and defined each state's path toward implementation.

B. Contextual Factors

Exhibit II-3 provides an overview of the major contextual factors that influenced FP/FS implementation. This is by no means an exhaustive list of factors. Rather, it represents the factors that several state and local stakeholders most commonly identified as most directly affecting their decisions concerning FP/FS. As noted in the exhibit, the issues facing the child welfare agency provide the immediate context for shaping FP/FS implementation. Superimposed on this subcontext are broader issues concerning the changing role of government and the relationship between federal, state and local governments. The flexibility of the FP/FS legislation created a "laboratory" in which new trends in government could be tested. States took advantage of the flexibility provided to test new prevention programs, particularly community-based programs that operated outside the child welfare system.

A brief discussion of immediate issues facing child welfare administrators is presented below. This is followed by a discussion of trends in governance.

Exhibit II-3:
Relationship Between Background and Context and FP/FS
Implementation Process



1. Child Welfare Issues

Although FP/FS-funded programs had the potential to address some of the issues facing child welfare administrators, they also raised many questions about which priorities to address and how best to address them. Among the common contextual issues that affected decisions about FP/FS implementation were the following:

- Difficulties in investigating the increasing number of child abuse and neglect reports;
- Lack of sufficient resources for prevention and early intervention services;
- Disproportionate representation of minorities in the child welfare system;
- Increased publicity surrounding child fatalities and serious injury;
- The need to respond to lawsuits and consent decrees; and
- Negative perception of the child welfare agencies within the community.

Each of these issues is briefly discussed below:

a. Investigating Increased Reports of Child Abuse and Neglect

Data from *The National Incidence Study of Child Abuse and Neglect* (NIS-3) (Sedlak & Broadhurst, 1996), noted that the number of children identified as victims of maltreatment (by either the child welfare agency or another major child-serving system -- schools, health care providers, police, etc.) increased 67 percent between 1986 and 1993; however, the percentage of maltreated children who received a CPS investigation decreased over this period. Of the 931,000 children identified as maltreated in 1986, 44 percent were investigated by the child welfare agency. By 1993, this percentage had declined to 28 percent (of 1,553,800 maltreated children). Of particular note, while the percentage investigated declined, the actual number of children investigated by CPS has remained somewhat stable (409,640 in 1986 versus 435,064 in 1993). This suggests that the capacity of the child welfare system to respond to reports has remained static.

All 10 states studied showed an increase in the number of child abuse and neglect reports received between 1984 and 1993, although the increase ranged from 4 percent in Vermont to 290 percent in Colorado (Curtis, Boyd, Liepold & Petit, 1995). For many of these

states, handling more reports meant that child welfare agencies had to focus on the most severe cases and the most troubled families.

Some states and communities had begun to address this problem by designing new systems and protocols for investigation. Of the 10 states studied in depth, Florida, Missouri, and West Virginia were conducting pilot tests of new "multi-track" CPS systems. Although these systems vary somewhat, all are intended to target more effectively and diversify the ways in which the agency responds to abuse and neglect allegations. A preliminary determination of a serious offense (e.g., sex abuse, severe physical abuse) would be investigated by CPS staff in the traditional manner, often in conjunction with law enforcement. However, reports determined as less severe (e.g., lack of supervision of children) would be served by a worker who assessed family needs and referred families to appropriate community-based services.

It is important to note that in addition to limiting the number of cases investigated, such reforms shift the burden of providing services from the public child welfare agency to communities, which may vary in their capacity to respond to family needs. In some states, FP/FS was seen as a mechanism for supporting community response to these needs.

b. Lack of Sufficient Resources for Prevention and Early Intervention Services

Not only has service capacity failed to keep pace with the incidence of child maltreatment, but the intent of P.L. 96-272 to re-orient child welfare services from a placement-oriented system to one that stresses prevention and family-centered services is not yet realized. In 1977, *The National Study of Social Services to Children and Their Families* (Shyne & Schroeder, 1980) reported that an estimated 1.8 million children were served by public child welfare agencies. Of these children, one-half million were in foster care. Seventeen years later, in 1994, *The National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families* (NSPPR) (U.S. Department of Health and Human Services [HHS], Children's Bureau, 1997) estimated that the number of children served by the child welfare system had declined to 1 million children. However, the number receiving foster care remained stable at one-half million. In other words, while there was a 60 percent decrease in the number of children receiving home-based services from 1977 to 1994 (as well as a

decline in the total number of children served), the number of children in foster care remained virtually unchanged.

The findings of the National Incidence Study and the NSPPR are not entirely unexpected. In 1989, Kamerman and Kahn noted that:

Child Protective Services (CPS) (covering physical abuse, sexual abuse, and neglect reports, investigations, assessments, and resultant actions) have emerged as the dominant public child and family service, in effect 'driving' the public agency and often taking over child welfare entirely. A repeated theme in state after state, county after county, is that the social service system has become so constricted that children can gain access to help only if they have been abused or severely neglected, are found delinquent, or run away. Doorways for 'less serious' or differently defined problems are closed (Kamerman & Kahn, 1989, p. 9).

c. Disproportional Minority Representation in the Child Welfare System

The findings of the recent national studies also identified another key issue -- the relationship of race/ethnicity to both the nature of the services provided and the outcomes achieved for children and their families. While the NIS-3 study found no differences in the incidence of child maltreatment among racial/ethnic groups (Sedlak & Broadhurst, 1996), the NSPPR found disproportionate numbers of African American children in the population served by child welfare agencies. Once in the child welfare system there were even greater differences in the types of services received by African American and white children. African American children were more likely than white children to be placed in foster care (63 percent versus 36 percent in 1994), and once in foster care, were more likely to remain in care for a longer period of time (18 months for African American children versus 11 months for white children) (HHS, Children's Bureau, 1997).

Although the reasons for the observed differences are not completely understood, some states and localities have made efforts to reduce possible biases within their systems. For example, in Colorado a Cultural Diversity Forum was created to review child welfare policies. In Santa Clara, employee membership organizations organized around ethnicity have played a central role in the planning and implementation of child welfare reform. The African American Employees' Organization, El Comite', and the Asian Pacific Employees' Organization have each issued strategic plans that advocate for issues such as increased cultural competence and enhanced community involvement in the delivery of child welfare services. Family Resource

Centers were developed utilizing paraprofessionals and former clients. In some states and localities, FP/FS planning and implementation built on these efforts.

d. Increased Publicity Concerning Child Fatalities

Recently, the media, Congress and state legislatures have focused their attention on serious maltreatment cases and child fatalities. This, in turn, has led to renewed concerns about child safety. Increasingly, "reasonable efforts" to prevent placement and "family preservation" efforts to keep families together are questioned as potentially jeopardizing the safety of children.

Many of the states visited in this study talked about the effect of isolated -- but high-profile -- cases on child welfare policy. They noted that although cases involving child fatalities were rarely those referred to family preservation programs, some advocates and legislators still held the "family preservation philosophy" (as opposed to a specific program) responsible for the child's death. This placed continued funding for family preservation programs in considerable jeopardy. As one state official noted, "We are one fatality away from having our family preservation program defunded." While child welfare administrators believed that children served by family preservation programs were safe, some did not consider it an appropriate time to expand FP services.

e. Lawsuits and Consent Decrees

Still another source of tension for child welfare administrators arises from lawsuits filed by various advocacy groups (and resulting consent decrees) on behalf of children in foster care. In 1993, approximately 26 states or localities were operating under consent decrees to provide additional protections and services to children (APWA, 1993). Yet state legislatures have not always increased child welfare funds to meet these court-ordered mandates. In essence, child welfare agencies must establish policies and programs by navigating a course between public concerns over child safety and court actions calling for increased service to prevent foster care. An example of this problem can be seen in Alabama.

Alabama

Alabama had instituted major reforms in their child welfare system as a result of a consent decree issued in 1991. These included providing services to prevent placement, placing children in less restrictive settings, and providing needed treatment services for children and families. Although the state made a commitment to institute the changes called for in the consent decree, the legislature has yet to authorize additional funds for this purpose, and there is no strong political sentiment for supporting such reform. Instead, the state is now seeking to vacate the decree. Caught between the court order and the political forces in the state, the child welfare agency has sought to maximize the use of various federal funding streams to institute reform.

f. Relationship with the Community

The current trend in intergovernmental relationships has favored the devolution of authority from federal to state governments. Congruent with this, states have further devolved authority to counties or districts, and sometimes even to specific communities within counties. While this trend poses challenges in areas such as welfare reform, given the current relationship between child welfare agencies and the communities they serve, this may pose especially unique problems. Often, despite efforts to provide preventive services before placing a child in foster care, child welfare staff are viewed by community members as "the people who will take your children away." These sentiments seem especially prevalent in racially-divided urban communities. Moreover, child welfare staff are often perceived as culturally insensitive, unaccepting of alternative methods of child-rearing and unresponsive to the underlying problems that may have led to child maltreatment.

Again, some states began to address this issue prior to FP/FS. The multi-track CPS systems described earlier as well as other efforts may improve community relations in addition to lightening the burden on CPS investigators. Also, some states had developed training curricula for child welfare staff on multi-cultural issues and other principles of family-centered practice. The family preservation program in Los Angeles presents another approach to addressing community concerns.

Los Angeles County Family Preservation Model

The family preservation program in Los Angeles County was designed to create networks of community-based programs to provide services to families. In order to be considered "community-based," the lead agency had to be located in the community to be served (defined by select high-placement zip codes) for a minimum of three years and providing services to children and families for a minimum of one year. Moreover, its board of directors had to reflect the ethnic/cultural/linguistic composition of families served and each Network's community advisory council had to reflect the ethnic composition of families served. Councils were to take responsibility for ongoing review of services and act as an advocate for families. Finally, all service providers' staff in a Network had to reflect the ethnic/cultural/linguistic composition of families served.

For other states and communities, FP/FS implementation represented the first effort by the child welfare agency to reach out to communities to help plan services for children and their families. For instance, public agency administrators in Santa Clara County noted that FP/FS marked the first time child welfare clients and community representatives were actively involved in planning an agency initiative.

Overall, decisions about FP/FS implementation were influenced by several problems and issues facing child welfare administrators. In some instances an individual factor may have had a major influence on FP/FS. For example, in Alabama, the agency's response to the lawsuit resulted in the development of a detailed plan for child welfare reform which in turn shaped FP/FS decisions.

In other instances, historic and contextual factors combined to influence FP/FS implementation. For example, Missouri's existing statewide family preservation program and previous inter-agency collaborations, combined with current efforts to limit formal CPS investigations, led decisionmakers to target FP/FS funds on promoting a community-based service delivery system.

In still other instances, contextual factors combined in more subtle ways to influence FP/FS implementation. Although it is difficult to state definitively, child welfare agencies appear to have been weakened politically by the various difficulties described above. When combined with trends in governance (described below), their lack of political power often influenced the way child welfare agencies responded to FP/FS.

2. Trends in Governance

While the child welfare context identifies **what** issues were addressed by FP/FS, the broader trends in governance depicted in Exhibit II-3 helped shape **how** FP/FS was implemented.

a. Decentralization

Since the 1980s, trends in federal human services programs have been marked by fewer federal resources and a concomitant decrease in federal regulation and program monitoring. While the trend is partially a result of fiscal concerns, there has also been growing recognition that government cannot solve all problems. The federal government is often seen as the least able to adapt and respond to local needs or best avail itself of local resources. There is a general recognition of the need for shared responsibility among different levels of government; between government and the private sector; as well as among government, members of the community, advocates and consumers.

Toward this end, some proposals to block grant federal programs (e.g., the Personal Responsibility and Work Opportunity Reconciliation Act of 1996), and support community development (e.g., enterprise zones) have been made. Within existing programs, the trend has been to limit government regulation and sanctions and develop partnerships with state governments. For example, the federal oversight in titles IV-B and IV-E has moved from emphasizing federal monitoring to stressing joint federal and state reviews and the development of mutually agreed upon corrective action plans.

Parallel decentralization trends have also occurred between states and local subdivisions (counties, districts, communities). In the 10 states participating in this study, stakeholders repeatedly noted trends toward diminished roles for state public agencies along with budget cutbacks in service provision to children and families. While some stakeholders attributed this to growing fiscal conservatism, stakeholders in other states (most notably Florida, West Virginia, California and Missouri), noted that the changing role of state agencies was coupled with efforts to enhance the role of communities in shaping and delivering health and social services in ways most responsive to families' needs. These efforts took various forms. For example, in Florida decentralization has focused on shifting authority from the state to the district level.

Florida

Health and Human Services boards were established in 1992 in each of the Department of Health and Rehabilitative Services' 15 District Offices. The boards worked in partnership with District Administrators to make decisions at the district level, especially on funding issues. The Governor has been supportive of decentralizing decision-making responsibility to the district level.

In contrast, West Virginia first centralized collaborative efforts by creating a Governor's Cabinet on Children and Families and then supporting the development of local collaboratives.

West Virginia

A Governor's Cabinet on Children and Families was established in 1990 as part of a larger educational reform effort. This body was intended to downsize state government by serving as a vehicle to prevent duplication of programs among state agencies serving children and families (social services, health, mental health and education) and by moving the decision-making process to the community level. Initially supported by foundation funds, the Cabinet made monies available for Family Resource Networks—collaborative bodies in local areas comprised of public and private agencies as well as consumers who would coordinate service planning and development in their geographic areas.

b. Shared Vision for Children and Families

While advocates of decentralization often focus on limiting the authority of federal and state government and its intrusion into family life, others support increasing local governance as a means of creating a shared vision for children and family services that reflects the values and needs of all members of the community. There has been an increasing recognition by many advocates that government alone cannot solve the range of problems confronting families today. A more inclusive process is needed in which all stakeholders are involved in establishing mutually agreed upon goals for children and families. This consensus of public and private organizations, community groups and individuals, in turn, will lead to greater support for and participation in service programs designed to achieve a shared vision for families. The funding

and opportunity provided in the FP/FS legislation for collaborative planning made FP/FS a logical focal point for developing a comprehensive and prevention-oriented approach to supporting families.

c. Collaboration

Cutbacks in funding at all levels of government has increased awareness of the importance of utilizing existing resources as efficiently as possible. This, in turn, has led to a re-examination of the traditional categorical approach to funding and delivering services. The growth of social programs in the 1960s led to the development of a numerous agencies and categorical programs, each with its own requirements and regulations. Many of the programs were simply "parachuted" from the federal government into states and eventually communities. As such, they developed independently of one another, producing overlap and, in some cases, conflict. Moreover, the categorical nature of each program meant that it was problem-specific in its coverage and did not have the mandate to comprehensively address family needs. Recognition of these problems led to efforts to improve collaboration among public agencies and to blend or co-mingle funds to create more comprehensive service delivery strategies. At the federal level, various initiatives to promote service collaboration or integration have been funded (e.g., Services Target of Opportunity in the 1970s, and the Services Integration Pilot Projects, 1984). However, changes in federal categorical requirements or regulations have been more limited.

In the 10 study states, collaboration efforts prior to FP/FS varied considerably. Although there were isolated instances of collaboration in most state and local service delivery programs, some states had engaged in more far-reaching and systemic collaborations, including efforts to blend funding streams. In addition to the collaborative bodies formed in Florida and West Virginia, Vermont offers another example of agency collaboration.

Vermont

Efforts to plan and implement community-based systems of care for children and families began in 1985 with the state's implementation of the Children and Adolescent Services System Program (CASSP). A state interagency team composed of social services, mental health and education was formed. In addition, local interagency teams composed of agency administrators with the authority to commit resources were formed in each of the state's 12 districts. Treatment teams of providers collaborated on service delivery on a case-by-case basis. The local interagency teams met regularly to resolve cases unable to obtain needed services in their communities and determined ways to blend funding and shape programs to fill specific service gaps identified by treatment teams during case planning.

These administrative structures were codified into state law in 1988. The law also mandated that an advisory group be formed composed of equal proportions of parents, providers and state agency representatives. The group was charged with advising the Governor and agency Commissioners on methods for formalizing the community-based system of care for severely emotionally disturbed (SED) adolescents.

d. Limited Funds/Competing Priorities

Another factor often cited as an incentive for child welfare reform is the fact that families today face multiple, complex problems. Data on several indicators suggest that many conditions are worsening and that the rise in child maltreatment is not an isolated indicator of the status of child well-being. The Annie E. Casey Foundation's *1996 Kids Count Data Book* noted "...our child poverty rate is among the highest in the developed world [p.16]. ...The post-assistance child poverty rate [i.e., including AFDC payments] in the United States (22 percent) is more than 50 percent higher than the next highest rate (Australia and Canada)..." (1995, p. 17). The report noted that child poverty was linked to other negative outcomes, including:

- The percent of low birth weight babies increased 6 percent from 1985-1993;
- Only 68 percent of mothers giving birth in 1990 had received adequate prenatal care;
- In 1993, the infant mortality rate was 8.4 per 1,000 live births;
- Every two hours, a child dies of a gunshot wound;
- During 1994, nearly 20 percent of those arrested for a violent crime were under the age of 18; and

- The share of families headed by a single parent increased from 22 percent in 1985 to 26 percent in 1993 (The Annie E. Casey Foundation, 1995).

The states selected for this study reflect these indicators. Among the 10 states, the child poverty rate ranged from 13.5 percent to 27.9 percent (the national average was 20.6 percent). The percent of children residing in single parent households ranged from 22 percent to 29 percent in study states. Many communities in which FP/FS services were subsequently delivered were under the constant stress of violence and poverty.

Given these needs for other services and limited resources, funding for family preservation and support must compete with needs for prenatal health care, substance abuse treatment, law enforcement efforts and education programs and other societal, family and child needs. While the recent emphasis on collaboration may improve efficient use of resources, collaboration alone cannot substitute for adequate resources. Competition often inhibits collaboration in states with low rankings on multiple indicators and few resources to share.

e. Welfare Reform

Perhaps the most far-reaching change in federal-state relationships can be seen in welfare reform. While the legislation creating "Block Grants for Temporary Assistance for Needy Families" (TANF) was not enacted until August 22, 1996, some type of block grant was expected to replace AFDC as FP/FS implementation began (The Personal Responsibility and Work Opportunity Reconciliation Action of 1996, title 1). Concerns over the impact of an AFDC block grant affected FP/FS decision-making in several ways:

- **Expectation of a Parallel Child Welfare Block Grant:** Various proposals before Congress in 1994-95 also included provisions for a child welfare block grant, combining FP/FS with other child welfare programs. The legislative proposals coincided with states' FP/FS planning, leaving many officials concerned that investing considerable effort into FP/FS planning might prove fruitless in the long term.
- **Effect on Families:** Although state officials could not predict the effect of TANF on families, some issues were raised. States were concerned about the effect of TANF on both the number of families that would need additional services and the types of services they would need. States expected an increased need for child care for those who found jobs as well as an increased need for concrete, emergency services for those whose benefits were terminated without obtaining employment. The net effect would limit the availability of services relied upon by child welfare families (e.g. family preservation, parent training). Most important, state officials were concerned that this would occur just as the

economic stresses created by TANF might result in increases in the incidence of child abuse and neglect.

- **Changing Relationships between HHS and the States:** TANF most directly altered the relationship between HHS and the states. States would be less reliant on federal funding, but would have greater flexibility in designing their own programs. At the federal level, there would be less emphasis on developing regulations and monitoring how states complied with the regulations.
- **Effect on Funds for Family Preservation:** Data from the state plans indicated that title IV-A Emergency Assistance Funds accounted for 8 percent of expenditures on both family preservation and family support. The TANF block grant was expected to affect child welfare agencies' access to funds for these programs.

The interdependence of the welfare and child welfare systems was perhaps best summarized by one child welfare administrator of a large metropolitan county included in the study, "You won't see any homeless families on our city's streets as a result of welfare reform. As soon as they hit the streets, we'll be forced to take the children into custody. And without more options, we'll be forced to place them in foster care." Whether or not these problems occur, the concerns relating to TANF shaped the dialogue about FP/FS services during the planning process and have influenced the types of services funded under FP/FS.

C. Summary

The above discussion highlights key issues and trends that were in place prior to the passage of FP/FS legislation that affected the provisions of the legislation, subsequent ACYF guidance, and the decisions made by states and communities in planning and implementing FP/FS. In 1993, the FP/FS legislation stood, in effect, at the crossroads between numerous, complex, and often competing issues and goals. Among the underlying tensions that influenced FP/FS implementation at the national, state and local levels were:

- The effort to increase collaboration and create a shared vision for children in an environment in which traditional categorical interests competed for scarce resources;
- The trend toward less government intervention and devolution of authority for human service programs versus the need for greater resources to address increases in child maltreatment;
- The movement toward the provision of preventive services, particularly home- and community-based services, to strengthen and empower families and reduce foster care placements versus growing concerns for child safety; and

- The need to improve often adversarial relations with families and communities.

The FP/FS legislation and related federal guidance reflect many of these factors. Although title IV-B, subpart 2 had several detailed requirements, it also provided the flexibility and latitude in program design and selection of target populations that is typically associated with block grants.

This context presented a clear challenge for those involved in FP/FS implementation. While this process provided ample opportunity to balance and resolve these seemingly conflicting forces, it also created an environment that could focus on false choices (e.g., strengthening families versus safety, family preservation versus family support, government direction and monitoring versus community ownership). In the following chapters, the influence of these various issues and the framework of the legislation on FP/FS planning and implementation will be noted.

CHAPTER III

PLANNING

A unique feature of the FP/FS legislation was that it allowed each state to spend up to \$1 million of its first-year FP/FS allocation on planning efforts, without having to match federal funds. States responded positively to this. Of the maximum \$32 million of first-year funds that could have been spent on planning, states allocated 72 percent for this purpose. Seven of the 18 states that received more than \$1 million in first-year FP/FS funds spent the maximum allowable amount on planning. Of the 33 states that received less than \$1 million, 29 allocated all of their first-year funds to planning.

The purpose of this chapter is to describe the federal guidance provided to states for planning, the extent to which states followed the guidance, and the key planning issues that shaped the state plans. A brief review of the federal guidance on planning and key contextual factors is provided below. This is followed by information from the 50 state plans concerning how states followed the federal guidance on planning. The remainder of this chapter focuses on the experiences of the 10 case study states on the following issues:

- Did states adhere to the legislative requirement not to use FP/FS funds to supplant existing funds for services?
- How did the locus of decision-making vary across states?
- How did the locus of control during planning affect the allocation of funds to FP and FS?
- How did the size and range of interests represented in the collaborative bodies affect the nature of the plans developed?
- How did the decision to delegate planning responsibilities to counties affect the nature of the plans developed?
- How was information obtained from needs assessments used in planning?
- How did states interpret federal guidance on community and consumer involvement in planning?

A. Federal Guidance

The federal legislation and guidance encouraged states to:

- Not supplant existing funds spent for family preservation and family support programs;
- Develop strategies for spending FP/FS funds over the five year period;
- Spend significant portions of funds on both family preservation and family support services. Federal guidance defined "significant" as a minimum of 25 percent in each area, but allowed states to justify spending less than that percentage on each type of program;
- Collaborate with a wide range of stakeholders including other state and local public agencies, private agencies, community-based organizations and consumers; and
- Provide a significant portion of the family support funds to community-based organizations.

These requirements and guidance formed the framework in which states conducted their planning efforts. However, other factors influenced the planning process. As shown in Exhibit III-1, the relationship between the issuance of federal guidance and the state planning process was an interactive one. Federal guidance in the form of three Program Instructions, a Notice of Proposed Rule Making and final regulations were issued between January 1994 and November 1996.

As noted in Exhibit III-1, Final Rules for FP/FS were not issued until November 1996, well after the planning process was completed. In the absence of federal regulations, ACYF issued Program Instructions to guide the development of the FP/FS applications, state plans and plan updates. These instructions, however, did not have the same force as Final Rules. While most states followed the primary elements of the guidance, some did not. In turn, ACYF could not require state compliance with the guidance.

In addition, other events at the federal level (depicted as the "clouds" in Exhibit III-1) influenced that state planning process. Early in 1995, the planning process coincided with proposals in Congress to consolidate FP/FS and other child welfare programs under a single block grant. The uncertainties created by the proposed legislation, coupled with the shutdowns in the federal government and delayed payments to states, dampened initial enthusiasm for

using FP/FS as a springboard for major reforms. While capped entitlement programs traditionally are considered a secure funding source, the possibility of the block grant had serious effects. Rather than developing strategic plans or examining alternative service delivery strategies, some states treated FP/FS as though it was a temporary source of funds suitable for funding one-time projects. Service providers, in turn, were reluctant to develop programs whose funding might terminate at any moment.

Even prior to the passage of welfare reform, expectations concerning welfare reform helped shape the planning process in some states. In August 1996, the passage of welfare reform caused other states to reconsider their initial FP/FS plans.

At the state level, planning continued for longer than the one-year period anticipated. The delays were due in part to the issues at the federal level, but were due to internal issues as well. These included:

- **Devolution to Localities:** Planning did not occur at the state level alone. Many states devolved some or all of their planning authority to localities. Some state planning bodies may have spent one year determining how and to whom to devolve planning decisions. The local planning bodies that received funds then spent several months in their own planning process.
- **Diversity of the Planning Bodies:** State planning bodies often included a diverse group of stakeholders who had not previously worked together. It took time for stakeholders to agree on "how" to plan before they could decide how to allocate FP/FS funds.

B. Overview of the Planning Process in the 50 States

Despite the uncertainties and delays noted above, data from the 50 state FP/FS applications suggest that states followed federal guidance, especially in four areas:

- Non-supplantation of existing funds;
- Formation of collaborative planning bodies;
- Shared responsibility for planning with counties and communities; and
- Conduct of needs assessments and other information gathering activities.

States' efforts in these areas are described below.

1. Non-Supplantation of Existing Funds

As will be evident by the extensive planning efforts described in this chapter, states endeavored to develop new approaches to service delivery and did not use FP/FS to finance existing programs. Both the child welfare agencies and the collaborative planning groups in most states noted how few resources were available for family preservation and support programs. FP/FS was viewed as an opportunity to expand on the existing array of services. In the case study states, it was evident that many new services were developed. Where existing service programs were expanded, states were able to identify what program elements existed before FP/FS and which staff positions or new activities were supported with FP/FS dollars.

2. Formation of Collaborative Bodies

The FP/FS legislation required that state plans be “developed jointly by the Secretary and the State, after consultation by the State agency with appropriate public and nonprofit private agencies and community-based organizations with experience in administering programs of services for children and families (including family preservation and family support services)” (OBRA, 1993, Section 432 (b)(1)).

Federal guidance to states in developing their FP/FS applications expanded on this requirement by strongly encouraging states to collaborate with a wide range of stakeholders. The Program Instruction stated:

In isolation, family support and family preservation services cannot effectively address the needs of children and families. Therefore, consultation and coordination should include the active involvement of major actors across the entire spectrum of the service delivery system for children and their families including:

- State and local public agencies, non-profit private agencies, and community-based organizations with experience in administering programs of services for children and families (including family support and family preservation).
- Representatives of communities, Indian Tribes, and other areas where needs for family support and family preservation are high.
- Parents (especially parents who are participating in or who have participated in family preservation programs) and other consumers, foster parents, adoptive parents, and families with a member with a disability.

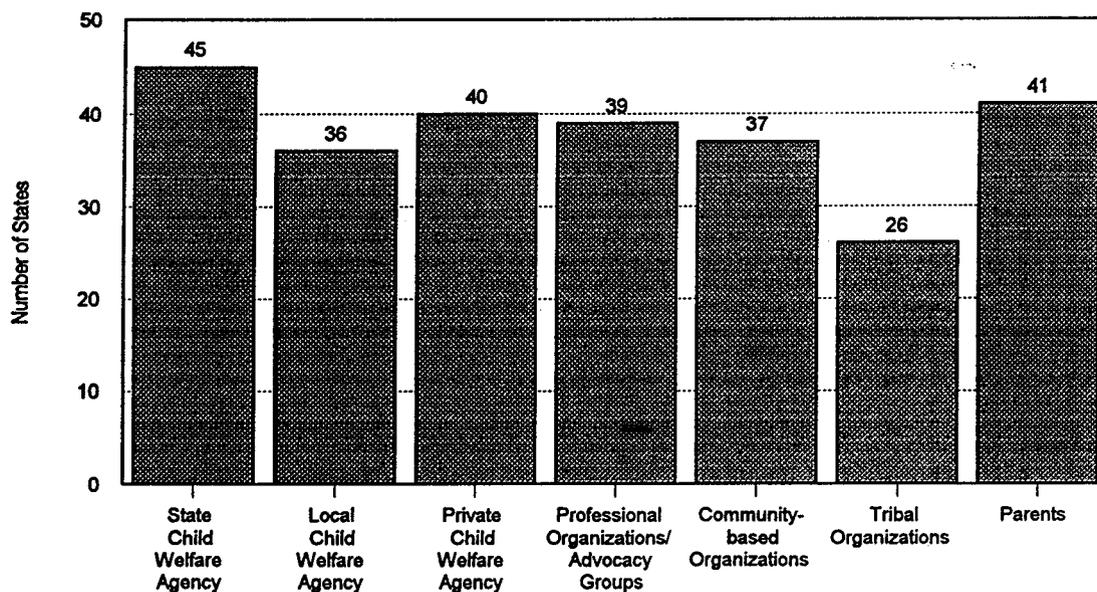
- State and local agencies administering Federal and federally-assisted programs... (HHS, 1994, p. 13).

The nature of this guidance reflects several issues and trends discussed in Chapter II. ACYF recognized that the funds available from FP/FS would not be sufficient to meet all family preservation and family support needs. Collaboration was expected to encourage agencies to consider how they might build on existing programs, share responsibility for serving common populations and consider ways in which the effectiveness of funding and other resources (e.g., facilities, staff) might best be utilized.

Furthermore, collaboration provided a means of addressing those issues pertaining to state and local relationships and increased community and consumer involvement. Including a diverse group of local-level stakeholders early in the FP/FS process might facilitate their "ownership" of the problems experienced by families in their community.

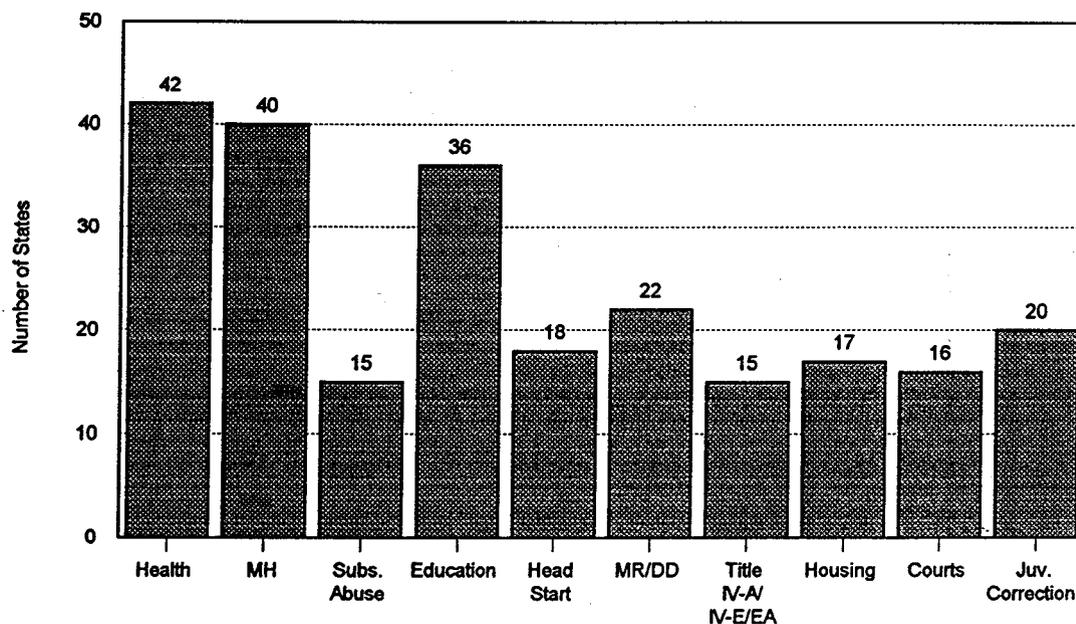
Data from the 50 state applications suggest that most states formed collaborative bodies that included a range of stakeholders. Forty-two of the 46 states that provided information noted plans for some type of advisory committee or planning body. Exhibit III-2 depicts the most frequently involved stakeholders and the number of states that reported including them.

**Exhibit III-2
Stakeholder Representation in the Planning Process**



Viewed from a programmatic perspective, states identified a range of public agencies to include in the process. Exhibit III-3 shows the 10 types of public agencies most frequently included in the planning process. Included in these are public health (42 states), mental health (40) and education (36). It is important to note that the involvement of public health agencies was facilitated by grants awarded by Maternal and Child Health to states to participate in the FP/FS planning process.

**Exhibit III-3
Other Types of Public Agencies Involved in the Planning Process**



3. Shared Responsibility for Planning

The majority of states included local agencies and organizations in a state-assembled planning body. However, some states delegated planning responsibilities to counties or other geographic subdivisions within their state. In their FP/FS applications, 31 states noted that the planning process was largely centered at the state level, while 19 states reported that they delegated or shared planning responsibilities with their counties. Some states supervised a

competitive grant award process (in which counties or local collaboratives could develop plans and submit proposals for funding). Other states distributed the FP/FS funds to all counties and allowed each county to develop its own local planning body to determine the use of FP/FS funds. Some states, having interpreted the guidance to encourage using alternative means of fund distribution, delegated funding to a local public body that was not the child welfare agency.

4. Needs Assessment/Data Collection

As part of the planning process, federal guidance encouraged states to spend their planning funds to conduct needs assessments, using available data whenever possible (ACYF, 1994). The needs assessments were expected to provide a catalog of existing programs and identify gaps in service delivery. States were expected to define a service continuum and identify where FP/FS funds could be best utilized. Like the guidance on collaboration, the needs assessments were intended to facilitate the development of a shared vision of the service continuum among all stakeholders.

Per the federal guidance, states collected information through the following approaches:

- **Formal Community Needs Assessments:** A total of 34 states had conducted or planned to undertake a needs assessment. In 22 states this effort was designed expressly to inform the FP/FS planning process, and in five states the needs assessment was conducted as part of a larger human services planning effort. Seven states relied solely on recommendations gained from previous needs assessments.
- **State Information Systems:** Twenty-seven states relied on data from state information systems to determine the number of abuse and neglect reports and foster care placements in various jurisdictions. They also used data from other sources (e.g., the health department and AFDC data) to identify areas of poverty and other indicators of children at risk (e.g., infant mortality, low birth weight and premature infants).
- **Focus Groups:** Twenty-six states held focus groups throughout their state as a way of ensuring input from consumers and providers of FP/FS services.
- **Public Hearings:** States publicized the FP/FS legislation and available funding and held hearings to allow consumers, providers and advocacy groups to identify issues and needs. Twenty-six states held public hearings, and 21 states held hearings devoted exclusively to FP/FS issues.

- **Surveys and Special Studies:** Twenty-four states conducted surveys of workers, private agency providers, consumers and professionals in related fields to determine service needs and available FP/FS resources. Fourteen state surveys were designed expressly to elicit information about FP/FS, while five states covered a range of child welfare or human services needs. Five states solely relied on previous surveys to inform their planning process.
- **Conferences:** Information for FP/FS planning was gathered from human services professionals through a variety of training sessions and conferences. In most instances, these were previously planned events, which included one or more sessions on FP/FS planning. These conferences primarily involved child welfare agency personnel, but some also included court personnel (e.g. judges and attorneys), private providers, educators and foster parents to help inform the planning process.

C. Key Planning Issues

The data in the state applications provide a snapshot of state planning efforts, but many of the key planning issues could only be discerned in the 10 states studied. A discussion of the key issues that emerged in the 10 case study states is provided below.

1. How Did the Locus of Decision Making Vary Across States?

Eight of the 10 case study states established a new interagency planning group for FP/FS. Two states, Vermont and Florida, previously had established interagency planning groups, which became responsible for FP/FS planning as well. Since collaborative program development was the established hallmark of Vermont's service delivery system, FP/FS funds were used to fill gaps in service delivery. The state was able, therefore, to incorporate FP/FS funding into its existing planning and implementation framework, and the availability of FP/FS planning funds had little effect on that framework.

Among the 10 study states, there are both commonalities and differences in the planning group structure and the decisions that were made. Exhibit III-4 summarizes who made key decisions and what these decisions were. Three models were noted that described the locus of decision making as centered in the following:

- **State Child Welfare Agency:** Although all of these states developed collaborative planning groups, the child welfare agency either made at least one critical decision about the use of FP/FS funds, strongly guided other stakeholders in the decision-making process, or used the planning body in an advisory capacity. Alabama, Georgia and Texas are examples of this model.

**EXHIBIT III-4
Locus of Decision Making on Key Issues**

STATE	DISTRIBUTION OF FUNDS TO LOCALITIES	FP/FS SPLIT	SELECTION OF SERVICE DELIVERY MODELS	SELECT SERVICE PROVIDER
Alabama	State Child Welfare Agency	State Collaborative Group	State Child Welfare Agency and Collaborative Group	State Child Welfare Agency
Arizona	State-Level Collaborative Planning Group	State made initial estimates- -actual split based on provider response to RFP	Provider Collaborative group	State-Level Collaborative Planning Group
California*	State-Level Collaborative Planning Group/Child Welfare Agency	State set parameters; county determination within parameters	County	County
Colorado	State-Level Collaborative Planning Group	State made initial estimates- -actual split based on provider response to RFP	Local Collaborative Group	Local Collaborative Group
Florida	State-Level Collaborative Planning Group	District-Level Planning Group	District-Level Planning Group	District-Level Planning Group
Georgia	State Child Welfare Agency with Collaborative Planning Group Input	Local Providers	Local Providers	State Child Welfare agency
Missouri	State Interdepartmental Directors Group	State Interdepartmental Directors Group	State Interdepartmental Directors Group/Local Planning Group Child Welfare Agency	Local Planning Group
Texas	State Child Welfare Agency	State Child Welfare Agency	FP-State Child Welfare Agency FS-Local Collaboratives	State Collaborative Group (FS)
Vermont	State Collaborative Planning Group	State Child Welfare Agency	Child Welfare Regional Administrator	Child Welfare Regional Administrator
West Virginia	Governor's Cabinet on Children and Families	Governor's Subcabinet. States made initial estimates--actual split based on provider response to RFP	Local Programs	Governor's Cabinet on Children and Families

* Responsibility of county-level decisions varied.

- **State-Level Collaborative Body:** In this model the state-level collaborative body made key decisions concerning FP/FS. While the child welfare agency initially established the collaborative body, a facilitator or someone outside the agency chaired or co-chaired the meetings. Five states followed this model -- Arizona, Colorado, Missouri, Vermont and West Virginia. In Arizona, Colorado and West Virginia the state planning group included local agency and private sector representatives.
- **Local Jurisdiction:** In these states, a decision was made to allot funds to all jurisdictions in the state and allow each jurisdiction to engage in their own planning process within certain specified guidelines. California and Florida are examples of this model.

Although one might expect that whether or not a state child welfare system was state or county-administered would be a major factor in the type of planning process established, this was not the case. Of the states that established the most decentralized process, one was county administered (California) and one was not (Florida). Of those states where the state child welfare agency had a leadership role, Alabama and Georgia are county-administered programs and Texas is state-administered. Instead, other state and local contextual factors helped to shape each state's planning structure and decision-making model. The planning structures and decision-making approaches in turn influenced the types of decisions produced. Examples of each planning model are provided below.

a. State Child Welfare Agency

In Alabama and Texas, the child welfare agency played the key role in determining the allocation of funds between family support and family preservation. Although both states had state-level interagency planning groups that played some decision-making role, the child welfare agency approached FP/FS planning with a clear vision of what they hoped to accomplish with the funds. In Alabama, the state child welfare agency in collaboration with an interagency group defined the parameters for both the FP and FS programs.

Alabama

When FP/FS was enacted, Alabama had completed an exhaustive three-year planning effort in response to a 1991 court consent decree. After considering service and funding options, the state had determined the directions it wanted to take in developing a comprehensive system of care. The new system of care included both a family preservation model (the Homebuilders model that already existed in some parts of the state) and a family support model (the community-based family center in Sunset Park in Brooklyn, New York). In addition, the planned reform effort had included a detailed needs assessment in each county, and a staged system for converting several counties each year to the new service delivery system. Although Alabama had developed some strategies for maximizing and pooling monies from several federal funding streams to implement their new system, the state legislature had not appropriated any additional funds to support the reform. FP/FS became a source of revenue for implementing parts of the new reform.

As a consequence, Alabama allocated only a small portion of its first year FP/FS funds to planning. A collaborative group was formed that provided input on the selection of counties and the allocation of funds. Members of the group also were instrumental in having a small amount of funds set aside for a home-visiting program in one city. The remaining funds were divided between expanding Alabama's family preservation program to other counties and establishing community-based family support centers. Within the framework established at the state level, local collaborative bodies had considerable latitude in designing family support programs that met the needs of their community.

In contrast, the Texas child welfare agency determined the type of family preservation model to be funded statewide, but involved others in FS planning.

Texas

The state controller had mandated that family preservation programs be established as a means of reducing the costs of foster care. The child welfare agency's budget was cut (in advance of establishing family preservation programs) in anticipation of these expected savings. The child welfare agency allocated 75 percent of its first-year funds to establishing family preservation programs throughout the state. In subsequent years, funds for family support were increased.

The inter-agency group was given the task of determining how to spend the remaining dollars on family support programs. The decision was made to issue a competitive RFP in which collaboratives formed by private sector programs could submit proposals to provide family support services. Beyond mandating a collaborative effort, the group did not mandate a specific program model or target population to be served. Instead, these choices were made by the provider collaboratives. The inter-agency group reviewed the proposals and selected the grantees.

In both states, similar contextual factors affected the direction they took in FP/FS planning. Both states had limited resources to devote to child welfare. Neither state had statewide family preservation programs, but the child welfare agencies in both states wanted to move in that direction and set aside FP/FS funds for that purpose. Although Alabama stressed the development of family centers and Texas stressed the development of collaboratives among providers to determine their own family support programs, both approaches left considerable latitude for local groups to establish the array of services best suited to the needs of their target population. Furthermore, although the child welfare agencies initiated the key decision on FP/FS allocation, they did not "keep" the money in the family preservation sphere -- more than half the funds in each state were spent on family support.

b. State Collaborative Body

Arizona, Colorado and West Virginia formed large collaborative bodies that included a diverse group of stakeholders. Although the groups varied in size, membership and the formality of their meetings, all groups were responsible for making key FP/FS decisions. West Virginia had the most structured planning group.

West Virginia

West Virginia's child welfare agency contracted with the Governor's Cabinet on Children and Families to manage the FP/FS planning and implementation process. The Subcabinet, in turn, established a steering committee, with the membership divided equally among three groups -- state representatives, community representatives and consumers. Meetings were run by a facilitator and a voting process was used to make decisions. All members of the group had to agree for a decision to be final.

Some funds were set aside for child welfare agencies to meet emergency needs of families. Most funds were initially used to establish local Family Resource Networks -- bodies that would coordinate services and assist service providers in applying to the Subcabinet for service delivery grants.

Arizona established a large and less formal planning group than West Virginia, and did not devolve any authority to local-level planning bodies.

Arizona

Arizona convened a 65-member collaborative group that included both state and local public agencies, private social service providers and other community representatives. Participation in the effort was fluid; some stakeholders joined the group during the planning process. Others that were invited did not actively participate.

The group was chaired by the state FP/FS coordinator from the state child welfare agency and an outside facilitator. No formal voting procedures were established; decisions were reached through informal consensus. The group divided into four subcommittees -- community forums, services, linkages, training and evaluation.

The planning group developed a theoretical continuum of care and a taxonomy for describing service points along the continuum. A Request for Proposals then was issued that requested proposals for service delivery (along any point in the service continuum). The Request for Proposals required that agencies (both public and private) work together to submit a single proposal that built on the resources of their respective organizations. The collaborative group then was responsible for awarding funds, with the approval of the child welfare agency. Although the state initially planned an equal allocation of funds between FP and FS, the proposals received more frequently focused on family support services. The actual allocation in the first year was 25 percent for family preservation and 75 percent for family support.

Although Missouri also had a state-level collaborative planning body that included a diverse group of stakeholders, key decisions eventually were made by the directors of state health and human services agencies.

Missouri

Although Missouri began its FP/FS planning by convening a 46-member group comprised of representatives from a range of fields representing both the public and private sectors, this group did not make final decisions concerning FP/FS implementation. The large group was considered too unwieldy to guide the planning process. In addition, there were concerns that the group would "divide the pie" along traditional service delivery lines rather than formulate new community-centered strategies. Some stakeholders noted that formation of the initial group may have raised the expectations of some participants and subsequently created ill will when the planning process was changed. A much smaller group comprised of the state directors for social services, mental health, health and education was established to guide the process. A non-profit organization, the Family Investment Trust (FIT), was established with foundation funding to guide the state directors' vision of service delivery reform. The state directors and leading private sector representatives formed FIT's board of directors. FIT staff helped organize meetings and develop technical assistance materials to support community implementation of FP/FS.

Through a review of data on county characteristics and collaborative history, Missouri selected seven counties to receive planning grants and eventually service delivery funds. The plan called for each of the counties to establish school-centered service delivery systems modeled after the pilot "Caring Communities" projects that the social services, mental health and education departments had previously funded. Beyond the requirement that services be school-centered, counties were free to design programs that best met their needs.

Prior to FP/FS, Missouri had funded family preservation services for child welfare families throughout the state and the mental health agency also had developed an extensive network of family preservation programs. Therefore, this plan was based on the desire of the state agency directors to increase community ownership of human services needs and to create the opportunity to make more fundamental changes in the service delivery process. To support this effort, funds were pooled from other sources to create a \$21 million funding stream (FP/FS accounted for \$2.4 million of the funds) for the "Caring Communities" effort.

c. Local Jurisdictions

Finally, while both California and Florida established state-level interagency groups, each state made an early decision to allot each county (California) or district (Florida) a proportional share of FP/FS funds. The localities were then required to engage in their own planning activities. Each local entity developed plans that were submitted for state approval. However, the states differed in the nature and extent of the guidance provided the local groups. In California, each County Board of Commissioners and Child Welfare Agency director determined the nature of the local planning process. The state also specified that counties were to spend at least 25 percent of their funds on family preservation and 50 percent on family support. In

contrast, Florida provided its districts with considerable guidance on how to plan, essentially creating a shared local/state model for planning and implementation.

Florida

Florida has a state-administered child welfare system that works through 15 district offices, which have decision-making authority. FP/FS funds were allotted to the District Administrators who were required to work driven with their Human Services Boards and other designated planning entities to conduct a community-driven planning process that built on community strengths. To support the planning process, the state provided funds for the districts to hire a local community facilitator. All community facilitators were to be hired by a specified date, and the state held a training session for all facilitators and collaborative partners, including Health and Human Service boards and juvenile justice planning liaisons.

The state established the allocation methodology, designating 75 percent of funds for family support and prevention. Districts had flexibility to change this allocation based on community needs and strengths. The state, however, encouraged districts to focus on developing community-based family support efforts because of the funding already invested in family preservation. Community facilitators received training on community mapping, and initiated mapping in targeted communities to identify strengths and resources.

2. How Did the Locus of Control During Planning Affect the Allocation of Funds to FP and FS?

Perhaps the most critical difference among the study states is the role played by the child welfare agency in decisions about the allocation of funds to family preservation or family support. As noted in Chapter II, historically family preservation services are rooted within the child welfare system. Although program models vary somewhat, virtually all states' family preservation models are funded by child welfare agencies. They provide intensive services of short duration for children and families who are at "imminent risk" of foster care or who have already been placed in foster care. While there has been much discussion concerning the ability of child welfare staff to operationalize the concept of imminent risk, families referred to family preservation programs have traditionally been clients of the child welfare agency or another agency with placement authority (e.g., juvenile justice, mental health). It is important to note that the FP/FS legislation did not, in its definition of family preservation, limit state options to intensive family preservation or reunification models. In addition, the legislation did not specify the target population for family preservation services. By including a broad range of services in its definition, the legislation opened the door for different interpretations of the service and

target populations. Federal guidance encouraged states to use the flexibility provided in the legislation.

Many stakeholders had little understanding of, or experience with, the severity of the cases typically seen by child welfare agencies or the importance of an intensive level of services to ensure child safety. Moreover, many stakeholders held negative opinions of the child welfare agency and did not believe they could successfully operate such programs. Based on case study interviews, some of the stakeholders also appeared to be unaware of the specific provisions of the legislation. While the legislation identified both family preservation and community-based family support programs, some stakeholders assumed all funds were to be used for community-based programs. This assumption may have led to a greater focus on family support rather than family preservation programs.

It appears that in instances where the state child welfare agency did not play a strong role early in the decision-making process, local child welfare agency directors and staff did not participate in the planning process, although some exceptions were noted in Los Angeles, and Pinellas/Pasco counties in Florida. Several factors emerged during case study interviews that singly, or in combination, may account for this occurrence:

- A belief that the direction taken by the state in forming broad-based collaborative bodies was indicative of the intent to use all or most funds for family support;
- The amount of funds available was too small to significantly affect child welfare services;
- The day-to-day crises experienced in child welfare agencies precluded attendance at frequent planning sessions;
- A perception (often accurate) that the collaborative groups formed were not predisposed to allocating funds for intensive family preservation;
- A belief that the early prevention services characterizing family support programs would reduce new allegations of abuse and neglect in the long term and, therefore, reduce the need for intensive services; and
- An inability to anticipate the results of the collaborative process.

In Alabama and Texas, the states that spent a significant portion of their FP/FS funds on intensive family preservation programs, the child welfare agency made an initial decision or was extensively involved in a group's decision to set aside funds for that purpose.

Collaborative bodies then were used to help direct the allocation of funds for family support programs.

In Arizona, Colorado and West Virginia, local child welfare directors were invited to attend the local planning meetings. However, the states did not place responsibility for planning with the local agencies, choosing instead to support a broader, grassroots-level group. Colorado reported that some county child welfare directors were unhappy with this decision and did not actively participate in the local planning process. Arizona also noted a lack of participation among local child welfare directors.

3. How Did the Size and Range of Interests Represented in the Collaborative Bodies Affect the Nature of the Plans Developed?

While the findings suggest that the nature of the collaborative bodies drove the decisions that were made, contextual factors determined the types of collaborative bodies that were formed and the scope of their decision making. Most notably, federal guidance, the desire to decentralize authority and responsibility to counties or communities, the nature and extent of existing state support for family preservation, and state financial problems all played a role in shaping the size and scope of the collaborative bodies' decision-making authority.

Also, many viewed the amount of funds available to be too limited for designing intensive family service programs that require greater funds per family than family support efforts. By emphasizing less costly, broad-based, preventive programs, FP/FS funds could be used to serve more families.

The size of the planning group and the diversity of its membership also appeared to affect the number of programs funded, and consequently the amount of funds allocated to each program or service. In general, large planning groups tended to fund several small programs, whereas the smaller groups were more likely to fund fewer but larger programs.

The planning groups in Alabama, Missouri and Texas were relatively small and primarily limited to public agency representatives. The plans generated from these groups targeted funds either by limiting the number of sites or program models funded. The result was that grants to local jurisdictions or collaborative groups were sizeable (e.g., \$100,000 to \$500,000).

These states had a more clearly articulated strategy for use of FP/FS funds; however, they did not limit providers' options in terms of the types of family support models to consider or the populations localities should target. States that had larger and more diverse planning

groups tended to "carve up the pie" -- using FP/FS as a funding stream to support a range of services. For example, in West Virginia the maximum grant for service delivery was \$36,000 for one county to \$90,000 for a multi-county area. This approach was a logical result of bringing together a diverse group of people -- many of whom had never worked together before -- to make decisions within a relatively short timeframe and at the same time build working relationships.

4. How Did the Decision to Delegate Planning Responsibilities to Counties Affect the Nature of the Plans Developed?

Among the 10 study states, Florida and California devolved their entire planning process to local jurisdictions, although the process in each state was quite different. In California, the county Boards of Supervisors, which traditionally administer discretionary funds, were the administrators of the FP/FS funds and responsible for approval of plans that then were forwarded to the state. In most counties, the Boards of Supervisors turned the FP/FS planning process over to the child welfare agency. In Los Angeles, a newly formed regional planning commission was responsible for the FP/FS plan, but they too relied heavily on the county child welfare agency in developing the plan. Based on the case studies conducted in Los Angeles, Fresno and Santa Clara, as well as discussions with state officials, the 57 county planning processes and resulting plans were very diverse.

In Florida, funds were given to each of Florida's Department of Health and Rehabilitative Services' (now the Department of Children and Families) 15 District Administrators and their respective Human Services Boards. Unlike California, the Human Services Boards were recently formed, and the FP/FS funds provided a somewhat unique opportunity for them to play a greater role in service delivery planning.

To assist the Boards, Florida funded and trained community facilitators to help conduct the planning process. Although state officials believe the nature and extent of the planning process varied based on the issues in each district and the relationships between the Board and the District Administrators, the case studies in both the Broward County District (Fort Lauderdale) and the Pinellas/Pasco County District (St. Petersburg) suggest that the FP/FS coordinators played a critical role in ensuring that the planning process included a range of stakeholders and actively focused on using funds to promote the development of community-based programs. Like the states with large planning bodies, the plans developed in these

districts tended to spread the monies among many providers and in several selected neighborhoods throughout their districts. While the emphasis was on funding family support programs, both districts expanded the intensive family preservation services they offered as well.

In summary, there were considerable differences in the way states approached devolution. In California, the state permitted each county to determine its own planning process. In contrast, Florida provided support and guidance to districts about how to plan and encouraged a focus on developing community-based family support and prevention programs. Nevertheless, one result of devolution in both states was to limit the ability of states to selectively target counties or communities to receive funds. Consequently, the pool of resources available to each successive layer of implementation continued to shrink, and grants to local child welfare agencies or service providers often were small.

5. How Was Information Obtained from Needs Assessments Used in Planning?

The needs assessments encompassed both quantitative and qualitative information collection efforts. Quantitative efforts included conducting consumer and provider surveys, gathering and analyzing demographic data by county, reviewing case records, examining databases and developing county-specific risk indicators.

Qualitative efforts included conducting focus groups, forums, public hearings, town meetings and consumer conferences. The resulting information from these activities in the 10 study states revealed common areas of local concern, including the need for more transportation, improved access to services within the community (i.e., "one-stop shopping"), employment opportunities, child care, respite care, parent support groups, access to services for persons with disabilities, more individual attention from caseworkers, and substance abuse prevention and treatment.

Common themes also emerged across states about the purpose and utility of the needs assessment/data collection process. Overall, the needs assessments activities appeared to be undertaken for reasons other than identifying gaps in service delivery. Primarily, the needs assessments/data collection activities served two purposes:

- **Providing Catalysts for Community Involvement:** The focus groups, public hearings and other activities provided mechanisms for making stakeholders aware of the legislation and its intent, galvanizing community interest in

developing family preservation and support programs, and facilitating collaboration among stakeholders. This was especially important in states that allocated funds to a collaborating or coordinating entity.

- **Targeting Communities and Identifying Baseline Information:** For some states, (most notably Alabama, Colorado, Missouri and West Virginia), part of their information gathering efforts included examining data bases from a range of health and human services agencies and identifying indicators of the status of children and families. Examples included not only child welfare data on abuse and neglect reports and foster care placements, but also data from: health departments on infant mortality and teen childbearing; education departments on reading and math scores and dropout rates; and from juvenile justice on arrests. Such data were used to identify local jurisdictions in greatest need of assistance. In Missouri and West Virginia, the data were also used to establish a baseline and subsequently monitor change in the outcomes expected from FP/FS.

In other words, the information collection processes were less about identifying needs (few surprises were noted) than about getting stakeholders invested in a comprehensive planning process. Irrespective of the types of planning bodies formed or needs assessments conducted, most stakeholders in all case study states and communities were pleased with the process in which they participated and the plans they developed. Many individuals noted that these events had not occurred in their state or community before or that they had not previously been included in such a process. From this perspective, the information gathering activities were largely successful.

6. How Did States Interpret Federal Guidance on Community and Consumer Involvement in Planning?

Most of the study states and communities undertook serious efforts to involve community-based organizations and consumers in their planning processes. Efforts were targeted toward minority groups, community-based organizations and parents. However, these efforts met with mixed results.

a. Minority Group Representation

Among the most successful efforts were those that specifically focused on ensuring inclusion of stakeholders of different races/ethnicities. Examples of these efforts include the following:

- **Colorado:** Concerned about the disproportionate number of minority children in the child welfare system, Colorado formed a Cultural Diversity Council. Members of the Council sat on all subcommittees of the planning group and were involved in reviewing all planning decisions.
- **Florida:** In addition to using its 15 district offices as the basis for planning, Florida created a "16th district" aimed at addressing issues of concern to migrant families. This group had its own planning coordinator, and separate funds were allocated to address migrant needs.
- **Santa Clara, California:** For the first time, the county included child welfare clients and community members in planning. The initial meeting was hosted in a hotel conference room selected to provide a neutral and pleasant environment. The county used bilingual facilitators at monthly meetings and provided refreshments and child care. Participants were promised a final celebration at the conclusion of the planning process. Their responsibility for developing a plan and deciding how FP/FS funding should be spent continually was reinforced.
- **Broward County, Florida:** The planning process included extensive community mapping efforts that resulted in selecting three communities in the county for family support services. Community mapping involved examining data on risk factors at the neighborhood level, as well as identifying available resources in each neighborhood. For each community, key stakeholders were approached and encouraged to assist in identifying both existing resources and needs. In one community, a neighborhood association was formed. Members of the association were then invited to assist the planning committee in reviewing the proposals received from service providers.

b. Community-Based Organizations

The results of efforts to involve community-based organizations were mixed. In part, this stems from variations in how states defined these organizations. Federal guidance per the NPRM defined community-based services as "programs delivered in accessible settings in the community and responsive to the needs of the community and the individuals and families residing therein. These services may be provided under public or private nonprofit auspices" (U.S. Department of Health and Human Services, 1994, p. 138). Under this definition, states often considered traditional, professionally staffed private provider agencies to be community-based organizations and believed they had complied with the guidance when private providers were included in the planning process.

However, other definitions of community-based organizations more typically reflect the concept that these organizations should be an integral part of the communities they serve. For

instance, the Family Resource Coalition defines community-based organizations as having the following characteristics:

- Parents participate in program decision-making and governance;
- Programs are culturally and socially relevant; and
- Staff members are representative of the participant population (Family Resource Coalition of America, 1996).

Fewer states made efforts to include organizations meeting the latter definition in their collaborative planning bodies, although representatives may have participated to a greater extent than was previously the case.

Whether or not they were part of the planning process, some states and communities made special efforts to include community-based organizations in subsequent service delivery, although problems were noted in this regard as well. Some states noted that community-based organizations often lacked the financial stability and history of managing state funds to be awarded state contracts (e.g., Colorado and Arizona). In those states that engaged in competitive procurements, stakeholders noted that professional providers were more experienced in proposal writing and more likely to be awarded contracts.

Several states effectively sidestepped these problems. One approach was through the creation of local collaborative groups that could then designate any organization as the fiscal agent. The fiscal agent would receive funds from the state and be responsible for all accounting functions. Note that the agent did not have to be the lead agency in providing services or managing the collaborative. It could be any organization with a sound financial history -- local colleges, school boards and United Way organizations were all used to fulfill this role. This approach was used in Colorado, Missouri and Texas.

Other states and localities (e.g., Santa Clara, California; Broward and Pasco/Pinellas counties, Florida) awarded "mini-grants" to both individuals and community-based groups for short-term activities. The grants ranged in size from approximately \$200 to less than \$5,000 in Florida, and were subject to simpler accounting requirements. In addition, they provided a method for involving a larger number of community stakeholders in service delivery.

c. Consumers

Similar issues exist when defining the term "consumers." For some it meant simply "parents and children." Under this definition, consumers were often PTA presidents or parent advocates, especially parents of children with disabilities. In other words, the consumers most likely to participate in planning efforts were those who were already actively involved in community or civic affairs. For example, in West Virginia one-third of the state steering committee was comprised of consumers who were most frequently individuals with a disabled child, handicapped youth, or adults who had been in foster care. Parents on the state steering committee seldom had contact with the child welfare or public assistance systems, or experience with such problems as substance abuse or teen pregnancy. Stakeholders in Texas also noted that parents of children with disabilities tended to dominate community forums.

Other states defined consumers as parents and children who received child welfare services, used the services of a family support program, had risk factors associated with service needs or lived in a community with high risk characteristics. States and communities that made efforts to attract consumers who previously had not been involved with formal service delivery systems faced greater challenges.

As indicated in both the 50 state applications and plans and the 10 state case studies, efforts to attract consumers to the planning process primarily focused on providing child care, transportation and stipends. States also tried to hold sessions at times and locations convenient for consumers, as well as provide meals or otherwise create a more "welcoming" environment.

To the extent that states and localities attempted to secure input from non-traditional consumers at single events (focus groups and hearings), they were sometimes successful; although several states noted that traditionally vocal consumers, especially parents of children with disabilities, tended to dominate these sessions.

Those states that tried to involve non-traditional consumers as members of an ongoing planning group – especially groups dominated by professional service provider or public agency staff – experienced greater difficulties. States and communities often noted that a consumer would attend one or two meetings but then would drop out or appear intimidated and not actively participate.

Most states appeared interested in improving consumer representation on the planning body, but were in a quandary about how to facilitate involvement. Some noted that they

believe local-level planning bodies are better able to achieve consumer participation than state planning bodies. Some states (e.g., Connecticut) established a separate committee for consumers that then reported to the planning body. Reasons noted by stakeholders for lack of consumer participation included the following:

- **Timing, Frequency and Location of Meetings:** Unlike one-time focus groups or hearings that were held in convenient locations and on weekends or evenings, planning bodies typically met in public agency facilities during traditional working hours.
- **Knowledge and Experience in Planning Issues:** Stakeholders believed consumers were in a good position to comment on barriers and issues concerning service delivery. However, planning meetings often focused on more "bureaucratic" issues such as the use of various funding streams, budget issues, procurement practices, and other factors of which consumers were understandably less knowledgeable.
- **Attitudes of Some Planning Group Members:** One stakeholder noted that the planning board included the "movers and shakers" in their county -- upper-middle class professionals who did not feel comfortable or relate well to those with economic or social problems. Another stakeholder noted that a member of their planning group made derogatory comments about people with substance abuse problems when a consumer with substance abuse problems was present.

A notable exception to this problem occurred in Broward County, Florida where the FP/FS coordinator made special efforts to involve members of the community in the planning process.

Broward County, Florida

Broward County's planning body was composed primarily of directors of public and private agencies and civic leaders. The group did include one consumer who lived in one of the poorer neighborhoods in the county, and had been active in the PTA and tenants rights efforts. This consumer noted that when she had become seriously ill and missed some planning meetings, the FP/FS coordinator called her to see how she was feeling and to keep her up to date on the activities of the group. As a result, the consumer continued to remain involved in the group's activities.

In addition, when one of the neighborhoods was targeted as an initial site for services, the FP/FS coordinator helped establish a neighborhood council. She then asked members of the council to be involved in reviewing proposals submitted by service providers. These consumers also noted that the FP/FS coordinator assisted them in reviewing the proposals by explaining the basic intent of the proposal and answering questions about terminology they did not understand.

D. Lessons Learned

Through their experience with FP/FS, states and communities learned valuable lessons about planning and collaboration. As noted in the discussions above, states tried various approaches to planning and collaboration. Many made false starts in the beginning but adapted their approaches as they matured. Among the lessons learned concerning the planning process are the following.

1. Size of the Planning Groups

Although Arizona and Colorado both successfully used large planning bodies (more than 50 stakeholders), many states and localities that started with large groups eventually pared them down, or used the groups in a more limited way. Arizona's and Colorado's successful management of large planning bodies was due, at least in part, to:

- Use of outside facilitators to manage group meetings;
- Formation of subcommittees to conduct the "work" of the planning group;
- Establishment of ground rules for operating the meeting (e.g., Arizona stakeholders agreed not to revisit "old" issues when some stakeholders had missed previous meetings); and
- Preparation and circulation of written summaries of meetings and subcommittee activities.

2. Use of Outside Facilitators and Planning Coordinators

States that used outside facilitators (e.g., Arizona, Colorado, West Virginia) noted the importance of the role the facilitators played in the process. They noted that the outside facilitator was viewed as a neutral party, and the facilitator encouraged those who were new to a planning process or somewhat suspicious of the intent of the planning process to participate fully. In addition, they were helpful in keeping the group on track, providing information about other states that was useful to the group, and preparing and distributing summaries of the meetings for all participants.

Although their role was much broader than that of a meeting facilitator, the coordinators hired in Florida were able to galvanize the planning process in their respective districts and ensure the inclusion of non-traditional stakeholders. Armed with the training provided through

the state-level planning group, they were able to guide the planning bodies in their development of community-based service delivery.

3. Targeting Specific Communities

As noted in the next chapter, states that targeted specific communities were able to devote a larger amount of funds to these efforts. As such, they had the resources to establish programs that could engage a range of stakeholders and serve as a magnet for attracting consumer involvement.

4. Requiring Providers to Develop a Collaborative as a Condition of Funding

Arizona, Colorado and Texas required providers to develop collaborative service delivery projects in order to receive funds. The service delivery projects in these states (described in Chapter IV) reflect the intent of creating service delivery networks that were more comprehensive and accessible to families.

5. Determining Service Delivery Strategies

Gathering a diverse group of stakeholders encouraged each county, community or provider collaborative to develop or select their own service delivery model. In general, there appeared to be little discussion in state planning sessions about the strengths and weaknesses of alternative service delivery models or strategies, and little guidance or direction to counties or providers in this regard. The 1994 ACYF Program Instruction contained examples of alternative models for both FP and FS programs, but planning sessions did not focus on examining the strengths and weaknesses of existing models. This may have been the result of a lack of time, a concern that it would be difficult to reach consensus if more specific direction was provided, or a desire not to limit the flexibility of local jurisdictions or providers. It also may reflect a prevailing notion that local, grassroots organizations have the knowledge and experience to select the most appropriate model to meet community needs.

It is important to note that identifying a model at the state level does not automatically preclude allowing local flexibility and ownership of the programs developed. Alabama's designation that family support funds be used for family centers did not inhibit local initiative. Rather it provided a focus and direction for community collaboration in determining the mix of desired services and in engaging existing providers to outstation staff at the centers.

6. Ensuring Child Welfare Involvement in Collaborative Bodies

FP/FS provided an opportunity for child welfare staff, other public agencies and communities to work together on common goals and to change the image other stakeholders have of child welfare. Yet in several states and communities, child welfare appeared to be an absent, or at least a silent partner, in this process. Some stakeholders with whom we spoke believed that there was a need to limit child welfare's role. They were concerned that child welfare would "keep all the money," use funds for routine child welfare functions and minimize the role of other stakeholders in the process. Yet an examination of the states in which the child welfare agency maintained leadership of the FP/FS planning process (e.g., Alabama and Texas) revealed that these concerns were unfounded.

Greater efforts are needed at both the state and local level to ensure child welfare's continued involvement in FP/FS. Their role is necessary to meet the FP/FS legislative and regulatory intent to build a stronger service continuum. FP/FS provides an opportunity for child welfare agencies to become more sensitive to the needs of the communities they serve and for community-based organizations to gain the knowledge and skills needed to ensure child safety.

E. Summary

In summary, the planning process was a relatively new experience for many participants. Most states embraced the planning process enthusiastically and attempted to follow the federal guidance.

The FP/FS planning funds were a catalyst for examining service delivery issues, facilitating collaboration and engaging new stakeholders in the service delivery process. States did not use FP/FS to supplement existing funds; rather they created new services or expanded existing programs. As demonstrated in Chapter IV, even in states that had difficulty securing participation from consumers and community-based organizations in the planning process, the resulting service delivery plans set the stage for greater community involvement at the local level.

Despite increased community involvement, in most states and localities the process seemed to fall short in terms of promoting detailed assessments of service delivery priorities, identifying target populations to be served and examining alternative service delivery models that might best meet identified needs. Apparently a one-year planning period was sufficient for generating interest and enthusiasm among stakeholders, but was not sufficient to examine

weightier technical issues in detail. In most instances, stakeholders attended FP/FS meetings in addition to their regular responsibilities within their own agencies. Most planning bodies did not have staff that could devote their time to technical issues. Planning groups typically met monthly or quarterly, with some additional time spent in meetings of various subcommittees. As a point of comparison, Alabama's planning effort for child welfare system reform involved a less diverse group of stakeholders, had staff and consultants assigned to develop components of the plan and spent three years in the process.

Finally, there were some unintended consequences of FP/FS planning. First, except in states where the child welfare agency made a decision to allocate funds for intensive family preservation and reunification services, such programs received little or no funding. While several states already had statewide family preservation programs, most did not have reunification programs.

The focus on family support programs may reflect the fact that the large and diverse planning bodies formed in some states had greater familiarity with, and interest in, promoting family support efforts. It also may reflect how states operationalized guidance that encouraged agencies to reach out to community-based organizations. While early efforts to identify service continuums were made in some planning groups, the groups appeared reluctant to be explicit in defining program models or funding programs at all stages of the continuum. As described in Chapter V, the programs funded were heavily oriented toward primary prevention programs. Furthermore, the need to achieve consensus among such diverse groups of stakeholders led most states away from targeting funds to specific communities or programs. Instead small amounts of monies were dispersed among a large group of services.

The FP/FS legislation provided considerable flexibility in determining how and for whom funds should be spent. States clearly used the flexibility to craft unique plans that set the template for the types of changes in local services expected from FP/FS implementation.

CHAPTER IV

LINKING PLANS TO SERVICE DELIVERY: MONITORING, FINANCING AND TRAINING ON FAMILY-CENTERED PRACTICE

In addition to the federal guidance on planning discussed in the previous chapter, guidance was also provided on program monitoring, financing and instilling principles of family-centered practice in all programs receiving FP/FS funds.

The purpose of this chapter is to describe state efforts to: (1) establish measurable goals and objectives and monitor progress toward these goals; (2) use FP/FS funds in coordination with other funding streams; and, (3) provide training that promotes the principles of family-centered practice in FP/FS-funded programs.

Within each of these areas, relevant federal guidance is first described. Findings from the 50 state plans and updates (where possible) and the case studies are then provided.

A. Monitoring

The FP/FS provisions of OBRA 1993 required that plans submitted by states: specify goals intended to be accomplished by the fifth year; describe the methods to be used to measure progress towards these goals; and insure that progress is reviewed and goals are updated annually.

Federal guidance largely echoed these requirements. In their five-year plans, states were required to:

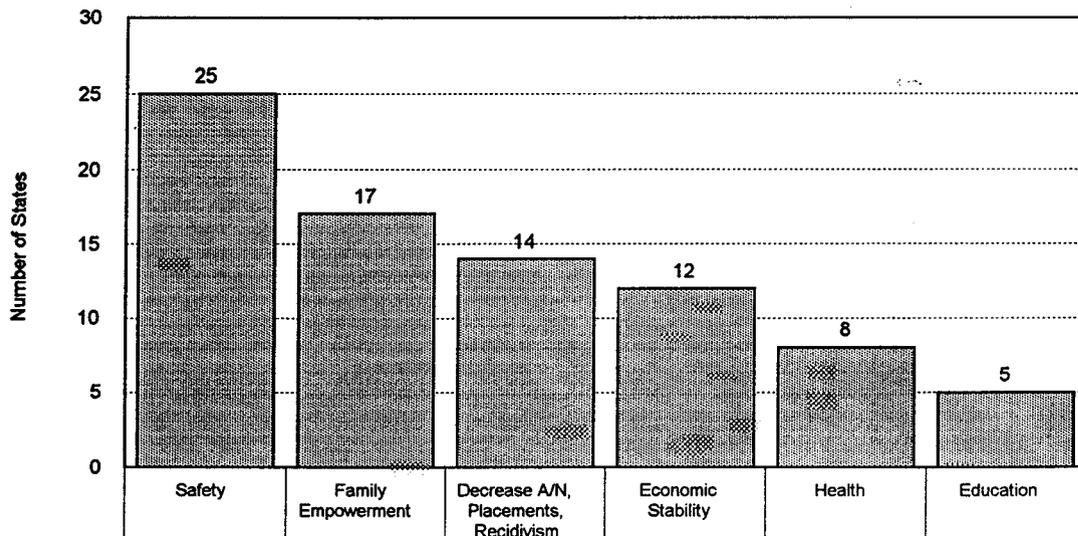
- **Specify the Goals to Be Accomplished by the End of the Fifth Fiscal Year:** Goals were to reflect: (1) improved outcomes for children, youth and families; and (2) the development of comprehensive, coordinated and effective service delivery systems.
- **Specify Detailed Objectives to Be Used in Measuring Progress Toward Accomplishing Goals:** Objectives were to be tied to individual goals and reflect realistic, specific, quantifiable and measurable statements.
- **Describe the Methods to Be Used in Measuring Progress Toward Accomplishing Goals:** States were instructed to: (1) specify processes and procedures for producing valid and reliable data and measuring progress; (2) develop interim benchmarks and multi-year timetables for achieving each objective; and (3) describe procedures ensuring information will be used for periodic reviews and updates.

1. Goals, Objectives, and Processes for Measuring Progress

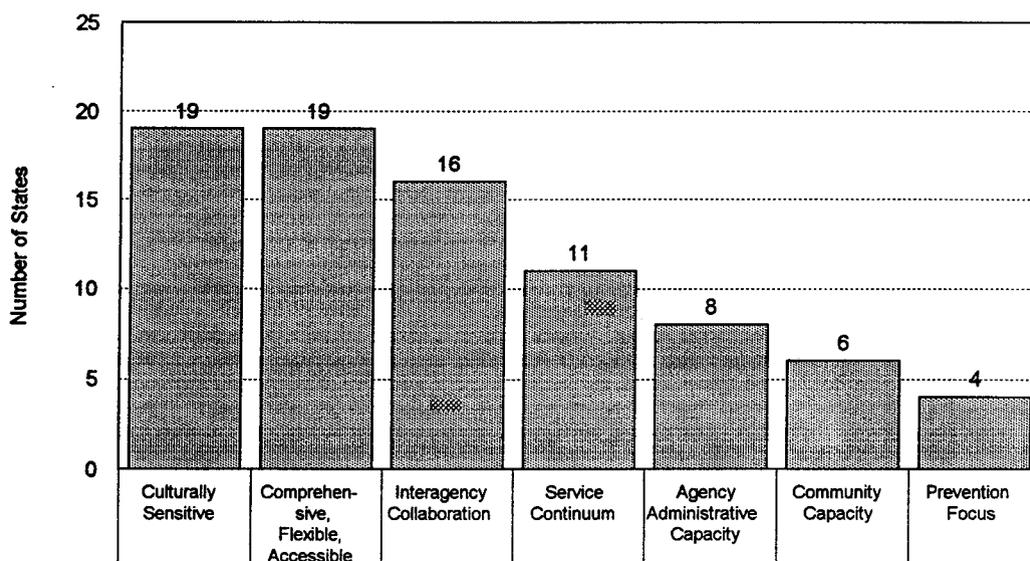
The analysis of the goals and objectives contained in the 50 state plans is described here. It is important to note that although most states developed goals and objectives for FP/FS implementation, the level of detail varied considerably from plan to plan. The majority of states articulated expected outcomes in qualitative rather than measurable terms. Nonetheless, the goals presented by states can be grouped into the following two major categories, as shown in Exhibits IV-1 and IV-2.

- **Child and Family Outcomes:** The major themes identified were safety; family empowerment; reducing abuse and neglect, out-of-home placement and recidivism; increasing economic stability; as well as improving health and education.
- **Service Delivery System Improvements:** The major themes identified were ensuring culturally sensitive service delivery; developing comprehensive, flexible, and accessible service systems; promoting interagency collaboration; expanding the services continuum; increasing agency administrative capacity; increasing community capacity to plan and deliver services; and shifting the focus of the service delivery system from a treatment-oriented system to a prevention-oriented system.

Exhibit IV-1
Goals Related to Child and Family Outcomes
(N=41)



**Exhibit IV-2
Goals Related to the Service Delivery System
(N=44)**



2. Problems with the States' Objectives and Measures

Although the types of goals and objectives noted were consistent with federal guidance, states had difficulty developing appropriate measures and indicators. Moreover, information resources and planned data collection methods were described even less consistently. Specifically, the analysis found:

- Thirty-six states described at least one objective that could be considered quantifiable (e.g., “reduce the number of abused and neglected children” as opposed to “improve child well-being”);
- Only 11 states developed objectives with specific targets (e.g., reduce abuse and neglect by five percent);
- For virtually all plans, data and information sources were not well-specified, especially for indicators that required data from other agencies (e.g., improved school performance); and
- Even those states that identified measurable objectives experienced difficulties in tracking progress and, most importantly, linking observed changes to FP/FS-funded programs.

a. Lack of Specificity

There were several explanations for the lack of specificity in goals and measures. Information obtained through the case studies provided insights into the difficulties states and communities faced when developing goals and measures and monitoring progress. First, some states -- especially those with a strong tradition of county administration and local control -- purposefully left the development of specific objectives to localities. For instance, guidance developed by California's State Collaborative Advisory Committee (SCAC) instructed counties to develop their own goals and objectives consistent with a statewide vision statement and six broad principles. In turn, the state child welfare agency reported that the plans submitted by counties varied in their level of detail and specificity. In others states, locally defined goals and objectives lost their specificity as the state incorporated them into overall statewide goals.

A second reason offered by those involved in the state-level planning process was that the designated planning period did not allow sufficient time to think through, and clearly specify, their measurable goals and objectives. Collaborative planning bodies often used subcommittees to address different issues. As a result, those specifying goals, measures and objectives were doing so independently of program funding and service delivery decisions. Thus, measurable objectives and service delivery efforts were not well linked.

Third, still other participants were realistic in their appraisal of their state's inability to adequately ensure that counties or programs reported and analyzed information on their progress towards goals and objectives. Without state-level staff at least partially dedicated to these functions or resources set aside at the local level for evaluation, monitoring progress was not feasible.

b. Measures of Progress Using Aggregate Data

Many states and localities planned to use data from existing management information systems, rather than establish new program-specific measures and reporting requirements. For example, trend data on such measures as foster care placement rates would be noted over the period of FP/FS implementation. Relying on existing data minimized the burden placed on programs. They were not required to track and record individual client data. Nevertheless, there were fundamental problems with this approach.

First, for the most part, programs implemented under FP/FS were quite small and only able to serve a limited number of families. As a consequence, it was unrealistic to expect that

these programs alone would have an observable effect on an entire state, county or even a neighborhood. One child welfare director summarized the problem of measurement in the following way, "We feel we have targeted these [FP/FS] funds exactly in the right direction. However, proving that may be nearly impossible given the impact of other much larger forces and funding streams that affect these problems. It's like dropping a pebble in the middle of the ocean and waiting for a wave to wash ashore as a result." In other words, even if programs produced positive results for a small number of families, it would not be enough to demonstrate significant changes, especially at a statewide level.

Second, it is unclear whether measures available on information systems were appropriate for the programs funded. Without clear logic models that link program activities with objectives and expected outcomes, the objectives may simply reflect the planning groups' hopes and wishes rather than realistic objectives for the funded programs.

Third, many programs were unaware of state-level (or even county-level) objectives that had been developed. State's efforts to decentralize programs involved organizations that were not tied formally into state data collection systems, and that often did not have the resources or capacity to collect data and report it to the state. Others who knew the objectives believed their programs were unlikely to achieve the level of change suggested, at least in the short term. They noted the following reasons:

- **Many Objectives Reflected Long-Term Goals That Have a Lagged Effect:** For example, enhanced child development may improve outcomes for children that may not be observed until much later in life;
- **Measures Were Inappropriate for the Intended Population:** Most measures were appropriate for families served by the child welfare system. In contrast, most programs were family support programs that served few, if any, child welfare families; and
- **Measures Were Inconsistent with the Type of Service Provided:** Some state plans included objectives concerning self-sufficiency (e.g., employment) or school performance even though many FP/FS-funded programs did not provide services directly related to these objectives.

c. Lack of Monitoring

Even in states that established measures of child and family outcomes, there is little evidence of follow-through in monitoring programs' progress. Most states did not report

changes in their 1996 annual plan updates. The case study states noted a lack of follow-through as well. There appear to be several reasons for this. As described above, the lack of quantifiable measures and the relevance of initially selected measures to the programs funded are partly accountable. In addition, changes in leadership or program staffing sometimes meant the persons who designed the initial monitoring plan were no longer involved in implementation.

The most notable problem, however, stems from a lack of state-level management structures to oversee programs after the planning phase ended. Although Missouri, Arizona, Florida and Alabama developed a management structure, other sites did not. It is important to note that these states had one or more staff members to perform data gathering and monitoring functions.

For example, Arizona consolidated its prevention programs, including those funded by FP/FS, within a newly-established Office of Prevention and Support Services in their child welfare agency. Along with its other activities, the newly-established office was charged with carrying out FP/FS planning and implementation. This includes both monitoring and evaluation activities. On-site program monitoring occurring at least twice yearly was planned. Projects were expected to complete monthly reports containing data on the types of services provided, the number of families receiving each type of service, and the ethnicity of children served. The planning collaborative continues to meet quarterly to provide oversight and direction for each year's funding.

In Florida's districts, the coordinator positions continued to monitor programs receiving FP/FS funds. Staff at the state level also are dedicated to monitoring districts' progress and expenditures. Oversight bodies derived from the initial planning groups in both the Broward County and Pasco/Pinellas districts continued to meet.

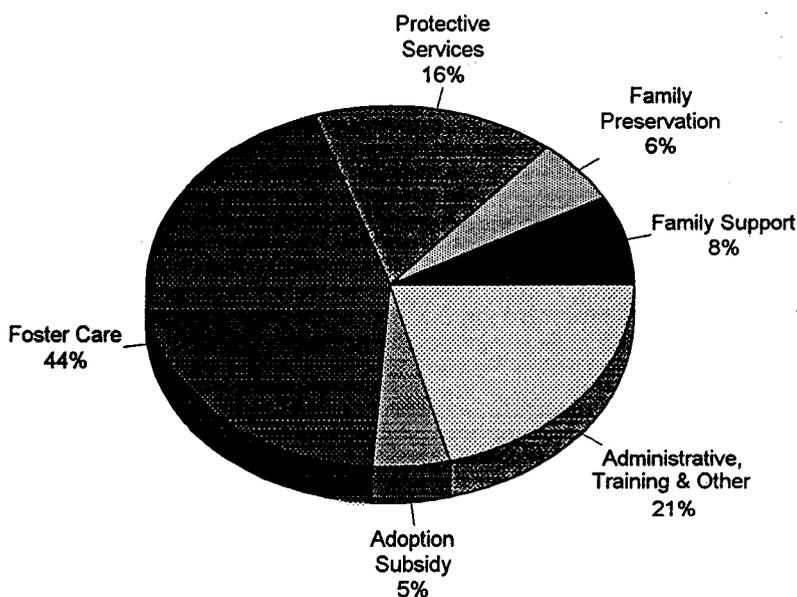
In sum, although all states identified goals and objectives, their level of sophistication varied widely. Moreover, even in states with clearly articulated objectives, the potential existed for additional problems to emerge in data collection and analysis. Many of the stakeholders with whom we spoke acknowledged they had either not fully addressed federal guidance or needed to revise their original plans. Stakeholders also noted they needed assistance determining appropriate measures and monitoring programs.

B. Financial Collaboration

A major theme of the federal guidance concerned utilizing FP/FS funding to leverage additional funds for program development. As noted in the federal guidance, "There is widespread consensus in the child and family policy community that these new dollars, although relatively small, can best be used strategically and creatively to stimulate and encourage broader system reform, which is already underway in many states and communities" (HHS, 1994, p. 2).

To fully appreciate the dilemma states faced in moving toward reform, Exhibit IV-3 indicates the percentage of state child welfare agency budgets (including FP/FS and other funding sources) that was spent on family preservation and family support programs.

Exhibit IV-3
Expenditures for Family Preservation and Support Programs as a
Percentage of All Child Welfare Expenditures FY 1997
(n=34)



Data available from 34 states show only 6 percent of child welfare agencies' budgets is spent on family preservation and 8 percent on family support services. In comparison, 44 percent of the budgets is allocated to foster care. Without financial support from other

agencies and funding streams, FP/FS funds were unlikely to be sufficient to reach the goals that states identified. Therefore, creatively combining or blending funds was important when expanding the size and scope of FP/FS programs to a level that could achieve systems reform.

Several states and localities made progress in this area. Financial collaboration was noted at two levels: (1) formalized blended funding streams agreed to by stakeholders at the state level; or (2) individual programs receiving funds, staff or facilities from multiple sources to provide a more comprehensive array of services.

Among the case study states, Missouri and West Virginia successfully blended multiple funding streams. In Missouri, administrators noted that passage of FP/FS (which contributes \$2.4 million to the Caring Communities Initiative) provided the state social services agency with the opportunity to invest in prevention activities along with other collaborating agencies. Prior to FP/FS, agency administrators spoke of blending funds to support local prevention programs, but no clear plan had developed. FP/FS provided the impetus for developing a concrete plan.

Missouri

Five state agencies (Social Services, Mental Health, Health, Elementary and Secondary Education, and the Department of Labor and Industrial Relations) agreed to participate in an inter-agency initiative. A joint legislative proposal was developed to undertake the expansion of the Caring Communities program that had been piloted in two sites. The legislation proposed that the agencies pool a total of \$21.6 million in public funds. A 10 percent match would be required from participating communities. With the support of the Governor, the legislation passed without opposition. No new general state revenues were generated for the effort. The initiative is funded entirely from redirected state and federal funds (including FP/FS and maximization of title IV-A) falling under the jurisdiction of each of the five public agencies.

The combined funding is a single item in the state's budget. Within this line item, a portion of the funds are allocated to each agency. A specialized state office within the Department of Social Services acts as the fiscal administrator. The office is authorized to reimburse invoices submitted by each Caring Communities site out of the pooled funding. Therefore, reimbursement is divided among the five agencies.

West Virginia also created a pooled funding source to support prevention efforts. This pool was smaller than Missouri's and included only a small percentage of FP/FS funds.

West Virginia

West Virginia established a pooled set of funds to be used for local planning and evaluation. Initiated by the Governor's Cabinet on Children and Families, the Family Resource Planning Fund combines funding from the departments of Health and Human Services, Education, Medicaid, the Child Care Development Block Grant, the Community Services Block Grant, and \$200,000 of second-year FP/FS funds. One-tenth of one percent is provided by each of these funding streams to create a blended funding pool. The Subcabinet uses FP/FS funds and the blended funding pool to support both Family Resource Networks and service delivery projects. Applicants seeking funds from the Subcabinet complete a single application and are typically unaware whether the funds received are from FP/FS or the blended funding pool.

The Family Center in Houston County, Alabama is an example of a local FP/FS program that accessed other funding streams to provide a more comprehensive array of services. Because Alabama chose to concentrate FP/FS funding only in select sites throughout the state, Houston County received a sizeable grant that enabled them to attract other funding sources.

Houston County, Alabama

The Family Service Center was situated in a former alternative school that already housed the city's Head Start Program and the County's JOBS Program. The Family Services Center received funding from several sources, although FP/FS funds accounted for its primary support. The Center received \$50,000 for planning and \$50,000 for services in 1994; \$305,000 in 1995; and \$340,000 in 1996. Other sources include:

- The Dove Foundation, a local family foundation: \$100,000 in 1994 for seed money to support the child care center;
- Community Development Block Grant Funds totaling \$100,000 were given by the local Housing Authority in 1994 to renovate the site. Since 1995 the program has received \$50,000 a year for program operations;
- Children's Trust Fund: \$15,000 for parent education through the child care center;
- The Governor's High Risk Youth Grant: \$17,000 for drug prevention efforts;
- Alabama Civil Justice Foundation: \$5,000;
- Through becoming a United Way Agency, the Center receives about \$2,000 a year;
- State and Federal Education funds pay for most adult education costs;
- The public school system donated the space and maintains the outside of the building; and
- The City of Dothan helped to renovate the facility and pays for utilities and maintenance inside the Family Services Center building.

In other states, stakeholders noted that blending funding streams was a very difficult undertaking. One official, frustrated by the lack of change in this area, noted that visible progress was often made at planning sessions until the issue of co-funding was raised. At that point, stakeholders' body language physically changed, "They lifted their hands off the table and folded their arms." There are several reasons for the difficulty experienced in blending funding:

- **Lack of Resources:** As noted in Chapter II, the amount of funds available for human services programs is limited, and pooling monies for FP/FS programs may reduce resources available to meet other important needs;
- **Existing Obligations:** For most participating agencies, existing funds already had been obligated or earmarked for specific programs, making it difficult to identify funds that could be made available in the short-term; and
- **Authority of Stakeholders:** The authority to obligate funds rests with the highest authorities within agencies. Representatives attending FP/FS planning sessions did not typically have the authority to commit funds on behalf of their agencies.

C. Training in the Principles of Family-Centered Practice

As discussed in Chapter II, traditionally child welfare agencies have been criticized for being insensitive to, or even "at odds" with, the clients and communities they serve. Irrespective of differences in their individual service delivery models, family preservation and support programs typically have shared a common set of principles intended to ameliorate these problems. The principles of family-centered practice can apply to all service delivery programs and were emphasized in federal guidance to states. The principles include:

- Supporting families is the best way to promote children's healthy development;
- Services are available to all family members;
- Services focus on identifying and building on family strengths, as opposed to family deficits or dysfunction;
- Service providers work with families as partners in identifying and meeting individual and family needs; and
- Services are delivered in a manner that respects cultural differences.

During the case study visits, it was difficult to assess how well these principles were implemented. Typically, participants in the planning process reported that all FP/FS programs were “family centered.” However, often stakeholders were unaware of the specific principles or could not explain how the FP/FS programs operationalized these principles. Occasionally stakeholders made comments that were inconsistent with the principles of focusing on family strengths and respecting cultural differences. Such comments were noted in discussions with all types of stakeholders – members of planning groups, local FP/FS coordinators, child welfare agency and FP/FS program supervisors and staff. Discussions with front-line staff suggested mixed results in terms of their understanding of how these concepts could be implemented. While some staff in child welfare agencies and FP/FS-funded programs clearly understood these principles, others did not. Examples include comments describing families as “hopeless,” “unwilling to do the best thing for their children,” or “beyond help.” When asked about positive attributes of families served, the response among staff in one child welfare agency was silence. Implementing family-centered practice principles did not preclude staff from assessing child safety and identifying instances where it would not be safe for a child to remain with a family. Staff, however, appeared to have difficulty connecting the principles of family-centered practice with their daily work with families.

Collectively, discussions with stakeholders suggest that additional training on the principles of family-centered practice is needed for all those involved in FP/FS implementation. Specific mechanisms for operationalizing these principles are needed as well.

Examples of sites that provided training on family-centered practice for FP/FS programs are Arizona, Alabama and Broward County in Florida. Each of these sites took a different approach to addressing the principles and helping staff to work through perceived inconsistencies between principles and practices of family-centered practice.

Arizona

The state's efforts to implement family-centered services are reflected in training, technical assistance and FP/FS project management. Specific activities included:

- All funded projects had to ensure 30 hours of family-centered training for each worker during the contract period. The cost of training was a required component of each project's budget;
- An assessment of existing family-centered training available to staff and administrators throughout the state was conducted, and a statewide family-centered training catalog/resources directory was created;
- A two-day "Family-Centered Practice Conference" was held. Over 300 persons attended including staff from state agencies, provider agencies, planning organizations and other groups;
- In order to provide technical assistance throughout the state, the Arizona Association of Family-Centered Practice was established; and
- Monitoring procedures for FP/FS-funded programs included a case review protocol designed to assess implementation of these principles.

Broward County, Florida also used a portion of its FP/FS funds each year to conduct training in family-centered services.

Broward County Florida

A local university was awarded a contract to design and conduct a four-day training for contracted FP/FS staff and other staff offering family support services in targeted communities. This training includes 32 hours delivered in 8-hour sessions over 4 weeks. The training addressed issues such as cultural sensitivity, family systems and structures, and the delivery of services in home settings.

In addition, Florida's training for child welfare staff includes training on family-centered practice. The assessment form used by CPS staff reflects these principles (e.g., a segment is devoted to identifying family strengths). Child welfare staff noted the importance of this component of the assessment form in helping them develop a more balanced and comprehensive understanding of the family.

Alabama took a less traditional approach to “training” local program planning and management staff for the new family centers.

Alabama

Prior to FP/FS, staff in family preservation programs received training from Behavioral Sciences, Inc. (the designers of the Homebuilders family preservation program).

As part of their child welfare reform initiative, an extensive training program, which focused on the principles of family-centered practice, was developed for training all child welfare front-line staff and their supervisors.

For the newly funded family support centers, Alabama required local officials who received FP/FS planning grants to visit the Family Service Center in Sunset Park, Brooklyn. State and local representatives traveled together to the Center where they could see the principles of family-centered practice in operation. While local planners at one site initially envisioned a center that focused on employment and training services, their visit resulted in the development of a center that included a comprehensive assessment process and a home visiting unit that addressed needs for parent training and early childhood development.

The examples above demonstrate several ways to provide “training” on the principles of family-centered practice. Sites should consider multiple approaches to this issue. However, it is important to note that training and assessment protocols can only partly instill these approaches. Reasonable caseloads and sufficient time to get to know families are also necessary. As a family preservation worker in Alabama noted, “Families often appear to be at imminent risk of placement when we first meet them. Over the course of working with them (about 10 hours per week for four to six weeks), we are better able to understand their strengths.”

D. Summary

Overall, states need assistance in all areas discussed in this chapter:

- **Establishing Realistic Objectives and Measures:** This includes moving away from the use of aggregate data sources and toward program specific data. Program logic models that link service interventions and funds to plausible outcomes should be developed to determine appropriate measures.

- **Program Management and Monitoring:** States and localities need to consider the roles of the original collaborating bodies. While such bodies can and should play a continuing role, they cannot substitute for having staff that perform routine assessments, gather and synthesize program data, and highlight progress made and barriers encountered in meeting realistic goals and objectives. Oversight groups then can use monitoring data to guide policy and shape future funding decisions.
- **Blended Funding:** This includes assistance in developing state-level pooled funding streams as well as guidance on how to collaboratively use resources (funds, staff and facilities) at the local level.

States and localities also may wish to consider the relationship between the amount of FP/FS funds given to programs and the subsequent ability of a program to attract other resources. The old business adage that “money attracts money” appears to apply to FP/FS programs as well.

- **Principles of Family-Centered Practice:** Training and support for these principles need to be institutionalized in all agencies and programs relating to FP/FS, and at all levels (from oversight bodies to front-line staff). They must focus on how to operationalize these principles.

Not surprisingly, management and support issues are perhaps the weakest areas of FP/FS implementation to date. Several factors appear to account for the problem. First, the legislation and guidance provided both funds and direction for planning and service delivery, but did not provide adequate resources or direction for management, monitoring and training. While the federal guidance told states to establish measurable objectives, it provided little direction on how to do so. Furthermore, states were not held accountable for omissions in this area. Similarly, no funds were provided for monitoring, quality control or evaluation (beyond 10 percent of each state’s allotment that could be used for administration).

At the federal level, the current focus on decentralizing authority for programs, coupled with the lack of funds for monitoring, appears to have created uncertainties about the appropriate degree of federal direction and state accountability. Similar issues plagued state monitoring and support of local efforts. However, the weaknesses cited in this chapter do not represent insurmountable problems. It is possible to institute mid-course corrections at both the federal and state levels.

CHAPTER V

SERVICE DELIVERY

A. Overview

The purpose of this chapter is to examine the various types of FP/FS-funded programs states and localities chose to implement. The plans and updates submitted by states provided sufficient information to determine that the majority of programs funded by FP/FS were family support programs. The most frequently provided service was parent training. However, the state reports do not provide enough detail to fully describe the nature and intensity of the services provided or the programs' target populations. This chapter focuses on the programs developed within the 20 local case study sites. Collectively, the FP/FS programs visited during the site visits appear to reflect the major program characteristics reported in the state plans -- predominantly family support programs with an emphasis on parent training.

The community site visits, conducted between September 1996 and May 1997, showed that the FP/FS-funded programs had been in operation for periods ranging from two months to two years. In addition to the issues noted in Chapter III, the multi-layered nature of the planning process within states (e.g., state planning, county planning, provider collaborative planning) extended the time needed before service delivery could begin at the local level.

Program and provider characteristics also affected the start-up period required before service delivery could begin. Some programs had well-established service delivery approaches, and FP/FS funds were used to expand these programs in new sites. In other instances, FP/FS funds were used to provide new services within an existing center or through an already established provider. In these instances, facilities and organizational structures as well as management and support staff were already in place. In contrast, other programs were newly established with FP/FS funds. Buildings needed to be refurbished, staff had to be hired, and policies and procedures needed to be developed before service delivery could begin. These programs were just beginning their operations at the time of the site visit.

Because of the variation among programs' implementation status, this chapter focuses on describing the basic design elements of the FP/FS-funded service delivery programs, rather than program operations. Design elements include: program type; amount of funds; target population; intake and assessment process; services available; and type of staffing. Issues such

as the number of families served and their characteristics and needs; the services most frequently provided; and changes in accessibility, utilization and satisfaction with services will be addressed in this study's final report.

B. Issues in Defining and Categorizing Programs

As noted in Chapter II, family preservation and family support programs differ in terms of their history, focus of service and intended target population. The federal legislation called for states to spend a significant amount of funds on both types of programs, or to justify the basis for spending less than 25 percent in either category. However, the legislative definitions of each program type were sufficiently broad to allow similar programs to be labeled family support in one state or community and family preservation in another.

To complicate this picture further, some states or localities considered a single program model (such as a family center) or a single service (such as a family advocate) capable of meeting the needs of the target populations. In these instances, states and communities believed they were meeting the legislative requirements and subsequent federal guidance to invest significant funds in both FP and FS, since programs were expected to serve a diverse group of families with different types of problems and different levels of need. Families with the most serious problems were considered family preservation cases. Those with fewer or less severe issues were family support cases. This approach further blurred the historically different service delivery characteristics of FP and FS. It also raises concern about whether a program that is "one size fits all" can respond successfully to the needs of very different target populations.

In order to distinguish more accurately among the major program models identified through the case studies, other program dimensions that reflected observed differences among the programs visited were reviewed. These dimensions included:

- **Service Delivery Structure:** Some programs provided in-home services, others were center based or office based. Still others encompassed a variety of office and community settings.
- **Target Population:** Programs varied in their intended target populations. The most frequently selected target populations were: families known to the child welfare agency and at risk of foster care placement; new mothers, especially teenage mothers; children with school behavior and learning problems; and all families residing within a neighborhood or other local jurisdiction. To a lesser extent, FP/FS-funded individual services for families with a specific problem.

These included respite care services for families with disabled children, drug treatment services for mothers known to the child welfare agency, services for juvenile offenders, and emergency cash assistance or vendor payments.

- **Available Services:** Programs varied in both the number and range of services provided. Some programs focused on providing an individual (e.g., social worker, nurse, case manager, advocate) to work with a family, typically to provide parent training and counseling. Workers might then refer a family to other service providers as needed. In contrast, other programs offered an array of services, including parent training and counseling, tutoring, recreational events, self-help groups, adult education, job training and employment, and child care.
- **Central Intake and Assessment:** Some programs had a formal process for enrolling families and conducting comprehensive assessments of their needs. In contrast, other programs offered a range of services, and families selected those services of interest to them. Note that in all instances, participation in FP/FS-funded services was voluntary. While programs with comprehensive assessment units made families aware of services that might be helpful to them, families were not required to accept services.
- **Staffing:** Program staffing requirements varied and are not easily categorized. For counseling and case management positions, program staff typically had bachelor's or master's degrees in social work or a related field. For some programs a key qualification was residence in a targeted community or representation of the racial/ethnic composition of the community. In many instances, staff both reflected the racial/ethnic composition of the community and possessed academic qualifications and relevant experience. Although it would be simplistic to describe program staffing qualifications as based on either academic qualifications or community representation, there was a difference among programs as to which factors dominated in their hiring decisions.

Despite the unique nature of many of the programs examined, there were general trends in the ways in which programs were arrayed across the dimensions described above. For example, home-based service delivery programs typically employed a professionally trained worker who conducted a comprehensive assessment of family needs. These programs were more likely to serve either child welfare families or new mothers. In contrast, center-based programs were likely to target all families in a community or school-age children with behavior or learning problems, offer a broad array of services, and employ individuals who lived in the targeted community.

Programs were categorized based on this review of program characteristics and structure. Additional characteristics of individual programs within each category are then described. Exhibit V-1 presents a summary of the major program categories, and the number

**Exhibit V-1
Summary of Major Program Categories and Key Characteristics**

Program Type	Number	Target Population	Centralized Intake/ Comprehensive Assessment	Staff Characteristics
In-Home Services				
Intensive Family Service	8	Child welfare families at risk of foster care placement.	All programs have comprehensive assessment.	Professional or team of professional/paraprofessional.
Parent Training	7	Varied - pregnant and parenting teens or new mothers; grandparents raising grandchildren; child welfare families.	Varied - most have centralized intake and comprehensive assessment.	Most staff have B.A. or M.S. Two programs emphasize staff who live in community.
Case Management	5	Families in targeted community in need of assistance, often facing a specific crisis.	Informal assessment; focus is on responding to needs identified by families.	Predominantly paraprofessionals who reside in community.
Center-Based Programs				
School-Based	4	Most focus on children exhibiting behavior or learning problems.	Varied - three programs have comprehensive assessments; one does not.	All predominantly rely on professional staff.
Community-Based	6	All families in targeted community.	Varied - three programs have centralized intake; three do not.	Varied - three primarily staffed with professionals; two emphasize staff who reside in community.
Networks				
	3	Varied - all residents in targeted community; grandparents; troubled youth.	All have assessment component; varied intake points.	Varied - combination of professionals; paraprofessionals; and volunteers who reside in community.
Mini-grant Programs				
	3	Varied - most focus on primary prevention efforts for all community residents.	None	Community residents.

of programs in each category that were reviewed during the community case studies, as well as their other characteristics. As shown in this exhibit, four major program categories were identified. Subcategories within two of the major categories are also defined. The categories include:

- **In-Home Service Delivery Programs:** This category included a total of 20 programs. In each of these programs services were delivered by a single provider and employed a case manager or social worker who met with families in their homes (or other community settings). Within this category, programs differed in terms of their target population, the intensity and duration of services provided and staff qualifications. Three subcategories were identified to capture these differences:
 - **Intensive Family Services:** This category includes the programs traditionally considered family preservation programs. Programs serve families known to the child welfare system, and are intended to prevent foster care placement or facilitate reunification when placement has occurred. Program staff typically have master's or bachelor's degrees in social work. Workers have small caseloads and may visit families several times per week. Services are typically of limited duration (four weeks to six months).
 - **Parent Training Programs:** These programs are typically intended for teen parents or new mothers with other risk factors. Like the intensive family service programs, most are professionally staffed. Most use a formal assessment protocol that determines the frequency of visits and the duration of service. Typically, home visits occur less frequently than in intensive family service models, but often continue for a longer period of time (e.g., up to three years).
 - **Case Management Programs:** Unlike the other home-based service programs, case management programs serve a broader target population. Typically, any families in a targeted community can access their services. Programs often are staffed by individuals who reside in the community. The frequency and duration of services vary considerably, and there is typically no limit on the duration of services. However, services often focus on resolving a specific conflict or emergency and are often of brief duration.
- **Center-Based Programs:** These include both school- and community-based centers.
 - School-based centers were targeted to children with behavior or learning problems, although the array of services available were intended for the children and their caregivers. School-based programs tended to rely on professional staff and included a formal assessment process. The nature and intensity of services varied.

- Community-based centers were typically accessible to all members of a targeted community. The centers varied considerably as to the type of services provided and the staff employed. While some centers had a central intake and assessment component, others did not.
- **Networks:** These programs were collaborative entities encompassing multiple service providers. In effect, they were "centers without walls." Although the programs in this group varied in terms of target populations and services provided, they represented a common approach to service delivery fostered by FP/FS. FP/FS funds were used to strengthen the relationships among existing service providers, adding case management services and improving referrals among providers.
- **Mini-Grant Programs:** The mini-grant programs awarded small grants to several community-based service providers. The services funded varied considerably but most were intended to provide primary prevention services and expand community involvement in service delivery. These programs were intended to attract new community-based service delivery providers to the process.

Although this classification system is useful for identifying programs with similar characteristics, programs often do not fall neatly into one category or another. For instance, several center-based programs or provider networks had a home-visiting component, and one intensive family preservation program had a community-support component. For this report, programs have been classified by their primary characteristic. A description of the programs in each category is provided below.

C. In-Home Service Delivery Programs

1. Intensive Family Services

As previously noted, relatively few states and communities chose to develop intensive family preservation programs. The capacity to deliver services to reunify families was even less developed. Although some states, like Missouri, had well-established family preservation programs in operation throughout the state, most states and communities visited acknowledged that available services did not fully meet demand (including the states that did use FP/FS funds to expand their intensive family services models). Front-line staff in child welfare agencies in almost every site indicated that they wished they had access to more intensive service programs, noting that the programs available were often full when they referred families to them.

Exhibit V-2 provides descriptive information on the intensive family services models funded under FP/FS. As noted in this exhibit, programs varied on caseload size, service duration, team versus single therapist staff configurations, and service provision by the public child welfare agency or private provider. It is interesting to note that in all locations except Broward and Pinellas/Pasco counties in Florida, the model funded under FP/FS was an expansion of the model that had already existed elsewhere in the state or county. Since these models are well-documented in the family preservation literature, they are described only briefly here.

In Broward County, a new program was funded. Family Builders for Adolescents, operated by Lutheran Ministries, is an intensive family preservation program based on the state's intensive family services program model. Through FP/FS, two teams (each with one therapist and one paraprofessional) were funded to offer services for single mothers whose teenagers were involved in gang-related activities or self-destructive behaviors.

**Exhibit 4-2
In-Home Services: Intensive Family Services**

FP/FS Funds	Number FP/FS-Funded Workers	Caseload Size/Service Intensity	Service Duration	Target Population/Referral Source(s)	Public/Private Agency	
Alabama						
Houston County (Family Options)	FY94 \$102,347 FY95 \$346,511 ⁸ FY96 \$275,000	1 supervisor (M.A.) 4 caseworkers (B.A.) 1 support staff	2 cases per worker. Services as intense as needed (available 24-hours, 7 days per week).	4-6 weeks.	Families in which foster care placement is expected within 7 days. Child welfare agency.	Private.
California						
Los Angeles County (FP Networks of Community Providers)	\$1.4 million per year over 5 years (for start-up of new FP Networks)	Unknown	Caseload size varies depending on assessed level of family need and lead agency assigned. 1-3 visits per week, depending on family's assessed level of need.	6-9 months with an additional 3-6 months of transitional services.	Families at risk of out-of-home placement residing in Network's lead agency zip code. Child welfare agency (Probation can also make a limited number of referrals).	Predominantly private. ⁹
Broward County (Family Builders for Adolescents)	FY95 \$104,103 FY96 \$104,103	2 social workers (M.A.) 2 paraprofessionals	6 cases per team. 2-7 visits per week.	3 months (with additional follow-up available).	Families with troubled adolescents and/or at risk of out-of-home placement. Juvenile Justice, child welfare agency, self referrals.	Private.

⁸ FY95 and FY96 amounts include \$250,000 (spread out over two years) for statewide training.

⁹ Lead agencies include one school district and a Department of Human Services for a separately incorporated area.

Exhibit V-2 (continued)

FP/FS Funds	Number FP/FS-Funded Workers	Caseload Size/Service Intensity	Service Duration	Target Population/Referral Source(s)	Public/Private Agency
Florida					
Pasco/Pinellas Counties (Family Continuity)	2 therapists (M.A.) 2 clinicians (B.A.) 1 community outreach worker	6 cases per team. Average 3 home visits per week.	6 months. Follow-up available up to 12 months.	High-risk families. Pasco -- child welfare agency. Pinellas -- welfare reform project.	Private.
Texas					
Dallas County (Intensive FP)	35 caseworkers	6 cases per worker. 10-20 hours of contact per month.	4 months, can be extended another 2 months.	Families at risk of foster care placement. Referrals made internally within child welfare agency.	Public.
San Antonio Region					
(Intensive Family Preservation -- IFP)	9 caseworkers (some have additional case assignments)	4-7 families per worker. 15-20 hours per month.	3 months.	Families at risk of foster care placement.	Public.
(Intensive Early Reunification -- IER)	5 caseworkers (some have additional case assignments)	6-8 families per worker. 8-20 hours per month.	3 months.	Families with children who have been removed under an emergency order for 30 days or less and returned home.	Public.

¹⁰ Contract amount includes both federal and local match and supports both family preservation and community support services.

Exhibit V-2 (continued)

FP/FS Funds	Number FP/FS-Funded Workers	Caseload Size/Service Intensity	Service Duration	Target Population/Referral Source(s)	Public/Private Agency
(Intensive Family Reunification -- IFR)	8 caseworkers (some have additional case assignments)	6-8 families per worker. 2 visits per week decreasing to 1-2 per month.	3-6 months.	Families with children who have been placed in foster care 30 days or longer. Referrals made internally within child welfare agency.	Public.

In the Pinellas/Pasco District in Florida, private agencies had been operating a Family Builders program and an Intensive Crisis Counseling Program before FP/FS. The planning body funded another agency to provide a somewhat different intensive family services delivery model. The Family Continuity Program is unique in two respects:

- **Target Population:** The program serves families in the welfare reform demonstration project in Pinellas County; and
- **Linkages to Community-Based Programs:** The program administrative and management staff provide technical assistance to community-based family centers. They are assisting two newly formed centers in developing necessary recordkeeping systems and providing guidance and support in developing their service plans (see text box).

**Family Continuity Program
Pasco/Pinellas Counties, Florida**

The Family Continuity Program offers intensive family preservation services by a team of one therapist and one counselor who provide services to a caseload of five to seven families for a maximum of six months. On average, families receive three visits per week. The program is also designed to address two of the key contextual factors that shape FP/FS programs -- welfare reform and support for community-based programs.

One unique aspect of the program is its relationship to Pinellas County's welfare reform demonstration. While the program receives referrals from the local child welfare office in Pasco County, referrals in Pinellas County are from the welfare reform demonstration project. Families referred by the welfare reform project must have serious issues that relate to abuse and/or neglect. Some of the families referred have current investigations pending with CPS. The intent is to provide the additional support needed by parents and their children as parents successfully transition from AFDC to work. Program staff reported that although initial referrals from the welfare reform program did not generally involve serious abuse or neglect issues, agency staff are now trained to refer appropriate families.

The second unique feature of the Family Continuity Program is that it provides technical assistance and support to community-based organizations. Program administrators note that the philosophy and concepts that guide their family preservation program can be applied to assisting community-based family support programs as well. Both individuals and communities require support that identifies and builds on strengths, develops relationships, and enables clients to mutually establish goals.

With this philosophy in mind, administrators have assisted a neighborhood family center by providing assistance to the director in establishing administrative systems and completing an application for status as a non-profit organization (501 (c)(3)), developing a skill bank for the center, and building community partnerships. For a school-based family support program, staff assisted in recruiting community volunteers, providing technical assistance to the volunteer coordinator, and facilitating community and parent educational forums.

Staff note that their new roles have taken time to develop and that there have been some difficulties along the way, such as building relationships between a predominantly white, professional staff and a predominantly African American neighborhood family center. Nevertheless, they have been able to work through these issues, and both the center director and the Family Continuity staff felt positive about their joint efforts.

2. Parent Training

Seven of the communities visited had funded home-based service programs that focused on parent training (see Exhibit V-3). While intensive family preservation programs generally focus on families involved with the child welfare system and at risk of having a child enter foster care, in-home parent training programs focus on families with risk factors that might eventually lead to abuse and neglect.¹¹

Several programs target mothers of newborns: the two programs in West Virginia; the Denver program; and the San Antonio program. Grandma's Hands in Denver targeted teen mothers. Within San Antonio's Great Start program, one of the provider agencies also focused on teen mothers. The programs are, to varying degrees, patterned after the Hawaii Healthy Start model or the Healthy Families America model. All work with new mothers continues until the child is of age to enter a pre-school program; the frequency of visits varies depending upon the severity of risk factors and the age of the child. Visits are typically made by staff with social work or nursing backgrounds. An exception to this is the Grandma's Hands program in the Denver Five Points neighborhood, which employs women within the community to provide brief (six weeks), more informal training for new mothers that focuses on infant care.

¹¹ As discussed later in the chapter, other FP/FS-funded programs also had components that included home-based visiting (see provider networks – Lincoln House in Phoenix and Healthy Grandparents in Atlanta, Georgia).

**Exhibit V-3
In-Home Services: Parent Training**

FP/FS Funds	Number of FP/FS-Funded Home Visitors	Caseload Size/Service Intensity	Service Duration	Target Population/Referral Source(s)
Colorado				
Denver – Five Points/Curtis Park Neighborhood (Babies Having Babies)	FY96 \$7,000	1 "Grandmother" at time of site visit (varies based on demand and availability of candidates)	6-8 weeks following birth (2 home visits prior to infant's arrival).	Teen parents residing in target neighborhood. Community agencies.
Florida				
Broward County				
(Project Kinship)	FY95 \$63,750 FY96 \$63,750	1.5 caseworkers	6-12 months.	Relatives caring for children who would otherwise be in foster care. Child welfare agency (primarily). Program also serves a limited number of other agency referrals, self-referrals.
(Parent Enrichment Center)	FY95 \$105,000 FY96 \$82,500 (to augment all Center services)	2 Parent Aides (paraprofessionals) and 1 B.A. caseworker (not solely FP/FS funded)	12 months.	Families with children under 12, especially those under 5 from target neighborhood. Child welfare, community agencies and self-referrals.
Texas				
Dallas/Forth Worth Region (C.A.R.E.)	FY97 \$145,000	4 case aides	Until needs are met.	Families expecting a child or with a child 0-3 residing in 1 of the 4 target areas. Community agencies.

Exhibit V-3 (continued)

FP/FS Funds	Number of FP/FS-Funded Home Visitors	Caseload Size/Service Intensity	Service Duration	Target Population/Referral Source(s)	
San Antonio Region (Great Start)	\$250,000 per year for 3 years	12 case managers (plus 3 assessment workers)	12-24 families per worker, varying by agency. 4-8 times per month, decreasing over time (varies by provider).	Until the focus child is 3 years old.	Mothers who have just delivered at one area hospital and are assessed to be at high risk of child abuse and neglect. Program's assessment workers refer families to 1 of the 3 providers within the service collaborative.
West Virginia					
Cabell/Wayne Counties (Healthy Families America)	FY96 \$25,000 FY97 \$50,000	2 home visitors	7-15 families per worker. 1 visit per week until the focus child is 2 years old, then monthly, and later quarterly, visits.	5 years.	First-time parents who are not Medicaid eligible but are identified as high risk and living in a specific community. Community clinics, hospitals, other community agencies.
Fayette County (Maternal Infant Health Outreach Worker -- MIHOW)	FY96 \$25,000 FY97 \$50,000	1 coordinator 5 outreach workers	7-12 families per worker. Monthly home visitation.	3 years.	Pregnant women or new mothers living in specific communities. Schools, health centers, other community agencies, self-referrals.

Perhaps the most unique program among the parent training efforts is the Kinship Care Project in Broward County. The program serves children who are placed by the courts with other relatives to prevent the need for the child welfare agency to assume custody. Most of the relatives are not licensed as foster parents and do not receive foster care maintenance subsidies to care for these children. The child welfare agency, aware that these families required special support, used FP/FS funds to expand the services of an existing therapeutic child care program for relatives to include a home-based services component (see text box).

**Kinship Care Project
Broward County, Florida**

The Child Care Connection is a private agency offering child care services for 25 years in Broward County that is experienced in the problems unique to kinship families. While most kin are grandparents, some of these grandparents began parenting in their teens and are presently caring for both their grandchildren and children. Also, they may be caring for offspring of more than one of their children. Thus, they are caring for a large number of children from different nuclear families and facing more than the typical level of stress. These kin are likely to feel both guilty and resentful toward their children for being put in the position where they must care for their grandchildren. Therefore, the program began providing therapeutic child care services for these families prior to FP/FS.

Families served in the center-based program are primarily referred by the child welfare agency, but some are self-referrals. The center-based services included activities for adults (stress management, parent education, budgeting, literacy, recreational activities, information and referral for other services). The center's services are intended to reduce social isolation and empower families. However, center staff had recognized that many of the families had problems (e.g., physical and mental health, transportation) that prevented them from using the services available at the center.

With FP/FS funds, the center hired two staff to conduct home visits to families who were not able to use center services. Staff visit families weekly, often as a team, and provide services for six months. In serious situations, home visits may be provided for up to one year. The program serves 20 to 24 families at one time and has a waiting list.

With the exception of the San Antonio parent visiting program, most of the parent training programs are small (one to two staff members). In some instances, FP/FS expanded the service capacity of an existing provider, as in the kinship care program identified above. In Cabell-Wayne Counties in West Virginia, the new home visiting program was intended to serve families that an existing program did not have the resources to serve.

3. In-Home Services: Case Management/Crisis Intervention

Unlike the home-based programs that focus on parent training, home-based programs focusing on case management/crisis intervention differ on several dimensions (see Exhibit V-4):

- **Target Population:** Generally services are targeted to all families in a specified catchment area, rather than to new mothers or other specific groups. Typically the programs engage in extensive outreach, publicizing their services throughout a community. Families served are likely to have heard about the services through a local church, service organization, friend or neighbor, or a media campaign.
- **Absence of a Predetermined Service Intervention:** These programs typically are very flexible in both frequency and duration of services. While the intensive family preservation programs or the parent training programs often have a prescribed minimum number of visits, limited caseloads, and an expected length of time for serving a family, case management/crisis intervention workers have much more flexibility. When asked to define the frequency and nature of their service intervention, they are likely to respond, "Whatever the family needs."
- **Staffing:** Although many of the staff in these programs have bachelor's or master's degrees, they are typically hired because they live in the targeted community, are similar to the racial/ethnic composition of the community and/or have experience in a community-based, family-oriented program. In other words, these positions are less likely to require specific academic credentials, and are more likely to stress staffs' work experiences and ability to engage families.
- **Services Provided:** While staff might provide counseling or parent training, their main function is to provide case management services, advocacy and assistance in resolving immediate crises. For example, they might assist a family in locating new housing, support a parent in a meeting with school officials if their child is having problems, or coordinate referrals to various other programs.

**Exhibit V-4
In-Home Services: Case Management**

FP/FS Funds		Number of FP/FS-Funded Workers	Caseload Size/ Service Intensity	Service Duration	Target Population/ Referral Source(s)
California					
Fresno County -- Huron (Domestic Violence Resource Center)	FY96 \$172,000 ¹²	2 case managers (plus contract and out- stationed staff)	Not established.	Indefinite--defined by clients needs.	Families in a small isolated rural community. Child welfare agency, schools, self referrals.
Santa Clara County (Family Advocates)	\$166,578 per year for four years	1 director 6 Family Advocates	8-25 families per worker, with 6-20 active at any one time (varies by worker). Varies based on need.	Indefinite--defined by client needs.	Children and families in 1 of 7 high-risk targeted zip codes. Community agencies.
Colorado					
Denver--Five Points/ Curtis Park (Community Outreach Service Center)	FY97 \$54,578	2 Family Advocates (FTEs)	Up to 20 families per FTE. Varies based on need.	Indefinite--defined by client needs.	Families in target community. Community agencies in the service collaborative, self- referrals.
Denver--Five Points/ Curtis Park Neighborhood (Family Life Specialist)	FY97 \$22,000	1 Family Advocate	18 families per worker. Weekly visits.	Continue as needed through high school completion.	At-risk youth ages 11-19 and their families. Juvenile courts, social services department and homeless shelters serving migrant families.
San Luis Valley (Family Advocates)	FY97 \$159,375	3 Family Advocates	15-30 families per worker. Varies based on needs.	Primarily short duration (less than 30 days).	Families with children in target community. Community agencies and self- referrals.

¹²Total budget for site is \$172,000, includes out-stationed and contract staff. Case Management component of contract is approximately \$80,000 (2 staff, transportation/flex funds and overhead).

The review of these programs suggests that perhaps the most difficult challenge in establishing family advocate positions is fulfilling the role of broker between families and other service delivery providers. There was a tendency for some family advocates who were interviewed to share the community's general distrust of public agencies (especially child welfare agencies) and to provide support and informal counseling services rather than refer families to other agencies. One program that is still struggling with this issue is the Family Advocates program in Santa Clara, California. The role of the advocates is somewhat different than initially intended in the county's plan (see text box).

**Family Advocates
Santa Clara County, California**

According to the county's plan, the Family Advocacy positions were funded with the portion of funds designated as family preservation services. The advocates were to "work as paraprofessional case managers with families at risk of having their children separated from the family ... referred by Family Preservation, Child Protective Services, school-linked services, AFDC, schools, or other service providers." Working collaboratively with the county's Family Preservation Program, which would provide supervision, the family advocates were to "provide peer support and serve as positive role models for the families."

At the time of the site visit, the Family Advocates had only accepted referrals for three months. Referrals received at that time seemed largely dependent on contacts developed individually by each of the six workers and included agencies/schools in which they were previously employed, AFDC eligibility workers, and mini-grant program recipients. Very few cases were referred by child welfare and most caseworkers were not fully aware and/or trusting of this resource. Moreover, other than a call once a referral had been received, typically there was little (if any) ongoing interaction with the child welfare agency. Half of the Advocates estimated the majority of their clients were child welfare involved while the other half estimated this to be 20 percent or less.

Once a referral had taken place, intake and initial case processing followed a common protocol for all cases. Goals were primarily family-determined with input provided by the Advocates. Varying according to need, services generally included individual and group counseling, transportation, and arranging for other services.

The Advocates, who reflect a range of ethnicities and cultures, are available evenings, wear pagers, and report that they frequently provide clients with their home phone numbers. All have B.A.s and have either advanced course work, a counseling/social services background, or both. Half have earned M.S.W.s. Their caseloads vary widely, from 8-25 cases, with 6-20 active at any one time. Workers distinguished between "active" cases with at least weekly contact, and "inactive" cases as those for which a month or two might elapse between contact. No referred cases had been refused, and there was no limit on service duration. Further, neither was anticipated.

The above example demonstrates the difficulty in linking child welfare agencies with community-based services. Santa Clara County is still struggling with this challenge and is considering approaches that will better link the family advocate positions with both the community and the child welfare agency.

In summary, there were 20 programs in the 20 case study sites that can be considered to be providing primarily in-home services. This includes seven intensive family preservation programs, seven home-based services that focus on parent training, and five that focus on case management and crisis intervention. These programs can be viewed as serving different target populations -- with the intensive family preservation programs focusing primarily on child welfare clients at risk of foster care placement, the parent training programs focusing on families with risk factors associated with abuse and neglect, and the case management/advocate positions serving all families residing in high-risk communities who experience a broader range of problems.

D. Center-Based Programs

The center-based programs are divided between those programs linked to schools and those linked to communities. The decision to link programs to schools versus communities is often difficult and may reflect several contextual factors. Among the factors that argue against using schools as the hub of family centers are the following:

- Parents with children under the age of five are less likely to become involved in school-based activities;
- The development of busing plans, magnet schools and private schools have often resulted in schools not having a neighborhood focus. For example in the Childs Park neighborhood in Pinellas County Florida, children attend 23 different schools; and
- Parents' own experiences in school may have been unpleasant. As a consequence, schools do not always represent a welcoming environment.

Nevertheless, schools have advantages as well. First, they are still the single, largest focal point of activity for children. The catchment area is easily defined, and there are implicit referral sources (teachers and other school personnel) and defined avenues for conducting outreach. Second, many schools house other activities, such as adult education, and community and recreational events. Third, many schools have already established some health

and social services programs within their schools. Finally, Missouri noted that it was simply a matter of "bricks and mortar." Schools have appropriate physical space, and it is unlikely that any other public agencies would have the resources to finance new construction. It should be noted that for the visited programs located at schools, stakeholders emphasized that the school was intended as a focal point for service delivery, but not as the only service delivery site.

Within these sites, FP/FS funds were used to establish 10 family centers -- four school-based centers and six community-based ones. In addition, many sites already had family centers in operation, and some of the services described elsewhere in this chapter were either added to existing family centers or coordinated with them (e.g., Denver family advocates were funded through an existing family center).

1. School-Based Centers

As shown in Exhibit V-5, school-based centers were funded in Fresno, California; St. Louis and Kansas City, Missouri; and Dallas, Texas. In California, the Department of Education had previously funded Healthy Start, a school-centered services program, with planning grants and three-year operations grants. In Fresno, these funds were about to expire, and FP/FS funds were primarily used to maintain school programs that would otherwise have been abolished.

In Missouri, St. Louis and Kansas City represent two of the six localities that received state funds expressly for the purpose of establishing school-centered programs. The Caring Communities program in St. Louis was initially funded as a demonstration project by the state social services, mental health and education departments. This became the model for the expansion of the Caring Communities program under FP/FS (in St. Louis, the model has been expanded to other schools with FP/FS funds).

One of the most striking aspects of the St. Louis Caring Communities model is that it provides a continuum of service, from prevention-related efforts to intensive family preservation services, and a centralized process for receiving referrals, assessing child and family needs and determining the appropriate level of service. The program provides services directed at children, their families, the school and the community.

**Exhibit V-5
School-Based Centers**

FPI/ES Funds	Number and Type of Schools Involved	Target Population/Referral Source(s)	Services Provided	Intake/Assessment/Referral Process	Staff Characteristics	Out-Stationed Professional Staff
California						
Fresno County (Healthy Start Neighborhood Resource Centers)	3 elementary schools (2 additional programs to open FY97).	Varies by site: students (and their families) with behavioral or learning disabilities. Community residents. School staff, child welfare agency, self-referrals.	Varies by site: individual and group counseling; home-visiting, anger management and self-esteem groups; parenting classes and support groups; literacy classes; ESL; child care and assistance with AFDC, Medi-Cal, Food Stamps applications. 1 site also offers limited health services (physicals, immunizations, dental screening).	No site has centralized intake/assessment. ¹³ Within sites, all programs complete intake forms and some conduct assessment (1 uses team assessment for students at risk of behavior/learning disability).	Professional staff with 1 Community Mobilizer per site recruited from the community (not all hired at time of site visit).	Yes--1 child welfare agency caseworker at 1 program.
Missouri						
Jackson County (Caring Communities Partnership)	16 elementary and high schools.	Students (and their families). School staff, self referrals.	Job readiness, parent education and support groups, school readiness/achievement services, health services, latchkey/recreational activities.	No centralized intake/ assessment. Wide variation between and within sites.	Professional staff with 1 Site Coordinator per site with direct knowledge of the site's community.	Yes.

¹³ At the time of the site visit.

¹⁴ Includes substantial other state and federal funding. Because funds are blended at the state level, it is not possible to break out federal funding.

Exhibit V-5 (continued)

FP/FS Funds	Number and Type of Schools Involved	Target Population/Referral Source(s)	Services Provided	Intake/Assessment/Referral Process	Staff Characteristics	Out-Stationed Professional Staff
St. Louis City (Caring Communities Partnership)	18 elementary and middle schools (6 previously existing).	Students (and their families) at risk of: educational failure, out-of-home placement, and/or juvenile justice involvement. School staff, self referrals.	<ol style="list-style-type: none"> Clinical services: intensive FP, lower-level case management, behavior therapy/day treatment, substance abuse. After-school program for children of working parents Additional staffed positions <ul style="list-style-type: none"> health liaison multi-cultural/educational enrichment coordinator Community activities: corner patrols, drug marches, respite visits, block units (neighborhood associations). 	Centralized team intake/assessment for clinical component. Other components accessed directly by students/community without assessment.	Professional staff with experience relevant to their position. 1 Site Coordinator per site with direct knowledge of the site's community.	Yes.
Texas						
Dallas (Youth Impact Center)	3 middle schools.	Students not currently receiving services from another program. Primarily school staff. ¹⁵	Case management, mental health counseling (individual and family), tutoring and educational assistance, job training and development, rites of passage, cultural awareness, emergency assistance, mentoring, support groups for teenagers.	Centralized intake and standardized assessment.	Professional staff.	Yes--17 providers have out-stationed staff at center.

¹⁵In the original plan, Child Welfare, Health and Mental Retardation, and Juvenile Justice were to be the primary referring agencies. However, since the program became school based, the majority of referrals originate from school staff.

A parent aide at one of the Caring Communities schools, who is also part of the Steering Committee, noted that since the project began, she is less frustrated when it becomes necessary to call in an abuse/neglect report to the child welfare agency. Now, she feels that the school has all possible services available, and that if a child were placed in foster care, it is not because services were not available to prevent removal (see text box).

**Caring Communities
St. Louis, Missouri**

In St. Louis, Caring Communities sites adhere to the basic structure described below. It is anticipated that eventually all 18 Caring Communities sites will reflect this structure.

1. Clinical Component: Referrals are made by teachers through the School Principal to the Caring Communities' Site Coordinator. Within one to two days, a team meeting is called representing all clinical components (below) to review the referral and conduct intake. Seven days following intake, the team is reconvened after meeting individually with the child's teachers and parents, and observing the child in the classroom. If possible, a home visit is conducted during this time. A lead caseworker, who incorporates all team members' observations into a master treatment plan with goals and objectives, is assigned. Reviews are conducted monthly and include the Site Coordinator and caseworker. Service options include:

- **Behavior Therapy/Day Treatment:** On-site school-based counseling and behavior modification conducted at least once per month with the child and twice per month with the parent. Targeted at children having trouble adapting socially in the classroom (typically one worker per site with a caseload of 15).
- **Substance Abuse:** On-site counseling and aftercare to families (the student is seen at least twice per week). This also includes school-based student co-dependency groups and drug prevention (typically one worker, with a caseload of 15).
- **Case Management:** Off-site referrals to services and counseling targeted at children at either: (a) moderate risk of out-of-home placement or (b) exiting Families First as described below. Child is seen at least twice per month (typically two workers, with a caseload of 15).

2. Families First: Children assessed to be at high risk of out-of-home placement at intake (or at other points during service delivery) are referred to Families First, a family preservation program following the Homebuilders' model (1-3 hours per day of either home-based or school-based visits, 5-20 hours per week for 6-10 weeks with follow-up). Typically, a Caring Communities site contracts with a community mental health agency for one or two off-site workers, each carrying a caseload of two.

3. Latch Key Program: On-site after school tutoring, snacks, and recreation for children of parents who are working full-time or enrolled in worker training.

4. Additional Staffed Activities Included: Health Liaison stationed in the nurse's office providing referrals, transportation, and follow-up with students and families on immunizations, medication, and other health needs; and a Student Assistance Coordinator providing cultural and academic enrichment classroom presentations.

Other activities include Corner Patrols to ensure safe passage to and from school, Drug Marches, Respite Nights, and Block Units (neighborhood associations).

Although the St. Louis Caring Communities program is not directly linked to child welfare, there is a relationship between the two entities. Child welfare staff have been outstationed at one school site as part of a demonstration effort to bring child welfare workers into greater contact with the community.

Furthermore, it is the policy of Caring Communities to work with families and the child welfare agency in a manner that supports families and ensures child safety. When a member of the Caring Communities staff believes there are problems sufficiently serious to warrant a report to the child welfare agency, they inform the family they are filing a report. If feasible, staff call in the report in the family's presence so that "everyone knows what has been said to whom." Caring Communities also asks CPS if they can remain involved with helping the family during the CPS investigation.

Somewhat surprisingly, the Caring Communities program in Kansas City is quite different. Although also a school-based system, there is no prescribed unified model of service. Each school site has a somewhat different array of services depending on need. Also, there is no common intake and assessment point that focuses on the needs of both children and families. Furthermore, the Kansas City program is somewhat more focused on supporting welfare reform initiatives by providing services to assist parents in obtaining GEDs and finding employment.

Another example of a school-based center is provided by the Youth and Family Impact Center (YFIC) in Dallas, Texas, which began as a community-based program intended to serve families with children ages 4-19, who live in or attend school in a specific zip code. The zip code was selected because it has the highest number of combined referrals to the child welfare, health, and juvenile justice agencies in the county. Shortly after the program was awarded its FP/FS grant, the program combined its resources with that of the school district and was located at a multi-service center operating on a school "campus" (see text box). The Director of YFIC noted that the location of the program on the school campus has resulted in less utilization of the program throughout the zip code area. Referrals are more likely to come from the co-located schools, and it is easier for the case managers to locate these students in comparison to students at other schools in the catchment area.

Although all of the programs described above are school based, they differ somewhat on the types of services offered and perhaps most important on whether they provide a comprehensive assessment of both child and family needs.

**Youth and Family Impact Center
Dallas, Texas**

The program began as a collaboration between approximately 20 service providers in response to the state's announcement of FP/FS funding. When the program was established, it asked public agencies for referrals of families with school-age children in the targeted zip code. They received more than 1,200 referrals and targeted 400 families who had been referred by more than one agency. Although the program serves children ages 4 to 19, the average age of the children at first contact is 12.

At the heart of the program are five case managers and a supervisor who assist referred children and families by first assessing the degree of risk, establishing a service plan, setting up appointments, linking them with services, and tracking and monitoring their progress. The case managers are mostly African American reflecting the race/ethnicity of the population served. There are also Hispanic, bi-lingual case managers who work with children from a school with a predominantly Hispanic population.

The program only closes its cases when the family moves from the area or the child turns 19. The program believes that their relationship to the children they serve should be like that of a parent and adult child, who always remain connected but whose degree of contact and involvement will vary over time. Depending on the level of risk assessed, case managers may visit a family up to twice a week, but eventually contacts may be limited to monthly visits or telephone contact. In January 1997, there were approximately 530 families who had received services and 425 active cases. Since the selection of the initial 400 cases, no referrals have been rejected.

In addition to the case managers, approximately 17 agencies outstationed staff on a part-time basis at the center. Among the services offered are the following:

- **Dallas County Mental Health/Mental Retardation:** Psychiatric evaluation, caseworker evaluation and case consultation;
- **Promise House:** Individual, family and group counseling;
- **Child Guidance Clinic:** Group therapy, social work therapy and psychological testing;
- **Dallas Public Schools:** Supplemental pay for teachers, school psychologists and counselors to provide counseling, tutoring and educational assistance to students;
- **YFIC and Letot:** A job developer from YFIC and a counselor from Letot will implement the Parent Involvement Program; funds cover materials, bus tokens, incentives, etc.;
- **West Dallas Community Centers:** Rites of Passage program;
- **Mexican Cultural Center:** Cultural group sessions in dance, theater and creative arts;
- **Community Council of Greater Dallas:** Intake of phone referrals from target zip code; and
- **North Texas Food Bank:** Food items, toiletries and other necessities for clients in need.

The co-located service providers meet quarterly. The case management supervisor facilitates these meetings to discuss specific cases and generally maintain the collaborative process.

2. Community-Based Centers

As shown in Exhibit V-6, the local sites in Alabama and Florida developed community-based family centers. These centers all focused on the same target population -- all families in a geographic catchment area -- but they varied in size, services offered and staffing patterns. In Florida's District 5 (which contains two counties funded with FP/FS funds), one center in each county was in operation at the time of the site visit. In addition, funds from the district's mini-grant program (see section D below) were used to support small, one-time projects or events within existing community-based centers. Prior to FP/FS, the Juvenile Welfare Board in Pinellas County had been supporting community-based centers that meet the Family Resource Coalition's definition of community-based organizations. In both Pinellas and Pasco Counties, centers are managed and staffed by members of the community; parents participate in program decision making and governance; programs are culturally and socially relevant; and staff members are representative of the target population. FP/FS funds have helped augment these community-based centers and expand this approach to service delivery (see text box).

Shady Hills Family Resource Center Pasco County, Florida

Pasco County, north of Pinellas County, is a predominantly rural county with a number of challenges including wide-scale illiteracy, lack of transportation and isolation. The Shady Hills Family Center opened in May 1996. It is housed in a church located in a remote corner of the County. FP/FS funds support a center facilitator, one support staff person, and subcontract services such as transportation and child care. FP/FS funds have helped attract other programs, such as a food distribution center for WIC (Women Infants and Children), and a weekly medical clinic funded by the Department of Health.

The Center's coordinator is a long-time resident of the county. She was formerly a waitress in a luncheonette, and as various stakeholders noted, "knew everybody and everything happening in the county." She has started four support groups at the Family Center -- one for parents, one for stepparents, one for grandparents raising grandchildren, and one for those who have lost a spouse or loved one. The Center also coordinates alternative activities for youth, provides child care for adults getting their GED at a nearby school, and sponsors community events such as parades and fairs.

The Center's board is made up of school and law enforcement representatives, service providers and a County Commissioner. They stated they have increased their knowledge about community outreach and engagement of families through FP/FS-sponsored training and that they are more aware of services and provide more referrals to existing services due to the monthly board meetings.

**Exhibit V-6
Community-Based Centers**

FP/FS Funds	Target Population/ Referral Source(s)	Services Provided	Intake/Assessment/ Referral Process	Staff Characteristics	Out-Stationed Professional Staff
Alabama					
Hale County (Family Resource Center)	FY94 \$25,000 FY95 \$187,500 FY96 \$200,000	County families. Public and private community agencies, courts, self-referrals.	In-home and office-based counseling, perinatal support, job placement and training, GED, adult education, after school tutoring and adult literacy, child care eligibility determination and legal assistance.	Family Support Specialist conducts intake and assessment. Families are referred to appropriate services.	Professional staff. Yes--Child care eligibility determinatio n and Legal Services staff.
Houston County (Family Service Center)	FY94 \$100,000 FY95 \$400,000 FY96 \$453,000	County families. Public and private community agencies, courts, self-referrals.	Counseling, case management, in-home parent education for teen parents, employment preparation and job placement, GED and literacy, drop-in ages 0-4 child care, parent education and training, dental clinic and preventive health care, immunizations, flexible funds and transportation vouchers.	Applicants complete a service application and interview. Intake worker informs the consumer about other available services, but only those services desired by the family are provided.	Two-thirds staff are professionals and one- third are former welfare recipients who have completed center services. Yes--Health Department provides dental/health clinic services. Local college provides adult education.
Arizona					
Winslow County (Family Resource Center)	FY95 \$123,434 FY96 \$164,579	Community families. Self-referrals, community agencies.	Parent education sessions, parent support groups, emergency cash assistance for concrete needs, intensive home- based FP services, mental health counseling and services, child care for teen parents, and youth advocacy (behavior coaches).	Intake workers conduct family assessment within 3 days of family's initial contact with the center (can be conducted in-home). Families are referred to appropriate services. Intake workers conduct follow-up and close cases after 3 months of inactivity.	Professional staff including Native American representation. No.

Exhibit V-6 (continued)

FP/FS Funds	Target Population/ Referral Source(s)	Services Provided	Intake/Assessment/ Referral Process	Staff Characteristics	Out- Stationed Professional Staff
Arizona					
Broward County (Drew Family Resource Center)	FY95 \$102,750 FY96 \$142,500 (for extending drop-in hours weekday afternoons/ evenings and Saturdays)	Family counseling and case management, parent-child interaction activities, parenting classes, GED and literacy, child care, emergency funds and clothing, a toy and book lending library, and health education and services.	Parents are required to fill out an intake form and complete a family support plan, identifying the family's goals, strengths and needs.	Predominantly professional staff. Community members contribute some services.	No.
Pasco County (Shady Hills Family Center)	FY96 \$51,000	Alternative activities for youth; support groups (for parents, grandparents, stepparents and survivors who have lost a loved one); child care for parents getting their GED; WIC; medical screening; community events.	No centralized intake/assessment.	Paraprofessionals from the community who have historically provided these services on an informal basis.	Yes--WIC and Medical Services staff.
Pinellas County (Olive B. McLin Family Center)	FY96 \$86,000	After school activities for children, community outreach and service coordination, computer classes and parent support groups.	No centralized intake/assessment.	Professional staff who are long-time community residents.	No.

The Olive B. McLin Neighborhood Family Center in St. Petersburg reflects the same principles as the Shady Hills Family Center described earlier. The Center is located in a predominantly African American community that had been the site of anti-police riots in 1996. There is considerable drug-related activity, and residents are reluctant to participate in community programs. The Center is staffed by a director and two part-time outreach workers. The board consists of members of four neighborhood associations that form the community served by the family center.

In contrast, the family centers in Hale and Houston counties in Alabama are staffed primarily with professionals. A greater variety of services are co-located at the centers, which have central intake and assessment processes. Also, the centers have become focused on providing assistance that will support welfare reform (see text box).

Houston County Family Center Alabama

In 1992, the Mayor of Dothan, the largest city in Houston County, formed a 38-member task force to focus on the academic needs of pre-schoolers. Using information gained from a survey of 1,200 parents of children in Head Start and the local elementary schools, as well as visits to other early intervention programs in the South, the program broadened its focus to include the entire family.

The task force selected a former alternative school as the site for the center. The building already housed the community's Head Start and JOBS program, and is located in an area accessible to three housing projects. The mayor used his influence to convince the school system to give the site to the Family Service Center and Community Development Block Grant funds were used to renovate the facility.

Initially, the task force conceived of the center as relying almost exclusively on co-located services and providing information and referral. However, after a site visit with state officials to the Family Life Center in Sunset Park, Brooklyn, state and center staff chose to develop a systems approach to serve families more comprehensively. In addition, the state required family centers receiving FP/FS funding to include: a strengths-based needs assessment; individual case planning; and case management services.

The combination of the state's FP/FS funding requirements and the service needs identified by members of the community have resulted in a comprehensive family center with four components: Intake/Assessment, Career Center, Health/Dental Center and the Child Care Center (see Exhibit V-6 for a detailed list of services). The Center started with 6 staff and now has 11 full-time, and 7 part-time staff, one-third of whom are former welfare recipients. In addition, the Department of Health provides staff for the clinic, and Wallace Community College is responsible for adult education and some of the employment-related services.

In addition to its on-site services, the center houses a home-visiting program staffed by a coordinator and three paraprofessionals for families at risk of abuse and neglect. The program serves approximately 75 families a year, but was assessing over 300 families annually. The program serves all cases referred from child welfare or from the county's intensive family preservation program as well as other families as space permits.

The 10 family centers supported with FP/FS funds represent a wide array of alternative models. They differ on whether they are community- or school-based, primarily staffed with professionals or paraprofessionals, and the types of services offered. Each addresses multiple needs of families to varying degrees. However, three aspects of the centers seem most critical in understanding the extent to which the centers can meet the child welfare objectives noted in state plans -- funding levels, intake and assessment procedures, and the role of welfare reform in shaping services:

- **Funding:** Centers differed considerably in the amount of resources available. In Missouri, where the state limited the number of targeted sites and combined FP/FS funds with other sources to create a central funding pool, programs were receiving more than \$2 million annually. The Dallas Youth and Family Impact Centers received \$500,000, and the Houston County family center received more than \$400,000 in second-year funding. Programs that received significant FP/FS funds were better able to attract other funding sources. They engaged other agencies and private providers in co-locating staff or providing space for the center. The smaller programs in both Broward County and Pinellas/Pasco counties appear less able to do this. These programs were in their infancy at the time of the site visits, and it is possible that over time they will attract additional support; however, this is likely to be a challenging effort since they have fewer resources to use to attract others into their centers.
- **Central Intake and Comprehensive Assessment:** A second key issue is the role of intake and assessment in the family centers. For some, such a process is contradictory to the concepts of a family center; most notably that participation in services is voluntary, that families should determine their own service needs, and that the centers should provide a welcoming environment and not one that appears bureaucratic or judgmental. Nevertheless, without such a process it appears that the value of comprehensive service centers may be underutilized. Note that those centers that have intake and assessment procedures still consider family participation in services voluntary. Furthermore, centers such as the one in Houston County have developed a process that is based on assessing strengths as well as needs and working with families to identify a mutually agreed upon plan.
- **Influence of Welfare Reform:** Finally, there is the question of the role of welfare reform in shaping the services offered by the family centers. Virtually all of the centers offered some support for families who were seeking their GED, but for some, adult education and job training were the focal point of services. Some sites considered addressing welfare reform issues their paramount concern. This was true not only in some of the programs described above, but in other communities that had previously established family centers and added additional services or outreach efforts through FP/FS. The question, however, is not whether FP/FS should support welfare reform, but how it can most appropriately do so.

There is an inter-relationship among the three issues identified above. Without adequate funding it will be difficult to develop comprehensive service centers. Without an adequate intake and assessment process, identified service needs are likely to focus on concrete issues relating to income and employment. Even in Alabama, where the state has required centers to provide a common intake and assessment process and offer services that go beyond job-related activities, there is concern that employment and training services will dominate these centers.

One state level official noted:

There has been some lack of clarity about the focus of family service centers. This seems to be the result of the federal push for welfare reform and the political climate in the state. We feel that the welfare reform initiative and the family preservation and support initiative need to go hand-in-hand and that you can't accomplish one without addressing the other. It is still, however, the purpose of family service centers utilizing FP/FS funds to support, strengthen and preserve families. Some of the services provided will also help families become self-sufficient, but this outcome is secondary to the goals of assisting families to be safe, healthy and stable.

For family centers this may mean providing both a range of services and a comprehensive family assessment. For home-based service programs, it is valuable to consider the Family Continuity Program in Florida, where the welfare reform demonstration project provides education and training and FP/FS funds are used to provide the parenting skills and other services needed to ensure that children remain safe and well cared for as parents transition into work.

E. Provider Networks

As noted in Chapter III, several states encouraged local providers to collaborate with each other to develop FP/FS-funded programs that built upon their existing services and created a more comprehensive approach to service delivery. While some providers collaborated to form or expand family centers or home-visiting programs, others formed networks to address a broader range of needs and formalize referral and case management efforts across provider agencies. One example of this is the Lincoln House in Phoenix, Arizona (see text box).

**Lincoln House
Phoenix, Arizona**

The Lincoln House Family Resource Center serves families in the North Phoenix community of Sunny Slope. Recipients may receive services through contacts with any of 17 providers in the network (nine are subcontractors and the remainder are unpaid collaborators). Once classified as eligible to receive services through Lincoln House, collaborating agencies complete the service tracking form and forward it to the Lincoln House case manager. Within Lincoln House, staff meet weekly for an hour for supervision and guidance on cases. Collaborating providers' staff meet with Lincoln House staff twice a month (once during the Multi-Disciplinary Team meetings, and once during Lincoln House sponsored business meetings) to discuss coordination issues, case management, and any other case-related issues. Supervisors also meet with Lincoln House on a quarterly basis. Evaluation meetings are also held once a month with a small working group of Lincoln House providers.

The following listing describes the services available, October 1996 - September 1997:

- **Lincoln House:** Information and referral, service coordination, case management, support to collaboration for planning, and coordination of resources and transportation;
- **Chris-Town YMCA:** Recreation and youth sports program, PALs program referrals (at-risk youth recreation center), and after school program;
- **Tumbleweed:** Outreach, assessment, counseling, referral to services, crisis intervention, shelter, 24-hour hotline;
- **Arizona Youth Associates:** Mental health, outreach, assessments, crisis assistance and linkage with mental health services;
- **Southwest Human Development:** Healthy Families, home visitation and family support, JCL-Family Assessments;
- **City of Phoenix, Step-up Program:** Case management, employment/training, and parenting;
- **Valley Big Brothers/Big Sisters:** Mentoring for fathers;
- **Parents Anonymous:** Bilingual parenting education/support; 24-hour crisis line;
- **Ninos Como el Mio (Kids Like Mine):** Outreach through bilingual newsletter; and
- **Northside Training Center:** Job preparation, classes for youth (16-21 years).

Still another type of collaborative network can be seen in the Project Healthy Grandparents program in Atlanta, Georgia. The program is run by the Georgia State University School of Nursing, but involves other professionals and students from the university. The program targets African American intergenerational families in which grandparents and great-grandparents are raising one or more grandchildren (see text box).

**Project Healthy Grandparents
Atlanta, Georgia**

Project Healthy Grandparents is based on an interdisciplinary approach to service delivery. Nurses make monthly visits to monitor the health of the grandparent and grandchildren. Children are checked for growth and development as well as immunization status. Grandparents have their cholesterol, weight, vision, blood pressure and diabetes status checked. Social workers make monthly home visits and determine referral needs and benefit eligibility, and provide parenting skills. The social workers develop a case plan for each family. Legal services typically related to guardianship and custody issues are provided in the home. College students provide tutoring to the elementary- and school-aged grandchildren on a weekly basis. In addition, the program uses professional staff, nurses social workers and attorneys as well as interns (law, nursing and social work) to provide services. The program also supports monthly parent education groups and support group meetings. The support group meetings are directed by the grandparents.

The program has an advisory board made up of community members and grandparents/consumers; all members are African American. The program is conducting an evaluation, examining implementation issues (process evaluation) and outcomes.

Still another type of network is Project Safe Place in Savannah, Georgia. This program focuses on organizing business and community leaders to provide a safe haven for children experiencing difficulties at home or who may have left home (see text box).

**Project Safe Place
Savannah, Georgia**

Project Safe Place, based on a national model, recruits businesses throughout the community to serve as safety sites for youth who find themselves in a dangerous or potentially dangerous situation. Youth can go to a Safe Place site to access needed services or support.

Safe Place has three program components: emergency shelter/safe sites, in-home support and counseling, and community resource and referral assistance, all of which are offered by Greenbriar (a private child and family services agency). When a youth arrives at a Safe Place site, an employee of the business/site ensures that the youth is safe before eliciting basic information about why the youth is seeking a safe haven. The employee then calls the toll-free Safe Place line at Greenbriar, and a Safe Place volunteer is dispatched to the site. The volunteer talks with the youth and allows the youth to determine whether to return home or go into shelter. Greenbriar staff follow up and meet with the parents of each Safe Place youth to the extent possible. Follow-up ranges from 60 days (without shelter) to 120 days (with shelter care). In-home counseling is provided by a master's level and bachelor's level social workers for the specified follow-up period. Staff also refer Safe Place youth to other community agencies and services.

A full-time coordinator with a bachelor's degree in criminal justice conducts the outreach component, works with the volunteers, plans events, recruits sites, and provides information about Safe Place to the community and potential sites. She works with the schools, making presentations to students and distributing Safe Place videos, fact sheets, and student cards that list the toll-free telephone number. Staff were able to obtain local discount coupons from businesses for the cards.

As noted above, the provider collaboratives have been used to accomplish different objectives. In Phoenix, Lincoln House brings together an array of professional services to assist families; Project Healthy Grandparents blends professional nursing and social work staff with volunteer undergraduate and graduate students to provide comprehensive services for grandparents raising grandchildren. These efforts are similar to some of the family service centers, yet they demonstrate that co-location of services is not essential to implement coordinated service delivery.

F. Mini-Grant Programs

The last major category of programs noted in the study sites were "mini-grant programs." Although some states used mini-grants to promote planning (West Virginia) or support some short-term child welfare services (Georgia), the most unique use of mini-grants can be seen in Broward and Pinellas/Pasco counties in Florida and in Santa Clara County in California. In these counties, the mini-grants were viewed as a mechanism for attracting new stakeholders to the process, especially members of the community who might not otherwise be involved.

As noted in the Chapter III discussion on state efforts to work with community-based organizations, state procurement practices were potentially an obstacle to financing these small, grassroots entities. Mini-grants provided a means of overcoming this obstacle. Furthermore, mini-grants could be used to improve linkages to programs and fill gaps in existing service delivery. For example, as previously described, the Family Continuity Program provided intensive family preservation services to mothers in the welfare demonstration program in Pinellas County. To further support this effort, another organization, the "R'Club," received \$1,900 to run an eight-week program called Super Saturday for children of mothers in the demonstration program. The program provided vocational and life skills sessions, addressed conflict resolution and took the children on field trips. Similarly, the Childs Park Neighborhood Family Center, which was receiving technical assistance from the Family Continuity Program, also received a \$2,500 mini-grant to purchase materials for an educational resource center.

In Santa Clara County, the Mini-Grant Program was the sole approach used for providing family support services (see text box).

**Mini-Grant Program
Santa Clara, California**

The yearly Mini-Grant Program in Santa Clara, Resources for Families and Communities (RFC), was publicized widely through agency mailings and press announcements. As specified in the grant announcement, developed by the RFC board and executive director, eligible groups within target zip codes were defined as community groups (such as neighborhood associations, home owners/tenant groups, neighborhood watch groups, etc.), groups affiliated with educational institutions (such as PTAs, Home Clubs, etc.), and groups affiliated with religious institutions. Ineligible groups included government agencies, educational institutions, religious institutions, and private, for profit businesses and corporations. Administrators stated that their targets were "non-traditional service providers" who configured around a particular problem in a particular community. Volunteer and community-based neighborhood organizations with no prior grant recipient history were especially encouraged to apply.

For the first year, a maximum grant award amount of \$15,000 was set. This was raised to \$20,000 for the second year, although typically grants fell far below these amounts. A total of 47 grants were awarded the first year and 50 the second year beginning January 1997. Listed in order of frequency, funded activities included: cultural/generational activities, child development/parenting classes, community outreach/presentations focused on prevention, public community resource assistance, child care for clients, assessing clients, computer learning/literacy tutoring, conflict resolution, and neighborhood clean-up.

While the services provided through the mini-grants reflected the needs in the communities they serve, they are potentially more valuable as an agent for reforming the degree of community involvement and bridging the gap between the public child welfare agencies and the communities they serve. While initial response to these programs was extremely positive, it is too early to determine whether they will have a long-term effect on community involvement.

G. Other Programs

The above categories represent the major program areas funded in the study states and communities, but other types of efforts were funded as well. For example, Vermont used funds for respite care; Pasco County, Florida funded information and referral services; aftercare services were provided in Savannah; and services for substance abusing mothers were provided in Atlanta.

In addition, many of the home-based and center-based programs set aside funds to meet emergency or concrete needs of families (e.g., paying a rent or utility bill). The community case summaries in Volume II provide a complete list of all programs funded in a given locality.

H. Summary

For the most part, states followed federal guidance by developing an array of family preservation and support programs, although they did not necessarily adhere to the legislation's definitions of family preservation and family support. Overall, most of the programs funded are more consistent with traditional family support efforts than family preservation programs for children at risk of foster care placement.

The extent of programs' diversity is a logical outgrowth of the flexibility provided in the federal legislation and guidance as well as the inclusive nature of the planning process that occurred in most states and communities. It would be unrealistic to expect that the amount of FP/FS funds and a one-year planning effort could fill all gaps in a service delivery continuum. The next steps for states should be to re-examine the service continuum, assess its current strengths and weaknesses, and continue to fill gaps. In light of the early emphasis on broadly targeted family support programs, continued examination of FP/FS programs should consider the following:

- Whether or not the current array of services adequately address the needs of children and families within the child welfare system;
- Whether or not there is a need for more intensive services (especially reunification programs) that both ensure child safety and support families;
- Whether or not family centers are able to comprehensively assess family needs, refer families to more intensive services when needed, and support and encourage families to avail themselves of such services;
- Strengthen the relationship between child welfare and community-based programs; and
- Re-examine the relationship between other funding sources, especially TANF, and the use of FP/FS funds to determine ways in which funding streams can be used to support more comprehensive services.

Despite the program gaps noted above, there are numerous examples of innovative programs including some that effectively link a range of programs that meet the needs of multiple target populations, including the most vulnerable children. Alabama's efforts to fund both intensive family preservation programs and family resource centers within each county and to ensure that both programs and the child welfare agency are aware of and utilize each other's resources is one such example. The range of services available within each Caring Communities

site in St. Louis and the development of sensitive policies for reporting abuse and neglect is yet another example of the ability to provide family-centered, community-based services that ensure child safety.

Still another innovative approach is reflected in the Family Continuity Program serving Pasco and Pinellas counties. By providing family preservation services to families in the welfare demonstration program, they are helping to ensure that the transition from welfare to employment does not adversely affect the safety and well-being of children.

The Family Continuity Program combines service delivery to the most vulnerable families with a process for building the infrastructure of community-based programs. By using program administrative and management staff to provide technical assistance and support for community-based programs, both ends of the service continuum are strengthened. Through their experience in operationalizing the principle of family-centered practice, program management staff have the inter-personal skills and cultural sensitivity necessary to work with and support new community-based efforts. The mini-grant program has also provided support for these efforts, while simultaneously facilitating the involvement of new stakeholders.

In a somewhat different vein, both the kinship care program in Broward County, Florida and the Healthy Grandparents Program in Atlanta, Georgia are addressing the needs of families whose children might otherwise be placed in foster care. Through a combination of center- and home-based services, these programs address the needs of a growing but often neglected segment of the child welfare population.

The range of programs developed with FP/FS funds demonstrate that programs do not have to be limited to one type of setting (either school or community) or to any single facility (networks). Some have also demonstrated the ability to attract diverse funding sources, co-locate staff, and establish links to other public and private service providers.

At present, it is too soon in the implementation process to determine differences in the degree of success among the various programs funded with FP/FS. It is, however, an appropriate time to examine the match between the service delivery approaches funded and the target populations served. It is also an appropriate time to consider approaches that improve the linkages among funded programs to more comprehensively address family needs and ensure child safety.

CHAPTER VI

CONCLUSIONS

The previous chapters in this report have described the various aspects of the FP/FS implementation process to date – planning, monitoring, financing, training, service delivery and program design. As evidenced throughout this report, there was no single story of FP/FS implementation, each state and locality's process reflected its unique history of family preservation and support services, its vision for a more comprehensive service delivery system, issues facing its child welfare system and the movement toward decentralizing decision-making authority for government programs. Federal guidance influenced the implementation process as well. States were encouraged to take advantage of the degree of flexibility provided in the legislation, collaborate with a broad range of stakeholders in developing a shared vision for children and families, and increase the role of communities in designing programs to meet their needs.

It is not surprising that this flexibility has produced mixed results. On one hand, FP/FS funds have been used to launch new community-based programs and encourage participation in the planning and service delivery process. A wide range of public and private agencies, as well as consumers were engaged. Many innovative approaches to service delivery were developed. States did not use FP/FS funds to supplant existing funds; rather, they used FP/FS funds to develop new program models and expand existing models.

It would be unrealistic to expect, however, that all aspects of FP/FS planning, financing, management and service delivery could be fully addressed in the early stages of implementation. As FP/FS implementation evolves, further attention should be paid to addressing the following questions:

- Are adequate FP/FS funds allocated to programs that serve the most vulnerable children (particularly abused and neglected children) and ensure their safety?
- How can the federal government assist states in establishing better outcome indicators and in measuring progress toward goals?
- What type of infrastructure (i.e., financing, monitoring, training) do states need to establish, support, encourage and improve community-based programs?

Most programs in the 10 case study states had just begun operations at the time of the site visits (September 1996 to June 1997). Since the programs were still in their infancy, it was too soon to draw conclusions about the results they might achieve. Nevertheless, there was sufficient information to examine the lessons learned to date, explore areas where further federal guidance and support to states and localities would be beneficial and identify promising service delivery efforts. Each of the case study sites had its strengths and weaknesses. Throughout this report, examples of innovative approaches to planning, management and service delivery were noted. Exhibit VI-1 identifies states and localities that had successful or innovative approaches in these areas. Detailed information on these efforts can be found in Volume II, State and Local Case Study Summaries. In the remainder of this chapter, the major findings and conclusions concerning planning, management, financing and training, and service delivery design are summarized.

A. Planning

The major aspects of the planning process examined were: collaboration; locus of decision making; needs assessment; and involving consumers.

1. Collaboration

Key collaboration issues include:

- **Inclusion of a Range of Stakeholders:** States responded enthusiastically to federal guidance and established collaborative planning bodies that included a broad range of public and private agencies. Efforts were made to include non-traditional stakeholders in the process.
- **Size of the Planning Group:** In some instances, the original collaborative bodies proved large and unwieldy. States corrected this problem by creating an executive or steering committee, establishing subcommittees to work on specific issues, and establishing ground rules that governed the meetings. States that prepared summaries of planning group and subcommittee meetings and promptly circulated them to all participants found this helpful.
- **Use of Outside Facilitators:** States that employed outside facilitators considered them very helpful. The facilitators were viewed as a neutral party; new stakeholders were less suspicious of the process and more likely to actively participate. In addition, the facilitators often worked between meetings gathering relevant state statistics and exploring activities in other states. They were able to share this information with planning group members.

**Exhibit VI-1
Innovative and Promising Approaches in FP/FS Implementation**

Issue	State, Locality or Program	Approach
PLANNING		
1. Utilizing Diverse Planning Bodies	Arizona - State-level planning Florida - District-level planning	Managed large, diverse decision-making body - used outside facilitator - provided summaries, written documents - established ground rules for meeting State support for local efforts created, funded and trained full-time coordinator positions.
2. Allocating Significant Funds to Both FP and FS	Alabama and Texas	Both states selected and funded FP model - Alabama -- involved local stakeholders in creating family centers - Texas -- state collaborative body reviewed proposals for FS awards. Private agencies had to establish FS collaborative to submit proposals.
3. Targeting Specific Communities	Alabama, Colorado and Missouri Broward County, Florida	All three states used existing data sources to rank counties by various indicators of need and target FP/FS funds to those communities with most need. Extensive community mapping of both need and existing resources -- targeted 3 neighborhoods to receive FP/FS funds.
4. Involving Consumers	Broward County, Florida Santa Clara County, California	FP/FS coordinator worked individually with community members to strengthen their participation in planning board and their review of service provider proposals. Child welfare agency turned decision making over to diverse group for the first time, actively declining to lead group process formally or informally. Used bilingual facilitator and provided child care and meals. Held meetings in a nice, neutral setting and promised a celebration at the conclusion of the plan's development.
FINANCING		
1. State Level -- Blending Funding Streams	Missouri West Virginia	Combined FP/FS funds (\$2.4 million) with other revenues from 4 agencies to create \$21.6 million pool for FP/FS program. Took a small percentage of FP/FS funds, along with Medicaid and other sources, to create a flexible funding pool to support local capacity building.
2. Program Level -- Attracting Other Funds, Facilities and Staff	Youth Impact Center in Dallas, Texas Family Center in Houston County, Alabama	Center located in school facility; includes outstationed staff from 17 providers. Facilities and maintenance provided by school board and city of Dothan; funds by United Way, private foundation, Community Development Block Grant and others.

Issue	State, Locality or Program	Approach
TRAINING IN PRINCIPLES OF FAMILY-CENTERED PRACTICE		
	Arizona	Required all FP/FS grantees to provide front-line staff with family-centered training; held statewide conference; established case review protocol for assuring implementation.
	Alabama	Required counties receiving FS grants to visit model center.
SERVICE DELIVERY		
1. Serving Child Welfare Population	Alabama, Texas, Florida, Georgia, and Los Angeles County, California Healthy Grandparents Program in Atlanta, Georgia, and Child Care Connection in Broward County, Florida Caring Communities in St. Louis, Missouri	All 5 states funded programs solely targeted to child welfare families. Both programs targeted to serve kinship care families. Explicit staff policies for reporting child abuse and neglect and continuing to work with families during CPS investigations.
2. Case Management	San Luis Valley, Colorado Youth Impact Center in Dallas, Texas	Family Advocates have strong linkages with child welfare and other public agencies. Dedicated staff perform case management functions -- referrals made to 17 collaborating providers for service.
3. Intake and Assessment in Family Centers	Houston and Hale Counties, Alabama Caring Communities in St. Louis, Missouri	Both counties have comprehensive intake and assessment units -- assessments reflect principles of family-centered practice -- home visiting for parent training available. Children/families referred to any part of program's clinical component (includes intensive FP, lower-level case management, behavior therapy/day treatment, substance abuse prevention) are assessed by a team representing all clinical components. Separate meeting held with the referring teacher. Within 7 days a lead caseworker is assigned who compiles a master treatment plan.

Exhibit VI-1 (continued)

Issue	State, Locality or Program	Approach
4. Relationship to Welfare Reform	<p>Family Continuity Program and Mini-Grant Program Pasco/Pinnellas District, Florida</p> <p>Alabama Family Centers</p>	<p>Intensive Family Services to families in welfare to work demonstration program; mini-grant to an organization to run Saturday mentoring and recreation program for children of mothers in the demonstration.</p> <p>States encouraged local family centers not to focus solely on employment and training; required intake and assessment component.</p>

2. Locus of Decision Making

Three decision-making models were identified in the case studies: **state child welfare agency model** in which the child welfare agency (with some input from other stakeholders) made at least one key decision concerning the use of FP/FS funds; **state-level collaborative body model** in which decisions were made by the entire planning body; and **local jurisdiction model** under which the state delegated planning authority to a local agency or planning body. The type of decision-making model used affected the decisions made:

- **Allocation of Significant Funds for FP and FS Programs:** States employing the child welfare agency decision model set aside funds for both FP and FS programs. While they involved other stakeholders in the decision-making process (especially as it related to family support programs), these states had a clear vision of the types of programs they wished to develop. In contrast, the collaborative planning bodies tended to include stakeholders who were knowledgeable about family support programs. Child welfare administrators were often not involved in this process. As a result, the collaborative planning bodies allocated few dollars for intensive family services or reunification programs targeted to the child welfare population.
- **Geographic Allocation of Funds:** States that delegated authority to the local level, divided their FP/FS funds proportionately among all districts or counties. In contrast, states using the child welfare agency decision model targeted funds to selected counties. Some of the sites using state-level collaborative bodies also followed this approach.
- **Size of Service Delivery Projects:** Funding allocations for programs were also affected by the size and diversity of the planning bodies. Large, diverse planning groups tended to achieve consensus by "giving everyone something." This resulted in numerous projects with few resources to achieve the often far-reaching goals that were established.

3. Needs Assessments

States followed federal guidance and engaged in a variety of formal and informal efforts to identify needs. They conducted surveys, held focus groups, examined existing statistical data and conducted public hearings. However, the success of the needs assessment efforts varies depending upon the criteria used to judge their effect:

- **Needs Assessment as a Catalyst:** The assessments provided mechanisms to engage a broad array of stakeholders and facilitate collaboration efforts. In this regard, state needs assessment efforts were largely successful.

- **Needs Assessment as a Technical Planning Tool:** Although some states used needs assessment data to target funds to specific counties (or communities) in their state, the needs assessment data were seldom used to identify family needs, examine existing resources and determine which program models might best address identified gaps in the existing service delivery system. It appears that a lack of time (some planning decisions were made prior to needs assessment completion), and the effects of other contextual factors played a greater role in making funding and service delivery decisions. In this regard, needs assessment efforts were less successful.

4. Involving Consumers

Most state and local planning groups made efforts to include non-traditional stakeholders in the planning process. While they were often successful in securing input from consumers through focus groups and public hearings, efforts to include these stakeholders in ongoing planning efforts were less successful. Two issues pertaining to consumer involvement emerged:

- **Definition of a Consumer:** While planning groups typically sought to include parents in the process, there was a tendency for consumer participation to be limited to parents who were active in civic affairs (e.g., a PTA president) or who were experienced advocates (e.g., parents of children with disabilities). Few planning groups focused on involving parents who received public assistance or services from the child welfare agency, were teenage parents or had substance abuse problems. This, in turn, affected perceptions of the services needed and the target population for FP/FS.
- **Efforts to Attract Consumers:** Planning groups attempted to attract new stakeholders primarily by providing day care and transportation services. Professional members of the planning group often noted that despite their efforts to get parents involved, they typically came to only one or two meetings and then dropped out. It appears that it is especially important to create a welcoming environment for families -- educating other members of the group to be sensitive to cultural differences and non-judgmental about problems; helping consumers understand technical and bureaucratic terminology; keeping in contact with consumers between scheduled meetings; and bringing them up-to-date when meetings are missed.

B. Linking Plans to Service Delivery

1. Financing

The federal government recognized that the amount of FP/FS funds by itself would be insufficient to address the range of needs experienced by children and families. One

expected outcome of collaboration was that it would lead to agencies and programs blending funding streams or jointly funding programs. Findings in this area varied by level:

- **State Level:** Both Missouri and West Virginia blended funding at the state level to create a larger pool of funds to support FP/FS initiatives. Other states, however, found it difficult to do so. A scarcity of funds, existing funding obligations, and a lack of authority of those involved in the planning process to commit funds to FP/FS programs are some of the reasons for these difficulties.
- **Program Level:** At the program level, there was evidence that more FP/FS programs were successful in attracting funds from other sources, gaining access to other agencies' facilities, and having staff from other programs outstationed at their center. It appears, however, that programs receiving sizeable FP/FS grants (i.e., over \$300,000) were better able to attract the resources of others. Small programs (under \$50,000) appeared less able to generate the level of interest necessary to attract support from other sources.

2. Management and Monitoring

Federal guidance requested that states identify outcome objectives for families and children, select measures and benchmarks, and monitor progress toward these objectives.

- **Establishing Measurable Objectives:** States encountered considerable difficulties in establishing measures that were realistic and appropriate for the service delivery efforts funded. Many states had plans to use aggregate data available on existing management information systems. However, it was unrealistic to expect that programs serving a small number of families could dramatically affect statewide or even countywide rates of foster care, teenage pregnancy or high school graduation.
- **Monitoring:** Although some of the planning groups were reconfigured as oversight committees as implementation began, they met on a limited basis and focused almost exclusively on allocation of the next year's FP/FS funds. Monitoring requires that staff are assigned to review programs, collect program data, analyze and interpret findings, and report to the oversight group. Although a few states had such staff in place (e.g., Arizona), most did not. While FP/FS funds were allotted for planning and service delivery, only 10 percent of a state's FP/FS dollars could be used for administrative costs. Without funds designated for this purpose, states did not appear to invest in creating management and monitoring structures.

States acknowledged problems in this area and desired assistance.

3. Training in the Principles of Family-Centered Practice

Although stakeholders involved in planning, management and service delivery believed that their programs were based on the principles of family-centered practice, it was not clear that they fully understood these principles or how to operationalize them. Additional training is needed for stakeholders at all levels in the implementation process in this area.

C. Service Delivery Design

To a large extent, the programs reviewed in the case studies did not fall neatly under the labels of “family preservation” or “family support” as defined in the legislation. Although federal legislation required states to spend a significant amount of funds on both family preservation and family support programs (defined in federal guidance as at least 25 percent of funds in each category or a justification if fewer dollars were allocated), most programs had characteristics typically associated with family support models, particularly primary prevention programs. Analysis of the national data indicated that approximately 64 percent of FY 96 funds were used for family support; however, an examination of the application of these terms to specific programs suggests that the actual allocation of funds to family support programs is even greater than 64 percent.

Several factors may have accounted for the way in which funds were allocated: (1) states and local planning groups were more familiar with family support programs; (2) states perceived that they had greater gaps in services at the primary prevention end of the continuum; (3) the small amount of funding could be stretched to serve more families if family support services were provided; and (4) states perceived the emphasis in federal guidance on community-based programs as emphasizing family support programs.

The apparent confusion over the definitions of family preservation and family support blurred the different service delivery characteristics and target populations traditionally associated with each program type. To clarify this issue, a different program classification was developed for this study that reflects the variety of FP/FS programs reviewed in the case study sites. The 36 major service delivery programs reviewed were divided into four major categories by the classification:

- **In-Home Service Delivery Programs:** This category included a total of 20 programs. Each of these programs had a case manager or social worker who met with families in their homes (or other community settings). Within this category, programs differed in terms of their target population, the intensity and duration of services provided and staff qualifications. Three subcategories were identified to capture these differences.
 - **Intensive Family Services:** This category includes the programs traditionally considered family preservation programs. Programs serve families known to the child welfare system, and are intended to prevent foster care placement or facilitate reunification when placement has occurred. Program staff typically have master's or bachelor's degrees in social work. Workers have small caseloads and may visit families several times per week. Services are typically of limited duration (4 weeks to 12 weeks, although some may serve families for 6 months).
 - **Parent Training Programs:** These programs are typically intended for teen parents or new mothers with other risk factors. Like the intensive family service programs, most are professionally staffed. Most use a formal assessment and protocol that determines the frequency of visits and the duration of service. Typically, home visits occur less frequently than in the intensive family services programs but often continue for a longer period of time (e.g., up to three years).
 - **Case Management Programs:** Unlike the other home-based service programs, case management programs serve a broader target population. Although programs tend to be situated in communities with high rates of poverty and other risk factors, any families in the targeted community could access their services. Programs are often staffed by individuals who reside in the community. The frequency of services varies considerably, and there is typically no limit on the duration of services. However, services are often episodic rather than continuous. The focus is on resolving a specific conflict or emergency and are of brief duration, although a family may return for services when other problems arise.
- **Center-Based Programs:** These include both school and community-based centers.
 - **School-based centers** were mostly targeted to children with behavior or learning problems, although the array of services available were intended to meet the needs of both children and their caregivers. School-based programs tended to rely on professional staff and included a formal assessment process. The nature and intensity of services varied.

- Community-based centers were typically accessible to all members of a targeted community. The centers varied considerably as to the type of services provided and the staff employed. While some centers had a central intake and assessment component, others did not.
- **Networks:** These programs were collaborative entities encompassing multiple service providers. In effect, they were "centers without walls." Although the programs in this group varied in terms of target populations and services provided, they represented a common approach to service delivery fostered by FP/FS. FP/FS funds were used to strengthen the relationships among existing service providers, adding case management services and improving referrals among providers.
- **Mini-Grant Programs:** These programs awarded small grants to several community-based service providers. The services funded varied considerably, but most were intended to provide primary prevention services and expand community involvement in service delivery. These programs were intended to attract new community-based service delivery providers to the process.

Within each of these categories, many promising and innovative programs were established. For example, one intensive family preservation program accepts referrals from the welfare reform demonstration in their county (Pinellas County, Florida). Caring Communities, the school-based centers in St. Louis, Missouri, provide a continuum of service that includes community-level prevention efforts, cultural and recreational activities, tutoring, after school programs, drug counseling and intensive family services. The Healthy Grandparents program in Atlanta, Georgia, is a network of health, social work, education and legal professionals, students and volunteers who provide multi-disciplinary services to both relative caregivers and the children in their care.

Nevertheless, issues and challenges have emerged in at least some of the states and communities visited. These include:

- **Child Welfare Agency Involvement:** Child welfare staff in some localities appeared largely unaware of the family support programs that were developed with FP/FS funds. Linkages between child welfare and family support programs in some communities appear weak, and a sense of distrust persists between the child welfare agency and other programs.
- **Centralized Intake and Comprehensive Assessment at Family Centers:** Some family centers consider central intake and assessment to be contrary to the principles of family-centered practice (e.g., that participation in services is voluntary, that families should determine their own service needs). In their efforts to ensure that centers provide a welcoming environment rather than

appearing judgmental or bureaucratic, some centers may miss the opportunity to comprehensively explore and address family needs. Yet, other family centers have found ways to merge the principles of family-centered practice with a comprehensive approach to service delivery. While they have intake and assessment procedures, they still consider family participation in services voluntary, and their assessment process is based on assessing strengths as well as needs. The centers work with families to identify a mutually agreed upon plan.

- **The Role of Case Managers and Family Advocates:** Though program planners defined these positions as brokers of services needed by families in the community, in some programs, case managers or advocates focus on direct assistance to families. Furthermore, some staff appear distrustful of public agencies and reluctant to make referrals. While the case management and family advocate positions were intended to provide a bridge between communities and public agencies, in some instances they appear to be deepening existing adversarial relationships.
- **Influence of Welfare Reform:** Virtually all of the centers offered some support for family members who were seeking their GED; however, for some, welfare reform issues such as adult education and job training were their paramount concern. The question, however, is not whether FP/FS should support welfare reform, but how it can do this most appropriately. Programs that support families' abilities to provide for the safety and healthy development of their children as they transition from welfare to work are consistent with the goals of FP/FS. Use of FP/FS funds largely as a supplemental funding source for education and training does not appear to reflect the definitions of FP and FS services provided in the legislation.

D. Summary

The description of the planning and early implementation of FP/FS, and the identification of issues requiring future attention, point in a common direction. Collectively, they suggest the focus of FP/FS to date has been on establishing broad-based preventive services programs that are accessible to a diverse population within a community. The types of programs funded appear to reflect trends toward devolving program design and implementation to the community level and increasing community ownership of human services programs. Also, the limited amount of FP/FS funds available may have encouraged

the development of less costly (and therefore less intensive) programs than those targeted toward families already facing problems of abuse and neglect.¹⁶

As the administrators of the FP/FS funds, this is an appropriate time for state child welfare agencies to examine the balance between the service delivery approaches funded and the needs of the target populations served. It is also important to review the realism of some program objectives in light of the funds allotted, to consider the optimal relationship between welfare reform and FP/FS funds, and to examine approaches that provide comprehensive, family-centered assessments of needs and linkages to appropriate services.

FP/FS implementation takes place within a complex and dynamic context. There are inherent tensions among the various factors that influence FP/FS implementation, and limited resources create considerable challenges for states in meeting the diverse needs of children and their families. However, given the flexibility provided in the legislation, there is also the potential to resolve, or at least lessen, the effects of competing influences. Some programs have demonstrated this ability. Using these examples as a basis for providing technical assistance, along with improved oversight and monitoring efforts, will aid the future development of FP/FS programs.

¹⁶As mentioned earlier, the legislation including the provisions reauthorizing FP/FS (the Adoption and Safe Families Act of 1997), expands the service categories to be funded to include family reunification programs and adoption promotion and support services. States' response to the new legislation will be documented in upcoming site visits.

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APPENDIX A

**FP/FS IMPLEMENTATION STUDY
ADVISORY PANEL MEMBERS**

**FAMILY PRESERVATION AND FAMILY SUPPORT (FP/FS)
IMPLEMENTATION STUDY
Advisory Panel Members**

MaryLee Allen, Director
Child Welfare and Mental Health Division
Children's Defense Fund
25 E Street, N.W.
Washington, DC 20001

Nilofer Ahsan, State Policy Analyst
Family Resource Coalition of America
20 North Wacker Drive, Suite 1100
Chicago, IL 60606

Richard Barth, Director
Family Welfare Research Group
School of Social Welfare
University of California at Berkeley
1950 Addison Street, Suite 104
Berkeley, CA 94704

Gordon Berlin, Executive Vice President
Manpower Demonstration Research Corp.
3 Park Avenue, 32nd Floor
New York, NY 10016

Kathleen Feely, Associate Director
Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202

Ron Haskins, Human Resources Majority Counsel
U.S. House of Representatives
Committee on Ways and Means
B317 Rayburn Building
Washington, DC 20515

Ivory L. Johnson, Deputy Director
County of San Diego Health and Human
Services Agency
Home Visiting Strategic Initiative
Children's Plaza
3665 Kearney Villa Road, Suite 370
San Diego, CA 92123

Dana Jones, Executive Director
Southern Maryland Tri-County CAC
P.O. Box 280
Hughesville, MD 20637

Judith Jones, Director
National Center for Children in Poverty
Columbia University School of Public Health
154 Haven Avenue
New York, NY 10032

Sheila B. Kammerman, Professor
Columbia University School of Social Work
622 W. 113th St.
New York, NY 10025

Elba Montalvo, Executive Director
Committee for Hispanic Children and Families
140 West 22nd Street, 3rd Floor
New York, NY 10011

Susan Notkin, Director
Program for Children
Edna McConnell Clark Foundation
250 Park Avenue
New York, NY 10017

Theodora Ooms, Executive Director
Elena Cohen
Family Impact Seminar
1730 Rhode Island Avenue, NW, Suite 209
Washington, DC 20036

Betsey Rosenbaum, Director
Child and Family Services
American Public Human Services Association
810 First Street, SE, Suite 500
Washington, DC 20002-4267

Barbara Solomon, Dean
Graduate School of Social Work
Bovard Administration
MRF 214, Mail Code 0411
University of Southern California
Los Angeles, CA 90089-0411

Anna Stone, Principal Assistant
Children's Services Section
Vince Geremia, Program Coordinator,
Family Preservation Services
Division of Family Services, DSS
Broadway State Office Building, P.O. Box 88
Jefferson City, MO 65103

Ying-Ying T. Yuan, Vice President
Walter R. McDonald & Associates, Inc.
12300 Twinbrook Parkway, Suite 310
Rockville, MD 20852-1606

APPENDIX B

SITE VISIT INTERVIEW PARTICIPANTS

**Interview Participants
Alabama State Level Site Visit**

NAME	TITLE/AGENCY
Division of Family and Children's Services¹	
Terrie Reid	Deputy Commissioner for Programs
Paul Vincent	Director, Division of Family and Children's Services
Becky Peaton	Implementation Planning Manager
Clara Price	Supervisor, Office of Program Support
Mike Norton	Family Options Coordinator
Sandy Arthur	Family Preservation and Support Implementation Coordinator
Carolyn Lapsley	Office of System of Care Program Manager
Freida Scoggins	SOC Supervisor
Lu Tosch	Supervisor, FCS Office of Training
Other State Officials	
Jim Ellis Etheredge	Director, Geneva County Department of Human Resources
Donna Glass	Dept. of Mental Health/Mental Retardation
Thelma Braswell	Administrative Office of Courts
Barry Blackwell	SDE Coordinator for Finance and Compliance, Division of Special Education Services
Wayne Rhodes	Coordinator, Multiple Needs Child
Sharon Gerogiannis	Social Work Consultant
Other Participants	
Gayle Sandlin	Social Work Director, SDPM
Glenda Trotter	Director, AL Council on Child Abuse
Walter White	Executive Director, Family Guidance Center
Katie Clark	Executive Director, AL Foster Parents Association
Genie Wehley	Executive Director, Family & Child Services
Carol Gundlach	Executive Director, AL Coalition Agency Domestic Violence
Jimmy Dobbs	Director, AGAPE
Richard Crow	Associate Dean, School of Social Work, Univ. of Alabama

¹The Division of Family and Children's Services is now known as the Office of Conversion and Compliance.

**Interview Participants
Arizona State Level Site Visit**

NAME	TITLE/AGENCY
Department of Economic Security	
Anna Arnold	Manager, Office of Prevention and Support
Catherine Osborn	Evaluation Specialist
Valerie Roberson	Children's Trust Fund Manager, Healthy Families
Anna Marie P. Leff	FS Specialist
Nancy Friedman	FP Specialist
Rachel White	Healthy Families Program Specialist
Eric Bost	Deputy Director, Department of Economic Security
Jim Hart	Assistant Director, Department of Economic Security
Mary Ault	Program Administrator, Department of Economic Security
Anna Arnold	Department of Economic Security
Ida Fitch	Department of Economic Security
Department of Health Services	
Jane Pearson	Department of Health Services
Steve Perkins	Department of Health Services
Anne Rock	Department of Health Services
Other Participants	
James Rodriguez	Arizona Head Start
Jorge Luis Garcia	Social Service Director, Pascua Yaqui Tribe of Arizona
Martha Rothman	Executive Director, TACC - Tucson Arizona
Fred Chaffee	Executive Director, Arizona Children's Home Association
Michelle Keal	Executive Director, Parents Anonymous
Regina Murphy-Darling	Executive Director, PACT
Darlene Dankowski	Executive Director, Open Inn, Inc.
Diane Ogles	Executive Director, Humanities Resources Builders, Inc.
Ginger Ward	Executive Director, Southwest Human Development
Brenda Wallace	Central AZ Association of Governments

NAME	TITLE/AGENCY
Carol Kratz	Maricopa Association of Governments
Lynn Potler	Social Services Plan
Phyllis Bigpond	Inter Tribal Council of Arizona, Inc
Polly Sharp	Inter Tribal Council of Arizona, Inc.
Ann Haralambie	Council of Attorneys for Children
Jannah Scott	Senior Program Associate, Children's Action Alliance
Don Fausel	Assistant Dean, Arizona State University
Jane Wabnik	Consultant, Education and Public Issues
Paul Newberry	AZ Department of Health Services
Sonya Pierce-Johnson	Administrative Office of the Courts
Linda Schacherbauer	AZ-NCPA
Susan Klein-Rothschild	Consultant
Becky Ruffner	State Coordinator, AZ Chapter - NCPA
Jane Irvine	Consultant, Assessment of Family Centered Practice
Laura White	District III Program Manager, Department of Economic Security

**Interview Participants
California State Level Site Visit**

NAME	TITLE/AGENCY
Child Welfare Services Bureau	
Patric Ashby	Chief
Carol Camarillo	Staff Anayst
Lisa Foster	AB 1741 Coordinator
Paul Gardner	Social Service Consultant
Larry Grandstaff	Consultant
Joyce Humphrey	Analyst
Marilyn Lewis	Program Manager
John Liddelel	Staff Anlayst
Sharon Rea	Staff Analyst
Greg Rose	Policy Consultant
Robert Y. Scott	Policy Consultant
Nancy Stone	Staff Services Manager
Office of Child Abuse Prevention	
Roberta Budal	Analyst
Eileen Carroll	Program Consultant
Cassandra Day	Associate Staff Services Analyst
Dathan Moore	Staff Services Manager/ Family Support
Bruce Kennedy	Chief
Children and Family Services Division	
Marjorie Kelly	Deputy Director
Charleen Gorrel	Public Health Nurse/ Consultant
Evelyn Heinover	Manager
Vincent Mandella	Chief of Specialized Programs

**Interview Participants
Colorado State Level Site Visit**

NAME	TITLE/AGENCY
Colorado Department of Human Services	
Charles Perez, Ed.D.	Community Development Specialist, Child Welfare Services
Pam Hinish	Home-Based Services Program Manager, Child Welfare Services
Karen Studen	Director, Child Welfare Services
Karen Beye	Managing Director, Child Welfare Services
Other Participants	
Oneida Little	Children and Families Specialist, DHHS, Administration for Children and Families
Joyce Jennings	Colorado Children's Trust Fund
Claudia Zundel	Director, Colorado Family Centers Initiative
Brian Benz	CO Office of Resource and Referral Agencies
Sandy Plummer	Crawford Family Resource Center
Nancy McDaniel	American Humane Association
Amy Winterfeld	Children's Division
Angelina De La Torre	Metropolitan State College
Darlene Sampson	Project Manager, Home Visitation 2000
Carmen Carrillo	Urban Children's Mental Health Coalition
Lucy Trujillo	Colorado Foundation for Families and Children
Cecilia Mascarenas	Denver Juvenile Court
Art Atwell	Division of Child Welfare
Gladys A. Johnson	Boulder County Department of Social Services
Doris Puga	Child Protection Administrator, Denver County Department of Social Services
Clyde Freeman	Administrative Support Services
Lauri Shera	Court Grant Administrator, Court Improvement Project
Beth Pfalmer	Director, Work and Family Resource Center
Joan Smith	Director, Family Resources Redrocks Community College
Melanie George-Hernandez	Director, Weld County Information and Referral Services
Donna Garnett	Center for Human Investment Policy

**Interview Participants
Florida State Level Site Visit**

NAME	TITLE/AGENCY
Florida Department of Health and Rehabilitation Services	
John Perry	Policy Supervisor
Linda Radigan	Assistant Secretary
Mike Haney	Chief, Family Preservation
Carol McNally	Admin., Family. Pres. and Support
Marcie Biddleman	State Community Facilitator
Atrica Warr	Alcohol and Drug Abuse Program
Mary Jane Rose	Child Welfare Coordinator
Sandy Erickson	Special Projects Manager
Susan Chase	Admin. MIS
Coleman Zuber	Project Manager, SACWIS
Vickie Goodman	Chief, Hotline
Trula Motta	Domestic Violence Coordinator
Margaret Taylor	Supervisor, Federal Funds/Quality Control
State Health Office	
Jim Bailey	State Health Office
Carol Graham	State Health Office
Terry Davis-Hoover	State Health Office
Trish Mann	State Health Office
Other	
Mary Bryant	Director, Early Intervention and School Readiness
Terri Eggers	Specialist, SED
Ted Granger	President, United Way of Florida
Mike Clark	Migrant Liaison, RCM Contract
Pat Nichols	Chief, Prevention and Intervention, Dept. of Juvenile Justice
Dr. Bob Roberts	Special Projects Coordinator, Training Plan
Audrey Fields-White	Training Specialist

NAME	TITLE/AGENCY
Stephanie Meineke	Executive Director, Parent Network/Prev. Comm
Rosa Morgan	Chief, Bureau of Community Assist, Dept. of Community Affairs

**Interview Participants
Georgia State Level Site Visit**

NAME	TITLE/AGENCY
Division of Family and Children's Services	
Sarah Brownlee	Acting Unit Chief
Anne Jewett	Adoption Unit
Jimmie Hill	FACETS (Management Information System)
Doris Walker	Manager, Foster Care
Linda Doster	Foster Care Consultant
Carol Campbell	Deputy Director
Sharon Bivens	Division Management
Virginia McCollum	Fiscal Analyst
Other Participants	
Toni Oliver	Executive Director, Roots
Elaine Graddy	Spalding County , DFCS
Frank Petrus	Associate Director, Child Welfare Institute
Juanita Blount-Clark	Family Connection Pew Initiative
Judy Bodner	Division of Public Health, First Steps
Lorraine Adams	President, Foster Parent Association of Georgia
Susan Phillips	Children's Trust Fund
Valerie Tuttle	Division of Mental Health
Karen Worthington	Project Director, Court Improvement
Barbara Essiet-Brown M.A.	Bibb County - DFCS
Cheryl Dresser	Department of Children and Youth Services
Pam Shapiro	Office of School Readiness
Oskar Rogg	CSI (Implementation of Plan)
Gloria Patterson	Kinship Care
David Helwig	Parent Aid Prevention of Unnecessary Placement (PUP) Homestead
Sharon Lyle	Work First

**Interview Participants
Missouri State Level Site Visit**

NAME	TITLE/AGENCY
Dee Campbell-Carter	Site Coordinator, Caring Communities
Guptal Mitchell	Caring Communities Specialist, Benton Elementary
John Fussner	Principal, Benton Elementary
Jeffrey R. Jones	Home School Coordinator, Benton Elementary
Kathy Martin	Chief Operating Officer, Caring Communities
Lynn Barnett	Special Assistant to Superintendents, Columbia School District
Vince Geremia	FPS Program Director, Division of Family Services, DSS
Marsha Shasserre	Community Enterprise Unit, Department of Social Services
Deborah Scott	Director of Caring Communities, Department of Elementary and Secondary Education
David Carson	Caring Communities Coordinator, Department of Health
Gary Stangler	Director, Department of Social Services
Jan Carter	Director of Caring Communities, Department of Mental Health
Connie Cahalan	Department of Mental Health
Ellen Leininger	Coordinator, Planning, Research and Evaluation, Department of Elementary and Secondary Education
Susan Zelman	Deputy Commissioner, Department of Elementary and Secondary Education
Robin Gierer	Community Enterprise Unit, Department of Social Services
Steven Renne	Deputy Director, Department of Social Services
Paul Rodgers	Director, Employment Security, Department of Labor Industrial Relations
Melinda Elmore	Division of MR-DD, Department of Mental Health
Jackie D. White	Deputy Director of Administration, Department of Mental Health
Sandra Moore	Director, Department of Labor and Industrial Relations
Marta Halter	County Director, Division of Family Services Boone County
Anna Stone	Division of Family Services, DSS
Carmen K. Schulze	Division of Family Services, DSS
Phyllis Rozansky	Executive Director, Family Investment Trust
Sandy Wilkie	Family Investment Trust
Phyllis Rozansky	Executive Director, Family Investment Trust
Khesha Duncan	Youth Mentoring Director, Job Center
Rosie Tippin	Principal, West Blvd. Elementary

**Interview Participants
Texas State Level Site Visit**

NAME	TITLE/AGENCY
Roger Friedman, Ph.D.	Facilitator, Contractor
Sue Marshall	Children's Trust Fund
Janie D. Fields	Executive Director, Children's Trust Fund
Sarah Winkler	Children's Trust Fund
Gerald B. Kaderli	Planning Associate, Client Self Support Services, DHS
Mary Jo MaGruder	Advocacy & Public Info Director, Disability Policy Consortium, Texas Planning Council for Developmental Disabilities
Homer Kern	Administrator, Program Assessment, DPRS
Pat Devin	Deputy Director, Protective Services for Families and Children, DPRS
Kathy Kramer	Director, Service Delivery Systems, Health and Human Service Commission
Linda Prentice	Children's Health Division, Texas Department of Health
Jennifer M. Cernoch, Ph.D.	Director, Texas Respite Resource Network, Santa Rosa Children's Hospital
Deborah Garza	Federal Programs Coordinator, Texas Juvenile Probation Commission
Judy Reeves	Texas Council on Family Violence
Judy Briscoe	Directory of Delinquency Prevention, Texas Youth Commission, Juvenile Corrections Agency
Cynthia Weisinger	IV-E Specialist, Texas Juvenile Probation Commission
Sandra Simon	CSS, DHS
Lesia Walker, MD, MPH	Children's Health Division, Texas Department of Health
Ray Worsham	Program Specialist, CSS, DHS
Nancy Winborn Emmert, MSSW	Program Specialist, Texas Youth Commission
Beverly Booker	Program Specialist, DPRS
Rita Powell	Texas Association of Licensed Services

**Interview Participants
Vermont State Level Site Visit**

NAME	TITLE	AGENCY
Cynthia Walcott	Policy and Practice Chief	Department of Social and Rehabilitative Services (SRS)
Lindy McGrath	Division Director	Agency of Human Services
Leane Garland Page	Operations Manager	Agency of Human Services
Sarah Gallagher	Consumer Involvement Coordinator	Agency of Human Services
Charles Biss	Director	Child, Adolescent and Family Unit
Linda North	District Director	Health Department
Brenda Bean	Coordinator	Program Development Child, Adolescent and Family Unit
John Taylor	Division Director	Office of Alcohol and Drug Abuse Programs
Lynda Murphy	Director	Training Unit
Sharon Moffatt	Division Director	Community Public Health Office of Field Operations
Richard Boltax	Program Specialist	Department of Education
Jerry Jeffords	District Director	Morrisville SRS
Brenda Daevst	Assistant Director	Training Unit
Scott Johnson	Louisville County Advisor	People in Partnership
Judy Sturtevant	Director	Vermont Federation of Families
Linda Clark	Intensive Family Based Services	Baird Center
Tom Hill	Director	Casey Family Services
Dave Connor	Coordinator	Lamoille Interagency Network for Kids, Lamoille Family Center

**Interview Participants
West Virginia State Level Site Visit**

NAME	TITLE
Office of Social Services Staff	
Michael O'Farrell	Children's Services Director
Shirlee Lively	Family Preservation/Independent Living Specialist and Program Contact Person with Cabinet
Deb Dodrill	Former Contract Specialist
Rosa McKinney	Foster Care Specialist
Kathie King	Child Protective Services Specialist
Pat Chase	Training Specialist
Other DHHR Staff	
Sue Sergi	Director of the Bureau for Children and Families and Chair of Steering Team
Beth Morrison	Assistant to the Director of the Bureau for Children and Families who Participated in Planning
Helen Snyder	Children's Mental Health Specialist and Designee for Supervisor on Steering Team
Scott Miller	Family Support Specialist who Participated in Planning
Donna Heuneman	Director of the Developmental Disabilities Planning Council and Steering Team Member
Pat Moss	Director of Maternal and Child Health and Former Steering Member
Other State Agency Staff	
Ginger Huffman	Department of Education Representative on Steering
Fred McDonald	Court Representative who Participated in Planning
Cabinet Staff	
Julie Pratt	Director of Cabinet and EX Officio Member of Steering Team
Barbara Merrill	Deputy Director and Director of West Virginia's Families First Project
Steve Heasley	Funding Specialist
Nawal Lutfiyya	Former Research and Evaluation Specialist, DHHR, Office of Maternal and Child Health

NAME	TITLE
Statewide Organizations	
Margie Hale	Director of West Virginia Kids Count Fund and Needs Assessment
Diane Reese	Co-Director of Coalition Against Domestic Violence and Steering Team Member
Michael Tierney	Chair of Children's Policy Institute who Participate in Planning Step-by-Step
Francie Roberta-Buchanan	Leader in Cabell-Wayne Family Resource Network
Pat Gracey	President of West Virginia Head Start Association and Steering Team Member
Sarah Ashley	Staff
Consumer Representatives	
Teri Toothman	Staff of Mountain State Parents CAN and Steering Team Member
Jack Petrock	Representative of Foster Parents Association and Steering Team Member
Gail Foley	Representative of Part H Early Intervention Council and Family Support Council and Steering Team Member
Josh Samples	Youth and Steering Team Member

**Interview Participants
Houston County (Dothan), Alabama**

NAME	TITLE	AGENCY
Family Services Center Board		
Linda O'Connell	Director, Family Services Center	FSC
Jack Sassor	Administrator	Wiregrass Rehabilitation Center
Gary Bennett	Administrator	Houston County. Health Dept.
Kaye Barbaree	Director	Juvenile Court Services
Mayor Alfred Saliba	Mayor of Dothan (& FSC Board President)	City of Dothan
Dr. Laurel Young	Director of Adult Services	Wallace State Community College
Glenn D. Franklin	Executive Director	Dothan Housing Authority
Rebekah Troutman	Project Director	Head Start Dothan City Schools
Marian Loftin	Director	University of AL Regional Office
State Department of Human Resources		
Sandy Arthur	FP/FS Coordinator	DHR
Clara Price	Program Manager, Conversion and Compliance	DHR
Becky Peaton	Program Manager	DHR
County Department of Human Resources, PA and JOBS		
Mary Paulk	Director	Houston Co. DHR
Regina Matthews	JOBS Case Manager	Houston Co. DHR
Rachel Bush	JOBS and Public Assistance Supervisor	Houston Co. DHR
Sherry Byrd	Financial Support Social Worker I	Houston Co. DHR
Cindy Byrd	Social Service Worker II	Houston Co. DHR
Karen Steelman	Financial Support Social Worker I	Houston Co. DHR
Rae Bryan	Service Social Worker I	Houston Co. DHR
Joan Helms	Senior Service Social Worker	Houston Co. DHR
Cynthia C. Ferguson	Service Supervisor	Houston Co. DHR

NAME	TITLE	AGENCY
Family Options		
Sandra L. Hatfield	Caseworker/Assistant Supervisor	Family Options
Michelle Moss	Administrative Assistant	Family Options
Cheryle Holloway	Caseworker	Family Options
Elinda Thomas	Caseworker	Family Options
Sandra Coleb	Caseworker	Family Options
Chuck Emmett	Supervisor	Family Options
Family Services Center		
William A. Block	Intake Social Worker	Family Services Center
Belinda Trice	Case Management Coordinator	Family Services Center
Starr Steward	Home Visit Coordinator	Family Services Center
Lori Gilley	Child Care Coordinator	Family Services Center
David Duke	Career Center Coordinator	Family Services Center
County Department of Human Resources, Foster Care/Treatment		
Stephanie L. Ford	Service Social Worker I	Houston Co. DHR
Barbara Phillips	Service Supervisor I	Houston Co. DHR
Ramonsy Smith	SSWII	Houston Co. DHR
Judy Watley	SSWI	Houston Co. DHR
Barbara Hornton	Service Supervisor I	Houston Co. DHR
Brian Ethredge	Service Social Worker I	Houston Co. DHR

**Interview Participants
Hale County, Alabama**

NAME	TITLE/AGENCY
Family Resource Center	
Dr. Richard Rhone	Executive Director, Family Resource Center
Suzanne Laurier	Project Director, Smart-Plus
Hannah Gantt	Family Support Specialist, Family Resource Center
Debra Eatman	Administrative Assistant, Family Resource Center
Eva Bryant	Job Developer, Family Resource Center
Department of Human Resources	
Sandy Arthur	Family Preservation and Support Coordinator, Chambers Co. DHR
Shirley Ward	Jobs CM, Hale DHR
Measkell Lee	Vista Volunteer, Hale DHR
Windi Stringfellow	Service/QA/RD, Hale DHR
Rose G. Shoduerich	Service Supervisor, Hale DHR
Gayle Hamilton	Jobs Supervisor, Hale DHR
Dan Gentry	Social Worker II, Hale DHR
Henrietta Davidson	Social Worker I, Tuscaloosa Co. DHR
Sharon Cantrell	Supervisor, Tuscaloosa Co. DHR
Che' D. Payne	Social Worker II, Tuscaloosa Co. DHR
Quentin A. Davis	Social Worker I, Tuscaloosa Co. DHR
Becky Peaton	Manager, State Office
Clara Price	Supervisor, State Office of Conversion and Compliance, State Office
Center Board of Directors	
Mary A. Jolley	Consultant
The Honorable William Ryan	District Judge, Hale Co.
Reverend Stephen Moore	GED Instructor, Family Resource Center
Clinton Brasfield	Educator, Family Resource Center
Teresa Costanzo	Director, Hale Co. DHR

NAME	TITLE/AGENCY
Other Participants	
Victor Score	Director, Secondary Education, Hale County Schools
Samuel Mockbee	Professor and Architect, Auburn University Rural Studio
Dan Butler	Superintendent, Hale County Schools

**Interview Participants
Phoenix (Sunnyslope Neighborhood), Arizona**

NAME	TITLE	AGENCY
Lincoln House Family Resource Center		
Lori Jordan	Director Outpatient Seviles	Arizona Youth Associates
Gail Loose	Program Manager	Tumbleweed
Rita Bresnahan	Project Director	Parents Anonomous
Heidi Baldwin	Director of Family Support Services	Southwest Human Development
Danny Ayala	Supervisor	Parks, Recreation and Library Dept.
Louis Vega, Jr.	Case Manager	Valley Big Brothers/Big Sisters
Todd A. Gold	Case Manager	Valley Big Brothers/Big Sisters
Lupe Zamora	Case Assistant	Lincoln House Family Resource Center
Cynthia Lopez	Family Support Specialist	Southwest Human Development
Margaret Hamill-Wilson	Program Coordinator	Parents Anonymous
Rafael Martinez	Case Worker	Lincoln House Family Resource Center
Lydia Lester	Counselor	Arizona Youth Associates
Sergio Gomez	Caseworker II	Step-up
B.J. Tatro	Lincoln House Evaluator	Consultant
Lincoln House, Planning Board		
Anna Arnold	Manager	DES
Janet Garcia	Executive Director	Tumbleweed
Jane Irvine	Consultant	
Cindy Miller	Executive Director	Northside Trng
Pam Clark	Principal	Sunnyslope School
Lydia Carbone	Coordinator	Lincoln House Family Resource Center
Sheila Gerry	Vice President	John C. Lincoln Hospital

NAME	TITLE	AGENCY
Ginger Ward	Executive Director	Southwest Human Development
Bill Peterson	Assistant Principal	Royal Palm Middle School-Washington School District
Amy Lieberman	Social Worker	Sunnyslope Elementary School
Central Phoenix CPS		
Mike Davidson	Unit Supervisor	CPS
Richard Johnson	APM	Central Phoenix

**Interview Participants
Winslow, Arizona**

NAME	TITLE/AGENCY
Winslow Family Resource Center Staff	
Brett Curry	Intake
Curlinda Singer	Intake
Rosalva Zimmerman	Parent Resource Coordinator
Karen Burchwell	First Steps Coordinator
Jennifer Alcott-Tapto	PA/Center Secretary
Deanna Webb	Program Director, Northern Arizona Parents Anonymous
Sandy Haggard	Coordinator
Winslow Family Resource Center Collaborative Agencies	
Lorraine Singer	Employment Specialist, Affiliation of Arizona Indian Center
David Daffern	Pastor, First Baptist Church
Tancy Coughlin	Case Manager, Northern Arizona Council of Government
Ron Harris	Principal, Northern Arizona Academy
Nancy C. Stehle	Programs Director, Community Counseling Centers
Bruce Packard	Program Director, Arizona Psychology Services
Linda Gerard	Program Director, Arizona Children's Home Association
Don McDaniel	City Administrator, City of Winslow
Fran McHugh	Executive Director, Public Housing
Winslow Coalition for Strong Families and MAT	
Julie Greer	BSW, Winslow Memorial Hospital
Linda Gerard	Program Director, Arizona Children Home Association
Margie Brakefield	JPO, Navajo Co. Juvenile Probation
Jim MacLean	Student Advisor, Winslow Jr. High
Jeanine Seger	MSW, Public Health Service
Winslow CPS	
C.J. Wischmann	Unit Supervisor
Aileene Vekez	Case Aide
Mary Lopez	Case Manager

NAME	TITLE/AGENCY
Loretta Montano	CPS Specialist II
Ruth E. Rhoads	CPS Specialist III
Arizona Department of Economic Security	
Lori White	Program Manager
Anna Arnold	Program Manager

**Interview Participants
Fresno County, California**

NAME	TITLE/AGENCY
Fresno County Department of Social Services	
Oscar L. Robinson	Systems Analyst
Gary W. Johnson	Systems and Procedures Analyst
Ernest Velasquez	Director
Jeffrey W. Stover	Senior Staff Analyst
Linda Orrante	Assistant Director, Social Work Services
Alan Peters	Associate Director, Administrative Services Division
Oscar Rebran	Systems Analyst
Harold Sohrweide	Systems Analyst
Janet Adams	Supervisor, Family Maintenance
Kit Baxter	SW Practitioner
Don Pierce	Principal Administrative Analyst
Lauri Moore	Program Manager
Linda Spalinger	SWS
Ruby Crowder	SW
Howard Himes	SWS
Terri Garcia	SW
Diane Juarez	SW
Maria Zarate	SWS
Fresno Coordinating Committee	
Honorable Gary Hoff	Presiding Judge, Juvenile Court, Superior Court
Dr. Larry Wilder	Assistant Superintendent, Fresno Cty. Office of Education
Charles S. Francis	Chief Executive Officer, Fresno Private Industry Council
Roger Palomino	Executive Director, Fresno Cty. Equal Opportunity Council
Susan Warner	Coordinator, County Administrative Office, Interagency Council for Children and Families
Terri Pierette	Principal on Special Assignment, Fresno Unified School District

NAME	TITLE/AGENCY
Mayfair School	
Al Sanchez	Principal, Mayfair School
Kathy Scott	Program Manager, Mayfair School, Mayfair Family Service Center
Dr. Jacqueline Smith	Executive Director, Comprehensive Youth Services
Jeff Mar	Project Director, East-West Community Services, Project SAFE
Domestic Violence Network of Huron	
Dalores Gaxiola	Director
Bertha Lopez	Case Manager
Tim Fahey	Consultant
Frances Anguis	Volunteer
Alice E. Escandor	Secretary

**Interview Participants
Los Angeles County, California**

NAME	TITLE	AGENCY
Department of Children and Families (DCF)		
Peter Digre	Director	
Bruce Rubenstein	Deputy Director	
Nancy Herrera	Division Director	
Rochele Coriffin	Program Coordinator	
Barbara Lane	Program Coordinator	
Eric Marts	Program Coordinator	
Alice Lodico	Program Coordinator	
Edwina Dorah	Analyst	
Armand Montiel	Contracts Manager	
Diane Berres	Senior Analyst, Administrative and Management Services	
Christina Khau	Supervisor, Administrative Claiming	
Other County Agencies		
Jacquie Lewis	Los Angeles Office of County Counsel	
Barbara Goul	Los Angeles Office of County Counsel	
Beverly Rush	Supervising Deputy Probation Officer, Family Perservation Program	
Mike McWatters	Principal Accountant, Office of Auditor Controller	
Other Collaborators		
Nancy Daly	Chair, Family Preservation and Support Policy Committee	
Vivian Weinstein	Family Preservation and Support Policy Committee	
Dr. Gloria Waldinger	School of Social Work, USC	
Maria Talavera	Consultant	
Delores Glaser	Community Volunteer	
Eva A. Garcia	Coordinator, Bienvenidos Family Services	
Niare Penrice	Assistant Coordinator, Bienvendios Family Services	
Rosalie C. Markovich	Executive Director, Boys and Girls Club of Pomona	

NAME	TITLE	AGENCY
Bill Ewing	Executive Director, Chief Development Program	
Dr. Sharon Watson	Executive Director, Children's Planning Council	
Jo Kaplan	Counselor, Children's Court	
Randy Pacheco	Judge, Children's Court	
Lula Meshack	Commissioner, Commissioner for Children's Services	
Anna M. Soto	Chairperson, Community life Commission, City Hall	
Linda Rodriguez	Program Manager, Compton Family Preservation	
Steve Stoltz	Executive Director, East Valley Boys and Girls Club	
Allen J. Kennett	Executive Director, Equiposie Services, inc.	
Cynthia Heard	Program Director, Long Beach Family Preservation Network	
Sandi Zaslow	Assistant Director, Five Acres	
Cynthia Rhodes	Family Perservation Coordinator, Five Acres	
Deloris Galley	Executive Director, Fountain of Youth	
Loretta Jones	Project Director, Healthy African American Families Project	
Lisa Nichols	Hyde Park Family Service Center	
Earl J. Vincent	Principal and Writer, LexiTech	
Ella Cootes	Deputy, Los Angeles School District	
Bernard Smith	Neighborhood Resource Center, USC	
Elizabeth Diaz	Neighborhood Resource Center, USC	
John Wesley Owley	Pomona Valley Youth Employment Services, Inc.	
Kim Nguyen	Assistant Director, Pomona Valley Youth Employment Services, Inc.	
Dorothy Komora	Pomona Neighborhood Center	
Alvin L. Askew	PREPARE Emergency Training Services	
Veronica Watts	Razzling Dazzling Creations	
Dr. Jacqueline McCroskey	Associate Professor, School of Social Work, USC	
Lillian Mobley	South Center Senior Citizen Center	
Mary B. Henry	South Center Senior Citizen Center	
Colleen Mooney	Director, South Bay Center for Counseling	
Susie Yellowhorse Jensen	JTPA Site Supervisor, Southern California Indian Center	

NAME	TITLE	AGENCY
Aurelia Eakins	T.H.E. Clinic	
Tressa Ferrier	The Children's Collective	
Anthony Campbell	Director, United Peace Officers Against Crime	
Margo Wainwright	Youth Intervention Program	
Bettye Brown	Director, Youth Intervention Project	
Yakiciwey Washington	Youth Intervention Project	
Kathy Rogers	Executive Director, YWCA West End	

**Interview Participants
Santa Clara County (San Jose), California**

NAME	TITLE/AGENCY
Department of Family and Children Services (DFCS), Social Services Administration (SSA)	
John Oppenheim	Director, DFCS, SSA
Zonia Sandoval Waldon	Division Director, DFCS, SSA
Jodie Harris	Coordinator, DFCS, SSA
Bill Aragon	Supervisor, DFCS, SSA
Ken Borelli	Court Services Program, Manager
Gil Villagram	Manager, Office of Community Development and Relations
Wil Carson	Program Specialist
Simone Duong	Social Worker
Joyce McEwen Crawford	Social Worker II
William Brennan	Family Preservation Resource Consultant
Family Resource Centers (FRC), DCFS, SSA	
Terri Robles-Bell	Community Support Liaison
Helen Lim	Social Work Supervisor, Asian Pacific Family Resource Center
Lorraine Gonzales Moore	Social Work Supervisor, Nuestra Casa Family Resource Center
Jim Ramoni	Social Work Supervisor, Ujirani Family Resource Center
Tuan Tram	Social Worker
Resources for Families and Communities (RFC)	
Jesus Orosco	Executive Director, RFC
Miguel A. Guerra-Ressy	Program Coordinator, RFC
Beatrice Navarro	Family Advocate, RFC
Yvette Simon-Byrd	Family Advocate, RFC
Carla M. Ruiz	Family Advocate, RFC
Tao Nguyen	Family Advocate, RFC
Monica Hoer Pin	Family Advocate, RFC
Delia Gomez	Family Advocate, RFC
Marilyn Thain	Treasurer, RFC

NAME	TITLE/AGENCY
Betty Siemer	Member, RFC Board of Directors and Executive Director, Second Start
Mike Gonzales	Member, RFC Board of Directors
Rosaleen Zlatunich	Member, FRC Board of Directors
Mary Peterson	Day Worker Program Grantee
Brenda Smith Ray	Cortland Esteem Program Grantee
Housing Authority of Santa Clara County	
Sandi Douglas	Community Services Coordinator

**Interview Participants
Five Points/Curtis Park Neighborhood
Denver, Colorado**

NAME	TITLE/AGENCY
Department of Human Services	
Charles Perez, Ed.D.	State Coordinator, Division of Child Welfare
Five Points/Curtis Park Community Collaborative	
Beniyah Biffle	Children of the Village
Judah Biffle	Tool Program
Jo Bunton Keele	Executive Director, Eulipians Youth Institute
Larry Curry	Team Member, Children and Family Preservation Services
Don Dohnau	Home of Neighborly Services
Rev. Dr. Barbara Franklin	Grandma's Hands
Tabitha Jephunneh	Family Care and Nurturing
Mary McNeil Jones	Community Council/Chairperson, Eulipions Youth Institute
Mary Miera	Family Advocate, Community Outreach Center
Constance Johnson Muhammand	Institute of Global Scholarship
Thabiti Ngozi	Family Advocate, Community Outreach Center
Isetta Crawford Rawls	Cultural Heritage Team, Kwanzaa Program
Ken Seeley	Executive Director, Colorado Foundation for Families and Children
Anna Totta	Catholic Charities
Olivia Williams	Community Outreach
Denver Department of Social Services (DDSS) Focus Group	
Pamela Freirson	CDH/CW
Donna Hamburg	FPP Coordinator, DDSS, Family and Children's Division
Clyde Freeman	CPS Resources Administrator, DDSS, Family and Children's Division
David Brown	CPS Intake Supervisor, DDSS, Family and Children's Division
Margaret Matzich	DDSS, Family and Children's Division
Jennie Quintana	Family Reunification, DDSS, Family and Children's Division
Rhonda C. Saavedra	DDSS, Family and Children's Division

NAME	TITLE/AGENCY
Jude Liquori	CPS Training Supervisor, DDSS, Family and Children's Division
Joan McIntosh	CPS Intake Services Administrator, DDSS, Family and Children's Division
Martin Frumpkin	DDSS, Family and Children's Division
Sharon Vesely	Secretary (to Clyde Freeman), Family and Children's Division
Anita Horner	DDSS, Family and Children's Division
Sheila Alimonos	DDSS, Family and Children's Division

**Interview Participants
San Luis Valley, Colorado**

NAME	TITLE	AGENCY
Saguache County Department of Social Services		
Connie Casteel	Director	Saguache Social Services
La Gente Project, San Luis Valley Advisory Council		
Steve Romero	Field Rep	Rocky Mountain SER
Delores Lucero	Parent Involvement Coordinator	Alamosa Head Start
Dawn R. Alellano	Field Rep.	Rocky Mt. SER
Victor M. Salazer	Coordinator	School to Work Alliance Prog.
Jennie Finley	Parent	
Ginger Garcio	Project Secretary	La Gente BOCS
Julie Geiser	Director	Alamosa County Nursing
Suzanne McGregor	Project Director	PITAN Group
Char Boutillette	Supervisor of Family Preservation Program	San Luis Valley Mental Health Center
Theresa Chavez	Director	Head Start-Costiella and Conejos Counties
Josephine Lopez	Family Advocate	La Gente Project SLV/BOCS
Dawn Simpson	Family Advocate	La Gente Project SLV/BOCS
Shirley Ortega	Adult Education Teacher	SLV Education Center

NAME	TITLE
La Gente Project, San Luis Valley, Board of Cooperative Services	
Betty Goulden	Coordinator/Director
Fred Smokoski	Interium Executive Director, San Luis Valley Board of Cooperative Services
Dawn Simpson	Family Advocate
Angie Salinas	Family Advocate
Josephine Lopez	Family Advocate
Jinger Garcia	Project Secretary
Other La Gente Collaborators	
Jeff Dilks	Pastor, First Baptist Church
Lonna Pelton Bloom	Valleywide Health Services
Costilla County Department of Social Services	
Jerry Gallegos	Director
Centennial School, Costillo County	
Bob Rael	Superintendent
Pam Herman	Principal
RioGrande Department of Social Services	
Stan Miskelley	Director
Gregg Yoshida	IM Tech III
Jerri Everett	Child Protection Caseworker III
Emilia M. Chavez	Social Service Supervisor
James Berg	Social Caseworker III
Conejos County Department of Social Services	
Albert Royal	Director

**Interview Participants
Broward County (Ft. Lauderdale), Florida**

NAME	TITLE	AGENCY
Broward County Executive Committee		
Teresa Herrero	Community Facilitator	HRS
David Ferguson, Ph.D.	Executive Committee	Child Abuse Prevention Task Force
Eileen Schwartz	Executive Committee	Office of Intergovernmental Affairs
Curtis Brown	Executive Committee	PTA Council
Loretta Duvall	Executive Committee	Human Services Quality Assurance
Nan Rich	Executive Committee, Chair	Children's Services Board
Mickey Segal, Ph.D.	Executive Committee	Nova Southeastern University
Charlene Swanson	Executive Committee	Family Support Training
Audrey Millsaps	Executive Committee	Health and Human Services Board, Children's Service Board
Mark Gross, Ph.D.	Executive Committee	Child Care Connection
Drew Family Resource Center, Collier City		
Claudia Wright	Volunteer	Collier City Neighborhood Council, Drew Family Resource Center
Estella Canty	Assistant Principal Drop-in Center Project Manager	Drew Family Resource Center
Bruce Roberts	Community Liaison	Drew Family Resource Center
Asuncion Khan	Social Worker	Drew Family Resource Center
Donna Armstrong	Social Worker/Parent Educator	Drew Family Resource Center
Walter Hunter	President	Collier City Neighborhood Council
Nina Hanson	Child Abuse Prevention Task Force	Broward Co. Schools teen Parent Program
Grantees		
Beverly Beguesse	Project Director	Parent Enrichment Center
Altamese Carter/ Germaine Baugh	Neighborhood Coordination in Franklin Park	Urban League

NAME	TITLE	AGENCY
Carol Smith	School Board	Social Work Dept.
Penny Eady	Foster Care Specialist	Human Services Program
Marianne Missi	Adoptions Specialist	Human Services Program
Felicia Del Valle	Project Manager	Lutheran Ministries Family Builders for Adolescents
HRS, Children and Family Services		
Jeerdean Vaughns	Program Operations Administrator	HRS
Linda Day	Foster Parent	HRS
Jocelyn Schuman	Sr. Foster Care Worker	HRS
Elke M. Kurt	Specialist Permanency Planning	HRS
John LaPallo	Program Administrator	HRS
Michele Fuhrman	Senior Counselor	HRS
Henrik Schroeder	CPS Investigator	HRS
Dawn Medzwiedzki	Counselor	HRS
Onzalo Haynes	Counselor	HRS
Winsome Smith	Counselor	HRS
Linda Gruskin	CYFC Supervisor	HRS
Diane Frazer	Administrator	HRS
Lynette Beal	Acting District Program Administrator	HRS

**Interview Participants
Pasco and Pinellas Counties (St. Petersburg), Florida**

NAME	TITLE/AGENCY
St. Petersburg Free Clinic	
Ann Doyle	Community Facilitator, Family Preservation and Support Services
Marcie Biddleman	Executive Director, St. Petersburg Free Clinic
Department of Children and Families	
Jim Hess	Program Administer, Family Safety and Preservation Program (D5), DCF
Lounell Britt	Operations Program Administrator, DCF
Maureen Helfrich	Operations Program Administrator, DCF
Sharon Johnson	Human Service Counselor, DCF
Darla Beach	Family Support Worker, DCF
Angela Smith	Human Services Counselor, Supervisor, DCF
Sheila Golden	P.S. Counselor, DCF
Steering Committee	
Browning Spence	Director, Community Initiatives, Juvenile Welfare Board
Rob Marlowe	Executive Director, Healthy Start - Pasco
Cathryn Rowdon	Director, First Call for Help - Pasco United Way
Khush Jagus	Project Manager, SEDNET
Jane Walker	Deputy Executive Director, St. Petersburg Free Clinic, Inc.
Mini-Grant Recipients	
Greg Gebler	Program Director, R'Club
Judy Patrick	Quality Assurance Director, R'Club
Debra Woodard	Director, Child's Park Neighborhood Family Center
Ronda Sparks	President, Sparks Consulting and Learning
Brandon Porter	Program Director, FCP
Family Continuity Program	
Yvette Leverett	Family Therapist, FCP
Joi Rockford	Outreach Counselor, FCP

NAME	TITLE/AGENCY
Jeff Richard	Vice President of Operations, FCP
Roxanne Fixsen	Director of Community Based Services, FCP
Renee Brott	Family Therapist, FCP
Brandon Porter	Program Director, FCP
David Scainge	Behavior Specialist, Richey Elementary
Shady Hills Community Center	
Kim Valerio	Elementary Reading Specialist
Alex Weinberger	Supervisor of Student Services, Pasco County School Board
Mike Asbell	Assistant Principal, Hudson High School, Adult Education
Rev. Tom Ash	Pastor, Shady Hills United Methodist Church
Elsie Logan	Director, Family Center
Ruth Ray	Secretary, Family Center
Craig Cocelti	Director, Great American Wagon Train, Inc.
Pat Mulieri	Pasco County Commissioner
Olive B. McLin Family Center	
James West	Coordinator

**Interview Participants
Atlanta Area, Georgia**

NAME	TITLE
Georgia Division of Family and Children Services	
Doris Walker	Chief, Foster Care
Cobb County Department of Family and Division of Family and Children Services	
Jane Jones	Deputy Director
Sue Terry	Social Service Program Director
Kay Anderson	Social Service Administrator, CPS
Paula Coleman	Social Services Supervisor
Sheronde Glover	Independent Living Program
Susan Marten	Social Services Supervisor
JoAnne Bone	Social Service Case Manager
Flynn Hamilton	Social Services Supervisor
Cobb/Douglas Community Services Board (Mothers Making a Change)	
Teresa Smith	Director of Adult Substance Abuse Services
Cheryl Halliburton	Case Manager Supervisor
Sharlyn Taylor	Residential Services Manager
Georgia State University School of Nursing (Project Healthy Grandparents)	
Beatrice Yorker	Associate Director, Project Healthy Grandparents
Cathy Campbell	Nursing Coordinator, Project Healthy Grandparents
Debbie Whitley	Assistant Director, Project Healthy Grandparents
Judy Perdue	Project Manager, Project Healthy Grandparents
Ortega Townsend	Social Worker, Project Healthy Grandparents
Merle Smith	Grantparent, Project Healthy Grandparents
Susan J. Kelley	Director, Project Healthy Grandparents
Lovell Lemons	Advisory Board Members, Project Healthy Grandparents
Kim Rasey White	Social Service Coordinator, Project Healthy Grandparents
Willie McElroy and grandson	Project Healthy Grandparents Participants
Cynthia McElroy	Project Healthy Grandparents

NAME	TITLE
The Bridge (Bridging for Success)	
Ann Starr	Executive Director
Samuel Canada	Chief Operating Officer
Becky Butler	Clinical Director
Cindy L. Willis	Aftercare Coordinator
Aljarion Willis	Aftercare Coordinator
Maria Thornell	Aftercare Coordinator
Jennifer Rogers	Regional Manager
Charlie Faye Glene	Foster Parent
Family Ties, Inc. (Homestead)	
Hugo Mullins	Director
Bibb County Department of Family and Children Services (Bibb County Granny House)	
Barbara Essiet-Brown, M.A.,	Casework Supervisor Senior
Earl Williams	Caseworker

**Interview Participants
Chatham County (Savannah), Georgia**

NAME	TITLE/AGENCY
Chatham County Department of Family and Children Services	
Fred D. Foster	Director
Mary Burdsal	Social Service Administration Supervisor
Brenda Pack	Grant Consultant
Debbie Bennett	Social Services Program Director
Legare Nadelman	Social Services Administrator
Denise M. Black	Social Services Case Manager
Jeff Baker	Social Services Case Manager
Linda Richardson	Social Services Case Manager
Amy Lutz	Social Services Case Manager
Angela Schroder	Child Welfare Supervisor
Kim Howard	Social Services Case Manager
Linda Anderson	Child Welfare Supervisor
Lutheran Ministries of Georgia (A + Parents)	
Laurie Cantrell	Chatham County- University of Georgia Extension Service
Beth Parr	Former A + Parenting Director
Coletta Balder	Director, Coastal Lutheran Ministries of Georgia
Leah Yates	A + Parents Coordinator, Lutheran Ministries of Georgia
Carolyn Thompson	A + Parents Helper, Lutheran Ministeries of Georgia
Barbara S. Myers	A + Parents, PCDS - Turning Point
Sadie W. Perkins	Child Care Specialist PCDS, A + Parent Facilitator, PCDS - Turning Point
Greenbriar Children's Center (Project Safe Place)	
Faye A. Johnson	Program Coordinator
Sherrene Sears	Coordinator
Bernita Williams	Director of Program
Yvette Johnson-Hayes	Executive Director

**Interview Participants
Jackson County (Kansas City), Missouri**

NAME	TITLE/AGENCY
Division of Family Services (Family preservation and family reunification services coordinators and contractors)	
Rebecca S. Thomas	Social Services Supervisor III
Denise Eichler	Social Services Supervisor I
Vince Geremia	CS Unit Manager
Beth Barker	Vice President, Clinical Services, The Children's Place
David Janssens	Associate Director
Division of Family Services (Family preservation and reunification services supervisor and specialists, including contractors)	
Lee Jennings	Social Services Supervisor I
Marion Ellis	Social Services Supervisor I
Paula Cherry	Family Preservation Services Specialist
Jackie Thomas	Family Preservation Services Specialist
Kerri Diehl	Family Preservation Services Specialist
Kisa Pierson White	Family Preservation Services Supervisor, The Children's Place
Mindy Mikesell	Family Preservation Services Specialist, The Children's Place
Kelly Schiltz	Family Preservation Services Specialist, The Children's Place
Michelle Graff	Family Preservation/Family Reunification Services Supervisor, Gillis Center
Mike Surprise	Family Preservation Supervisor, Gillis Center
Bea Bubenik	Family Reunion Specialist, Gillis Center
Shannon Gunter	Family Reunion Specialist, Gillis Center
Karen McCormick	Family Preservation Services Specialist, Gillis Center
Debbie Reed	Family Preservation Services Specialist, Gillis Center

NAME	TITLE/AGENCY
Division of Family Services (Child welfare supervisors)	
Traci Spellman	Social Service Supervisor I
Cheryl Treadwell	Social Service Supervisor I
Marion Ellis	Social Service Supervisor I
Agustin Torres	Social Service Supervisor I
Kim Rosa	Social Service Supervisor I
Pam Anderson	Social Service Supervisor II
Tammy Moore	Social Service Supervisor I
Linda Bowie	Social Service Supervisor III
Peggy Gilliland	Social Service Supervisor II
Division of Family Services (Child welfare workers)	
Mia Banks	Investigator
Pat Butcher	Social Services Worker - Alternative Care
Marni Freeman	Social Services Worker - Family-Centered Services
Karon Bishop	Social Services Worker - Alternative Care
Jami Stewart	Social Services Worker II - Alternative Care
Connie Odom Soper	Social Services Worker II- Family-Centered Services
Hope Peterson	Social Services Worker II
Shonda Johnson	Social Services Worker II - Family-Centered Services
Division of Family Services (Child welfare program managers)	
Thomasita Nosir	Director, CS
Connie Pyles	Training Technician II
Judy Swearinger	Program Manager - Downtown
Linda Bowie	Program Manager - Midtown
Rebecca S. Thomas	Program Manager - South
Ladonna Seegriller	Program Manager - SE
Rosalyn Wilson	Resource Development Coordinator
Kathy Preel	Program Manager - East
Laura Bregg	RN III
Judy Cerwick	Contracts

NAME	TITLE/AGENCY
Diane Kolhler	Children's Services Program Administrator
Virginia Parkinson	Program Manager - Uptown
LINC (Caring Communities)	
Tim Decker	Coordinator, Comprehensive Neighborhood Services
Candace Cheatham	Neighborhood Development Coordinator
Felicia Safir	Neighborhood Development Coordinator
Caring Communities (Ft. Osage and Independence school districts)	
Arthur Butler	Principal
Peggy Giokaris	School Social Worker
Sue Norlund	Social Worker
Larry Eicchner	Principal
Debra Gordon	Buckner Wingsapn Coordinator
Barbara Fields	Principal, Buckner
Gayla Hirst	Wingspan Coordinator
Carol Marcks	Assistant Superintendent
Lisa McDonald	Caring Communities Coordinator
Cindi Weikel	Caring Communities/Wingspan Secretary
Greg Wilson	Social Service Worker, Ft. Osage
Roger Myers	Principal
Brad Smith	Randall Site Coordinator
Jane Skinner	Assistant Principal, Site Coordinator, Sante Fe Trail Elementary
Rick Jackson	Head Start Transition Director
Lindy Griffith	Social Worker

NAME	TITLE/AGENCY
Caring Communities: (Kansas City School District principals and staff)	
James May	Site Coordinator
Janis Bankston	Student Services Coordinator, SS Chick Elementary School
Steven A. McClellan	Site Coordinator, Ladd Elementary School
Hester J. Ladd	Principal, Ladd Elementary School
D. Maxwell	James School
Jo Lynn Nemeth	Principal, McCoy School
Chita L. Gibbs	Principal, Bancroft
W. Bowie	Principal, Central
Darryl Bush	Site Coordinator, SS Chick Elementary School
Richard Crowder	Principal, Blenheim
Caring Communities: (KCMO schools' mental health support staff)	
Shelia Marshall	Social Worker, James School
Joyce Peeples	Families First Therapist, J.S. Chick School
Lisa Greene	Parent School Liaison, James School
James Franklin	LCSW, Don Bosco
Sean Akridge	LINC Site Coordinator, Woodland
Dalana Graham	School Nurse, Woodland Samuel Rodgers
Cordelia A. Davis	Adhoc Group Against Crime-Liaison, Woodland
Thomas Jeffers	Adhoc Group, Woodland
Marilyn McDonald	School Nurse, Bancroft
Douglas Walker	James Elementary
Nicola Kalfus	MSW Social Worker, Bancroft Elementary
Belinda Bynam	Case Manager, Boys and Girls Club
John B. Crawford	MSW Social Work, Heart of Family Services
Rudy Summerville	LMSW, Central High Children Mercy Hospital School
Natalie Hill	Site Coordinator, LINC

NAME	TITLE/AGENCY
LINC (Caring Communities: CNS Co-Chairs)	
Jim Caccamo	Executive Director, Partnership for Children
Richard Morris	Businessman
James Nunnelly	Jackson County Courthouse, Project COMBAT

**Interview Participants
St. Louis (City), Missouri**

NAME	TITLE/AGENCY
Linda Pryor	Family Preservation Specialist, Central Baptist Family Support
Rosemary Pates	Director Therapeutic Services, Annie Malone - CFSC
Alicia D. Buck	Family Reunion Specialist, Annie Malone - CFSC
Reginald Johnson	Substance Abuse Worker, Caring Communities
Cynthia D. Dardin	In-Home Therapist, Caring Communities
Khatib Waheed	Director/Caring Communities
Veronica Banks	Operations Manager, Caring Communities
Vickie Boyd	In-Home Therapist, Caring Communities
Sam Word	Student Assistant Coordinator, Caring Communities
Robbie Carothers	Family Preservation Specialist, Central Baptist Family Support
Vince Geremia	FPS Director, DFS, DSS
Marsha Shasserre	Community Enterprise Unit, Department of Social Services
Susan Shelton	CSS III, DFS
Jacqueline Smothers	SSW II, DFS
Theresa Munoz	School Based Social Worker, DFS
Bobbi Ciabattoni	Social Service Worker II, DFS
Allen Duckworth	SSS I, DFS/Prince Hall
Mary Healey	SSW II, DFS
Grace Givens	SSW I, DFS
Sheri Gee	SSW II, DFS
Grace Dortich	SSS I, DFS
Valerie Prince	SSW II, DFS
Dennis Gordan	SSW II, DFS
Gertrude M. Pate	SSS III, DFS
Barb Benson	Family Preservation Specialist, DFS
Allen Winbush	SSS I, DFS
Bianca Arrington	SSW II, DFS

NAME	TITLE/AGENCY
Charley Wright	SSW II, DFS
Joyce Davis	SSS III, DFS
Bob Heltibrand	SSS III, DFS
Bernice Etok	SSS I, DFS
William E. Jones	SSS I, DFS
Mary Schmitt	SSS III, DFS
Kathi Rathbone	SSS III, DFS
F. Richard Rohde	SSW II, DFS
Helen Riechmann	SSS III, DFS
Nina Brady	SSW II, DFS
Kay Miller	SSW II, DFS
Carol Bish	Assist. to Children's Serv. Director, DFS
Bonnie Washeck	Family Preservation Coordinator, DFS
Tena Thompson	Children's Services Director, DFS
Beverly Bates	FPS Director, Edgewood Children's Center
Simon Koski	FPS Supervisor, Edgewood Children Center
Mike L. Haefner	FPS Family First Supervisor, Edgewood Children's Center
Guss C. Baer	FPS Supervisor, Edgewood Children's Center
Relda Owens-Matthews	FPS, Family Resource Center
Phyllis L. Miller	FPS, Family Resource Center
Michael Ruberton	Family Reunion Supervisor, Family Resource Center
Carla Mueller	Family Preservation Program Manager, Family Resource Center
Valer Cat	FPS Supervisor, Family Resource Center
Beverly A. Sowell	Family Preservation Specialist, Family Resource Center
Bridgette Todd	Family Preservation Specialist, Family Resource Center
Marie Dily	Family Preservation Specialist, Edgewood Family Preservation
Herman Allen	Family Preservation Specialist, Edgewood Family Preservation
Jerry Reid	Family Reunion Specialist, Family Resource Center
Regina Williams	Clinical Supervisor, Families First, Caring Communities Program, Hopewell

NAME	TITLE/AGENCY
Tasha Little	Case Manager/Therapist, Caring Communities Program, Hopewell
Lori Smith	Behavior Therapist, Caring Communities Program, Hopewell
Lanette Madison	Family Preservation Specialist, Caring Communities Program, Hopewell
Suzanne Page	Family Preservation Specialist, Caring Communities Program, Hopewell
Angela Barrett	Family Preservation Specialist, Caring Communities Program, Hopewell
Vivian Whitley	Community Representative Pierre Laclede Elementary School
Elam King	Site Coordinator, Sigel Caring Communities Program
Gerald Arbini	Principal, Sigel Elementary Communities Education Center
Robert Ward	Principal, Walbridge Communities Education Center
Mahala Ransom	Site Coordinator, Walbridge Caring Communities

**Interview Participants
San Antonio Region, Texas**

NAME	TITLE/AGENCY
Great Start Community Advisory Board	
Rose Orsborn	Regional Director, Texas Department of Protective and Regulatory Services
Mayme B. Williams	Director, ACCD
Mary Flanagan	Director, Community Initiatives, United Way
Reg. H. C. Bender	Co-Chair, Success-by-Six
George Block	Tri-Chair, Success-by-Six
Olza Guerre	Executive Director, Child Abuse Prevention Services
Charles Mazuca	Administrative Assistant, City of San Antonio
Great Start Service Providers	
Anthony A. Scott, Ph.D.	Assistant Professor of Pediatrics (Project Evaluator), University of Texas Health Sciences Center
Cindi Garcia-Martinez	Program Director, Family Support Services, Child Abuse Prevention Services
Louis Amezcuita	Program Director, Services for Families, Youth and Children, Family Service Association
Tommie Lee	Program Coordinator, Family Services Association
Jon Meyer	Program Director, Baptist Children's Home Ministries
Rebecca C. Cervantes	Executive Director, Avance San Antonio, Inc.
Rihl A. Zad	Associate Director, Avance San Antonio, Inc.
Isaac A. Cordenis	Fatherhood Program Coordinator, Avance San Antonio, Inc.
Rita San Miguel	Coordinator Adult Education Services, Avance San Antonio, Inc.
Norma Cardenas	Coordinator, Parent Services, Avance San Antonio, Inc.
Manuel Garza	Employment Development, Education and Training Coordinator, Avance San Antonio, Inc.
Eva Wedholm	Coordinator of Early Childhood Education, Avance San Antonio, Inc.
Sharon Castillo Bonilla	Coordinator, Case Management Services, Avance San Antonio, Inc.
Great Start Frontline Staff	
Dorothy Hoskin	Family Services Worker, Family Service Association
Laura Alizadeh	Family Services Worker, Family Service Association

NAME	TITLE/AGENCY
B. Christina San Miguel	Family Services Worker, Avance San Antonio, Inc.
Liticia Benavides	Family Services Worker, Avance San Antonio, Inc.
Kimberly Secich	Family Services Worker, Child Abuse Prevention Services
Leslie McCrary	Family Services Worker, Baptist Children's Home Ministries
Angie Orredi	Family Services Worker, Baptist Children's Home Ministries
Texas Department of Protective and Regulatory Services	
Julie Leake	Family Preservation Supervisor
Linda Fisher	CPS Supervisor IV
Janie Kelsey	Supervisor II
Jackie Lerche	CPS Supervisor II
Debbie Romero-Lopez	CPS Supervisor IV
Jeanne Hackett	Supervisor II
Sue W. Cambre	Supervisor II
Luba Hansin-Jones	Program Director
Kami Small	CPS Supervisor
Sandy Hermes	CPS Supervisor IV Intensive Family Preservation/Reunification Worker
Louise Blalack	Family Preservation Worker, CPS Supervisor IV
Eddie Gentry	CPS Supervisor
Lynn Lambert	CPS Supervisor

**Interview Participants
Dallas/Fort Worth Region, Texas**

NAME	TITLE/AGENCY
Texas Department Protective and Regulatory Services (CPS Staff)	
Joellen Goff	Deputy Regional Director
Diane M. Keller	Program Director
Beverly Booker	Program Director
Carol Gardner	Program Director
Susan McKay	Program Director
Margie Wright	Lead Program Director
Dianne Bippert	CPSS IV
Holly Campidilli	CPSS III
Georgia Burleson	CPSS IV
Jan Price	CPSS IV
Pamela MacKay	CPSS III
Barbara L. Davis	CPSS IV
Deborah O'Bannon	CPSS IV
Lynne Roland	CPSS III
Brenda Luedke	CPSS IV
Katie Gerber	CPS Supervisor II
Floyd Brown	CPS Supervisor II
Pat Saunders	CPS Supervisor II
Joy Walton	CPS Supervisor II
Peggy Walker	CPS Supervisor II
Jacqueline Freeman	CPS Supervisor II
R. Casey Arilla	CPS Supervisor II
Judy Foster	CPS Supervisor II
Rebeca Bledsoe	CPS Supervisor II
Dawn Ford	CPSS IV
Lorraine Paul	Caseworker
Susan Connelly	CPSS III

NAME	TITLE/AGENCY
Kris Miller	CPSS IV
Kim Allred	CPS II
Anita Rager	CPSS IV
Debra Anderson	CPSS II
Darrell Johnson	CPSS III
Laura Ard	Supervisor
Mark McDonald	Supervisor
Gloria Fobbs	CPSS IV
Anita Penney	Supervisor
J. I. Piles	Supervisor
Sophia Czaykowski (for R. Blanchard)	Supervisor
Youth and Family Impact	
Truman Thomas	Executive Director
Ramonia Simpson	Case Manager Supervisor
Michael Parker	Center Manager
Cindy Lovelace	Evaluation Assistant
M. Paul Bertram	Case Manager
Shaundee Hastings	Case Manager
Charles LaShawn Sanders	Case Manager
Michael Williams	Case Manager
Curtis L. Crockett	Case Manager
Catholic Charities Staff	
Jillian Elliott	Community Resource Coordinator
Jimmie Farris	Case Aide
Dora Guevara	Case Aide
Hortencia Barraza	Case Aide
Maria Cardona	Case Aide
Youth and Family Impact Co-Located Services Staff	
Holly Manos	LMSW

NAME	TITLE/AGENCY
Kimberly Harrison	Director
Kerry Shelton	Tutor
Kimberly A. Washington	Tutor
Renee Seban	Family Life Educator
Terri Adams	LMSW

**Interview Participants
Lamoille Valley Region, Vermont**

NAME	TITLE	AGENCY
Social and Rehabilitative Services		
Gerald Jeffords	District Director	Social and Rehabilitative Services (SRS)
Harry Adamek	Social Services Supervisor	SRS
Linda Courchaine	Administrative Assistant	SRS
Anita Winette	Worker Assistant/ Clerical Support	SRS
Henriette Lockwood	Social Worker	SRS
Sherry Lulek	Social Worker	SRS
Kim Revoir	Social Worker	SRS
Karen Kennedy	Social Worker	SRS
Diane M. Le Clair	Social Worker	SRS
Leane Page Garland	Social Services Operations Manager	SRS
People in Partnership/ACCESS		
Barb Crowe	Clinical Coordinator	Children and Family Services Lamoille County Mental Health
Scott Johnson	Coordinator	People in Partnership
Linda Smith	Resource Manager Juvenile and Rehabilitative Services (JRS) Liaison with ACCESS	JRS
Nadell Fishman	Volunteer Program Coordinator	Clarina Howard Nichols Center
Shirley Hayden	Emergency Service Coordinator	Lamoille County Mental Health
David Connor	Co-Director	Lamoille County Mental Health
LINT		
Jean Cotroneo	Student Service Coordinator	LSSU
Ann Martin	Executive Director	Lamoille Family Center
Mini-Grant Recipients		
Rhonda Barr	Co-Director	Lamoille Family Center
Linda Cramer	Director	Stone Alliance Farm

NAME	TITLE	AGENCY
Carolyn Hunter Richter	School Counselor	Hardwick Elementary School
Casey Family Services		
Sara L. Kobylenski	Director, Vermont Div.	Casey Family Services
Judi Daly	Social Worker	Casey Family Services
Naomi Clemmons	Evaluator	University of Vermont

**Interview Participants
Cabell and Wayne Counties, West Virginia**

NAME	TITLE
Wayne County Department of Health and Human Resources	
Charlie Workman	Community Service Manager
Linda Watts	Child Welfare Supervisor
Debbie	Child Protective Services Worker
Tina	Child Protective Services Worker
Cabell County Department of Health and Human Resources	
Sharon Winkler-Serena	Community Service Manager
Information and Referral Service	
Francie Roberts-Buchanan	Director
Prestera Mental Health Center	
Robert Hansen	Director
Action Youth Care	
Bruce Decker	Director
Anessa Baxter	Family Service Specialist
Christina	Family Service Specialist
Healthy Families America (Team for West Virginia)	
Angie Whitley	Family Support Coordinator
Kim Wilds	Family Support Worker
Amy Lisner	Family Support Worker
West Virginia University	
Ann Baker	Extension Service
Starting Points	
Pauline Sturgill	Coordinator
Hunting Housing Authority	
Bill Dotson	Executive Director

NAME	TITLE
Cabell-Wayne Family Resource Network	
Ray Childers	Director
Debbie Harris	Coordinator
Southwestern Community Action Council	
Mary Jane Bevins	Director
Huntington City Council	
Betty Barrett	Council Member

**Interview Participants
Fayette County, West Virginia**

NAME	TITLE
Fayette County Department of Health and Human Resources	
Bob James	Community Service Manager
Dan Holstein	Child Protective Services On-going Supervisor
Kathryn Toler	Child Protective Services Investigative Supervisor
Dale Campbell	Child Protective Services Worker
Kathy Vicars	Child Protective Services Worker
Liisa Sebastian	Child Protective Services Worker
Other Organizations	
Sarah Ashley	Coordinator, Fayette Family Resource Center
Rosetta Maguire	Maternal Infant Health Outreach Worker (MIHOW), New River Health Association
Jean Evansmore	Coordinator, Starting Points