Dear fy:

PHILIP L. GRAHAM FUND

MARY M. BELLOR
President

October 17, 1996

Nicole Rabner
The White House
Washington, DC 20502

Dear Ms. Rabner,

Please convey my thanks to the First Lady for sending me the summary of her August meeting on adoption and the photograph. I'm delighted to have both. My thanks, as well, for having been included in the group. For a small, street-level foundation like this one, it's enormously helpful to hear what major national foundations are doing and thinking about critical issues. Although we rarely are in the vanguard, what we glean from the majors can inform and guide our grantmaking in the implementation phase of reform.

Reading through the meeting summary, I was struck by how much is being done or attempted. I had the same notion as I read through the advance comments of meeting participants. There seem to be plenty of models and ideas -- what is needed is the collective will to implement them. If the First Lady chooses adoption reform as her priority during the next four years, the possibilities for meaningful reform would increase several fold.

The hard part is deciding how she could best use her position for strongest gain. Three areas where strong leadership could make a difference are (1) public awareness, (2) legal and policy reform and (3) prevention, or family preservation.

Although anecdotal stories abound, nothing has happened to create a groundswell of public support for adoption or reform. Part of the problem is that children in foster care or awaiting permanent placement are largely invisible to the public eye.

The public needs to know more about the universe of children in temporary placements, the pain and damage they suffer and the years of uncertainty they undergo while waiting for a permanent home that all too often never materializes. In an earlier time when so many children without parents were placed in orphanages, the public had a very clear sense of who and where they were and why they needed adoptive homes. Today, children in temporary placement are essentially invisible. It may be that foster homes are better than orphanages, but orphanages did give the public a graphic picture of the plight of a child without a home. We need to do this again, through a continuing information, public education and publicity campaign.

My second priority would be reform at the state and local level through the courts and legislative bodies. If the public first is engaged through an information campaign, reform efforts should have a better chance of success. With respect to reform, I thought Nancy Daly's remarks and written comments were particularly relevant. Permanency as the first, not last, goal should be the objective, and the interests of the child should have at least equal status with the interests of the parent. (I would place the child's interest ahead of the parent's, since the child is truly defenseless.)

Finally, I would work very hard at prevention. We might consider establishing large group homes in vulnerable neighborhoods, where children could find temporary respite. I believe the group home model offers a more stable environment, is less disruptive for a child, and would lend urgency to the permanency process. It is too easy to let children languish for years in foster homes -- a neighborhood-based group home model could force earlier resolutions.

At the same time, we should establish comprehensive service centers in neighborhoods, where families in trouble can get immediate and sustained help, where neighbors can alert staff to problems, where communities can come together in common cause to protect and nurture children and wrap a protective net around families. Home-based services like Healthy Families America should be part of the mix. Much more needs to be done, as well, to encourage fathers to reclaim their rightful rewards and responsibilities as parents.

Of course, these suggestions all sound so simple and obvious, while the issues surrounding adoption reform and family preservation are anything but simple. It's good that we have a First Lady who is not put off by daunting challenges -- and surely she would have many, many allies in the cause of getting children into secure and loving homes. I would be proud to play any role in the crusade.

Sincerely,

Mary Ann Bellow

A PROGRAM OF THE
YOUNG LAWYERS DIVISION

AMERICAN BAR ASSOCIATION

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October 21, 1996

Proposals for 1997 Presidential Child Protection Initiatives

(1) Continuing Federal Support for Child Protection Court Improvement -- including Resource Center Support for States, and Conferences where Courts can Meet and Share Ideas -- as well as New Efforts to Encourage States to create *Unified Family Courts*

In addition to providing current small block grant funding to eligible states, there should be a new program of competitive discretionary grants to support innovative, carefully evaluated, projects. There is, in the child welfare field, a tremendous need for court improvement (e.g., case resolution delays, caseworkers waiting for hours in courtroom waiting areas, families having their cases constantly switching among judges, etc.), There are some real reform models, like the Cincinnati and Grand Rapids juvenile courts, and there is a receptiveness to and excitement within many court systems for these reforms. Yet, federal nurturance is needed -- as well as a continued spotlight on such reforms -- and it will take sustained effort to make the profound judicial system changes that are really needed.

There is also a critical need to enhance the stature and services that the nation's children and family courts possess. The White House ideally would build on Recommendation 2 of the just-issued report of the U.S. Commission on Child and Family Welfare (i.e., that courts have appropriate resources, high-quality judges, and well-trained court personnel).

(2) Enhancing Timely Adoptions for Abused, Neglected, and Abandoned Children

There is an urgent need for development of refined grounds for the termination of parental rights, for expanded use of alternatives to termination such as guardianship, and for encouraging use of a new "Cooperative Adoption" approach that will stimulate more voluntary relinquishments. As the recently enacted CAPTA reauthorization provisions on termination of parental rights (in P.L 104-235) demonstrate, there is cause to worry about hasty and ill-thought-out actions in the states. The federal government can and must support good technical assistance in this area.

(3) Advancing Professionalism in the Field of Child Welfare

The staff of the ABA Center on Children and the Law, as well as many others in the child welfare field, want to see government intervention to protect children made into a real profession -- meaning that caseworkers and others would have clearly defined knowledge and sets of skills, the need to be tested and prove competence, admission to the ranks of child protection professionals only after demonstrating highly refined skills, and adequate compensation. What can the federal government do about this? Steps to move in this direction include developing tough competency tests and curricula that emphasize forensic skills such as investigation, case plan preparation, progress reviews, case documentation, court preparation, and testimony. Using pilots for special curricula and testing (i.e., at first, funding a special "elite" credentialing process), the federal government could help begin an effort to build toward real national professionalization of social casework and competent legal practice, in child welfare.

(4) Better Organization of Delivery of Services to Avoid Common Delays due to Waiting Lists

There are three basic elements (or "pillars") of permanency planning: 1) Good goal-oriented and time-limited casework; 2) speedy and fair court proceedings; and 3) a good array of services that are delivered *without delay*. If there are major delays in service delivery, the best case planning and court proceedings will not guarantee timely permanent homes for children. What can the federal government do? It can focus on this problem in both training and technical assistance, and it can ask states to measure their own performance in the timely delivery of services.

(5) Experiments with the New Zealand Family Group Conference Approach and with Child Welfare System Mediation Programs, which include Thorough Social Science Evaluations

While New Zealand's new family-centered approach as an alternative to the traditional child protection litigation process is very promising, it is a radical new device that needs to be carefully tested and evaluated. There are also increasing numbers of projects in which conflicts between child protection agencies, parents, relatives, and prospective caretakers are formally mediated. Evaluations of all these efforts should emphasize outcome measurement (e.g., reincidence of abuse and neglect). That is critical, because we must be sure that family group conferences and child protection mediation programs do not endanger children.

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SANTA BARBARA • SANTA CRUZ

Child Welfare Research Center

Center for Social Services Research
School of Social Welfare
120 Haviland Hall # 7400
Berkeley, California 94720-7400
Tel: (510) 642-1899
Fax: (510) 642-1895

PROPOSED FEDERAL INITIATIVES TO IMPROVE CHILD WELFARE SERVICES

General Approach

Focus child welfare efforts on achieving legal permanence for abused and neglected children (i.e. safe reunification and adoption) and away from long-term foster care and guardianship.

Refocus child welfare services around child protection and promotion of child well-being by promoting the duration of in-home services and the quality of out-of-home care.

Promote discussion of the premise that helping children to achieve positive adult outcomes (especially, self-sufficiency) is a fundamental goals of child welfare services and should be considered in policy making, service design, and practice.

Training

Support the continued development of child welfare training by clarifying the federal intent that training funds provided by states and universities will be matched at the 75% rate--without cost allocation, restrictions to foster care or adoption, or other burdensome limitations.

Assist in the development of the training infrastructure for assisting TANF and child welfare staff to work together to assist children whose families cannot take advantage of TANF and are, therefore, at risk of unacceptable developmental harm.

Policy

Clarify that pursuit of reunification and early concurrent planning for adoption are not incompatible and that referral for adoption planning does not, in and of itself, indicate that reasonable efforts have not been made.

Provide assistance to states to maintain children in foster care until age 22 as long as they are pursuing higher education.

Provide federal financial participation on behalf of children who are adopted and may, nonetheless, need residential placements.

Find mechanisms to support adoption agencies in the recruitment of families and placement of children.

Develop new initiatives and resources related to IVB (Part I) that strengthen services to families who are reported for abuse and neglect but do not now receive services.

Research

Recreate the research and development infrastructure for child abuse and child welfare services at the Children's Bureau in order to build national capacity to conduct rigorous descriptive, developmental, and evaluative research.

Continue to expand collaboration with ASPE, SAMHSA, and NIH to fund basic research, program evaluation, and the development of research centers.

Support analysis of reentry of foster children who have gone home back into foster care and the possible developmental and fiscal effects of shortening the time frames for reunification.

Support longitudinal linking of welfare, child abuse, child welfare, juvenile justice, mental health, special education, and criminal justice data so we can better understand--among other things--the pathways from victimization to victimizer and better design social services to reduce crime.

Prepared by Richard P. Barth, October 21, 1996

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Responses to White House Questions to Consider

1. My area of *expertise* is child welfare services research which I conduct as the Principal Investigator of Berkeley's Child Welfare Research Center.

The *most troubling aspect* of the child welfare system that I observe is the confusion about the goals and priorities of the child welfare system. This results in children who could be protected not being protected and children who could achieve permanence not achieving permanence.

2. The *federal government role* should include the development of programmatic initiatives; the creation of accurate and timely information for decision and policy making; and the support of training, research, and services. The federal government can make the *largest contribution* by maintaining and expanding financial support for services. Resources for training to improve the quality of services and research to understand the impact of services (or lack of services) also need to be maintained or extended.

3. The *outcomes of the child welfare system* are shown in the diagram below. The outcomes are ordered by their importance. If higher level outcomes can be ensured, then lower level outcomes should also be pursued. Lower level outcomes should not be pursued at the expense of higher level outcomes. *Success* should be measured by consistent protection and timely achievement of permanence. Specifically, no young child who is not residing with relatives should remain in foster care for more than four years.

LEVEL I: Child Protection
LEVEL II: Legal Permanence (reunification whenever feasible or adoption)
LEVEL III: Lifetime Developmental Opportunities
LEVEL IV: Extended Family, Psychological, Cultural, Racial, and Community Continuity

4. My first action would be to develop a procedure for close monitoring of effects on child welfare services of welfare reform. At the same time, I would enlist a variety of mechanisms to inform the public about the constraints, challenges, and benefits of child welfare services for children.

5. Interesting solutions include: (1) concurrent reunification and adoption planning for children unlikely to go home; (2) restructuring of adoption services to enable and reward efficiency, (3) shared family care (placing whole families in foster care together), (4) intensive family reunification services, and (5) intensive interdisciplinary case management for infants at risk of abandonment.

Richard P. Barth, Ph.D. October 21, 1996

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

30-Aug-1996 01:09pm

TO: (See Below)

FROM: Lyndell Hogan
Domestic Policy Council

SUBJECT: Child Welfare Chat Sessions

Attached is a list of confirmed participants for the September child welfare discussion sessions.

The first session is scheduled for Thursday, September 19 from 1:30-3:30; the second is scheduled for Friday, September 20 from 1:00-3:00 p.m. Both sessions will take place in Carol Rasco's office on the 2nd Floor of the West Wing.

Please call me at 6-5567 is you have any questions.

Thanks.

Confirmed Participants, DPC Child Welfare Discussion Sessions

Thursday, September 19, 1:30 p.m.-3:30 p.m.

--Thomas Curran, M.S.W., J.D., staff attorney in the Child Advocacy Unit of the Defender Association of Philadelphia, 70 N. 17th St., Philadelphia, PA 19100 or 19103, 215-568-3190, 4-12-57

--Paul A. Mones, Attorney and Children's Advocate, 503-225-1054; 503-225-0102 (fax); Portland, Oregon, May 5, 1952

--Susan Notkin, Director of Program For Children, Edna McConnell Clark Foundation, 250 Park Ave., Suite 900, NY, NY 10177-0026, 212-551-9100, 212-986-4558 (fax), 9-2-56

--Desmond (Des) K. Runyan, M.D., DrPH, Professor of Social Medicine and Pediatrics, University of North Carolina, Department of Social Medicine, Wing D of the Medical School, Room 381, CB#7240, Chapel Hill, NC 27599-7240, 919-962-1136, 919-966-7499 (fax), 8-27-50

--Ricardo M. Urbina, U.S. District Court Judge and Children and Families Advocate, United States Court House for the District of Columbia, 333 Constitution Ave., NW, Chambers 4311, Washington,

D.C., 20001, 202-273-0576, 202-273-0328 (fax), 1-31-46

Friday, September 20, 1:00 p.m.-3:00 p.m.

--Jane Beveridge, Child Welfare Manager, Child Protection Unit, Colorado Department of Human Services, 1575 Sherman, 2nd Floor, Denver, CO 80203, 303-866-5951, 303-866-2214 (fax) Not yet confirmed

--Larry T. Douglas, Community Development Coordinator, National Indian Child Welfare Association, 3611 Southwest Hood St., Suite 201, Portland, OR, 97201, 503-222-4044; 503-222-4007 (fax); 6-25-42

--Denise Leong, Queen Lili 'Uokalani Children's Center, Honolulu, Hawaii, 808-847-7991; 808-841-6449 (fax)

--Mr. Adrian Rodriguez, M.S.W., Founder, Positive Alternatives For Youth, Bowman Middle School, 2501 Jupter Rd., Plano, TX 75074-4828, 214-519-8881, Ext. 4727, 214-519-8920 (fax)

--Linda K. Tauber, Children's Social Worker III, County of Los Angeles, Dep. of Social Services, Children's Services, Lancaster, CA 93534, 805-945-0942 (phone and fax)

Distribution:

TO: Carol H. Rasco
TO: Jeremy D. Benami
TO: Jennifer L. Klein
TO: Lester D. Cash

CC: Kenneth S. Apfel
CC: Nancy-Ann E. Min
CC: Jill Pizzuto
CC: Elizabeth E. Drye
CC: Dorothy K. Craft

To: Carol Rasco
Jeremy Ben-Ami
Jen Klein

From: Lyn Hogan

Date: August 7, 1996

Re: Briefing Memo for Child Welfare Discussion

In this discussion, we will be focusing on the financing and delivery of child welfare services. In particular, we hope to explore ways in which the financing structure of the child welfare system influences outcomes. We also hope to stimulate a spirited discussion on managed care for child welfare services.

For your information, I've attached an article from NASW news on managed care as well as a draft policy paper on the same topic. Also attached is a list of confirmed participants for the discussion and a copy of the questions I faxed to the participants.

If you have any questions, please call me.

Thanks.

M E M O R A N D U M

To: Child Welfare Discussion Participants

From: Lyn Hogan
Senior Policy Analyst
Domestic Policy Council

Date: August 7, 1996

Re: Questions To Consider for The White House
Child Welfare Discussion

As I said in the fax I sent earlier, we are delighted that you are able to join us on Thursday, August 7 from 1:30 p.m.-3:30 p.m. in Carol Rasco's office at the White House to discuss the child welfare system.

This meeting is an informal opportunity for Carol Rasco to discuss with you your views about the state of the child welfare system and your recommendations to improve the system.

We would like to keep the conversation open and creative. However, we have put together a list of questions for you to consider to help guide your thinking and drive the discussion.

1) In your opinion, what role should the federal government play in addressing the problems in the child welfare system? Should it be simply financial? Should it be financial and programmatic? To what extent should the federal government prescribe child welfare policy to the states? In what way can the federal government make the biggest contribution?

2) What is and/or should be the end product of the child welfare system? How do we measure success or failure?

3) Would you say that the various funding structures of the child welfare system create incentives for prolonged foster care placements over adoption or family reunification? Can you give us a concrete example to support your opinion?

4) Is there a way to structure the flow of dollars to drive permanency planning over prolonged foster care stays? If so, what would be the intended and unintended consequences of such an action?

5) Have you, or others in your state, considered managed care with capitated payments for foster care rather than daily maintenance payments?

Please arrive at the Northwest Corner Gate of The White House, closest to 17th Street, N.W. *Remember, you must bring a photo I.D. with your birthdate to be admitted to The White House.*

Confirmed Participants
Child Welfare Chat Session
August 8, 1996
1:30 p.m.-3:30 p.m.

Mr. Jess McDonald
Director
Illinois Department of
Children and Family Services
Springfield, IL
217-785-2509; 217-785-1052 fax

Ms. Clarice Walker
President
National Black Child Development Institute
202-387-1281; 202-234-1738 fax

Ms. Marjorie Smith
Commissioner
Dept of Medical Assistance
Atlanta, Georgia
404-656-4507; 404-651-6880 fax

Mr. Donald Schmid
Director, Children and Family Services
North Dakota Department of Human Services
Bismarck, ND
701-328-4811; 701-328-2359 fax

Laurie Rankin
Executive Vice President and Principal
Blatner Associates
Health and Human Services Consultants
Princeton, NJ
609-466-0200; 609-466-1010 fax

From the White House

Carol Hampton Rasco
Assistant to the President
for Domestic Policy

Lyn Hogan
Senior Policy Analyst
Domestic Policy Council

Jeremy Ben-Ami
Deputy Assistant to the President
for Domestic Policy

Chris Ellertson
Program Examiner
OMB

Jennifer Klein
Special Assistant to the President
for Domestic Policy
First Lady's Office/Domestic Policy Council

From the Department of Health and Human Services

Carol Williams
Associate Commissioner
Children's Bureau
Administration On Children, Youth and Families

DRAFT

MANAGED CARE AND CHILD WELFARE: ARE THEY COMPATIBLE?

Institute for Human Services Management

Over the next several years, the child welfare system will move toward managed care. This movement raises two questions: 1) Will managed child welfare subsume all of the flaws and weaknesses of managed care as it currently exists? and 2) Will managed care benefit the field of child welfare in any way? This paper examines the forces behind the movement toward managed care in child welfare, attempts to identify the unique elements of child welfare that must be considered in planning managed care, hypothesizes on how managed care can benefit child welfare, and raises important design issues for child welfare managed care. Part II of this paper examines operational issues in designing child welfare managed care.[1]

Why Managed Care in Child Welfare?

Does managed care make sense for child welfare? Unfortunately, most of those who have already answered this question affirmatively are legislators, county commissioners, governors' policy staff, and leadership of managed care companies. In the public sector, most current support is from those who know relatively little about child welfare, but are in positions to make it happen. There is an undeniable surge of support for managed care, which is offered as the "quick fix" solution to a range of public human service problems. Managed care is inevitably moving toward child welfare due to three factors:

- Managed care is becoming widespread for Medicaid clients;
- Managed care is perceived as the solution to "out of control" human service budgets; and
- Private child welfare providers are already developing managed care systems for other payers.

[1] Part II of this paper, entitled *Managed Care and Child Welfare: Issues in System Design* is due to be completed in January 1996.

Managed care is becoming widespread for Medicaid clients. Most states are developing medical care managed care systems for Medicaid clients; many states also include behavioral health care as well. Valid or not, managed care is generally perceived as successful in curtailing the rate of growth in Medicaid expenditures. In many states, managed care has been imposed on child welfare clients through other service systems, mostly medical care or behavioral health services.

Under managed care for both medical and behavioral health care, the child welfare worker's role is analogous to the worker's role in getting appropriate educational services for clients. That is, the worker is responsible for making sure the client gets what he/she needs, but has little power in the decision making process against a monolithic bureaucracy. No longer can the worker simply take the client to the appropriate provider and authorize treatment. The worker serves primarily as an advocate for services, rather than as the authorizing agent. Most would agree that advocating for services takes considerably more time and energy than authorizing services.

Under Medicaid managed care, one solution to the dilemma of control over service authorization is for the child welfare system itself to pay for the services, then no managed care gatekeeper approvals would be required. This alternative, however, requires that the child welfare system forgo Medicaid reimbursement on the services purchased. While the importance of this decision may change under a Medicaid block grant, it is a costly decision under an entitlement scenario.

Like it or not, where managed care under Medicaid is being implemented on a large scale basis, there is tremendous commitment to its success. Good news about its success will fill press releases, thus assuring continued and growing support. Child welfare is likely to be pulled onto the managed care bandwagon as legislators and governors ask: If managed care works in Medicaid, why can't it work in child welfare?

Managed care is perceived as the solution to "out of control" human service budgets. While managed care has become popular, if not mandatory, under Medicaid, it is becoming the "solution of choice" for all seemingly "out of control" human service budgets. Absent Medicaid, child welfare is now in the forefront of "out of control" budgets. After some gains in controlling the foster care population in the mid-80s (as a result of P.L. 96-272), the costs of out-of-home care for children and youth with special needs have soared. Often, the only other human service program with similar levels of expenditure growth is juvenile corrections. In corrections, however, there is still support for removing delinquents from the community, so less attention is paid, at least for the present, in cost control for juvenile corrections.[2]

[2] Eventually and inevitably, in states where youth are placed in private treatment facilities at high costs, the managed care movement will encompass juvenile corrections as well.

Private child welfare providers are developing managed care systems for other payers. While responsibility for children's mental health, child welfare and juvenile corrections is often located in separate state or local public agencies, the private agencies serving children, youth and families often serve all three groups of clients and are paid by all three systems. Many private child welfare providers have already begun planning for or implementing managed care through the mental health system. Since it makes sense for them to design a system of care that serves all clientele, many private providers are beginning to approach child welfare agencies with proposals for managed care. Through provider associations and professional organizations, information, technical assistance, and actual experience on how to undertake managed care is becoming increasingly available. There will be tremendous pressure from private providers over the next several years to privatize segments of the child welfare system.

How Does Child Welfare Differ from Other Systems that Have Implemented Managed Care?

Child welfare as a field differs from other fields that have implemented managed care. Because it is different, managed care models developed for child welfare will have to be different as well. In this section, differences in the child welfare field that are fundamental to how services are delivered will be discussed. These differences include:

- Services are involuntary;
- The goals of the system are child safety and permanency;
- The state's role as parent demands consideration of ethical issues; and
- The system has limited control over conditions and interventions.

Services are involuntary. The primary and most significant difference between child welfare and other systems that have implemented managed care is its involuntary nature. Clients do not usually come to the child welfare system looking for help, unlike the mental health and the medical care systems. In those systems, people looking for help want it badly enough to advocate on their own behalf: If they are sick, they go to the doctor, they take prescribed medicine; if they don't get well, they go back to the doctor. The patient's interest in his own well being motivates him to advocate on his own behalf. This is not the case with the typical child welfare client. *Clients do not usually come to the system looking for help, and once in the*

system, are often resistant, if not hostile, to the "help" that is offered. Furthermore, they are not given the opportunity to determine when they are "well," and no longer in need of system interventions. In fact, child welfare interventions may be imposed on unwilling families by the courts or police.

The goals of the system are child protection and permanency. Another significant difference between the child welfare system and other systems that have implemented managed care is the overriding goals of child protection and permanency, and how these goals affect the treatment process. Child welfare cases are opened because the system assesses a threat to the child's well being. The factors that contribute to this assessment include family, household and community considerations. The interventions needed to reduce the risk of harm to the child may be remarkably minor or incredibly complex. Unlike other systems, the goal of the intervention involves more than stabilization or improvement in the *child's* individual level of functioning. The child welfare system concerns itself with the entire family environment in which the child will grow and develop. The impact of this mandate is that the family is critical to the child's intervention. Furthermore, *the interventions provided to the parents* may be critical to, or may be the *only* intervention provided on behalf of the child. In some instances, the intervention provided to the child cannot be undertaken apart from the intervention provided to the parent. The child welfare worker will place value on leaving the child in the home for treatment (to assure parental involvement and "connectedness" with the child) versus removing the child to an alternative setting (even when that alternative may be an easier treatment setting for the child) if it is perceived that the parents' involvement would otherwise wane.

Conversely, the child may have to be removed from his home if the risk of harm to the child is deemed to be too high. Furthermore, the child may not return home until the risk factors within the family/ household are reduced. Under these circumstances, the child's primary needs may be interventions provided to the parents. Recalcitrant, hostile or uncooperative parents may prolong the intervention required for a seemingly simple problem.

When parents are not available to the child, the goal of the system is to find parents for the child, or find a suitable and permanent living arrangement, which will offer appropriate interventions, supervision and guidance until the child reaches adulthood. This responsibility is far broader than any role defined in other systems where managed care has been implemented. While both medical care and mental health may require involvement by parents or other family members in the treatment process, this involvement is usually adjunct to the intervention provided to the child.

The state's role as parent demands consideration of ethical issues. In both the medical and mental health public systems, professionals maintain the right to refuse an expensive treatment if the client is a poor candidate for success. Frail, ill, or aged clients may not be given (or prioritized for) organ transplants; resistant clients will not be given substance abuse treatment. Each system has procedures for assessing the client's likelihood of successful completion of treatment, thus allowing the system to undertake a cost/ benefit analysis of providing the treatment to that client: Is the client likely to get better as a result of the intervention, thus making the expenditure of scarce resources on that client worthwhile? If the answer is no, the intervention may be denied (or placed at such a low level of priority that it will never be provided). This procedure represents a peace-time version of the concept of "triage."[3] This concept is otherwise known as the rationing of scarce resources. This rationing process occurs within all human services, including medical care. Rationing can become controversial when it results in withholding treatment from clients in need.

The mental health system has always viewed itself as a voluntary service system, that is, clients must ask for services. Because of scarce resources, the mental health system has always been able to prioritize the provision of services.[4] Under managed mental health, clinical protocols are the guidelines used to determine who qualifies for the various types of services based on symptoms. These protocols may include criteria that are used to exclude clients in need as well. For example, a child's symptoms could meet all of the clinical criteria for acceptance into the service, but fail to meet "other related" mandatory criteria, which would result in his being rejected for that service. Examples of "other related" criteria include such conditions as:

- Family members or guardian will commit to necessary evaluations/ treatments as a condition of admission and continuing stay;
- At the time of admission, the discharge residence is known;

[3] Originally the concept of triage was intended to produce the greatest benefit from limited treatment facilities for war casualties, by giving treatment to those who were likely to survive because of it, but withholding treatment from those who were not likely to survive even with treatment, and those who would survive without it.

[4] While the mental health system has traditionally prioritized clients based on established criteria, their legal ability to do so changed for Medicaid-eligible children under the Omnibus Reconciliation Act of 1989 (OBRA'89). This law required that all services deemed necessary for Medicaid-eligible children must be provided. This eliminated the states' ability to refuse to serve clients or to place them on indefinite waiting lists for services. The requirements of OBRA'89 have not been fully recognized and implemented in all states. Where it has been implemented, some states have restricted services by narrowly defining medical necessity. The status of these requirements is uncertain under the proposed Medicaid block grants.

- The client is not amenable to treatment/ or doesn't accept the need for treatment; and
- The child's behavior would be too disruptive to the treatment milieu.

In the child welfare system, the state has custody of a large group of children. The concept of "custody" means that the state is acting as the parent on either a temporary or permanent basis. The system is swamped with adolescents whose emotional and behavioral problems are severe, and for whom the likelihood of successful "recovery," however defined, through costly residential treatment is either unknown or low. Part of the child's poor prognosis may be due to the unwillingness of family members to participate, the failure of the child to accept his need for treatment, the child's behavior, or the parents' refusal to care for the child after treatment. (Some of these problems are caused by the child's long term involvement in the child welfare system.) While the mental health system may refuse to treat these youth based on a set of mandatory conditions, *in the child welfare system, it would not be ethical to refuse treatment to a child because of doubt that the treatment would be effective.* The state as parent must seek and pay for treatment for a child in need, regardless of that child's potential for recovery. There can be no rationing of resources that excludes a child because he is "too sick," or doesn't have the family characteristics of children who benefit from treatment.

The system has limited control over conditions and interventions. Another major difference in the child welfare system is that treatment needs are rooted in societal problems, which often are not fixable by a single intervention, specialist or system. Child welfare problems are rooted in social problems (e.g., poverty, unemployment, poor education, adolescent pregnancy, neighborhood drugs and violence, etc.) where the conditions that result in symptoms cannot be eliminated, and appropriate interventions can be neither easily determined nor achieved. Nor is the solution to the problem always fixable within the expertise of the child welfare system itself. In medicine, for example, a problem may require a range of medical specialists to resolve; in mental health, a problem may require a range of mental health professionals. A child welfare problem, on the other hand, may require child welfare expertise, medical specialists, mental health specialists, and a range of other professionals, including educators and social service workers from housing experts to homemakers. The ability or willingness of the needed range of professionals to understand and treat their specialties within the context of a broader set of problems and child welfare goals is often limited, as each specialist prioritizes his own professional goals. Moreover, the child welfare worker often must deal with a juvenile judge whose assessment of the problems and needed interventions may be very different, and who may order specific interventions regardless of diagnostic evidence to the contrary presented by the worker.

How Could Managed Care Benefit Child Welfare?

The nature of the child welfare system complicates and changes how managed care must be conceptualized and designed to meet the needs of the client population. Child welfare managed care should not simply follow the path of managed care in medical or behavioral health care. Certainly the pressure will exist merely to adapt already existing managed care systems without concern for the unique elements of the child welfare system. This type of approach is not likely to serve the best interests of children and families or the child welfare system itself.
An understanding of the nuances of the child welfare system will be paramount to undertaking this design effort. Managed care companies hoping to expand from medical or behavioral health managed care into child welfare managed care will not be able to rely solely on their behavioral health experience in the development process.

The child welfare field requires an entirely new conceptualization of managed care, including a clear delineation of the goals to be achieved. While policy makers may regard managed care as a means to harness spiraling costs, managed care can have a different, more positive set of goals within the context of child welfare. *The design of managed care for child welfare should begin with identification of the weaknesses in the current system that may be addressable through managed care.* Key among these weaknesses are:

- The current system is one where major players (private providers) in the service delivery system do not have, and therefore will not take responsibility for how the system operates;
- The current system has fiscal incentives for providers to behave counter to the system's goals (i.e., incentives to keep kids in placement rather than return them home as quickly as possible);
- Child welfare diagnostic skills are weak, and there is little ability to empirically link symptoms, diagnoses, interventions and outcomes;
- Utilization data are fragmented or unavailable.

The current system is one where major players (private providers) in the service delivery system do not have, and therefore will not take responsibility for how the system operates. In most states, private child caring agencies provide a substantial portion of the care and services to families involved in the child welfare system. Most of these agencies are voluntary agencies that raise a portion of the funds used to provide care to public child welfare clients. These providers

are essential to the system. Yet in most states, the private sector is not viewed as a partner in the service delivery process, but as a resource only. In support of the current system, it must be recognized, as stated earlier, that there are so few players in the system over which the child welfare worker has any authority (e.g., the schools, the courts, medical and mental health professionals, etc.), that one can understand the reluctance a worker may feel in taking on a "partner." Nevertheless when tragedy occurs in the child welfare system, as it inevitably does, the public child welfare system stands alone, and is often charged with hiding behind confidentiality to cover incompetence. In fact, during several of the child welfare class action lawsuits that have been filed around the country, the private child caring agencies provided some of the most damning testimony against the public system. In many areas of the country, earned or unearned, there is little confidence in the public system. Partnering with the private sector in a reasonable way could serve to restore confidence by creating an oversight function in the public sector, thus sharing responsibility for the system's actions.

The current system has fiscal incentives for providers to behave counter to the system's goals (i.e., incentives to keep kids in placement rather than return them home as quickly as possible). Private residential child caring agencies are traditionally paid based on a per diem rate provided for each child in care, which often is lower than the provider's actual costs. The rate may be based on a particular level of supervision and treatment provided within a particular program; based on an average level of cost among programs with similar characteristics; based on the characteristics of a particular child requiring care, based on available funding, or based on historic patterns. Regardless of the basis of rate determination, there is often little incentive built into the rate structure to serve the most difficult children within a defined category. If a difficult child requires more care than the average child within that program, it will cost the provider more to serve that child. Furthermore, if a child is relatively easy to serve within a rate category, the provider has an incentive to keep the child in care -- the bed is filled, the costs are low relative to what they might be with a more difficult child. If the bed remains empty, there is no reimbursement. A reduction in the level of service provided to any child, because his level of functioning improves, will mean a reduction in the payment. All of these factors serve as incentives to keep children in care. Added to these perverse financial incentives, is the tendency for workers to focus on emergency situations, thus ignoring stable placements. The result is a system that is likely to have more children in out-of-home care than necessary.

Child welfare diagnostic skills are weak and there is little ability to empirically link symptoms, diagnoses, interventions and outcomes. In both the medical system and, to a lesser extent, mental health, there is at least general agreement regarding symptoms, diagnoses, treatment, and expected outcomes. In child welfare, the relationship between symptoms, diagnosis, interventions and outcomes is murky at best. The intervention needed to "cure" a child welfare problem is not

always clear. The system has developed a limited set of interventions that are offered to address most identified problems. Frequently these interventions are offered based on availability more than on demonstrated need.

The diagnostic process in child welfare has not been well developed. Development efforts to date have focused on risk assessment and family assessment/ problem identification. Some of the instruments developed require highly trained staff to exercise professional judgment in completing them. This can be problematic, when the neighborhoods and regions with the worst child welfare problems are more likely to be staffed with the least experienced and trained workers. Furthermore, staff are often not competent to diagnose some of the more serious emotional problems common within the child welfare system today.

Exacerbating, or perhaps underlying, the problem of diagnostic capability in child welfare is the lack of evaluative data linking symptoms, diagnoses, interventions and outcomes. Unlike medical care (and to some extent the mental health field), child welfare has very limited outcome data. *Part of the reason behind this dearth of outcome data is that there is no general consensus within the field regarding outcome indicators or measures.* There have been few long term studies of the effects of various interventions on family or child functioning or child safety. Regardless of the efforts that have been made to treat child abuse and understand what interventions lead to successful outcomes, clinical research and evaluation is extremely limited. In child welfare, *the relationship between symptoms, diagnoses, interventions and outcomes is measured anecdotally rather than empirically.* The result is a decision making process that relies on what interventions are available, since it is not always clear what is needed.

This problem is one of the biggest impediments to the image of child welfare. Child welfare professionals simply do not have systematic evidence that the services they provide do any good. Without this evidence, the system is susceptible to attack at every budget hearing and unanticipated family tragedy.

Utilization data are fragmented or unavailable. In the medical and mental health systems, utilization data, essential to developing capitated rates, is usually available and relatively accurate. This is due to the uniform and detailed billing requirements of the Medicaid program.[5] In child welfare, however, systems development is not uniform across states, and frequently fragmented

[5] This is also due to federal requirements for the development of Medicaid management information systems, and the availability of enhanced federal funding to pay for their development, which has been available in the Medicaid program for over a decade. Similar mandates for child welfare, along with enhanced federal funding, has only been made available in the last 2 years.

within a state. For example, often client tracking data is kept separately from service payment data. Furthermore, it is not unusual for contracts to be paid based on costs versus services provided to individual clients. Therefore, developing utilization patterns, trends, and costs based on per client units of service provided becomes a nearly impossible task. Without these data, it is often difficult for managers to identify how many clients were provided with what services, at what cost, and over what period of time. Child welfare is often viewed by legislators as a large black box into which millions of dollars flow, but from which only a very general picture of what happens to the money emerges.

Each of these areas can and must be addressed in child welfare if managed care is to be implemented. Addressing each of these four areas would well serve the field of child welfare regardless of the success of managed care in saving dollars. Each agency designing managed care should identify their goals for managed care as they begin the design process.

Can Managed Child Welfare Save Money?

State and local public child welfare administrators studying managed care currently are doing so primarily due to budgetary concerns. Their budgets have been cut, their budgets are about to be cut, they have been warned of upcoming cuts, or they are anticipating the effect of the recent political tide on their budgets. That is to say that the primary impetus toward managed care has been budgetary. Managed care has been touted as the way to get human service budgets under control. But other than those portions of child welfare services that have fallen under behavioral health managed care, or very limited pilot projects, there is no real evidence that managed care can save money in child welfare. Furthermore, it must be clear whether the concept of saving money means spending less than is currently spent or curtailing the growth in expenditures. Obviously the former is a more formidable goal.

There are three competing factors within the current system that will effect whether managed child welfare can save money. Each state (and county within county administered systems) will have to weigh their position relative to each factor in order to gauge its potential for savings. They are:

- Current utilization of high cost residential placements;
- Current level of underserving children and families; and

- Current provider payment levels.

Current utilization of high cost residential placements. The clearest mechanism in managed care that saves money is the reduction in high cost placements. Once there is fiscal incentive to reduce the level of care, children are moved home or to less costly placements. In jurisdictions where there are large numbers of children in high cost residential placements, money will be saved under managed care. In jurisdictions where significant effort has been made to reduce these placements already, there will be less savings.

Current level of underserving children and families. In many jurisdictions, large numbers of clients do not get the services needed because of funding limitations. Under managed care, service provision would be based on clinical protocols, without reliance on waiting lists to ration resources. To the extent these protocols define a level of service that has heretofore not been provided, costs will increase under managed care.

Current provider payment levels. If current provider payment levels are so low that the cost of care is substantially subsidized by the private sector, then there will be less potential for saving money under managed care.

Additionally, there are a number of specific managed care design decisions that will affect the ability of managed care to save money for a system. These will be discussed in Part II of this paper. Until all of these issues are resolved, there is no way to estimate the cost of managed care, let alone the potential for savings.

What Are the Most Significant Development Issues for Managed Child Welfare?

While there are many design and operational issues that must be addressed in order to implement managed care in child welfare, a few of these issues will require a major developmental effort because their current state is weak and undeveloped. They are:

- The development and role of practice protocols;
- Expectations and the definition of outcomes; and
- Control, capitation and financial risk.

The development and role of practice protocols. Clinical or practice protocols must be developed by child welfare experts in the public and private sectors within a state. The protocols are the key instrument that links symptoms, diagnoses, interventions and outcomes. They are the tool used to link the assessed problems (or diagnoses) with the interventions, to guide the length of time an intervention is to be provided, and to determine what outcomes are needed to reduce or terminate service provision. The protocols will be adjusted over time based on systematically measured outcomes.

Currently, there is no single tool that links symptoms, diagnoses, interventions and outcomes. The child welfare field typically uses tools to link symptoms to diagnoses, and to link diagnoses to general categories of service (e.g., level of risk determining in-home versus out-of-home care, level of symptoms determining service/ payment levels for out-of-home care, etc.). But there are very few tools in use that link an assessment of problems with specific interventions and expected outcomes. Child welfare workers rely on risk assessment tools to determine in-home versus out-of-home services, family assessments to determine level of needs within the family, level of care assessments and service and placement availability to determine interventions to be provided, and their own experience to determine expected outcomes. The length of time an intervention is provided is dependent on many factors (e.g., the worker's caseload, the intervention being provided, the court system, the cooperativeness of the client/ family, administrative case reviews, the experience and training of the worker, demands for services, etc.).

The reliance on worker discretion in determining the services provided based on the identified needs represents both the strength and weakness of the child welfare system. The level of experience and training of child welfare workers varies considerably. Highly skilled and experienced workers often are able to craft an individualized service plan specific to each client/ family. However, the child welfare system in many states and larger urban areas is plagued by high caseloads, poorly trained staff, and inexperienced staff due to high turnover rates. Under these circumstances, reliance on worker discretion in determining and overseeing the service plan should not be considered a system strength.

Managed care in child welfare would result in a standardized assessment and decision making process, a relatively standardized, but flexible range of interventions offered, a standardized set of conditions under which the interventions would be offered, clearly define and measurable expected outcomes of the interventions, and pre-determined time frames for achieving those outcomes. *In spite of the fact that this standardization would reduce worker discretion, if the tools used were well crafted and continuously updated, they could in fact improve the decision making process, and still represent an individualized service plan based on the needs of each particular family.* But a well crafted tool can only be developed with input from both the public

child welfare system and the private child care providers, each of whose point of view and experience is critical and necessary to the process.

The public child welfare agency that delegates the development of this tool to a private managed care company virtually ensures that the bottom line will be primary. Conversely, *the public agency that actively controls the development of this tool can protect the child welfare system, as well as the children and families served, from many of the expected and dreaded predilections of managed care -- under serving the client population.* This tool will be the key to the success of managed care with respect to the children and families served.

While standardization is required under managed care, child welfare practitioners must understand that protocols structure the decision making process, but still allow for justifiable exceptions. A justifiable exception would require a reasoned argument based on convincing evidence.

The structuring of the decision making process would allow for a more systematic and rigorous comparison of the relationship between symptoms, diagnoses, interventions and outcomes. This in turn, should result in a system that can benefit from experience, a trait lacking in the current system. Currently, it is only the individual workers who benefit from experience.

Expectations and the definition of outcomes. Managed care does not promise that it will cure all who enroll. It does not promise that those who enroll will be healthier. It is designed to provide financial incentives to practitioners to find and treat problems early, to provide quick and efficient services to enrollees, to insure that the client gets only those services clinically justifiable and only for as long as necessary, and still provide professionally competent care. It is a process of managing and allocating resources efficiently. It recognizes that some clients will not be cured, some will not improve, some may require long term expensive treatment, although most will not.

Doctors are not expected to prevent cancer; mental health practitioners are not expected to prevent mental illness. While both fields may know and understand many risk factors that may result in illness, they cannot force people to avoid those risk factors. The same is true in the child welfare field. Professionals know many risk factors associated with child abuse, but they cannot assure that all children will live in households without those risk factors.

Both the medical and mental health fields have generally reasonable expectations placed on them. Unfortunately, expectations of the child welfare system are higher: The system is expected to prevent child abuse, prevent the murder of children at the hands of their caretakers, heal all children who are abused, and find parents for all children without them. While these

expectations are outrageously unrealistic to those who understand the system, they are not unrealistic to the general public.

The process of defining outcome measures for the child welfare system should not begin with unrealistic expectations (i.e., a reduction in incidents of child abuse). Outcome measures should include those indicators over which the system has reasonable control. They should address the impact of the interventions directed by the system itself.

Within medical and mental health managed care, one of the primary outcome measures is client satisfaction. Managed care organizations are quite adept at measuring client satisfaction with sophisticated surveys geared toward the educational level of the client. Another set of outcomes measured include process measures such as the number of rings before the phone is answered, the time required to get an appointment, the time spent in the waiting room, etc. The quality of the service actually provided is measured through quality assurance procedures and adherence to professional credentialing.

In both the medical and mental health fields, there is a general assumption of professional competence by the actual practitioners. Managed care is merely an organizational overlay that changes incentives and procedures. Therefore, the measures used to evaluate managed care are procedural and perceptual in nature.

Child welfare is different in two ways. First, acknowledging some exceptions, there is not a general assumption of competence within the current system. In most areas, there is considerable suspicion and skepticism about the competence of the child welfare system. Second, managed care in child welfare is not just an organizational overlay. Managed care has built-in incentives that undermine the single most important purpose of the child welfare system -- to protect children -- by failing to remove children at risk or returning them home prematurely. For these reasons, while child welfare should not over-promise on outcome measures, the measures developed for managed care in child welfare must be more substantive and extensive than those used in the medical and mental health fields.

Control, Capitation and Financial Risk. Due to issues raised in earlier sections of this paper, the child welfare system is not a particularly good candidate for capitation. The first issue is that of limited control over the conditions and interventions. Assuming financial risk requires some degree of control, it has already been argued that control is more limited in child welfare than in other fields that have implemented managed care. One of the biggest problems in that regard is the role of the courts. While most judges agree with and respect the advice of the child welfare worker, many do not. In these instances, many make their own decisions regarding the treatment type or even individual facility, without regard to the recommendations of child welfare

professionals. This phenomenon means that the managed care provider would not have control over the treatment plan.

Another court related problem occurring in some areas is that the backlog is such that changes in custody status are not processed timely. This can result in children remaining at a level of care longer than is clinically necessary. Again this would represent an expenditure outside the control of a managed care provider. These court issues represent some of the most troublesome issues for child welfare managed care. Some believe that over time the issue will resolve itself on the assumption that, rightly or wrongly, judges will become more comfortable with the clinical expertise and competence of the managed care provider than they have been with the typical public sector worker.

The second problem child welfare faces in developing a capitated system is the lack of reliable utilization data. The lack of a single information system, the reliance on manual record keeping, changes in the way data are kept, etc. will all affect the ability to develop reliable historical utilization data, which will be needed to develop a reliable capitation rate.

The third problem is the lack of information regarding how the basic capitation rate should be adjusted given assumed, but relatively unknown levels of over-utilization of current services and under-serving of current clients. These unknowns translate into unpredictable financial risk for a managed care provider.

The fact is that there may be too many unknown or uncontrollable risk factors for a managed care provider to be willing to assume financial risk under capitation. In the initial stages of Medicaid managed care, providers were given "no risk" contracts. One could argue that there are significantly more unknowns and uncontrollables in child welfare than there were in Medicaid at that time. Capitation and financial risk issues must be considered very carefully in the initial planning for managed care. Compiling the necessary data and evaluating its completeness and reliability will affect the willingness of a provider to assume financial risk. Even with a level of financial risk assumed, there may have to be "stop-loss" protections offered to ameliorate some of the risk.[6]

[6] The technical issues related to financial risk protections and the types of capitation methods are discussed in Part II of this paper.

Conclusions

The development of child welfare managed care cannot simply be an extension of Medicaid or behavioral health managed care. The child welfare system has unique qualities that require a re-conceptualization and re-design of managed care to meet its needs and responsibilities. This effort will require the collective thinking of child welfare management and line staff in both the public and private sectors. The complexity of the issues will require more time and energy than most governors and legislators may be willing to allow. Therefore it is crucial that this planning begin immediately. Whether child welfare managed care will produce any savings is unknown, but any effort to significantly change the system for the purpose of cost savings should be accompanied by an effort to improve the system as well. If the only purpose of implementing managed care is to cut costs, there are easier ways for the system to accomplish that goal (though no cuts will be painless to the children and families served). Managed care is a significant enough system change that it should not be undertaken unless its underlying goals are overall improvement in the child welfare system.

This paper, still in draft form, was written by Tracey Feild. Part 2 of the paper, still incomplete, will address specific design and operational issues in managed care for child welfare. If you would like to receive a copy of the revised version of this paper, or a copy of Part 2, or make comments on this paper, please contact:

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States Turn to Managed Care as Dollars Dwindle

Child Welfare: Under New Management?

By SUSAN LANDERS *NASW NEWS*

WITH MANAGED CARE viewed by many as the lifeboat for the nation's health care structure, the child welare system is edging its way toward umping aboard.

"The child welfare system is seen as roken' and in need of fixing," reported he Institute for Human Services Manageent of Washington, D.C., recently. Child velfare operations in at least 21 states are nder c supervision because they ailed to take proper care of abused or neglected children, the institute said, and tates have launched reform initiatives imed at mitigating many of the problems.

Just as a number of states have turned o managed care to rescue floundering Medicaid systems, many are now seeking he same sort of solution for their child velfare w

According to Charlotte McCullough of he Child Welfare League of America, which has formed a Managed Care Institute to examine the issue: "Managed care s in your future — if it's not already in our face."

Forty-one of the 49 state child welfare ervices administrations surveyed by the eague said they are considering applying r are planning to apply managed care rinciples to the financing and delivery of heir child welfare services.

The league survey also pointed up vast ariations among those states, ranging rom different definitions of managed care o different target populations.

Although managed care's impact on hild welfare services remains to be seen, hanges it has wrought in Medicaid serice delivery can be examined (April 1995 ews).

The Child Welfare League found that mong survey respondents in states here foster children are enrolled in Medaid managed care plans, 37 percent reorted improved access to services, 7 percent said access was worse, 11 percent ought it hadn't changed and 44 percent aid they didn't know.

Of service quality, 22 percent of respon*ents said it was better*, 3 percent said it as worse, 15 percent said it was the ame and 50 percent didn't know.

Ohio is planning a state-wide child welre initiative that will depend heavily on anaged care. The state's child welfare rograms are county-run, and each ounty will have the option of joining the itiative or opting out, explains social orker Gayle Channing Tannenbaum, legative director for the Public Children's ervices A ciation in Ohio. State offi*ials were awaiting federal approval for* eir plan at the *News* deadline.

The 88 Ohio counties that would be le to participate in a managed care sysm vary greatly in size. One county's popation is 1.5 million; another's is 11,000.

Tannenbaum predicts that counties here caseloads have leveled off will parcipate in the managed care initiative, hile those where they are still climbing - primarily because of the continued revalence of crack cocaine use — won't ot to join in.

Dan Schneider, director of the chilen's services association, says he is exted about the new initiative. "If I were in county," he declares, "I would jump on *It's a superb opportunity to do some* reative stuff with some pretty rigidly catgorical money."

Ohio seized the opportunity to revamp child welfare delivery system in re to Social Security Act amendments Congress passed in 1994. The amendments established a new waiver program that allows states more flexibility in designing and operating their child welfare programs.

As many as 10 states will be granted waivers allowing them to sidestep some requirements established under Social Security Act titles IV-E (Foster Care and Adoption Assistance) and IV-B (Child Welfare Services).

However, the waivers carry some requirements of their own. They limit the states' initiatives to five years in duration and require them to be "cost neutral" and well evaluated, says Michael Ambrose of the U.S. Children's Bureau, which oversees the waiver process.

Fourteen states had submitted proposals for waivers as of mid-May, and several others had expressed interest in applying. The proposals suggested a range of novel approaches to child welfare service delivery, Ambrose said in March at a Child Welfare League conference in Washington, D.C.

Most of the proposals do not involve managed care. For example, Michigan proposed to increase its emphasis on family-preservation and family-support services and decrease reliance on out-of-home care by using Title IV-E funds to provide services.

Delaware's proposal has two components. The first would establish multidisciplinary teams of social workers and substance-abuse counselors to connect families with community resources. The second would provide assisted guardianships for children who are in long-term foster care and whose natural parents' rights cannot be terminated.

A number, however, do take a managed care approach.

The District of Columbia proposes using rate setting and caps to develop a community-based therapeutic model of services as an alternative to placing children in more restrictive institutional settings.

New York state plans to use capitated payments for child welfare services. Any resulting savings would be reinvested in preventive and aftercare services in a child's local community, according to the state.

Although New Jersey did not apply for a federal waiver, it too has a plan to turn state child welfare services over to a managed care firm. New Jersey would select a firm to manage contracts now held by the state with the 1,300 agencies that provide the services.

Ohio's waiver proposal, described by Ambrose as a "classic managed care proposal," has already passed some federal scrutiny and was viewed by many as being farther along the path toward approval than proposals of many of the other states.

Isaac Palmer, deputy director of Ohio's child care and family services, described his state's waiver proposal at the Child Welfare League conference.

Ohio is exploring changes, said Palmer, because of escalating numbers of children in foster care, a shortage of foster homes, overuse of high-cost services, children's too-lengthy stay in foster care and the uncertainty of federal funding.

States are taking a gamble that they will be able to provide needed services while staying within spending limits and be able to save dollars that can be used for "front-end services," he said.

Managed care "is not the wolf at the door or your faithful dog Rover, it is not Luke Skywalker or Darth Vader," Palmer said. "Managed care is what you make it."

Child protection agencies tend to be frightened of managed care because it seems to profit by denying services, is viewed as cold and impersonal and is believed to force good practice to take a back seat to "utilization review," he noted.

Agencies are juggling many balls at the same time, Palmer maintained. They must balance intake, removals, juvenile court, adoptions and rules. Often, the ball that gets dropped is placement of the child.

Managed care companies can save money in child placement by maintaining children in less-costly family foster homes, he contended. Cost rises according to type of placement. In Ohio, the cost of regular foster homes is estimated at $20 per day; that of residential homes, at $145.

All too often, said Palmer, costly care is used because only those facilities will agree to keep the child. And the child, once admitted, often remains.

If a provider knows that "the longer I keep a child, the more reimbursement I will get," Palmer stated, the provider will likely keep the child.

Ohio intends to put the incentive in the hands of the provider — which could be another county or a private company, he said. The provider would be given funds and would determine where the child should be placed. The result, according to Palmer: "The incentive for high-cost placement is eliminated."

Managed care companies could provide the support that foster families need, he asserted. Daily calls of support could be made, higher daily rates could be paid to foster parents, and the number of available foster care homes could be increased through effective marketing.

Managed care companies could "write a check to get a screen door fixed, or they could send someone to help if a foster parent is sick," Palmer explained.

Ohio counties could maintain control of services by including all requirements in a carefully drafted contract, he said. For example, kinship care could be wrapped into the contract.

The managed care contract must include all levels of care, he noted. "The provider will naturally move children toward the least-restrictive settings. This is good management and good care." And the provider must be allowed to determine when a child moves from more expensive to less-expensive levels of care.

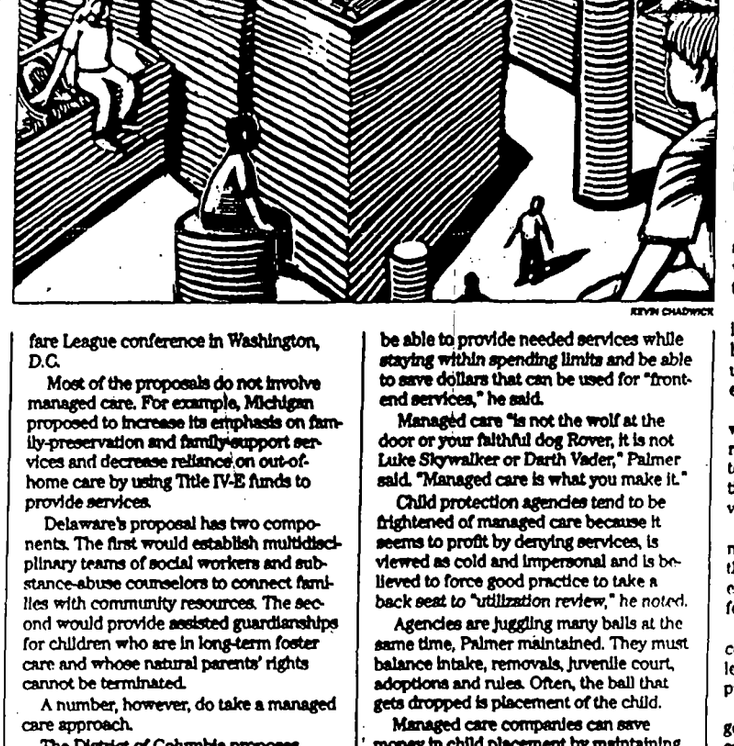
For managed care to work in child welfare, said Palmer, strides must be taken in accountability, standardized protocols, outcome measures and data gathering.

In response to such concerns, the Child Welfare League's National Advisory Committee on Managed Care has developed a set of principles to guide child welfare providers and managed care organizations in putting managed care approaches to child welfare services into action.

The league's overriding principle is "to ensure access to high-quality services that achieve permanency for children in the most cost-effective manner."

Also among the league's principles:

- A full array of services must be available that are geographically accessible, with enough provided in enough locations to meet identified needs.
- Rapid intakes, accurate and timely initial assessments, the use of standard best-practice protocols and continuous utilization management are essential to ensure appropriate levels of care.
- The focus must be on the family whenever possible, and services should reflect cultural sensitivity and competence. The child and family should be active participants in setting goals and developing case plans.
- Systems must be designed to ensure maximum staff continuity in managing the child's and family's treatment plan to ensure confidentiality consistent with professional standards.
- Performance and satisfaction outcome measures must be defined and collected to influence system design and improvement.
- Adequate protections against negligent treatment or inappropriate denial of care, including clear grievance and appeals procedures, must be enforced.
- Funds must be adequate to ensure support for the full array of services, including non-acute care, prevention and early intervention.
- Whenever possible, dollars should be spent with the goal of achieving long-term independence from the child welfare system and other publicly funded systems.
- Benefits should be balanced with costs. Expectations for cost containment should be understood by all concerned.



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He is a terrific guy and has a lot of good ideas. We should be in frequent touch with him.

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Agency: The White House

Telecopier #: (202) 456-7028

TELECOPY FROM:

Name: Peter Digre, Director

Agency: County of Los Angeles
Dept. of Children and Family Services

Phone #: (213) 351-5600

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PETER DIGRE
Director

August 1, 1996.

Jeremy Ben-Ami, Deputy Assistant to the President
for Domestic Policy
Domestic Policy Council
The White House
OEOB, Room 217
Washington, DC 20500

Dear Mr. Ben-Ami:

It was such a pleasure to meet you last Monday and have the opportunity to discuss areas of mutual interest in the field of child welfare. I hope that you will have the opportunity to accompany Carol Rasco during her visit in September and perhaps we would have more time to spend together.

I am attaching an assortment of information that I feel may be very useful to you.

Attachment I is a copy of my testimony of June 27, 1996 before the House Ways and Means Subcommittee on Human Resources entitled, *"Adoption Assistance and Child Welfare Act: Securing Child Safety and Promoting Legal Permanency"*.

Attachment II is a two-page fact sheet on how the Federal government can help get more children adopted.

Attachment III consists of four important pieces of California legislation for you review related to child safety, adoptions and successful transition into independent living.

Lastly, Attachment IV is a list of six individuals with considerable expertise in the field of adoptions that you may wish to contact.

Thank you again for visiting with us and I look forward to our future interactic n on issues of mutual concern.

Sincerely,

PETER DIGRE, DIRECTOR

PD:ca

Enclosures

FACT SHEET

In California, thirty percent of infants who come into non-kin foster care at birth are still in care four years later. Eighty percent of them have lived in more than one home during that time. Almost 40% have been in three or more homes. After six years, over 50% will have had three or more placements. Every one of these infants could, and should, have had a safe and permanent home and family. We are wasting children's lives through lack of direction and inaction.

The federal government can help these children by:

1. **Modifying the Reasonable Efforts Requirement of Title IV-E of the Social Security Act to Require Reasonable Efforts for Permanency.**

Federal Law requires states to make reasonable efforts to prevent or eliminate the need for removing a child from home. The law says nothing about ensuring that children who can't go home are adopted. Federal law should clearly establish *permanency* as the goal of the reasonable efforts requirement. Juvenile Courts should be responsible for monitoring progress in freeing children for adoption and locating families for them.

2. **Recognizing the Fact That Some Parents Cannot Reunify with Their Children.**

Some parents are not, and will never be, capable of caring for their children safely. Recent legislation in California recognizes the fact that it is *unreasonable* to make efforts to reunify children with parents who have severely abused them or their siblings, killed another child, had their parental rights terminated in the past, had extensive histories of untreated addiction, or had violent criminal histories. Unless these parents prove that they can, and will, change dramatically, their children should have the right to be adopted by families that will love and care for them. Federal law should not require reasonable efforts for these parents.

3. **Establishing a Clear Priority for Adoption Over Guardianship in Federal Law.**

Guardianship is simply not permanent. Guardianships end at age 18, do not cross state lines, and can be terminated at will or challenged by biological parents. Guardians cannot determine what happens to the child if the guardian

dies or becomes incompetent to care for the child. In California, eight percent of guardianships disrupt each year, while well under one percent of adoptions are set aside. Federal law must clearly recognize that, for a child who cannot return home, adoption is the only alternative that offers permanency.

4. Ensuring that Federal Law Favors Concurrent Planning and Relative Adoption.

Children's lives should be as stable as possible. Encouraging foster parents to adopt their foster children increases stability. Concurrent planning means that, instead of ignoring the fact that some children do not go home, we plan for this possibility as soon as a child enters the system, and look for a home that can be permanent. Federal law should encourage early planning for permanency, and clearly state that planning for permanency does not violate the reasonable efforts provisions of the law.

Relatives should also be encouraged to adopt. While kinship care is more stable than other forms of foster care, it is not a permanent solution. Children in kinship care live with the fear that their lives can be changed at any moment based on the decision of a judge or social worker or even an accident of fate. Adoption must be made more attractive to relatives so that children in kinship care have true legal stability.

5. Strengthening the Adoption Assistance Program.

Agencies often require foster families to make a financial sacrifice in order to adopt. The Adoption Subsidy Program should ensure that adoption is rewarded and neither child nor parent suffers a financial loss.

6. Target Family Preservation/Support on Post-Adoption Services

These OBRA 93 programs are well suited to provide non-disruptive post-adoption support to families who adopt special needs children. Availability of these programs is a vital issue for adoptive families. Adoptive parents also need help to deal with the special problems these children face. Existing funding programs like Family Preservation and Support should be targeted at providing services to families who have adopted these children.

7. Assisting States in Targeted Recruitment of Adoptive Families

Foster children need adoptive families who are willing to accept, work with, and love children with special needs. Unfortunately, these children are often invisible. White House leadership, in focusing attention on them, is a first step in a major recruitment effort. The Federal government, working with foundations, should also encourage demonstration projects and the sharing of information about recruitment techniques.

ATTACHMENT IV

LIST OF INDIVIDUALS WITH EXPERTISE IN ADOPTIONS

Judith Goodhand, Director
Cuyahoga County Children Services
3955 Euclid Avenue
Cleveland, OH 44115
Phone: (216) 431-4500
Fax: (216) 432-3379

Carole Shauffer, Executive Director
Youth Law Center
114 Sansome Street, Suite 950
San Francisco, CA 94104-3820
Phone: (415) 543-3379
Fax: (415) 956-9022

Greg Coler
Transactive Corporation
16627 Woodland Avenue
Austin, Texas 78741-2554
Phone: (512) 912-4010
Fax: (512) 912-4110

Joan M. Reeves, Commissioner
City of Philadelphia
Department of Human Services
1401 Arch Street, Room 312
Philadelphia, Pennsylvania 19102
Phone: (215) 686-6000
Fax: (215) 686-8605

Rev. Wayne Thompson, President
National One Church, One Child, Inc.
c/o First Baptist Institutional Church
3144 Third Avenue South
St. Petersburg, Florida 33712
Phone: (813) 323-7518
Fax: (813) 323-4790

Elizabeth Cole
Children's Services Consultant
286 Thompson Mill Rd.
New Hope, Pennsylvania 1893[illegible]
Phone: (215) 598-0414

E X E C U T I V E O F F I C E O F T H E P R E S I D E

30-Jul-1996 03:40pm

TO: Carol H. Rasco
TO: Jeremy D. Benami
TO: Jennifer L. Klein

FROM: Lyndell Hogan
Domestic Policy Council

SUBJECT: Confirmed participants for Chat 2

Confirmed Participants
Child Welfare Chat Session
August 8, 1996
1:30 p.m.-3:30 p.m.

Mr. Jess McDonald
Director
Department of Children Services
Springfield, IL
217-785-2509
217-785-1052 (fax)

Ms. Clarice Walker
President
National Black Child Development Institute
202-387-1281
202-234-1738 fax

Ms. Marge Smith
Director, Medicaid
Atlanta, Georgia
404-656-4479

Mr. Donald Schmid
Director, Children and Family Services
North Dakota Department of Human Services
Bismark, ND
701-328-4811
701-328-2359 fax

Laurie Rankin
Executive Vice President and Principal
Blatner Associates
Health and Human Services Consultants
Princeton, NJ

609-466-0200
609-466-1010 fax

62878

M E M O R A N D U M

To: Carol Rasco
Jeremy Ben-Ami

cc: Elizabeth Drye
Carol Williams, HHS

From: Lyn Hogan

Date: July 17, 1996

Re: July 18 Child Welfare Chat Session
Briefing Memo

Following is a list of those attending the child welfare chat session. Also attached is a one-page list of questions we sent to the participants. (Several participants called me asking for more structure, so Jeremy and I drafted the attached memo with questions and faxed it out.) Finally, the last attachment is a draft agenda. Please let me know if you'd like changes.

Thanks.

Confirmed Participants

Marylee Allen
Senior Program Advisor
Children's Defense Fund
Washington, DC
Expertise: Child Welfare Policy

Conna Craig
President and Founder
Institute For Children
Cambridge, MA
Expertise: Foster Care and Adoption, author of "What I Need Is A Mom: The Welfare State Denies Homes to Thousands of Foster Children," published in Policy Review.

Kathleen Feely
Associate Director
Casey Foundation
Baltimore, MD
Expertise: Child and Family Systems Reform

Mark Hardin
Director, Child Welfare
ABA Center On Children and the Law
Washington, DC
Expertise: Juvenile and Family Court Reform

Dr. Alfred Kahn
Professor Emeritus and Special Lecturer
Columbia University School of Social Work
Distinguished Visiting Professor
Fordham University Graduate School of Social Work
Co-Director
Cross-National Studies
New York, NY
Expertise: Family and Child Welfare, Child Welfare Systems, Social Service Planning, Income Maintenance

Jane Spinak
Attorney In Charge of
Juvenile Rights Division
Legal Aid Society
New York, NY
On leave from Columbia University School of Law where she teaches Family Law and runs a legal clinic for children and families
Expertise: Family Court, Family Law, Juvenile Justice

From the White House

Carol Hampton Rasco
Assistant to the President
for Domestic Policy

Jeremy Ben-Ami
Deputy Assistant to the President
for Domestic Policy

Lyn A. Hogan
Senior Policy Analyst

From Health and Human Services Staff

Carol Williams
Associate Commissioner
The Children's Bureau
Administration On Children, Youth and Families
Department of Health and Human Services

M E M O R A N D U M

To: Child Welfare Discussion Participants

From: Lyn Hogan
Senior Policy Analyst
Domestic Policy Council

Date: July 16, 1996

Re: Questions To Consider for The White House
Child Welfare Discussion

As I said in the fax I sent yesterday, we are delighted that you are able to join us on Thursday, July 18 from 3:00 p.m. to 5:00 p.m. in Carol Rasco's office at the White House to discuss the child welfare system.

This meeting is an informal opportunity for Carol Rasco to discuss with you your views about the state of the child welfare system and your recommendations to improve the system.

Several of you have called asking for more detail on the structure of the discussion. We want to keep the conversation open and creative so have tried to keep it unstructured. However, we have put together a list of questions for you to consider to help guide your thinking and drive the discussion.

1) What is your area of expertise and from your work, what have you found to be the most troubling aspect of the child welfare system?

2) In your opinion, what role should the federal government play in addressing the problems in the child welfare system? Should it be simply financial? Should it be financial and programmatic? To what extent should the federal government prescribe child welfare policy to the states? In what way can the federal government make the biggest contribution?

3) What is and/or should be the end product of the child welfare system? How do we measure success or failure?

4) If you were in charge of child welfare policy, what would be your first action?

5) What interesting solutions or approaches to the child welfare system problems have you come across in your work?

Please arrive at the Northwest Corner Gate of The White House, closest to 17th Street, N.W. *Remember, you must bring a photo I.D. with your birthdate to be admitted to The White House.*

Draft Agenda

Child Welfare Chat Session
Thursday, July 18, 1996
3:00 p.m.-5:00 p.m.
The White House

I. Welcome
Carol Rasco

II. Brief Self-Introductions

III. Discussion

(Carol--Here we can leave it open-ended; we can follow the questions above; or we can break the discussion into topic areas, e.g. legal system, foster care and adoption programs, etc. What's your preference?)

IV. Closing Remarks

Dear _____,

I am writing to invite you to join me in a meeting at the White House with foundation leaders to discuss how to improve our nation's adoption system.

As I hope you are aware, the President and I have for many years been vitally interested in improving the lives of America's children, especially those who become involved in the child welfare system. As First Lady, I have tried to highlight the tens of thousands of children who wait for adoptive families through my writings, public service announcements and a series of White House events and discussions.

I know we share a commitment to ensuring that each child grows up in a safe, loving family and that your foundation has shown leadership on moving our country toward that important goal. I think we can all benefit from sharing information on best programs and practices, obstacles to adoption and recommendations for solutions. Partnerships in the governmental, business and philanthropic communities are critical.

I hope you will be able to join me at the White House on Friday, August 2nd, at 10:00am. Nicole Rabner of my staff will contact you to determine your availability; please feel free to call her at 202/456-6266 with any questions.

Sincerely yours,

Hillary Rodham Clinton

July 11, 1996

Dear _____:

As I hope you are aware, the President and I have been vitally interested over a long period of time in improving the lives of America's children, especially those who become involved in the child welfare system. As a young attorney many of my cases concerned foster care, permanency placement and adoption issues.

I remain committed to ensuring each child grows up in a safe, loving family. Both the President and I have done public service announcements encouraging people to adopt children with special needs. Last November we hosted, along with the Dave Thomas Foundation for Adoption, a White House ceremony highlighting the importance of finding homes for waiting children. We were pleased to welcome several other foundations to that occasion, but I didn't have a chance to learn of all the efforts going on nationally in this important area.

As we continue to encourage partnerships in the governmental, business and philanthropic community it would be very helpful to get a clearer picture about the scope of the reform efforts in foster care, permanency and adoption.

I would like to invite you to the White House to participate in a half-day program to discuss current and future projects in the permanency planning area. I'm interested in your research about best programs and practices, perceived obstacles to adoption and recommended solutions. Your role as change agents in grass root and governmental reform has provided you with a wealth of experience and I would like to learn from you.

I would invite you to make a brief individual presentation on your foundation's work and share with my staff and your colleagues where you feel further emphasis and reform efforts should be applied. By coalescing our knowledge we can move forward together to improve opportunities for families for America's waiting children.

Nicole Rabner of my staff will contact you by _____ to determine your availability.

Sincerely,

David Hamburg
President
Carnegie Corporation of New York
437 Madison Avenue
New York, NY 10022
Main : (212) 371-3200
Fax : (212) 753-0395

Douglas W. Nelson
Executive Director
Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
Main : (410) 547-6600
Fax : (410) 547-6624

Michael A. Bailin
President
Edna McConnell Clark Foundation
250 Park Avenue, Room 900
New York, NY 10177-0026
Main : (212) 551-9100
Fax : (212) 986-4558

Julie L. Rogers
President
Eugene and Agnes E. Meyer Foundation
1400 16th Street, NW, Suite 360
Washington, DC 20036
Main : (202) 483-8294
Fax : (202) 328-6850

Kathy Whelpley
Acting Executive Director
Freddie Mac Foundation
Mailstop 259
8200 Jones Branch Drive
McLean, VA 22102
Main : (703) 903-2214
Fax : (703) 903-3585

David Begholg
President
George Gund Foundation
1845 Guildhall Building
45 Prospect Avenue West
Cleveland, OH 44115
Main : (216) 241-3114
Fax : (216) 241-6560

James C. McKay
President
George Preston Marshall Foundation
35 Wisconsin Circle, Suite 525
Chevy Chase, MD 20815
Main : (301) 654-7774

J. Gary Haller
President
German Protestant Orphan Asylum Association
5342 Saint Charles Avenue
New Orleans, LA 70115
Main : (504) 895-2361

Alan Hassenfeld
CEO
Hasbro Children's Foundation
32 West 23rd Street
New York, NY 10010
Main : (212) 645-4055
Fax : (212) 645-6815

William Richardson
President and CEO
W.K. Kellogg Foundation
One Michigan Avenue East
Battle Creek, MI 49017-4058
Main : (616) 968-1611
Direct: (616) 969-2153
Fax : (616) 969-2118

Calvin Cafritz
President
Morris and Gwendolyn Cafritz Foundation
1825 K Street, NW, 14th Floor
Washington, DC 20006
Main : (202) 223-3100
Fax : (202) 296-7567

Peter And Eileen Norton
Norton Family Foundation
225 Arizona Avenue
2nd Floor West
Santa Monica, CA 90401
Main : (310) 576-7700
Fax : (310) 576-7701

Colburn Wilburn
President
David and Lucile Packard Foundation
300 Second Street, Suite 200
Los Altos, CA 94022
Main : (415) 948-7658
Fax : (415) 948-5793

Mary M. Bellor
President
Philip L. Graham Fund
c/o The Washington Post Company
1150 Fifteenth Street, NW
Washington, DC 20071
Main : (202) 334-6640

Larry Kressley
Executive Director
Public Welfare Foundation
2600 Virginia Avenue, NW, Suite 505
Washington, DC 20037-1977
Main : (202) 965-1800
Fax : (202) 625-1348

Dave Thomas
Dave Thomas Foundation

? Edna McConell
Clark Foundation

Leonard Smith
Skillman Foundation
Detroit

Foundation for Child Development
Barbara Blum
N.Y.

M E M O R A N D U M

To: Carol Rasco
Jeremy Ben-Ami
Jennifer Klein
Nicole Rabner
Diana Fortuna

From: Lyn Hogan

Date: 7/11/96

Re: List of child welfare experts

As discussed in our meeting, attached is a rough and preliminary list of potential participants in the informal discussion sessions Carol, Jeremy and I are putting together on the child welfare system.

Everyone on the list is either someone I have worked with in the past or someone who comes highly recommended. If anyone has additional suggestions, questions, or comments, please pass them on to me. I'll continue to develop the list over the next month.

Chat List, confirmed for July 18

Marylee Allen
Senior Program Advisor
Children's Defense Fund
202-662-3573
DOB 8-14-44

Conna Craig
President and Founder
Institute For Children
Cambridge, MA
617-491-4614
DOB 1-21-1963

Kathleen Feely
Casey Foundation
410-547-6600
Good on dollars to states for reforms
DOB 4-28-50

Mark Hardin
Director, Child Welfare
ABA Center On Children and the Law
202-662-1740
DOB 9-13-45

Dr. Alfred Kahn
Professor
Columbia University School of Social Work
212-854-5449
212-854-4320(fax)
DOB 2-8-1919

Jane Spinak
Attorney In Charge of
Juvenile Rights Division
(40,000 children move through her division each year)
Legal Aid Society
On leave from Columbia University School of Law where she teaches
Family Law and has run a legal clinic for children and families
212-577-3300
DOB 6-11-52

Others To Invite

Marilyn Benoit
Devereux Children's Center of Washington
202-282-1200

Angela Blackwell
VP
The Rockefeller Foundation
212-869-8500
spoke with her, very interested but couldn't make it

Rick Barth
UC Berkley

Barbara Blum
Foundation For Child Development
talked with her, couldn't make July 18 discussion but would love to talk with us anytime

Sandra Chapungo
Associate Dean
Catholic University
School of Social Work

Terry Cross
Involved with the national child welfare system for Indians
Portland, OR

Sheryl Dicker
Permanent Judicial Commission on Justice For Children
914-422-4425

Peter (or Paul?) Digree
Child Welfare Administrator
Los Angeles, CA

Bernadette Dorn
or Bruce Blair
Clinic On Family Law
Northwestern Univeristy
Evanston, IL

Leornard Dustin
National Association of Black Social Workers
914-428-5590 (h)
313-862-6700 (w)
Detroit, MI
Call into him.

Judge Leonard Edwards
San Jose, CA
Has done a lot in child welfare: writing, work in the courts, was director of association of California judges

Gene Flango
or Pam Petrakis
W.K. Kellogg Foundation
Project, "Improving Courts Handling of Foster Care and Adoption Cases"
313-875-3400

Jim Giribino
University of Connecticut

Judge Ernestine S. Gray
Orleans Parish Juvenile Court
New Orleans, LA
504-565-7300

Gerome Hanley
Commissioner of Mental Health
South Carolina
(has done a lot of work on child welfare)

Sister Mary Paul Janchill
Director
Clinical Services
Center For Family Life in Sunset Park
Brooklyn, NY
718-788-3500

Gene Jouinoni
School of Social Work
UCLA

Shelia Kamerman
Columbia University School of Social Work
212-854-5449
Invited to first discussion, out of the country

David Liederman
Child Welfare League of America
DC

Marsha Lowry
Children's Rights Project
212-944-9800

Ruth Massinga
The Casey Family Program
Seattle, Washington

long-term foster care planning
206-282-7300

Barbara Matula
Director, Division of Medical Assistance
Department of Human Resources
North Carolina
919-733-2060
919-733-6608 fax

Judge Mitchell
Baltimore, MD
juvenile court judge

Susan Notkin
Edna McConell Clark Foundation
212-551-9100
expert on community-based child protection system

Bill Pierce
National Commission For Adoption
DC
215-625-0551

Michael Piraino
Chief Executive Officer
CASA
Seattle, WA
206-270-0072
Spoke with him earlier re: his work with CASA. Has been involved in child welfare reform via the foster care system for some time. Very knowledgeable. I didn't mention the discussion sessions to him, but should have him come in.

Robert Pratski
National Council for Juvenile Family Judges
Reno, Nevada

Lori L. Rankin
Executive Vice President
Blatner, Associates, Inc.
Health & Human Services Consultants
83 Princeton Ave., Suite 2C
Hopewell, NJ 08525
609-466-0200
609-466-1010 fax

Harold Richmond
Prof.
Chapin Hall Center For Children
University of Chicago
312-702-1234

Spoke with him, really wanted to come but his schedule wouldn't permit it. He comes highly recommended

Betsy Rosenbaum
APWA
202-682-0100
Spoke with her generally about child welfare reforms and the court system, did not mention the discussion sessions because I had already confirmed six people. Though she seems very good, we should invite to the next session.

Donald Schmid
Director
Children and Family Services Division
North Dakota Department of Human Services
Bismark, ND
701-328-2310

Ralph Smith
Casey Family Services
CT
203-929-3837

Shelly Smith
National Council of State Legislatures
Denver, CO
303-830-2200

Gary Stangler
Director
Missouri Dept. of Social Services
573-443-5477 (h)
573-751-4815 (w)
Call into him.

Ted Stein
Professor
SUNY School of Social Work
expert on law suits, good on system reform

Bob Swartz
Juvenile Law Center
Philadelphia, PA
215-625-0551
215-625-9589 (fax)

Clarice D. Walker
President
National Black Child Development Institute
DC

Michael Wald
Director
Child Welfare Agency
San Fran, CA
Former Professor
Stanford Univeristy Law School