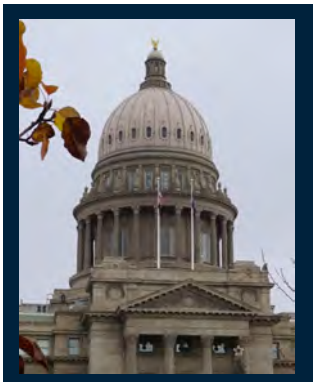
Evaluation report
March 2018

Child Welfare System: Reducing the Risk of Adverse Outcomes

Office of Performance Evaluations
Idaho Legislature

Promoting confidence and accountability in state government



Office of Performance Evaluations

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Joint Legislative Oversight Committee 2017–2018

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From the director

March 1, 2018

Joint Legislative Oversight Committee
Idaho Legislature

Our report offers a roadmap for the Legislature and all child welfare partners on how to reduce the risk of adverse outcomes for children and youth in Idaho's child welfare system. The underlying theme of the report is a need for more strategic collaboration among all partners as they implement our recommendations.

We believe the Legislature is in the best position to facilitate strategic collaboration by providing a venue for an ongoing discussion of complex policies, operations, and budget issues overlapping jurisdictional and disciplinary boundaries.

This collaboration is extremely important because its success directly affects our children. The words of a former foster youth we spoke with give us every reason to continually strive for an effective child welfare system:

> Other people are able to call their parents, but I can't because I don't have that person to call. I am completely alone. Some people actually have somewhere to go for Christmas.

We thank officials and staff of Health and Welfare, Juvenile Corrections, the Supreme Court, and counties for their assistance in conducting the evaluation. Our special thanks to current and former foster youth for sharing their thoughts and experience.

Sincerely,

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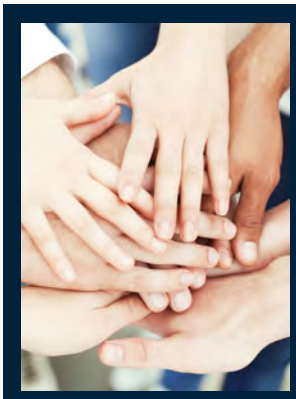
Formal responses from the Governor, the Department of Health and Welfare, the Department of Juvenile Corrections, and the Supreme Court are in the back of the report.



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Executive summary

Why we were asked to do this evaluation

In our 2017 report, *Child Welfare System*, we identified the importance of a systems approach to child welfare. Cooperation, coordination, and collaboration among stakeholders are critical for the child welfare system to function well. Our 2017 report focused on the experiences of youth in foster care. However, there are additional aspects of the child welfare system before and after foster care that require attention.

As a result of our report and the continued interest of the legislative Interim Foster Care Study Committee, we were asked to look at three additional aspects of the child welfare system: (1) keeping children safe and out of foster care when possible, (2) preventing youth from crossing between the child protection and juvenile justice systems, and (3) preparing youth who are exiting the child welfare system for transitioning to independent living as adults.

We approached this evaluation with a systems view to address the depth and complexity of each of these three separate but interrelated topics. We have arranged our findings and recommendations for each topic in separate chapters, but all of the chapters are interconnected.

What we found and next steps

We analyzed data routinely collected by stakeholders and found it was insufficient to fully address the requesters' questions. We used different analytical approaches specific to each topic to add new knowledge about the child welfare system.

To better understand the factors that affect the use of diversion services to keep children from being placed in foster care, we systematically analyzed files from 70 child welfare cases—a task no stakeholder in Idaho has undertaken.

To identify characteristics of dual system youth and the connections between the child protection and juvenile justice systems, we matched and analyzed data from the Department of Juvenile Corrections, the Department of Health and Welfare, and 30 Idaho counties. Although stakeholders have attempted to match system data before, they were not able to complete the process.

We conducted focus groups to hear firsthand from youth in foster care and youth who aged out of foster care. We think the youth voice is best suited to tell about the struggles of learning independent living skills and transitioning to adulthood.

We analyzed files from 70 child welfare cases.

Foster care diversion

The Department of Health and Welfare's Child and Family Services Division uses diversion actions to keep children from being unnecessarily placed in foster care. In diversion actions, children may stay at home or with a relative or family friend while safety threats are addressed. In our analysis of cases, we found a complex interaction of conditions that determine whether children are diverted from foster care and whether those diversion approaches were effective. The conditions fall under six broad areas:

- Attitudes and behaviors of children's caregivers as identified by social workers in case narratives and analyses of safety factors
- Severity and immediacy of reported safety threats
- Availability and willingness of extended family to provide housing, monitoring, or direct assistance to ensure safety

About one-fourth of all referrals that received safety actions diverted children from placement in foster care.

About 19% of diversions escalated to foster care placements.

Regional management and regional practices

Involvement and decisions of child protection partners, such as the courts and prosecutors

The relationship, role, or involvement of the party who reported the maltreatment

To address these findings, we made recommendations in three areas: data collection, consistency in application of the safety model, and the role of child protection partners.

Improve data collection and reporting capabilities

Child and Family Services should substantially expand and improve its data collection and reporting capabilities for diversion actions. Its data systems do not support the collection practices necessary for systematic analysis of the use and effectiveness of diversion actions. Improved collection and reporting capabilities will allow Child and Family Services to more efficiently analyze the data necessary for understanding the use and effectiveness of diversion actions.

Data systems do not support the collection practices necessary for systematic analysis of diversion actions.

Reduce inconsistency

Child and Family Services should develop a strategy or method for measuring and monitoring the effect of its efforts to improve the consistency of social workers' and supervisors' use, documentation, and implementation of diversion safety actions.

Child and Family Services should clarify its intended role for out-of-home diversion actions by establishing clear policies and standards for implementation. We found a lack of clarity and guidance on the use of diversion actions. Policies and standards should include criteria that clearly define when foster care is most appropriate, when in-home diversion actions are appropriate, and when out-of-home diversion actions are appropriate.

We found a lack of clarity and guidance on the use of diversion actions.

The Legislature should consider clarifying statute to express legislative intent about the acceptability and use of out-of-home diversion actions. Idaho statute allows for out-of-home diversion actions but provides no guidance as to the circumstances under which out-of-home diversion actions would be appropriate.

Strengthen the role of child protection partners

Child and Family Services should develop a plan for improving child protection partners' engagement and consistency in efforts to prevent children from being placed unnecessarily in foster care. Child protection partners are influential in efforts to keep children out of foster care when appropriate. None of the child protection partners, including Child and Family Services, can single-handedly prevent the need for foster care or improve the use and effectiveness of diversion actions.

Child and Family Services should make use of the established multidisciplinary teams where possible but should also include strategies for engaging partners individually when necessary.

The Legislature should consider explicitly stating, and if necessary, enhancing the roles that established multidisciplinary teams play in preventing children from being placed unnecessarily in foster care. Legislative direction may help Child and Family Services' efforts to strengthen the role of child protection partners.

Dual system youth

Data sharing is constrained by collection methods and the legal framework.

Youth who have contact with the child protection system and the juvenile justice system are known as dual system youth. Dual system youth are at greater risk for adverse outcomes as adults than youth who have contact with only one system. A state-level multiagency group and independent agencies have attempted to learn more about dual system youth in Idaho. Our analysis of juvenile justice and child protection data confirmed the challenges other stakeholders experienced when trying to identify and learn about dual system youth. Data sharing between agencies is constrained by differences in data collection methods and the legal framework.

In addition to limitations in data sharing, the multiagency group encountered obstacles when it attempted to convert dual system information into action. Members of the multiagency group participated voluntarily out of a shared interest and investment in youth and they operated without any administrative staff. The group ran into a roadblock when they could not secure funding to implement a multiagency framework pilot project in Bannock County.

Formalize a governance structure

We recommend formalizing a governance structure that builds upon the interagency and interjurisdictional leadership approach started by the multiagency group. A formalized governance structure will help agencies maintain the ongoing collaboration, organization of resources, and long-term attention needed to revise, develop, and implement policies and practices to better serve dual system youth.

Analyze and revise legal framework for data sharing

Agencies should jointly conduct a formal, in-depth analysis of the relevant laws and policies that define Idaho's current framework. Policies should facilitate sufficient, efficient, and consistent data sharing. A supportive legal and policy framework will be the foundation of successful collaboration and integration efforts for dual system youth.

Independent living

The youth-driven approach to independent living planning presents some challenges including poor youth awareness of services and benefits and a lack of motivation to participate in independent living, particularly after youth age out of foster care. Youth we spoke with expressed a desire to know more about services and benefits available to them. A gap in caseworker knowledge may contribute to poor youth awareness of services and benefits. The experiences youth described to us in focus groups also made clear the importance of a stable support network and the consequences of having a false sense of support.

Poor awareness of benefits and a lack of motivation to participate in the program are challenges to a youth-driven approach to independent living planning.

Strengthen training

Child and Family Services should address the gap in caseworker knowledge and youth awareness by strengthening training materials. Child and Family Services has indicated that it is in the process of revising the independent living training curriculum. Updated training materials should emphasize understanding of eligibility requirements, when it is important to communicate that information, and how to consistently deliver that information to youth and caregivers.

Clarify benefit policies

Child and Family Services should clarify benefit policies to address caseworker confusion. Caseworkers who responded to our questionnaire demonstrated confusion about eligibility requirements for education and training vouchers and room and board. Clearer written policies will improve caseworkers' ability to inform youth of the benefits they are eligible to receive.

Improve dissemination of information

Child and Family Services should improve independent living information delivery by creating comprehensive materials that can be easily accessible for caseworkers, caregivers, and youth. The independent living documentation given to youth is incomplete and inconsistently provided across the state. These materials should be available in printed form and on a dedicated web page. They should clearly explain benefit eligibility and services available to youth in each region.

Update resource guides

Child and Family Services should update resource guides and make them available to all independent living youth. Youth in our focus groups specifically noted that they need a guide with information about resources such as where to go to get a discounted hotel room, a free mattress, or health care.

Legislative role

As discussed in this report, each child protection partner has a role and responsibility to influence the outcomes for children and youth in Idaho's child welfare system. However, no single child protection partner can do it alone. The Legislature can improve collaboration among child protection partners, facilitate a systems approach, and ensure that responsibility for outcomes is shared by all partners by establishing a system-wide oversight entity, as recommended in our 2017 child welfare report.

Introduction

Legislative interest

Amid concerns about Idaho's child welfare system, an interim foster care committee was established during the 2016 legislative session to study several issues affecting children and youth placed in foster care. At the same time, the Joint Legislative Oversight Committee directed our office to evaluate the child protection and foster care systems. We conducted the evaluation and released our report *Child Welfare System* in February 2017.

The report identified the importance and interconnectedness of the many aspects and partners that compose the child welfare system. Similarly, the interim committee acknowledged the importance of a system-wide corrective approach for improving outcomes for children and youth placed in foster care.

The work completed by the 2016 interim committee, in addition to findings from our evaluation, sparked questions leading three legislators to request a continued and expanded evaluation of the child welfare system. The requests for evaluation are available in appendix A.

The requesters asked that we evaluate efforts and options to (1) keep children safe and out of foster care when possible, (2) prevent youth from crossing between the child protection and juvenile justice systems, and (3) prepare youth who are exiting the child welfare system for transitioning to independent living as adults. See appendix B for the evaluation scope.

Evaluation approach

Each of the three topics that requesters asked us to evaluate are separate and unique from one another. As a result, we approached each topic as its own distinct evaluation, each with separate and unique methodology. See appendix C for our methodology.

We have arranged our findings and recommendations into three chapters, one for each topic. The chapters each stand alone and are not intended to be read sequentially.

We approached the overall project from a systems perspective.

Although we treated each topic as a methodologically distinct unit, we approached the overall project from a systems perspective to address the depth and complexity of each of these three separate, but interrelated topics. Child protection is a complex arrangement of systems, agencies, community partners, and stakeholders that spans jurisdictions and disciplines.

An important theme that emerged from all three chapters is that none of the child protection partners, including Child and Family Services, can single-handedly prevent the need for children to be placed in foster care, prevent youth from encountering the juvenile justice system, or prepare youth for transition into adulthood and independence. Significant improvement in any of the areas requires cooperation and shared responsibility among all partners.

Foster care diversion

2

Federal and state law requires Child and Family Services to make reasonable efforts to keep children in their homes whenever possible and appropriate.

Study requesters were interested in information about the tools that Child and Family Services has available to keep children from being placed in foster care. They asked that we evaluate efforts and options to divert children and youth from placement in foster care.

We looked specifically at (1) the diversion actions used by Child and Family Services, (2) if those actions are used appropriately, and (3) if those diversion actions are successful at keeping children out of foster care.

Data systems do not support collection practices necessary for systematic analysis of diversion safety actions.

Child and Family Services can track and report basic aggregate information about the use of diversion safety actions. However, we found that its data systems prevent systematic and ongoing analysis of foster care diversion. For example, it is impossible to design a query that can identify cases in which imminent danger had been declared. As a result, Child and Family Services has had limited ability to systematically execute, monitor, and improve diversion safety actions.

Data system limitations also played a central role in our approach to evaluate Child and Family Services' efforts to avoid unnecessary placement of children in foster care.

We reviewed information and data from Child and Family Services about its efforts to prevent the need to place children in foster care. However, the information did not clearly define what portion of cases had diverted children from foster care through alternative approaches, which factors affect the use of alternative approaches, or how effective alternative approaches have been at diverting children from foster care.

In addition, we found no criteria or benchmark to determine whether the portion of diverted cases was appropriate. In other words, no one knows exactly how many cases are diverted, how often alternative approaches are being used, or how often they should be used.

To provide a more complete understanding of the use and effectiveness of diversion approaches, we analyzed a combination of administrative data and case records. We conducted a systematic analysis of 70 case files (60 diversion and 10 foster care) to identify factors that affected the frequency and effectiveness of diversion safety actions. We had to review files manually, a labor-intensive process.

No one knows exactly how many cases are diverted, how often alternative approaches are being used, or how often they should be used.

Our findings include results from a manual review and analysis of 70 case files.

Through our case review and data analysis, we were able to more completely estimate the portion of cases in which children were diverted from foster care in fiscal year 2016. We found a complex interaction of conditions that determine whether children were diverted from foster care and whether those diversion approaches were effective. The conditions fall under six broad areas:

- Attitudes and behaviors of children's caregivers as identified by social workers in case narratives and analyses of safety factors
- Severity and immediacy of reported safety threats
- Availability and willingness of extended family to provide housing, monitoring, or direct assistance to ensure safety
- Regional management and regional practices
- Involvement and decisions of child protection partners such as the courts and prosecutors
- The relationship, role, or involvement of the party who reported the maltreatment

A complex interaction of conditions determined whether diversion approaches were used and were effective.

In 2016, Child and Family Services received about 22,346 reports of maltreatment. Social workers determined that **39.8%** required further action.

About one-fourth of all safety actions diverted children from foster care.

When Child and Family Services receives a report of maltreatment, social workers in the central intake office evaluate the report and determine whether it meets the statutory definition of abuse, abandonment, or neglect and requires further action. In 2016, Child and Family Services received about 22,346 reports of maltreatment. Social workers determined that 8,884 (39.8 percent) of those reports required further action.

For reports that require further action, social workers in regional offices conduct assessments and make formal safety determinations based on 14 safety factors outlined in the Child and Family Services practice standards. Social workers evaluate the safety of children by applying criteria known as safety thresholds to the 14 safety factors. When a safety factor is below an established threshold, safety assessors consider the safety factor to be a safety threat and declare the child to be unsafe.

Children are considered safe when a threat of serious harm is not present or imminent or the protective capacities of the family are sufficient to protect the child.

Children are considered unsafe when a threat of serious harm is present or imminent and the protective capacities of the family are not sufficient to protect the child. Two types of danger meet this criteria: present danger and emerging danger.

> **Present danger:** A clearly observable behavior or a threat that is actively causing serious harm, is about to cause serious harm, or is likely to cause serious harm in the present time.
>
> **Emerging danger:** Safety threats that are highly likely to cause serious harm to a child if not immediately controlled.

If children are determined to be safe, no further safety action is necessary even if social workers suspect a risk of future maltreatment. However, if children are in present or emerging danger, they are unsafe and a strategy for ensuring their safety must be developed.

> **Safety plan:** A safety plan is a written agreement developed by the caseworker and family to control or manage present or emerging danger. Safety plans contain services and actions to address only safety threats and are not intended to change behavior over a longer period of time.

Safety factor: Formally defined family conditions or behaviors that can be assessed to determine the presence of serious harm to a child or a threat of serious harm that is imminent.

Child and Family Services' practice standards use 14 safety factors that are nationally recognized and accepted by child welfare programs as best practice.

Safety threshold: The point at which family conditions become a safety threat. The safety threshold is crossed when any one of five criteria are met:

1. Severity of maltreatment: Harm that can result in significant pain, serious injury, disablement, grave or debilitating physical health or physical conditions, acute or grievous suffering, terror, impairment, or death.

2. Immediacy of maltreatment (immediate to near future): A belief that threats to child safety are likely to become active without delay; a certainty about an occurrence within the immediate to near future that could have severe effects.

3. Out-of-control maltreatment: Family conditions which can affect a child and are unrestrained; unmanaged; without limits or monitoring; not subject to influence, manipulation or internal power; out of the family's control. No responsible adult in the home can prevent the emerging danger from happening, even if they want to do so.

4. Observable or describable maltreatment: Danger is real; can be seen or understood and can be reported; is evidenced in explicit, unambiguous ways.

5. A child vulnerable to maltreatment: A child is dependent on others for protection.

Safety threat: Risk factors that have crossed the safety threshold to become present or emerging danger. When safety threats are identified within a family, the children are living in a state of danger.

10.8%
of all cases that required a safety assessment received a safety action.

Of the 8,884 reports of maltreatment that required a safety assessment, about 962 (10.8 percent) received safety actions.

The type of safety action most familiar to the public is foster care. However, the need for a safety action does not necessarily mean that children must enter foster care. After social workers have determined that a safety action is necessary, they must determine the most appropriate type of action for the circumstances of the specific case. Throughout this chapter we refer to two basic categories of safety actions.

> **Foster care safety action:** A safety action in which children are removed from their home and placed in a licensed foster home. In all foster care safety actions, the court has placed children in the custody of the state.
>
> **Diversion safety action:** A safety action in which children reside at home or with relatives or family friends. The diversion action is based on either a voluntary agreement with parents or by a protective supervision order of the court.

25.5%
of cases that received a safety action diverted children from foster care.

In fiscal year 2016, children were placed in foster care in 74.5 percent of the 962 cases with safety actions. The remaining 25.5 percent of cases with safety actions diverted children from foster care.

19%
of all diversions were escalated to foster care either during or shortly after a diversion action.

Social workers are expected to continually review the progress of safety actions and make modifications when necessary. Diversion actions that are not working well can be escalated to foster care safety actions. We found 19 percent of all diversion safety actions were escalated to foster care safety actions either during or shortly after a diversion action.

Three caregiver behaviors or living conditions are responsible for most of the cases that required safety actions.

Our analysis showed that the majority of safety threats in cases with diversion safety actions were the result of three caregiver behaviors: caregiver substance abuse, hazardous home conditions, and physical abuse.

The terms we used to categorize caregiver behavior are not precisely defined industry terms and can leave readers with a wide range of interpretations. The following examples from our review offer a more consistent understanding of the behaviors in each classification. We have identified the primary contributing behavior in each example. However, in many of the examples, other behaviors such as substance abuse were also significant contributing factors.

Caregiver substance abuse (diversion case files)

"Mother of newborn tested positive for methamphetamines, amphetamines, and marijuana."

"At the time of delivery, mother tested positive for opiates and did not have a prescription. Baby exhibiting signs of withdrawal."

"Drug abuse issues impacting parents' ability to care for their children and meet the children's needs. Family required to leave housing program because drugs and paraphernalia present."

"Parents and child tested positive for methamphetamines. Child exposed to methamphetamines by parents using meth in the bedroom that they shared with the child."

Hazardous home conditions (diversion case files)

"The home was full of dog feces and garbage."

"The home had dirty dishes, dirty clothes, dirty diapers and the baby's room had feces on the wall and pillow with a smell of urine."

"Living room had piles of items and boxes, kitchen had numerous dishes that had not been washed, the counters were inaccessible as was the stove due to miscellaneous items and piles of unwashed dishes. Bedrooms were so cluttered that they could not be entered, posing a fire hazard. The dishwasher had exposed wiring causing concerns for electrical shock to the children."

"Cat feces and bird feces on the floor throughout the home and old food throughout the home and knives within reach of the very young child."

"Home was in disarray with dirty diapers, vomit, rotten food, and some fecal matter on the child seat and high chair."

Physical abuse (diversion case files)

"Child reported that mother hit them with a clothes hanger on the arms and legs."

"Child had gotten into a fight with father. Father got mad and slapped the child in the face and pushed the child down."

"Child in hospital with injuries that do not match father's description."

"Child has injuries to face and leg from an altercation with the father."

Out of the three behaviors, substance abuse was by far the most common caregiver behavior of concern. According to its priority guidelines practice standard, Child and Family Services "will respond only to referrals involving substance abuse where the use of drugs or alcohol seriously affect caregivers' ability to supervise, protect, or care for their children." In about 32 percent of the files we reviewed, substance abuse seriously affected caregivers' ability to supervise, protect, or care for their children.

Although substance abuse was the primary concern in about one-third of cases, it was frequently identified as significantly contributing to other threatening behaviors. Overall, caregiver substance abuse was present in about 63 percent of case files we reviewed.

Substance abuse by caregivers was present in about 63% of case files.

Caregiver behaviors or living conditions cause the need for safety actions but are not the focus of safety action decisions.

We found no meaningful difference between the descriptions of caregiver behaviors or living conditions in case files with diversion actions and the descriptions in case files with foster care.

For example, the following hazardous home descriptions are examples from case files we reviewed in which children were placed in foster care instead of being diverted. By comparing the descriptions from the foster care case files to the descriptions from diversion case files on page 19, we found that differences in behaviors were not the reason for differences in safety action type.

Hazardous home conditions (foster care case files)

"The carpet was soiled with urine and feces. The kitchen stove, counters, table were smeared with filth and residue. Kitchen sinks had standing water. Plumbing not working. Trash littered throughout the house."

"There was animal feces and urine found throughout home. There were holes in the floor in the hallway next to the children's rooms. The porch was not stable and did not have a railing to prevent serious injuries for someone falling off. There were large amounts of clutter in the home, making it extremely difficult for the family to exit the home safely in the event of an emergency."

"There were clothing and other miscellaneous items strewn about the home and covering the floor to the point where you could not walk on the floor in most of the home; you had to walk on the debris. The kitchen was piled high with miscellaneous items and had no apparent place to prepare food or clean dishes. There was no running water, working toilet, or shower in the home. The home was heated with space heaters which appeared to be a fire hazard."

"Bugs were covering the floor of the bathroom. The floor cannot be seen as it is covered with garbage, food, clothes and dishes. Leaking toilet has resulted in mold in the bathroom. Toilet does not currently work. Child's car seat was soaked with urine."

After social workers determine that children are unsafe, their focus shifts to identifying the best way to mitigate or control the safety threats.

"The fridge and freezer doors were open and there was food and garbage all over. It appeared the children had spread food and garbage everywhere. Children had been locked in unsanitary room with dog feces on the carpet and a soiled diaper laying on the floor."

Although it may seem counterintuitive, it is by design that social workers do not focus on behaviors or conditions when selecting the appropriate safety action. Behaviors and living conditions are the focus when determining whether children are safe. However, after social workers determine that children are unsafe, their focus shifts to identifying the best way to mitigate or control the safety threats that result from the behavior.

Social workers answer four questions to determine whether a safety threat can be controlled while children remain home:

Are there sufficient, appropriate, reliable resources available and willing to provide safety services?

Are the adults in the home willing to cooperate with and allow an in-home safety action?

Is the home calm enough to allow safety providers to function in the home?

Is there at least one parent or caregiver in the home?

Regardless of the type of safety action chosen, social workers are expected to ensure the action meets 10 criteria Child and Family Services has specified in its practice standard for comprehensive assessment. The criteria state that a safety action must do the following:

Use a well thought out approach
Use suitable people
Provide the right safety actions at the right times
Control and manage the safety threats
Remain in effect as long as safety threats exist
Control and manage present or emerging danger
Have an immediate effect
Be immediately accessible and available
Contain safety services and actions only
Not contain promissory commitments

As with caregiver behaviors, the safety factors social workers identified did not appear to be the focus of decisions about safety action types.

Child and Family Services formally recognizes 14 safety factors. Safety factors are intended to guide social workers' decisions about whether children are safe. The factors are not intended to guide decisions about the type of safety action used.

Fourteen safety factors

1. Caregivers cannot, will not, or do not explain a child's injuries or threatening family conditions.

2. A child has serious physical injuries or serious physical symptoms or conditions from maltreatment.

3. One or more caregivers intended to seriously hurt the child.

4. The living environment seriously endangers the child's physical health.

5. The child demonstrates serious emotional symptoms, self-destructive behavior or lacks behavioral control that results in provoking dangerous reactions in caregivers.

6. A child has exceptional needs that affect his or her safety that caregivers are not meeting, cannot meet, or will not meet.

7. A child is fearful of the home situation or people within the home.

8. One or more caregivers lack parenting knowledge, skills and motivation necessary to assure a child's safety.

9. One or more caregivers are threatening to severely harm a child or are fearful they will maltreat the child or request placement.

10. No adult in the home is routinely performing parenting duties and responsibilities (food, clothing, age appropriate supervision and nurturance that assure child safety).

11. A child is perceived in extremely negative terms by one or more caregivers.

12. Caregivers do not have or use resources necessary to assure a child's safety.

13. One or more caregivers will not or cannot control their behavior, or are acting violently or dangerously.

14. Caregivers refuse child welfare intervention, refuse access to a child, or there is some indication that the caregivers will flee.

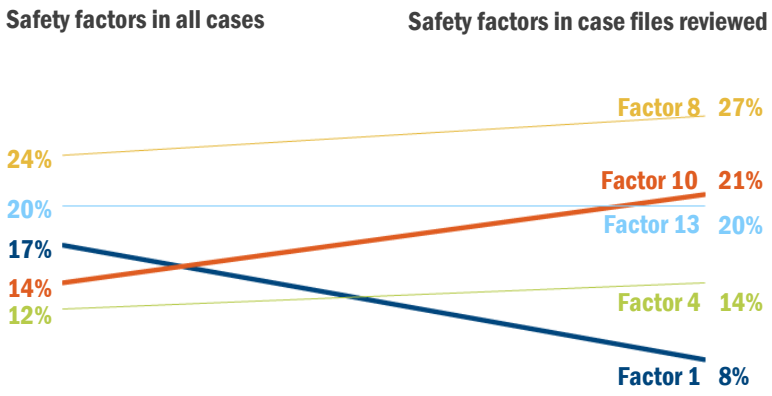
5 safety factors accounted for about 90% of all safety threats identified by safety assessors in fiscal year 2016.

Given the intended purpose of the 14 safety factors, we did not expect to find any relationship between the safety factors and safety actions. As expected, overall, we found that most safety factors were not strongly related to safety action type. However, we found that 2 of the 14 factors did appear to have a relationship with safety action decisions.

Exhibit 1 shows that two safety factors were present in diversion actions at rates substantially different from the average rate for all foster care and diversion safety actions combined. Safety factor 1 occurred less often than expected in cases with diversion actions. Conversely, safety factor 10 occurred more often than expected in diversion safety actions.

Exhibit 1

Safety factor 1 occurred less often and factor 10 occurred more often than expected in the diversion cases we reviewed.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

Diversions with safety factors 1 and 10 escalated to foster care at rates significantly above average.

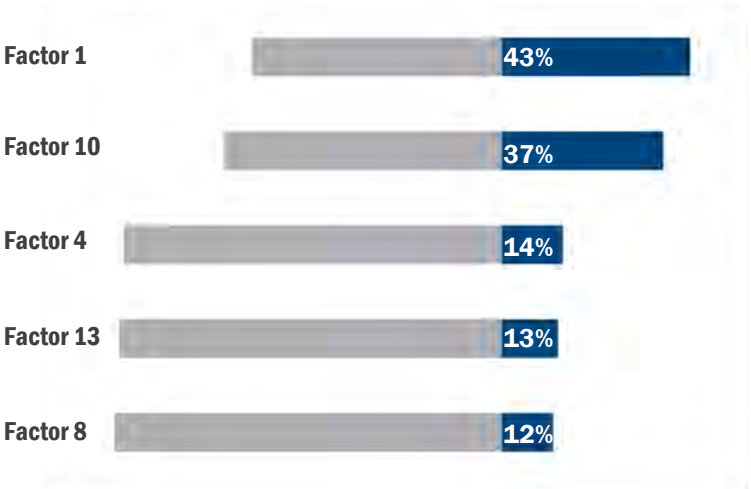
Although behaviors, conditions, and safety factors are not the focus of safety action decisions, our analysis shows that diversion actions may not be well suited to some behaviors or safety factors.

Overall, in fiscal year 2016, about 19 percent of diversion cases escalated to foster care. In contrast, we estimate that about 43 percent of diversion cases with safety factor 1 present and 37 percent of diversion cases with safety factor 10 present escalated to foster care.

Exhibit 2 compares the portion of diversion cases that escalated to foster care for each of the five most frequently used safety factors.

Exhibit 2

Safety factors 1 and 10 increased the likelihood that diversions were escalated to foster care.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

Because of limitations in Child and Family Services' data systems, analysis of the specific causal factors driving the use and effectiveness of diversion placements with safety factors 1 and 10 was not feasible. However, analysis of the relationship and its underlying causal factors would give Child and Family Services important insight into informal, unintended, or unacknowledged aspects of social workers' placement decisions.

Diversion actions were about three times more likely to be used in priority III referrals than in priority I referrals.

Although specific behaviors or safety factors do not have a significant effect on the use of diversion actions, the immediacy and severity of allegations in reports of maltreatment substantially affect the use of diversion actions.

When a report of child maltreatment is made to Child and Family Services, social workers at the central intake unit assess the reported facts and assign a response priority. Central intake workers can select from three priority levels as defined in Child and Family Services' priority response guidelines. If referrals do not meet Child and Family Services' intake and screening standard for a safety assessment, the referrals are said to be screened out and documented but not assigned a response priority.

> **Priority I**: "A referral is a Priority I when a child is in immediate danger involving a life-threatening or emergency situation; CFS shall respond immediately."
>
> **Priority II**: "A referral is a Priority II when a child is not in immediate danger, but allegations of abuse, or serious physical or medical neglect, are clearly defined in the referral."
>
> **Priority III: "**A referral is a Priority III when a child is not in immediate danger, but allegations of abuse or neglect are clearly defined in the referral as a result of the parent or caregiver failing to meet the age appropriate needs of the child."

Response priority	Required initial response time	Required time to see children of concern	Law enforcement notification requirement
I	Immediate	Immediate	Must be notified
II	Within 24 hours	Within 48 hours	Must be notified within 24 hours of receipt of referral
III	Within 72 hours	Within 120 hours	No notification requirement

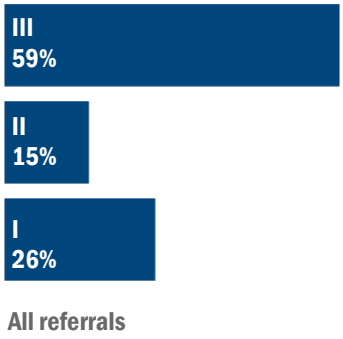
Children required safety actions in **63.9%** of all **priority I** referrals.

Children required safety actions in **29.6%** of all **priority III** referrals.

Exhibit 3 shows that the largest portion of referrals in fiscal year 2016 was assigned priority III.

Exhibit 3

Priority III referrals accounted for the largest portion of all referrals.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

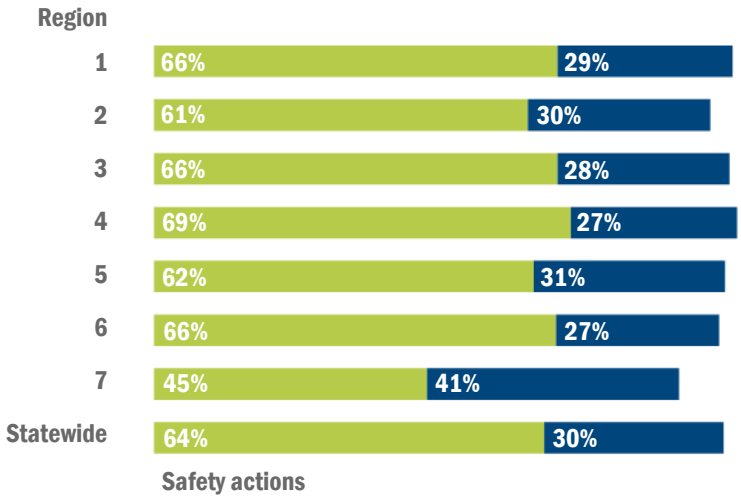
After central intake determines a response priority, it sends cases to the appropriate region for social workers to conduct a safety assessment. Safety assessors are then responsible for deciding whether children are safe or unsafe.

On average, children were found to be unsafe in 63.9 percent of all priority I referrals. In contrast, children were found to be unsafe in 29.6 percent of all priority III referrals. Exhibit 4 shows that with one exception, those proportions are fairly consistent among regions.

Exhibit 5 shows that diversion safety actions were used nearly three times more in priority III referrals than in priority I.

Exhibit 4

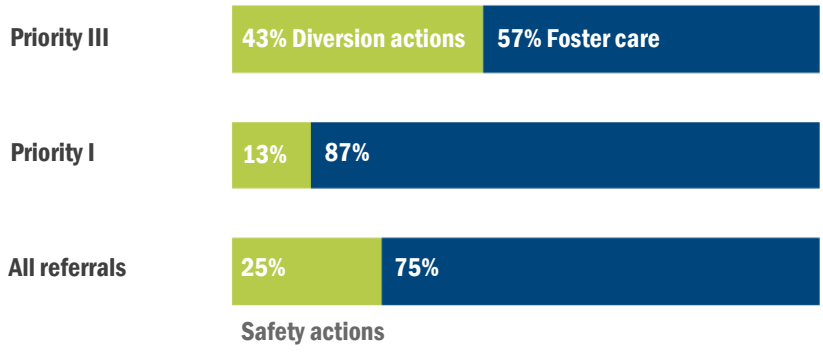
Priority I and priority III are responsible for similar proportions of safety actions in each of the 7 regions.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

Exhibit 5

Diversion actions were used nearly 3 times more frequently in priority III referrals than in priority I referrals.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

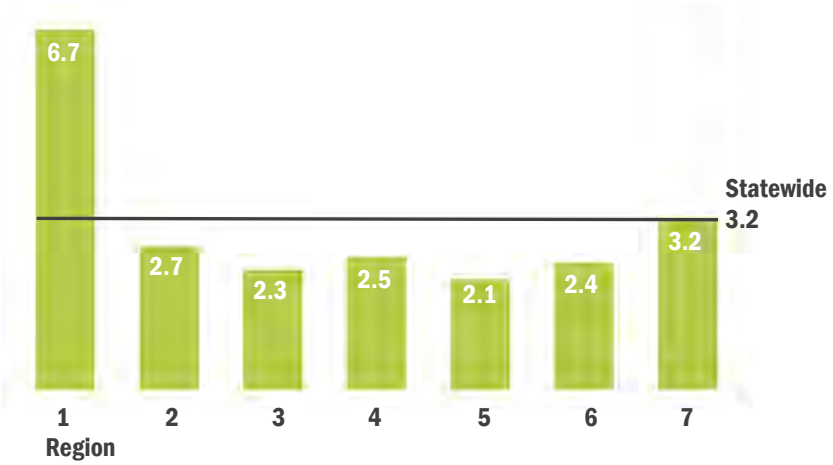
Regions exhibited little variation in the ratio of diversion actions resulting from priority III and from priority I referrals.

With one significant exception, we observed that regions exhibited only moderate variation in the ratio of diversion actions that resulted from priority III referrals to diversion actions that resulted from priority I referrals. As shown in exhibit 6, region 1 was about 6.7 times more likely to use a diversion action for a priority III referral than for a priority I referral. By contrast, most other regions used diversions between two to three times more often for priority III referrals than for priority I referrals.

Exhibit 6

Most regions used diversion actions 2–3 times more often for priority III referrals than for priority I referrals.

Ratio of diversion actions that resulted from priority III referrals to diversion actions that resulted from priority I referrals



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

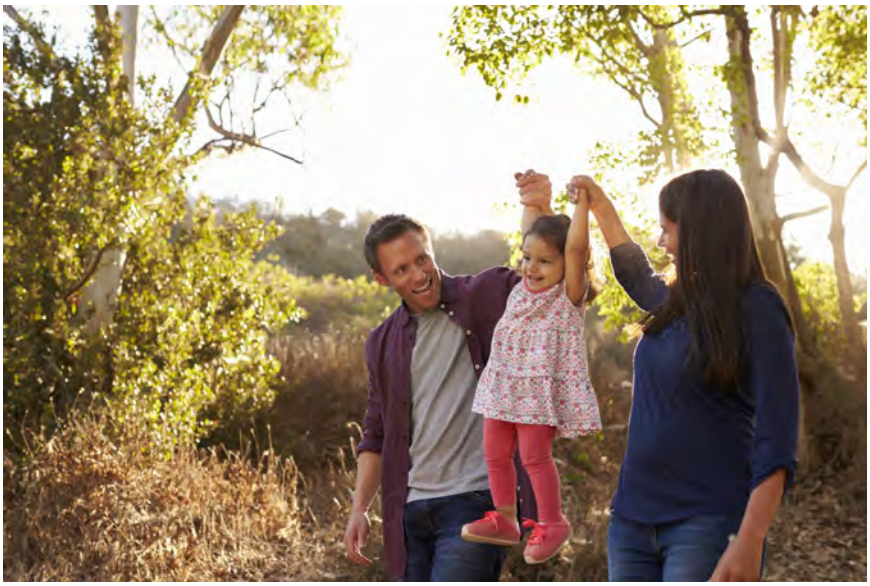
Region 1 was higher than other regions because one law enforcement agency had been declaring imminent danger in nearly all cases. As soon as Child and Family Services informed the agency about its unusually high use of imminent danger, it adjusted its practice.

Regional management had a measurable effect on how frequently children were diverted from foster care.

Despite finding little regional variation in the ratio of diversion safety actions for priority III to priority I referrals, we found significant differences in the overall use of diversion actions among regions. In addition, we found that regional management had a measurable effect on the use of diversion actions.

Regional management is only one of many factors that affect regional use of diversion actions. Other influential factors also affect regional use:

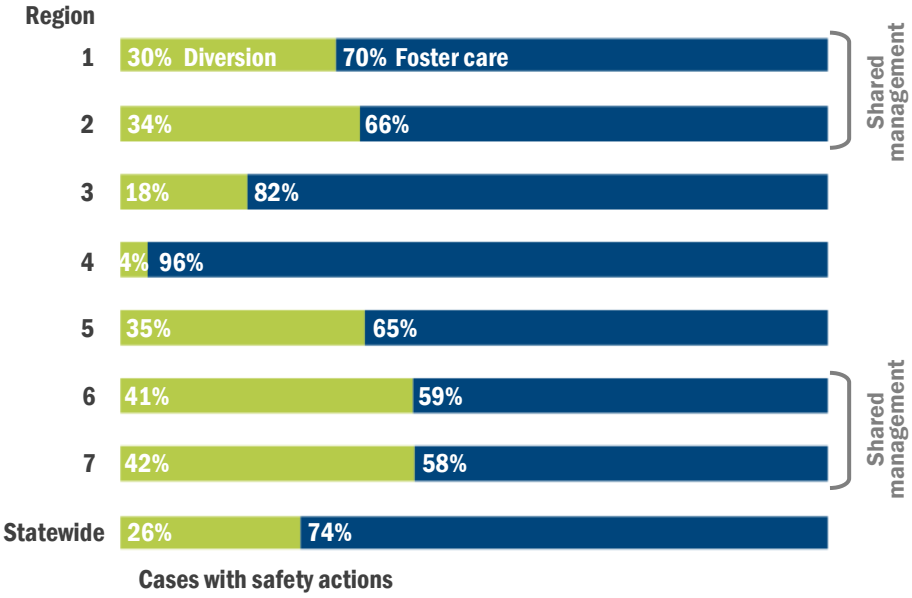
- Staff workload, turnover, experience, and training
- Consistent adherence to the safety model
- Availability of relatives, friends, or in-home contractor services
- Expectations, preferences, and practices of child protection partners



Some regions share the same management team. Exhibit 7 shows strong similarities in diversion rates within those regions. Given the influence and interaction of multiple factors, we conclude that the influence of regional management does more to explain similarities in diversion rates between regions that share management than it does to explain differences among regions that do not share management.

Exhibit 7

Regions that share management show strong similarities in diversion action rates.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

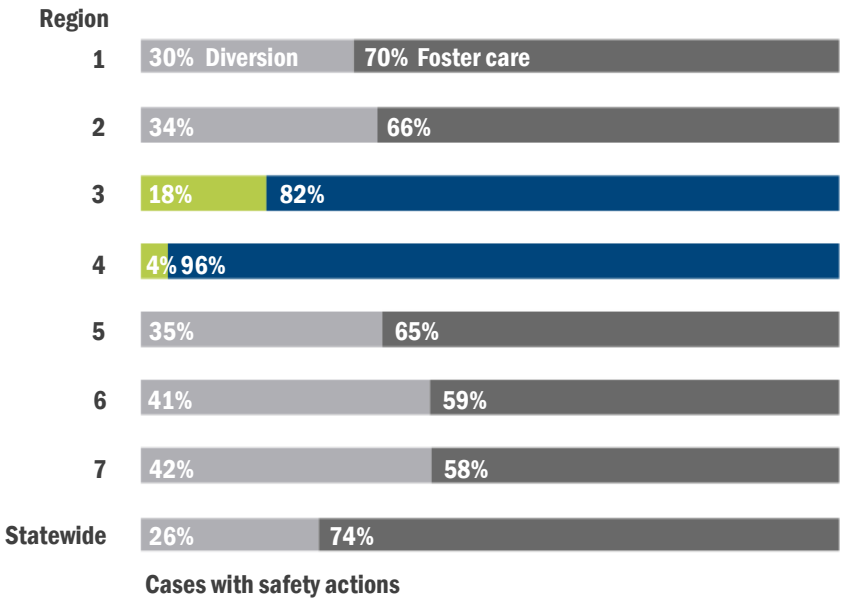
Exhibit 8 shows that region 3 and region 4 use diversion safety actions much less often than do other regions. The difference observed in region 3 and region 4 illustrates how the interaction of multiple factors can have a substantial effect on the use of diversion actions.

The differences in region 4 are even greater when diversion cases that escalated to foster care cases are included in the analysis. In fiscal year 2016, region 4 resolved only one maltreatment case without placing children into foster care. The remainder of diversion cases in region 4 escalated to foster care.

If region 4 were to increase its use and effectiveness of diversion actions to the average statewide rate, it would reduce its foster care cases by about 22 percent.

Exhibit 8

Regions 3 and 4 use diversion actions at a significantly lower rate than all other regions.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

Inconsistent application of the safety model continues to be a concern.

State statute and Child and Family Services' practice standards set out basic requirements and expectations for the formal voluntary agreements that serve as the basis for diversion actions. As part of our review of cases, we looked for alignment between practice and the following statutory requirements:

> Be in writing
>
> State the behavioral basis of each parent and necessary third person
>
> Contain such other terms as the department and each parent having joint custody shall deem appropriate under the circumstances
>
> Specify the services or treatment to be undertaken
>
> Be signed by all persons including:
>
> > The child, if appropriate
> >
> > Every parent having joint custody of the subject child
> >
> > Any other full-time or part-time resident of the home
> >
> > All other persons the department considers necessary to the agreement's success

Five areas of inconsistent practice emerged from the cases we reviewed.

After we had finished our independent review of case files with diversion actions, we requested that staff at Child and Family Services share with us their observations and findings from their review of the case files. Child and Family Services' observations closely aligned with our findings. Five areas of inconsistent practice emerged from the cases we reviewed.

Misalignment between safety determinations and safety action decisions

Some of the inconsistent application of the safety model stems from social workers struggling to adjust to recent changes in practice standards. At the end of 2014, Child and Family Services implemented significant revisions to its safety model. The primary goal of the new safety model was to improve statewide consistency in safety determinations. The revised safety model was also intended to ensure that Child and Family Services only developed safety actions for families with children who were unsafe and not for families with children who were only at risk of maltreatment.

Before implementation of the new safety model, social workers could identify children as safe, conditionally safe, and unsafe.

> Children are considered to be conditionally safe when threats of danger exist and a safety action is being implemented to resolve the threats of danger. For example, a child is conditionally safe in a dangerously unsanitary house when the child stays with a relative until the family cleans the house and the unsanitary conditions no longer exist. —Former safety model

In the new safety model, children are either safe or unsafe; there is no option for conditionally safe. Children who do not meet the criteria for present or emerging danger are safe and should not receive a safety action.

The difficulty some workers have had adapting to the new safety model was clear in the cases we reviewed. The results of the safety determination, safety plan analysis, and safety action type aligned in about half of the cases. In about one-fourth of cases, the safety action type did not align with the safety determination or the safety plan analysis. Most of this misalignment was due to social workers determining that children were safe but still creating safety actions.

In addition, about one-fifth of cases we reviewed did not have the safety plan analysis documented, making it impossible for a reader to determine whether the social worker thoroughly evaluated the appropriateness of the safety action decision.

About one-fifth of cases we reviewed did not have documented safety plans.

Inappropriate safety monitors or insufficient natural supports

The most common discrepancy found in the safety plans we reviewed was that social workers did not always identify appropriate safety monitors. Workers often identified themselves or parents as the safety monitors. For example, safety monitors specified by social workers included "mom will call caseworker," "interacting with mom face-to-face," and "social worker will keep in contact with all parties." In these cases, if no other safety monitor could be identified, a diversion safety action should likely not have been used.

In multiple cases, social workers failed to include natural support systems in the safety plan.

In multiple cases, social workers also failed to include natural support systems in the safety plan. Social workers listed themselves or service providers as supports to the family. For example, social workers would only list the action participants as the parents or as the parents and a service provider. All safety plans should specify additional natural supports such as a relative or a neighbor.

Incorrect types of activities for parents

In multiple safety plans, social workers created itemized task lists for parents instead of specifying safety services and actions. In some cases, social workers listed out long-term changes and services for the parents to participate in. For example, vocational rehabilitation was listed as a task for the father in one case. Instead, social workers should have specified safety services and actions for immediately controlling safety threats.

Inconsistent use of official forms

Some safety plans were documented using methods other than Child and Family Services' official safety plan forms. Multiple cases contained documents listed as safety plans that were created by workers using their own format such as MS Word documents, voluntary agreements, or written documentation of verbal agreements. None of these formats covered all the items listed on Child and Family Services' safety plan form.

The voluntary agreement was the only one of these documents that had a parent's signature; however, that agreement was vague and did not state any specifics of the allegations. Others were only documentation of verbal agreements made between the

social worker and family, such as “grandparents agreed to keep an eye on their children” or written statements of “caseworker will monitor safety of child in his mother’s care.”

Inadequate, untimely, or unclear documentation of safety plans

Some safety plans were not documented clearly enough for families to easily follow, and some were not documented until months after the referral date. Safety plan documentation is a way to clearly manage safety threats and keep children safe. The safety plan should also help family and supports clearly understand what the safety concerns are and how they should be managed. When safety plans are not clear and simple or if the written plan is not available, families or their supports can struggle to follow the plan.

In several safety plans, workers did not specify the times and frequency that support systems were expected to help the family be successful. Instead, workers listed out how frequently the mother had been drinking or the work schedules of people in the home.

Families or their supports struggle to follow the safety plan when it is not made available or not clearly written.

The availability and willingness of relatives to provide housing, monitoring, or assistance strongly influenced the use of diversion safety actions.

Safety plans consist of specific actions expected to mitigate or eliminate safety threats created by caregiver behaviors. However, safety actions are not intended to change or eliminate threatening caregiver behaviors. The type of actions included in a plan depend on what is necessary to mitigate the identified danger.

In foster care safety actions, foster parents carry out safety actions. However, diversion actions require relatives, friends, or community supports to carry the actions out. That requirement makes diversion safety actions all but impossible to implement without the availability of relatives, friends, or community supports.

About two-thirds of diversion cases relied on extended family or friends to ensure the safety of children.

The key role of family in diversion safety actions was clear in the diversion cases we reviewed. We found that about two-thirds of diversion cases relied on extended family or friends to take direct action toward ensuring the safety of children.

The reliance on relatives, friends, and community supports is both a strength and weakness of diversion actions. In general, family and community involvement has been shown to improve outcomes and reduce trauma.

However, finding relatives who are willing and able to mitigate safety threats quickly enough to prevent children from being placed in foster care is a challenge for social workers. As a result, diversion actions are easier to implement when relatives or friends made the referral, the caregiver or children identify friends or relatives who may be available and willing, or social workers or law enforcement are already aware of relatives or friends who may be willing to provide safety actions.

In the vast majority of diversion cases we reviewed, the relative or friend who provided safety actions was either the referring party or someone identified by the caregivers of the child who had been maltreated.

Examples of safety actions and their accompanying activities or services

Crisis management: Resolves a crisis in order to control the threat to child safety. A crisis in this context is a sudden precipitating event or onset of conditions that make the caregiver unable to function and provide protection to the child. Activities or services may include crisis intervention and counseling and resource acquisition.

Behavioral management: Controls the caregiver behavior that is a threat to child safety. Activities or services may include emergency medical treatment, substance abuse intervention, emergency mental health care, stress reduction, and supervision and monitoring.

Social connection: Reduces social isolation and provides social support to parents who may be inexperienced, anxious, overwhelmed with parenting responsibilities, in need of encouragement, or developmentally disabled. Activities or services may include basic parenting assistance, homemaker services, in-home babysitting, and supervision and monitoring.

Separation: Provides respite for caregivers and children by removing adults or children from the home for a period of time. Separation is a temporary action which can happen for one hour, a weekend, or several days in a row. Activities and services may include the planned absence of caregivers from the home, respite care, day care, after school care, and short-term placement of the child outside of the home.

Resource support: Addresses a shortage of family resources or poor resource utilization that threatens child safety. Activities and services may include resource acquisition, transportation services, employment assistance, and housing assistance.

In some diversion safety actions, children are able to remain in their home, whereas in other diversion actions children reside out of their home:

Diversion actions with in-home placements: Children stay in their home or at least stay with their parents or caregivers.

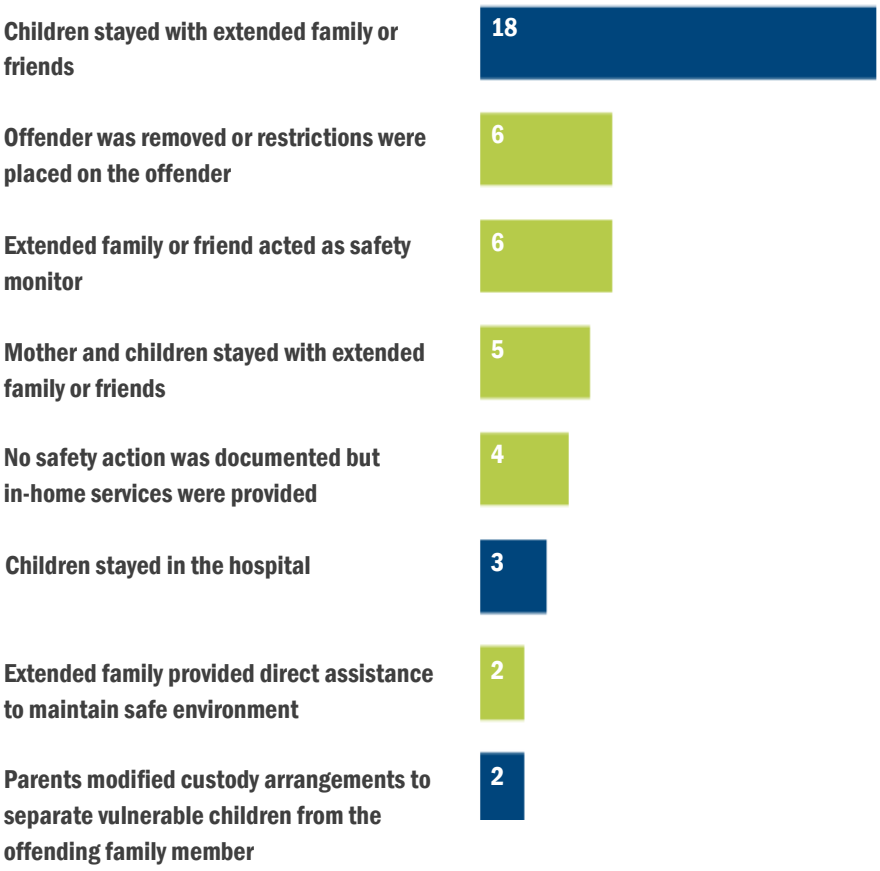
Diversion actions with out-of-home placements: Children do not enter foster care but do not reside with their parents or caregivers.

Exhibit 9 illustrates the types of diversion actions used for in-home and out-of-home placements. About half of all diversion actions were out-of-home placements.

Exhibit 9

We found 8 types of diversion actions in the in-home and out-of-home case files we reviewed.

Number of case files for each intervention type



Note: Some case files did not specify safety actions and are not shown in the exhibit.

Source: Office of Performance Evaluations review of a sample of fiscal year 2016 child protection case files.

Assuming out-of-home diversions occur at the same rate in all cases as they did in the case files we reviewed, we estimate about 13 percent of all cases with safety actions in fiscal year 2016 began as diversions with in-home placements. After we accounted for any of the in-home diversion actions that escalated to foster care, we found that 10 percent of cases with safety actions were resolved completely in their home. The remaining 90 percent of cases required children to be placed outside of their home, either through an out-of-home diversion action or foster care.

Of cases with safety actions, we estimate 10% were resolved in the home.

Out-of-home diversion actions are also known as kinship diversion.

Diversion actions with out-of-home placements require clear guidance and careful application.

Although in-home and out-of-home diversion actions keep children from being placed in foster care, they are not necessarily interchangeable or equivalent. Nationally, out-of-home diversion actions are also known as kinship diversion.

Researchers, social workers, and child protection agencies generally agree with the advantages in-home safety actions have when used appropriately. In contrast, out-of-home diversion actions have been the subject of considerable debate. In addition, the Annie E. Casey Foundation found that not all jurisdictions allow kinship diversion and those that do vary considerably in their policies and practices.

Supporters argue that out-of-home diversion actions:

- Promote family autonomy
- Avoid the negative effects of foster care

Critics argue that out-of-home diversion actions:

- Do not have federal guidelines for their use by child welfare agencies
- Do not require caregivers to go through the foster parent licensing process
- Do not make caregivers eligible for the same financial supports as licensed foster parents
- Separate children from their parents without the same safeguards of court oversight as in foster care safety actions
- Do not have well understood outcomes

National disagreement about the use of out-of-home diversion actions underscores the need to give its use careful consideration. Decisions about the role of out-of-home diversion actions should be explicit and include clear policies and standards for implementation. Policies and standards should include criteria that clearly define when foster care is most appropriate, when in-home diversion actions are appropriate, and when out-of-home diversion actions are most appropriate.

In Idaho, the distinction between in-home and out-of-home diversion actions is murky at best. Additionally, there is little clarity about when placement in licensed foster care is necessary or when kinship diversion is an appropriate alternative.

In Idaho, the distinction between in-home and out-of-home diversion actions is murky at best.

Idaho Code § 16-1631 defines three broad options for Child and Family Services to resolve child maltreatment issues:

> (1) resolve the matter in such informal fashion as is appropriate under the circumstances; or (2) seek to enter a voluntary agreement with all concerned persons to resolve the problem in such a manner that the child will remain in his own home; or (3) refer the matter to the prosecutor or attorney general with recommendation that appropriate action be taken.

The first option leaves room for out-of-home diversion actions but provides no guidance as to the circumstances under which out-of-home diversion actions would be appropriate.

Child and Family Services' practice standards provide little additional guidance. The standards give clear criteria for determining when an in-home action is appropriate. They also state that "safety [actions] may be done in the home or may include out of home [actions] when child safety can only be assured through temporary placement with relatives or in substitute care." However, the standards are unclear about the criteria or circumstances under which an out-of-home safety action requires foster care or when an out-of-home diversion action would be appropriate.

We believe that the lack of guidance on the use of out-of-home diversion actions explains some of the inconsistency described throughout this chapter.

Decisions about the role of out-of-home diversion actions should also be based on analysis of the risks and benefits of the approach. We saw no evidence that out-of-home diversion actions had better or worse outcomes than in-home diversion actions. The rate of diversion actions that escalated to foster care was about equal for in-home and out-of-home diversion actions. However, our ability to determine the effectiveness or outcomes of out-of-home diversion actions was limited by data availability.

We saw no evidence that out-of-home diversion actions had better or worse outcomes than in-home diversion actions.

Child protection partners can affect whether children are placed in foster care.

Child and Family Services cannot make the decision to remove a child.

State and federal laws require Child and Family Services to make reasonable efforts to prevent or eliminate the need for removal of children from their home. As our analysis has shown, Child and Family Services' management and social worker practice affect the use and effectiveness of diversion actions. However, the expectations, preferences, practices, and legally defined roles of child protection partners such as the court, prosecutors, law enforcement, medical professionals, and schools also affect the use and effectiveness of diversion safety actions.

Courts, prosecutors, and law enforcement

Law enforcement officers, prosecutors, and the courts decide whether children should be removed from their home.

Although significant attention is given to Child and Family Services' role in preventing children from entering foster care, Child and Family Services cannot make the decision to remove a child. Law enforcement officers, prosecutors, and the courts decide whether children should be removed from their home.

In Idaho, children cannot be placed in foster care unless the court issues an order of removal or law enforcement declares imminent danger. Likewise, if the court issues an order of removal or law enforcement declares children in imminent danger, Child and Family Services cannot keep children in their home or return them to their home without court approval.

Idaho statute specifies that the process for removing maltreated children from their home requires the attorney general or prosecuting attorney first file a petition with the court. If the court finds that the children should be removed from their present condition, the court can issue an order to remove the children. An exception to this process is allowed when a law enforcement officer determines that children are in imminent danger.

In addition to the ability to order children to be placed in foster care while a child protection case proceeds, the court can also require children to remain in their home while a case proceeds. If the court determines that the children appear safe without removal, it can issue a protective order allowing the children to remain home while the child protection case proceeds.

To ensure that children are given the opportunity to remain home or at least to avoid placement in foster care, Idaho Code § 16-1619(6) requires that when the court places children in the legal custody of the department, the court makes detailed written findings as to whether the department made reasonable efforts to prevent placement of the children in foster care, including findings, when appropriate, that address the following:

> Reasonable efforts were made but were not successful in eliminating the need for foster care placement of the child.
>
> The department made reasonable efforts to prevent removal but was not able to safely provide preventive services.
>
> Reasonable efforts were made but were not successful to temporarily place the child with related people.
>
> Reasonable efforts were not required because the parent had subjected the child to aggravated circumstances.

The requirement for a formal finding of reasonable effort means that for every child who was placed in foster care, a judge has considered Child and Family Services' efforts to prevent the need for that child to be placed in foster care.

Medical professionals

Medical professionals do not directly make decisions about children entering foster care like law enforcement and the courts. However, medical professionals are valuable in preventing the need for children to enter foster care.

Medical professionals often see warning signs of maltreatment before any of the other child protection partners. They also are likely to have less adversarial relationships with families than are law enforcement or Child and Family Services. Additionally, medical professionals can counsel families, advocate for children, and educate and advise about child care. For example, according to research:

> Healthcare providers [who] take the time to educate expectant mothers effect significant reductions in prenatal substance abuse. Early intervention for substance-exposed infants can also prevent a lifetime of expensive services and costs to the criminal justice system.

Medical professionals often see warning signs of maltreatment before any of the other child protection partners.

Schools have the most frequent contact with children out of all the professionals who work with maltreated children.

Schools

According to the US Children's Bureau, schools and educators are also important partners in preventing and treating child maltreatment. Schools are uniquely positioned to support maltreated children and their families in several ways. Schools have the most frequent contact with children out of all the professionals who work with maltreated children. Generally, schools have the expertise needed to address special needs. Schools can also provide a sense of stability from day to day for children and provide activities and programs that can support maltreated children and their families.

Differences in diversion rates among maltreatment referral sources show how child protection partners have influenced foster care placements.

Law enforcement and medical professionals were responsible for about one-fourth of all prioritized referrals but over half of all safety actions.

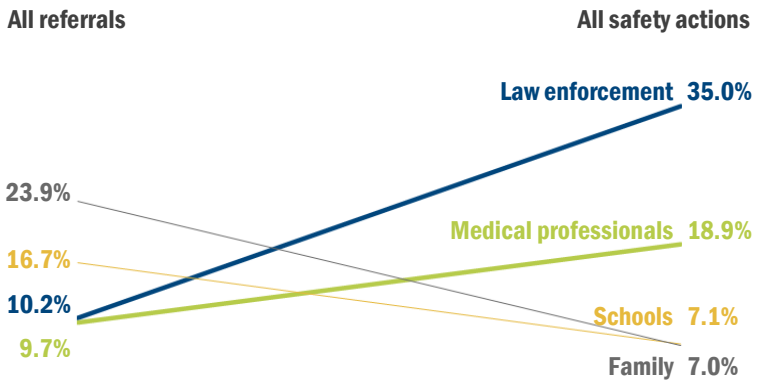
Child and Family Services receives reports of child maltreatment from many sources in the community. Four key child protection partners are law enforcement, medical professionals, schools, and families. They accounted for about 60 percent of all referrals and about 68 percent of all safety actions.

We found that the importance and influence of child protection partners was reflected in the rates at which child maltreatment reports from each partner resulted in diversion safety actions.

Exhibit 10 shows that schools and families were responsible for the largest portion of overall referrals, but law enforcement and medical professionals were responsible for the largest portion of referrals that resulted in safety actions.

Exhibit 10

Law enforcement and medical professionals were responsible for a disproportionate percentage of referrals that resulted in safety actions.



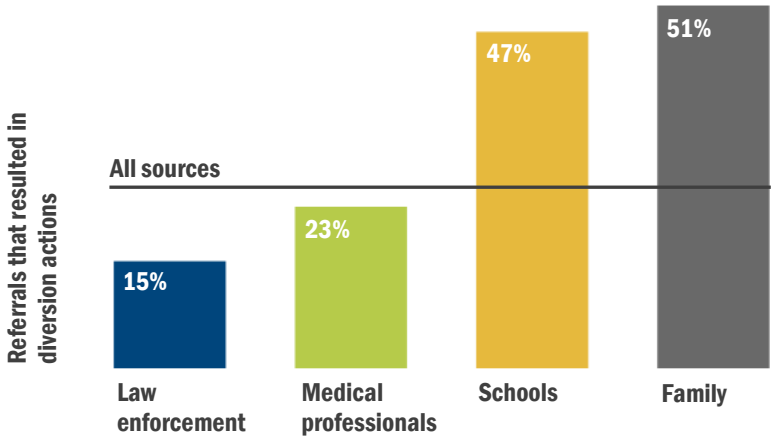
Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

Referrals from law enforcement and medical professionals were least likely to have safety actions that kept children at home.

As shown in exhibit 11, referrals from law enforcement or from medical professionals had diversion rates that were below average for all sources. In contrast, school and family referral sources had diversion rates significantly above average.

Exhibit 11

Referrals from law enforcement or medical professionals were less likely to result in diversion actions than other referral sources.



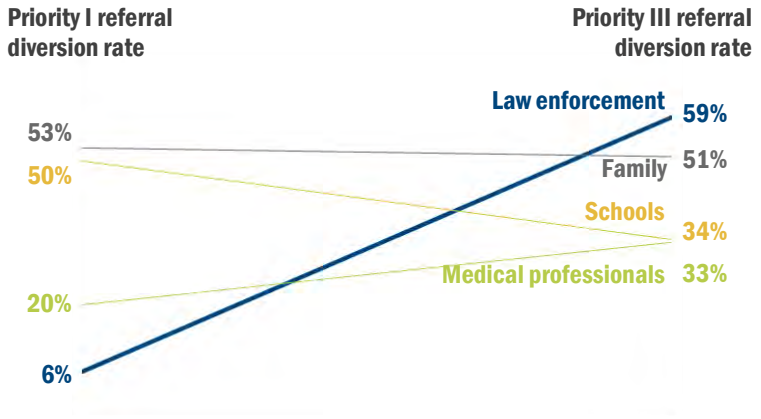
Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

Safety actions from priority I law enforcement referrals were far more likely to result in foster care than were safety actions from any other referral source.

As shown in exhibit 12, priority I law enforcement referrals resulted in a substantially lower rate of diversion safety actions than did any other referral source. In contrast, law enforcement had the highest rate of diversion safety actions for priority III referrals.

Exhibit 12

Priority I law enforcement referrals resulted in a lower rate of diversion actions than any other referral source.

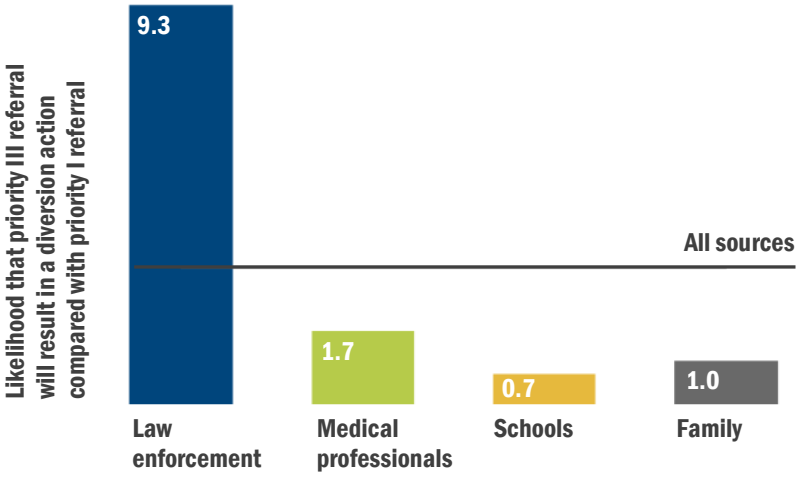


Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

The assigned response priority had a larger effect on diversion safety action rates for law enforcement referrals than it did for other sources. Exhibit 13 shows that a safety action from a priority III law enforcement referral was about nine times more likely to be a diversion action than was an action from a priority I law enforcement referral. In contrast, other sources' diversion action rates were fairly similar between priority I and priority III referrals.

Exhibit 13

Priority III law enforcement referrals were 9 times more likely to result in a diversion action than a priority I law enforcement referral.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

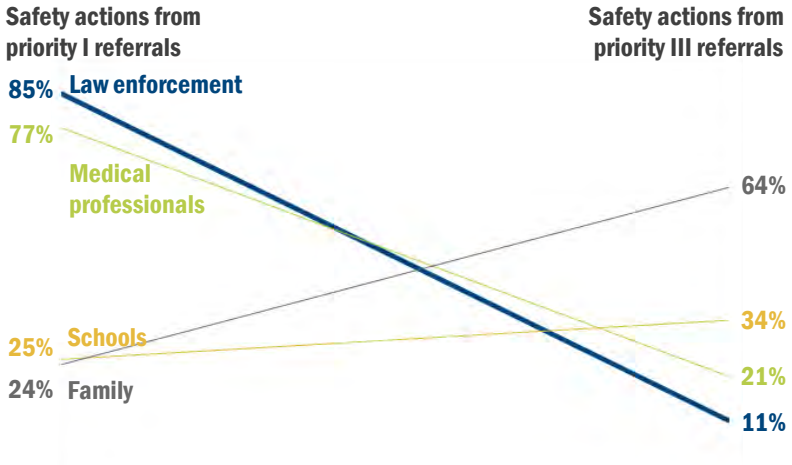
Although law enforcement had the highest rate of diversion safety actions for priority III referrals, exhibit 14 shows that priority III referrals from law enforcement accounted for a much smaller portion of all safety actions than they did for any other referral source.

Any case in which law enforcement is declaring imminent danger must be assigned priority I.

The significantly higher rate of foster care safety actions for priority I law enforcement referrals should be expected given that any case in which law enforcement is declaring imminent danger must be assigned priority I. However, law enforcement has discretion in deciding when to declare imminent danger and the way law enforcement uses its discretion can make a substantial difference in whether children are placed in foster care.

Exhibit 14

The vast majority of safety actions from law enforcement and medical professionals were the result of priority I referrals.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, fiscal year 2016.

For example, we analyzed a small sample of foster care case files in which children were placed in foster care because of hazardous conditions in the home. In about three-fourths of the cases, law enforcement declared imminent danger. In contrast, law enforcement only declared imminent danger in about 4 percent of diversion cases we reviewed.

Region 1's experience with law enforcement on page 30 is a good example of how imminent danger declarations can significantly affect how often diversions are used. In 2016 one law enforcement agency in region 1 had been declaring imminent danger in nearly all cases. As a result, region 1's priority referrals had an exceptionally low portion of diversion actions.

Another reason law enforcement referrals result in fewer diversion actions than family or school referrals is because relatives, friends, or community supports are needed in a diversion action. Invested family members or friends are easier to find when families or schools report maltreatment.

Family members or friends are easier to find when families or schools report maltreatment.

The Legislature has emphasized the need for collaboration among child protection partners when investigating reports of child maltreatment.

According to the US Department of Justice, the multidisciplinary team approach is one of the most effective methods for ensuring cooperation among professionals involved in child protection. The multidisciplinary team approach formally defines roles and responsibilities for interagency coordination of child protection cases.

In 1996, the Idaho Legislature created Idaho Code § 16-1617 requiring prosecutors to establish a multidisciplinary team approach in each county. The statute specifies the minimum composition of teams:

> Law enforcement personnel, department of health and welfare child protection risk assessment staff, child advocacy center staff where such staff is available in the county, a representative of the prosecuting attorney's office, and any other person deemed to be necessary due to his or her special training in child abuse investigation.

The statute also requires the following of teams:

> Develop written agreements signed by member agencies specifying the role of each agency, procedures to be followed to assess risks to the child and criteria and procedures to be followed to ensure the child victim's safety including removal of the alleged offender.

Although statute mentions that teams shall include removal of the alleged offender in their procedures for ensuring the safety of child victims, it does not include any direction, guidance, or expectation that the teams consider foster care prevention in their roles or protocols. As a result, protocols primarily focus on coordinating efforts to investigate maltreatment reports and gather evidence to prosecute offenders and not on roles, expectations, or approaches to preventing children from being placed in foster care.

Statute does not include any direction, guidance, or expectation that multidisciplinary teams consider foster care prevention in their roles or protocols.

Although statute and the protocols say little about the role or expectations for each child protection partner in preventing the need for children to be placed in foster care, the multidisciplinary teams have proven to be useful for addressing the issue.

For example, in its Annual Progress and Services Report, Child and Family Services illustrated the potential for multidisciplinary teams to improve the use of diversion safety actions:

> After participating in [a multidisciplinary team] meeting, local detectives had questions about their role in the enhanced safety model; as a result, law enforcement is beginning to involve Child and Family Services early in their investigations and making child safety decisions in partnership with social workers. This allows Child and Family Services to identify potential services to prevent children from entering foster care and ensuring safety thresholds are met before a child is declared in imminent danger.

Conclusion and recommendations

We found that about one-fourth of all safety actions initially avoided placement of children in foster care. Because there is no benchmark or standard for how many diversion actions should be expected, we could not make a judgment about whether 25 percent is above or below the rate of diversion actions that should be expected. However, any effort to increase diversions is worthwhile if it keeps more children safely with their family.

Through our analysis of child protection data and our review of diversion cases, we have identified opportunities to improve efforts to keep children out of foster care when appropriate.

Improve data collection and reporting capabilities

We found that one of the most important next steps Child and Family Services can take to improve its ability to prevent children from coming into foster care is to improve its data collection and reporting capabilities. Improved collection and reporting capabilities will allow Child and Family Services to more efficiently analyze the data necessary for understanding the use and effectiveness of diversion safety actions.

There is no standard for how often diversion actions should be used; however, any effort to increase diversions is worthwhile if it keeps more children safely with their family.

Child and Family Services should substantially expand and improve its data system to enable the needed data collection and reporting capabilities for diversion safety actions. Child and Family Services is in the process of modernizing its child protection data system. It should ensure that improvements include capabilities for data collection and reporting that support efficient analysis of the following key diversion action information:

- Total number of diversion actions that have been used
- Characteristics of diversion actions including the assigned safety monitor, whether the action was in-home or out-of-home, what safety actions were specified, and duration of the safety actions
- Factors that led to diversion escalations to foster care
- Effect of child protection partners on the use of diversion actions
- Frequency and effectiveness of out-of-home diversion action use

Missed opportunities for diversion actions including specific impediments to diversion action use

Causes of region to region variation in the frequency and effectiveness of diversion action use

Link between safety threats related to safety actions, services, and outcomes

Reduce inconsistency

In addition to the data system limitation, we found that Child and Family Services can improve its ability to prevent children from entering foster care through consistent application of the safety model and addressing differences in regional management.

Through our case review, we found inconsistency in social workers' use, documentation, and implementation of diversion safety actions. We also found that Child and Family Services is aware of the need to improve the consistency of social workers' application of the safety model. The inconsistency appears to be in large part a subset of at least two of the general consistency issues we observed in our 2017 evaluation *Child Welfare System:*

Child and Family Services has a strong culture of adaptability at the policy level but struggles with resistance to change at the implementation level.

Child and Family Services lacks consistency in its management, accountability, and approach to conducting business.

In response to our 2017 findings about inconsistent accountability, management, and practice, Child and Family Services (1) began developing and implementing a coaching model that outlines and measures key competencies and expectations for workers and supervisors to promote consistency and (2) created a plan for monitoring the completion of safety assessments, which included accountability measures for overdue assessments and a project to create a safety assessment fidelity tool.

We also found a lack of clarity and guidance about the use of out-of-home diversion actions. The lack of clarity and guidance has contributed to a portion of the inconsistent use and effectiveness of diversion safety actions.

Child and Family Services should develop a strategy or method for measuring and monitoring the effect of its efforts to improve the consistency of social workers' and supervisors' use, documentation, and implementation of diversion safety actions.

Child and Family Services should clarify its intended role for out-of-home diversion actions by establishing clear policies and standards for implementation. Policies and standards should include criteria that clearly define when foster care is most appropriate, when in-home diversion actions are appropriate, and when out-of-home diversion actions are most appropriate.

The Legislature should consider clarifying statute to express legislative intent about the acceptability and use of out-of-home diversion actions.

Strengthen the role of child protection partners

In addition to the improvement needed in Child and Family Services, we also found that child protection partners can be influential in efforts to keep children out of foster care when appropriate.

Child and Family Services, the courts, prosecutors, law enforcement, medical professionals, and schools all have distinct roles in responding to or preventing child maltreatment. However, they also clearly have overlapping responsibility and potential for preventing children from being placed in foster care. None of the child protection partners, including Child and Family Services, can single-handedly prevent the need for foster care or improve the use and effectiveness of diversion safety actions. Significant improvement requires cooperation and shared responsibility among all partners.

Child and Family Services should develop a plan for improving child protection partners' engagement and consistency in efforts to prevent children from being placed unnecessarily in foster care. The plan should address areas of concern we have identified, such as the inconsistency of diversion use for priority III referrals from law enforcement. The plan should also be based on analysis of trends in diversion data after Child and Family Services has improved its data collection and reporting capacity.

Child and Family Services should make use of the established multidisciplinary teams where possible but should also include strategies for engaging partners individually when necessary.

To assist Child and Family Services in its efforts, we recommend that the Legislature consider explicitly stating, and if necessary, enhancing the roles that established multidisciplinary teams play in preventing children from being placed unnecessarily in foster care.

3 Dual system youth

Youth who have been maltreated are at risk of adverse outcomes as adolescents and adults. Youth who have committed delinquent acts are at risk for similar adverse outcomes.

When youth have been involved with child protection and juvenile justice, they are referred to as dual system youth. Dual system youth are at greater risk of adverse adult outcomes compared with youth involved in only one system. These outcomes include poor health and chronic disease, mental health disorders, substance abuse, arrest, and low rates of education and employment.

Compounding the problem, youth who have been maltreated are more likely to engage in delinquent behaviors than are youth who have not been maltreated.

The link between child maltreatment and youth delinquency has led agencies, policymakers, and researchers to look for ways to better understand the relationship and find strategies to help at-risk youth avoid the path toward adverse outcomes.

Because of data sharing challenges, stakeholders have struggled to gain a complete understanding of dual system youth in Idaho.

The Department of Juvenile Corrections has been increasingly interested in measuring and tracking dual system youth. In addition to its ongoing data collection practices, Juvenile Corrections has made several attempts to determine how many of the youth it serves have had contact with both systems.

In 2012 Juvenile Corrections reached out to the Department of Health and Welfare for data needed to count the number of youth in state custody who had received other social services. Together, they identified approximately 90 youth who had contact with at least one of the divisions of Health and Welfare. Juvenile Corrections found that of the youth committed to its custody between January 1 and May 31, 2012, about 35 percent had received children's mental health services, 30 percent had been in foster care, and about 24 percent had child protection safety assessments from Health and Welfare but were not placed in foster care.

Multiagency group

In 2015 an Idaho group of seven stakeholders representing the courts, the Department of Juvenile Corrections, and the Department of Health and Welfare came together to work on understanding the factors that bring youth into contact with both systems and strategies to improve outcomes for those youth.

The group of stakeholders participated in the Multi-System Integration Certificate Program sponsored by the Center for Juvenile Justice Reform at Georgetown University. To receive the certificate, the group reviewed multiple agency case files of six youth who first had contact with child protection and later with juvenile justice. The group has not formally analyzed or reported the results but has identified some characteristics that may be common among dual system youth.

In addition to the detailed review of six cases, the group attempted to quantify the number of dual system youth from federal fiscal years 2013 to 2015 and describe their basic experiences and system contacts. The task was time consuming

Significant data limitations prevented the multiagency group from making firm conclusions.

and required many assumptions to be made about the data. Because of significant data limitations, they did not make their findings public.

On behalf of the multiagency group, Health and Welfare calculated the number of youth who exit the custody of Juvenile Corrections and are immediately placed in foster care under Idaho Juvenile Rule 16. The rule allows the court to expand the case to child protection if maltreatment is suspected. Those findings were not shared outside of the group.

Idaho Supreme Court

Separately, in 2015 the Idaho Supreme Court conducted a manual search of case files to identify and count Rule 16 youth. Rule 16 allows for a Juvenile Corrections Act case to be expanded into a Child Protection Act case at any point in a Juvenile Corrections Act proceeding. As a result, Rule 16 can affect juveniles who were never committed to the Department of Juvenile Corrections. The court's effort to count Rule 16 cases included all youth who fell under the Juvenile Corrections Act and was not limited to youth who had been committed to the Department of Juvenile Corrections.

Juvenile Corrections

In September 2016, Juvenile Corrections reported that 7.5 percent of all youth committed to its custody were living in foster care immediately before being committed. Although the analysis provided an idea of the number of youth involved with both systems it was limited to a small portion of youth involved in the juvenile justice system.

The analysis only included youth involved with state level juvenile justice. However, approximately 95 percent of juvenile justice is administered through county probation and detention centers. In addition, the analysis excluded youth who had been in foster care at some point in their past but not when they were committed to Juvenile Corrections' custody.

Juvenile Corrections also collects information about child protection experiences as reported by youth in their Initial Custody Level Assessment. In a report covering the period January–September 2017, Juvenile Corrections found that of the youth who were given an Initial Custody Level Assessment during that period:

- 4.9 percent had child protection involvement without foster care that was verified by Health and Welfare.
- 17.9 percent had child protection involvement with foster care that was verified by Health and Welfare.
- 13.8 percent had been determined by Health and Welfare to be victims of nonsexual maltreatment.
- 10.6 percent had been determined by Health and Welfare to be victims of sexual maltreatment.

Each of these efforts by stakeholders has improved understanding of dual system youth. However, all of the stakeholders have struggled with limited access to the data collected by the multiple agencies involved, inefficient processes for sharing data among agencies, time intensive tasks needed to connect and analyze the data, and uncertainty about the legal framework for data sharing. As a result, stakeholders are still working to develop a complete picture of Idaho's dual system youth and an approach to data sharing that can support ongoing assessment.

Stakeholders have struggled with the following:

Limited access to data

Inefficient processes for sharing data

Time intensive tasks to connect and analyze data

Uncertainty about the legal framework for data sharing

Our analysis of multiagency data allows stakeholders to have a better understanding of dual system youth.

We collected, matched, and analyzed data from multiple agencies.

To answer the question of how many dual system youth are in Idaho, we had to collect, match, and then analyze data from multiple agencies. We first collected data for youth involved with the juvenile justice system who were committed to Juvenile Corrections or placed on probation in 2014 or 2015. We then requested data from Health and Welfare for all children who had a child protection referral that had been prioritized for assessment at any point between January 2005 and September 2017. After we had both data sets, we were able to link data for youth who appeared in both.

Our approach allowed us to provide policymakers and stakeholders more complete information by answering two questions:

How many youth have contact with both systems?

What child protection experiences did the dual system youth have in common?

How many youth have contact with both systems?

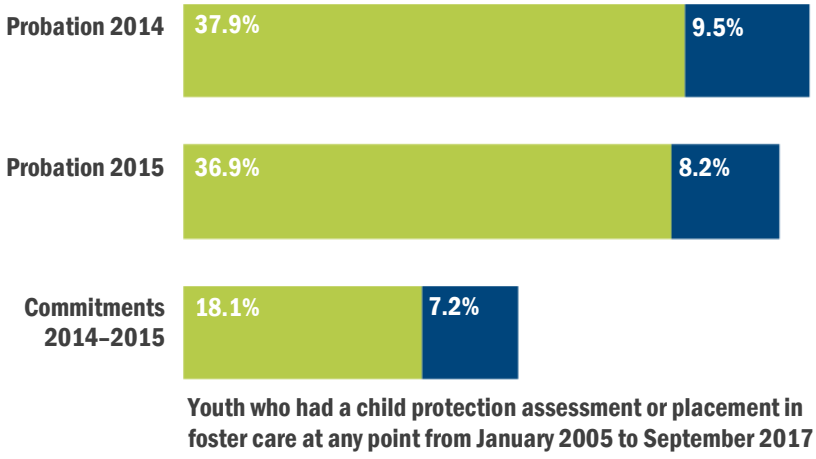
At least one-third of the youth in the juvenile justice system had a child protection assessment.

We found that out of approximately 1,870 youth who were on probation in the 30 counties for which we received data or who were committed to the Department of Juvenile Corrections' custody in either 2014 or 2015, about 640 also had some contact with the child protection system at some point from January 2005 to September 2017.

Exhibit 15 shows the breakdown of the percentage of youth on probation or committed to Juvenile Corrections in 2014 or 2015 who had contact with the child protection system at some point from January 2005 to September 2017.

Exhibit 15

More youth in the juvenile justice system had child protection assessments than had foster care placements.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, 2005–2017; Department of Juvenile Corrections commitment data, 2014–2015; individual county probation data, 2014–2015.

To better identify opportunities to prevent maltreated youth from developing delinquent behaviors, research on dual system youth describes multiple pathways dual system youth might follow.

Pathway	Definition
Pathway 1	A youth currently under the care of child protective services becomes involved with the juvenile justice system at some level.
Pathway 2	A youth with a previous, but not current, case with child protective services enters the juvenile justice system.
Pathway 3	A youth who is currently a victim of maltreatment but is unknown to the child protection system enters the juvenile justice system. Upon investigation, a referral to child protection is made.
Pathway 4	A youth who exits juvenile justice (most often a correctional facility) and enters the child protection system because they do not have a safe place to live.

A vast majority of dual system youth had child protection involvement before coming in contact with juvenile justice.

We found six pathways that better describe child protection experiences of dual system youth in Idaho. Exhibit 16 shows that the vast majority of dual system youth had child protection involvement sometime before being placed on juvenile justice probation or committed to Juvenile Corrections and about 20 percent of dual system youth were in the custody of Health and Welfare when they began probation or commitment.

Exhibit 16

Six pathways describe child protection experiences of dual system youth in Idaho.

	Pathway
47%	Had a child protection case that ended **before** juvenile justice probation or commitment
21%	Had a child protection case that was active **during** placement on juvenile justice probation or commitment but had no other child protection cases before or after juvenile justice probation or commitment
16%	Had a child protection case that began only **after** ending juvenile justice probation or commitment
9%	Had a child protection case that ended **before** juvenile justice probation or commitment and a child protection case that began **after** ending juvenile justice probation or commitment
4%	Had a child protection case that ended **before** juvenile justice probation or commitment and had a child protection case that was active **during** placement on juvenile justice probation or commitment
3%	Had a child protection case that was active but closed **during** placement on probation or commitment and had a child protection case that began **after** ending juvenile justice probation or commitment

Factors that affect delinquency and adult adverse outcomes

Research has identified four factors that increase the likelihood of delinquency and six factors that increase the likelihood of adult adverse outcomes.

Maltreatment may increase the likelihood of delinquency by 47–55% and the likelihood of committing a violent offense by 96%. However, not all maltreated youth will go on to engage in delinquent behaviors. Available research indicates that four factors may increase the likelihood of delinquency:

- Maltreatment during adolescence rather than childhood
- Prolonged or repeated maltreatment
- Multiple moves while in foster care
- Placement in a group home while in foster care

Youth who experience both maltreatment and delinquency may be at even greater risk for adverse outcomes as adults. For example, two recent studies in Los Angeles County and New York City found that increased risk of less desirable adult outcomes among youth who exited from child protection and juvenile justice was associated with the following experiences in child protection:

- Greater number of individual episodes in foster care
- Multiple moves during last foster care episode
- Exiting custody from a group home
- Type of placement
- Older age at first entry
- Older age at last placement

What child protection experiences did the dual system youth have in common?

Understanding all of the factors that move youth further along the continuum of risk will help agencies create long-term solutions specific to the needs of youth in Idaho.

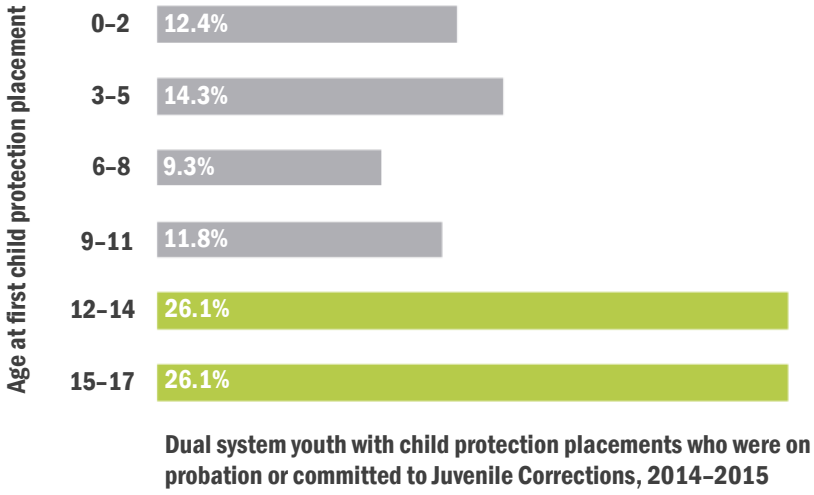
We have identified some initial trends in the characteristics, experiences, and factors that lead to less desirable outcomes among dual system youth in Idaho.

Youth who experience both maltreatment and delinquency may be at even greater risk for adverse outcomes as adults.

Exhibit 17 shows that more than half of maltreated youth on probation or committed to Juvenile Corrections in 2014–2015 who were placed in foster care had their first placement between the ages of 12 and 17.

Exhibit 17

More than half of dual system youth with child protection placements had their first placement from ages 12–17.



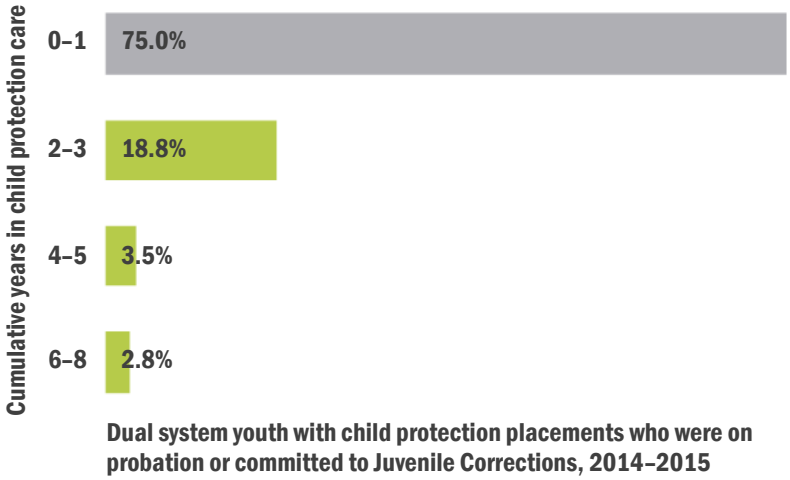
Dual system youth with child protection placements who were on probation or committed to Juvenile Corrections, 2014–2015

Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, 2005–2017; Department of Juvenile Corrections commitment data, 2014–2015; individual county probation data, 2014–2015.

Exhibit 18 shows that 25 percent of maltreated youth on probation or committed to Juvenile Corrections in 2014–2015 experienced extended time in foster care of two or more years.

Exhibit 18

25% of dual system youth with child protection placements experienced two or more years in foster care.

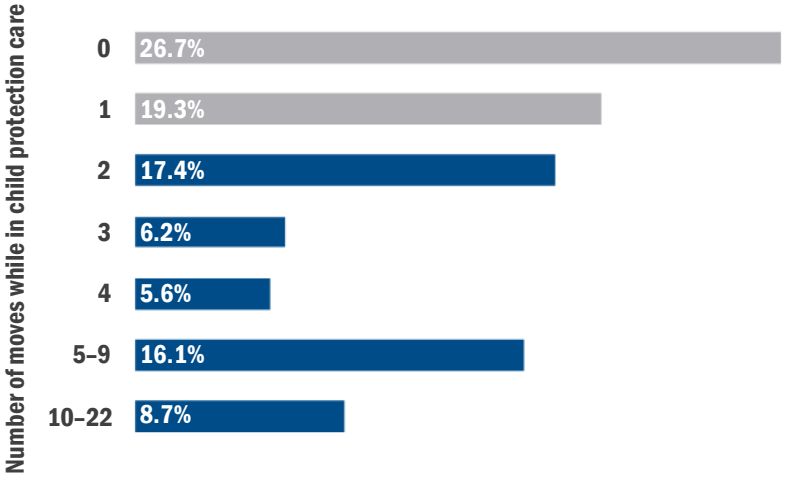


Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, 2005–2017; Department of Juvenile Corrections commitment data, 2014–2015; individual county probation data, 2014–2015.

Exhibit 19 shows the breakdown of how many times maltreated youth on probation or committed to Juvenile Corrections in 2014–2015 experienced a placement change while in foster care. The majority of youth were moved at least once while in foster care and over half of all youth were moved at least twice.

Exhibit 19

Over half of all dual system youth in foster care were moved at least twice while in care.



Dual system youth with child protection placements who were on probation or committed to Juvenile Corrections, 2014–2015

Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, 2005–2017; Department of Juvenile Corrections commitment data, 2014–2015; individual county probation data, 2014–2015.

Exhibit 20 shows how often dual system youth had experienced different types of child protection placements.

Exhibit 20

Youth experienced a wide variety of child protection placement types before and after probation or commitment.

Type of child protection placement experienced by youth	% in placement before probation or commitment	% in placement after probation or commitment
Nonrelative foster care	79.8	49.4
Home visit	36.3	31.2
Relative foster care	29.8	23.4
Group home	9.7	27.3
Detention facility	8.1	31.2
Shelter care	8.1	6.5
Children's treatment facility	7.3	41.6
Hospital	6.5	2.6
Parental care	6.5	0
Treatment home	5.6	7.8
Fictive kin	4.8	13.0
Casey family	4.0	11.7
Therapeutic care	3.2	0
Psychiatric hospital	1.6	2.6
Public psychiatric hospital	1.6	0
Alcohol drug treatment facility	0.8	6.5
Preadoptive nonrelative	0.8	1.3
Preadoptive relative	0	1.3
Juvenile Corrections	0	9.1

Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, 2005–2017; Department of Juvenile Corrections commitment data, 2014–2015; individual county probation data, 2014–2015.

About 75% of dual system youth in our data set had been referred to child protection but never had a placement.

Of the dual system youth in our data set, about 75 percent had been referred to child protection but never had a child protection placement. Of those who did have a placement, exhibit 21 shows that about 30 percent experienced more than one placement episode.

Exhibit 21

Of the dual system youth with a child protection placement, about 30 percent experienced more than one placement episode.

Dual system youth on probation or committed to Juvenile Corrections in 2014–2015 who had at least one child protection placement episode

Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, 2005–2017; Department of Juvenile Corrections commitment data, 2014–2015; individual county probation data, 2014–2015.

Multiple barriers affect agencies' ability to collect and analyze data for dual system youth.

Our collection and analysis of data from multiple agencies enabled us to make important additions to the understanding of dual system youth. However, the process also confirmed the challenges agencies have encountered and underscored the necessity of having sufficient, complete, and correct data from all agencies involved with dual system youth.

For example, when we collected data on youth involved in juvenile justice, we found that data for commitments was tracked directly by the Department of Juvenile Corrections. However, specific data for probations were only available from counties. Juvenile Corrections compiles probation data from a majority of counties in the Idaho Juvenile Offender System (IJOS) and has worked with additional counties to share probation data manually. Despite Juvenile Corrections' efforts to compile county probation data, we were still unable to obtain probation data for 14 counties.

Juvenile Corrections tracks commitment data while counties maintain probation data.

The missing counties should not have significantly affected the proportions of dual system youth we reported. However, the difficulty we encountered in obtaining data from all counties underscores the challenges agencies face in trying to share data needed to better understand and serve dual system youth.

Juvenile diversion data presented another challenge when we tried to account for all types of juvenile justice involvement. Juvenile diversion is an intervention strategy that redirects youth away from formal juvenile justice system involvement while still holding them accountable. Because the idea behind diversion is to help youth correct their trajectory without the unintended consequences of probation or a juvenile justice record, many counties do not maintain records for diversion cases after the diversion activities are completed.

Counties do not maintain records for juvenile justice diversion cases after completion.

Without diversion data, a complete picture of dual system youth is not possible. However, the diversion program is intended to reduce contact with juvenile justice and therefore indirectly contributes to a reduction in the number of youth who have contact with both child protection and juvenile justice.

Counties, Juvenile Corrections, and Health and Welfare do not use a common identifier.

Another significant limitation to identifying dual system youth is how youth are identified in each system. Counties, Juvenile Corrections, and Health and Welfare do not use a common identifier. As a result, any effort to identify dual system youth requires time intensive processes. In addition, lack of a common identifier means that any data entry differences or errors can create significant challenges for matching youth between systems.

These examples are not an exhaustive list of all of the challenges to efficient data sharing. However, they characterize the necessity of agencies sharing sufficient, complete, and correct data and the difficulty and inefficiency of current data sharing options.

The multiagency group encountered obstacles when it attempted to convert dual system information into action.

The multiagency group recognized that collecting and sharing data is a key step toward mitigating the factors that negatively affect dual system youth. The group also understood that data sharing is only the first step. However, as illustrated by the experience of the multiagency group, relatively minor obstacles can easily become major roadblocks in the context of an ad hoc collaborative effort that is dependent on voluntary participation from multiple agencies across multiple jurisdictions.

After conducting its case file review and data analysis, the group was interested in implementing a multiagency framework, called the Crossover Youth Practice Model, in Bannock County as a pilot project, and if successful, implement it across the state. The framework helps agencies collaborate to improve outcomes for youth known to both systems. However, the group experienced several obstacles when they attempted to transition from knowledge to action. The most significant obstacle was that the group did not know where to seek funding for the framework.

The multiagency group was unsure where to seek funding for the framework and decided to pause its efforts until this report was completed.

All members of the group participated voluntarily out of a shared interest and investment in youth. However, commitment to their primary responsibilities left little time to develop and pursue strategies to address obstacles such as funding limitations, particularly without formal leadership or administrative support to spearhead their efforts.

With no clear path forward and competing demands for the group's time, its momentum slowed. When we met with the group to discuss its efforts, members of the group expressed interest in continuing the group's efforts but chose to wait for the results of our evaluation to be published before deciding on a path forward.

With no clear path forward and competing demands for the group's time, its momentum slowed.

Obstacles encountered by Idaho to identify and improve outcomes for dual system youth are similar to those historically encountered in other jurisdictions.

Data sharing and collaboration challenges are not unique to Idaho. Jurisdictions across the country experience the same barriers, particularly with data sharing among agencies that have separate federal and state confidentiality requirements.

In 2016 the National Center for Juvenile Justice recognized several barriers to collecting data about dual system youth that can prevent jurisdictions from understanding the population size, level of system involvement, basic characteristics, or history with each system.

In most states, child protection and juvenile justice are separate agencies with separate data systems that do not have the capabilities to link data. Even in states where child protection and juvenile justice operate as a single agency, the two programs may use separate data systems. The inability to share data prevents jurisdictions from identifying or quantifying dual system youth. States with decentralized child protection or juvenile justice systems have an even more difficult time linking county data with state data.

When agencies do not share data systems, common identifiers such as birth date or case number can be used to link data across multiple data systems, but this process comes with its own challenges. For example, agencies do not necessarily collect information the same way or use the same numbering system for cases. When agency data systems do not share common identifiers, agencies must match individual youth with an algorithm. Using an algorithm is a resource intensive process and often requires staff to manually match youth. This process is also highly vulnerable to human error.

Limited access to historical case data also creates challenges to identifying youth known to both systems. Limited historical, as well as incomplete, data can prevent jurisdictions from identifying youth with earlier system contact. Most studies about youth known to both systems focused on a single point in time. Just three states—Delaware, Florida, and Tennessee—can report the annual number of dual system youth.

Just three states—Delaware, Florida, and Tennessee—can report the annual number of dual system youth.

Two national methodologies help jurisdictions overcome collaboration and data challenges.

The results of our analysis in conjunction with the work done by agencies in the past provide a basic foundational starting point for understanding factors that affect dual system youth in Idaho. However, the limitations of data collection and sharing will continue to impede a more comprehensive and ongoing understanding of these youth.

Two national methodologies address the challenges of collaboration and data sharing and help jurisdictions develop coordinated services for dual system youth:

Framework	Sponsor
Crossover Youth Practice Model	Center for Juvenile Justice Reform at the Georgetown University's Public Policy Institute
Dual Status Youth Initiative	Robert F. Kennedy Children's Action Corps

Both methodologies recognize that the inability to communicate and collaborate across child protection and juvenile justice causes significant problems to better serve these youth. Aside from different missions and philosophies, the inability to share information about youth between systems is often the most challenging barrier that jurisdictions face. Ineffective or duplicated program delivery, multiple concurrent court cases, unaddressed trauma, and inadequate permanency plans are just some of the ways the inability to share information can negatively affect these youth.

The two methodologies offer different approaches but share many similarities. Both methodologies advocate early prevention and intervention. They provide jurisdictions with strategies to improve outcomes for youth who are involved with child protection and juvenile justice.

Both methodologies advocate early prevention and intervention.

As mentioned earlier, Idaho's multiagency group began work on the Crossover Youth Practice Model in 2015. The practice model is designed to improve agencies' ability to identify and respond as early as possible to youth who are at risk of or are in the process of involvement with child protection and juvenile justice.

"There is no resistance to if—it's how to share data at this point."

The model specifies a wide array of intervention strategies and practice modifications for all agencies involved. However, before implementing the strategies and practice modifications identified in the model, agencies must have the ability to share data quickly and reliably enough to divert youth from juvenile justice or better meet the needs of those who cannot be diverted.

The multiagency group has come to agree that more efficient data sharing is necessary but has not yet determined how data can be shared quickly and reliably. As one member of the group explained, "There is no resistance to if—it's how to share data at this point."

The Dual Status Youth Initiative takes a different but complementary approach to the Crossover Youth Practice Model. The initiative recommends building capacity through formalizing the collaborative relationships, leadership, governance structure, policies, legal framework, and technical infrastructure necessary to address the question of how to share data.

The Dual Status Youth Initiative specified many steps that can help agencies address the challenges of determining how to share data and continue progress on implementing the Crossover Youth Practice Model. We identified two of these as the most important next steps Idaho can take:

Formalize a governance structure that is able to sustain the long-term collaboration necessary for implementation of the practice model started by the multiagency group in 2015

Analyze and revise the laws and policies that constitute the legal foundation for interagency collaboration and data sharing

Formalize a governance structure

We recommend formalizing a governance structure that builds upon the interagency and interjurisdictional leadership approach started by the multiagency group.

A formalized governance structure will help agencies maintain the ongoing collaboration, organization of resources, and long-term attention to revise, develop, and implement policies and practices needed to better serve dual system youth.

States have used a variety of approaches for establishing formalized governance structures. For example, some states have relied on memorandums of understanding among agencies to define mission, objectives, roles, and responsibilities, whereas other states have taken a more structured approach by establishing governance through statute or executive order.

Regardless of the approach chosen, the documents establishing a formal governance structure should have several key characteristics:

Establish a management and organizational structure
The design of the management and organizational structure should take into consideration the need for staffing and funding. Both staffing and funding proved to be barriers in the multiagency group's work on implementing the Crossover Youth Practice Model.

Define the legal responsibility and authority of parties
This definition should include decision making authority to oversee subcommittees responsible for data collection, policy and legal analysis, and program assessment.

Outline a unified vision with defined goals and desired outcomes
All efforts to collect or share data and strategies for multiagency collaboration should directly link to the goals and outcomes.

Specify participants
The Dual Status Youth Initiative recommends that at a minimum, child protection, juvenile justice, and the courts should be represented. Ideally, education, health care, mental health, substance abuse, and other social service partners would be represented as well.

If the Legislature is interested in establishing interagency and interjurisdictional leadership responsible for system collaboration, it could follow the approach used to establish county-level multidisciplinary child protection teams. Section 16-1617 of Idaho's Child Protective Act directs prosecuting attorneys in each county to develop interagency multidisciplinary teams that would establish collaboration protocols for investigation of child abuse and neglect referrals. The statute also defines the minimum characteristics expected in each team including participants, designated leadership, and a clear mission.

Analyze and revise Idaho's legal framework for data sharing

Before agencies begin to develop processes or technology for sharing information and data, agencies should make every effort to ensure the legal framework is as conducive as possible to their efforts.

All agencies must work within a framework of laws and policies that define their options for collaboration and system integration for dual system youth. The legal framework can be a source of significant support but also significant barriers.

Child Welfare League's *Guide to Legal and Policy Analysis for Systems Integration* identifies specific supports and barriers. For example, one support is a statutory purpose or policy that articulates legislative support of goals for system collaboration and integration efforts. The guide identified barriers created by legal frameworks such as statutory language that restricts the sharing of information essential to case coordination, or policies that fail to clearly articulate confidentiality or information sharing guidelines.

Because a supportive legal and policy framework is foundational to the success of dual system youth collaboration and integration efforts, we recommend that stakeholders conduct a formal in-depth analysis of the relevant laws and policies that define Idaho's framework. Stakeholders should then recommend and implement revisions, clarifications, and improvements to the legal and policy framework that will support effective and efficient collaboration and integration of all systems that affect dual system youth.

Stakeholders should consider using the committee structure recommended in the Child Welfare League's guide. The guide emphasizes the importance of conducting legal and policy analysis in a committee structure that has the necessary legal expertise in addition to subject matter expertise.

The legal framework of laws and policies can be a source of significant support but also significant barriers.

Any group assigned to implement our recommendation should consider the following central questions that the Child Welfare League's guide identified as recurring among many of the groups in other jurisdictions who have undertaken similar efforts.

What information sharing or confidentiality concerns affect coordinated case management and service delivery as well as efficient and effective court processes?

How do specific state statutes define the goals, practices, and procedures of the state's child serving systems and how do these provisions impact the ability of agencies to work together?

How are resources allocated between child welfare and juvenile justice systems and to what extent does that allocation impact systems integration?

Have the participating agencies identified funding sources provided by the federal or state government that specifically support system integration?

Are agency mandates clear, communicated to staff, and met by the agencies? Is it understood which system is responsible for the legal and physical custody of a child involved in both child welfare and juvenile justice?

How do court practices impact the ability of agencies to effectively serve clients and is the court supporting or can it support interagency strategies?

What are the legal issues surrounding the development of information management systems?

Independent living

Each year in Idaho, about 65 youth turn 18 while in foster care without being adopted or reunified with their families. In the absence of a stable and permanent home, the state acts as a surrogate parent and is responsible for providing tools and resources to prepare these youth to become independent adults.

The experiences and concerns shared by youth in testimony to the interim foster care committee in 2016 raised concerns among committee members about how well Idaho is meeting the needs of youth in care as they prepare for living on their own. This chapter explains how Idaho provides independent living services and highlights how the youth-driven approach presents challenges that must be addressed, including youth motivation, youth awareness, caregiver and community support, and caseworker interaction.

To better understand the experiences of youth, we conducted focus groups with young adults who were in foster care or had recently transitioned to adulthood. We interviewed the independent living program specialist and used a staff questionnaire to gather information about how the independent living program works in each region.

Despite state efforts, youth still fall through the cracks for multiple reasons such as developmental maturity, an unstable support network, a lack of transitional housing, and rigid federal and program benefit rules.

From ages 14 until their 21st birthday, youth receive a combination of formal and informal services to help prepare them for living as independent adults.

Idaho's independent living program is designed to meet the needs of youth in seven key aspects of their development.

The federal government has established guidelines to help states provide services and benefits that older youth in foster care need to succeed as independent adults. In Idaho, Child and Family Services provides these services and benefits through the Idaho Chafee Foster Care Independence Program, also known as the Independent Living Program. Independent living services are available to all eligible youth from the time they are 14 until their twenty-first birthday, regardless of reunification or adoption.

Child and Family Services uses the Integrated Transition Practice Framework developed by the Casey Family Program to help older youth acquire independent life skills. The framework identifies seven different types of development needed for a successful transition to adulthood:

Cultural and personal identity formation
Supportive relationships and community connections
Physical and mental health
Life skills
Education
Employment
Housing

Child and Family Services' staff who responded to our questionnaire described a variety of services and classes available to youth that address these seven development needs. Exhibit 22 lists examples of the range of independent living services offered.

Idaho implements the framework with an independent living plan developed by a youth, their caseworker, and their support system. Support system members may include caregivers or other supportive adults. The plan identifies activities and services to meet the youth's goals in each of the seven areas of development. Some services are informal and do not have a specific task or class associated with them. For example, instead of attending a financial literacy class, a caseworker may teach a youth one-on-one about budgeting or help them set up a bank account. Many independent living services offered to youth depend on community partnerships and contracts with service providers. Some communities are more resource rich than others and offer more options for youth.

Exhibit 22

Seven development needs are addressed through a variety of services or classes.

Development need	Examples of services or classes
Cultural and personal identity formation	Cultural classes Help pay for quinceañera DNA testing to learn about heritage
Supportive relationships and community connections	Flights, bus tickets, or gas vouchers to help unite youth with siblings or extended family Connect youth with adult mentors Connect youth with community resources
Physical and mental health	Counseling and psychosocial groups Healthy living classes Equine therapy Gym memberships or exercise equipment Medical exams
Life skills	Life skills groups Casey Life Skills courses Cooking classes Driver's training Financial literacy classes Bank account set up
Education	Tutoring Help with completing high school or GED Help with filling out FAFSA Setting up college tours
Employment	Help filling out a job application Resumé classes Job shadowing and training Interview skills training Purchase interview clothes
Housing	Develop housing plan Move-out kits Room and board Groceries and household needs

Transition planning

In addition to an independent living plan, all youth who are age 17 while in care are federally required to have a transition plan. Transition planning is designed to assess the youth's readiness for independence and further prepare them for adulthood.

A transition plan is developed at two points before youth turn 18: within 60 days before or after their 17th birthday and within 90 days before their 18th birthday (or at exit from foster care). The transition plan should be directed by the youth, and the youth should identify adults to participate in the planning process. These participants may include the resource parents, biological parents when appropriate, siblings, mentors, educators, service providers, tribal members, or other adults identified by the youth as part of their support network.

The transition plan should clearly identify specific options for housing, health insurance, education, local opportunities for mentors and continuing support services, and workforce supports and employment services.

Youth determine the detail and depth of their plans as well as their level of participation.

Youth are not required to participate in the independent living program.

Federal guidelines require that youth play a major role in the development of their own independent living plans. Caseworkers assist youth, but the planning process is designed to put youth in charge of determining their goals. Youth are not required to develop a plan at all, although staff we spoke with said youth almost always have a plan. When youth decline to participate, Child and Family Services ensures that youth have some form of a plan. For example, caseworkers may (1) create plans and identify needs for youth, or (2) document that no needs were identified and continually assess needs.

Within 90 days of turning 14, youth in foster care complete the Casey Life Skills Assessment to determine their strengths and areas of need. The results help guide youth in identifying goals and tasks in each of seven areas of development. The assessment

and plan are updated annually to reflect the youth's evolving goals.

When youth do not complete a task, there are no consequences other than the youth may not receive an incentive or be able to proceed to other activities. For example, if a youth has unsatisfactory grades or attendance, they may not be able to participate in driver's education.

Youth need direction and support to realize the benefits of a youth-driven approach.

From our focus groups, interviews, and questionnaires, we identified four factors that may influence youth participation in independent living. First, youth may lack motivation to participate and may not develop very detailed plans or strive to accomplish goals. Second, they may be unaware of services and benefits available to them. Third, youth may not have a dedicated adult in their life to support and encourage participation. And finally, a caseworker's level of interaction may directly affect the youth's goal planning, activities, and knowledge about the program.

Youth motivation

Given that youth choose their level of involvement, motivating youth to participate is a key task for caseworkers. Staff reported using multiple strategies to motivate youth. Some caseworkers use financial incentives and offer youth cash or clothing vouchers if they achieve a goal. Caseworkers in one region give laptops to responsible youth to help them complete their education.

Caseworkers may use financial incentives to motivate youth participation.

If youth do not seem interested in completing identified tasks, the independent living plan may be modified to align with the youth's evolving interests. Caseworkers put youth in contact with their regional independent living coordinator to further motivate them to connect with the program. Independent living coordinators help identify services for youth and act as a liaison with community partners.

Region 1 began a partnership with Goodwill GoodGuides in 2016 to form a mentorship program, and three foster youth alumni were trained to be mentors. Unfortunately, staff from region 1 reported that no actual mentoring has taken place yet and the program is at a standstill due to staff turnover, a lack of interest, and difficulty in recruiting foster youth alumni who are ready to

No actual mentoring has taken place yet and the mentoring program is at a standstill.

mentor. Youth we spoke with in our focus groups suggested a mentorship program could help transitioning youth. They knew about region 1's mentorship program and indicated they would like to see the program implemented and expanded to the entire state.

Youth awareness

Youth need to be made aware of their options so they can make choices about their future. Incomplete information at certain stages could mean the difference between having funding for college or not. If they do not understand they have to finish high school or get a GED within a specific timeframe to be eligible for education and training vouchers, they may miss out on important education opportunities.

If youth are adopted just before turning 18, they should be made aware that certain benefits will no longer be available to them. For youth who exit care after becoming eligible for independent living services, the age at which they exit will determine the benefits available to them. Exhibit 23 shows the benefits available to three key age groups of youth upon exiting care.

Exhibit 23

The age that youth exit foster care determines the benefits available to them.

Exit age	Independent living plan	Education and training voucher	Medicaid	Room and board
14–15	✔			
16–17	✔	✔		
18+ (aged out)	✔	✔	✔	✔

Source: Department of Health and Welfare, Division of Family and Community Services, Child and Family Services, *Child Welfare Practice Standard*, "Working with Older Youth."

Youth we spoke with expressed several ideas that illustrate their desire to have increased awareness of the services and benefits available to them. They were uncertain about their eligibility for Medicaid, driver's training, and education and training vouchers. Several youth mentioned that they were unaware of community resources or were not sure what supports they could access. One youth said it was up to them to ask their caseworkers about resources. Some youth expressed frustration with a lack of communication with their caseworkers. All of these comments highlighted an important question: How can you ask about access to things you do not know exist?

Some youth were frustrated by their uncertainty about what benefits and resources are available.

When asked how benefit eligibility information is communicated to youth, staff from all seven regions said this information was given orally. Staff from two regions noted that multiple documents are available to youth about independent living but no specific document includes all eligibility information. Staff from two regions said they did not have a packet of eligibility information but recognized the need for one.

When asked about the availability of state and regional resource guides for youth, staff demonstrated confusion and inconsistent practices. In two regions, resource guides are available but they are outdated. In another two regions, a self-rescue manual is available. However, most staff from those regions were unaware that resource guides were available. Staff from another region noted that they have a resource guide but it is provided on an inconsistent basis. Staff from one region reported there is no resource guide available.

Caregiver and community support

Youth in foster care are at a disadvantage because they may not have a stable adult in their life or a consistent support network. Child and Family Services addresses this need by involving the foster parent or caregiver in the youth's plan. Foster parents are encouraged to participate in the Casey Life Skills Assessment and offer input about the youth's strengths.

Training about independent living is part of the foster parent curriculum. To help foster parents understand the needs of older youth, members of the Idaho Foster Youth Advisory Board participate in foster parent training and share personal experiences. The Idaho Foster Youth Advisory Board is a group of current and former foster youth who work to ensure the voice of foster youth is heard and respected.

In some cases, older youth are assigned a guardian ad litem. In fiscal year 2017, 66 percent of independent living eligible youth with open child protection cases were served by a guardian ad litem. Guardian ad litem program directors we spoke with described the important role the guardian ad litem can play for youth in transition. They form a relationship with the youth and can help the youth get services to address needs that may not be met by the independent living program.

Without a stable adult to rely on, youth are at greater risk for falling through the cracks.

A permanency pact is developed for the youth before turning 18 that identifies adults who have promised to be a support for them. Supports may include a home for the holidays, an emergency place to stay, occasional meals, or a person to talk to when things get tough. Without a stable adult to rely on, youth are at greater risk for falling through the cracks.

One youth we spoke with said:

> Other people are able to call their parents, but I can't because I don't have that person to call. I am completely alone. Some people actually have somewhere to go for Christmas.

Caseworker interaction

Staff said managing crises takes precedence over independent living services.

Caseworkers are required to have monthly face-to-face visits with youth in foster care and discuss their progress in meeting the goals outlined in their independent living plans. The quality and frequency of caseworker interaction impacts the level of motivation, awareness, and connection that youth have with caregivers and community supports. Unfortunately, we heard from staff that other emergencies and demanding duties often limit their ability to offer independent living services.

Staff in every region identified workload issues as a barrier to developing plans with youth in a timely manner. They reported not having enough time to schedule assessments and planning meetings or enter completed plans into their database. Managing crises takes precedence over independent living services.

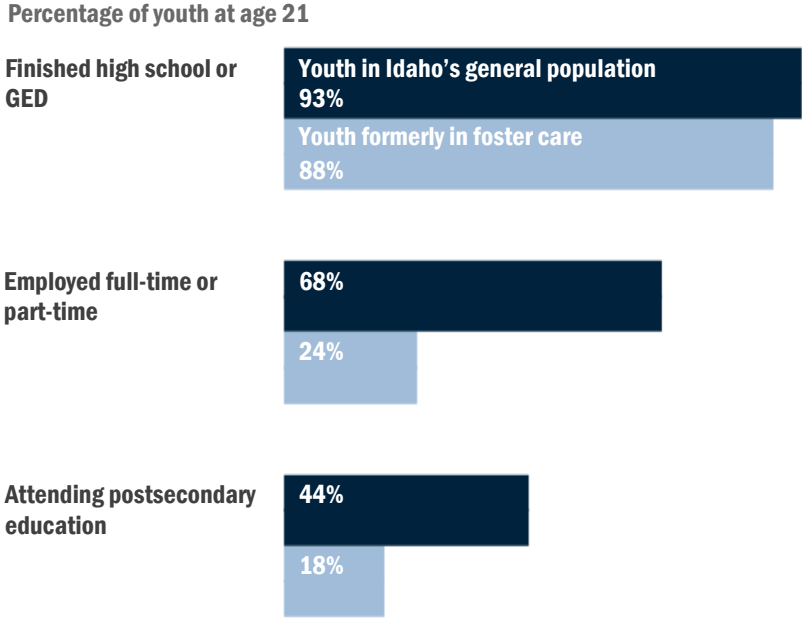
Despite state efforts, youth face adverse outcomes when they turn 18.

To help understand the outcomes that youth who were formerly in foster care experience, states are federally required to survey youth and submit data to the National Youth in Transition Database. To meet this requirement, Child and Family Services surveys a group of youth multiple times: once at age 17, once at age 19, and for the final time at age 21. Surveys were completed for the first group in 2015.

Child Trends, a nonprofit research organization, completed analysis of the federal fiscal year 2015 National Youth in Transition Database survey. The results demonstrate that foster youth in Idaho are at greater risk for adverse outcomes compared with the general population of Idaho youth. Exhibit 24 shows that Idaho youth formerly in foster care are less likely than the general population of Idaho youth to finish high school or a GED, be employed, or attend postsecondary education.

Exhibit 24

Youth formerly in foster care are at greater risk for adverse outcomes compared with youth in the general population of Idaho.

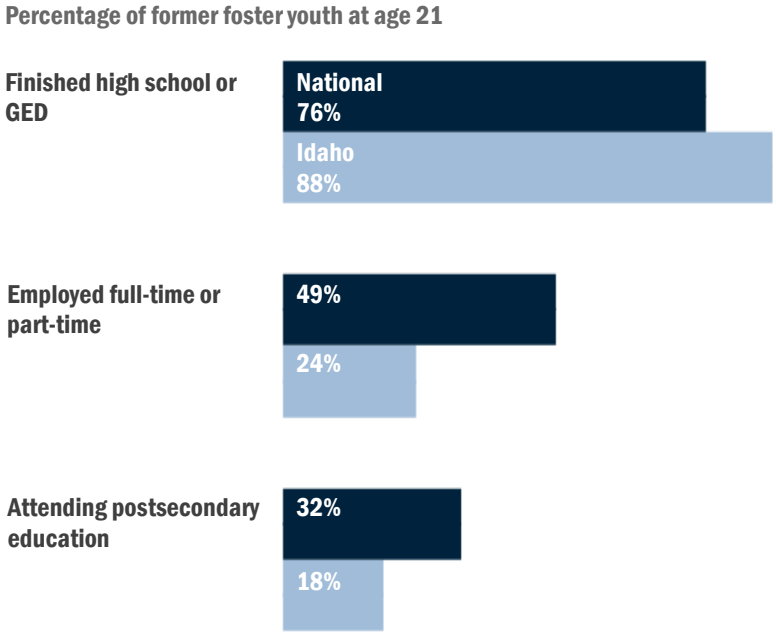


Source: Child Trends, *Transition-Age Youth in Foster Care in Idaho*, https://www.childtrends.org/wp-content/uploads/2017/09/Transition-Age-Youth_Idaho.pdf. Data on youth formerly in foster care are from the National Youth in Transition Database.

Idaho youth who were formerly in foster care have mixed results compared with their counterparts nationally. Exhibit 25 shows that Idaho's youth fare better than the national average of foster youth in high school and GED completion but are less likely to be employed or attend postsecondary education.

Exhibit 25

Idaho youth formerly in foster care have mixed outcomes compared with foster youth nationally.



Source: Child Trends, *Transition-Age Youth in Foster Care in Idaho*, https://www.childtrends.org/wp-content/uploads/2017/09/Transition-Age-Youth_Idaho.pdf. Data on youth formerly in foster care are from the National Youth in Transition Database.

Youth struggle without stable caregiver relationships or community connections.

Youth said they had a false sense of support.

Program staff reported that not having a solid, healthy support system in place was the biggest challenge for youth in transition to adulthood.

Youth we spoke with told us they had a false sense of support. In one situation described to us, a youth thought their foster parent was going to be there for them, but they were kicked out of the

house at 18 and the relationship was abruptly ended. Another youth told us:

> Everyone in our lives is temporary. We don't want to make relationships because we are terrified they will go away.

When youth are adopted or placed in a guardianship, Child and Family Services and the youth have certain expectations of what will be provided by caregivers as the youth get older. Expectations of the caregiver include a safe home, medical insurance, and financial assistance—all resources that parents usually provide their children. Unfortunately, adoptive parents or guardians do not provide these resources to older youth in some circumstances.

For older youth in care, the need to establish a support network is critical. However, even if youth think they have a support network, they have no guarantees those supports will be there when youth exit care.

Youth may not be developmentally ready for an immediate transition to independence at 18.

Youth in foster care have often experienced emotional or physical trauma. This trauma impacts their social and emotional development. Program staff noted that sometimes youth in foster care are emotionally behind compared with their peers.

Although independent living plans and life skills classes try to address emotional development, many youth are simply not ready for independence at age 18. Idaho allows youth to stay in a licensed foster care placement past the age of 18 if they are working toward completion of high school or a GED and on track to finish by age 19. This arrangement depends on youth being in foster care placement and foster parents consenting to continued care.

According to a recent report by Child Trends, 23 states have expanded foster care beyond the age of 18 to allow youth more time to mature and prepare for living on their own. These states have chosen to allow youth to stay in foster care for an additional 1–3 years using federal program dollars under Title IV-E of the Social Security Act. An additional four states have recently passed policies to begin extending foster care beyond the age of 18.

Many states have expanded foster care beyond the age of 18.

47%

of 21-year-old Idaho youth formerly in foster care reported homelessness in a national survey.

Transitioning youth experience a high rate of homelessness after exiting foster care.

Of the 21-year-olds in Idaho who participated in the National Youth in Transition Database's federal fiscal year 2015 survey, 47 percent reported homelessness in the past two years. This percentage compares unfavorably with the national average of 27 percent for youth who were formerly in foster care, reported by Child Trends.

Youth struggle to find housing when exiting care at age 18. One staff member reported that youth sleep on people's couches or live in garages or substandard living situations. Several youth we spoke with experienced homelessness after turning 18. One youth said:

> "I stayed with friends and in a shelter when I was homeless.

Another youth wished there was "more support in being able to find cheap housing because 80 percent of the time housing is the biggest worry for people coming out of foster care and into adulthood."

Youth and staff we spoke with noted the need for more transitional housing. Transitional housing provides youth temporary housing while simultaneously letting them practice life skills in preparation for living on their own.

The need for housing supports is not unique to Idaho. In a recent survey of state independent living programs by Child Trends, 21 states identified housing as the primary area in need of improvement.

Youth exiting foster care do not always choose to take advantage of the services offered to them.

Youth and staff we spoke with said that after turning 18, youth are tired of being connected to the child welfare system. After potentially years of system involvement, they want freedom and autonomy. However, the services and benefits available to them require continued contact with the system, and youth may not understand the importance of maintaining that relationship.

The type of placement youth are in at age 18 may affect their choice to continue involvement with the independent living program. One staff member noted that the less family-like a youth's last placement was before turning 18, the more unlikely

the youth would stay involved with the independent living program.

Youth may not see the value in independent living services when they turn 18. Staff reported that youth may overestimate their own abilities and underestimate the difficulties of being on their own. One youth we spoke with said:

> Sometimes it takes falling into the gutter to realize you need help.

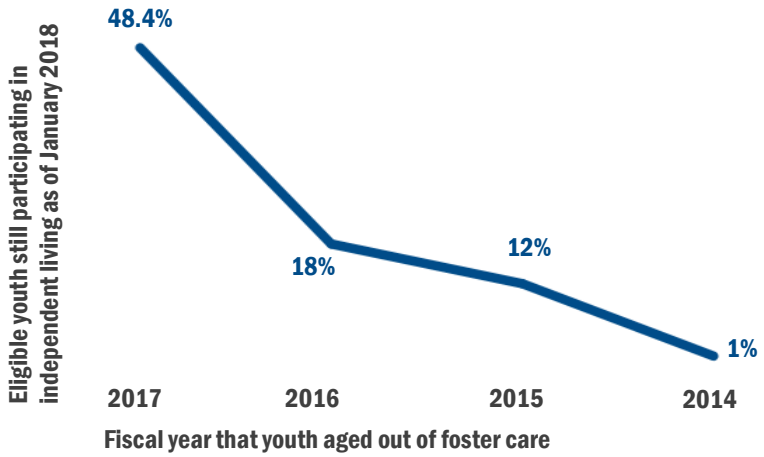
Staff reported that youth may want to pursue relationships with family members they did not have access to when in care. Those same family members may not be supportive of the youth's continued connection to programs in Child and Family Services.

Exhibit 26 shows the declining rate of participation in independent living for youth who aged out of foster care.

Some youth have underestimated the difficulties of being on their own.

Exhibit 26

Participation rates in independent living steeply declined after youth aged out of care.



Source: Office of Performance Evaluations' analysis of Department of Health and Welfare child protection data, 2014–2017.

Youth who have opted out of independent living services are able to reengage with the independent living program at any point before turning 21. If they leave the independent living program at 18 but decide at 20 they need help, they can contact their caseworker to initiate services again. Unfortunately, we heard from multiple staff that youth may not have formed a relationship with their caseworker. Not having a relationship may inhibit youth from reengaging with the independent living program when they are struggling.

For youth who age out of foster care, benefits are not always practical or possible to access.

Youth who age out of foster care are eligible for room and board assistance, education and training vouchers, and Medicaid until the age of 26. However, federal and program rules allow for little to no flexibility. Rigid rules, complicated application processes, developmentally difficult goals, and a gap in caseworker and youth knowledge about eligibility are all factors which may prevent youth from accessing benefits.

Requirements for room and board benefits are not consistent among regions.

Rigid or inconsistent rules and complicated processes

Program staff reported that the room and board payment process can create barriers for youth who have aged out of foster care. Youth must find a living situation with a formal rental agreement to access room and board. The payment process is inconsistent among the regions. In some regions, room and board payments are only given directly to property managers, landlords, or homeowners. In other regions, the room and board payments may be given to youth directly. In addition, if youth have chosen to live in an unhealthy environment or have roommates who are unwilling to complete required paperwork, some regions may not pay room and board.

Idaho Medicaid is available to youth who age out of foster care until they are 26. However, if youth decide to move to another state, they lose that benefit. One youth told us after turning 18, they had planned to move to another state to live with their grandparents but remained in Idaho so they would not lose health care coverage.

Staff said the application process for education and training vouchers is complicated and cumbersome for youth.

Developmentally difficult goals

Many youth are not developmentally or emotionally ready for college upon exiting foster care. Staff reported that youth may be struggling to finish high school or their GED, a necessary requirement for accessing education and training vouchers. One staff member wrote:

> “Youth are generally not ready for college at 18. We see them typically ready for college in their early 20s once they have gone through some healing and repairing of their trauma.

Youth who age out of foster care and youth who exit care between 16 and 18 years of age are eligible to apply for education and training vouchers up until the age of 21. If they are enrolled in the Education and Training Voucher program on their twenty-first birthday and making satisfactory progress toward completion of their education or training program, they continue to remain eligible until the age of 23.

Unfortunately, we heard from youth and staff that attending college is a difficult goal with steep consequences when youth do not succeed. One youth said:

> "I wish that when I failed college I had more resources. It seemed like when I failed I lost all of my main support. I became homeless and lost a lot of my support system. I wish I knew that college wasn't my only option.

Participants in the Education and Training Voucher program are a mix of youth who have aged out of foster care and youth who exited care between the ages of 16 and 18. Below are the annual education and training voucher enrollment numbers for the past four fiscal years:

Fiscal year 2017	25
Fiscal year 2016	31
Fiscal year 2015	45
Fiscal year 2014	36

Although education and training vouchers provide access to higher education, some youth simply are not ready for the challenge within the program's federal timeframe.

Gap in knowledge about benefit eligibility

One youth we spoke with said:

> "I never realized college was actually an option for me.

As mentioned earlier, youth we spoke with voiced confusion about eligibility for benefits. Several staff comments indicated confusion among caseworkers about eligibility requirements for benefits. For example, staff in two regions demonstrated confusion about room and board eligibility and requirements. Staff in another region were confused about the eligibility requirements for education and training vouchers. We did not intend to assess the extent of confusion with staff and it did not appear to be widespread, but a gap in caseworker knowledge plays an important role in youth awareness of benefit eligibility.

Youth and staff reported confusion about eligibility for benefits.

Child and Family Services is in the process of updating the social worker training curriculum for working with older youth. They anticipate the new training will be implemented beginning in April 2018. The updated curriculum involves selected youth in each region who will participate in the training curriculum.

Recommendations

The youth-driven approach of independent living plans empowers youth in their preparation for adulthood. However, we found limitations to the youth-driven approach in Idaho, including poor youth awareness of services and benefits and a lack of motivation to participate in independent living, particularly after youth exit care. Youth awareness and motivation can be improved through caregiver and community supports and caseworker interaction.

Strengthen training

Child and Family Services should address the gap in caseworker knowledge and youth awareness by strengthening training materials. Caseworkers need to be properly trained on the details of all independent living program services and benefits. They need to understand eligibility requirements, know when it is important to communicate that information, and know how to consistently deliver that information to youth. Caseworkers also need to communicate services and benefit information to the youth's caregivers and supportive adults. Child and Family Services has indicated that it is in the process of revising the independent living training curriculum.

Clarify benefit policies

Child and Family Services should clarify benefit policies to address caseworker confusion. Caseworkers who responded to our questionnaire demonstrated confusion about eligibility requirements for education and training vouchers and room and board. Clearer written policies will improve caseworkers' ability to inform youth of the benefits they are eligible to receive.

Improve dissemination of information

Child and Family Services should improve independent living information delivery by creating comprehensive materials that can be easily accessible for caseworkers, caregivers, and youth. The independent living documentation given to youth is incomplete and inconsistently provided across the state. These materials should be available in printed form and on a dedicated web page. They should clearly explain benefit eligibility and services available to youth in each region.

Update resource guides

Child and Family Services should update resource guides and make them available to all independent living youth. Youth we spoke with specifically noted that they need a guide with information about resources such as where to go to get a discounted hotel room, a free mattress, or health care. The Annie E. Casey Foundation's *Guide to Mapping Community Assets for Transitioning Youth* lists step-by-step instructions for creating a repository of community resources. Other states have chosen to make services, benefits, and resource information available online in one user-friendly site. New Jersey's website, the Youth Resource Spot (www.njyrs.org), was created with input from youth and provides an example of a comprehensive and accessible resource repository.

A Requests for evaluation

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Sen. Cherie Buckner-Webb

Rep. Christy Perry

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House of Representatives
State of Idaho

To: Joint Legislative Oversight Committee

From: Representative Christy Perry and Senator Abby Lee

Subject: Child Protection Services

Date: March 13, 2017

The 2016 Idaho legislative interim committee which focused on foster care showed a genuine interest in vastly improving outcomes for children in foster care through a system wide corrective approach. More information was needed before legislative action was to be taken this year. The committee also eagerly awaited the study by the Office of Performance Evaluations commissioned by JLOC in 2016.

The recent report from the Office of Performance Evaluations delivered in February of 2017, identified the importance and interconnectedness of the various aspects and partners of the child welfare system but primarily focused on services provided while children are in the child welfare system. There are at least three other key areas where children may be able to benefit from services and support: (1) preventive measures, (2) the connection between the child welfare system and the juvenile justice system, and (3) support for youth who are aging out of the child welfare system.

There was particular interest from the legislative interim committee to address preventive measures. Although the recent OPE report did provide some information about evidence based preventive services, much more information is needed to determine which proactive measures may help reduce the need for children and families to receive child protection services.

There is also an interest in receiving more information regarding "cross over kids" or "dual status youth" as they are referred to. These children cross over between child protective services and the juvenile justice system. Are there services or actions which could be initiated at critical decision points to help prevent this cross over from occurring?

After speaking with a few former foster children it had become abundantly clear that supports to foster children who "age out" of the system are critically important. We would like the Office of Performance Evaluations to provide information about the supports that are available to youth who have been in the child welfare and juvenile justice systems. As well as, provide a clearer picture regarding how many of these youth go on to enter the adult corrections system.

Thank you for your consideration.

Christy Perry
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Idaho State Senate

SENATOR CHERIE BUCKNER-WEBB

Assistant Minority Leader

March 13, 2017

Joint Legislative Oversight Committee
Attn: Co-chair Senator Cliff Bayer
Attn: Co-chair Representative Mat Erpelding

Dear Senator Bayer and Representative Erpelding,

The recent report from the Office of Performance Evaluations identifies the importance and interconnectedness of the various aspects and partners of the child welfare system but focuses on services provided while children are in the child welfare system. There are at least three other key areas where children may be able to benefit from services and support: (1) preventive measures, (2) the connection between the child welfare system and the juvenile justice system, and (3) support for youth who are aging out of the child welfare system.

The Office of Performance Evaluations report provided information about evidence based preventative services and indicated that prevention is an area that Idaho can further explore. The information provided in the OPE report is an important first step in addressing the need for preventive services, however, more information is needed to determine how to help reduce the need for kids to have child protection and juvenile justice services. Further, we would like the Office of Performance Evaluations to provide information about the supports that are available youth who have been in the child welfare and juvenile justice systems.

Specifically, we would like the Office of Performance Evaluations to answer the following questions.

- Are preventative services identified and shared across the system?
- How many children in the child welfare system end up in the Juvenile Justice System or Department of Corrections?
- What supports are available for teens aging out of the child welfare system vs. adoption?

Sincerely,

Cherie Buckner-Webb

Senator Cherie Buckner-Webb

Evaluation scope

Each of the three areas is a point along a continuum of risk. With the appropriate intervention, a child or youth is hopefully diverted from progressing along that continuum, reducing the risk of adverse outcomes.

This evaluation will identify intervention strategies used to divert children and youth from progressing along the continuum of risk. To the extent possible, we will determine how successful the strategies are in preventing children and youth from experiencing adverse outcomes. We will also identify additional or alternative strategies that could be implemented.

Evaluation requesters, policymakers, and stakeholders should expect this evaluation to provide information, findings, and where appropriate, recommendations specific to the following questions for each of the three areas.

1. Divert children and youth from entering foster care

What strategies do the Department of Health and Welfare use to divert children and youth from entering foster care?

What criteria do the department use to select which children, youth, and families will receive diversion services?

What quality assurance practices are in place to help ensure diversion strategies are consistently implemented?

How effectively do diversion strategies keep children and youth safe without the need for foster care?

How are diversion strategies funded?

What strategies have other states developed to help increase the number of children and youth diverted from foster care?

2. Prevent children and youth from crossing between the child welfare and juvenile justice systems

How many children and youth in Idaho have contact with both the child welfare and juvenile justice systems?

What are the characteristics of these children and youth?

What strategies do the Department of Health and Welfare, the Department of Juvenile Corrections, and the courts use to prevent children and youth from having contact with both systems?

How effectively have prevention strategies limited the number of children and youth who have contact with both systems?

Have other states developed strategies that could be implemented in Idaho to help prevent children and youth from having contact with both systems?

3. Prepare youth who are transitioning to independent living as adults

What resources and services are available to youth through Idaho's Independent Living Program?

What criteria are used to determine eligibility for resources and services for youth transitioning to independent living as adults?

What quality assurance practices are in place to help ensure youth receive adequate, appropriate, and consistent services?

How effectively are youth advised and prepared to access resources and services needed for independent living as adults?

How are services funded?

What opportunities exist for the Department of Health and Welfare, either through the Independent Living Program or other programs, to meet the needs of youth transitioning out of foster care to life as independent adults?

Methodology

In our 2017 report, *Child Welfare System*, we identified the importance of a systems approach to child welfare. Our 2017 report focused on the experiences of children and youth in foster care.

After the release of our 2017 report, legislators expressed interest in children's and youths' experiences before and after foster care. Legislators requested that we expand our work by conducting a detailed examination of three areas that lead to adverse outcomes for children and youth:

- Keeping maltreated children and youth safe without the need for them to enter foster care
- Preventing children and youth from crossing between the child welfare and juvenile justice systems
- Preparing youth who have had involvement with the child protection system for independent living as adults

We scoped this evaluation broad enough to meet the substantial information needs of legislators. However, we also kept the evaluation to a size that could be completed in time to inform continuing reform planned by legislators for the 2018 legislative session.

In addition, we designed this evaluation as a roadmap to help the Legislature and all child welfare partners in their ongoing efforts to reduce the risk of adverse outcomes for children and youth in Idaho's child welfare system.

Approach

Child protection is a complex arrangement of systems, agencies, community partners, and stakeholders that spans jurisdictions and disciplines. For example, questions from the legislative

request for evaluation at a minimum involved the Department of Health and Welfare, the Department of Juvenile Corrections, the Administrative Office of the Courts, county probation and parole programs, community service providers, multiple nonprofit organizations, and former foster youth advocacy groups.

We determined that a mixed methods approach best fits the complexity and broad perspective required to answer the three questions. We also determined that a mixed methods approach would improve the credibility, usability, and value of our findings and recommendations by grounding our quantitative findings in the contextual experiences of stakeholders.

We involved sponsors and stakeholders in the evaluation process to understand their perspectives on key issues and keep them apprised of the evaluation scope, methodology, and processes.

Data collection and analysis

Each of the three topics that requesters asked us to evaluate are separate and unique from one another. As a result, we approached each topic with its own distinct set of questions, criteria, and data collection methods.

Although we treated each topic as a distinct unit, we approached the overall project from a systems perspective to address the depth and complexity of each of these three separate but interrelated topics.

Literature review

Our review was conducted, in part, to answer the following questions:

> What factors lead to adverse outcomes for youth in foster care, dual system youth, and youth who age out of foster care?
>
> What approaches have been used to keep maltreated children safe while keeping them out of foster care?
>
> What challenges do agencies face when attempting to coordinate efforts and share data for dual system youth?
>
> How have agencies addressed data sharing and coordination for dual system youth?

What are the needs of youth in foster care when they transition to adulthood?

What are the common challenges and strategies for preparing youth in foster care for independent living?

We also referred to the literature review we conducted for the 2017 evaluation. The 2017 literature review focused on evidence-based programs that prevent the need for child protection. Several of the programs identified in the 2017 review were also shown to have been effective approaches for preventing involvement with juvenile justice.

Interviews

The complex political and administrative landscape of child protection required the evaluation team to identify key stakeholders and work with them to develop a more explicit understanding of the various relationships, responsibilities, and interactions among and between stakeholders.

We conducted more than 30 interviews with the following stakeholders:

Legislators, including the study requesters and the cochairs of the interim Legislative Foster Care Study Committee

Magistrate judges

Staff at the Department of Health and Welfare, Child and Family Services

Staff at the Department of Juvenile Corrections

Staff at the Administrative Office of the Courts

Members of Idaho's multiagency group working on improving outcomes for dual system youth

Staff at Juvenile Probation Services for Ada County and Juvenile Probation for Canyon County

Community organizations and service providers, such as Idaho Voices for Children, Advocates Against Family Violence, researchers involved in the Voice of Youth Count, and the Youth Homelessness Workgroup

Staff at the federal office of Juvenile Justice and Delinquency Prevention

Executive director of the Robert F. Kennedy Children's Action Corps., National Resource for Juvenile Justice

Director of the Center for Juvenile Justice Reform at Georgetown University's McCourt School of Public Policy

Interviews varied in length from 60 minutes to 2 hours. Most interviews conducted were in person, and some were over the phone. The questions were open-ended and most interviews had multiple participants.

These interviews allowed us to identify common themes about concerns, problems, and challenges stakeholders face in their efforts to reduce the risk of adverse outcomes for especially vulnerable children and youth.

Diversion data

Idaho had never completed a comprehensive analysis of the use of diversion actions to prevent placement of children in foster care.

To provide a more complete understanding of the use and effectiveness of diversion approaches, we analyzed a combination of administrative data and case records.

Data for the diversion chapter came from three separate queries of Child and Family Services' data systems: (1) all child protection referrals for fiscal year 2016, (2) all child protection removals for fiscal year 2016, and (3) all cases in which families had first-time, in-home safety actions in fiscal year 2016.

First-time, in-home safety actions were a subset of all fiscal year 2016 referrals and included only cases with families who had not had an in-home safety action or removal in the previous 10 years. Some of these cases included families who were the subjects of previous investigations that had been completed and closed before the investigation that led to the 2016 in-home safety action. We included removals that took place after the in-home safety action had started but before June 30, 2017.

Case file review

We conducted a systematic analysis of 70 case files to identify factors that affected the frequency and effectiveness of diversion safety actions. Child and Family Services data systems lacked the capability necessary to query the information we needed for our review. Therefore, we had to review files manually, a labor-intensive process. The sample included 60 case files that used diversion actions, 30 of which escalated to foster care. The additional 10 case files had no diversion actions. In these 10 cases, hazardous home conditions were the reason that children entered foster care.

Given the complexity and depth of each case file, we developed a standardized information collection form. This form ensured consistent review from one case to another. It had 55 questions that were closed or open-ended. Questions covered topics such as the role of reporting parties, involvement of extended family, caregiver behaviors causing or contributing to maltreatment, diversion actions considered, and safety actions taken.

Dual system youth data

Given our role in legislative oversight, our enabling legislation, and the relationship of trust we have developed with many of Idaho's executive branch agencies, we have access to a greater breadth and depth of data across agencies than is usually available to other organizations. We took advantage of our unique access to conduct data collection and analysis that had not been feasible for individual agencies.

We matched and analyzed data from the Department of Juvenile Corrections, the Department of Health and Welfare, and 30 Idaho counties to identify characteristics of dual system youth and the connections between the child protection and juvenile justice systems.

We first collected data for youth involved with the juvenile justice system who were committed to Juvenile Corrections or placed on probation in 2014 or 2015.

We then requested data from Health and Welfare for all children who had a child protection referral that had been prioritized for assessment at any point between January 2005 and September 2017. After we had both data sets, we were able to link data for youth who appeared in both.

Our approach allowed us to provide policymakers and stakeholders more complete information by answering two questions:

What portion of youth had contact with both systems?

What child protection experiences did the dual system youth have in common?

Foster youth focus groups

Youth are best suited to tell about their struggles while learning independent living skills and transitioning to adulthood. We conducted focus groups to hear firsthand from youth in foster care and those who aged out of foster care.

We held two focus groups with members of the Idaho Foster Youth Advisory Board. Board members represented all seven regions of Idaho and volunteered their time to advocate for current and former foster youth.

Participants in the first focus group were ages 18–21. We planned an activity to identify participants' independent living needs and followed up with a discussion of open-ended questions. Participants in the second focus group were ages 15–17. They also participated in a discussion with open-ended questions. Three evaluators were present in both focus groups.

Independent living questionnaire

We developed a questionnaire with 13 questions to gain a better understanding of the services offered through the independent living program and the barriers to youth participation. We sent the questionnaire to Child and Family Services program managers for all seven regions. Program managers had discretion to choose relevant staff to respond to the questionnaire. We received responses from all seven regions with several regions providing responses from multiple staff.

Independent living data

Using data from the Department of Health and Welfare, we analyzed the change in participation rates for eligible youth in the years after they turned 18. Data included youth participation in independent living as of January 2018 and totals for youth who turned 18 each year from fiscal years 2014 to 2017.

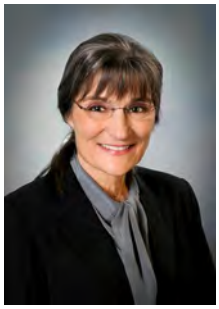
Responses to the evaluation

Changes in the system clearly will require a collaborative effort with the courts, prosecutors, law enforcement, medical professionals and schools. This is no small task, but I encourage all these organizations to work together to improve the system for the at-risk children in our state.

—Butch Otter, Governor

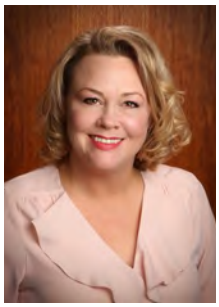
Since receiving last year's OPE report on the Child Welfare System, we have moved toward creating a culture of fostering critical thinking as well as ensuring consistency and accountability. The information included in your report confirmed the direction we are taking and has given us a better perspective of some of the issues at hand.

—Russ Barron, Director
Department of Health and Welfare



Your report documents the necessary steps that system partners could take in order to provide the best possible opportunity for dual system youth to reverse the trends you have identified.... The Department supports the recommendation of a formalized governance structure to define and sustain efforts to support dual system youth.

—Sharon Harrigfeld, Director
Department of Juvenile Corrections



The report accurately captures many of the challenges associated with serving [dual status youth], particularly those relating to data collection, information sharing, and collaboration between stakeholders. The courts have long been committed to working with the Legislature and other partners to address these challenges in order to improve outcomes for these particularly vulnerable youths.

—Sara Thomas, Administrative Director
Idaho Supreme Court

C.L. "BUTCH" OTTER
GOVERNOR

February 26, 2018

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Dear Director Mohan,

Thank you for the opportunity to respond to the draft report, *Child Welfare System: Reducing the Risk of Adverse Outcomes.* I appreciate your review of the various systems in place that were developed to keep children and teens from entering foster care unnecessarily.

The report details some gaps that need to be addressed, such as the lack of data collection and reporting capabilities, and consistency in using diversion plans.

However, as cited in the report, "none of the child protection partners, including Child and Family Services, can single-handedly prevent the need for foster care or improve the use and effectiveness of diversion safety plans." Indeed, changes in the system clearly will require a collaborative effort with the courts, prosecutors, law enforcement, medical professionals and schools.

This is no small task, but I encourage all these organizations to work together to improve the system for the at-risk children in our state.

Thank you again for your time and commitment to researching the important topic of child welfare needs in Idaho.

As Always – Idaho, "Esto Perpetua"

CLO/tp

C.L. "Butch" Otter
Governor of Idaho

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "Butch" Otter - Governor
Russell S. Barron - Director

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February 27, 2018

Via Email: rmohan@ope.idaho.gov

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St., Ste. 202
Boise, ID 83720-0055

Dear Mr. Mohan;

I want to thank you and your staff for the time and effort spent on the Child Welfare System: Reducing the Risk of Adverse Outcomes. As the report highlights, the complexity of the system necessitates an analysis of the individual, interposed against keeping children safe and preventing foster care placement when possible; the connection between the child welfare system and the juvenile justice system; and support for youth who are aging out of the child welfare system. We sincerely appreciate your staffs' investment in the project and the approach taken to conduct a thorough evaluation of each focus area.

The information included in the report addresses many system improvements we are currently working on, and has informed system improvement efforts moving forward. A few areas we are focusing on include:

- Ensuring children's safety is the most critical work we do. In addressing safety, we understand that removing children from their families and the world they know is traumatizing. It is essential that we work with families to keep children safe within their own homes whenever possible. The decision to remove a child from the family and home is neither one Child and Family Services, nor those tasked with the ultimate decision – law enforcement and the courts – takes lightly. In Idaho, approximately 2.9 children per thousand enter foster care. Nationally approximately 3.6 children per thousand enter foster care. We are acutely aware of the complex balance as to when to attempt to institute a safety plan within the home versus when foster care is necessary to ensure a child's safety. To err too much either way can have a profound impact on children's safety and wellbeing.

  In 2014, our Child and Family Services program implemented a new safety model designed to better resolve these issues. When we are more targeted in identifying the safety issues, we can clearly articulate our concerns to families and match them with needed services, thus increasing the opportunity for families to keep their children safe at home. This evaluation

was timely in highlighting current inconsistencies in the implementation of the model throughout the state. These inconsistencies are being addressed through newly implemented measures of our safety model.

We also acknowledge the need for data system enhancements to assist us in better tracking the work we do and to support the analyses of our outcomes. We are currently in year two of a five-year project to redesign our data system.

We know we are not alone in this work. The report illustrates how our partners in law enforcement, the courts, school systems, and medical professionals are crucial to the work of ensuring children's safety.

- National research, as well as your report, calls attention to the fact that behaviors leading to juvenile justice involvement are often in part an outgrowth of past or current trauma. Accountability and treatment need to go hand-in-hand in order to produce positive outcomes for our youth. We are committed to ongoing collaboration with our juvenile justice partners to ensure better outcomes for our dually served youth.

- The report was very helpful in clarifying the need for further definition and communication of Independent Living (IL) program services. We currently have an array of IL services across the state, but it is evident our current structure of administering these services primarily via contractors or Department Independent Living coordinators may be leading to knowledge gaps with the social workers who provide day-to-day case management for the youth in our care. We need to ensure that our case managers have a solid understanding of IL eligibility, assessment, and services so they are able to more effectively communicate IL opportunities to youth, foster parents and other supportive adults in youths' lives.

Since receiving last year's OPE report on the Child Welfare System, we have moved toward creating a culture of fostering critical thinking as well as ensuring consistency and accountability. The information included in your report confirmed the direction we are taking and has given us a better perspective of some of the issues at hand.

Thank you again for your time and attention to improving Idaho's child welfare system.

Sincerely,

Russell S. Barron

RUSSELL S. BARRON
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C.L. "BUTCH" OTTER
Governor

SHARON HARRIGFELD
Director

February 15, 2018

Mr. Rakesh Mohan, Director
Office of Performance Evaluations
P.O. Box 83720
Boise, ID 83720-0055

Dear Director Mohan:

Thank you for the opportunity to respond to the report on Child Welfare System: Reducing the Risk of Adverse Outcomes in Idaho. I understand that the report will be finalized and distributed to the Joint Legislative Oversight Committee soon, and that the Department's response will be incorporated.

As you indicate in the report, the Department has been increasingly interested in measuring and tracking dual system youth in efforts to reduce adverse outcomes. Dual system youth are at a significantly greater risk to develop negative outcomes in adulthood including poor health and chronic disease, elevated rates of substance use disorders, lower rates of education, and ongoing mental health concerns. Further, the Department agrees that through better data collection and research, appropriate resources and strategies can be identified to have more positive outcomes for dual systems youth. It is, therefore, vital that system partners collaborate effectively to provide policy, services and supports to address dual systems youth.

Your report documents the necessary steps that system partners could take in order to provide the best possible opportunity for dual system youth to reverse the trends you have identified. The Idaho Department of Juvenile Corrections would be happy to assist in looking at legal and policy frameworks to support more effective service delivery to dual systems youth. Further, the Department supports the recommendation of a formalized governance structure to define and sustain efforts to support dual system youth.

Thank you again for your efforts to provide vital information as all system partners collaborate on improving the outcomes of the youth we serve.

Sincerely,

Sharon Harrigfeld

Sharon Harrigfeld
Director

SH:mp

THE STATE OF IDAHO
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February 27, 2018

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson Street, Ste. 202
Boise, ID 93720-0055

Dear Mr. Mohan,

Thank you for the opportunity to comment on the Office of Performance Evaluation's (OPE) report on the *Child Welfare System: Reducing the Risk of Adverse Outcomes.* I greatly appreciate the work that your staff put into analyzing and shedding light on these incredibly important and complex policy issues.

My comments are directed primarily at the section of the report dealing with dual status youth, as this section implicates the courts. The report accurately captures many of the challenges associated with serving this population, particularly those relating to data collection, information sharing, and collaboration between stakeholders. The courts have long been committed to working with the Legislature and other partners to address these challenges in order to improve outcomes for these particularly vulnerable youths.

I appreciate OPE's recommendations that the Legislature create a formalized governance structure to facilitate ongoing collaboration and review the laws and policies that govern collaboration and data sharing. I would like to offer a couple of thoughts for the Legislature to consider as they contemplate these recommendations. First, there are a number of interagency entities in place that have been tasked with addressing policy issues pertaining to Idaho's child welfare and juvenile justice systems. It might be worthwhile to explore whether one or more of these entities might serve as a useful forum for policy discussions related to dual status youth.

Secondly, the courts would welcome the opportunity to engage in future collaboration around this issue as the report suggests. However, the nature of that participation would depend upon the makeup and responsibilities of the governance structure created for this purpose. The report cites the multidisciplinary county teams created pursuant to §16-1617 as a possible model to promote interagency collaboration. Because these multidisciplinary teams are convened by the prosecutor in each county, in part to investigate particular child protection cases, it would not be appropriate for representatives of the Judiciary to participate on a team that follows this model. It may be more appropriate for the courts to serve on a statewide interagency committee tasked with researching broad policy issues and formulating recommendations. The Governor's Task Force on Children at Risk would be an example of this type of entity. In addition, in formulating roles and responsibilities for a multiagency governance structure, care should be taken to ensure that the separation of powers between the branches of state government is appropriately maintained.

Thank you again for the opportunity to comment on this report. We look forward to further collaboration in an effort to improve Idaho's response to the challenges confronted by dual status youth. Please do not hesitate to contact me with any questions.

Sincerely,

Sara Thomas
Administrative Director of the Courts
Idaho Supreme Court

Office of Performance Evaluations

ope

Idaho Legislature