



Implementation of Alabama's R. C. Consent Decree Creating a New Culture of Practice

Background

This paper was prepared to provide ideas for a child welfare system faced with a massive, statewide litigation driven reform that encompassed changes in policy, workload, information systems, provider performance, staff training, resource development, front-line practice and child and family outcomes. Attempting to support such massive organizational change across an entire system was proving to be challenging and where change in the quality of practice was concerned, disappointing. The Child Welfare Group, which was in an advisory role, was asked to prepare a background paper on Alabama's experience in approaching change on a similar scale, in which it approached reform incrementally in groups of counties each year. The following narrative reflects the experience of Paul Vincent, Director of The Child Welfare Policy and Practice Group who was the Alabama child welfare system's director during its reform implementation and that of several of his colleagues.

The Settlement

The agreement of the Alabama Department of Human Resources to negotiate a settlement of the two-year old class action child welfare litigation occurred only a few weeks before trial, leaving little time to reach agreement on the complex issues of enforceable obligations and implementation. Rather than prolong the negotiation process and out of the realization that neither party was certain that it could define the specific steps needed to improve the system, the parties decided to begin with agreement on a set of best practice principles that would govern implementation. These principles described the practice to which each county was expected to convert within the term of the decree.

A set of goals was also included in the principles, intended to strengthen clarity about the Department's mission. Those goals were:

1. *Protect class members from abuse and neglect; and*
2. *Enable class members to:*
 - *live with their families; and when that cannot be achieved through the provision of services, to live near their home;*
 - *achieve stability and permanency in their living situation;*
 - *achieve success in school; and become stable, gainfully employed adults.*

To achieve these goals, the new system of care is expected to operate according to the following principles:

The principles selected included for example, the expectation that all interventions would be directed by a strength and needs based individualized service plan (ISP), developed with the significant involvement of the child and family within a family team. Others included the creation of a comprehensive array of home-based and other services, frequent, normalized visiting between children in out-of-home care and their families, placement in close proximity to families, timely permanency and stability, placement in least restrictive settings and appropriate use of seclusion, restraints, medication and behavior modification.

One of the most challenging principles stated,

The strengths and needs of the class member and his/her family shall dictate the type and mix of services provided; the type and mix of services provided shall not be dictated by what services are available. Services must be adapted to class members and their families; class members and their families must not be required to adapt to inflexible, pre-existing services that are unlikely to be effective.

Each class member had a right under the decree to a strength and needs based individualized service plan, meaning that over time all children and their families received essentially a new plan.

A total of twenty-nine principles were selected. A complete list is found in the Appendix. These principles constituted Alabama's first "Practice Model" and retained their influence even through periods where political forces

attempted to dismantle the reform.

The decree also included a separate Agreement Regarding Implementation that specified structural and organizational changes that would become part of an implementation plan. It provided for implementation of the reform, or “System of Care” as it was titled, in fifteen percent of the counties each year, meaning that implementation was intensive for the groups of counties selected each year. The decree provided for implementation of the first group of counties (six were selected) to be a sort of pilot, after which a formal implementation plan would be developed.

The First Year

Shortly after the court approved the settlement, the parties met and literally said jointly to each other, “Where do we go from here?” There were few relevant models in the field and no child welfare system at the time was attempting to achieve the objectives of the decree in the way the parties had chosen. Initially, DHR (the child welfare agency) invited a group of external experts in the field to a series of planning meetings to brainstorm the implementation process. Some of these consultants had a systems orientation, but most were selected for their familiarity with the approach to practice embodied in the decree. They came from mental health, child welfare, developmental disabilities and even special education backgrounds.

Early meetings resulted in the recommendation that the first counties chosen should be those most interested in reform, with the strongest leadership and the broadest community support for change. It was also clear that they should be selected to represent both rural and urban, large and small communities. Counties statewide were invited to “apply” to be a stage one county and to demonstrate the interest of key stakeholders such as judges and providers.

Because counties saw the stage one status as a vehicle to acquiring more resources, many counties expressed interest. None had the slightest idea how frustrating and difficult conversion of practice to the R. C. principles would be or how much of the first year would involve trial and error.

It is useful to know at this point how little internal capacity the system had to implement this decree. The promising practice everyone embraced was essentially foreign to everyone. Staff had never seen it fully realized and had little ability to teach it to the work force of caseworkers and providers. Even the expert consultants, soon to be called external consultants, had little experience implementing such approaches in an entire system.

As a next step, the Department decided to assign an external consultant to each of the first six counties to help them organize their approach to change, to mentor at the case and unit level the use of family meetings and creation of ISP's and to assist counties to change their service array. These external consultants were paired with state child welfare consultants who would be mentored by the external consultant and take over the technical assistance duties for future counties beginning the conversion process. These Departmental consultants joined a new System of Care (SOC) Office that had responsibility for county conversion to practice consistent with the principles. External consultants visited their county monthly for 3-4 days per month and SOC consultants visited more frequently.

External consultants were formed into what was called a consultant council that met with state level leadership regularly, identifying barriers and brainstorming solutions. These two-day meetings were free-flowing discussions that helped invent solutions to the periodic problems in implementation that arose. They also provided a forum for directing and coordinating the work of consultants.

Selection of the System of Care Consultants was vital to their success. Those selected were generally younger, more recent MSW's who were attracted by the challenge and open to learn new approaches to working with families. Later in this paper, the difficulty caused by using staff with a lower merit system status for such important roles will be discussed as a major system barrier.

After choosing the six counties, the Department convened a Kick-Off Conference at a retreat to which the leadership and supervisors of each stage one county were invited. The external and System of Care Consultants led the training and discussion and paired with their assigned counties to begin the conversation about implementation.

The Department decided to commit the modest additional revenue available in the year one of implementation to two areas, training the work force in the new practice and providing flexible fund dollars to the stage one counties to permit them to acquire the unique services necessitated by individualized service plans. The decision was made, to the dismay of county staff, to delay using new revenue to hire additional caseworkers, in part because there wasn't enough money to make a significant difference in workload. More important, however, we believed that it was of first importance to make the existing work force competent. New staff were not added until the beginning of the next fiscal year.

Work on curriculum development actually began prior to the settlement. A non-profit technical assistance organization was selected to craft a curriculum that would strengthen practice and Linda Bayless, now with The Child Welfare Group, led the technical assistance team. After the approval of the settlement agreement, the training team used the decree's principles to guide the content of the training. Resources were invested to hire additional Departmental trainers. Again, new trainers were selected based on their enthusiasm and openness to new ideas. Once the curriculum was completed, staff trainers did not train independently until they had observed the complete training delivery by the training consultants, co-trained with them and trained solo, with consultants observing and coaching. They became quite skilled in modeling and training this very practice-based curriculum.

Counties were informed that all staff would need to complete the four classroom weeks of the new training. No line staff were trained until their supervisors completed training.

In beginning the R. C. implementation process, stage one counties had little in way of structural system supports. They had the principles and an external and internal consultant that could coach and mentor practice consistent with the principles. Each county got a substantial sum of flex dollars for use in implementing plans. The training curriculum had been completed and stage one counties were required to release as many staff to training as possible, with the goal of getting all staff trained within the first year. State office leadership held monthly meetings with stage one county leadership to share successful approaches, problem solve and most enjoyed by the counties, criticize the State office for not getting needed support to them fast enough.

During this period the environment in the stage one counties was the most unstructured they had ever encountered. Due to the lack of state office capacity to develop functional policy reflective of the decree's principles and recognition that not enough was yet known about how policy could best support the new practice, issuance of new conforming policy was deferred until the experimentation in stage one could teach the field what was needed. Because large numbers of staff were in training, other staff had to cover their caseloads while they were away. The State office relaxed some case related timeliness deadlines out of realization that counties couldn't conform to standards and meet the retraining goals.

Because some parts of the child welfare policy manual were essentially obsolete, county staff relied heavily on the decree's principles, the new training they had received and the coaching and modeling by the consultant teams to shape their practice. Frankly, the practice related content of the

manual got little attention even prior to the decree. Caseworker practice had been governed more by worker bias and the local office practice culture than State office influence.

Early Changes

Training

The training curriculum and its delivery had become a powerful lever for change at the local level. It was designed to follow the natural process of casework, with week one devoted to engagement, week two assessment, week three strengths based planning and week four, intervention. Later an additional module was added devoted to child and family team meetings. The content of the training was largely practice related rather than topical or procedural in focus. Specialized topics and process issues were dealt with in separate in-service settings. Trainers had become skilled in modeling the practice and were effective in actually developing fundamental skills in the four areas of practice represented. Video taping of role plays was used to permit participants see their own practice and refine it.

A major and unexpected benefit of the training was the way it helped diminish the differences workers perceived between themselves and the families they served. It was not uncommon to hear participants remark with regret at how they could have treated families so harshly and disrespectfully in the past. “We don’t do that anymore” was a frequent reflection on past practice. This new self-awareness that things needed to change had a major impact on changing the local practice culture.

One additional reason that the training reached the level of effectiveness that it did was the structure of the training. Training was in residential settings, so all staff except those living in close proximity to the training spent four weeks together with the same participant group. This opportunity to learn together and form trusting relationships within their training group permitted participants to take the risks to expose their skills and values in the classroom that enhanced skill development and reflective practice.

Despite the inconvenience of having so many staff away at training, generally county directors were eager to get staff admitted to the next training cohort. In fact their biggest frustration was that there were not enough trainers.

Front-Line Practice

As staff completed training and returned to front-line practice, because each stage targeted a small group of counties, they soon joined an entire local work force united in values, goals, approach and skills. Unlike the first group of training graduates, they were unlikely to hear, “We don’t do that here” from seasoned staff. Since the child and family team meeting training had not yet been developed, external and System of Care Consultants developed local family meeting facilitation skills through coaching in actual cases. Staff quickly saw the power of these meetings to produce meaningful changes in outcomes. External stakeholders also became advocates of the process as they were enlisted in family teams. Halfway through stage one, a juvenile court judge and county director in one of the counties involved even sent a video taped Christmas thank you for including them in the first stage. The judge referred specifically to the positive impact of family meetings she had observed from the bench. She noted that the Department and families were more likely to be united in their efforts, that parents and teens were more committed to their plans and that cases closed more quickly.

Consultants spent considerable time helping counties strengthen their service array. It quickly became evident that the conventional array of services like residential care, counseling and parenting classes weren’t responsive to the creative plans evolving from family teams. Consultants helped county directors engage their provider community and identify the new supports that were necessary to respond to child and family needs. One external consultant helped her medium sized county develop a new contract RFP for what were called “cluster services”. These were an array of flexible in-home supports like individual attention services for youth, therapeutic visitation supports, parent skills development provided in-home, in-home medication management and educational advocacy. To provide broader support, a state level resource development manager was appointed.

Early Challenges

Concurrent with these surprising early successes was the presence of a frustrating array of bureaucratic and other organizational obstacles that impeded timely implementation of systemic supports for the new local practice. It took months to reach agreement between the Department’s attorneys, fiscal and program staff on the use of flexible funds and design of simple contracts for use with individual children and families. Counties would develop these very creative and promising plans within the family team only to find that they couldn’t spend the flexible dollars provided to them. Families, stakeholders and workers were rightly impatient with this

problem. Locally, it affected the credibility of the reform until it was resolved.

Once the barriers to spending money were resolved, to the surprise of many, it was difficult to get caseworkers to employ this flexibility creatively. They had difficulty in thinking about matching services to needs, so conventional services were too often the only option considered. And they feared that they might misspend the funds if they were used unconventionally. The coaching by consultants helped them develop skill in what became known as “service crafting”. Once this barrier was overcome, workers became so creative that the need for some formal guidance on spending was required, beyond existing safeguards. While using flex funds to pay the bail for a mother arrested due to a domestic altercation is effective in avoiding a foster care placement, such an expenditure would test the patience of even the most compassionate auditor or editorial writer.

Much of the residential community came to embrace the reform and eventually flourished by diversifying to provide an array of home-based supports that replaced the revenue from beds no longer needed. A smaller subset of group home operators and for-profit residential treatment operators never accepted the reform and undermined it at every opportunity. Some of those went out of business because the youth they served could be appropriately served in home-based settings. The system never found a way to convince them that other approaches were better for children.

Another system barrier was the personnel system. To put it mildly, the State’s personnel agency never joined the R. C. team. When resources permitted the addition of staff to stage one counties, the unresponsiveness of the personnel system became even more apparent. For example, the best candidates on registers often were at the bottom of the list and unreachable. It was almost impossible to bring in expertise from the outside. At one point the obvious lack of internal capacity at the State level became a major issue with plaintiff attorneys. The Department had been unable to access senior staff with expertise in Medicaid maximization, resource development and policy, among others. Efforts to hire external experts as staff members were blocked by the personnel system and merit system rules. Only after plaintiffs’ secured agreement in writing as a modification to the decree did the permission to hire ten additional senior staff occur and then only after the threat of a motion to hold the Department in contempt.

Resource development was the other major system barrier. Most providers offered a single service and had little ability to adapt existing services to respond to individual child and family needs. Most services were delivered

in provider settings, so getting providers to reach beyond their walls was extremely challenging. As a result, there was system driven instability for children in care, as they had to move to access a different or more intensive service array. Also, providers were clustered in urban areas, leaving little infrastructure to build on when the need for new services was identified in rural communities. Particularly problematic was the lack of state level expertise to lead a resource development initiative.

Ultimately, a number of strategies emerged to expand resources. Incentives for diversification were provided through the provision of funding for brief start-up periods prior to actual service delivery. A number of residential providers chose to move into intensive home-based services and therapeutic foster care and State funding was provided for several months to support the development of programs and hiring of staff.

The resource development team helped individual rural counties develop partnerships with contiguous counties to provide enough service demand to attract new providers to a different region of the state.

Counties were permitted to use flexible dollars to add to the supports offered by a traditional provider. So based on the path developed in a family's individualized service plan, for example, flex funds could enable a counseling agency to hire a retired special education teacher to extend home-based coaching for a foster parent taxed by the child's disruptive behavior. As they succeeded, these individualized responses to families gave providers confidence in investing in diversification on a more organized scale.

Perhaps appropriately, the tension between providers who wanted predictability in service demands and the Department, which continued to demand that interventions be based on one-child-at-a-time individualized service plans, was never completely resolved. Meeting needs remained a little messy at times, but produced a much more effective response than merely shopping from a convenient menu.

Consolidating Success

Earlier than anyone expected, the convergence of workers who through training and coaching had internalized the values of the principles, the routine use of child and family team meetings that facilitated family ownership of plans, reliance on the individualized service plan to drive interventions and the creative use of flex funds began to change outcomes in Stage one counties. There were significant reductions in entries into care, lengths of stay declined, child multiple moves dropped significantly and

reliance on congregate care declined by forty to fifty percent in some localities. The individualized service plan envisioned in the principles assumed primacy in a way that overshadowed conventional bureaucratic procedures and barriers.

While the data system was cumbersome and limited in scope, it did provide enough information to provide counties a simple quarterly snapshot of performance outcomes against the principles. So counties could compare themselves with peers in regard to, for example, entry/exit rates, multiple moves, percentage of children in congregate settings, adoptions and re-entry rates. These reports further demonstrated the attention of leadership to practice and fostered healthy competition among counties to strengthen their performance. Negative trends identified regions needing greater attention and supports.

A monthly System of Care Newsletter was developed to highlight examples of good case practice, creative use of flex funds, breakthroughs due to new approaches and to provide general information about organizational issues. The newsletter served as another among many examples of the value and priority assigned to practice by the state office.

Inventing the Qualitative Service Review (QSR)

Toward the end of the first year of implementation, the parties chose to tackle an issue that had been deferred in the language of the decree, how to measure compliance with the principles. Conventional case record reviews were obviously insufficient to assess the degree of child and family involvement in planning or the quality of assessment. The recently appointed court monitor, who had been a consultant to the reform, suggested adapting an approach he had used in developmental disabilities institutions as a method of measuring resident habilitation. Case notes had been found to be insufficient to determine whether residents were actually progressing toward independence.

This approach, relying heavily on face-to-face interviews and observation of residents in their daily activities, was used by the monitor to propose an alternative to ordinary compliance reviews. The version suggested was found to be unresponsive to key child welfare concepts and seasoned Department staff revised it to create a tool more focused on issues of permanency and family issues. While the final version was overly structured compared to the most recent protocols, the new QSR provided a revealing picture of the child and family's status and system performance.

In addition to providing local and state level staff with feedback on practice

development opportunities, the QSR demonstrated to local systems and staff that practice quality was so important that it would be measured regularly. It was clear that county staff felt a greater sense of responsibility for practice consistent with the principles, knowing that it would be periodically examined.

Being developed as a reviewer also had a system changing effect. Staff that were taught to conduct reviews describe the experience as opening their eyes to what hadn't been happening and pointing to what should be. The review experience consistently changed staff perspectives about practice.

Adaptations for Stage Two

By the time planning for stage two implementation occurred, the lessons learned from stage one provided better structure for the next phase. External and SOC consultants knew better how to approach changing the local practice culture. Approaches to county conversion planning had been tested in stage one and were used to create a set of formal expectations which stage two counties used to develop their plans. Even though each county approached the change process somewhat differently, a chronology of conversion emerged that appeared to be the most effective in strengthening practice

The QSR began to be implemented and pointed to outcomes and system performance that needed improving. It also disabused many of the idea that, "We already do that."

The confusion over using flex funds had diminished, permitting ISP's to be more effectively implemented. The unexpected early successes in stage one helped convince some doubters that the new approaches were promising, expanding the base of support for the reform. Some key written policies that were needed to support the principles began to be completed, providing greater clarity about direction. Stage two counties finally were able to see the principles more fully operationalized by visiting stage one counties. This helped answer the frequent question, "What does a system of care look like?" This had been an issue since the decree was improved, reflecting the inability of staff to see new practice as being outside of the boundaries of a "program".

Last, adding stage two counties to the list of counties in the conversion process, which included all of stage one (being no where near completing conversion), focused attention on the increasing lack of capacity within the state level child welfare division. There were not enough external and SOC

consultants to support the not-yet-completed stage one plus the additional counties in stage two. As a result more were recruited and hired. Additional trainers were also hired to support the growth in staff needing training. The biggest challenge involved many of the existing division staff that had been somewhat by-passed in the interactions with stage one. They had been maintaining daily operations and missed important opportunities to be exposed to the new practice. They had little contact with external consultants and many had not completed the new training. This unintentional, but harmful neglect meant that the division continued to operate with two cultures, one focused on the reform and the other, waiting for their turn to join it (or in some cases, dreading it). It took a considerable length of time to convert the division to practice consistent with the principles and the internalization of the principles continued to be resisted by some.

Life on the Front Line in Stage One

Interviews with state level staff, staff from counties in stage one and a former external consultant provided additional insights into life at the front line in the early days of implementation.

Counties began the process with what was called a “desk audit”. The key elements of each open case were extracted and provided a county-wide profile of the caseload more textured than just numbers. This analysis revealed themes about child and family status that identified children lingering in group care, home-based cases that had remained open with little progress over long periods of time and children moving frequently, for example. Counties selected populations to begin the ISP process with strategically, based on where the greatest stresses were occurring.

Training was developed called “Safe Case Closure” (more accurately, safe case resolution, as some cases need to remain open) that with the assistance of external and SOC consultants, permitted many cases to be closed. These cases included a number of cases already receiving little attention, but also included difficult, time consuming cases on which the staff were stuck. The question posed was essentially, “What do this child and family need to resolve the safety, permanency and well-being issues they face”. Caseloads began to decline as this process evolved and staff had more time to devote to other parts of their caseload.

Generally speaking, external consultants were highly valued. One stage two county staff member described that role as follows.

External consultants were invaluable to counties. Ours taught us new ways to engage and interview, new ways to think and to be creative and ways to improve ourselves in the process. She provided new ideas in an environment that had been barren from the top down. The conversion for us couldn't have happened without her because it was the continued support of ACT (the new training) and the principles that kept the momentum going. She encouraged and coached us in the practice of what we had learned. Through the state office, we had access to a pool of experts who helped us with new ideas, concepts foreign to county staff, such as wrap-around services. We were empowered to become good consumers of services that would benefit our families, which we had not been able to do in the past. We came to understand that services should have an expected outcome, that professional assessments should be prescriptive, that other stakeholders had obligations within the planning process. We were able to develop community resources. Most importantly, we saw families differently, as partners, although reluctantly at first. We became strength-based in our practice. These were all the results of ACT training and our external consultants.

Our consultant individualized her consultation to suit our need. We asked for additional training in specific cases, development of interviewing skills with particular populations, assessment. On difficult cases, she made visits to children and facilities. She would ask "Why not?" when we said we couldn't do something, or ask how something might happen, which allowed us to do that on our own. She was unlikely to give us the answer, which I found frustrating at first, but it taught us to think and was effective in developing our capacity. This process empowered us in our work with providers. She helped us to see families differently. She didn't meet with every worker, but we tried to extrapolate her work so that it had greater benefit to the agency. We had the ideal environment for this to occur. Because her time was limited it was important that she have persons with whom she could connect who could implement the change. We constructed our internal plan in a way that used her time to best advantage and allowed her expertise to reach the greatest audience.

This was done with specific strategies. We learned to use our own strengths which we were able to identify as a result of an external perspective and training. We defined expectations for

ourselves. We supported the expectations. We began to practice differently, with less difficult cases first, using skills we had learned in ACT and from our consultant, not that we became as expert as she, but we saw significant success. We met with our providers to ask their cooperation and input and to share what we would want from them. We developed new resources and used others more creatively. The success resulting from the change improved job satisfaction as well as case outcomes.

*ACT taught us new skills and gave us a different perspective. It provided the framework for our work with families. It established **first steps first**. The ISP was developed after we had engaged the family and was not a stand-alone element of practice. In our current work with states (meaning CWG's), I see that this is missing and probably accounts for the lack of buy-in for the FTM we try to promote. In Alabama, we came to understand that the relationship with families needed to effect change could be established by the use of skillful casework techniques. Once we had "joined" (I hated that word when I first heard it in this connection.) with families we could understand what we needed to do to address risk.*

From that came the assessment and the ISP. The ISP was not isolated or independent from the relationship. In our County, for the most part, we had treated families with respect. The idea that practice, which already appeared to conform to that expectation, should change fueled the initial response and likely is the reaction other states have. ("We already do that.") Defining engagement with training by experts helped us to see the value of creating an environment where we could discuss risk and its causes. Partnership had been missing. It was the way that the training was presented and the expertise of the trainers that accomplished the practice change.

Key Contributors to Success

To summarize the lessons learned in the early years of the reform, the following factors of implementation were key contributors to the success of implementation.

1. The importance of different practice was a major emphasis of the decree

2. The principles selected served a prominent governance role in the approach to practice, creating the system's first practice model.
3. The system leadership recognized the ineffectiveness of prior practice and the harm it could cause and focused on changing it, not defending it.
4. Phased implementation permitted the delivery of intensive technical assistance to counties, pushing the change process deeper than possible in a statewide approach to implementation.
5. Training was matched to the principles, designed to develop actual skills and delivered by skilled trainers that could model the skills and coach performance in the classroom. Participants remained in the same training cohort through the classroom weeks, creating cohesion within the group. All staff were required to complete the training. Having a critical mass of trained staff in each of the county stages provided for a uniform vision of practice and more thorough internalization of the principles.
6. Training, coaching and other supports empowered workers to internalize the principles and instilled a sense of "whatever it takes" in helping children and their families. Because they were helped to master facilitation skills, workers facilitated family team meetings themselves in most cases and experienced newfound satisfaction in supporting the team's assistance to families.
7. External and SOC consultants had real consultative and coaching skills that were desired by counties. Because they were also representatives of the system leadership, external consultants weren't perceived as just another consultant counties could choose to ignore. Their currency, however, was their engagement abilities and skill.
8. The opportunity to test new approaches in stage one permitted the most effective implementation strategies to be replicated for later stages.
9. Flexible dollars used correctly changed outcomes.
10. Smaller caseloads made consistent high quality work more achievable.

11. The quality of local leadership was perhaps the key variable in effectively completing conversion to practice consistent with the principles. Counties with weak leadership took much longer to convert and had difficulty in sustaining it.
12. The QSR's development provided valuable feedback and highlighted accountability for good practice.
13. The state level child welfare division changed its role and relationship to counties from "permission giver" to treating counties as a customer to be supported. Balancing the role of superintendence and support required constant attention.
14. Continuity of leadership during the first six years of implementation meant that there was consistent and informed direction from the top that maintained the learning environment essential to the success of this process of change.

Implications for Other Child Welfare Systems

The changes that occurred in Alabama were highly influenced by the presence of the decree and its unique design. However, the reform elements that produced the change could be employed successfully by any system. The focus on individualized, strength based practice as the method of changing outcomes, the retraining of staff, extensive use of family meetings, individualized planning, flex funds and the use of the QSR can be incorporated into system design without the pressure of a lawsuit. In an increasing number of jurisdictions, these elements are being adopted as part an internal change agenda.

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APPENDIX

Alabama's R. C. Consent Decree

The consent decree spells out as the goals of the new system of care, to:

Protect class members from abuse and neglect; and

Enable class members to:

- live with their families; and when that cannot be achieved through the provision of services, to live near their home;
- achieve stability and permanency in their living situation;

- achieve success in school; and
become stable, gainfully employed adults.

To achieve these goals, the new system of care is expected to operate according to the following principles:

1. **Class members shall live with their families.** Exceptions are to be made only when:

- it is not possible, through the provision of services (including intensive home-based services), to protect a class member living with his/her family from imminent, serious harm; or
- it is not possible, though the provision of services, including intensive home-based services, to protect a class member from serious harm upon reunification with his/her family.

2. **Class members and their families shall have access to a comprehensive array of services, including intensive home-based services, designed to enable class members to live with their families.**

These services should be designed to enhance the natural support networks of class members and their families. Other services to which class members and their families shall have access, if required to enable class members to live with their families, are: parenting skills and household management training; peer support; homemaker services; day care; respite care; help with housing; crisis services; mental health services; services for substance abuse; and “facilitative” services. Class members and their families shall have access to such services when the class member is living with his/her family or when the goal is for the class member to return home or live with a relative. When the goal is for the class member to return home, services should also be provided to the parents to prepare and enable them to care for the class member when he/she returns home. When the goal is for the class member to live with a family member, services should be also provided to the family member to prepare and enable the family member to care for the class member.

3. **Class members, while in foster care or DHR custody, shall have access to a comprehensive array of services that address their physical, emotional, social and educational needs.**

3. **Both class members and family members may refuse placement-prevention services.**

Class members and family members may refuse other services, to the extent permitted under law.

4. Class members and their families shall be encouraged and supported to access services.

To this end, the “system of care” shall develop and implement strategies to promote the utilization of services by class members and their families. These strategies shall include the use of community aides, the provision of transportation services, the development of ethnically and culturally sensitive services, and referral to peer support groups. When class members or their families refuse or fail to access services, the reasons for their doing so shall be assessed and the services that have been offered shall be modified or alternative services shall be offered to encourage acceptance of services.

5. Class members and their families shall receive individualized services based on their unique strengths and needs.

The strengths and needs of the class member and his/her family shall dictate the type and mix of services provided; the type and mix of services provided shall not be dictated by what services are available. Services must be adapted to class members and their families; class members and their families must not be required to adapt to inflexible, pre-existing services that are unlikely to be effective.

7. Services to class members and their families shall be delivered pursuant to an individualized service plan.

There must be a reasonable prospect that the services provided will achieve their purpose. The services must be of a type and mix likely to achieve the goal for the child. The services must also be of a type and mix likely to be effective in meeting the needs to which the plan is designed to respond.

a. Individualized service plans shall be based on a comprehensive, individualized assessment of the strengths and needs of the class member and his/her family. In the case of class members in foster care or DHR custody, this assessment shall include an examination of the class member’s (i) developmental, behavioral, emotional, family, and educational history and (ii) strengths and weaknesses in behavioral, emotional, educational, and medical/physical areas.

b. Individualized service plans shall include specific services to reinforce the strengths and meet the needs of the class member and his/her

family. Each plan shall identify the specific steps to be taken by DHR staff, other service providers, class members, and the class members' parents and family toward meeting the short-term and long term objectives of the plan.

- c. The "system of care" shall carefully monitor implementation of the individualized service plan and the progress being made toward the goal and objectives of the plan.
- d. The goal and the objectives of the individualized service plan will be updated as needed. Services identified in the plan will be modified as needed to meet the goal and objectives of the plan (for example, by adding new services or providing services in a different way). Steps shall be taken to prevent and address deterioration in the functioning of class members.

8. The "system of care" shall address the needs of class members believed to be victims of sexual abuse.

- a. Timely, professional assessments shall be conducted of class members believed to be victims of sexual abuse. DHR shall ensure that such assessments provide clear, prescriptive guidelines for treatment of the sexual abuse.
- b. The individualized service plans of class members believed to be victims of sexual abuse shall specifically identify both the class member's needs as a sex abuse victim and services to be provided in response to those needs.

9. Class members, parents, and foster parents shall be accurately and timely informed, in language understandable to them, concerning: rights under the decree (including the right to be treated in accordance with the "principles" or "standards"); the goal for the class member; individualized service plans, including objectives; services, including placements; and options.

10. Class members, parents, and foster parents shall be encouraged and assisted to articulate their own strengths and needs, the goals they are seeking for themselves, and what services they think are required to meet these goals.

11. Class members, their parents, and foster parents shall be involved in the planning and delivery of services.

This includes the ISP. The right of class members, parents, and foster parents to participate in treatment planning and delivery may be restricted only according to a specified administrative process. DHR shall promulgate a policy, acceptable to both parties, describing under what circumstances and according to what procedures restrictions may be imposed.

- a. The class member shall be treated as a partner in the planning and delivery of services if the class member is age 10 or older and, if the class member is under the age of 10, when possible.
- b. The class member's parents shall be treated as partners in the planning and delivery of services if the class member is living at home or if the goal is for the class member to return home.
- c. Foster parents shall be treated as partners in the planning and delivery of services whether or not the goal for the class member is to return home.
- d. When necessary, services shall be provided class members and parents to enable them to participate as partners. Such services shall include transportation assistance, advance discussions, and assistance with understanding written materials.

12. The “system of care” shall promote class members’ visitation with their parents and family.

- a. The matter of visitation shall be addressed in the class member's individualized service plan. The frequency and circumstances of visitation shall depend on age and need. Visitation shall be viewed as an essential ingredient of family reunification services. Hence, when the goal is for the child to return home or live with a family member, visitation will be actively encouraged; assistance with transportation will also be provided.
- b. Visitation may be arranged by the class member, the class member's parents or family, or the foster parents, as well as by DHR staff and the staff of residential facilities, in accordance with the individualized service plan.
- c. Supervision of visitation shall be required only when there is a danger that the parent or family member with whom the class member is visiting will harm the class member unless the visit is supervised. ‘When supervision of visitation is required, such supervision may be provided,

as appropriate, by the class member's foster parents, as well as by DHR staff, the staff of residential facilities, or other designated persons.

13. The “system of care” shall be sensitive to cultural differences and the special needs of minority ethnic and racial groups.

Services shall be provided in a manner that respects these differences and attends to these special needs. These differences and special needs shall not be used as an excuse for failing to provide services.

14. The “system of care” shall conduct timely investigations of allegations that class members are being abused or neglected while living at home or with a relative or while in foster care or DHR custody.

14. The “system of care” shall embrace the philosophy of service delivery in home-based and community-based settings.

Class members shall receive services in the least restrictive, most normalized environment that is appropriate to their strengths and needs.

a. Class members shall be placed in the least restrictive, most normalized living conditions appropriate to their strengths and needs. The class member's own home shall be considered the least restrictive, most normal placement. Following are other placements listed in ascending order in terms of restrictiveness: independent living; a foster home; a therapeutic foster home; a group foster home; a group home; a child care institution; an institution. Institutional care shall be used only in an emergency and as a last resort. Class members shall be placed in family settings, whenever they can be cared for in such a setting with supportive services.

b. Siblings shall be placed together. DHR may promulgate a policy, acceptable to both parties, identifying circumstances in which exceptions to this principle may be permitted.

c. The “system of care” shall not initiate or consent to the placement of a class member in an institution or other facility operated by DMH/MR or by DYS unless the placement is the least restrictive, most normalized placement appropriate to the strengths and needs of the class member.

d. Class members, when in foster care or DHR custody, shall be integrated to the maximum extent feasible into normalized leisure and work activities.

e. DHR shall vigorously seek to assure that class members, when in foster care or DHR custody, are integrated to the maximum extent feasible into normalized school settings and activities.

16. Class members from Jefferson, Mobile, Montgomery, Madison, Houston, Tuscaloosa, Etowah, Calhoun, Walker, Lee, and Dallas counties shall be placed within their home county when removed from their homes.

Class members from other counties shall be placed within the region in which their home county is located. Exceptions to this principle are to be permitted only in exceptional circumstances with the written permission of the Director of the Division of Family and Children's Services or his/her designee. DHR shall promulgate a policy, acceptable to both parties, that describes when such exceptional circumstances are present.

17. The "system of care" shall promote permanency in class members' living situations.

- a. 'When the goal is that the class member shall return home or be discharged to a family member, the "system of care" shall vigorously seek to achieve this goal.
- b. When the goal of return home or discharge to family has been achieved, the "system of care" shall vigorously seek to avoid reentry of the class member into foster care.
- c. The "system of care" shall make timely, competent decisions concerning whether and when class members should return home.
- d. When a decision is made that a class member should not return home, DHR shall seek a timely dispositional hearing.
- e. When the goal is that the class member not return home, the "system of care" shall vigorously seek a permanent living situation for the class member.

18. The "system of care" shall promote stability in class members' living situations.

- a. The "system of care" shall be designed to minimize multiple placements. The "system of care" shall be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the class member.
- b. Individualized service plans shall identify whether a class member is at risk of experiencing a placement disruption and, if so, will identify the steps to be taken to minimize or eliminate the risk.
- c. Appropriate training will be required for, and appropriate supportive services will be provided to, foster parents and staff of residential facilities in order to minimize placement disruptions. In the case of foster parents, the services shall include intensive home-based services and respite care.
- d. The "system of care" shall forbid summary discharges from placements. DHR shall promulgate a policy, acceptable to both parties,

that describes steps that must be taken prior to a class member's discharge from a placement. The policy may permit in exceptional circumstances the placement of a class member in a temporary, emergency setting without prior notice to DHR.

e. The "system of care" will avoid temporary, interim placements. Class members shall be placed in settings that could reasonably be expected to deliver long term care if necessary. To this end, DHR will not place class members in shelters unless (i) the full array of services the class member needs can be provided the class member while residing in the shelter and (ii) it is likely that the class member's stay in foster care will not extend beyond his/her stay in the shelter. f. The "system of care" will vigorously seek to ensure that law enforcement officers, juvenile court personnel, and others do not remove class members from their home and place them in foster care or DHR custody without first notifying the "system of care" and providing the system an opportunity to intervene to prevent the removal or placement.

19. The "system of care" shall ensure that the services identified in individualized service plans are accessed and delivered in a coordinated and therapeutic manner.

20. Services shall be provided by competent staff who are adequately trained and supervised and who have appropriate caseloads.

The competence of staff staff's training and supervision, and staff's caseloads shall be deemed adequate when the "system of care" is able to comply with the standards set forth in this decree.

21. Services provided class members and their families shall meet relevant professional standards in the fields of child welfare, social work, and mental health.

22. The "system of care" shall require that any behavior modification program employed in the treatment or management of a class member be individualized and meet generally accepted professional standards, including that:

- a. The program rely primarily on rewards instead of punishments;
- b. The program be based on a careful assessment of the antecedents of the behavior that the program is designed to change; and
- c. The program be consistently implemented throughout the day, including in school, residential, and leisure activity settings.
- d. The "system of care" shall take an active role in seeking to ensure that local education agencies and the Alabama Department of Education (i) recognize class members' educational rights and (ii) provide class members with educational services in accord with those rights. Among

other things, the “system of care” shall advocate for class members who are subjected to inappropriate and/or illegal disciplinary measures.

23. The “system of care” shall promote smooth transitions for class members to adult service systems and/or independent living when class members “age out” of the system.

The individualized service plans of class members who are expected to “age out” of the system shall provide for such transitions.

24. The “system of care” shall accord class members the following rights: the right of access to counsel and the courts, the right of access to family members, the right to be free of excessive medication, and the right to be free from unnecessary seclusion and restraint.

DHR shall promulgate policies, acceptable to both parties, describing and protecting these rights. The policies shall provide that:

- a. Class members shall be permitted to freely communicate by telephone or mail with (i) legal counsel of the class member’s choosing, including the class member’s guardian ad litem, and (ii) organizations that provide legal services.
- b. Class members shall be permitted to freely communicate by telephone or mail with (i) the class member’s parents and family members and (ii) adult friends of the class member including former foster parents. This right may be restricted only pursuant to procedures and in circumstances specifically identified in written policy.
- c. Class members retain the right to communicate and visit with their parents and family even when the class member is in the permanent custody of DHR (i.e., parental rights have been terminated). When the class member is in permanent custody, the matter of his/her communication with parents and family members shall be addressed in the class member’s individualized service plan. Such communication may be restricted when it would undermine or defeat attainment of the goal or objectives identified in the plan.

25. Class members, parents and foster parents shall be made aware, in an effective manner, of the availability of advocacy services to assist them in protecting and advancing their rights and entitlements.

26. Class members shall be provided effective assistance and support in applying for SSI benefits. (Where it is necessary that the class member’s parents apply for benefits, such assistance and support shall be provided to the parents.)

26. Class members shall be enrolled, if eligible, in the EPSDT program and shall receive comprehensive screens that meet the requirements

of federal law and are provided according to a professionally acceptable schedule.

27. The “system of care” shall promote early identification and timely intervention in order to enhance the likelihood of positive outcomes.

29. The “system of care” will identify, assess, and disseminate state-of-the-art methods, strategies, and materials for serving class members and their families.