

**Department of Social Services
Systems Mapping of Residential Care
Procurement Planning**

This paper presents the results of a Systems Mapping effort undertaken in support of the DSS system of care procurement. Specifically, it focuses on one of the central goals and challenges of the initiative: reducing DSS' reliance on residential placements and increase the community tenure of kids now in or at risk of long-term care. Readers should keep in mind that the system of care initiative encompasses a wide range of service types and lead agencies will work with a range of families/children with various levels of service need. This analysis focuses on a subset of those services and families. References in this paper to the lead agencies' responsibilities are largely with regard to this subset, not to the entire initiative.

The paper presents a set of causal diagrams that examine the following types of questions:

1. What capabilities and services need to be in place for the system of care procurement to have the desired impact? What are the consequences of not having certain services/capabilities in place? What could make things worse rather than better?
2. Where is the most productive place to start? Which populations and/or sets of services offer the highest leverage and greatest potential for results from the early stages of the system of care procurement?

At first glance, the diagrams look like a confusing jumble of loops and circles, resulting in their nickname: "spaghetti diagrams". However, readers who examine them will likely find that their experiences in the service system are reflected in these loops. In fact, the purpose of systems mapping is to diagram the many inter-connected factors that influence our collective ability to care for children. Systems mapping allows managers and policymakers to better understand the causes of complex social and organizational problems and how organizational change and new policies can help deal with those problems or potentially make them worse. This analysis was conducted for DSS' Procurement Management Team (PMT) in order to build a shared understanding about how DSS' current system functions and how the new system should be designed.

Gary Hirsch is the consultant for the Systems Mapping work. Members of the Systems Mapping Working Group include: Chris Joyce, Ellen Finnegan, Susan Maciolek, John Renzi, Sal Scibelli, Bob Wentworth, and Judy Abrahams. Assistance with data was provided by Mary Kennedy and Ros Walter of the DSS IT Division.

Introduction

A principal goal of the System of Care initiative is to reduce the utilization of long-term residential settings by

- avoiding residential placements for children who might otherwise have had them,
- shortening the stays of children for whom residential placement is unavoidable, and, in general,
- moving kids from residential settings to the community and toward permanency.

This paper presents a “Systems Map” of the causal factors that affect the utilization of long-term residential settings and potential impact of programs and policies designed to reduce utilization and move kids toward the community. The Systems Map consists of a set of diagrams that make it easier to visualize these forces and how they interact with each other. The Map makes it possible to develop a shared understanding of these forces and provide a framework for discussing them. This framework then enables us to identify the

- leverage points through which DSS can influence its utilization of residential settings,
- set of programs that must be in place for the effort to succeed,
- potential for unintended consequences that can undermine the effort,
- mechanisms for building on early successes and extending the impact of the system of care initiative, and
- starting points and sequence of steps by which the system of care initiative can be implemented.

These insights can then inform and help to shape the system of care procurement currently being planned.

Children Entering Residential Programs

Figure 1 on Page 3 indicates that the number of children in long-term residential programs, the focus of the effort, depends on the rate of children entering these programs and the average length of time they spend there. Opportunities for affecting the number in residential settings naturally involve reducing the number entering and shortening the average time they spend in residential care. As shown in Figure 1, the number entering residential care each year depends on

- the number potentially requiring residential care, as a result of demographic factors such as a “bulge” in the population of adolescents,
- the prevalence of serious problems with high-risk behaviors such as fire-setting,
- “failing up” through less intensive settings that cannot meet the needs of these children or deal with the risk they represent,
- court orders for DSS custody and residential placement, and
- alternatives for those children that provide the necessary levels of clinical, educational, and other services and safety for the children and those around them.

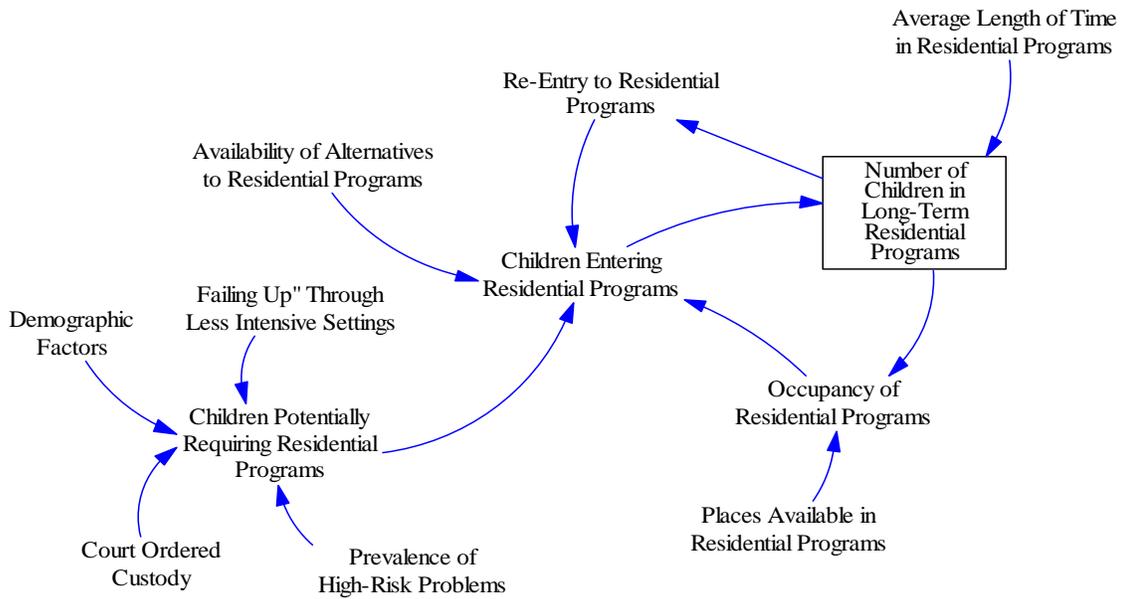


Figure 1: Overview of Factors Affecting Residential Placement

Utilization of long-term residential settings grew by 22.6% from 1999 to 2003 with most of that increase occurring from 1999 to 2001 (see Table 1 on Page 4). The factors that affect potential demand for residential care differ in terms of the Department’s ability to influence them. Part of the increase in demand over the past few years is thought to be the result of the increase in the 10-17 population in Massachusetts that was expected to grow, for example, by 15.9% between 1995 and 2000. Fortunately, this rate of increase is expected to subside, growing by only 6.2% between 2000 and 2005. The prevalence of high-risk problems such as fire-setting and sexual abuse is also somewhat beyond the department’s control. (There was some feeling that at least a few kids seen with these behaviors as adolescents were previously seen by DSS as children in protective cases.)

The role of the courts and the process of “failing up” through less intensive settings may be more amenable to influence by DSS, though one of these settings, Departmental foster care is nominally outside the focus of the system of care procurement. The other less intensive settings, specialized foster care and short-term residential care are included in the system of care procurement. Experience with influencing the courts is perceived to be mixed. However, some Area Offices are thought to have had success with placing at the courts workers who can see cases coming before custody is assigned to DSS and move them toward the care of other agencies that might be more appropriate. The process of “failing up” from less intensive settings may be driven partially by the erosion of places in those settings. As shown in Table 1, placements in Departmental Foster Care declined by almost 12% from 1999 to 2003 while overall caseload and placements in residential care and specialized foster care were increasing. The decline in Departmental Foster Care is all the more significant since it includes placements in kinship homes that increased by 24% during the same period.

	Year					Pct Change 1999-2003
	1999	2000	2001	2002	2003	
Not in Placement	29222	31267	32461	30361	32227	10.3%
Placed in:						
Departmental Foster Care	6887	6712	6473	6220	6077	-11.8%
% of Those in Placement	68.6%	65.0%	61.9%	58.7%	56.9%	
Specialized Foster Care	1054	1239	1410	1531	1664	57.9%
% of Those in Placement	10.5%	12.0%	13.5%	14.5%	15.6%	
Short-Term Residential	262	257	280	316	355	35.5%
% of Those in Placement	2.6%	2.5%	2.7%	3.0%	3.3%	
Long-Term Residential	1680	1931	2012	2048	2060	22.6%
% of Those in Placement	16.7%	18.7%	19.2%	19.3%	19.3%	
Other	156	187	282	475	516	230.8%
% of Those in Placement	1.6%	1.8%	2.7%	4.5%	4.8%	
Total in Placement	10039	10326	10457	10590	10672	6.3%
DSS Total	39261	41593	42918	40951	42899	9.3%

Table 1: DSS Utilization by Setting, 1999-2003

The availability of alternatives to residential programs is very much within the focus of the system of care initiative. As shown in Figure 2 on Page 5, the availability of alternatives to residential care requires both places for kids to live, for those who cannot stay at home, and a wide array of supportive services that can be customized to their needs and keep them safely in the community. As children diverted from residential care are placed in alternatives such as foster care, there are fewer places for others, especially if the number of Departmental foster care places continues to erode. The lack of places may constrain further diversion from residential care or else displace other kids who ultimately find their way to residential care.

The supportive services include school and after-school programs, mental health and other family based services, other wraparound services to meet highly individualized needs, respite care to provide relief for biological and foster parents, and 24/7 crisis intervention services to deal with problems that cannot be avoided. These services are interdependent. Failing to provide some of them may create risk or other problems that make it difficult to keep certain kids safely in the community. School programs were seen as a special concern since they must be developed based on good relationships with local school systems and these tend to vary among Area Offices and school systems. Schools need to be involved in crafting plans for kids rather than just being informed about them. Respite care was also seen as important for preventing burnout by biological

and foster parents. With these services, a number of children diverted from residential care to an alternative program can remain with biological families at home. The availability and effectiveness of these supportive services will affect the length of time that children must remain in an alternative program.

Lead agencies must have the capacity (and funding) to develop necessary services initially in advance of demand for those services and to continue service development over time as the number of families they serve grows. Lack of adequate capacity may cause service development to compete with service management responsibilities and cause one or the other to suffer. Regional Resource Centers can help with service development if they can effectively mesh their work with that of the lead agencies.

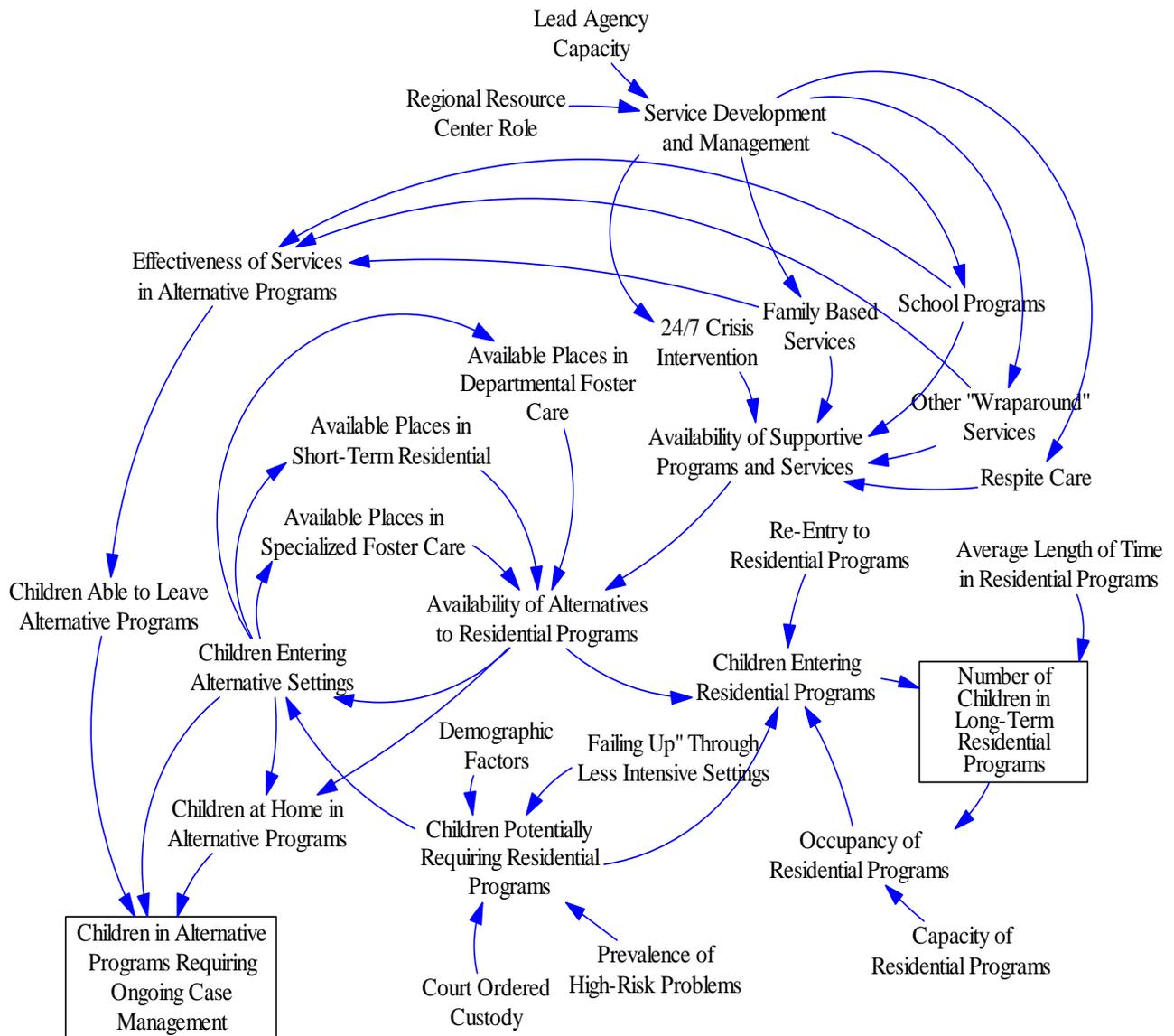


Figure 2: Availability of Alternatives to Residential Programs

Figure 3 shows the relationship of lead agency capacity to other causal relationships.

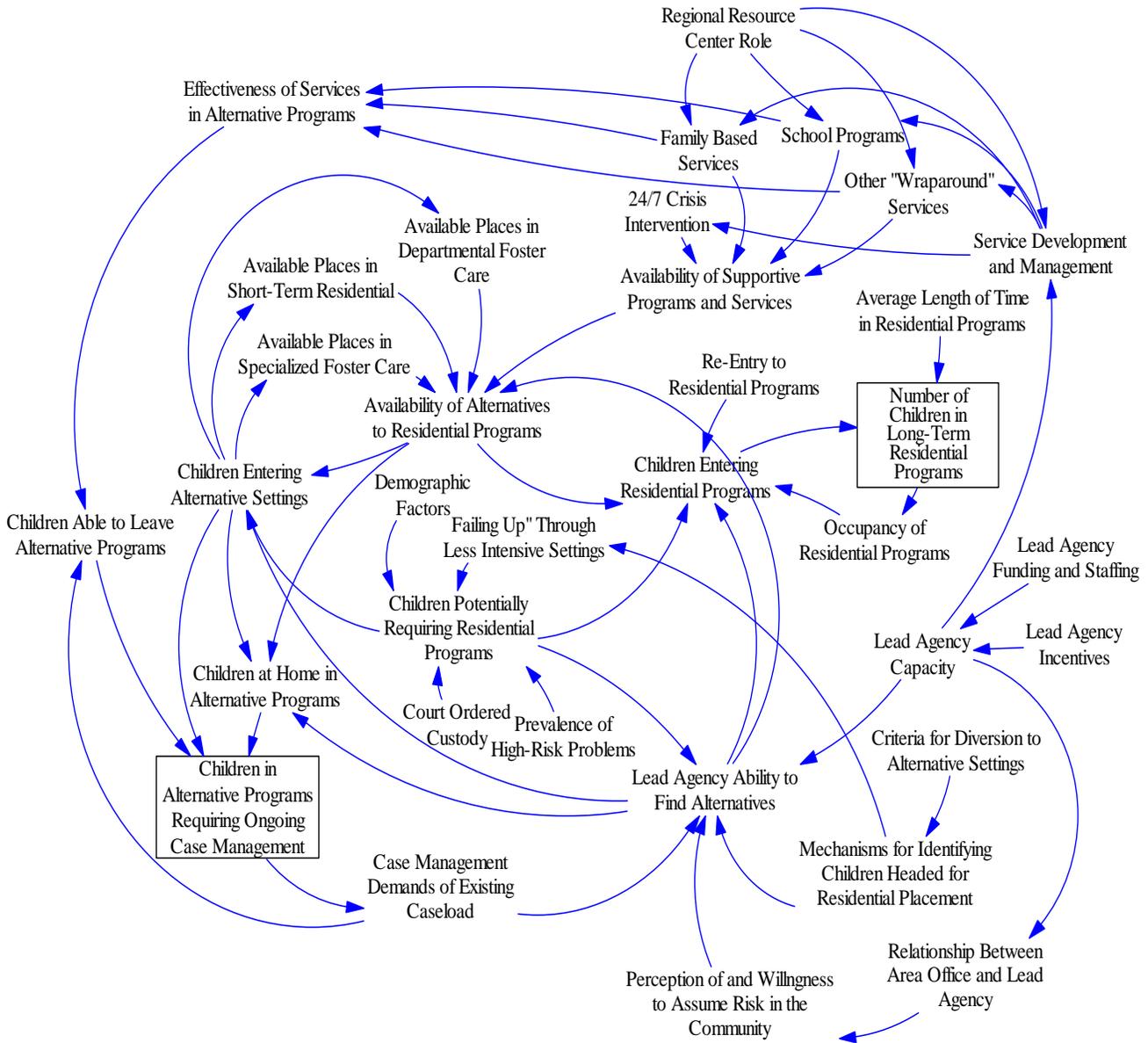


Figure 3: Lead Agency Role in Finding Alternatives to Residential Utilization

Lead agencies will have a key role in identifying alternatives to residential care for these high-risk children. Their ability to do so will depend on having the necessary capacity to spend the time required to understand the needs of each child and explore the range of alternatives for residential care. As the caseload of the lead agencies increases over time, the demands of ongoing service management will compete with finding alternatives for children new to the program. A lack of sufficient capacity may limit the ability to accommodate new children or reduce the effectiveness of ongoing service management and result in longer than necessary times to complete the alternative programs. As indicated earlier, service management will also compete with service development.

The ability of these agencies to find alternatives also depends on the existence of mechanisms to identify children headed for residential care. These mechanisms include agreement with DSS area staff on criteria for identifying children who may be headed for residential care and are candidates for diversion to alternative programs. If these mechanisms work well enough, they can catch cases at an early stage and short-circuit the process of “failing up” that leads some children unnecessarily to residential care and the concomitant damage that such a process creates. This, of course, requires that the lead agencies have the necessary capacity for handling these cases that do not yet present a pressing need for residential care.

The perception of and willingness to assume risk are important variables that will affect the movement of kids to the community. Residential program and DSS staff may see risk differently than the lead agencies do and resist movement to the community and want to see children back in residential settings quickly if problems emerge. Lead agencies may be able to influence perceptions of risk through the safety and community tenure plans they craft. However, changes in practice through the Child Welfare Training Institute, CQI, and other efforts may ultimately be necessary to increase willingness to accept risk and the variability in conditions encountered in the community vs. residential facilities.

Average Time in Residential Programs

The average length of time in residential programs is the other key determinant of the number in those programs at any point in time. Figure 4 shows a number of the factors affecting average stays. These include the:

- needs of the children in residential programs and the speed with which they can respond to the therapies that are offered
- match between children’s needs and program strengths which, in turn, is affected by the range of residential programs available
- fraction of children who can be accommodated at residential programs in or near their home communities which, in turn affects the frequency with which they can visit with their families and the degree of attention they may get from lead agency and area office staffs (compared to kids in more distant placements)
- quality of the programs and availability of program models oriented toward more rapid movement back to the community
- availability of alternative placements such as foster care and of the supportive services (such as those shown in Figures 2 and 3) required to keep both children at risk and others safe in the community
- rate at which children and their families achieve readiness for return to the community which, in turn, is affected by the frequency of visiting, availability of family based services while the child is in residential care (which are often not provided, thereby delaying return home), and availability of residential program staffs to teach behavior management skills to parents
- financial incentives to lead agencies and residential programs that may help to shorten long-term stays

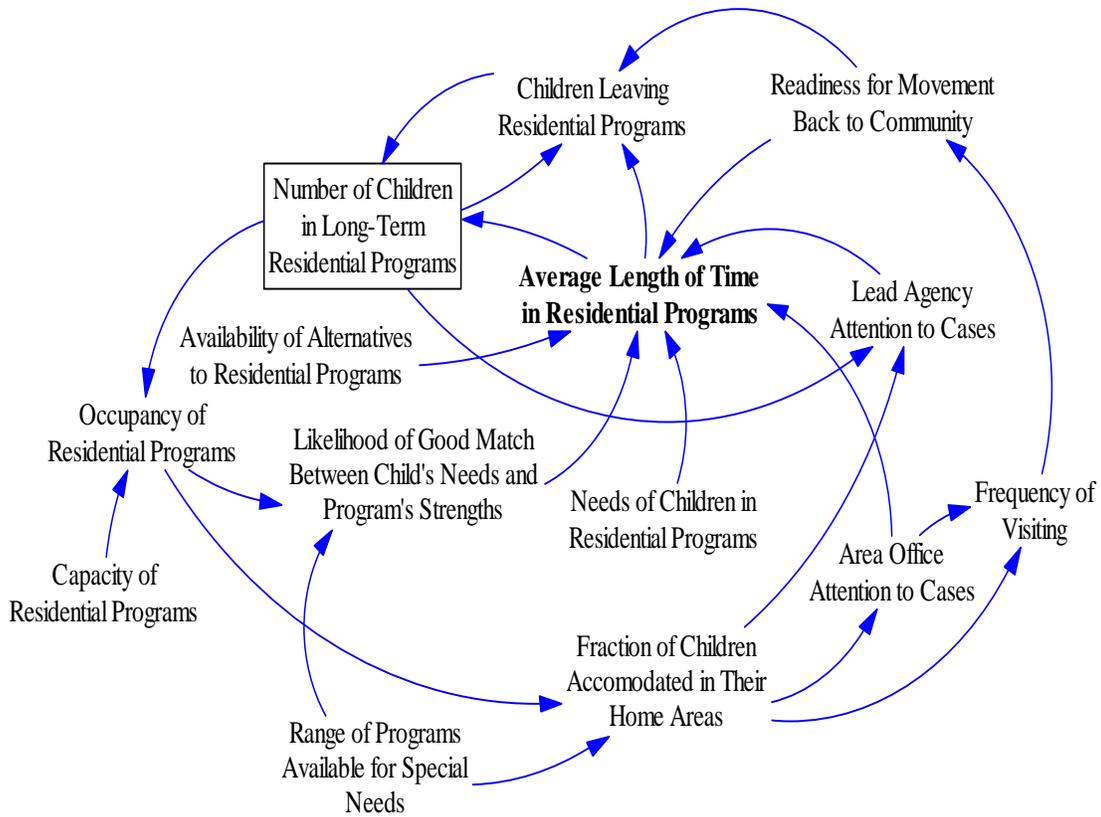


Figure 4: Factors Affecting Average Stays in Residential Programs

The length of time in residential programs can be affected at two levels. One is to identify the subset of children who may need to be in residential programs for some time, but whose stays can be greatly shortened with the right residential program models, alternative placements in the community, and supportive services. This subset is likely to consist of younger children who have the potential for reunification with their biological families or kin and whose families have been visiting and otherwise actively involved. The other way to have impact is to shorten the long stays of those children who do not fall into this subset and are likely to remain in residential settings for a while. These would typically be adolescents for whom independent living is the goal.

Lead agencies can play an active role in accelerating return to the community or to independent living. However, they need to have sufficient capacity to both pursue opportunities for early return of children to the community and manage the services for children in alternative settings who were diverted from residential programs or discharged early. They also need additional capacity to develop needed programs on their own and in concert with the regional resource centers. The key is getting children in the right programs and managing the process of building readiness for return to the community. If things go well, there can be positive feed backs such as places being made available in residential programs that allow more children to be in or near their home communities or in programs that better match their needs. These children would

then be able to make more rapid progress and also be candidates for earlier return to the community.

A few other variables affect length of time in residential care. Readiness for movement back to community is also affected by the availability of family services that help to assure the family is making progress toward reunification while the child is in a residential program. The staff of the residential program can also be helpful in teaching parents and others behavior management skills to be used once the child is back in the community.

Implications for the System of Care Procurement

1. Avoiding Unintended Consequences--The Importance of Matching Capacity and Demand

An important requirement for System of Care implementation is having the appropriate rate of growth. The relationships identified in this Systems Map suggest some potential consequences of pushing too hard and

- exceeding the capacity of lead agencies and residential programs to ready children for return to the community and
- diverting children from residential care without first creating the necessary capacity for keeping them safe in the community.

Increased re-entry to residential care is one potential consequence. Sending children back to the community before they and their families are ready may cause them to re-enter care later. Inappropriate placements in the community may also create risky situations that lead to other consequences such as the loss of foster parents who are affected by those placements and disruption of relationships with school systems that must deal with inappropriate behavior. These effects, in turn, make it difficult to place other kids in the community. These inappropriate placements will also set back the progress that the children and their families were making toward return home. Problems caused by inappropriate placements may erode the trust between Area Office and lead agency staffs and cause second-guessing that reduces efficiency. Being unable to meet their service and financial targets may also impair the financial health of the lead agencies and further reduce their ability to manage the movement of children back to the community.

There may be other unintended consequences of system of care implementation. For example, having more residential places become available with earlier discharges could simply make it easier for other kids to be admitted if there is not an effective diversion program in place. In addition, lead agencies will now be responsible for both family based services and the residential population. Concentrating on the “high-end” cases because of departmental mandates and incentives built into the procurement may cause less needy cases to be neglected until they develop more serious needs and may require residential care. A lack of sufficient funding for and volume of family based services may also contribute to less serious cases becoming more severe over time and presenting a need for new residential placements.

While savings from reducing long-term residential utilization should be possible in time, additional resources are likely to be required in the near term as the system of care is implemented. Taking these resources from other services (the system of care procurement includes nearly every DSS purchased service) may simply create unintended consequences and new problems, some of which could lead to greater demand for residential services in the future. Ironically, areas that have worked to reduce residential utilization in the past may not be able to readily produce new savings to fund additional services for diversion. These areas may require some additional resources.

2. Where to Start?

These potential adverse effects of having demand get ahead of capacity suggest that the choices of where to start and the rate at which the System of Care effort “ramps up” are very important. Starting in the right place can help to leverage the effects of the System of Care initiative and help to propel it toward more widespread implementation. The choice of where to start can be a function of either of two things:

- where the need is greatest or
- where the capability is greatest and there is the greatest likelihood of success.

Need might, for example, be reflected in the degree to which a region or area utilizes long-term residential as a fraction of its total placements and caseloads. High utilization may reflect greater needs of the children being served or may instead reflect the lack of sufficient alternatives that result in kids “failing up” until they reach residential care. Need may also be reflected by a large fraction of children being in residential placements outside and far from their own communities. Though some of these are in distant programs for very special needs such as fire-setting or sexual behavior, others may simply be out of their communities because of a lack of available residential beds nearby. Reducing long-term residential utilization in those communities can make room for kids to be in programs closer to their communities and might make it possible as a result to go home sooner.

Another approach to a starting point based on need would be to identify groups of kids with similar needs for which a set of programs could be developed more economically. These kids might be ones who have a home to go to, have parents willing to be actively involved, and perhaps willing to serve as a support group for each other. The programs could be ones that can be provided by a lead agency and network of providers already in place and functioning well. Areas working with residential programs that are willing to adapt their programs to shorter stays may represent good starting points. Children with disrupted adoptions represent another potential cluster, but it is less clear what services need to be provided for these cases.

Capability for achieving results quickly could be the other criterion for choosing a starting point. For example, areas in which existing agencies have already done a good job of creating networks of services that help children stay in the community or leave residential programs sooner would be one place to start. Areas that have good

relationships with local school systems would be another criterion since education is such an important service for kids who are in the community. Areas in which Area Directors are willing to support the necessary practice changes for the system of care to succeed are also potential starting points. There should be incentives for Areas willing to get out in front and create prototypes that other Areas can then learn from.

Diversion from residential care and shortening the stays of those in residential settings need to be coordinated rather than being thought of as separate options for where to start. Shortening residential stays can produce more immediate savings that then fund other services, but is harder to accomplish since it involves working with the both the residential programs and the community resources required to create an alternative placement. Diversion only involves the community resources and thus may be easier to accomplish, but only produces savings over time as residential utilization is less than it otherwise would have been. Freeing places in residential settings without a good diversion program in place may, as indicated earlier, result in those places being filled by other kids.

3. Building on Early Successes

Building on early successes will be important for assuring the system of care initiative's long-term impact. Learning from prototype efforts is essential. This will, in turn, require good data systems that help to track what works and what doesn't and makes that information available throughout the department. Reinvesting any savings from reducing long-term residential utilization in alternative services and placements is also critical.

The system of care should ultimately be thought of as a continuum of services that prevent needs for residential care, deal quickly and firmly with cases that begin to become unstable, divert kids headed for residential care, and shorten the stays of those who do end up in residential settings. This will require careful coordination between DSS Area Offices and lead agencies. Time of DSS caseworkers freed by lead agencies taking more responsibility for difficult cases should be reinvested in cases that have less severe needs in order to prevent them from developing into future needs for residential care. Alignment of incentives between DSS Area Offices and lead agencies is important for the system of care to provide this continuum of services in an effective manner.