2009 Quality Service Reviews

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1. Introduction

The Child and Family Services Agency (CFSA) is committed to providing quality care to the children and families we serve in the District of Columbia. To enhance case practice and system performance, the agency has fully instituted a Quality Service Review (QSR) process to gather data and provide feedback about individual child welfare cases and the system as a whole. CFSA began using this best practice in October 2003, in partnership with the Center for the Study of Social Policy (CSSP), to supplement ongoing collection and assessment of quantitative data. The QSR examines case practice, system performance, and outcomes for individual children and families to identify strengths and areas that need improvement. Together, quantitative and qualitative data provide a deeper understanding of family dynamics and needs and of service delivery system performance. While the QSR does not include a large enough sample to generalize findings to the entire population of children and youth in the District's child welfare system, it does provide a snapshot of what is working and not working for those in the sample. To facilitate this process, CFSA has a dedicated unit of trained QSR reviewers whose principal responsibility is coordinating, conducting, and reporting on QSRs.

Quality Service Reviews are an essential component of CFSA's continuous quality improvement approach to sustaining best practices and a high performing service delivery system. CFSA has an agency-wide Practice Model and has collaborated with community partners to develop In-Home and Out-of-Home Practice Protocols, which outline values and guiding principles in effective practice and service delivery. These protocols offer solid strategies for improving the quality of case practice. CFSA purposefully aligned tenets of the Practice Model with QSR indicators. Following a series of semi-annual QSRs beginning in 2005, we shifted the process in 2007 to a monthly unit-based review of CFSA cases and an annual review of private agency cases. The unit-based approach increases opportunities for peer networking and for staff to receive coaching in applying the QSR and CFSA Practice Model protocols on the job. In 2008, we expanded this unit-based approach to private agencies with child welfare case management responsibilities and continued this practice in 2009.

The QSR process requires social workers to provide a history of cases in a random sample. Pairs of reviewers go through each case record for background, which allows them to assess how social workers use written assessments and evaluative information in case planning and decision-making. Reviewers interview as many stakeholders as possible, beginning with the social worker and including the child, birth parents, caregivers, guardian *ad litem*, family members, school staff, service providers, and others. Reviewers then rate a series of indicators that assess the status of the child, parent/caregiver, and system. Next, they conduct a debriefing with the social worker and supervisor to share strengths, challenges, and recommended next steps regarding the case. For each case in the sample, reviewers write a narrative, or "case summary," that highlights effective case practices and areas in need of improvement.

The QSR Unit randomly selects cases to include in the QSR. For unit-based QSRs, the sample consists of one case per social worker in a unit, with each unit having two to five social workers. The case review process is the same as for unit-based and larger QSRs, with one notable addition at the unit level. For each case reviewed, QSR specialists develop specific next steps collaboratively with the social worker. Two months after the review, QSR specialists evaluate whether or not social workers implemented these steps and whether doing so improved the status of the case.

Reviewers

A qualified and trained set of reviewers typically consisting of a Lead/Mentor Reviewer and a Partner/Shadow Reviewer gather the QSR information. We draw these reviewers from among CFSA Quality Service Review Specialists; other trained professionals from child welfare, mental health, and education; and citizens from the community. In 2009, trained reviewers from CFSA, D.C. Department of Mental Health, Center for the Study of Social Policy, Consortium for Child Welfare, Foster and Adoptive Parents Advocacy Center (FAPAC), Citizen's Review Panel, and experienced consultants from other states came together to conduct the QSRs.

The review team applies a structured CFSA QSR protocol to conduct an impartial assessment of the quality of services and social work practices in District child welfare. All reviewers participate in a rigorous two-day training on the QSR protocol, which focuses on critical thinking and interviewing and assessment skills. The reviewers learn to conduct independent and objective assessments based on information they gain from the review and can support with evidence.

After completing classroom training, Shadow Reviewers have the opportunity to pair with an experienced Lead/Mentor Reviewer to conduct a QSR. The Lead/Mentor Reviewer takes the lead on the case for the Shadow Reviewer's first review experience. A Shadow Reviewer has the opportunity to become a Partner Reviewer after successfully reviewing two or more cases. Mentors evaluate Shadow Reviewers to assess their interviewing, assessment, and analytical skills.

To gather as much qualitative data as possible, QSR Reviewers employ their interviewing skills to ensure interviewees are comfortable and at ease. Thus, new information often comes to light, some of which may not have been shared previously among all the team members. While reviewers are responsible for protecting confidentiality, they are also required to inform all interviewees of their responsibilities as mandated reporters.

The Lead/Mentor reviewer is responsible for conducting the interviews and takes the lead in the debriefing session with the social worker and supervisor. During the debriefing, the Lead/Mentor Reviewer is responsible for outlining the strengths and challenges within the case and providing detailed feedback to social workers and supervisors. The Lead/Mentor Reviewer ensures that next steps are developed in collaboration with the social worker and supervisor based on review findings for the improvement of each case and the child welfare service delivery system as a whole. It is imperative that the reviewers provide strengths-based feedback to the social workers and their supervisors to establish a trusting work relationship and for the social workers to genuinely commit to the process of development next steps. In concert with the Partner/Shadow Reviewer, the Lead Reviewer prepares a comprehensive and concise written case summary that documents findings and recommendations for each case.

In 2010, CFSA will begin to certify Lead and more experienced Mentor Reviewers. The certification process, which entails successful participation in training and at least four reviews, reflects reviewers' skills and knowledge of QSRs.

Sample

In 2009, CFSA reviewed a total of 83 cases using the QSR process throughout the year: Table 1 provides details about the sample. It included 62 CFSA-managed cases (33 in-home and 29 out-of-home) as well as 21 out-of-home care cases from eight of the 19 private agencies with case management responsibility.

Table 1: Characteristics of QSR Sample			
Case Management Responsibility	CFSA	62	
	Private provider	21	
Length of Time Case Open	0-2 years	59	
	3-5 years	20	
	6-8 years	2	
	9-18 years	2	
Placement Setting	Specialized Foster Home	7	
	Traditional Foster Home	14	
	Kinship Foster Home	11	
	In-Home	32	
	Protective Supervision	3	
	Independent Living Program	2	
	Pre-adoptive home	3	
	Group Home	3*	
	Residential Treatment Facility	2	
	Dept of Youth Rehabilitative Services	4**	
	Abscondance	1	
	Infant & Maternity Home	1	
Permanency Goal	APPLA	17	
	Adoption	9	
	Guardianship	7	
	Reunification	18	
	Family Stabilization	32	
Age/Gender	Age	Male	Female
	0-5	7	7
	6-10	11	10
	11-15	14	11
	16-20	11	12

*Includes one specialized group home.
** Includes two children only committed to DYRS.

Reviewers completed over 560 interviews, with an average of seven interviews per case. Twelve cases were reviewed in conjunction with the District's Department of Mental Health (DMH) during their annual Dixon Community Service Reviews (CSR) in March 2009. That review focuses on children and youth receiving mental health services. DMH selected the sample, which included open child welfare cases. All other cases reviewed, whether managed by CFSA or a private agency, were selected at random from the caseload of each social worker in targeted units or agencies.

Children and youth involved in these cases ranged in age from 9 months to 20 years. Their cases had been open from three weeks to 15 years. Average time in care was 2 years. Median time in care was 1 year.

QSR Protocol

In the fall of 2004, national experts from Human Systems and Outcomes, Inc. facilitated meetings to tailor a QSR protocol specifically for the District's child welfare system. Representatives from all areas of CFSA, the Healthy Families/Thriving Communities Collaboratives, Consortium for Child Welfare, Foster and Adoptive Parent Advocacy Center (FAPAC), and Children's National Medical Center participated in the development process. Since then, CFSA has further refined the protocol to conduct focused QSRs that look at in-home cases, where the children are at home with family and not in foster care, and cases involving teens.

Protocol Structure

The QSR protocol has three sections: **Child Status**, **Parent/Caregiver Status**, and **System Status**. Table 2 lists indicators for each section. For Child Status, reviewers examined the situation of the child within the past 30 days for the indicators shown.

Parent/Caregiver Status has four indicators. Reviewers rate parents only if they have an in-home case or the child's goal is reunification. Caregivers include foster and kinship parents and staff of group homes, independent living programs (ILPs), and residential treatment centers (RTCs).

The multiple indicators of System Status assess the overall child welfare system performance based on a specific practice framework. This framework was the basis for CFSA's original Practice Model and is reflected in even greater detail in the more recent In-Home and Out-of Home Practice Protocols. The system includes all people working with the child and family, such as child welfare staff, school staff, service providers, and legal personnel.

Table 2: QSR Indicators by Section

Child Status Indicators	
• Safety	• Emotional/behavioral well being
• Stability	• Academic status
• Permanence	• Responsible behavior
• Health/physical well being	• Life skills development
Parent/Caregiver Status Indicators	
• Physical support of the child	• Participation in decisions
• Emotional support of the child	• Progress toward safe case closure
System Status Indicators	
Practice Performance Indicators	Attributes and Conditions of Practice
• Engagement	• Tracking and adjustment
• Coordination and leadership	• Pathway to safe case closure
• Team formation/functioning	• Maintaining family connections
• Assessment and understanding	• Family Court interface
• Case planning process	• Medication management
• Implementation	• Informal family support/connections

Collectively, these three sets of indicators allow reviewers to thoroughly assess functioning of the child welfare system as represented by the cases reviewed and to identify what is working and areas in need of improvement in serving children and their parents and caregivers.

Protocol Scoring

Reviewers score indicators based on a six-point scale. Table 3 presents the "QSR Interpretive Guide for Child Status" as an example. The scale runs from **1—adverse** status—to **6—optimal** status. After scoring, the protocol provides two options for viewing findings:

- By **zones**—**Improvement**, **Refinement**, or **Maintenance**—or
- By **status**—**Acceptable** or **Unacceptable**.

We used status as the basis for analyzing data from QSRs in 2008. Appendix A provides charts for each indicator according to both zones and status.

Although the QSR sample is randomly drawn and covers a diverse population of cases from across the agency, the review sample is not statistically representative of the total population, making it impossible to generalize findings with any reliability. These findings, however, offer insights into ways to improve practice. Information from the case stories is the primary source for areas identified as strengths and challenges.

Score Reliability

In addition to requiring that all reviewers undergo training and be paired with another reviewer, CFSA has taken other steps to guarantee the reliability of the scores and findings from the QSRs. Beginning in July 2009, all case stories are reviewed by a minimum of two management staff, both to provide feedback on the readability of the story and to ensure that the numerical ratings are consistent with the information in the story. This process works well with the time structure of the unit-based QSRs and allows the ratings to be reconciled with a standardized written document. It is an alternative to the role played by the Case Judge in other jurisdictions.

CFSA also established a refresher training for QSR reviewers to provide an opportunity for those who had not used the protocol for a while to update their knowledge of the instrument and the expectations of the process. This training was offered for the first time in 2010.

Table 3: Example of QSR Scoring Protocol

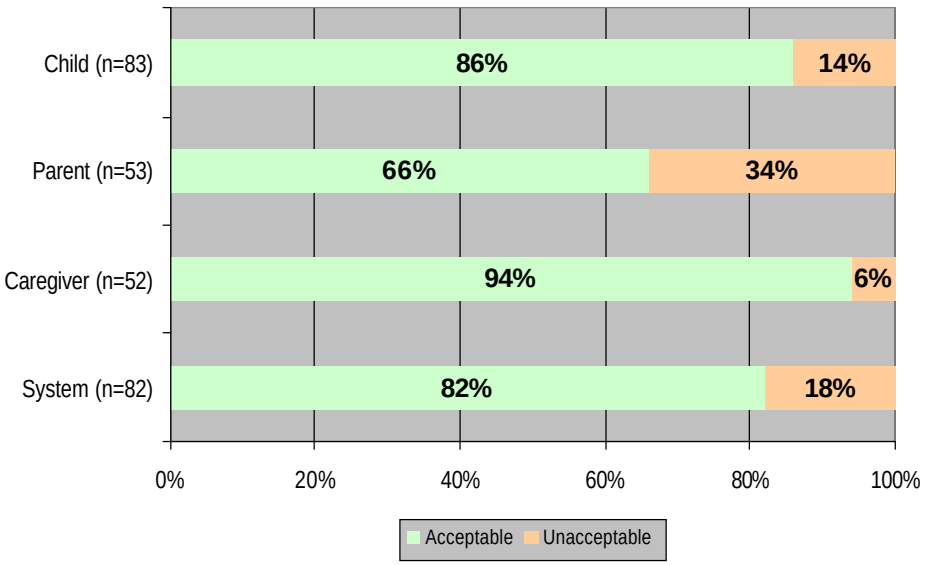
QSR Interpretive Guide for Child Status

Zones	*Scoring*	*Status*
MAINTENANCE Status is favorable. Maintain and build on a positive situation.	6 = OPTIMAL Best or most favorable status for this child in this area (taking age and ability into account). Child is doing great! Confidence is high that long-term goals or expectations will be met.	**ACCEPTABLE**
	5 = GOOD Substantially and dependably positive status for the child in this area, with an ongoing positive pattern. This status level is consistent with attainment of goals in this area. Situation is "looking good" and likely to continue.	
REFINEMENT Status is minimal or marginal, possibly unstable. Make efforts to refine situation.	4 = FAIR Status is minimally or temporarily sufficient for child to meet short-term goals in this area. Status is minimally acceptable at this time but may be short term due to changes in circumstances, requiring adjustments soon.	
	3 = MARGINAL Status is marginal/mixed, not quite sufficient to meet the child's short-term objectives now in this area. Not quite enough for the child to be successful. Risks may be uncertain.	**UNACCEPTABLE**
IMPROVEMENT Status is problematic or risky. Act immediately to improve situation.	2 = POOR Status has been and continues to be poor and unacceptable. Child seems to be "stuck" or "lost" and is not improving. Risks may be mild to moderate.	
	1 = ADVERSE Child status in this area is poor and getting worse. Risks of harm, restrictions, exclusion, regression, and/or other adverse outcomes are substantial and increasing.	

Summary of 2009 QSR Results

Figure A summarizes overall findings about child, parent, caregiver, and system status for the 83 cases we reviewed in 2009. Charts with data for each indicator appear in Appendix A.

Figure A: Summary of Overall Status, 2009



Overall Child Status was rated acceptable in 86% of cases. The highest-rated child status indicators were Safety of the Child at School at 96% acceptable and at home at 95% acceptable. The indicator for Emotional/Behavioral Well-Being at Home for children was acceptable in 94% of cases. This is a significant finding in that children's emotional needs were frequently met and, subsequently, their behavior at home was predominantly positive.

On the other end of the spectrum, Life Skills Development, which is rated for youth between the ages of 15 and 21, was the lowest indicator at 54% acceptable. While there were a total of 27 youth in this sample, this rating, which reflects how children obtain the skills necessary to lead independent lives, warrants further discussion in the Challenges Section of this report. Another significantly low-rated indicator was Academic/Learning status, which was rated acceptable in only 69% of cases. Given the fact that a child's education and learning status impact his/her current and future functioning, this marginal rating is significant and is also discussed further in this report.

Parent status was rated for children involved in in-home/family stabilization and protective supervision cases or with a goal of reunification. If parents were involved but the goal was not family stabilization or reunification, reviewers described the parents' participation in the case stories but did not rate it quantitatively. In those cases only the current caregivers were rated.

In 2009, 32 children had the goal of family stabilization. Of these children, 25 resided with their mothers, 3 with their fathers, 2 with both parents and 2 with grandparents. Of the eighteen children with a goal of reunification, 2 were living with their mothers and 1 lived with both parents, all under protective supervision. Parents' Emotional Support of the Child was the highest rated indicator for parents. This will be highlighted further in the Findings Section. The Overall Parent Status was rated as 66% acceptable,

which is a significantly low rating. This indicator encompasses all the parent indicators and reflects the parents' level of initiative and involvement in the case and their level of participation in working towards achieving the permanency goal. In many instances the birth father's identity or current whereabouts were unknown to team members on the case, contributing to the low rating for this indicator. The latter is a systemic challenge discussed in detail later in this report.

Out-of-home caregivers, including foster parents, kinship care parents, and congregate care staff, received a high Overall Caregiver Status rating of 94%. Details of their participation appear in the Strengths Section of this report.

The Overall System Status indicator was rated at 82% acceptable. Two of the highest rated status indicators—each at 90 %—were Engagement of the Child and Team Formation and Functioning. Maintaining Family Connections was also relatively high at 84% acceptable. The system has historically performed poorly in engagement, assessment, and implementation of services with fathers. The 2009 ratings were 34% for Engagement, 42% for Assessment, and 26% for Implementation of services for fathers. The system also rated low in Assessment of mothers at 65%. The findings of these indicators are discussed in depth in Section 3. Finally, Pathway to Safe Case Closure, which is crucial to children, was rated at 63%.

QSR Scores Over Time

While previous QSRs are not completely analogous to the 2009 QSRs, it is still worthwhile to look at trends in overall status over the past three years. In 2007 (76 cases), 2008 (62 cases), and 2009 (83 cases), the QSR Unit reviewed cases with a mix of permanency goals as well as CFSA and private-agency cases. As Figure B shows, System Status improved in 2009 compared to 2007 and 2008. Child Status decreased slightly but remains at a high level. As shown in Figure C, caregiver status has made incremental increases over the past three years. However, Parent Status has remained at an unremarkable 63% for three years.

Figure B: Historical Comparison of Child and System Status

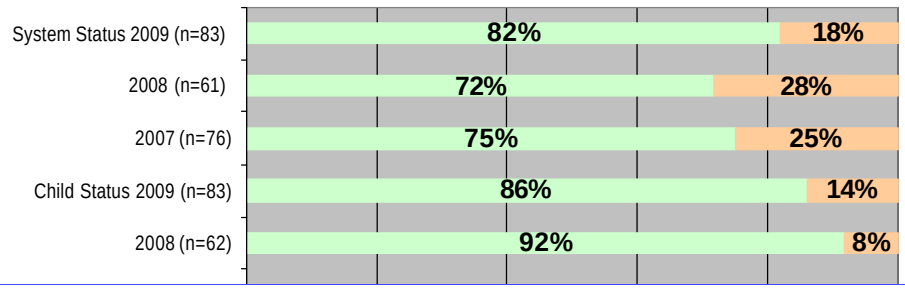


Figure C: Historical Comparison of Parent and Caregiver Status

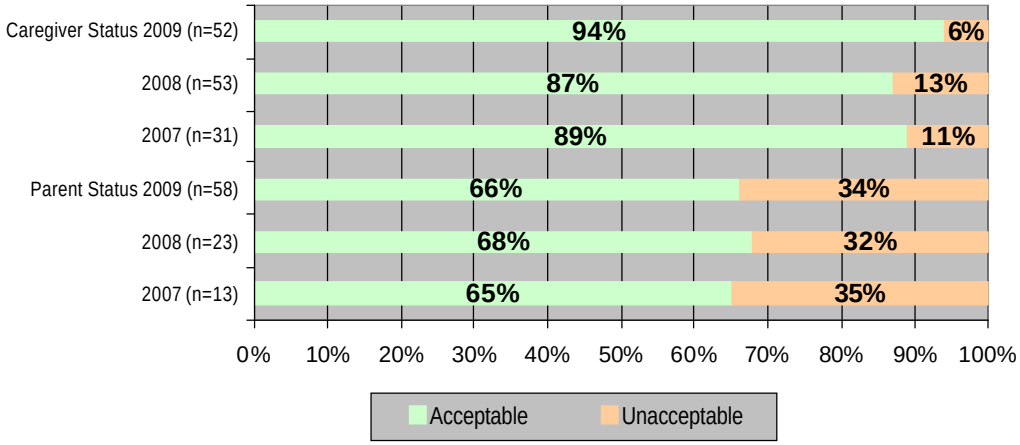


Table 4: Comparison of Indicator Ratings—2008/2009				
	Indicator	***2008***	***2009***	***Change***
Improved	Caregiver progress to safe case closure	68%	100%	+32%
	Team formation/functioning	52%	77%	+25%
	Coordination and leadership	61%	80%	+19%
	Implementation: Father	23%	42%	+19%
	Engagement: Child	73%	90%	+17%
	Assessment and understanding: Child	77%	90%	+13%
	Parent participation/engagement	59%	72%	+13%
	Case planning	61%	71%	+10%
	Emotional/behavioral well being: Home	84%	94%	+10%
	Implementation: Mother	57%	67%	+10%
	Emotional/behavioral well being: School	81%	89%	+8%
	Engagement: Mother	62%	70%	+8%
	Implementation: Child	72%	80%	+8%
	Post-permanency support	75%	83%	+8%
	Maintaining family connections	77%	84%	+7%
	Assessment and understanding: Mother	57%	63%	+6%
	Engagement: Father	29%	35%	+6%
	Parent emotional support	77%	83%	+6%
	Caregiver emotional support	91%	96%	+5%
	Caregiver physical support	91%	96%	+5%
	Stability: Home	65%	70%	+5%
Maintained	Family Court interface	91%	90%	n/a
	Caregiver participation/engagement	89%	90%	n/a
	Stability: School/daycare	73%	73%	n/a
	Assessment and understanding: Father	26%	26%	n/a
Declined	Life skills development	68%	54%	-14%
	Academic/learning status	82%	69%	-13%
	Parent physical support	83%	74%	-9%
	Responsible behavior	77%	68%	-9%
	Pathway to safe case closure	70%	63%	-7%
	Health/physical well being	97%	92%	-5%

While the overall status ratings for 2009 show improvement, Table 4 highlights individual indicators that have improved, remained the same, or declined compared to 2008. (The table lists only those indicators with a variation of at least five percentage points.)

Caregiver Progress to Safe Case Closure had the largest improvement in 2009—a 32-point increase to 100%. Caregivers rated for this indicator were guardianship resources and pre-adoptive parents. This indicator measured the degree to which they have made progress toward meeting the requirements for safe case closure including, but not limited to, integrating the focus child/youth into their family and establishing and sustaining the conditions and supports necessary to provide for the focus child/youth.

Team Formation and Functioning had the second highest increase (25 points), followed by Coordination and Leadership (19 points). The level of participation and engagement of caregivers remains the same. This indicator measures the degree to which all caregivers are ongoing participants in the planning, decision-making, implementation and monitoring of services to the child/youth to meet safe case closure requirements. Caregivers were evaluated on their participation in case planning meetings, level of communication with service provider team and level of advocacy for meeting the child/youth's needs.

While indicators for Engagement and Implementation of services for fathers have increased slightly, the ratings continue to fall in the unacceptable range and remains an area in need of improvement by the system. Assessment of fathers remains unacceptable at 26%.

Of the seven indicators listed with a decrease in percentages, four are Child Status indicators. While the overall status of these indicators is acceptable, there has been over a 10% decrease in ratings in 2009. The indicators with the most significant change, Academic/Learning Status and Life Skills Development will be discussed further in this report.

2. Findings

This section highlights some of the strengths and challenges found in the cases reviewed in 2009. Excerpts from the case summaries have been included as examples of the various trends noted. Ratings for many of the indicators described in this section gave us an opportunity to look closely at how the core principles of the Practice Model and Practice Protocols are infused into everyday practice as well as the impact these principles, when applied, have on individual cases. We have highlighted excerpts from both the In-Home and Out-of-Home Practice Protocols throughout this section to demonstrate the relationship between Practice Model tenets and the QSR Protocol Indicators.

Selected highly-rated indicators are described in more detail in the Strengths Section; similarly, a sample of low-rated indicators is described in the Challenges Section. Areas identified below as strengths are not necessarily those with the highest ratings, nor were they rated as acceptable in 100% of cases. Similarly, areas identified as, challenges were not rated as unacceptable in every case, or even in a majority of cases. In fact, *the areas described as challenges were rated acceptable overall in most cases,* but the percentage of acceptably-rated cases was lower than other indicators. We have selected these issues because they illustrate growth or success in particular practice areas or are specific areas of needed practice change identified in the QSRs.

There were many areas identified as strengths given the high scores in 2009, including Caregiver Physical Support and Caregiver Emotional Support (both at 96%) and Health/Physical Well-Being (92%). This section provides in-depth discussion of strengths including:

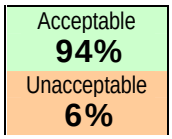
- Child's Emotional/Behavioral Well-Being at Home.
- Parent's Emotional Support of the Child.
- System's Engagement, Assessment/Understanding of the Child.
- Coordination and Leadership.
- Case Planning Process.
- Team Formation and Functioning.

In regard to challenges, this section explores:

- Child's Academic/Learning Status.
- Youth's Life Skills Development.
- Parents' Progress to Safe Case Closure.
- System's Pathway to Safe Case Closure.

Strengths

Child's Emotional/Behavioral Well-Being at Home



Emotional/Behavioral Well-Being at Home was acceptable in 94% of cases reviewed in 2009, a 10% increase from the 2008 review. This finding correlates with the high rating for Parent and Caregiver Emotional Support of the Child. When parents and caregivers are actively involved in the children's lives and are providing the essential emotional support that they need, reviewers see a decrease in disruptive behaviors in the home.

Reviewers assess a child's emotional and behavioral well-being by looking at his or her current level of functioning in his or her daily settings. Additionally, they look at the degree that the child is symptom-free of mood, thought, and/or behavioral disorders that could interfere with his or her capacity to participate in and benefit from his or her daily activities. Many children had DSM-IV diagnoses and were receiving services to meet their mental health needs. Of the 83 cases reviewed, 31 children/youth were

known to DMH, of which 25 were receiving therapeutic services to address a range of mental health and emotional needs.

The 17-year-old focus youth in Case #5 received individual therapy and medication management as well as counseling from her school social worker. *"The focus youth's Individual Plan of Care notes her diagnoses as major depression, anxiety, and post-traumatic stress disorder. She receives monthly medication management (20 mg of Prozac) and weekly individual therapy. Her psychiatrist stated that the anti-depressant alleviates the [focus youth's] depression and nervous habits, such as nail biting."* The reviewers also commented that this focus youth implemented healthy coping strategies in her daily living and, when team members had concerns about her emotional well-being, they quickly intervened. *"The school social worker reported engaging the focus youth in a contract whereby she will approach the social worker if she needs help or support. The foster parents likewise reported that they developed a crisis plan with the focus youth in the event that she becomes depressed."*

In Case #70 the 13-year-old focus youth was placed in kinship care with her paternal grandparents after experiencing severe physical abuse at the hands of her father. *"Based on interviews and observations, it appears that the focus youth and her paternal grandparents have a very close and trustful relationship."* The grandparents actively participated in family therapy with the focus youth and her parents and served as an anchor and avid supporter of the youth who has flourished under their care.

> *By all accounts, the focus youth is very resilient and has been able to address many of her emotions and feelings in therapy regarding the physical abuse in her birth home. There have been tremendous improvements and advances in her attitude and demeanor. In family therapy sessions, she is described as being engaged and as an active participant. Interviewees described her as initially presenting with some depressive symptoms which have dissipated. It is clear that the foster parents are sincere in their concern for the safety of the focus youth and her siblings and they would continue to be a crucial support to the children if they were to return home.*

Parent's Emotional Support of the Child

Acceptable
83%
Unacceptable
17 %

Birth parents ranked high at 83% acceptable for Emotional Support of the Child, a 6% increase from 2008. This indicator correlates with the high acceptable ratings for Emotional Well-Being of the Child at Home (94%) and at School (89%). When parents are emotionally involved in their children's lives, whether children reside in or out of their home, it will positively affect their emotional well-being and behavior at home and at school.

In Case #38 the focus child was said to have made significant progress in therapy, which included play therapy with the birth mother, step-father and younger sister. *"The birth mother has also taken on an active role in providing support and guidance to the focus child in the foster home. She shares a close relationship with the focus child and they were observed to be very affectionate with each other. The mother has been very consistent with visitation even during inclement weather and maintains regular phone contact with the foster family and the focus child.*

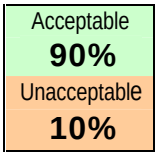
The birth mother's support and active participation in her child's therapy has contributed to the focus child's *"significant progress in therapy, which positively contributed to her overall well being. Due to the progress that the focus child was making in therapy, it was recommended for her to have overnight visits with her mother. Currently, therapy sessions are working toward the transition from unsupervised visits to overnight visits then to permanently living with her birth mother. Family play therapy with the birth mother, step-father, and younger sister is also being considered*."

In Case #53:

Reviewers observed the focus child with her mother and she seems to be very attached to her mother and the mother appears to be very affectionate with the child. The child's father visited the home during the interview and reviewers noted that the child reached for her father and was very playful with him. The focus child smiled a lot with reviewers and appeared very pleasant during the visit.

In Case #19 the birth father was described as a man "*who loves his daughter and is active in her life. The father readily listed numerous strengths of his daughter; how smart she is, how well behaved she is, how loving she is, etc. He smiled as he discussed her and said several times that she was his "heart". The father lives downstairs from the child, and therefore is able to spend a great deal of time with her. He takes the focus child to and from school and keeps in contact with her teachers. He supervises his daughter, takes her out to play, and takes her to other appointments as needed. He also has a positive relationship with the child's mother and maternal grandmother".*

System's Engagement of the Child



The central focus of this indicator is placed on the diligence shown by the team in taking actions necessary to engage and build quality relationships with children and families to overcome barriers to their participation. Engagement of the Child was one of the two indicators rated the highest for system indicators. This was the case in 2008 and again in 2009, where there was a 17% increase in the rating. There was strong evidence that the team was establishing trust based relationships and partnering with our youths, who felt respected. As demonstrated in the examples listed below, positive engagement yields positive outcomes.

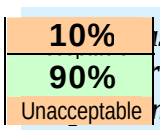
Engagement is the process of connecting with the child/youth, mother, father, extended family, primary caregiver, and other team members for the purpose of building an authentic, trusting, and collaborative working relationship.

CFSA Out-of-Home Practice Protocol

In Case #62, the youth is a 19-year-old female with a permanency goal of APPLA. This case clearly demonstrated the effectiveness of engaging the youth to work on her case plan, allowing her to be an integral part of the team.

The youth has been able to establish a good working relationship with everyone working on her case. She was very satisfied with the services she has been receiving from the team. It was clear that the youth is very involved with the case planning process and was instrumental in the development of her case plan. All key service participants have a shared understanding of the youth and a good assessment of her situation.

In Case #40, the youth was a 19-year-old female with a goal of APPLA, who was satisfied with the team working with her and felt that they were there to help her. *"The youth indicated that she feels that her social worker takes the time to talk and meet with her. She indicated that the team asks her opinions and asks her to participate in creating a plan for the present and for her future. She also feels that her team 'gets things done for me, is honest with me, and listens to me.'"*



ssessment is an integral part of ring families and minimizing nce on formal social services. We recognize that families and children possess strengths that provide the foundation for change.

CFSA In-Home Practice Protocol

System's Assessment/Understanding of the Child

Assessment and Understanding of the Child was one of the two highest rating indicators in the

system status. There was a significant improvement for this indicator from 2008 to 2009, where there was a 17% increase in the ratings. This demonstrates that social workers and other team members continue to utilize a good combination of clinical, functional, educational and informal assessment techniques to identify our children's needs. There is also a strong correlation between Engagement of the Child and Assessment and Understanding indicators. Having a thorough understanding of the child and family derives from a high level of engagement in order to build a strong trust-based relationship.

As seen in Case #40 above for the Engagement of the Child indicator, the benefits of having the youth involved in a quality relationship offered team members the opportunity to conduct more of an in-depth assessment. This is a clear demonstration that positive engagement contributes to a comprehensive assessment.

> *Team members seem to have an optimal assessment and understanding of the focus youth. Reviewers noted that each interviewee had the knowledge necessary to understand the focus youth and her family's strengths, needs and challenges.*

In Case #54, the focus youth is a 14-year-old female, with a permanency goal of APPLA. The youth has a history of multiple placement disruptions and is also known to the juvenile system. The youth was described as being very angry, especially towards her mother, whom she blamed for her being in the system. The team had a good understanding of the youth's situation and was conducting ongoing assessments to ensure that the youth's underlying needs were being met.

> *The focus youth has individual therapy to help her cope with her behavioral problems and anger towards her mother. In fact, it was reported that the focus youth did not relate well to her first therapist and, therefore, she was not making any progress. This situation was immediately addressed and the focus youth was referred to a new therapist. Based on information obtained and documentation observed, she is making significant progress in therapy.*

Additionally, *"the team also seems to have a good assessment and understanding of the youth and her family and was able to verbalize to reviewers the barriers that were preventing the case from moving closer to safe case closure".*

Case #35, demonstrated the team's understanding of the youth's strengths, challenges and underlying issues that must change in order for the youth to achieve safe case closure. The focus youth is an 18-year-old male, with a permanency goal of APPLA. The youth resides in a residential treatment facility that offers a specialized program for adolescent males who exhibit sexually reactive and sexually offending behaviors. Reportedly, the youth has a history of molesting his two younger brothers and having consensual sex with his sister.

The team described him as being *"polite, intelligent, resilient, and is goal oriented. He is also said to have a wonderful sense of humor and the ability to take the leadership role among his peers. Treatment team members feel that the youth has made great progress in accepting responsibility for his behavior and in accepting the consequences from those actions. Regarding challenges, team members feel that the youth still struggles with the loss of his mother and the separation from his family. He needs to continue to improve his use of coping skills and be more consistent in expressing and managing his anger in a healthy and safe manner".*

Coordination and Leadership

2008	*2009*	**61%**	**79%**
Acceptable	Acceptable	Unacceptable	Unacceptable

39%	21%

This indicator assesses the social worker's ability to effectively lead the team (which consists of the child/youth, birth family, caregivers, and service providers) through the decision-making process. In addition, it assesses the social worker's effective coordination and continuity in assessment, planning, organization, and provision of services to the child and family.

There was a significant increase of 18% for Coordination and Leadership in 2009, in comparison to 2008. This is a good indication that social workers are demonstrating the skills necessary to lead and coordinate teams to achieve positive results. One of the first steps toward development of a successful team involves the social worker maintaining regular communication with the right people.

In Case #39, the social worker was seen as the single point of coordination, due to his ability to maintain communication with team members, keeping them abreast of the activities on the case.

> *All parties interviewed stated that the social worker was the clear leader of this case. He contacts all team members to give updates and reminders on court dates and calls to give the status and outcomes from court by phone and/or email to those who were not able to attend.*

Likewise in Case #37, *"the social worker is the identified leader and coordinator of this case. She is the one leading the team by keeping team members informed and involved. The worker has been able to effectively engage the parents and has established a good working relationship, which has been beneficial to the case and its progress"*.

In Case #12, a guardianship case, both the social worker and the foster mother were working together to ensure that all the appropriate services were in place for the focus youth.

> *Reviewers were very impressed with how the foster mother and social worker were able to work together to coordinate the required services and they seemed to have a good working relationship."*

Team Formation and Functioning

2008	*2009*
Acceptable **52%**	Acceptable **78%**
Unacceptable **48%**	Unacceptable **22%**

The Team Formation and Functioning indicator was rated at 78% for 2009 in comparison to 52% in 2008. This indicator assesses to what degree the "right people" for the child/family have formed a working team that meets, talks, and plans together to achieve the goal of case closure. It measures how well members of the service team collectively function as a united body in planning services and evaluating results. This indicator also measures the level of cohesive and effective teamwork and collaborative problem-solving that benefits the child and family.

Case #18, exemplifies utilization of the principles of the Practice Model in actual practice:

> *The team convenes periodically, via telephone as necessary, to discuss any concerns or issues as it relates to the focus youth's needs and services. Once identified, services were implemented in a timely manner and were of good quality to ensure that the focus youth's disabilities were being addressed. Furthermore, services were being monitored to target high priority needs, such as the numerous placement disruptions, and were being reassessed to ensure effectiveness.*

In Case #44, "t*here appears to be a clear and cooperative team of most of the right people that*

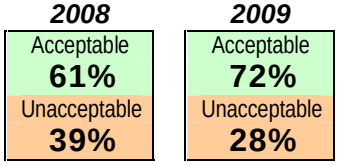
Through teaming, social workers, family, and other team members gain the opportunity to collaborate in planning and decision-making.

CFSA Out-of-Home Practice Protocol

meets, talks, and plans together. While the paternal great grandmother is seen as the team leader, which is appropriate within this in-home case, the social worker is coordinating and working with the right people."

In-home Case #50 was described as having "*good teaming, in that the social worker and FSW are located in the same building and are able to communicate on a regular basis for updates and changes. The birth mother and focus youth are satisfied with the functioning of the team. The team members are committed to providing and referring the family to services and resources; for example, mentoring and mental health services."*

Case Planning Process



Fundamentals of case planning include assessing the individual strengths and needs of each child, developing comprehensive case plans that build on strengths and meet needs, and adjusting service strategies as the parties make—or fail to make—progress. In addition, planning consists of helping to build a safety net and a stable family infrastructure as the pathway to permanency. Youth and their families should be actively involved in case planning, and case plans should include time-limited, measurable outcomes that, when achieved, will lead to permanence and safe case closure.

Case planning is a cooperative effort in which the social worker assesses the child/youth and family needs in partnership with the family and other team members.

CFSA Out-of-Home Practice Protocol

It was clear that in 2009, social workers were more diligent in practicing effective case planning and soliciting participation from all team members. The following three cases are examples of how social workers have been demonstrating this principle in practice.

(Case #2) *Most team members praised the social worker for her diligence in this case and identified her as the leader and the coordinator of services/information sharing. There is a good team that meets and plans together. There have been multiple meetings in this case including FTMs (Family Team Meeting), ITILPs (Individual Transitional Independent Living Plan), school meetings, group home meetings, and other CFSA meetings. Case planning appears to try to address the youth's needs regarding mental health services, employment, and school.*

(Case #51) *They invite her to meetings and work hard to accommodate both the birth mother's and the grandmother's schedules in order to optimize their participation – even holding over or rescheduling meetings when the mother is late.*

(In-Home Case #24) *The paternal grandmother is involved with the case planning process and is aware of the tasks that are included in her case plan. Some team members are aware of the goals that must be accomplished, which seem to be specific to the family's needs. Seemingly, services are implemented in a timely manner and are being monitored and adjusted to ensure that not only the focus child, but the family's needs are being met.*

For In-Home Case #81:

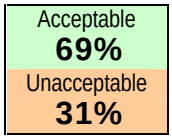
Case planning in this case appears to be a team effort. Team members commented that the family is asked their opinions on how the case should move safely towards case closure. The birth mother has signed the case plan and has had a voice in what services

are offered to her family. The tasks and goals in the case plan are realistic and appear to address the reasons the case became involved with CFSA.

Although the afore-mentioned areas can be identified as strengths, we recognize that these scores can and should be higher, and that there is still room for improvement even in areas where practice is generally positive. In addition, the following are areas where the agency's overall ratings were low enough to suggest a need for changes in practice.

Challenges

Academic/Learning Status



One child indicator that did not produce a high rating and declined compared to 2008 scores was Academic/Learning status. In 2008, this indicator was rated at 82% acceptable. In 2009 this indicator was rated 69% acceptable, which is a low rating for such an important aspect in a child's life. This raises concerns about children's educational needs and how the system is meeting those needs. Frequently, when children have undiagnosed or untreated mental health problems and/or they are struggling with adjusting to foster care, they have difficulty focusing in school.

The 14-year-old focus youth in Case #3 gave birth to a child prior to the QSR and was receiving specialized educational services. Even with these specialized services, she still struggled to fully engage in school.

> *The youth is in seventh grade and receives special education services. She has an existing IEP and is said to function at the fourth grade level. Prior to giving birth in December 2008, the youth was on medical leave due to the pregnancy and was provided an in-home teacher through DCPS (District of Columbia Pupil Services). Within the last month, the youth has not cooperated with the in-home teacher and she is past her allotted hours for this service. The youth has not yet returned to school since she requires medical clearance by her OB/GYN. Reportedly, the youth has been refusing to allow the doctor to examine her. In addition, she has refused to get the required immunization necessary for school. Other school issues include the fact that the youth has attended multiple schools over the last two years. She has a history of truancy. She refuses to participate in tutoring.*

Need for Improved Service Coordination: Occasionally, specific services are identified for children, such as tutoring, counseling, and mentoring, but implementation for all recommended services is lacking even when several other services are in place. For children with high service needs it is imperative that the service team communicate regularly to ensure that all services are tracked and adjusted to meet the child's needs.

The focus youth in Case #15 was reportedly receiving tutoring and mentoring, but there was no verification from the team that the youth was actually getting these much-needed services. Reviewers also noted that the focus youth was in group and individual therapy, but not actively participating. However team members were unclear as to why he was not fully engaged in these services.

> *The focus youth is in the seventh grade at a level IV school. He is one of nine students in a classroom. He has two teachers and a one-to-one aid that sits with him all day. At school, the focus youth is supposed to receive one hour of group therapy (which he*

usually sleeps through), one hour of individual therapy (which he often refuses), and thirty minutes each of occupational therapy and speech and language therapy. He is currently failing all subjects as he produces only about 5% of class work per week. He submits almost zero homework. He has a tutor/mentor that is supposed to be working with him for six hours per week. Several team members are working on identifying an alternative school that would better suit the focus youth's behavioral needs.

Medical issues can also sometimes interfere with academic performance. The focus child in Case #55 was a 12-year-old male who was diagnosed with end-stage renal failure. He attended dialysis three times a week in the afternoons for over a year, and, thus, missed many hours of school. The reviewers wrote:

The focus child is in fifth grade and receives full-time special education services. Team members report that he has mild mental retardation with an IQ of 64. He is, however, currently functioning on a second grade level. Team members speculated that the focus child's academic delays might be due to a combination of factors such as untreated mental health problems and missed school due to medical appointments.

Reviewers noted in the case summary that the social worker diligently worked with the hospital staff to change the child's dialysis appointments to later in the evening, so he would not miss additional school time.

Youth Life Skills Development

Acceptable
54%
Unacceptable
46%

Life Skills Development rated lowest of all the child status indicators. Foster youth between the ages of 15 to 21 should be coached by their social workers, caregivers, and other team members in independent living skills such as problem-solving, obtaining and maintaining employment and housing, maintaining a bank account, using public transportation, and forming healthy relationships with adults and peers.

In some instances, youth may frequently be in abscondance, and thus not be available to participate in the programs available to them that would provide these skills. There are also some teenagers who have not reached the maturity level necessary to focus on learning about the responsibilities of adulthood. The latter is not uncommon in many teenagers who have had safe, secure, and intact family situations, but it is especially relevant with foster youth, many of whom had to struggle to have their emotional and developmental needs met as children. Trying to learn the skills to be a functioning adult is challenging when those needs and milestones have only been partially or not at all met.

Caregivers' Lack of Emphasis on Life Skills Development: The rating of 68% in 2008 was significantly low, but the rating of 54% in 2009 raises concerns about the system's focus on and ability to provide instruction of these essential skills for children who may eventually age-out of care. Without training in life skills or access to learning them through reliable family members, committed foster parents, and accessible community supports, these children are at risk for not functioning up to their potential once they become adults.

There are several challenges with providing training in life skills to teenagers, which may be reflected in the low ratings. Some youth were committed to the Department of Youth Rehabilitation Services (DYRS) and placed at residential detainment or treatment centers where the focus is often on maintaining appropriate behavior and not developing independent living skills.

In Case #35, the focus youth was committed to DYRS after being arrested for prostitution. This youth was never committed to CFSA, but he and his younger sister had an in-home case open with CFSA. The

youth was detained at a juvenile detention center at the time of the QSR, and he turned 18 a few days after the review. His independent living skills were also underdeveloped.

> *The reviewers questioned why services had not been identified for the focus youth prior to his arrest and subsequent detainment. One team member noted that the current social worker was assigned to the case in the spring of 2009, and she only had a few weeks to work with the focus youth before he was detained. It was also reported that the focus youth was frequently in abscondance since his mother died, thus implementing services was reportedly a challenge.*

While this youth's CFSA in-home case would be closing due to his age, he was committed to DYRS and would still continue to receive services, such as placement at a therapeutic group home, counseling, educational planning, and most likely life skills development.

A 19-year-old youth in Case #41 also received a low rating on the Life Skills Development indicator. In her case, teaming was rated highly and team members agreed that the social worker put forth maximum effort to encourage the child to participate in CFSA's Center for Keys for Life or at least attend an independent living program where she could obtain those skills. Despite the excellent teaming, coordination, and leadership in this case, the youth was not willing or able to put forth the effort to learn more independent living skills.

> *The focus youth has been enrolled in five different settings to pursue her education, vocational training or employment within the last two years; however, she has not completed any of the programs. There are plans in place to re-enroll the focus youth at a vocational training program for the home health aide certification. Team members are concerned that this will be the focus youth's second attempt and there is a strong probability that she will not follow through. According to the youth, she did not wish to engage in a program that was too long and informed reviewers that two weeks was a long time. She would like a program that she could complete in a few days. Those interviewed stated that they found the focus youth's nonchalant behavior and lack of responsibility to be very frustrating for the team and for the court. Team members were concerned that legally she is an adult and her case is fast approaching closure; however, she has not acquired any life skills that would sustain her as an adult.*

This youth was placed with her paternal grandparents, who were committed to providing care to her as long as she needed it even after her case closes with CFSA and the court. The reviewers noted that some team members felt that the grandparents were enabling the youth's lack of maturity by cooking all of her meals, picking her up whenever she needed a ride, and buying all of her clothing. These actions, however, reassured reviewers that the youth had their long-term support.

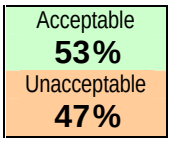
While the indicator for Life Skills Development was the lowest among all of the child indicators, there were several youth reviewed who were rated highly for life skills development. The 20-year-old youth in Case #61 was focused on achieving his personal goals and successfully demonstrated his maturity.

> *Overall, the focus youth has demonstrated extremely responsible behavior. He has maintained excellent grades and continues to be eligible for a full college scholarship. He follows the rules at the independent living program when he is staying there and cooperates with the staff and his social worker. The focus youth maintains a balanced bank account and keeps in touch with the Center for Keys for Life staff. He participates in his quarterly Youth Transition Plan meetings, at which time progress regarding his goals for independent living are assessed and discussed. He exudes a positive emotional*

outlook even while sharing his frustrations about the foster care system. According to all of the team members, the focus youth's maturity is an asset and the foundation for his continued success.

Team members, according to the reviewers, noted that this focus youth had the motivation and maturity to accomplish his goals, and the system implemented the services necessary for his success.

Parents' Progress to Safe Case Closure



Under parent status, the Progress to Safe Case Closure indicator assesses to what degree birth parents are making progress toward becoming independent and sustaining independence from the child welfare system. It also measures to what degree the birth parents have made necessary changes to reunify, stabilize and preserve the family. For example, are the necessary provisions in place to keep the child safe within the home, have necessary parent behavior changes been maintained and have supports been established within the home.

In 2009, a total of 50 cases were rated in the category of Progress to Safe Case Closure for birth parents; 18 with a goal of reunification and 32 with a goal of family stabilization.

Foster care is a short-term intervention. Therefore, the goal of every social worker is to help children and youth achieve permanence as quickly as possible, ensuring future stability.

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Lack of Motivation: In the last year 47% of birth parents were unable to show progress, and maintain the necessary changes toward safe case closure. A major barrier that contributed to low ratings in this area was an apparent lack of motivation by parents to actively participate in their service plans to mitigate the circumstances that lead to their family's CFSA case. Examples are illustrated below:

In Case #63:

The birth mother is not helping this case move towards case closure. She refused individual counseling, she tested positive for marijuana use, has not completed the APRA assessment, and she has not been visiting the focus youth at his group home unless it is for a scheduled meeting.

In Case #27 reviewers noted that the birth mother was not actively participating in her service plan, therefore delaying permanency for the focus youth.

The mother seems to have made little progress toward case closure… [t]he mother seemed to have no sense of urgency to complete drug treatment. She stated that she was currently not using drugs because she was "too busy to get with the bad people" who encourage her to use. Although she did say that she does not want to use drugs again, she stated that "anything can happen" and that she had to be very much cognizant that certain circumstances could tempt her to use again. While the mother indicated during the interview that she thought substance abuse counseling had been a positive experience for her, it was clear that she does not think it was required of her for case closure.

Though the previous two cases have different permanency goals, reunification and family stabilization respectively, they have similar challenges. The birth mothers were not taking the necessary steps required to enroll and participate in drug treatment, which was included in both of their case plans, to move toward closing their cases.

In Case #21 reviewers noted that:

> [*T*]*he birth mother has not actively participated in this case over the last three months and she is showing unacceptable progress towards safe case closure. She has not made herself available for the agreed upon substance abuse assessment outlined in the Family Team Meeting. She has not made any efforts to locate her own substance abuse program (although she had stated that she preferred to find her own program), nor has she attended any NA or AA meetings. She has not signed a release of information for the social worker to review her drug test results that are required as a part of her probation even though proof of negative drug tests could provide evidence that could lead to her child welfare case being closed.*

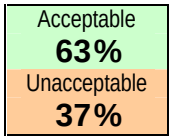
The social worker on this case had made diligent efforts to engage the birth mother in services.

> *While* [*the birth mother*] *admits that the social worker has asked her what is important to her, has asked her how they can work together to close the case safely, and agreed to all the items in the Family Team Meeting plan, she stated that she does not agree with the agency's concerns and does not feel that the goals and objectives are necessary. She has not taken any steps to make use of the mental health contact information provided by the social worker, even though she verbalizes the need for and the desire to receive help with her grief and loss issues.*

The birth mother's lack of motivation and participation was the leading cause for the closure delay in this case.

> *There are no clear plans or timelines for case closure should the children be found to be safe and provided for by the mother or family members even if the mother chooses never to get treatment for her addiction. This case has been open for a year and a half. If the mother does not understand the agency's concerns regarding how her substance abuse impacts her parenting, she will continue to resist assistance and the case will continue to stalemate.*

System's Pathway to Safe Case Closure



The system indicator, Pathway to Safe Case Closure assesses to what degree is there a clear, achievable case goal including concurrent and alternative plans. It also evaluates to what degree are barriers to safe case closure identified and addressed. For older youth, this indicator assesses whether or not team members are actively planning for the youth's transition from care. In 2009 there was a 6% decline as compared to 2008 for this indicator.

Need for Post-Permanency Supports: Without the appropriate formal and informal supports in place post-permanency, caregivers and older youth will have difficulty maintaining the conditions necessary for safe case closure. It is imperative that families and older youth are connected to informal supports within their extended families and formal community supports and services. We must ensure that families are aware of the availability of these services and facilitate their access to them.

The case examples listed below illustrate that even with a highly rated team and excellent leadership; the challenges to achieving safe case closure continue to be problematic for workers.

In Case #23 the Pathway to Safe Case Closure indicator was rated in the improvement zone for this in-home case. In this case the 5-year-old focus child had a medical condition that required constant monitoring and treatment through frequent hospital and doctor visits. Reviewers described the pathway toward case closure as "*decidedly unclear*". They further reported that:

> [*T*]*he social worker, supervisory social worker, and FSW (Family Support Worker) acknowledged that they cannot envision a realistic trajectory toward safely closing the case. They identified the mother's need for virtually constant oversight, support, and guidance in caring for her family, difficulty in accomplishing tasks independently, and her comprehension as barriers to case closure.*

One of the individuals interviewed cited *"CFSA's involvement as essential to ensuring that the focus child receives regular medical care"*. Reviewer's further noted that:

> [*T*]*here has been no identification of a relative or friend who could be responsible for ensuring that the focus child receives every possible support to prevent relapse; instead, the social worker and FSW try to provide some level of the necessary vigilance, and the focus child's medical team continues to diligently remind and prompt the mother. In addition, the FSW reported that he is actively involved in ensuring that the healthy children attend their asthma and well-child appointments because the mother struggles to do so.*

In this case reviewers noted that the service team had difficulty identifying the next steps and requirements for safely closing this case given the multiple needs of the family, most notably the need for informal support.

Instability of a youth often contributes to the failure of the case achieving safe case closure. In Case #60, the focus youth is a 19-year-old female with a goal of APPLA. Since her entrance into the foster care system, she was placed in several foster homes, one group home and had multiple psychiatric hospitalizations due to her explosive behavior and suicidal ideology. There were also several incidents of abscondance. At the time of the review, the focus youth was in abscondance.

> *Stability for the focus youth has been poor for the past six months, since the disruption of her placement with her younger sister. Team members are not confident that, even if the youth did return to be placed, she would stop absconding. The last time the social worker saw the youth was a few weeks prior to the review, when the social worker ran into the youth at the Courthouse. The youth was with a boyfriend, who was there for drug testing. She refused to be placed and would not give her boyfriend's contact information. Since then she has left sporadic messages for the social worker, stating both that she wants her case to be closed and, more recently, that she wants to return for placement. Each time she has said she wants to return for placement, she has not followed through.*

Although there was evidence that the team made consistent efforts to engage with the focus youth to get her involved with her case plan, these efforts were unsuccessful and team members had concerns for the youth's future. *"Because the youth was in abscondance for the entire review period, with no indication she planned to return, her pathway to permanence is unclear. While there is a case plan that could be implemented if the youth does return, at the time of the review she was not on a path to a positive exit from foster care"*.

In-Home Cases: Key System Indicators, 2006 and 2009

While the above sections focused on examining the QSR data from 2007, 2008 and 2009, 2006 was the only year that had a comparable number of in-home cases reviewed (40 in 2006 and 35 in 2009.) It is worthwhile to explore how far in-home "system" practice has come.

There are three key system indicators examined in this section: Coordination and Leadership, Team Formation and Functioning, Case Planning. Engagement and Assessment and Implementation indicators cannot be used in this examination because in 2006 those indicators included the child and parents, and this changed in 2008 when indicators were broken out to allow for analysis of the child, mother, and father individually.

Figure D: Historical Comparison of In-Home Practice
2006 n=40 and 2009 n=34

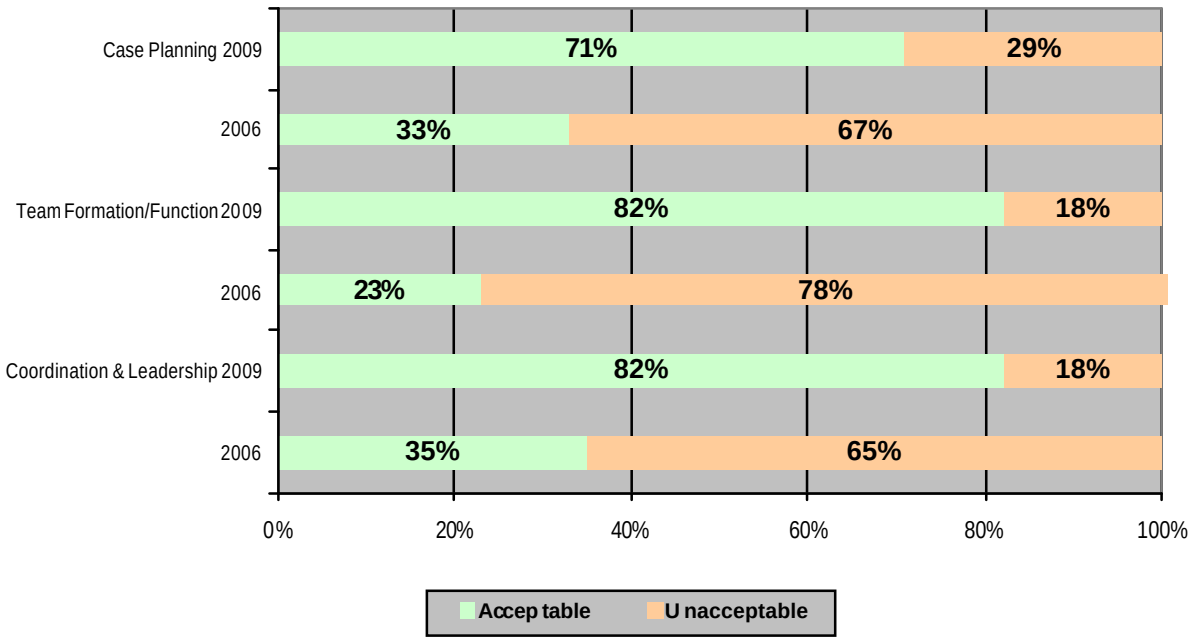


Figure D shows dramatic increases in acceptable ratings of over the three years. In 2006, all four applicable system indicators were rated "unacceptable" in over 50 % of the cases; the most significant "unacceptable" rating of 78 percent was for the Team Formation and Functioning indicator. According to the Spring 2006 QSR Report,

> *Forming high-functioning teams with families and other service providers is an important aspect of In-Home practice. Social workers' intentional efforts to develop and*

maintain a team of service providers and family members enhances case planning, assessment, identification of appropriate services, and progress toward safe case closure. Our findings indicate that CFSA and other providers have work to do to build and reinforce the practice skill of team development and leadership among social workers.

In addition, the low ratings of Coordination and Leadership by social workers (65%) and Case Planning ultimately negatively impacts the ability to safely achieve case closure for children (53%).

Two contributing factors for this increase in indicator ratings could be the creation of the specialized in-home units in 2006 and co-location of 10 in-home units within the Healthy Families/Thriving Communities Collaborative offices at the end of 2008.

According to the Fall 2005 QSR Annual Report, *"court-involved (out-of-home) cases rated higher on child, parent, and system status indicators than non-court-involved (in-home) cases. This meant that children and families CFSA monitored at home were at higher risk of being unstable and unsafe."* Following that review, CFSA implemented a structural change by dividing out the In-Home cases and creating specialized in-home units. This demarcation allowed in-home social workers to focus intensely on children and their families residing at home without having to also work on out-of-home cases and court requirements.

In February 2006, CFSA introduced an agency-wide Practice Model that established values, guiding principles, and practice standards that, when consistently implemented, will strengthen families and help to ensure safety, permanence, and well being for children. Since the Practice Model reflected indicators in the QSR protocol, the QSR was an ideal method of measuring CFSA progress in implementing desired case practices. Later that year in the spring of 2006, the QSR Unit reviewed 40 in-home cases as a first look at the level of practice in the newly created in-home units.

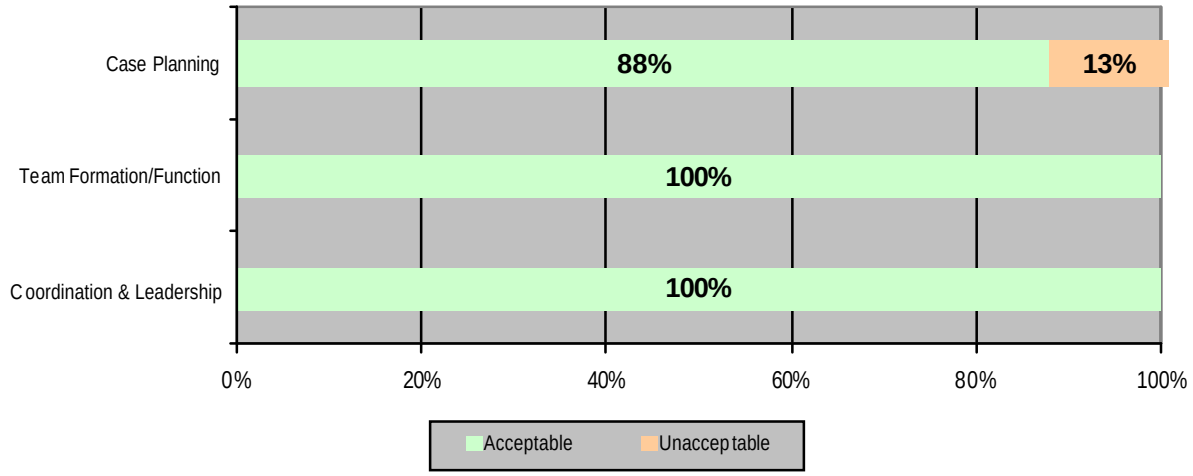
The Spring 2006 QSR Report concluded that *"court-involved cases rated higher than non-court-involved cases on both child and system status indicators. CFSA has separated social worker caseloads into In-Home and Out-of-Home, which should allow social workers to focus intensively on families not involved with the court system. In-home practice is unique, and social workers will benefit from a specific model of practice for working with families in their natural settings."*

The 2006 report recommended that CFSA fully implement the Practice Model and continue to evaluate in-home practice to ensure that the model was successful.

In 2006, in an effort to improve in-home services, the Healthy Families/Thriving Communities Collaboratives and the Collaborative Council, in conjunction with CFSA, formed the Partnership for Community-Based Services (PCBS). In December 2007 PCBS built upon the 2006 Practice Model highlighting practice standards specific to in-home cases. In an effort to better implement the In-Home Practice Model, PCBS included the co-location of 10 CFSA in-home units into Collaborative office sites around the District between September 2008 and November 2008. The purpose of the co-location of CFSA staff into the Collaboratives was to increase the level of communication and joint team work between the two agencies. Co-location also allows for CFSA staff and family members to have easier access to each other, Collaborative agency staff and to community resources.

During 2009, the QSR Unit reviewed 35 children/youth that were residing at home and successfully rated 34 cases[1]. Of the 34 cases rated, 31 children/youth were receiving in-home services from a social worker co-located at a neighborhood Collaborative. Only eight of those co-located cases had both a CFSA Social Worker and Collaborative Family Support Worker teamed on the case at the time of the review.

Figure E: CFSA-Collaborative Teaming, 2009



Of the eight cases teamed with Collaborative staff, all eight received acceptable ratings in Coordination and Leadership and Team Formation and Functioning (Figure E). Coordination and Leadership in teamed Case #51 is clearly described as positive below:

> *The social worker is the identified team leader and it appears as though she maintains communication with involved team members and has attempted to engage additional people who are not active participants (i.e., the named father, and the birth mother's sister). People spoke highly of her and the work that she is attempting to do with the family. She invites people to team meetings. She asks their opinions and concerns related to the children and their mother. She monitors the homemaker services and has created a clear united front with the Collaborative Family Support Worker.*

Positive team formation and functioning is illustrated in Case #50. The Family Support Worker was clearly very engaged in this case as he participated in school-based meetings and had made connections with school staff. The Family Support Worker was calling the youth in the morning to make sure he got up for school. In addition,

> *The social worker and FSW have made efforts in coordinating with school staff to get updates on the focus youth's attendance. This case has good teaming, in that the social worker and FSW are located in the same building and are able to communicate on a regular basis for updates and changes. The birth mother and focus youth are satisfied with the functioning of the team. The team members are committed to providing and referring the family to services and resources; for example, mentoring and mental health*

[1] In one case, the birth mother and the youth did not make themselves available for their scheduled interviews. Without their viewpoint it was impossible for QSR reviewers to objectively and accurately rate system status indicators

services. For example, team members have a fair understanding of the strengths and needs of this case. They are working diligently to ensure that the focus youth will attend school regularly in the fall and that the birth mother commences mental health counseling along with medication management.

It is expected that ratings in these areas will continue to increase for cases that are teamed and collaboratively managed by CFSA Social Workers and Healthy Families/Thriving Communities Collaboratives' Family Support Workers. This partnership has yielded many positive outcomes for children and their families thus far. Evaluation and enhancement of this partnership will continue in the upcoming years.

Working with Fathers

In 2007 and 2008, the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau conducted Child and Family Services Reviews (CFSRs) in 31 states and the District of Columbia. Their purpose is to (1) ensure conformity with Federal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist States to enhance their capacity to help children and families achieve positive outcomes.[2]

The Children's Bureau's found that for the 31 jurisdictions reviewed, sufficient efforts to assess needs were made for 79 percent of mothers and 46 percent of fathers. Sufficient efforts to involve mothers in case planning were made in 74 percent of cases and efforts to involve fathers were made in 48 percent of cases. These numbers illustrate that child welfare nationwide is not engaging birth fathers at an acceptable rate.

In June 2007, the Children's Bureau conducted CFSA's CFSR onsite. Sixty-five cases were reviewed, including 39 foster care cases and 26 in-home cases. The January 2008 "Final Report from the Children's Bureau" reported that CFSA failed at engaging and assessing fathers in their children's cases. The report indicated that, *"CFSA assessed and met the needs of birth fathers in only 24 percent of the [reviewed] cases; whereas with birth mothers, the outcome was 77 percent."*[3] CFSA was found to be far below the already inadequate national average of 48 percent.

Following the CFSR, the CFSA Quality Service Review Unit decided to draw attention agency-wide to the importance of involving fathers and to highlight the federal standards for fatherhood engagement.

The unit coordinated various fatherhood awareness activities, including hosting two brown bag lunch forums on engaging fathers and engaging incarcerated fathers, and providing social workers with tip sheets on "Obstacles and Strategies for Fatherhood Involvement" and "How to Locate an Incarcerated Parent through the Federal Bureau of Prison's Website". In addition, the QSR Unit made specific changes to the 2008 QSR Protocol in order to gather more detailed information on how CFSA and the private agencies work with birth fathers. Prior to this change, the engagement, assessment and implementation indicators have been rated based on the child and parents in their totality. The QSR Unit decided to divide the three indicators further in an effort to better assess the child, mother and father on an

[2] U.S. Department of Health and Human Services Administration for Children and Families, "Children's Bureau Child and Family Services Reviews Fact Sheet", February 23, 2009, http://www.acf.hhs.gov/programs/cb/cwmonitoring/recruit/cfsrfactsheet.htm (accessed January 27, 2010).
[3] U.S. Department of Health and Human Services Administration for Children and Families, "Final Report District of Columbia Child and Family Services Review January 2008", n.d., <http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/scorecards/cfsr_final_report_dc_to_sharlynn_bobo_01-08-08.pdf> (accessed January 27, 2010).

individual basis. The QSR Unit has been committed to making efforts to locate and invite fathers, especially incarcerated fathers, to participate in QSR interviews and was able to interview 17 fathers in 2009, an increase from 8 in 2007.

Engaging Fathers

According to the 2008 QSR data, there were 38 cases (out of 62 cases reviewed) where rating fathers were applicable, yet only 14 cases had evidence of father involvement. Of the 38 applicable cases, engagement of fathers was rated 71 percent unacceptable. Assessment and understanding was rated 74 percent unacceptable and implementation of services for fathers was rated 77 percent unacceptable. Figures F and G. illustrate comparative acceptable ratings for mothers and fathers in 2008.

Despite the efforts made by the agency in response to the 2007 CFSR and the 2008 QSR findings of poor engagement and assessment of fathers, the 2009 QSR data shows little improvement in these areas. In 2009 out of 83 cases, there were 62 cases where engagement of fathers was rated. Of these 62 cases, 65 percent were rated unacceptable as many of these fathers had limited or no contact with the social worker. For example, in Case #26, the birth father was reportedly very involved in the life of his 6-year-old daughter and was even described by the birth mother as a *"very good father"*. It was reported that the focus child and her brother spend weekends with their father and had dinner with him twice a week. The father also worked closely with the child's school and it was stated that the school *"preferred working with the father because they felt he was more consistent [than the birth mother]."* According to the case summary, *"The social worker has never had a conversation with him [the father] even though the mother provided her with his contact information. Therefore, it is unknown as to whether or not he would have wanted to be involved with the services being provided to the focus child and her family."*

Case #52 illustrates the same lack of attempts to engage a father who is present in the life of his child. In this case, the 3-year-old male resides with his birth mother, but his father spends time with him at least once a week. Team members admitted that there had been *"a lack of outreach and engagement with the birth father and the paternal relatives."*

The importance of engagement of fathers is not a new concept to CFSA. In February 2006, the agency created the "Practice Model: Our foundation for effective child welfare practice" which outlined standards for best practices in working with children and their families While this document did not explicitly differentiate between mothers and fathers, it did lay out the foundation for engaging and supporting birth families and their relationships with their children. In December 2007, CFSA finalized and disseminated its In-Home Practice Model focusing on best practices with children and their families within their home setting. In July 2009, the Out-of-Home Practice Model was released, outlining practice standards for children placed outside of their homes and their birth/resource families. Both practice models outline the, "attributes of excellence in practice that is consistently: child safety-centered; family-focused; community connected and strength-based and solution focused. (Partnership for Community-Based Services, "In-Home Practice Model", December 2007 and Child and Family Services Agency, "Out-of-Home Practice Model", July 2009.)" In addition, both practice models broadly define "family" to include "mothers, fathers, and other significant adults who may or may not be currently involved in the child's or youth's life." The In-Home Practice Model makes clear that CFSA and Healthy Families Thriving Communities Collaborative staff should "recognize the value of fathers to their children and understand the issues unique to work with fathers." (Partnership for Community-Based Services, "In-Home Practice Model", December 2007).

Figure F: Historical Comparison of Parent Indicators for Mothers

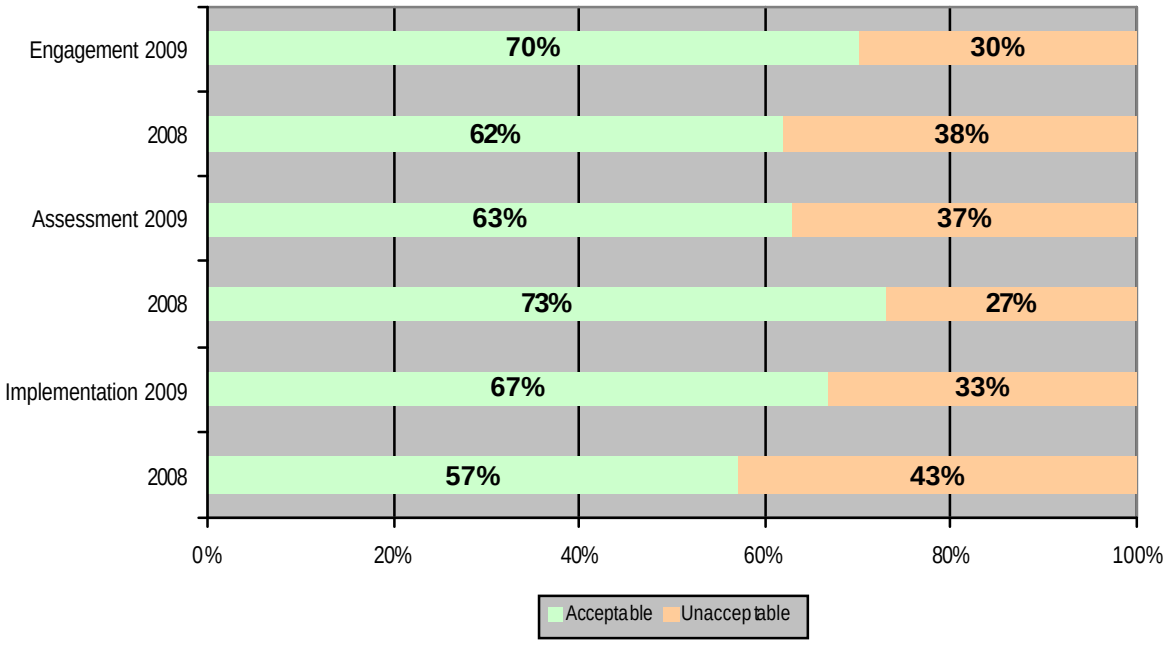
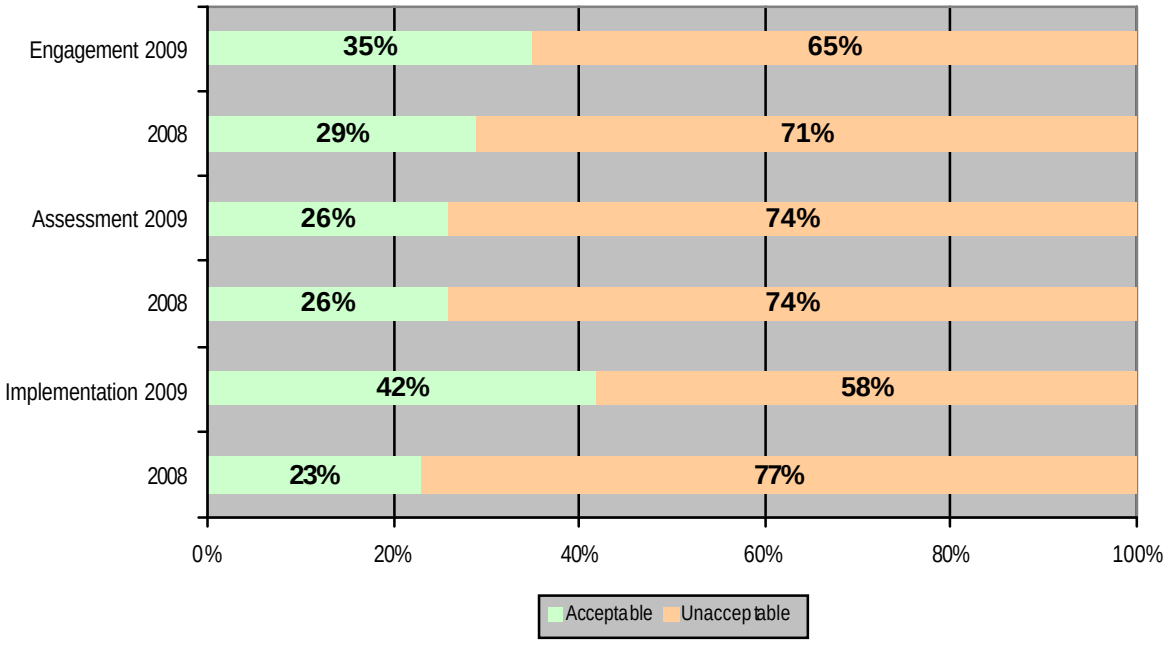


Figure G: Historical Comparison of Parent Indicators for Fathers



Furthermore, the Out-of-Home Practice Model specifically directs social workers to engage birth parents, including *"non-custodial parents"*. The practice model highlights engagement as an *"essential part of strength-based case management"*. It goes further in saying:

> *Engagement is not a one-time effort to build rapport at the beginning of a case but an ongoing process of staying sensitively in step with a child or youth and his/her family throughout their involvement with the child welfare system. Engagement means being sensitive to the nuances of change and responding appropriately. It includes periodically incorporating new members, including family members who have not yet participated, into the team and re-assessing and adjusting the case plan to reflect changing circumstances and/or needs*[4].

Cases 1 and 68 further illustrates CFSA's failure to locate and engage incarcerated fathers. In the first case, there was no evidence that the agency attempted to contact the father of a 16-year-old female in any way. *"The focus youth reported that she would like to know her father and possibly visit with him; reportedly, her inability to do so makes her feel depressed. Because no one speaks with the youth about her father, reviewers doubt that the parties involved with the youth are aware that she gets depressed when she thinks about her father."*

In the second case (#68), an incarcerated birth father was interviewed during the QSR and expressed that he would like to have a more *"consistent relationship"* with his daughter and *"become an active participant in her care and well-being."* It was also reported that he would like to participate by phone for court hearings and other meetings. Reviewers found that the social worker was *"unaware of which correctional facility he [the father] was in, his expected release date and that he was even interested in participating by phone for court proceedings."* In addition, it was found that paternal relatives had not been sought out for this focus youth; however, the birth father expressed that paternal relatives were interested in having a relationship with her.

As previously stated, the Out-of-Home Practice Model highlighted that "engagement is not a one-time effort to build rapport at the beginning of the case, but an ongoing process…." This statement reinforces the federal standards that require efforts to engage "absent" parents every six months. The Out-of-Home Practice Model outlines steps for re-engagement in order to attempt to bring isolated, distant, or absent parents in as active team members. Steps include sending certified letters, making visits to the last known address, making phone calls, obtaining information from additional family members and utilizing CFSA's Diligent Search Unit. It is critical for social work staff to understand that until a birth father's parental rights have been terminated or the child achieves permanency, it is CFSA's responsibility to consistently attempt to engage him as a parent in the case planning process.

The data revealed that in some instances, social workers have allowed birth fathers to distance themselves from the case. An example of this is illustrated in Case #34. The focus youth was an 18-year-old male residing in a residential treatment facility. The case record showed a great deal of historical attempts to engage the father, but his continued denial of the youth's problems and lack of participation in recommended therapeutic services negatively impacted the team, and he then began to distance himself from the case. *"This lack of positive engagement has been frustrating for the team and due to the youth's permanency goal of APPLA it seems as though the team has made minimal attempts to continue to engage the father [during the review period]."*

The father in Case #3 also detached himself from his 14-year-old daughter's case. It was reported that the father had been involved in the case *"on and of"*. He had attended meetings, including a FTM, and *"he*

[4] Child and Family Services Agency, "Out-of-Home Practice Model", July 2009.

used to search the community looking for the youth when she was in abscondance. If he found her he would bring her back to CFSA." It was indicated that this man *"encouraged her to take advantage of offered services to improve herself."* Team members felt that the father *"dropped out of the case due to feelings of failure in helping his daughter"* and that *"his own life issues [recent re-incarceration] may be holding him back from continued involvement."* QSR reviewers felt that *"continued encouragement from the social worker could go a long way with this father. He may be in need of additional services when he exits jail and re-enters the community."*

Despite CFSA's overall struggle with attempting to locate absent fathers, several social workers were found to be utilizing the exact steps laid out in the practice models, which yielded positive results in the case. Cases 51 and 82 illustrates that with determination social workers can employ quality efforts in locating birth fathers. In the first case (#51) the 2-year-old focus child lives with her birth mother and has a permanency goal of Family Stabilization. The social worker was able to obtain information about the father from the mother and submitted a Diligent Search referral in order to locate him. Once she received information, she sent a certified letter to the address. In addition, the Family Team Meeting Specialist went to that address in order to invite him to a planned FTM.

In the second case (#82), the social worker contacted the father's attorney to try and obtain updated information on the birth father of a 15-year-old youth. The social worker submitted a Diligent Search referral based on information gained from the attorney. A report was completed by Diligent Search and three addresses were provided. The social worker gave a copy of the report to the father's attorney and planned on sending letters to each address in an effort to contact the birth father and engage him in the case.

Assessment and Implementation

In most cases, engagement, assessment and implementation go hand-in-hand. Naturally, when there is a lack of engagement of a birth father, it is impossible to assess his needs or his suitability as a caregiver or supportive person. Without engagement or assessment, services cannot be identified or offered. In the 2009 QSR data, there were three cases (#'s 14, 29, and 83) where engagement of the father received an acceptable rating, yet assessment and implementation received unacceptable ratings. In Case #14, there had been a great deal of social worker turnover on the case. Although the social workers changed, there had been a basic level of engagement with both the mother and father as the family attended the court mediation, the FTM, and had reviewed the case plan. When asked about their interaction with the newest social worker, both parents smiled and expressed positive thoughts about her. It was evident that a good level of engagement had been achieved as both parents were able to verbalize several of the things they needed to accomplish for reunification and had reportedly participated in the development of the case plan. While they here has been limited forward movement, they are aware of what the social workers and the court would like for them to complete.

The case summary highlights that this family has domestic violence, substance abuse and mental health issues. Despite the positive engagement of the father, *"the system has a superficial assessment of him and his current functioning. There is a lack of historical information that could provide a context to current functioning; strengths, challenges, and needs."* The case summary goes further in reporting:

> *There is no leader responsible for coordinating the lengthy list of referrals or service implementation for the parents. Referrals that were supposedly done by the first social worker have not been followed up on causing a delay in service implementation and attendance and could lead to a duplication of referrals. Without a social worker to monitor services and engage the parents, it is highly unlikely that they will be able to address the identified challenges and make forward movement towards safe case closure within ASFA timelines.*

The lack of a full assessment in this case can lead to delays in achieving the permanency goal for this focus child. Additional challenges include an inaccurate assessment of current needs, misidentification of services, delays and duplication in service provision.

Effects on Permanency

When fathers are not engaged in the case planning process, it can hinder permanency planning by excluding fathers and paternal family members as placement or life-long connection options. A clear example of how not engaging the birth father and/or paternal relatives can impact permanency is illustrated in Case #57. This case is of a 10-year-old female residing in a foster home with the goal of Adoption. The birth father had recently been released from prison. Upon his release he attended court hearings for the children and met with the social worker to discuss permanency options. The birth father provided five names of family members who he wanted to be considered as permanency options. A paternal cousin was found to be a viable option and agreed to step forward; the team *"immediately jumped into action."* While this is a positive outcome for the focus child, it is important to point out that prior to the father's release from prison, very little engagement by the team had occurred. The case summary indicated the following:

> *Multiple team members commented that they did not engage the father because 'he wasn't in the picture' because he was incarcerated. No one assessed him for the appropriateness of contact with the focus child while he was incarcerated. In addition, there was no evidence that the birth father was given the opportunity to identify placement options for the focus child while he was incarcerated. It could be speculated where the children would be right now if the birth father had identified his cousin earlier in the case.*

Case #54 highlights another case of a father who has not been engaged in case planning or permanency planning for his 14-year-old daughter, who has a permanency goal of APPLA. This father is incarcerated, but has maintained contact with his daughter. The case summary mentioned that the father *"expressed his disappointment that the social worker never contacted him or kept him included in what was happening with his children"* although he did comment that his attorney kept him updated on how his child's case was progressing. This father was then able to speak with his own father and stepmother about having the focus youth come back to live with them. He was therefore helpful in identifying additional family members that could be placement or supportive resources for the focus youth.

A third example can be found in the case of a 14-year-old male with the permanency goal of APPLA (#33.) The case summary indicated that a diligent search for this young man's father had previously been conducted and an address in Virginia was identified; however, the father had since moved and no follow-up has taken place. It was also reported that this young man did not have any contact with his paternal relatives. The lack of efforts in actively searching for his father and paternal family members further limits this 14-year-old's permanency options, and when considering his goal of APPLA, his potential for creating life long connections.

Notwithstanding the large percentage of unacceptable ratings for working with fathers, it is important to highlight examples of cases where fathers are valued and engaged. In the case (#71) of an 8-year-old male with the goal of reunification with both of his parents, the birth father was said to be actively involved in the case. He had completed parenting and anger management classes. He was employed and *"reportedly had a strong bond with his son."* The summary further indicates:

> *Several factors have contributed to the excellent progress made thus far toward safe case closure. The team has reached out and engaged the birth parents, foster parents, and*

focus child in order to develop strong assessments of each of them. Team members demonstrated a thorough understanding of the birth parents' and the focus child's strengths and needs. Regarding implementation of services for the birth parents, the agency referred them to parenting and anger management classes, which they successfully completed, and the birth mother took the initiative to participate in individual therapy and to obtain medication management. The birth parents and foster parents were actively involved in the case planning process, and all team members were aware of what needs to be accomplished for safe case closure.

Case #37 features a 6-year-old Latino female, who is currently residing in a foster home. Her permanency goal is reunification with her parents, although it could be changed to reunification with just her father as he is considered the more motivated and active parent. The parents had been separated, but reconciled after the children were removed from their home as they thought a two parent household would be more *"acceptable for reunification."* Moreover,

It was reported by all team members that the father was the driving force for the family and is very committed to ensuring that he is reunited with his children. He actively participates in the services and communicates regularly with some team members in regards to the focus child and her well-being. The father volunteers to pick up the focus child each morning and drive her to school and bring her home after school. This arrangement was agreed upon by the team. Additionally, he picks up the focus child and her sister every Saturday and takes them to the park or for an activity.

The worker has been able to effectively engage the parents and has established a good working relationship, which has been beneficial to the case and its progress. Additionally, the parents' feel respected and felt that they were being included in the decision making and were equal partners on the team. The social worker was available for discussions, clarifications and to help guide the parents through the process. This was very critical for the parents, due to their cultural beliefs and language barrier.

This case exemplifies the best practice standards around engaging the family and building a trust-based relationship as outlined in the Out-Of-Home Practice Model. This case has evidence of both parents being respected, listened to, and valued. It appears as though the case management was family-focused and strength-based. The social worker assessed the strengths and needs of each parent and was able to build upon the strengths in ways that were moving the participants towards safe case closure. This case shows that when the tenants of quality practice are followed and valued, a family can be strengthened and a case can actively move forward towards permanency.

There were five cases (# 36, 44, 74, 79 and 80) where children were residing with their father or with both parents and where engagement, assessment and implementation of services had acceptable ratings. In Case #44, the birth father and his grandparents were providing care for his three children. One point to highlight centered on implementation of services for the birth father. This father was committed to attending the 13-week Fatherhood Initiative Program and was able to access support from this program even beyond this time limit. The case summary indicated that *"The birth father has recently turned his learning into action and is trying to be more consistent in imposing consequences for bad behavior with the focus child, including the withdrawal of games and toys, and in using time-out strategies."* This is a fine example of how a good assessment and link to appropriate services has helped increased this father's knowledge and skills in parenting his children effectively.

In Case #80 the 9-year-old focus child was living with both of her parents. The social worker was successful in linking the father to the Addiction, Prevention and Recovery Administration (APRA) for

linkage to a substance abuse program and he "*appears to be participating fully in treatment and reportedly is now becoming more involved in the management of the household.*" It was further reported:

> *The biological family expressed great satisfaction with the overall quality and amount of assistance that they are receiving. They have a very high regard for the ongoing social worker and expressed feeling that they could trust and rely on her. In addition to the CFSA worker, there are extended family members who serve as supports including a paternal grandmother and paternal aunt of the oldest sibling. The mother impressively spoke of how she understands the value of the involvement of these family supports.*

Reviewer Recommendations

In 2009, reviewers attempted to address the aforementioned issues regarding social worker and team member efforts to engage fathers in the case planning process for their children. Of the 61 cases rated for engagement of birth fathers, 41 cases were rated unacceptable. In 29 of those cases there were next steps related to fathers; 9 of these cases had a recommendation in the category of Diligent Search/Locate; and 20 cases had recommendations in the category of Form Relationship with Parent or Teaming.

At the time of the 60-day follow-up, of the 9 cases with a recommendation in the category of Diligent Search/Locate for the birth father, 5 were found to be successful, 3 were In Progress, and one was categorized as Not Applicable (or No longer Needed). The following 2 cases are examples of successful completion of the recommendation. In Case #1, the social worker spoke with the birth mother and found out that the birth father was incarcerated in Kentucky. She worked with the family and was able to initiate a relationship between the child and her father.

In Case #33, the social worker was successful in obtaining information on the birth father without a Diligent Search referral. The social worker contacted the father and he attended the scheduled mediation hearing and also brought the youth's sister with him. The birth father is residing with his mother and they were willing to participate in the case planning process; however the focus youth was refusing to have a relationship with the father at that time. The plan was for this issue to be addressed in therapy. This case highlights the essential responsibility of child welfare social workers to engage fathers as active team members.

Case #49's recommendation was still in progress at the time of the follow up. The social worker submitted a Diligent Search referral, which was successful; however, at the time of the follow-up, the Diligent Search Unit had not yet reported their findings to the social worker. In a second case (#77), the social worker reportedly spoke with the birth mother about contact information for the birth father, but she was not forthcoming. The mother did not want any contact with the father. Reviewers suggested that the social worker continue to talk with the birth mother about the focus youth's feelings about his father to ascertain if he wanted to see him and then use those feelings to spur the mother to reconsider her objections.

Of the 20 cases with recommendations in the category of Form a Relationship with Parent or Teaming, 18 recommendations were completed by the social worker. Some of the recommendations specified that the social worker was to reach out to the birth mother or another family member in order to obtain information on the birth father. Other recommendations were for the social worker to send a letter to the birth father and/or one of his relatives in order to make contact and ask for participation in the case. Additional recommendations were to invite the father to participate in meetings or court hearings.

In Case #21, the social worker agreed to send a certified letter to the father's last known address (which was later returned undelivered) and contact the paternal grandmother for information. The social worker had spoken with the birth mother about the birth father and the paternal grandmother, but she was not

forthcoming with information. The social worker went further and spoke with the birth mother's brother and two aunts regarding contact information for the birth father and his relatives. No one was able to provide information, but indicated that they would try to obtain information and inform the social worker if they learned anything. This is a great example of a social worker diligently trying to obtain information on a birth father and his family.

Case numbers 54 and 72 are examples of how connecting with the birth father lead to contact between the child and their father. In the first example (#54) the social worker was to contact the birth father in prison and update him on the case plan. The worker made contact and was also made arrangements for the youth and her father to write to each other. There is also a plan for the youth to be transported to New York to visit with her father. The social worker is planning to accompany the youth one weekend to conduct the visit. In the second case (#72), the social worker agreed to ask the child's therapist to supervise phone calls between the youth and her birth family, including her father. This recommendation was successfully achieved as phone calls between the youth and her parents have begun.

In one case (#68) the social worker worked with the father's attorney in order to have the father participate in the next court hearing by telephone from prison. The social worker also agreed to discuss paternal family member involvement in this case with the father. After the social worker's discussions with the father, the worker has been in contact with a paternal aunt and uncle. She made two home visits with these relatives and visitation between the youth the paternal uncle began.

One case (#61) had a recommendation of sending letters to the mother, grandmother and father. At the sixty-day follow-up, this next step was still in progress. The social worker spoke with the birth mother and the grandmother, but he did not obtain any updated contact information for the birth father. The social worker planned to talk to the focus youth in an attempt to gain additional information.

The QSR Unit is dedicated to continuing our efforts to bring fatherhood issues to a forefront in 2010. The unit is committed to creating a next step around fathers 100 percent of the time when engagement of fathers is rated "unacceptable". Additionally, the unit will continue its efforts of increasing social worker awareness by hosting workshops, providing information tools, and participating in committees around the agency working on this issue.

Conclusion

Since the CFSR in 2007, the 2008 and 2009 QSR data illustrate that CFSA has not made significant improvement in working with fathers. While there are several cases where social workers and teams are reaching out and engaging fathers, it seems that the lack of effort to involve fathers remains a systemic challenge for the agency, which ultimately can impact the agency's ability to achieve permanence in a timely manner and provide additional life-time supports to children. The data also revealed that social workers are very capable of using their knowledge and skills in identifying successful strategies to use to ensure that fathers have an opportunity to participate in the case planning process for their child as well as impacting their progress to safe case closure.

Next Steps

At the end of each case review, the social worker, supervisor and reviewers meet to identify and agree upon a small number of next steps. These are specific actions that the worker can take in the immediate future to address issues identified during the review and to move the child closer to permanence. We have broadly categorized these next steps illustrating the areas most frequently identified as in need of improvement at the top of the list. The teams agreed upon a total of 315 next steps, an average of four to five per case. Table 5 shows all the categories of next steps and the number of times reviewers suggested a step that fell into each category.

Table 5: Categories of Next Steps

Rank	Category	Frequency
1.	Teaming	37
2.	Refer/participate in services	33
3.	Work directly with family	25
4.	Education	24
5.	Case planning	23
6.	Communicate with service provider	22
7.	Form relationship with family member	20
8.	Health/dental	15
9.	Evaluation	14
10.	Mental health	12
	Diligent search	12
11.	Court/legal	11
	Permanence	11
12.	Family Team Meeting	9
	Family visits	9
	Safety/risk	9
13.	Services tracking/adjustment	8
14.	Other	7
15.	Financial assistance	5
16.	Address placement issues	4
17	Informal supports	3
18.	Life skills development	2
	Total	315

The Teaming category included next steps such as the social worker facilitating a meeting between the birth parent, focus child, pre-adoptive foster parent, GAL, and the birth parent's attorney in order to discuss the goal of adoption and plans for the future. Examples of services in the Refer/Participate in Services category include a social worker making a referral to the local collaborative for supportive services, individual and family therapy, and substance abuse and domestic violence assessments. Specific examples of next steps in the category of Work Directly with the Family included the social worker speaking with the birth parents about appropriate discipline of the children and how to utilize the techniques learned in parenting classes, clarifying the roles of each household member in keeping children safe, and making efforts to engage and encourage the birth father and paternal relatives to actively participate in the focus child's life. In the Education category, next steps included following up with educational advocates for the status of school placements and assisting a parent in advocating for additional services, such as tutoring, in the child's IEP. For Case Planning, next steps were focused on developing a cooperative case plan with parents and team members outlining specific measurable tasks to be completed in order to safely close the case. In the Communicate with Service Providers category, a specific recommendation was for the social worker to contact the family therapist for an update on the consistency of family sessions and the plan for future appointments. Lastly, examples of next steps in the Other category, included social workers following up on housing issues for families and assisting families with furniture vouchers.

Sixty-Day Follow-Up

QSR specialists returned 60 days after the review to evaluate whether or not social workers had acted on the agreed upon next steps. QSR specialists were able to conduct a sixty-day follow-up on 82 of the 83 cases reviewed (one case had no next steps as it was nearing closure). QSR Specialists determined the

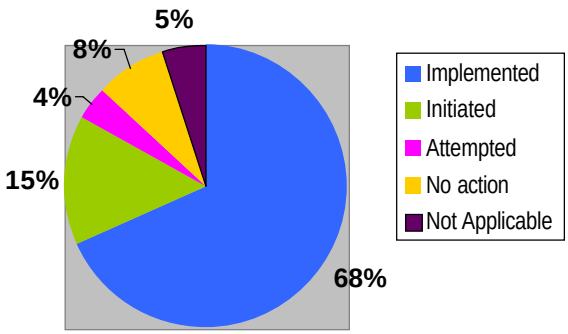
status of each next step based on a follow-up interview with the social worker and supervisor and a review of current FACES data, the possible outcomes were as follows:

- Implemented (next step was completed),
- Initiated (steps have been taken, but the recommendation has not been fully implemented),
- Attempted (despite the efforts of the social worker or other team members, the recommendation was not completed because of resistance from the client).
- No Action (next step was not completed), or
- Not Applicable (next step is no longer relevant to the case based on recent case events i.e. case closure, or a change in placement.)

Information from the sixty-day follow-up was shared with supervisors and program managers. Information gathered in follow-up discussions with social workers appears at the end of each unit-based case summary (Appendix B).

Specialists found that social workers had implemented 68% and initiated an additional 15% (Figure H) of the 315 next steps. Four percent of next steps were attempted by social workers; however they were not completed due to resistance from another party in the case. For example, in Case #21 the next step was for the social worker to talk with the mother about how a review of her clean urinalysis tests would work toward case closure. However, at the sixty-day-follow up QSR specialists learned that the social worker spoke with the birth mother about releasing her drug testing results, but she continued to refuse to sign a release of information or provide copies as proof.

Figure H: 60-Day Followup on QSR Recommendations



QSR Specialists found no action taken on 8% of next steps. There was no definitive information gathered as to why the next steps were not followed in those cases, nor were there any patterns or trends found regarding those next steps. Five percent of the next steps were no longer applicable for various reasons. For example, in Case #4 the next step was for the social worker to work with the focus youth's caregiver and service team members on ensuring that mental health services for the youth would continue once the child welfare case was closed. However, it was learned at the sixty-day-follow-up that the youth was arrested and detained and that services would now be coordinated by the Division of Youth Rehabilitative Services.

Implementation of recommended next steps often led to progress in cases. One hundred percent of recommendations for Permanency, Evaluation, Address placement issues, Safety/risk, and Working directly with families were followed or were in progress. As compared to 2008 data on the sixty-day follow-up, social workers continued their case planning and teaming efforts to ensure that children and youth had appropriate permanency plans in place. Social workers achieved or initiated over 90% of all mental health-related next steps, as well as next steps to communicate with service providers to ensure the provision and delivery of appropriate services to families. Recommendations for Diligent Search resulted in successfully reuniting a child with an absent birth mother or father.

Data from the 2009 QSRs reveal that 68% of next steps were implemented in comparison to only 38% in 2008. Based on the information gathered at the sixty-day follow-up, recommendations and next steps developed in concert with social workers and supervisors at the unit level have had a positive impact on outcomes for children overall, than at the macro level. The follow up component of the QSR creates a level of accountability for direct service staff to complete specific tasks that moves individual cases further towards permanency and safe case closure.

5. Summary and Recommendations

The following is a recap of major findings from the 2009 QSRs.

Strengths

- Children's health and safety needs were met. Parents and caregivers adequately managed risk factors to ensure children's safety. Children's medical and dental health needs were identified and addressed in a timely manner.

- Parents and caregivers were meeting children's emotional needs, thus creating and promoting a home environment where children can thrive emotionally.

- Significant improvements were seen in teaming on cases reviewed. Service teams functioned more cohesively, ensuring that the necessary services were in place for children. Reviewers found many team members were aware of current case status and on the same page with the permanency goal and service plan as compared to 2008.

- One hundred percent of resource families (17 guardianship and pre-adoptive families) were actively participating in the case plan to achieve timely permanency for children.

Challenges

- We found insufficient outreach to fathers to include them in the case planning process early on and throughout the life of the case.
  - § In many cases youth maintained communication and connections to their fathers and paternal relatives unbeknownst to social workers and team members.
  - § In some instances, specifically for in-home cases, mothers have chosen not to share the identity of birth fathers. However, it is required of social workers and the team to address the mother's reluctance and or hesitance in providing this information.
  - § Once identified, diligent efforts should be made to locate fathers and engage them in the case planning process for the child/youth.

- Biological parents were not receiving adequate and timely service provision.
  - § Service teams must place emphasis on tracking and adjusting services for parents to ensure that permanency timelines are adhered to.
  - § Services must be targeted to address the behaviors that present safety and risk factors that prevent children from returning to their parents' care.
  - § Creative resource planning is necessary to ensure that he unique needs of biological parents are met.

- While some cases had highly rated teams and excellent leadership, challenges to timely achievement of permanency goals and achieving safe case closure were problematic for social workers. The data reveal that there continues to be a lack of concurrent planning for alternate goals. Concurrent planning must start at the beginning of each case and should be considered

regardless of the permanency goal. Primary and alternate plans should be worked on simultaneously so that if one plan falls through, another is already in process and little time is lost toward case closure.

With the implementation of the In and Out-of-Home Practice Model training and coaching at the unit level, it is expected that system indicators, specifically those in the areas of working with mothers and fathers, case planning, and pathway to safe case closure, will show improvement in the coming year. Program managers and supervisors can use the unit-based data from the QSR to set goals for their staff that are aimed at the challenge areas identified for each unit. Using the Practice Protocols and QSR as guides, systemic change can and will be achieved.