Our Children
Our Communities
Our Future

A child welfare system's capacity and performance must reflect commitment to safety, permanence, and well being for abused and neglected children.

2005 Needs Assessment Report

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Chapter I: Introduction

A. Background

In 1989, a civil rights class action suit [LaShawn A. v. Dixon] was brought against the District of Columbia's Department of Human Services (DHS). As a result of the suit, the District of Columbia established the Child and Family Services Agency (CFSA) and in conjunction with a court monitor, created the *LaShawn* Implementation Plan to reform child welfare in the District of Columbia.

Chapter XV, Outcome 2, of the *LaShawn* Final Implementation Plan mandates that CFSA will complete a needs assessment every two years beginning in 2003. Then, within 90 days of completing the Needs Assessment, CFSA must revise the separate Resource Development Plan to translate broad findings of the Needs Assessment into recommendations and a specific plan for developing necessary services and ensuring appropriate, stable placements.

Chapter XV, Outcome 3, describes the Resource Development Plan as

[I]dentifying the services required and how they will be funded/developed. The Plan shall specify the quantity of each category of resources and services, the time period within which they will be developed, and the specific steps that will be taken to ensure that they are developed. CFSA will then take necessary steps to implement this plan..

The Resource Development Plan will identify the following specific elements:

- Number of emergency placements, foster homes, group homes, therapeutic foster homes, and institutional placements that children in CFSA custody will require during the upcoming fiscal year
- How CFSA will improve and initiate community-based services to prevent unnecessary placement, replacement, adoption, and foster home disruption
- How CFSA is moving to ensure decentralized neighborhood- and community-based services
- Strategies for recruiting, training, and retaining foster and adoptive families based on annual assessment of need

.

B. Overall Approach

The *CFSA 2005 Needs Assessment* does not strive to meet every possible goal for collecting information that could improve performance. It is not an isolated study. It is but one of a number of CFSA activities designed to improve the alignment of services with practice, child and family needs, and with our overall goals of safety, permanence, and well being. We have incorporated information from some other activities (such as the geographic case assignment model evaluation and the Fall 2005 Quality Service Review) into the Needs Assessment. We plan to include additional information from other projects in the Resource Development Plan, especially from the Levels of Care Initiative currently underway. That initiative involves developing a model to promote consistency and fairness in reimbursement for various levels of out-of-home care.

In conducting the *2005 Needs Assessment*, CFSA has taken a bold step in practice improvement. The report is a self-evaluation tool that includes evaluation of the entire child welfare system from multiple perspectives, incorporating the experiences of children, families, providers, social workers and stakeholders. It identifies gaps in services, resources, and supports for birth families and kinship and foster parents. By exposing those gaps, we hope to gain a picture of needs and to engage our partners in a reform that will

ultimately make the District's child welfare system a model for the nation.

Chapter VI, Outcome 2, of the *LaShawn* Final Implementation Plan states that CSFA will conduct a "comprehensive examination of the effectiveness and sufficiency of current placement supports." The plan also requires a focus on needs for crucial services (such as community-based preventive services) that help foster parents and congregate care providers ensure stable and appropriate types of placements. Child Welfare experts also advised going beyond the usual list of formal services (such as mental health services or parenting classes) and to pay close attention to informal supports (such as extended family, neighbors, or a trusted teacher or coach), and one-of-a-kind activities (such as dance therapy or art classes).

We accepted the experts' advice in designing the *2005 Needs Assessment* and made the following choices about the depth and breadth of information to include:

- *A critical look at community-based and preventive supports that will potentially keep children at home* – Among our reasons were lessons from past research in the District and clinical experiences that suggest a need for more community services in the District; CFSA's commitment to a practice that links families to their communities; and the expectation that the Resource Development Plan will propose next steps in community-based, preventive, and placement services.

- *Strategies to look at informal as well as formal supports for families* - First, we included opportunities for survey and focus group participants to comment on a variety of areas beyond formal supports. Second, instead of interviewing birth parents by telephone as we did in 2003, independent contractors interviewed them in person. The majority of these interviewers held MSW degrees and all participated in a four-hour interviewer training workshop to ensure they identified needs that would make practice more flexible and more family- and community-focused.

- *A variety of methods to gather information* - We included surveys (web-based to increase staff and stakeholder response rates), focus groups (with the assistance of 2005 Needs Assessment External Committee members), and literature review of recent internal and external studies related to the well-being of children in the District of Columbia. We also increased the size of our 2003 sample (169) to 503 for 2005.

- Examination of the effectiveness and sufficiency of current placement supports as outlined in the Implementation Plan, Chapter VI, Outcome 2:

Beginning March 31, 2005, and every two years thereafter, CFSA will complete a bi-annual assessment of the effectiveness and sufficiency of its placement support service programs. Consistent with the findings of this assessment, CFSA will modify its placement support service programs, if needed, to ensure that placements for children are appropriate and stable.

- *Special studies in areas such as domestic violence* – Although these studies are without detailed, qualitative information, they are helpful and informative. Included in these special studies is a literature review of national and District research. This review provides current knowledge as a context for understanding challenges and needs that emerged from the Needs Assessment.

C. Areas of Inquiry

The *2005 Needs Assessment* relies on 2003 conclusions for its general direction but with a new approach that provides data that CFSA needs to develop its vision for the future. Our 2003 assessment indicated major needs for mental health services for children, affordable housing for families, and substance abuse treatment for parents and youth. Through implementation of the *2004 Resource Development Plan*, however, CFSA made significant progress in bridging those gaps. Some of the improvements include:

- Creation of three new mental health services for children and youth at home and in out-of-home placement from the D.C. Department of Mental Health (DMH): Multi-Systemic

Therapy, Intensive Home and Community Based Services, and Mobile Response and Stabilization Services – all are presently in the initial implementation stage.

- Co-location of DMH workers at CFSA to facilitate consultation with social workers regarding family mental health needs.

- DMH approval of a number of Core Service Agencies to provide ongoing mental health services to children and families in their own communities.

- Implementation of CFSA's Rapid Housing Program made possible through Federal funding.

- Collaboration with the Addiction Prevention and Recovery Administration (APRA), including development of an agreement with APRA to detail substance abuse specialists to CFSA's Child Protective Services Administration to assist in identifying client treatment needs, facilitating referrals for services, and providing a range of substance abuse treatment services for youth and birth parents.

- Continued partnership between CFSA, the Family Court and APRA to implement and monitor the Family Treatment Court program (a residential substance abuse treatment program that allows women to keep their children with them).

For the *2005 Needs Assessment*, we examined three substantive domains particularly derived from the 2003 consensus-building process:

- Service needs of children and birth families in general, with special focus on maternal depression and reunification
- Placement supports
- Domestic violence

Additionally, we elected to explore two areas that are particularly prominent in the lives of youth in the District:

- Trauma and the impact of violence
- HIV/AIDS

Finally, with these areas of inquiry as our foundation, we formulated five major research questions:

1. What services, resources, and/or supports can help to prevent families and children from entering the child welfare system?

2. What services, resources, and/or supports do CFSA birth families need, particularly to achieve the goal of reunification?

3. What services, resources, and/or supports can help maintain stable out-of-home care for youth and young adults?

4. What is CFSA's need for services and training regarding community and domestic violence?

5. What are the implications of the HIV/AIDS epidemic for CFSA youth, staff, resource parents, and providers?

D. Findings

Our overall findings revealed a consistent, thematic repetition of the following major concerns:

Bureaucratic/Systemic Barriers

- The referral system for services through CFSA providers is inconsistent and cumbersome.
- The process for staff to access agency vehicles is problematic, especially in an emergency.
- Social workers voiced frustration regarding school administrators' delivery of critical client information.
- Social workers reported having to use personal funds to purchase items for clients.

Service Delivery Gaps

- Foster children need more direct support from the public school system in the District.
- Some Collaboratives[1] as well as other community-based service providers are occasionally slow in responding to client

[1] *The District's Healthy Family/ Thriving Communities Collaboratives are CFSA's primary vehicles for neighborhood-based child welfare services.*

needs. CFSA needs to increase use of other community-based agencies to serve clients.

- Substance abuse and mental health services are not available in all wards of the District.
- Available services are not always adequate for clients.
- Both social workers and birth parents cited the need for additional community-based

  support groups. Access would help parents when they are open to receiving such support.
- Relatives expressed the need for greater post-permanency support after they've achieved guardianship of children.

Changing Demographics

- There is a growing need to provide for additional therapeutic placements. Alternatives or additional therapeutic foster care resource parents must be developed, contractors must be held accountable for providing therapeutic slots.)
- A large number of grandparents are raising their grandchildren in the District without benefit of appropriate services.
- CFSA's foster parent population is aging.
- Seasoned foster parents are unable and/or unwilling to work with older youth who exhibit behavioral issues.
- The proportion of older youth in foster care will likely continue to grow over the next few years unless CFSA makes concerted efforts to achieve permanence for this population.
- About sixty percent (58%) of foster care sibling groups are placed with all or some of their siblings

Additional Training/Partnerships

- Social workers and group home workers do not receive skill and sensitivity training to care for youth with unique service needs.
- Foster parents and social workers do not receive formal training in caring for HIV/AIDS-infected children.
- Multi-disciplinary training in cultural competence and sensitivity should be made available to judges.
- Everyone in the system needs additional training to ensure permanence for children.
- Partnerships to enhance training and resource development opportunities are lacking with other District agencies and community-based organizations.
- CFSA needs to partner with the District's Public School System (DCPS) to ensure that the unique needs of children and youth involved with the Agency are met.

Communication Issues

- All study group participants cited improved communication as a major need that CFSA must address to ensure successful outcomes.
- Increased communication is necessary between Maryland and the District regarding the Interstate Compact for the Placement of Children (ICPC).
- Communication breaks down between CFSA upper management and social workers.
- Communication is unclear and often inconsistent between social workers and foster parents regarding roles and responsibilities.
- Communication between social workers and birth parents is often tenuous and sporadic.
- Social workers reported feeling disrespected and overlooked by judges during court proceedings
- Better communication is necessary between the social workers and Collaboratives, and a clearer understanding of the services provided by the Collaboratives is needed.

E. Structure of the Report

The next two chapters (II & III) of the report provide important background and context. Chapter II, on Methodology, describes the approaches taken in conducting the needs assessment and the strengths and limitations of our data sources. Chapter III summarizes other recent studies of the District that were particularly important in shaping our thinking, including the DC Court Improvement Project and the 2005 Quality Services Review. From there, Chapters IV through VIII present the major results by research question as described above.

Chapter IV highlights the specific challenges and service needs of birth parents before involvement

with CFSA, what they need to achieve reunification once their children enter the system, and how they can maintain a safe home post-reunification. It also addresses specific needs of youth in care; youth aging out of care; and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth. We have also included additional information about social worker challenges and needs.

Chapter V focuses on placement and placement support services from a systemic perspective. A description of children in foster care in the District, characteristics of the foster parents who serve these children, and placement projections and trends are provided. Also included is this chapter is a comprehensive examination of the effectiveness of current placement supports to include the challenges and needs of resource (foster, kinship and adoptive) parents and social workers.

Chapters VI - VIII highlights findings from the special studies conducted. Each of these chapters begins with a literature review that includes national and District background information and closes with several next steps suggested by the research to date. Chapter VI highlights the challenges and needs of children and families struggling with domestic violence, its impact on children, and CFSA's current response to these challenges and needs.

Chapter VII explores the overall impact of violence in the District of Columbia, particularly the issue of trauma, implications of living in a violent community, and its impact on birth parents and children in foster care.

Chapter VIII explores the extent of HIV/AIDS among children served by CFSA. It identifies challenges CFSA staff and foster parents face in addressing the needs of these children. ■

Methodology

Chapter II

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  - *Surveys*
  - *Focus Groups*
  - *Telephone Interviews*
  - *Administrative Data*
- Data Analyses
  - *Quantitative Analyses*
  - *Qualitative Analyses*
  - *Geographic Information Systems (GIS)*
- Limitations of the Study

Chapter II: Methodology

A. Overview

The 2005 study used a multi-tiered approach incorporating both quantitative and qualitative research techniques, including intensive interviews, surveys, focus groups, administrative data extracted from FACES,[2] and other relevant studies. Table 1 summarizes the full array of information sources and data collection methods used in the study. Table 2 lists the variety of sources from survey and interview participants.

1. Surveys

Survey instruments from 2003 were modified to address research question #3 (supports for out-of-home care) and to include external stakeholders in the survey process. Research questions #1 (prevention supports) and #2 (reunification supports) were carried over from the 2003 Needs Assessment to re-evaluate clients' overall needs.

General Needs Assessment Surveys

A total of 195 CFSA social workers, 78 kinship/foster parents, 19 Collaborative and private agency workers, and 46 external stakeholders completed the General Needs surveys. *(Appendices C through I contain survey instruments designed specifically to address research questions #1 through #3.)* Each instrument had a qualitative as well as quantitative component. The quantitative component engaged respondents in selecting from a list of choices. The qualitative component asked open-ended questions. We made the surveys available on the web so that most groups could access them easily.

[2] *FACES is the District of Columbia's Federally-certified Statewide Automated Child Welfare Information System (SACWIS).*

Table 1: Information Collection Methods and Data Sources

Interviews and Surveys	• Birth parents of children involved with CFSA • CFSA social workers, supervisors, program managers, administrators, and deputy directors • Collaborative and other private agency social workers • Foster parents • Community stakeholders
Focus Groups	• Placement • Community violence • HIV/AIDS • Latino birth parents • Foster and Adoptive Parent Advocacy Center (FAPAC)
Statistics and Other Data	National Statistics: • U.S. Census Bureau • New York City Administration for Children's Services • California Department of Social Services District (CFSA): • FACES • Office of Clinical Practice (OCP) • Office of Planning, Policy & Program Support (OPPPS) • Semi-annual report to federal Adoption and Foster Care Analysis and Reporting System (AFCARS)
Literature	CFSA: • *Fall 2005 Quality Service Review Report* • *Revamping Youth Services: Preparing Young People in Foster Care for Independence* • Foster Parent exit questionnaire • Geographic Case Assignment Model • Evaluation Report: Moving Towards an Optimal Model for Community-Based Service Delivery External: • *Assessment of the District of Columbia's Progress as of June 30, 2005*, Center for the Study of Social Policy • *Children and Family Services Administration Staff HIV/AIDS Training Needs Assessment*, Mosaica • *District of Columbia Court Improvement's 2005 Program Reassessment, Stephanie Minor-Harper's Office* • *Every Kid Counts in the District of Columbia*, D.C. Children's Trust Fund

Domestic Violence Survey

The sample included African American (28.6%) and Caucasian (28.6%) workers with a college and/or graduate degree (87%). A total of 28 domestic violence workers completed the DV survey. Twenty-five percent had a degree in social work. The average age was 32 years, and the average professional time in the field of DV was 6.1 years. Most workers had provided outreach/social worker/case manager/counselor/family support (46.4%) for an average of 3.8 years in their current position. Another 14.2% identified themselves as DV advocates.

HIV/AIDS Survey

Given the sensitivity of this area, we e-mailed surveys to Program Administrators with specific instructions for how to seek responses from workers with HIV/AIDS-affected children and/or youth on their caseload. We did not collect any identifying information. We received a total of 12 surveys, which represents a 50% response rate, based on CFSA's Office of Clinical Practice estimate of 20 HIV/AIDS-related cases.[3]

2. Birth Parent Interviews

In order to attain the random sample of 94 CFSA birth parents, we asked FACES to generate phone lists of birth parents who reunified with children between October 2004 and June 2005.[4] The sample included parents with children in foster care and with children at home but monitored by CFSA. Before contacting the birth parents, independent social work professionals completed a four-hour training session on how to conduct the interview for uniformity. We included several standardized scales in the interview instrument, such as the Center for Epidemiologic Studies Depression Scale (CES-D) and the Post-Traumatic Stress Disorder scale (PTSD) which covered depression, domestic violence, and stressful/traumatic life events.

The ages of respondents ranged from 19 to 68 years with an average age of 37. The majority were African American (89%) females (96%) with an average of four children. More than half (79%) were not married; nearly 65% reported completing high school or a GED.

In addition, Dr. Sandra Crewe, associate professor, Howard University School of Social Work, conducted two in-depth interviews with birth parents about their mental health needs, particularly in regard to maternal depression.

3. Focus Groups

A dozen focus groups discussed domestic violence, placement supports, and HIV/AIDS. Each group included representatives from numerous fields of expertise external to CFSA, including representation from the Office of the Attorney General and the Collaboratives. Table 3 provides details on the focus groups, including the names of experts who volunteered their time to facilitate.

4. Telephone Interviews Regarding HIV/AIDS

It was important to get input from community stakeholders since this study was our first attempt to explore HIV/AIDS issues in the District's child welfare system. Telephone interviews were conducted with a small group of several child welfare experts as well as experts in the field of HIV and AIDS, including representatives from the Collaboratives, private agencies, community organizations, CFSA Clinical Practice, and the Attorney General for the District.

We asked participants one question: What do you think are the two or three most urgent needs that CFSA should be addressing regarding HIV/AIDS for the children and families in the District?

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[3] *CFSA's Office of Clinical Practice estimates 20 known cases of children in foster care who are HIV-positive or have AIDS. Two of the 12 children cited in the sample have parents who are infected. The children themselves are not physically impacted by HIV/AIDS.*

[4] *Many phone numbers listed for birth parents were incorrect or disconnected.*

5. Administrative Data

We collected an assortment of administrative data on placement which included U.S. census data, national foster care statistics, and CFSA statistics.

We also identified variables that FACES reports could provide. From the extracted reports, we created longitudinal database files for historical analysis, relational database files for cross-sectional analysis, and spatial database files for geographic analysis.

We used AFCARS (Adoption and Foster Care Analysis and Reporting System) data that CFSA submits semi-annually to the U.S. Department of Health and Human Services, Administration for Children and Families (ACF), Children's Bureau. We then reviewed national foster care data from ACF for a comparison of District and national placement trends.

Finally, through longitudinal data observation, we identified trends and patterns over time. We performed a regression analysis using the same time series data to obtain projected data for FY06, focusing particularly on age and gender distribution of the foster care population.

B. Data Analyses

1. Quantitative Analyses

Applications used for data collection and analysis included the Statistical Package for the Social Sciences (SPSS), Microsoft Excel, and Geographic Information System (GIS) mapping software Arcview 9.1. Our primary data analysis techniques were descriptive statistics (frequencies, percentages, averages, median, and sum). We also produced some multiple cross tabulations. Following careful examination, we selected information and/or conducted additional analyses as needed.

Table 2: Survey and Interview Participants

Participants	*N*	*Data Collection Methods*
Birth parents (interviews)*	94	Contractors conducted field interviews◊
CFSA social workers, supervisors & program managers	195	Link to online survey sent via email
Collaborative & private agency workers	22	Link to online survey sent via email
Foster parents	78	▪ In collaboration with the Office of Training Services (OTS), surveys were given to participants in CFSA Foster Parent Training, Sept. 2005 ▪ In collaboration with the Foster & Adoptive Parent Advocacy Center (FAPAC), surveys were given to participants in their Foster Parent Training
Community stakeholders (representatives from private child welfare agencies, advocacy organizations & other District agencies)	46	Online, hard copy surveys, and telephone interviews
Domestic violence community stakeholders	28	Sample participants included: ▪ DC Coalition Against Domestic Violence (DCCADV) ▪ My Sister's Place ▪ Domestic violence workers attending a Mayor's Advisory Committee on Child Abuse & Neglect (MACCAN) training
Workers with clients affected by HIV/AIDS (includes children who either have HIV or AIDS or whose parent has the disease)	12	Survey emailed for supervisors to distribute to workers
LGBTQ survey to workers with clients who self-identify as lesbian, gay, bisexual, transgender, or questioning	28●	Link to online survey sent via email
Total participants	**505**	

** Conducted in collaboration with Dr. John Murphy (University of the District of Columbia)*

◊ Nineteen (19) birth parent interviews were telephone interviews.

●Twenty-eight social workers provided information about 36 LGBTQ youth and youth dealing with HIV .

Table 3: Focus Groups

Topic/Focus	#	*Facilitator*	*Participants*
Placement	2	Clare Anderson (Center for the Study of Social Policy) OPPPS Staff (CFSA)	CFSA social Workers Placement Services Administration Staff
Community Violence	2	Hope Hill, Ph.D. (Howard University) John Murphy, Ph.D. (University of the District of Columbia)	CFSA teens/young adults
Domestic Violence	2	Tricia Bent-Goodley, Ph.D. (Howard University)	CFSA social workers AAGs Comm. Collaboratives
HIV/AIDS	1	Cheryl Williams, MD (CFSA, OCP) Cheryl Durden, RN (CFSA, OCP)	CFSA social workers and supervisors
Latino Birth Parents	1	Elena Cohen (CSSP) Catherine Higgins (CFSA, OLM)	Latino Birth Parents
FAPAC Forum	4	FAPAC staff & foster parent volunteers	Foster Parents (2) Kinship Parents (1) Adoptive Parents (1)
Total groups	**12**		

Additionally, we downloaded national population census data from U.S. Census Bureau estimates (2000 and 2004). On the basis of age, gender, and race, we compared characteristics of foster children in the District with all of the children in the District.

2. Qualitative Analyses

Diverse qualitative information was collected from focus groups, narrative responses in surveys, and interviews. Audiotapes of focus group discussions were transcribed by independent contractors. Using note-based analysis, they reviewed sentences until themes emerged across groups. They then identified quotations to verify the themes.

3. Geographic Information Systems (GIS) Mapping

After extracting street addresses from FACES, OPPPS used GIS mapping software (Arcview) to geo-code locations of placement resources and homes of children in care. We then overlaid the geo-coding results with boundaries, such as city wards or Collaborative service areas. We also translated the same information into a density analysis and created maps.

C. Strengths and Limitations of the Study

We were extremely fortunate to receive a wide range of forthright information from workers, stakeholders, foster and birth parents who participated in the surveys, focus groups and interviews. The invaluable responses from these methodologies succeeded in helping us recognize new areas for our focus on improvement, as well as areas where we are continually improving.

Not every data item we wished to collect was available in our existing FACES reports. Unfortunately, FACES does not have a warehousing capability that allows researchers to situate data outside the operational system for ease of access and analyses. Warehousing would expand data collection capacity and improve the quality of data analyses. At the time of our placement data collection, the latest available information came from June 30, 2005. This information is sufficiently up-to-date to show the current picture of our foster population and placement trends.■

Recent Reviews of Service Needs in the District of Columbia

Chapter III

IN THIS SECTION:

- DC Court Improvement Project
- Every Kid Counts in the District of Columbia
- Citywide Comprehensive Substance Abuse Strategy for the District of Columbia
- Child and Family Services Agency Staff HIV/AIDS Training Needs Assessment
- Fall 2005 Quality Services Review
- The Geographic Case Assignment Model
- Foster Parent Exit Questionnaire

Chapter III: Recent Reviews of Service Needs in the District of Columbia

Over the past two years, there have been a number of reviews conducted for various aspects of service needs for District children and families. The information gathered in this chapter provides important background context for the *2005 Needs Assessment*.

1. DC Court Improvement Project

The DC Court Improvement Project, in collaboration with the Family Court's Juvenile and Neglect Branch, conducted a program reassessment in July 2005 that consisted of surveys completed by 162 CFSA social workers and 144 foster parents. The survey questions centered on the relationships between the courts and CFSA social workers and foster parents. Overall, social workers indicated that they were "satisfied" (41%) or "somewhat satisfied" (32%) with how the Court is handling child abuse and neglect cases in the District. When asked to identify items that present the greatest challenges regarding effective case management in child abuse and neglect cases, 77% of the social workers indicated that collaboration among professionals in the child abuse and neglect/dependency court system is the greatest challenge/barrier affecting case management of abuse and neglect cases at Family Court, followed by adequate representation for all parties (67%).

The comments presented by the social workers overwhelmingly stress the desire for fewer families and children on their caseloads in order to devote more quality time and attention to the needs and services for the children they serve. More than half (51%) of the social workers reported that they handle cases of fewer than 15 families but they cited too much paperwork, unrealistic court mandates and requirements, and difficulties handling the various levels of multiple needs for the children in their care. Although agency social workers do see an improvement by the courts in the handling of abuse and neglect cases, social workers also reported frustration with judges' lack of regard for workers' clinical expertise and recommendations. On the positive side, their comments identified shorter waiting times for hearings, improvement in the quality of service to families, usefulness of the "one family, one judge" concept, and having judges who better understand child welfare policies. They indicated a need, however, for more involvement of the Guardian ad Litems (GALs) with their cases, and better collaboration between social workers, attorneys, and service providers in order to quickly resolve the issues that come before the court in the best interests of the families.

Some foster parents noted that it might take anywhere from 2-4 days (11%) or even 5 days or more (7%) to hear from workers after leaving a message. Most foster parent participants (77%), however, reported having an excellent or good relationship with social workers. Nearly 80% noted that when they leave a message for the social worker, the worker usually responds within 24 hours. In general, most (72%) foster parents reported that social workers encourage them to attend court hearings and/or to provide written information about the child in their care for court review.

Foster parents commented that social workers are too overworked to communicate effectively or to engage more personally with the families and children. Their comments emphasized the need for more training and more adequate education for special needs children, a need for a guidebook of available opportunities for children, a guidebook of rules on foster parenting, and better communication with the GALs, and the courts.

2. Every Kid Counts in the District of Columbia– 12th Annual Fact Book 2005

The *2005 Every Kid Counts in the District of Columbia* offers longitudinal statistical information on the factors that affect the lives of children and families in the District. Released on December 15th 2005, the document includes a report card highlighting the indices of children's well being for 2004 and whether these indices changed for the better, for the worse, or did not change from the previous year. Through geo-mapping, this report shows selected indicators of children's well-being by ward, neighborhood cluster, race and ethnicity. The 2005 recommendations include the following strategies to address family attachment and community support, homeless children and families, child health, safety and personal security, and education:

- More supportive services for communities and families are needed, especially for single heads of household.
- The District needs to move away from reliance on emergency shelters and place more emphasis on the promotion of obtaining and maintaining permanent housing.
- Targeted prenatal care for vulnerable mothers is needed, especially for women who abuse substances, teens, women with HIV/AIDS, and single mothers.
- A holistic continuum of care for at-risk youth must be developed.
- The District must increase activities and/or programs to reduce child abuse and neglect.
- Creative efforts to increase community safety should be continued and expanded.
- Enhanced services for treatment of substance abuse are necessary.
- Educational achievement levels of students must be improved.

A second publication, the *2005 Kids Count Data Book*, examined four important but widely unaddressed obstacles facing parents nation-wide: substance abuse, domestic violence, prior incarceration, and depression. These obstacles, as well as the recommendations identified in the District Kids Count publication, are echoed in CFSA's *2005 Needs Assessment*.

3. Citywide Comprehensive Substance Abuse Strategy for the District of Columbia (September 2003)

In response to the impact of substance abuse on the District's health, safety and financial stability, Mayor Anthony A. Williams appointed an executive-level *Interagency Task Force on Substance Abuse Prevention, Treatment, and Control* to prepare and recommend a citywide Substance Abuse Strategy and budget. According to the Mayor's Order, the Task Force is charged with "enhancing the effectiveness of the city's health, social service, and criminal justice system by monitoring use of federal grant funding together with local funding to implement innovative substance abuse programs." Further, the Mayor's Order requires the Task Force to "establish well-defined performance outcome measures that will facilitate an assessment of costs and benefits of investments in substance abuse prevention, treatment and control."

Among the policy and program priorities of the Substance Abuse Strategy is intervention to prevent the early onset of drug use by District youth. Strategies include expanding the use of coalitions and neighborhood organizations; planning, implementing, and evaluating an intervention/prevention infrastructure; increasing utilization of existing evidence-based prevention programs; utilizing evidence-based environmental strategies to change individual and community norms; and increasing the effectiveness of the District's prevention workforce by training youth development and prevention professionals to implement effective prevention strategies. Another objective of the Substance Abuse Strategy is to increase the long-term substance abuse treatment capacity for youth and women with children. This objective is particularly relevant to the population served by CFSA.

4. CFSA Staff HIV/AIDS Training Needs Assessment

In accordance with the Family Ties Project (FTP), Mosaica: The Center for Nonprofit Development and Pluralism conducted a systematic assessment of CFSA's current HIV policy and its training needs. The study included a combination of CFSA staff surveys, a focus group with foster parents, and interviews. This study's findings are included in Chapter VI on the exploration of needs regarding HIV/AIDS and CFSA children and families.

5. Fall 2005 Quality Services Review

The Quality Improvement Administration (QIA), with the assistance of the Center for the Study of Social Policy (CSSP), conducted its second semi-annual Quality Service Review (QSR) in the Fall of 2005. The QSR is a qualitative review of randomly selected cases. The Fall 2005 QSR reviewed the cases of thirty-nine children and youth: fourteen cases had investigations closed in June 2005, ten cases had the goal of adoption, and fifteen had goals other than adoption. Six cases were managed by private agencies. During the two weeks of the Fall review, 297 interviews were conducted with parents, children, social workers, supervisors, attorneys, teachers, therapists, and other service providers.

While the QSR noted areas of strength, such as the overall positive status of the children reviewed (they were safe, healthy, and in appropriate placements), the Review also highlighted the following challenges:

- Difficulties in stabilizing children's placements and moving them toward permanency
- Practice that is crisis-driven and/or court-driven
- Lack of teaming between service coordinators, leading to a break-down in the implementation of services and progress toward achieving goals
- Services implemented via court order without the team and family working together on behaviorally-based goals to lead to safe case closure
- Domestic violence and substance abuse issues

6. The Geographic Case Assignment Model: Moving Towards an Optimal Model for Community-Based Service Delivery Evaluation Report (Child and Family Services Agency)

The Geographic Case Assignment Model is a Child and Family Services Agency (CFSA) initiative implemented in January 2004. The Model's premise is that workers' increased utilization of neighborhood and community service providers will foster a stronger community/neighborhood-based support system for the children and families served by CFSA. In addition, the geographic case assignment model strives to achieve greater interaction and collaboration between the community and the Agency. The CFSA evaluation study was conducted with key administrators and frontline workers to assess staff knowledge and familiarity with community resources within each assigned geographic division. We further examined the current geographic division and caseload distribution among the administrations to determine if any adjustments were needed and we identified the benefits and challenges experienced in relationship to the geographic divisions.

Major challenges identified in the model were the overall lack of available resources and the preference of some community organizations to serve only clients in certain wards of the District. Focus group participants cited the following overall needs: resource development (especially in the areas of housing, transportation, mental health services, and substance abuse treatment services), clarification of roles between CFSA workers and the Collaboratives, and more collaboration with the District Public School System.

7. Foster Parent Exit Questionnaire

Early in January 2005, CFSA developed a Foster Parent Exit Questionnaire which was mailed with a postage-paid return envelope to 280 former foster parents. Only 22 surveys were completed and returned. Nonetheless, we took note of those responses and the participants' primary reasons precipitating their decisions to stop fostering:

- **Permanency achieved with the children in their care**

  "Child reunified & I needed a break."

  "Only became a foster parent to avoid child from going into care…child reunified."

  "I adopted the child."

- **Difficulty managing foster child with biological children in the home**

  "Child's jealous behavior lead to a lot of issues with my own kids…also, no support to deal with the child."

  "With a growing family of biological children that included an infant, toddler & school-aged children, it was difficult to manage a foster child's needs."

  "Mate had concerns because of 3year- old daughter in the home."

- **Lack of communication which lead to feelings of distrust toward social worker, particularly in contracted, private agency settings**

  "Social worker withheld crucial information."

  "Social worker was not truthful and not available."

  "Social Services (via telephone) were not helpful during a crisis. The police actually threatened the social services employee (via telephone conversation) to get pertinent information."

  "No children were placed in my home. The [private] agency you sent me to [for licensing] sent incomplete paperwork…once that was fixed however, I still did not get any kids."

  "[I] tried over & over to get help from [Private Agency] and had no outcome. It had come to a point where I asked them to pick the children up."

- **Licensing issues**

  "License was not renewed."

  "License was revoked due to allegations."

- **Lack of training/no training**

  "[I] did not know that children maintained contact with family once they were removed from home."

On average, respondents who completed the surveys had served as foster parents for 3.8 years. A majority (95%) of the survey respondents had been foster parents in Maryland (11) and the District (10).

Birth Parents and Children

Chapter IV

IN THIS SECTION:

- Challenges Facing Birth Parents
  - *Socioeconomic Barriers*
  - *Multiple Stressors*
  - *Lack of Social Supports*
  - *Lack of Community Resources*
  - *Lack of Access of Services*
  - *Lack of Parenting Education*
  - *Specific Challenges of Latino Families*
- Service Needs of Birth Parents
  - *Intervention Services*
  - *Aftercare Services*
- Service Needs of Children & Youth
  - *Quality Health and Mental Health Services*
  - *Community-based Resources & Partnerships*
  - *Quality Education*
  - *Life Skills*
  - *Youth Aging Out of Care*
  - *Lesbian, Gay, Bisexual, Transgender & Questioning Youth (LGBTQ)*

Chapter IV: Birth Parents and Children

A. Challenges Facing Birth Parents

Most of our families are headed by single parents, who are under tremendous stress attempting to provide the basic necessities for their children.—Social Worker, Oct. 2005

For most families served by CFSA, multiple stressors challenge their potential to achieve stability. These challenges are often compounded by multi-generational cycles of poverty, a lack of community support, lack of access to appropriate services, and lack of quality education. The following six most prominent challenges to birth parents and children emerged from the *2005 Needs Assessment*:

- ***Socioeconomic barriers*** - poverty and related issues, unemployment, lack of adequate housing, lack of education, etc.
- ***Multiple Stressors*** - such as substance abuse, parent and child mental health issues, and domestic violence
- ***Lack of social supports*** - such as extended family, friends, and community
- ***Lack of community resources*** - community-based prevention programs
- ***Lack of access to services*** for substance abuse and mental health treatment
- ***Lack of parenting support and/or education*** - parenting classes, assistance with children's behavioral issues, knowledge of child welfare policies, and education

1. Socioeconomic Barriers

Almost all of the in-home cases I have received are already experiencing severe financial problems, and the issues that occur due to financial crisis have little to do with why I am supposed to be there in the first place.—Social Worker, Oct. 2005

A lot of our clients lack the ability to obtain quality services that will stay intact once the case is closed. Our clients lack the skills and education to obtain employment that will keep their families above the poverty line.—Social Worker, Oct. 2005

Birth parents and social workers reported that issues associated with poverty and low socioeconomic status make it difficult for families to maintain safe and suitable living environments. Both expressed that families are continuing to struggle to meet the basic needs of their children: food, clothing, and adequate furniture. They also identified lack of employment and lack of transportation as barriers to safety and well being. Naturally, these influences have a negative impact on families.

Lack of adequate permanent housing (78%) was the greatest barrier identified. Families voiced concerns about being overcrowded in small apartments with several children. Due to their socioeconomic status, many families reside in drug-infested and crime-ridden neighborhoods.

Their living environment then becomes an additional barrier to safety.

2. Multiple Stressors

A District-wide report found that many individuals who abuse substances also have mental illness (*The Mayor's Interagency Taskforce on Substance Abuse, Prevention, Treatment & Control, 2003*). When such multiple stressors are combined with poverty, it is exceedingly difficult to carry out parental responsibilities.

While substance abuse (80%) and mental health (71%) are prominent barriers identified by study participants, families involved in the child welfare system often have a number of additional issues that bring them to the attention of the agency. The most consistently reported barriers for families include poor parent/child relationships (76%), behavioral problems at home (71%) and at school (66%), and parental/family violence (58%). Social workers frequently reported they don't have the time required to help families address the multiple stressors that brought them to the agency. Social workers feel they only begin to scratch the surface of many complex issues when it is time to close the case. In most cases, by the time CFSA gets involved, the family is in full crisis and it becomes an uphill battle to backtrack and provide solutions from that point forward.

3. Lack of Social Supports

If I could have had some assistance with the baby, I would not have been driven to leave him alone. I needed some opportunity to rest.—Birth Parent, Oct. 2005

Generational dysfunction of the family [results] from a lack of having grandparents, aunts and uncles, cousins and others that you can turn to for support.—Social Worker, Oct. 2005

Lack of social support is an ongoing barrier for families involved in child welfare. In many cases, families are estranged from other family members. Some may already have relatives or friends caring for their children, while others may have relatives and/or friends who are unable to care for the additional children. Families are further isolated by substance abuse, mental health issues, and the lack of biological fathers' involvement in their children's lives. Alienation coupled with other compounding issues can quickly create an environment of chaos and crisis that families are not equipped to handle on their own.

Many CFSA families have single, female heads of household. For these mothers, supportive services and resources in the community are essential, such as housing assistance and services for adolescents (mentoring, academic support, and/or counseling).

4. Lack of Community Resources

Most families would prefer to bypass community agencies because of the red tape as well as the way they are treated by employees of these agencies.—Social Worker, Oct. 2005

Many social workers commented on the lack of community-based, prevention services for families. They believe there are limited resources in the District. Both social workers and parents reported a lack of mentoring/tutoring services, and a lack of quality counseling for children. Other examples of challenges identified both by social workers and parents include a lack of community-based General Educational Diploma (GED) programs, job training programs, childcare, after-school services, and on-going activities for children.

5. Lack of Access to Services

Substance abuse treatment and depression are major obstacles. Substance abuse services are, at times, limited or time-limited, which is just another hurdle for our less motivated clients. Without effective services, our clients will continue to have barriers.—Social Worker, Oct. 2005

Lack of access to critical services, such as adequate substance abuse and mental health treatment, continues to be a tremendous barrier and challenge for families. Some factors related to this serious issue include the referral process, an insufficient number of slots for in-patient substance abuse treatment, and a lack of family-centered programs.

Social workers often cited the lack of quality mental health treatment facilities either in the

city or in the neighborhoods of the families who need them. Many parents and children with mental health issues must then go outside their communities to seek these critical services. As a result, it is difficult for social workers to motivate families to engage in and/or follow up with mental health appointments. In addition, due to financial hardship, many parents struggle to pay for transportation to get to scheduled appointments.

Social workers also cited a lack of quality substance abuse treatment facilities. This view is supported by the Mayor's Interagency Taskforce on Substance Abuse (2003) which reported the District's treatment capacity is not equal to the demand. Of 60,000 individuals needing treatment for substance abuse in 2002, only 14 % received it. This treatment gap left almost nine out of ten individuals without services. To increase capacity, the city has since implemented a new treatment voucher system, and added new providers to the treatment network.

6. Lack of Parenting Education

I need more skills [to deal with] behavioral problems and more community support in raising my kids, including after-school care.—Birth Parent, Sept. 2005

Parents need specialized work on how to break the cycle or pattern of behavior—not just parenting classes but training that is more specific to learning about one's self, environment, and raising healthy children.—Social Worker, Oct. 2005

Although parents did not indicate the need for "parenting classes" in the traditional sense, many felt that they needed help with parenting. Twenty-five percent reported that they were struggling to deal with their children's behavioral problems, both in school and at home. Many social workers (76%) further illuminated this finding by identifying poor parent/child relationships as a significant barrier to maintaining a safe, stable and nurturing environment.

In many of the communities in which these families live, positive parenting role models are scarce. Youth and families can benefit greatly from positive parenting role models but many of the communities in which these families live need additional resources and services. Workers often cited intergenerational abuse and neglect as a contributing factor. Many families involved with CFSA also have one or more children with special-needs (often severe in nature). Many parents do not know how to provide the intensive, sometimes around-the-clock care these children require.

7. Specific Challenges of Latino Families

As a result of the increasing numbers of Latino children entering the child welfare system in the District, CFSA conducted a focus group of Latino birth parents. Participants were members of an anger management group that meets weekly. They included two fathers, four mothers, and one grandmother. While limited to this single group, the challenges identified by these Latino respondents were consistent with those birth parents of other racial/ethnic groups we interviewed. They cited four major challenges: access to on-going counseling for parent/child relationships, domestic violence and other mental health issues, assistance with child care/day care services, and children's school truancy problems.

8. Summary of Challenges for Birth Parents

We asked birth parents to identify the major challenges facing them approximately six months prior to CFSA intervention. The reported challenges - substance abuse, lack of permanent housing, and poor parent/child relationships - had long been a part of these vulnerable families' everyday struggles.

While social workers (89%) identified drug/alcohol treatment as equally important for families working toward reunification, both social workers (82%) and parents (46%) consistently identified housing assistance as the most needed resource to speed reunification. In conjunction, both social workers (80%) and birth parents (27%) reported that families require help with basic needs such as food, clothing, and furniture. Social workers also identified needs

for parent education/training, childcare services, and outpatient mental health treatment.

Twenty-five percent of parents identified behavior problems with their child both at home and at school. Parents also expressed frustration over their inability to control their child's behavior. Parents reported difficulties with children running away, stealing, lying, and exhibiting aggressive behavior toward them. Overall, 20% reported that poor parent/child relationships were a challenge before CFSA's involvement. This finding is consistent with challenges social workers indicated.

B. Service Needs of Birth Parents

As shown in Table 4, a significant disparity exists between the responses of social workers and parents to the top ten family service needs. While 80% of social workers identified substance abuse as a major challenge, birth parents tended not to identify this as a major issue at all. Instead, birth parents were more likely to identify service needs for their children, such as tutoring, mentoring, or day care. Similarly, seven of the top ten needs were considered prevalent by 80% or more of the social workers who tended to answer questions with regard to the needs of all families they serve. Only two of the top ten needs (mentoring and counseling) identified by social workers were considered prevalent by the majority of birth parents.

Table 4:
Top Ten Family Service Needs (Descending Order)

Social Worker Perspective		*Birth Parent Perspective*	
Treatment for DV/family violence	88%	Mentoring services	56%
Intensive case management	88%	Counseling for child	51%
Local directories of resources	86%	Help with search for affordable housing	48%
Parent education/training	85%	Local directories of resources	47%
Housing assistance	82%	Housing assistance	46%
Help with search for affordable housing	81%	Counseling for parent	43%
Alcohol/drug treatment services	80%	Special education services/tutoring	40%
Basic needs (food, clothing, furniture)	78%	Basic needs (food, clothing, furniture)	36%
Ongoing communication with social worker	76%	Mental health services	35%
Financial support	75%	Child care	33%

Overall, the needs identified by social workers and birth parents reveal that families require on-going supports, services and resources to provide a safe and stable home environment for their children. Intervention and aftercare services are also categories of need that emerged. These supports and services are crucial for reunification and stability.

1. Intervention Services to Preserve Families and Speed Reunification

Having short-term classes that teach our birth parents how to keep their children safe, secure, and mentally and physically healthy would be very beneficial.—Social Worker, Oct. 2005

Birth families agreed with social workers on some services to facilitate reunification, but they highlighted additional needs: updated (and well maintained) local directories of community resources, individual counseling for parents and

children, on-going parenting classes, and mentoring/tutoring services.

Support groups are needed to address parents feelings of inadequacy and stressors related to being a single parent with a myriad of problems.—Social Worker, Oct. 2005

Parents need support groups to talk about the frustrations they face with economic circumstances and the difficulties they face when trying to provide for their children. These parents need to know how to be self-sufficient and knowledgeable on how to access resources without CFSA becoming involved again— Social Worker, Oct. 2005

In both 2003 and 2005, social workers and parents raised the need for ongoing mental health counseling for maternal depression. Depression is a serious mental health condition that can undermine the quality of relationships. When untreated, depression can delay or prevent reunification. This service need is critically important for assisting parents to achieve reunification, and for maintaining a stable, nurturing environment for their children. Birth parents also cited depression as a top challenge before CFSA intervention.

To underscore the importance of ongoing counseling for parents to address issues associated with depression, CFSA conducted in-depth interviews with two birth parents currently involved with the agency. Both are single African American women, one residing in Ward 4 and the other residing in Ward 5. Parent #1 has six children, ages 26, 25, 17, 14, 13, and 7. Three do not reside with her. Parent #2 has three children, ages 13, 11, and 7 months. None of her children reside with her.

Both of these birth parents identified struggles with substance abuse as a factor in their depression. Support groups that focus on remaining drug-free were helpful to them, but focusing on their drug-using experiences in a support group environment tended to make them more depressed, resulting in the desire to "use" again. The two parents discussed at length the importance of remaining drug-free. Both identified at least one outcome goal as "being a better mother." They also reported that being drug-free alleviated some symptoms of depression, such as not eating and sleeping. Based on these interviews, CFSA will evaluate "what works best" with support groups aimed at concurrent issues, such as depression and substance abuse.

Each parent reported having no contact with their social workers until court appearances. They also described feeling abandoned by the system that took their children. These responses reveal the need for consistent interaction and improved communication between social workers and birth parents, especially when children are removed from the home. Assigned social workers need to routinely address the guilt and fear related to the removal. (When probed about support after CFSA removed their children, both stated "None.")

When asked about referrals and information that CFSA offered them, these two parents described the need for more accuracy and more current information. Many times the service providers were no longer providing a particular service by the time these birth mothers attempted to make contact with a provider. At the point of initial contact with parents, social workers need to routinely offer an updated directory of community resources.

These findings may represent only two current adult clients' thoughts and views, but they serve as a valid starting point for further exploration of particular service needs as CFSA updates the Resource Development Plan.

2. Aftercare Services to Support Reunified Families

Respondents overwhelmingly agreed that housing assistance and mentoring services for children were the most important aftercare resources that can help families remain stable following CFSA involvement. In addition, eighty percent of social workers felt that ongoing counseling for parents is important. Seventy-seven percent (77%) of social workers further cited child/day care services as necessary

resources. They also identified parent education and/or training, parent support groups, tutoring for children, and continued support with basic needs.

CFSA recognizes that the return of a child to his/her home only begins the reunification process for a family. Maintaining a safe, nurturing environment after reunification requires sufficient safeguards and appropriate resources so that issues that led to out-of-home care do not overwhelm the family again. Aftercare services are an essential component to providing these safeguards, and another priority to be addressed in the Resource Development Plan.

C. Service Needs of Children & Youth

Four prominent themes emerged regarding the needs of children and youth involved in the District's child welfare system. These needs were identified across program areas both by CFSA and Collaborative social workers:

- **Access to quality health and mental health services** such as routine medical and dental care and mental and behavioral health services
- **Additional community-based resources and partnerships** such as recreational after-school programming, tutoring, and mentoring
- **Quality education services** to meet individual needs
- **Life skills building programs** to prepare youth for the challenge of transitioning out of foster care and into adulthood

We also elected to pay special attention to the needs of youth aging out of care, and to the specific needs of the Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth population.

1. Quality Health and Mental Health Services

The quality of services is crucial. Without (at the very least) average quality services, the client is doomed to fail, and so are CFSA's efforts. It's simply a waste of time and resources. I'd rather have a couple of highly qualified service providers than a lot of weak ones.—Social Worker, Oct. 2005

All social workers felt strongly that current levels of service are not adequately meeting children's needs. The social workers were especially concerned that children are not receiving routine health care and related services. They cited an on-going struggle to ensure that children have access to these necessary services. They viewed the need for children's dental services as especially acute.

Social workers also cited the need for quality mental health services and providers to address the overwhelming number of issues confronting the foster care population. Foster youth struggle with separation and abandonment, depression, low self-esteem, rejection, and loss. Many youth have mental health issues that have been misdiagnosed or untreated for years. Social workers continually identify this need. Eighty-nine percent of social workers reported making a referral for counseling, while 82% made referrals for in-patient mental health services for children in the past six months.

2. Community-Based Resources and Partnerships

If resources were adequately distributed throughout the city, families may be more adequately served.—Social Worker, Oct. 2005

Fifty-six percent of birth parents identified mentoring services as their greatest need in the past six months. Social workers (97%) also identified a need for mentoring services for children.

Social workers further identified the need for quality partnerships with community-based prevention programs, emphasizing community health/mental health providers. They identified a need for an effective partnership with the District of Columbia Public Schools in order to

secure a satisfactory level of basic educational services for children. They also cited monetary support and transportation assistance to get children to appointments and activities.

3. Quality Education

Educational assessments (91%) and tutoring (88%) were the two major services that social workers requested for clients in the past six months. They reported that youth are not being adequately assessed and/or appropriately placed in educational settings that meet their individual needs. As a result, many have less opportunity to achieve academic success than do their counterparts living in stable home environments.

The *Geographic Case Assignment Model Evaluation Report* (2003) indicated that school officials lack discretion when social workers visit children at school. They routinely breach confidentiality, causing unnecessary embarrassment for children. The report also found that social workers experience difficulty with school officials when attempting to gain access to client records and general information regarding children. School administrators do not always recognize District government badges as valid credentials for obtaining information without a court order.

Educational needs of foster youth continue to be a principal concern. For some older youth, education is not a priority. They face other issues (such as placement disruptions and abscondance), and many are unwilling to engage in an educational program. Quitting school at age 16 is a reality for far too many youth. Others do not attend regularly. These youth do not anticipate the consequences of not having a high school diploma or GED to assist them in obtaining job training and/or gainful employment.

4. Life Skills

Social workers reported that youth are not learning the skills necessary to make sound decisions once they leave foster care. Many are not involved in skill building programs. They do not have opportunities to practice decision-making strategies or life skill techniques in day-to-day functioning.

5. Youth Aging Out of Care

There is a lack of preparation for adulthood—i.e., education, employment, housing, and family resources. Teens and young adults in foster care may be enabled by their judges which gives them a false sense of reality for when they [age out of] care. Youth also lack the motivation to change their current lifestyle.—Social Worker, Oct. 2005

To address the complex needs of youth aging out of foster care, CFSA released the following white paper in June 2005: *Revamping Youth Services: Preparing Young People in Foster Care for Independence*. This report outlined a best practice approach to improving outcomes for youth:

- Foster youth must develop critical life skills before age 21. Every youth should achieve specific benchmarks in case planning/life skills building, family/permanent connections, education, employment/vocation, health/mental health, and housing.

CFSA is not alone in recognizing that foster youth face unique challenges when transitioning out of the system. A survey by the DC Court Improvement Project revealed that social workers need to establish a trusting relationship with youth to coach them toward transitioning. Long periods of out-of-home placement during childhood and adolescence significantly place them at higher risk for unemployment, poor educational outcomes, health issues, early parenthood, long-term dependence on public assistance, increased rates of incarceration, and homelessness (CWLA, 2005).

Social workers reported that youth aging out of care have not mastered basic skills such as budgeting, completing high school, peer interactions, job skills training, positive interactions with birth family, or navigating multiple systems for assistance. Although the youth naturally want to become independent, the "system" keeps them "dependent" by not engaging them in the decision-making process prior to aging out of the system.

The District's primary vehicle for preparing foster youth age 16 and older for independence is CFSA's Center of Keys for Life (CKL). While some youth receive services through CKL, many do not participate. They rely instead upon foster parents and congregate care providers to help them prepare for adulthood. As noted above, many youth move frequently, resulting in a lack of consistency in services. CFSA needs to ensure that youth not enrolled in the independent living program have equal access to services. CFSA is implementing a program for preparing young people in foster care for independence, with full implementation scheduled for March 2006.

6. Lesbian, Gay, Bisexual, Transgender and Questioning Youth (LGBTQ)

I have a client who is lesbian, and I have tried to locate services that would cater to her needs in a sensitive, supportive, empathetic manner. There do not seem to be a lot of LGBTQ-sensitive agencies out there.—Social Worker, Oct. 2005

LGBTQ youth in foster care face special challenges. They may experience teasing, bullying, and/or physical assault by others who do not accept alternative sexual orientations. Running away, suicide attempts, drug and alcohol abuse, and other destructive behaviors are common results when these particularly vulnerable youth do not have support and acceptance.

At the time of the survey, CFSA was serving 34 self-identified LGBTQ youth: 23 females and 11 males, all African American, ranging in age from 13 to 21. The majority (73%) self-identified as homosexual, while 15% said they were questioning, 6% were transgender, and 6% self-identified as bisexual.

Social workers highlighted difficulties in securing appropriate placements for these youth, citing many providers are uncomfortable or unwilling to provide care for youth who self-identify as LGBTQ. It takes much longer to find an appropriate placement in these cases.

The Special Services section of CFSA's new HealthCare Policy addresses the needs of Lesbian, Gay, Bisexual, Transgender and Questioning Youth. This policy provides guidance for social workers regarding physical and mental health and other supportive services for this population.

Social workers currently serving the LGBTQ youth reported the most significant needs for this group are:

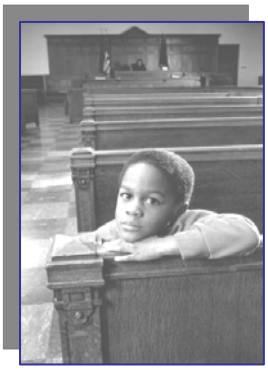
- Identification of LGBTQ-friendly placement resources;
- Identification of LGBTQ support groups, mentoring, and counseling;
- Sensitivity training for social workers, supervisors, and group home staff; and
- Revision and updating of CFSA policies and practices.

Placement and Support Services

Chapter V

IN THIS SECTION:

Chapter V: Placement and Support Services



As stated in the Introduction to the *2005 Needs Assessment*, our evaluation of placement support services responds directly to Chapter VI, Outcome 2, of the *LaShawn* Implementation Plan:

Beginning March 31, 2005, and every two years thereafter, CFSA will complete a bi-annual assessment of the effectiveness and sufficiency of its placement support service programs. Consistent with the findings of this assessment, CFSA will modify its placement support service programs, if needed, to ensure that placements for children are appropriate and stable.

Within 90 days of completing this assessment, CFSA (in consultation with the Court Monitor) is to develop specific strategies to implement recommendations.

CFSA will propose to the Monitor and plaintiffs action steps for inclusion in the Implementation Plan to implement recommendations to assure appropriateness and stability of placements.

To provide a well-rounded placement study, we identified the following information as necessary:

- Demographic profiles of the current foster care population and providers
- Demographic profiles of foster care placement types
- Placement trends and projections
- An examination of the sufficiency and effectiveness of CFSA's placement support services programs

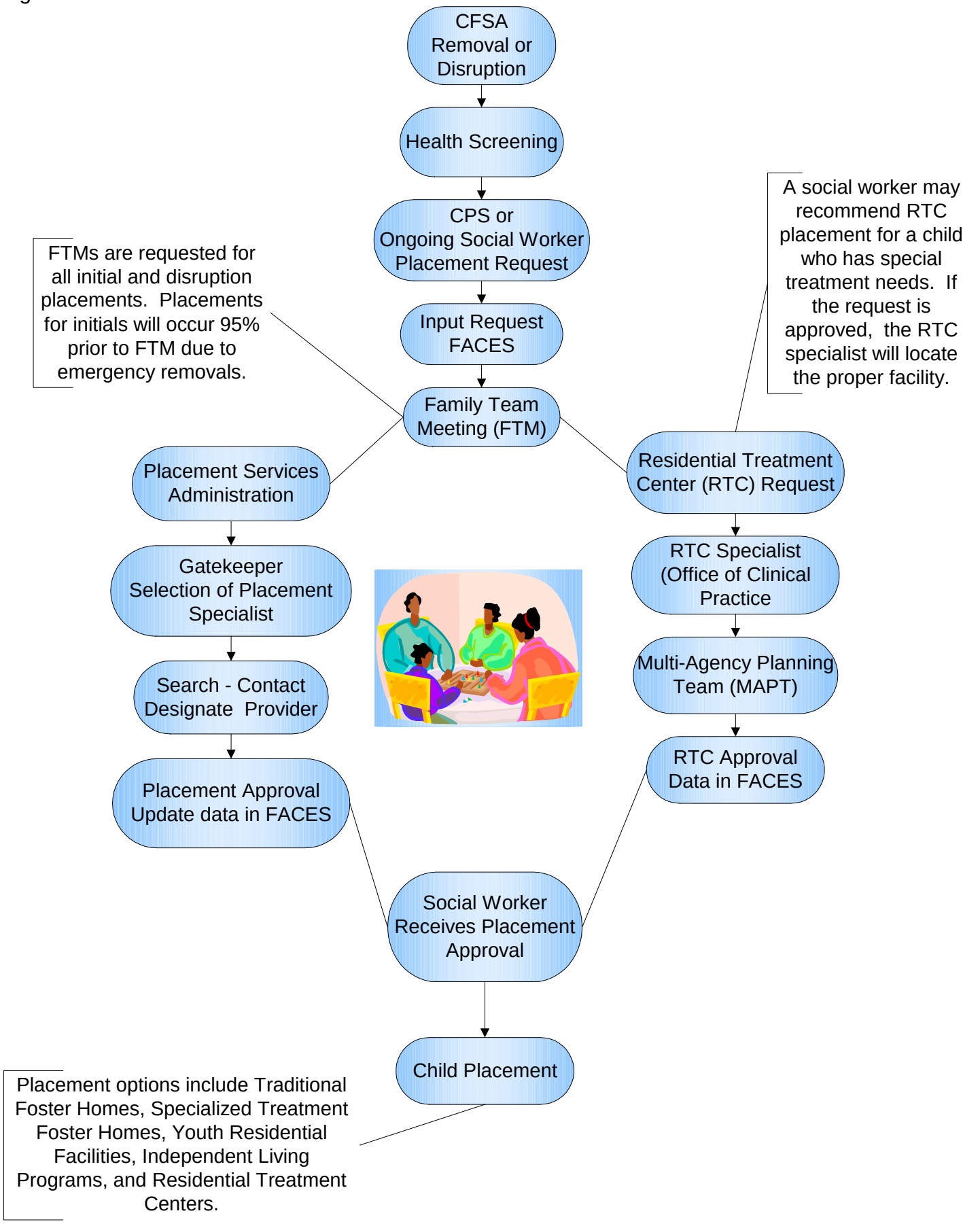
We collected data from a variety of sources. These included the General Needs Assessment Social Worker Survey, surveys designed especially for resource parents, placement focus groups with CFSA workers and resource parents, interviews with CFSA social workers and placement support staff, an array of administrative data, and a spatial data analysis. *(See Chapter II for a detailed description of the study methodology.)*

A. The Placement Process

1. Placement Process Flowchart

As Figure A shows, the placement process begins when CFSA removes a child from the home as the result of an investigation, or when a child already in foster care experiences a placement disruption. In either case, CFSA takes the child for a health screening immediately after removal and before placement. The social worker then requests a placement (or replacement in the case of disruption) through a formal placement request in FACES. Alternatively, the social worker may call or visit CFSA's Placement Services Administration [or the Residential Treatment Center (RTC) Specialist in the Office of Clinical Practice], and then document the request in FACES.

Figure A.


CFSA Removal or Disruption
Health Screening
CPS or Ongoing Social Worker Placement Request
Input Request FACES
Family Team Meeting (FTM)
FTMs are requested for all initial and disruption placements. Placements for initials will occur 95% prior to FTM due to emergency removals.
A social worker may recommend RTC placement for a child who has special treatment needs. If the request is approved, the RTC specialist will locate the proper facility.
Placement Services Administration
Gatekeeper Selection of Placement Specialist
Search - Contact Designate Provider
Placement Approval Update data in FACES
Residential Treatment Center (RTC) Request
RTC Specialist (Office of Clinical Practice
Multi-Agency Planning Team (MAPT)
RTC Approval Data in FACES
Social Worker Receives Placement Approval
Child Placement
Placement options include Traditional Foster Homes, Specialized Treatment Foster Homes, Youth Residential Facilities, Independent Living Programs, and Residential Treatment Centers.

The social worker will also schedule a Family Team Meeting (FTM) shortly following all home removals or placement disruptions.[5] (Due to the frequent emergency nature of home removals, however, 95% of placements occur prior to the FTM. In the case of disruptions, FTMs should occur prior to replacements unless the case involves a return from abscondance, an imminent risk to self, or the FTM is court ordered.) Participants in the FTM will review the circumstances of the removal or placement disruption and determine the best plan to ensure the child's safety, well being, and potential for permanent placement. This review includes identification of appropriate placement type, as necessary.

If a child has special treatment needs, or upon recommendation of a psychiatrist, psychologist or therapist, the social worker may refer the initial placement request to the RTC Specialist in the Office of Clinical Practice (OCP). Upon receiving the request, the RTC Specialist coordinates a Multi-Agency Planning Team (MAPT) meeting, which will include representatives from DC Superior Court, DC Department of Youth Rehabilitative Services, DC Department of Mental Health, DC Public Schools, and the child's family. The MAPT team reviews the child's information and decides whether he/she needs RTC placement. If the team determines that the child needs RTC placement, the RTC Specialist locates an appropriate facility. A Department of Mental Health official must grant approval before the placement decision is final. If the MAPT team concludes that the child does not need RTC placement, the case goes back to CFSA's Placement Services Administration for the regular placement process.

All placement requests are referred by the Placement Services Administration to the Placement Gate Keeper, who reviews the requests for specific criteria and assigns an appropriate Placement Specialist to each case. The Placement Specialist will then seek out the most appropriate provider to meet the child's needs. This search generally begins with a list of family-based care providers unless the placement request is for an older youth. In which case, the placement specialist may elect to contact a congregate care provider (either group home or independent living facility).Once a provider is designated and able to place to child, the Placement Specialist reports the information to the Gate Keeper, who informs the social worker and the Placement Data Manager. The Placement Data Manager ensures final approval in the FACES database.

2. Recent Improvements in the Placement Process

The placement process involves a series of complicated and challenging activities among different staff from different offices. To streamline the process, CFSA modified and improved several steps during FY05. We centralized and consolidated placement procedures, negotiated interstate placement agreements, and increased accuracy of data entry into FACES.

Centralized Placement Administration

CFSA combined four disparate placement functions into a centralized Placement Services Administration (PSA) that functions as both the hub and tracking mechanism for placement activity. Under the leadership of a Program Administrator who reports directly to the Deputy Director of Program Operations, PSA provides 24/7 placement services and resources for children/youth entering foster care or in need of replacement. PSA also ensures documentation of placement information in FACES.

Social workers have expressed great satisfaction with a centralized placement entity. They indicate that PSA has led to improved communication, including quick and clear answers to placement questions.

Interstate Compact for the Placement of Children (ICPC)

CFSA staff reported dramatic improvement in the ICPC process. They indicated in focus

[5] *Participants in the FTM include the child or youth (if appropriate), biological parents and/or other family members, the social worker, resource parents, involved clinicians and service providers, and relevant specialists and representatives. A trained facilitator leads the meeting.*

groups that procedures for placing children out of state are streamlined and more efficient.

Working to ensure compliance with regulations in the state of Maryland has greatly improved CFSA understanding of the ICPC process. Nonetheless, we had a significant number of children in placements without ICPC approval, including a backlog spanning several years. CFSA established a 60-day project to reduce this backlog which was a significant success. The greatest remaining challenge is reaching agreement with Maryland around a process for the emergency licensing of kinship homes, mostly in Prince George's County. The inability to license kinship homes in Maryland on an emergency basis has contributed to the recent placement crisis in the District. CFSA's Placement Administration is working diligently with Licensing and Monitoring to keep our Maryland homes updated and licensed through our Maryland providers.

Technology Supports

Supervisors are now able to input placement data directly into FACES. This change in access has not only increased data accuracy but it also ensures greater quality control. "In-process" placements in FACES are now declining, and the number of children/youth with placements identified correctly is increasing.

In addition, CFSA has moved FACES from a server-based platform to an Internet-based platform that allows both CFSA social workers and foster care providers to update and report their placement information [including locations and dates] whenever and wherever they have access to the Internet. We expect this will contribute to greater efficiency in documenting placement information in FACES.

B. Children in Foster Care in the District of Columbia

According to the U.S. Census Bureau, the District of Columbia had 553,523 residents as of July 1, 2004. The total population under age 21 was 126,048 (23%). As of June 30, 2005, CFSA had 2,617 children/youth - or roughly 2% - in legal and/or physical custody.[6] This means that about two out of every 100 children in the District of Columbia are in the foster care system.

In our assessment of the District's foster care population, we included data on trends, age and gender distribution, and general characteristics of children entering care for the first time.

1. Trends in the Foster Care Population

To examine trends in foster care, we looked at the total foster care population at the end of every month for 42 months (1/31/02-6/30/05). Based on that historical trend line, we forecast numbers for the upcoming months (Table 5).

Table 5: Projected Foster Care Population	*Actual*		*Projected*	
	9/30/04	**6/30/05**	**9/30/05**	**9/30/06**
Number of children	2743	2617	2652	2536
Projected range (95%~105%)	N/A	N/A	2519~2785	2409~2663
Source: FACES report CMT232, OPPPS regression analysis				

As Figure B shows, the total number of children in foster care has steadily decreased over the past two years, reaching the lowest level to date as of June 30, 2005. If this trend continues through FY06 (September 30), the foster care population will be approximately 2,536 (or somewhere between 2,409 and 2,663).

[6] *CFSA's foster care population data is not the same point-in-time measurement as the Census Bureau population estimates. Our data present population statistics as of June 30, 2005. Any errors due to this difference are likely to be minor. In fact, the number of children in foster care as of July 31, 2004, was 2,719, very close to the Census Bureau's estimated population measurement point. This is still about 2.2% of the total child/youth population.*

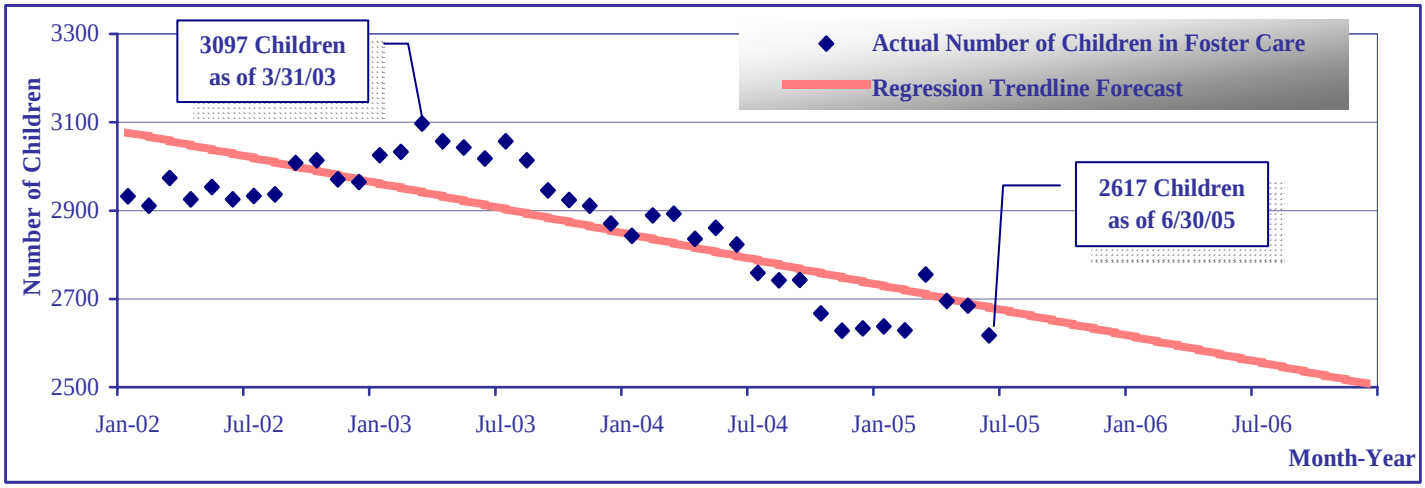


Figure B: Foster Care Trend *Source: CFSA Monthly Summary Statistics; FACES Report CMT232; OPPPS Regression Analysis*

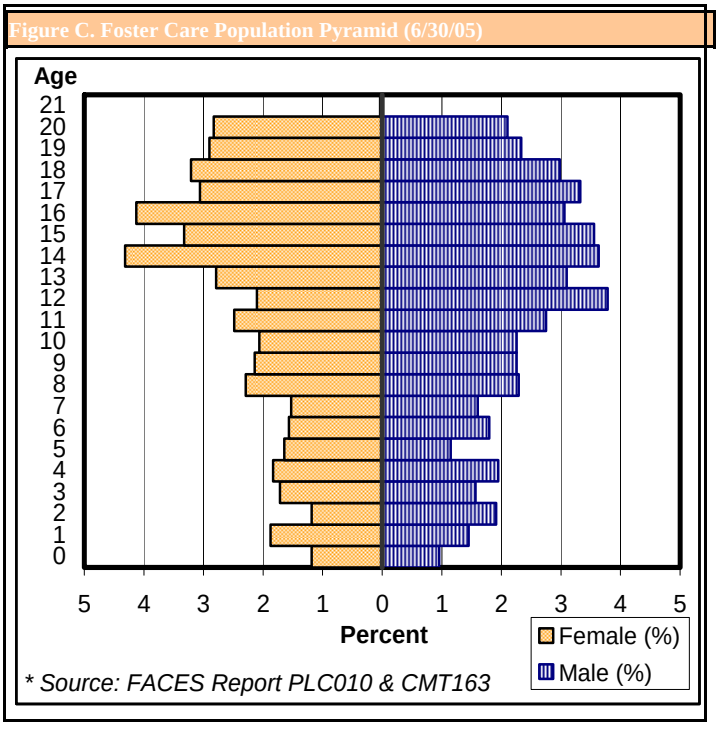


Figure C represents the age and gender distribution of the current foster care population in the District of Columbia. According to the pyramid, youth aged 12 or older constitute almost 57% (or 1,480) of the total foster care population (2,671 as of June 30, 2005). This pyramid also shows that there are more females than males over 13 years of age, yet between the ages of 9 and 13 years there are more male children than female children.

As shown in Figure D (below), the number of older District of Columbia youth in care is greater than other states, especially the proportion of youth age 19 or more. Nationwide, the figure of older youth is only about 2%, while in the District it is over 10%. Most states discontinue care when a youth reaches age 18; the District keeps youth in foster care until age 21 (in accordance with the District of Columbia child support statute).

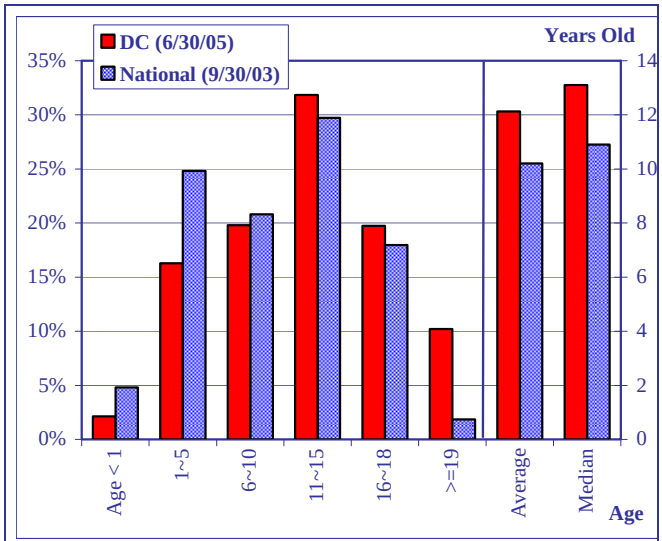


Figure D: Comparison of Foster Care Population - District versus National

Source: CFSA FACES Report CMT232; The AFCARS Report Preliminary FY2003 Estimates, DHHS/ACF

As shown in Figure D, the number of older District of Columbia youth in care is greater

than other states, especially the proportion of youth age 19 or more. Nationwide, the figure of older youth is only about 2%, while in the District it is over 10%. Most states discontinue care when a youth reaches age 18; the District keeps youth in foster care until age 21 (in accordance with the District of Columbia child support statute).

This high proportion of older youth raises the average and median ages[7] of the foster care population in the District. The nationwide average is 10.2 years while the average for the District is 12.1 years. The median age is 10.9 years for the nation and 13.1 years for the District.

Table 6 further illustrates the growing proportion of these older youth. At the end of December 2001, youth age 12 and older made up about 45% of the total foster care population. By the end of June 2005, this group had grown to 57% of the total. Especially noteworthy is the increase in youth age 18 and older: from 11.7% in December 2001 to 16.4% in June 2005.

Table 6:
Actual Foster Care Population, 12/01-6/05, and Projected Foster Care Population, 9/05-9/06

Time Frame	Age							
	0-2	3-5	6-8	9-11	12-14	15-17	18-21	Total
12/01	204 (6.8%)	380 (12.7%)	481 (16.1%)	571 (19.1%)	533 (17.9%)	466 (15.6%)	349 (11.7%)	100%
12/02	185 (6.2%)	352 (11.9%)	461 (15.6%)	532 (17.9%)	547 (18.5%)	503 (17.0%)	384 (13.0%)	100%
12/03	216 (7.5%)	302 (10.5%)	416 (14.5%)	492 (17.1%)	545 (19.0%)	482 (16.8%)	418 (14.6%)	100%
12/04	203 (7.7%)	253 (9.6%)	338 (12.8%)	396 (15.0%)	480 (18.2%)	538 (20.4%)	425 (16.1%)	100%
6/05	224 (8.6%)	258 (9.9%)	290 (11.1%)	365 (13.9%)	516 (19.7%)	535 (20.4%)	429 (16.4%)	100%
9/05	235 (8.9%)	240 (9.1%)	284 (10.7%)	355 (13.4%)	512 (19.3%)	567 (21.4%)	460 (17.3%)	100%
9/06	245 (9.7%)	208 (8.2%)	228 (9.0%)	298 (11.7%)	497 (19.6%)	584 (23.0%)	476 (18.8%)	100%
Trend	↑	↓	↓	↓	↑	↑	↑	

Note: Projections stem from a regression analysis based on point-in-time data for the past 5 years.

[7] *Median age is the midpoint age that separates the younger half of a population from the older half.*

Another study demonstrates that this expanding proportion of older youth between 2001 and 2005 was not due to new entries in care (*See Table 8*). Rather, it reflects the past delays in achieving permanence for children who are now growing up in the system. Based on these trends, CFSA must continue to make diligent efforts to achieve permanence for older youth in District foster care.

Newborns and toddlers have become another fast growing segment of the foster care population. As Table 6 shows, children age 0-2 were just less than 7% of the total foster care population only four years ago. We project this percentage will increase almost to 10% by the end of the next fiscal year (9/30/06).

In contrast, the number of children between ages six and 11 has declined. In December 2001, children in this age group constituted just over 35% of the foster care population. By June 2005, the numbers had dropped to 25%.

According to the U.S. Department of Health and Human Services, 52.5% of the nationwide foster care population was male in September 2003. At that time, the picture in the District was similar: 51.5% of the foster care population was male (Figure E). Throughout FY04, the percentage of males hovered around 52%. Then the trend reversed.

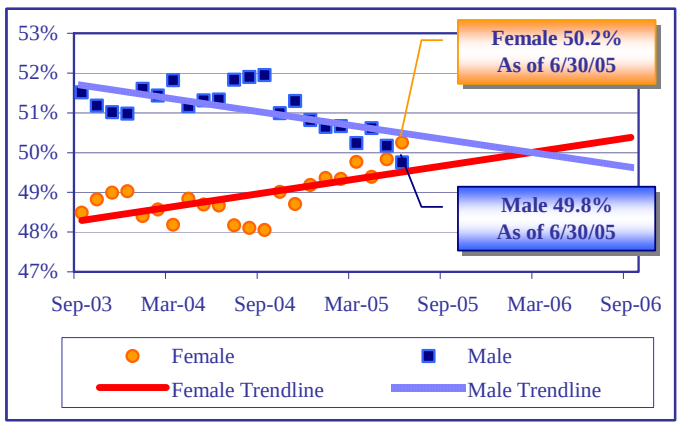


Figure E: Trend in Gender Distribution of Foster Care Population, 9/03-9/06

Source: FACES Report PLC156; OPPPS Regression Analysis

Note: OPPPS regression analysis is based on 21 point-in-time data for the past 21 months.

In June 2005, CFSA had more females in care than males. If this reverse trend continues in upcoming years, it will likely affect placement resource needs for females, especially for teen mothers.

3. Race and Ethnicity

In June 2005, 92.4% of the District's foster child population was African American (Table 7).

Table 7: Race/Ethnicity of Children Entering Foster Care, FY02-FY05

Hispanic Origin / Race	Hispanic	Non-Hispanic	Unknown[2]	Total	Percent
African American	26	2283	108	**2417**	**92.4%**
Caucasian	31	6		**37**	**1.4%**
Others[1]	6	9	2	**17**	**0.7%**
Unknown[2]	18	3	125	**146**	**5.6%**
Total	**81**	**2301**	**235**	**2617**	**100%**
Percent	**3.1%**	**87.9%**	**9.0%**	**100%**	

Source: FACES Report CMT163 & Edu002, 7/15/05

Notes: 1) Others include American Indian, Alsakan Native, Asian, Native Hawaiian , and other Pacific Islander.

2) Workers could not determine the child's race/ethnicity or did not enter the information in FACES.

This percentage is much higher than the total proportion of African American children residing in the District. According to the U.S. Census Bureau's most recent population estimates (July 2004), 67.6% of children under age 21 in the District were African American. (In 5.6% of the foster care cases, the child's race was not in FACES).

FACES reported that Hispanic/Latino children constitute about 3.1% of the total foster care population. CFSA social workers, however, only started recording Hispanic origin a year ago.[8] In addition, social workers did not identify ethnic origin in about 9% of children in FACES. CFSA will better understand the extent to which we are serving Latinos once proper data is collected.

[8] *Approximately 9.6% or 12,120 of the District population under age 21 was identified as Hispanic/Latino as of July 1, 2004.(U.S. Census Bureau, Population Estimates for 2004, 8/10/05).*

4. Initial Entry into Foster Care

Over the past four years, the overall number of initial entries into foster care declined by almost 40%. Within the decline, however, initial entries of individual populations have varied. As Table 8 shows, 37.4% of children coming into care in FY02 were under age 6. This number jumped to over 43% in FY05. Entry into care of children ages 12 to 14 increased only slightly from 15.2% in FY02 to 17.5% in FY05.

In contrast, the number of children between ages 6 and 11 coming into foster care dropped from 33% in FY02 to 27% in FY05. Youth entering care over age 15 steadily declined from FY02 through FY04 – then increased in FY05.

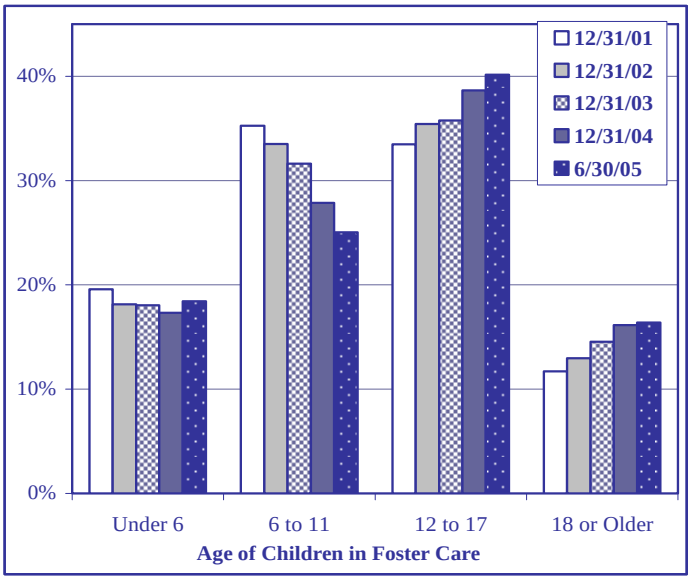
Table 8: Trend in Age of Children at Initial Entry into Foster Care

Age	FY02	FY03	FY04	FY05	Trend
0-2	21.7%	24.3%	27.0%	24.4%	↑
3-5	15.7%	16.0%	15.6%	18.7%	↑
6-8	15.6%	16.0%	15.6%	13.3%	↓
9-11	17.4%	15.7%	15.9%	13.8%	↓
12-14	15.2%	15.7%	16.2%	17.5%	↑
15-21	14.3%	12.2%	9.6%	12.3%	↓
N/A	0.2%	0.1%	0.0%	0.0%	
Total %	100.0%	100.0%	100.0%	100.0%	
Total children	974	764	716	587	↓

Source: FACES Report CMT282 & PLC208

The age distribution of children entering foster care is notably different than that for children already in foster care. Figure F shows that the proportion of teens in foster care increased from FY01 to FY05 even while the number of teens entering foster care (ages 15-21) decreased from FY02 through FY04 (Table 8). As noted earlier, this finding indicates that youth are growing up in the system instead of achieving permanence.

Figure F: Age Distribution of All Children in Foster Care



Source: FACES Report CMT232 & PLC156

Data are point- in- time as indicated. Refer to Error! Reference source not found. regarding detailed numbers and percentages.

C. Types of Placements

1. Current Placement Resources by Provider Type

Most children served by CFSA are in family-based care, which includes kinship, traditional foster and pre-adoptive homes. As Table 9 shows, CFSA had 2,617 children in foster care at the end of June 2005. More than 76% were in family-based care.

Table 9: Providers Caring for Children, 6/30/05

Provider Type	# of Providers	# of Children
Foster Home	1,210	2,005 (76.6%)
Group Home	15	179 (06.0%)
Independent Living	11	192 (07.0%)
Residential Treatment	36	154 (06.0%)
Other	N/A	87 (04.4%)
Total		2,617 (100%)

Source: FACES Re port PLC208

Congregate care settings provided for more than 350 of the total youth. CFSA placed these youth either in an Independent Living Program (ILP), a traditional group home, or a Residential

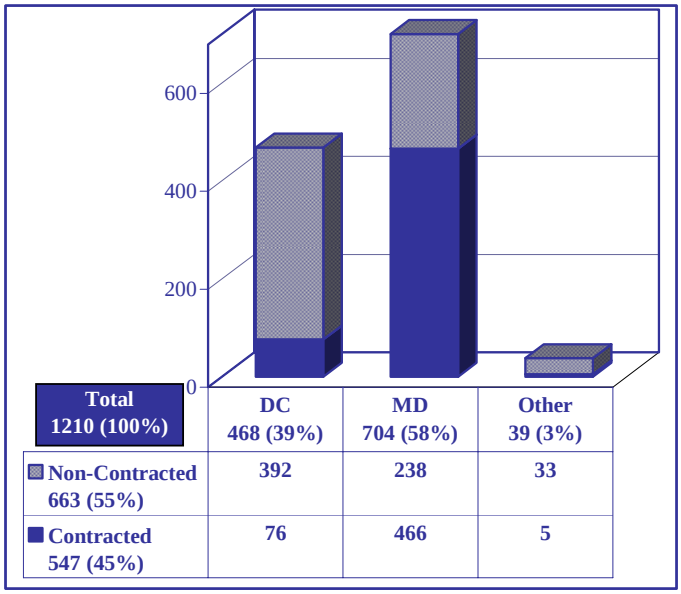
Treatment Center. Eleven different (ILPs) either operated their own facilities or contracted residential units for older youth (n=179), including teen parents. Fifteen providers supplied diagnostic and emergency facilities (2), traditional group homes (10), and/or specialized (therapeutic) group homes (3). Children requiring the highest level of specialized care were placed in Residential Treatment Centers (RTCs). Unfortunately, the Washington metropolitan area has very few local RTCs. Of the 36 RTC facilities serving CFSA children, 28 are located more than 100 miles outside the District. At the end of June 2005, 92 (59.7%) of 154 children in RTCs were residing in these 28 distant facilities.

2. Geographic Distribution of Foster Homes

At the end of June 2005, agencies under contract to CFSA licensed and monitored approximately 45% of the foster homes caring for CFSA children. The remaining 55% were recruited and licensed by CFSA, or a Maryland licensed child placement agency. Of the contracted homes, the vast majority of these (85%) were in Maryland. The majority of non-contracted homes (n=392) were in the District with the remainder in Maryland (n=238) and other states (n=33) (see Figure G).

In total, 704 foster homes were located in Maryland. These Maryland homes constitute 58% of all the foster homes in which the District's children/youth were placed. Thirty-nine percent (n=468) of the foster homes were in the District with the remaining 3% in other jurisdictions.

Figure G:
Foster Home Providers by Oversight and State, 6/30/05



Total 1210 (100%)	DC 468 (39%)	MD 704 (58%)	Other 39 (3%)
Non-Contracted 663 (55%)	392	238	33
Contracted 547 (45%)	76	466	5

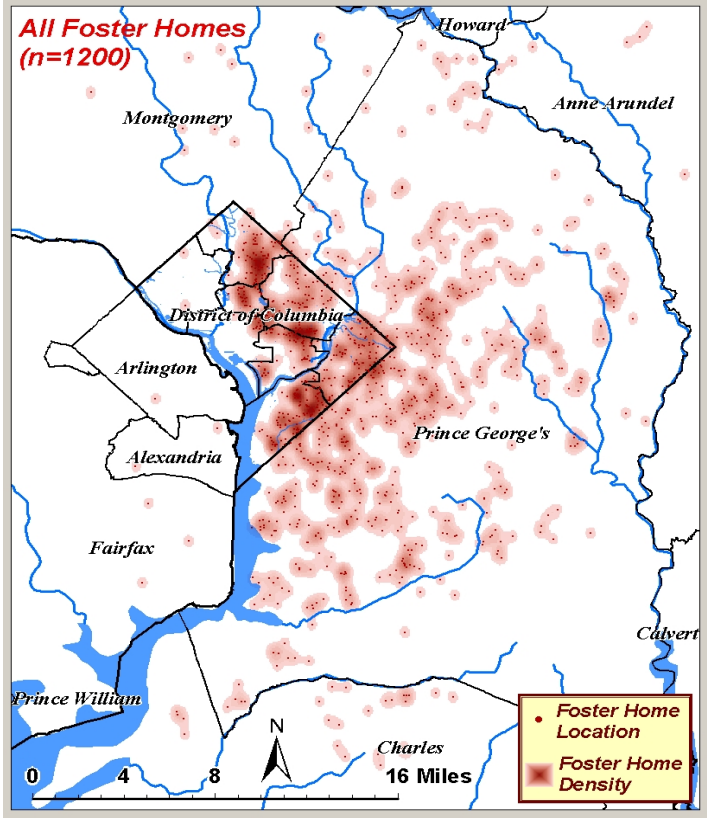
Source: FACES Report PRD 138

Figures H and I further display the location of these foster homes both in the District and the surrounding metropolitan area. Figure H shows that most Maryland foster homes are in Prince George's County, southeast of the District line. A number of foster homes are even further south in Charles County, Maryland.

Within the District, 45% of foster homes are in Wards 7 and 8 where the majority of substantiated child neglect and abuse investigations originate.[9] A little less than 35% of the foster homes are in Wards 4 and 5, which had 24% of substantiated child neglect and abuse investigations during FY05. Wards 1-3 collectively have less than 10% of all foster homes as of 6/30/05.

[9] *Of the total number of substantiated child neglect and abuse investigations in the District of Columbia during FY2005, approximately 51% originated from Wards 7 & 8.*

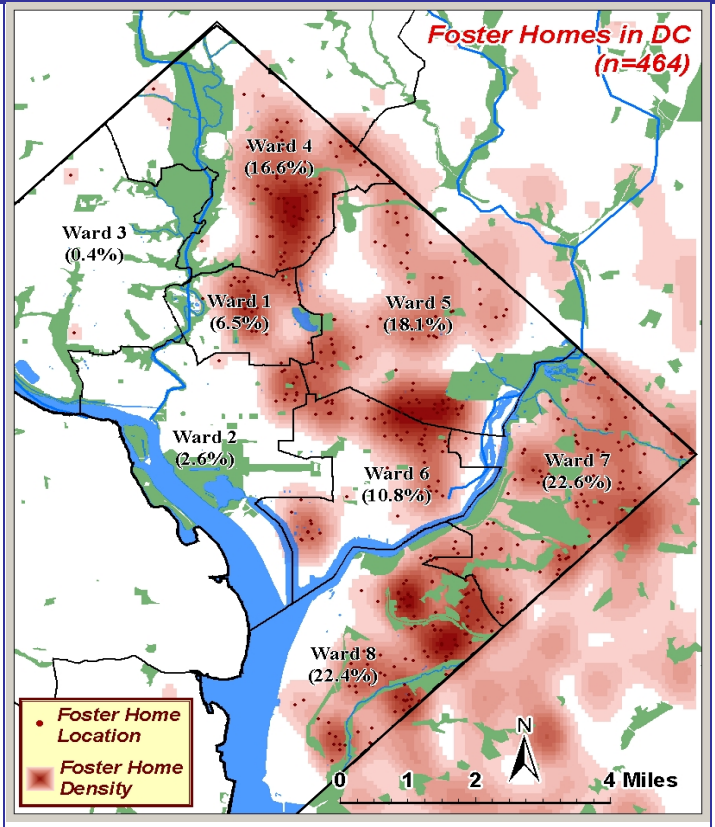
Figure H: Geographic Distribution of All Foster Homes with Children Placed as of 6/30/05



Source: FACES Report PRD133 and OPPPS Placement Geographic Analysis Findings

Note: As of 6/30/05, CFSA had 1210 foster homes with children placed throughout the United States. Of those, geographic locations for 1200 have been identified through geocoding. This map displays density of foster homes in the Washington MetropolitanArea.

Figure I: Geographic Distribution of Foster Homes with Children Placed in DC as of 6/30/05



Source: FACES Report PRD133 and OPPPS Placement Geographic Analysis Findings

Note: As of 6/30/05, 468 foster homes out of 1210 were located in the District of Columbia. Of those, geographic location and ward information for 464 homes are identified on the above map.

3. Foster Home Providers by Oversight

Table 10 reveals that CFSA contracted foster homes are likely to have fewer children than those of non-contracted foster homes. The non-contracted foster homes also have a slightly higher ratio of children per provider (1.73) than contracted homes (1.57). This discrepancy incorporates placement data for therapeutic foster homes, which are always contracted and usually licensed for only one or two children who require special care. (CFSA can override this licensing restriction to keep sibling groups together if the home has the physical capacity to accommodate all the siblings.) It is important to note that the number of contracted therapeutic foster homes has expanded to meet the needs of the increasing numbers of children/youth in therapeutic foster care.

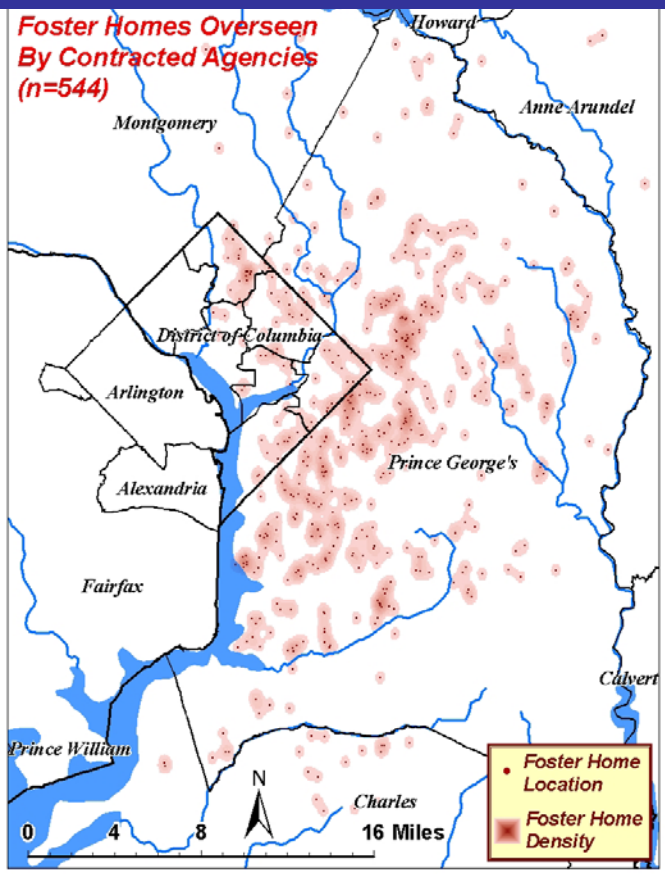
Table 10: Children Per Contracted versus CFSA Foster Home Provider, 6/30/05

	Contracted	*CFSA*	*Total*
Providers	547 (45%)	663 (55%)	1210
Children	860 (43%)	1145 (57%)	2005
Children per provider	1.57	1.73	1.66

Source: FACES Report PLC208

Geographic distribution is another difference between contracted and non-contracted foster homes. While the majority of contracted foster homes are in Maryland, non-contracted foster homes are concentrated inside the District or on the border between the District and Prince George's County, Maryland (Figures J and K).

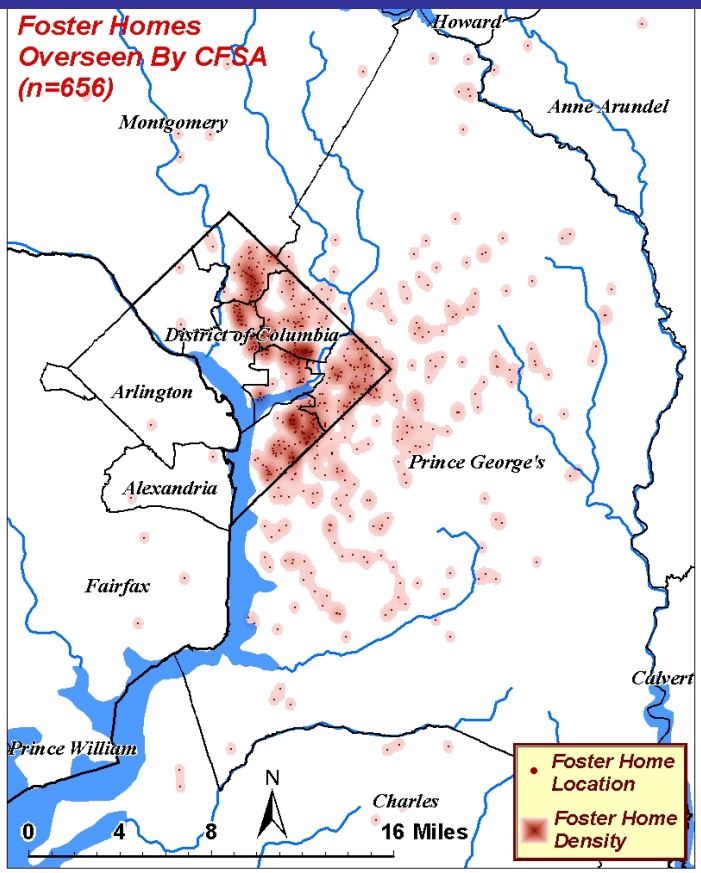
Figure J: Geographic Distribution of Foster Homes (with Children Placed) Under Contracted Private Agency Oversight, 6/30/05



Source: FACES Report PRD133 and OPPPS Placement Geographic Analysis Findings

Note: As of 6/30/05, CFSA had 547 foster homes with children placed that were being overseen by contracted provider agencies. Of those, geographic locations for 544 have been identified through geocoding.

Figure K: Geographic Distribution of Foster Homes (with Children Placed) Under CFSA Oversight, 6/30/05



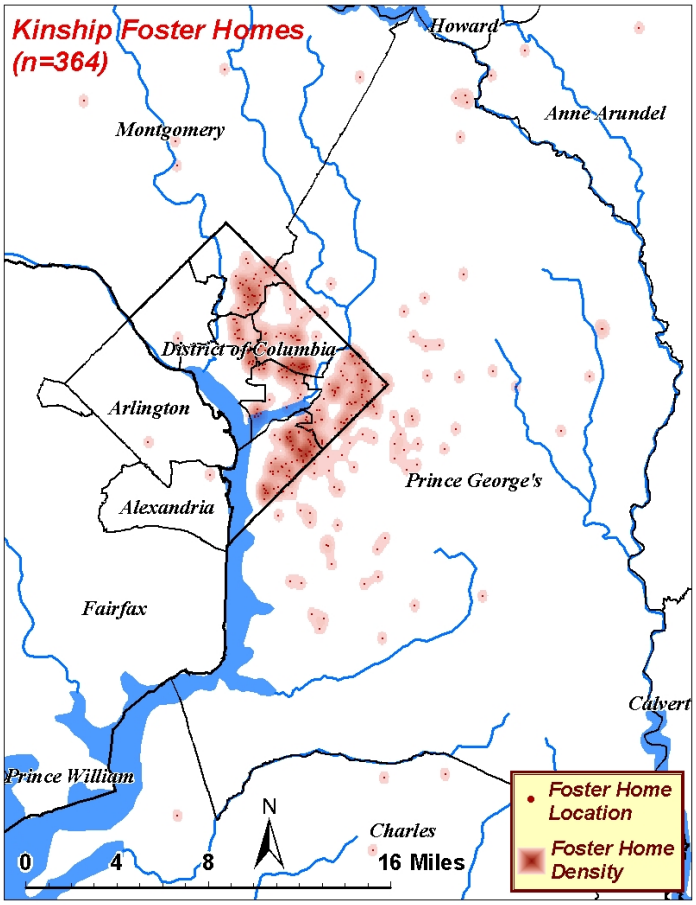
Source: FACES Report PRD133 and OPPPS Placement Geographic Analysis Findings

Note: As of 6/30/05, CFSA had 663 foster homes with children placed that were being directly overseen by CFSA. Of those, geographic locations for 656 have been identified through geocoding.

4. Kinship Care versus Traditional Care Providers

In general, CFSA recruits, licenses and monitors kinship care providers directly. Non-kinship, traditional providers are recruited, licensed and monitored both by CFSA and contracted private agencies. As depicted in Figure L, a majority (71%) of kinship providers were located in the District at the end of June 2005. As depicted in Figure L, a majority (71%) of kinship providers were located in the District at the end of June 2005. Only 36% of traditional care providers were residing in the District at that time (Figure M). The ratio of children to provider was very different for traditional and kinship homes: 1.89 versus 1.62.

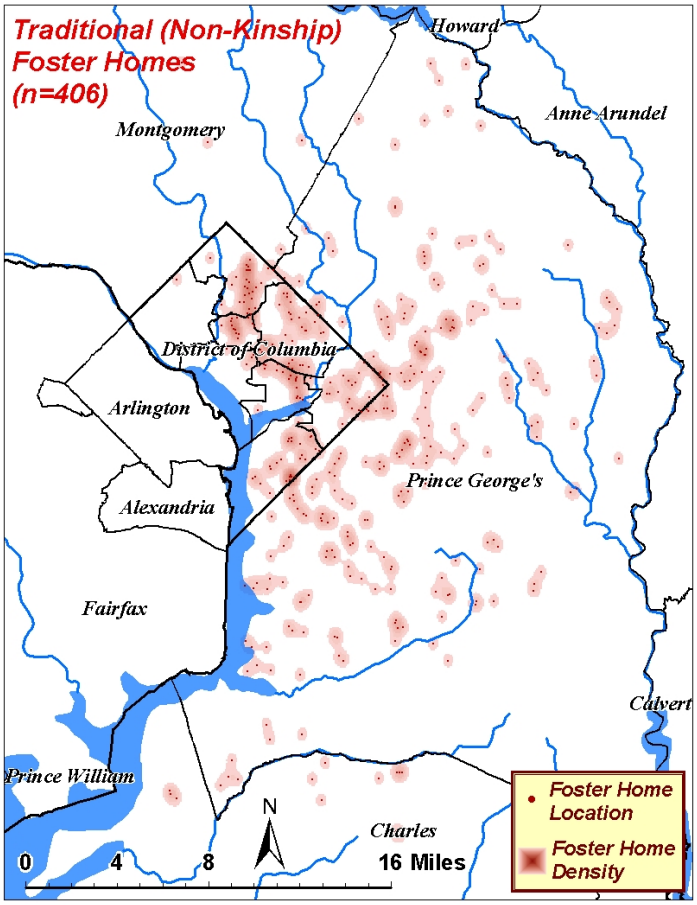
Figure L: Geographic Distribution of Kinship Foster Homes with Children Placed, 6/30/05



Source: FACES Report PRD133 and OPPPS Placement Geographic Analysis Findings

Note: As of 6/30/05, CFSA had 367 foster homes providing kinship care services. Of those, geographic locations for 364 have been identified through geocoding.

Figure M: Geographic Distribution of Traditional Foster Homes with Children Placed, 6/30/05



Source: FACES Report PRD133 and OPPPS Placement Geographic Analysis Findings

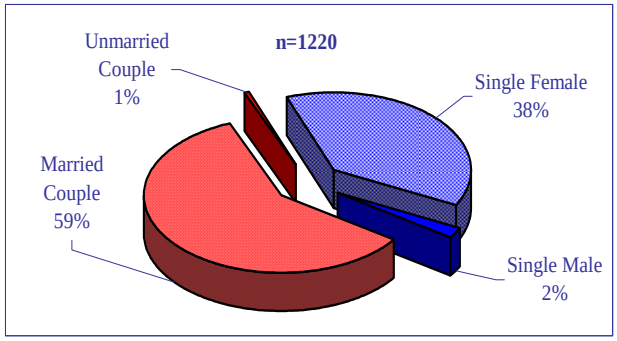
Note: As of 6/30/05, CFSA had 412 foster homes providing non-kinship traditional foster care services. Of those, geographic locations for 406 have been identified through geocoding.

5. Foster Parent Characteristics

For our analysis of foster parent characteristics, we included information on foster family structure and the birth years of first-time foster parents.

Figure N shows the majority of foster parents are married couples (59%). A sizeable number, however, are single-parent families with a female head of household (38%). Single male foster parents are extremely rare.

Figure N: Foster Family Structure



Source: CFSA AFCARS 2004B Data, 11/10/04

Data: From CFSA's AFCARS foster care report, element 49, regarding foster family structure. According to these data, 3,159 children were in care from April through September 2004. Of those, 792 were not with a foster parent. Family structures for 1,147 children were not reported. Percentages above are based on information for the remaining 1,220 children.

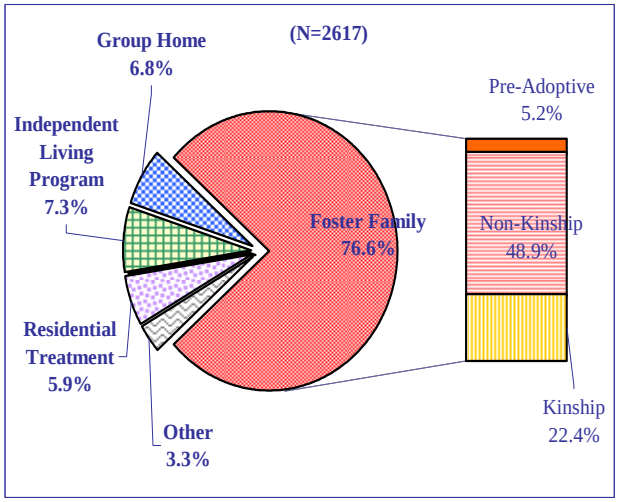
In 2004, almost one-third of the foster parents were between ages 41 and 50. Foster parents between ages 51 and 60 also constituted a relatively large group (28%). One in five foster caregivers was older than age 60. In sum, nearly half (49.3%) the District's foster parents are older than 50.

6. Trend in and Projection of Placement Needs

CFSA is committed to providing family-based care, which is most conducive for a child's well-being and healthy development, for the majority of children who must leave their birth families to be safe. This commitment has demonstrated results (Figure O).

As of June 2005, CFSA had 76.6% (n=2,005) of foster children in family-based care. This is slightly higher than the most recent reported national average of 73.7% (as of September 2003, AFCARS). Of those 2,005 children, 587 (22.4%) were in kinship care. (This figure does not include kinship parents seeking to adopt children in their care.)

Figure O: Placement Settings of Children in Foster Care, 6/30/05



Source: FACES Report CMT163 & PLC010

Notes: "Group Home" includes diagnostic & emergency facilities, traditional, and specialized group homes. "Independent Living Program (ILP)" includes main facilities, residential units, and teen parent programs. "Other" includes hospitals, correctional facilities, abscondances, and "awaiting placement."

Because the District has a high percentage of older youth in care, the proportion of placements in Independent Living Programs (ILPs) is also high. Only 1.1% of the national foster care population is in Independent Living, while 7.3% of the District foster care population resides in an ILP.

Although we have used regression analysis to project the foster care population for upcoming fiscal years, we recognize that a number of factors affect this method of forecasting. For example, the increase in the numbers of older youth requires a corresponding increase in ILP placements, despite CFSA's primary determination to place all children in family-based foster care. In addition, CFSA has contracted in the past with private providers based on estimated needs. These needs have often been outdated by the time the actual placements occurred. While CFSA does its best to develop placement resources in

Table 11: Actual and Projected Number of Children by Placement Setting

Placement Setting		Actual			Projected			
		9/30/03	9/30/04	6/30/05	9/30/05		9/30/06	
					No.	Range	No.	Range
Family-based Care	Kinship	691 (23.5%)	588 (21.4%)	587 (22.4%)	602 (22.7%)	572-632	596 (23.5%)	566-626
	Traditional	1,712 (58.1%)	1,578 (57.5%)	729 (27.9%)	743 (28%)	705-780	710 (28%)	775-746
	Specialized			552 (21.1%)	557 (21%)	529-585	533 (21%)	506-559
	Pre-adoptive			137 (5.2%)	141 (5.3%)	134-148	139 (5.5%)	133-146
Group Home	Emergency	292 (9.9%)	196 (7.1%)	34 (1.3%)	32 (1.2%)	30-33	25 (1%)	24-27
	Traditional/Specialized			145 (5.5%)	141 (5.3%)	134-148	127 (5%)	120-133
Ind. Living Program	Main facility	122 (4.1%)	196 (7.1%)	49 (1.9%)	53 (2%)	50-56	56 (2.2%)	53-58
	Residential			89 (3.4%)	93 (3.5%)	88-98	91 (3.6%)	86-96
	Specialized			4 (0.2%)	5 (0.2%)	5-6	5 (0.2%)	5-5
	Teen Parent			50 (1.9%)	50 (1.9%)	48-53	51 (2%)	48-53
Residential Treatment		97 (3.3%)	135 (4.9%)	154 (5.9%)	154 (5.8%	146-162	139 (5.5%)	133-146
Other		32 (1.1%)	50 (1.8%)	87 (3.3%)	82 (3.1%)	78-86	63 (2.5%)	60-67
Total		129	2,743	2,617	2,652	2,519-2,785	2,536	2,409-2,663

Source: FACES Report CMT232; OPPS placement projection
Notes: Some percentages do not total 100% due to rounding. Some columns of projected numbers may not add up since we derived them from projected percentages. Projected ranges are between 95%-105% of projected numbers. FACES did not include updated information for one group home for 6/30/05; we adjusted data to maintain accuracy of projections. "Other" includes hospitals, correctional facilities, abscondance, and "awaiting placement". Projected total foster care population numbers match those in Table2.

response to fluctuating needs, the best resources are simply not always available. We nevertheless forecasted the foster care population for each placement setting for FY06 as shown below in Table 11.

The above projections for congregate care settings are especially influenced by several historical factors:

- Between 2003 and 2005, teen parent settings converted to ILP settings.
- In 2004, new CFSA contracts required that youth move to ILPs after age 17.
- CFSA policy no longer allows for children under age 13 to be placed in congregate care settings (unless necessary to meet special needs). This policy dramatically reduced the number of young children in congregate care.

We expect that the projected percentage of kinship placements will increase slightly by the end of FY06 since CFSA intends to aggressively pursue kinship placements as a primary resource. We anticipate that traditional non-kinship foster care and specialized foster care placements will remain at current levels. Placements in emergency facilities and traditional group homes will likely continue to decrease while the needs for ILP placements will likely increase. The "other" category includes children awaiting placement. CFSA expects this number to decline due to the recent establishment of the centralized Placement Services Administration. In fact, the percentage and number of children/youth in this category has already significantly decreased in recent months.

D. Placement Support Services

1. Existing Placement Support Services and Use

As a supplement to ongoing social work and case management, placement support services are available to children/youth in care and to out-of-home caregivers (primarily foster parents). These services facilitate placements, stabilize children in placements, prevent placement disruptions, and enhance a caregiver's skills for meeting the needs of children in foster care. From interviews and focus groups, we compiled a list of the support services available in FY05 (Table 12).

Table 12: Placement Support Services 10/04 – 6/05
Ongoing Mental Health/Behavioral Services
Family Counseling
Multi-Systemic Therapy (began 1/05)
Mobile Response & Stabilization Services (MRSS) (began 1/05)
Intensive Home & Community Based Services (began 1/05)
Substance abuse treatment
Child Care
Tutoring
Mentoring
Flex Funds
Removals and Family Team Meetings (FTM)
Respite Care: • COG • CFSA Contracted
Foster Parent Support Groups
Foster Parent In-Service Training (10/04-6/05)
24/7 Placement Staff availability (Began 4/2005)
Medical Consultation through OCP nursing staff
Transportation Assistance
OVS Clothing Closet
Source: CFSA Clinical Practice and Permanency & Family Resource Administration

2. Services Identified by Workers

Placement support services included outpatient therapy, 24-hour in-home stabilization for acute crises, and community-based services such as tutoring and mentoring. CFSA staff also identified the three new mental health services (Intensive Home- and Community-Based Services, Mobile Response and Stabilization Services (MRSS), and Multi-Systemic Therapy). They had greater difficulty identifying services or supports that assist foster parents in providing stable placements for children. They did not mention, for example, substance abuse treatment, medical consultation, 24/7 availability of placement support staff, FTMs, respite care, child care, transportation assistance, or the clothing closet. They did identify all the services provided through CFSA's Family Resource Division: support groups, training, and unspecified activities for children and foster parents (e.g., the back to school activity).

When asked to describe how CFSA develops and implements creative services for children and foster parents, staff talked about the formal, 24-hour emergency crisis intervention service (MRSS) which prevents hospitalization and placement disruption. They did not mention meeting individual needs or using flexible funding to access less traditional supports.

3. Services Identified by Foster Parents

While foster parents felt social workers did a good job of informing them about services available to children in their care, they also talked about communication challenges and social workers' lack of knowledge. Foster parents reported issues of high social worker turnover and new workers being unaware of the full range of services available.

Services that foster parents requested and used most were consistent with service needs birth parents identified. The top eight services foster parents requested included outpatient mental health services (36%), mentoring (34%),

tutoring (35%), educational assessments (32%), counseling (31%), transportation (25%), day/childcare (25%), and respite (20%).

E. Assessment of Placement Resources

Staff and foster parent focus group participants identified five categories of primary concern:

- Access to placement resources
- Appropriateness of placement resources
- Management of placement resources
- Systemic issues affecting the placement process
- Therapeutic Foster Homes

1. Access to Placement Resources

(a) Staff Perceptions

Social workers tend to place children wherever a bed is available, not necessarily with regard to the child's individual needs. This is particularly true for children who require placement during evenings and weekends when requests may be high and social workers may be unable to meet individual needs within available options. Social workers indicated they are often unable to find placements unless another placement vacates due to disruption. These perceptions underscore the importance of need for appropriate, readily available placement resources.

i. Older Youth in Care

The increasing number of older youth in foster care presents several placement resource challenges. Some older youth are exhibiting special or therapeutic needs, especially those who have been in care for many years. CFSA is having difficulty maintaining these youth in stable placements because their needs outstrip current resources. Placement support staff indicated that the difficulty is exacerbated when foster parents do not receive adequate training or adequate support in caring for these high-end youth. CFSA needs to craft effective strategies to meet the needs of these youth while maintaining their placements.

ii. Other Youth with Special Placement Needs

Two additional groups of youth with special foster care placement needs are teen mothers and lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. Providers have particular difficulty meeting the needs of LGBTQ youth if other youth in the placement are not accepting. At times, the safety of the LGBTQ youth may be at risk in these settings. In direct correlation to this challenge, staff also perceived a gap between the types of children/youth needing placement and the types of children whom foster parents will accept for placement. This affects the availability of homes for youth in general and particularly for youth in special populations and children/youth with special needs.

iii. Licensing Kin in Maryland

The inability to provide temporary licenses to foster youth relatives residing in Maryland is a major factor in placement challenges. While CFSA has worked with Maryland to reach an agreement on this issue, we have made insufficient progress to balance the need.

iv. Initial Placement Needs

Focus group participants reported that Child Protective Services (CPS) social workers have no time for adequate assessments of a child's placement needs at the time of an investigation or removal. This responsibility falls to the ongoing social worker who receives the case from CPS after initial placement. Participants identified Family Team Meetings (FTMs) as a mechanism for assessing placement needs but also identified a need to ensure that FTMs occur in a timely fashion. Key people, such as parents, must always be present.

NOTE: We held placement focus groups shortly after CFSA implemented removal FTMs. Brief experience may have affected staff perceptions of FTM effectiveness in assisting with assessment of the need for placement and identifying the appropriate placement type for children entering care. Data

available from the FTM Unit indicated that of 165 removal FTMs conducted between January and June 2005, 138 (83.6%) took place within 72 hours. While a breakdown of family participants by type of FTM was not available, in the period from January through June of 2005 an average of 148 family members participated in all FTMs monthly. Implementation of Structured Decision Making (SDM) should enhance social worker ability to make better assessments earlier in the case. SDM strategies are now in process.

v. After-Hours Staff / On-Call Staff

Our placement focus groups were held before CFSA centralized the placement function. Many of the identified needs reported by the focus group participants (such as additional "on call" and weekend/evening staffs) have been addressed by the establishment of the Placement Services Administration. Placement support staff became available 24/7 in April 2005. In addition, OCP Clinical Support and Health Services staff is available 24/7 to provide on-call consultation through the hotline. The OCP manager frequently provides guidance regarding placement options for children with complex mental health and medical conditions. OCP's on-call staff includes a physician, nurses, and a clinical psychologist. (Social workers in CPS actually make emergency after-hours placements.)

vi. Communication Between Frontline Staff and Family Resource Workers

Participants expressed a need for increased collaboration between social workers and the Family Resource Division in order to provide more support for foster parents and to stabilize placements. After receiving feedback from these participants, CFSA reorganized family support worker responsibilities and created the Family Support Unit in October 2005. The sole function of social workers in this unit is to provide support to CFSA foster parents.

vii. Cars

A shortage of government vehicles assigned to CFSA obviously makes it difficult to support placements through visits and transporting children. In response to this identified need, CFSA has been able to contract with a rental agency to provide a better fleet management plan. Staff and supervisors received training on requesting and scheduling for these cars.

viii. Medical Care

Participants identified a need for increased accessibility to medical services through DCKids.[10] Although DCKids offers same-day and next-day appointments, the no-show rate for CFSA clients is high. Staff suggested that DCKids dedicate a clinic one or two days a week to service CFSA children only. They saw this as a way to expedite evaluations and to make services more accessible. Participants also recommended that DCKids open clinics in the community, making it more convenient for families and social workers to keep children's appointments.

ix. Matching Foster Parents to Children

A major concern identified by Latino birth parents was the safety and well-being of their children if removed from the home. They spoke at length about concerns with the quality of care their children received in foster homes, location of foster homes, communication problems with foster parents and social workers, and issues related to visitation.

(b) Foster Parent Perceptions

Both foster and kinship parents raised issues concerning expedited licensing and re-licensing in Maryland, reimbursements for out-of-pocket expenses, inadequate disclosure of a child's prior behavioral issues, consistency between CFSA's stated vision and actual practice, and respite services. Foster parents responding to the *2005 Needs Assessment Survey* expressed frustration that problems in these areas hinder their ability to maintain stable placements for children:

Truthfulness from [the] agency, honesty regarding placements and behavior; trusting CFSA to be a credible partner.

[10] *DCKids is an independent, non-profit, multi-issue advocacy program serving youth and children in the District of Columbia.*

CFSA is not credible or trustworthy about information shared with foster parents. Foster parents do not trust that CFSA is not withholding serious information about previous behavior, such as fire setting, guns, violence, etc.

I need respite and overnight care.

i. Transportation assistance

I need transportation for him to and from school.—Foster Parent, 2005 Needs Assessment Survey

To address issues related to transportation, the Foster and Adoptive Parent Advocacy Center (FAPAC) coordinated a meeting with CFSA staff and foster parents in September 2005. The results were documented:

Transportation causes a lot of tension between foster parents and social workers. Both social workers and foster parents agreed that we have seen transportation cause a barrier to our children receiving necessary services as well as disruptions in placements. We identified that although improving relationships between foster parents and social workers would do a great deal towards resolving some of the communication breakdowns involving transportation so that people could work together, both families and the agency do suffer from lack of actual (transportation) resources. Therefore, although some of our suggestions focus on the foster parent-social worker relationship, others focus on the absolutely essential need to increase transportation resources.

Underscoring the FAPAC statement is a general concern of social workers that many foster parents are not escorting foster children to medical and other appointments. Social workers think foster parents need to provide this service, and CFSA needs to hold them accountable when they do not.

Foster parents say they are too busy to transport the child or attend sessions.--Social Worker, 2005 Needs Assessment Survey

ii. Communication

Findings from the Court Improvement Project indicate that nearly 80% of foster parents reported their social workers usually responded within 24 hours whenever they leave messages. The CFSA Foster Parent Survey respondents, however, reported that social workers do not return calls

Foster parents still cannot reach workers. Workers don't return calls, supervisors don't return calls, sometimes have to go up three levels to get response.

You call and keep getting the answering machine referring you to the supervisor.

iii. Behavioral Issues

Many foster parents cited inability to control rebellious teens and the impact of this behavior on other children:

Agency restrictions on discipline of teens allow them to get away with things other children do not.

Teens are harder now than before. Can't let children with these behaviors free in neighborhood (children on drugs, who steal cars, etc.).

The child was disrespectful and would stay away from home for days at a time.

The kid brought drugs into my home and started selling them out of my home.

Teens try to parent younger children, perhaps even to spank them, and foster parent does not know how to deal with that.

iv. Training

CFSA foster parents agreed with staff regarding the need for training and support. Focus group participants were asked, "What are some problems?" One response was, "No training or support that teaches skills regarding how to parent children with these hard behaviors. No education about how to work with real needs of real children, how to meet their needs, how to protect yourself, and ramifications of behavior."

vi. Social Worker/Foster Parent Relationships

Foster parent focus group participants stated that social workers interfere in setting ground rules in homes, question foster parent authority in front of the children, and allow children to "split" them from foster parents. Sometimes they have plans with children that exclude foster parent input.

With regard to special populations, foster parent focus group participants expressed that, "Social workers need to be educated about gender identity issues and learn to accept children with these issues."

(c) Kinship Perceptions

Kinship parents, in particular, identified needs for post-guardianship services, post-adoption respite services, and training /assistance in managing the behavior of rebellious teens They identified the ability to control errant teenage behavior as crucial to placement stability for teens and children in foster care.

Social work staff and kinship parents frequently had different understandings of the needs of children. Kinship parents expressed that social workers describe children's behavior as "normal" when they see the behavior as "special" and needing additional supports to manage. More assessment of a child's/youth's needs is required before placement with kin.

(d) Adoptive Family Perceptions

Adoptive parents in the FAPAC focus group identified the need for adoption information for prospective adoptive parents, legal services for adoption, mental health services for adopted children, and post-adoption services with follow-up. Some needs identified by adoptive parents were the same as needs identified foster parents:

Inadequate disclosure of child's mental health and medical history and that of his/her parents and siblings

Psychological evaluations sooner.

Counseling and other services in place to "come with the kid" and to follow the child into new placements.

2. Appropriateness of Placement Resources

Staff identified the need for an array of appropriate placements for youth, emphasizing the need for recruiting exceptional quality foster parents for teens. Participants were concerned that kinship providers may not be adequately prepared to provide appropriate placements for children with therapeutic needs. Participants also identified the need for additional training and support for these caregivers. There is need for a FACES link to DC Kids so that social workers can directly access and update information regarding medical appointments, examinations, etc.

3. Management of Placement Resources

(a) Additional Training for Temporary Kinship Licensure

Participants stated that social workers need additional training in the temporary kinship licensure process. If the social workers are well trained, licensure and placement in a kinship home might be a first option for placement rather than a traditional foster care placement.

(b) Disruption Staffings

Frontline staff workers need to make more effective use of disruption staffings and/or FTMs to support placements and avoid disruption. Social workers stated that an FTM took approximately 1.5 weeks to schedule so they had often tried multiple interventions on their own (when placements seemed unstable). Disruption staffings were an intervention of last resort, which rendered it of little value when attempting to salvage a placement. FTMs only bought enough time to locate another placement. (Until September 2005, CFSA held re-placement FTM only upon request for selected cases. As of September 2005, the Interim Director mandated that all

children/youth being re-placed must have an FTM.)

(c) Coordination of Services

Many providers serving CFSA foster youth are located outside of the District; some of these do not accept D.C. Medicaid. Social workers cited the need to identify more providers who will accept D.C. Medicaid. They also stated a need for therapeutic services to be more localized in communities where children live. To address this concern through its contracts, CFSA has mandated that congregate care providers develop relationships with the Core Service Agencies (CSAs) in their areas, utilizing them for mental and behavioral health services for the youth. By encouraging these types of service relationships, CFSA provides the youth with an established rapport that can follow the youth when he/she leaves foster care.

(d) Judicial System

Court orders often specify a particular placement type or a specific provider, regardless of resource availability or whether the provider is under contract with CFSA. Focus group participants felt that judges may not understand resource issues or the placement process. Social workers further perceive that judges do not respect their professional opinions. Participants indicated that in these situations, Assistant Attorneys General (AAGs) may not always support the social worker's effort to explain in court the limitations affecting placement decisions.

Placement issues frustrate both social workers and judges. One extraordinary example was that of a judge who required a social worker to stay in court for six hours until CFSA found a new placement for a foster child.

(e) Streamlining DCKids

Although CFSA workers noted the relative ease with which they are able to obtain medical screenings for new placements, or placement changes, they identified a need to streamline the DCKids process after initial placement. Participants stated it is difficult and time-consuming to obtain medical, dental, and/or eye exams.

4. Systemic Issues Affecting the Placement Process

(a) Timing of Individualized Services

During the discussion of the placement process, participants pointed out instances where the court ordered services before social workers had a chance to evaluate the child's needs. There seemed to be an emphasis on providing extensive services without these initial assessments. The court's view is that CFSA does not conduct assessments early enough in the case.

(b) Lengthy Referral Process

Participants identified the need to streamline the Office of Clinical Practice (OCP) referral process. Social workers indicated that the process feels burdensome. It often takes two months or more for services to materialize from the time of a referral. Participants described the process: two to three weeks to get connected to the provider through OCP, two to three weeks for the initial appointment, and another two to three weeks for assignment of a therapist. Social workers reported they must repeatedly follow up with providers or with OCP to ensure services are in place.

(c) Feedback on Service Providers

Respondents identified a need for evaluation tools or other mechanisms to report and/or elevate their concerns regarding the quality of service providers.

(d) Reduce Number of Placement Changes

Although not every placement change is a disruption, frequent placement changes are never in the best interests of children. We tracked children with multiple placements both within the past year and throughout their lifetime in foster care. We then examined the characteristics of those children.

As of September 2005, CFSA had 2,550 children in care. Of those, 1,048 (41%) had

experienced three or more placement changes throughout their stay in foster care. Of that group, 345 children (13.5%) had been in at least three different placements during the last 12 months. In particular, one out of every five youth age 15 and older had lived in at least four different placements in foster care.

The predominant group with frequent placement changes is female, ages 15 to 21 (Table 13). This age group (n=126) constitutes about 37% of all children with multiple placements. Regardless of age, 59% of all children with multiple placements are female.

Table 13: Age and Gender of Children with Frequent Placement Changes, 9/15/05

Age	*No. of changes: Females*	*No. of changes: Males*	*Total*
<3	6	8	14 (3%)
3-5	8	10	18 (5%)
6-8	11	9	20 (6%)
9-11	18	16	34 (10%)
12-14	33	37	70 (20%)
15-17	74	33	107 (31%)
18-21	52	32	84 (24%)
Total	202 (59%)	143 (47%)	345 (100%)

Source: FACES Reports PCL159 and PLC108

After narrowing the list to 28 children who had experienced at least six different placements during the past year, we found 75% were female. Except for two, all were age 12 or older.

CFSA attributes these statistics to the movement of girls through contract and practice, in particular the circumstances surrounding teen pregnancy. When a teen girl becomes pregnant, CFSA moves her to a teen parent setting where she can receive specialized care. While the intent is to provide the expectant mother with the care, education, and support she needs to become an effective parent, this practice nonetheless results in a placement change and impacts the data.

5. Therapeutic Foster Homes

Ineffective discharge planning when a child/youth comes out of a residential treatment program often leaves children/youth without immediate access to the services they need upon return to the community.—Social Worker, June 2005

CFSA staff who participated in focus groups reported that one of the most critical issues affecting placement in 2005 was a general lack of placement resources for children with "therapeutic needs". This characterization, however, oversimplifies an issue that has been exacerbated by four key challenges:

- **A backlog of children waiting for placement:** Therapeutic slots are not increasing at the same rate as placement need. CFSA has had a backlog 80 children waiting for therapeutic placement for the past 18-months.

- **Ineffective use of contracted placements:** CFSA contracted with a private agency for 100 therapeutic slots in 2005, but only about 50 slots have been made available to date. CFSA needs to hold contracted agencies accountable for providing the full number of slots in their contracts.

- **Keeping children in therapeutic settings too long:** Often when youth are ready to step down from therapeutic placements to traditional foster care or a group home, we cannot find a provider willing to take them because of their previous behavioral issues. A therapeutic placement can then become an ongoing placement rather than a time-limited option. This also means that a potential resource is unavailable for the next child/youth needing the service.

- **Inability of foster parents to deal with teens:** Most CFSA foster parents (particularly those who reside in the District) are older and less tolerant of the challenging behavior of this generation of teens in foster care.

Actualizing therapeutic care in placement is a process. Resource parents must be devoted, not just well trained. The child's evaluation and assessments must be current to ensure identification of a placement that will meet his/her needs. The court often mandates that CFSA place youth in therapeutic care within a specified, shortened time frame. If the placement resources are not available, this court order creates another layer of burden for the placement process.

One option for addressing this issue is better management of current resources, including increased accountability of contracted agencies. CFSA must monitor the criteria for placing a child in a therapeutic placement, including bringing in services such as mobile crisis stabilization.

Focusing on permanence is another critical need to ensure that youth do not stay in therapeutic settings beyond a necessary time. One strategy is for CFSA to expend more effort engaging birth families to deter the need for placements. We must also continue to focus on what we have to do to achieve permanence (even if that means the child will need post-permanency supports because he or she cannot return home).

CFSA has already begun to design and implement a step-down review process in which we look at the case of each child in therapeutic care every 12 months to determine appropriateness of the setting. In addition, CFSA is currently looking at evidenced-based approaches toward achieving permanency, such as multidimensional foster care which has been successful in other child welfare agencies.

Finally, CFSA needs to evaluate the in-service foster parent training curriculum (and possibly pre-service training as well) to ensure that foster parents receive adequate preparation to care for CFSA children, particularly teens.

F. Special Analysis: Sibling Placements

Preserving the bond between brothers and sisters is often an essential part of a child's/youth's emotional well-being. Placing siblings together, or at least enabling them to maintain contact after separation, will preserve their connections with one another, and thus improve their chances for long-term well-being and permanency, regardless of the placement goal. This special analysis introduces national statistics regarding sibling placement, and describes how CFSA is currently faring in reference to placing siblings together.

Further analysis on the impact that sibling groups of different genders is also provided. We selected 327 sibling groups of two children, which make up 654 children in total, and compared gender between siblings with their placement status. As shown in Table we concluded that siblings are more likely to be separated when they are not of the same gender.

Also discussed are the challenges to keeping siblings together, and those issues that arise when siblings are not placed together. Finally, recommendations and strategies are provided for how to effectively address these challenges and how to best meet the needs of sibling groups while they are in foster care.

1. Sibling Placements Nationwide

It appears that quantitative data on sibling placements is not an indicator typically collected and reviewed. Few jurisdictions measure or publish outcomes on sibling placements and each jurisdiction has different measurement methodologies. However, overall we have found that overall about 65% of children entering the foster care system have

at least one sibling and about 30% have four or more. Among these sibling groups, about 75% end up living apart while in foster care.[11]

Sibling Groups in California

According to the Center for Social Services Research at the University of California (2005), 67% of children in California's child welfare system had at least one sibling in out-of-home care as of October 2004. Among those children:

- Forty-two percent (42%) were placed with all of their siblings;
- Sixty-six percent (66%) were placed with all or some of their siblings;
- Thirty-four percent (34%) were placed with none of their siblings.[12]

Sibling Groups in New York

The Administration for Children's Services (ACS) in New York City monitors placement activities of sibling groups for children entering care on a regular basis. Their most recent Performance Report *(Indicator 2: Neighborhood-Based Placements, Citywide Summary*, 10/20/05) includes the following data:

- During the first half of the calendar year 2005, NYC had 2,429 children who entered care, and of those, 48% of children (1162) either had a sibling already in care or had themselves entered care on the same day as their sibling(s).
- The 1162 children came from 595 families; of those 592 sibling groups,
  - Fifty-nine percent (59%) included siblings placed together.
  - Twenty-two percent (22%) included some of the siblings placed in the same foster home or facility and some not.
  - Nineteen percent (19%) included no siblings in the same home or facility.

According to another report published in 2001by New York's ACS:

- In FY99, 67% of children (7,502) in NYC foster care had one or more siblings in care. Of those children, 53% were placed with all of their siblings together, 26% were placed with at least one of their siblings, and the remaining 21% were completely separated from all of their siblings.

2. Sibling Placements in the District

The Agency had no previous study and there were some barriers in collecting data. Review of national data and other jurisdictions, however, allowed us to explore a variety of methodologies to asses the current picture of sibling placements in the District of Columbia. We successfully obtained some meaningful information that illustrates the current picture of sibling placements in more detail than has previously been available.

(a) Size of Sibling Groups in the District's Foster Care System

The percentage of DC children who have siblings in foster care is at a level similar to the state of California (see Table 14).

Table 14: Size of Sibling Groups in Care as of 9/30/2005

Sibling Groups	*# of Children in Care*	*# of Families*
One Child	922	922
Two Children	654	327
Three Children	417	139
Four Children	280	70
Five or more	281	48
Total	**2554**	**1506**

Source: OPPPS 09-30-2005 Placement Database (DB) constructed from FACES Reports CMT163, PLC002, PLC101.

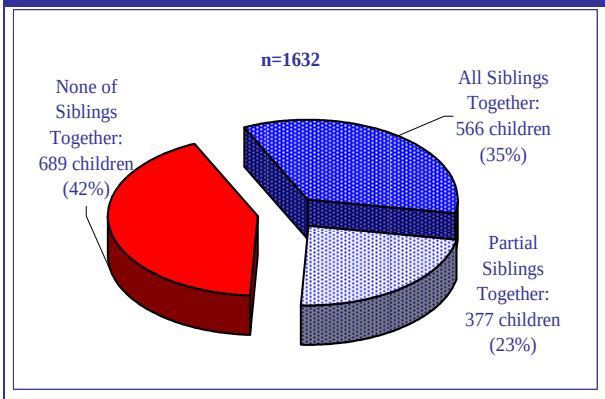
[11] ***Source:*** *The Sibling Bond: Its Importance in Foster Care and Adoptive Placement, published by the National Adoption Information Clearinghouse of the Children's Bureau (2002).*

[12] ***Source:*** *The California Department of Social Services, supported by The Center for Social Services Research at the University of California (2005).*

As of September 30, 2005, there were 2554 foster care children originating from 1506 families in the District of Columbia. Of these, 64% (n=1632) from 584 families had one or more siblings placed in foster care. Of those, 561 children from 118 families had four or more siblings placed in foster care (see Table 14).

We took particular note of foster children who had one or more siblings in foster care in order to identify whether they were together or placed separately. Of the 1632 children with siblings in care, 35% (n=566) were placed with all of their siblings together while 65% or 1066 children were placed separately from at least one of their siblings. Of the 1066 children, 377 children were in a foster placement with one or some of their siblings while the remaining 689 children were in foster care with none of their siblings. In other words, of the 1632 children with siblings in care, 42% (n= 689) were placed with none of their siblings while 58% (n= 943) were placed with at least one or more siblings together.

Figure P:
Placement of Children with Siblings in Foster Care as of 9/30/05



Source: OPPPS 09-30-2005 Placement Database

We further observed sibling placement trends by sibling group size. Table 15 demonstrates that as sibling group size increases, the chances that a child being placed with all of his/her siblings will decrease, but the chances of being placed with at least some siblings increases.

Table 15. Siblings Placement by Size of Group (9/30/05)

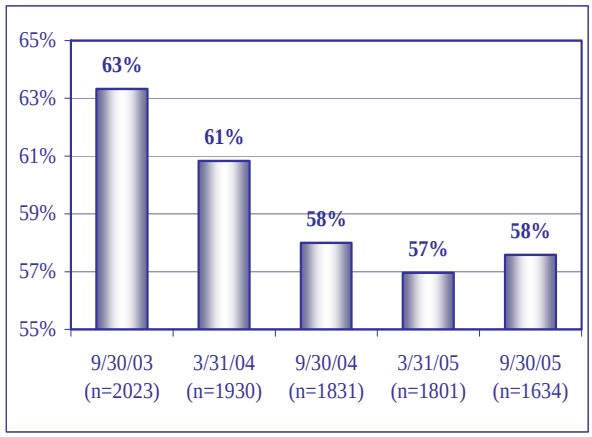
Size of Sibling Groups	Number of Children	All Placed Together	All or Some Placed Together	None Placed Together
2 Siblings	654	54%	N/A	46%
3 Siblings	417	27%	52%	48%
4 Siblings	280	20%	60%	40%
5 Siblings	130	12%	72%	28%
6+ Siblings	151	23%	76%	24%

Source: OPPPS 09-30-2005 Placement Database

(b) Sibling Placements Over Time

Over the past couple of years, the percentage of children who had siblings in care decreased. On September 30, 2003, 69% of the then total number of children in care had siblings also in care. Compare this to September 30, 2005 when 64% of children had siblings in care (see Figure Q).

Figure Q. Percentage of Children Placed with all or some of Siblings Together (9/30/03 ~ 9/30/05)



Source: FACES Report PLC003

(c) Characteristics of Sibling Groups

We further observed characteristics of children by sibling placement status, learning who is likely to be placed together and who tends to be placed separately.

Age Distribution

- Older youth are likely to be in foster placements that separate them from their siblings.
- Younger children are likely to be in foster care placement with their siblings together while older youths tended to be separate from their siblings.
- Approximately 65% of children placed with none of their siblings are 12 years or older while 62% of children placed together with their siblings are younger than 12 years old. It is inferred that the increase of older youth in foster care impacts on sibling placements as well.

Age Difference

Based on the information collected from interviews with placement staff, we built a hypothesis that age difference between siblings affects the likelihood of intact placement. We studied age differences of 654 children (327 sibling groups) who had only one more sibling in care by their intact placement status and concluded that the smaller the age difference between siblings, the more likely they will be together in placement.

The difference between the groups placed separately and the groups placed together seems less significant than we expected. The median age gap for a group of children placed separately is 3 years while that for the group of children placed together is 2 years.

Gender Difference

Additional analysis finds that gender difference is an element that affects sibling placements. We selected 327 sibling groups of two children, which make up 654 children in total, and compared gender between siblings with their placement status. As shown in Table , we concluded that siblings are more likely to be separated when they are not of the same gender.

Table 16. Gender Difference by Intact Placement with Siblings in Care (9/30/05)

Gender Difference Between Siblings	Total Sibling Groups of Two Children	Placed Together	Placed Separately
Same	145 (100%)	81 (56%)	64 (44%)
Different	182 (100%)	71 (39%)	111 (61%)
Total	327 Group (654 Children)	175 Group (350 Children)	152 Group (304 Children)

Source: OPPPS 09-30-2005 Placement Database

(d) Placement Type

At the end of FY05 (September 30, 2005), there were 2554 children in foster care in the District of Columbia. Of these, 63.9% (or 1632 children) had one or more siblings also placed in foster care.

Among the 1632 children with siblings in care, 57.8% (or 943 children) were placed with at least one or more of their siblings. This includes 35% of children who were placed with ALL of their siblings. A total of 689 children (or 42.2%) were not placed with any of their siblings at then end of 2005 fiscal year. When children who absconded, or are in correctional facilities, hospitals, group homes, ILPs, RTC, or medically fragile are excluded from those who were not placed together (see Table 16) - the percentage of children are placed with at least one sibling significantly increases to 64.5%, while just under 36% are not placed with a sibling.

Table 17. Status of Siblings Not Placed Together (9/30/05)	
Reasons for Exclusion	**# of children**
Abscondance	4
Diagnostic and Emergency Care Aged 12 & Younger	6
Diagnostic and Emergency Care Aged 13 & Older	1
Hospital (Non-Paid)	1
Independent Living Main Facilities Programs Aged 16 - 21	17
Independent Living Residential Units Aged 18 - 21	34
Juvenile Corrections	3
Medically Fragile & Mental Retardation	4
Not in Legal Placement - Awaiting Independent Living Placement	1
Not in Legal Placement - Awaiting Therapeutic Foster Home	2
Proctor Foster Care	7
Residential Treatment Facility	54
Specialized FC Teen Parent	1
Specialized Group Home	4
Teen Parents Program	20
Therapeutic Foster Family	13
Total # of Children to be Excluded	**172**
Source: OPPPS 09-30-2005 Placement Database (DB) constructed from FACES Reports CMT163, PLC002,& PLC010	

3. Keeping Siblings Together

(a) Challenges

Based on our study findings presented above, we summarize characteristics and circumstances of children who are placed separately from their siblings as follows:

- A large group of siblings
- A large age gap between siblings
- Children with special needs
- Older youth in a sibling group or older sibling groups
- Youth placed in independent living program or group homes
- Siblings groups of different gender

Our surveys and interviews with the Placement Administration staff indicate that one of the major reasons given for separating siblings is the lack of resource parents able and willing to take sibling groups. Many of our foster or adoptive parents are not willing to accept sibling groups; then workers feel that they have no other option than to separate the children. The lack of affordable, larger homes in the District impacts this situation. The Agency values recruiting foster and adoptive homes within the District and placing siblings together, yet the available, affordable housing stock in the District does not support families desiring to provide care for large sibling groups. Foster parent focus group participants stated, "Regulations regarding space create barriers to placement of sibling groups."

Another barrier identified by the Placement Administration staff is the practice in the recruitment and licensing offices of allowing foster parents to select an age range for the children they will accept into their homes. Placement Administration staff believe this discourages foster parents from accepting sibling groups for placement, especially if the age difference between siblings is large. In the last year, however, recruitment and licensing staff have encouraged foster parents to designate a broader age range so that they can be more available to meet placement requests.

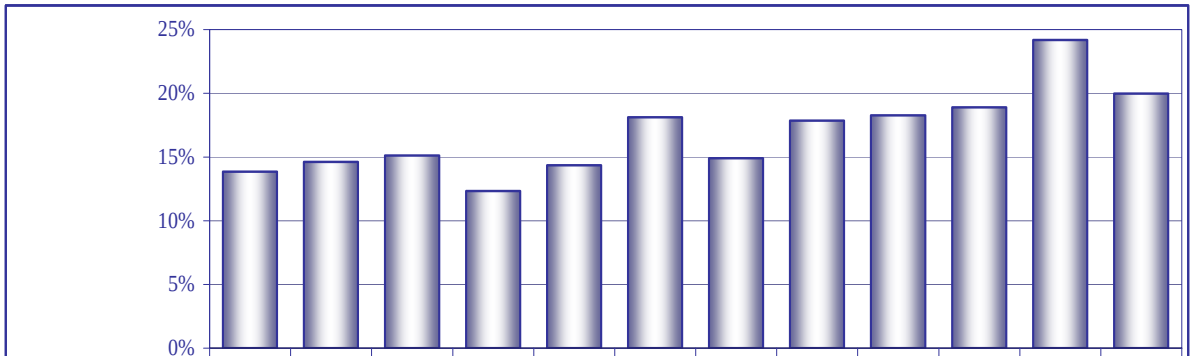
Some of the literature reviewed also suggests that if placed separately, the children will each receive the focused attention of their new parents, and this will help each develop to his or her highest potential (The Siblings Bond, NAIC, 2002).

(b) Visitations Between Separated Siblings

If the sibling groups are separated, both CFSA's Best Practice Implementation Plan and Placement policy encourage workers to support regular visitation among siblings. Study findings, however, reveal that sibling visitation is far below the required standard.[13]

[13] *According to the Implementation Plan, by June 30, 2005, 70% of children placed apart from their siblings will have at least twice monthly visitation with some or all of their siblings.*

Figure R. Twice Monthly Visitation Between Siblings Placed Apart (FY2005)



	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05
Number of Children	1163	1135	1158	1144	1122	1191	1154	1154	1105	1090	1050	1066
Twice Monthly Visit	13.8%	14.6%	15.1%	12.3%	14.3%	18.1%	14.9%	17.9%	18.3%	18.9%	24.2%	20.0%

Source: CFSA FACES Report CMT219

In the month of September 2005, only 20% of children had twice monthly visitations with their separated siblings (see Figure S). It is suspected that some visitation facilitation may not be documented in the system because it occurred without a social worker's assistance. The Agency's performance level is nonetheless alarmingly low.

Additional factors create barriers to implementing frequent visitations:

- If each child in the same sibling group has a different worker, it may be hard to coordinate visitation.
- If a child is placed in a residential treatment facility located outside the Washington Metro region, sibling visitation for this child is not likely to occur.

Separation of siblings also implies other visitation issues. When siblings are placed separately, both workers and birth parents have to make more than one visit. The inherent scheduling challenges of making visits to more than one placement will naturally reduce visitation rates.

(c) Overcoming Challenges

The most crucial needs for overcoming sibling placement challenges are recruiting and supporting resource families who are willing, able, and prepared to care for sibling groups. Special recruitment and training strategies may bring more sibling-friendly resources to the Agency. The following strategies have been useful in other jurisdictions:

- Use of sibling group photographs in information packages or posters;
- Introducing foster parents to the benefits of sibling placements and the importance of the sibling bond; and
- Training foster parents in use of coping skills in caring for sibling groups.
- Foster parents in the placement focus group suggested, "help in dealing with how to parent more than one child, how to deal with issues in a family full of children with other children watching."
- The Agency should also ensure that families, particularly kinship families receive all the financial support and subsidies to which they are entitled, especially through available flex funding.

- Through trainings and practice guidelines, the importance of sibling placements also needs to be emphasized to the agency staff, including placement specialists, recruitment units, caseworkers, supervisors and administrators. It should be incorporated into judicial trainings provided to attorneys, guardians ad litem, and judges as well.

It is important that siblings have the same worker, if possible. In our current case management system, older youth with the goal of alternative permanent living arrangements are referred to the Office of Youth Development, which may be contributing to the separation of siblings.

(d) More Frequent Visits

CFSA did not conduct a case study on the barriers to sibling visitation, but some literature suggests the following issues are challenges to establishing visits between separated siblings:

- One of the siblings may be sick.
- Children run away before a visit can happen.
- There may be resistance from the foster parents.
- Siblings may not be placed in close proximity.

(e) Other Recommended Strategies

The following strategies are recommended for addressing the special needs of siblings in care:

- Assign one worker for all siblings whenever possible.
- Develop case management teams.
- Adopt a family-centered rather than a child-centered approach.
- Document all of the reasons for and against separating the children.
- When sibling groups must be separated, develop concrete plans for sibling visitations.
- When children are placed separately, have older children participate in planning for younger ones.
- Place children within the same school district.
- Train and encourage foster parents to facilitate and maintain contacts and visitations among siblings.
- Ensure that siblings have all contact information for each sibling, including postal and email addresses.
- When distances keep siblings from visiting one another, encourage their frequent communication by phone, and/or letters/email.

G. Summary of Needs

It is notably troubling that CFSA staff and foster parents could not identify the broad range of support services available to foster youth and resource families. Despite CFSA's diligent efforts to expand and provide effective services, focus group participants and survey respondents still identified eight actions necessary to provide proper placement support:

1. Increase Placement Slots

Based on projections of placement needs, CFSA should marginally increase the number of traditional foster home, pre-adoptive home, and Independent Living Program slots in FY06. We anticipate that segments of the District foster care population requiring these services will marginally increase in FY06.

2. Promote Existing Placement Support Services

CFSA must educate staff, foster parents, and other stakeholders about the wide range of support services available and keep them informed about how to use these services. Monitoring will indicate whether social workers (and others) are drawing upon services regularly to support placements and decrease disruptions.

3. Develop and Improve Management of Available Resources

Staff raised the issue of appropriate placements for children/youth, particularly for special populations (teen parents, LGBTQ youth, and children/youth with behavioral/mental health issues). In addition, there is a growing number of youth who require frequent placement changes. This population needs immediate attention. Staff made several recommendations to provide for these needs:

- CFSA must develop and maintain a cadre of homes specifically for emergency placements.

- Foster and kinship parents must have access to training [and support] to prepare them for caring for rebellious teens and children/youth with behavioral/mental health issues.

- CFSA needs to manage therapeutic placements more efficiently so that children/youth do not remain unnecessarily in placements for extended periods of time. (This may require developing more local step-down options.)

- Emergency kinship licensing and placement issues with Maryland must be resolved. (The inability to place children/youth with available, appropriate kin in Maryland leaves CFSA struggling to find open—and appropriate—placement slots in the District's limited inventory. This is a bottleneck that undermines overall availability of resources and CFSA's ability to manage placement resources in the children's best interests.)

4. Increase Transportation Resources

The lack of sufficient transportation resources undermines a social worker's ability to visit children, youth, and families in line with best practice standards. It is especially important to note that transportation resources are necessary for family visits. Transportation issues also impact the ability of children, youth, and families to keep scheduled medical, dental, mental health, and other service and educational appointments. Both foster parents and CFSA staff suggest, however, that providing transportation is not sufficient to meet the need for youth to access medical care. Suggestions for on-site medical services for children in foster care reinforce the need for more creative solutions than just increasing the number of cars available to CFSA staff.

5. Develop Post-Permanency Services

Adoptive and kinship parents highlighted a particular need for post-adoption and guardianship services (respite, mental health, and follow-up case management services). They also expressed the need for continued support in caring for children/youth with special needs and difficult behaviors.

6. Improve Working Relationships

CFSA staff and foster parents emphasized the need for improved communication. Their working relationships must be built on mutual trust and respect. Similarly, CFSA staff highlighted the need for improved relationships between social workers and the court, and between social workers and AAGs. All of these professionals need to be able to hold each other accountable for quality service delivery, to respect professional differences, and to work together with consideration for the best interests of children and families.

7. Allocate Sufficient Time for Assessments and Streamline Referral Process

Social workers need time to complete early, thorough assessments of child/family needs to make "first placement/best placement" decisions, establish effective service plans, and implement appropriate services. At the same time, social workers want a streamlined referral process for evaluations and services through the Office of Clinical Practice.

8. Implement Strategies to Reduce Multiple Placements

Placement staff reported that a small segment of the foster care population moves frequently. These young people generally have high-end needs that quickly drain CFSA placement resources. CFSA needs a focused strategy for meeting and managing the service and placement needs of this group of youth to stop the revolving door of ineffective placements that hinder their well-being. ■

Domestic and Family Violence

IN THIS SECTION:

Chapter VI: Domestic and Family Violence

The population we work with . . . is very reluctant to . . . peel this onion of history on abuse and pain . . . .

--Domestic Violence Focus Group Participant, September 2005

According to the National Coalition Against Domestic Violence (NCADV), one in four women will experience domestic violence in her lifetime. Between 3.3 million and 10 million American children will witness domestic violence annually.

This chapter examines what we know about domestic violence, its impact on CFSA families, and the District's responses to this issue.[14]

[14] *CFSA recognizes and services families struggling with myriad variations of family violence. Although we are aware that male perpetrator to female victim is only one type of family violence, it is the primary focus of this Chapter. Male to female violence represents the majority of referrals that we receive for domestic violence services, per anecdotal reports.*

A. Literature Review and Local Statistics

1. Overview of Domestic Violence (DV)

Clear definitions of domestic violence and children's exposure to it must be determined in order to estimate accurately the prevalence of the exposure, as well as to determine appropriate methods that verify exposure has actually taken place (Fantuzzo & Mohr, 1999; Rossman *et al.*, 1999).[15] "Clear definitions," however, vary among researchers. Some argue that exposure to domestic violence means physically seeing the violence as it occurs. Others claim seeing the after-effects of the violence (e.g., bruises, scratches) warrants a definition of exposure. For this study, we used broad definitions of domestic violence (verbal/emotional, physical and/or sexual) and exposure to domestic violence (from physically witnessing and/or hearing the violence as it occurs to seeing the after-effects).

Many studies consistently indicate that exposure has negative effects on various areas of child development (Edleson, 1999; Fantuzzo & Mohr, 1999; Health Canada, 1996; Osofsky, 1999). Of particular concern is the risk of physical violence directed toward a child who witnesses domestic violence. Osofsky's 1999 study found that children who witnessed domestic violence were 15 times more likely to be physically abused and neglected than the national average.

Research has also identified clear associations between exposure to domestic violence and

[15] *All references are cited in Appendix B.*

emotional and behavioral difficulties (Edleson, 1998; Fantuzzo & Mohr, 1999; Osofsky, 1999). Excessive irritability, sleep disturbances, and emotional distress are documented effects (Zeanah & Scheeringa, 1996; Bell, 1995; and Drell *et al*., 1993 in Osofsky, 1999). Exposure to domestic violence at a young age interferes with normal development of trust. Exposure can further disrupt natural exploratory behaviors that form the basis for child autonomy (Garbarino *et al*., 1992; Leavitt & Fox, 1993; and Osofsky & Fenichel, 1993 in Osofsky, 1999). Additional studies of school-age children exposed to domestic violence show negative effects in overall functioning, attitudes, social competence, and school performance (Garbarino *et al*., 1992 and Leavitt & Fox, 1993 in Osofsky, 1999). These negative effects continue to surface in studies on adolescents exposed to domestic violence at an earlier age. These studies identified high levels of aggression, anxiety and increased behavioral problems as a result of exposure, compared to children from non-violent families (Loeber *et al*., 1993 in Osofsky, 1999).

Domestic violence greatly compromises the parenting potential of both mothers and fathers. Its effects influence the family even when the perpetrator is no longer in the home or in contact with the family. It is especially crucial to consider the safety of family members when considering whether later interactions between the family and the perpetrator are appropriate. The female head of household often struggles alone with these challenges, particularly the challenges associated with their children's coping mechanisms.

2. Domestic Violence and Child Welfare

Increased research on domestic violence and how it intersects with child welfare provides a basis for understanding professional response, impact on children, and changes in parenting potentials. Several patterns emerge. For example, women in general, but particularly women of color, frequently hesitate to reveal domestic violence to child welfare workers for fear of having their children removed from the home. These fears are justified as inequity of removals (more African American and Latino children) is well documented. In one study, many clients reported domestic violence to their child welfare worker only during a 90-day case review, as opposed to revealing this information at intake or during a 30-day case review. One explanation for the delay is the level of comfort the client feels after a certain amount of time interacting with the social worker.

Despite the serious affects of domestic violence on child development, including mental health consequences, health issues, and/or behavioral problems (Allen, *et al*., 2003; Lehmann, 2000; Davis & Carlson, 1987), sufficient evidence supports keeping the child in the home. Additional trauma can occur when the child is subsequently removed as a result of domestic violence (Chipungu & Bent-Goodley, 2004). Furthermore, women are often more willing to work with child welfare professionals when the child is still in the home (Kopels & Sheridan, 2002), often using strategies to protect the children even within the context of the violence (Mohr, Fantuzzo & Abdul-Kahir, 2001).

(a) Intervention/Prevention

The majority of child welfare agencies lack specific assessments, procedures, and/or services for addressing domestic violence (Carter *et al*., 1999). As a result of these systemic weaknesses, child welfare intervention does not necessarily ensure a positive outcome either for the child or the battered parent. In fact, the potential for more intrusive measures increases, such as out-of-home placement. The child welfare professional must then ascertain what supports are in place for the child when removed from his/her home. In addition, does the system offer the mother a safe alternative to her present situation? Is leaving her home required for her to be reunited with the child? Are there services to help the woman recover from the combined trauma of violence and

separation from her child? Does the woman have support services to help her find new housing, income, and/or training for improved parenting skills? (Carter *et al.*, 1999)

Unless the child welfare system is equipped to support the non-offending parent, reporting the domestic violence to child protective services may not be an effective intervention strategy. It may be more fruitful to look to other community-based agencies. Many women's shelters, for example, incorporate programs for children who witness violence. They offer services to meet the needs both of mother and child while simultaneously ensuring continued safety without child welfare intervention. Such community-based resources and agencies traditionally provide support and resources to empower their clients and to advocate on their behalf.

Determining how best to respond to the issue of children's exposure to domestic violence requires systematic documentation of the numbers of children who are actually exposed. Research should also identify factors that will protect against potential negative effects of exposure, not just identifying factors that may increase risk of exposure.

A number of critical protective factors may help children cope with the presence of violence in their lives. Masten *et al.* (1999), Rutter (1994) and Werner (1994) describe the following three components necessary for a child's healthy development: a caring adult, a community safe haven, and the child's own internal resources (Osofsky, 1999). Maran and Cohen (1993) also highlight the importance of having a caring adult. In fact, a strong relationship with a caring, positive adult, generally a parent, is the most important protective resource a child can have for coping effectively with exposure to violence (Osofsky, 1999). This factor reinforces the importance of serving and supporting battered mothers, particularly to help them meet the needs of their children while also addressing their own concerns.

(b) Domestic Violence and Other Jurisdictions

Across the nation, a broad range of interventions is emerging to meet the needs of children exposed to domestic violence. Among these are school-based programs, educational initiatives for professionals, and therapeutic interventions. Other examples include combined programmatic strategies within state agencies (Aron & Olson, 1997).

California

- Co-location of advocates for domestic violence consultation and supportive services in child welfare offices
- Implementation of family court models that address overlapping domestic violence and child abuse cases
-
- In 1994, San Diego's Children's Services Bureau (the county child welfare agency) and the Adult Probation Department established the Family Violence Project, a separate administrative unit to handle all cases active in both departments. A two-person social worker-probation officer team manages the cases in the unit.

Massachusetts[16]

- Development of cross-system protocols and partnerships to ensure coordinated services and responses to families
-
- The Massachusetts Department of Social Services (DSS) developed and adopted a domestic violence protocol in 1993. It established a Domestic Violence Unit consisting of in-house specialists who assist DSS social workers with specific cases and provide them with extensive, statewide training. This domestic violence initiative concentrates also on creation of those services that strengthen the potential for the child welfare system to achieve

[16] *Domestic Violence Unit, Massachusetts Department of Social Services, Boston, Massachusetts, 1996.* http://aspe.hhs.gov/hsp/cyp/dv/pt4.htm

best practices. Specialists serve battered women directly as they model best practices for DSS social workers.

Michigan

- Creation of Domestic Violence Units within child welfare agencies
-
- Michigan incorporated a domestic violence division into its family preservation program, Families First, in 1993. In conjunction with the Family Violence Prevention Fund, the state developed and instituted the training curriculum for family preservation workers. Michigan also created a program to provide family preservation services to at-risk families living in battered women's shelters.

Oregon

- Cross training for domestic violence and child welfare advocates
-
- The Office for Services to Children and Families (SCF) initiated efforts to change case practice throughout the state by cross-training child protection workers and domestic violence workers on the relationship between the two forms of abuse. Oregon also ran pilot programs that placed domestic violence advocates in two local SCF offices.

(c) Domestic Violence Prevalence in the District

The District does not have a central government body that specifically tracks domestic violence-related statistics. Agencies and organizations serving domestic violence victims individually maintain databases. The following statistics are provided by the DC Coalition Against Domestic Violence (DCCADV):

- In calendar year 2004, the Domestic Violence Intake Center (DVIC) at the DC Superior Court served more than 6,000 victims. DVIC's satellite office at Greater Southeast Community Hospital served an additional 1,000.
- Approximately 30 to 40 domestic violence victims seek a protection order from DC Superior Court every weekday.
- The District has only 48 designated emergency beds for domestic violence victims.

The Metropolitan Police Department (MPD) also tracks current trends via domestic violence-related phone calls received during the calendar year. These calls increased steadily from 2000 to 2003 (Table 20), including calls for service, calls reporting domestic violence and/or domestic violence assault, and domestic violence-related incidents. Of the 7,449 unique addresses making calls for domestic violence in 2004, MPD reported that almost 13% made three or more calls.

Table 18: Domestic Violence-Related Calls to MPD

2000	6,269
2001	7,141
2002	9.045
2003	10,215

Source: MPDC Domestic Violence Fact Sheet, 2005

(d) Referrals within CFSA

CFSA's Office of Clinical Practice has a Domestic Violence Specialist (DVS) who acts as a point person for social workers who suspect or know a client is facing family violence. The DVS completes assessments and referrals for domestic violence services and conducts staff training on domestic violence. She also supports social workers who have clients struggling with domestic violence.

When social workers identify cases of domestic violence, they must refer the client to the DVS and prepare the client to expect a call from the DVS. This preparation helps the

client understand the role of the DVS in advance and increases receptivity to the call. During the initial referral, the DVS will get as much background information as possible from the social worker. She tries to contact the client within 24 hours of referral. The DVS may also receive referrals from group homes, the Collaboratives, Family Team Meetings (FTMs), and administrations throughout CFSA.

Over the past fiscal year, the DVS noted a significant increase in referrals from workers, particularly from the CPS Administration. From FY04 to FY05, referrals increased by 90%, in large part due to the rise in staff awareness and the influence of a Child Protection Services (CPS) Administrator with a strong background in domestic violence.

Table 19: Referrals to CFSA Domestic Violence Specialist

FY04	93
FY05	178

Source: CFSA Office of Clinical Practice

The DVS also said that during transfer staffings, she had seen an increasing number of cases in which the CPS social worker made a referral and/or noted that the ongoing social worker needed also to make a referral.

The DVS indicated she still receives calls from workers who only recently learned she is on staff. This lack of inter-office communication highlights the need for continued outreach to staff, review of internal information dissemination processes, and training on the referral process.

B. CFSA Clients and Domestic Violence

More than 58% of CFSA social workers, supervisors and program managers (77 of 131) identified domestic/family violence as one of the greatest challenges for birth parents prior to entering the child welfare system (*2005 Needs Assessment Worker Survey*). Focus group participants provided some additional, detailed information in regard to the secrecy that surrounds domestic violence and the subsequent difficulty of discerning prevalence when clients fear revealing their experience to a child welfare worker. The majority of participants agreed that domestic violence is present in approximately 25-50% of child welfare cases. They also indicated that many women and children have a limited array of coping strategies to deal either with the immediate or long-term consequences of domestic violence.

Research from the *2005 Needs Assessment* revealed seven prominent barriers that prevent clients from seeking and/or obtaining help for domestic violence:

- Intergenerational Abuse
- Fear of Being Stigmatized
- Fear of Child Removal
- Fear of Deportation
- Limited Coping Skills
- Lack of Specialized Resources
- Dual Diagnosis

1. Intergenerational Abuse

About half (48%) of CFSA social worker survey respondents reported that many families have already experienced domestic/family violence in relationships/living situations before seeking services. In addition, 44% of respondents indicated their clients have a family history of domestic/family violence. Focus group participants indicated their caseloads include many DV victims who have observed abuse in their families of origin and are acting out learned behavior. Social workers further stated that violence during teen dating is influenced and reinforced when teen boys witness women experiencing and/or tolerating abuse. Male teens often see abuse as "acceptable" because they view violence as a measure of masculinity.

2. Fear of Being Stigmatized

Survey participants emphasized that women who experience domestic violence often avoid seeking help because they are afraid of being "stigmatized as crazy" or being re-traumatized during therapy.

3. Fear of Child Removal

Social workers reported that many women fear CFSA will remove their children if they admit to violence in the home.

4. Fear of Deportation

For immigrants, language can be a major barrier to accessing services. Over a third (35%) of social worker respondents reported this barrier, along with client fear that getting involved in the child welfare system will lead to deportation.

5. Limited Coping Skills

Many women and children in the child welfare system lack appropriate skills to offset stress. They have limited coping strategies to deal with the immediate and long-term consequences of abuse. Social workers described children as struggling with recurring memories of abuse and trying to make sense of the terror experienced after exposure to domestic violence. Some participants talked about the perpetrator as terrorizing the entire family. The DVS noted that safety planning is critical with these families so that in the midst of crisis, they can draw on pre-established options to ensure their safety.

6. Lack of Specialized Resources

Domestic violence professionals indicated they have access to an array of services for families, such as counseling, legal services, financial assistance, housing, safety planning, and emergency services. CFSA focus group participants, however, repeatedly said the District lacked resources—specifically, shelter accessibility, emergency housing, and/or immediately accessible funds. Some focus group participants reported putting hotel fees on their personal credit cards to get clients to safe settings because obtaining CFSA flex funds is too difficult. The CFSA DVS also highlighted slow access to emergency funds as well as the lack of available beds in shelters for domestic violence victims. Some participants identified a lack of programs that will take women with male children over age 12 or 13, which limits client options if they do not wish to separate from their children.

CFSA refers domestic violence clients to two shelters in the District: House of Ruth (which can accommodate approximately six families) and My Sister's Place (which has space for approximately 15 to 20 families, as well as space for women without children). Other shelters in the broader metropolitan area will take District residents, but only if they have multiple beds available.

7. Dual Diagnosis

Participants stated that individuals and families struggling with the long-term effects of domestic violence are also experiencing the stressful impact of the associated trauma on their mental health.

I would say 90 percent of my clients who are dually diagnosed have already experienced domestic violence. They were on drugs, they had pimps, you know what I'm saying? They're sick; they need medication. They don't realize that they're dually diagnosed, and a lot of dually diagnosed people are associated with domestic violence.—DV Focus Group Participant, September 2005

C. Summary of Needs

Fully 62% of CFSA social worker survey respondents identified treatment for domestic/family violence as a primary need for birth parents to secure reunification. The worker survey also asked what services CFSA could improve to assist the families experiencing domestic violence. Responses included the following:

- Intensive and ongoing training for staff (line workers, attorneys, etc)
- Developing relationships with advocates for DV victims in the community, including prevention work
- Committing funds and resources to transitional housing
- Creating a Domestic Violence Unit to merge child welfare and domestic violence services from Intake to case closure
- Increasing education for service providers to respond more effectively to families affected by domestic violence
- Improving the legal/judicial system

The survey also asked social workers to identify general areas in need of improvement to assist these families. Four categories of recommendations were cited:

- Improve methods of identifying domestic violence
- Increase staff and resources
- Increase awareness and offer more training
- Build cultural competence

1. Improve Methods of Identifying Domestic Violence

While the social worker might suspect the abuse, it is difficult to discern whether it is actually occurring due to issues of denial and secrecy. One participant described victims as being very "guarded". Participants stressed the need for enhanced tools to assess domestic violence. They felt strongly that a thorough assessment requires additional resources, particularly because women often hide the abuse during the data gathering process which skews the results.

2. Increase Staff and Resources

With domestic violence, it is important to ensure the safety both of mother and children, even if that means separating the family temporarily. Some cases are more difficult, particularly when CFSA removes the children from the home but their mother remains in danger. Only one program in the District, My Sister's Place, takes unattached women.

The DVS stressed the importance of permanent resources to support women for the longer term as they strive to achieve self-sufficiency after leaving their abusive environment. If clients base their decision to leave an abusive environment on the existence of temporary assistance, they may be more vulnerable once that assistance is exhausted. The need to identify resources for these women and their families still exists afterwards.

The focus groups stressed that domestic violence "changes the family environment," undermining the well being of children and battered parents alike. CFSA may need to turn to resources outside the scope of child welfare to address these changes. For example, when children are placed in new schools, social workers inevitably must share information with those school officials who are qualified help the child adjust. For children, it is challenging to make new friends and learn a new route to school.

[J]ust making sure that the guidance counselors of the children's classes know what the children have faced and that they have someone, the social workers are working with the family very closely to give them necessary support and just for them to build new resources in the community that they have moved to. Just whatever it takes, making sure they open all doors to communicating with them, and just that they are welcome at any time to come by and talk when they have to talk.—DV Focus Group Participant, September 2005

Focus group participants also cited the need for increased access to shelters, particularly after 5 p.m. on Fridays. They emphasized the need to secure slots for CFSA clients in existing shelters in addition to exploring the possibility of CFSA creating some form of housing for domestic violence survivors and their children. They emphasized CFSA has no emergency housing to provide a safe, secure location for clients.

The DVS indicated she has tried to encourage social workers to go back to their units to access CFSA funds to cover the cost of a hotel or emergency housing when all other options fail. Focus group participants responded that bureaucratic systems do not function quickly in emergencies. They stressed the need to have money readily available and a willingness to work with businesses outside the list of contractors when needs arise.

When it comes to environmental adaptation, I think they need to be able to make monies readily available to change locks on the clients' doors and other things. . . .—DV Focus Group Participant, September 2005

Supporting focus group participants' need for quick access to funds and resources, the DVS highlighted the critical need for ready money to cover emergency accommodations as well as to secure or hold designated slots for CFSA referrals to safe houses. Some participants suggested providing some clients with cell phones that can only call 911.

Focus group participants voiced a need for CFSA to share up-to-date resource tip sheets with staff regularly. They suggested having buttons and stickers to share immediately with clients. They asked for resource information pamphlets that they could distribute to clients while in the field. This information should include bilingual services and should be translated accordingly. (CFSA Clinical Practice recently created a brochure on teen dating violence that they hope social workers will distribute to parents of teens.)

I've been asking to get a second person who is bilingual and they're telling me to use the hotline. I don't think it's fair to have somebody talking on the hotline, translating, when you have a client there who is in crisis and we're trying to work through this piece.—DV Focus Group Participant, September 2005

Participants discussed loss of subsidized housing when a client goes into a shelter. This provision often results in women staying in abusive relationships. Without a clear understanding of the process, social workers cannot provide women with accurate information or options for alternate housing.

The DVS raised the issue of resources for perpetrators of domestic violence. Typically, CFSA makes referrals (some court-ordered) to batterers' groups. These groups appear to be the best intervention, and approximately four agencies in the District offer this service. Unlike programs for victims, all batterer services have a cost attached. When CFSA is involved, we assume the cost because the majority of batterers deny having funds to pay for the group. The DVS reported that she has seen only one case where the batterer was open to paying for the group himself.

3. Increase Awareness and Offer More Training

Focus group participants emphasized the need for increased education in the community. They mentioned that many women and adolescents do not know they are experiencing domestic violence. Rather, they see it as "just fighting" or "being in an argument." Consequently the abuse may become very severe before victims report it, as opposed to reporting the circumstances during earlier or less dangerous stages of violence.

The DVS talked about the need for ongoing education among judges, attorneys, and social workers. In some instances, a judge has ordered family or couples counseling between a victim of domestic violence and the perpetrator. If the social worker or attorney is unable to articulate why the joint counseling will not be therapeutic for the victim, the DVS can work with AAGs and social workers to get the order vacated. Once the judge receives justification that the court order is not in the best interest of the client, it is not difficult to get the order vacated.

Participants also indicated the need for sensitivity training on domestic violence. They emphasized that the training should include practical advice about managing challenges and identifying nuances inherent in this issue.

Participants emphasized a need for improved internal communication that is up to date with current domestic violence literature. It could be included in training or memoranda.

Focus group participants requested interdisciplinary training, suggesting that it occur on an ongoing basis with different topics covering the various ranges and levels of domestic violence. This type of training is already available through the Mayor's Advisory Committee on Child Abuse & Neglect (MACCAN). As part of the Children's Justice Act Grant from the U.S. Department of Health and Human Services, MACCAN provides bi-annual interdisciplinary trainings to child welfare and domestic violence professionals. Each discipline hosts annual training for the other. For example, child welfare professionals have educated domestic violence workers about child welfare issues and practices. In turn, domestic violence professionals have trained child welfare social workers.

Social workers expressed a concern regarding their safety. They wondered what safety information or supports are available to staff and whether counseling was available. The DVS raised this issue as well. Social workers may be especially at risk in cases where domestic violence is undeniably present and the batterer is still in the home or able to enter it. The DVS suggested increasing collaboration between CFSA and the Metropolitan Police Department (MPD) in hopes that officers be able to respond immediately to a request to accompany social workers to a home where domestic violence is reported. The DVS indicated that current MPD response is sometimes delayed as a result of other departmental demands or criminal activities. Social workers then go without police backup, which is not safe.

The DVS indicated that whenever possible, she meets clients in a neutral location. This can be difficult when clients do not have financial means or access to transportation to get to the meeting place.

4. Build Cultural Competence

Participants suggested exploring culturally competent expressions for terms such as "domestic violence" and "therapy". The DVS added that social workers need improved sensitivity training in regard to their cultural competence when working with families where domestic violence is present. In addition to sensitivity training, participants emphasized the need for culturally competent mental health and domestic violence services. One participant shared that a client chose to stay in an abusive relationship instead of going to a shelter because no one there spoke Spanish, and she was extraordinarily uncomfortable and intimidated.

[M]y experience with African Americans and Africans who don't readily go to seek help is really because, culturally, they are used to going to family members and extended relatives to get supports and would open more to their traditional rulers and friends and families for that help.--DV Focus Group Participant, September 2005 ■

Trauma and Community Violence

IN THIS SECTION:

Chapter VII: Trauma and Community Violence

Because I work in therapeutic foster care, . . . my greatest focus and concern is finding appropriate mental health care for the children who are wards of the city. There are not enough therapists trained in trauma based syndromes, Post-Traumatic Stress Disorder(PTSD), Dissociative Identity Disorder (DID), Dissociative Symptoms.—Stakeholder, Stakeholder Needs Assessment Survey, 2005.

Exposure to physical violence (e.g., assault, rape, gun violence, etc.), places individuals at risk of developing psychological trauma such as Post-Traumatic Stress Disorder (PTSD), depression, anger, and/or anxiety (Flannery & Quinn-Leering, 2000; Glodich, 1998).

The community violence assessment is CFSA's initial examination of the relationship between exposure to violence and strategies that children and adolescents in the District employ to cope with psychological trauma. It also explores our current capacity to identify and serve clients suffering from PTSD and the effects of trauma.

CFSA surveyed 94 birth parents and conducted two focus groups with foster youth (age 16 and older) to collect data relevant to the District. To date, we have been unable to determine how many of our clients have witnessed violence or been victims of incidents unrelated to their current child protection case. Hence, this examination advances only our preliminary understanding of children's needs as they enter care.

A. Literature Review

1. Impact of Exposure to Violence on Children

Children have long been exposed to violence through the media and in their communities. The extent of a child's exposure to violence may vary, however. Some children may experience "chronic community violence." Others may be exposed to violence in the home (Osofsky, 1999). Removal from the home and placement in foster care may exacerbate the impact of child exposure to community and/or family violence. Previous studies have shown that violence-exposed children are prone to aggressive outbursts, heightened fear and anxiety, regression and depression, and difficulties with concentration and school performance (Oravecz, 2004; Barnett, Miller-Perrin & Perrin, 1997; Cichetti & Lynch, 1993; Osofsky *et al.*, 1993).

PTSD can affect children of all ages. Infants and toddlers with PTSD display disorganized or agitated behavior and may become withdrawn, fearful, or aggressive. Adolescents experience nightmares and intrusive thoughts about traumatic events. They may become easily startled or avoid reminders of the trauma. Other traumatic reactions may include feeling depressed, angry, fearful, alienated, or betrayed. Some young people may experience suicidal thoughts and feel they will not reach adulthood. These reactions are common among adolescents chronically exposed to community violence. Other trauma-related reactions may include lowered self-esteem, learning difficulties, increased risky behaviors such as running away, drug or alcohol use, suicide attempts, or inappropriate sexual activities. Risks generally increase with the severity of

the violence and continued proximity to community violence.

2. Impact of Exposure to Violence on Adults

Research with adults demonstrates clear relations between exposure to interpersonal violence and PTSD. For instance, Resnick and others (2003) noted that interpersonal violence (e.g., rape, physical assault) increased risk of PTSD relative to other potentially traumatic events (e.g., disasters, accidents). In addition, interpersonal violence may be linked to other outcomes such as depression and substance abuse (Kilpatrick et al., 2003).

The Northwest Foster Care Alumni Study (2005), which included interviews with 479 foster care alumni ages 20 to 33, reported several surprising findings. Alumni of foster care programs had rates of PTSD *twice* that of U.S. war veterans and *six times higher* than the general American public (25.2% compared to 4%). In addition, 30% of Northwest Alumni had lifetime symptoms of PTSD compared to 6.9% of the general public—more than a four-fold difference. The rate of recovery from PTSD was much lower for Northwest Alumni. Only 15.9% of affected foster care alumni versus 41.9% of the affected general public were recovering from PTSD. The study concluded that PTSD, along with depression and social phobia, may be the most significant mental health condition of those exiting the foster care system.

3. Community Trauma and Violence in the District

Although District crime statistics declined in 2004, the city continues to have a serious crime problem, especially the troubling increase in juvenile homicides involving firearms. Auto theft and armed robbery are ongoing crimes plaguing the District but ones which have far-reaching effects. A significant number of perpetrators use stolen autos to commit other crimes, some of which have resulted in the death of innocent people.

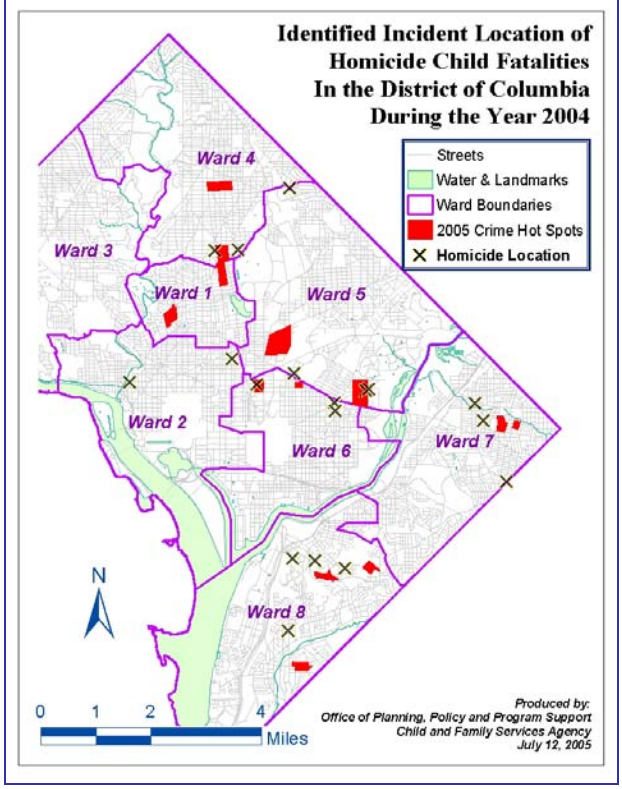
Gun Violence

In 2004, CFSA reviewed 21 juvenile homicides that did not involve abuse from a parent or guardian. Nineteen (19) of these homicides were due to gunshots, and two were due to vehicular homicide.

Crime Hot Spots

Based on an analysis of violent crime statistics from the Metropolitan Police Department (MPD) for 2004, the Deputy Mayor's Neighborhood Services Office identified 12 District crime "hot spots" in early 2005. Six months later, CFSA's Child Fatality Report (June 2005) identified 25 District children known to CFSA who were victims of homicide in FY04. Figure T shows the identified incident locations for 18 of these 25 homicides. (Six of the child homicides occurred outside the District; the exact location of the seventh child homicide could not be identified.)

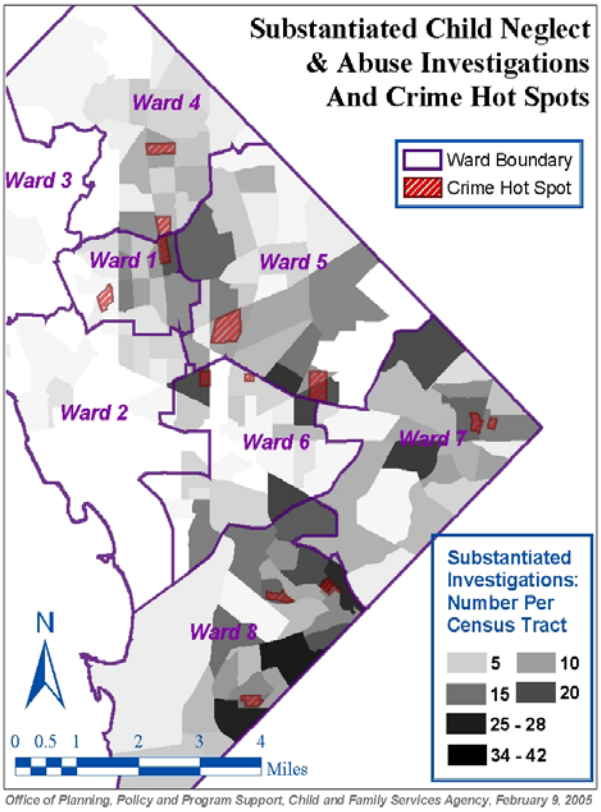
Figure S: Geographic Location of Child Fatalities in the District of Columbia



As shown in Figure U, the majority of child fatality incidents occurred inside the crime hot

spots or in their neighboring communities. The highest number of homicides (4) took place in Ward 8. Six homicides occurred inside or near crime hot spots on the borders of Wards 5 and 6. (More than half of all CFSA substantiated child abuse/neglect reports come from Wards 7 and 8.)

Figure T: Crime Hot Spots and Substantiated Child Abuse & Neglect Cases



Office of Planning, Policy and Program Support, Child and Family Services Agency, February 9, 2005

While 18 child homicides is not a large enough sample to build concrete conclusions, it is clear that children who enter the District's foster care system are exposed to increasing amounts of youth violence.

CFSA also looked at proximity of crime hot spots to locations of substantiated abuse/neglect reports. In FY04, CFSA substantiated 1,257 child abuse/neglect reports. Figure U shows that while some areas with high numbers of substantiations are adjacent to crime hot spots, most are not.

B. Violence-Related Experiences

The majority of stakeholders (over 70%) felt that exposure to violence should be one of the top three priorities for CFSA (along with drug/substance abuse and domestic violence).

No one is trained in trauma-based symptomology, and the children in care experience those symptoms in spades.—Community Stakeholder, Oct. 2005

1. Experiences of Birth Parents

Women responding to the birth parent survey had suffered an average number of two traumatic events. Forty-two percent had experienced two or more traumas, 34% had experienced one trauma, and 22% had experienced no trauma. Of those who had experienced multiple traumatic events, almost 16% indicated they were most traumatized by sexual assault from someone they knew (Table 22).

Table 20: Most Traumatic Event According to Female Birth Parent Victims of Multiple Traumas

Sexual assault by acquaintance	9 (15.8%)
Life-threatening illness	7 (12.3%)
Sexual assault by stranger	6 (10.5%)
Physical assault by acquaintance	6 (10.5%)
Physical assault by stranger	5 (08.8%)
Imprisonment	3 (05.3%)
Accident	3 (05.3%)
Statutory rape	1 (01.8%)
Disaster	1 (01.8%)
Other trauma	16 (28.1%)
Total	57 (100.0%)

Of those women responding to the Post-Traumatic Stress Disorder (PTSD) measure, nearly 80% had experienced at least one traumatic event. These included sexual assault, serious accident, imprisonment, life-threatening illness, and assault (Table 22).

Women who suffered with PTSD reported having been threatened by a perpetrator with serious injury, witnessed serious injury, or been victims of serious injury. In other cases

(or in addition to all of the above), these women had been threatened with death. Such events lead the victim to intense feelings of fear, helplessness, and/or horror. The levels of trauma these birth parents reported greatly increased their vulnerability and decreased their sense of security and ability to care for their children.

Table 21: Birth Parent Reports of PTSD Severity	
Mild	24 (43.6%)
Moderate	20 (36.4%)
Moderate to Severe	11 (20.0%)
Total	55 (100%)
Twenty-nine parents did not respond.	

2. Extent of Trauma and Violence Exposure of CFSA Youth

My neighborhood is noisy and violent. Man, you can hear gunshots all night.—CFSA Youth, Oct. 2005

Youth who participated in the focus groups on violence reported a constant potential for violence in their communities. About half the participating youth felt that their neighborhoods are dangerous. Responses ranged, however, from youth identifying their neighborhoods as "perfect," to "death traps." A majority of youth noted the high visibility of the drug culture and its potential for inciting violence.

I see a lot of drug selling.—CFSA Youth, Oct. 2005

Two participants were involved with the criminal justice system (a female who needed to leave early to see her parole officer and a male whose friend was murdered by gunfire the previous month).

While many youth expressed general fear and anxiety related to violence in their community, they also made comments that suggested they have been desensitized to its prevalence. One female youth mentioned that she does not stay around her local recreational facility because she might be shot.

When youth were asked what they did to refrain from being victimized in their neighborhoods, the two most common responses were "stay out of it" and not "snitch on others" in the neighborhood.

C. Summary of Needs

1. Increase Knowledge

According to CFSA's Child Protective Services Administrator, approximately one-third of clients who become known to the agency via the hotline are victims of physical abuse. Currently, CFSA social workers are not trained to identify signs of PTSD.

According to CFSA's Deputy Director for Clinical Practice, CFSA has a strategy in place for referring children to DC KIDS for trauma assessments. CFSA also plans to hire trauma specialists in the future. These specialists will help train social workers to gauge the effects of Post-Traumatic Stress Disorder and other ills resulting from violence within the community. They will also help children to cope with the trauma of removal from home.

2. Establish Positive Peer Groups for Youth

Respondents suggested promoting positive peer groups as an alternative to gangs or negative peer groups that may lead to criminal activity.

3. Incorporate Anti-violence Components in Youth Programs

Youth participants agreed that age-appropriate youth development programs should include anti-violence components. Identification, prevention and response to trauma are essential next steps for CFSA to ensure best practices for youth in foster care. ■

HIV/AIDS

IN THIS SECTION:

Chapter VIII: HIV/AIDS

[The foster parent] didn't even know what universal precautions were. They talked to her about that in the hospital, but prior to that, it wasn't discussed in foster parent training. She is a wonderful foster parent. I think she just didn't know.—CFSA Social Worker, Sept. 2005

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) have reached epidemic proportions in the District. The *2005 Needs Assessment* is CFSA's first attempt to ascertain the impact of HIV/AIDS on the city's child welfare system and to identify service needs and gaps. We addressed three research questions:

1. What is the scope of the HIV/AIDS epidemic among children in CFSA foster care? How many CFSA children are affected by HIV/AIDS? ("Affected" means either the child is infected or has a parent or sibling who is infected.)
2. What are the primary needs of CFSA children and families who are impacted by HIV/AIDS?
3. What gaps/barriers/challenges exist for CFSA workers who serve children affected by HIV/AIDS on their caseload?

In addition to our current assessment, CFSA plans to host a roundtable forum in 2006 that will bring together academicians, practitioners, community leaders, policy-makers, and advocates to discuss issues regarding HIV/AIDS in child welfare. We are committed to developing a clearer understanding of and better responses to HIV/AIDS issues of children and families we serve.

A. Literature Review

Identification of HIV-positive children is critical to addressing their medical needs in foster care (Simms, Dubowitz & Szilagyi, 2000). It is important to obtain information about HIV exposure status, particularly for infants born to women with a history of injection drug abuse and/or multiple partners. Approximately 7,000 HIV-infected women, most of whom were infected through heterosexual contact or as a consequence of illicit drug use, give birth annually in the United States (Centers for Disease Control [CDC], 1994).

About two-thirds of children who test HIV positive at birth through conventional testing methods will test negative before age 2. Thus, HIV testing is important both for prevention and treatment.

1. Overview of Methods

Due to the sensitive nature of the subject matter, the data collection process was subject to limitations. We were unable to collect data directly from HIV/AIDS infected/affected children, youth, and families involved with CFSA. People infected/affected by HIV/AIDS tend not to self-identify for participation in a focus group or survey. Moreover, CFSA currently lacks a procedure or protocol for identifying every HIV/AIDS infected/affected child receiving services. CFSA cannot gather data on its HIV/AIDS population from the FACES system. Unless a child or client self-

identifies, CFSA's means of targeting study participants is limited.

We did examine data collected from a variety of sources. These included the General Needs Assessment Social Worker Survey, a special HIV survey designed only for those CFSA social workers who have a client on their caseload affected by HIV/AIDS, an HIV/AIDS focus group with CFSA social workers, stakeholder telephone interviews, and the recent report on CFSA's *Staff HIV/AIDS Training Needs Assessment* written by Mosaica: The Center for Nonprofit Development and Pluralism.

As part of the Family Ties Project, Mosaica conducted a systematic assessment of CFSA's current HIV policy and training needs. It also included a combination of CFSA staff surveys, a focus group with foster parents, and interviews. A total of 113 CFSA staff and providers participated in the study.

2. National HIV/AIDS Epidemic

Nearly 1.5 million people in the U.S. have been infected with HIV, including more than one-half million who have already died. Although advances in HIV/AIDS treatment have substantially reduced AIDS-related morbidity and mortality rates, much remains to be accomplished. An estimated 42% to 59% of people living with HIV/AIDS are not receiving the necessary treatment and care (Kaiser Family Foundation, 2004).

Disproportionate Impact on Minority Populations

Racial and ethnic minorities have been disproportionately affected by HIV/AIDS. For example, the African Americans represent an estimated 12% of the U.S. population but in 2003, the African American population accounted for 50% of new AIDS diagnoses. Kaiser (2005) reports the estimated AIDS prevalence among African Americans, in particular, increased by 37% between 1999 and 2003 compared to a 22% increase among whites. The AIDS case rate per 100,000 African Americans was 95 times that of whites in 2003 (Kaiser Family Foundation, 2004).

The Latino population represents an estimated 14% of the U.S. population, but in 2003, Latinos accounted for 20% of new AIDS diagnoses. African Americans and Latinos together now represent the majority of new AIDS cases, cases of Americans living with AIDS, and deaths among persons with AIDS in the U.S. They are followed by American Indian/Alaska Natives, whites, and Asian Pacific Islanders.

Women of Color

Women of color are particularly affected by HIV/AIDS. African American women account for 64% of estimated new HIV infections among women, and Latinas account for 18%. In 2001, HIV was the leading cause of death among African American women between ages 25 and 34 (Kaiser Family Foundation, 2005).

Risky Behaviors among Youth

Various risky behaviors put youth and young adults (ages 10 to 29) at higher risk for HIV and other sexually transmitted diseases (STDs) than other age groups. More than two-thirds (68%) of the estimated new AIDS diagnoses among women are due to heterosexual contact and 29% to injection drug use. At least one-half of all new HIV infections are estimated to be among those under age 25. Most young people are infected through sexual encounters.

As with the adult population, young females and young people of color have been particularly affected. In 2001, teen girls represented more than half (56%) of reported HIV cases among those ages 13 to 19. Twenty-one percent of all young people included in this age group were African American.

3. Affect of HIV/AIDS on the Child Welfare System

Every child welfare system must be able to address AIDS and HIV issues appropriately, especially those that stem from situations where (1) a child already in foster care is diagnosed as HIV positive, (2) an infected child is entering foster care, or (3) an uninfected child is in need of placement

because the AIDS-infected mother is too ill to care for him/her or has died of AIDS (Taylor-Brown, 1991). A 1995 study of children in foster care in Los Angeles, Philadelphia, and New York City found that as many as 78% had a parent with a history of substance abuse. Only 9%, however, were tested for HIV (Halfon, Mendonca & Berkowitz, 1995; Committee on Pediatric AIDS, 2000).

With the exception of those in care who were born HIV positive through parental drug use, there is a lack of information about the HIV exposure status of District youth in foster care, particularly adolescents and teens in out-of-home placements. Like adults, adolescents may become HIV-infected as a consequence of sexual activity or drug use. Because HIV is classified as one type of sexually transmitted disease (STD), other STDs can serve as indicators of HIV high-risk behavior (DC Department of Health, 2003). According to the Committee on Pediatric AIDS (2000), children and youth in foster care should be tested for HIV under the following circumstances:

- A sibling or parent is HIV-infected.
- A current or past sexual partner is HIV-infected or at increased risk of HIV-infection.
- There is a diagnosis of an STD.
- There is a history of illicit substance use or abuse.
- Adolescents who are sexually active or have a history of sexual activity and those whose medical history is unavailable should also be considered for testing.

4. HIV/AIDS in the District

Consistent with the national trend, the number of annual AIDS-related deaths has declined in the District over the past 10 years, from a peak of 742 in 1993 to 41 in 2002. This is attributable to use of semi- retroviral medication, which slows the progression of HIV to AIDS and lengthens the average time a person can survive. Despite this fact, HIV/AIDS is still one of the most severe health problems facing the District, both in terms of disability and lost lives. The D.C. Department of Health estimated 9,375 District residents were living with HIV/AIDS at the end of 2003. Among those, 63 were under 13 years of age.

Appleseed Center's recent report, *HIV AIDS in the Nation's Capital* (2005), states the local HIV/AIDS rate is among the highest in the nation:

The District has an AIDS incidence rate of 170.6 per 100,000 people. This is an increase from the District's AIDS incidence rate in 2001, which at 119 cases per 100,000 was the highest rate among cities with populations over 500,000…

HIV disproportionately affects the African American community in the District. Although African Americans comprise a higher percentage of the District's population compared to the nation (slightly less than 60% of the District's population but only 12% of the nation), they account for 75 % of the AIDS cases. African American women represent 90% of new cases of female HIV/AIDS, with the strongest concentration among the poor of Ward 8 (Appleseed Center, 2005). Factors such as poverty and inadequate access to health care increase the vulnerability, particularly for persons of color.

Latinos, who account for only 8 percent of the City's population, have the second highest rate of new HIV/AIDS diagnoses. When compared to other ethnic groups, Latinos are more likely to learn of their disease at a more advanced stage.

Inadequate HIV data collection has led to limited information on teens, young adults, and transgender individuals. Creation of a better information collection system on HIV/AIDS, as proposed by the Appleseed Center, will make it easier to assess just how widespread the HIV/AIDS epidemic is among these groups.

5. CFSA HIV Policy

The District's child welfare program developed an HIV policy in 1999 that CFSA still uses today. It covers definitions and basic facts about HIV and AIDS, including modes of transmittal and the four stages along the continuum of HIV as identified by the Centers for Disease Control (CDC). General medical consent forms that parents sign when a child comes into foster care do not authorize CFSA to test a child for HIV/AIDS. CFSA's HIV policy clearly states that under no circumstances may a CFSA worker, foster parent, congregate care provider, or contract agency provide informed consent for HIV testing of a child in placement. To follow through with HIV/AIDS testing of a child in placement, CFSA must obtain specific consent from the birth parents. If parental rights have been terminated/relinquished, or if the birth parent is unavailable, unable, or unwilling to consent, CFSA must obtain a court order granting the agency medical guardianship for the specific purpose of HIV testing.

B. Impact of HIV/AIDS for Children served by CFSA

In 2003, the CDC reported 63 people under age 13 in the District had HIV/AIDS. Differing time periods preclude an exact statistical analysis, but CFSA may be serving roughly 30% of the CDC-identified children.

CFSA's Office of Clinical Practice (OCP) reports CFSA is currently serving 20 children who are either HIV-positive or have AIDS. OCP says these children are primarily infants or young children whose predominant mode of exposure was perinatal transmission from mother to child.

CFSA social workers completed the HIV survey for only 12 children. Of these twelve, ten were HIV/AIDS infected (9 were HIV-positive, one had AIDS), and two were uninfected children of HIV/AIDS-infected parents. Four of the 10 HIV-positive children were at least age 16. A follow-up reconciliation revealed two children on the survey who were not on OCP's known list of 20 cases.

While such a small sample has major limitations, findings reveal a first glimpse of the impact of HIV/AIDS on children we serve.

Ages of the ten children medically diagnosed with HIV or AIDS ranged from several months to 18 years (Figure V). Three were diagnosed after coming to the attention of CFSA. Two of those three were over age 15. Eight children contracted the virus from their parent.

Figure U: Diagnosis of HIV Status by Age

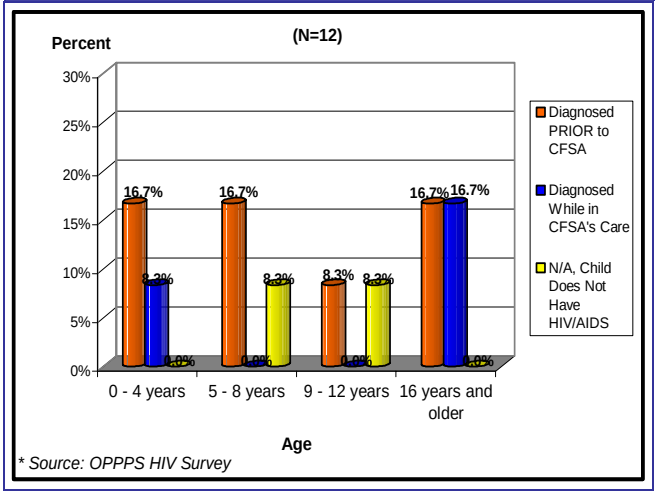
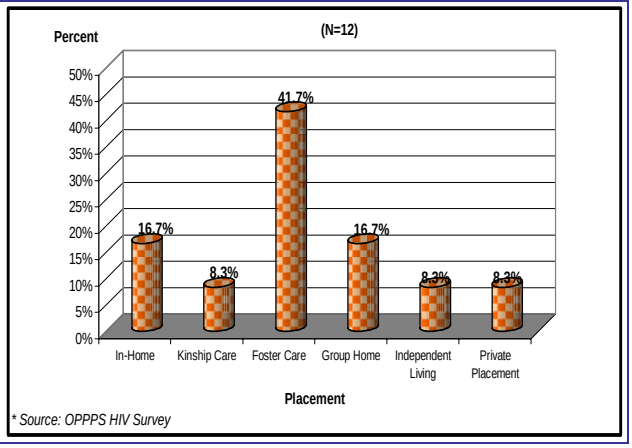


Figure V: shows that a majority of the children (83.3%) were in out-of-home care. Not quite 34% were in foster homes, 16.7% were in group homes, and 8.3% were in kinship care. Teens were more likely to be placed in group homes or independent living while infants and young children tended to be placed in family settings.

Figure V: HIV Child's Placement Type



According to their social workers, 60% of the children diagnosed with AIDS (or who tested HIV-positive) showed no major physical symptoms. Some unrelated physical ailments were cerebral palsy, mild and severe mental retardation, and daily convulsions. One child was mute, and another had a G-tube to supplement his/her food intake. Most were taking several medications except for one 19 year-old who was not following through with services because he/she thought they were unnecessary. This young adult was HIV-positive but exhibiting no physical symptoms.

C. Summary of Needs

We identified ten basic needs that are consistent with those outlined in studies published by the Appleseed Center (2005) and the American Academy of Pediatrics (2000).

1. Promote HIV Awareness and Education

The foster parent said 'a friend of mine told me that I had to wash all my dishes with bleach'. . . . [N[obody in the FTM knew how to respond to that.—Social Worker, Oct. 2005

The stigma associated with HIV/AIDS presents specific challenges for social workers and foster parents. Focus group participants described several instances where lack of knowledge and understanding about HIV/AIDS led to improper care of the child in foster care. This information is consistent with the Mosaica study, which reported that major barriers to foster parents' willingness to take in an HIV/AIDS-infected child were comfort level and concern about how other children living in the home would respond.

2. Increase Basic Knowledge of Universal Precautions

The Mosaica study found that resource parents need basic knowledge of the disease and its progression. They need to develop sensitivity to the particular issues that victims must face. They need to know how to discuss HIV/AIDS and risky behavior with other children/youth placed in their home; how to handle questions by neighbors, school personnel, or other children in the home; and how to support the parent or child/youth living with the disease.

Foster parents should always take universal precautions when children come into their homes, whether or not a communicable disease is identified. Understanding what it means to take universal precautions, however, appears to be a major challenge for foster parents.

[The foster parent] disclosed that she was afraid that if the child got in the family shower, then everyone would get HIV…In the end, the child told me that he was used to it [and] just used a washcloth. That's what hurt me the most.—Social Worker, Oct. 2005

Focus group feedback indicated that social workers are not trained to respond to HIV/AIDS-related inquiries from foster parents. They need to know how to respond to foster parents' questions about the HIV/AIDS virus in general as well as answering specific questions about implementing universal precautions.

We have had two babies this year who were not tested initially, but who later became very ill and required hospitalization. If they had been tested upon entering care, they could have received treatment and perhaps avoided hospitalization.—Registered Nurse, Oct. 2005

3. Increase Training about HIV

Although CFSA has offered six sessions on HIV/AIDS infection and prevention within the past two years, we currently do not have ongoing in-service training. Our HIV policy contains basic information about HIV and AIDS, but the Mosaica study revealed a need

for training that incorporates basic guidance around confidentiality, HIV counseling and testing, communication with clients, and encouraging foster parents to use universal precautions (regardless of a child's known health status).

Focus groups raised the issue of client refusal to take necessary medications. Social workers also expressed concern for children's well-being when HIV-infected birth parents refuse to take medications, especially when the goal is reunification. They were additionally concerned about HIV positive children/youth in foster care who fail to take treatment seriously because they are not exhibiting any symptoms.

4. Establish Protocols

The fact that there were HIV/AIDS infected children identified in the survey who were unknown to the OCP exposes a glaring need in the internal communication that occurs between front line social workers and OCP staff. All OCP clinical support and health services staff should be informed immediately of any child who is infected or affected by HIV/AIDS.

The OCP-known cases are primarily young children who have contracted HIV perinatally. For children whose exposure was other than perinatal (such as sexual abuse victims, promiscuous behavior, intravenous drug use, etc.), OCP's options for detecting HIV are limited by statute, which limits CFSA's ability to test children at-risk of contracting the virus.

5. Increase Access to Services

Limited services in the community and lack of knowledge about available services remain major challenges for social workers. In 2004, CFSA developed a resource directory that includes some HIV/AIDS resources.

6. Use HIV Risk Assessment

CFSA's HIV policy requires that we conduct an HIV risk assessment as part of the initial family assessment at intake. The policy requires social workers to update the assessment during out-of-home placement and throughout the life of the case. Social workers indicate, however, that they do not regularly complete the HIV risk assessment, and that the initial family risk assessment does not contain any questions or items specifically addressing HIV/AIDS. Rather, social workers tend to focus during the family assessment on general health conditions. The Mosaica study found that 67% of staff indicated they do not include HIV/AIDS as part of their general risk assessment.

7. Recruit Foster Parents

While CFSA strives to match children with the most appropriate foster parents, we often have to place children in the first available home, which may not be the best placement, particularly for a child with HIV/AIDS. A CFSA social worker in the focus group noted that she placed a child whose birth parent had AIDS with a foster parent who was not knowledgeable about the disease. The foster parent expressed some fear but took the initiative to go to the hospital and talk to nurses. The foster parent was very open to finding out more information about HIV/AIDS.

8. Establish a Support Group for Youth

Social workers indicated a need for support groups for youth affected by HIV/AIDS. These youth need to be allowed a safe, supportive environment to deal with and express their feelings of anger, fear, and isolation. Group support can also influence youth to reduce risky behavior and to live responsibly with their disease.

9. Identify Affected Children Early

Community stakeholders overwhelmingly identified the need to establish a protocol for early identification of foster children affected by HIV/AIDS. CFSA needs a legal mechanism for getting clients' HIV/AIDS-related

information if we are going to be able to provide all necessary and appropriate services.

CFSA needs to revisit the agency's position of not testing children in care, or testing only those with a history or those who are symptomatic.—CFSA Social Worker, Sept. 2005

10. Provide Drug Abuse Treatment

Since HIV/AIDS can typically co-occur with substance abuse, parents and youth need a full range of effective drug treatment options. These services could help to facilitate reunification and to support parents and youth in developing a healthy lifestyle. Moreover, they are essential to mitigate the health risks associated with substance abuse that potentially has fatal consequences. ■