The Government of the District of Columbia

Child and Family Services Agency

2007 NEEDS ASSESSMENT REPORT

"Helping to make a difference in the lives of children and families in the District of Columbia"

Acknowledgements

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Executive Summary

The District of Columbia Child and Family Services Agency's (CFSA) *2007 Needs Assessment* is an intentional evaluation of current and projected placement and placement resource services for children, youth, and families served by the child welfare system. It particularly examines the resource needs of siblings, children with special needs, older youth, and youth who experience multiple placements. Additionally, it takes a special look at one of the most vulnerable populations -- children ages 0 – 3 years.

The results of the *2007 Needs Assessment* have already assisted the Agency to plan for prioritizing and addressing the needs of children, youth, and families. The timely provision of services, including supportive services, is a critical factor in the Agency's ability to ensure placement stability and permanency for children. The Agency must have access to a range of placement options that can adapt to a changing population. As practice changes occur, and as CFSA engages in activities to fully impact placements, especially for youth, the projections will be altered as needed. Alongside CFSA's resource and organizational development strategies, capacity building continues to occur through interagency partnerships, public-private collaborations, research, and careful integration and implementation of Best Practices and Promising Approaches in child welfare service delivery. The ongoing confluence of these efforts also helps CFSA to attain and sustain safety, permanence, and well-being for its clients.

CFSA has initiated planning for the 2008 Resource Development Plan (RDP), the Agency's vehicle for translating the broad findings of the *Needs Assessment* into key recommendations and specific action steps. Although CFSA is aware that it cannot immediately address every need identified in this assessment, the RDP is designed specifically to meet the most critical placement and placement resource needs.

Approach

Utilizing both quantitative and qualitative research methods, the *2007 Needs Assessment* focuses directly on placement needs that are anticipated over the next two years. The *Assessment's* research design (see *Appendix B*) consists of a self-administered survey, interviews with key informants, administrative data, survey findings, focus groups (comprised of youth, staff, foster

parents and adoptive parents), and other material sources. Non-linear regression analysis is used to provide valuable information on the future of CFSA's foster population.

Study limitations are detailed in *Appendix B, Methodology*. CFSA recognizes that a number of factors affect the non-linear regression analysis. It should be emphasized that the projected trends provide only possible future indications of demographics and placement, not a certain outcome. Should the Agency's current resources shift, or additional services and supports be put into place, the projected demographic make-up of the CFSA population would shift accordingly. Further, the projections do *not* take into account CFSA initiatives that are currently underway (such as the Levels of Care approach and Performance-Based Contracting). Nor do the projections take into account planned initiatives (such as the focused effort to increase available family-based care while concurrently reducing the need for congregate care). Any future initiatives that CFSA may implement could also impact these projections.

Key Findings

- ***The number of youth in foster care over age fourteen continues to grow.***
  As of September 2007, youth between the ages of 14 and 21 comprised 54% (n=1212) of the total number of youth in foster care. By December 2009, this age population is projected to increase to 64%. Similarly, once older youth are in the Agency's care, there is a dearth of foster parents who feel prepared to manage the youth's behavior and maintain their safety. The youth subsequently tend to experience greater placement instability, including more placements in congregate care settings, and an increased number of emergency placements.
- ***The need for emergency placements is projected to increase.***
  In September 2007, there were a total of 21 children and youth in emergency placements, approximately half of whom were aged 13 and older. By December 2009, 86% of youth requiring emergency placements are projected to be 13 and older. The increase in the numbers of youth who are over age thirteen and who enter (and/or remain in) CFSA's custody is at least partially attributed to the lack of community-based programs, such as the Persons in Need of Supervision (PINS) program,[1] as well as a lack of community supports and resources for parents of teenagers, specifically at-risk teens. Many parents

[1] See chapter on *Prevention*.

and caregivers in the District feel ill-equipped to supervise their teenage children or to provide for their healthy development. As a result, the need for emergency placements increases.

- ***The number of children and youth in family-based foster care settings is projected to decrease.***

  In September 2007, 71% of children in care resided in a family-based foster care setting. The computed monthly projections indicate an 8% decrease by December 2009, such that it is possible only 63% will be residing in family-based foster care then. It should also be noted that the percentage of those children and youth placed in kinship homes is projected to decrease from 22% in 2007 to 15% in 2009.

  CFSA needs to develop and implement effective recruitment and retention strategies for kinship, traditional foster care, and pre-adoptive families especially for those that are interested in providing placements to clients with more unique needs, such as parenting older youth, youth who identify as LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Questioning), and children with special medical and behavioral needs.

  One of the Agency's core principles/values is that children ought to be placed with kin whenever possible. In order to fulfill this goal, there is a clear need to identify and utilize more paternal relatives as placement resources. Even as we continue to develop paternal resources, kin face challenges to becoming placement resources as a result of issues related to the Interstate Compact for the Placement of Children (ICPC) in Maryland and Virginia. Although negotiations with the state of Maryland are currently underway and are promising, CFSA clients need these negotiations to be successful sooner rather than later.

  The Agency faces challenges recruiting traditional foster families as well as pre-adoptive families. The need for resources is reflected in the projections for the number of children and youth in pre-adoptive placements. On September 30, 2007, these children and youth comprised 34% (178 of 519) of the actual number of children and youth with a goal of adoption. By December 2009, the children and youth in pre-adoptive placements are

expected to comprise 21% of all children and youth projected to have the goal of adoption.

Retention of foster families as placement resources was also identified as a key need. Kinship, traditional foster and pre-adoptive parents universally cited poor communication between social workers and caregivers, as well as between foster parents and birth parents as major obstacles to retention. Services to specifically support family-based foster care, such as respite and easy access to child care, were also mentioned as important to retention.

- ***The number of children and youth placed in congregate care settings is projected to increase.***

  Of the total population of children and youth in CFSA's custody, the number placed in congregate care settings[2] is projected to increase from 22% (as of September 2007) to 23% by December 2009. While this minimal overall increase may not be significant, what is of concern is the change in the distribution of the population of youth placed in specialized congregate care settings. For example, the proportion of teen parents who will require independent living facilities is expected to increase from 30.6% to 44% of the total population of youth requiring independent living placements. If there is no intervention to reverse the projections, the percentage of children and youth requiring placement in residential treatment settings is expected to increase from 6.6% of the total CFSA population to 7.7% of the population. As family-based foster care decreases, the need for therapeutic placements is projected to increase.

  As mentioned previously, a second mitigating factor in the use of congregate care settings may be the lack of community supports to meet the high-end mental and behavioral needs of some children and youth in care. As a result, many children are placed in congregate care facilities for the lack of a better option. Unfortunately, many of CFSA's current contracted congregate care facilities do not have focused areas of expertise to meet the needs of youth with special needs, including teen parents, youth that frequently abscond, youth transitioning from residential treatment centers, and youth at different

[2] Congregate care settings include traditional and specialized group homes, independent living facilities and residential treatment centers.

developmental levels that are transitioning to independence. The lack of specialization in congregate care facilities often compromises the effectiveness of these facilities and results in longer lengths of stay for children and youth.

- ***The number of children and youth experiencing multiple placements continues to increase.***

  The projected trends for the youth who will experience multiple placements show an increase of 7% from 23.9% to 30.9% between September 2007 and December 2009. The percentage of children and youth experiencing multiple placements[3] increased from 18.4% in September 2006 to 23.9% in September 2007.

  CFSA continues to struggle with placement stability, especially for older youth. While such placement instability can be partially attributed to the relatively low percentage of children and youth in CFSA's custody who are placed with kin, stakeholders noted that kinship and foster parents often did not possess the necessary skills and supports to care for children and youth with behavioral and emotional difficulties. The lack of skills and supports can lead to placement disruption when caregivers feel unable to manage some of the behavioral and emotional issues. Further, when kinship and foster parents begin feeling overwhelmed, neither social workers nor foster parents consistently and proactively initiate Family Team Meetings to stabilize those placements and access needed supports.

- ***Children ages 0 to 3 constitute the largest proportion of child abuse and neglect allegations, substantiations, and entries into foster care as compared to other age groups.***

  As of March 2007, children ages 0 to 3 represented 25% of all substantiated child abuse and neglect cases in the District. The implications of this finding are compelling and alarming, given the vulnerability of this population.

  In December 2006, children age 3 and under comprised 9.67% of the District's total foster care population. By December 2008, the percentage is forecasted to increase to 10.9%, and by December 2009, to 11.4%. Although the overall percentage of 0 to 3 in

[3] CFSA defines multiple placements as children experiencing three or more placements during the course of their most recent placement episode.

foster care is expected to increase, the actual number is expected to decrease along with a large expected decline in the total number of youth and children in foster care. For infants and toddlers entering foster care, the *2007 Needs Assessment* found that improving access to child care, ensuring referrals to early intervention services, and identifying and addressing maternal depression were important needs to address.

In closing, additional details on these key findings and others gleaned from the literature review are provided throughout the *2007 Needs Assessment* report. The final *Discussion* chapter links recurring themes as well as highlights salient issues that will continue to be examined by CFSA as the Agency strives to fulfill its mission.

Introduction

Background

Since 2003, the D.C. Child and Family Services Agency (CFSA) has been conducting biennial needs assessments to identify and re-evaluate systemic needs and gaps in the Agency's child welfare programs and services. CFSA culls the information resulting from these assessments and prepares a resource development plan (RDP) accordingly. The RDP addresses the needs and strives to fill in the service gaps. The goals for both the *Needs Assessment* and the RDP have remained constant over the last four years: to improve the lives of the District's maltreated children and to assist them along with their families into healthy futures. Above all, the Agency is dedicated to the safety, permanency, and well-being of the children and families it serves.

CFSA also conducts smaller-scale, specialized needs assessments in various program areas to examine organizational development and to continually maintain practice improvement. The Agency has found that these "interim assessments" are exceedingly efficient, manageable, and effective vehicles for data-based arrival at the all-encompassing biennial assessment. This *2007 Needs Assessment* includes pertinent information produced by the smaller-scale research and reports, particularly in the arenas of prevention, placement, and placement stability.

In contrast to previous assessments with broad scopes, this *Assessment* analyzes the District's current placement resources, identifies service gaps, and projects future placement and supporting resource needs for children and families. In addition, there is a special section addressing the 0-3 age population that came to the attention of CFSA as a result of increased data.

Since the Child and Family Services Agency is acutely aware that placement instability is harmful to children, the Agency's intent is always to place a child in the best possible setting for each child's particular needs. Historically, placements in the District of Columbia have been challenged by disparities in inter-jurisdictional rules and regulations resulting in an over-dependence upon congregate care placements, and a high incidence of multiple placements. From the very onset of entry into the child welfare system to the moment a child reunites with the family, or is able to secure permanence through guardianship, kinship care, adoption, or

independence, the Agency continuously provides supports and resources to maintain stability and achieve permanence.

CFSA's Vision for Placement Stability

CFSA promotes placement stability through values and principles that guide decision-making and strategy development. Our vision also reflects best practice standards in child welfare:

- Children and youth deserve placement stability. The first placement must be the best placement.
- A child's needs are assessed in order to make appropriate placements with caregivers who can best meet those needs.
- Children and families shall be incorporated into the decision-making process for best placement options.
- Every child aged 12 and under shall be placed in a family setting. All children shall be placed in a family setting whenever possible, kin being the favored first choice.
- Siblings are placed together whenever possible.
- Congregate care placements are used only to provide intensive, time-limited services for youth, aged 13 and older, who may be unable to function effectively in family settings.
- No child younger than 16 shall be slated for Alternative Planned Permanent Living Arrangement (APPLA) as a permanency goal.
- Congregate care programs are limited to eight residents per facility, except for youth with specialized needs.

These values and basic principles are underscored by the Agency's Practice Model which was established in 2006 to guide the work of social workers and support staff. (See *Appendix A)* These values should be used to evaluate every placement and planning action or decision made for children entering foster care or currently in care.

Stressing high and appropriate standards for family-based placements, the Agency nonetheless recognizes that individual decisions may require difficult trade-offs: e.g., placing children in congregate care to keep siblings together. In hopes of eradicating some of these difficult types of trade-offs, CFSA is in the process of implementing two major practice improvements: Performance-Based Contracting (PBC) and Levels of Care (LOC).

The PBC initiative begins with a conversion from service contracts to performance-based contracts so as to hold CFSA providers accountable for achieving defined outcomes for children and families. Ultimately, providers will be paid in accordance with their outcome accomplishments. The goal is for CFSA and our providers to hold both shared ownership and a

shared vision of mutually-desired child welfare outcomes. It is not yet known how implementation of PBC will impact placement options or placement decisions but it is certainly expected that barriers to permanency will be alleviated. CFSA further intends to emphasize increased permanency rates in our performance-based contracts with family-based foster care providers. CFSA shall then re-examine PBC over the next several years to assess its effect.

The "Levels of Care" approach will revamp the current method of rate setting for reimbursement to foster parents. The model allows for flexibility in reimbursement based on the needs of individual children and on the supports provided by foster parents to meet those needs. By providing financial support to maintain a child in a foster home, CFSA expects that this new rate-setting methodology will help avoid a placement change to a specialized home, congregate care or residential treatment. As such, implementation of LOC is also expected to increase accountability while simultaneously providing a cost-containment approach for the increase in family-based foster care settings. It should be noted that CFSA expects that implementation of PBC and Levels of Care will positively impact the picture painted in this *Needs Assessment*.

Overall Approach

The *2007 Needs Assessment* focuses directly on placement resources and placement supports that are anticipated over the next two years. Projections include specific placement needs and supports for children ages 0 – 3, a rising population in foster care nationally and in the District of Columbia. Children with special needs,[4] older youth, children who experience multiple placements, and sibling groups are examined as well. These populations also present significant technical and adaptive challenges for CFSA and the child welfare system in general.

A detailed description of the research methodology used to generate various data is included as *Appendix B.* In brief, the research design consisted of both quantitative and qualitative components, including a self-administered survey; focus groups comprised of youth, staff, foster parents, and adoptive parents; administrative data; interviews with key informants; survey findings; and other material sources (see *Appendix F* for Survey Instruments). The placement projections were calculated using non-linear regression analysis, a method of forecasting that has

[4] The Office of Clinical Practice (OCP) defines this population as all CFSA children with any medical, developmental, cognitive or physical impairment including children who require long-term medication/treatment for a condition or require medication/treatment for a recurring condition that if left untreated may lead to serious illness.

some limitations. For example, estimated needs are often outdated by the time an actual placement occurs. Further, a projected increase in the numbers of older youth, for instance, will correspond to a projected increase in the need for congregate care placement settings. Yet, CFSA's primary determination is to place all children in family-based foster care, so successful increases in such placement resources will impact the presently projected need for group homes and/or independent living programs.

Report Structure

Before engaging in a detailed discussion of CFSA's placement and placement support needs, it is important to begin with those services and supports that act as protective factors for children and families. In due course, these factors contribute to placement stability and to the reduction of occurrences of child maltreatment. Therefore, the first chapter after this introduction builds on the findings of the *Assessment of District Programs to Prevent Child Abuse and Neglect* (2006). This prevention assessment is one of the Agency's interim reports since the *2005 Needs Assessment*. Based on data from this interim assessment, the chapter focuses on the District's current capacity to strengthen families and to prevent children and youth from entry (and/or re-entry) into foster care.

The next chapter covers the demographics of children in foster care in the District of Columbia. CFSA's foster population is broken out by age groups and relevant circumstances, setting the stage for the following four chapters which provide a more detailed analysis of current placement types, circumstances, and needs. These chapters each include an in-depth review of the particular placement type and its affiliated projections, a brief literature review, challenges identified by stakeholders, and potential solutions based on best practices. Chapter VIII is solely devoted to a discussion of placement stability, including strengths and challenges, and strategies to address those challenges. Chapter IX is a special focus on the 0 – 3 population. The report ends with a discussion and conclusions that will link directly to development of the 2008 Resource Development Plan. Appendices are provided with additional information that incorporates the bibliography of sources cited in each chapter's literature review, as well as a detailed explanation of the methodology used in gathering data for the *Assessment*, and a copy of the Agency's Practice Model.

Chapter I
PREVENTION

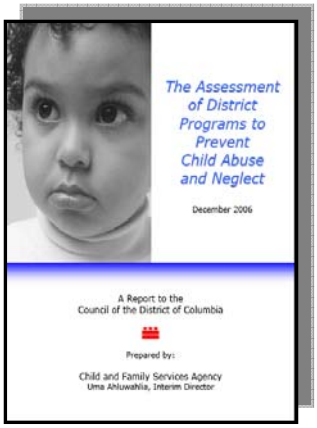
Prevention

The Issue

CFSA recognizes that for children to be maintained in safe, stable and permanent living situations, reliable partnerships must exist within the communities where families live. It is essential then to examine the community-based and preventive supports in the District that contribute to a reduction in the incidence of child abuse and neglect and keep children from entering foster care. In this manner, CFSA may more accurately assess the foster care placement and placement support needs.

As discussed previously, this chapter reviews the District's overall efforts to prevent child abuse and neglect, and subsequent entry into the child welfare system. It also presents an overview of a myriad of community-based programs, as well as collaborative community efforts, that provide reliable services and supports for stabilizing families and preventing re-entry of children into foster care.

Background



In 2006, the Council of the District of Columbia enacted legislation requiring a District-wide assessment of child abuse and neglect (CAN) prevention services and service gaps.[5] The result was the *Assessment of District Programs to Prevent Child Abuse and Neglect* (henceforth referred to as the *2006 Prevention Assessment*), and the following components were incorporated:

(1) an inventory comprised of 30 public and 85 private CAN prevention programs (which included primary and secondary prevention programs[6])
(2) an analysis of the funding sources for these programs
(3) a determination of whether each program's services are evaluated for effectiveness
(4) an analysis of gaps in services

It is important to note that less than 30% of the inventoried prevention programs, both public and private, reported having a specific focus on CAN prevention. Rather, the majority of

[5] Assessment of District Programs to Prevent Child Abuse and Neglect Act of 2006
[6] "Primary" prevention programs are designed to prevent child abuse and neglect risk factors; "secondary" prevention programs are designed for those children whose risk factors are already demonstrated, and for persons who have demonstrated a propensity for child abuse and/or neglect.

respondents indicated that their programs provide a range of family support services which may indirectly reduce the prevalence of CAN.

In order to capture key stakeholder input on the strength of the District's continuum of prevention services, the *2006 Prevention Assessment* employed an instrument recommended and provided by the National Child Welfare Resource Center for Organizational Improvement (NRCOI). Utilizing an array of programs comprising 96 services, the instrument revealed the continuum of supports needed to prevent entrance into the child welfare system, and to facilitate the process of exiting the system and achieving permanency. All services are administered by government and public agencies, as well as community-based and private organizations. The services each fall under one of the following five categories:

1. Community/Neighborhood Prevention, Early Intervention Services
2. Investigative, Assessment Functions
3. Home-Based Interventions
4. Out-of-Home Services
5. Child Welfare System Exit Services

Of these five categories, only the *Community/Neighborhood Prevention, Early Intervention* category was considered for services to be identified by the *2006 Prevention Assessment*.

Need for Services

The assessment process invited stakeholders to identify the strengths, weaknesses, and service needs in the District's prevention/early intervention array. Stakeholders[7] ranked over half of the 27 services reviewed as both critically important and not meeting the needs of the District due to a lack of resources. The group agreed that with few exceptions, the majority of the following prevention/early intervention services have insufficient capacity to meet the District's needs:

[7] See *Appendix D* for full listing of Stakeholders.

- Transportation Assistance
- Employment Assistance
- Primary Child Health Care
- Child Dental Care
- Educational Services for Children
- Home Visits to Parents with Newborns
- Life Skills Training/Household Management
- *Parents Anonymous* or Other Forms of Parent-Led Support
- School-Based Personal Safety Curriculum
- School-Based Family Resource Workers
- Mentoring for Adults
- Mentoring for Children and Youth
- Child and Family Advocacy
- Cash Assistance
- Utilities Assistance
- Housing Assistance
- Child Care Assistance

While the findings of the *2006 Prevention Assessment* centered on primary prevention/early intervention, it should be noted that many of the same service needs for child welfare-involved children and their caregivers were also identified in CFSA's July 2007 *Assessment of In-Home Practice*.[8] The following service needs were identified in the *Prevention Assessment* as lacking capacity to meet the District's needs. The same needs were again identified in the *Assessment of In-Home Practice* as components that support a stable and healthy home environment for children and families:

- Child dental care[9]
- Child psychological/psychiatric evaluations
- Mentoring and tutoring services for children
- Counseling to address school absenteeism
- Counseling/psychotherapy for children and primary caregivers
- Parenting classes

CFSA has also completed an assessment of mental health needs in conjunction with the Department of Mental Health (DMH). The results indicate that there is not a sufficient number of providers skilled in working with child mental health issues. It is crucial for the District to have an accessible cadre of providers capable of supporting families dealing with mental health and substance abuse issues, exposure to domestic violence, and issues associated with child abuse and neglect (for example, sexual abuse, and post-traumatic stress syndrome). An increase

[8] Report from Quality Assurance (August 2007)
[9] November 2007: The Superior Court of the District of Columbia Family Court initiated a dental health services needs assessment with CFSA's Office of Planning, Policy, and Program Support and the Office of Clinical Practice – Health Services Division.

in reliable supports in the community to assist these families will greatly facilitate the District's efforts to alleviate the risk factors impacting child abuse and neglect, and to achieve real permanency for all of the children and youth served by the child welfare system, whether those children are living at home or with relatives, or transitioning to post-adoption or guardianship finalization.

The *2006 Prevention Assessment* stakeholders also identified CAN outreach/education as a particular service that needs improved coordination, as well as training for mandated reporters. While CFSA does have trainers on staff who provide mandatory reporter training in response to requests from the community, there does not appear to be a city-wide mandatory training that is consistently implemented by schools, the medical community, community-based organizations, and/or the faith-based community. The implementation and tracking of such a curriculum has the potential to strengthen the partnership between CFSA and the community, and to enhance primary prevention programs targeted towards the reduction of child maltreatment. Increasing awareness of and appropriate responsiveness to child abuse and neglect is a key priority of mandatory reporter training. There is a need in the District to increase both awareness and responsiveness.

Challenges

Advocacy

The *2006 Prevention Assessment* identified a number of existing prevention and early intervention services that could be improved as the District continues to address the barriers for residents to access and receive these services. Stakeholders felt that improving advocacy on behalf of District residents to help them access services is one area that warrants a stand-alone initiative. Currently, some informal advocacy exists through service delivery and through the efforts of some providers on behalf of consumers, but it is not reinforced city-wide. Better communication between clients and staff was also identified as an area that would increase access to services. CFSA youth participating in focus groups for this *2007 Needs Assessment* further identified the need for improved support. Collaborative relationships between social workers and the youth will improve communication and advocacy on behalf of the youth, helping youth to access services.

Housing

Housing continues to be the most pressing service need. As reported in CFSA's January 2004

Quality Service Review (QSR), "*the lack of adequate housing was identified in some cases as an obstacle to keeping children safely with their families or returning children from foster care*." In the previous CFSA *Needs Assessments* (2003, 2005), housing was also identified as one of the most critical issues impacting permanence for children and their caregivers. These findings were reiterated in CFSA's 2007 Child and Family Services Review.[10]

In the *2006 Prevention Assessment*, Housing Assistance was ranked "minimally" available with eligibility as the greatest barrier both for families and for individuals. Eligibility requirements may exclude individuals, especially those returning to the community from prison. For women with children, a dearth of shelter beds for families creates another eligibility barrier, often resulting in homelessness. With limited affordable housing in the District and limited housing assistance, families are frequently forced to find alternative housing in Maryland and Virginia which creates another series of service need challenges when some family members are still in the District's system. Increased advocacy at all levels – neighborhood, community and District-wide – is required to address this urgent housing need for some of the District's most vulnerable residents. It is an issue that should be taken on city-wide (see *Strengths to Build Upon* below).

Eligibility

Some challenges to accessing prevention/intervention services are directly related to laws and/or policies. These laws and policies may warrant an official review and/or modification based on current population needs and demographics. For example, income requirements may exclude a family from participating in a housing assistance program; infants and toddlers who have disabilities or are at risk for having developmental delays or other special needs must

[10] The Child and Family Services Review is the process by which the federal government assesses child welfare programs in all 50 states. CFSA completed the onsite portion of the second round of Child and Family Services Reviews on June 29, 2007.

demonstrate a delay of 50% or greater in one or more of five domains[11] in order to qualify for early intervention services; and women with older male children have more difficulty accessing domestic violence shelter beds than women with female children.

Employment

Employment Assistance was also identified as a service need, particularly for males who have been incarcerated. Many of these males are fathers, adding to the challenges of adequate support for families. (See chapter on *Family-Based Care.*) The District's Court Services and Offender Supervision Agency estimates approximately 500-550 non-custodial parents return from prison to the District of Columbia each year. Of these, approximately two-thirds (65%) self-report that they are unemployed at the time of release. The remaining one-third who report employment at the time of release characterize their jobs as unstable, seasonal, or limited to day labor.[12] Although individuals may complete the educational and vocational training requirements of an employment program, many still face barriers when trying to access employment.

Culturally Competent Parent Support

As the District's population continues to diversify, there is a corresponding need to expand services to accommodate the varying needs of our community members. Parent Education, for example, needs adjustment or expansion to meet the needs of more culturally diverse families. Research-based models such as the Effective Black Parenting and the Los Niños Bien Educados Programs are culturally-adapted parenting skill-building programs that can be used as models for the District of Columbia. Through a partnership with the Department of Health's Addiction Prevention and Recovery Administration (APRA), CFSA is implementing the Effective Black Parenting Program for female clients referred to APRA's Women's Services

[11] The five domains are cognitive, physical, speech, social/emotional and adaptive. Children who demonstrate a delay of 50% or greater in one or more of the domains are referred for direct services to address the areas of concern. The types of cases that tend to be eligible for services include: Down syndrome/mental retardation, severe microcephaly, sensory impairments, fetal alcohol syndrome and seizure disorders. In the District, the Department of Human Services' Early Care and Education Administration's (ECEA) Infants and Toddlers with Disabilities (ITD) program tracks the delivery of services to children with disabilities and developmental delays.

[12] Source: District of Columbia Superior Court Family Court's Fathering Court Initiative (2007). Data gathered from CSOSA's Autoscreener between May 1, 2006 and September 30, 2006.

Center for out-patient substance abuse treatment. As the program grows and CFSA is able to determine the impact of this culturally-specific parenting model, and with increased resources, the Agency will seek to expand services to birth fathers in treatment, as well as look at other culturally-appropriate models.

Stakeholders agreed that education or assistance around the parenting of older children is particularly lacking, especially those services which assist parents of older children with behavioral and emotional problems. The need for specialized Parent Education/Classes was also highlighted in the *2007 Needs Assessment* focus group findings, both for birth parents and for foster parents and kin. The need for training to address age- and child development-specific issues is coupled with the clear need for culturally-specific training to address issues raised by diverse cultures when it comes to what is considered appropriate and effective parenting. The stakeholder group emphasized that the most effective parenting programs are those that can be individualized or specialized rather than general classes that do not address particular needs of the population served.

Other Needs

Stakeholders participating in the *2006 Prevention Assessment* identified a number of services and/or resources that were not included as part of the prevention service array. These following service needs also emerged during discussions among the *2007 Needs Assessment* focus groups:

- Respite for all families (not just for foster families)
- Programs to support parents of older children who are classified as Persons in Need of Supervision (PINS)
- Services/supports to address the needs of runaways

Strengths to Build Upon

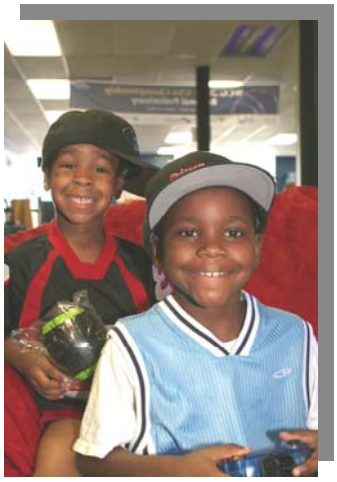
Persons in Need of Supervision (PINS)

In spring 2007, the Office of the City Administrator convened a PINS Work Group to design a continuum of services to support families with youth who are at-risk of entering the juvenile justice or child welfare systems. The Work Group includes representation from CFSA; the Departments of Youth Rehabilitative Services, Mental Health, and Human Services; the Office of the Attorney General, and the Criminal Justice Coordinating Council. Recommendations

from the Work Group are expected to be delivered to the City Administrator and the Mayor in early 2008.

Healthy Families Thriving Communities (HFTC) Collaboratives

The *2006 Prevention Assessment* identified a wide range of programs that support children and families in the District. The key services provided by many of these programs are available through seven neighborhood-based Collaboratives that are located strategically throughout the District, allowing easy access for CFSA-involved families and for those at risk of entering the child welfare system. Through its contracted relationship with the HFTC Collaboratives, CFSA refers families to the specific Collaborative most convenient to them geographically. In the event that a particular service is unavailable at a family's local Collaborative, families may be referred to a Collaborative outside of their catchment area.



The Collaboratives offer an array of services for abuse/neglect prevention, family and foster care support, and aftercare services. These services represent points along the continuum of child welfare supports - from prevention through permanency - including case management, visitation, housing assistance, parent/caregiver support, foster parent support, information and referrals, and aftercare services for local youth aging out of care.

In 2006, CFSA contracted with an external evaluator to review CFSA referrals to the Collaboratives. The purpose of the research was to describe the characteristics and the experiences of CFSA-referred families to the Collaboratives and to examine whether alleged child victims of abuse and neglect (who were served by the Collaboratives) were subsequently re-victimized. It is important to note that this study did not assess the impact of the Collaboratives, that is, it is not possible to determine how the observed outcomes differ from those that would have occurred without the Collaboratives' intervention. The evaluator (Child Trends), reviewed referrals from the Collaboratives' database and matched/verified information with CFSA referrals and FACES. The sample included a total of 1,111 children with prior CFSA referrals who were served by the Collaboratives between April and September 2005. A final report is expected in early 2008 at which time the following (initial) findings will be revised, if necessary:

- Of the 1,111 children referred to the Collaboratives by CFSA, approximately 77% (859 children) had reported allegations of abuse or neglect prior to being referred for community-based services.[13]

- Among those children with prior child abuse and/or neglect allegations (n=859), 24% (205 children) had a second allegation of abuse or neglect occur within one year of their start date with the Collaboratives. Less than half (44%) of those allegations were substantiated. Recidivism or re-victimization was higher among prior alleged victims of abuse.

- Overall, 26% (or 288 children) had a CFSA case opened within two years of being referred to the Collaboratives for services.

The evaluator cautions that data on the reoccurrence of child abuse and neglect are difficult to interpret and, alone, are not necessarily an appropriate measure of the Collaboratives' overall performance. This does, however, provide some baseline data to consider as the Agency works to further evaluate and improve its efforts to strengthen the existing array of prevention services.

In November 2006, the Collaborative Council was awarded a grant through the D.C. System of Care Project to develop a cadre of family support workers to provide case management/peer supports for families with children/youth with complex emotional and behavioral needs. This grant is an important step forward in bringing family supports to the community level for children with intensive needs. The Collaborative Council will oversee additional funding to support provision of nontraditional supports and services that are identified by the family and youth in the context of a Family Team Meeting, thus supporting in a tangible way a family-centered action plan intended to maintain the youth in his or her own home and community.

In 2007, CFSA implemented two positions dedicated to community engagement and program improvement: the Collaborative Liaison Program Manager and the Collaborative Liaison Community Engagement Monitor. The positions are responsible for providing support to the Collaborative Liaison Program Manager in order to maximize the community resources through building community capacity.

[13] Note that if a combination of abuse and /or neglect allegations were reported for a child, a hierarchy of sexual abuse-physical abuse-neglect was used to determine the most appropriate reporting category to be used. Currently, information regarding the disposition of these allegations is not available.

The *Partnership for Community-Based Services* is one of the Agency's newest initiatives, promoting the shared mission of CFSA and the HFTC Collaboratives to "improve the long-term safety, permanence, and well-being of children and to strengthen their families." Through this joint process, CFSA and the HFTC Collaboratives have created a practice model for in-home services. The new community-based model seeks to keep children safe and to provide avenues, resources and supports for strengthening the family system while keeping families together. (See *Appendix D* for the initiative's vision statement and logic model.)

To effectively implement this community-based model, all 10 CFSA in-home units (supervisors and social workers) will be co-located with the HFTC Collaboratives by early 2008. Once co-located, workers will be teaming on cases to improve outcomes for families who come to the attention of the child welfare system.

Housing

The Rapid Housing Program has been a valuable addition to the existing array of housing-related services in the District. This program is a partnership between CFSA, the Community Partnership for the Prevention of Homelessness (TCP), and the HFTC Collaboratives. It provides short-term assistance to families in need of housing for family preservation and/or reunification. The program also assists youth aging out of foster care with time-limited assistance to facilitate their transition to independence. CFSA provides funding for housing resources while TCP administers the funding, and the HTFC Collaboratives provide case management and support services. In FY07, the program served 74 families with a total of 164 children, in addition to more than 85 transitioning youth (including 28 teen parents with a total of 44 children).

CFSA has also partnered with the Family Treatment Court (FTC) to address the lack of available housing and supportive services for women exiting residential substance abuse treatment. The "FTC Transitional Housing Program" is focused on meeting the housing and recovery needs of families, particularly women with children. Beginning in FY06, CFSA has utilized a combination of local and federal resources to formalize agreements with transitional housing programs to provide for the female-headed households. In FY08, CFSA will continue its efforts, awarding grant funds to two community-based organizations in the District whose transitional

housing programs will support a minimum of seven families who complete residential treatment for a period of up to twelve months.

In November 2007,[14] the Mayor announced a wide-ranging plan to address the issue of limited housing and chronic homelessness among District residents. Under the proposed plan, approximately 350 chronically homeless people will have access to existing housing and an array of supportive social services. In addition, approximately 150 units designated as permanent supportive housing will be built to house chronically homeless and low-income residents. The Mayor's plan also calls for partnership between the city and the interfaith network to build approximately 5,000 homes as part of a project to provide affordable housing to low- and moderate-income workers in the District. In December 2007,[15] the U.S. Department of Housing and Urban Development awarded $18.2 million in grants to agencies and private organizations in the District to support homeless programs, including permanent and transitional housing assistance, job training and child care. These efforts mark an important step in the District to address the urgent housing needs of many of the families served by CFSA and its partner agencies.

Other Promising Practices

In addition to the above-mentioned strengths to build upon, CFSA is pursuing several promising practices. In FY07, CFSA awarded grant funds to support evidence-based prevention models and promising practices for services that address the medical, behavioral and educational needs of at-risk children and their families. The goal of the programs is to prevent the entry of families into CFSA through pre-emptive provision of intensive short- and long-term home- and community-based services (see *Appendix E* for an overview of the FY07 Prevention Grantees). At the end of the first grant year, CFSA and the grantees will complete an evaluation to determine the outcomes of service delivery and to identify whether there is a need to expand the capacity of these programs to address unmet needs among the target population. In addition, the District's Department of Health will lead broad effort in 2008 to expand home visits to pregnant

[14] Moreno, Sylvia. 2007 Nov. *Fenty Unveils Housing Plan for Low-Income, Homeless*. Washington Post. <http://www.washingtonpost.com/wp-dyn/content/article/2007/11/13/AR2007111302597.html >. Accessed 2007 Nov. 20.
[15] LeDuc, Daniel. 2007 Dec. *City Receives Homeless Program Grants*. Washington Post. http://www.washingtonpost.com/wp-dyn/content/article/2007/12/21/AR2007122102401.html>. Accessed 2007 Dec 22.

women and new moms, launch a public information campaign to promote healthy pregnancies, implement aggressive prenatal HIV testing, distribute thousands of free cribs and enhance links to substance abuse treatment, among other programs.[16] Although the program objective is to reduce infant mortality rates in the District, it is expected that these primary prevention efforts will have also an impact on reducing the incidence of child abuse and neglect and subsequent entry into the child welfare system among this population.

CFSA also administers the District Government's Grandparent Caregivers Program which provides monthly financial assistance to low-income grandparents and other relatives who are raising grandchildren, great grandchildren, or great nieces or nephews outside the child welfare system. Recent passage of the local Safe and Stable Homes Act made three changes in program regulations:

- Grandparents no longer need to have legal custody of the child to be eligible.
- Clearances (both criminal and Child Protection Registry) are now good for two years instead of one, which eases re-certification for participants.
- Parents, under certain conditions, may live with the grandparents and child.

CFSA administers the program on a first-come/first-serve basis up to the level of annual funding in the District budget. With a waiting list of approximately 85 children, the program is currently running at capacity, serving over 300 households with almost 500 children.

Strategies

Despite an extensive array of available services, CFSA's previous *2003 and 2005 Needs Assessments*, as well as the *2006 Assessment of District Programs to Prevent Child Abuse and Neglect*, and subsequent internal assessments of in-home practice, continue to reveal several gaps

[16] Neibauer, Michael. 2007 Dec. *Infant Mortality Rises in the District*. The Examiner. < http://www.examiner.com/a-1115410~Infant_mortality_rises_in_District.html>. Accessed 2007 Dec. 20.

in the District's continuum of prevention/intervention services. These gaps relate not only to evidence-based approaches to CAN prevention and prevention of re-entry into foster care, but to the basic necessities that support family life. The Agency's assessments support the view that access to job training, employment, and safe, affordable housing is essential to support families in raising physically and emotionally healthy children to become productive, contributing citizens.

To begin to address these complex needs, the District has allocated funding to CFSA dedicated for the expansion of prevention supports and resources. As detailed above, the first year of prevention grants will target families at risk of involvement with the child welfare system by providing intensive home- and community-based services. Planning for the distribution of FY08 funding is currently underway and will continue to focus on addressing the need for a wide array of supports and resources along the child welfare continuum, as identified by the *2007 Needs Assessment* and other reports.

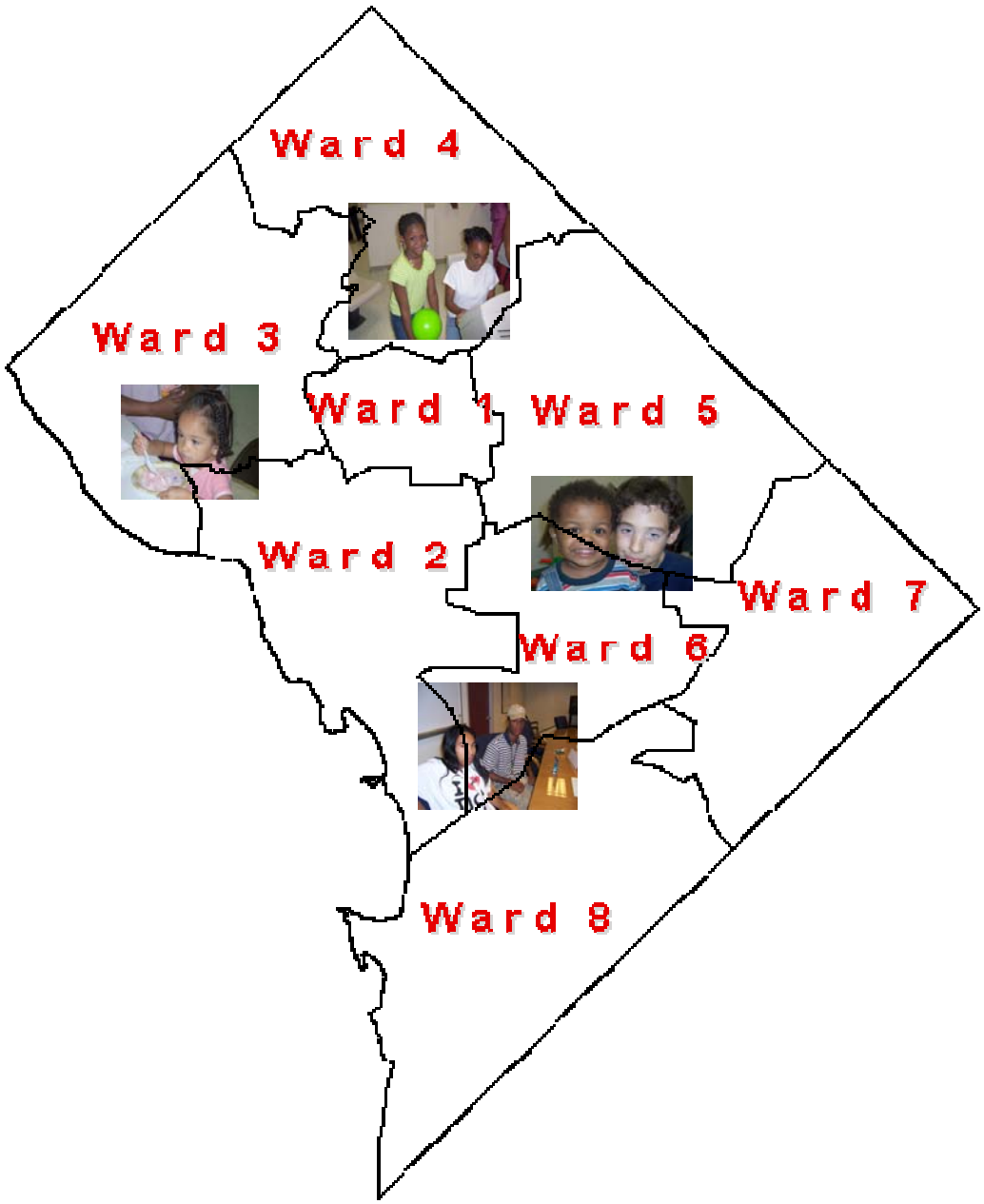
Summary of Needs

- Specialized parent support/education:
  - *Development and implementation of culturally appropriate training to support parents and caregivers of older youth*
- Improved outreach/education about child abuse and neglect:
  - *Development and implementation of a city-wide mandatory reporter curriculum*
- Improved advocacy for families to access services, including improved relationships/communication with service providers:
  - *Specialized training for social workers to strengthen collaborative and communication skills with clients and providers*
  - *Specialized training/supports for families to improve self-advocacy and awareness of available resources at various points along the continuum of child welfare services*

The above key issues are among the priority areas that the Agency can begin to address over the next fiscal year through the development and implementation of the Agency's 2008 Resource Development Plan. As the Agency continues its efforts to ensure the safety, well-being and permanency of youth and families in the District of Columbia, prevention strategies and resources will continue to be a priority aim.

Chapter II

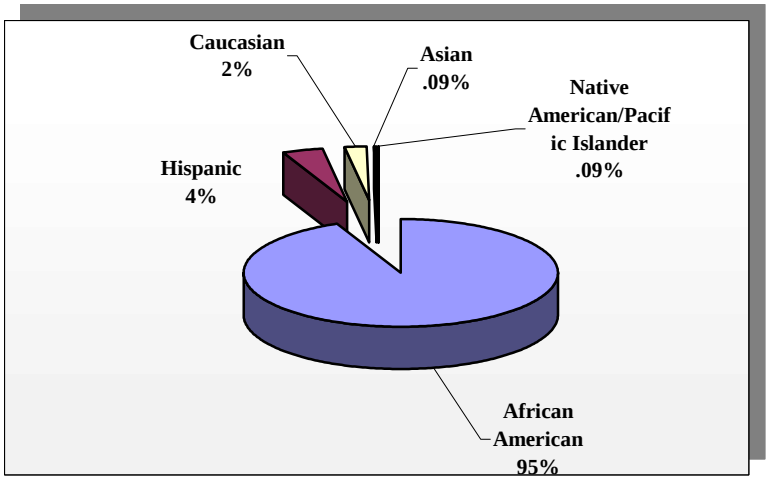
DEMOGRAPHICS OF CHILDREN IN FOSTER CARE



Demographics of Children in Foster Care

A key benefit to demographic research is the possible application of data for development of policy and implementation of practice standards. This chapter provides a detailed description of the current foster care population and subsequent projections for how demographic characteristics may change by December 31, 2009. The Child and Family Services Agency recognizes that projections do not necessarily equal actualities. Notwithstanding their limitations, the information in this chapter will be actively considered in the development of CFSA's strategies for addressing placement needs for children and families served by the District's child welfare system.

Figure 1 – FY07 CFSA Population by Race and Ethnicity



Gender, Race and Ethnicity

Kids Count[17] data as of 2005 indicates that there were 112,837 children under age 18 in the District of Columbia. Within this population, 70.7% were African-American, 14.9% were Caucasian, 10.7% were Hispanic, 1.6% were Asian, and 1.4% were American Indian/Alaskan Native. In comparison, according to the Census as of July 2006, the total population in the District of Columbia was 581,530. Fifty-five percent were African-American, 34.5% were Caucasian, 8.2% were Hispanic, 3.4% were Asian, and a slight percentage were Native American/Pacific Islander (n =203). The gender breakdown in the District yielded 46.8% of the population as male and 53.1% of the population as female. The Census' child population breakdown for the District detailed that youth under age five comprised 6%, youth ages 5-9 comprised 5%, youth ages 10-14 comprised 5.3% and youth ages 15-19 comprised 6.7% of the total population.

At the end of FY07 (September 30th), 95% of youth in CFSA's care were African-American. 4.32% of the children in foster care were identified as Hispanic. There is some indication,

[17] On July 25, 2007, the Annie E. Casey Foundation released the 18th annual KIDS COUNT Data Book, a national and state-by-state effort to track the status of children in the U.S.

however, that the percentage of Hispanic youth is disproportionately under-represented in foster care. Just over 2% of children identified as Caucasian, 0.09% identified as Asian, and 0.09% identified as Native American/Pacific Islander. Comparatively, the gender breakdown was 52.1% males and 47.9% females.

Age Distribution of Children and Youth in Care

There were 2,243[18] children and youth in care at the end of FY07. Twenty-five percent (n=561) were youth between the ages of 15 and 17. Youth aged 18 to 21 accounted for the second highest percentage, 22% (n=493) of the total foster youth population. The third highest percentage was ages 12 to 14, reflecting just over 13% of youth in care.

Table 1 – FY07 Age Distribution

Age Distribution - as of Sept. 30, 2007

Age Range	30-Sep-07	% of Pop.
under 3	206	9.2%
3-5	204	9.1%
6-8	189	8.4%
9-11	221	9.9%
12-14	361	16.1%
15-17	562	25.1%
18-21	500	22.3%
Total	2243	100%

Data Souce: FACES Report, PLC156
report run date 10/15/2007

Projected Age Distribution of Children and Youth in Care[19]

Based on 2005 and 2006 data and the computed yearly projections for 2009, Table 2 below summarizes the projected changes for the overall CFSA population by age group.

Based on yearly projections for the total population, the number of children and youth in foster care is calculated to decrease from 2,301 (average number of youth in care in FY07) to 2,013 by December 2009.[20] Monthly placement population projections forecast the total population decreasing to 2018. Concurrent to these possible population decreases, the number of youth ages 15-21 is expected to increase. This growth is the combined result of legacy cases and older youth entering care for the first time in higher proportions.

[18] 2, 243 is point-in-time data capturing the total foster care population as of September 30, 2007.

[19] Percentages are rounded to the nearest tenth

[20] Age subgroup projections were computed yearly due to the lack of availability of disaggregated data by age group in the identified trend data period, whereas placement type projections were computed monthly based upon the availability of disaggregated data within the identified trend data period.

Table 2: District Foster Care Population Projection by Age										
		12/31/06 (actual)		9/30/07 (actual)		12/31/09 (projected)				
	Age group	Number	% of total pop.	Number	% of total pop.	Lowest	Mean	Highest	% of total pop.	Trend
Children 	<3 years	221	9.67%	206	9.18%	207	230	253	9.65%	↑
	3-5 years	197	8.62%	204	9.09%	102	113	124	8.09%	↓
	6-8 years	193	8.44%	189	8.43%	53	59	65	7.83%	↓
	9-11 years	265	11.59%	221	9.85%	81	90	99	9.96%	↓
	Subtotal	876	38.32%	820	36.55%	443	492	541	35.53%	↓
Youth 	12-14 years	381	16.67%	361	16.09%	260	289	318	16.57%	↓
	15-17 years	588	25.72%	562	25.06%	632	702	772	26.87%	↑
	18-21years	441	19.29%	500	22.29%	477	530	583	21.04%	↑
	Subtotal	1,410	61.68%	1,423	63.45%	1,369	1,521	1,673	64.47%	↑
		2,286	100.00%	2,243	100.00%	1,812	2,013	2,214	100.00%	↓
Data source: FACES Report PLC156										

Younger Children

As of September 2007, the percentage of children under age three comprised 9.67% percent of the population in care. By December 2009, this population is projected to increase by nearly two percent to 11.4% of the total population. Based on the past two years, the trends indicate a constant 3% decrease for youth between the ages of three and five (from 8.62% in 2007 to 5.61% in 2009). The population of youth aged six to eight is projected to decrease by 5.5%, the largest decrease in a population sub-group over the projected period. Youth between the ages of nine and eleven also continue the decreasing trend, comprising 11.6% of the population as of September 2007 and only comprising 4.47% of the total population projected for December 2009. Percentage decreases for youth ages twelve to fourteen are similar to the previous subgroups for ages three and five, with this population decreasing by 3% between September 2007 and December 2009.

Table 3 – CFSA Older Youth Population Projections

Older Youth Population Projections			
	Older Youth	Total Population	%
December-08	1261	2144	58.8%
December-09	1293	2013	64.2%
Data Source: PLC156; regression analysis: yearly projections			

Older Youth

Since FY06, older youth[21] have consistently comprised a significant percentage of the population in care. Overall, the combined ages of 14 to 21 year olds accounted for just over half (54%, n=1212) of youth in care (n=2243) by the end of FY07. This percentage

[21] "Older youth" projections are calculated for youth ages 14 to 21; projections by age sub-groups are categorized in separate age groupings as detailed in Tables 1 and 2.

is expected to increase to 64% (1293 of 2018) by December 2009 (see Table 3). Such a relatively large proportion of older youth in care clearly requires that placement resources respond to this age group's particular needs.

Children and Youth with Siblings in Care

The percentage of children in care who are part of a sibling group has consistently decreased. Since September 2006, when 56% (n=1297) of the total population was part of a sibling group, percentages have decreased by approximately 2-3% every reporting period (see Table 4). Based upon the historical trend, the actual number of sibling groups is projected to decrease by 216 children and youth between September 2007 and December 2009. At the close of the projected period, the percentage of youth in care who are part of a sibling group is forecasted to be almost 48% -- nearly half of the foster care population.

Table 4 – Sibling Groups Projections

Sibling Groups Projections (# of children with one or more siblings)					
	Lowest	**Mean**	**Highest**	**Total Population**	
September-06		**1297**		2313	56.07%
December-06		**1264**		2286	55.29%
September-07		**1179**		2243	52.56%
December-07	1045	**1161**	1277	2121	54.74%
September-08	974	**1082**	1190	2083	51.94%
December-08	951	**1057**	1163	2060	51.31%
September-09	887	**986**	1085	2003	49.23%
December-09	867	**963**	1059	2018	47.72%

Data Source: FACES Report PLC003

**Monthly projections. Regression analysis - 12 point in time data (over 13 months)*

Summary of Needs

In general, CFSA's total population of children in care is expected to decrease by a count of 230, with an indicated mean value of 2013 by December 2009. This represents a projected decrease of 10.2%. The Agency needs to address these projections without presuming that the data are inflexible. Again, it is necessary to point out that while projections do not specifically guide CFSA's practice, they influence it. It is therefore prudent to note that population projections indicate increases for the youngest and oldest populations while in-between sub-group populations are projected to decrease between three and five percent. Simultaneously, redistributions of age group percentages indicate the need for CFSA to be adaptable in its preparedness, which must include appropriately responsive resources. More specifically, the youngest in care will require special services and an intensive effort to hold them close to

families as they are still in the most critical stages of development. The oldest in care will require specially-trained resource parents who are willing and able to respond to the unique challenges facing these older youth as they strive to develop into healthy, independent, and self-sufficient young adults. Both trends present a challenge of creativity for the Agency and its community-based partners. Together, CFSA and its stakeholders need to adjust the use of available resources and to increase the availability of tailored ones. More detailed needs are examined in subsequent chapters.

Chapter III

FAMILY-BASED FOSTER CARE

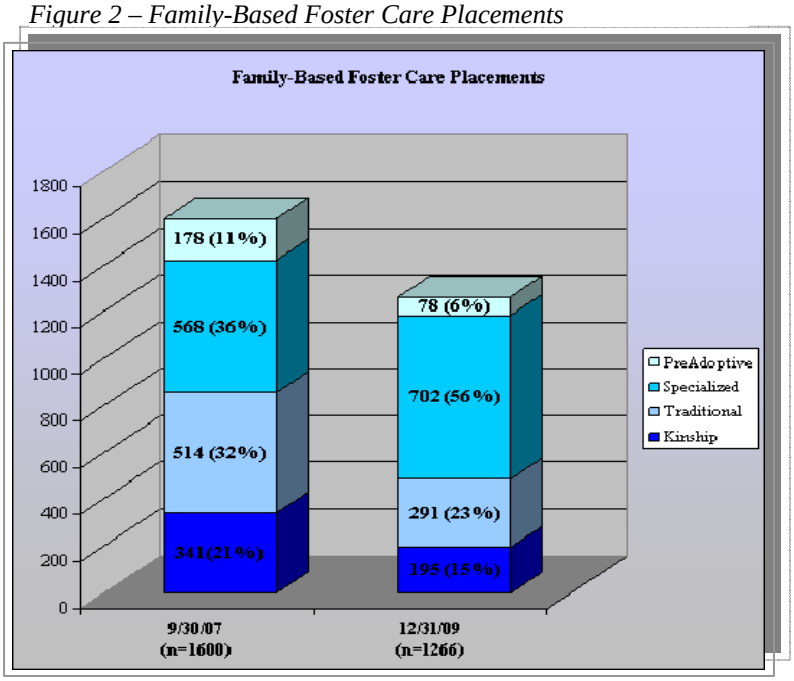
Family-based Foster Care

The Issue

Several placement types fall under the rubric of family-based foster care, including traditional and kinship foster homes, specialized foster homes, and pre-adoptive homes. This chapter addresses forecasted trends in the number of children that will be placed in traditional, kinship, and specialized foster homes through December 2009.

In September 2007, 71% (n=1600) of children in care resided in a family-based foster care setting. If the Agency fails to positively intervene to begin increasing the number of children and youth placed in family-based settings, computed monthly projections three years hence indicate only 63% (n=1266) will be residing in family-based foster care (by December, 2009). This marked decrease of 8% is an alarming reminder that changes in the demographics of children and youth must be met by changes in resources. Further, among those children and youth who are placed in family-based care settings, the percentage placed in kinship homes is expected to decrease from 21% in 2007 to 15% in 2009. Accordingly, the percentage of children and youth placed in non-kinship family foster homes is expected to increase from 79% to 85%. These combined projected trends counter the Agency's core value that children deserve to be placed specifically with kin, whenever safe and appropriate, but certainly in family-based settings when kinship placements are not available.

Figure 2 – Family-Based Foster Care Placements



Without intervention, the percentage of children placed in specialized foster homes is expected to increase from 36% in 2007 to 56% in 2009. Specialized foster care is a time-limited program for

children who have been diagnosed with specialized psychological, emotional, behavioral, and/or physical needs. In most cases, the clinical needs of children in specialized care are expected to diminish as a result of the intensive services provided, so children are able to transition to lower levels of care. Ideally, transitioning to a lower level of care should be accomplished through maintaining the child's current placement. Currently, specialized foster care in the District requires children to change placement when moving to a lower level of care. CFSA's Practice Model emphasizes the important use of available community-based supports so that children with specialized needs can be served by resources in their community, rather than being placed in a specialized foster home.

Overall, declining numbers of children placed in family-based foster care have other implications for the Agency's ability to serve its clientele, particularly in regards to achieving permanency. Data from North Carolina revealed that children placed in family-based foster care had a shorter length of stay and were more likely to reunite with their families than children placed in group care (Duncan, et al. 2007). The results of these studies are a critical guidepost as the District of Columbia strives to achieve the National Standards put forth by the Administration for Children and Families. Currently, the District ranks 34th out of 47 states and U.S. territories with regard to timeliness and permanency of reunification. The following data demonstrates the challenges facing the District:

- For the time period between April 1, 2006 and March 31, 2007, the median time to reunification for a child in CFSA's custody was 10 months. The national median is 6.5 months. Over the last three years, CFSA's median time to achieve reunification has consistently increased.
- Of the children who exited foster care to reunification between April 1, 2006 and March 31, 2007, only 57.6% reunified with their families in 12 months or less. The national median was 69.9%. The percentage of children who are reunited with their parents in 12 months or less has decreased over the last three years.

Kinship Care

Making every effort to place children and youth with kin at the outset of their entry into foster care is critically important. The CFSA Practice Model states that children deserve to be placed with kin whenever possible. Further, federal law obliges all states to "consider giving preference to an adult relative over a non-related caregiver when determining placement for a child,

provided that the relative caregiver meets all relevant State child protection standards"[22] in order to receive federal payments for foster care and adoption assistance.

Literature Review

The Washington State Institute for Policy's report, *Placement Decisions for Children in Long Term Foster Care*, reminds child welfare professionals that the least restrictive placement setting should be pursued for any child who must be placed in foster care (Doran & Berliner, 2001). The least-to-most restrictive placement settings are as follows:

- Child's own home
- Relative's home (kinship care)
- Out-of-home care in a family setting that provides a child with a primary parental attachment
- Treatment or specialized foster care
- Rehabilitative group placement
- Short- and long-term psychiatric facilities

Kinship care research points to a number of factors that support the use of relatives as a placement resource (Conway & Hutson, 2007; National Conference of State Legislators, 2007):

- Children in kinship care experience greater stability. They are found to experience fewer placement changes than children placed with non-kinship foster parents.
- Children placed in kinship care are more likely to retain their family connections, neighborhood, culture, language and heritage.
- Children in kinship care report more positive perceptions of their placements and have fewer behavioral problems.
- Because children usually know and have a relationship with relatives, kinship care can ease the pain of child welfare intervention and placement.
- Kinship care often allows siblings to be placed together.
- Kinship care often allows ongoing and frequent parental contact which can facilitate reunification and minimize the pain of separation.
- Kinship care and the use of a naturally-occurring support system which is already in existence is important in post-reunification; these systems remain in place, functioning long after child welfare closes a case.
- Kinship care is an available alternative to the shortage of foster homes.

[22] 42 U.S.C. 671(a)(19)

Kinship placement is the preferred placement type if reunification with the birth parents is determined not to be in the child's best interest. Nonetheless, children placed in kinship care tend to remain in foster care significantly longer than children placed in non-kin foster care (Cook and Ciarico, 1998; Courtney, 1994). Children placed with kin are also less likely to be reunified with their parents (AFCARS, 1998; Berrick et al., 1995; Testa, 1997) and less likely to be adopted (Berrick and Needell, 1999; Berrick et al., 1995) when compared to children placed in non-kin care. Longer lengths of stay in care and a decreased likelihood of exiting the child welfare system are trends that have been attributed to numerous factors, including relatives who are reluctant to adopt children in their care (Gleeson, 1999) and workers approaching the issue of permanency with kin differently than they would approach the issue of permanency with traditional foster families (Beeman and Boison, 1999).

Challenges

Currently, the Agency's major strategy for recruiting kinship care providers is through Family Team Meetings (FTM). The Family Team Meeting model enables appropriate family members the opportunity to step forward and support the child within their familial network. The success of FTMs with regard to identifying kin is indisputable, but the projections nonetheless clearly indicate that children placed in kinship care will be a shrinking percentage of the foster care population through 2009. As such, the Agency needs to strengthen its efforts with regard to recruitment of kinship foster placements through the FTM process. The federal Child and Family Services Review specifically identified CFSA's failure to consistently reach out to fathers and paternal kin as a clear deficit in placing children with relatives.

The Adam Walsh Child Protection and Safety Act of 2006 might also influence the successful recruitment of kinship care providers. It requires that the District of Columbia's Title IV-E State Plan (which qualifies the District for federal payments for foster care and adoption assistance) reflect assurances for all prospective foster and adoptive parents to have a criminal background check, regardless of whether Title IV-E funds are being sought for the child. The Act also requires assurances that an applicant may not be approved or licensed as an adoptive or foster parent if the criminal record check reveals a felony conviction for child abuse or neglect, spousal abuse, a crime against children, or a crime involving violence. Further, if Title IV-E funds are

expected to be utilized, the Adam Walsh Act compels child welfare agencies to write assurances in the State Plan that applicants shall not be approved or licensed as a foster or adoptive parent if (within the five years prior to the application) they have felony convictions for physical assault, battery, or a drug-related offense. Through the local enacting legislation,[23] the District has retained the ability to use non-Title IV-E funds to provide foster care and adoption subsidies in cases where the Adam Walsh requirements are waived because the placement is deemed to be consistent with the health, safety, and welfare of the child.

A final longstanding, historic barrier to expediting the placement of children and youth with relatives has been the Agency's inability to grant temporary foster care licenses to kin living in Maryland or Virginia. Over several years, the District and the state of Maryland unsuccessfully attempted to resolve some of these issues. In October of 2007, however, the District and Maryland resumed negotiations on a variety of issues related to the Interstate Compact on the Placement of Children (ICPC). Two major meetings have been convened with Maryland's Secretary of the Department of Human Resources (DHR), in addition to ongoing staff-level working groups that meet regularly. In the short period of time since resuming negotiations, significant progress has been made on the issue of emergency kinship placement. Specifically, Maryland has agreed to a pilot program that will allow the District to place children with kin on an emergency basis. The pilot program will be implemented in 2008.

In addition to challenges associated with recruiting relatives as caregivers, the *2007 Needs Assessment* focus groups identified challenges associated with maintaining kinship placements. Many kinship caregivers stated that they would benefit from dedicated kinship workers and services. Caregivers also expressed concerns about obtaining some services. Specifically, kinship caregivers noted that dental services and clothing vouchers were difficult to access. Further, when mental health services were available, they were not always effective. Finally, caregivers noted that communication with social workers was often inconsistent, especially when cases were continually reassigned to different social workers.[24]

[23] DC Official Code §4-1305.06(d)

[24] CFSA acknowledges the importance of having a consistent caseworker throughout the life of any given case. Research shows that the likelihood of a child reaching permanency is reduced by 52% with just one single change in caseworkers (Potter & Klein-Rothschild, 2002). While caseworker turnover is not currently an issue at CFSA, private agencies struggle with social worker retention. In 2008, Howard University and the Consortium for Child

Strengths to Build Upon

An external evaluation by the American Humane Association found that children in CFSA's care had a statistically higher rate of placement with kin as the result of family participation in the Family Team Meeting (FTM). As previously noted, FTMs are CFSA's primary strategy for recruiting kinship care providers.

The success of the FTM process over the last few years clearly demonstrates that the Agency has a sound infrastructure on which to ramp up efforts to recruit kinship providers. In FY07, a total of 2075 family members participated in FTMs. Of the 661 FTMs held between October 2006 and September 2007, an average of 3.2 family members participated per FTM each month. In FY07, 193 FTMs had a potential relative or in-home placement identified at the meeting, although due to other barriers, not all children were placed with relatives.[25] These numbers demonstrate that families are consistently engaging in the FTM process as active contributors, demonstrating a capacity to maintain strong kin networks.

In addition to Family Team Meetings, CFSA also is in the initial phase of implementing the Family Finding strategy for achieving permanency. This model will help CFSA workers locate lost family members, particularly for older youth in care. Once family members are identified and express an interest in reconnecting with the youth, social workers discuss the possibilities of placement and/or permanency.

The Youth Connections Conferences (YCC) is another strategy that assists youth with a goal of Alternative Planned Permanent Living Arrangements (APPLA) to have the opportunity to form strong family connections in preparation for adult living. The YCC is a youth-driven process. The youth chooses significant persons involved in their lives to help them develop a comprehensive plan to prepare the youth for adulthood and to explore life-long connections after they transition from care.

Welfare are planning to conduct a joint empirical study of older youth who enter foster care, including the impact of case worker turnover.

[25] Barriers included, but are not limited to, ICPC issues with Maryland, failure to pass criminal background checks, and failure to meet other licensing standards.

CFSA also has a Diligent Search Unit (DSU) staffed with trained investigators. When social workers are unable to locate kin through the aforementioned processes, DSU works to locate biological parents and extended family members. The DSU uses a myriad of methods, including database and Court record searches, in addition to conducting interviews with known family members. The Unit has had a consistent success rate, ranging from 88% in 2006 (January to October) to 95% in 2007 with 546 parents located out of a total of 575 cases received.[26] Despite the DSU's strong record, its critical strength is underutilized, especially with regard to engaging fathers and paternal family members from the outset of a case. As the Agency builds on its DSU strengths, it will continue to focus on the expansion of paternal kinship care as a fundamental resource for children and youth.

CFSA will also work with the District's Department of Human Services (DHS) to support fathers and paternal kin. The District of Columbia Fatherhood Initiative (DCFI) is one example of a federally-funded program that seeks to expand the array of neighborhood-based services and supports available to fathers. DCFI is dedicated to preparing fathers to play a more positive role in the lives of their children, in addition to encouraging fathers to provide financial support for their children. Under the DCFI initiative, over 30 community-based organizations will receive grant funds from the DHS to implement services that engage fathers and link them to supports throughout the District, including employment/training programs, health insurance, rental and utility assistance, food, transportation and legal services. During FY08, CFSA will continue to partner with DHS to support access and availability for these services.

New in FY08, the D.C. Family Court and D.C. Attorney General announced implementation of the Fathering Court program. Although not specifically targeting fathers involved with CFSA, the Fathering Court will focus on fathers who have recently been incarcerated, providing them with the necessary tools for becoming emotionally and financially responsible for their children. The Fathering Court will also combine case management and community resources – with an emphasis on employment – to

[26] The remaining 29 of the 575 were unable to be located due to the lack of identifying information [such as name and/or address], lack of contact with other family or friends, or possibly because of homelessness.

give non-custodial parents the ability to meet the needs of their children. The program will initially provide services for 45 fathers over a 12-month period.

Recruitment of kinship placement resources has greatly benefited from the Temporary Licensing of Foster Homes for Kin regulation which was promulgated in April 2004. This regulation allows kin residing in the District of Columbia to receive a temporary foster home license, which expedites the placement of a youth in their home. In order to receive a temporary license, however, the prospective caregiver must receive satisfactory results from a home safety assessment, in addition to a clean record check from the National Crime Information Center (NCIC), the Child Protective Register (CPR), and the Federal Bureau of Investigation (FBI). These checks are warranted for all residents in the home over age 18. The temporary license is initially active for 120 days, and may be renewed for an additional 90 days. During the temporary licensing period, the prospective caregiver is required to complete foster parent training in preparation for permanent licensing. As previously mentioned, the inability to grant temporary licenses for kin in Maryland and Virginia has historically been a barrier to placing children in kinship homes, although current discussions with the state of Maryland are showing demonstrated progress.

Finally, with regard to retention of kinship caregivers, CFSA is utilizing a portion of the District's federal FY07 Appropriation to support kinship care expansion and stabilization. The Agency anticipates that this funding allotment will help to stabilize kinship placements and to provide kin with the supports they need to care for children.

Strategies

CFSA must make concerted efforts to increase the kinship placement opportunities for children and youth. In order to do so, the Agency must increase recruitment of kinship providers, continue to work to remove the barriers to placement in Maryland and Virginia, and increase supports for kinship caregivers.

Feasible strategies exist to meet all three of the aforementioned needs. First, to increase the recruitment of all kinship providers, including fathers and paternal kin, stakeholders suggested that CFSA build on the strengths of Family Team Meetings, Family Finding, Youth Connections

Conferences, and the Diligent Search Unit. Second, continuing ICPC negotiations with Maryland will help remove the barriers to temporary licensure for kin located outside of the District. Additionally, targeting a portion of the District's federal Appropriation to expand and stabilize placement with kin will support recruitment and retention of kinship providers. Lastly, stakeholders recommended that CFSA explore the possibility of adding staff to the Foster Parent Support Unit that specialize in providing support to kin. The additional support would help kinship caregivers cope with challenges related to caring for their relative's children.

Traditional Foster Care

If placement with kin is not a viable option, placement in a traditional foster home is CFSA's preferred second option. As of December 2007, 32% of children and youth placed in CFSA's custody were residing in traditional foster homes.

Literature Review

Children grow best in stable family and community settings and children's developmental needs are most likely to be met within family environments (Doran & Berliner, 2001). Family-like settings are especially critical to meeting children's social and emotional needs, such as attachment to a caring and responsive adult, and a predictable and consistent environment (Foster Care Task Force, Delaware, 2001). Providing stable and nurturing families can bolster the resilience of children in care and ameliorate negative impacts on their developmental outcomes (Harden, 2004).

Challenges

According to projections, the number of children placed in family-based foster homes through 2009 is expected to decrease from 71% to 63% of the total population of children in out-of-home care. In order to counter this trend, the Agency will have to commit focused efforts on foster parent recruitment. Recruitment efforts will need to be specifically dedicated to finding foster families who are willing to care for teens age 15-21, particularly since CFSA expects to see the largest increase in this population over the next two years.

Traditional foster parents participating in the *2007 Needs Assessment* focus groups also raised concerns with regard to foster parent retention. Many of those concerns mirrored those of

kinship providers, including access to much-needed services. In part to address foster parents' concerns regarding accessing services, CFSA established the Foster Parent Support Unit (FPSU) in 2005. The FPSU strives to establish a supportive culture throughout CFSA to empower foster parents as caregivers, to enrich their understanding of CFSA expectations, policies and procedures, to operate as a liaison and enhance the working relationship between the foster parent and the social worker, and to promote a positive fostering experience that they would be willing to share with others. This unit offers and/or coordinates many support services:

- a dedicated support worker who is available to hear and resolve issues/concerns, as well as arrange meetings, coordinate services and referral requests, address subsidy payment issues, and ensure a stable placement for the child
- assistance in navigating the complex maze of government services for children and families
- access to crisis intervention services during and after business hours
- respite care and referrals for special services, such as child care, tutoring, transportation, mental health consultations, etc.
- coordination of educational services with the child's social worker
- dissemination of information directly to foster parents regarding administrative changes that directly impact their roles as resources for children and youth
- access to community resources that support and advocate for foster, kinship and adoptive parents

Unfortunately, the FPSU is only available to foster parents who are contracted through CFSA, which means that foster parents in Maryland and Virginia contracted through private agencies do not have access to these services. Focus group participants identified this major challenge as a factor impacting foster parent retention.

Foster parents also highlighted additional challenges related to service delivery when children are placed in Maryland or Virginia. The following challenges were included in the foster parents' list:

- *Access to health care* - Insufficient numbers of medical and dental providers in Maryland and Virginia accept D.C. Medicaid, making appointments difficult to arrange and payments complicated.
- *Transportation* - Foster parents in Maryland and Virginia often have to travel longer distances to access services that are necessary but only available in the District.
- *Record transfer* - Records from other jurisdictions may not transfer with the child. Sometimes a child's Individualized Education Plan, for example, is not included from a prior jurisdiction's placement. Workers must complete a new plan at each new placement, a cumbersome and inefficient case-planning procedure.

Traditional foster parents also noted that communication with social workers needs improvement. One key stakeholder suggested that it would be valuable to have an Ombudsman to help negotiate disagreements between the Agency and foster parents when such issues cannot be resolved through the traditional chain of command. Others agreed. In addition, they commented that communication with birth parents was poor or non-existent. This finding should be especially concerning to the Agency since positive communication between foster parents and birth parents is usually imperative for helping to secure expeditious reunification. Finally, foster parents raised concerns that they do not consistently receive placement packets, preventing them from being able to fully respond to the child's needs in the initial days of a new placement, in addition to creating stress for the foster parent.[27]

Strengths to Build Upon

Every two years, the Agency develops a comprehensive recruitment plan to review traditional foster parent recruitment needs and to identify the numerical and programmatic goals for recruitment. The plan outlines acceptable recruitment strategies, projects the length of various aspects of the recruitment process, and specifies the necessary resources to accomplish the articulated recruitment goals. The Agency's plan also focuses recruitment strategies on the specific populations (identified by market research) that are more likely to foster and/or adopt District children/youth. The comprehensive recruitment plan provides an important infrastructure from which the Agency can build as it strives to increase traditional foster home placements.

Through an Annie E. Casey Foundation (AECF) Family-to-Family grant, CFSA recently had a marketing consultant evaluate and provide recommendations for bolstering the Agency's recruitment and retention of foster (and adoptive) parents. Specifically, the consultant recommended the following strategies:

- Conduct an in-depth quantitative survey to gather data about foster and adoptive parents' attitudes and perceptions. Use the data to improve communication via facilitated

[27] CFSA does have a process in place to verify whether foster parents have received placement packets. The Placement Administration asks foster parents if the packet was received when they confirm the placement. If the placement packet was not received, the Placement Administration notifies the program administrator for the case who addresses the issue with the program manager, supervisor, and social worker. In addition, a daily log records the status of each child's placement, including a foster parent's receipt of the placement packet. This log is distributed to all appropriate staff.

substantive conversations between staff and foster parents, and to conduct message testing for the D.C. area prior to any broad scale media efforts.
- Conduct foster parent exit interviews to gather information about key points of dissatisfaction.
- Design an organizational structure that promotes coordination of recruitment, licensing, and placement functions.
- Create an information system that provides standard recruitment, retention, and critical vacancy data.
- Conduct open forums with foster parents, advocates, staff, and management with the initial goal of improving trust and communications, and the ultimate goal of implementing programs to recruit, retain, and support current foster parents.
- Assess effectiveness of community-based development efforts versus media-related efforts, including a return-on-investment analysis.
- Create a "Teen Speakers Bureau" to help recruit foster parents specifically willing to welcome teens into their homes.

With regard to the provision of services and supports that may help with retention, foster parents cited the following strengths on which the Agency can build:

- Children in District foster care have access to therapists, mentors, social workers and tutors. These easily accessible services should be maintained and, whenever possible, expanded.
- Respite care services are available and valued. These services should be maintained and, whenever possible, expanded.
- D.C. Medicaid is available to cover children's medical and dental health needs.
- Surrogate parent classes are available and helpful. These classes provide the foster parent with proper skills for advocating on the behalf of child.
- The Foster Parent Support Unit is especially valuable when foster parents are unable (for whatever reason) to reach their social workers. The Unit's services should be promoted and expanded.
- Summer camp is responsive to needs of the child. Expansion and promotion of a variety of summer camp opportunities will add to this existing strength.

Noted above as a valued strength, respite services are critical to traditional foster care families. Through a partnership with the Metropolitan Washington Council of Governments (COG), District foster parents are able to access community-based respite services at no cost. In FY08, COG will continue its work with the *Work of Heart Respite Program*, tapping into the existing cadre of trained and licensed volunteers to help identify respite parents willing to provide in-home respite for families with large sibling groups or

families with children with special needs who might otherwise not be accommodated.

In order to enhance foster parents' abilities to care for older youth, the Office of Youth Development is offering training in Positive Youth Development (PYD). The PYD process prepares young people to meet the challenges of adolescence and adulthood. Through a coordinated, progressive series of activities and experiences, youth build leadership skills, trust, and self-confidence. The PYD approach suggests that helping young people to achieve their full potential is the best way for them to avoid risky behaviors and to become socially, morally, emotionally, physically, and cognitively competent.

The Mockingbird Family Model (MFM) is another support program that foster parents report as a very successful experience. This unique model of extended, supportive family foster care includes licensed CFSA foster homes in the District of Columbia. As a whole, these homes are defined as a constellation which includes Satellite Parents and a Hub Parent(s). While the Satellite Parent is identified as a willing and able participant in the MFM project, the Hub Parent is defined as the primary source of support to the Satellite Families. This support includes preserving placements, strengthening familial relationships, increasing achievement and positive development, and nurturing permanency plans for the children in the constellation. The Hub Family can support between four (4) to ten (10) licensed Satellite Families, usually located near the Hub Family's home. In the pilot phase, there were two constellations in the Northeast and Southeast quadrants. As a result of the pilot's success, two additional constellations will be funded in the Northwest and Southwest quadrants.

Finally, CFSA is utilizing a combination of federal and local dollars to fund a Birth Parent Advocate Project. The current vision for the Project is creative, proactive engagement between CFSA and birth parents whose children are in out-of-home foster care placements but who are expected to return home within six months. Among other interventions, the Birth Parent Advocate Project will support strong collaborative relationships between birth parents and foster parents by facilitating early "teaming" shortly after the child is placed in out-of-home care. The newly-available funding will provide the necessary resources to help address foster parents' concerns regarding strained communication with birth families.

Strategies

To increase recruitment of traditional foster families, CFSA should discuss and implement the most appropriate recruitment recommendations put forth by the independent marketing consultant funded by the Annie E. Casey Foundation. In order to increase retention, CFSA must augment the supports available to foster families. Specifically, implementing the Birth Parent Advocate Project will help facilitate positive communication between birth parents and foster parents. The Agency must also work to research and implement the relevant recommendations put forth by the independent marketing consultant aimed at strengthening the collaboration between CFSA and foster parents. Finally, CFSA stakeholders recommended that the Agency should consider expanding the Foster Parent Support Unit to reach foster parents in Maryland who are contracted through private agencies.

Specialized Foster Care

Without a focused intervention, the percentage of children and youth placed in specialized foster homes is projected to increase from 32% (September 2007) to 56% (December 2009) of all children in family-based placements.

Literature Review

Specialized foster care has been defined in a variety of ways in the literature, but it is most commonly understood as a remedial care program for troubled children and youth in the least restrictive environment possible. The foster parent is trained to implement planned remedial supervision and care, leading to positive changes in the child's behavior (R.E.A.C.H. of Louisville, 2001). The basic premise of specialized foster care relies on the assumption that family and community environments are the most natural and conducive places to promote child development. CFSA policy defines specialized foster care as a time-limited placement in a licensed foster home that addresses the needs of children and youth who have been diagnosed with serious to severe mental, emotional and physical health problems.

There is a growing number of children in foster care who are seriously emotionally and behaviorally disturbed. Their needs simply cannot be met by traditional family foster care. For these maltreated and/or neglected children, specially-trained, structured, and caring (i.e., specialized) foster families can serve a critical role in providing remedial and corrective experiences (Foster Care Task Force, State of Delaware, 2001). Specialized foster care also

allows for these special needs children to receive individualized, highly structured, intensive treatment services while living in a nurturing, family environment.

At its core, specialized foster care is a form of mental health treatment in which the agent of change is the relationship between the child, foster parent(s), and other family members. Instead of living in a facility to receive treatment, children and youth in specialized foster care are maintained in the community and benefit from structured experiences in a home, in a neighborhood, and in a community school. (R.E.A.C.H. of Louisville, 2001). Specialized foster care is often a better treatment choice for youth who previously would have been placed in group homes.

The following benefits are noted throughout the literature:

- Infants, young children, and teens with special needs benefit from treatment foster care.
- Treatment foster care is a less expensive, more effective alternative to institutional care.
- Treatment foster care programs provide more integrated, comprehensive services in a community setting compared to institutional care. At follow-up, children discharged from treatment foster care show better adjustment and greater stability than children who were institutionalized.
- Children in treatment foster care programs spend more time with adults who supervise and teach; children in residential or institutional care spend more time with deviant peers.

Despite the benefits of specialized foster care (as compared to congregate care), the literature reinforces the importance of placing children in the least restrictive setting, which would be traditional family-based settings.

Challenges

The rise in the number of specialized placements can be attributed to two primary variables: first, an increase in the actual numbers of children who need extra help to respond to the physical, psychological, and emotional stressors of child abuse and neglect; and second, a decrease in children "stepping down" from specialized settings to traditional foster home settings.

Strengths to Build Upon

While the Agency acknowledges that there will always be a group of children who benefit from specialized foster care, CFSA hopes to increase kinship and traditional foster parents' skills, as well as community supports, so that fewer children require specialized foster care settings. A major strength that CFSA can draw upon is the technical assistance received by the Georgetown University Center for Child and Human Development. The Center has helped to educate CFSA, HFTC Collaborative and Consortium social workers, and resource parents to work with children with specialized developmental needs. The aim of this technical assistance is to reduce the need for specialized foster care by preparing all foster parents to work with children with developmental needs.

As mentioned in the Introduction, another program which may help curtail the use of specialized foster care is the "Levels of Care" approach which will revamp the current method of rate setting for reimbursement to foster parents. The model allows for flexibility in reimbursement based on the needs of individual children and on the supports provided by foster parents to meet those needs. By providing financial support to maintain a child in a foster home, CFSA expects that this new rate-setting methodology will avoid a placement change to a specialized home, congregate care or residential treatment. Currently, the Agency is completing a pilot study of Levels of Care from a random sample of 230 children in foster care. Again, the idea is for all foster parents to be trained to care for children with different levels of needs.

Finally, more targeted mental health services will be an additional resource impacting specialized placements. In partnership with the Department of Mental Health (DMH), CFSA recently completed an assessment of the mental health needs of children in care. The report identifies large and serious gaps in the mental health service delivery system. Using the information in the assessment, CFSA and DMH are now working together to write a resource development plan to address the needs identified. This process should help both CFSA and DMH address the mental and behavioral needs of many children currently requiring specialized foster care. By putting community-based services into place, these children will be more likely to receive the services necessary for them to maintain, and where possible, improve their overall well-being, safety and permanency.

Strategies

The number of children and youth placed in specialized foster homes is projected to increase over the next two years. In order to decrease the need for more specialized foster homes, CFSA and the Department of Mental Health must work to amplify the number of community-based supports for children with mental health and behavioral challenges. CFSA should also move towards implementing the Levels of Care model to allow for flexibility of foster care maintenance payments based on the individual needs of children. The Levels of Care approach will also create the opportunity for all foster parents to gain the skills necessary to care for children and youth with varying levels of need.

Summary of Needs

Projections indicate that the number of children in family-like settings will decrease by December 2009 unless CFSA makes concerted efforts to increase the use of family-based, traditional, and kinship foster care. Increased focus on kinship and foster parent recruitment is critical to this effort, including a stronger emphasis on reaching out to fathers and paternal relatives during the FTM process. More focused marketing strategies are also needed for recruiting traditional foster parents who are willing to care for older youth.

Retaining current kinship and traditional foster parents is also critical. Strategies suggested by stakeholders to do so include exploring the addition of specialized kinship support workers to the FPSU, and taking steps to build more positive relationships between social workers, management, advocacy groups, and foster parents. Finally, CFSA can help mitigate the number of children projected to be placed in specialized foster homes by working closely with DMH to strengthen community-based mental and behavioral health resources. As noted above, moving forward with the Levels of Care approach will help to ensure that foster parents feel confident to work with all children, regardless of their level of need.

Chapter IV
ADOPTIVE PLACEMENT

Adoptive Placement

The Issue

If CFSA does not make positive intervention, the percentage of children and youth who have the goal of adoption and are placed in pre-adoptive homes is projected to decline dramatically by December 2009. On September 30, 2007, the number of children and youth in pre-adoptive placements comprised 34% (178 of 519) of the actual number of children and youth with the goal of adoption. By December 2009, the number of children and youth in pre-adoptive placements is expected to comprise just 21% of all children and youth projected to have a goal of adoption (78 of 370).[28]

Table 5 – Adoption Goal

Adoption Goal *(number of youth served w/goal of adoption)*					
	Lowest	**Mean**	**Highest**	**Total Pop.**	**Percent**
September-06		**575**		2313	24.86%
December-06		**557**		2286	24.37%
September-07		**519**		2243	23.14%
December-07	435	**483**	531	2121	22.77%
September-08	395	**439**	483	2083	21.08%
December-08	381	**423**	465	2060	20.53%
September-09	345	**383**	421	2003	19.12%
December-09	333	**370**	407	2018	18.33%

Data Source: FACES Report ADP047

** Monthly projections: Regression analysis - 12 point in time data (over 31 months)*

Table 6 – Pre-Adoptive Placements

Pre-Adoptive Placements					
	Lowest	**Mean**	**Highest**	**Total Pop.**	**Percent**
September-06		**240**		2313	10.38%
December-06		**212**		2286	9.27%
September-07		**178**		2243	7.94%
December-07	137	**152**	167	2121	7.17%
September-08	106	**118**	130	2083	5.66%
December-08	98	**109**	120	2060	5.29%
September-09	76	**84**	92	2003	4.19%
December-09	70	**78**	86	2018	3.87%

Data Source: FACES Report ADP047

** Monthly projections: Regression analysis - 12 point in time data (over 31 months)*

[28] Data included in this section comes from FACES. Data kept by staff members indicate slightly different actuals, but the trend is similar.

Increasing the number of children placed in pre-adoptive homes is critical to ensure that children with the goal of adoption are reaching permanency in a timely manner. Achieving permanency is a critical focus of the Administration for Children and Families, and is measured nationally using the National Standards' Permanency Composites. The following statistics indicate the comparison between the District's and national data:

- The District of Columbia ranks 28th out of 47 states and U.S. territories with regard to timeliness of adoption.
- For children exiting foster care between April 1, 2006 and March 31, 2007, the median time to adoption for a child in CFSA's custody was 38.3 months. The national median was 32.4 months. Over the last three years, CFSA's median time to adoption has consistently decreased.
- Of the children who exited foster care to adoption between April 1, 2006 and March 31, 2007, only 15.6% were adopted in 24 months or less. The national median was 26.8%. The percentage of children who exit foster care to adoption in less than 24 months has fluctuated over the last three years.

One day after we moved in my mom asked me what was the magic that turned me around. I said being with my brothers and sisters and knowing I had a forever family. She said they would never give up on us and that families stick together through the good times and bad times. My mom tells people that successful families don't happen by accident. There are reasons you have to be flexible. Parents have to accept the child for who they are, have realistic expectations and communicate openly. I want to tell other teens it is okay to love two sets of parents. My adoptive parents are my real parents.

Robert, www.AdoptUSKids.com

Literature Review

Despite nationwide initiatives aimed at getting more children out of foster care and into permanent adoptive homes, the number of children in need of permanent families (including adoption) continues to be large (Howard, 2006). At the end of 2005 the estimated number of children waiting to be adopted was 115,000 (AFCARS, 2005). In 2006, the Urban Institute Child Welfare Research Program released a state-by-state analysis of trends in U.S. foster care adoption legislation, highlighting both barriers and promising approaches that many states have developed to place children from foster care into permanent adoptive homes They found that barriers can and often do occur throughout the adoption process. In the key findings of the report, the Urban Institute found that barriers to foster care adoption were found to mostly occur in five areas:

1. Termination of parental rights (TPR) hearings
   Barriers include insufficient services to parents prior to TPR efforts, back-and-forth petitions and hearings between the courts and the child welfare system, reluctance by the court system to terminate parental rights if an adoptive home has not been identified, and requests by parents to have "another chance".
2. Recruitment of adoptive homes
   Barriers include difficulty finding homes that reflect the ethnic and racial diversity of the children needing permanent placement, as well as finding homes for children with special needs, which includes children with behavioral problems and/or disabilities, older children, and sibling groups.
3. Child welfare case management
   Barriers include high staff turnover which often leads to a discontinuity in services, high caseloads, and insufficient staff training that often leads to delays in the adoption process. Delays are also frequent when cases are transferred between workers, sometimes with incomplete case records. A 2002 study by Potter and Klein-Rothschild revealed that a single change of caseworker during the year reduced the likelihood of permanency by 52%.
4. Court Case Management
   General court delays and insufficient court resources are commonplace throughout the country. Barriers include repeated continuances, overcrowded dockets, difficulty scheduling hearings, preconceived (judicial) notions on adoption, lack of communication with the child welfare agency, and child abuse/neglect cases being low on a priority list. Another significant barrier is the lack of child welfare training for judges, attorneys and court personnel.

5. Establishment or change of permanency goal
   Many states experience delays when changing a goal to adoption, which means the adoption efforts are not pursued in a timely manner. Barriers also include preferring a permanency goal of long-term foster care over adoption.

Other barriers noted throughout the literature review include a lack of uniformity in the inter-jurisdictional placement process; failure to practice concurrent planning; delays in completing home studies and the absence of dual-licensing; delays in initiating the diligent search process to locate biological parents; failure to make diligent efforts to provide services that some families need to reunify with their children, which results in appeals; and the fact that many teens (14 and older) may choose not to be adopted in favor of keeping the connection with their families (Rycus et al, 2006; Macomber et al, 2004).

Rycus et al (2006) also found that successful educational experiences of adopted children appear to correlate with successful adoption outcomes. Many children available for adoption have special educational needs (as well as health care, mental health, and other developmental needs) and many foster parents do not get the requisite guidance and support to navigate the educational system (and other systems). The literature reports that behavioral and emotional problems of many adopted children pose considerable challenges for their adoptive families and have been identified as the single greatest source of stress in families who adopt older children and children with special needs (Groza, 1999; Casey Family Services, 2003). The inability for many adoptive parents to access specialized services and resources for their children sometimes results in adoption disruptions.

A study by the Evan B. Donaldson Adoption Institute (2005), *Listening to Parents: Overcoming Barriers to Adoption of Children from Foster Care*, revealed a number of barriers that keep prospective adoptive parents from completing the adoption process. These include the discrepancy between the demographics of children available and the demographics of children sought by potential adoptive parents, difficulty contacting the agency or an unpleasant initial contact with the agency, a seeming emphasis on weeding out applicants rather than recruiting them, and frustration with the numerous (often drawn out) steps of the adoption process. As a result of these and other factors, the attrition rate of applicants rises sharply from initial call to adoption.

Challenges

A focus group of social workers involved in adoptive parent recruitment efforts highlighted the difficulty they experience in finding adoptive homes for children with special needs, as well as teens. Focus group participants also noted that there were insufficient monetary resources to support recruitment efforts and that the lengthy adoption process often discourages families from becoming pre-adoptive placement resources. Similarly, a focus group of adoptive parents highlighted the lengthy adoption process as a deterrent for families that may be interested in becoming a pre-adoptive placement. According to the FY06-FY07 Foster and Adoptive Parent Recruitment Plan, recruitment efforts for pre-adoptive parents should streamline strategies to address the "under-adopted" population of CFSA children and youth.

Concrete supports for pre-adoptive and adoptive parents are also critical to ensuring that all children with a goal of adoption have a pre-adoptive placement. The focus group of recruitment social workers underscored the importance of support groups and a buddy system for adoptive families.

Staff members reported that support networks were especially important because children's behavioral and emotional problems often pose considerable challenges for their adoptive families. The literature notes that the behavioral and emotional problems have been identified as the single greatest source of stress in families who adopt older children and children with special needs (Groza, 1999; Casey Family Services, 2003). This makes knowledge of available services, the ability to access specialized services and resources for their children, and ongoing support of adoptive parents vitally important. The staff noted that information for adoptive parents regarding the Center of Keys for Life eligibility and programs is a must. Further, recruitment staff noted that there are an insufficient number of post-permanency staff members to support adoptive families.

Adoptive parents also expressed a need for on-going training to improve their capacity to care for their adopted children. They asked that training address the many unique needs of children with varying challenges; citing "the one-size-fits all approach to training is not effective." Specifically, adoptive parents requested training on the developmental needs of children.

CFSA stakeholders have also expressed concern that adoption subsidies end for children at age 18, although families can receive foster care payments for a child until 21. This creates a financial disincentive to adopt children and youth, particularly those nearing age 18. Currently, CFSA is studying potential criteria for extending the adoption and guardianship subsidy beyond age 18.

In summary, CFSA must increase recruitment and support of pre-adoptive families in order to realize the vision of balanced placements with children and youth in need.

Strengths to Build Upon

As previously mentioned, a marketing consultant funded by the Annie E. Casey Foundation recently completed an evaluation of CFSA's foster and adoptive parent recruitment efforts.[29] Recommendations from the evaluation are an important resource to build upon as CFSA seeks to strengthen adoptive parent recruitment. Those recommendations regarding the assessment of effective and efficient community-based development efforts versus media-related efforts are specifically helpful, in addition to the suggestions for conducting research and message-testing prior to launching media campaigns, and creating a "Teen Speakers Bureau" to increase interest in pre-adoptive homes for teens. As CFSA takes hold of these recommendations, there is justifiable expectation for a increase in the numbers of foster and adoptive parents willing to care for children and youth in the District of Columbia.

CFSA also recognizes the importance of supporting those foster and adoptive parents who have already committed themselves to the care of children and youth. The Agency recognizes that foster parents will stay connected to CFSA if they feel valued, respected and supported. Retaining our foster parents is critical to maintaining an adequate pool of homes to support safety, help children achieve permanence through adoption, and improve children's well-being. Strong supports and resources will always be vitally important, especially since foster parents represent a large percentage of persons who adopt children from CFSA.

In January of 2006, two staff members were identified to address families' post-permanency concerns. The staff members begin this work with families prior to adoption finalization to ensure services are in place. By continuing supportive work for a short time after finalization, staff further ensures the strengthening and stability of the family. Post-adoption services are also provided by the workers, allowing families to receive short-term assistance for emerging issues, and to help them overcome crises. In collaboration with the Department of Mental Health,

[29] For more information regarding the AECF-funded marketing consultant's recommendations, please see pp. 37-38.

CFSA has also ensured that post-permanency families have access to existing community-based mental health services.

Finally, the social workers serve to link children and families to the Post-Permanency Family Center, which is operated by Adoptions Together, Inc. The Center provides supports and resources designed to promote family well-being, and is an integral component serving District families at all stages of the adoption process. The Center offers support groups, training, information about and referral to community services, a resource library, and a 24-hour Crisis Helpline. The Center also provides short-term counseling and referrals for on-going clinical services as necessary.

CFSA has entered into an additional contract with Adoptions Together, Inc., to provide specialized clinical adoption training to private mental health providers who accept Medicaid. The goal is to increase the capacity of mental health providers who provide therapeutic services to children and families. CFSA also has entered into a contract with the Center for Adoption, Support and Education, Inc. (C.A.S.E.) to provide clinical services for children and families who are going through the adoption process.

In cases where adoption has been ruled out as a permanency option, either because a child older than 14 refuses to consent or because kin feel uncomfortable seeking the termination of parental rights, CFSA is able to offer guardianship as an alternative. Guardianship provides financial assistance at the same rate as adoption subsidies to kinship families caring for relative children. Both District and out-of-state kinship caregivers are eligible for guardianship subsidies which continue until the child leaves the home or reaches age 18. In FY07 alone, 143 children achieved permanency through the guardianship process.

Strategies

Many foster parents become pre-adoptive parents. As such, the Agency's strategy to recruit more pre-adoptive families should mirror the same strategy for foster parent recruitment. This strategy includes discussing and implementing the most appropriate recommendations put forth by the independent marketing consultant funded by the Annie E. Casey Foundation.

To decrease the amount of time it takes to achieve adoption, the District must simultaneously decrease the amount of time that it takes to terminate parental rights, when appropriate. In FY08, CFSA is planning to work with the Court Improvement Project and the D.C. Family Court to reduce the amount of time it takes to achieve adoption. In order to facilitate this process, non-custodial parents need to be notified early in the life of a case. For every case, CFSA must also focus on utilizing concurrent planning so that progress toward the goal of adoption will be underway should it become the primary permanency goal.

Finally, the Agency must increase post-permanency supports for adoptive parents, and children and youth who have been adopted. The Agency should consider increasing the number of staff or community-based services that provide post-permanency supports to better meet the needs of adoptive families. A mechanism should be put into place by which every pre-adoptive parent is linked with a "buddy" or support group to guide them through the adoption process and help them overcome any obstacles they may face post-permanency. On-going training opportunities for adoptive parents should also be implemented so that adoptive parents can continually improve their ability to care for their children.

With regard to supports for children and youth, the Agency should work to conduct a more comprehensive mental and behavioral health assessment of each child and secure the appropriate community resources prior to finalizing the adoption. CFSA should also continue to collaborate with the Department of Mental Health to ensure that community-based mental and behavioral health services remain available and accessible to post-permanency families in the District.

Summary of Needs

CFSA must continue its dedicated and concerted efforts to increase the number of pre-adoptive homes available to children in order to avoid a situation whereby the number of children with the goal of adoption exceeds the supply of pre-adoptive homes. Recruitment is obviously critical to this effort, including more focused media-marketing strategies. Providing pre-adoptive and post-adoptive parents with adequate supports is another crucial tactic that must be achieved. Strategies to succeed in these efforts include decreasing the length of time it takes to achieve adoption, expanding the number of staff and/or community-based services to support children and families during post-permanency stages, linking adoptive parents with "buddies" or support

groups, creating on-going opportunities for training, and ensuring that children with adoption have a thorough mental and behavioral health assessment. All of these efforts must be linked to services in the community so that post-permanency support systems are both reliable and effective. In this way, the Agency's efforts will be reinforced and the families will have a safety-net to the best of the District's ability.

Chapter V
CONGREGATE CARE PLACEMENT SETTINGS

Congregate Care Placement Settings

The Issue

Of the total population of children and youth in CFSA's custody, the proportion placed in congregate care settings[30] is projected to increase from 22% (n=487) as of September 2007 to 23% (n=462) by December 2009. Although this one percent increase may not seem dramatic or alarming, it is in direct conflict with the Agency's Practice Model which emphasizes the importance of placing children and youth in family-like settings.

Group Homes

Group home placement in general is projected to increase from 6% to 7% of the total CFSA population. The proportion of children and youth residing in traditional versus specialized group homes is projected to remain nearly constant (11%) through 2009. Most recently (as of September 2007), 88.7% of youth in congregate care were placed in traditional group homes.

Literature Review

The National Survey of Child and Adolescent Well-Being (NSCAW) (2002) found that children in group homes were four more times as likely as those in foster care (and ten more times as likely as those in kinship care) to report that they do not like the people with whom they live. They were also more likely to report never seeing their biological mother or father. A 2003 study conducted in the City of New York revealed that, in general, congregate care does not work well for youth. It does not provide a "family-like" setting, fails to meet the service and primary needs of youth, and the quality of staff is quite poor (Freundlich, 2003). Group homes also provide the most restrictive out-of-home placement option for children and youth in foster care (Baker & Calderon, 2004).

> ***You can tell by talking to the kids where they have been raised. Our youth who go to good foster homes thrive. They have the ability to take positive risks, take advantage of what life has to offer. Our other youth who don't have that…don't finish school. They keep enrolling in school and attending here and there. But their ability to succeed is squashed somehow.***
>
> *- CFSA Social Worker*

While it is preferred that children in out-of-home care live with relatives, some children have physical or behavioral needs that require the structure and services of residential or group

[30] Congregate care settings include traditional and specialized group homes, independent living facilities and residential treatment centers.

settings. Group homes may also be used for pregnant and parenting teens, or sometimes large sibling groups (due to the shortage of foster parents willing and capable of caring for them).

Challenges

CFSA workers agree that a group home setting is not the most desirable for youth. It is difficult, if not impossible, to create a family-like setting in such a placement. Group homes are also particularly unsuitable for youth who are entering care for the first time, according to staff. In addition to the trauma of leaving a lifelong home environment, institutional issues impact the transition period and contribute to the likelihood of disruption. These issues include favoritism, staff frustrations, conflicts between group home staff and residents, and internal conflicts amongst residents. Further, informal, yet important, independent living skills such as relationship-building, cooking, housekeeping, financial responsibility and home management are difficult to teach in a group home environment.

Another serious concern is the dearth of foster parents and social services staff who are both skilled and trained to work with teens. Given that pre-teen and teenage years can be tumultuous, caregivers need patience but they also need guidelines and skill sets to help them be creative and yet remain firm when parenting.

> ***I have this one client, he just turned 18. He's been in (a specialized foster home) for the last six years. And he gets a lot of structure there and he's therapeutically dealt with on every level. But then he leaves there and goes to this group home and there's no therapeutic intervention for him. The group home staff use a behavior-based model, not a therapeutic model. You can't make them understand that, okay, it's one thing to take something from him because of a negative perspective, but then from a positive perspective, if he does something good, you know, give him something back, so he can see the difference. But they can't understand that because they don't come from that perspective.***
>
> ***-Social Worker Focus Group***

All youth deal with the emotional volatility of their teenage years, but the teens in foster care also struggle with complex issues such as abandonment, disconnection from birth families, substance abuse and mental health issues. Fragility of relationships between youth and their families, and lack of supports for older youth are primary reasons for conflicts and behaviors that lead caregivers to conclude they can no longer care for teens. This causes family and foster placements alike to disrupt at a high rate for older youth, and subsequently, results in a greater need for appropriate placements.

CFSA staff and *2007 Needs Assessment* focus group participants identified several systemic issues that have and will continue to contribute to the increase of group home placements if not addressed. A major concern is the lack of compulsion for youth (particularly those who have turned 18) to accept and/or participate in services provided by the Agency, particularly therapeutic and mental health services. Older youth also tend to discontinue other stabilizing behaviors, such as taking medication, as they assert their right to make decisions for themselves. Accordingly, it is very important for CFSA and its contracted providers to encourage healthy and positive transitions into young adulthood and independence. Such encouragement must take place at the earliest opportunity in order to help "reframe" the youth's perspectives and orientation to the helping process. It must include training for foster parents and staff to effectively use operant conditioning, i.e., positive and negative reinforcement.

Data trends also show an increased number of teenagers entering care for the first time, contributing to an increase in group home placements. These are often "disconnected" youth over the age of 16 who are not working and who are not in school.[31] There is a definitive lack of placement resources for these youth, including proper transitional housing.

Strengths to Build Upon

In the 2005 White Paper, *Revamping Youth Services: Preparing Young People in Foster Care for Independence,* CFSA reviewed best practices for preparing youth for adulthood. The Agency has subsequently adopted a youth development approach, establishing benchmarks for youth services. Youth who participated in focus groups identified several services available to them: mentoring, tutoring, case management related to life skills, mental health services, participating in the Keys for Life College Prep program, and health insurance. Expanding upon these existing services may be one strategy to strengthen the current capacity of foster care providers to care for youth in family-based settings.

> ***"It takes kids awhile in CKL until they are full enough (of positive reinforcement) to start doing (positive) things."***
> *- CFSA Social Worker*

[31] Definition by Andrew Sum as found in *Leave no Youth Behind: Opportunities for Congress to Reach Disconnected Youth*, Center for Law and Social Policy (CLASP), July 2003, p.9.

Although the aforementioned services are positive indicators of assistance to youth in care, youth also expressed concerns related to the services offered. Many older youth, for example, indicated that social workers are frequently inaccessible to help them receive services. Others felt that the Center for Keys to Life (CKL) program should be introduced at a younger age.

CFSA is beginning to utilize Multidimensional Treatment Foster Care (MTFC) as a placement strategy for youth in congregate care, including residential treatment centers. MTFC is a cost-effective alternative to regular foster care, group or residential treatment, and incarceration for youth who have problems with chronic disruptive behavior. (For more information on MTFC, please see the chapter on *Emergency Shelter Placements*.)

Strategies

CFSA will attempt to eliminate the use of congregate care for all children under age 12 by December 2009 and decrease the use of congregate care overall. As the Agency continues work to achieve this goal over the next two years, there should be a steady increase in the number of children and youth in family-based settings and a decrease in the number of children and youth in group care. Once this transition is final, there should be an overall decline in the generalized use of congregate care with more emphasis on providing short term specialized services to children and youth in these placements and providing caregivers and youth with the resources and supports they need to maintain stable placements.

As previously mentioned, stable placements require placement resources that are better prepared to meet the emotional and developmental needs of all children and youth, particularly those who are in congregate care placements. Placement and recruitment staff members who participated in the focus groups recommended training for foster parents and staff to address the unique concerns of teens. Strengthening family connections – particularly for youth 18-21, regardless of permanency goal – would also ensure that youth ultimately achieve positive permanency outcomes and reduce family placement disruptions. Likewise, family connections are also critical resources to help youth thrive during and after the transition to independence.

Independent Living

The percentage of youth placed in independent living facilities is projected to remain constant at approximately 7% of the total CFSA population. Nonetheless, the proportion of teen parents that will require independent living facilities is expected to increase from 30.6% to 44% of the total population of youth requiring independent living placements.

Literature Review

Almost ten years ago, the federal government recognized the need to address adolescents preparing for independent living. The Foster Care Independence Act of 1999 (also referred to as the Chafee Act) and the John H. Chafee Foster Care Independence Program both address the crises that adolescents experience in preparation for aging out and during their attempts to transition into independent living (Administration for Children & Families Children's Bureau, 1999). At the time, the Chafee Act doubled federal funding for states to overhaul the way they assess and meet adolescent permanency needs (Oldmixon, S. & Smith, C., 2007).

More recently, research indicates that youth living in out-of-home placements, particularly those "aging out of care" often need highly intensive and specialized services to prepare them for independent living (Freundlich et al. 2007). Approximately 20,000 older youth age out of the child welfare system each year (Administration for Children & Families, 2004).

> *I'm ready for (independent living), right? but I think when I move out of the system, I might, won't have as much benefits, or help and I don't think they teach me enough to be ready for that and I think I be ended up somewhere where I don't want to be for the rest of my life. That's the honest truth.*
>
> *-Male Youth (15-17)*
> *Focus Group Participant*

In response, child welfare agencies around the country are changing their approach to working with youth through a major shift in focus from independent living to youth development (New York City Administration for Children's Services, 2006). States are working to ensure positive outcomes for youth leaving foster care so that they may become healthy, productive adults. The following strategies are in effect nationally (Oldmixon, S. & Smith, C., 2007):

- Promoting stable, permanent connections to caring adults
- Assisting youth with management of their physical and mental health needs
- Supporting economic success through education and employment programs
- Providing life skills training to help youth navigate the adult world

- Improving access to stable and safe housing
- Structuring opportunities for youth to provide input on state policies and programs

Challenges

Although independent living programs (ILPs) can be invaluable for preparing youth to age out of the child welfare system, placement into such programs is not driven by the attainment of certain developmental milestones. Most youth are not placed in ILPs because they demonstrate a readiness for transition to independence, nor are the placement decisions primarily age-driven. The ILP placements are generally based on a combination of the youth's age and available resources.

Typically, youth are placed in the first independent living setting available because there is no other placement option or because it is the youth's choice. Ideally, placement decisions would maintain youth in more traditional settings until the youth demonstrated specific developmental milestones (measurable maturity, readiness for independence, etc.). Overall, older youth themselves acknowledge a lack of preparedness for independence. Many have expressed an anxiety about aging out, feeling that they do not have an advocate/voice and they are uncertain about their futures. When youth are not adequately prepared for independent living, and perhaps prematurely given the freedom and privacy of their own living space, they are more likely to engage in behavior that will not serve their true best interests.

Focus group participants also indicated concern over some youth who appear to intentionally attempt to manipulate their way into ILP spots through threats of running away and/or other acting-out behaviors. The youth, however, believe such "tactics" will result in a favorable change to a more liberal placement. The perception that more resources are available in an ILP may also lead youth to vie for ILP slots. Once youth are informed that their counterparts in ILPs receive monthly stipends of up to several hundred dollars, these programs become coveted placements. In reality, much of the stipend is used for paying rent and other monthly obligations, and there is not much left for the youth's discretionary spending. Still, youth desire to have the option of making such decisions, particularly if these options are not provided in their current placement setting.

Despite the attractive characteristics of ILPs, services and safety are both concerns. Many older youth feel that the services offered in ILPs are inadequate to prepare them for transitioning out of foster care. In addition, some older youth feel that program staff workers are slow to respond to needs, such as repairing appliances. The issue of gender bias has also surfaced. Concerns were expressed by older female focus group participants that the child welfare system gives preferential treatment to boys over girls when it comes to ILP placements. When the ILP placements are located in high-crime areas of the city, which indeed some are, youth are concerned for their safety. One youth shared that some programs state that they offer support but never truly provide it. One program, for example, promised to provide him with new furniture but failed to do so. Once the lack of attention was reported to CFSA, the matter was tended to, but the fact that the matter needed to be reported is problematic.

Strengths to Build Upon

CFSA developed a Teen Bridge Program designed to serve teens who need extra support and assistance to prepare for independence but who are not ready for traditional ILPs. Contracted to one of the Agency's private providers, the program is a concept model that bridges the gap between ILPs and traditional group homes. The current program has a capacity to serve 6 female youth. It is staffed by thoroughly trained and skilled workers who are familiar with the particular needs and challenges of the female teens. Typically the girls placed there have had behavioral issues elsewhere in the community, and most have been in foster care for years, although a few might be new entries. Many have tried traditional ILP placements and did not adjust well to the lack of structure. For example, they could not maintain a job, stayed out all night, or had difficulties with landlords. Some of the girls were referred straight from RTC placement as a continuum of care model with positive results. Indeed, most of the girls are thriving in the placement and additional beds have just been purchased. A complementary program for teen males will also be implemented. Once the Teen Bridge Program is expanded to serve males, there will be a total of 16 placement slots. A program such as this is always in high demand, particularly if it has shown success, and there is already a waiting list for entry.

Placement staff indicates that, at minimum, an addition of 10 beds is needed for 2008 to meet the current demand for the program.

Strategies

As current independent living programs must adhere to the licensing and operating regulations outlined by the District of Columbia Municipal Regulations, it may be requisite to revise the regulations to support a transitional living model. To this end, the Agency is exploring the program at Covenant House and its model for transitional living for older youth. Possibilities include placement of older youth (19-21yrs) in a licensed setting (like the Covenant House main facility) with strong life skill supports and training for anyone with the goal of an Alternative Planned Permanent Living Arrangement (APPLA). It should be noted, however, that the use of APPLA as a permanency goal must become the exception and should be very difficult to justify so that CFSA can maintain the principles set forth by the CFSA Practice Model.

As discussed, youth aged 18 to 21 present a particular challenge for placement. Increased support for their transitions is necessary. It is possible to access such support in-house through CFSA's Office of Youth Development (OYD). Currently, the OYD conducts case management for youth aged 16 and older with a goal of APPLA. OYD will begin to serve teens without regard for their permanency goal – some APPLA, others not. Simultaneously, the Agency must structure a solid transitional model that is developmentally-appropriate and focused on working with older youth. One strategy is identification of apartments/residences that can be available to the youth up to 24 months after aging out of foster care.

The addition and/or expansion of other specialized programs and services will ensure that special populations of youth in independent living programs will receive the individualized care that they need. Models of shared housing will support a gradual transition to independence. Such additions are critical to create true permanence and stability for youth. For example, CFSA is beginning to partner with a community-based program to implement an innovative program designed to support the service and program challenges faced by younger female teen parents.

CFSA is also partnering with the Casey Strategic Consulting Group (CSCG) to assess and analyze the high number of youth, ages 13 and older, placed in care. Assessments will examine resource family capacity, community-based services, licensing issues, and placement process issues. Analyses will include reasons why older children enter care, existing efforts designed to create permanency for youth, and existing programs and services provided for older youth who will be aging out of foster care. The end product of these assessments and analyses will be a set of recommendations for addressing the needs of older youth in care – permanency, services, engagement, youth voice, more effective transition planning, diversifying placement options, and alternative strategies to keep older youth from entering the foster care system. In effect, CFSA will be redesigning our independent living model, providing settings that create a genuine transition to independence from foster care while more realistically preparing older youth to live on their own.

Residential Treatment Centers

Children who require the highest level of specialized care[32] are placed in residential treatment centers (RTCs). This type of specialized care may include treatment for neurological impairments, medically fragile conditions, sexual abuse and/or sexual offense, as well as treatment for youth in foster care who have also been in the juvenile justice system for various crimes (assault, possession of weapons, robbery, theft, etc.). Based on current data, the percentage of children and youth requiring placement in residential treatment settings is projected to increase from 6.6% (n=148) of the total CFSA population to 7.7% (n=155) of the population. It is requisite that CFSA respond to these projections with well-planned options.

Literature Review

Over a decade ago, the lack of strong data supporting the efficacy of residential care led the U.S. General Accounting Office (1994, p. 4) to observe, "Not enough is known about residential care programs to provide a clear picture of which kinds of treatment approaches work best or about the effectiveness of the treatment over long term. Further, no consensus exists on which youth are best served in residential care…or how residential care should be combined with community-

[32] Specialized care is treatment care that cannot be provided in a traditional foster home.

based care to serve at-risk youth over time." Today, almost one-fifth of our nation's children living in out-of-home care are placed in residential or group care (Freundlich et al. 2007).

To the extent that congregate care is used as a placement resource for youth whose special needs require this level of care, research has identified several characteristics of effective residential care programs. Bilchik (2005) notes that effective programs function with one or more of the following objectives:

- Value and engage families; commit to finding permanent connections for every child, even when parents cannot be those connections.
- Use competent, individualized assessment of strengths and needs, and ongoing measurement of progress.
- Offer an array of positive, competency-centered therapies.
- Plan for aftercare from the day of admission, interfacing with the community-wide network of services in other relevant areas including the schools.

In an extensive review of the literature in support of a research agenda for child welfare, Meadowcroft and her colleagues (1994) concluded that residential care is more expensive than specialized foster care, serves a population with similar problems, places children in more restrictive settings at discharge, and produces fewer behavioral improvements. Such findings led the Surgeon General to report that residential treatment has not shown substantial benefits to children and youth with mental health problems and may have adverse effects because of behavior contagion spreading from one child to the next. The report concludes that for youth who manifest severe emotional or behavioral disorders, the positive evidence for home- and community-based treatments contrasts sharply with the traditional forms of institutional care, which can have deleterious consequences (U.S. Surgeon General, 2000).

Additionally, a 2004 study conducted by the Illinois Department of Children and Family Services found that residential care was primarily used as the placement of last resort—only after youth have experienced multiple placements or have been placed in locked settings (Budde et al, 2004). The study also revealed that residential care programs were serving more troubled youth than in previous years. Almost 60% of youth who entered residential care in 2002 were experiencing negative discharge outcomes. Many youth who left residential care for foster care or for potentially permanent family settings eventually returned to higher levels of care. Youth who experienced more placements prior to entering residential care were also more likely to have

negative discharge and post-discharge outcomes. Boys were at higher risk than girls of entering residential care and of experiencing negative residential care discharge and post-discharge outcomes.

Compared to children in family-based foster care, Barth (2002) found that re-entry rates of youth in residential treatment were demonstrably higher. Further, there were fewer aftercare services available to ease the transition out of the residential treatment center (RTC). Most youth who enter group settings funnel down into residential treatment, and arrive there with increasingly complex and recalcitrant problems (Bilchik, 2005).

Many jurisdictions are working diligently to reduce this reliance on congregate/group care settings. For example, ten years ago, over 65% of children in care in the state of Kansas were placed in residential facilities and group homes. Today, more than 90% of their children in care are in a family-like setting. Kansas began this journey toward excellence in child welfare when it made the decision to enter into performance-based contracts with child welfare agencies around the state. This public-private partnership has enabled the state to continually raise the bar on service delivery (Kansas Dept. of Social and Rehabilitation Services, 2006).

With the support of Annie E. Casey Foundation's Casey Strategic Consulting Group, as well as its Center for Effective Child Welfare Practice, the state of Maine has successfully launched a number of initiatives to significantly reduce its reliance on residential care in favor of family based placements, kinship placements and permanency options. As a result, between the period of July 2004 to July 2007, the number of youth in residential settings was reduced by 54.6% (from 747 to 336). At the same time a paradigm shift has taken place in the culture of the agency. Statements often heard in the past such as "This child is unable to live in a family" are routinely challenged. Most staff members have shifted to a belief that every child deserves a family and it is the social worker's job to find them one, regardless of that child's issues.

The vast majority of the children who moved out of residential settings moved in with kin, biological parents, "fictive kin"[33] or into an independent living program, with flexible services in place to meet their needs. Key strategies included introducing family team meetings to make

[33] "Fictive kin" is a term denoting individuals unrelated by blood or by marriage but with an emotional bond strong enough to be labeled "familial".

important case decisions, creating teams to assess and support permanency options for youth, and developing solutions to overcome common barriers to family-based placements. Maine also changed its policies and procedures in ways that discouraged the use of congregate care. Finally, residential providers have shifted to providing short term, intensive, evidenced-based treatment that is family centered.

Challenges

Although CFSA currently utilizes twenty-six RTCs, only two of these residential treatment centers are located within the District of Columbia. Two others are located within 100 miles and the other twenty-two are located more than 100 miles outside of the District. The highly-specialized needs of some of the Agency's youth require placement at these distant facilities, but the issue of distance greatly impedes visitation from biological family members.

Strengths to Build Upon

CFSA's Office of Clinical Practice is working closely with the Agency's Quality Improvement Administration to assess patterns and trends in the numbers of youth placed in residential treatment centers. The intent of the study is to better determine location needs versus actual placement locations, based on youth profiles, including any relevant emotional, physical, and behavioral difficulties. The study will also examine treatment capacity.

Additionally, the District has submitted a state plan amendment requesting an increase in the Medicaid reimbursement rate to match the rates of other jurisdictions, making it more viable for the District to place children in RTC facilities closer in proximity to Washington, D.C.[34] The District's rate for Medicaid reimbursement is presently much lower than the national average, including rates in surrounding jurisdictions like Virginia and Maryland. If approved, the state plan amendment will increase the District's standard rate and provide the District flexibility to match the rates of other states.

[34] It should be noted, however, that providers of some highly specialized treatment areas may still be unavailable in closer locations.

Strategies

Almost unanimously, staff recommends an increase in the quantity, quality, and variety of specialized placements and services for youth. Individualized or wrap-around services, particularly those that address mental health needs, are also widely recommended.

CFSA's implementation of the mental health wraparound pilot in 2008[35] will result in a fundamental shift in the way the District delivers services to children and youth with complex emotional and behavioral needs. Wraparound is an approach to care that has evolved through efforts to help families with the most challenging children function more effectively in the community. More specifically, rather than relying on Psychiatric Residential Treatment Facilities (PRTF), wraparound services incorporate a definable planning process that results in a unique, individualized set of community services and natural supports that "wrap around" a child and family to further their efforts towards safety, permanency, and well-being. The philosophy that led to wraparound is relatively simple: identify the community services and supports that a family needs and provide them as long as they are needed. The wraparound process is expected to help build the District's capacity to serve 24 to 30 children.

The District is also planning to implement new crisis-management services to include the availability of "crisis beds" as well as a Mobile Response Stabilization Team. One of the primary objectives of crisis beds is to circumvent psychiatric inpatient hospitalization for youth ages 6 to 21. The crisis beds will provide psychiatric stabilization and rehabilitative services that address the psychiatric, psychological, and behavioral needs of the children and youth who need these services.

Mobile crisis response is based on the assumption that community-based care is more humane, more therapeutic, and less stigmatizing than institutional care. One of the primary objectives of the Mobile Response Stabilization Team is to provide timely, flexible and accessible service 24 hours a day, 7 days a week, to stabilize crisis situations.

[35] The Request for Proposals was released in November 2007 and will close in January 2008.

Additionally, CFSA is planning to work with the Maryland Child and Adolescent Community Innovations Institute, which is within the Department of Child and Adolescent Psychiatry at the University of Maryland. The Innovations Institute plans to help CFSA implement services that were identified in the *2007 CFSA-DMH Mental Health Needs Assessment*. Moreover, the Institute will conduct a cost analysis for implementing a new service array to meet the mental health needs of the children and youth in foster care in the District of Columbia. The Institute will review each service category to determine the opportunities for Medicaid funding, calculate the projected increase or decrease in projected demand for each service category, and estimate the cost for developing capacity to deliver the service. This could range from specialty training for existing providers to setting up new provider entities.

CFSA and the Department of Mental Health (DMH) are also collaborating to identify and support local provider(s) with the capabilities and skills to become future members of a proposed "CFSA Choice Providers Network", which shall respond to the unique needs of children and families served by the child welfare system. This concept creates a framework for the organization and concentration of existing and planned services and support for the District's continuum of care for children.

All of the above-mentioned resources are necessary to address the core challenges that many children and youth are facing which, when not addressed, lead to placement instability and disruption. Most are in agreement that, when possible, intense and individual attention would greatly improve outcomes for children and youth.

Summary of Needs

As stated at the onset of this chapter, current projections indicate that in the absence of practice change, by December 2009, the proportion of children and youth placed in congregate care settings (traditional and specialized group homes, independent living facilities and residential treatment centers) will increase from 22% (n=487) to 23% (n=462) of the total population of children and youth in CFSA's custody. Although congregate care is necessary in some instances, CFSA's vision is to decrease its overall reliance on these placement types, to deliver services to children in District within a 100-mile radius, and to improve the array and quality of congregate care services that are available.

The following needs were identified:

- There is a need for foster parents and social services staff who are specially trained to work with teenagers.
- There is a need to have a more thorough screening and assessment process for determining placements.
- The proportion of teen parents is projected to increase; therefore the capacity of current placement settings to care for this special population and their children will need to be assessed and developed, as necessary.
- ILP programming, services, and curricula need to be developmentally- and age-appropriate.
- There is a need to increase the placement capacity of the Teen Bridge Program by at least ten (10) slots in 2008.
- There is also a need for appropriate transitional housing and transitional programs for children and youth returning from residential treatment centers.
- Lastly, the need exists to better engage and empower youth turning 18 years old so that they continue to develop positively, access services and maintain healthy and productive lifestyles in the absence of mandatory intervention.

Chapter VI
EMERGENCY SHELTER PLACEMENTS

Emergency Shelter Placements

The Issue

A number of circumstances drive the need for short-term emergency shelter placements in the District of Columbia:

1. Increase in the number of older youth entering foster care for the first time due to lack of community-based supports and resources for parents of at-risk teenagers
2. Lack of immediately available family-based care settings
3. Biases within the child welfare system, e.g., initial placement requests or searches for congregate care over family-based care settings
4. Court orders – Judges may order children or youth be placed in or remain in an emergency shelter placement for a variety of reasons:
    a. To keep siblings together
    b. To minimize placement changes while a kin provider is being licensed
5. Access to specialized services to address the specific needs of a child or youth as they transition from one placement to another

Presently, CFSA contracts with three facilities to provide emergency shelter care services when a child's circumstances require immediate placement but kinship or non-relative family foster care is unavailable, or inappropriate. Children and/or youth placed with these providers may remain in the emergency shelter placement for up to 30 days while CFSA and family stakeholders identify an appropriate family-like setting for them. Emergency shelters focus on ensuring the general safety of residents but (depending on the provider) children may receive an array of individualized services to prepare them for the transition to permanency.

Children aged 12 years and under are placed, when necessary, in one facility that provides for this age group's basic needs. It is a diagnostic program with a multi-disciplinary team that attends to the child's medical, developmental, and emotional needs. The on-staff pediatric nurse practitioner and registered nurses attend to each child's medical issues and needs. This facility also provides children access to a visiting physical therapist as necessary. The placement agency employs clinicians who evaluate each child's emotional needs, conduct short-term individual or group therapy, and make referrals when needed. For school-age

children with educational needs, the staff works in conjunction with the child's public school teacher to plan a developmental learning program.

Two other emergency shelter placements serve youth aged 13 years and older. One of these provides emergency shelter placement for males only, while the other accepts both males and females. While there is no diagnostic element to either program, these agencies provide tutoring, adjustment counseling, behavior modification programming, and linkage to community services (depending on the resident youth's individual needs).

Analysis of CFSA data reveals that the current number of younger children in need of emergency placements is at least doubled that of older youth. Over the course of a year, anywhere between 20 to 25 children (age 12 years and under) may require emergency placements during any given month. In contrast, only 8 to 10 youth (age 13 years and older) will require emergency placement during any given month.

As indicated in the Demographics chapter, the trend toward an increasing number and proportion of older youth in foster care is projected to continue. As such, statistical projections indicate that the demographics of children and youth who may need emergency placement is forecasted to shift dramatically. By December 2009, only 14% of the children who may need emergency placement are projected to be age 12 years and younger, while 86% are projected to be 13 years and older.

CFSA's vision is to reduce the overall number and proportion of children and youth residing in congregate care placements in general, and in emergency shelter placements in particular. CFSA will focus on meeting the needs of these youth while actively developing preventive measures to stem the trend. Simultaneously the Agency will be planning to build capacity (as appropriate), and to address the changing needs of a fluctuating population of children who may need emergency shelter care.

Literature Review

Child welfare systems across the country often use emergency shelter care when alternative care arrangements cannot be made with the child's extended family or with a traditional foster family (Oakes & Freundlich, 2005). It allows for a transition period whereby child welfare workers are

able to attempt to prevent more extended placement for children in crisis by giving staff members and families time to work out a solution that is in the best interest of the child. In the state of Minnesota, for example, emergency shelter is intended to provide a brief period for assessment of the parent's capacity to care for the child, as well as time to search for kinship caretakers, or time for a crisis team to find a stable solution for a child removed from a complex multi-problem family (Wattenberg, Luke & Cornelius, 2004). A 2005 study by Children's Rights found that children and youth are placed in emergency shelter care for two major reasons: a shortage of foster families and the convenience of caseworkers and law enforcement officials.

The shortage of placement resources often makes it difficult to move children from emergency shelter care settings, resulting in many children remaining in emergency care placements for periods that far exceed the designated time limits. The study by Children's Rights (2005) found that older children, children of color, and children with emotional and behavioral problems have particularly long stays in emergency care settings. There are a number of concerns about the impact of long stays in emergency shelters on children's health and well-being. Oakes and Freundlich (2005) found that many children remain in emergency care without receiving necessary medical and mental health care or without enrollment or attendance in school. Such settings are also detrimental to infants, toddlers, and latency-age children because they often fail to meet the children's developmental and emotional needs (Oakes & Freundlich, 2005).

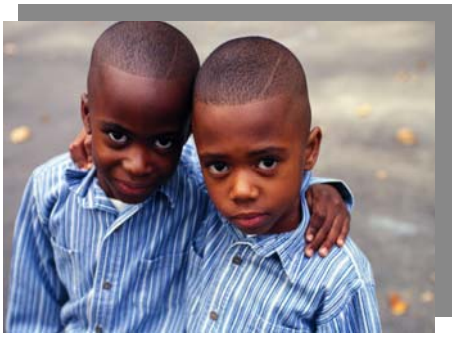
In regards to the long-term ramifications of an emergency shelter placement, there is an unfortunate scarcity of research. An in-depth examination of the outcomes for children placed in emergency shelters and emergency family foster care is essential. No study to date has addressed either the question of whether children discharged from emergency shelters are more (or less) able to maintain their next placement, or if children placed in emergency shelters are more (or less) likely to achieve their permanency goal. Further, there is little information regarding the psychosocial effects of emergency shelter placement on children, which is usually a good predictor of later placement disruption and permanency. This type of information could be exceedingly useful to CFSA. As the Agency continues to work with its community partners to prevent (when appropriate) emergency shelter placements and to develop innovative strategies for existing emergency shelter care programs, research findings on psychosocial effects could

provide concrete direction for establishing "comprehensive care" shelters for the abused and/or neglected child, and when necessary, for his or her family.

Researchers and child welfare professionals recommend eliminating or reducing the use of emergency shelter care, and promoting foster family care as the most effective approach to meeting the placement needs of children and youth entering the foster care system. This is in line with CFSA's Practice Model and current placement resource development initiatives to meet the needs of children and youth through increasing family-based foster care and decreasing dependence on congregate care.

Challenges

Historically, CFSA has relied on emergency shelter services for younger children's specialized needs (including space requirements for siblings) because the Agency had yet to find the proper combination of qualified family-based foster care resources equipped to handle those specialized needs. Younger children (12 and under) entering the child welfare system are often a part of a sibling group or they are single children who have specialized developmental or medical needs. Less common among this age group are children who have had a placement disruption in foster care due to serious behavioral issues, or who have required emergency intervention and diagnostic services. Placement disruptions such as these are more typical of older youth (13 years or older).



Despite the large numbers of children who are part of sibling groups, CFSA is greatly challenged to find caretakers willing to accept a sibling group (sometimes in the middle of the night) on the relatively short notice that is typical of an emergency placement. More often, CFSA places the sibling groups in an emergency shelter placement for no more than 30 days by rule, but usually for no more than 7 days in practice. During this time frame, workers diligently search for an appropriate foster family home.

As noted, immediate placement for single children with specific medical or developmental needs is difficult due to the paucity of qualified foster family resources. These children more often

require a level of care that some foster parents are unwilling and/or ill-equipped to provide. Even professionals can be challenged when faced with the care of drug addicted infants, or young children who may have a specific medical condition (such as sleep apnea or 24-hour heart monitoring, etc.). Very few foster parents meet the criteria to care for these children, including availability on short notice. Ultimately, many of the children in need of diagnostic assessment for their mental and behavioral health needs are simply not appropriate candidates for the available family-based foster care homes; their individual circumstances necessitate a short time in emergency shelter to receive stabilizing services.

Children 13 years of age or older most commonly arrive at an emergency shelter following a placement disruption due to abscondence and/or behavioral issues. These youth require short-term placements until CFSA and its partner agencies determine a more appropriate placement. Again, the Agency has had difficulty recruiting and maintaining foster families who can accept older youth into their homes on short notice, and who are equipped with the skills to help stabilize the youth. Similar to the younger or medically fragile child, the older youth with behavioral problems may require a level of care that is just beyond the characteristic majority of individuals who offer their homes for foster care.

In situations when an emergency shelter placement is necessary because the Agency is unable to immediately identify a long-term placement option, it is critical that enough emergency beds are available. Currently there is a lack of available emergency shelter beds for girls ages 13 and older. The primary emergency shelter provider with bed slots for females recently communicated to CFSA that it would no longer receive referrals for adolescent girls. (One reason may be that females are more likely to abscond from a placement, which makes the intake process unreliable for the provider.) With regard to the male youth, eight emergency shelter beds are available for youth, ages 13 and older. Unfortunately, the actual numbers of youth needing these beds supersedes the availability.

Strengths to Build Upon

As a measure to prevent emergency shelter placement in congregate care facilities, CFSA developed the ST*A*R foster home program (Stabilization and Respite Homes). ST*A*R homes provide round-the-clock placement capability for any child or youth who is medically

cleared and not in need of acute psychiatric services. The placement capability includes placement after initial home removals, after placement disruptions, return from abscondence, and/or other circumstances where a child may require emergency assistance. The program is designed to serve children and youth of any age, but most children in ST*A*R beds are teenagers. The ST*A*R Program also provides 5- to 10-day emergency placements in a family setting for children who come into placement after regular work hours (with the average stay being 7 days). During this time, services and resources are put into place to facilitate a smooth transition into an appropriate foster home. The first ST*A*R home opened in August 2006. Currently, CFSA administers 12 ST*A*R beds throughout the District. The current capacity appears to be meeting current needs for emergency shelter placements.

CFSA has also been successful in maintaining its commitment that no child shall stay in an emergency placement for more than 30 days. Only in circumstances where a child has been court-ordered into a particular emergency shelter, or when it is prudent to allow a child to remain in such a placement for a number of days pending the approval of a kinship care placement will a child remain in an emergency shelter for more than 30 days.

To address the particular needs of medically fragile and developmentally-delayed children in need of placement, CFSA has recently awarded family-based contracts to three high-quality care providers for a capacity of 40 beds. Implementation is currently underway. Building future capacity for this population, which comprises a large percentage of children in need of emergency shelter placements, will dramatically impact the need for emergency shelter placements.

Along with the strengths outlined above, CFSA is taking a look at some promising practices. In partnership with the Department of Youth Rehabilitation Services (DYRS), CFSA has selected two contractors to recruit, train, and support specially-selected foster parents to provide Multi-Dimensional Treatment Foster Care (MTFC) for children and youth between the ages of 12 and 17 with specialized behavioral needs. These youth are statistically more likely to experience multiple placements. It is crucial that even a small pool of foster parents be readily available to

provide them with stable placements. The CFSA MTFC implementation team has been working with vendors and the MTFC model developer to determine how to increase the number of appropriate referrals to the program. Although there are some obstacles yet to overcome, CFSA is committed to the implementation of the model.

Strategies

CFSA must pro-actively prepare itself to address the two-pronged data projections for 2009: 1) a growing population in need of emergency shelter care, 2) the changing demographic of older youth dominating emergency shelter care resources. Strategies to address these projections should include, but must not be limited to, the following objectives:

- dedicated prevention activities and services that support existing placements and decrease the impending need for emergency placements
- expansion and "renovation" of existing resources
- innovative development of new resources to deal with the multi-faceted needs of children and youth who will remain in need of emergency placements, despite CFSA's best efforts to find more appropriate placements for them

In specific regard to reducing unexpected placement disruptions, and mitigating emergency removals for children already in care, it is essential for CFSA to oblige our workers, our foster parents, and our committed community and inter-governmental agency partners toward the following goals:

- Dedicated utilization of Family Team Meetings as a prevention tool - Foster parents must actualize their role as advocates on behalf of themselves and the child or youth in their home. They must be encouraged and supported to request FTMs to address issues early on, no matter how inconsequential the issue might seem if there is any belief at all that these issues may lead to a placement disruption. Social workers must also be able to recognize key indicators of potential disruptions, and view FTMs as the Agency's primary strategy for preventing placement disruption. FTMs must be viewed as "spending time to save time" rather than a time-consuming process.
- Enhanced placement supports for foster parents - To every extent possible, CFSA needs to expand respite care programming, and to offer specialized training to foster families to equip them with the skills to deal with the variety of individual needs presented by the children and youth who have traditionally required emergency shelter care placements. The more foster parents who have the skills required to parent this population, the greater the likelihood that emergency shelter placements can be avoided altogether.
- Enhanced Mental Health/Substance Abuse assessment services for in-home families - Through the recent permanency and in-home redesign, the Agency is now actively making in-home services more robust, with the intent of reducing removals. This activity

needs encouragement and more research to support the justification that enhanced assessment services will either prevent or reduce the need for emergency shelter care placements.

Another potential promising practice includes the professional foster parent model. Up to six foster youth would reside in a family-based foster home staffed by two professional live-in foster parents. These parents would be trained to deal with various needs and demographics of children in their care. As professional foster parents, they would be capable of providing a stable living situation for as long as is necessary. CFSA is actively investigating whether this professional foster care model will complement the Agency's mission, vision, and Practice Model.

In order to decrease the need for emergency placements for older youth, CFSA will fund a community-based primary prevention program for youth between the ages of 13 to 21 who come to the attention of CFSA and/or community-based organizations, and who are at risk of being removed from their home (or where there is risk of abuse or neglect due to conflict with the primary caregiver). Evaluation of this program (see *Appendix E*) will determine the impact of such an approach on the first-time entry of older youth into the child welfare system and the need for emergency shelter placements.

It has already been stated that the needs of children in emergency shelter placements aren't specific to one particular demographic. Such needs will consistently be based on the particular circumstances of the child. It may seem obvious that the needs of a fourteen-month-old neglected infant recently removed from her mother differ greatly from those of a fourteen-year-old youth who recently disrupted out of her previous placement. Yet, the emergency placement process must reflect a conservative preparation for handling both situations, and as such, the providers of emergency shelter care must be well prepared to deal with the myriad issues that accompany children who need this service. The placement process may indeed require an unprecedented and concerted effort to establish a pool of well-trained professional foster parents who are willing to care for different populations of youth, and who are equipped to deal with the particular issues of children throughout the child welfare spectrum. This is particularly true in

light of the projections indicating a shift in the emergency shelter care population from predominantly children under 12 years to overwhelmingly children 13 years and older. The Agency's examination of appropriate planning measures will prepare all parties involved for successful handling and provision for these needs in the District.

Summary of Needs

- Enhanced utilization of Family Team Meetings to preempt potential placement disruptions
- Enhanced placement supports for foster parents, particularly respite services and skill-building trainings to address the specialized needs of older youth and other children needing emergency shelter placements
- Expanded pool of foster families who can accept older children into their homes on short notice and who are equipped with the skills to help stabilize the youth
- Expanded emergency shelter placement resources for youth aged 13 years and older, particularly for females in this age range
- Research study on long-term ramifications of emergency placement on placement stability and permanency for children and youth

Chapter VII
PLACEMENT STABILITY

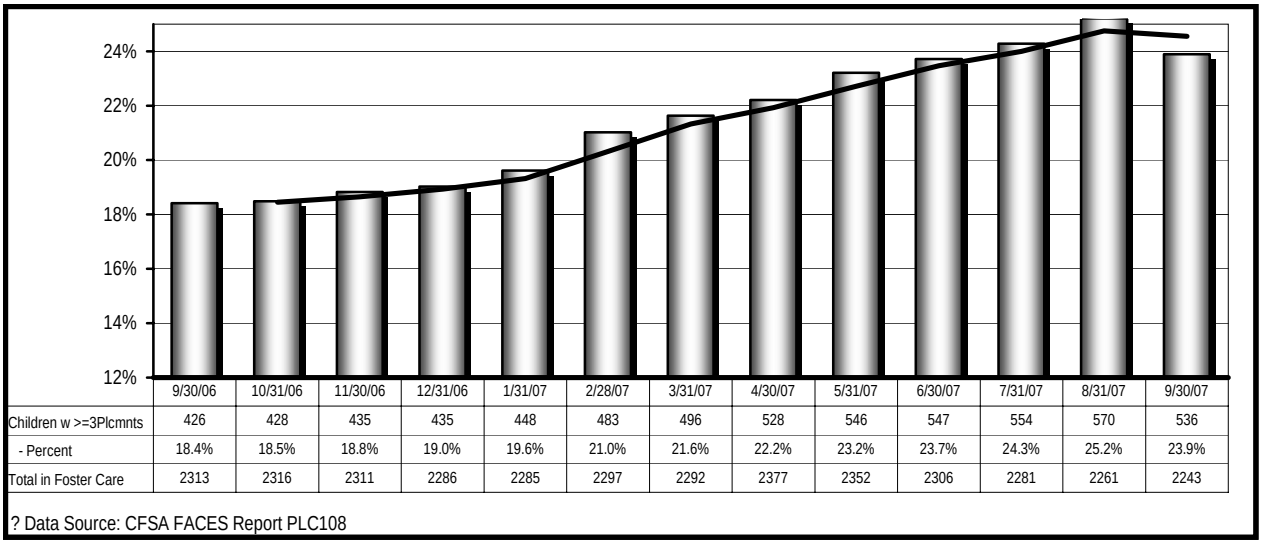
Placement Stability

The Issue

The subject of children experiencing multiple placements is of critical importance to the Agency, and a highlighted concern within CFSA's Practice Model. The Practice Model notes that one of the core values of the Agency is to ensure that children "have a stable, nurturing foster care setting that meets their needs." Multiple placements are consistently cited by researchers as detrimental to the overall development and self-esteem of children. The percentage of children and youth in CFSA's custody who experienced multiple placements[36] increased from 18.4% in September 2006 to 23.9% in September 2007. The projected trends for the multiple placement population through December 2009, unfortunately, mirror these increases.

> ". . . key informants noted the increased likelihood that pre-teens and teens experience multiple placements and observed greater stability associated with kinship placements. GALs described how placement changes compromise the ability of children to trust and bond; teenagers spoke of their emotional responses to moving from place to place and experiencing the multiple losses of friends, schools and community; and social workers recounted firsthand experiences of the impacts of placement instability on children."
>
> *Source: An Assessment of Multiple Placements for Children in the District of Columbia, Center for the Study of Social Policy, July 2006, p. 45.*

Figure 3 – Multiple Placements September 2006 – September 2007



	9/30/06	10/31/06	11/30/06	12/31/06	1/31/07	2/28/07	3/31/07	4/30/07	5/31/07	6/30/07	7/31/07	8/31/07	9/30/07
Children w >=3Plcmnts	426	428	435	435	448	483	496	528	546	547	554	570	536
- Percent	18.4%	18.5%	18.8%	19.0%	19.6%	21.0%	21.6%	22.2%	23.2%	23.7%	24.3%	25.2%	23.9%
Total in Foster Care	2313	2316	2311	2286	2285	2297	2292	2377	2352	2306	2281	2261	2243

? Data Source: CFSA FACES Report PLC108

[36] CFSA defines multiple placements as children experiencing three or more placements during the course of their most recent placement episode.

In addition to CFSA's concern about the issue of multiple placements and the impact on children, placement stability is also an area that is being closely monitored by the Administration for Children and Families (ACF) as part of the Child and Family Services Reviews. According to the data that the District submitted to ACF for the period between April 1, 2006 and March 31, 2007,

- Of all children in care more than 8 days but less than one year, 80.7% experienced two or fewer placement settings. The national median for this measure was 83.3%.
- Of all children in care more than one year but less than two years, 49.7% experienced two or fewer placement settings. The national median for this measure was 59.9%.
- Of all children in care for more than two years, 32.2% experienced two or fewer placement settings. The national median for this measure was 33.9%.

Nationally, the District ranks 35th out of 51 states and territories with regard to placement stability. CFSA's Program Improvement Plan (PIP)[37] includes strategies to improve achievement of permanency for children and to engage families in case planning. The Agency expects that as an additional benefit, these strategies will also positively influence achievement of placement stability for children and youth.

Failure to meet national standards simply translates into failure to achieve our stated mission for the District's children and families: safety, permanency, and well-being. The Child and Family Services Agency is acutely aware that research data emphasizing the harm resulting from multiple placements can and must be used to assist CFSA in reversing the current trends.

CFSA is focused on substantially improving child and youth well-being by increasing placement stability for children and youth in out-of-home care over the next year. To that end, the District's Amended Implementation Plan (AIP)[38] requires achievement of the following benchmarks in regards to the reduction of multiple placements for children in care:

a. Of all children in care at least 8 days and less than 12 months (FY07 and subsequent years), 88 percent shall have two or fewer placements.

[37] Following the Statewide Assessment and Onsite Review, States develop a Program Improvement Plan (PIP) to address areas in which they were found to be out of conformity with any one of the outcomes or systemic factors under review. The PIP planning and implementation process is intended to be an extension of the collaborative planning process that States use to develop the 5-year Child and Family Services Plan (CFSP).

[38] In February 2007 the Amended Implementation Plan (AIP) in was approved. The AIP spells out what the District must do to meet remaining terms and conditions of the *LaShawn A. v. Fenty* lawsuit by December 31, 2008, providing an opportunity to end court oversight of child welfare in the District in early 2009.

b. Of all children in care for at least 12 months but less than 24 months (FY07 and subsequent years), 65% shall have had two or fewer placement settings.
c. Of all children in care for at least 24 months (FY07 and subsequent years), 50% shall have had two or fewer placement settings since October 1, 2004 or entry into care (if entry was after October 1, 2004).

Literature Review

A great deal of literature exists regarding the importance of placement stability. The research consistently reveals that movement through multiple placements disrupts the continuity of a child's relationship to family, community, schools, and medical care (Harnett, Falconnier, Leathers, & Testa, 1999). Further, multiple placements are frequent. During any 12-month period, up to 50% of children in foster care disrupt from their placements and have to be moved to another home or to a more restrictive setting (Smith, Stormshak, Chamberlain, & Bridges Whaley, 2001).

Numerous studies have shown that multiple placements have commensurate multiple and negative consequences (Harden, 2004; Rubin, Allessandrini, Feudtner, & Trevor, 2004; Barber & Delfabbro, 2003; Doran & Berliner, 2001). Research generally confirms that placement instability results in a range of emotional, behavioral, and developmental problems that persist over a lifetime (Wattenberg, Wells, Nguyen, & Martinson, 2003). More specifically, a number of studies have linked placement instability to children's aggression, coping difficulties, poor home adjustment, low self-concept (McMahon, 2005), and an increased likelihood of failed permanent placements, higher rates of delinquency, and greater risks of the youth dropping out of school (Chamberlain, Price, Reid, Landsverk, Fisher, & Stoolmiller, 2006). Placement disruption also brings with it financial costs for the child welfare system, along with higher medical costs for children (Rubin, Alessandrini, Feudtner, Mandell, & Trevor, 2004). It is estimated that placement disruption requires an average of 25 social worker hours to remedy the problems affiliated with disruption (Chamberlain, Price, Reid, Landsverk, Fisher, & Stoolmiller, 2006).

Placement instability is the result of several factors (McMahon, 2005; Wattenberg, Wells, Nguyen, & Martinson, 2003). One common factor is attributed directly to the behavioral problems of the child. This factor is a sort of "catch-22", disruptive behaviors are identified both as a cause and as a consequence of placement disruption (Newton, Litrownik, & Landsverk,

2000). Other widespread factors were recently identified by the National Resource Center for Foster Care and Permanency Planning (NRCFCPP) in a 2004 analysis of the Child and Family Services Reviews (CFSRs). These factors include insufficient support for foster parents, too few foster homes, misuse of emergency shelters and temporary placements, and lack of placements for children with special needs. The Resource Center further identified disruption factors associated with the foster family, such as the foster family dislike or rejection of the child, or a stressful event occurring in the foster family prior to or during placement. Other key factors include the age of the child. Infants, for example, may develop behavior disorders associated with attachment deficiencies. Adolescents, on the other hand, learn to habituate to volatile short-term placements (Wattenberg, Wells, Nguyen, Feher, Martinson, & Swenson, 2003). Children with severe emotional or behavioral problems are also more likely to experience placement disruption (NRCFCPP, 2004). Across the board, placement instability studies indicate that the longer a child awaits permanency while remaining in foster care, the more likely they are to experience multiple placements.

Research also suggests that placement stability is affected by worker characteristics, particularly the social worker's individual involvement with the family. Workers who have continuity and more frequent contact with birth parents and foster parents directly and positively influence placement stability (Harden, 2004).

As previously stated, foster parent characteristics also influence placement stability. Foster parents who have the training and skills to tolerate a child's behavioral or emotional problems can prevent placement disruption. Authoritative foster mothers who set limits while being accepting of behavioral infractions are less likely to become upset when children misbehave (Redding, Fried, & Britner, 2000). Therefore, foster-family-centered interventions that include training, support, access to services for self and child in care (McMahon, 2005), coupled with careful and thoughtful matching of child to foster parent, can support and enhance placement stability (CSSP, 2006).

Given the harm done to the overall well-being of a youth in foster care as a result of placement instability, child welfare agencies must find ways to connect the child to the most appropriate setting at the onset of the foster care experience. A truly holistic approach, that is taking into

account the "whole child", must include psychological and physical needs (Doran & Berliner, 2001), as well as the skill and ability of the foster parent to manage the children. This is a critical factor that impacts placement stability. It is therefore incumbent upon child welfare agencies to be certain they provide support for foster families to perform well in the important role that they play in the lives of children (Massachusetts Citizens for Change [MCC], 2001). The reduction of multiple placements should be the goal that drives all foster care improvement efforts (MCC, 2001).

Challenges

Placement Process

When asked how often CFSA initially places a child or youth in the best placement to address the child's needs, 58.1% of CFSA staff and 69.6% of staff with the private agencies said, "Sometimes." Many respondents (across both groups) identified Agency-related factors as the primary challenges in the initial placement process, including the following two prominent causes:

- Inadequate information provided about the child prior to placement
- Inappropriate placement matching for child-to-foster parent — including the impact of emergency placements on an agency's ability to make an appropriate child-foster parent match. In addition, while awaiting a specialized placement, children are sometimes placed temporarily in other settings that (for obvious reasons) are not equipped to meet their needs.

> ***My most difficult experience has been with a 15-year old male who has had 5 placements since he came into care approximately 6 months ago. Multiple services were offered and made available to him but he has always failed to make himself available.***
>
> - Social Worker Focus Group

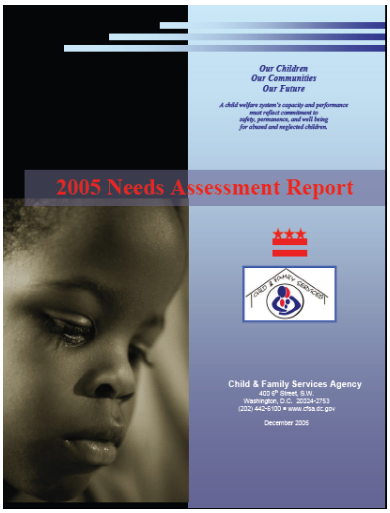
Maintaining Stable Placements

Social workers and support staff at CFSA and at private agencies were also asked questions regarding challenges to maintaining placement stability and to accessing placement supports. Across both groups, the overarching theme cited behaviors of the child or youth and/or the foster parent's inability to address child behavioral issues. These behavioral issues often put placements at risk of disrupting. In general, respondents summarized eight issues that put placements at risk of disrupting:

- ***Previous placement disruptions*** — while there is rarely one single factor that causes placements to disrupt, prior disruptions appear to make it more difficult to successfully place children again.

- ***Limited resources to support children returning from residential treatment –*** concentrated services are needed to help both youth and resource parents respond to the sensitive transition of returning from residential treatment.
- ***Abscondence –*** children and youth with a history of abscondence are more difficult to place.
- ***Non-compliance with available supports*** — including (or especially) teens' refusal of treatment/supports.
- ***Co-occurring problems*** — substance abuse, mental health issues, and severe emotional/behavioral issues.
- ***Lack of knowledge*** — foster parents often lack even pragmatic information for successfully parenting older youth with co-occurring issues. There is also a lack of available of services and supports for these parents.
- ***Lack of support*** — including community supports.

An important group with particularly sensitive challenges for placement stability is that of youth in foster care who identify as Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ). In the *2005 Needs Assessment*, social workers expressed concerns over placement availability for these youth and/or for youth who are perceived to be LGBTQ, including acceptance of the youth by others in the placement, even to the extent that the youth may need to be re-placed for his or her safety in these settings. Findings from the *2007 Needs Assessment* indicate that youth in foster care who identify as LGBTQ continue to face unique challenges and consequences when they do not have adequate support and acceptance. Two major challenges were identified in supporting these youth: lack of LGBTQ-friendly placement resources and lack of foster parent sensitivity training.



When workers were asked to identify the level of difficulty for placing youth who identify as LGBTQ (from 1 being not difficult to 5 being very difficult), respondents rated the youth 4 out of 5 (difficult to place). The primary reason cited was because of the youth's sexual orientation or sexual identity. They reported that providers are often uncomfortable (or unwilling) to provide care for youth who self-identify as LGBTQ, so is takes much longer to find an appropriate placement for these youth.

Although CFSA has not officially tracked data relating to the placement stability of youth who identify as LGBTQ, data from 15 self-identified youth (in March 2007) show a higher rate of multiple placements (10.13 placements per youth) compared to overall multiple placement rates (3.98 placements).[39] These LGBTQ youth also experienced a longer out-of-home care period (6.76 years) compared to CFSA's overall youth in care (4 years).

Placement criteria should include the youth's emotional and behavioral needs, as well as their personal needs. Sexual orientation should not be the sole factor when placing a child. LGBTQ-affirming group homes can, however, provide safe and secure living environments for young people who identify as LGBTQ to be themselves and to receive affirming support from adults. Currently, the cities of Los Angeles, San Francisco, New York, Boston, Detroit and Philadelphia provide youth who identify as LGBTQ with gay-affirming group homes. Some group homes are exclusively for gay males and male-to-female transgender youth (Green Chimney's, New York) and other homes are co-ed (Philadelphia).

Foster parent focus groups indicated that they would be better prepared for parenting youth who have identified as LBGTQ if they had essential training in gay-affirming approaches for parenting. Additionally, foster parent training should include information on available LGBTQ-sensitive support resources. CFSA and Private Agency staff (in surveys) concurred.

Placement Stability and the Child and Family Services Review (CFSR)

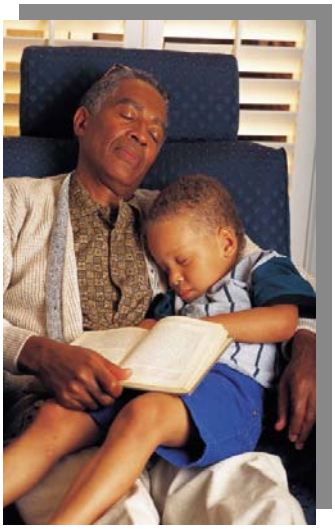
During the Child and Family Services Review Statewide Assessment process, the following factors were also identified as having impacted the Agency's declining performance with regard to placement stability:

- The current pool of placement providers is not diverse enough in its skill set to meet the needs of District children and youth in foster care.
- There is an inadequate capacity to recruit and retain foster parents both at CFSA and at the private agencies.
- Matching children with appropriate caregivers is very difficult in the current crisis-based placement environment, limiting optimal placements.
- Specialized models of foster care are not achieving the desired results of improved outcomes for children in care.

[39] It is important to note that no additional data regarding the nature or reason for the placement move was provided. Thus, it cannot be assumed that sexual orientation was the primary reason these youth experienced multiple placements.

- Private providers' ability to update placement data in FACES[40] has improved the accuracy of CFSA's placement data, which has brought to light the amount of movement that occurs within contract agencies' networks of homes and highlighted the extent of the multiple placement problem.

Expanding and diversifying placement resources and increasing placement stability are critical goals for CFSA. The Agency is actively seeking kinship resources to expand the pool of foster homes. There is a concern among stakeholders, however, that many kin families have not been able to meet the licensing requirements. Barriers include the difficulties kin families often experience obtaining clear criminal background checks as part of the licensing process, inadequate housing (including the presence of lead paint which takes time to abate), and relatives who are reluctant to attend foster parent training classes.



In addition to these challenges, many relatives of District children reside in Maryland where temporarily licensing kinship providers is curtailed by state law for all families, regardless of the residency of the child in need of a placement. An ICPC (Interstate Compact on the Placement of Children) placement cannot be finalized until a home is licensed. This directly affects CFSA's ability to make the first placement the last placement for children in care. CFSA has recently made significant in-roads, however, with the state of Maryland to resolve issues related to the temporary licensing of kin living in Maryland (see chapter on *Family-Based Foster Care*). Resolution of these issues is projected to allow increased numbers of children entering foster care to be placed with willing and capable relatives rather than remaining in traditional foster care.

Another challenge to the placement process is low utilization of Family Team Meetings to prevent placement disruption. The percentage of FTMs held that prevent placement changes has remained static at 24% over the 12 months between September 2006 and August 2007. Of the 54 children who had placement disruption FTMs in September of 2006, only 13 (24%) were prevented from changing placements. In August 2007, another 24% of FTMs prevented placement changes, this time for 15 children and youth. The percentage is low, but it should be

[40] FACES is CFSA's Statewide Automated Child Welfare Information Systems database (SACWIS).

noted that not all placement changes are indicative of a negative outcome. Many children end up residing with kin after the FTM, a positive outcome that is nevertheless recorded as a placement change.

As previously stated (see chapter on *Emergency Shelter Placement*), there is a definite need for increased promotion and utilization of Family Team Meetings for placement stability. It has been noted that FTMs are frequently used to plan the next placement, not prevent placement disruption. Additionally, foster parents must be informed of their rights to request an FTM, actualize their role as advocates, and be pro-active in their efforts to prevent disruptions when appropriate. It has also been suggested by Stakeholders that social workers will benefit from advanced training to recognize the early signs of a potential disruption. Once able to recognize key indicators of potential disruptions, workers can team with foster parents to schedule FTMs in advance of a placement crisis.

Staff report that placement instability directly correlates with risky behavior. In particular, staff participating in an abscondence workgroup noted prostitution is both a major safety and placement stability concern with some of the older youth. The actual numbers may be even greater than what is currently suspected. Staff also indicated that youth perceive prostitution as their only means of survival, particularly when they lack family connections and supports to assist them. Other reasons given include a history of sexual abuse prior to entering care. It was also noted by staff that there are adults who encourage and involve these youth in prostitution but these adults are not aggressively pursued and convicted. The situation requires a concerted effort by the District and relevant agencies to address this issue.[41] Other issues that threaten this population include an increase in criminal activity among females, poor relationship choices (such as dating drug dealers) and frequent curfew violations and/or brief abscondences from their placements.

Strengths to Build Upon

Creation of a 24-hour, centralized Placement Administration has streamlined the placement request process and incorporated an evaluative Placement Change Request Form. Current data shows that there has been an overall reduction in repetitive placement requests. By continuing to

[41] CFSA recognizes this as an issue and it is under consideration for further in-depth study.

document services and efforts to maintain the existing placement, CFSA can further assess areas in need of improvement. Presently, before a child can be removed from the placement, providers must give at least 10 business days' notice to the foster parents. This time delay allows for additional interventions, such as a Family Team Meeting.

The Family Team Meeting (FTM) has proven to be an effective tool for avoiding placement disruptions. These meetings can be requested by a social worker, a foster parent, and even a guardian ad litem. The goal of such meetings is always to identify issues and put services in place to ensure placement stability. If a placement disruption cannot be prevented as a result of the FTM, CFSA ensures that children are provided with a comprehensive and appropriate assessment. Follow-up action plans must then determine the child's service and placement needs within 30 days. CFSA also provides supportive services to prevent the disruption of a beneficial foster care placement in order to avoid the need for a placement change.

CFSA has also adopted the practice of granting temporary licensure for kinship placements within the District of Columbia. Since March 2005, the Agency has approved 311 kinship homes using temporary licensure. Placing children in kinship care (after appropriate clearances) is especially critical since this has been found to be the safest and most stable form of substitute care available for children (Testa, 2002; CSSP, 2006). Placement with relatives nearly cuts in half the likelihood that a child will experience a placement change (Zinn, De Coursey, Goerge, & Courtney, 2006). Of course, if kinship families do not receive adequate support and resources, these placements may disrupt as well.

Seeking to expand placement resources through the implementation of evidence-based and promising practices, the following programs were implemented in FY07 to improve placement stability in general for children and youth in out-of-home care:

- CFSA has partnered with the Department of Youth Rehabilitation Services (DYRS) to provide Multidimensional Treatment Foster Care (MTFC) (see chapter on *Emergency Shelter Placements*). While MTFC is a hopeful support to avoid emergency shelter placement, it is equally expected to help reduce multiple placements for children and youth between the ages of 12 and 17 with specialized behavioral needs.

- Another placement support program previously cited is the Mockingbird Family Model (MFM). Already demonstrating great success, the program provides respite and support to a "hub" of foster families (see chapter on *Family-Based Foster Care*).

Strategies

Increasing placement with kin is the best way to promote placement stability (Testa, 2002; CSSP, 2006) which makes it a priority for CFSA. In September 2007, however, only 15.2% of children and youth in foster care were placed in kinship foster homes. Through the FTM process, CFSA has expanded its efforts to identify relatives, engage them in the planning process, and assess them as possible placement resources. In addition, as cited previously, CFSA is developing a proposal to utilize a portion of the Federal FY07 Appropriation to support kinship care expansion and stabilization.

As indicated earlier, it is recommended that the expansion of the Teen Bridge Program and the Mockingbird Model will support placement stability. (For details on these programs, see chapters on *Family-Based Foster Care* and *Congregate Care*.)

Another promising placement strategy concerns the implementation of an inter-agency and community-partnered LGBTQ Taskforce. This Taskforce was created as a result of CFSA's 2006 Resource Development Plan (RDP) which incorporated findings from both the *2005 Needs Assessment* and from the 2005 White Paper on Revamping Youth Services. Youth involved with CFSA who have self-identified as LGBTQ have also participated during the past year to outline future goals. Among these goals, the Taskforce has identified a number of objectives that will help CFSA to improve attitudes of staff and foster parents towards youth who identify as LGBTQ, in addition to augmenting knowledge about sexual identity, and increasing resources and supportive services. Over the next year, the LGBTQ Taskforce will be working with key partners to develop additional programs and strategies to support the LGBTQ population, including but not limited to the following proposals:

> I have a new young man [youth in foster care] now that is a cross-dresser. He only has 90 more days [left] in the system. No services have been in place for him up until this time, and he certainly needs some. He does not have a job, first of all. What is he going to do after he gets 90 more days, where is he going, what's going to happen, who's going to assist him? Everybody I call and talk to acts like I'm talking a foreign language. They don't know, they don't understand…we don't know what to do with a child in this situation.
>
> - DC Foster Parent Focus Group Participant

- Develop a mandatory Agency curriculum that includes sensitivity training for social workers, supervisors and group home staff
- Identify and implement evidence-based training models that prepare foster parents to parent older teens, youth from special populations, youth with special needs and youth who identify as LGBTQ
- Develop and implement support groups and mentoring programs for foster parents, youth who identify as LGBTQ, etc.
- Identify a range of LGBTQ-friendly resources, including placement and services

Other steps to increase overall placement stability for the general CFSA population include the following strategies:

- Utilize technical assistance from the Annie E. Casey Foundation (AECF), Casey Strategic Consulting Group to recruit the right mix of foster parents, and to upgrade support to retain resource families.
- Utilize technical assistance from national resource centers around restructuring the District's placement and service continuum for youth.
- Expand the use of FTMs, Family Finding and Youth Connections Conferences to identify permanent connections for youth.
- Implement the Levels of Care approach to foster parent reimbursement rates, through use of a Child Needs/Provider Interventions assessment instrument.
- Acquire more specific data on the issue of multiple placements and begin implementation of recommendations from the Fall 2006 QSRs that focused on teens and multiple placements.

Summary of Needs

- Foster parent training that provides evidence-based techniques for handling a child's or youth's behavioral or emotional problems
- Development of foster family-centered interventions, including training, support and access to services for both the foster parent and the child or youth in care
- Careful and thoughtful matching of child or youth to foster parent
- Increased numbers of "first placement-best placement" option, taking into account the "whole child", including psychological and physical needs
- Appropriate placement resources to facilitate "first placement-best placement" results
- Increased availability of support services for children/youth returning from residential treatment
- More effective foster parent recruitment and retention strategies
- Implementation of a temporary kinship licensing process for willing relatives living in Maryland
- Promotion and increased utilization of Family Team Meetings to prevent potential placement disruptions before they occur
- Training social work staff to recognize the early signs of a potential disruption and engage in an intervention strategy to preserve the placement

Chapter VIII

A SPECIAL LOOK AT CHILDREN AGES ZERO TO THREE

A Special Look at Children Ages Zero to Three

The Issue

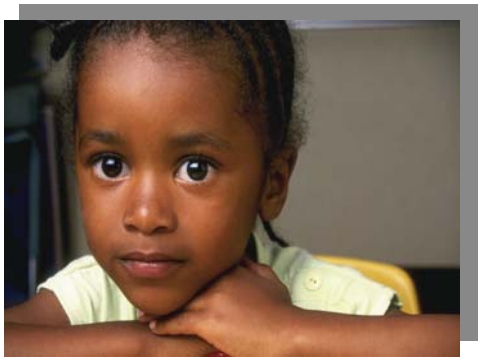
Due to their intrinsic dependence on others to care for them, children between birth and three years are at the highest risk for life-long emotional, mental, and physical problems when they are victims of abuse or neglect, homelessness, domestic violence, and/or prenatal exposure to drugs or alcohol. In the absence of early intervention, their extreme vulnerability to harm cannot be underestimated. These risks become particularly worrisome in light of statistics indicating that infants are the fastest growing category of children entering foster care in the United States, accounting for 1 in 5 admissions (Dicker, Gordon & Knitzer, 2002).

The *2007 Needs Assessment* is CFSA's first attempt to describe what is known about infants and toddlers (ages three and younger) who come to the attention of the District's child welfare system. More specifically, this special analysis details the allegations that brought this group to the attention of CFSA, the types of medical and other service needs they have, the incidence of their entry into foster care, as well as information regarding placement and support needs, and achievement of permanence. National and District statistics regarding children ages zero to three in foster care are also provided.

A Note on the Methodology

Note that the information reported in this chapter includes additional data from FACES on both in-home and foster care cases for children ages 0-3. Also included are findings from a random sample survey of 52 open cases in FY07 through June 30, 2007. Social workers assigned to each case self-surveyed for this *2007 Needs Assessment.* (See *Appendix B*)

National Foster Care Trends



Research shows that young children who have experienced physical abuse have lower social competence, show less empathy for others, have difficulty recognizing others' emotions, are more likely to be insecurely attached to their parents, and have elevated rates of aggression which

manifest even in toddlers (National Research Council, 1993). These children may also exhibit signs of delays in language acquisition, cognitive skills, and age-appropriate behavior (Shonkoff & Phillips, 2000). It is critical, therefore, that child welfare systems are linked to early intervention services. When out-of-home care is necessary, CFSA placement decisions for this vulnerable age population must promote security and continuity, as well as quality care.

National statistics show a marked increase in the number of infants and young children (ages 0 – 3) entering child welfare systems across the nation. These statistics particularly show:

- Infants under three months of age are the most likely to enter care.
- More than one-third of infants enter foster care directly from the hospital.
- One-third of infants discharged from foster care re-enter the child welfare system.
- The likelihood of reunification with a biological family is lower for infants; adoptions are more frequent.
- Nearly 80% of infants in care are pre-natally exposed to substance abuse.
- More than half of the youngest foster children will experience developmental delays – 4 to 5 times the rate found among children in the general population. (Dicker & Gordon, 2004)

Zero to Three Population Served by CFSA

Substantiated CPS Investigations

As of March 2007, children ages 0-3 represented 25% (n=374 of 1487) of substantiated cases in the District. Of these, infants under age 1 comprise the largest age group (34.5%) for which CFSA investigated allegations of child abuse and neglect within the first nine months of FY07. Reports of alleged abuse or neglect received on children ages 1-3 are relatively evenly distributed. Of note, the majority (87%) of the allegations of child abuse and neglect of children 0-3 involve infants and toddlers with at least one sibling. (See Table 7)

Table 7 – Allegations of Child Abuse and Neglect of Children Age Zero to Three

Allegations of Child Abuse and Neglect of Children Ages Zero to Three						
Child Age	Siblings		Total	Siblings		Total
	No	Yes		No	Yes	
	#	#	#	%	%	%
<1	66	240	306	7.4%	27.1%	**34.5%**
1	24	178	202	2.7%	20.1%	**22.8%**
2	15	162	177	1.7%	18.3%	**20.0%**
3	13	188	201	1.5%	21.2%	**22.7%**
Total	**118**	**768**	**886**	**13%**	**87%**	**100%**

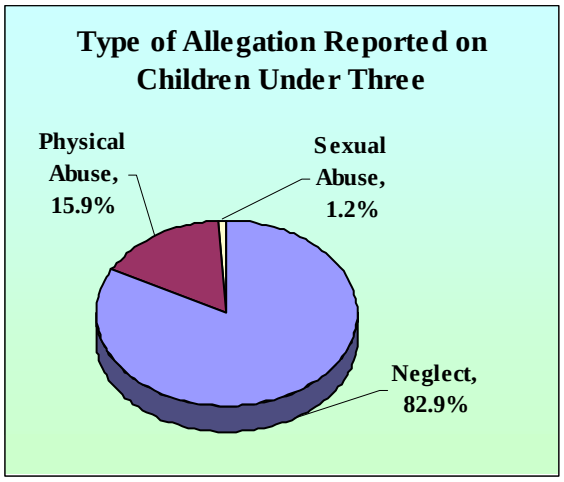
Type of Allegation Reported

Of the 886 child abuse and neglect allegations involving children ages 0-3, more than half

(51%) of these children were African-American, while less than 1% were Caucasian, and the remaining 48.3% were unknown or not reported. With regard to ethnicity, 5% were identified as Hispanic.

While it is not uncommon for multiple allegations involving a single child to be reported to CFSA, child neglect was the most frequent allegation during the first nine months of FY07 for children ages 0-3 years. Over 80% of the referrals alleged child neglect, 15.9% were allegations of child abuse and less than 2% were allegations of sexual abuse. (See Figure 4) More specifically, allegations of parental substance abuse (18.9%) and lack of supervision (9%) were the primary reasons for referrals of neglect involving children ages 0-3 years.

Figure 4 – Allegation Type by Referral



During October 1, 2006 to June 30, 2007, children younger than age 1 made up a slightly larger proportion of FY07 referrals compared to toddlers ages 1-3. Child neglect was the primary allegation reported and the most common allegation of neglect cited was parental substance abuse. Other allegations involving children under age 1 also included medical neglect (7.8%) and parents unwilling or unable to provide care (9.8%). Lack of supervision and inadequate physical care were the most frequently reported allegations involving 2 year-olds. These types of allegations reinforce the necessity of early and ongoing parent education, as well as the basic care supports needed by parents of these young babies and toddlers.

The results of the survey also affirmed that a majority of child abuse and neglect investigations involving infants and toddlers did not result in home removals. Only 16% (142 of 886) of the FY07 substantiated investigations involving infants and toddlers as of June 30, 2007 resulted in the child being removed and placed in foster care.

Comparison of District to National Foster Care Trends

In December 2006, children age three and under comprised 9.67% of the District's total foster care population. By December 2008, that percentage is forecasted to increase to 10.9%, and by December 2009, to 11.4%. The actual number of 0-3 year-olds in foster care, however, is expected to peak in 2008, and then is projected to decline over time. Despite the actual decrease in numbers, the proportion of children in care ages 0-3 is forecasted to increase. In accordance with this trend, the Agency will need to adjust the availability of resources, as well as prepare for any unexpected shifts in demographics.

Table 8 – Foster Care Entries and Re-Entries by Age

FY2005			FY2006			FY2007		
Age Range	**Entries**	**Re-Entries**	**Age Range**	**Entries**	**Re-Entries**	**Age Range**	**Entries**	**Re-Entries**
Age 0-3	16.0%	***3.0%***	**Age 0-3**	24.7%	***6.0%***	**Age 0-3**	31.6%	***10.0%***
Age 4-7	21.9%	***19.5%***	**Age 4-7**	20.5%	***14.4%***	**Age 4-7**	19.4%	***16.5%***
Age 8-11	18.4%	***18.0%***	**Age 8-11**	15.6%	***18.6%***	**Age 8-11**	14.3%	***20.0%***
Age 12-14	16.3%	***15.8%***	**Age 12-14**	12.0%	***21.0%***	**Age 12-14**	14.1%	***18.8%***
Age 15-17	17.0%	***21.8%***	**Age 15-17**	18.3%	***23.4%***	**Age 15-17**	16.2%	***27.1%***
Age 18-21	10.3%	***21.8%***	**Age 18-21**	8.9%	***16.8%***	**Age 18-21**	4.5%	***7.6%***

Data Source: FACES Report PLC208; run date(s) 9/30 2005-2007

The Third National Incidence Study of Child Abuse and Neglect (1993)[42] reported a 1.9% increase in child abuse and neglect from 2.2% in 1986 to 4.1% in 1993 for all children under age 18 entering care in the United States. The highest rates of abuse or neglect were among children 0-3 years old with 40% of first-time entries into foster care occurring in this age group (Sedlak & Broadhurst, 1996). The same increasing trend has manifested in the District of Columbia with regard to entries. For example, in FY06 and FY07, children ages 0-3 comprised the largest age demographic to enter care (see Table 8). In contrast, in FY05, entry distribution among all age groups was relatively even, with the exception of youth ages 18-21. The 0-3 population comprises the lowest percentage of re-entries consistently for FY05 and FY06, and the second lowest percentage of re-entries for FY07.

[42] NIS is a congressionally mandated, periodic research effort to assess the incidence of child abuse and neglect in the United States. The NIS gathers information from multiple sources to estimate the number of children who are abused or neglected children, providing information about the nature and severity of the maltreatment, the characteristics of the children, perpetrators, and families, and the extent of changes in the incidence or distribution of child maltreatment since the time of the last national incidence study. The fourth National Incidence Study of Child Abuse and Neglect (the NIS-4) is now underway.

The Zero to Three Survey

As previously stated, a snapshot of 52 children, ages three and younger, who were placed in foster care as of June 30, 2007[43] was captured in a special survey completed by their social worker (see *Appendix F*). The survey attempted to answer the following questions:

- Why are children 0-3 years entering care?
- What issues are being monitored while these children are in care?
- What information can be gathered on the primary caretaker?
- What is the impact of sibling groups on placement for this population?
- Are kin placement options being fully explored and utilized?
- Are the services afforded this population effective?

The survey instrument also captured data on safety, permanency, and well-being. Included are subcategories of siblings and kinship care, needs and services, and placement supports. In addition, social workers completed information on child, parent and social/environmental risk factors.

Table 9 - Zero to Three Survey Findings: Age Distribution

Child Age	Number	Percent
	#	%
>1	10	19.2%
1	23	44.2%
2	10	19.2%
3	9[44]	17.3%
Total	52	100%

Overall, a majority of the 52 infants and toddlers depicted in this survey were African-American (96.2%). Nearly 60% (59.6%) were male and over half (63.5%) were age 1 or younger. (Table 9)

Child Safety Concerns

The survey instrument inquired as to the initial allegations that brought the child to the attention of CFSA, in addition to the identification of other issues being monitored. Survey findings revealed 80.8% of the 52 children were victims of neglect, which included parental substance abuse, abandonment and incarceration. Approximately 20% (19.2%) of the cases involved allegations of physical abuse.

More than one allegation was reported for a majority of the 52 children, but parental substance abuse was the most prevalent allegation identified (64.5%).

[43] Please see *Methodology*, Appendix B, for limitations of survey findings.
[44] Note that four of the nine toddlers aged 3, turned 4 during the data gathering period.

Type of Allegations Reported by Age

Of the10 infants under one year old, 30% entered care due to allegations of neglect *and* abandonment. Other cited allegations included parental substance abuse (20%), physical abuse (10%), and caretaker's inability to cope (10%). Among the 23 children age 1 but not yet 2 years old, nearly 50% of allegations involved neglect and 17.4% involved parental substance abuse. Other allegations involving one year olds included abandonment (8.7%), domestic violence (4.3%), incarceration of parent (4.3%), physical abuse (4.3%), caretaker's inability to cope (4.3%), and parent's alcohol usage (4.3%). For those children ages two and three, allegations of neglect were also high (50% and 40% respectively). Twenty percent of children age 3 entered care due to a caretaker's inability to cope. Physical abuse allegations were highest for the oldest age group, those who had reached age four. Neglect and parental substance abuse allegations for this age group were also substantive (25% each). (See Table 10 following)

Table 10 – Zero to Three Survey Findings: Allegation by Type

Allegation Type by Age

Allegation	Less than 1	%	Age 1	%	Age 2	%	Age 3	%	Age 4	%
Neglect	3	**30.0%**	11	**47.8%**	5	**50.0%**	2	**40.0%**	1	**25.0%**
Medical Neglect	0	0.0%	1	4.3%	0	0.0%	0	0.0%	0	0.0%
Sustance Abuse	2	20.0%	4	**17.4%**	1	10.0%	0	0.0%	1	**25.0%**
Abandonment	3	**30.0%**	2	8.7%	0	0.0%	0	0.0%	0	0.0%
Domestic violence	0	0.0%	1	4.3%	0	0.0%	0	0.0%	0	0.0%
Incarceration of parent	0	0.0%	1	4.3%	0	0.0%	0	0.0%	0	0.0%
Parent's alcohol usage	0	0.0%	1	4.3%	1	10.0%	0	0.0%	0	0.0%
Caretaker's inabilty to Cope	1	10.0%	1	4.3%	1	10.0%	1	20.0%	0	0.0%
Physical Abuse	1	10.0%	1	4.3%	2	**20.0%**	2	**40.0%**	2	**50.0%**
Total	**10**	**100%**	**23**	**100%**	**10**	**100%**	**5**	**100%**	**4**	**100%**

Well-Being

Social workers for the 52 cases answered questions about pre-natal care, delivery, and development of the children. The answers for 21 cases regarding pre-natal care indicated that the mother had received pre-natal care in 71% (n=15) of the cases. This information, while incomplete, is somewhat positive. It appears that more mothers received pre-natal care than not. The Agency still needs to know what, if any, circumstances prevented pre-natal care, and for those who did receive pre-natal care, what circumstances impacted their capacity to care for their child post-natally. These subtle shifts in parenting could be a key starting point for future prevention strategies.

In over 82% (n=43) of the cases, the children in care were born full-term. Only 3 children were known to be born prematurely. Six cases were unknown. Full-term birth certainly indicates a measure of well-being, although it does not fully capture overall well-being until the child is screened for developmental delays, and other risk factors. Such data must be cross-referenced with pre-natal care and characteristics of the birth mother if CFSA is to identify the underlying causes for the 0-3 population coming into care.

Just over 26% (n=14) of the children were identified as having developmental delays. The status of developmental delays was unknown for 2 of the children in the sample. The primary developmental issues identified were delayed speech, language and motor skills. One case indicated the child had low muscle tone, while another indicated failure to thrive as a developmental issue.

Although the majority of children in the sample were not born prematurely, 38.5% (n=20) were identified as having significant medical issues which ranged from bronchitis to a rare blood deficiency. Asthma and eczema were the most frequently identified medical conditions. Additional issues included one case where a child had an enlarged spleen and kidney. Other issues included a pituitary cyst, a sickle cell trait, a heart murmur, tremors, positive testing for cocaine, a dermatoid cyst above the eye, and severe allergies. These numerous and varied medical conditions indicate the degree to which medical care must be accessible and delivered for the 0-3 population in care.

Permanency

Social workers were asked to identify the permanency goal for each child (including reunification, guardianship, and adoption). Reunification was the highest recorded permanency goal. Of the 52 children whose cases were reviewed, 36 had (or have) reunification or living with other relatives as the permanency goal.[45]

Reunification is the preferred permanency goal. Sometimes, however, reunification is either not in the child's best interest or it cannot be achieved. If the permanency goal was not identified as reunification, the review inquired "why not?" Among the reasons cited were the whereabouts of

[45] **Note:** "living with other relatives" is not a goal established by the federal Adoption and Safe Families Act [ASFA] nor is it recognized in Agency policy. Social workers nonetheless identified this as a separate goal.

parents were unknown or the parent had become disengaged, the parent was not interested in reunification, or the parent or caretaker failed to follow court-ordered protocols.

In general, the survey findings sought to understand obstacles and delays to permanency. Respondents provided individual case examples for each of the following permanency options:

a) Adoption
    1. A pre-adoptive family has not been identified and petition is pending.
    2. The plan for adoption is in place and the stakeholders are waiting for the child to turn two years old so the adoptive parent will qualify to receive an adoption subsidy under the special needs category.

b) Reunification
    1. The biological mother is non-compliant with court-ordered services that require outpatient drug treatment, individual psychotherapy and/or vocational assessment.
    2. Sobriety of the caretaker was a predominant issue.
    3. Lack of family support prevented one teen mom from permanently caring for her child.
    4. Housing for the mother was an initial problem, but has since been resolved.
    5. The caretaker is frequently incarcerated and sporadically a part of the planning process for the child.

c) Kinship Care
    1. In some instances, background clearances and the kinship licensing process have been prolonged. A paternal grandmother has been very slow to respond in getting the requisite information back to the licensing party.

Despite numerous reasons preventing timely permanency, steady progress is still being made to pursue concurrent goals. In one case, the concurrent plan is guardianship with the maternal aunt (who is taking steps to satisfy District licensing requirements). Until the birth parent in this case follows a substance abuse treatment plan, reunification is unlikely. Workers did highlight other similar cases where progress has been steady and the case should close within one year.

Table 11 – Zero to Three Survey Findings: # of Siblings in the Family

# of Siblings in the Family	
1 sibling	9
2 siblings	8
3 siblings	6
4 siblings	4
5 siblings	1
6 siblings	2
7 siblings	2
9 siblings	1
11 siblings	2
12 siblings	1

Sibling Placement

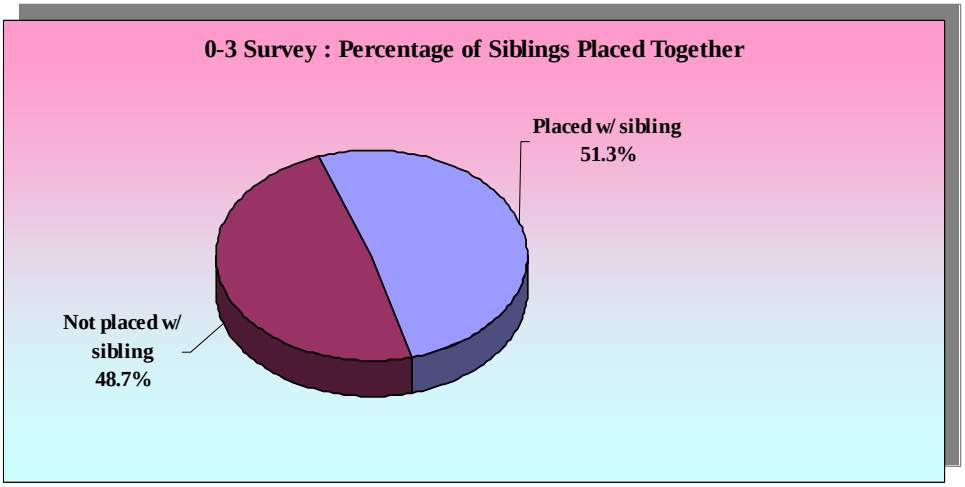
Respondents were asked the number of siblings in the family of each case. There was one sibling group of seven, a sibling group of 4, two sibling groups of 3, and one sibling group of four. Within the subset of the 52 cases, information was provided on forty-

nine cases. Of those forty-nine cases, 10 children did not have siblings, and 39 children were identified as part of a sibling group. Sibling group size varied from one to twelve children.

Of the thirty-nine cases that indicated sibling groups, the survey findings revealed that in 94.9% (n=37) of the cases all children from the sibling group entered foster care.[46] Of those children, 51.3 % (n=19) were placed with at least one sibling and 48.7% (n=18) were not placed with siblings.

The size of the sibling group appeared to impact the likelihood of siblings being placed together.[47] In the cases where siblings were placed together, the largest sibling group was two. In cases where siblings were removed but not placed together, the number of siblings in the group varied from two to seven.

Figure 5 – Zero to Three Survey Findings: Percentage of Siblings Placed Together



A snapshot of two specific cases detailing why siblings were not placed together indicated the following features:

- All siblings had been removed and the mother's parental rights for these children were terminated; all had achieved permanency and their cases were closed prior to the birth of the child whose case was sampled.
- All siblings were removed but the client has a different father; the other three children were placed together with their biological paternal grandmother.

The aforementioned findings reveal some of the placement complexities associated with siblings birthed of the same mother but not of the same father (or vice versa), in addition to additional birth

[46] In one cases not all the children were removed at the same time.

[47] The sample yielded a distinctly high unknown percentage documenting the exact number of siblings in each group.

and foster parent sensitivities. It also requires the Agency to be flexible and discerning when selecting the best placement for all children. In addition to the two examples given above, other common reasons that siblings were not placed together were included a lack of placement resources for sibling groups of three or more children, and a lack of kin resources.

Kinship Placement

In 23% (n=12) of the cases surveyed, children were placed with kin.[48] Generally speaking, the reasons children were not placed with kin revolved around a lack of kin resources. There were also reports of unresponsive kin, or kin not coming forward at the FTM, as well as kin never having been identified. In one case, the age of the grandmother and the licensing of her home were issues that prevented the child from being placed with kin. Another case detailed the mother and stakeholders wanting to pursue reunification but not wanting to place the child with the maternal grandmother (who already had permanent custody of an older sibling). As a result, the child was placed with a non-relative prior to reunification.

Family Team Meeting (FTM)

Eleven of the 52 children in the sample had FTMs prior to their entry into care and 6 FTMs were held after the child was removed. Six respondents were unsure if an FTM had been held before or after removal and 29 respondents indicated that an FTM did not occur at all. At least one case indicated that the child was relinquished and CFSA did an immediate intake (the mother indicated that she could harm the child and the child was brought in from the hospital). Although exact circumstances for not having an FTM were not reported, as previously stated (see chapter on *Placement Stability*), CFSA needs to continue to promote and encourage the use of the FTM as an essential vehicle for increasing placement with kin whenever possible.

Risk Factors

The 0-3 survey findings concluded with identification of risk factors for the child, for the parents and family as a unit, as well as social/environmental risk factors. Among child risk factors, 26.7% of the respondents identified premature status, and 21.2% indicated childhood trauma as risk factors. Parental risks factors were identified as depression/anxiety (57.7%), substance abuse

[48] Only 48 respondents answered the question related to kinship placement.

(53.8%), personal insecurity (46.2%), and low tolerance for frustration (44.2%).[49] Among the identified social/environmental risk factors, stressful life events and parental unemployment were identified, including homelessness (48.1%), as well as low social economic status (40.4%).

Table 12 – Zero to Three Survey Findings: Risk Factors

Child Risk Factors	**Number**	**Percentage**
Premature birth, birth anomalies, low birth weight, exposure to toxins in utero	**14**	*26.9%*
Temperament: difficult or slow to warm up	**4**	***7.7%***
Physical disability	2	***3.8%***
Cognitive	2	***3.8%***
Emotional disability	0	***0.0%***
Chronic or serious illness	2	***3.8%***
Childhood trauma	**11**	***21.2%***
Child aggression, behavior problems	3	***5.8%***
Attention deficits	1	***1.9%***
Parental/Family Risk Factors	**Number**	**Percentage**
Poor impulse control	19	***36.5%***
Depression/anxiety	**30**	***57.7%***
Low tolerance for frustration	23	***44.2%***
Feelings of insecurity	**24**	***46.2%***
Insecure attachment with own parents	15	***28.8%***
Childhood history of abuse	14	***26.9%***
High parental conflict, Domestic violence	21	***40.4%***
Family structure- single parent with lack of support, high # of children in household	22	***42.3%***
Social isolation, lack of support	14	***27.5%***
Parental psychopathology	14	***26.9%***
Substance abuse	**28**	***53.8%***
Separation/divorce, especially high conflict divorce	1	***2.0%***
Age	18	***34.6%***
High general stress level	18	***34.6%***
Poor parent-child interaction, negative attitudes and attributions about child's behavior	15	***28.8%***
Inaccurate knowledge and expectations about child development	16	***30.8%***
Social/Environmental Risk Factors	**Number**	**Percentage**
Low SES	**21**	***40.4%***
Stressful life events	**25**	***48.1%***
Lack of access to medical care, health insurance, adequate child care, and social services	10	***19.2%***
Parental unemployment; homelessness	**25**	***48.1%***
Social isolation/lack of social support	14	***26.9%***
Exposure to environmental toxins	0	***0.0%***
Dangerous/violent neighborhood	11	***21.2%***
Community violence	15	***28.8%***
Poverty	**19**	***36.5%***
High prevalence of crime	12	***23.1%***
High prevalence of illegal drug use	15	***28.8%***
Low educational attainment	**19**	***36.5%***

[49] In the *2003 Needs Assessment,* maternal depression surfaced as a significant risk factor.

Challenges

Substance Abuse

The correlation between neglect and substance abuse must be addressed when CFSA provides services to these children and families. Survey findings brought to the forefront the significant impact that parental substance abuse has in the lives of children ages 0-3. Almost two thirds of the survey findings indicated that the mother was a substance abuser. The drugs of choice were crack cocaine, marijuana, PCP, and prescription pain killers. Regardless of the type of substance, preventing substance abuse among primary caretakers in general is a critical challenge that no individual agency can address alone.

Difficulties Since Entering Care - Placement Disruptions

Respondents indicated that in 67% of cases, the child had not experienced any difficulties since entering care and in 63% of cases, the child had not experienced any placement disruptions.[50] Primary issues related to a child experiencing difficulty when entering care related to bonding and separation issues. The following issues relating to placement stability were also captured:

- Medical issues of child impacting caretaker ability and willingness to care for child
- Child struggling with absence and loss of both birth parents
- Placement disruption of kin placement because kin not licensed
- Placement disruption due to foster parent circumstances (e.g. foster parent no longer wanted to care for child, foster parent illness, foster parent relocation)

Services Offered

Social workers noted that there is a good array of services available to support the needs of children ages 0-3, but indicated that they do not always have time to access those services. Supervisors must monitor caseloads and task lists so that a child is never without a service due to a worker who doesn't have time to access that service.

Although respondents noted there are many services in place, they also highlighted some of the existing service gaps. Respondents cited delays in accessing speech and language therapy services, both critical services for younger children. Some respondents also identified difficulties in accessing providers located in the District when a child is placed in Maryland.

[50] Only 45 respondents answered the question related to placement difficulties. Forty-six respondents answered the questions related to placement disruptions.

Respondents repeatedly stated that there are issues with accessing child care. One worker gave the example of a foster parent who may not be currently employed, but who would like to begin working again. Voucher rules, however, require foster parents to submit pay stubs in order to qualify for child care. Thus, the foster parent cannot start a job without child care being arranged, but the Agency won't pay for child care until the foster parent can prove that she (or he) is working.

Systemic Problems

Workers indicated that developmental assessments should be done as early as possible. Many times, according to some workers, assessments are scheduled, but must be cancelled, due to conflicting commitments (e.g., the appointment conflicts with the need to be in court for another case). One worker expressed frustration that there is not enough support in keeping appointments from the social service assistants (SSAs) or from the supervisors. This concern re-emphasizes the need for supervisors to monitor caseloads.

As noted above, respondents felt that improved communication between CFSA and private agencies concerning important medical information following a case transfer from CFSA would strengthen placement stability for all children in care, but especially for this vulnerable group of children.

Advocacy on behalf of birth parents was also identified as an area that could support stability after reunification. One worker gave the example of a birth mother who encountered many challenges when trying to obtain needed documentation to access services for her child. If someone had been available to help her navigate through the appropriate systems, then this availability might have facilitated, as well as expedited her ability to connect to the appropriate resources.

As with other populations in foster care, temporary kinship licensing in Maryland was identified as a primary issue both in placement disruptions and in moving a case towards permanency. Although it has already been noted in previous sections of the *Assessment* that CFSA is making strides in this regard, it is nonetheless important to reiterate this issue as a systemic challenge to achieving timely permanence for children.

It has been noted throughout the review that the 0-3 population requires significant medical care (as is the case with this age group even outside of the child welfare system). Accordingly, respondents identified transportation to and from medical appointments as a frequent issue for birth parents (and foster parents) caring for infants and toddlers. In one case, a social worker cited the example of a foster parent who does not transport the child at all, which places an extra burden on the worker. Social workers in the sample suggested that one approach to alleviate the challenge of meeting the transportation demands is for foster parents "to meet the workers half way."

Needs and Services for Placement Support

Child Care

Respondents identified child care as the primary service need for foster parents. Overall, respondents had mixed experiences with child care payments and accessibility of child care and child care services. Child care and child care services are crucial components for a caregiver's ability to function as a provider. These services must be prioritized for all residents in the District of Columbia, but especially for the population being served by CFSA.

Other types of services being utilized while the children were in foster care included those related to developmental screening and evaluation, medical monitoring, and a variety of therapies: physical, occupational, speech and language, and play therapies. Additional services include Head Start programs and medical services, such as surgery. Most of these services were very accessible and effective, except for child care.

Additional issues surrounding child care included the following basics:

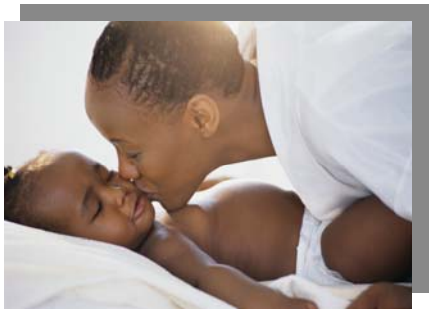
- Need for an improved payment process
- Aid in locating child care services
- Need for assistance with the child care process (streamlining)
- Need for infant child care slots

Better Understanding of Care Needs for 0-3 Population

A primary concern identified by respondents was cognitive stimulation and social interaction for children. Workers and foster parents may need supplementary training to assure the achievement of developmental milestones of children in care. Age-appropriate stimulation is critical for this young population.

In many of the cases reviewed, respondents indicated that foster parents did not realize the substantial number of medical appointments required. Social workers gave the example that foster parents may be resistant if they do not fully grasp the importance of making sure the child actually attends numerous appointments. In addition, a better understanding of processes related to visitation and reunification is needed so that foster parents can truly be advocates for the child's well-being. Respondents felt overall that workers, parents, and foster parents need to engage in a dialogue to ensure complete understanding. The social worker should encourage birth parents to attend all medical appointments. Within this same conversation, levels of bonding with a child and a foster parent should be addressed. Bonding can be misconstrued by a birth parent. A child (especially at ages 0-3) will naturally begin viewing the foster parent as their birth parent, particularly if visitation does not occur regularly. Some respondents felt this issue can be addressed if visitation with birth parents is increased to at least once or twice per week. Additionally, the Practice Model should be reinforced so that foster and biological parents work as a team on behalf of the child(ren). When necessary, the worker can interact as a mediator between the foster parent and birth parent, or a Family Team Meeting may be scheduled.

Information Sharing and Training



Foster parents may not realize the heightened degree of care that infants require. Respondents found that some foster parents may become overwhelmed, and quickly return the child to the Agency. A key solution shared by workers was inclusion of information about the needs of the 0-3 population during foster parent training. This information, however, must not be limited to the amount of time it takes to put child care in place. It must include a list of readily available and accessible services and supports. The information must also be reinforced by social workers. Respondents indicated that training would be beneficial to help the foster parents gain realistic expectations and understanding of children in this age group.

Several respondents indicated that improved communication between CFSA's Office of Clinical Practice and private case management agencies, specifically in regards to the exchange of medical documentation and information, scheduling and occurrence of medical appointments, is an area of "information sharing" that will facilitate placement stability following a case transfer from CFSA.

Early Intervention

Since the amendment of the 1974 Child Abuse Prevention and Treatment Act (CAPTA) (P.L.108-36), states are now required to develop "provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services." In the District of Columbia, the Department of Human Services' (DHS) Early Care and Education Administration (ECEA) oversees the District of Columbia Infants and Toddlers with Disabilities Services Program (ITDSP), formerly known as the Early Intervention Program, a prevention and intervention strategy that promotes the identification and screening for developmental delays in infants and toddlers up to three years of age. Child Find is the program responsible for the identification, screening and evaluation of children and youth who are suspected or have a diagnosed disability or developmental delay, in order to provide early intervention and special education services under the law.

Safeguarding the development of children ages 0-3 is critical to healthy mental, physical and emotional development. Respondents reported that 17 of the 52 clients had been referred to Early Intervention, 23 were not referred and the status of referrals for 12 children was unknown. Reasons identified by respondents for not referring children to services included lack of familiarity with early intervention. One respondent indicated the child had been referred for speech and hearing assessments. Other assessments or testing included neurology and radiology, physical examination (other than regularly-scheduled pediatric appointments) and early development checks. Some respondents shared that the child had already undergone developmental screenings through his/her pediatrician. These responses, especially those that include "unknown status", underscore the importance of promoting and accessing early intervention services for every eligible infant and child entering the District's foster care system.

CFSA and DHS/ECEA have signed an inter-agency agreement (Memorandum of Understanding, or MOU). This partnership details the roles and responsibilities of each stakeholder to ensure referrals for any child under the age of three (with a substantiated allegation of child abuse and/or neglect) for screening and evaluation for developmental delays. Under the terms of the MOU, CFSA has provided funding to support the projected expansion of ECEA's current capacity to complete evaluations and make referrals for services in a timely manner, following the initial

screening. These combined inter-agency efforts are truly a tailored scheme to assure the healthy development of CFSA's most defenseless population.

Strengths to Build Upon

Most respondents found that the foster care placement process for this population was working well. A significant percentage of respondents felt able to meet the needs of the children in this age range with the exception of those who needed child care services and transportation services. Respondents indicated that placement of this population is not very difficult, yet they stress that foster parents need to better understand the extra care required of infants and toddlers.

Respondents noted that a helpful resource is the Board of Child Care, which has a child care specialist who provides foster parents with important linkage to nearby day-care resources. Respondents indicated that overall, Maryland agencies have been helpful and responsive for county-based referrals for child care resources. CFSA's Child Care Specialist has also been helpful in identifying child care resources for District foster parents.

These strengths are presently complemented by several promising practices. For example, CFSA nurses assigned to the Child Protection Services Administration (CPS) make initial visits to all infants entering foster care, including all 0–3 year old children who are considered medically fragile. Upon request, these nurses will also make home visits to other children in this age range who are entering foster care. These home visits help with early identification of developmental needs and ensure that children's medical needs are addressed. Nurses in OCP also conduct follow-up home visits for children in care with developmental and medical needs. This practice is a very effective "built-in" prevention strategy for children's well-being and safety. Nurses can anticipate developmental issues early and make suggestions for referrals.

Although the data indicated that few FTMs were conducted within the sample cases reviewed, respondents indicated that FTMs are a value-added component to case practice. CFSA has implemented FTMs for all removals and the Agency must continue to monitor the application of Agency policy concerning FTMs and removals.

Strategies

The enhancement of the District's current array of prevention services aimed at this group of children and their families (see chapter on *Prevention* and *Appendix E*) is among the Agency's most strident strategies to address the increasing numbers of children ages 0-3 who are coming to the attention of CFSA. These efforts will be further supplemented by the District's expansion of home-visiting and supportive resources for pregnant women and new mothers. Evaluation of these efforts over time will determine the impact of early intervention on the incidence of child abuse and neglect among the 0-3 population with linkages to community-based services playing a crucial part.

Effective November 1, 2005, the Agency released an Administrative Issuance (AI) that served to inform CFSA staff of the mandatory requirement to refer eligible children ages 0-3 to ECEA for early intervention screenings and assessments. The Agency will re-issue the AI and propose training accordingly to ensure staff members are aware of the requirement and understand the process for making referrals.

As noted, respondents frequently identified challenges with accessing child care. Analysis of the current process, including eligibility requirements of both CFSA and ECEA, and identification of areas where potential delays can be easily addressed, may help to streamline the overall process and facilitate access to services.

It is part of the mission of the CFSA Practice Model to best serve every child and youth in care through placement with relatives, whenever possible. This is especially critical for infants and toddlers for whom stability is critical to help them achieve developmental milestones. Family Team Meetings (FTMs) are a solid vehicle for identifying relatives for kin placement. Yet, FTMs had not occurred for over half of the 52 cases surveyed and 69% of the children were not placed with relatives. CFSA must work to ensure that every child has a Family Team Meeting upon entering care, and that FTMs are held if there is a threat of a placement disruption.

Chapter IX
Discussion

Discussion

Relevant findings and recurring themes have been raised throughout the *2007 Needs Assessment* report. This final chapter draws together the prominent, and sometimes conspicuous, placement support and placement resource needs - both current and projected - of the children and youth served by the District of Columbia's Child and Family Services Agency.

Achieving permanency through family-based foster care is a focal area for the Agency, supported by numerous studies indicating that the developmental needs of children and youth are best met in family-like settings and that children placed in such settings often experience shorter stays in foster care. Increasing our capacity for care is a key strategy to achieving a comprehensive family-based child welfare system.

Projections, albeit not immoveable, still indicate that the reality of children being placed in family-based settings could decline over the next two years. In particular, the largest projected decline involves kinship foster homes. Combining these projections with the need to increase present capacity, it becomes obvious that CFSA must secure kinship placements with a specific focus on engaging paternal family members, when appropriate, in order to support meaningful outcomes for the children and families. Further, the Agency must strengthen the recruitment and retention of highly-skilled foster families who will be committed and trained to work with children and youth who may have special needs or who may otherwise present challenges.

The following strategies to advance recruitment of kinship and traditional foster parents will help CFSA to ensure first and only placements in the most family-like setting possible:

- increased use of Family Team Meetings, Family Finding, Youth Connections, and the Diligent Search Unit to engage family members, especially paternal relatives
- providing foster parents with full information about the child at the time of placement
- increased capacity through careful and thoughtful matching of children and youth to foster parents
- implementation of a kinship licensing process for willing relatives living in Maryland

Since successful recruitment must be partnered with successful retention, thoughtful preparation and support is required for foster parents. Based on current trends, foster families must be adequately prepared to parent a growing population of older youth who are universally

challenging (as they naturally test all boundaries on their path to independence). A significant need also exists for foster parents who can provide stable and supportive homes to youth who identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ). Given these realities, a major emphasis must be placed on the need to update support services and training for foster parents (and for social workers), providing both with evidence-based approaches to address common issues related to behavioral and/or emotional problems of children and youth in foster care.

Kinship and traditional caregivers have cited communication issues as a barrier to retention. Most common was the caregivers' concern that communication with social workers was inconsistent, particularly when there was a change in worker. This speaks to the definitive need for improvement in engagement skills, and on-going communication between caregivers and social workers. Further, CFSA must guard against social worker burnout. Discontinuities in services to families due to high case worker turnover can lead to multiple placements and delays in permanency for children (Landsman, et al. 1999).

The Agency must also work to change systemic factors that assume a "congregate care only" placement option, including placement of youth in residential treatment centers. By increasing the number of community-based services offered in the District, and updating the skill-level of foster parent providers, children and youth will be more likely to have their needs met within the community, rather than having to go to congregate care or to a specialized residential treatment center. Initiatives, such as the Levels of Care approach will begin to address this need, but the Agency should further explore models that other states have used to reduce their reliance on congregate care.

The *2007 Needs Assessment* projects an increase in children and youth who will need emergency placement settings. The temporary nature of placement in an emergency shelter results in multiple placements for a child or youth. Multiple placements have been identified as one of the most serious problems facing children in foster care today. Improved recruitment and retention strategies should offset this need for emergency placement settings and its potential negative ramifications for placement stability.

The data indicate that teenage girls have the highest instability rate, resulting in increased risky behavior. Social workers have reported that a small but worrisome number of some youth (both female and male) in CFSA's custody have been involved in prostitution, which not only presents stability concerns, but also significant safety issues. Social workers and foster parents also report that many older youth, especially after reaching age 18, refuse to comply with stabilizing services, such as counseling and medication management. Finally, stakeholders noted that many youth feel entitled to enter an Independent Living Placement (ILP) at age 18, regardless of whether they are socially, emotionally or developmentally ready to make such a change. These youth are particularly motivated to move to ILPs because of the relatively large allowance that "funds" independence for them. Older youth can successfully move to ILPs from family-based foster homes but these moves undermine the Agency's efforts to provide placement stability for teens: the Agency's present decision-making approach to placing youth in ILPs needs to be improved.

The *2007 Needs Assessment* also reports a projected decline in the number of children with the goal of adoption who will actually be placed in pre-adoptive homes. Social workers noted that it was critical for pre-adoptive parents to be linked to strong support networks to help guide them through the often challenging adoption process. Feedback from both adoptive and pre-adoptive parents cited the length of time that it takes to achieve adoption as a major barrier for foster families who are considering adopting the children in their care.

Finally, CFSA was prompted to take a special look at children ages 0-3 years due to a disturbing trend in the District and across the nation which forecasts an increase in this very young group of children entering the foster care system. A closer look found that the majority of infants who enter foster care do so as a result of neglect. Older toddlers (up to 5 years old) more often enter care as a result of abuse. This finding provides the Agency with an opportunity to work more intensively to reduce risk of neglect in the community and increase protective factors to prevent the placement of young children into care. This includes strengthening the family so that children are carefully and safely supervised. In this regard, one of the Agency's newest initiatives, The Partnership for Community-Based Services, involves the co-location of CFSA staff in the community. This important effort will help CFSA to engage directly with resources and supports for fulfilling needs of children and youth, particularly the needs of the at-risk infant

and toddler population. In addition, the Agency is strengthening the current array of prevention services in the District to be available for pregnant or post-partum women (up to three months) who may demonstrate high-risk behaviors, or have particular medical, behavioral, and educational needs (see *Appendix E*). This evidence-based approach shall serve to prevent the entry of families into CFSA through the provision of intensive long-term home- and community-based services. Program evaluation over time will determine the anticipated impact of this approach on reducing the incidence of abuse and neglect among the 0-3 population and the subsequent impact on entry of this vulnerable group of children into foster care. Given that children under age three represent 25% of substantiated cases of child abuse and neglect in the District, emphasis on prevention is imperative.

The *2007 Needs Assessment* identified statistical projections of placement types that, without intervention, could lead to circumstances that would contradict the core values and principles of the CFSA Practice Model. Consequently, key recommendations and action steps will be developed to circumvent these and other findings through CFSA's resource development plan (RDP). The RDP shall ensure that (1) the *2007 Needs Assessment* projections are offset by active engagement among all stakeholders to place children and youth into family-like settings, particularly with kin whenever possible, (2) CFSA reduces its reliance on congregate care and (3) children in CFSA's care experience safe and stable foster care placements. Additionally, CFSA's current key initiatives are expected to diminish the likelihood that the projections will be realized.

Although the predominate age groups in the population to be served by CFSA are projected to shift by 2009, the number of placement slots by placement category will not significantly change due to the overall decrease in the total foster care population. Coupled with the initiatives previously mentioned, one must again conclude that staff and providers must be competently prepared to work with the challenges of the shifting populations.

As the Child and Family Services Agency promotes and implements its core principles and values, the Agency recognizes that child maltreatment prevention efforts are critically important to future generations. It will continue to work to integrate prevention and support services across District programs, and to devote its collaborative work with numerous community-based

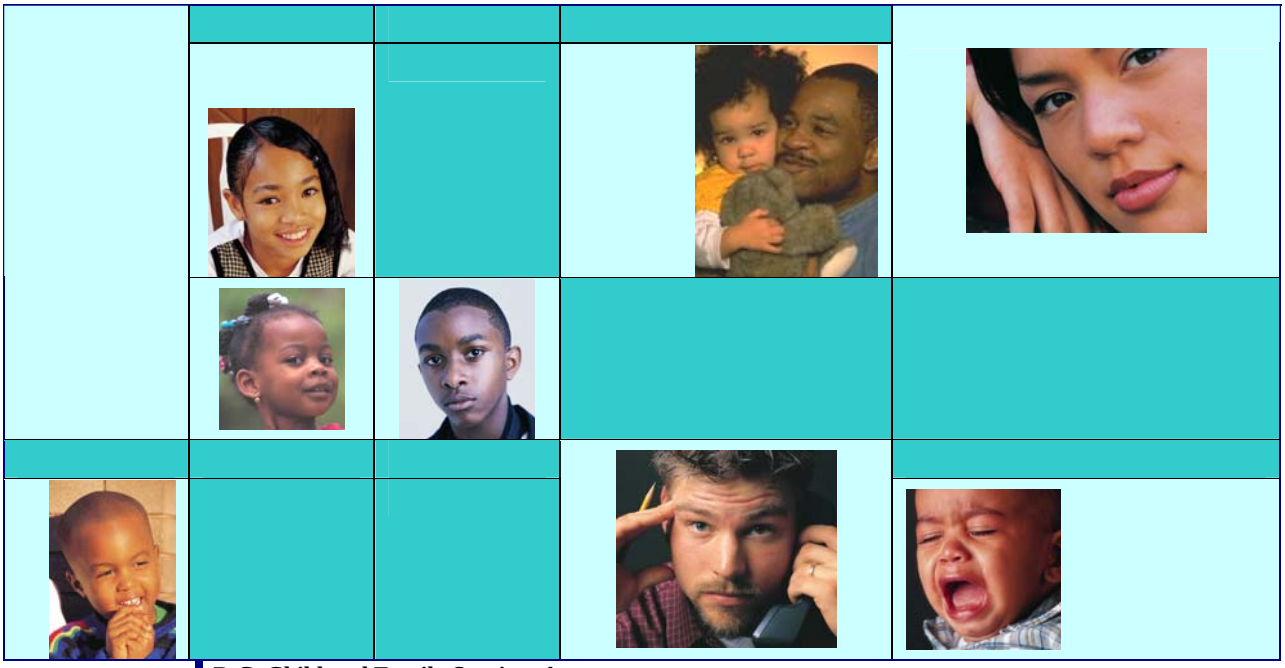
programs to prevent child abuse and neglect. CFSA shall always serve to strengthen and support children and families in the District of Columbia so that their well-being is secured and they receive what they need to live safely in a permanent home.

Appendix A – The Practice Model

Practice Model

Our foundation for effective child welfare practice

November 2005



D.C. Child and Family Services Agency
400 Sixth Street, S.W.
Washington, D.C. 20024-2753
www.cfsa.dc.gov

Primary Goals

CFSA's mission is to improve the safety, permanence, and well-being of abused and neglected children and to strengthen troubled families in the District of Columbia. Our child welfare practice strives to achieve **four principal outcomes**.

Children are safe.

Safety of children is our paramount concern, and we address it in every intervention, every plan, and every contact. We assess risk factors and engage birth, foster, and adoptive families in keeping children safe.

Families are strengthened.

Perhaps the greatest challenge in child welfare is balancing the goals of (1) preserving birth families while (2) ensuring children's safety within their development need for permanence. The importance of family and significance of a child's attachment to parents are immeasurable. We make every effort to engage and support birth families to prevent child placement. When we must place children for their safety, foster care is a short-term intervention. We make every effort to assist parents in overcoming difficulties through services, to strengthen ties between children and parents, and achieve reunification. When reunification is not possible within 15 months, we achieve permanence for children through guardianship or adoption.

Children and teens have permanence.

All children need a stable, nurturing family to grow and develop to their full potential. When birth families cannot or will not ensure the safety and well-being of their children, we locate a family to which the child can belong. We find permanent families quickly for every child, teen, and young adult and finalize guardianships and adoptions within 27 months. When young adults age out of foster care, they have a permanent family or enduring connection to a caring adult committed to serving in a parental capacity and to a network of mentors and friends in the community.

Child and teen developmental needs are met.

Children and youth require assistance to achieve healthy physical, intellectual, social, and emotional development. We identify needs consistent with different stages of a child's development and coordinate resources to meet them. We prepare young people for self-sufficiency, including developing their abilities to meet their basic needs, communicate, form relationships, make decisions, solve problems, and resolve conflicts. We recognize permanence as an essential component of child and adolescent well-being. ■

Core Principles and Values

Child welfare social workers use a professional helping relationship as the vehicle for achieving desired outcomes for children. They assess, respond to, and influence family decisionmaking, behaviors, and circumstances. They take the lead in promoting urgency about permanence based on a child's sense of time. Program Operations supervisors and managers set standards, communicate expectations, monitor performance, coach and model effective behavior, provide developmental feedback, and show concern for how workers are experiencing their job. All other CFSA functions and employees support social workers, supervisors, and managers in serving abused and neglected children and families.

Children First

Child safety, permanence, and well-being are our top priorities.

Family

Families are the focus of child welfare: preserving families, supporting foster families, building new adoptive families, and ensuring child and teen attachment to families. We recognize that all families have strengths and deserve a voice in decisions about their children. We serve families from diverse cultural backgrounds in a responsive manner.

Respect

All clients are worthy of **respect**. We inform them of their rights and responsibilities. We safeguard confidentiality and ensure due process.

Urgency

A child's sense of time and the **urgency of permanence** drive our practice. We aim to effect change so that children achieve outcomes within time frames that meet their need for permanence, as embodied in the Adoption and Safe Families Act. All parties cooperate and remain accountable to the child.

Leadership

We assume **primary responsibility** for ensuring child safety, influencing family change, leading the drive to permanence, and promoting teamwork among all parties in the best interests of the child.

Assessment

We identify behaviors and conditions that place children at risk of abuse or neglect or of not achieving permanence. We focus our actions and resources on **what drives problem behaviors and conditions** rather than on symptoms or trigger incidents. We recognize that poverty, substance abuse, mental illness, and other severe difficulties strongly influence behavior, and we factor them into assessments and intervention/change strategies.

The social worker relationship with clients is **proactive**, **focused**, and **time limited**. We influence underlying factors that create or sustain

Intervention

problem behaviors and conditions. We use a **professional helping relationship** to encourage family change that leads to positive outcomes for children. We regularly monitor children at home and in out-of-home care to ensure their safety and well-being. We modify intervention/change strategies and case plans as child and family needs change.

Authority

We have a legal obligation to protect children and to engage families in taking action. We use **child welfare and Court authority** when necessary and appropriate to ensure child safety while maintaining a helping relationship with the family. We fully disclose to parents the consequences of and time frames for their behavior. We do meaningful, timely concurrent planning.

Placement

Removal from home is traumatic for children, even when it safeguards their welfare. We place children in out-of-home care **only when they cannot be safe in their birth homes**. When we must place children, they deserve to:

- Know why they are entering foster care.
- Be safe from further abuse or neglect in our care.
- Be placed with their siblings.
- Be placed with kin whenever possible.
- Have a stable, nurturing foster care setting that meets their needs.
- Be in foster care only as a short-term, interim step to permanence.

Teamwork

A system of partnerships among preventive, foster care, legal, service, and other resources is essential to achieve safety, permanence, and well-being for children. We **assemble**, **coordinate**, and **lead** appropriate and inclusive multidisciplinary teams in providing prompt, effective, quality services to children and families. ■

Leadership Principles for Social Work Supervisors and Managers

Focus

- **Get results through others.** Do not merely delegate but provide leadership, direction, education, and support that achieve results. Link tasks and outcomes to the agency mission and primary goals.
- **Use power and influence.** Be comfortable gaining staff commitment and compliance and shaping their behavior toward necessary outcomes.
- **Be visible.** Achieve agency goals along with responding to staff needs. Stay constantly visible to those above and below in making difficult decisions.
- **Manage conflict.** Communicate expectations clearly and directly and give negative feedback effectively, when necessary. Allow for conflict of ideas in support of positive change.

Production

Focus on results and emphasize urgency of achieving them. Set high standards of quality and excellence. Model excellence.

Communication of Expectations

Articulate expectations of the job. Have clear practice standards and communicate them effectively. Ensure clarity of work assignments. Engage staff in setting goals and objectives that reflect the underlying values of their work.

Coaching

Emphasize practice protocol, set developmental goals with staff, and provide regular counseling to them to improve performance. Observe worker performance and provide feedback to enhance existing skills. Model effective behavior and decisionmaking.

Control

Systematically monitor performance against expectations. Track case activity and progress on delegated assignments.

Feedback

Give frequent positive, negative, and developmental feedback that is very specific. Compare results against expectations to clarify performance issues.

People

Demonstrate concern for how workers experience the job. Listen to worker concerns. Be genuine with staff. Build trust. ■

Practice Protocol for Social Workers

Respond and Engage	Accept and investigate reports of child abuse and neglect wherever they may occur in the city. Build rapport with parents, children, extended family members, and other supporters through respect, honesty, and professionalism. Balance the mission and desire to help with the authority to intervene and need to protect.
Assess	Identify the current situation and underlying factors. Understand family strengths, needs, and wishes. Listen and observe. Assess child safety and degree of risk. Justify and document findings.
Plan	Partner with parents, children (when appropriate), extended family, and other supporters to select interventions, supports, and services that build on strengths while addressing underlying factors, needs, and wishes. Establish a goal of reunification within 15 months or guardianship/adoption within 27 months. Communicate directly about desirable outcomes, requirements for case closure, time frames, rights, and responsibilities. Develop a comprehensive case plan promptly (and in advance of initial Court activity when the Court is involved).
Coordinate and Lead	Assemble internal resources, other agencies, and community service providers to support the case plan. Coordinate service team activities. Lead the drive to meet child and family goals. Advocate for the child and family with the service team, as needed.
Serve	Ensure prompt, effective delivery of services to fulfill case plan requirements and meet the child's goal within mandated time frames. Encourage and support parents, the child, and others in engaging (not merely participating) in services.
Monitor and Evaluate	Visit regularly to check child safety, child-family engagement in services, and effectiveness of services in stimulating positive change. Communicate directly about achievements and areas in need of improvement. Reassess child safety and risk throughout the life of the case. Ensure steady progress toward the child's goal. Document findings from every visit.
Adjust	Adapt requirements and services to address changing circumstances. Update the case plan. If necessary, change the child's goal.
Reassess and	Achieve permanence for every child, teen, and young adult through reunification, guardianship, adoption, or other life-long connections.

Close

Ensure safety and stability for children and teen/young adult mastery of self-support skills. Arrange for appropriate, time-limited after-care and post-permanency services. Document results of the final assessment and overall outcomes. Close the case. ■

Appendix B – Methodology

To complete the 2007 Needs Assessment, CFSA utilized the same research design used in previous needs assessments. This design includes both quantitative and qualitative components, which consists of a self-administered survey, focus groups comprised of youth, staff, foster parents and adoptive parents, administrative data, interviews with key informants, and other material sources. The placement projections were calculated using non-linear regression analysis. Further, this 2007 Needs Assessment looks closely at four specific populations of children and youth: children with special needs[51], youth ages 14 to 21, sibling groups, and children ages 0 to 3. We chose to focus on these specific sub-populations because of the unique challenges that they pose for the Agency currently and, we anticipate, over the next three years.

Self-Administered Survey

The needs assessment incorporated a self-administered survey through Survey Monkey. Over a month period, respondents[52] were surveyed to gather feedback on placement needs in addition to special populations focal questions on 0 – 3, older youth, sibling groups and children with special needs. The survey purpose was to produce statistical and qualitative descriptions of the needs identified by the survey respondents. The survey served as the means to combine data collection strategies- qualitative and quantitative. The survey protocols utilized open-ended questions in addition to questions that would produce numerical description of the sample population.

Survey Methodologies

The survey methodologies included sampling, protocol design and data collection. The sampling frame incorporated was a probability sample, a sample that allowed for each individual in the identified population the opportunity to have data collected about them. The sample approach involved outreach to persons and programs committed to

Analysis

Standardized measurement was applied to the data content, ensuring comparable analysis of all responses to the survey. Data analysis employed aggregate data from both qualitative and quantitative components of the survey. Analysis of the data collected identified that the response rate was variable and highly correlated to the number of programs operated by any given entity.

Strengths

Survey research methods served as both a quantitative and qualitative component of the prevention assessment. The strength of the survey was rooted in allowing for a genuine random sample. The sample design of the survey was user friendly and easily accessible. Another survey strength was the detail of the instrument. The instrument was comprehensive in scope, allowing respondents the opportunity to critically outline their respective programs. The detail, although an integral component of the quality of response, also presented a challenge to respondents (see *Appendix B* for methodology limitations).

[51] CFSA Office of Clinical Practice (OCP) defines this population as all CFSA children with any medical, developmental, cognitive or physical impairment including children who requirelong-term medication/treatment for a condition or require medication/treatment for a recurring condition that if left untreated may lead to serious illness.

[52] CFSA participants included: social workers, social work associates, social worker supervisors, program managers, administrators, support staff (specifically support staff from Placement Administration & OCP (Office of Clinical Practice). Private agency participants included: case-carrying workers & supervisory staff.

Focus Groups

Staff members from the Office of Planning, Policy, and Program Support, in collaboration with the internal and external stakeholder groups, developed the protocols used during the focus groups. As expected, there was some variation in questions asked during each group, although the general content of the questions remained similar. The variation in focus questions were driven by the following three factors:

- Questions were developed based on the expertise, position, roles, and responsibilities of the group members. For example, focus groups with foster parents focused on foster parent needs, whereas questions posed to agency workers were directed towards agency protocol and practice with children in care.
- Depending on the focus group members, questions were prioritized so that the most critical questions were asked first in the event of time constraints.
- Questions were refined after the completion of each group as the facilitators learned which questions worked and which ones did not.

Participants in the caregiver focus group included foster parents residing in the District of Columbia (9) and Maryland (4) and kinship care parents (5), who were a separate group. Telephone interviews were conducted with (3) foster parents in Virginia, covering the following placement types:

- kinship care
- pre-adoptive placement
- traditional foster care placement

Focus groups were also conducted with older youth (ages 18-21) in care. Three (3) focus groups were conducted with these youth: females ages 16-18, females ages 18-21, and males ages 17-21.

Data Analysis

After each focus group, notes and audiotapes were reviewed by research staff for content analysis to identify major themes in and across groups. An electronic database, *NVivo* qualitative software, was used to organize and code the data for analysis.

Administrative Data

A variety of past and current CFSA administrative data on placement was compiled from FACES management reports to identify trends and patterns. In addition, for the review of the 0-3 population, FACES created a special report which captured 0 – 3 referral data for FY05 through FY07.

Key Informant Interviews

The Needs Assessment utilized key informant interviews are a qualitative means to collect more in-depth information on the issue area content. The techniques used were telephone interviews and face-to-face interviews. The objective of this method was to better understand issues brought to the fore in focus groups and/or better detail responses received through other research methods employed during the assessment. The interviews provided more candid responses on specific topics addressed throughout the

needs assessment. Key informant interviews better allow for further insight of subject matter in deconstructing hypotheses and conclusions.

Placement Projections Methodology

Statistical Analysis

The statistical model is the primary model employed to compute the projections of placement types. The placement projections incorporated a non-linear, exponential growth model, utilizing point-in-time data for each month over a thirty-one month period, beginning in January 2005 through June 2007. The projections are predicted values, whereby there is a y value for each given x value. The known values are existing x values and y values and the projection was the resulting new value that identifies the correlating linear relationship between the exiting values. Placement projections were conducted for the following placement types: family-based foster care, group homes, residential treatment facilities, independent living facilities and two special groups – older youth ages 14-21, sibling groups. In addition for each projected value there is a range from lowest to highest value, computed through calculating 10% above and 10% below the mean value determined.

Non-Linear Regression Model

A non-linear regression model was also utilized to project placement types. This analysis applied an exponential growth model to existing values. The exponential growth model applies logic whereby growth is based upon returns of y-values for a series of x-values. The projections - predicted values, were calculated based upon specified existing x values and y values.

Regression Tool Functionality- R squared

The functionality of the regression tool applied to each projection was analyzed through calculation of the r-squared for each placement type. The quality of each placement type fit was measured by the statistical value of r-squared. The closer the r-squared value to 1, the better the model fit the data – demonstrated by the regression line going through each designated point within the model.

Values Lens Model

The aforementioned statistical approach has been incorporated for the current Needs Assessment and RDP. Moving forward, the applied approach will incorporate a values approach, modeled within a practice model framework. The future projection method will employ a value lens that identifies a projection based upon ideal value framework and the qualitative conversation around the identified quantitative value will direct the process of projecting toward the ideal.

Total Population – Methodology

The projections for overall population projections were computed through non-linear regression analysis. The principal purpose of the model used was to predict the value of unknown variables based upon known variables. The overall population projections incorporated point-in-time data for each month over a sixty-two month period, beginning in January 2002 through February 2007.

The functionality of the regression tool was analyzed through calculation of the r-squared. The quality of the population projection fit was measured by the statistical value of r-squared. The closer the r-squared value to 1, the better the model fit the data – demonstrated by the regression line going through each designated point within the model.

Zero to Three Survey Methodology

The survey methodology employed included sampling, protocol design and data collection. The sampling frame incorporated was a probability sample, a sample that allowed for each individual in the identified population the opportunity to have data collected about them.

Cases

The zero to three survey analyzed fifty-two cases of children in care with substantiated cases that were between the ages of zero and three in FY07. The cases reviewed were both CFSA-managed cases and private agency-managed cases.

Research Limitations

Survey Limitations

Methodological limitations attached to the project, were evidenced in the survey were inclusive of the following: non-response error that can result in a biased sample, question design and error that can result in inaccurate responses and quality of response, random sampling error which presents risks in identifying the subset of a population as representative. The length and detail of the survey appeared to present challenges to respondents. CFSA crafted protocols to meet the required standard as detailed by the amended implementation plan, yet the exhaustive nature of the survey was an obstacle that correlated with the response rate and quality of response. Standard limitations of non-response error, question design or protocol development and random sampling error are detailed below:

Non-response error – Of the total private agency respondents, a total of 30 persons started the survey, however; only 12 (40%) individuals completed the survey. Comparatively, of the 157 CFSA staff that started the survey, 63 individuals completed the survey (40.1%).

Question design and error – While the survey protocols sought to capture detailed information, there exists a standard margin of error.

Random sampling error – The risk associated with identifying a sample population as representative is a stand research methodological error address in the social sciences.

0-3 Survey and Focus Groups Limitations

The random sampling error component of both the survey and the focus groups conducted was an identified research limitation. More specifically, the risk associated with identifying a sample population as representative is a standard research methodological error addressed in the social sciences, whereby the responses yielded from the sample populations are considered representative of a greater whole.
.

Statistical Analysis Limitations

The projections incorporated non-linear regression analysis. The exponential growth model proved the most statistically significant, based upon the r-squared calculation. The projections, however, employed only a statistical model which does not address human condition, as if found in human services. Therefore, trend data – the core of the actuals, provides quantitative explanation for peaks and dips in a population, social condition components can not be taken in to affect with this model.

Appendix C – Stakeholder Participants: 2006 Prevention Assessment

1. Catholic Community Services Parenting Program/ Washington Parent Education Collaborative (WPEC).
2. Safe Shores/D.C. Children's Advocacy Center (DCCAC)
3. Foster & Adoptive Parent Advocacy Center, Director
4. Georgia Avenue/Rock Creek East Family Support Collaborative, Community Resource Coordinator
5. Columbia Heights/Shaw Family Support Collaborative (CH/SFSC)
6. Girls and Boys Town
7. The D.C. Trust Fund /Parents Anonymous
8. Center for Child Protection and Family Support
9. Mary's Center for Maternal and Child Care, Inc.

Appendix D – Partnership for Community-Based Services

Proposed Vision Statement:

> *Every child in the District of Columbia shall live in a safe, stable, permanent home, nurtured and supported by healthy families, strong communities, and a coordinated cohesive child welfare system of care.*

This Partnership will serve as a national model guiding the work of public, private and community based organizations to build an effective system of care for children and families in the community. The Partnership compels:

- Government systems to integrate principles, values and evidence-based practices that empower families to lead the service delivery process;
- The community to advocate for needed services and participate in supporting families; and,
- Stakeholders to hold the system accountable for family progress.

IN-HOME LOGIC MODEL

Resources	Activities	Outputs (key practice outputs)	Short-Term	Medium-Term	Long-Term	Goal
			Family level outcomes			Families remain stable and intact.
Strengths-based, family-centered practice model	Shared responsibility for engaging the family	# and % of families receiving services jointly from CFSA and Collaborative staff	Caregivers recognize the safety needs of their children.	Caregivers demonstrate improved coping mechanisms and developmentally appropriate nurturance.	Children remain safe.	
Families	Help the family assess (and reassess) its needs and strengths	% of families participating in completion of assessment tools			Caregivers demonstrate adequate and effective parenting skills to promote child safety.	
Credentialed CFSA and Collaborative staff	Help the family decide on a goal and steps toward reaching that goal	# and % of case plans co-written and signed by family members	Families recognize the components of a stable, healthy and secure living environment.	Families demonstrate the ability to maintain a stable, healthy and secure living environment without consistently relying upon emergency intervention.	Families have financial and housing stability.	
Training and education on strengths-based family engagement	Empower family members to generate their own solutions through their active participation in the development and implementation of the activities in the case plan	# and % of case plans meeting the quality standards established in the practice protocol	Families report increased contact with and an understanding of the importance of informal and formal support networks.	Families demonstrate the ability to effectively identify and access necessary formal and informal supports for themselves and their children.	Families have strengthened social connections with formal and informal supports.	
Assessment tools	Help the family make a written plan for pursuing these goals	# of hours engaged in face-to-face contact with families	Families can identify their own strengths and understand the importance of using those strengths to achieve case plan goals.	Families effectively advocate for their own needs.	Families access concrete services and supports independently.	
Neighborhood-based service delivery system	Communicate desirable outcomes, requirements for safe case closure, time frames, and rights and responsibilities clearly and directly	% of home visits meeting the quality standards established in the practice protocol	Families recognize their developmental and well-being needs.	Families address their physical, emotional, behavioral, and academic needs.	Caregiver functioning is adequate to promote child well-being.	

Federal and local funds	Visit the family regularly to ensure child safety, child-family engagement in services, and effectiveness of services in stimulating positive change	% of home visits linked to case plan goals			Family and child well-being is improved.	

IN-HOME LOGIC MODEL

Resources	Activities	Outputs (key practice outputs)	Short-Term	Medium-Term	Long-Term	
Multi-system partners	Advocate for and with a family with other agencies, schools and businesses	% of referrals made that successfully link families to needed resources				
	Coordinate family meetings, when appropriate	# and % of family meetings held for all families served				
			System level outcomes			
	Facilitate multi-system planning and service provision	% of cases safely closed within 12 months	Multi-system partners identify the processes and supports to function in partnership with families as a multi-system team addressing families' immediate needs and risk factors.	Multi-system partners continue to team to meet the underlying service needs of families.	Abuse and neglect rates are reduced.	Families remain stable and intact.
	Increase service collaboration and access	% of family meetings with multiple service providers attending			Community and public resources are used more efficiently.	
		% growth in service array available	Multi-system partners understand strengths-based, family-centered practices.	Multi-system partners continue building strengths-based, family-centered practices.	Family engagement and outcomes are improved.	

Appendix E – FY07 Prevention Grantees

The FY07 prevention grantees are implementing the following programs:

Parent-Teen Conflict Resolution and Respite Care (PTCRRC)

PTCRRC services are time-limited, intensive home- and community-based treatment for youth beyond parental control or manifesting truancy and other delinquent behaviors, and their caregivers at risk of becoming involved with CFSA. A component of the immediate conflict resolution intervention includes a parent-initiated one-time only respite program for youth not to exceed five (5) days. Conflict resolution interventions will continue as the youth is transitioned back into the home at the end of the respite period. As the family returns to pre-crisis functioning, they will continue to receive support through a broad range of evidence-based therapeutic services designed to address clinical, social and educational problems. Services will continue for a period of up to six (6) months. This program began in September 2007 and is projected to serve a minimum of 75-100 families during the first year.

Healthy Start Healthy Families

This evidence-based home visitation program has been shown effective in reducing infant mortality and improving well-being outcomes for children. In addition, this type of program has been shown to positively impact clients who were screened for maternal depression at the onset of services. Beginning in FY08, this resource will serve families at risk of becoming involved with CFSA in the wards with the highest incidence of allegations of child abuse and neglect (Wards 5, 6, 7 and 8). This program began in October 2007 and is projected to serve 75-125 families during the first year.

Appendix F – Survey Instruments

0-3 SOCIAL WORKER SURVEY

Part I.

Safety

1. What allegation(s) brought the child to the attention of CFSA? *(check all that apply)*

Physical Abuse	Parent's Alcohol Abuse
Sexual Abuse	Parent's Drug Abuse
Neglect	Incarceration of Parent
Child Exposure to Drugs	Death of Parent
Child Disability	Caretaker's Inability to Cope
Child's Behavior Problem	Abandonment
	Relinquishment
	Emotional Abuse

Other (specify) _____

2. Are there any other issues being monitored? *(check all that apply)*

Parent's physical disability	Child's physical disability	Homeless (living in a shelter)
Parent's serious/chronic illness (specify)	Child's serious/chronic illness (specify)	Denied services that child needed
_____	_____	
Pregnancy	Depression	Domestic/family violence
Problems with child care	Could not pay rent/mortgage/could not find work/laid off from work/heat and utilities turned off	Poor work schedule
Death of family member or close friend	Child's behavior problems at home	Not enough living space in housing for family
Drug/alcohol (specify drug/substance of choice) _____	Lack of permanent housing (living with relatives/friends)	Domestic violence

Lack of permanent housing (living with relatives/friends)

Parent's serious/chronic mental health

Other (specify) _____

3. Who was the child's primary caretaker(s)? If it is not the birth parent(s), please identify the primary caretaker (e.g. maternal grandmother).

4. Is the birth parent(s) a known substance abuser?

No

Yes
If yes, what is the drug of choice?
_____

Well-being

5. Was child born premature?

No

Yes

6. Does the child have any developmental delays? If yes, please specify?

No

Yes *(Please specify)*_____
_____

7. Does the child have any medical issues?

No

Yes (briefly describe the medical issues below)
_____

8. Did the mother/child receive pre-natal or post-natal care?

No

Yes

Permanency

9. What is the child's permanency goal? **Concurrent goals.**

Reunify with parent(s) or principal caretaker(s)
Live with other relative(s)/kin
Adoption
Emancipation
Guardianship
Goal not set at time of interview
N/A - Child is not longer in foster care: Child exited foster care to (identify the child's permanency exit goal- e.g. guardianship, reunification, etc.) _____

10. If reunification was not the planned permanency goal, please briefly explain why it was not chosen for the child and what is needed to reunify? [***FOR CHILDREN NO LONGER IN FOSTER CARE*** **-** If the child did not exit to **reunification**, please explain why it was not chosen].

11. What do you think is preventing this case from moving to permanency? [***FOR CHILDREN NO LONGER IN FOSTER CARE –*** SKIP QUESTION].

12. Has the child experienced any difficulties since coming into care? (If so, are these difficulties common to children age 3 and younger in care or for children in general coming into care) *Please indicate why or why not*. [***FOR CHILDREN NO LONGER IN FOSTER CARE –*** Did the child experience any difficulties since coming into care? If so, please describe]?

13. Have there been any disruptions in placement. *If yes, please explain.* [***FOR CHILDREN NO LONGER IN FOSTER CARE –*** Was there any disruptions during placement? If so, please explain].

Needs & Services

14. List any needs identified for the child. [***FOR CHILDREN NO LONGER IN FOSTER CARE –*** List any needs identified for the child when he/she was in care].

15. What services are/were the child(ren) receiving to address his/her needs?

    a. How accessible are the services?

    b. Are the services effective? If not, why not?

16. Are there services needed that the child is not receiving? *(If so, please list)*

17. Has a referral been made to Early Intervention? If not, why not. (Early invention is….)

Placement Supports

18. Please specify **placement** challenges related to youth ages 0-3 (please disaggregate by age as seen below)

    a. less than 1 year old

    _____
    _____
    _____
    _____
    _____

    b. 1 year old

    _____
    _____
    _____
    _____
    _____

    c. 2 years old

    _____
    _____
    _____
    _____
    _____

    d. 3 years old.

    _____
    _____
    _____
    _____
    _____

19. What would you recommend the Agency put in place to reduce these **placement** challenges (please disaggregate by age below).

    a. less than 1 year old

    _____
    _____
    _____
    _____
    _____

    b. 1 year old

    _____
    _____
    _____
    _____
    _____

    c. 2 years old

_____
_____
_____
_____
_____

d. 3 years old

_____
_____
_____
_____
_____

20. Please describe any other issue-areas related to **placements** and the 0-3 population that should be considered.

Siblings

21. Does the child have a sibling?

No Yes

a. If yes, how many siblings are in the family?

b. What is the gender/age(s) of each sibling?

c. Were all siblings removed from the home?

No Yes

If *no*, please explain.

22. When the 0-3 child was removed, was he/she placed with one or more siblings? If not, why was the child not placed with at least one other sibling?

Kinship

23. Was the child placed with kin? If no, why not?

24. Was an FTM conducted prior to the child's removal? If so, what was the outcome of the FTM?

Closing

25. What is working well (or what worked well) in regards to the Agency's ability to meet the needs of the 0-3 population?

26. Is/was there any other important information about the child and/or the 0-3 population that should be reported? If yes, please note/explain.

27. Is/was there any other important information about the child not asked that should be reported? If yes, please note/explain.

SOCIAL WORKER PLACEMENT SURVEY

CFSA is conducting its 2007 Needs Assessment Survey to better serve the placement needs of children and families in the District of Columbia, and your response would be greatly appreciated. If you are a social worker, social work supervisor, or program manager in the Child Protection Services, In-Home & Reunifications I & II, Office of Youth Development, Adoptions, Office of Clinical Practice, Placement or Permanency & Family Resource Administrations then we want to hear directly from you.

1. What is your current type of position?

- Line staff (social workers)
- Line staff (social services assistant)
- Supervisory staff (supervisors, program managers, administrators)
- Support staff (all others)

2. What administration do you currently work in?

- Child Protective Services (CPS)
- In-Home & Reunification(I & II)
- Office of Youth Development (OYD)
- Permanency & Family Resources
- Placement Administration
- Office of Clinicial Practice (OCP)

3. How long have you worked for CFSA?

- Less than one year
- One year to less than two years
- Two years to less than three years
- Three years to less than five years
- Five years to less than ten years
- Ten years or more

4. What is your highest licensure status? Please select one.

- Licensed Social Worker (LSW)
- Licensed Graduate Social Work (LGSW)
- Licensed Independent Social Work (LISW)
- Licensed Independent Clinical Social Work (LICSW)
- N/A (please explain)

5. Gender:

- Female
- Male

On this page, please discuss some of your experiences with regard to the placement of foster children. We are seeking information on caseload placement challenges.

6. Highest level of education:

- BSW
- MSW
- DSW
- Bachelors degree in non-social work field
- Masters degree in non-social work field
- Ph.D.
- Medical Degree (MD, RN)
- JD
- Other

7. Age:

- Under age 25
- 26 to 35 years old
- 36 to 45 years old
- 46 to less than 55 years old
- Age 56 or older

8. What works well in the placement process at CFSA?

9. Based on your current experience:

	Never	Infrequently	Sometimes	Frequently	Always
How frequently is CFSA's INITIAL placement match for a child the best fit for what the child needs?					

10. Please explain in detail your response to question 9.

11. In your experience,how difficult is it to place the following groups of children who enter foster care? [1= Not Difficult, 2=Slightly Difficult, 3= Somewhat Difficult, 4=Difficult, 5= Very Difficult]

	1	2	3	4	5	N/A
Infants and toddlers (age 0-3)						
Children between the ages of 4-13						
Female youth (age 14-17)						
Female youth (age 18-21)						
Male youth (age 14-17)						
Male youth (age 18-21)						
LGBTQ youth (lesbian,gay, bi-sexual,transgender and questioning)						
Sibling groups of 2						
Sibling groups of 3 or more						

Sibling groups of different genders

Sibling groups of the same gender

Sibling groups of children with a large age difference (ie: 5 years or more)

Children with major medical disabilities (ie:)

Children with minor medical disabilities (ie:)

Children with severe emotional problems (ie:)

Children with severe behavioral problems (ie:)

Children with severe mental health problems(ie:)

Pregnant Teens

Teen parents with 1 child

Teen parents with more than 1 child

Youth that are substance abusers

Youth w/developmental delays

Other (please specify)

12. Please discuss your MOST DIFFICULT experience related to appropriate placement of a child on your caseload.

13. Please identify the resources/services that you feel are most needed to reduce the difficulty in placing children in each of the cateogories identified. (ie: support group for teen moms)

Infants and toddlers (age 0-3)
Children between the ages of 4-13
Female youth (age 14-17)
Female youth (age 18-21)
Male youth (age 14-17)
Male youth (age 18-21)
LGBTQ youth (lesbian,gay, bi-sexual, transgender and questioning)
Sibling groups of 2
Sibling groups of 3 or more
Sibling groups of different genders
Sibling groups of the same gender
Sibling groups of children with a large age difference (ie: 5 years or more)
Children with major medical disabilities (ie:)
Children with minor medical disabilities (ie:)
Children with severe emotional problems (ie:)

Children with severe behavioral problems (ie:)
Children with severe mental health problems (ie:)
Pregnant Teens
Teen parents with 1 child
Teen parents with more than 1 child
Youth that are substance abusers
Youth w/developmental delays

14. How do you determine the placement supports needed to maintain the placement of children on your caseload (eg: risk assessment tools)?
15. What training, supervision or information have you received that helps you determine needed placement supports for children on your caseload?
16. What challenges have you encountered when trying to access placement supports for the children on your caseload?
17. What more could be done to ensure a child's first placement is their last placement?

On this page, please tell us about the stressors or constraints that often lead to placement disruptions for children on your caseloads.
In some cases, placement disruptions occur due to the foster child. Using the listing below, please answer questions 18-21.
REASONS PLACEMENT DISRUPTIONS OCCUR:
*Child was withdrawn and hurtful to self
*Attachment disorder or abandonment
*Child's socially offensive behavior or lack of sensitivity
*Poor academic performance
*Child did not get along with caregiver's biological child in the home
*Child had problems in school (socially)
*Child did not handle parental visits well
*Child's severe aggressive behavior in the home
* Child had difficulties being separated from siblings
*Abscondence
* Juvenile delinquency
*Medical Reasons
*Sexual Abuse
*Poor self-image

18. Are there any additional reasons, related to the foster child, that a placement may disrupt? If so, please identify them and explain why.
19. Given the reasons listed, why do you think a placement may disrupt? (eg: needed resources)
20. What do you think the agency should do to prevent placement disruptions?
21. Among the placement settings listed below, indicate the most frequently supported reason (based upon the listed reasons provided and added by yourself) a placement disrupts.
TRADITIONAL FOSTER

KINSHIP
ADOPTIVE
GROUP HOME
INDEPENDENT LIVING
In some cases, placement disruptions occur due to the caretaker. Using the listing below, please answer questions 22-25.
REASONS PLACEMENT DISRUPTIONS OCCUR:
*Caretaker had poor relationship with birth family
*Caretaker had safety concerns regarding the child
*Insufficient respite was provided for the Caretaker
*Caretaker's physical disability impeded ability to care for child
*Caretaker had poor (either real or perceived) relationship with worker/agency
*Caretaker was not culturally competent
*Caretaker had limited or no contact with the worker
*Mutual expectations of caretaker and child were unrealistic
*Services needed for the child did not exist
*Difficulties presented by the child exceeded caretaker's capabilities
*Child's physical disability created issues for caretaker

22. Are there any additional reasons, related to the caretaker, that a placement may disrupt? If so, please identify them and explain why.
23. Given the reasons listed, why do you think a placement may disrupt. (eg: needed resources)
24. What do you think the agency should do to prevent placement disruptions?

On this page, please discuss your successes and challenges accessing placement support services for children in foster care.

25. Among the placement settings listed below, indicate the most frequently supported reason (based upon the listed reasons provided and added by yourself) a placement disrupts.
Traditional Foster Care
Kinship
Pre-Adoptive
Group Home
Independent Living
Facility

26. Based on your current experience, please rate your level of agreement with the following statement:
In order to help the caretaker maintain a safe and stable living environment for children in their care, the following services are critical:
Strongly
Disagree
Somewhat
Disagree
Neutral

Somewhat
Agree
Strongly Agree
Counseling for child
Outpatient mental health services for child
Inpatient mental health services for child
Drug treatment for child
Mentoring services for child
Tutoring for child
Educational assessment of child
Special education services
Bilingual service delivery/service providers
English as second language services
Domestic/family violence treatment for child
Support group for child
Anger Management Training
Alcohol treatment for child
Transportation services
Child remains under same worker while in care
Child/day care services (for working resource parents - kinship)
Child/day care services (for working resource parents - non-kinship)
Respite care
Foster parent training/education on easing the adjustment period of newly placed children
Foster parent support group
Educating and training foster parents on foster care issues
Foster parent training on child development

Intensive case management services for foster parents

Local directories of community resources and service providers

Foster parent training on conflict resolution

Ongoing communication with the worker

Family Team Meetings (initial)

Family Team Meeeting (disruption)

Mediation/Facilitated Interaction with the birth parent

Help with basic needs (food, clothing & furniture) - (kin)

Financial support (i.e. Housing and Utilities Assistance) (kin)

Family Counseling

Suicide prevention services

Runaway prevention and intervention services

27. Are there any additional critical services needed to help the caretaker maintain a safe and stable living environment? If so, what are they and please explain why.

28. From the list above, which three services have you found to be most effective with children and their caretakers? Please explain your answer.

1. 2. 3.

29. From the list above, which three services have you found to be most needed with children and their caretakers?

1. 2. 3.

30. From the list above, which three services have you found to be most ineffective with children and their caretakers?

1. 2. 3.

31. What services do you most often access for children and their caretakers when it appears a placement disruption is imminent?

32. What barrier(s) do you face when assisting children and their caretakers in receiving necessary services?

33. How could CFSA minimize or remove these barrier(s)?

34. If you have any concerns about the placement process, the availability of a particular type of placement, or assistance that was not given please let us know

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